

**2009-2010 Regular Session
State Legislative Report as of 06/16/2009**

Priority Board Bills

AB 98 (De La Torre) Mandated Benefit: Insurer Maternity Coverage

This bill would require individual or group health insurance policies that cover hospital, medical or surgical expenses to cover maternity services. For a summary and current status of this bill see page 4 of this report.

AB 542 (Feuer) Adverse Medical Events

This bill would require MRMIB to adopt new regulations and implement non-payment policies regarding adverse medical events, which was a topic addressed by AB 2146 (Feuer, 2007-08). For a summary and current status of this bill see page 5 of this report.

AB 786 (Jones) Individual Health Insurance Coverage

This bill is similar to SB 1522 (Steinberg, 2007-08). It would require DMHC and CDI, by September 1, 2010, to develop a system to categorize all individual health care service plan contracts and health insurance policies into ~~five~~ six coverage choice categories and would limit out-of-pocket costs for covered benefits. For a summary and current status of this bill see page 6 of this report.

***AB 1383** (Jones) Additional Funding for Children's Health

This bill would require the Department of Health Care Services (DHCS) to calculate and impose a "coverage dividend fee" on specified hospitals, to be used for making supplemental reimbursements for expanding health care coverage for children, among other things. For a summary and current status of this bill see page 7 of this report.

SB 227 (Alquist) MRMIP Expansion

This bill would, among other things, significantly alter the funding and benefit structure of the Major Risk Medical Insurance Program (MRMIP) and would expand MRMIB's role in the coverage of high-risk individuals. For a summary and current status of this bill see page 8 of this report.

SBX3 26 (Alquist) CHIPRA Implementation

This bill is meant to backup SB 311 (Alquist, 2009-10), which died in the regular session. For a summary and current status of this bill see page 1 of the special session report.

**2 Year Priority Board Bills
(Not Moving During This Session)**

AB 1201 (V. Manuel Perez) Reimbursement for Childhood and Adolescent Immunizations

This bill would require all health care plans and insurers, and specifically Healthy Family Program (HFP) plans, to reimburse physicians and physician groups for childhood and adolescent immunizations at a rate no less than the actual cost of acquiring the vaccine plus the cost of administering it. The author intends to reintroduce this bill next year.

SB 1 (Steinberg) Statewide Children's Health Care Coverage

This bill would, among other things, expand the income eligibility level for the Healthy Families Program (HFP) to 300% of the Federal Poverty Level (FPL), allow families with income greater than 300% of the FPL to purchase enrollment in the HFP, and would repeal immigration status as an eligibility criterion for Medi-Cal and the HFP. The author has not decided whether he will reintroduce this bill next year.

SB 311 (Alquist) CHIPRA Implementation

This bill would implement CHIPRA. In particular, it would require MRMIB to implement the dental-only coverage and would specify the subscriber eligibility criteria for that coverage.

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* New bill since the 05/20/2009 Board meeting.

Assembly Bills

AB 2 (De La Torre) Rescission of Health Insurance Coverage

Version: *Amended 06/02/2009*

Sponsor: California Medical Association

Status: *06/04/2009-Senate FIRST READING*

This bill is substantively the same as AB 1945 (De La Torre, 2007-08). The bill would require health plans and insurers to obtain prior approval from the Department of Managed Health Care (DMHC) Director and the California Department of Insurance (CDI) Commissioner, respectively, before rescinding any health coverage. *It would restate existing law that allows for the cancellation or non-renewal of individual health plan contract or policy enrollments or subscriptions for failure to pay the premium.* It would require the DMHC Director and CDI Commissioner, beginning January 1, 2011, to jointly establish an independent process for reviewing health plans' and insurers' requests to rescind an enrollee's coverage. It would prohibit a plan or insurer from rescinding an individual health contract or policy unless the health plan or insurer demonstrates that the enrollee "made a material misrepresentation or material omission" about his or her medical history in the application process, the misrepresentation or omission was intended in order obtain health care coverage, the plan or insurer completed medical underwriting before issuing the plan contract and sent a copy of the completed application to the applicant with a copy of the health care contract or policy. The bill would also permit each regulator to assess other administrative penalties and suspend or revoke a plan's license or insurer's business certificate if they rescind coverage without prior DMHC or CDI approval. It would also require DMHC and CDI to establish by regulation a pool of approved questions for use on individual coverage applications by health plans and insurers that elect to sell individual coverage, and would require the plans and insurers, no later than six months following passage of the regulation, to use only questions that are approved by the DMHC and CDI. The bill would require that on and after January 1, 2011 all individual health care applications be reviewed and approved by DMHC and CDI prior to being used by plans and insurers, and would add underwriting requirements of plans and insurers when reviewing applications.

AB 56 (Portantino) Mandated Benefit: Mammography Screening

Version: *Amended 06/01/2009*

Sponsor: Author

Status: *06/04/2009-Senate FIRST READING*

This bill would require individual and group health care insurance policies to cover mammography screening and diagnosis beginning July 1, 2010. Current law already requires this of health care plans. It would further require that health plans and disability insurers give written notice to their respective female enrollees and policyholders of their eligibility for breast cancer testing using nationally recommended testing guidelines for women. *The amendments of 06/01/2009 did not necessitate a revision of this summary.*

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* New bill since the 05/20/2009 Board meeting.

AB 98 (De La Torre) Mandated Benefit: Insurance Policy Maternity Coverage
Version: Amended 04/13/2009
Sponsor: Author
Status: **06/03/2009-Senate FIRST READING**

This bill would require all individual or group health insurance policies that cover hospital, medical or surgical expenses and are issued, amended, renewed, or delivered on or after January 1, 2010, to cover maternity services. The bill excludes specialized health insurance and other specified insurance coverage.

AB 108 (Hayashi) Rescission of Individual Health Insurance Coverage
Version: Amended 03/24/2009
Sponsor: Author
Status: **05/21/2009-Senate HEALTH and JUDICIAL. Set for hearing in Senate Health 06/17/2009**

This bill would prohibit a health care plan and insurer from rescinding an individual contract or policy for any reason or from canceling, limiting, or raising premiums on contracts or policies due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not, after 18 months following issuance of an individual contract or policy.

AB 235 (Hayashi) Mandated Benefit: Emergency Psychiatric Services
Version: Amended 04/14/2009
Sponsor: California Hospital Association
Status: **05/21/2009-Senate HEALTH. Set for hearing 06/17/2009**

This bill would add admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital to those emergency services that must be provided when necessary to relieve or eliminate a psychiatric emergency medical condition.

AB 244 (Beall) Mandated Benefit: Mental Health Services
Version: Amended 05/05/2009
Sponsor: Author
Status: **06/11/2009-Senate HEALTH**

This bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, to include the diagnosis and treatment of a mental illness for a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV (DSM IV). The bill would exclude Medi-Cal, accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care contracts and policies. It would also exclude CalPERS plans and insurers unless CalPERS purchases a plan, contract, or policy that provides mental health coverage.

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* New bill since the 05/20/2009 Board meeting.

AB 513 (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding
Version: Amended 05/05/2009
Sponsor: WIC Association
Status: **06/03/2009-Senate FIRST READING**

This bill would require health care insurance contracts and policies that cover maternity care to also cover specified consultation and equipment rental related to breast-feeding. The bill also clarifies that this requirement would not mean that health care plans and insurers would not be required to provide breast-feeding support benefits to women and children enrolled in Medi-Cal, Healthy Families, or Access to Infants and Mothers programs when the plans or insurers contract with any of those programs.

AB 542 (Feuer) Adverse Medical Events
Version: Amended 05/05/2009
Sponsor: Author
Status: **06/11/2009-Senate HEALTH**

This bill is similar to AB 2146 (Feuer, 2007-08). It would expand the definition of adverse events that are subject to statutory regulation. It would require the Department of Managed Health Care (DMHC), in collaboration with the State Department of Public Health (DPH), the State Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), the California Public Employees' Retirement System (CalPERS), and the Department of Insurance (CDI), to adopt by regulation by September 1, 2010 policies and practices governing the nonpayment to a health facility for substantiated adverse events by state public health programs. The bill would require these DMHC regulations to be consistent with those developed by the federal Centers for Medicare and Medicaid Services (CMS) and to be updated annually, beginning January 1, 2012, to reflect CMS policy changes. The bill would then require DPH, DHCS, MRMIB, CalPERS and CDI to adopt regulations that are identical or substantially similar to these DMHC regulations.

This bill would require DPH to collect information on the occurrence of substantiated adverse medical events and to report this information to state government payers, including DHCS and MRMIB. It would further require that these state payers maintain confidentiality of the information and that they share the cost of collecting and distributing it in proportion to their receipt of it. The bill would require DPH to determine whether adverse events reported are substantiated. The bill would specifically require MRMIB and DHCS to implement the non-payment policies and would prohibit health facilities from charging patients for care and services when payment is denied by MRMIB and its plans or by DHCS.

The bill would allow MRMIB to contract with a review organization to carry out these regulations for the Healthy Families Program and to the extent possible for the Access for Infants and Mothers program and the Major Risk Medical Insurance Program. The bill would allow the same for DHCS and its programs.

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* New bill since the 05/20/2009 Board meeting.

This bill would require medical and nursing directors of health facilities to report adverse events annually to their boards or similar oversight bodies and would require that contracts between health facilities and health care plans be consistent with the nonpayment policies developed by DMHC. The bill would prohibit health facilities from charging for substantiated adverse events and would require the facilities to disclose the event to the applicable payer. The bill would require implementation of its measures only to the extent that federal financial participation for state health programs is not jeopardized.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Health Insurance Policies

Version: Amended 04/29/2009

Sponsor: Insurance Commissioner

Status: **05/28/2009-Senate FIRST READING**

This bill would allow the State Insurance Commissioner to penalize health insurers who unlawfully rescind health insurance policies in an amount up to \$5,000 for each unlawful rescission. The bill would subject health insurers to a penalty of up to \$5,000 for each act of post-claims underwriting. If the insurer knew or had reason to know that the act of post-claims underwriting was unlawful it would further authorize the Commissioner to increase the penalty up to \$10,000 for each act or violation. The bill would require that the civil penalties and disciplinary actions provided for in the bill be determined at a hearing in accordance with the Administrative Procedure Act.

AB 786 (Jones) Individual Health Insurance Coverage

Version: **Amended 06/02/2009**

Sponsor: Health Access

Status: **06/04/2009-Senate FIRST READING**

(The text below in italics only has been added to the summary to clarify what was already in this bill.) This bill is similar to SB 1522 (Steinberg, 2007-08). This bill would require, by September 1, 2010, the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) to jointly develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into ~~five~~ six coverage choice categories *and would require DMHC and CDI to assign all health plan contracts and insurer policies to the appropriate category. The bill would require that the first four categories be applicable to both individual health care service plan contracts and individual health insurance policies. The bill would define those categories as follows:*

- 1. The first category would provide the most comprehensive benefits and the lowest cost sharing, would be comparable to coverage provided by large employers to their employees, and would be described as such.*
- 2. The second category would provide benefits and cost sharing that fall between the first and the third categories.*
- 3. The third category would be the midpoint of the individual market for contracts and policies that cover medical, surgical, and hospital expenses and that meet the coverage requirements of existing applicable law.*

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* New bill since the 05/20/2009 Board meeting.

4. *The fourth category would apply to both health care service plan contracts and health insurance policies and would have the highest cost sharing permitted by law for health care service plan contracts.*

The bill would require that the fifth ***and sixth*** categories must be applicable only to individual health insurance policies, must include coverage for medical, surgical, and hospital expenses, must meet the minimum benefit standards applicable to health insurance policies under the Insurance Code and must have ***either of the following***:

5. the highest cost sharing and the lowest benefit levels among all ~~five~~ ***six*** categories, or
6. ***benefit limits not otherwise permitted under this bill or current law, regardless of cost sharing or comprehensiveness of coverage.***

Effective January 1, 2011, the bill would prohibit the fifth ***sixth*** coverage category from having a maximum out-of-pocket expenditure that exceeds \$10,000 per year ***for covered services by in-network providers***, adjusted annually for inflation.

The bill would require individual health care contracts and policies offered or sold on or after January 1, 2011, to contain a maximum dollar limit on out-of-pocket costs for covered benefits ***increased annually according to the medical consumer price index*** and would require at a minimum that they cover hospital, medical, and surgical expenses. The bill would authorize health care plans and insurers to offer products in any coverage choice category, subject to restrictions. The bill would also require health care plans and insurers to establish prices for individual contracts and policies that reflect a reasonable continuum between the coverage choice categories having the lowest level of benefits and the categories having the highest level of benefits. ***The bill would exempt from these measures individual health insurance contract and policy renewals issued prior to April 1, 2011.***

***AB 1383** (Jones) Additional Funding for Children's Health

Version: Amended 06/11/2009

Sponsor: The Daughters of Charity Health System , California Hospital Association, California Children's Hospital Association

Status: 06/11/2009-Senate HEALTH

This bill would require the Department of Health Care Services (DHCS) to pay supplemental amounts to specified hospitals and to Medi-Cal managed health care plans for Medi-Cal hospital services and would require Medi-Cal rates to equal the federal upper payment limit. This bill would require DHCS to calculate and impose on specified hospitals, contingent on approval by the federal Centers for Medicare and Medicaid Services, a "coverage dividend fee." The bill would require the coverage dividend fees then be used for making the supplemental reimbursements to hospitals, expanding health care coverage for children and making the supplemental payments to managed health care plans, in that priority order. The bill is contingent on enactment of other legislation that would specify more precisely the method for calculating the coverage dividend fee.

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* New bill since the 05/20/2009 Board meeting.

***AB 1445**

Version: Amended 06/01/2009

Sponsor: California Primary Care Association

Status: 06/03/2009-Senate FIRST READING

The bill would require that federally qualified health centers (FQHC) or rural health clinics (RHC) that include the cost of encounters with more than one health professional on the same day at a single location as constituting a single visit when establishing its FQHC or RHC rate must apply for an adjustment to their per-visit rate. It would also require the FQHC or RHC to bill a medical visit and another health visit that take place on the same day at a single location as separate visits.

AB 1503 (Lieu) Provider Reimbursement for Unpaid Emergency Health Care Services

Version: Introduced 02/27/2009

Sponsor: Health Access, Western Center on Law and Poverty

Status: 06/11/2009-Senate HEALTH

This bill would adapt fair pricing provisions established for hospitals by AB 774 (Chan, 2006) to emergency physicians. The bill would also modify current criteria for providers requesting reimbursement from the state Maddy Emergency Medical Services Fund (Maddy Fund), which was established to partially reimburse providers for uncompensated emergency care. For patients with high medical costs (as defined by the bill) and incomes at or below 350% of the federal poverty limit, the bill would also require providers to provide a discount in fees to the patient. This discount would limit payment to the provider to the greater of the rate paid by Medi-Cal, Healthy Families Program (HFP) or other state health program in which the provider participates. With exceptions, the bill would prohibit garnishing the wages of patients receiving the providers discount or selling their primary residence. It would further require providers to notify patients who do not have third-party coverage that the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program or discounted payment care.

ACA 22 (Torlakson) New Cigarette Tax

Version: Introduced: 4/16/2009

Sponsor: Author

Status: 04/23/2009-Assembly Committees on GOVERNMENTAL ORGANIZATION and REVENUE AND TAXATION

This bill, in addition to current taxes imposed by the Cigarette and Tobacco Products Tax Law, would tax cigarette distributors \$0.074 for each cigarette distributed and for the wholesale cost of tobacco products, would tax dealers and wholesalers \$0.074 for each cigarette or tobacco product they stock and would impose additional taxes on cigarette and tobacco product stamps.

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* New bill since the 05/20/2009 Board meeting.

Senate Bills

SB 158 (Wiggins) Mandated Benefit: Human Papillomavirus Vaccination

Version: *Amended 06/01/2009*

Sponsor: American College of Obstetricians and Gynecologists

Status: *06/09/2009-Assembly APPROPRIATIONS*

This bill is similar to bills AB 16 (Evans, 2007-08) and AB 1429 (Evans, 2007-08). It would require that individual and group health care plan contracts and health care insurance policies that are amended or renewed on or after January 1, 2010, and that include coverage for treatment or surgery of cervical cancer, must also provide coverage for the human papillomavirus vaccination. *The amendments of 06/01/2009 did not necessitate a revision of this summary.*

SB 161 (Wright) Mandated Benefit: Parity Coverage for Orally-Administered Cancer Medications

Version: *Amended 05/21/2009*

Sponsor: Kerry's Touch African-America Breast Cancer Association

Status: *06/08/2009-Assembly HEALTH*

This bill would require that health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, and that cover cancer chemotherapy treatment, must also provide coverage for cancer medications administered orally, and specifies that such coverage must be on an equal basis with coverage provided for cancer medications administered intravenously or injected. For this purpose, the bill would require health plans and insurers to compare the percentage cost share for oral cancer medications and intravenous or injected cancer medications and apply the lower of the two as the cost-sharing provision for oral cancer medications. The bill would also prohibit health plans and insurers from increasing enrollee cost sharing for cancer medications. *The amendment of 05/21/2009 would exclude CalPERS from these requirements.*

SB 227 (Alquist) MRMIP Changes

Version: *Amended 05/28/2009*

Sponsor: Author

Status: *06/15/2009-Assembly HEALTH*

This bill is similar to AB 2 (Dymally, 2007-08) and AB 1971 (Chan, 2005-06). It would require health care plans and insurers to accept individuals eligible for the Major Risk Medical Insurance Program (MRMIP) regardless of health status or previous health care claims experience. It would require plans to provide guaranteed-renewable coverage to persons assigned by MRMIB with the same level of benefits as the MRMIP, as determined by MRMIB, and to charge those persons premium rates determined by MRMIB. It would permit plans to avoid covering these individuals by instead paying a fee determined by MRMIB. The fees would be paid to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) and transmitted to MRMIB within 30 days of receipt. The bill would allow MRMIB to obtain loans from the General Fund for all necessary and reasonable expenses, to be repaid with interest no later than

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* New bill since the 05/20/2009 Board meeting.

January 1, 2017. The bill would require MRMIB to establish a process for individuals in the Guaranteed Issue Pilot program to voluntarily re-enroll into the MRMIP. This re-enrollment would be conditioned on the absence of a MRMIP waitlist. The bill would allow plans and insurers without preexisting condition provisions in their contracts to impose a waiting or affiliation period, not to exceed 90 days, before the coverage issued becomes effective.

The bill would require MRMIB to establish the scope of coverage for the program and minimum standards for plan participation. It would require that benefits in the program provide comprehensive coverage, including, effective January 1, 2011, lower subscriber cost sharing for primary and preventive health care services and the medications necessary and appropriate for the treatment and management of chronic health conditions. It would require benefits, subscriber cost sharing, and out-of-pocket costs to be appropriate for a program serving high-risk and medically uninsurable persons. It would require MRMIB, to the greatest extent possible, to establish benefits that are compatible with comprehensive coverage products available in the individual health insurance market, but not less than the minimum benefits required under the Knox-Keene Act. It would permit MRMIB to offer more than one benefit design option with different subscriber cost sharing in the form of copayments, deductibles, and annual out-of-pocket costs. The bill would require coverage in the program to have no annual benefit limit and no lifetime limit of less than \$1,000,000. It would change current law to permit rather than require MRMIB to prescribe a period of ineligibility before applying for the program if the individual was previously terminated for nonpayment of premium. It would also permit this, with MRMIB discretion, if the individual voluntarily disenrolled from a participating health plan.

The bill would require MRMIB to establish subscriber contributions at no more than 150% of the standard average individual rate for comparable coverage. For subscribers at or below 300% of the federal poverty level the bill would require a sliding scale with lower contribution requirements, but in no case would subscriber contribution be permitted lower than 110% of the standard average individual rate for comparable individual coverage, unless federal funds are received. Upon receipt of federal funds and contingent upon the amount and their allowable use, it would require MRMIB to offer enrollment to individuals who are on the waiting list, if any. When there is not a waiting list, it would require the Board to lower subscriber contributions for subscribers at or below 300% of the federal poverty level to no less than 6% of income, and would also permit lower subscriber contributions for subscribers over 300% but less than 400% of the federal poverty level to no less than 6% of income with any remaining federal funds. The bill would require any remaining federal funds to be used to recalculate the fee charged to plans and insurers that elect to not provide guaranteed-renewable coverage to persons assigned by MRMIB. The bill would further permit the board to exclude from the subscriber contribution that portion of the standard average individual rate that is attributable to the elimination of the annual benefit maximum and to the increase in the lifetime benefit maximum. Commencing February 1, 2010 and annually thereafter, the bill would require health plans and insurers to notify MRMIB whether they will cover individuals assigned to them or alternatively pay a fee as determined by MRMIB. It would further require plans and insurers to report to MRMIB the total number of covered lives by May 1 of each year. MRMIB would be required to determine the amount of the fee, which would be limited to no more than \$1 per member per month. Commencing January 1, 2010 and at least annually thereafter, the bill would require the Guaranteed Issue Program (GIP)

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* New bill since the 05/20/2009 Board meeting.

plans and insurers to report the number of covered lives remaining in continuation coverage and other information MRMIB requires to implement GIP.

The bill would require MRMIB to appoint an 11-member panel that would be ready to advise MRMIB on this program by February 1, 2010. It would require the advisory panel to make recommendations to:

1. Improve the quality of health care provided to subscribers in the program.
2. Advise MRMIB on policies and program operations.
3. Make recommendations to ensure the affordability of coverage for subscribers, especially low-income subscribers.
4. Make recommendations to ensure the cost-effectiveness of health care provided to subscribers in the program.
5. Meet at least quarterly, unless deemed unnecessary by the chair.

It would require MRMIB to respond to the panel in writing when MRMIB rejects any of the panel's written recommendations. By September 1, 2010 it would require MRMIB to make recommendations to the Legislature based on the panel's recommendations regarding the status of benefits and premiums provided to federally eligible defined individuals. It would further require MRMIB to obtain an actuarial analysis and comparison between benefits and premiums in the program and those in the individual market for federally eligible defined individuals, to recommend needed policy changes and to discuss the impact of any changes in the program on premium rates and coverage for federally eligible defined individuals.

It would require MRMIB, on or before July 1, 2012, to report to the Legislature on the implementation of the bill, including an implementation and transition plan for an alternative approach to ensuring quality coverage for high risk, potentially high cost individuals, other than a segregated high risk pool, that may include a reinsurance mechanism or a risk adjustment mechanism, or both. The transition plan would be required to outline the steps MRMIB would need to take in order to replace the program with an alternative mechanism by January 1, 2014.

~~The bill would augment current appropriations from the Cigarette and Tobacco Products Surtax Fund (Proposition 99) by approximately \$6 million. The bill would require MRMIB to use accumulated fees that exceed operation costs for this program to reduce fees in the following year. The bill would provide authority for emergency regulations to implement this measure.~~

SB 499 (Ducheny) MRMIB Reporting of the Use of DMHC Fines Transferred to MRMIP

Version: Introduced 02/26/2009

Sponsor: Author

Status: **06/11/2009-Assembly APPROPRIATIONS**

This bill would require MRMIB to report to the Legislature no later than March 1, 2010, and annually thereafter, on the amount and use of fines and administrative penalty funds transferred to the Major Risk Medical Insurance Fund as a result of SB 1379 (Ducheny; Chapter 607, Statutes of 2008) and the effect of those funds on the waiting list for the Major Risk Medical Insurance Program.

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* New bill since the 05/20/2009 Board meeting.

SB 543 (Leno) Minors: Consent to Mental Health Treatment

Version: Amended 06/01/2009

Sponsor: National Association of Social Workers

Status: 06/03/2009-Assembly FIRST READING

~~This bill would amend existing law that allows a minor 12 years of age or older to consent to outpatient or residential mental health treatment only if both of the following are true in the opinion of the attending professional person: 1) the minor is mature enough to participate intelligently in the services, and 2) the minor would either present a danger of serious harm to self or others without that treatment, or is the alleged victim of incest or child abuse. The bill would instead require that either conditions 1) or 2) above must be true rather than both. It would also require that if the minor is the alleged victim of incest or child abuse, the minor must also be, in the professional person's opinion, mature enough to participate intelligently in the outpatient or residential mental health services. The bill states that, though current law requires a professional person to make his or her best efforts to notify the parent or guardian of the provision of residential services, notification of a minor's parent or guardian is not required for the minor to receive outpatient mental health treatment or counseling services. The bill would require a professional person to first consult with a minor before determining that it would be inappropriate to involve the minor's parents in the mental health treatment or counseling of the minor. The bill would also expand the definition of a "professional person" for these purposes to include a licensed clinical social worker and a chief administrator of a specified agency who is a "professional person," as defined.~~

SB 600 (Padilla) New Cigarette Tax

Version: Amended 06/09/2009

Sponsor: American Cancer Society

Status: 03/19/2009-Senate HEALTH. Set for hearing 06/17/2009

This bill would create the Tobacco Tax and Health Protection Fund. It would, in addition to existing cigarette taxes, impose an additional tax upon every dealer and wholesaler of cigarettes at the rate of \$0.075 for each cigarette distributed on or after the first calendar quarter commencing more than 90 days after the bill's enactment. It would further require cigarette distributors to pay a cigarette indicia adjustment tax for each California cigarette tax stamp at the rate of \$1.875, \$1.50 or \$0.75 per stamp depending on the type of stamp and would deposit these new taxes into the fund.

The bill would require that funds then be transferred from the Tobacco Tax and Health Protection Fund to the California Children and Families First Trust Fund, the Hospital Services Account, the Physician Services Account, the Public Resources Account, the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund, and the Breast Cancer Fund, as needed to offset the revenue decrease directly resulting from imposition of the bill's new taxes. The bill would allow these funds only to supplement existing levels of service, not to fund existing levels of service.

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* New bill since the 05/20/2009 Board meeting.

SB 630 (Steinberg) Mandated Benefit: Orthodontic Reconstructive Surgery for Cleft Palate
Version: Amended 05/20/2009 and 06/01/2009
Sponsor: Author
Status: 06/15/2009-Assembly HEALTH

This bill is similar to SB 1634 (Steinberg, 2007-08), which was vetoed. This bill would prohibit health care plan contracts and insurance policies from excluding coverage for dental or orthodontic services that are medically necessary to provide or to complete reconstructive surgery for cleft palate procedures coverage for dental or orthodontic services medically necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to create a normal appearance. The bill would exclude Medi-Cal managed care plans that contract with the Department of Health Care Services that do not provide coverage for California Children's Services (CCS) or dental services.

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* New bill since the 05/20/2009 Board meeting.

**Bills MRMIB Will No Longer Report To The Board
After The 06/17/2009 Board Meeting**

(Note: staff will watch for these bills to be reintroduced during the next session)

AB 29 (Price) Dependent Children Age Limit for Health Insurance Coverage

Version: Amended 03/24/2009

Sponsor: Author

Status: **06/02/2009-FAILED deadline in Assembly APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill, effective January 1, 2010, would have prohibited those plans and insurers that terminate coverage for dependent children when they reach a specified age from setting that limit at less than 27 years of age. It would have exempted collective bargaining contracts effective prior to January 1, 2010. The bill would have further stipulated that employers would not be required to pay the cost of coverage for dependents between 23 and 27 years of age.

AB 89 (Torlakson) Cigarette Tax for Children's Health Care

Version: Introduced 01/05/2009

Sponsor: Author

Status: **06/08/2009-FAILED Deadline in Assembly REVENUE & TAXATION**

This bill failed to pass from house of origin by June 5. This bill would have, shortly following its passage, imposed a new tax of 10.5 cents on each cigarette and a new tax ranging from \$1.05 to \$2.625 for each pack of cigarettes in addition to current tobacco taxes. The bill would have created the Tobacco Excise Tax Account and deposit the tax into the Account, which would have been used for general and children's health care, education, tobacco cessation services, and lung cancer research. This bill would have taken effect immediately.

AB 163 (Emmerson) Mandated Benefit: Amino Acid-Based Elemental Formulas

Version: Amended 04/13/2009

Sponsor: American Partnership for Eosinophilic Disorders

Status: **06/02/2009-FAILED Deadline in Assembly Appropriations**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill would have required health care insurance policies and non-specialized plan contracts amended or renewed on or after January 1, 2010, and that provide coverage for hospital, medical, or surgical expenses, to have provided coverage for the use of amino acid-based elemental formulas, regardless of the delivery method, for the diagnosis and treatment of eosinophilic gastrointestinal disorders when the prescribing physician issued a written order stating that the amino acid-based elemental formula is medically necessary. Eosinophilic disorders are characterized by having elevated levels of a certain type of white blood cell in the digestive system.

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* New bill since the 05/20/2009 Board meeting.

AB 214 (Chesbro) Mandated Benefit: Durable Medical Equipment
Version: Amended 04/23/2009
Sponsored: Debra and Doctor Coalition
Status: **06/02/2009-FAILED Deadline in Assembly APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill would have required health plan contracts and health insurance policies issued, amended, received, or delivered on or after January 1, 2010 to cover Durable Medical Equipment (DME) and services. DME is equipment designed for repeated use and that is used for treating a patient and/or for preserving the patient's functioning.

AB 259 (Skinner) Mandated Benefit: OB/GYN Services From a Certified Nurse-Midwife
Version: Introduced 02/11/2009
Sponsored: Author
Status: **06/08/2009-FAILED Deadline in Assembly HEALTH**

This bill failed to pass from house of origin by June 5. This bill would have required health care plans and insurers to allow their enrollees to obtain obstetrical and gynecological (OB/GYN) services directly from a certified nurse-midwife without prior approval from another physician, another provider, or the health care service plan. The bill would have also amended current law that limits this requirement to OB/GYN physician services by expanding it to include all OB/GYN services.

AB 689 (Calderon, Charles) Cigarette and Tobacco Products Tax Law: Tobacco Products
Version: Amended 04/23/2009
Sponsor: California Distributors
Status: **06/08/2009-FAILED Deadline in Assembly INACTIVE file**

This bill failed to pass from house of origin by June 5. This bill would have revised the definition of tobacco products relative to the Tobacco Tax and Health Protection Act of 1988 (Proposition 99). Where current law differentiates "cigarettes" from "tobacco products," the bill would have redefined tobacco products as any articles or products that are made of or contain any level of tobacco. Current law limits such articles or products to only those that contain at least 50 percent tobacco. A change to the Tobacco Tax and Health Protection Act of 1988 requires a four-fifths vote of both Legislative houses and is then allowed only if the change is consistent with the act.

AB 783 (Anderson) Abolition of State Agencies, Commissions, and Boards
Introduced: 02/26/2009
Sponsor: Author
Status: **06/08/2009-FAILED Deadline in Assembly BUSINESS & PROFESSIONS**

This bill failed to pass from house of origin by June 5. This bill would have abolished, on January 1, 2022, all statutorily created state agencies, boards, and state commissions that are funded by General Fund revenues, except for the Franchise Tax Board.

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* New bill since the 05/20/2009 Board meeting.

AB 812 (De La Torre) Medical Loss Ratio Reporting
Version: Amended 05/05/2009
Sponsor: Author
Status: **06/02/2009-FAILED Deadline in Assembly APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill would have required health care plans and insurers to annually report the medical loss ratio of each health plan product or health insurer policy to the Department of Managed Health Care beginning January 1, 2010.

AB 1126 (Hernandez) Balance Billing CalPERS Members
Version: Introduced 02/27/2009
Sponsor: CalPERS
Status: **06/08/2009-FAILED Deadline in Assembly PUBLIC EMPLOYEES, RETIREMENT AND SOCIAL SECURITY**

This bill failed to pass from house of origin by June 5. This bill would have prohibited health care providers from balance billing CalPERS members for covered emergency services and care. The bill would have allowed providers to bill only the member's health benefit plan for emergency services and care.

AB 1201 (V. Manuel Perez) Reimbursement for Childhood and Adolescent Immunizations
Version: Amended 04/28/2009
Sponsor: California Medical Association
Status: **06/02/2009-FAILED Deadline in Assembly APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill would have required all health care plans and insurers, and specifically Healthy Family Program (HFP) plans, to reimburse physicians and physician groups for childhood and adolescent immunizations at a rate no less than the actual cost of acquiring the vaccine plus the cost of administering it. The bill would have included but not limited the vaccine acquisition cost to the invoiced purchase price plus reasonable costs associated with shipping, handling, insurance, and storage. Beginning January 1, 2010, the bill would have required new immunizations not currently included in a contract or policy to be reimbursed at this rate. Also beginning January 1, 2010, the bill would have prohibited health care plans and insurers that provide coverage for childhood and adolescent immunizations from imposing any cost-sharing mechanism for administering childhood or adolescent immunizations or for related procedures. It would have further prohibited plan contracts and insurance policies from containing a reimbursement limit for childhood and adolescent immunizations.

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* New bill since the 05/20/2009 Board meeting.

AB 1314 (Jones) California Health Care Reform Plan

Version: Amended 04/13/2009

Sponsor: Author

Status: 06/02/2009-FAILED Deadline in Assembly APPROPRIATIONS

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill would have required the California Health and Human Services Agency (CHHS), in consultation with consumers, health care providers, and health care stakeholders, to develop a plan to enact comprehensive reforms to the California health care system and make implementation recommendations to the Legislature no later than April 1, 2010. It would have required the plan to include strategies to accomplish all of the following: 1) expand health care coverage for low- and moderate-income children and adults using an approach that includes contributions from individuals, employers, and the government; 2) reduce the number of uninsured persons in the state; 3) maximize the acquisition of federal health care funds; 4) increase provider payments to ensure adequate access to primary and specialty health care for persons in state and local sponsored health care programs; 5) give quality and performance rewards to health care providers; 6) fund reimbursement mechanisms to support a health care safety net and delivery system; 7) improve fee-for-service health care delivery systems in state and local health care programs to better coordinate and manage health care services, emphasize timely primary and preventive care, and reduce the use and overuse of high-cost emergency and hospital inpatient services; and 8) improve coordination and efficiency of state and local health care programs and mental health care programs.

ACA 1 (Silva) Legislative Vote Requirement For Expenditures

Version: Introduced 12/01/2008

Sponsor: Author

Status: 04/20/2009-Assembly APPROPRIATIONS-***Suspense file***

Given this bill's inactivity, we are removing it from this report but will report it again if it is amended or moved in the future. This bill would require the Department of Finance to analyze all bills introduced or amended and to report to specified legislative entities whether the bill would result in more than \$150,000 in annual expenditures. ACA 1 would require that such bills may pass from the Legislature only upon a 2/3 approval vote of each house.

ACA 4 (Bass) Vote Requirements For Budget Bills

Version: Introduced 12/03/2008

Sponsor: Author

Status: 04/20/2009-Assembly APPROPRIATIONS

Given this bill's inactivity, we are removing it from this report but will report it again if it is amended or moved in the future. This bill would exempt budget bills and budget implementation bills (trailer bills) from being subject to the referendum process. It would also require these bills to go into effect immediately upon being signed by the governor. It would define budget and trailer bills in such a way as to limit them to budget issues. It would further exempt budget and trailer bills passed on or before June 15 from the requirement that they

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* New bill since the 05/20/2009 Board meeting.

receive a 2/3 approval vote in the Legislature, thereby allowing them to be passed with a majority vote only.

SB 1 (Steinberg) Statewide Children's Health Care Coverage

Version: Amended 2/12/2009

Sponsor: 100% Campaign

Status: **05/01/2009-FAILED deadline in Senate HEALTH**

This fiscal bill failed the May 1 deadline to pass from policy committee to fiscal committee.

This bill was similar to AB 1 (Laird, 2007-08) and SB 32 (Steinberg, 2007-08). By January 1, 2010 and insofar as state funds were appropriated for its purposes, this bill would have expanded the income eligibility level for the Healthy Families Program (HFP) to 300% of the Federal Poverty Level (FPL) and would have repealed immigration status as an eligibility criterion for Medi-Cal and the HFP. The bill also stated its intent that the Managed Risk Medical Insurance Board (MRMIB) would have been allowed to implement the expansion only to the extent that funds were appropriated for that purpose. The premium rate for the 250% to 300% FPL population would have been 150% of the premium rate enrollees pay in the 200%-250% FPL category.

The bill would have also, by July 1, 2011, established the Healthy Families Buy-In Program and would have allowed children uninsured for the previous six months and in families with income greater than 300% of the FPL to purchase enrollment in the HFP and obtain coverage identical to the HFP coverage. The bill would have deemed Buy-In enrollees eligible for the California Children's Services (CCS) Program and would have required that these enrollees pay MRMIB the full cost of the HFP health, vision and dental coverage plus the per capita actuarial value of the CCS services. The bill would have further required the state to reimburse counties for the cost of meeting administrative standards for that portion of the county caseload that provides services to Buy-In children.

By July 1, 2011, the bill would have allowed families to self-certify their income when initially applying for HFP, and it would have required MRMIB and stakeholders to simplify the annual renewal forms, such as providing the forms pre-populated with the enrollee's eligibility information and a check-list identifying whether eligibility information items are correct. It would have also required MRMIB and stakeholders to establish a process of renewal by phone.

The bill would have expanded Medi-Cal eligibility for children ages 6 through 18 from 100% of FPL to 133% of FPL by January 1, 2010. Upon implementation of this expansion, the bill would have required MRMIB and the Department of Health Care Services (DHCS) to develop a process to transition eligible children from local Children's Health Initiative (CHI) programs to Medi-Cal and the HFP. The bill also, to the extent federal financial participation were available, would have establish the Medi-Cal Presumptive Eligibility Program by July 1, 2011 for new Medi-Cal/HFP applicants.

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* New bill since the 05/20/2009 Board meeting.

SB 56 (Alquist) Universal Access to Health Care Coverage

Version: Amended 05/05/2009

Sponsor: Author

Status: **06/02/2009-FAILED Deadline in Senate APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill stated the intent of the Legislature to, by 2012, enact health care reform that would ensure all Californians have access to affordable, quality health care coverage. It also stated legislative intent to equitably distribute the responsibility for providing and paying for health care coverage between individuals, employers and government, and to further reduce the reliance on medical status or conditions as criteria for medical underwriting of individual coverage. The bill also stated the intent of the Legislature, by 2010, to provide a foundation for future reforms, such as ensuring coverage for all children, allowing workers to set aside pre-tax health care dollars, beginning to draw down federal funds for covering low-income adults and families, and reducing the use of medical underwriting.

The bill would have created the California Health Benefits Service Program (CHBSP) within the Department of Health Care Services (DHCS). It would have allowed plans contracting with specified county entities to form joint ventures to “create integrated networks of public health plans that pool risk and share networks.” The bill would have required these joint ventures to seek to contract with designated public hospitals, county health clinics, community health centers, and other traditional safety net providers. It would have required the CHBSP to identify legal or financial barriers or incentives to forming these joint ventures and to report these findings to the Legislature by November 1, 2010.

SB 270 (Alquist) Health Information Technology Advisory Panel

Version: Amended 05/05/2009

Sponsor: Author

Status: **06/02/2009-FAILED Deadline in Senate APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. The bill would have created a health information technology advisory panel to advise the Governor and the Legislature on health information technology implementation in California. The panel would have been required, among other things, to make recommendations to maximize the state’s eligibility and award of federal stimulus funds related to the use of health information technology, advise the Governor and the Legislature on a mechanism for designating a non-state entity that would implement requirements related to accessing federal stimulus funds, make recommendations to ensure that safety net providers have access to federal stimulus funds for which they are eligible, and make recommendations for sources necessary to match federal dollars in the award of funds made available through ARRA.

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* New bill since the 05/20/2009 Board meeting.

SB 311 (Alquist) CHIPRA Implementation

Version: **Amended 05/20/2009**

Sponsor: Author

Status: **06/02/2009-FAILED Deadline in Senate APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill was identical to SBX3 26 (Alquist, 2009-10). This bill stated the intent of the Legislature to implement key elements of the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), including receiving federal matching funds for enrolling eligible immigrant children, implementing changes to citizen documentation requirements, ensuring parity in state mental health and substance abuse coverage, establishing new payment methods for clinics participating in the Healthy Families Program, measuring quality of care within child health programs, and taking advantage of the increased federal funding that may be available to California, including funding for performance bonuses and outreach.

Contingent upon federal financial participation and only to the extent that the Legislature appropriates funds for the following purpose, this bill would have required the Managed Risk Medical Insurance Board (MRMIB) to **apply the prospective payments system to services provided under the Managed Risk Medical Insurance Board (MRMIB) by federally qualified health centers and rural health clinics as required by CHIPRA.**

~~provide dental only coverage to children eligible for the Healthy Families Program who are enrolled in a group health plan or employer-sponsored coverage that does not provide dental benefits or cost sharing as authorized by CHIPRA.~~

The bill would have deemed regulations necessary to implement this coverage as emergency regulations and would have exempted such regulations from requirements to substantiate the emergency in writing.

SB 316 (Alquist) Minimum Loss Ratio

Version: **Amended 05/28/2009**

Sponsor: Author

Status: **06/08/2009-FAILED Deadline in Senate INACTIVE File**

This bill failed to pass from house of origin by June 5. This bill would have required full service health care service plans and health insurers to expend on benefits no less than 85% of the aggregate dues, fees, premiums, and other periodic payments they receive with respect to contracts or policies issued, amended, or renewed on or after January 1, 2011 2013. The bill would have authorized these plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, except as specified. The bill would have required these plans and insurers to annually, commencing January 1, 2011 2013, provide written affirmation of compliance with the bill's requirements to the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI), and would have also required these plans and insurers to annually, commencing January 1, 2011 2013, report to the

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* New bill since the 05/20/2009 Board meeting.

DMHC or CDI the medical loss ratio of each individual and small group plan product and policy form issued, amended, or renewed in California. It would have also required plans and insurers to report the ratio when presenting a plan for examination or sale to any individual or group consisting of 50 or fewer individuals. **The bill would have prohibited DMHC from assessing compliance with these reporting requirements within the 12-month period after the date a plan has complied unless the plan certifies that it failed to meet its medical loss ratio, or DMHC believes the plan's certification of its medical loss ratio is incorrect.**

SB 438 (Yee) Medi-Cal Eligibility Determination

Version: Amended 05/06/2009

Sponsor: California Nurses Association

Status: **06/02/2009-FAILED Deadline in Senate APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This version of SB 438 was similar to the final version of SB 1459 (Yee, 2007-08), which also failed. This bill would have required the Department of Health Care Services (DHCS), subject to approval of any necessary state plan amendments and only if and to the extent federal financial participation is available, to implement a program for accelerated enrollment of pregnant women in the Medi-Cal program. The previous version of the bill would have transferred eligibility determination for the Healthy Families Program (HFP) from the current administrative vendor to county welfare offices. The bill in its last version, rather than transferring this responsibility, would have instead required county welfare offices to forward Medi-Cal share-of-cost applications to the Managed Risk Medical Insurance Board (MRMIB) for determination of eligibility for HFP. The bill would have required DHCS to begin implementing these requirements on the first day of the second month following the month in which federal approval of the necessary state plan amendments is received, or on July 1, 2010, whichever was later.

This bill would have also required counties, upon receiving Medi-Cal applications for children and pregnant women, to determine, preliminarily, whether the applicant "appears" eligible for Medi-Cal benefits and, if so, to grant accelerated enrollment. Upon granting accelerated enrollment, it would have required the county to make a final determination whether the child or pregnant woman is eligible for Medi-Cal. If the county then determined the applicant was actually ineligible, the bill would have required the county to discontinue accelerated enrollment. If the county determined the child was eligible for the Medi-Cal program with a share of cost, the bill would have required the county to enroll the child in Medi-Cal and then forward the application to MRMIB to evaluate the child for eligibility in HFP.

SB 727 (Cox) Mandated Continuation Coverage, Cal-COBRA

Version: Amended 04/30/2009

Sponsor: Author

Status: **06/08/2009-FAILED Deadline in Senate APPROPRIATIONS—Suspense File**

This bill failed to pass from house of origin by June 5. This bill would have required health care plans and insurers to offer continuation coverage to subscribers and enrollees covered by an employer group benefit plan that the employer terminates without providing a successor group

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* New bill since the 05/20/2009 Board meeting.

benefit plan to its employees. The bill would have required that the employees be active at the time the plan is terminated. The bill would have required the continuation coverage be under the same terms and conditions as the terminated coverage and that it extend for not less than 18 months from the date the employer terminates the group benefit plan. The bill would have required the continuation coverage to cease if the covered employee is terminated for cause.

SB 810 (Leno) Universal Health Care

Version: Amended 04/23/2009

Sponsor: One Care Now, Health Care For All

Status: **06/02/2009-FAILED Deadline in Senate APPROPRIATIONS**

This fiscal bill failed to report to the floor from fiscal committee by May 29. This bill stated the intent of the Legislature to establish a single system of universal health care coverage and a single public payer for all health care services in California. To that end, this bill would have created the California Healthcare Agency, an independent agency under the control of a Healthcare Commissioner appointed by the Governor on or before March 1, 2010 and confirmed by the Senate. The bill would have required the system to become operational no later than two years from the date the Secretary of the California Health and Human Services agency determines that the Healthcare Fund, created for this bill's purposes, would have sufficient revenues to fund the costs of implementing the bill. The California Healthcare Agency would have supervised the California Healthcare System Plan. The bill would have prohibited any health care service plan contract or health insurance policy, except for the California Healthcare System Plan, from being sold in California for services provided by the system. It would have required the Managed Risk Medical Insurance Board (MRMIB) to serve, with other departments and agencies, on an advisory panel that would make recommendations to the Commissioner on how to establish the system throughout local regions. All people physically present in California with the intent to reside in the state would have been eligible for the California Healthcare System Plan.

SCA 1 (Walters) Vote Requirements For Budget Bills

Version: Introduced 12/01/2008

Sponsor: Author

Status: 01/29/2009-Senate RULES Committee; and the ELECTION, REAPPORTIONMENT AND CONSTITUTIONAL AMENDMENTS Committee

Given this bill's inactivity, we are removing it from this report but will report it again if it is amended or moved in the future. This bill would exempt budget bills from the referendum process. It would also exempt from the 2/3 legislative vote requirement any General Fund appropriation in a fiscal year that, when combined with all General Fund appropriations passed for that same fiscal year, total less than 5% of the General Fund appropriations made as of that same date during the immediately preceding fiscal year.

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* New bill since the 05/20/2009 Board meeting.