

**2009-2010 Session**  
**State Legislative Report as of 7/19/2010**  
**Overview of Priority Board Regular Session Bills**

**\*AB 342** (Perez) Demonstration Project Waivers

Along with SB 208 (Steinberg and Alquist), this bill includes the statutory provisions necessary to implement a new federal Section 1115 waiver to establish organized health care delivery systems for children eligible for services under the California Children Services (CCS) program, which could include HFP children.

**AB 542** (Feuer) Hospital Acquired Conditions

This bill would require the Department of Health Care Services and MRMIB to implement nonpayment policies and practices for hospital acquired conditions.

**AB 1602** (Perez) Health Care Coverage

This bill would enact the California Patient Protection and Affordable Care Act, and would create the California Health Benefit Exchange to determine eligibility and enrollment and arrange for coverage with participating health, dental and vision plans.

**AB 1653** (Jones) Extension of Quality Assurance Fee

This bill would extend for an additional six months—through June 30, 2011—the quality assurance fee that AB 1383 (2009) imposed on specified hospitals to take advantage of a possible extension of the increased federal match provided under the stimulus bill. A total of \$80 million of the proceeds per quarter is required to be paid for health care coverage for children.

**AB 2470** (Del La Torre) Individual Care Coverage

This bill would establish standardized procedures and forms for applicants in the individual health care market. It also sets forth specific conditions in which penalties may be assessed against the industry related to policy cancellations, with penalties on health insurers collected then deposited into the Major Risk Medical Insurance Fund to support the Major Risk Medical Insurance Program.

**\*SB 208** (Steinberg and Alquist) Demonstration Project Waivers

Along with, AB 342 (Perez), this bill includes the statutory provisions necessary to implement a new federal Section 1115 waiver to establish organized health care delivery systems for children eligible for services under the California Children Services (CCS) program, which could include HFP children.

**SB 890** (Alquist) Health Care Reform Implementation

This bill would enact major changes to rules governing the individual insurance market that would affect standard benefit plan designs, and make other changes to standardize the enrollment application process.

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\* New bill added since the last Board meeting

**SB 900** (Alquist) California Health Insurance Exchange

This bill would establish the California Health Benefits Exchange within the California Health and Human Services Agency to implement specific functions imposed by the federal Patient Protection and Affordable Care Act.

**SB 1163** (Leno) Health Care Coverage: Denials: Premium Rates

This bill would establish additional reporting for both the individual and group health insurance industry when coverage is denied or offered at a rate higher than the standard. This information is required to be reported annually to the Managed Risk Medical Insurance Board and relevant committees of the Legislature.

**SB 1431** (Simitian) County Health Initiative Matching Fund

This bill would allow C-CHIP counties participating in CHIM (County Health Initiative Matching) Fund to apply to the Managed Risk Medical Insurance Board for receipt of matching federal funds to provide health care coverage to eligible children whose family income is at or below 400 percent of the federal poverty level.

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\* New bill added since the last Board meeting

## Assembly Bills

\*†**AB 342** (Perez) Demonstration Project Waivers

Version: Amended 6/23/2010

Sponsor: Author

Status: 6/30/2010 - Assembly APPROPRIATIONS

This bill is one of two companion bills (AB 208 (Steinberg and Alquist) is the other) that include the statutory provisions necessary to implement a new federal Section 1115 waiver. California currently has several waivers, including the Medi-Cal Hospital/Uninsured Care waiver (hospital financing waiver) which will expire in August 2010. Among other things, the bill would require in accordance with the waiver, that DHCS establish organized health care delivery systems for children eligible for services under the California Children Services (CCS) program. The bill would permit MRMIB to enroll children in Healthy Families in these organized health care delivery models. Currently, both bills contain identical language.

†**AB 542** (Feuer) Hospital-Acquired Conditions

Version: Amended 7/15/2010

Sponsor: Author

Status: 7/15/2010-Senate APPROPRIATIONS

This bill requires the Department of Health Care Services to convene a technical working group to recommend nonpayment policies and practices for hospital acquired conditions to the department by February 1, 2011, and implement nonpayment policies and practices for the fee-for-service Medi-Cal program by July 1, 2011. MRMIB would then require contracted managed health care plans to implement the nonpayment policies and practices through their contracts with providers. This is the most recent effort to reduce the incidence of hospital acquired conditions. The bill has recently been amended to conform with the Patient Protection and Affordable Care Act (PPACA) requirements that the Secretary of Health and Human Services develop regulations providing for the nonpayment of hospital acquired conditions under Medicaid. In its current form, the bill does not provide for MRMIB representation on the technical working group.

**AB 1445** (Chesbro) Visits to Federally Qualified Health Centers and Rural Health Clinics

Version: Amended 6/1/2009

Sponsor: California Primary Care Association

Status: 7/9/2009-Senate APPROPRIATIONS

The bill would allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed by Medi-Cal for more than one patient visit per day if the individual sees more than one health care professional at the time. An example of this situation would be if the patient had an appointment with a health care professional and a mental health professional on the same day at the same location. Another example would be a situation where a patient had an

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

appointment for an illness and then on the same day became injured and needed to return that day to the same location. Federal law currently allows two visits per day, but Medi-Cal does not provide reimbursement. As MRMIB intends to use the Medi-Cal process to pay prospective payment rates to clinics, this could also affect HFP costs. This change in reimbursement was vetoed by the Governor in 2007 as SB 36 (Steinberg) due to General Fund costs.

**AB 1600** (Beall) Mental Health Parity

Version: Introduced 1/4/2010

Sponsor: Author

Status: 6/24/2010-Senate APPROPRIATIONS

This bill would require health plan contracts and insurer policies issued, amended or renewed on or after January 1, 2011, to cover the diagnosis and treatment of substance abuse and mental illnesses as defined in the American Psychiatric Association's Diagnostic and Statistical Manual IV. Presently, MRMIP contracts with Knox-Keene plans to provide coverage. If it continues to do so, MRMIP would have to delete current limitations on mental health benefits. As a result of these changes, the rates that MRMIP health plans charge MRMIB may increase. Those increased costs would be partially passed on to the subscribers through higher premiums and partially covered by the program, in which case the enrollment cap may be required to be lowered because of the fixed appropriation.

†**AB 1602** (Perez) (Principal Coauthors: Bass and Monning) Health Care Coverage

Version: Amended 6/24/2010

Sponsor: Author

Status: 7/1/2010-Senate APPROPRIATIONS

This bill would enact the California Patient Protection and Affordable Care Act and create the California Health Benefit Exchange as an independent public entity. It would create a governing body for the Exchange, appointed by the Governor and the Legislature to implement the requirements for American Health Benefits Exchanges as set forth in Section 1311 of PPACA and establish the California Health Trust Fund as a continuously appropriated fund. With regards to MRMIB, at minimum, the Exchange is required to determine eligibility for, and enroll individuals in, public programs, including Healthy Families. As a result, collaboration with MRMIB would be necessary. Without further regulatory guidance from the federal Department of Health and Human Services regarding PPACA, it is impossible to quantify the extent of this collaboration or the level of involvement by MRMIB. The bill would also prohibit *all* health plans and health insurers from including any lifetime coverage limits or annual coverage limits. This prohibition could require MRMIB to lower the MRMIP enrollment cap to absorb costs associated with this action.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

†**AB 1653** (Jones) Extension of Quality Assurance Fee

Version: Amended 7/15/2010

Sponsor: Author

Status: 7/15/2010-Senate APPROPRIATIONS

This bill would extend the quality assurance fee that AB 1383 (2009) imposed on specified hospitals for an additional six months—through June 30, 2011—in order to take advantage of a possible extension of the increased federal match provided to Medi-Cal by the American Reinvestment and Recovery Act. AB1383 required DHCS to use the combined state and federal funds for supplemental reimbursements to hospitals and managed health care plans and to provide \$80 million per quarter of the year for health care coverage for children. It is possible that a portion of these funds could be allocated to be matched by CHIP federal funds for HFP. Any funds that MRMIB may or may not receive as a result of AB 1383 are being addressed through the budget process.

\***AB 1825** (De La Torre) Maternity Services

Version: Introduced 2/11/2010

Sponsor: Author

Status: 7/15/2010 – Senate APPROPRIATIONS SUSPENSE

This bill would require every individual or group health insurance policy, as specified, to cover maternity services. It would define maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. Although there would be no direct impact to MRMIB programs because maternity services are already included, to the extent that there are a number of AIM subscribers that simultaneously carry private insurance that does not cover maternity services, there could be an indirect impact to the AIM program.

\***AB 2244** (Feuer) Health Care Coverage

Version: Amended 7/1/2010

Sponsor: Author

Status: 7/1/2010 – Senate APPROPRIATIONS

This bill would require guaranteed issue of health plan and health insurance products for children in 2011 and adults in 2014. It would also prohibit the pre-existing condition exclusions or limitations for children beginning in 2011. The bill would establish standard individual market rating factors (age, geographic region, family composition and health benefit plan design). The bill would also limit premium variation for children's coverage until 2014 by requiring health plans and health insurers to use "rate bands" that limit premium variation to no more than a specified percentage of a standard rate for a child in each particular rating category and benefit plan.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

**\*AB 2345** (De La Torre) Health Care Coverage  
Version: Amended 6/16/2010  
Sponsor: Author  
Status: 7/15/2010 – Senate APPROPRIATIONS

This bill would require group and individual health care service plan contracts and health insurance policies to provide coverage, and not impose cost-sharing requirements, for preventive services as specified by the Patient Protection and Affordable Care Act (PPACA). It expresses the intent of the Legislature to enact legislation to adopt as state law various patient protection provisions of the PPACA and to require DMHC and the Department of Insurance to post a link on their respective Internet websites to the Internet website of the federal Department of Health and Human Services to provide information about affordable and comprehensive health care coverage options.

**†AB 2470** (De La Torre) Individual Health Care Coverage  
Version: Amended 6/16/2010  
Sponsor: California Medical Association  
Status: 6/30/2010 – Senate APPROPRIATIONS

This bill would prohibit a health plan or health insurer from rescinding or canceling a health plan contract/health insurance policy unless there was a material misrepresentation or material omission in the information submitted by the applicant, and the health plan/insurer demonstrates that the applicant intentionally misrepresented or intentionally omitted material information on the application with the purpose of misrepresenting his or her health history in order to obtain health care coverage. It would establish in the Department of Managed Health Care and the California Department of Insurance the independent review process for the review of decisions to cancel or rescind individual health plan contracts and health insurance policies for misrepresentation. The bill would also set forth specific conditions in which penalties may be assessed against the industry related to policy cancellations, with penalties on health insurers collected then deposited into the Major Risk Medical Insurance Fund to support the Major Risk Medical Insurance Program.

**AB 2533** (Fuentes) Health Care Coverage: Quality Rating  
Version: Amended 6/23/2010  
Sponsor: California Medical Association  
Status: 7/1/2010 – Senate APPROPRIATIONS

This bill would expand provisions of law that require every health care service plan and certain health insurers to file with the respective departments a description of policies and procedures related to economic profiling used by the plan or insurer and its medical groups and individual practice associations. Economic profiling means any evaluation of a particular physician, provider, medical group or individual practice association based in whole or part on the economic costs or utilization of services associated with the medical care provided or authorized

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\* New bill added since the last Board meeting

† Priority Board bills

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by a specific physician. The bill would expand these provisions to apply to quality ratings used by the plan or insurer with respect to individual or group performance of physicians.

**AB 2578** (Jones) Health Care Coverage: Rate Approval

Version: Amended 5/28/2010

Sponsor: Author

Status: 6/24/2010 – Senate APPROPRIATIONS

This bill would require that all health care service plans obtain approval from the Department of Managed Health Care and all health insurers obtain approval from the Department of Insurance in order to increase a premium, co-payment, coinsurance obligation, deductible, or other charge. This bill would not have an impact on MRMIB programs because participating health plans do not contract directly with MRMIB subscribers.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

## Senate Bills

### **SB 56** (Alquist) County Joint Health Plan Ventures

Version: Amended 6/3/2010

Sponsor: Author

Status: 6/30/2010 - Assembly APPROPRIATIONS SUSPENSE

The bill would allow health plans governed by various county bodies (boards of supervisors, special commissions, health system, health authority or medical services plan) to form joint ventures to create integrated networks of public health plans that pool risks, share networks or jointly offer health plans to individuals and groups. The intent of the legislation is to facilitate establishment of affordable health coverage options in the individual and group markets.

### \*†**SB 208** (Steinberg and Alquist) Demonstration Project Waivers

Version: Amended 6/22/2010

Sponsor: Author

Status: 6/30/2010 - Assembly APPROPRIATIONS

This bill is one of two companion bills (AB 342 (Perez) is the other) that include the statutory provisions necessary to implement a new federal Section 1115 waiver. California currently has several waivers, including the Medi-Cal Hospital/Uninsured Care waiver (hospital financing waiver) which will expire in August 2010. Among other things, the bill would require, in accordance with the waiver, that DHCS establish organized health care delivery systems for children eligible for services under the California Children Services (CCS) program. The bill would permit MRMIB to enroll children in Healthy Families in these organized health care delivery models. Currently, both bills contain identical language.

### **SB 543** (Leno) Minors: Consent for Mental Health Treatment

Version: Amended 9/3/2009

Sponsors: National Association of Social Workers, California Chapter; Mental Health America of Northern California; GSA Network; and Equality California

Status: 9/11/2009 - Assembly INACTIVE FILE

This bill would allow a minor who is at least 12 years old to consent to outpatient mental health treatment or counseling services if the attending “professional person,” as defined, determines the minor is mature enough to participate intelligently in the mental health treatment or counseling services. It would require involvement of the minor’s parents in the treatment or services unless the “professional person” determines, after consulting with the minor, that the parental involvement would be inappropriate.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

**SB 810** (Leno) Single-Payer Health Care Coverage

Version: Amended 1/13/2010

Sponsor: One Care Now, Health Care For All

Status: 6/30/2010 – Assembly APPROPRIATIONS

This bill states 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. All people physically present in California with the intent to reside in the state would be eligible for the California Healthcare System Plan. It would prohibit 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. Finally, this bill would require 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.

†**SB 890** (Alquist) Health Care Reform Implementation

Version: Amended 6/15/10

Sponsor: Author

Status: 7/6/10 – Senate FLOOR

This bill would enact major changes to rules governing the individual insurance market that would affect standard benefit plan designs, and make other changes to standardize the enrollment application process. This measure would require a plan or insurer to offer and market one standard benefit plan design in each of five different coverage categories and require discontinuation of plans that did not meet the standard benefit design. It would create the Individual Insurance Market Reform Commission that would review and suggest changes to the standard benefit plan designs and would require health insurance regulators to jointly adopt regulations based on the Commission's suggestions. This measure would also allow an individual plan subscriber or policyholder, on the annual renewal date, to transfer on a guarantee issue basis to another plan of the same or lower coverage category or actuarial value. The bill would also enact a minimum amount of expenditure by percentage on health care benefits.

†**SB 900** (Alquist) California Health Insurance Exchange

Version: Amended 6/23/10

Sponsor: Author

Status: 6/30/10 – Assembly APPROPRIATIONS

This bill would establish the California Health Benefits Exchange within the California Health and Human Services Agency. The exchange would be required to implement specific functions imposed by the federal Patient Protection and Affordable Care Act: To enter into contracts with health care service plans and health insurers seeking to offer coverage in the Exchange, and provide a choice in each region of California among the five levels of coverage specified in the federal Act. Further, the bill would require the Exchange be governed by a board appointed by

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\* New bill added since the last Board meeting

† Priority Board bills

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the Governor and Legislature and would create the California Health Benefits Exchange Fund in the State Treasury.

**\*SB 1088** (Price) Health Care Coverage: Dependents

Version: Amended 6/23/2010

Sponsor: Author

Status: 6/30/2010 – Assembly APPROPRIATIONS

This bill would prohibit, with specified exceptions, the limiting age for dependents covered by health plan contracts and health insurance policies from being less than 26 years of age, pursuant to the Patient Protection and Affordable Care Act (PPACA). The bill would prohibit health plan contracts and health insurance policies from being required to cover a child of a child receiving dependent coverage.

**†SB 1163** (Leno) Health Care Coverage: Denials: Premium Rates

Version: Amended 6/23/2010

Sponsor: Health Access

Status: 6/30/2010 – Assembly APPROPRIATIONS

This bill would require a health insurer or service plan that offers health care coverage in the individual and group markets to provide to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing in clear, easily understandable language. This bill would require a plan or insurer to annually disclose to the Department of Managed Health Care or the Department of Insurance the standards, processes and criteria used by the plan or insurer to deny coverage to applicants. The bill would also require annual reporting of demographic information on denials, including the reason why. This information would be required to be reported annually to the Department of Managed Health Care and the Managed Risk Medical Insurance Board. In addition this bill would increase from 30 to 180 days the required notification period plans must wait prior to increasing premiums.

**†SB 1431** (Simitian) County Health Initiative Matching Fund

Version: Amended 4/7/2010

Sponsor: San Mateo County

Status: 6/23/10 – Assembly HEALTH

This bill would allow C-CHIP counties participating in CHIM (County Health Initiative Matching) Fund to apply to the Managed Risk Medical Insurance Board through which to receive matching federal funds to provide health care coverage to children who are eligible but unable to enroll in HFP as a result of enrollment policies. These would be children whose family income is between 300 and 400 percent of the federal poverty level. Funding to serve this population would be one-half local funds and one-half federal matching funds. No state funds would be used to support this expansion.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.

## **Bills MRMIB Will No Longer Report to the Board**

### **AB 1887** (Villines) Temporary High Risk Pool

Version: Amended 6/10/2010

Sponsor: Author

Status: 6/29/10 – CHAPTERED

This bill establishes the Federal Temporary High Risk Health Insurance Fund to be continuously appropriated to the Managed Risk Medical Insurance Board and implements associated administrative provisions.

### **SB 227** (Alquist) Federal Temporary High Risk Insurance Pool

Version: Amended 6/21/2010

Sponsor: Governor Schwarzenegger

Status: 6/29/2010-CHAPTERED

This bill establishes a federal temporary high risk insurance pool in California in accordance with the federal Patient Protection and Affordable Care Act of 2010. The bill provides MRMIB with the authority to enter into an agreement with the federal Department of Health and Human Services to administer the pool.

### **SB 316** (Alquist) Health Care Coverage: Disclosures

Version: Amended 12/17/2009

Sponsor: Author

Status: 6/2/2010 - Assembly DEAD

This bill failed the July 2<sup>nd</sup> deadline for policy committees to meet and report bills. Current law requires health plans and insurers, when presenting a plan contract or policy for examination or sale to a group of 25 or fewer individuals, to disclose the minimum loss ratio (ratio of premiums paid to health services or claims paid v. administrative costs) for the preceding year. This bill would broaden this mandate and apply it to groups of 50 or fewer individuals.

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\* New bill added since the last Board meeting

† Priority Board bills

Developments since the previous Board meeting underlined.