

**2009-2010 Regular Session  
State Legislative Report as of 07/28/2009**

**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 3 of this report.

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

This bill would require MRMIB to adopt new regulations and implement non-payment policies regarding hospital-acquired conditions, which was a topic addressed by AB 2146 (Feuer, 2007). For a summary and current status of this bill see page 4 of this report.

**AB 786** (Jones) Individual Health Insurance Coverage Categories

This bill is similar to SB 1522 (Steinberg, 2007). 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 coverage choice categories and would limit out-of-pocket costs for covered benefits. For a summary and current status of this bill see page 5 of this report.

**\*AB 1011** (Jones) Implementation of AB 1383

This bill states the Legislature's intent to enact legislation that would implement the provisions of AB 1383, including the supplemental payments to hospitals and funding for children's coverage. For a summary and current status of this bill see page 6 of this report.

**AB 1383** (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health;  
Urgency Measure

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 Medi-Cal hospital reimbursements and to pay for health care coverage for children, contingent on enactment of AB 1011 and receipt of all federal approvals. For a summary and current status of this bill see page 6 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 9 of this report.

**SBX3 26** (Alquist) CHIPRA Implementation

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

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

**2009-2010 Regular Session  
State Legislative Report as of 07/21/2009**

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

Version: **Amended 07/23/2009**

Sponsor: California Medical Association

Status: **07/15/2009-Senate APPROPRIATIONS**

This bill is substantively the same as AB 1945 (De La Torre, 2007). 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 require DMHC and CDI to impose administrative penalties upon plans and insurers that prolong the review process or that fail to implement its decisions and would require that penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund, **and that penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP, subject to appropriation by the Legislature.** The bill would also 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.

**AB 56** (Portantino) Mandated Benefit: Mammography Screening

Version: **Amended 07/08/2009**

Sponsor: **The American College of Obstetricians and Gynecologists**

Status: **07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)**

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. **The bill would add participating physician assistants to those providers who may refer enrollees for covered breast cancer diagnosis and screening.** It would further require that health plans and disability insurers **provide enrollees with information regarding recommended timelines to undergo tests for the screening or diagnosis of breast cancer.** ~~give~~

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

written notice to their respective female enrollees and policyholders of their eligibility for breast cancer testing using nationally recommended testing guidelines for women.

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

Version: Amended 04/13/2009

Sponsor: **California Commission on the Status of Women**

Status: **07/09/2009-Senate APPROPRIATIONS. Set for hearing 07/23/2009**

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 06/23/, 06/26 and 07/23/2009**

Sponsor: Author

Status: **07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)**

This bill would prohibit a health care plan and insurer after ~~18~~ **24** months following issuance of an individual contract or policy 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. **The bill states it would not limit a plan or insurer's lawful options when a subscriber makes a willful misrepresentation.**

**AB 235** (Hayashi) Mandated Benefit: Emergency Psychiatric Services

Version: Amended 06/11/2009

Sponsor: California Hospital Association

Status: **06/29/2009-Senate THIRD READING (needs concurrence in Assembly)**

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. The bill would exempt Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services from the bill's requirements to provide additional emergency services and care.

**AB 244** (Beall) Mandated Benefit: Mental Health Services

Version: Amended 05/05/2009

Sponsor: Author

Status: **07/16/2009-Senate APPROPRIATIONS**

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

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

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.

**AB 513 (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding**

Version: Amended 05/05/2009

Sponsor: WIC Association

Status: 07/15/2009-Senate APPROPRIATIONS

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) Hospital-Acquired Conditions**

Version: Amended 06/18/2009

Sponsor: Author

Status: 06/11/2009-Senate HEALTH (needs concurrence in Assembly)

This bill is similar to AB 2146 (Feuer, 2007). 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 and implement by regulation by September 1, 2010 uniform policies and practices governing the nonpayment to a health facility for hospital acquired conditions 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 and would prohibit health facilities from charging patients for care and services when payment is denied by MTRMIB and its plans or by DHCS.

In addition to reporting adverse events as required by current law, this bill would require medical and nursing directors of health facilities to report hospital acquired conditions annually to their boards or similar oversight bodies and would require that contracts between health facilities and health care plans be consistent with these nonpayment policies developed by DMHC. The bill would prohibit health facilities from charging for hospital acquired conditions 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.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

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

Version: **Amended 07/23/2009**

Sponsor: Insurance Commissioner

Status: **07/15/2009-Senate APPROPRIATIONS**

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 Categories

Version: **Amended 06/30/2009**

Sponsor: Health Access

Status: **07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)**

This bill is similar to SB 1522 (Steinberg, 2007). This bill would require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to jointly develop a system to categorize all individual health plan contracts and insurance policies sold on or after September 1, 2012 into a total of no more than 10 coverage categories and having at least two categories in common between the departments. It would require the categories to be based on benefit levels and out-of-pocket costs. The bill would require all individual health care plan contracts or insurance policies issued, amended or renewed on or after January 1, 2011 to have a maximum out-of-pocket limit. The maximum out-of-pocket limit for contracts and policies issued, amended or renewed on or after April 1, 2011 must be \$10,000 per person, per year. The bill would require DMHC and CDI to jointly develop standard definitions and terminology for covered benefits and cost-sharing provisions for all health care service plan contracts and insurance policies to be offered and sold to individuals on or after September 1, 2012. The bill would require the Office of Patient Advocate to maintain a web site containing a benefits matrix of all available individual health plan contracts and insurance policies. Would require broker or agents to make prospective insureds aware of the matrix when marketing or selling an individual health policy.

~~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 six coverage choice categories, four of which must be applicable to both individual health care service plan contracts and individual health insurance policies. The fifth and sixth categories would be applicable only to individual health insurance policies and would be established based on either~~

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

- ~~1. the highest cost sharing and the lowest benefit levels among the six categories and would be required to apply where the benefit levels and cost sharing requirements do not otherwise meet the requirements of this bill or~~
- ~~2. benefit limits not permitted under this bill or current law regardless of cost sharing or comprehensiveness of coverage.~~

~~Effective January 1, 2011, the bill would prohibit the 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 at a minimum to 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 1011** (Jones) Implementation of AB 1383

Version: Amended 06/29/2009

Sponsor: Author

Status: 06/18/2009-Senate FIRST READING (needs concurrence in Assembly)

This bill states the Legislature's intent to enact legislation that would implement the provisions in AB 1383, which would impose a "coverage dividend fee" on designated hospitals, use the fee to draw down federal funds, and then use these state and federal funds to make specific supplemental Medi-Cal payments and expand health care coverage for children.

**AB 1383** (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health; Urgency Measure

Version: **Amended 07/01, 07/09 and 07/15/2009**

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

Status: **07/09/2009-Senate APPROPRIATIONS (needs concurrence in Assembly). Set for hearing 07/23/2009**

This bill would require the Department of Health Care Services (DHCS) to calculate and impose on hospitals, except for designated public hospitals, a "coverage dividend fee," to be repealed by January 1, 2013, and contingent on approval by the federal Centers for Medicare and Medicaid Services. The bill would require the coverage dividend fees to be placed into a fund to then be used to draw down federal funds. The bill would require the combined state and federal funds to be used by DHCS for making supplemental reimbursements to hospitals and managed health care plans and to provide for ~~expanding~~ health care coverage for children. The bill would require Medi-Cal

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

rates to equal the portion of the applicable federal upper payment limits as specified equal the federal upper payment limit. The bill requires that \$80 million of the fee revenues be used for children's health coverage each quarter of the year. The bill would make the supplemental payments contingent on the collection of the fees and would make the collection of the fees contingent on enactment of other urgency legislation (see AB 1011) that would precisely specify the method for calculating the fee. The bill would require DHCS to seek all federal approvals and waivers necessary to maximize federal financial participation and to implement the bill. It would require DHCS, subject to legislative approval, to explore program reforms, which may include, among other things, improvements in the coordination of care for children.

The Senate Health Committee estimates that if the fees are matched by federal Children's Health Insurance Program funds, the combined funds could amount to almost \$1 billion to expand children's coverage and the supplemental payments to hospitals, coupled with federal matching funds, could amount to several billion dollars. The bill would become effective immediately upon being signed by the Governor.

**AB 1445** (Chesbro) Visits to Federally Qualified Health Centers and Rural Health Clinics  
Version: Amended 06/01/2009  
Sponsor: California Primary Care Association  
Status: 06/18/2009-Senate HEALTH

The bill would require federally qualified health centers (FQHCs) and rural health clinics (RHCs) to apply to the Department of Health Care Services for an adjustment to their per-visit rate when they count as a single visit the cost of multiple encounters with health professionals that occur on the same day at a single location. It would also require FQHCs and RHCs 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, 2005) 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.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

**AB 1541** (Assembly Health) Implementation of CHIPRA

Version: *Amended 06/16 and 07/23/2009*

Sponsor: Assembly Health Committee

Status: *07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)*

This bill would declare the intent of the Legislature to implement a provision of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. It would exclude an employee or eligible dependent from being considered a "late enrollee" by health plans or insurers when the individual, in addition to meeting existing criteria, requests enrollment in a health plan or contract within 60 days after termination of their enrollment in the Healthy Families Program (HFP), *the Access for Infants and Mothers (AIM)* or termination of their ~~no~~ ~~share-of-cost~~ Medi-Cal coverage. The bill would also raise the number of days from 30 to 60 that an enrolled eligible employee has in which to request enrollment for a dependent after notifying the plan or insurer of the loss or pending loss of the dependent's coverage in HFP *or AIM* before the plan or insurer may consider the dependent a late enrollee. Current law allows plans and insurers to exclude late enrollees from coverage for 12 months following the late enrollee's application for coverage.

**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.

---

Deleted bill content is ~~stricken~~, and new bill content or status is *bold italic underlined*.

\* New bill since previous Board meeting.

## Senate Bills

**SB 158** (Wiggins) Mandated Benefit: Human Papillomavirus Vaccination

Version: **Amended 06/17/2009**

Sponsor: American College of Obstetricians and Gynecologists

Status: 06/09/2009-Assembly APPROPRIATIONS-**Suspense File (needs concurrence in Senate)**

This bill is similar to bills AB 16 (Evans, 2007) and AB 1429 (Evans, 2007). 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 06/17/2009 amendment did not necessitate a revision to 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, **American Cancer Society**

Status: **07/07/2009-Assembly APPROPRIATIONS**

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 bill would exclude CalPERS from these requirements.

**SB 227** (Alquist) MRMIP Expansion

Version: **Amended 07/13/2009**

Sponsor: Author

Status: **07/01/2009-Assembly APPROPRIATIONS (needs concurrence in Senate)**

The Board originally took a position of "support if amended" on this bill. **Because the author amended the bill to cap the maximum subscriber contribution at 125% of the standard premium for comparable coverage, the Board is now in "support" of the bill.** SB 227 is similar to AB 2 (Dymally, 2007) and AB 1971 (Chan, 2005). The bill would ensure long-term stable funding for the Major Risk Medical Insurance Program (MRMIP), thereby expanding the program to cover more individuals. It would accomplish this by requiring health care plans and insurers to elect to either provide guaranteed-renewable coverage to individuals eligible for the MRMIP or to pay a fee. The bill would eliminate the annual \$75,000 benefit limit and would require MRMIB to increase the lifetime limit to no less than \$1,000,000. The bill would also require MRMIB, conditioned on the absence of a MRMIP waitlist, to establish a process for individuals in the Guaranteed Issue Pilot program to voluntarily re-enroll into the MRMIP.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

**The bill would now require MRMIB to establish premiums at no more than 125% of the standard average individual rate for comparable coverage, which is consistent with existing maximum subscriber contribution rates. Please see the July 22, 2009, letter of support included in the Board packet for more information on this bill.**

**SB 499** (Ducheny) MRMIB Reporting on Use of DMHC Fines  
Version: Introduced 02/26/2009  
Sponsor: Author  
Status: 06/11/2009-Assembly APPROPRIATIONS-**Suspense File**

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.

**SB 543** (Leno) Minors: Consent to Mental Health Treatment  
Version: **Amended 06/25/2009**  
Sponsor: National Association of Social Workers, **California Chapter; Mental Health America of Northern California; GSA Network; and Equality California**  
Status: **06/22/2009-Assembly JUDICIARY (needs concurrence in Senate)**

**The 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. The bill 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.** 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: **06/18/2009-Senate REVENUE & TAXATION-Suspense File**

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

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.  
\* New bill since previous Board meeting.

distributors to pay a cigarette indicia adjustment tax for each California cigarette tax stamp at the rate of SL875, \$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.

**SB 630** (Steinberg) Mandated Benefit: Orthodontic Reconstructive Surgery for Cleft Palate

Version: **Amended 06/22/2009**

Sponsor: California Society of Plastic Surgeons

Status: **07/01/2009-Assembly APPROPRIATIONS (needs concurrence in Senate)**

This bill is similar to SB 1634 (Steinberg, 2007), which was vetoed. This bill would expand the current definition of reconstructive surgery to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, thereby requiring health plan contracts and insurance policies to cover these services. 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. (6/24)

**\*SR 24** (Price) Nationwide Universal Children's Health Care Coverage

Version: Introduced 07/14/2009

Sponsor: Author

Status: 07/17/2009-Adopted

This resolution urges Congress and the President to enact bipartisan health care legislation that includes health care coverage for all children.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

\* New bill since previous Board meeting.

**Update to  
2009-2010 Regular Session  
State Legislative Report as of 07/29/2009**

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

Version: **Amended 07/23/2009**

Sponsor: California Medical Association

Status: **07/15/2009-Senate APPROPRIATIONS**

This bill is substantively the same as AB 1945 (De La Torre, 2007). 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 impose administrative penalties upon plans and insurers that prolong the review process or that fail to implement its decisions and would require that penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund. **It would further require that penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP, subject to appropriation by the Legislature.** 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.

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

Version: Amended 04/13/2009

Sponsor: **California Commission on the Status of Women**

Status: **07/09/2009-Senate APPROPRIATIONS. The hearing scheduled for 07/23/2009 was cancelled**

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.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

**AB 108** (Hayashi) Rescission of Individual Health Insurance Coverage

Version: Amended 07/23/2009

Sponsor: Author

Status: 07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)

This bill would prohibit a health care plan and insurer after ~~18~~ **24** months following issuance of an individual contract or policy 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. **The bill states it would not limit a plan or insurer's lawful options within the first 24 months when a subscriber makes a willful misrepresentation.**

**AB 513** (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding

Version: Amended 07/23/2009

Sponsor: WIC Association

Status: 07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)

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

Version: Amended 07/23/2009

Sponsor: Insurance Commissioner

Status: 07/15/2009-Senate APPROPRIATIONS

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. **The bill would require these penalties to be deposited in the Major Risk Medical Insurance Fund and to be used for the Major Risk Medical Insurance Program, upon appropriation by the Legislature.**

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

**AB 1383** (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health; Urgency Measure

Version: **Amended 07/15/2009**

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

Status: **07/09/2009-Senate APPROPRIATIONS (needs concurrence in Assembly). The hearing scheduled for 07/23/2009 was cancelled.**

This bill would require the Department of Health Care Services (DHCS) to calculate and impose on hospitals, except for designated public hospitals, a "coverage dividend fee," to be repealed by January 1, 2013, and contingent on approval by the federal Centers for Medicare and Medicaid Services. The bill would require the coverage dividend fees to be placed into a fund to then be used to draw down federal funds. The bill would require the combined state and federal funds to be used by DHCS for making supplemental reimbursements to hospitals and managed health care plans and to provide for ~~expanding~~ health care coverage for children. The bill would require Medi-Cal rates to **equal the portion of the applicable federal upper payment limits as specified** ~~equal the federal upper payment limit~~. The bill requires that \$80 million of the fee revenues be used for children's health coverage each quarter of the year. The bill would make ***the supplemental payments contingent on the collection of the fees and would make*** the collection of the fees contingent on enactment of other ***urgency*** legislation (***see AB 1011***) that would precisely specify the method for calculating the fee. The bill would require DHCS to seek all federal approvals and waivers necessary to maximize federal financial participation and to implement the bill. ***It would require DHCS, subject to legislative approval, to explore program reforms, which may include, among other things, improvements in the coordination of care for children.***

The Senate Health Committee estimates that if the fees are matched by federal Children's Health Insurance Program funds, the combined funds could amount to almost \$1 billion to expand children's coverage and the supplemental payments to hospitals, coupled with federal matching funds, could amount to several billion dollars. The bill would become effective immediately upon being signed by the Governor.

**AB 1541** (Assembly Health) Implementation of CHIPRA

Version: **Amended 07/23/2009**

Sponsor: Assembly Health Committee

Status: **07/15/2009-Senate APPROPRIATIONS (needs concurrence in Assembly)**

This bill would declare the intent of the Legislature to implement a provision of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. It would exclude an employee or eligible dependent from being considered a "late enrollee" by health plans or insurers when the individual, in addition to meeting existing criteria, requests enrollment in a health plan or contract within 60 days after termination of their enrollment in the Healthy Families Program (HFP), ***the Access for Infants and Mothers (AIM)*** or termination of their ~~no-share-of-cost~~ Medi-Cal **program** coverage. The bill would also raise the number of days from 30 to 60 that an enrolled eligible employee has in which to request enrollment for a dependent after notifying the plan or insurer of the loss or pending loss of the dependent's coverage in HFP **or**

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.

**AIM** before the plan or insurer may consider the dependent a late enrollee. Current law allows plans and insurers to exclude late enrollees from coverage for 12 months following the late enrollee's application for coverage.

---

Deleted bill content is ~~stricken~~, and new bill content or status is **bold italic underlined**.