

**State Legislative Status Report  
2007-2008 Regular Session  
June 23, 2008**

Note: Status information reflects information available as of 06/19/2008.

**ASSEMBLY BILLS**

**AB 1** (Laird) Health care coverage.

Version: Amended 09/07/2007

Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)

Status: 09/12/2007-Held at ASSEMBLY DESK.

Note: AB 1 is identical to SB 32 (Steinberg).

The bill would:

- Expand eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Create the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would make unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Delete specified citizenship and immigration status requirements for Medi-Cal and HFP and would require the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Require the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and develop a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Establish the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Med-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deem children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

**AB 2** (Dymally) Health care coverage.

Version: Amended 09/07/2007

Sponsor: Author

Status: 09/11/2007-Senate Floor INACTIVE FILE.

Note: MRMIB support.

This bill would:

- Require insurers in all markets to either sell individual coverage on a guaranteed issuance basis with community rating (no rating for age, health status or geography) or elect to pay a fee to help finance the Major Risk Medical Insurance Program (MRMIP).
- Require health plans and insurers to either pay a per life fee, adjusted by MRMIB and capped at \$1.50 per life, to fully fund the MRMIP, eliminating any wait lists for the program, or agree to provide coverage to persons eligible for the MRMIP, based on their market-share of covered lives in the state.

*\*New status since last board meeting*

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- As of January 1, 2008, eliminate annual benefit caps for the MRMIP and require at least \$1 million lifetime benefit cap; cap out-of-pocket costs at \$2,500 or lower per person and \$4,000 per family, and; reduce consumer costs for primary and preventative care and medications for chronic conditions.
- Require MRMIB to appoint an 8-member advisory committee (volunteers) to advise the board on topics related to operation of the program and improving quality and cost-effectiveness of program operations.
- Provide coverage on or after January 1, 2009 for persons newly eligible for HIPPA through MRMIP.
- Allow, after January 1, 2009, persons enrolled in Guarantee Issue Program (GIP) coverage to enroll in MRMIP.
- Reduce subscriber premiums in MRMIP over time, based on a percent of the cost in the private market for comparable coverage: from 137% currently to 125% on January 1, 2008, and on January 1, 2009, at 120% for persons above 300% FPL and 110% for persons below 300% FPL.
- Require MRMIB to report to the Legislature by July 1, 2011 regarding implementation of the provisions of the bill, and specific information regarding program operations.

**\*AB 16** (Hernandez) Human papillomavirus vaccination.

Version: Amended 05/21/2008

Sponsor: Author

Status: 06/23/2008-Set for hearing in Senate APPROPRIATIONS.

The previous version of this bill concerned students' immunizations. This bill now changes the authority for making referrals for annual cervical cancer screening to a licensed health care practitioner. Current law gives authority to "the patient's physician, surgeon, nurse practitioner or certified nurse midwife." The bill also requires that individual and group health policies which cover cervical cancer treatment or surgery, issued on or after January 1, 2009, also cover a vaccination for human papillomavirus.

**\*AB 368** (Carter) Hearing aids.

Version: Introduced 02/14/2007

Sponsor: Author

Status: 06/25/2008-Set for hearing in Senate HEALTH.

This bill would require health care service plans and health insurers to offer or provide coverage up to \$1,000 for hearing aids to all enrollees, subscribers, and the insured less than 18 years of age. The bill would provide that the requirement would not apply to certain types of insurance.

**\*AB 1150** (Lieu) Health care coverage: underwriting practices.

Version: Amended 01/16/2008

Sponsor: Author

Status: 06/30/2008-Senate APPROPRIATIONS.

This bill would prohibit health plans and insurers from basing employee or contractor compensation on performance goals or quotas for recommending the rescission, cancellation, or limitation of coverage or the resulting cost savings to the health plan or insurer.

*\*New status since last board meeting*

*\*\*New bill since last board meeting*

**\*AB 1554** (Jones) Health care coverage: rate approval.  
Version: Amended 06/18/2008  
Sponsor: Author  
Status: 06/25/2008-Senate HEALTH.

This bill would require approval by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) of an increase in the amount of the premium, co-payment, coinsurance obligation, deductible, and other charges under individual and group policies issued by health plan or health insurers. This would not include a Medicare supplement contract or policy or health plan contracts issued through a state program including Medi-Cal and the Healthy Families Program. It would create the 7-member California Health Care Rate Advisory Board (CHCRAB) and would require the DMHC and CDI to solicit comments from CHCRAB when adopting regulations related to this bill. It would also establish criteria for the DMHC and CDI to use when reviewing and approving rates paid by health plans and insurers for medical and non-medical expenses.

**\*AB 1945** (De La Torre) Health care coverage.  
Version: Amended 04/02/2008  
Sponsor: California Medical Association  
Status: 06/24/2008-Set for hearing in Senate JUDICIARY.

This bill would require health plans and insurers to obtain prior approval of the Department of Managed Health Care (DMHC) Director and the California Department of Insurance (CDI) Commissioner respectively before rescinding any health coverage. It would require the DMHC Director and CDI Commissioner to consult together and contract with one or more independent review organizations by January 1, 2010 to review rescissions, and require the regulators to ensure that the persons and organizations performing reviews do not have specified conflicts of interest with health plans or insurers. The bill would also permit each regulator to assess 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 a standard application for individual coverage and require health plans and insurers to use this application if they elect to sell individual coverage.

**\*AB 2549** (Hayashi) Health care coverage: notification.  
Version: Amended 04/03/2008  
Sponsor: Author  
Status: 06/25/2008-Set for hearing in Senate HEALTH

This bill would prohibit health plans and health insurers from rescinding an individual health insurance policy for any reason after six months from the date of its issuance. It would also permit a policyholder or insured who believes that his or her individual health insurance policy was wrongfully rescinded to request a review of the rescission by submitting a complaint to the Insurance Commissioner or the Department of Managed Health Care.

*\*New status since last board meeting*  
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**\*\*AB 2580** (Arambula) Health: immunizations.  
Version: Amended 04/01/2008  
Sponsor: California Immunization Coalition,  
Status: 06/19/2008-Senate APPROPRIATIONS

This bill would remove existing age exceptions to immunization requirements for admittance into elementary or secondary schools, child care centers, day nurseries, nursery schools, family day care homes or development centers. It would also require, on or after July 1, 2009, that pupils be fully vaccinated against pertussis before admission to 7th grade in these institutions. It would also add the American Academy of Family Physicians to the list of those organizations which the Department of Public Health may consider when determining other diseases for which pupils must be vaccinated.

**\*AB 2589** (Solorio) Health care coverage: public agencies.  
Version: Amended 04/22/2008  
Sponsor: Santa Ana School District  
Status: 06/19/2008-Senate APPROPRIATIONS

This bill would require health plans or health insurers to report annually to governing boards of public agencies with whom they contract the name and address of any agent, broker, or individual related to the public entity's contract or policy to whom they paid a commission or fee and the amount paid.

**\*AB 2967** (Lieber) Health care cost and quality transparency.  
Version: Amended 04/15/2008  
Sponsor: Service Employees International Union  
Status: 06/19/2008-Senate APPROPRIATIONS

This bill would create the California Health Care Cost and Quality Transparency Committee (HCCQTC) in the Health and Human Services Agency (CHHSA) to develop a plan to improve medical data collection and reporting practices. The bill would also require the CHHSA Secretary and the Committee to implement strategies to improve health care quality and meet related requirements. The Committee would establish a fee schedule and would identify other financial resources to implement the bill. The bill would require an appropriation in the annual Budget Act in order to be implemented. This bill would sunset the existing California Health Policy and Data Advisory Commission (CHPDAC) on July 1, 2009, and replace all references to the CHPDAC with references to the HCCQTC.

**ACA 14** (Strickland) State-funded benefits.  
Version: Introduced 02/22/2008  
Sponsor: Author  
Status: 06/12/2008-Assembly JUDICIARY.

This bill would place an initiative on the ballot which, if passed by voters, would amend the State Constitution to require that specific proof of U.S. citizenship or one's right to lawfully reside in the United States be provided as a condition of eligibility by persons 18 years of age or older applying for a non-emergency state-funded public benefit, with some exceptions. Allowable proof would be defined as a California driver's license or State-issued identification card that meets applicable document and issuance requirements of federal law, a U.S. passport, or a permanent resident alien card issued by the U.S. government.

*\*New status since last board meeting*  
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**\*AJR 54** (Laird) State Children's Health Insurance Program.  
Version: Amended 05/28/2008  
Sponsor: 100% Campaign  
Location: 06/25/2008-Set for hearing in Senate HEALTH

Note: MRMIB support.

This resolution would urge the President and the Congress of the United States to rescind the federal Centers for Medicare & Medicaid Services directive of August 17, 2007 that restricts states' authority to cover children under the State Children's Health Insurance Program.

*\*New status since last board meeting*  
*\*\*New bill since last board meeting*

## SENATE BILLS

**SB 32** (Steinberg) Health care coverage: children.

Version: Amended 09/07/2007

Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)

Status: 09/11/2007-Assembly FLOOR INACTIVE FILE.

Note: SB 32 is identical to AB 1 (Laird).

The bill would:

- Expand eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Create the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would make unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Delete specified citizenship and immigration status requirements for Medi-Cal and HFP and would require the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Require the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and develop a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Establish the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Medi-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deem children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

**\*SB 697** (Yee) Health care coverage: provider charges.

Version: Amended 09/07/2007

Sponsor: Author

Status: 06/24/2008-Set for hearing in Assembly HEALTH.

This bill would explicitly prohibit any health care provider who is given documentation that a person is enrolled in the Healthy Families program from "balance billing" the subscriber for health care services.

**\*SB 775** (Ridley-Thomas) Childhood lead poisoning.

Version: Amended 06/17/2008

Sponsor: Physicians For Social Responsibility, National Health Law Program

Status: 06/24/2008-Set for hearing in Assembly HEALTH

The bill would require the Department of Public Health to make information on lead poisoning available to all health care providers that administer perinatal or prenatal care services as specified, and would require providers to explain this information to pregnant women at the earliest opportunity. It would require DPH and the State Public Health Officer to report to the legislature and the public on the status of the state's lead poisoning prevention programs and lead screening activities, respectively. It would require the State Public Health Officer to report to the legislature and Governor on the effectiveness of the state's lead screening efforts including the establishment of benchmarks for

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Healthy Families, Medi-Cal and the Child Health and Disability Prevention Program. This bill would require laboratories that test for lead poisoning to report findings to the Department of Public Health. It would also require licensed health care providers to conduct or refer for a blood lead test when providing services to low-income children at specified ages who are enrolled in publicly funded programs.

**SB 840** (Kuehl) Single-payer health care coverage.  
Version: Amended 07/10/2007  
Sponsor: Author  
Status: 07/10/2007-Assembly APPROPRIATIONS.

This bill would establish the California Healthcare System to be administered by the newly created California Healthcare Agency, under the control of a Healthcare Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would provide that a resident of the state with a household income at or below 200% of the federal poverty level would be eligible for the type of benefits provided under the Medi-Cal program. The bill would create several new offices to establish policy on medical issues and various other matters relating to the health care system.

**\*\*SB 973** (Simitian) California Health Benefits Service Program.  
Version: Amended 06/05/2008  
Sponsor: TBD  
Status: 06/24/2008-Set for hearing in Assembly HEALTH

This bill is essentially the same as SB 1622, which failed to meet the deadline for passage from the Senate Appropriations Committee. This bill would create the California Health Benefits Service Program (CHBSP) within the Department of Health Care Services (DHCS). The CHBSP would identify barriers and incentives to establishing joint-ventures between local initiatives, local health plans, county organized health systems (COHS) and county health authorities with the County Medical Services Program (CMSP) and would assist local health care entities to support development of the joint-ventures. The bill would also create a stakeholder committee with six members appointed by the DHCS Director, representing CSMP, health care providers, employers, and COHS, which would report findings to the Legislature by January 1, 2009 and annually thereafter. The bill would require that all joint ventures be licensed by the Department of Managed Health Care (DMHC). The DMHC would be allowed flexibility in issuing new, modified or combined licenses to local initiatives or COHS in order to contract with the MRMIB or to provide coverage in individual or group markets. The bill would require private funding be received by the state prior to implementing nearly all CHBSP activities.

**\*SB 981** (Perata) Health care coverage: non-contracting hospital-based physician claims.  
Version: Amended 06/17/2007  
Sponsor: Author  
Status: 06/24/2008-Set for hearing in Assembly HEALTH

This bill would require health plans to pay a non-contracting emergency room physician the lesser of the physician's full charge or the newly created "interim payment standard" as defined. The bill would create various payment rates and standards for non-contracted emergency room physicians and would require the Department of Managed Health Care to adjust the interim payment standard every

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12 months. It would create the Independent Dispute Resolution Process (IDRP) to resolve payment disputes between health plans and providers and would authorized it to assess penalties on health plans that show a pattern of “willfully violating” the provisions of this bill or that “engage in practice intended to abuse” the IDR. It would also require that noncontracting emergency physicians seeking resolution from the IDR to first use the health care plan’s dispute resolution process. This bill would become effective on July 1, 2009 and sunset on December 31, 2013

**\*SB 1440** (Kuehl) Health care coverage.

Version: Amended 06/16/2008

Sponsor: California Medical Association

Status: 06/24/2008-Set for hearing in Assembly HEALTH

Current law does not limit the amount of administrative expenses that health plans or health insurers may pay with money derived from sources other than subscribers. This bill would require full-service health care service plans or health insurers to spend at least 85% of the dues, fees, premiums, and other periodic payments received by the health plan or health insurer on health care benefits beginning January 1, 2009. The bill would define “health care benefits” for the purpose of determining administrative expenses. For the purpose of determining the cost/benefits ratio, the bill would permit a health plan or health insurer to average its total costs across all its California health care plan contracts or health insurer policies. The bill would require health plans and insurers, as of June 1, 2009, and then annually, to report to their regulator that they meet these requirements. It would also allow their regulator to fine or otherwise penalize them for failure to comply.

**\*SB 1522** (Steinberg) Health care coverage: coverage choice categories.

Version: Amended 06/11/2008

Sponsor: Health Access

Status: 06/18/2008-Assembly APPROPRIATIONS

This bill would require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) by April 1, 2009 to jointly adopt regulations to develop systems to categorize all full-service (non-specialized) health plan contracts and health insurance policies offered and sold to individuals (non-group coverage) into 5 coverage benchmark categories. It would require each full-service plan and insurer offering individual coverage to offer at least one contract or policy in each coverage category and meet various standards for price, benefits, type of product (HMO, PPO, EPO, POS, indemnity model, etc.). The bill would require that full-service plans and insurers be given flexibility in establishing provider networks for the new products as long as they meet access-to-care standards and other specified requirements. The bill includes other related requirements for full-service plans and insurers regarding pricing of products and their regulation. It would also require that all individual coverage sold on or after January 1, 2009 contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits. It would require DMHC and CDI to annually report on contracts and policies offered in each category and enrollment by category and, every three years, to review and consider revising the standard benefit packages to meet the needs of consumers. It would require DMHC and CDI to develop a notice about the range of cost and benefits to facilitate comparison shopping for individual coverage, and require health plans and insurers to provide the notice to consumers when marketing products or sending information about purchasing or renewing coverage. It would require the University of California Health Benefits Review Program (UCHBRP) to report on specific data about individual coverage issues 3 months prior to the development of the new benefit levels by DMHC and CDI, and allows DMHC and CDI to request additional UCHBRP reports prior to their annual and triennial reviews of benefits.

*\*New status since last board meeting*

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**\*SB 1525** (Kuehl) Health care service plans: onsite medical survey.

Version: Amended 04/24/2008

Sponsor: Author

Status: 06/18/2008-Assembly APPROPRIATIONS

Existing law requires the Department of Managed Health Care (DMHC) to survey health plans' procedures for obtaining health services, regulating utilization, and assuring quality of care. This bill would add a requirement that the DMHC also review health plan procedures for making determinations of medical necessity. It would also require plans and insurers to report to DMHC or the California Department of Insurance (CDI), and, upon request, to enrollees and providers the rates of initial delays, denials, or modifications of health care services or payments, and the specific rates of delay, denial or modification due to services' being medically unnecessary or uncovered benefits.

**\*SB 1553** (Lowenthal) Health care service plans.

Version: Amended 05/23/2008

Sponsor: California Society of Clinical Social Work, California Association of Marriage and Family Therapists

Status: 06/24/2008-Assembly HEALTH

This bill would add access and continuity of care requirements for mental health plans and plans offering mental health services. The bill would also increase involvement of mental health practitioners in consulting with and resolving disputed requests for authorization, modification or denial of services by health plans and contracting medical providers offering professional mental health services. It would improve public access to information about grievance processes at health plans and the Department of Managed Health Care and would make it easier for the public to obtain information from health plans' about their processes for authorizing, modifying or denying services.

**\*SB 1634** (Steinberg) Health care coverage: cleft palates.

Version: Amended 04/23/2008

Sponsor: California Society of Plastic Surgeons

Status: 06/24/2008-Assembly HEALTH

This bill would require health plans and health insurers, on or before January 1, 2009, to cover medically necessary orthodontic services for cleft palate procedures upon prior authorization and completion of the utilization review processes.

*\*New status since last board meeting*

*\*\*New bill since last board meeting*

**Managed Risk Medical Insurance Board  
Bills No Longer Being Tracked**

Note: Reflects information available as of 06/19/2008.

**\*AB 1774** (Lieber) Health care coverage: uterine and ovarian cancer screening tests.

Version: Amended 04/22/2008

Sponsor: Cancer Schmancer

Status: 05/23/2008-Assembly APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would require health insurance policies issued, amended, or renewed, on or after January 1, 2009, to provide coverage for any medically necessary test, as determined by health care providers, to screen for and diagnose gynecological cancers. Current law authorizes health plans, not providers, to make this determination. The bill further requires the test to be provided consistent with national professional standard guidelines.

**\*AB 2088** (Beall) Public health: tobacco fees: Secretary of Addiction Prevention and Recovery Services.

Version: Amended 04/07/2008

Sponsor: Author

Status: 05/23/2008-Assembly APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would create a new cabinet-level Secretary of Addiction Prevention and Recovery Services who would oversee alcohol abuse and drug abuse issues in the state. It would also create the Addiction Prevention and Recovery Board within the State Department of Alcohol and Drug Programs.

**\*AB 2847** (Krekorian) Health care coverage.

Version: Amended 04/23/2008

Sponsor: California Medical Association

Status: 05/23/2008-Assembly APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would require health plans and insurers, until January 1, 2014, to disprove a provider's determination of medical necessity when a plan or insurer is legally challenged about its decision to deny, delay or modify health care services. The bill also would allow treating providers, under specified conditions, to apply directly to the health plan's or insurer's regulator for independent medical review of denied, limited or delayed health care services.

**\*AB 2861** (Hayashi) Mental health services.

Version: Amended 06/17/2008

Sponsor: California Hospital Association

Status: 06/25/2008-Set for hearing in Senate HEALTH.

This bill was amended to no longer concern or impact MRMIB. The previous version of this bill would require, with exceptions, a health care service plan to reimburse providers for emergency mental health services provided to its enrollees until the enrollee is stabilized. Prior authorization would not be required as long as federal or state law require that emergency services be provided without first questioning the patient's ability to pay.

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**\*AB 2902** (Swanson) Public health outreach: community health care workers.  
Version: Amended 05/23/2008  
Sponsor: Ron Dellums, Mayor of Oakland  
Status: 06/25/2008- Set for hearing in Senate HEALTH.

This bill was amended deleting any reference to the Healthy Families Program (HFP). The previous version of this bill would have required the Office of Multicultural Health, State Department of Public Health, to encourage the use of community-based health care workers to target underserved communities, including encouraging the Healthy Families program to use and reimburse these workers, when cost effective.

**\*AB 3027** (De Leon) Health care coverage: disclosures: foreign languages.  
Version: Amended 04/02/2008  
Sponsor: Latino Issues Forum  
Status: 05/23/2008-Assembly APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would require that the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) jointly develop a “notice,” on or before January 30, 2009, to inform subscribers how to access “interpretive” services to assist them in communicating with their doctor, plan or insurer. The notice would also include DMHC and CDI contact information to assist subscribers “with difficulties in, or complaints about, accessing” their health plans or insurers. The notice would be required to be written in all languages for which Medi-Cal materials are required to be written. The bill would require, on and after March 2, 2009, that health plans and health insurers distribute the document to subscribers with “annual enrollment or disenrollment correspondence, all notices and forms, and any appointment-related information,” and in at least one separate mailing on June 1 of each year.

**\*SB 1459** (Yee) Healthy Families Program.  
Version: Amended 05/13/2008  
Sponsor: California Nurses Association  
Status: 05/23/2008-Senate APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would require the MRMIB to change existing (centralized) systems to transfer Healthy Families program eligibility determination to 58 (decentralized) county welfare departments beginning on or before July 1, 2009. It would:

- Require MRMIB to consult with the Department of Health Care Services (DHCS), and require DHCS and MRMIB to consult with stakeholders, including counties and client advocates, to change existing systems and develop procedures for the transfer.
- Allow HFP to continue to use a private vendor to collect premiums and assist with health plan selection. However, the intent is to incorporate these functions, to the extent possible, into the Medi-Cal managed care enrollment broker administered by DHCS.
- Require counties to assume full responsibility for eligibility determinations by January 1, 2010.

This bill would also create the California Health Care Program (Cal-Health) to be established by the Secretary of California Health and Human Services (CHHS) with assistance from the MRMIB and the State Department of Health Care Services (DHCS). Cal-Health would:

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- Coordinate efforts to market HFP, Medi-Cal and CalHealth to persons potentially eligible for these programs;
- Permit “participating providers” to screen and enroll children into 60-day accelerated temporary coverage in HFP or Medi-Cal, to the extent allowed by federal law, and create an electronic process and systems infrastructure to perform these functions;
- Secure sufficient information to ensure that counties are able to screen and refer applicants ineligible for programs within Cal-Health but potentially eligible for other state health care programs;
- Include information about Cal-Health on the joint HFP-Medi-Cal application;
- Prohibit Medi-Cal asset tests for children and adults under Section 1931(b), to the extent allowed by federal or other laws, and
- Require preschools, and public elementary and secondary schools to inform all parents of enrolled children about Cal-Health and allow application to be submitted at these schools, and require providers and urgent and emergency services to inform children admitted for care about Cal-Health.

The bill would also:

- Implement “accelerated enrollment” for pregnant women, beginning one month after federal approval or on July 1, 2009, whichever is later, as permitted by federal and other law;
- Eliminate (centralized) “single point of entry” for accelerated HFP and Medi-Cal enrollment of children and pregnant women, and, instead, require 58 (decentralized) counties to perform these functions and coordinate with Medi-Cal’s enrollment broker for case management.

**\*SB 1540** (Correa) Health care coverage: children.

Version: Amended 04/23/2008

Sponsor: Author

Status: 05/12/2008-Senate RULES

This bill failed the deadline for bills to pass from their house of origin. This bill states the intent of the Legislature to launch a pilot program in Orange County to improve health care services to children’s dental health, early developmental screenings and intervention, and to immunization. Provisions of the previous version of this bill regarding details about the pilot program were deleted.

**\*SB 1593** (Alquist) Health care coverage: children.

Version: Amended 05/07/2008

Sponsor: TBD

Status: 05/23/2008-Senate APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would require MRMIB and the Department of Health Care Services (DHCS) to develop a process for transitioning children under age 19 from coverage in Children’s Health Initiatives (CHIs) into enrollment in Healthy Families or Medi-Cal and would create a fund for this purpose. It is contingent on enactment of legislation during the 2007-08 Regular or Extraordinary Session that would expand eligibility “at or below 300 percent” of FPL in HFP or Medi-Cal. It would also limit children covered through this bill to those currently enrolled in CHIs. It would require the MRMIB to administer the fund created by this bill. It would require the fund moneys to be distributed by July 1, 2009 to CHIs using a formula the MRMIB, children’s advocates and CHIs would jointly develop. It would allow the MRMIB to adopt emergency regulations to implement the transition of children from CHIs into HFP or Medi-Cal.

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**\*SB 1622** (Simitian) California Health Benefits Service Program.

Version: Amended 03/25/2008

Sponsor: American Federation of State County Municipal Employees

Status: 05/23/2008-Senate APPROPRIATIONS. In suspense file.

This bill failed to meet the deadline for passage from Appropriations. This bill would create the California Health Benefits Service Program (CHBSP) within the Department of Health Care Services (DHCS) to identify barriers and incentives to establishing joint-ventures between local initiatives, local health plans, county organized health systems (COHS) and county health authorities with the County Medical Services Program (CMSP). The CHSBP would include six members appointed by the DHCS Director, representing CSMP, health care providers, employers, and COHS, and would report findings to the Legislature by January 1, 2009 and then annually. The bill would require all joint ventures to be licensed by the Department of Managed Health Care (DMHC). The DMHC would be allowed flexibility in issuing new, modified or combined licenses to local initiatives or COHS in order to contract with the Managed Risk Medical Insurance Board or to provide coverage in individual or group markets.

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Long-term comprehensive balance billing data is not readily available for HFP or AIM subscribers. However, a review of complaints made to MRMIB's Benefits and Quality Monitoring Division from January 2007 to March 2008 shows that 4% or 16 of 456 complaints received by the division were about balance billing, excluding contacts from subscribers who transferred health plans. This data does not represent the extent of balance billing among HFP and AIM subscribers since these subscribers may or may not report balance billing occurrences to their health plans, the DMHC, the MRMIB, or instead they may simply pay some or all of any balance billing charges without filing a grievance with any entity.

A 2007 APCO Insight Survey estimates 1.76 million insured Californians were balance billed for emergency room services in the last two years. Of these, 56 percent (985,600) personally paid the bill.

SB 697 is expected to have a negligible impact on MRMIB's administrative and benefits costs, and it is not anticipated to require any additional regulations nor to conflict with MRMIB's current policies.

On behalf of the MRMIB and approximately one million children and pregnant women served through the *Healthy Families* and the *Access for Infants and Mothers* programs, we strongly urge passage of SB 697.

Sincerely,

Lesley Cummings  
Executive Director

cc: Assembly Health Committee Members  
Jennifer Kent, Office of Governor Arnold Schwarzenegger  
Senator Leland Yee  
Almis Udrys, Assembly Republican Caucus  
Kevin Hanley, Assembly Republican Caucus  
Managed Risk Medical Insurance Board Members