

# Senate Health Committee

## Summary of Significant Legislation, 2009-2010

### AGING AND LONG-TERM CARE

**SB 303 (Alquist) - Nursing facility residents: informed consent.** Codifies existing regulations that establish a skilled nursing facility (SNF) resident's right to informed consent concerning the use of psychotherapeutic drugs. Specifies the type of information residents must receive in order to give informed consent, and requires nursing home staff to verify informed consent prior to the administration of a psychotherapeutic drug. *Vetoed.*

**SB 687 (Alquist) - Long-term health care facilities: healthcare-associated infection.** Prohibits a person from being refused placement in a long-term health care facility (LTCF) based on the diagnosis of a healthcare-associated infection (HAI) or a positive test for the presence of an organism. Requires long-term health care facilities to implement appropriate infection control measures for patients diagnosed with an HAI and requires each facility to maintain a record of infections. *Held in Senate Appropriations Committee.*

**SB 732 (Alquist) - Medi-Cal: long-term care reimbursement: cost reporting methodology.** Requires the Department of Health Care Services (DHCS) to establish a skilled nursing facility (SNF) cost reporting methodology that allows the department to adjust Medi-Cal reimbursement rates in an expedient manner. Subsequently amended to allow DHCS to continue the use of provider bulletins in implementing the Medi-Cal Long-Term Care Reimbursement Act and SNF quality assurance fee instead of regulations for one additional year. *Referred to Assembly Health Committee; hearing canceled at the request of author.*

**SB 998 (Liu, Alquist) – Long-term care: assessment and planning.** Requires the Department of Health Care Services, in consultation with a stakeholder group, to develop or identify a long-term care assessment tool for use in case management. Additionally, requires each county to establish a long-term care case management program for persons who are Medi-Cal recipients or applicants or individuals eligible for both Medicare and Medi-Cal and who are residing in a long-term health care facility, who apply for admission to a long-term health care facility or are at imminent risk of being placed in a long-term health care facility. *Held in Senate Appropriations Committee.*

**AB 215 (Feuer) - Skilled nursing facilities: ratings.** Requires a long-term health care (LTC) facility that provides skilled nursing care to post, in accordance with specified requirements, the overall facility rating information determined by the federal Centers for Medicare and Medicaid Services (CMS). *Chapter 420, Statutes of 2009.*

**AB 317 (Yamada) - Adult day health care centers.** Exempts two veterans facilities (one in Ventura and one in Lancaster) from the moratorium prohibiting the enrollment of adult day health care centers into the Medi-Cal program. *Vetoed.*

**AB 392 (Feuer) - Long-term health care facilities.** Appropriates \$1.6 million from the Federal Health Facilities Citation Penalties Account to the Department of Aging for local ombudsman programs. Takes effect immediately as an urgency statute. *Chapter 102, Statutes of 2009.*

**AB 773 (Lieu) - Health facilities citations: notifications.** Requires long-term care facilities to post Class "AA" and "A" citations for 120 days. This bill deletes the requirement in existing law that the posting be prescribed in regulations issued by the Department of Public Health (DPH), and that the violations be posted until the violation is corrected to the satisfaction of DPH, up to a maximum of 120 days. This bill deletes the requirement in existing law that the citation become final before it is required to be posted. Additionally, the bill specifies the minimum locations where the citation must be posted, the paper and font size of the posting (which must include the name and address of the facility) and require the posting to include whether the citation is a Class AA or Class A citation. *Chapter 472, Statutes of 2009.*

**AB 931 (Fletcher) - Emergency drug supply container limit.** Increases the limit on the number of forms of drugs from 24 to 48 that can be stored in a secured emergency supplies container (known as an "emergency kit") provided by a pharmacy to a skilled nursing facility or an intermediate care facility. Caps the number of psychotherapeutic medications in an emergency kit but allows the number to be increased by the Department of Public Health through a program flexibility request granted to a facility based on the needs of the facility's patient population, as specified. Allows the Department of Public Health to increase the limit on the number of doses in an emergency kit from 4 to 16. *Chapter 491, Statutes of 2009.*

**AB 950 (Hernandez) -- Hospice providers: licensed hospice facilities.** Establishes hospice facility as a new health facility licensing category under the authority of the Department of Public Health. Requires DPH to develop regulations governing licensure of hospice facilities by June 30, 2015. Defines services that a licensed hospice facility must provide. Requires facilities to meet the same staffing standards applicable to congregate living health facilities. Permits licensed and certified hospice services providers to provide inpatient hospice services through the operation of a hospice facility. *Held in Senate Appropriations Committee.*

**AB 1593 (Yamada, Knight) – Adult day health care centers.** Exempts two veterans' facilities (the William J. "Pete" Knight Veterans Home of California, Lancaster and the Veterans Home of California, Ventura) from the moratorium on the certification and enrollment of new Adult Day Health Care (ADHC) centers into Medi-Cal, contingent upon an appropriation of funds in the annual Budget Act. *Vetoed.*

**AB 2555 (Feuer, Jones, Nielsen) – Ombudsman programs: appropriation.** Appropriates \$1.6 million from the State Health Facilities Citation Penalties Account (State Account) to the California Department of Aging (CDA) for local ombudsman programs. Takes effect immediately as an urgency statute. *Held in Senate Appropriations Committee.*

## **AIDS/HIV/HEPATITIS**

**SB 1029 (Yee) - Hypodermic needles and syringes.** Allows individuals over 18 years of age to obtain up to 30 syringes or needles for personal use without a prescription from a pharmacy beginning January 1, 2011 until December 31, 2018. Authorizes pharmacists and physicians to distribute up to 30 needles

to an individual over 18 years of age without a prescription solely for personal use beginning January 1, 2011 until December 31, 2018. Repeals the Disease Prevention Demonstration Project (DPDP), thereby removing a requirement for local governments to first provide authorization to local pharmacists who wish to furnish or sell hypodermic needles or syringes to persons 18 years of age or older. Requires all pharmacies that furnish nonprescription syringes to provide for safe disposal of syringe and sharps waste. Requires all pharmacies to provide information to purchasers of nonprescription syringes on access to drug treatment, HIV and hepatitis screenings, and safe disposal of syringe and sharps waste. Requires the websites of the Office of AIDS and the California State Board of Pharmacy to provide information on access to drug treatment, HIV and hepatitis screenings, and safe disposal of syringe and sharps waste. *Vetoed.*

**AB 221 (Portantino) - HIV testing: skin punctures.** Permits HIV (human immunodeficiency virus) counselors to perform basic skin punctures for the purpose of administering rapid HIV tests. Permits an HIV counselor to perform specified HIV tests if he or she has been trained in rapid HIV test proficiency for skin puncture blood tests, oral swab tests, and in universal infection control precautions, consistent with best infection control practices established by the Division of Occupational Safety and Health in the Department of Industrial Relations and the federal Centers for Disease Control and Prevention (CDC). *Chapter 421, Statutes of 2009.*

**AB 1045 (John A. Pérez) - HIV and AIDS reporting.** Provides that a clinical laboratory shall not be required to report CD4+ T-Cell test results to a local health officer if the clinical laboratory can demonstrate that the CD4+ T-Cell test result is not related to a diagnosed case of HIV infection. *Chapter 501, Statutes of 2009.*

**AB 1397 (Hill) - Tissue donation.** Modifies the responsibilities of physicians who provide insemination or advanced reproductive technologies (ART) to HIV discordant couples, where one partner is HIV positive and one is HIV negative. Provides that the physician providing insemination or ART is not responsible for providing prophylactic testing, monitoring, and follow-up of the recipient, but is required to recommend follow-up testing of the recipient for HIV and HTLV, as specified. Requires the physician to additionally inform the recipient of the need to provide documentation, prior to treatment, that she has established an ongoing physician relationship with another physician to provide for her medical care during and after completion of fertility services. Allows the Department of Public Health to adopt as regulations for facilities that process sperm the guidelines developed by the American Society for Reproductive Medicine pertaining to facilities that process sperm, as well as updates to those standards, through a modified rulemaking process. *Vetoed.*

**AB 1487 (Hill) – Tissue Donation.** Extends the date by which the California Department of Public Health (DPH) is required to adopt regulations prescribing sperm processing facilities' handling and storage of sperm from donors who are carriers of HIV and human T-lymphotrophic virus (HTLV) from January 1, 2010 to January 1, 2014. Requires that, in the absence of any regulations from DPH, sperm processing facilities are to follow guidelines developed by the American Society for Reproductive Medicine (ASRM) and allows DPH to adopt ASRM standards as initial regulations. Allows DPH to use a modified rulemaking process to develop the required regulations. Requires the recipient to document that she has a physician to provide ongoing care during and after her fertility services. Removes the responsibility of a physician providing ART from prophylactic testing, monitoring, and follow-up of the recipient. Provides that this is an emergency statute and is effective immediately. *Chapter 444, Statutes of 2010.*

**AB 1701 (Chesbro) – Hypodermic needle and syringes.** Extends the sunset date of the Disease Prevention Demonstration Project (DPDP), which permits registered cities or counties to authorize licensed pharmacists to provide 10 or fewer syringes to a person without a prescription, from December 31, 2010 to December 31, 2018. Stipulates that the act shall not become operative if SB 1029 of the 2009-10 Regular Session is enacted and takes effect on or before January 1, 2011. *Chapter 667, Statutes of 2010.*

**AB 1858 (Blumenfeld) – Hypodermic needles and syringes: exchange services.** Permits the Department of Public Health (DPH) to authorize certain entities to provide hypodermic needle and syringe exchange services consistent with state and federal standards, including those of the United States Public Health Service, in any location where DPH determines that the conditions exist for the rapid spread of HIV, viral hepatitis, or any other potentially deadly or disabling infections that are spread through the sharing of used hypodermic needles and syringes. Provides that these entities must have the capacity to commence needle exchange services within three months of authorization and to collect evaluative data in order to assess program impact. Additionally requires these entities to have adequate funding to provide needle exchange services, HIV and viral hepatitis prevention education services, and safe recovery and disposal of used sharps waste for all its participants. Requires DPH to provide biennial reports to local health officers in jurisdictions where DPH has authorized needle exchange services. Establishes that these provisions become inoperative on January 1, 2016. *Vetoed.*

**AB 2541 (Portantino) - Reporting of certain communicable diseases.** Deletes the provision in existing law that that excludes HIV infections from being reported to the Department of Public Health electronically. Provides that health care providers and local health officers may submit cases of HIV infection by a secure and confidential electronic reporting system established by the department, including facsimile. Authorizes specified disclosures of public health records relating to HIV or AIDS between specified local public health agency staff, health care providers, specified state public health agency staff, and HIV positive individuals who are the subject of the records, for the purposes of enhancing completeness of sexually transmitted disease reporting to the federal Centers for Disease Control and Prevention (CDC) and offering and coordinating care and treatment services to HIV positive persons. Increases the penalties for negligent, willful or malicious disclosure of content of any confidential public health record to a third party, except as otherwise authorized by law. *Chapter 470, Statutes of 2010.*

**AJR 13 (Ammiano) - Blood donation.** Requests the President of the United States to encourage, and the Secretary of the United States Department of Health and Human Services to adopt, policies that repeal the current donor suitability and deferral policies of the Food and Drug Administration (FDA) regarding blood donation by men who have had sex with other men and, instead, direct the FDA to develop science-based policies. *Resolution Chapter 164 of 2010.*

## **ALCOHOL AND DRUGS**

**SB 268 (Harman) - Alcoholism or drug abuse recovery or treatment facilities: licensing.** Requires applicants seeking licensure as a residential alcoholism or drug abuse recovery treatment facility to include in the application to the Department of Alcohol and Drug Programs (DADP) a certification that the proposed facility complies with local zoning, or is a legal non-conforming use, and to submit a fire clearance approved by the State Fire Marshall (SFM) or local fire prevention officer that is valid for the two-year duration of the license. *These provisions were subsequently amended out of the bill.*

**SB 707 (DeSaulnier) – Alcohol and other drug counselors licensing and certification.** Establishes a system of registration, certification, and licensing for alcohol and other drug counselors by the Department of Alcohol and Drug Programs (DADP). Creates three categories of certified counselors beginning with a Certified Alcohol and Other Drug Counselor, and including an advanced and clinical supervisor certification, who would all be certified by DADP to practice alcohol and drug counseling in a program licensed or certified by DADP. Establishes a Licensed Alcohol and Other Drug Counselor (LAODC) who may maintain an independent practice and can also provide clinical supervision. *Held in Senate Appropriations Committee.*

**SB 1071 (DeSaulnier) – Personal income tax credit: prescription drugs: controlled substances tax: CURES.** Imposes a tax on every manufacturer and importer, or other person that makes the first sale in the state, of a Schedule II, III or IV controlled substance, at the rate of \$0.0025 per pill. Creates a fund to support the Controlled Substance Utilization Review and Evaluation System (CURES). Authorizes a tax credit for medications for persons 55 years of age or older, as specified. *Failed passage in Senate Health Committee.*

**AB 217 (Beall) – Medi-Cal: alcohol and drug screening and brief intervention services.** Establishes a screening and brief intervention (SBI) services program for pregnant women or women of childbearing age within the Medi-Cal program, to be administered by the Department of Health Care Services, in collaboration with the Department of Alcohol and Drug Programs, for the purpose of allowing local funds to be used to secure federal matching funds for these services. Provides that participation in the screening and intervention program shall be voluntary for a Medi-Cal beneficiary and that the results shall be subject to all confidentiality requirements applicable to medical records. *Vetoed.*

**AB 417 (Beall) - Medi-Cal Drug Treatment Program: buprenorphine.** Requires buprenorphine services to be included within the scope of Drug Medi-Cal services, subject to certain requirements (buprenorphine is used to treat opioid addiction). Additionally, this bill requires a narcotic replacement therapy dosing fee for buprenorphine to be established. This bill would not be implemented if the Department of Health Care Services determines the provisions of this bill require an unbundling of Drug Medi-Cal reimbursement rates. *Held in Senate Appropriations Committee.*

**AB 564 (Portantino) – Substance Abuse Treatment Fund: prohibition of excessive salaries.** Establishes a limitation on the amount of compensation a director, officer, or employee of a nonprofit substance abuse treatment facility may receive from public sources, not to exceed a certain federal compensation limitation, and establish specified compensation requirements for any director, officer, or employee who collects rent from a drug treatment facility. Establishes restrictions on the distribution of funds from the Substance Abuse Treatment Trust Fund, it would amend the Substance Abuse and Crime Prevention Act of 2000. Requires the restrictions on compensation be included in any contract that the state enters into for drug treatment. *Vetoed.*

**AB 2221 (Beall) – Substance abuse: treatment facilities.** Authorizes residential treatment facilities licensed by the Department of Alcohol and Drug Programs (DADP) to include facilities that provide limited residential medical services to adults recovering from alcohol and drug abuse provided that the facility is not otherwise required to have a separate health facility license. Requires that the medical services be provided by a multidisciplinary team and that the program at the facility be accredited by a nationally recognized accrediting organization. *Held in Senate Appropriations Committee.*

**AB 2268 (Chesbro) – Alcohol and drug abuse.** Authorizes physicians and surgeons in California who are registered with the U.S. Attorney General, pursuant to specified federal law, to provide addiction treatments that are allowed under federal law. *Chapter 93, Statutes of 2010.*

## **CHILDREN’S HEALTH**

**SB 1 (Steinberg) – Health care coverage: children.** Expands eligibility for the Medi-Cal program and the Healthy Families Program by modifying the income requirements applicable to those programs, and by making coverage available regardless of citizenship or immigration status. Requires the Managed Risk Medical Insurance Board and the State Department of Health Care Services to make specified technological improvements to the existing eligibility determination and enrollment systems for the Medi-Cal program and the Healthy Families Program and to develop a process to transition the enrollment of children from local children’s health initiatives into those programs by July, 1 2011. *Referred to Senate Health Committee; hearing postponed at request of author.*

**SB 438 (Yee) - Healthy Families and Medi-Cal enrollment.** Requires the Department of Health Care Services, to seek federal approval for an option to accelerate Medi-Cal enrollment for children and pregnant women who apply for Medi-Cal at a county welfare office. Transfers Healthy Families program eligibility determination to county welfare offices. *These provisions were subsequently amended out of the bill.*

**SB 1051 (Huff) - Emergency medical assistance: administration of Diastat.** Allows a parent or guardian of a pupil with epilepsy who has been prescribed diastat to request that one or more school employees be trained to administer the drug when a nurse is not available. Schools can notify staff of the request for volunteers electronically. Stipulates that no one shall be threatened, coerced, or intimidated into volunteering. Requires schools to notify parents or guardians of their child's potential eligibility for services or accommodations through a Section 504 plan and encourage the parents and guardians to pursue that option. In the absence of a 504 plan, schools may create individualized health plans, seizure action plans, or any other appropriate health plan designed to acknowledge and prepare for a child's health care needs in school, which may include the use of trained school volunteers. Requires schools that choose to train unlicensed volunteers in the administration of diastat to develop a school plan with specified components. *Held in Senate Appropriations Committee.*

**SB 1109 (Cox) – California Children and Families Program: funding.** Eliminates existing allocations of tobacco tax revenue under Proposition 10 to state and local county children and family’s commission accounts and, instead, requires those funds to be used for the Healthy Families and Medi-Cal programs, subject to approval by the voters. Requires provisions be placed on a statewide ballot. *Failed passage in Senate Health Committee.*

**SB 1200 (Leno) – Health care coverage: timeliness of care.** Requires the Department of Managed Health Care (DMHC) and the Insurance Commissioner to develop regulations to ensure timeliness of care for school age children who must receive medically necessary services during school hours. Requires health care service plans and carriers to work with local education agencies to provide reimbursement for covered services provided to a child during school hours and to ensure adequate availability of licensed health care professionals to accommodate the necessary medical needs of children during school hours. Requires DMHC and the insurance commissioner to update existing regulations to include these provisions by January 1, 2012. *Held in Senate Appropriations Committee.*

**SBX8 41 (Cox) – California Children and Families Program: funding.** Eliminates existing allocations of tobacco tax revenue under Proposition 10 to state and local county children and family’s commission accounts and, instead, requires those funds to be used for the Healthy Families and Medi-Cal programs, subject to approval by the voters. Requires provisions be placed on a statewide ballot. *Failed passage in Senate Health Committee.*

**SJR 31 (Pavley, Alquist) - Individuals with disabilities: tax exempt accounts.** Urges the President and Congress to immediately enact currently proposed federal legislation creating tax-exempt accounts for individuals with developmental disabilities. *Resolution Chapter 54, Statutes of 2010.*

**AB 627 (Brownley) - Child care: nutritional requirements.** Establishes a pilot project under which a number of licensed child care centers and child day care homes that participate in the federal Child Care and Adult Food Program would receive higher state meal reimbursement to implement higher nutrition and physical activity standards. The pilot would include an evaluation conducted by an independent agency to assess the health, nutrition and other related impacts on children, providers, and parents. The pilot would be designed and implemented by the California Department of Education (CDE) only if the Superintendent of Public Instruction determines that non-General Fund funding sources, including federal or grant funds, are available to implement the pilot project. *Vetoed.*

**AB 2072 (Mendoza) – Hearing screening: resources and services.** Requires the California Department of Education (CDE), with the assistance of an advisory stakeholder panel, to develop an evidence-based informational pamphlet about visual and auditory communication and language options for infants identified as deaf or heard of hearing. Stipulates that the stakeholder panel consist of 15 members that are appointed by the Governor and the legislature. Creates the Language and Communication for Deaf and Hard of Hearing Children Fund in the State Treasury and provides that implementation shall only occur upon determination by the Director of Finance that sufficient donations have been collected and deposited into the fund. Provides that no state funds shall be used to implement these provisions. *Vetoed.*

**AB 2084 (Brownley) – Child day care facilities: nutrition.** Requires licensed child day care facilities to serve only low or nonfat milk to children ages two or older; limit juice to a maximum of one serving a day; and make clean drinking water available. Prohibits licensed child day care facilities from serving beverages with added sweeteners, natural or artificial. Exempts beverages provided by parents to the health care facility for their children, or beverages deemed medical necessities by a licensed physician. Authorizes the Department of Social Services to update the bill’s provisions based on changes of the Dietary Guidelines for Americans. Takes effect January 1, 2012. *Chapter 593, Statutes of 2010.*

## **CLINICAL LABS AND TISSUE BANKS**

**SB 744 (Strickland) - Clinical laboratories: deemed status.** Requires the Department of Public Health (DPH) to issue a certificate of deemed status to laboratories accredited by certain private, nonprofit organizations that they deem meet state licensure or registration requirements, provided that specified conditions are met. Except as otherwise authorized, provides that Department of Health Care Services shall not conduct routine inspections of a laboratory issued a certificate of deemed status. Allows DPH to conduct complaint investigations, sample validation inspections, and require submission of proficiency testing results to ensure compliance with state standards. Requires clinical laboratories to pay an application fee based on the number of tests it performs or expects to perform, as specified.

Requires DPH to report to the Legislature by July 1, 2013 the extent to which the state oversight program meets or exceeds federal oversight standards as specified. *Chapter 201, Statutes of 2009.*

**SB 975 (Price) – Tissue bank licensing.** Repeals the requirement that the Department of Public Health adopt regulations governing licensed tissue banks, and instead requires tissue banks to meet standards set forth in the edition of Standards of Tissue Banking in effect on January 1, 2011 as published by the American Association of Tissue Banks (AATB) pertaining to the collection, processing, storage, or distribution of human tissue. *Referred to Senate Health Committee; hearing canceled at the request of author.*

**SJR 15 (Alquist) - Public health laboratories.** Encourages the federal Centers for Medicare and Medicaid Services (CMS) to amend regulations, and the US Congress and President to enact legislation, to allow non-doctoral, non-board-certified persons to serve as local public health laboratory directors if they are qualified under the law of the state in which the public health laboratory is located, with the goal of ensuring adequate public laboratory support for response to communicable disease events, ensuring an adequate supply of public health laboratory directors, and increasing national security through adequate disease identification. *Resolution Chapter 46, 2010.*

**AB 599 (Hall) - Forensic blood alcohol testing laboratories.** Provides that, until the effective date of specified regulatory changes, for forensic alcohol labs that are accredited in the forensic alcohol analysis discipline or subdiscipline by the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB), compliance with the standards of that accrediting body is sufficient to comply with proficiency testing requirements pertaining to forensic alcohol labs. Requires proposed changes to regulations dealing with forensic alcohol laboratories to be submitted to the California Health and Human Services Agency by December 31, 2010. *Vetoed.*

**AB 995 (Block) - Tissue bank licensing.** Exempts from tissue bank licensing requirements the storage of certain federal Food and Drug Administration (FDA) regulated tissue-based products by a person who is licensed to provide health care services and who is acting within the scope of their license, provided the tissue-engineered product has been obtained from a licensed tissue bank and is stored in strict accordance with federal Food and Drug Administration regulations and guidelines, and is used for the purpose of implantation into, or application on, a patient and is not intended for further distribution. Requires, in order to be eligible for the exemption, the entity or organization where the physician or podiatrist who is eligible for the exemption is practicing to notify DPH, as specified. *Chapter 497, Statutes of 2009.*

## **DOMESTIC VIOLENCE**

**SB 273 (Corbett) - Domestic violence.** Changes the definition of domestic violence in the comprehensive shelter-based service program administered by the Maternal, Child, and Adolescent Health Division Branch in the Department of Public Health to explicitly extend services to males, and makes the program subject to specified anti-discrimination provisions. Additionally changes the definition of domestic violence in the statewide domestic violence program administered by the California Emergency Management Agency to explicitly extend services to males. *Chapter 177, Statutes of 2009.*



**AB 1003 (John A. Pérez) - Domestic violence grants.** Allows the number of grants awarded in the Equality in Prevention and Services for Domestic Abuse Program to be increased beyond the four annual limit currently permitted, changes the process by which these grants are awarded, and provides standards for domestic violence programs staff who provide services using these grant awards. *Chapter 498, Statutes of 2009.*

## **EMERGENCY MEDICAL SERVICES**

**AB 235 (Hayashi) - Emergency services and care.** Extends the definition of emergency services and care to include additional screening, examination, and evaluation by appropriate medical professionals to determine if a psychiatric emergency medical condition exists, and clarifies hospital and health plan responsibilities regarding psychiatric emergencies. *Chapter 423, Statutes of 2009.*

**AB 911 (Lieu) - Emergency rooms: overcrowding.** Requires all hospitals that operate emergency departments to assess the condition of its emergency department by determining a crowding score, as specified. Requires hospitals to develop and file full capacity protocols that correspond to the crowding score with the Office of Statewide Health Planning and Development. *Vetoed.*

**AB 1272 (Hill) - Emergency medical services: trauma center: helicopter landing pad.** Permits an emergency medical services (EMS) agency to submit a request for notification by a city, county, or city and county of a notice of any zoning variance, permit, amendment, or entitlement for use that would permit the construction or operation of a heliport or helipad on the property of a general acute care hospital. Permits the local EMS agency, or an EMS agency from a county adjacent to the proposed heliport or helipad, after receiving the notice, to prepare a report, as specified, to consult with representatives of the city, county, or city and county regarding that report, and to provide written comments and appear at a hearing regarding the proposed construction or operation of a heliport or helipad. *Died in Senate Rules Committee.*

**AB 1475 (Solorio) - Emergency medical services.** Limits counties' reimbursement for administering county Maddy Emergency Medical Services Funds to the actual administrative costs or ten percent, whichever is lower, including for administration of the additional penalty assessment funds that are authorized until January 2014. *Chapter 537, Statutes of 2009.*

**AB 1503 (Lieu) - Emergency medical care: billing.** Requires emergency physicians who provide emergency medical services in the emergency room of a hospital to provide discounts to financially qualified uninsured patients, including those with incomes below 350 percent of the federal poverty level. Requires each hospital to include information about emergency physician's obligations in the hospital's written policy on discounted payments and charity care. Requires emergency physicians to limit their expected payment for services from financially qualified patients to an amount that is initially no greater than 50% of the median of billed charges based on a nationally recognized database. Places constraints on the debt collection activities of emergency physicians with regard to financially qualified patients. *Chapter 445, Statutes of 2010.*

**AB 2153 (Lieu) - Emergency room crowding.** Requires all hospitals that operate emergency departments to assess the condition of its emergency department by determining a crowding score, as specified. Requires hospitals to develop and file full capacity protocols that correspond to the crowding score with the Office of Statewide Health Planning and Development. *Placed on Senate inactive file.*

**AB 2173 (Beall) – Emergency air transport: penalty.** The Emergency Medical Air Transportation Act imposes an additional penalty of \$4 upon every conviction for an offense involving a vehicle violation, except certain parking offenses, to provide for increased Medi-Cal funding of emergency air ambulance transportation. Requires each county board of supervisors to establish in the county treasury an emergency medical air transportation act fund into which the penalty collected pursuant to this bill would be deposited. *Chapter 547, Statutes of 2010.*

**AB 2248 (Hernandez) – Emergency medical care.** Requires a county, that establishes a Maddy Emergency Medical Services Fund (Maddy Fund) for reimbursement of emergency medical services (EMS) related costs, to provide additional information regarding the moneys collected and disbursed in a report required to be submitted to the Legislature on an annual basis. *Vetoed.*

**AB 2456 (Torrico) – Medical services: regulation.** Requires the Emergency Medical Services Authority (EMSA) to develop regulations establishing standards for policies and procedures applicable to the functions, certification, and licensure of emergency medical technician (EMT) personnel. Allows an Emergency Medical Services (EMS) provider to appeal a determination made by the Director of EMSA, regarding these regulations, to the EMS Commission, and allows the Commission to overrule the determination of the Director. *Vetoed.*

## **ENVIRONMENTAL HEALTH**

**SB 759 (Leno) - Federal state of emergency: aerial spraying of pesticide: inert ingredients: information.** Prohibits the use of pesticides for aerial spraying near populated areas or specified sites in certain emergency circumstances, unless the manufacturer had previously disclosed the complete ingredient list to the Office of Environmental Health Hazard Assessment (OEHHA). Requires OEHHA to disclose ingredient information to local governments and specified health care providers in effected areas, and requires the director to seek federal reimbursement for all state costs associated with the emergency, as permitted by federal law. *Held in Senate Appropriations Committee.*

**SB 797 (Pavley) - Product safety: bisphenol A.** Prohibits the manufacture, sale or distribution of any bottle or cup that contains bisphenol A, at a level above 0.1 parts per billion (ppb), if the bottle or cup is designed or intended to be filled with a liquid, food, or beverage intended primarily for consumption by children three years of age or younger. Also prohibits the manufacture, sale or distribution of liquid infant formula in a can or plastic bottle containing bisphenol A or lined with a material containing bisphenol A. Requires manufacturers to use the least toxic alternative when replacing bisphenol A in containers, and prohibits manufacturers from replacing bisphenol A with carcinogens or reproductive toxicants, as specified. Repeals these prohibitions if the Department of Toxic Substances Control (DTSC) adopts regulations pursuant to the current "Green Chemistry" provisions of AB 1879 (Feuer and Huffman), Chapter 559, Statutes of 2008, regarding the use of bisphenol A. *Senate refused to concur in Assembly amendments.*

## **FOOD SAFETY, LABELING AND NUTRITION**

**SB 173 (Florez) - Food safety: testing and recalls.** Provides that the State Public Health Officer may adopt regulations for the voluntary recall of food that, without intervention, could transmit an illness that

could kill or seriously affect the health of humans, including, in addition to the original condition, those clinically plausible secondary illnesses, infections, pathogens, contagions, toxins, or conditions arising from the effects of the original condition. *Vetoed.*

**SB 190 (Wright) - Misbranded food: pomegranate juice.** Directs the Department of Public Health to adopt regulations establishing definitions and standards of identity for 100 percent pomegranate juice in consultation with interested parties by July 1, 2011. Clarifies that the regulations must apply regardless of the origin or source of the pomegranates. Requires moneys deposited on or after January 1, 2010, into the Food Safety Fund, to be made available, upon appropriation by the Legislature, to fund the development and adoption of the regulations required by this bill. *These provisions were subsequently amended out of the bill.*

**SB 241 (Runner) - Retail food facilities.** Establishes “single operating site mobile food facility” as a new category of mobile food facilities regulated under the California Retail Food Code, imposes various requirements on these facilities, and revises standards applicable to mobile food facilities and satellite food facilities, makes additional technical and non-substantive amendments to the California Retail Food Code, and declares that these provisions will take effect immediately as an urgency statute. *Chapter 571, Statutes of 2009.*

**SB 453 (Padilla) - Food safety.** Requires an individual involved in the preparation, storage, or service of food to obtain a food handler card within 30 days after his or her hire date commencing January 1, 2011. Requires the California Department of Public Health (DPH) to develop and implement standards for accrediting food handler certification organizations and guidelines for approved food handler courses by June 1, 2010. *Held in Senate Appropriations Committee.*

**SB 602 (Padilla) – Food safety.** Requires an individual involved in the preparation, storage, or service of food to obtain a food handler card within 30 days after his or her hire date at a food facility, with specified exceptions, as of June 1, 2011. Mandates at least one of the accredited food safety certification examinations required under current law to be offered online. *Chapter 309, Statutes of 2010.*

**SB 888 (Yee) – Food safety: Asian rice-based noodles.** Requires manufacturers of Asian rice based noodles, as defined, to place a label on the product indicating the date and time of manufacture and include a statement that the noodles must be consumed within eight hours of manufacture. Allows a food facility to sell Asian rice-based noodles that have been at room temperature for no more than eight hours. *Chapter 508, Statutes of 2010.*

**SB 1255 (Padilla – Schools: nutrition: beverages.** Restricts the sale of electrolyte replacement beverages from being sold in elementary, middle, and high schools from 30 minutes before the start of the school day, to 30 minutes after school has ended, commencing July 1, 2011. *Held in Assembly Appropriations Committee.*

**AB 627 (Brownley) - Child care: nutritional requirements.** Establishes a 12-month or more pilot project in which a number of licensed child care centers and child day care homes that participate in the federal Child Care and Adult Food Program would receive higher state meal reimbursement to implement higher nutrition and physical activity standards. The pilot would include an evaluation conducted by an independent agency to assess the health, nutrition and other related impacts on children, providers, and parents. The pilot would be designed and implemented by the California Department of

Education (CDE) only if the Superintendent of Public Instruction determines that non-General Fund funding sources, including federal or grant funds, are available to implement the pilot project. *Vetoed.*

**AB 2084 (Brownley) – Child day care facilities: nutrition.** Requires licensed child day care facilities to serve only low or nonfat milk to children ages two or older; limit juice to a maximum of one serving a day; and make clean drinking water available. Prohibits licensed child day care facilities from serving beverages with added sweeteners, natural or artificial. Exempts beverages provided by parents to the health care facility for their children, or beverages deemed medical necessities by a licensed physician. Authorizes the Department of Social Services to update the bill's provisions based on changes of the Dietary Guidelines for Americans. Takes effect January 1, 2012. *Chapter 593, Statutes of 2010.*

**AB 2432 (John A. Pérez) – Food facilities: prepackaged nonpotentially hazardous foods.** Exempts a permanent food facility that has less than 300 square feet of display area, and that sells only prepackaged food that is not potentially hazardous food, from the requirements of the California Retail Food Code, except for specified provisions. *Chapter 682, Statutes of 2010.*

**AB 2720 (John A. Pérez) – Public health: food access.** Creates the California Healthy Food Financing Initiative (CHFFI) and CHFFI Fund in the State Treasury until January 1, 2014 to expand access to healthy foods in underserved communities. Provides that the CHFFI Fund be comprised of state, federal, and private funding and be allocated by the Legislature. Requires the California Department of Food and Agriculture (CDFA), in consultation with the Department of Public Health and Department of Social Services, to prepare recommendations to promote food access by July 1, 2011. Permits CDFA to coordinate efforts to implement the federal Healthy Food Financing Initiative and maximize its funding. *Vetoed.*

## **HEALTH CARE REFORM IMPLEMENTATION**

**SB 227 (Alquist) - Health care coverage: temporary high risk pool.** Requires the Managed Risk Medical Insurance Board (MRMIB) to enter into an agreement with the federal Department of Health and Human Services (DHHS) to administer a qualified high-risk pool to provide health coverage, until January 1, 2014, to individuals who have pre-existing conditions, consistent with the federal Patient Protection and Affordable Care Act. Establishes the authority and requirements for MRMIB in administering the federal pool, consistent with federal law. Appropriates \$761 million from the Federal Trust Fund to MRMIB. Makes this bill operative contingent upon enactment of AB 1887 (Villines), and both bills would sunset on January 1, 2020. Takes effect immediately as an urgency bill. *Chapter 31, Statutes of 2010.*

**SB 900 (Alquist, Steinberg) – California Health Benefit Exchange.** Establishes in state government the California Health Benefits Exchange (Exchange) as an independent public entity. Requires the Exchange be governed by a board that includes the Secretary of the Health and Human Services Agency (Agency) and four members with specified expertise who are appointed by the Governor and the Legislature. Specifies the expertise required for board membership and the duties of board members, the duration of terms of board members, and enacts conflict-of-interest provisions that apply to board members and Exchange staff. Provides that its provisions only take effect if AB 1602 (Perez) (see below) is also chaptered. *Chapter 659, Statutes of 2010.*

**SB 1088 (Price) - Health care coverage: dependents.** Prohibits health plans and health insurers from using a limiting age for dependent children covered by their parent's health plan contract, or health

insurance policy, from being less than 26 years of age beginning on or after September 23, 2010. Allows, but does not require, employers to pay premiums associated with extending dependent coverage for those between 23 and 26 years old. Specifies timelines for health plan contracts and insurance policies for those 26 years of age. Clarifies circumstances for young adults who previously lost or were denied dependent health coverage to re-enroll on their parent's health plan or insurance policy, and requires plans and insurers to provide written notice related to those circumstances. **Chapter 660, Statutes of 2010.**

**SB 1163 (Leno) – Health care coverage: denials: premium rates.** Requires health plans and health insurers to file with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) (regulators) specified rate information for at least 60 days prior to implementing any rate change. Requires rate filings to be actuarially sound. Increases, from 30 days to 60 days, the amount of time that a health plan or insurer must provide written notice before a change in premium rates or coverage becomes effective. Requires health plans and insurers that decline to offer coverage or that deny enrollment for a large group applying for coverage, or that offer small group coverage at a rate that is higher than the standard employee risk rate, to provide the applicant with reason for the decision. **Chapter 661, Statutes of 2010.**

**AB 1602 (John A. Pérez) – California Health Benefit Exchange.** Specifies the duties and authority of the California Health Benefits Exchange (Exchange). Requires the Exchange to determine the minimum requirements health plans must meet for participation in the Exchange and the standards and criteria for selecting health plans to be offered in the Exchange. Requires the Exchange to provide in each region of the state a choice of qualified health plans, at each of the five levels of coverage contained in federal law (a platinum, gold, silver, bronze and catastrophic level benefit plan). Provides that its provisions only take effect SB 900 (Alquist) (see above) is also chaptered. **Chapter 655, Statutes of 2010.**

**AB 1887 (Villines) – Temporary high risk pool.** Establishes the Federal Temporary High Risk Health Insurance Fund (Fund). Requires money in the Fund to be continuously appropriated to the Managed Risk Medical Insurance Board (MRMIB) for the purpose of establishing a federal temporary high-risk pool established under SB 227 (Alquist) for individuals with a pre-existing medical condition. Takes effect immediately as an urgency statute, contingent upon the enactment of SB 227. **Chapter 32, Statutes of 2010.**

**AB 2244 (Feuer) – Health care coverage.** Requires guaranteed issue of health plan and health insurance products for children in 2011 and adults in 2014. Establishes standard individual market rating factors (age, geographic region, family composition and health benefit plan design). Limits 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 for children who are in an open enrollment period. **Chapter 656, Statutes of 2010.**

**AB 2345 (De La Torre) – Health care coverage: preventive services.** Requires health care service plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the provisions of federal Patient Protection and Affordable Care Act regarding coverage of, and cost-sharing for, preventive services, and any rules or regulations issued pursuant to the Act. **Chapter 657, Statutes of 2010.**

**AB 2354 (V. Manuel Pérez) – Promotores: medically underserved communities: federal grants.** Requires the Department of Public Health (DPH) to assess the grants available pursuant to the federal

Patient Protection and Affordable Care Act for funding opportunities related to the use of promotores. *Held in Senate Appropriations Committee.*

**AB 2470 (De La Torre) – Health care coverage.** Prohibits a health plan or health insurer from rescinding or canceling a health plan contract/health insurance policy unless there was fraud or an intentional misrepresentation of material fact. *Chapter 658, Statutes of 2010.*

**AB 2787 (Monning) – Office of the California Health Ombudsman.** Establishes the Office of the California Health Ombudsman, governed by a chief executive officer known as the California Health Ombudsman. Requires the Ombudsman to educate consumers on their health care coverage rights and responsibilities, assist consumers with enrollment in health care coverage, and resolve problems with obtaining federal premium tax credits. Requires the Ombudsman, and the services provided by local consumer assistance programs under this bill, to also be funded from a fee on health plans and health insurers. *Held in Senate Appropriations Committee.*

## **OTHER HEALTH CARE COVERAGE BILLS**

**SB 56 (Alquist) - California Health Benefits Service Program.** Permits health plans that are governed, owned, or operated by a county board of supervisors, a county special commission, a county-organized health system, or a county health authority, and the County Medical Services Program, to form joint ventures among themselves for the purpose of providing coverage in the individual and group health insurance markets. Permits the joint ventures to consist of contractual relationships to pool risk or share networks, or to provide for the joint offering or marketing of health plans to individuals and groups. Requires participating health plans, in forming joint ventures, to seek to contract with designated public hospitals, county health clinics, primary care clinics, and other traditional safety net providers. Requires joint ventures to meet all the requirements of the Knox-Keene Health Care Service Plan Act of 1975. *Vetoed.*

**SB 727 (Cox) - Cal-COBRA.** Requires health plans and health insurers to offer continuation health coverage to active employees of small employers with 2-19 employees whose employer terminated a group benefit plan and did not provide a successor plan. The bill would apply to employees of small businesses with 2 to 19 employees. Would take effect as an urgency statute. *Held in Senate Appropriations Committee.*

**SB 810 (Leno) – Single payer health coverage.** Establishes the California Healthcare System (CHS), an entity that would provide affordable and comprehensive health care coverage for all Californians. Requires the CHS to provide specified health care benefits and to negotiate or set fees for health care services and pay claims for those services. Establishes a new state agency, the California Healthcare Agency (CHA), to oversee the CHS. Requires the Governor to appoint a Healthcare Commissioner to head the CHA and assigns several duties to the Commissioner. Requires the Commissioner to seek all necessary federal waivers, exemptions, agreements, and legislation to implement the CHS. Requires the Commissioner to seek approval to direct current federal payments for health care programs to the CHS, which would then assume responsibility for the services provided by those programs. Prohibits the sale of private health care service plans and health insurance policies in the state. Provides that a resident with an income at or below 200% of the Federal Poverty Level (FPL) is eligible for benefits like those provided by California's existing Medi-Cal program. Creates various offices and boards to aid in the administration of the CHS. Establishes the Healthcare Fund within the State Treasury, into which funds would be deposited to support CHS costs. *Died on Assembly Floor.*

**SCA 29 (Strickland) – Health care coverage.** Amends the state Constitution to require voter approval of a state or federal program that: (a) requires individuals to obtain health care coverage; (b) requires a health plan or health insurers to guarantee issue to all applicants; (c) requires employers to either provide health care coverage to their employees or pay a fee or tax to the state or the federal government in lieu of providing that coverage; (d) that allows an entity created, operated, or subsidized by the state or federal government to compete with health plans and health insurers in the private sector; or, (e) creates a single-payer health care system. *Failed passage in Senate Health Committee.*

## **OTHER HEALTH INSURANCE REGULATION BILLS**

**SB 158 (Wiggins) - Health care coverage: human papillomavirus.** Requires every individual or group health care service plan contract issued, amended, or renewed, on or after January 1, 2010, that includes coverage for treatment or surgery of cervical cancer, to also provide coverage for an annual cervical cancer screening test and a human papillomavirus vaccination upon the referral of the patient's health care provider. Coverage includes the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration. This bill excludes specialized health care service plan contracts, Medicare supplement, short-term limited duration health insurance, CHAMPUS-supplement, TRI-CARE supplement, or to hospital indemnity, accident-only, and specified disease insurance. *Vetoed.*

**SB 220 (Yee) – Health care coverage: preventive health services: tobacco cessation.** Requires a health care service plan (health plan) contract or health insurance policy issued, amended, renewed or delivered after January 1, 2011 to cover specified tobacco cessation treatments. Requests the California Health Benefits Review Program of the University of California to prepare an analysis of the cost savings as a result of the provisions of this bill and states that this bill shall become inoperative if the state determines that the requirements of this bill will result in additional costs to the state. Requires certain health care plans and health insurers to provide coverage for specified preventive services without cost sharing, consistent with federal law. *Vetoed.*

**SB 296 (Lowenthal) - Mental health services.** Requires health care service plans and health insurers that provide professional mental health services to issue identification cards to all enrollees and insureds containing specified information by July 1, 2011, and provide specified information relating to their policies and procedures on their Internet web sites by January 1, 2012. *Chapter 575, Statutes of 2009.*

**SB 529 (Wyland) - Health care coverage: FDA approved treatments.** Requires a health care service plan contract or a health insurance policy that provides coverage of a health condition to also provide coverage for any federal Food and Drug Administration approved treatment of that condition. Provides an exemption for investigational new drug applications. *Died in Senate Health Committee.*

**SB 630 (Steinberg) - Health care coverage: dental/orthodontic reconstructive surgery.** Defines reconstructive surgery, as of July 1, 2010, to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, except as specified. Imposes a state-mandated local program since a willful violation of this provision by a health care service plan would be a crime. *Chapter 604, Statutes of 2009.*

**SB 890 (Alquist, Steinberg) – Health care coverage.** Requires health plans and health insurers to categorize all individual market products into tiers based on actuarial level, as specified. Requires health plans and health insurers to allow an individual to transfer without medical underwriting to any other individual plan contract offered by that same health plan or health insurer that provides equal or lesser benefits upon the annual renewal date of the contract or policy. Requires health plans and health insurers to meet federal annual and lifetime limits and the medical loss ratio requirements (MLR) in specified provisions of the federal health care reform law, and any federal rules or regulations issued under those provisions. *Vetoed.*

**SB 961 (Wright) - Health care coverage: cancer treatment.** Prohibits health plan contracts and health insurance policies that provides coverage for cancer chemotherapy treatment to establish limits on enrollee out-of-pocket costs for prescribed, orally administered, nongeneric cancer medication. Require the carrier contract or policy to review the percentage cost share for oral nongeneric cancer medication and intravenous or injected nongeneric cancer medications and apply the lower of the two as the cost-sharing provision for oral nongeneric cancer medications, and require the provisions of the bill to remain in effect only until January 1, 2015, and as of that date are repealed, unless a later enacted statute deletes or extends that date. *Vetoed.*

**SB 1169 (Lowenthal) – Mental health claims: prior authorization.** Requires health care service plans and health insurers to assign a tracking number to a claim or provider request for authorization, provide acknowledgment of its receipt and use the tracking number in subsequent communication regarding the claim or request. Clarifies that any form of treatment or benefit limitation for mental health care services be applied under the same terms and conditions as other benefits under the plan or policy, as per mental health parity. *These provisions were subsequently amended out of the bill.*

**SB 1283 (Steinberg) - Health care coverage: grievance system.** Modifies consumer health coverage grievance procedures administered by the Department of Managed Health Care (DMHC) by: (1) clarifying that the DMHC may send a written notice of the final disposition of the grievance against a health plan, as specified, after 30 calendar days of receipt of the request for review only if the Director determines that, due to extraordinary circumstances, additional time is reasonable necessary to fully and fairly evaluate the relevant grievance and if the delay is in the interest of the enrollee, (2) requiring DMHC to make a determination within 15 calendar days of receipt of the request for review, rather than 30 calendar days, as to what additional information is necessary for DMHC to complete its review of the grievance and make a determination, and (3) striking out a provision that authorizes DMHC to pursue specified options if the grievance involves clinical services that are being denied on the basis of a “coverage decision.” *Vetoed.*

**AB 2 (De La Torre) - Individual Health Care Coverage.** Imposes specific requirements and standards on health care service plans licensed by the Department of Managed Health Care (DMHC) and health insurers subject to regulation by the California Department of Insurance (CDI), (collectively carriers) related to the application forms, medical underwriting, and notice and disclosure of rights and responsibilities for individual health plan contracts, and health insurance policies, including the establishment of an external independent review process to approve or deny a carrier’s decision to cancel or rescind an individual’s health care coverage. Requires carriers to demonstrate that an applicant intentionally misrepresented or intentionally omitted material information on the application prior to the issuance of a contract or policy, among other requirements, in order to rescind or cancel an individual plan contract or policy. Requires DMHC and CDI to establish a per-case reimbursement schedule to pay for independent reviews, and requires the costs of the independent review system to be paid for by the carriers, as specified. *Vetoed.*



**AB 56 (Portantino) - Health care coverage: mammographies.** Requires health insurers to provide coverage for mammography services, upon referral by a provider, beginning July 1, 2010. Excludes self-insured employee welfare benefit plans from this requirement. Allows physician assistants to make referrals, to the extent allowed by their scope of practice. Requires health plans and health insurers to notify subscribers or policyholders of recommended timelines for testing, unless exempted. Provides an exemption for specialized health insurance, Medicare supplement insurance, short-term limited duration health insurance, CHAMPUS supplement insurance, TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance from the requirement to provide the information above. Expands the method by which health plans and health insurers may notify a subscriber or policyholder of recommended timelines for an individual to undergo tests for the screening or diagnosis of breast cancer. *Vetoed.*

**AB 98 (De La Torre) - Health care coverage: maternity services.** Requires every individual or group health insurance policy, unless exempted, to cover maternity services. Provides an exemption for specialized health insurance, Medicare supplement insurance, short-term limited duration health insurance, vision-only, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement insurance, TRI-CARE supplement insurance, hospital indemnity, accident-only, and specified disease insurance. Defines 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. *Vetoed.*

**AB 108 (Hayashi) - Individual health care coverage: rescission.** Prohibits health care service plans and health insurers from rescinding plan contracts or insurance policies for any reason after 24 months following their issuance. *Chapter 406, Statutes of 2009.*

**AB 119 (Jones) - Health care coverage: pricing.** Eliminates an exception in current law that allows health plans and health insurers to use gender as a basis for premium, price, or charge differentials, when used on valid statistical and actuarial data, beginning January 1, 2011. *Chapter 365, Statutes of 2009.*

**AB 244 (Beall) - Health care coverage: mental health services.** Expands the coverage requirement for certain 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, of a person of any age under the same terms and conditions applied to other medical conditions. Defines mental illness for this purpose as a mental disorder as defined in the Diagnostic and Statistical Manual IV. Clarifies that specified health plans or insurers that are exempt from the bill include Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only insurance policies. *Vetoed.*

**AB 513 (De Leon) - Health care coverage: breast-feeding.** Requires health care service plan contracts and health insurance policies issued, renewed, or amended on or after January 1, 2010, that provides maternity coverage to provide coverage for lactation consultation with a lactation consultant and for provisions of a personal electric or personal manual breast pump or coverage for the rental of a hospital grade electric breast pump. *Vetoed.*

**AB 591 (De La Torre) - Insurance: referral fees: health plans and insurance: filings: identification cards.** Prohibits health care service plans and health insurers from increasing premium rates for individual health insurance contracts and policies for a period of 90 days from the operative date of the

bill, with exceptions. Thereafter, prohibits plans and insurers from increasing premium rates for individual contracts or policies by more than the average percentage increase in the medical care component of the consumer price index for the immediately preceding calendar year. Requires plans and insurers that file proposed premium rate increases for individual coverage to comply with all other state and federal laws. Prohibits a plan or insurer from increasing the premium rate it charges a subscriber or policyholder of an individual contract or policy during the 12 months following the last premium rate increase. *Held in Senate Appropriations Committee.*

**AB 684 (Ma) - Claim reimbursement: late payments: dental services.** Increases the interest rate health plans and health insurers covering dental services must pay for uncontested claims, and claims that the carrier determines to be payable that are not reimbursed within 60 working days. Requires the interest that accrues to be paid to the carriers' respective regulating agency for enforcement of specified laws, upon appropriation. Requires carriers offering dental coverage to follow a specified process for requesting additional information related to a claim. *These provisions were subsequently amended out of the bill.*

**AB 718 (Emmerson) – Health care coverage: federally eligible defined individuals: preferred provider products: premium rates.** This bill would define, for purposes of premium caps for preferred provider (PPO) coverage for individuals eligible for continuation coverage under state and federal law, the "average premium paid" as an amount calculated on an annual basis by the Managed Risk Medical Insurance Board (MRMIB) using a weighted average, based on each plan's or insurer's enrollment in MRMIP within each designated geographic region, as specified. *Referred to Senate Health Committee; hearing canceled at the request of author.*

**AB 730 (Ma) - Health insurance: unlawful postclaims underwriting: penalties.** Increases the maximum civil penalty for each act of post-claims underwriting, as prohibited in the Insurance Code, from \$118 to a maximum of \$5,000 for each act, and up to \$10,000 for each act or violation where the health insurer knew or had reason to know that the act was unlawful. Requires that the first \$118 of each penalty collected for post-claims underwriting violations be deposited in the General Fund and the balance of any penalty revenue be deposited in the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for the Major Risk Medical Insurance Program. Requires civil penalties and disciplinary actions imposed against insurers for specified violations of the Insurance Code, including post-claims underwriting violations, to be determined at a hearing conducted in accordance with the Administrative Procedures Act. *Vetoed.*

**AB 1449 (Jones) – Health care coverage: solicitation.** Revises, and makes specific to individual health care coverage, the duty established for agents, brokers, solicitors, or sales representatives, who assist an applicant in completing applications for individual health care coverage to help an applicant provide answers to health questions accurately and completely. *Held in Senate Appropriations Committee.*

**AB 1521 (Jones) – Health care coverage: solicitation.** Prohibits the variation in the compensation that health care service plans or health insurers pay to a solicitor for the sale of, offer of, or application for, an individual health plan contract or insurance policy that would depend on the health status, claims experience, industry, or occupation of the individual. *Held in Senate Appropriations Committee.*

**AB 1541 (Committee on Health) – Health care coverage.** Extends from 30 days to 60 days the time period an individual or dependent, who has lost or will lose Healthy Families Program (HFP) coverage, the Access for Infants and Mothers (AIM) Program coverage, or Medi-Cal program coverage, has to

request enrollment in group coverage without being considered a late enrollee. *Chapter 542, Statutes of 2009.*

**AB 1543 (Committee on Health) – Medicare supplement coverage.** Makes conforming changes to the requirements and standards that apply to Medicare supplement contracts and policies for the purpose of complying with recent federal law changes contained in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) affecting the benefits, the issuance and the pricing of these policies. *Chapter 10, Statutes of 2009.*

**AB 1600 (Beall) – Health care coverage: Mental health services.** Requires health plans and insurers to cover the diagnosis and medically necessary treatment of a mental illness of a person of any age under the same terms and conditions applied to other medical conditions. Clarifies that specified health plans or insurers that are exempt from the bill include Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only insurance policies. *Vetoed.*

**AB 1759 (Blumenfield) - Health care coverage: premium rates.** Requires health plans and insurers to provide separate, disclosures to companies and other large group purchasers at the point of sale, explaining the circumstances under which a change in premium rates or applicable copayments, coinsurance or deductibles may occur. The disclosures must include defined terms and specific examples of the circumstances under which changes in rates may occur. *Vetoed.*

**AB 1825 (De La Torre) - Maternity services.** Requires every individual or group health insurance policy, as specified, to cover maternity services, as defined. Allows an individual insurance policy to have an exclusionary period of up to 12 months until December 31, 2013. *Vetoed.*

**AB 1826 (Huffman, Feuer) - Health care coverage: prescriptions.** Requires a health plan or health insurer that covers outpatient prescription drug benefits to provide coverage for a drug that has been prescribed for the treatment of pain. Prohibits the health plan or insurer from requiring the subscriber or enrollee to first use an alternative prescription drug or over-the-counter drug, as specified. *Held in Senate Appropriations Committee.*

**AB 2035 (Coto) Self-funded dental benefit plans: administrators.** Requires the third party administrator (TPA) of a self-funded dental benefit plan to include a disclosure in the explanation of benefits (EOB) document and benefit claim forms which provides the contact information for the federal Department of Labor (DOL), which regulates self-funded plans, in the event the consumer has a payment dispute with the plan. *Referred to Senate Health Committee; hearing canceled at the request of author.*

**AB 2093 (V. Manuel Pérez) - Immunizations for children: reimbursement of physicians.** Prohibits health plans or health insurers from requiring a physician or physician group to assume financial risk for the costs of required immunizations by requiring those health plans or insurers, that provides coverage for childhood and adolescent immunizations, to reimburse a physician or physician group for costs related to administering the vaccine, in addition to the cost of acquiring the vaccine. Defines administrative cost to include physician time, clinical staff time, and office staff time, as well as other practice expenses associated with providing the immunization such as storage, insurance, supplies, and medical equipment. Specifies a floor for administrative cost reimbursement as an amount not less than that specified in the most current annual Medicare physician fee schedule. Prohibits a health plan or insurer from requiring cost-sharing for immunizations for enrollees or insureds. *Vetoed.*

**AB 2042 (Feuer) - Health care coverage: rate changes.** Prohibits health plans and health insurers from altering rates, as specified, or any benefits more than once per calendar year, for individual plan contracts and policies that are issued, amended, or renewed on or after January 1, 2011, with certain exceptions including allowing a plan or contract to lower premiums if it does not otherwise alter cost sharing or any benefits and if the reduction in premium is consistent with other provisions of state and federal law. *Vetoed.*

**AB 2110 (De La Torre) - Health care coverage: premium payments: grace periods.** Requires health insurance policies and health care service contracts, issued, amended, or renewed on or after January 1, 2011, to provide a grace period of 50 days for the payment of each premium falling due after the first premium, during which the policy continues in force. Makes enrollees and insureds, if they fail to pay the premium owed during the grace period, liable for any medical costs incurred during the grace period, except as specified. *Placed on Senate inactive file.*

**AB 2275 (Hayashi) - Dental coverage: noncovered benefits.** Prohibit a full service or specialized health plan or insurer, with respect to plan contracts and policies issued, amended, or renewed on or after January 1, 2011, that cover dental services, from requiring a dentist to accept an amount set by the plan or insurer as payment for non-covered dental care services provided to an enrollee or insured. Prohibit providers from charging more for non-covered dental services under a plan contract or insurance policy than their usual and customary rate for those services. Requires the evidence of coverage (EOC) and disclosure form, or combined EOC and disclosure form to include disclosures to consumers regarding their potential costs related to non-covered services. *Chapter 673, Statutes of 2010.*

**AB 2389 (Gaines) - Health care coverage: health facilities: cost and quality information.** Prohibits a contract by, or on behalf of, a licensed health care facility, as defined, and a health plan or insurer from containing a provision that restricts the ability of the health plan or insurer to furnish information to enrollees and insured on the cost range of procedures or quality of services performed by the facility, as specified, and provides an appeals process for cost and quality of care data, as specified. *Placed on Assembly inactive file.*

**AB 2533 (Fuentes) - Health care coverage: quality rating.** Expands the reporting requirements required of health plans and health insurers related to economic profiling of physicians, providers, medical groups, or individual practice associations (IPAs) to also apply to quality rating, as defined. Requires health plans and insurers to make such filings with their respective departments immediately upon adoption, or within 30 days of making any changes. Modifies the required content of such filings, as specified. Requires a health plan or insurer that submitted a filing prior to January 1, 2011, to update the filing by March 31, 2011, to comply with the bill's requirements, and to reflect the health plan or insurer's current policies and procedures. *Placed on Senate inactive file.*

**AB 2540 (De La Torre) - Health insurance: postclaims underwriting: unfair and deceptive practices.** Adds postclaims underwriting to the definition of unfair methods of competition in the business of health insurance. Increases the maximum civil penalty for health insurance post-claims underwriting from \$118 per violation to \$5,000 per violation. Also increases that amount to \$10,000 for each act of post-claims underwriting that the insurer knew was unlawful. *Vetoed.*

**AB 2578 (Jones, Feuer) - Health care coverage: rate approval.** Requires health plans and health insurers, effective January 1, 2012, to apply for prior approval of proposed rate increases, under specified conditions, and imposes on the Department of Managed Health Care (DMHC) and the

California Department of Insurance (CDI) specific rate review criteria, timelines and hearing requirements. Any proposed rate that is not acted on by DMHC or CDI on its own discretion within 60 days would be deemed approved. *Failed passage on Senate Floor.*

## **HEALTH CARE FACILITIES AND CLINICS**

**SB 148 (Oropeza) - Mammogram machines: inspection: posting of results.** Requires a facility that operates a mammogram machine to post notices of serious violations, as defined, in an area that is visible to patients. Requires the facility to post the notice within two working days after receipt of documents from the Department of Public Health and requires that the documents remain posted for a minimum of five working days or until action correcting the violation has been completed, whichever is later. *Chapter 169, Statutes of 2009.*

**SB 196 (Corbett) - Emergency medical services.** Increases from 90 to 120 days the public notice a general acute care hospital must provide prior to closing or downgrading an emergency department (ED) and includes employees among the entities who must be notified. Increases from 30 to 60 days the public notice a general acute care hospital or acute psychiatric hospital must give prior to closing a facility or eliminating or relocating a supplemental service. *Vetoed.*

**SB 221 (Walters) – Home dialysis agencies.** Repeals existing statute which provides for the licensing and regulation of home dialysis agencies, and makes findings and declarations that the statute has created confusion and misunderstandings with respect to dialysis services provided in skilled nursing facilities (SNFs). *Chapter 39, Statutes of 2009.*

**SB 289 (Ducheny) - Hospitals: seismic safety: periodic reports.** Requires a person or entity that seeks approval to operate or manage a general acute care hospital to file with the Department of Public Health (DPH) a statement that describes their plan for the hospital to comply with hospital seismic safety requirements. Provides new extensions of hospital seismic deadlines for hospitals that plan to mitigate targeted structural deficiencies, or whose projects have been subject to local planning delays, as specified. Requires hospitals to report information on the status of their buildings in meeting 2030 seismic standards, which require hospital buildings to be able to remain functional following an earthquake and to submit a master plan for buildings that need to be rebuilt or replaced. Requires information that is submitted by hospitals to the Office of Statewide Health Planning and Development (OSHPD) to obtain extensions to be complete and accurate, as specified. Requires hospitals with buildings at risk of collapse to post public signs, as specified. *Vetoed.*

**SB 360 (Yee) - Health facilities: direct care nurses.** Extends current requirements pertaining to orientation and training of nursing staff to new hires, casual, per diem, registry, and traveler staff. Specifies procedures through which the competency of direct care registered nurses must be demonstrated and validated. Provides that patient care staff who are undergoing orientation, and who have not had their competency demonstrated and validated, shall not count as staff for the purposes of meeting minimum nurse-to-patient ratios. Deletes existing law allowing the Department of Public Health (DPH) to take into consideration the unique nature of the University of California teaching hospitals when establishing licensed nurse-to-patient ratios. *Held in Senate Appropriations Committee.*

**SB 364 (Florez) - Health facilities: Joint Task Force on Hospital Conversion and Patient Care.** Requires the Legislature to create the Joint Task Force on Hospital Conversion and Patient Care.

Requires the task force to evaluate substantive health policy and finance issues related to health reform and the governance of medical foundations. Requires the task force to submit a study within 12 months that addresses the governance structure of medical foundations, models of care that produce cost-effective outcomes, the consequences of hospital conversions. Conditions the work of the task force on the identification of sufficient financial resources. *Held in Assembly Appropriations Committee.*

**SB 442 (Ducheny) – Clinic corporations: licensing.** Streamlines the administrative requirements for a clinic corporation to apply for licensure for an affiliate primary care clinic or a mobile health care unit operated as a primary care clinic (collectively known as affiliate clinics). *Chapter 502, Statutes of 2010.*

**SB 499 (Ducheny) - Hospitals: seismic safety.** Allows hospitals that sought, but did not receive, seismic reclassifications to qualify for an up-to-two year extension that is available to hospital buildings that have filed building plans, submitted a construction timeline, and are under construction. Modifies reporting requirements for hospitals with Structural Performance Category - 1 buildings. Requires hospitals to include additional information in the reports concerning buildings they intend to retrofit, replace, or remove from acute care service and subjects hospitals that do not submit reports as required to fines, as specified. Authorizes OSHPD, until January 1, 2013, to utilize computer modeling, as specified, for purposes of determining the structural performance category of general acute care hospital buildings. Provides that OSHPDs submissions to the California Building Standards Commission related to this authority, or for the purposes of implementing conforming changes in nonstructural performance categories, shall be deemed to be emergency regulations. *Chapter 601, Statutes of 2009.*

**SB 608 (Alquist) – Hospitals: seismic safety.** Provides for an extension of hospital seismic deadlines of up to three years for hospitals that document that a local planning delay will cause them to miss the January 1, 2013 deadline. Allows the Office of Statewide Health Planning and Development (OSHPD) to grant an additional extension of up to two years, beyond the three years, for projects that do not provide acute care services and meet other criteria regarding life support systems and structural risk, as specified. *Chapter 623, Statutes of 2010.*

**SB 726 (Ashburn) - Health care districts: rural hospitals: employment of physicians.** Expands and extends an existing pilot project allowing qualified health care districts to directly employ physicians by extending the sunset date for the pilot project from January 1, 2011, to January 1, 2018. Expands the scope of the pilot project to include rural hospitals, eliminates the cap that limits employment of physicians to 20 statewide, expands the pilot program to counties with a population of greater than 750,000, eliminates the requirement that hospitals have a net loss from operations in 2000-2001 fiscal year in order to participate in the physician hiring pilot program, and eliminates the requirement that the hospital have at least 50 percent of patients days caring for Medi-Cal, Medicare and uninsured patients. Requires a report and evaluation be submitted to the Legislature on the pilot program. *Failed passage in Senate Business, Professions and Economic Development Committee.*

**SB 1083 (Correa) – Health facilities: licensure.** Recasts existing provisions applicable to single consolidated licenses for children’s hospitals. Permits the Department of Public Health to issue a single consolidated license for a children’s hospital that has facilities located not more than 35 miles apart. *Held in Senate Appropriations Committee.*

**SB 1237 (Padilla) -- Radiation control: health facilities and clinics: records.** Requires health facilities and clinics that use imaging procedures that involve computed tomography X-ray systems (CT) for human use to record the dose of radiation on every CT study produced during a CT examination.

Requires facilities that furnish CTs to be accredited, and to report to the Department of Public Health, the referring physician, and the patient, an event in which the administration of radiation results in an overdose, as specified. *Chapter 521, Statutes of 2010.*

**SB 1368 (Committee on Health) - Health care.** Requires local emergency medical services agencies to send Maddy Emergency Medical Services Fund reports to the Emergency Medical Services Authority. Expands the authority of the Office of Statewide Health Planning and Development to insure financings that are for the purpose of refinancing short-term loans that are secured elsewhere to start a project. *Chapter 526, Statutes of 2010.*

**SJR 13 (Oropeza) - New dialysis clinic licensure and certification.** Urges the federal Centers for Medicare and Medicaid Services (CMS) to adopt regulations, and the Congress and President to enact legislation, to improve, speed up, and streamline the process for timely licensure and certification surveys of new dialysis clinics to provide patients with access to these services as soon as possible, and to eliminate the chilling impact on new clinic construction in California. Cites several factors demonstrating a need for more timely licensure and certification of new dialysis clinics. *Resolution Chapter 45, Statutes of 2010.*

**AB 57 (Price) - University of California hospitals: staffing.** Requires the Department of Public Health (DPH) to establish a procedure for collecting and reviewing written staffing plans developed by the University of California (UC) general acute care hospitals, acute psychiatric hospitals, and special hospitals. Requires DPH to review documentation from each hospital concerning several aspects of its patient classification plan. Makes various findings and declarations concerning inadequate hospital staffing. *Vetoed.*

**AB 303 (Beall) - Medi-Cal: Hospitals: designated public hospitals: seismic safety requirements.** Allows specified county and University of California disproportionate share hospitals (DSH) that contract with the California Medical Assistance Commission (CMAC) to serve Medi-Cal patients to receive supplemental Medi-Cal reimbursement from the Construction and Renovation Reimbursement Program (CRRP) for new capital projects to meet state seismic safety deadlines for which plans have been submitted to the state after January 1, 2007 and before December 31, 2011. *Chapter 428, Statutes of 2009.*

**AB 523 (Huffman) - Hospitals: seismic safety.** Allows the Office of Statewide Health Planning and Development (OSHPD) to grant a two-year extension of the 2013 seismic deadline for a hospital building that is under the control of a health care district, but is operated by a third party under a lease that extends at least through December 31, 2009, based on a declaration that the district has lacked, and continues to lack, unrestricted access to the hospital building for seismic planning purposes during the time of the lease. Establishes a series of interim deadlines and requirements the hospital must meet in order to qualify for the extension. States that the Legislature intends by this act to affirm the existing hospital seismic deadlines, and intends for the extension provided by the bill to be a one-time extension that is intended to address the unique needs of Marin General Hospital. *Chapter 243, Statutes of 2009.*

**AB 542 (Feuer) – Hospital acquired conditions.** Requires the Department of Health Care Services (DHCS) to convene a technical working group to evaluate options for implementing non-payment policies and procedures for hospital acquired conditions (HACs) for the fee-for-service Medi-Cal program consistent with federal laws and regulations. Requires DHCS to implement non-payment policies and procedures for HACs for the fee-for-service Medi-Cal program by July 1, 2011 that are

consistent with the Patient Protection and Affordable Care Act and to consider the recommendations of the technical working group. *Vetoed.*

**AB 773 (Lieu) - Health facilities: citations: notifications.** Requires long-term care facilities to post Class "AA" and "A" citations for 120 days. This bill deletes the requirement in existing law that the posting be prescribed in regulations issued by the Department of Public Health (DPH), and that the violations be posted until the violation is corrected to the satisfaction of DPH, up to a maximum of 120 days. This bill deletes the requirement in existing law that the citation become final before it is required to be posted. Additionally, the bill specifies the minimum locations where the citation must be posted, the paper and font size of the posting (which must include the name and address of the facility) and require the posting to include whether the citation is a Class AA or Class A citation. *Chapter 472, Statutes of 2009.*

**AB 818 (Hernandez) - Health facilities: connection ports and patient safety.** Delays the prohibition on a health facility using a tubing connection that would fit into a connection port other than the type for which it was intended until the earlier of January 1, 2014 or 36 months after the International Organization for Standardization (ISO) publishes a new applicable design standard for epidural connections, and the earlier of January 1, 2013, or 24 months after ISO publishes an applicable design standard, for intravenous or enteral connections. Requires the Advanced Medical Technology Association to report annually to the Legislature on the progress of the development of those standards. Requires hospitals and skilled nursing facilities to include measures to prevent adverse effects associated with misconnecting intravenous, enteral feeding, and epidural lines in their patient safety plans. *Chapter 476, Statutes of 2009.*

**AB 1083 (John A. Pérez) - Health facilities: security plans.** Requires hospital security and safety assessments to be conducted not less than annually, and requires hospital security plans to be updated annually. Provides that hospital security plans may additionally include efforts to cooperate with local law enforcement regarding violent acts at the facility. Requires hospitals to consult with affected employees and members of the medical staff in developing their security plans and assessments. *Chapter 506, Statutes of 2009.*

**AB 1544 (Health) - Hospitals: outpatient clinic services.** Establishes timeframes and procedures for the Department of Public Health (DPH) to act on applications by general acute care (GAC) hospitals to add a new, or modify an existing, outpatient clinic service as a supplemental service. Specifies that an onsite inspection is not required prior to approving the application but allows DPH to conduct an inspection prior to approving or denying an application if it determines that the hospital does not meet the requirements of the department. Limits an outpatient clinic service to providing nonemergency primary health care services in a clinical environment to patients who remain in the outpatient clinic for less than 24 hours. *Chapter 543, Statutes of 2009.*

## **HEALTH CARE INFORMATION AND MEDICAL PRIVACY**

**SB 270 (Alquist) – Health care providers: medical information.** Clarifies existing law related to delays in reporting unauthorized access to, and use or disclosure of, a patient's medical information to the Department of Public Health. Extends the sunset of the California Office of HIPAA [Health Insurance Portability and Accountability Act] Implementation (CalOHI) until January 1, 2013. *Chapter 501, Statutes of 2010.*



**SB 337 (Alquist) - Health information.** Revises the timelines for reporting of unauthorized access to, or use or disclosure of, patients' medical information, and provides limited exemptions to the reporting timelines in cases where law enforcement agencies are investigating such privacy breaches. Authorizes the California Health and Human Services Agency to apply for federal health information technology and health information exchange grants. Requires the governor to designate a qualified nonprofit entity to apply for federal health information exchange grants on behalf of the state if no application is made by the state. *Chapter 180, Statutes of 2009.*

**SR 21 (Alquist) - Relative to electronic health records.** Urges the President and Congress to amend or clarify the Health Information Technology for Economic and Clinical Health Act to allow medical groups and independent practice associations to receive federal health information technology stimulus funding, to deploy electronic medical record systems on behalf of their physicians, as specified. *Adopted by the Senate.*

**AB 278 (Monning) - Health information exchange: demonstration projects.** Authorizes the California Office of Health Information Integrity (CalOHII), also known as the California Office of HIPPA Implementation (CalOHI), to establish and administer demonstration projects to evaluate potential solutions to facilitate health information exchange (HIE), as specified. Authorizes California-based healthcare entities, as defined, to submit an application with CalOHII to be approved as demonstration project participants, as defined. Authorizes CalOHII to approve up to four demonstration projects annually. Requires any costs associated with the support, assistance, and evaluation of approved demonstration projects to be funded exclusively by federal funds or other non-General Fund sources. Repeals the provisions of the bill on the date the Director of CalOHII executes a declaration stating that the grant period for the State Cooperative Grant Agreement for HIE has ended. *Chapter 227, Statutes of 2010.*

## **HEALTH CARE PERSONNEL**

**SB 838 (Strickland) – Cal-COBRA: premium assistance.** Extends the state law requirements placed on health plans and health insurers (health plans) offering Cal-COBRA coverage to notify qualified beneficiaries of their potential eligibility for federal premium assistance, and to allow them to enroll in coverage. *Chapter 24, Statutes of 2010.*

**SB 1119 (Wright) – Health care staffing.** Requires agencies that refer licensed nursing staff for temporary employment in health facilities, including general acute care, acute psychiatric, and special hospitals, to meet requirements similar to those that apply to the referral of licensed nursing staff to long-term care facilities. Requires an employment agency that refers temporary staff for employment in a health facility to do a number of things to prevent patient abuse by temporary staff, including verifying that temporary nurses are licensed and in good standing and have passed a criminal clearance process and have had health exams and tuberculosis screening, and to report suspension or termination for cause of licensed vocational nurses and licensed psychiatric technicians to the respective licensing boards. Requires a health facility that makes a report of an unfit nurse to send a copy of the report to the employment. Subjects employment agencies that violate the bill's provisions to civil penalties, as specified. *Vetoed.*

**AB 657 (Hernandez) – Health professions workforce: master plan.** This bill would require the Office of Statewide Health Planning and Development (OSHPD), in collaboration with the California

Workforce Investment Board and based on information provided by the health care workforce clearinghouse, to establish the Health Professions Workforce Task Force (task force) to assist in the development of a health professions workforce master plan for the state. The task force would be required, by October 31, 2013, to submit a complete statewide health professions workforce master plan to OSHPD and the Legislature. *Vetoed.*

**AB 1542 (Jones) – Medical homes.** Establishes a definition of a medical home in which a patient establishes an ongoing relationship with a physician or other licensed health care provider working in a physician-directed practice team to provide comprehensive, accessible and continuous evidence-based primary and preventative care and to coordinate the patient health care needs across the health care system. Prohibits health care practitioners from representing that they provide medical homes unless they meet specified standards. *Assembly refused concurrence in Senate amendments.*

## **MEDI-CAL, HEALTHY FAMILIES, AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS**

**SB 208 (Steinberg) - Medi-Cal: demonstration project waiver.** Authorizes the Department of Health Care Services (DHCS) to require the mandatory enrollment of seniors and people with disabilities (SPDs) in a Medi-Cal managed care plan commencing the later of June 1, 2011, or obtaining federal approval from the federal Centers for Medicare and Medicaid Services (CMS) and allows a phase-in over a 12 month period. Establishes the Public Hospital Investment, Improvement and Incentive Fund consisting of intergovernmental transfers from counties or other specified governmental entities, to be matched with federal funds if approved by CMS and authorized by the waiver, and to be used for investment, improvement and incentive payments for designated public hospitals and the affiliated governmental entities (Counties and UC). Requires DHCS to seek federal approval for a Medicare, Medicaid, or combination, demonstration project or waiver for persons who are Medi-Cal and Medicare eligible (dual eligible) in up to four counties. Requires DHCS to establish, by January 1, 2012, organized health care delivery models for children eligible for CCS and Medi-Cal. Provides that the state will receive specified amounts of federal funds as the match for state health programs. Extends existing statutory provisions related to the 2005 Medi-Cal Hospital/Uninsured Care Waiver. Makes technical and clarifying changes to the hospital provider fee enacted by AB 1383 (Jones) Chapter 627, Statutes of 2009 and as amended by AB 1653, Chapter 218, Statutes of 2010, to conform to the Medi-Cal State Plan Amendment and modifications requested by CMS. Provides that enactment is contingent upon enactment of AB 342 (John A. Perez and Monning). *Chapter 714, Statutes of 2010.*

**AB 342 (John A. Pérez) – Medi-Cal: demonstration project waivers.** Authorizes the Department of Health Care Services to implement the provisions, terms and conditions of the proposed new federal Medicaid Demonstration Project waiver, A Bridget To Reform, pursuant of Section 1115(a) of the Social Security Act and to begin approving local Coverage Expansion and Enrollment Demonstration (CEED) projects, proposed by local eligible entities. Establishes requirements for the CEED projects related to administration, enrollment eligibility and medical homes. Conditions enactment upon the enactment of SB 208. Provides that it is an urgency measure. *Chapter 723 of the Statutes of 2010.*

**SB 1 (Steinberg) – Health care coverage: children.** Expands eligibility for the Medi-Cal program and the Healthy Families Program by modifying the income requirements applicable to those programs, and by making coverage available regardless of citizenship or immigration status. Requires the Managed Risk Medical Insurance Board and the State Department of Health Care Services to make specified

technological improvements to the existing eligibility determination and enrollment systems for the Medi-Cal program and the Healthy Families Program and to develop a process to transition the enrollment of children from local children's health initiatives into those programs by July, 1 2011. *Referred to Senate Health Committee; hearing postponed at the request of author.*

**SB 114 (Liu) - Medi-Cal: independent foster care adolescents.** Requires an independent foster care adolescent, who is in foster care on his or her 18th birthday, to be enrolled in Medi-Cal without any interruption in coverage and without requiring a new application. Requires the Department of Health Care Services to develop and implement a simplified form for redetermination, and requires independent foster care adolescents to fill out and return this form only if information previously reported is no longer accurate. *Held in Senate Appropriations Committee.*

**SB 311 (Alquist) - Healthy Families Program: prospective payment system.** Requires the Managed Risk Medical Insurance Board to apply the Medicaid prospective payment system to services provided under the program by federally qualified health centers and rural health clinics and would authorize the board to adopt emergency regulations to implement that requirement. Provides that the program will not take effect until a separate appropriation is made and the state receives matching federal funds. States the intent of the Legislature to enact legislation that would implement other provisions of the federal Children's Health Insurance Program Reauthorization Act of 2009. *These provisions were subsequently amended out of the bill.*

**SB 438 (Yee) - Healthy Families and Medi-Cal enrollment.** Requires the Department of Health Care Services, to seek federal approval for an option to accelerate Medi-Cal enrollment for children and pregnant women who apply for Medi-Cal at a county welfare office. Transfers Healthy Families program eligibility determination to county welfare offices. *These provisions were subsequently amended out of the bill.*

**SB 771 (Alquist) – Medi-Cal.** Lengthens the period for which Medi-Cal would allow 12-month continuous Medi-Cal eligibility for children, in order for the state to qualify for additional federal funds via a temporary increase in the Federal Medical Assistance Percentage (FMAP), contingent upon adoption of certain federal legislation. Makes the reinstatement of 12-month continuous eligibility effective only during the time period that the increased FMAP is available. *These provisions were subsequently amended out of the bill.*

**SB 966 (Alquist) Medi-Cal: medical homes.** Directs the Department of Health Care Services to establish a definition of medical home, consistent with specified guidelines and establish a timetable for Medi-Cal managed care plans to provide beneficiaries with a medical home. *Held in Senate Appropriations Committee.*

**SB 1063 (Cox) – Healthy Families Program.** Requires MRMIB to set copayments for prescription drugs in the Healthy Families program so that any copayment for a brand drug is at least 150 percent of the copayment for the equivalent generic drug, except where there is no generic or medical necessity requires the use of the branded drug. Requires MRMIB to set copayments for emergency health care services in the Healthy Families program so that any copayment charged for those services is at least 150 percent of the copayment for the highest nonpreventive health care service. Eliminates the current requirement that copayments established by MRMIB for Healthy Families not exceed the copayment level established for state employees, effective January 1, 1998, through the Public Employees Retirements System (PERS). Increases the annual family copayment maximum for the HFP by \$100 (to \$350 total). *Held in Senate Appropriations Committee.*

**SB 1091 (Hancock) – Medi-Cal: individuals in county juvenile detention facilities.** Enables counties to receive Medi-Cal reimbursement for medical and mental health services they provide to eligible individuals less than 21 years of age entering county juvenile detention facilities for up to 30 days or until adjudication. *Vetoed.*

**SB 1109 (Cox) – California Children and Families Program: funding.** Eliminates existing allocations of tobacco tax revenue under Proposition 10 to state and local county children and family’s commission accounts and, instead, requires those funds to be used for the Healthy Families and Medi-Cal programs. *Failed passage in Senate Health Committee.*

**SB 1236 (Alquist) – Medi-Cal: utilization controls.** Requires the Department of Health Care Services to establish an alternative to the use of designated public hospital inpatient Treatment Authorization Requests (TARs). (TARs are the route by which providers receive authorization for specified treatments and services provided on behalf of Medi-Cal patients.) Requires the alternative TARs process established by this bill to become inoperative if it results in increased GF costs or public hospitals use funds other than public funds to draw down federal financial participation. *Held in Assembly Appropriations Committee.*

**SB 1378 (Strickland) – Medi-Cal: expansion limitation.** Prohibits expansion of eligibility in the Medi-Cal program pursuant to federal health care reform, unless the federal government fully funds the expansion. *Failed passage in Senate Health Committee.*

**SB 1431 (Simitian) – County Health Initiative Matching Fund.** Expands eligibility for children enrolling in the County Health Initiative Matching Fund (CHIM) program which uses local funds to match federal Children’s Health Insurance Program funds, specifically increasing the eligibility for CHIM to children in families whose income is at or below 400 percent of the federal poverty level and provides that a child is eligible even if they meet the requirements for Healthy Families but are unable to enroll when entry is restricted because of insufficient funds. *Vetoed.*

**SBX8 41 (Cox) – California Children and Families Program: funding.** Eliminates existing allocations of tobacco tax revenue under Proposition 10 to state and local county children and family’s commission accounts and, instead, requires those funds to be used for the Healthy Families and Medi-Cal programs, subject to approval by the voters. Requires provisions be placed on a statewide ballot. *Failed passage in Senate Health Committee.*

**AB 217 (Beall) - Medi-Cal: alcohol and drug screening and brief intervention services.** Establishes a screening and brief intervention (SBI) services program for pregnant women or women of childbearing age within the Medi-Cal program, to be administered by the Department of Health Care Services, in collaboration with the State Department of Alcohol and Drug Programs, for the purpose of allowing local funds to be used to secure federal matching funds for these services. Provides that participation in the screening and intervention program shall be voluntary for a Medi-Cal beneficiary and that the results shall be subject to all confidentiality requirements applicable to medical records. *Vetoed.*

**AB 411 (De La Torre) - Skilled nursing facilities: quality assurance fee: Medi-Cal reimbursement.** Requires a skilled nursing facility (SNF) that is part of a continuing care retirement community to pay the SNF quality assurance fee until July 31, 2011 by eliminating an exemption from paying the fee for such facilities. Additionally, this bill repeals a requirement that the weighted average Medi-Cal SNF reimbursement rate for the 2009-10 and 2010-11 rate years not be increased over the amount in the

2008-09 year. Instead, this bill would require, for the 2009-10 rate year, the weighted average Medi-Cal SNF reimbursement rate to not exceed 2.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year. Additionally, this bill would result in an increase in the weighted average Medi-Cal SNF reimbursement rate for the 2010-11 rate year in an amount not to exceed 5 percent of the prior fiscal year. This bill would take effect immediately as an urgency statute. *These provisions were subsequently amended out of the bill.*

**AB 511 (De La Torre) - Medi-Cal: ambulance transportation services providers: quality assurance fees.** Imposes, as a condition of participation in the Medi-Cal Program, a 5.5 percent quality assurance fee (QAF) on ambulance transportation services providers until the 2015-16 fiscal year. Requires the Board of Equalization to administer the fee. Requires the Department of Health Care Services to seek necessary federal approvals. Requires revenue from the QAF to be used exclusively to enhance federal financial participation under Medi-Cal, provide additional reimbursements or to support quality improvement efforts. Implements this bill only if the state receives federal approval and legislation is enacted during the 2009-10 legislative sessions that make an appropriation to fund a Medi-Cal rate increase for ambulance transportation services providers. *Referred to Committees on Health and Revenue and Taxation; hearing canceled at the request of author.*

**AB 754 (Chesbro) - Medi-Cal: mental health plans.** Commencing July 1, 2011, requires the Department of Mental Health to allocate and distribute the full contracted amount of General Fund payment for the managed mental health care program, exclusive of the Early and Periodic Screening Diagnosis, and Treatment Program specialty mental health services provided under the Medi-Cal specialty mental health services waiver, at the beginning of the contract period. The allocated funds shall be considered to be funds of the plan that may be held by the Department of Mental Health. Requires the Department of Mental Health to develop a methodology to ensure that these funds are held as the property of the plan and shall not be reallocated for other purposes. *Placed on Senate inactive file.*

**AB 839 (Emmerson) - Medi-Cal: providers: remedies.** Changes Medi-Cal provider remedies, including specifying the judicial remedy when there is a dispute over processing or payment of money and modifies the date for the beginning of a period when a health care provider is barred from enrollment in Medi-Cal as specified in law. *Chapter 255, Statutes of 2009.*

**AB 896 (Galgiani) - Health care programs: provider reimbursement rates.** Extends the current requirement that inpatient payment rates for the California Childrens Services Program and the Genetically Handicapped Persons Program be 90 percent of the Medi-Cal hospital interim rate until January 1, 2011, after which provider payment rates for services rendered in those programs must be identical to the Medi-Cal rates of payment for the same service performed by the same provider type. Prior to the enactment of AB 896, the requirement that inpatient rates of payment be 90 percent of the Medi-Cal hospital interim rate sunset January 1, 2010. *Chapter 260, Statutes of 2009.*

**AB 1076 (Jones) - Medi-Cal.** Requires the Department of Health Care Services to expand the Medical Case Management (MCM) Program to include Medi-Cal beneficiaries who have two or more chronic conditions and have used the hospital emergency department (ED) four or more times in the previous twelve months, and specifies the type of services which must be included in case management services. Requires the Medi-Cal disease management benefit to include the designation of a primary care provider as a patient's medical home. *These provisions were subsequently amended out of the bill.*

**AB 1142 (Price) – Medi-Cal proof of eligibility.** Requires hospitals to provide proof of a person's Medi-Cal eligibility to hospital-based providers, ambulance service providers and other providers of professional services. Requires Medi-Cal providers to ensure that patient debts that are sold to a collection agency will be recalled under specified circumstances. *Chapter 511, Statutes of 2009.*

**AB 1269 (Brownley) - Medi-Cal: eligibility.** Effective March 1, 2010, extends, and increases eligibility for, the Medi-Cal California Working Disabled Program (CWD Program). Permits individuals otherwise eligible for the CWD program, but who are temporarily not working, to remain in the program for up to 26 weeks, provided the individuals continue to pay monthly premiums that is equal to five percent of their individual countable income during the temporary nonworking period. This provision is subject to federal financial participation (FFP). Extends specified resource exemptions to apply for the beneficiary under any other Medi-Cal program under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. *Chapter 282, Statutes of 2009.*

**AB 1383 (Jones) - Medi-Cal: hospitals: supplemental payments: coverage dividend fee.** Imposes a coverage dividend fee on hospitals, except for designated public hospitals, for a period that would end on December 31, 2010. Requires hospitals to be paid supplemental payments which, when combined with their other Medi-Cal payments, would be in an amount equal to the upper payment limit for hospital outpatient and inpatient services, as specified. Requires Department of Health Care Services (DHCS) to pay Medi-Cal managed care plans enhanced payments as part of the monthly capitated payment for the exclusive purpose of making supplemental payments to hospitals for the provision of Medi-Cal hospital services. Requires the DHCS to submit state plan amendments to the federal government and seek any necessary approvals to implement a system of supplemental payments for hospitals. Requires revenue from the fee to be used only to make specified increased Medi-Cal payments to hospitals, the administrative costs of DHCS and to pay for health care coverage for children. *Chapter 627, Statutes of 2009.*

**AB 1445 (Chesbro) - Medi-Cal: federally qualified health centers and rural health clinics.** Allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed by Medi-Cal for multiple visits by a patient with a single or different health care professional on the same day at a single location, when a patient has an appointment with a mental health professional or has contracted an illness or been injured and requires additional treatment. *Held in Senate Appropriations Committee.*

**AB 1541 (Committee on Health) - Health care coverage.** Extends from 30 days to 60 days the time period an individual or dependent, who has lost or will lose Healthy Families Program (HFP) coverage, the Access for Infants and Mothers (AIM) Program coverage, or Medi-Cal program coverage, has to request enrollment in group coverage without being considered a late enrollee. Deletes the requirement that a Healthy Families Program enrollee be disenrolled because of “aging out” of the program or exceeding the program’s income limits in order to be considered a late enrollee. *Chapter 542, Statutes of 2009.*

**AB 1568 (Salas) - Veteran’s Benefits.** Requires the Department of Health Care Services (DHCS) to work in conjunction with various state and local agencies, to use the federal public assistance and reporting information system (PARIS) to identify veterans enrolled in the Medi-Cal program, and to assist them in obtaining federal veterans' health care benefits. Repeals provisions requiring DHCS to select three consenting counties to participate in PARIS. *These provisions were subsequently amended out of this bill.*

**AB 1653 (Jones) – Medi-Cal: hospitals: managed health care plans and mental health plans: quality assurance fee.** This bill amends the methodology for the calculation, collection, and distribution of the existing provider fee established by AB 1383 (Jones) on general acute care hospitals for the 21 months spanning April 1, 2009, to December 31, 2010. Makes various changes to the formulas used to determine the amount of supplemental payments made to private and designated public hospitals. Expands the definition of a nondesignated public hospital. Defines the payments made by the department to the managed health care plans and mental health plans as increased capitation payments and increased payments, respectively, and changes the definition of a managed care plan. Requires the Department of Health Care Services (DHCS) to determine the amount of increased capitation payments for each Medi-Cal managed care plan and to consider prescribed factors in making that determination. Makes various changes to the provisions relating to the increased payments to mental health plans, including requiring DHCS to take into consideration prescribed factors when making these payments. Provides that the quality assurance fee shall not be imposed on a converted hospital, as defined, for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years. *Chapter 218, Statutes of 2010.*

**AB 1872 (Galgiani) – Health care programs: provider reimbursement rates.** Extends the January 1, 2011 sunset on the requirement that hospital inpatient payment rates for the California Children's Services Program, the Genetically Handicapped Persons Program, and other specified health care programs be 90 percent of the Medi-Cal hospital interim rates of payment, as developed by the Department of Health Care Services. Repeals the requirement that, effective January 1, 2011, the rates of payment for non Medi-Cal patients be identical to payment rates for the same service performed by the same provider type under the Medi-Cal Program. *Held in Senate Appropriations Committee.*

**AB 2352 (John A. Pérez) – Medi-Cal: organ transplants: antirejection medication.** Requires Medi-Cal beneficiaries to remain eligible to receive Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant, unless during that time the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. *Chapter 676, Statutes of 2010.*

**AB 2599 (Bass) – Medi-Cal: South Los Angeles.** Requires the Department of Health Care Services and the California Medical Assistance Commission (CMAC) to ensure Medi-Cal funding, as specified, for a new private nonprofit hospital that will serve the population formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor Hospital (MLK-Harbor). *Chapter 267, Statutes of 2010.*

**AB 2645 (Chesbro) – Mental health: skilled nursing facilities: reimbursement rate.** Requires the reimbursement rate for services in institutions for mental disease (IMDs) that are skilled nursing facilities (SNF) to be the same as the rates in effect on July 1, 2009 from July 1, 2010 to June 30, 2012. Would take effect as an urgency statute. *Chapter 554, Statutes of 2010.*

## **MEDICAL RESEARCH**

**SB 343 (Alquist) - Stem cell research: intellectual property standards.** Requires that intellectual property standards that the California Institute for Regenerative Medicine's Independent Citizen's Oversight Committee develops to include a requirement that each grantee, and the licensees of the grantee, to submit to the institute for approval a plan that will afford uninsured Californians access to any drug that is, in whole or in part, the result of research funded by the institute. Specifies that the plan

must require that the grantees and licensees provide drugs to California state and local government funded programs at one of the three benchmark prices in the California Discount Prescription Drug Program, except when the institute adopts a waiver. ***Referred to Senate Health Committee; hearing canceled at the request of author.***

**SB 1064 (Alquist) - California Stem Cell Research and Cures Act.** Makes a number of changes to the governance and oversight of the California Institute for Regenerative Medicine (CIRM) and its oversight committee, the Independent Citizen's Oversight Committee (ICOC), established under Proposition 71 for the purposes of overseeing a \$3 billion state investment in stem cell sciences, including make grants and loans for stem cell research, for research facilities, and for other vital research opportunities. Requires CIRM, under the guidance of the ICOC, to create a succession plan addressing changes in leadership in CIRM and ICOC, as specified. Eliminates the 50-employee maximum for the CIRM. Requires CIRM, under the guidance of the ICOC, to create, by January 31, 2012, a transition plan to address the expiration of current bond funding, and to submit that plan to the Governor, the Controller, and the Legislature. Requires a performance audit of CIRM to be conducted every 3 years, as specified. Requires the ICOC to disclose, in all meeting minutes, a summary of vote tallies, including each board member's votes and recusals. Requires the intellectual property standards developed by the ICOC to include a requirement that each grantee, and exclusive licensee of the grantee, submit to the CIRM a plan that will afford Californians access to any drug that is, in whole or in part, the result of research funded by the CIRM, except when the ICOC adopts a waiver, as specified. Requires specified grant recipients to share a fraction of the revenue they receive from licensing or self-commercialization of an invention or technology that arises from research funded by CIRM, as specified. ***Chapter 637, Statutes of 2010.***

**SB 1187 (Strickland) – Human experimentation.** Extends, until January 1, 2014, an existing exception to the Protection of Human Subjects in Medical Experimentation Act, which prohibits any person from being subjected to any medical experiment unless the informed consent of the person is obtained. The exception allows medical experimental treatment to be provided to a patient without the patient's informed consent in a life-threatening situation, if prescribed conditions are met. These conditions include, but are not limited to the patient's situation necessitates urgent intervention and available treatments are unproven or unsatisfactory, the patient is unable to give informed consent as a result of the patient's medical condition, obtaining informed consent from the patient's legally authorized representatives is not feasible before the treatment must be administered, and valid scientific studies have been conducted that support the potential for the intervention to provide a direct benefit to the patient. ***Chapter 108, Statutes of 2010.***

**AB 1931 (Torricon) - Injury prevention.** Eliminates the repeal date for the Spinal Cord Research Program (Roman Reed Program). Eliminates, in statute, the Spinal Cord Injury Research Fund within the State Treasury and instead codifies current practice to permit the University of California to establish a fund, independent of the State Treasury, to accept public and private funds for spinal cord injury research programs and grants, as prescribed. ***Chapter 457, Statutes of 2010.***

## **MENTAL HEALTH**

**SB 152 (Cox) - Medi-Cal funding: mental health services.** Commencing March 1, 2010, requires the Department of Mental Health to send a reimbursement claim to the State Controller within 90 days after the receipt of a mental health service claim from county contractors, with specified exceptions. Provides that interest will accrue on the claim beginning on the 91<sup>st</sup> day after submission, to be paid in equal parts



from the budgets of the Department of Mental Health, the Department of Health Care Services, and the California Health and Human Services. *Referred to Assembly Health Committee; hearing canceled at the request of author.*

**SB 296 (Lowenthal) - Mental health services.** Requires health care service plans and health insurers that provide professional mental health services to issue identification cards to all enrollees and insureds containing specified information by July 1, 2011, and provide specified information relating to their policies and procedures on their Internet web sites by January 1, 2012. *Chapter 575, Statutes of 2009.*

**SB 743 (Committee on Health) - Health facilities: psychiatric patient release.** This bill clarifies the immunities from civil and criminal liability that are granted to specified hospitals and their staff related to the detention of persons who cannot be safely released from the hospital because they are a danger to themselves, to others, or are gravely disabled, as defined. Extends the immunity from civil and criminal liability to specified facilities and staff for the detention of any person who meets specified criteria, whether or not they qualify for a 72-hour evaluation, and for the actions after release of a person who was detained up to 24 hours and who meets specified criteria. *Chapter 612, Statutes of 2009.*

**SB 1169 (Lowenthal) – Mental health claims: prior authorization.** Requires health care service plans (health plans) and health insurers to assign a tracking number to a claim or provider request for authorization, provide acknowledgment of its receipt and use the tracking number in subsequent communication regarding the claim or request. Clarifies that any form of treatment or benefit limitation for mental health care services be applied under the same terms and conditions as other benefits under the plan or policy, as per mental health parity. *These provisions were subsequently amended out of the bill.*

**AB 244 (Beall) - Health care coverage: mental health services.** Expands the coverage requirement for certain 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, of a person of any age under the same terms and conditions applied to other medical conditions. Defines mental illness for this purpose as a mental disorder as defined in the Diagnostic and Statistical Manual IV. Clarifies that specified health plans or insurers that are exempt from the bill include Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only insurance policies. *Vetoed.*

**AB 398 (Monning & Chesbro) - Acquired brain trauma.** Transfers the administrative duties and oversight of the California traumatic brain injury program from the Department of Mental Health to the Department of Rehabilitation, and extends the program's sunset date from July 1, 2012 to July 1, 2019. *Chapter 439, Statutes of 2009.*

**AB 710 (Yamada) - Veterans Substance Abuse and Mental Health Fund.** Requires the Department of Veterans Affairs to consult with the Department of Mental Health and the Department of Alcohol and Drug Programs to identify federal funds available for funding community-based organizations that provide substance abuse and mental health services to veterans, as specified. If identified, the Department of Veterans Affairs would apply for federal Substance Abuse and Mental Health Services Administration funds through the Department of Mental Health or the Department of Alcohol and Drug Programs. Requires The Department of Veterans Affairs to establish a process to certify the eligibility of community-based organizations and to establish criteria for determining renewal of funding for recipient organizations. *Held in Senate Appropriations Committee.*

**AB 1571 (Committee on Veterans Affairs) - Mental health services: county plans: veterans.**

Includes veterans and representatives from a veteran's organization in the list of local stakeholders required to be consulted in the development and update of each county's Mental Health Services Act plan. Requires the Department of Mental Health to inform the California Department of Veterans Affairs of county plans that have outreach programs or that provide services specifically for veterans. *Chapter 546, Statutes of 2009.*

**AB 1600 (Beall) – Health care coverage: mental health services.** Requires health plans and insurers to cover the diagnosis and medically necessary treatment of a mental illness of a person of any age under the same terms and conditions applied to other medical conditions. Clarifies that specified health plans or insurers that are exempt from the bill include Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only insurance policies. *Vetoed.*

**AB 2199 (Lowenthal) – Sexual deviation research.** Removes the requirement that the Department of Mental Health (DMH) be responsible for research into the causes and cures of sexual deviation, including deviations conducive to sex crimes against children, and the causes and cures of homosexuality. Requires DMH to instead, plan, conduct, and cause to be conducted scientific research into the prevention of sex crimes against children and into methods of identifying those who commit sexual offenses. *Chapter 379, Statutes of 2010.*

## **ORGAN AND TISSUE DONATION**

**SB 1395 (Alquist) - Organ donation.** Requires that a person applying for, or renewing, a California driver's license or identification card to indicate whether or not he or she will be an organ donor. Directs the Department of Motor Vehicles to take specified steps to implement this provision. Requires the department to report to the Legislature and to Donate Life California the amount of funds being donated through the department. Authorizes creation of an altruistic living donor registry to sign up individuals who are willing to be kidney donors. *Chapter 217, Statutes of 2010.*

## **PRESCRIPTION DRUGS**

**SB 341 (DeSaulnier) - Pharmaceuticals: adverse drug reactions: Drug Safety and Effectiveness Program.** Requires the California Department of Public Health to make every effort to enter into a contract with the University of California to establish a program to evaluate scientific literature related to the safety and effectiveness of prescription drugs and to communicate that information to consumers and prescribers. Requires that the program include specified components, including an Internet Web site designed to disseminate information to health care professionals and consumers on the relative safety and effectiveness of those drugs, and, until January 1, 2015, a prescription education service, if the department and the University of California enter into a contract or agreement to establish the program. *Held in Senate Appropriations Committee.*

## **PUBLIC HEALTH**

**SB 769 (Alquist) -Federal funding: supplemental appropriations: pandemic flu.** Provides that federal funding received pursuant to the federal Supplemental Appropriations Act, 2009 (Public Law

111-32) for pandemic flu preparedness and response is subject to appropriation by the Legislature for allocation by the Department of Public Health in the same proportion as stipulated in the 2008-09 federally approved collaborative state-local plan (30 percent to the state, 70 percent to the counties). The department may establish a minimum allocation of less than one hundred thousand dollars (\$100,000) to local health jurisdictions, if the department consults with the California Conference of Local Health Officers and the County Health Executives Association of California. Extends the repeal date from January 1, 2011 to January 1, 2013 of provisions that affect the expenditure of federal funding by local health jurisdictions for the prevention and response to public health emergencies. **Chapter 506, Statutes of 2010.**

**SB 880 (Yee) – Public safety: snow sport helmets.** Requires persons less than 18 years of age to wear a properly fitted and fastened snow sport helmet while operating snow skis or a snowboard or related device. Imposes a fine of twenty-five (\$25) dollars for a violation. Dismisses the fine for the first violation. Requires ski resorts to post signs giving notice of the requirements and fines at the resort, and on their website and trail maps. Becomes operative only if AB 1652 is chaptered. **Chapter 278, Statutes of 2010.**

**AB 223 (Ma) – Safe Body Art Act.** Enacts the Safe Body Art Act to provide minimum statewide standards for the regulation of tattooing, body piercing, and permanent cosmetic application. Provides statewide requirements for the performance of ear piercing with a mechanical device. Repeals current law governing the development of standards for these businesses. **Vetoed.**

**AB 517 (Ma) - Safe Body Art Act.** Enacts the Safe Body Art Act to provide minimum statewide standards for the regulation of tattooing, body piercing, and permanent cosmetic application. Repeals current law governing the development of standards for these businesses. **Vetoed.**

**AB 1020 (Emmerson) - Public swimming pools: anti-entrapment devices and systems.** Conforms state law to recently enacted federal pool safety standards, the Virginia Graeme Baker Pool and Spa Safety Act, by requiring a public swimming pool, as defined, to be equipped with anti-entrapment devices or systems that meet federal requirements, with specified exemptions. Requires every public swimming pool constructed on or after January 1, 2010, to meet certain anti-entrapment specifications, and requires that a public swimming pool constructed prior to January 1, 2010, be retrofitted to comply with these anti-entrapment measures, unless the pool was already retrofitted to meet the requirements of the VGB Act. Requires an owner that already retrofitted pools pursuant to the enactment of the VGB Act, to certify to the Department of Public Health that the retrofit was completed. Allows the Department of Public Health to impose an annual fee on the owners of public swimming pools, and creates the Recreational Health Fund within the State Treasury to collect these fees. **Chapter 267, Statutes of 2009.**

**AB 1100 (Duvall) - Potable reuse demonstration water.** Defines potable reuse demonstration water (PRDW) as secondary effluent (treated wastewater) from a wastewater treatment facility, operated by a wastewater treatment agency with a source control program that goes beyond conventional source control. The water must be treated to remove particulates by specified processes. In order to be classified as PRDW, the water must meet or exceed all federal and state drinking water standards and all maximum contaminant levels (MCLs) set by the Department of Public Health for public drinking water. Allows the operator of a facility that produces PRDW to bottle and distribute the water for educational purposes, provided the operator first tests samples of the water in accordance with current federal and state bottled water testing standards, and sets a limit of no more than 1,000 gallons of PRDW to be bottled per year. Provides that the water is not to be sold or exchanged for financial consideration.

Imposes other bottling and labeling requirements. *Failed passage in Senate Environmental Quality Committee.*

**AB 1652 (Jones) – Public safety: ski resorts.** Requires ski resorts to prepare an annual safety plan and a monthly report containing details about any fatal incidents resulting from a recreational activity. Requires annual safety plans and monthly reports to be made available to the public within 30 days of a request. Requires ski resorts to establish signage and safety padding policies. Becomes operative only if SB 880 is chaptered. *Vetoed.*

**AB 2000 (Hagman) – Rabies: vaccinations.** Exempts a dog from the rabies vaccination requirement whose life would be endangered by the vaccine, as determined by a licensed veterinarian, on an annual basis. Prohibits a dog exempted from the vaccination to be off the premises of the owner unless on a leash not more than six feet in length. Prohibits a dog exempted from the vaccination to have contact with an unvaccinated cat or dog. *Held in Senate Appropriations Committee.*

**AB 2354 (V. Manuel Pérez) – Promotores: medically underserved communities: federal grants.** Requires the Department of Public Health (DPH) to assess the grants available pursuant to the federal Patient Protection and Affordable Care Act for funding opportunities related to the use of promotores. *Held in Senate Appropriations Committee.*

**AB 2786 (Committee on Health) – Reportable diseases and conditions.** Allows the California Department of Public Health (DPH) to establish the list of communicable diseases and conditions for which clinical labs must submit specimens to the local public health laboratory. Allows DPH to modify the list at any time, in consultation with the California Conference of Local Health Officers (CCLHO) and the California Association of Public Health Laboratory Directors (CAPHLD). Limits the current exemption from penalties and fines for failure to report a reportable disease and condition to diseases or conditions that have been printed in the California Code of Regulations in the preceding six months. Authorizes additional disclosures of public health records relating to human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) between specified local and state public health agency staff, health care providers, and HIV positive individuals who are the subject of the records. Increases penalties for negligent, willful or malicious disclosure of content of any confidential public health record to a third party, except as otherwise authorized by law. *Vetoed.*

## **TOBACCO**

**SB 400 (Corbett) - Electronic Cigarettes.** Provides that electronic cigarettes are drugs under state law, making them subject to the Sherman Food, Drug, and Cosmetic Law. Makes electronic cigarettes illegal unless they have received federal Food and Drug Administration approval or clearance. *Vetoed.*

**SB 600 (Padilla) - Cigarette and tobacco products taxes: Tobacco Tax and Health Protection Fund.** Imposes a \$1.50 tax on cigarettes and, indirectly, an equivalent tax on tobacco products. Provides that 85 percent of the funds resulting from the tax will be deposited into the General Fund and 15 percent into the Tobacco Tax and Health Protection Fund, which is created by the bill, for tobacco control, tobacco disease research, and lung cancer research. Creates the Tobacco Tax General Fund Account within the State's General Fund. Requires Board of Equalization (BOE) to adjust the tax rate to reflect any changes in the California Consumer Price Index (CCPI). *Died in Senate Rules Committee.*

**SB 602 (Padilla) - Retail tobacco sales: licenses.** Prohibits the State Board of Equalization (BOE) from issuing new retail tobacco licenses in areas of over concentration. Repeals the current restrictions that limit BOE's enforcement actions against retail tobacco license holders for violations of underage sales laws to periods when the percentage of underage sales, as measured by the statewide youth purchase survey, is 13 percent or more. Requires enforcement agencies to notify BOE of retailers' violations of underage sales laws. *These provisions were subsequently amended out of the bill.*

**SB 882 (Corbett) - Electronic Cigarettes.** Prohibits the sale or distribution on electronic cigarettes to a minor less than 18 years of age, and establishes infractions for violating this prohibition. *Chapter 312, Statutes of 2010.*

**AB 574 (Hill) - Health facilities: smoking.** Prohibits smoking in all areas of acute care hospitals, including the general hospital campus, buildings, parking areas, plazas, and sidewalks. *Vetoed.*

## **WOMEN'S HEALTH/REPRODUCTIVE HEALTH**

**SB 158 (Wiggins) - Health care coverage: human papilloma virus.** Requires every individual or group health care service plan contract issued, amended, or renewed, on or after January 1, 2010, that includes coverage for treatment or surgery of cervical cancer, to also provide coverage for an annual cervical cancer screening test and a human papilloma virus vaccination upon the referral of the patient's health care provider. Coverage includes the conventional Pap test, a human papilloma virus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration. This bill excludes specialized health care service plan contracts, Medicare supplement, short-term limited duration health insurance, CHAMPUS-supplement, TRI-CARE supplement, or to hospital indemnity, accident-only, and specified disease insurance. *Vetoed.*

**SB 836 (Oropeza) – Breast cancer screening: expanded coverage.** Requires the Department of Public Health (DPH) to provide breast cancer screening and diagnostic services to any individual 40 years of age or older, and to provide services to any individual who is symptomatic, upon a doctor's recommendation, if other state eligibility criteria are met. *Held in Senate Appropriations Committee.*

**AB 52 (Portantino) - Umbilical cord blood collection.** Requests the University of California (UC) to develop a plan to establish and administer the Umbilical Cord Blood Collection Program (UCBCP), previously required by the Department of Public Health, for the purpose of collecting units of umbilical cord blood for public use, as specified. Increases the fee for birth certificate copies by \$2 to provide funds to implement the UCBCP, and requires the UC to implement the plan, contingent on an unspecified amount of funds being available in the UCBCP Fund (Fund). *Chapter 529, Statutes of 2010.*

**AB 113 (Portantino) – Breast cancer screening: mammography.** Requires health care service plan contracts and health insurance policies that are issued, amended, delivered, or renewed on or after July 1, 2011, to provide coverage for mammography, for screening or diagnostic purposes upon referral by a health care professional, based on medical need, instead of age. *Vetoed.*

**AB 359 (Nava) - Breast cancer screening: digital mammography.** Permits a provider under the Every Woman Counts breast cancer screening program to employ digital mammography commencing

January 1, 2010, and to be reimbursed by the Every Woman Counts program. *Chapter 435, Statutes of 2009.*

**AB 543 (Ma) - Perinatal care: Nurse Family Partnership.** Authorizes the use of Nurse-Family Partnership Program grant moneys as a match for other grants administered by the Department of Public Health. Extends, from January 1, 2009 to January 1, 2014, the date on which the California Families and Children Account ceases to exist, if it has insufficient funds to implement the Nurse-Family Partnership Program. *Vetoed.*

**AB 1317 (Block) - Assisted oocyte production: advertisements.** Requires a specified warning in all advertisements for human egg donations associated with the delivery of fertility treatment. Requires donors to fertility treatment centers be provided with medically accurate information regarding potential risks. Clarifies that the entity advertising for egg donors for reproductive purposes is responsible for providing medically accurate information to a potential donor as part of the screening process before the donor signs a binding contract. *Chapter 523, Statutes of 2009.*

**AB 1640 (Evans, Nava) – Breast/cervical cancer screening.** Establishes additional requirements, including age requirements, in order for a client to receive services under the Every Woman Counts (EWC) program. Requires the Department of Public Health (DPH), 90 days prior to making policy changes to the EWC program, to send written notice outlining the proposed changes to contractors providing services, and to notify the Legislature if these changes would restrict access or reduce services offered. Replicates provisions in the Revenue and Taxation Code, relating to the Breast Cancer Fund, in the Health and Safety Code. *Vetoed.*

**ACR 74 (Portantino, Hill) – Umbilical cord banking.** Makes a number of legislative findings and declarations related to public and private umbilical cord blood collection as a means of providing treatment for blood cancers and other diseases. States that the Legislature desires to find ways to help California gain a viable public umbilical cord blood banking system to ensure that all races and ethnicities have an equal probability of finding a match when medically necessary. *Resolution Chapter 116, Statutes of 2010.*