

**Legislation Analyzed by the Department of Managed Health Care  
2008 Assembly and Senate Bills (AB and SB) Vetoed by the Governor**

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

This bill would require a health care service plan and a health insurer to elect to either accept for coverage persons eligible for the Major Risk Medical Insurance Program (MRMIP) that have been assigned to the plan or insurer by that program, regardless of health status or previous health care claims experience, or alternatively to pay a fee to support MRMIP based on market share, as specified. The fee would be set at specified amounts and could be passed along on an equal basis to individual plan subscribers or policyholders of the plan or insurer. The bill would make continuous appropriations of funds for this purpose. The bill would authorize MRMIP, with the approval of the Department of Finance, to obtain loans from the General Fund, for expenses related to administration of the fund. This bill contains other related provisions.

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**AB 16 (Evans): Human papillomavirus (HPV) vaccination.**

This bill would require a referral for a cervical cancer screening to be from the licensed health care practitioner who is providing care to the patient and operating within the scope of practice permitted for the licensee. The bill would also expand the coverage to include an HPV vaccination, as specified. This bill contains other related provisions.

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**AB 30 (Evans): Health care coverage: phenylketonuria: inborn errors of metabolism.**

This bill would revise the definition of the term "formula" for purposes of existing law that covers treatment for phenylketonuria. It would make related technical changes. The bill would also extend this coverage requirement for health care service plans and insurers, as specified, to inborn errors of metabolism, as defined. This bill contains other related provisions.

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**AB 54 (Dymally): Health care coverage: acupuncture.**

This bill would require health care service plans and health insurers to provide coverage for acupuncture under a group plan or policy, except as specified, and as subject to the requirement described above.

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

This bill would require health care service plans and health insurers, on or after January 1, 2009, to offer, at minimal cost, coverage up to \$1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds less than 18 years of age. The bill would provide that the requirement to provide this coverage would not apply to certain types of insurance. This bill contains other related provisions.

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**AB 1057 (Beall): Adult health coverage expansion program.**

This bill would authorize a specified local initiative to provide complementary products, as defined, and provide health care services coverage to the spouses or domestic partners or dependent children of program enrollees. This bill contains other related provisions.

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**AB 1155 (Huffman): Health care service plans.**

This bill would require the Department of Managed Health Care, upon a final determination that a health care service plan has underpaid or failed to pay a provider, as specified, to assess an administrative penalty, as specified, and to require the plan to pay the provider the amount owed, plus interest, as specified. The bill would authorize the Department to exempt a plan from paying the administrative penalty if the Department makes a written finding that paying both the penalty and the provider would jeopardize the financial solvency of the plan. The bill would also specify that a provider shall not be required to resubmit a claim to a plan unless the Department makes a determination that an extraordinary circumstance exists and requires the plan to reimburse the provider for the cost of resubmission, as specified. This bill contains other related provisions.

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**AB 1887 (Beall): Health care coverage: mental health services.**

This bill would expand specified mental health coverage requirements for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2009, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System, unless the board elects to purchase a plan, contract, or policy that provides mental health coverage. This bill contains other related provisions.

**AB 1945 (De La Torre): Individual health care coverage.**

This bill would require the Department of Managed Health Care and the Department of Insurance to jointly, by regulation, establish standard information and health history questions for health care coverage applications. Applications would be restricted to this pool of approved questions. Starting January 1, 2010, all health care service plan applications would require approval from the Director of the Department of Managed Health Care prior to use. The bill would also set standards clarifying "complete medical underwriting," and requiring all health plans to meet the criteria before issuing contracts. AB 1945 would also prohibit health plans from cancelling or rescinding contracts, except under specified conditions. Similar provisions would apply to health insurers regulated by the Department of Insurance.

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**AB 1962 (De La Torre): Maternity services.**

This bill would require specified health plan contracts and insurance policies to provide coverage for maternity services, as defined.

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**AB 2220 (Jones): Health care service plans: emergency room physicians and surgeons: contracts.**

This bill would require health care service plans operating under the Knox-Keene Health Care Service Plan Act of 1975 to resolve provider disputes through mediation, as specified. The bill contains other related provisions.

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**AB 2861 (Hayashi): Emergency services and care: psychiatric emergency medical condition.**

This bill would define a psychiatric emergency medical condition. Within the definition of emergency care, it would allow (a) the admission or transfer of a patient to a psychiatric unit within a general acute care hospital or (b) the admission or transfer of a patient to an acute psychiatric hospital for the purpose of providing care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. Transfer is permitted only if, in the opinion of the treating provider, the patient's medical condition is such that, within a reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the transfer of the patient. This bill would require a provider to notify the patient's health plan, or the plan's contracting provider, of the need for the transfer. It would also require a hospital that transferred a patient pursuant to these provisions to seek to obtain the name and contact information of the patient's health plan, document its attempt to ascertain this information, and notify the health plan of specified information related to the transfer. The

bill would also require that health plans provide noncontracting hospitals with their contact information, updating the information as necessary (a minimum of once per year).

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**SB 349 (Perata): Health care coverage: electronic billing.**

This bill would require that, if a subscriber or enrollee of a health care service plan, or a policyholder or certificate holder of a health insurer does not consent to electronic billing, the plan or insurer shall provide a paper copy of any bill directed to that subscriber, enrollee, policyholder, or certificate holder at no charge. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions.

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**SB 840 (Kuehl): Single-payer health care coverage.**

This bill would establish the California Healthcare System, to be administered by the newly-created California Healthcare Agency, under the control of a Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. The bill would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would provide that a resident of the state with a household income, as specified, at or below 200% of the federal poverty level, would be eligible for the type of benefits provided under the Medi-Cal program. The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Healthcare System. The California Healthcare System would then assume responsibility for all benefits and services previously paid for with those funds. This bill contains other related provisions.

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**SB 973 (Simitian): California Health Benefits Service Program.**

This bill would create the California Health Benefits Service Program within the State Department of Health Care Services. The bill would require the Department of Health Care Services to perform various duties, subject to the availability of sufficient private donations, as determined by the Department of Finance, relative to creation of joint ventures between certain county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans and, subject to the availability of sufficient private donations as determined by the , would create a stakeholder committee, as specified. The bill would also authorize the Director of the Department of Managed Health Care to provide regulatory and program flexibilities to facilitate licensing of specified entities providing coverage pursuant to the bill.

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**SB 981 (Perata): Health care coverage: noncontracting emergency physician claims.**

This bill would enact various provisions applicable to noncontracting emergency physicians, as defined. The bill would require that payment for each coded and charged covered emergency medical service rendered by a noncontracting emergency physician be made at the lesser of the physician's full charge or at the interim payment standard, as specified. The bill would authorize the physician to file a complaint with the Department of Managed Health Care if a health care service plan or its contracting risk-bearing organization underpays or fails to make that payment. The bill would require the department to investigate the complaint, make a determination within a specified time period, and, if the complaint is substantiated, take appropriate enforcement action and require the plan or its risk-bearing organization to make specified payments. This bill would enact other related provisions.

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**SB 1198 (Kuehl): Health care coverage: durable medical equipment.**

This bill would require a health plan and a health insurer to offer coverage for durable medical equipment, as defined, as part of their group plan contracts or group policies.

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**SB 1440 (Kuehl): Health care coverage: benefits.**

This bill would limit the amount a health plan may expend for administrative costs in a fiscal year to a specific percentage of the payments it receives for providing health care services to its subscribers and enrollees, and would prohibit a plan from expending less in the form of aggregate benefits than a certain percentage of those payments. The bill would also revise the definition of administrative costs for purposes of that provision.

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**SB 1563 (Perata): Pervasive developmental disorders.**

This bill requires the Department of Managed Health Care and the Department of Insurance to establish the Autism Workgroup for Equitable Coverage.

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

This bill would require health care service plans and health insurers to cover orthodontic services for cleft palate procedures, as specified.

NOTE: Unless indicated otherwise, all bills become effective on January 1, 2009. Copies of bills are available on the Legislative Counsel Webpage at [www.leginfo.ca.gov](http://www.leginfo.ca.gov).