



California Medical Association

Physicians dedicated to the health of Californians

LEGISLATIVE HOT LIST

CMA's Legislative Hot List provides a summary and current status of CMA-sponsored bills, as well as the progress of other significant legislation followed by CMA's Center for Government Relations. The Hot List represents only a small sampling of the hundreds of bills CMA is following this year. For the current status or more information on a specific bill, please contact the appropriate lobbyist identified at the end of each bill summary by e-mail or by calling 916/444-5532.

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Status items in **RED** have changed status in the last week, or have a hearing within the next week.

JULY 26, 2010

CMA Sponsored Legislation	Status	Staff
<p>AB 583 (Hayashi) HEALTH CARE PRACTITIONERS: DISCLOSURE OF EDUCATION CMA is co-sponsoring this bill with the California Society of Plastic Surgeons. It is becoming increasingly difficult for the public to identify the license, education, and training of health care professionals who practice in the state and many are unable to distinguish between physicians and non-physicians. To protect the public's health and safety, this "truth in advertising" legislation will require a health care professional to disclose information in various health care settings to help patients understand who will be helping them with their health care, such as information about their license, education, and recognized board certification.</p>	<p>On Senate Floor. 2-year bill.</p>	<p>Carolyn Ginno</p>
<p>AB 1235 (Hayashi) PEER REVIEW This bill improves an already robust peer review system to make it even more effective in ensuring high quality care in California hospitals. Nearly all peer review in California is done in an efficient and timely manner that protects patients from quality of care deficiencies. However, the current peer review system can be strengthened. For example, improper or biased review can be utilized to remove physicians for non-quality of care concerns. In rare circumstances peer review can be delayed to the point that patients are placed in danger by the inability to promptly remove a physician that is providing substandard care. This bill is a reintroduction of AB 120 which CMA sponsored last year but was vetoed by the Governor. The veto was based on the fact that AB 120 was joined to a bill the Governor objected to. AB 1235 is not joined with the same provisions that led to the veto of AB 120.</p>	<p>On Senate Floor.</p>	<p>Dean Grafilo</p>
<p>AB 2093 (M. Perez) ADEQUATE VACCINE REIMBURSEMENT Co-sponsored with AAP and CAFP, the bill would require health plans and insurers to reimburse physicians for costs to administer recommended vaccines that are already required to be covered; prohibit health plans and insurers from charging co-payments, deductibles or other out-of-pocket expenses that deter parents from immunizing their children; and prohibit health plans and insurers from including the cost of immunizations in a policy's dollar limit provision. CMA has extensive policy on this issue that has been highly ranked by the House of Delegates.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Teresa Stark</p>
<p>AB 2248 (Hernandez) EMS/MADDY FUND ACCOUNTING Co-sponsored with the Chapter of the American College of Emergency Physicians (CAL/ACEP), this bill would clarify the EMS/Maddy Fund reporting requirements in existing law. A House resolution was passed in 2009 on this issue, stating the need for timely and accurate reporting by counties. This legislation will expand the level of detail that counties are required to report to the state in order to make it easier for members of the public, including physicians, to access thorough and helpful information on counties' Maddy Funds. Nearly every county in the state has a Maddy Fund, and the economic downturn has led to a significant increase in the number of uninsured in California,</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Carolyn Ginno</p>

CMA Sponsored Legislation	Status	Staff
<p>increasing pressure on these critical resources. In many cases the Maddy Fund is a physician's only source of payment for providing emergency care to this population, and so it is essential that these monies be thoroughly accounted for and effectively spent.</p>		
<p>AB 2470 (De La Torre) <u>UNLAWFUL RESCISSION</u> This bill is intended to stop the unscrupulous practice of rescission, where HMOs retroactively dump innocent patients off their insurance after they file claims. This legislation will ensure that health plans and insurers do not act as "judge and jury" whenever they want to rescind or cancel a policy in the individual market by requiring a plan or insurer to obtain approval from an independent review organization prior to rescinding coverage and protecting enrollees rights during the review process. This bill will conform with the new federal health reform law by establishing that health plans and insurers must prove fraud or intentional misrepresentation prior to rescinding a patient.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Teresa Stark</p>
<p>AB 2533 (Fuentes) <u>QUALITY MEASUREMENT</u> AB 2533 requires health care service plans and insurers to file with the Department of Managed Care or Department of Insurance a description of policies and procedures related to quality or physician rating of physicians or surgeons used by the plan or insurer. Quality rating or physician rating is an attempt of a health care service plan, insurer, or a third party to develop, evaluate or rate the performance of a physician or surgeon based on quality measurement and insurance claims data. Many insurers are attempting to rate physicians based on quality or costs measures without the consent of physicians. For example, the California Physician Performance Initiative (CPPI) has been ongoing for the past two years, yet, problems continue to exist. Given that there are many concerns about the accuracy of the claims data used by insurers, and the irreparable harm such ratings may bring to a physician's personal and professional reputation or how patients could be misled by the information, CMA believes that health plans, insurers, or any third party contracted to conduct a quality rating program should be required to simply disclose a description of the policies and procedures related to the rating.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Dean Grafilo</p>
<p>AB 2586 (Chesbro) <u>NETWORK TRANSPARENCY</u> This bill would require the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to more effectively enforce network adequacy requirements in current law and ensure that provider directories are accurate. The bill would require DMHC/DOI to regularly review provider networks to ensure that the required physician-to-patient ratios are being maintained, as well as to ensure that the networks and directories do not include doctors who are noncontracted, out-of-network, deceased, retired, have moved, or whose practices are closed to new patients. Providing these departments with better network adequacy enforcement tools will improve access and continuity of care and will equip patients with full and complete information about their health care provider network. AB 2586 will help ensure consumers and employers are being offered real value in exchange for their health care premiums.</p>	<p>Held on the Assembly Appropriations Suspense File.</p>	<p>Teresa Stark</p>
<p>SB 1031 (Corbett) <u>MEDICAL MALPRACTICE COVERAGE FOR VOLUNTEER PHYSICIANS</u> In order to encourage more physicians to provide voluntary care to Californians in need, CMA, in conjunction with the Medical Board, will use this bill to provide malpractice coverage to volunteer physicians. Currently, CMA staff is managing a work group comprised of insurers, hospitals, clinics and the Medical Board that is charged with finding a solution to this ongoing problem, including public coverage, requiring government agencies to cover physician employees who volunteer and mandates on other insurers to provide funds. This bill will address a key barrier to improving access to care.</p>	<p>Assembly Business and Professions Committee.</p>	<p>Dean Grafilo</p>

CMA Opposed Legislation

	Status	Staff
<p>AB 646 (Swanson) PHYSICIANS AND SURGEONS: EMPLOYMENT This bill was amended in Assembly Health Committee to establish a pilot program to allow Healthcare Districts located in an underserved area to directly employ and charge for physician services. Districts would be allowed to hire up to 5 physicians with an ability to request up to 5 additional contracts and would allow physicians to be employed up to 2031.</p>	Failed Senate Business and Professions Committee (4-2).	Dean Grafilo
<p>AB 648 (Chesbro) RURAL HOSPITALS: PHYSICIAN SERVICES This bill, as amended in Assembly Health, would allow a rural hospital that serves an underserved area or population to directly employ and charge for physician services. The demonstration project would last up to 10 years and allow the hospital to employ up to 10 physicians. To be eligible, the hospital must demonstrate that it can document that it has been unsuccessful in recruiting a physician for 12 months and the CEO certifies to the MBC that there is a critical unmet need in the community.</p>	Failed Senate Business & Professions Committee, 4-4. Reconsideration granted.	Dean Grafilo
<p>SB 726 (Ashburn) HOSPITALS: EMPLOYMENT OF PHYSICIANS AND SURGEONS This bill, as amended in Assembly Health Committee, will allow virtually all Healthcare Districts and Rural Hospitals to directly employ up to 5 physicians in a pilot program. The CEO of a facility must show they have been unsuccessful in recruiting a physician for 12 months, that no currently contracted physician or physician with privileges will be supplanted, and the physician was not recruited from an FQHC. Employment contracts can be up to 10 years but may be renewed if signed prior to December 31, 2017. The Medical Board of California would be responsible for an interim report on the success of the pilot program due in 2013 with a final report due in 2016.</p>	Passed Assembly Floor on 06/17/10. (43-24). Senate Rules Committee.	Dean Grafilo
<p>SB 810 (Leno) SINGLE PAYER HEALTH CARE This bill is a reintroduction of SB 840 (Kuehl) from last session. The bill would create a single-payer system of health care in California. Specifically, SB 810 creates a single payer purchasing pool and would prohibit most private health insurance from being sold.</p>	Assembly Appropriations Committee (8/4/10).	Dean Grafilo

Health Reform Bills

	Status	Staff
Temporary High Risk Pool		
<p>SB 227 (Alquist) HEALTH CARE COVERAGE: TEMPORARY HIGH RISK POOL (Support) This bill establishes the Federal Temporary High Risk Pool (FTHRP) Program in California to draw down federal health reform funding for state high risk pools, one of the first coverage expansions in the federal Patient Protection and Affordable Care Act (PPACA), where individuals with pre-existing conditions can purchase coverage. Like the existing Major Risk Medical Insurance Program (MRMIP), the new high-risk pool will be administered by the state's Managed Risk Medical Insurance Board (MRMIB). CMA supports the development of the temporary high-risk pool, as it will provide an avenue to coverage for those with complex medical conditions, in the time between now and when the ban on pre-existing conditions exclusions takes effect for everyone in 2014. This bill is a companion measure to AB 1887 (Villines).</p>	Signed by the Governor (6/29/10). Takes effect immediately.	Carolyn Ginno
<p>AB 1887 (Villines) TEMPORARY HIGH RISK POOL (Support) This bill creates in the State Treasury the Federal Temporary High Risk Health Insurance Fund to receive the federal funding made available in the federal Patient Protection and Affordable Care Act (PPACA) for high-risk pools. Additionally, AB 1887 will permit the state to solicit new contracts for the new federal program. This bill is a companion measure to SB 227 (Alquist), which contains most of the implementing language for the temporary high-risk pool in California.</p>	Signed by the Governor (6/29/10). Takes effect immediately.	Carolyn Ginno

Health Insurance Exchange

AB 1602 (Perez) [HEALTH CARE COVERAGE](#) (Support if Amended)

This bill will establish the California Health Benefit Exchange. The bill requires the Exchange to be governed by a board that includes the Secretary of the Health and Human Services Agency and four appointed members with expertise in the health care marketplace who cannot be affiliated with health plans/insurers, providers, facilities or clinics. The Exchange will determine the minimum requirements carriers must meet for participation in the Exchange and the standards and criteria for selecting health plans to be offered in the Exchange, and would require the Exchange to facilitate the purchase of health plans by qualified individuals. The Exchange must 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 (platinum, gold, silver, bronze and catastrophic level benefit plans). The bill also enacts several federal health insurance market reform provisions for which CMA has long advocated. CMA strongly supports expanding access to care, and believes the Exchange will promote competition and choice in the marketplace and provide more affordable insurance coverage options for California's low-income uninsured. However, CMA believes the bill can be improved and will request several amendments pertaining to the operation of the Exchange. CMA will also continue to work with the legislative leadership on this bill and future legislation to ensure that important federal law is implemented and effectively enforced so the Exchange works well for patients and providers, in line with CMA policy.

Senate
Appropriations
Committee (8/2/10).

[Teresa Stark](#)

SB 900 (Alquist) [CALIFORNIA HEALTH BENEFITS EXCHANGE](#) (Support if Amended)

This bill will establish the California Health Benefit Exchange. The bill requires the Exchange to be governed by a board that includes the Secretary of the Health and Human Services Agency and four appointed members with expertise in the health care marketplace who cannot be affiliated with health plans/insurers, providers, facilities or clinics. The Exchange will determine the minimum requirements carriers must meet for participation in the Exchange and the standards and criteria for selecting health plans to be offered in the Exchange, and would require the Exchange to facilitate the purchase of health plans by qualified individuals. The Exchange must 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 (platinum, gold, silver, bronze and catastrophic level benefit plans). CMA strongly supports expanding access to care, and believes the Exchange will promote competition and choice in the marketplace and provide more affordable insurance coverage options for California's low-income uninsured. However, CMA believes the bill can be improved and will request several amendments pertaining to the operation of the Exchange. CMA will also continue to work with the legislative leadership on this bill and future legislation to ensure that important federal law is implemented and effectively enforced so the Exchange works well for patients and providers, in line with CMA policy.

Assembly
Appropriations
Committee (8/4/10).

[Teresa Stark](#)

Market Reform and Coverage Expansion

AB 1825 (De La Torre) [MATERNITY SERVICES](#) (Support)

This bill will close a loophole exploited by health insurance companies in order to sell cheap, "subprime" non-comprehensive health insurance that lacks maternity coverage. This bill brings two bodies of law into conformity by requiring all individual and group health insurance policies regulated under the Department of Insurance to cover maternity services, while HMOs regulated by the Department of Managed Health Care (DMHC) are already required to meet these standards. This bill will ensure fair, affordable access to maternity coverage in health care benefits, regardless of the type of plan offered.

Senate Appropriations
Committee Suspend
File.

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AB 2244 (Feuer) [HEALTH CARE COVERAGE](#) (Watch)

This measure is intended to provide early implementation of federal health reform for a

Senate
Appropriations

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<p>segment of the market that already has substantial subsidies (children) and to provide a transition to health reform modeled on the small employer market rules by phasing in modified community rating, and limiting and then eliminating premium variation based on health status. This bill requires guaranteed issue of health insurance for children in 2011 and adults in 2014, in conformity with federal law. For children's premium rates prior to 2014, this bill requires the use of "rate bands" that differ from federal law to limit premium variation in the individual market based on the phased in approach taken in the state's small group health insurance law, where health plans and health insurers file a standard rate based on a particular age, family size, geographic area and benefit plan design. While the goals are laudable, this bill goes well beyond the provisions in PPACA, and does not couple an individual mandate with the guaranteed issue provisions.</p>	<p>Committee (8/2/10).</p>	
<p>SB 890 (Alquist) HEALTH CARE COVERAGE (Support) This bill phases in federal health reforms related to the individual insurance market, including portability of health insurance. The bill would require there be only five HMO products and five PPO products to ease comparison shopping for patients. The bill also requires health insurers to cover medically necessary basic health care services, like maternity, and prohibits health insurers from having an annual or lifetime benefit limit. The bill requires health plans to change premium rates for adults based on one-year changes in a person's age and establishes standard rating factors and limits on premium variation. This bill is co-sponsored by Kaiser Permanente and Health Access and is intended to level the playing field between HMOs and PPOs and target insurers like Blue Cross that offer confusing products that attract enrollees with low rates, but inadequate coverage.</p>	<p>Assembly Floor.</p>	<p>Teresa Stark</p>
<p>SB 1088 (Price) HEALTH CARE COVERAGE: DEPENDENTS (Support) This bill implements provisions of the recently enacted federal Patient Protection and Affordable Care Act (PPACA) that requires health plans and health insurers to expand coverage to dependents up to age 26. This bill conforms state statute to federal law by preventing young adults who are enrolled on their parents' insurance from being terminated prior to their 26th birthday.</p>	<p>Assembly Appropriations Committee (8/4/10).</p>	<p>Teresa Stark</p>
<p>Rate Review / Rate Regulation</p>		
<p>AB 591 (De La Torre) HEALTH CARE COVERAGE: PREMIUM RATES (Oppose) This bill imposes a 90-day moratorium on increases in premium rates, and would prohibit health plans and insurers from increasing premium rates by more than the average percentage increase in the medical care component of the consumer price, unless the plan or insurer files an application with the Department of Managed Health Care or the Department of Insurance, respectively, and the application is approved by that department. The bill would prohibit approval of an application unless the applicant completes an audit showing that its medical loss ratio would meet or exceed that which is required in federal law. The bill would also prohibit a plan or insurer from increasing the premium rate it charges a subscriber or policyholder during the 12 months following the last premium rate increase. While it takes a different form, this is still a 'rate regulation' bill, which CMA has historically opposed. Physicians will still likely take the brunt of the impact of state agency rate-setting. This bill's benefit to consumers and patients is also dubious, as it gives health plans and health insurers carte blanche to raise rates regularly based on medical inflation.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Teresa Stark</p>
<p>AB 2578 (Jones) HEALTH CARE COVERAGE: RATE APPROVAL (Oppose) This bill would require the Department of Managed Health Care and Department of Insurance to approve any increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges under the health care service plan or health insurance policy. While CMA is very concerned about the effect of skyrocketing premiums on individuals and small businesses, a full rate regulation scheme could give insurance companies an excuse to further squeeze dollars out of health care delivery. CMA has supported enforceable medical loss ratios, which require health plans to fund</p>	<p>Senate Appropriations Committee suspense file.</p>	<p>Teresa Stark</p>

medical treatment instead of administration, as an alternative to rate regulation.		
<p>SB 1163 (Leno) HEALTH CARE COVERAGE: DENIALS: PREMIUM RATES (Oppose Unless Amended)</p> <p>This bill conforms to federal law and guidance on rate review in order to qualify California to obtain available rate review federal grants. CMA is objecting to vague language that would require the plan or insurer, in an application to increase premiums, to include “disaggregated information about assumptions about trends in the medical inflation rate of physician services”. This information would be submitted to the Department, posted on its web site, and posted on the health plan or insurer web site. While the author and sponsor have indicated it is not their intent to make public individual physician rate information, CMA is asking for clarifying language to ensure that individual physician rate information is kept confidential and that the Department only uses the information for rate review purposes.</p>	<p>Assembly Appropriations Committee (8/4/10).</p>	<p>Teresa Stark</p>

Bills of Interest	Status	Staff
<p>SB 1246 (Negrete McLeod) NATUROPATHIC MEDICINE (Watch)</p> <p>CMA has worked with the author to amend the bill, and CMA has since gone neutral on the language. The bill expands the category of people that may perform clinical laboratory tests or examinations that are classified as waived to include licensed naturopathic doctors and defines a naturopathic medical assistant. In working with the author and sponsor, amendments were made to ensure that the provisions which allow naturopathic assistants to perform specific duties did not go beyond medical assistants and where appropriate, are inferior. This includes not being permitted to apply and remove dressings, and limits the naturopathic assistants' role with ambulation and transfers.</p>	<p>Assembly Appropriations Committee (8/4/10).</p>	<p>Dean Grafilo</p>
<p>AB 542 (Feuer) NON-PAYMENT FOR ADVERSE EVENTS (Watch)</p> <p>In the face of strong CMA opposition, this bill was dramatically narrowed by the author before its first committee hearing. The bill now applies only to hospitals and merely requires the state to adopt regulations establishing uniform policies and practices governing the nonpayment to hospitals for hospital acquired conditions by public and private payers, consistent with those developed by the federal Centers for Medicare and Medicaid Services (CMS). The original problematic language creating a state Patient Safety Committee that would substantiate a broader list of adverse events and determine nonpayment policies for all providers was removed. CMA will continue to provide suggestions to further improve this bill and will stay engaged in the discussion.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Teresa Stark</p>
<p>AB 977 (Skinner) PHARMACISTS: IMMUNIZATION ADMINISTRATION (Watch)</p> <p>This bill has been significantly narrowed from its introduced version, at CMA's request. The bill now creates a temporary pilot project that allows only pharmacists associated with independent community pharmacies to administer influenza immunization to adults only pursuant to standardized protocols developed by the Medical Board and Board of Pharmacy. This provision is in addition to current law that allows pharmacists to administer any immunization to a person of any age pursuant to a “prescriber protocol.”</p>	<p>Senate Business & Professions Committee.</p>	<p>Teresa Stark</p>
<p>AB 1826 (Huffman) HEALTH CARE COVERAGE: PRESCRIPTIONS (Support)</p> <p>This bill would prohibit a health care service plan or a health insurer from requiring enrollees or health care providers to utilize a “fail first” or step-therapy process for prescription medication treatments for pain. CMA policy (HOD407-09) recognizes health insurer abuse of step-therapy and calls for better enforcement to end this practice and protect patients and physicians. Furthermore, numerous CMA policies insist that health plans must not interfere in physician prescribing practices. The choice of medications should be made by treating physicians. (HOD 906-97, HOD814a-98, HOD714-00, 718-00) CMA supported an identical measure in 2009.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Teresa Stark</p>

Bills of Interest	Status	Staff
<p>AB 2112 (Monning) PRESCRIPTION RECORD PRIVACY ACT (Support) This bill will prevent the sale of data collected by pharmacies on physician prescribing habits for the purposes of marketing. Prescribing data can be used for multiple purposes but this bill will prevent its use by pharmaceutical companies in direct to prescriber advertising or marketing visits by detail representatives.</p>	<p>Assembly Committee on Health. Hearing Cancelled.</p>	<p>Dean Grafilo</p>
<p>AB 2352 (Perez, J) MEDI-CAL: ORGAN TRANSPLANTS: ANTIREJECTION MEDICATION (Support) Provides that a Medi-Cal beneficiary shall remain eligible to receive antirejection medication (paid by Medi-Cal) for up to 2 years following an organ transplant, unless during that period they become eligible for Medicare or obtain private health insurance that would cover it. CMA sponsored a nearly-identical bill last year, AB 998 (Perez, J.) which would've extended the time requirement to 3 years.</p>	<p>Senate Appropriations Committee (8/2/10).</p>	<p>Carolyn Ginno</p>
<p>SB 700 (Negrete McLeod) PEER REVIEW (Support) The bill has been gutted and amended and now contains the contents of SB 840, which the CMA supported last year. SB 840 was vetoed by the Governor. The bill allows a physician who has an 805 report filed against them to submit explanatory or exculpatory information that would be available through the Medical Board of California (MBC) when information is requested about that physician. The bill also requires the MBC to remove an 805 if a court finds peer review was conducted in bad faith. Further, if a peer review body makes a proposed final determination that a physician acted with gross negligence resulting in patient harm or practiced medicine under the influence of drugs or alcohol and a patient was injured, the peer review body shall notify the MBC. This information shall remain confidential but allows the MBC to initiate an investigation. The bill makes other technical changes to the peer review system and includes a definition of peer review.</p>	<p>Assembly Appropriations Committee (8/4/10).</p>	<p>Dean Grafilo</p>
<p>SB 1029 (Yee) HYPODERMIC NEEDLES AND SYRINGES (Support) This bill expands statewide and extends a local pilot project that allowed pharmacists to provide up to 10 syringes without a prescription if they were registered with a local health department in a county that had opted into the program. CMA supported the original legislation establishing the pilot project, and CMA policy (HOD122-00) supports the deregulation of syringe and needle sale in California, and the sale of syringes and needles without prescription at licensed pharmacies.</p>	<p>Assembly Appropriations Committee (8/4/10).</p>	<p>Teresa Stark</p>
<p>SB 1210 (Florez) TAXATION: SWEETENED BEVERAGE TAX (Support) This bill would levy a one cent tax at the manufacturer level for every teaspoon of sugar placed into a sweetened beverage or concentrate. The revenues collected from this tax, estimated to be approximately \$1.5 billion annually, would be deposited in the Childhood Obesity Fund to pay for childhood obesity prevention programs throughout the state. Over-consumption of sugar-sweetened beverages, especially among very young children, is a primary culprit in the childhood obesity epidemic and is linked to diabetes. CMA policy (721a-09) supports increased taxes on sodas and other sugar sweetened beverages with the revenues to be utilized for public health education efforts on obesity prevention and treatment.</p>	<p>Senate Committee on Revenue & Taxation Suspense File.</p>	<p>Teresa Stark</p>