**OLMSTEAD ADVISORY COMMITTEE**

# **LEGISLATION WATCH LIST**

# 2012-13 Legislative Session

The California Health and Human Services Agency (CHHS) compiles and updates a Legislation Watch List related to Olmstead implementation activities. The list is developed based on Olmstead Advisory Committee input.

Committee members are asked to submit information on bills that have a substantial impact on Olmstead implementation—whether advancing or impeding implementation—that should be included on the list.

The following Legislation Watch List helps to flag bills for the Secretary of CHHS as well as guide discussion at Committee meetings.

**STATE LEGISLATION:**

**ASSEMBLY BILLS**

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| **AB 43:** | Monning (D) |
| **STATUS:** | S. APPR. SUSPENSE FILE - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**5/27/2011   **Medi-Cal: eligibility.** Would require the State Department of Health Care Services to establish, by January 1, 2014, eligibility for Medi-Cal benefits for any person who meets these eligibility requirements. This bill would permit the department, to the extent permitted by federal law, to phase in coverage for those individuals. This bill contains other related provisions and other current laws. |

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| **AB 52:** | Feuer (D) |
| **STATUS:** | S. INACTIVE FILE - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/1/2011   **Health care coverage: rate approval.** Would further require a health care service plan or health insurer that issues individual or group contracts or policies to file with the Department of Managed Health Care or the Department of Insurance, on and after January 1, 2012, a complete rate application for any proposed rate, as defined, or rate change, and would prohibit the Department of Managed Health Care or the Department of Insurance from approving any rate or rate change that is found to be excessive, inadequate, or unfairly discriminatory. The bill would require the rate application to include certain rate information. The bill would authorize the Department of Managed Health Care or the Department of Insurance to approve, deny, or modify any proposed rate or rate change, and would authorize the Department of Managed Health Care and the Department of Insurance to review any rate or rate change that went into effect between January 1, 2011, and January 1, 2012, and to order refunds, subject to these provisions. The bill would authorize the imposition of fees on health care service plans and health insurers for purposes of implementation, for deposit into newly created funds, subject to appropriation. The bill would impose civil penalties on a health care service plan or health insurer, and subject a health care service plan to discipline, for a violation of these provisions, as specified. The bill would establish proceedings for the review of any action taken under those provisions related to rate applications and would require the Department of Managed Health Care and the Department of Insurance, and plans and insurers, to disclose specified information on the Internet pertaining to rate applications and those proceedings. The bill would require the Department of Managed Health Care or the Department of Insurance, or the court, to award reasonable advocate's fees , including expert witness fees, and other reasonable costs in those proceedings under specified circumstances, to be paid by the plan or insurer. This bill contains other related provisions and other current laws. |

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| **AB 714** | Atkins (D) |
| **STATUS:** | S. 2 YEAR - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/30/2011   **Health care coverage: California Health Benefit Exchange.** Current law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and employers. Current state law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers by January 1, 2014. This bill would, until June 30, 2013, require the State Department of Health Care Services, the State Department of Public Health, and the Managed Risk Medical Insurance Board, respectively, to disclose information on health care coverage through the California Health Benefit Exchange to every individual who has ceased to be enrolled under the programs described above, except that, with respect to the cancer treatment and screening programs, the Family PACT program, and the programs for treatment of HIV/AIDS, the disclosure would be made to each enrollee, and for the Family PACT Program, the disclosure would be made by Family PACT providers and on and after July 1, 2013, as specified. The bill would require certain hospitals, when billing, to include additional disclosures regarding health care coverage through the Exchange. This bill contains other current laws. |

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| **AB 1083:** | Monning (D) |
| **STATUS:** | S. INACTIVE FILE - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**9/2/2011   **Health care coverage.** Current law, the federal Patient Protection and Affordable Care Act, imposes various requirements, some of which take effect on January 1, 2014, on states, health plans, employers, and individuals regarding health care coverage. Pursuant to the requirements of that act, current state law establishes the California Health Benefit Exchange for the purpose of, among other things, making available qualified health plans to qualified individuals and employers, as specified. The bill would also require all policies of individual health insurance that are offered, sold, renewed, or delivered on or after January 1, 2014, to provide coverage for essential health benefits, as defined, except as specified. This bill contains other related provisions and other current laws. |

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| **AB 1296:** | Bonilla (D) |
| **STATUS:** | A. CHAPTERED - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**9/1/2011   **Health Care Eligibility, Enrollment, and Retention Act.** Would enact the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, which would require the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements. The bill would specify the duties of the agency and the State Department of Health Care Services under the act, and would require the agency to provide specified information to the Legislature by July 1, 2012, regarding policy changes needed to implement the bill. The application development requirements of the bill would otherwise be operative January 1, 2014, except as specified. |

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| **AB 1453:** | Monning (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**4/17/2012   **Essential health benefits.** Commencing January 1, 2014, current law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill. This bill contains other related provisions and other current laws. |

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| **AB 1461:** | Monning (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**4/9/2012   **Individual health care coverage.** Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, from imposing any precurrent condition provision upon any individual, except as specified. The bill would require a plan or insurer, on and after January 1, 2014, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services, but would require plans and insurers to limit enrollment to specified open enrollment and special enrollment periods. Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans. The bill would enact other related provisions and make related conforming changes. This bill contains other related provisions and other current laws. |
| **AB 1580:** | Bonilla (D) |
| **STATUS:** | S. THIRD READING - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Health care: eligibility: enrollment.** Current law provides for various programs to provide health care coverage to persons with limited financial resources, including the Medi-Cal program and the Healthy Families Program. Current law establishes the California Health Benefit Exchange (Exchange), pursuant to the federal Patient Protection and Affordable Care Act (PPACA), and specifies the duties and powers of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and facilitating the purchase of qualified health plans through the Exchange. Current law, the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, operative as provided, requires the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements. Current law provides that the application or case of an individual screened as not eligible for Medi-Cal on the basis of household income but who may be eligible for Medi-Cal on another basis shall be forwarded to the Medi-Cal program for an eligibility determination. This bill would make technical and clarifying changes to these provisions. |

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| **AB 1761:** | John A. Perez (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **California Health Benefit Exchange.** Would prohibit an individual or entity from holding himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless that individual or entity has a valid agreement with the Exchange to engage in those activities. The bill would specify that it is an unfair business practice for health care service plans, entities engaged in the solicitation of health care service plan contracts, and persons engaged in the business of insurance to violate this provision. Because a willful violation of the provisions governing health care service plans is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other current laws. |

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| **AB 1800:** | Ma (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/26/2012   **Health care coverage.** Would, commencing January 1, 2014, require a health care service plan contract and a health insurance policy, except for a specialized plan or policy, to provide for a limit on annual out-of-pocket expenses for certain covered benefits, except as specified, and would provide that this limit shall not exceed that federal limit. The bill would also provide, commencing January 1, 2014, that these provisions shall not be construed to affect the reduction in cost sharing for eligible insureds described in federal law. This bill contains other related provisions and other current laws. |

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| **AB 1846:** | Gordon (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/28/2012   **Consumer operated and oriented plans.** Would authorize the Director of the Department of Managed Health Care to issue a health care service plan license, and the Insurance Commissioner to issue a certificate of authority, to a consumer operated and oriented plan (CO-OP) established consistent with PPACA, as specified. The bill would specify that a CO-OP issued a license or a certificate of authority is subject to all other provisions of law relating to health care service plans or insurance, respectively, and would further specify that a CO-OP insurer and any solvency loan obtained by the CO-OP pursuant to PPACA are subject to certain requirements imposed on mutual insurers. The bill would authorize the director and the commissioner to request documentation relating to a CO-OP's solvency or start-up loan. The bill would prohibit a CO-OP from converting or selling to a for-profit or nonconsumer-operated entity after receiving a solvency loan, would require a CO-OP to comply with specified governance standards, and would authorize the director to revoke a CO-OP health care service plan's license, and the commissioner to revoke a CO-OP insurer's certificate of authority, for violating those prohibitions. The bill would authorize the departments to enact regulations implementing these provisions and would enact other related provisions. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other current laws. |

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| **AB 1970:** | Skinner (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/18/2012   **Social Services Modernization and Efficiency Act of 2012.** Current law provides for protection, care, and assistance for people of the state, and the promotion of the welfare and happiness of all people in the state by providing appropriate aid and services to the needy and distressed. Programs established for this purpose include CalWORKs, which provides cash assistance and other social services to needy families, using federal Temporary Assistance for Needy Families (TANF) block grant program, state, and county funds, and CalFresh, whereby nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. Counties administer the CalWORKs and CalFresh programs. This bill, the Social Services Modernization Act of 2012, would require a final operational state plan submitted by any department administered by the Secretary of California Health and Human Services state agency to a federal agency in the context of providing public social services to be electronically available on the relevant department's Internet Web site, as specified. This bill contains other related provisions and other current laws. |

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| **AB 2034:** | Fuentes (D) |
| **STATUS:** | S. APPR. SUSPENSE FILE - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/15/2012   **Medical care: genetically handicapping conditions.** Would require the State Department of Health Care Services to develop a plan for the administration of the GHPP after the implementation of the PPACA. This bill would require the plan to address, among other things, preservation of the availability of wrap-around services that would otherwise not be available through the PPACA and the addition of genetic amyotrophic lateral sclerosis to the list of conditions covered under the GHPP or any subsequent care model developed after implementation of the PPACA . This bill would require the department to submit the plan to the relevant fiscal and policy committees of the Legislature by July 1, 2013. This bill contains other current laws. |

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| **AB 2266:** | Mitchell (D) |
| **STATUS:** | S. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/25/2012   **Medi-Cal: Enhanced Health Homes for Frequent Hospital Users with Chronic Conditions.** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Current federal law authorizes a state, subject to federal approval of a state plan amendment, to offer health home services, as defined, to eligible individuals with chronic conditions. This bill would require the department, upon approval of a state plan amendment and subject to the availability of specified funding, to establish a program to provide health home services to frequent hospital users, as prescribed. If federal matching funds are available, this bill would require the department to prepare, or contract for the preparation of, an evaluation of the program, and to complete the evaluation and submit a report to the appropriate policy and fiscal committees of the Legislature within 18 months after designated providers have been selected and have begun to seek payment. |

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| **AB 2370:** | Mansoor (R) |
| **STATUS:** | THIRD READING - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/20/2012   **Mental retardation: change of term to intellectual disabilities.** Current federal Medicaid provisions require a state to describe its Medicaid program in its state plan, which is required by federal law to provide for, among other things, a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded. This bill, which would be known as the Shriver "R-Word" Act, would revise various statutes to, instead, refer to a person with an intellectual disability. The bill would also state the intent of the Legislature not to make a change to services or the eligibility for services. This bill contains other current laws. |

**SENATE BILLS**

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| **SB 677:** | Hernandez (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**5/23/2011   **Medi-Cal: eligibility.** Would require, to the extent required by federal law, the State Department of Health Care Services to use the modified adjusted gross income of an individual, or the household income of a family, if applicable, for the purposes of determining income eligibility for Medi-Cal or under a Medi-Cal waiver, except as specified. The bill would provide that these provisions shall become operative on January 1, 2014. Because each county is responsible for making Medi-Cal eligibility determinations, the bill would increase the duties of county officials and would thereby impose a state-mandated local program. This bill contains other related provisions and other current laws. |

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| **SB 703:** | Hernandez (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/25/2012   **Health care coverage: Basic Health Program.** Would establish in state government a Basic Health Program, to be administered by the State Department of Health Care Services. The bill would require the department to enter into a contract with the United States Secretary of Health and Human Services to implement the Basic Health Program, and would set forth the powers and the duties of the department relative to determining eligibility for enrollment, setting premiums for coverage, and selecting participating health plans under the Basic Health Program, subject to requirements under federal law. The bill would require the department to permit enrollment in the Basic Health Program on January 1, 2014. The bill would create the Basic Health Program Trust Fund for those purposes and would make moneys in the fund subject to appropriation by the Legislature, except that if the annual Budget Act is not enacted by a certain date, the bill would authorize the department to transfer specified funds from the trust fund to health plans in order to comply with certain requirements, thereby making an appropriation. The bill would require the Basic Health Program to be funded by federal funds, private donations, premiums paid by eligible individuals, and other non-General Fund moneys available for that purpose. Notwithstanding those provisions, the bill would authorize the department to obtain loans from the General Fund for initial startup expenses, to be repaid by July 1, 2016, and would establish a procedure for continued coverage of individuals under the California Health Benefit Exchange if costs of the Basic Health Program exceed moneys available from specified sources. The bill would require the department to request an evaluation of the Basic Health Program and to seek funding for the evaluation from an unspecified independent nonprofit private foundation. This bill contains other current laws. |

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| **SB 951:** | Hernandez (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**4/16/2012   **Health care coverage: essential health benefits.** Commencing January 1, 2014, current law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill. This bill contains other related provisions and other current laws. |

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| **SB 961:** | Hernandez (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**4/9/2012   **Individual health care coverage.** Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, from imposing any precurrent condition provision upon any individual, except as specified. The bill would require a plan or insurer, on and after January 1, 2014, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services, but would require plans and insurers to limit enrollment to specified open enrollment and special enrollment periods. Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans. The bill would enact other related provisions and make related conforming changes. This bill contains other related provisions and other current laws. |

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| **SB 970:** | De Leon (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**5/29/2012   **Health Care Reform Eligibility, Enrollment, and Retention Planning Act: coordination with other programs.** Would require a county human services department to allow an applicant initially applying for, or renewing, health care coverage using the single state application developed pursuant to the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, with the applicant's consent, to have his or her application information used to simultaneously initiate applications for CalWORKs and CalFresh, as specified , unless the Secretary of Health and Human Services determines that to do so would delay the implementation of the single, standardized application for state health subsidy programs, as defined by specified current law . The bill would require the California Health and Human Services Agency to convene a workgroup of human services and health care advocates, legislative staff, and other specified representatives, to identify other human services and work support programs that might be integrated into this cross-application process. Implementation of the process created by the bill would be required by December 31, 2015, except as specified. This bill contains other related provisions and other current laws. |

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| **SB 1008:** | Committee on Budget and Fiscal Review |
| **STATUS:** | S. CHAPTERED - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/25/2012   **Public social services: Medi-Cal.** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. One of the methods by which these services are provided is pursuant to contracts with various types of managed care health plans. This bill would revise terminology used in these provisions and would require the department to establish demonstration sites, as defined, in up to 8 counties not sooner than March 1, 2013. This bill would require the department to enter into a memorandum of understanding (MOU), with specified terms and conditions, with the federal Centers for Medicare and Medicaid Services (CMS) in developing the process for selecting, financing, monitoring, and evaluating the health care models for the demonstration project, and would require the department to require a demonstration site, as defined, to comply with specified requirements to the extent that the terms and conditions of the MOU do not address the specific selection, financing, monitoring, and evaluation criteria. This bill would require the department, with exceptions, to enroll dual eligible beneficiaries into a demonstration site unless the dual eligible beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled in specific entities, as specified. This bill contains other related provisions and other current laws. |

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| **SB 1036:** | Committee on Budget and Fiscal Review |
| **STATUS:** | S. CHAPTERED - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/26/2012   **Public social services: in-home supportive services.** Would establish the California In-Home Supportive Services Authority (Statewide Authority) and would deem the authority a joint powers authority and a public entity separate and apart from the parties that have appointing power to the authority, as specified, or the employers of those individuals so appointed. This bill would require the authority to be the entity authorized to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment with representatives of recognized employee organizations for any individual provider who is employed by a recipient of supportive services. This bill contains other related provisions and other current laws. |

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| **SB 1186:** | [Steinberg](http://sd06.senate.ca.gov/)/Dutton |
| **STATUS:** | A. Assembly Floor, Second Reading (8/10/12) |
| **BRIEF SUMMARY:** | **Date of last amendment:**8/8/2012   **Disability Access: Liability.** This bill would require an attorney to provide a written advisory to a building owner or tenant with each complaint or settlement demand for any construction-related accessibility claim, as specified. The requirement to provide the written advisory would apply where the attorney or party has filed a complaint in state or federal court on the basis of one or more construction-related accessibility claims. This bill also would prohibit an attorney or other person from issuing a demand for money to a building owner or tenant, or an agent or employee of a building owner or tenant, or from receiving any payment, settlement, compensation, or other remuneration pursuant to a demand for money that is provided or issued without or prior to the filing of a complaint on the basis of one or more construction-related accessibility violations, as specified.  This bill would require a commercial property owner to state on a lease form or rental agreement if the property being leased or rented has been inspected by a certified access specialist. Existing law establishes the California Commission on Disability Access to develop recommendations that will enable persons with disabilities to exercise their right to full and equal access to public facilities, and that will facilitate business compliance with disability access laws and regulations to avoid unnecessary litigation. Existing law requires the commission to study specified disability access issues, and to make reports on those issues to the Legislature.  This bill would provide that the functions and responsibilities of the commission include the concurrent and prospective review of legislative measures, including this measure, and recommendations on any additional ideas or options to promote disability access and reduce unnecessary litigation. |

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| **SB 1196:** | Hernandez (D) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/28/2012   **Claims data disclosure.** Would provide that no contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health care service plan or a health insurer and a provider or supplier, as specified, shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to specified individuals, to a qualified entity, as defined. The bill would further require a qualified entity to comply with the requirements established by PPACA, as well as with any rules, regulations, and guidelines adopted pursuant to that law, as specified, relative to data obtained pursuant to these provisions. This bill contains other related provisions and other current laws. |

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| **SB 1321:** | Harman (R) |
| **STATUS:** | S. HEALTH - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**5/30/2012   **California Health Benefit Exchange: executive board.** Would require the board of the California Health Benefit Exchange , if any part of the federal Patient Protection and Affordable Care Act (PPACA) is amended, invalidated, or repealed, to report to the Legislature regarding the impact on the Exchange of the PPACA sections amended, invalidated, or repealed and to provide the Legislature with a plan, to be included with the report, on how the Exchange will operate given the PPACA sections amended, invalidated, or repealed. The bill would require the board to halt all work related to implementing the Exchange if the board does not provide the Legislature with the report within a specified period of time. The bill would prohibit state moneys from being used to fund any Exchange operations or related functions, or to replace or supplant federal funds currently or previously dedicated to Exchange operations or related functions. This bill contains other related provisions. |

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| **SB 1387:** | Emmerson (R) |
| **STATUS:** | A. APPR. - As of 8/2/2012 |
| **BRIEF SUMMARY:** | **Date of last amendment:**6/27/2012   **Metal theft.** Would prohibit any junk dealer or recycler from possessing a reasonably recognizable, disassembled or inoperative fire hydrant or fire department connection, including, but not limited to, bronze or brass fittings or parts, a manhole cover or lid, or any part of that cover or lid, or a backflow device and connections to that device , that was owned by a public agency, city, county, city and county, special district, or private utility, without a written certification on the letterhead of the entity that owns or previously owned the material and that the entity has sold or is offering the material for sale, and that the person possessing the certificate and identified in the certificate is authorized to negotiate the sale of the material. The bill would require a junk dealer or recycler who unknowingly takes possession of prohibited material as part of a load of otherwise non-prohibited materials without written certification to notify the appropriate law enforcement agency by the end of the next business day upon discovery of the prohibited material. By imposing this prohibition, the violation of which would be a misdemeanor pursuant to other provisions of current law, this bill would impose a state-mandated local program. This bill contains other related provisions and other current laws. |