CAHIP Bills

Thursday, 03/14/2024
Sorted by: Measure

AB 4 | **Arambula, D** | **HTML** | **PDF**

Covered California: expansion.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Support		Faith		CAHIP TOP PRIORITY BILL, Priority 3

Notes

Notes - CAHIP supports AB 4 as amended 7-13-23 which would authorize Covered California to begin the work of implementation needed to ensure people not otherwise eligible due to immigration status can enroll in health coverage equivalent to what is available through Covered California. This will bring California closer to our goal of universal coverage without the need to enact single payer. Prior to recent amendments, the bill would require Covered California, in consultation with stakeholders and the legislature, to develop options for expanding access to affordable health care coverage to Californians regardless of immigration status and report these options to the Governor and Legislature.

Bill information

Status: 09/01/2023 - Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules. (Based on 07/13/2023 text)

Location: 09/01/2023 - Senate 2 YEAR

Introduced: 12/05/2022

Last Amend: 07/13/2023

AB 236 | **Holden, D** | **HTML** | **PDF**

Health care coverage: provider directories.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Re-check		Faith		CAHIP TOP PRIORITY BILL

Notes

Notes - CAHIP is closely WATCHING AB 236 which requires health plans to annually audit and delete inaccurate provider listings, and subjects health plans to administrative penalties if it fails to meet prescribed benchmarks for accuracy. The bill further requires a health plan

to provide information about in-network providers to enrollees and insureds upon request and limits the cost-sharing amounts an enrollee is required to pay for services from those providers.

Bill information

Status: 01/30/2024 - Read third time. Passed. Ordered to the Senate. (Ayes 59. Noes 9.) In Senate. Read first time. To Com. on RLS. for assignment.

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Current law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. (Based on 01/22/2024 text)

Location: 01/30/2024 - Senate RLS.

Introduced: 01/13/2023

Attachments factsheet

Last Amend: 01/22/2024

AB 892 | **Bains, D** | **HTML** | **PDF**

Kern County Hospital Authority.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Watch		Faith		CAHIP TOP PRIORITY BILL

Notes

Notes - CAHIP is closely watching AB 892 which specifies that all entities controlled, owned, administered, or funded by the Kern County Animal Hospital Authority are subject to transparency laws. As the closure of Madera Community Hospital has shown, the loss of public hospitals and medical facilities can strain already limited health care resources and further restrict access to care in California's most disadvantaged communities. The San Joaquin Valley is already in the midst of a health care workforce shortage with an insufficient number of doctors, nurses, and health providers to care for the Valley's growing population. As the area's only Level II Trauma Center, the stability and success of Kern Medical is critical to the overall health care of the entire region. As a public agency, AB 892 requires that the Authority operate in compliance with the Meyers-Milias-Brown Act, Ralph M. Brown Act, and the California Public Records Act to ensure Kern Medical is operated transparently and with accountability to the public and the workforce.

Bill information

Status: 09/14/2023 - Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/7/2023)(May be acted upon Jan 2024)

Summary: Current law requires the Kern County Hospital Authority to provide management, administration, and other controls as needed to operate the medical center, and maintain its status as a designated public hospital. The Meyers-Milias-Brown Act contains various provisions that govern collective bargaining of local represented employees, and requires the governing body of a public agency to meet and confer in good faith regarding wages, hours, and other terms and conditions of employment with representatives of recognized employee organizations. Current law, the Ralph M. Brown Act, requires each legislative body of a local agency to provide notice of the time and place for its regular meetings and also requires that all meetings of

a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The California Public Records Act requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies. This bill would require that all entities controlled, owned, administered, or funded by the authority be subject to the Meyer-Milias-Brown Act, the Ralph M. Brown Act, and the California Public Records Act. (Based on 02/14/2023 text)

Location: 09/14/2023 - Senate 2 YEAR

Introduced: 02/14/2023

AB 2028 | **Ortega, D** | **HTML** | **PDF**

Medical loss ratios.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Oppose		Faith		CAHIP TOP PRIORITY BILL, Priority 1

Notes

Notes - OPPOSE L1 for CAHIP per vote at Bill Review 3-7-24

Bill information

Status: 02/12/2024 - Referred to Com. on HEALTH.

Summary: The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Current law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Current law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department. This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured. (Based on 02/01/2024 text)

Location: 02/12/2024 - Assembly HEALTH

Introduced: 02/01/2024

AB 2180 | **Weber, D** | **HTML** | **PDF**

Health care coverage: cost sharing.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Support		Faith		CAHIP TOP PRIORITY BILL, Priority 3, Rx

Notes

Notes - Support L3 for CAHIP per vote at Bill Review 3-7-24

Bill information

Status: 02/26/2024 - Referred to Com. on HEALTH.

Summary: Would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan contract or health insurance policy. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program. (Based on 02/07/2024 text)

Location: 02/26/2024 - Assembly HEALTH

Introduced: 02/07/2024

AB 2200 | **Kalra, D** | **HTML** | **PDF**

Guaranteed Health Care for All.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Oppose		Faith		CAHIP TOP PRIORITY BILL, Priority 1

Notes

Bill information

Status: 02/08/2024 - From printer. May be heard in committee March 9.

Summary: Would, under the California Guaranteed Health Care for All Act, create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds. (Based on 02/07/2024 text)

Location: 02/07/2024 - Assembly PRINT

Introduced: 02/07/2024

AB 2435 | **Maienschein, D** | **HTML** | **PDF**

California Health Benefit Exchange.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Support		Faith		CAHIP TOP PRIORITY BILL, Priority 2

Notes

Notes - Support L2 for CAHIP per vote at Bill Review 3-7-24 2-22-24 watch per meeting with PR. Cov Ca reached out on this bill. We will discuss in our annual meeting.

Bill information

Status: 02/26/2024 - Referred to Com. on HEALTH.

Calendar: 04/02/24 A-HEALTH 1:30 p.m. - 1021 O Street, Room 1100 BONTA, MIA, Chair

Summary: Current state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the Patient Protection and Affordable Care Act (PPACA). Current law specifies the powers of the executive board. Current law authorizes the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2025, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Current law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. Current law provides that these extensions apply to a regulation adopted before January 1, 2022. This bill would extend the authority of the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025. (Based on 02/13/2024 text)

Location: 02/26/2024 - Assembly HEALTH

Introduced: 02/13/2024

AB 2668 | **Berman, D** | **HTML** | **PDF**

Coverage for cranial prostheses.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Support		Faith		CAHIP TOP PRIORITY BILL, Priority 2

Notes

Notes - Support L2 for CAHIP per vote at Bill Review 3-7-24

Bill information

Status: 03/04/2024 - Referred to Com. on HEALTH.

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. (Based on 02/14/2024 text)

Location: 03/04/2024 - Assembly HEALTH

Introduced: 02/14/2024

AB 2753 | **Ortega, D** | **HTML** | **PDF**

Rehabilitative and habilitative services: durable medical equipment and services.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Watch		Faith		CAHIP TOP PRIORITY BILL

Notes

Notes - Watch as a priority for CAHIP per vote at Bill Review 3-7-24

Bill information

Status: 03/04/2024 - Referred to Com. on HEALTH.

Calendar: 04/02/24 A-HEALTH 1:30 p.m. - 1021 O Street, Room 1100 BONTA, MIA, Chair

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under current law, essential health benefits include, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified. (Based on 02/15/2024 text)

Location: 03/04/2024 - Assembly HEALTH

Introduced: 02/15/2024

AB 3260 | **Pellerin, D** | **HTML** | **PDF**

Health care coverage: reviews and grievances.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Support		Faith		CAHIP TOP PRIORITY BILL, Priority 3

Notes

Notes - Support L3 for CAHIP per vote at Bill Review 3-7-24

Bill information

Status: 03/11/2024 - Referred to Com. on HEALTH.

Calendar: 04/02/24 A-HEALTH 1:30 p.m. - 1021 O Street, Room 1100 BONTA, MIA, Chair

Summary: Current law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law requires these decisions to be made within 30 days, or less than 72 hours when the enrollee faces an imminent and serious threat to their health. Current law requires a health care service plan to establish a grievance system to resolve grievances within 30 days, but limits that timeframe to 3 days when the enrollee faces an imminent and serious threat to their health. Existing law requires a plan to provide a written explanation for its grievance decisions, as specified. This bill would require that utilization review decisions be made within 72 hours when the enrollee’s condition is urgent, and would make a determination of urgency by a referring or treating health care provider binding on the health care service plan. If a health care service plan fails to make a utilization review decision within the applicable 72-hour or 30-day timeline, the bill would automatically entitle an enrollee to proceed with a grievance. (Based on 02/16/2024 text)

Location: 03/11/2024 - Assembly HEALTH

Introduced: 02/16/2024

SB 263 | **Dodd, D** | **HTML** | **PDF**

Insurance: annuities and life insurance policies.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Watch		Faith		CAHIP TOP PRIORITY BILL, Priority 2

Notes

Notes - CAHIP is watching SB 263 which has been amended to reflect a compromise amongst stakeholders. Now the bill will enhance and update the existing Annuity Suitability law and make it the strongest suitability law in the country. Additionally, the language contains enhanced training requirements for life agents who sell life insurance products that tend to be more complex than the traditional term life products. This consumer protection will help to ensure that agents have the proper training to help consumers make educated decisions about their life insurance needs.

Bill information

Status: 02/29/2024 - Signed by the Governor

Summary: Existing law generally regulates classes of insurance, including life insurance and annuities. Existing law requires insurers to establish a system to supervise recommendations and set standards and procedures for recommendations for annuity products, which applies to any recommendation to purchase, exchange, or replace an annuity made to a consumer that results in the purchase, exchange, or replacement that was recommended. Existing law requires an insurance producer recommending the purchase or exchange of an annuity to have reasonable grounds for believing that the recommendation is suitable for the consumer, as specified. This bill would limit application of these provisions to (1) a recommendation of an annuity made before January 1, 2025, that results in the purchase, exchange, or replacement that was recommended and (2) a sale of an annuity made before January 1, 2025, that is not based on a recommendation. (Based on 02/21/2024 text)

Location: 02/29/2024 - Senate CHAPTERED

Last Amend: 02/08/2024

Introduced: 01/30/2023

SB 1236 | **Blakespear, D** | **HTML** | **PDF**

Medicare supplement coverage: open enrollment periods.

Tracking form

Organization	Position	Priority	Assigned	Subject	Group
CAHIP	Oppose		Faith		CAHIP TOP PRIORITY BILL, Priority 1

Notes

Notes - 3-7-24 Oppose L1 for CAHIP per recommendation at Bill Review. FLB will schedule a meeting with Author's office. Currently: Med Sup Members can already move one time per year within 60 days of their bday. Blue Shield already does no underwriting. This bill will drive up costs. NY did this and now they have less carriers and higher costs.

Bill information

Status: 02/29/2024 - Referred to Com. on HEALTH.

Summary: Current federal law provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage

of Medicare deductible, copayment, or coinsurance amounts, as specified. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. (Based on 02/15/2024 text)

Location: 02/29/2024 - Senate HEALTH

Introduced: 02/15/2024

Total Measures: 12
Total Tracking Forms: 12