

2006 FEDERAL AND STATE LEGISLATIVE REPORT

**SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
OFFICE OF POLICY AND PLANNING**

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I. Introduction

A. Legislation and the Strategic Plan

Goal IV, Objective 2 of the 2004 update of the Department of Public Health's (the Department) Strategic Plan directs staff to "Pursue State and federal health policy changes consistent with Department priorities." Specifically, staff is tasked to:

- a. Engage in local, State, and federal advocacy efforts through the Mayor's Office; and
- b. Advocate for State and federal legislative changes addressing programmatic issues.

Advocacy efforts on behalf of the Department are coordinated through the Office of Policy and Planning (OP&P). Through legislative analysis, participation in statewide and national coalitions, and in collaboration with community partners and colleagues from other counties, OP&P reviews and analyzes State and federal legislation and its impact on the Department. The Department works closely with the Mayor's Office of Policy and Finance to advocate for policy changes that improve the health of San Franciscans.

B. The State Legislative Process

In accordance with City policy, the Department, like other City departments does not take positions on State or federal legislation. Instead, the Department, through OP&P, works closely with the Mayor's Office of Policy and Finance and the Mayor's State Legislative Committee to recommend that the City take a position (support, oppose, watch) on specific health-related legislative items. The Mayor's Office approves the Department's recommendations in one of two ways:

1. by approving the Department's State Legislative Plan, which outlines the Department's recommendations on issues likely to arise during the legislative session. (The Department's 2007 State Legislative Plan is attached as Appendix A.)
2. through the approval of the Mayor's State Legislative Committee for issues that are not addressed in the State Legislative Plan.

Because the City responds to a large number of bills coming from all departments, OP&P only recommends those items that have a significant impact on the Department. In other instances, the Department relies on the positions taken by statewide coalitions of which the Department is a member. These coalitions include the County Health Executives Association of California (CHEAC), the California Conference of Local Health Officers (CCLHO), the California Association of Public Hospitals (CAPH), and the California Hospital Association (CHA), among others. Through its participation in these coalitions, the Department ensures that the City's position is represented in coalition positions.

Finally, the Department may not recommend that the City take a position on legislation that is clearly not moving. Though the legislation may be important, the City's and the Department's efforts are better spent on issues other than inactive legislation.

C. The Federal Legislative Process

As with State legislation, the Department works through the Mayor's Office of Policy and Finance to advocate for changes in federal policy. The Department may also work through the City's federal lobbyist, although this is usually done in conjunction with the Mayor's Office. Like the Department's work with statewide coalitions, Department staff also participate in coalition with national organizations, including the National Association of Hospitals and Health Systems (NAPH), the Public Health Pharmacy Coalition, the Communities Advocating Emergency AIDS Response (CAER) Coalition, and others to influence federal policy. Through its participation in these national organizations, the Department ensures that the City's position is represented in federal matters. Because the responsibility and federal funding for health care largely flow to the states, the majority of the Department's advocacy efforts are focused at the State level.

II. Federal Legislative Summary

A. Overview of the Legislative Session

The second session of the 109th Congress convened on January 3, 2006 under Republican leadership in both houses. Some of the major debates that the legislature undertook included illegal immigration and border security, same-sex marriage, stem cell research, tax relief and reform, terrorism and homeland security, and the ongoing war in Iraq. None of these issues, however, saw any resolution. According to CNN, "Of the 383 pieces of legislation that were signed into law during the two-year 109th Congress, more than one-quarter dealt with naming or renaming federal buildings and structures -- primarily post offices -- after various Americans."¹ The 109th Congress has been called, "...one of the most lethargic of all time," by the Washington Post "...deplorable on civil rights," by the NAACP, and "...one of the most partisan, and least productive, in history." by National Public Radio.

One issue that Congress was unable to come to agreement on was a budget. The Office of Management and Budget (OMB) estimated that by the end of federal fiscal year (FFY) 2006, the federal deficit would reach \$423 billion, making it the fifth straight year of federal overspending. Faced with potential government shutdown, in March 2006, Congress passed and the President signed legislation to raise the debt ceiling to \$9 trillion. The national debt now stands at nearly \$8.7 trillion. This is fourth time in five years that Congress has voted to raise the debt ceiling. When President Bush took office in 2001, the national debt stood at \$5.6 trillion. To date, under the Bush administration, the national debt has increased by 55 percent.

B. Federal Budget

As of January 24, 2007, the federal government continues its operations on a Continuing Appropriations Resolution, which is set to expire on February 15, 2007. This is the third Continuing Resolution for FFY 2007. Despite Republican control of both houses and the White House, Congress was unable to pass a budget prior to start of FFY 2007 on October 1, 2006 and before it adjourned in December.

¹ <http://www.cnn.com/POLITICS/blogs/politicalticker/2006/12/109th-congress-success-at-naming.html>

On February 6, 2006, President Bush sent his FFY 2007 budget proposal to Congress. His budget includes \$2.8 trillion in federal spending. Last year, the President pledged to cut the federal deficit in half by 2009, and his 2007 budget attempts to reach that target. The FFY 2007 budget projects the federal deficit to decline to \$205 billion over the next five years. However, the five-year estimate does not account for the impact of extending tax cuts, reforms to the Alternative Minimum Tax (AMT), or the ongoing costs of war.

Federal funding for health programs in the President's budget account for one-fifth of all federal spending. The President proposes \$647 billion for total spending on health programs under the Department of Health and Human Services (DHHS). Of that, 57 percent would be spent on Medicare, 33 percent on Medicaid, nine percent on public health programs, and less than one percent on the State Children's Health Insurance Program (S-CHIP), known as Healthy Families in California.

As a way to reach his spending targets, the President proposed to reduce spending in FFY 2007 on health entitlement programs and to limit new funds for discretionary health programs. Some of the highlights include:

- A \$36 billion decrease in Medicare spending over the next five years through reduced payments to providers (hospitals, skilled nursing facilities, home health providers, hospices, ambulances, rehabilitation facilities), and increases in premiums for higher income beneficiaries.
- A \$14 billion decrease in Medicaid spending over the next five years through a cap on payments to local government health care providers at "no more than the cost of furnishing services," restrictions on states to assess taxes on providers as a way of increasing federal matching funds, ending payments for administrative services that "are already funded through the Temporary Assistance to Needy Families (TANF) program, efforts "to further reduce Medicaid overpayments for prescription drugs," reductions in federal reimbursement for services provided by certain case managers, and limits on payments when a third party may be liable.
- A proposal to freeze federal funding for the S-CHIP (Healthy Families) program at the 2007 level of \$5 billion.
- Promoting a more consumer-driven health care system by promoting Health Savings Accounts (HSAs) through tax credits, increases in the allowable contributions, and tax deductions for taxpayers who purchase a high-deductible health plan in conjunction with a HSA.
- Reforms to the health insurance market, including establishment of association health plans (AHPs).
- Cuts to the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA).
- A \$2.3 billion increase over Congress's \$3.3 billion appropriation for pandemic flu readiness.
- A \$2 billion increase to expand the number of Health Centers.
- A \$169 million increase to expand health information technology.

- A \$1.7 billion increase for domestic and global HIV/AIDS activities.

C. Deficit Reduction Act (S. 1932)

The Deficit Reduction Act (DRA) was signed by President Bush on February 8, 2006, two days after he released his FFY 2007 federal budget. The DRA is designed to do what its name implies, reduce the federal deficit, and if fully implemented would reduce the federal deficit by \$39 billion over the next five years. A significant portion of those savings, \$4.8 billion, are expected to come from the Medicaid program. Specific Medicaid funding cuts include:

- Elimination of federal limits on premiums and cost sharing for Medicaid beneficiaries.
- Limitations on benefits for certain populations.
- Increases in the penalties and the look-back period for improper asset transfers to qualify an individual for Medicaid nursing home care.
- Changes in the way state Medicaid programs pay for prescription drugs.
- Requirements that new enrollees and current enrollees at re-determination provide documentation of their citizenship status.
- Tightening of the definition of what qualifies under the Medicaid Targeted Case Management (TCM) program.

The DRA also includes a number of new Medicaid spending provisions, including:

- An additional \$2 billion to pay states that incurred Medicaid and S-CHIP costs as a result of relocation of Hurricane Katrina evacuees.
- A buy-in provision for families with a disabled child and incomes below 300 percent of the federal poverty level (FPL).
- Additional spending for the elderly and disabled population by allowing states to offer home- and community-based care as an optional service rather than requiring a waiver.

While the 2007 Budget has not yet been passed and signed, and given the change in the composition of the 110th Congress, passage of the President's budget as written seems unlikely, many of the Medicaid proposals in the President's budget shift costs to the states. Given this federal move to pull back from Medicaid funding as well as other federal cost-saving attempts, states may begin to face financial pressures which motivate them to use options such as the increased cost sharing and benefits reductions that the DRA makes available to them. This will only serve to push costs further down the line to counties.

D. Ryan White CARE Act Reauthorization

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the largest source of funds directed at the care of persons living with HIV/AIDS. In 2006, San Francisco received just over \$29 million in CARE Act funding. On December 19, 2006, President Bush signed the reauthorized CARE Act, more than a year after it had expired. Through on-going appropriations, the CARE Act continued through FFY 2006 and into

2007 under FFY 2005 terms. Despite a number of attempts to pass a reauthorized CARE Act, Congress recessed for mid-term elections without passing one.

Prior to recessing at the end of September, Congress made an attempt to pass a bill reauthorizing the CARE Act that would have severely impacted San Francisco. Under the proposed legislation, “hold harmless” language, designed to protect cities and states from funding reductions sufficiently drastic to devastate existing service networks, would have been dropped in the fourth year of the five-year reauthorization. Instead, funding from San Francisco and other cities hit hard in the early years of the epidemic, would have been used to fund care in “emerging communities,” mostly in rural and southern states. That proposal would have cost San Francisco \$23.6 million over the five-year life of the Act. While it passed in the House, it failed in the Senate postponing further action until after the mid-term election.

When Congress reconvened its post-election lame-duck session on December 3, 2006, it again took up the issue of CARE Act reauthorization. With democrats retaking both houses in the November mid-terms, the mood regarding the funding formula for the CARE Act changed significantly. Prior to reconvening Sen. Ted Kennedy (D-Massachusetts) and Sen. Michael Enzi (R-Wyoming) put together a compromise bill, which passed unanimously in the Senate on December 6 and the House on December 9th. The bill sunsets in three years in order to deal with the “emerging communities” issue. Under its terms, funding will be maintained at 95 percent of the previous year, and for its three year life will never be allowed to fall below 95 percent of its FFY 2006 level. Although San Francisco will lose funding, \$1.5 million in year one and \$4.5 over the three years of the Act, this is a far better deal for the City than any proposal considered prior to the elections.

E. Looking Forward

Although it appears that the Iraq war will dominate much of the discussion in Washington, a number of health care and health-related issues remain on the Congressional plate. With their return to power in both houses for the first time in 12 years, democrats pledged to move quickly on an agenda of health care, homeland security, education and energy proposals. In her remarks upon becoming House Speaker, Rep. Nancy Pelosi (D-San Francisco) promised, “A new America with a vibrant and strengthened middle class for whom college is affordable, health care is accessible, and retirement reliable.” By mid-January, the House had already passed legislation on raising the minimum wage from \$5.15 to \$7.25 per hour and loosening the ban on embryonic stem-cell research. Democrats are also committed to eliminating the “doughnut hole” in Medicare prescription coverage. Additionally, House Speaker Pelosi has banned smoking in the Speaker’s Lobby, a notorious gathering place for smokers.

III. State Legislative Summary

A. Overview of the Legislative Session

The opening of the Legislature in January marked the start of second year of its two-year legislative session. This was an active session for health-related bills, with issues ranging

from lead plumbing to hospital financing. It was also the first time in California's history that a single-payer universal healthcare bill, SB 840, reached the Governor's desk. Governor Schwarzenegger vetoed that legislation noting that "socialized medicine is not the solution to our state's health care problems." More detail on the bill is included below.

It was also a good session for San Francisco health-related bills. All three of the bills that the Department sponsored, trauma services (AB 50), mobile methadone coverage (AB 631), and the community-living support waiver (AB 2968), were passed and signed by the Governor. All three of those bills are discussed in more detail below.

B. State Budget

On June 27, 2006, the California Legislature passed the 2006-07 State budget along with implementing legislation. The Governor signed the budget on June 30, after using his line item veto authority to reduce appropriations by \$112 million. The budget package authorized total State spending of \$127.9 billion. Overall, health programs fared well in the 2006-07 program. Some highlights included:

- An additional \$50 million statewide to enroll eligible children and retain covered children in the Medi-Cal and Healthy Families program. Funds were distributed through a competitive application process and San Francisco received \$180,000 for its children's outreach efforts.
- An additional \$45.8 million statewide for disaster preparedness, including funds for pandemic flu preparedness, chemical and radiation disasters, disease surveillance, and hospital surge capacity. San Francisco received an additional \$208,000.
- A Medi-Cal rate increase for skilled nursing facilities (SNFs) yielded \$10.88 per patient day at Laguna Honda Hospital (LHH) for a total annual net of \$2.25 million.

C. State Coverage Initiative (SB 1448)

SB 1448 is the enabling legislation for the Health Care Coverage Initiative as required under the Special Terms and Conditions of the State Medicaid Section 1115 demonstration project waiver relating to hospital financing and health care coverage expansion that became effective on September 1, 2005. In order to participate and draw down federal Medicaid matching funds, counties need to submit an application to the California Department of Health Services (DHS), which includes plans for covering uninsured individuals. Awards are for a three-year period, and grantees are required to provide the matching funds necessary to claim federal funding.

DHS released its Request for Applications on November 1, 2006. Applications were due on January 11, 2007. A total of \$180 million per year over the three years of the grant will be distributed on a competitive basis as follows:

- Awards will be distributed geographically.

- Within each geographic area listed below, the evaluation committee will array the applications from the highest to the lowest ranking application, and select the highest ranking application within each of the following three areas:
 1. The Greater Bay Area (including Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma Counties).
 2. Southern California (including Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties).
 3. The remaining area of the State, not listed in 1 and 2, above.
- Following selection of the three applications from the areas listed above, the evaluation committee will array the remaining applications from the highest to the lowest ranking and select two or more applications with the highest ranking(s) statewide.

The Department submitted its application for \$82.6 million over the three-year grant period for implementation of the Health Access Program (HAP). An award response from DHS is due March 1, 2007.

D. Victim Compensation: Trauma Services (AB 50)

AB 50, which appropriates \$1.3 million in funds for the Trauma Recovery Center at San Francisco General Hospital/University of California, San Francisco (UCSF), was passed by the legislature and signed by the Governor. Assemblyman Mark Leno introduced the legislation, which the City and the Department sponsored. Funding commenced July 1, 2006, and is being appropriated from the Restitution Fund to the Claims Board.

In signing the bill, the Governor said: “To the Members of the California State Assembly: I am signing AB 50. The Trauma Recovery Center (TRC) located at San Francisco General Hospital/UCSF has shown itself to be a very successful, nationally recognized model program. Given that the TRC has demonstrated its success by increasing the number of victims served while simultaneously decreasing the cost of services, I do not want to jeopardize its existence. However, I am very concerned about the use of Restitution Funds even though this money would be used to provide services to victims in a more efficient manner. Thus, I am signing this bill in recognition that this will be a one-time appropriation in order to ensure that the program still exists so that it can be replicated throughout the State. I believe that every victim in every county of California should have access to similar programs that increase the availability and success of victim services while reducing overall costs of administration. Therefore, I am directing the Victims Compensation and Government Claims Board and the Department of Finance to assess the cost of implementing similar programs on a statewide basis and to determine the availability and condition of any appropriate funding sources. Sincerely, Arnold Schwarzenegger.”

E. Medi-Cal Coverage for Mobile Methadone Treatment (AB 631)

AB 631, passed by the legislature and signed by the Governor, provides Medi-Cal reimbursement for mobile methadone vans by requiring the California Department of Alcohol and Drug Programs (DADP) to establish a mobile narcotic treatment program (MNTP). MNTPs would need to meet one of the following requirements: 1) Hold a

primary narcotic treatment license; or 2) Be affiliated and associated with a primary licensed narcotic treatment program. A MNTP meeting requirement 2 would be exempted from the requirement to have a separate license from the primary license holder with which it is affiliated and associated. Assemblyman Mark Leno carried this legislation, which was sponsored by the City and the Department.

F. Medi-Cal Community Living Support Benefit (AB 2968)

AB 2968, passed by the legislature and signed by the Governor, creates a Medi-Cal reimbursement rate structure for community living support services to assist San Francisco beneficiaries who would otherwise be homeless, living in shelters, or institutionalized. This bill was introduced by Assemblyman Mark Leno and was sponsored by the City and the Department. This is a San Francisco-specific waiver that will provide community-based care targeted to individuals seeking to leave Laguna Honda Hospital (LHH) or persons at imminent risk of entering LHH absent such services.

Prior to this legislation, Medi-Cal provided a single reimbursement rate for the range of services beneficiaries need when they were in an inpatient institutional setting. However, no such designated reimbursement rates existed for community-based living services in San Francisco. This created significant barriers to the provision of community-based care for Medi-Cal beneficiaries, especially those who are homeless, who have multiple and complex service needs that often require these services in a residential setting such as a Residential Care Facility for the Elderly (RCFE). While Medi-Cal reimbursement was available for coordinated services to meet a wide range of patient needs in inpatient settings, like LHH, the City was forced local general funds to coordinate care provided in the community. This significantly limited these efforts, and some types of residential settings were not covered, including RCFEs.

Implementation of this legislation will mean more options for lower income individuals in need of long-term care, simplification of uncoordinated and complex reimbursement, and reductions in inappropriate inpatient care, consistent with the Supreme Court's Olmstead decision. Currently, DPH staff is working with the California Department of Health Services staff to implement AB 2968 through a federal Medicaid waiver with the federal Centers for Medicare & Medicaid Services.

G. Proposition 85

Proposition 85, put forward on the November 2006 California ballot, would have amended the California Constitution to prohibit abortions for unemancipated minors (under age 18) until 48 hours after the physician's notification of the minor's parent or legal guardian, except in the case of medical emergency or with parental waiver. It did permit the minor to obtain a court order waiving parental notice based on clear and convincing evidence of the minor's maturity or best interest. Proposition 85 failed with 54 percent voting no and 46 percent voting yes.

Proposition 85 was essentially a reprise of Proposition 73, which California voters defeated in November 2005 by a margin of 53 percent to 47 percent. Like Proposition 85, Proposition 73 would have amended the California Constitution to prohibit abortions

for minors until 48 hours after physician notification of a parent or guardian. It also contained a provision for judicial waiver of parental consent.

Both the Health Commission and the Board of Supervisors opposed passage of Proposition 85.

H. Proposition 86

Proposition 86, also on California's November ballot, would have imposed a \$0.13 tax per cigarette (\$2.60 per pack) sold in California with the funds raised through the tax distributed to health programs, including:

- Hospital emergency and trauma care
- Nursing education
- Non-profit community clinics
- California Healthcare for Indigents Program (CHIP)
- Tobacco cessation and other health treatment and services programs
- Children's health insurance (Statewide expansion of the Healthy Kids program)
- Heart disease, cancer and other health maintenance and disease prevention programs
- Tobacco control and disease research

Proposition 86 failed with 52 percent voting against and 48 percent voting in favor. Both the Health Commission and the Board of Supervisors supported passage of the proposition.

I. Summary of Selected Health-Related Bills Enacted in 2006

AB 959 (Frommer) Medi-Cal: health facilities: reimbursement - This bill expands eligibility for supplemental Medi-Cal outpatient reimbursements to state facilities and to clinics owned or operated by the state, cities, counties, the University of California and health care districts by enabling these entities to draw down additional federal funds using their own funds as a certified public expenditure.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 162, Statutes of 2006.

AB 1920 (Chan) Medi-Cal: hospital funding - This bill extends for a second year the methodology for distributing funds under the hospital financing waiver established by SB 1100 (Perata), Chapter 560, Statutes of 2005.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 270, Statutes of 2006.

AB 1953 (Chan) Lead plumbing - This bill would revise the term lead free to mean not more than 0.25% lead when used with respect to pipes and pipe fittings, plumbing fittings, and fixtures.

SF Position: Support

Status: Chaptered by the Secretary of State, Chapter Number 853, Statutes of 2006. In the Governor's Press Release regarding AB 1953, he stated: "*Protecting public health is a top priority, I signed this bill to reduce the amount of lead exposure in California's drinking water. We need to make sure that the water we consume is safe for everyone especially our children.*"

AB 2384 (Leno) Nutrition: Healthy Food Purchase Pilot Program - This bill would require the Department of Health Services to develop a "Healthy Food Purchase" pilot program to increase the sale and purchase of fresh fruits and vegetables in low-income communities.

SF Position: Support

Status: Chaptered by the Secretary of State, Chapter 236, Statutes of 2006.

AB 2745 (Jones) Hospitals: discharge plans: homeless patients - This bill prohibits hospitals from "dumping" homeless patients in another county for the purpose of receiving supportive services, without prior notification and authorization.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 794, Statutes of 2006.

AB 3070 (Chan) Medi-Cal: demonstration project: hospital funding - This bill makes clarifying corrections to hospital financing waiver established by SB 1100 (Perata), Chapter 560, Statutes of 2005.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 327, Statutes of 2006.

SB 162 (Ortiz) State Department of Public Health - SB 162 establishes a new Department of Public Health within the existing Health and Human Services Agency and statutorily transfers some responsibilities from the Department of Health Services to the new CDPH, effective July 1, 2007.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 241, Statutes of 2006.

SB 437 (Escutia) Health care coverage - This bill declares the intent of the Legislature that all children in California have health care coverage by December 1, 2010. Enables more uninsured children to enroll in the health coverage program for which they are eligible by simplifying the application and enrollment process. According to the administration, the bill will allow approximately 94,000 children to enroll in or retain their health coverage under Medi-Cal and Healthy Families.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 328, Statutes of 2006.

SB 1299 (Speier) Controlled substances: precursors: phencyclidine: methamphetamine - SB 1299 creates a new felony crime for the possession of the chemicals used to make methamphetamine or phencyclidine (PCP) with the intent to sell, transfer, or furnish them to another person with the knowledge the chemicals will be used to manufacture methamphetamine or PCP.

SF Position: Support

Status: Chaptered by the Secretary of State, Chapter Number 646, Statutes of 2006.

SB 1469 (Cedillo) Medi-Cal: eligibility: juvenile offenders - This bill requires county juvenile detention facilities to notify county welfare departments about the release of a ward so that eligibility for Medi-Cal can be determined starting January 1, 2008.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 657, Statutes of 2006.

SB 1500 (Speier) Drug programs - This bill authorizes the Department of Drug and Alcohol Programs to conduct a statewide public education campaign to prevent the abuse of methamphetamine in California.

SF Position: Support

Status: Chaptered by the Secretary of State, Chapter Number 662, Statutes of 2006

SB 1534 (Ortiz) Public benefits - This bill permits local governments to provide aid, including health care, to persons who, but for Section 411 of the federal welfare reform act, would meet eligibility requirements for any aid.

SF Position: Watch

Status: Chaptered by the Secretary of State, Chapter Number 801, Statutes of 2006.

SB 1661 (Cox) Health facilities: seismic safety: construction - This bill would authorize the Office of Statewide Health Planning and Development to grant an additional two-year extension of the January 1, 2013, Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 deadline if the hospital building subject to the extension is under construction at the time of the request for this extension and the hospital has made a good faith effort to comply with the January 1, 2013, deadline.

SF Position: Support

Status: Chaptered by the Secretary of State, Chapter Number 679, Statutes of 2006.

J. Summary of Selected Health-Related Bills that Failed in 2006

AB 264 (Chan) Health care service plans: pediatric asthma - This bill requires a health care service plan contract to include coverage for outpatient training and education necessary to use the medications and devices prescribed for the treatment of pediatric asthma.

SF Position: Support

Status: Vetoed - In his veto message the Governor stated: *"I am returning AB 264 without my signature as the bill is unnecessary. Existing law and regulations already require health plans to provide coverage for the treatment of asthma as well as effective health education services which include information regarding personal health behavior and health care."*

AB 2076 (Laird) Drug paraphernalia: clean needle and syringe exchange projects - This bill permits a public entity that receives money from the Department of Health Services for HIV prevention and education to use that money to support authorized clean needle and syringe exchange projects (NSEP). AB 2076 was held at the Assembly Desk

as the Governor's office informed Assemblyman Laird that he would be vetoing it, but would work with him next year to pass legislation.

SF Position: Support

Status: Dead

AB 2607 (De La Torre) Medi-Cal: managed care: persons with disabilities - AB 2607 enacts the Mandatory Medi-Cal Managed Care Pilot Program authorizing the Department of Health Services to select two counties where seniors and persons with disabilities will be assigned on a pilot basis as mandatory enrollees to new or existing managed care plans.

SF Position: Support

Status: Dead

AB 2754 (Chan) Hospitals: staffing - AB 2754 would have required hospitals to adopt and annually update a plan or procedure for determining staffing levels of professional and technical classifications.

SF Position: Watch

Status: Dead

SB 840 (Kuehl) Single-payer health care coverage - SB 840 would create the California Health Insurance System, a single payer health care system, administered by the California Health Insurance Agency, to provide health insurance coverage to all California residents.

SF Position: Support

Status: Vetoed - In his veto message the Governor stated: *"I must return SB 840 without my signature because I cannot support a government-run health care system. Socialized medicine is not the solution to our state's health care problems."*

SB 1208 (Ortiz) Tobacco products - This bill prohibits transportation of cigarettes to persons in California except when such shipments are made to a licensed entity.

SF Position: Watch

Status: Vetoed – Governor's Veto Message: *"I am returning Senate Bill 1208 without my signature. This bill would prohibit cigarette sales via the Internet to individual California consumers and only permit shipping of cigarettes via the Internet to state of California tobacco licensed businesses. Existing law reduces youth access to cigarettes over the Internet by requiring Internet sellers and shippers to verify the age of the purchaser, similar rules that apply to alcohol sales and shipments. In addition, the Board of Equalization is currently uses the federal Jenkins Act to recover excise taxes from Californians that have purchased cigarettes via out-of-state Internet websites. Sincerely, Arnold Schwarzenegger"*

SB 1288 (Cedillo) Medi-Cal: minors: drug and alcohol treatment - This bill would expand the scope of benefits in the Minor Consent Medi-Cal to include services for youths suffering from substance abuse disorders.

SF Position: Support

Status: Vetoed - Governor's Veto Message: *"I am returning Senate Bill 1288 without my signature. I strongly support efforts to help people recover from drug addiction and recently provided \$670 million in statewide drug treatment programs, an increase of \$53 million over the previous year. While I support providing improved access to substance abuse treatment services for adolescents, I cannot support this bill as it would substantially expand Drug Medi-Cal services and result in millions of dollars of new state costs. I believe this policy can be more appropriately addressed during the budget process. Sincerely, Arnold Schwarzenegger"*

SB 1329 (Alquist) Community development: healthy food choices - This bill requires the Department of Food and Agriculture in partnership with the Department of Health Services to establish the "Healthy Food Retailing Initiative" to provide residents of underserved communities with retail food markets that offer high quality fruit and vegetables.

SF Position: Support

Status: Dead

SB 1353 (Romero) Medi-Cal: provider enrollment - This bill makes specified physicians eligible for expedited enrollment in the Medi-Cal program and permits a Medi-Cal physician provider to change locations within the same county by filing a change of location form.

SF Position: Watch

Status: Vetoed – Governor's Veto Message: *"I am returning Senate Bill 1353 without my signature. I am concerned that it may unintentionally result in tens of millions in fraudulent claims by interfering with Medi-Cal fraud activities designed to protect program integrity. These efforts include in-depth background checks and pre-enrollment inspections. As demonstrated by the recent Medi-Cal Payment Error Study, which found that 8.4 percent of dollars paid by Medi-Cal (\$1.4 billion) contained errors, including fraud, we must continue to be vigilant in our efforts. I share the author's interest in getting Medi-Cal providers enrolled faster to provide greater access to care. The majority of providers applying for enrollment are approved expeditiously within 30 days. However, roughly 700 applications per year require increased scrutiny and results have shown that 64 percent of those applications result in recommendations for denial or additional action. A key goal of Senate Bill 1353, is to expedite re-enrollment of providers moving within a county. This issue has been largely addressed administratively by improvements in the provider enrollment process and allowing providers moving to a new location to continue to bill Medi-Cal while their application is being processed. Additionally, by streamlining enrollment of providers belonging to a physician group, restructuring its paper processing, and improving staff training and oversight, the Department of Health Services has improved Medi-Cal provider enrollment and significantly reduced processing time. The Department of Health Services will continue to improve the provider enrollment system, while balancing the need to retain key tools to fight fraud and abuse. Sincerely, Arnold Schwarzenegger"*

SB 1398 (Chesbro) Medi-Cal: managed care: reimbursement - This bill requires the Department of Health Services annually provide to the appropriate policy and fiscal

committees of each house of the Legislature, as part of the May Revision of the annual Budget Act, specified information regarding all Medi-Cal managed care plans.

SF Position: Support

Status: Vetoed - Governor's Veto Message: *"Senate Bill 1398 would require the California Department of Health Services to provide to the Legislature, on an annual basis, specific information about the Medi-Cal rate setting process. This would include the methodology used and rate adjustments made or planned. Disclosing this information conflicts with existing law which requires that Medi-Cal managed care capitation rates and supporting documentation for contracts negotiated by the California Medical Assistance Commission remain confidential for four years. Further, this bill would impose unworkable requirements, such as requiring reports of unknown information like potential future rate adjustments. While I support providing the Legislature information to assist in the development of sound fiscal and programmatic policy, I am returning SB 1398 without my signature as it conflicts with important confidentiality protections and elements of the rate setting process that are critical to California's effective Medi-Cal rate negotiations. Sincerely, Arnold Schwarzenegger"*

SB 1414 (Migden) California Fair Share Health Care Act - This bill would require an employer with 10,000 or more employees in the state, who does not elect to contribute the difference in support of the Medi-Cal program, to spend a specified percentage of the total wages the employer paid to employees in the state in the immediately preceding calendar year, on employee health insurance costs.

SF Position: Support

Status: Vetoed - In the Governor's Veto Message he stated: *"Unfortunately, SB 1414 does nothing to address the health care challenges we face. Singling out large employers and requiring them to spend an arbitrary amount on health care does nothing to lower costs or guarantee that even one more person has health care coverage."*

K. Looking Forward

The new two-year session of the California legislature looks to be a busy one for health. Both Assembly Speaker Fabian Nunez (D-Los Angeles) and Senate President Pro Tem Don Perata (D-Oakland) have introduced legislation to expand health care coverage for Californians, AB 8 and SB 48, respectively. This was closely followed by Governor Schwarzenegger's Health Care Proposal for health care coverage for all Californians. In his proposal he includes three essential building blocks: prevention, health promotion, and wellness; coverage for all Californians; and affordability and cost containment. Some of the elements of his plan include:

- Providing incentives to promote healthy lifestyles
- Preventing medical errors and hospital-acquired infections
- Ensuring the availability of emergency rooms and trauma care
- Covering all Californians through a variety of means:
 - Covering all children, including undocumented children, under 300 percent FPL through the Medi-Cal and Healthy Families programs
 - Requiring parents/guardians of children over 300 percent FPL to provide coverage through an employer-based or individual plan

- Requiring all adults to have a minimum level of coverage (individual mandate) by enrolling all adults under 100 percent FPL in the Medi-Cal program, providing a subsidized purchasing pool for adults 100 to 250 percent FPL, and requiring individuals over 250 percent FPL to obtain coverage through an employer-based or individual plan
- Providing coverage through uninsured undocumented adults through county government
- Requiring employers of ten or more employees to offer health coverage or contribute four percent of payroll toward the cost of their employees' health coverage
- Directing more funds to doctors and hospitals while requiring hospitals to contribute back four percent of gross revenue and doctors to contribute back two percent of gross revenues
- Ensuring affordability and cost containment by increasing Medi-Cal reimbursement, requiring health plans and hospitals to spend 85 percent of revenues on patient care, enhancing tax breaks for individuals and employers who purchase insurance, reducing regulatory barriers, encouraging health information technology, and leveraging State purchasing power through Medi-Cal.

Given the public's focus on the state of health care in California and across the country, these proposals provide the first opportunity in a number of years for health care system reform.

IV. Appendix A: State Legislative Plan