ADOPTIONS, CHILD WELFARE, AND FOSTER CARE

SB 591 (Scott) – Dependent Children: Caregiver Information
Expands the amount of information that a foster parent is to receive from a child protection agency where a child is placed with that parent.
Status: Chapter 812, Statutes of 2003

SB 693 (Murray) – Undersecretary of Foster and Child Welfare
Establishes, within the state Health and Human Services Agency (HHSA), the position of Undersecretary of Foster Care Coordination. Requires the Secretary of HHSA to appoint the Undersecretary and obtain confirmation by the Senate.

Directs the Undersecretary to coordinate the activities of state and local agencies that provide for the needs of children placed in foster care. Based, in part, on a recommendation from the Little Hoover Commission.
Status: Held under Submission in the Assembly Appropriations Committee - Two Year Bill

SB 950 (Alarcon) – Dependent Children: Truancy, Education, and Juvenile Court
Authorizes the juvenile court to adjudge a child who comes within the definition of an habitual truant, as specified, as a result of the willful failure of a parent, guardian, or other person having control or charge of the child to ensure that the child attends school, to be a dependent child of the juvenile court.

Imposes, by expanding the jurisdiction of the juvenile court to include these children, additional duties on local employees, thereby creating a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

Provides that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.
Status: Died in the Senate Health and Human Services Committee

AB 380 (Steinberg) - Children's System Of Care Program: Evaluation Standards
Requires each county that operates a Children's System of Care program to collect and maintain data that demonstrates the outcomes of the program in that county.

Permits the source of data to be county social services, probation, or mental health departments, school districts, caseworker records, or parent/caregiver records.

Requires participating counties to provide outcome data annually to the Department of Mental Health.

Requires the data to include:

- The number of persons served and the number who received extensive community mental health services.
- Short-term or long-term cost savings, cost avoidance, and cost effectiveness for out-of-home placement, hospitalization, and detention.
- Improvements in school attendance.
- The number of persons served who had contact with local law enforcement, the reduction in the number of juvenile violations, and the reduction in the number of state and local placements in juvenile halls or the California Youth Authority.
- Client benefit outcomes.
- Youth and family perspectives on system interventions.
- System of care access.
- Mental health treatment and service costs, excluding hospitalization.
- Psychiatric hospitalization and out-of-home placement costs.

Status: Held on Senate Floor Inactive File - Two Year Bill

AB 408 (Steinberg) – Dependent Children

Establishes processes within child protection to ensure that no child leaves foster care without a life-long connection to a committed adult.

Provides that every child adjudged to be a dependent of the juvenile court shall be entitled to participate in age-appropriate extracurricular, enrichment and social activities and that no state regulation or policy may prevent or create barriers to participation in those activities.

Provides that caregivers shall use a "prudent parent" standard in determining whether to give permission for a child residing in foster care to participate in such activities.

Requires the social worker to ask a child who is 10 years old or older to identify any such individuals, consistent with the child's best interest, and permits the social worker to ask a child younger than 10, when appropriate.

Requires the reviewing body, at a permanency planning progress review as to a child over the age of 10 years who is placed with a nonrelative, to identify individuals other than the child's siblings who are important to the child and actions necessary to maintain those relationships.

Requires training for county child protective services social workers in the importance to children in out of home placements of maintaining relationships with individuals important to those children and methods for identifying such individuals and maintaining those relationships.

Status: Chapter 813, Statutes of 2003

AB 458 (Chu) - Foster Care: Discrimination Based on Sexual Orientation

Finds and declares that foster children are harmed by discrimination, whether that discrimination is aimed at them or their caregivers, and that county child welfare departments, group home facilities and foster family agencies have a legal responsibility to provide care, placement, and services to foster children and others without discriminating based on actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status. The same legal obligation extends to foster parents and relative caregivers after they have accepted children into their homes; the bill further finds that if they cannot fulfill this responsibility with respect to an individual child, they should notify the child's social worker and seek additional training, counseling, or other assistance.

Includes within the Foster Youth Bill of Rights the right to fair and equal access to all available services, placement, care, treatment, and benefits, and to not be subjected to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

Includes training on the rights of foster children enumerated above within the existing trainings required for licensed foster parents, both pre-placement and post-placement of a foster child, relative caregivers, group home administrators, and licensing personnel in group homes and foster family agencies.

Sets forth the policy of the State of California that persons engaged in providing care and services to foster children, have fair and equal access to programs, benefits, services, and licensing processes, and shall not be subjected to discrimination or harassment on the basis of their clients' or their own actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

Clarifies that nothing in this section shall be interpreted to create or modify existing preferences for foster placements or to limit the local placement agency's ability to make placement decisions for a child based on the child's best interests.
Status: Chapter 331, Statutes of 2003

AB 490 (Steinberg) - Education: Foster Children

Requires local educational agencies (LEA) and county offices of education to accept full or partial coursework for credit while attending a public school, juvenile court schools, or nonpublic school or agency.

Requires educators, county placing agencies, care providers, advocates, and juvenile courts to work together to ensure stable school placements.

Requires that most pupils in a licensed children's institution or foster family home attend programs operated by their local school district.

Requires that, before a decision is made to place a student in a juvenile court school, the parent, guardian, or the person holding the right to make educational decisions first consider placement in a regular public school.

Requires each county office of education to appoint a staff person to act as education liaison for foster youth to ensure proper placement, enrollment in school, and checkout from school, and to assist him or her in transferring from one school to another by seeing that records, credits, and grades are transferred.

Provides for the immediate enrollment in a new school of a foster child even if the child is unable to produce records or clothing normally required.

Requires that, at the initial detention or placement or any subsequent change in placement of a student in foster care, the LEA serving the student shall allow him or her to continue his or her education in the school or origin for the remainder of the school year.

Requires the education liaison for the new school to contact the prior school and provide all records to the new school within two business days.

Makes the transfer of school records for students in foster care the responsibility of both the LEA of the school of origin and the county placing agency.

Allows a life quality assessment to be conducted for developmentally disabled foster youth with the consent of the court or social services agency. Requires a copy of the assessment to be provided to the court or social services agency upon their request.
Status: Chapter 862, Statutes of 2003

AGING AND LONG-TERM CARE

SB 120 (Margett) – Home Improvement Loans for Elderly and Disabled Persons
Establishes within Department of Housing and Community Development (HCD) the Elderly and Disabled Persons' Revolving Home Improvement Loan Program to provide no-interest home improvement loans to qualified elderly and disabled individuals to make non-major home modifications, charging HCD to develop and administer the program.

Grants loans to elderly and disabled persons earning up to 150% of the area median income but gives priority to extremely low, very low and low-income households. The maximum loan amount is $5,000. Loans shall be subject to a repayment schedule, not to exceed three years.

Creates the Elderly and Disabled Persons' Revolving Home Improvement Loan Fund (hereafter Loan Fund) in the State Treasury and would provide that HCD implement this program if, and only to the extent that, funding is appropriated for this purpose.

Specifies that if the borrower does not own the property, loan funds will only be available for home improvements that have received the written approval of the owner and that loan funds can not be used for the acquisition of real property.

Requires HCD to do the following:

- Adopt regulations to carry out this program including, but not limited to, identifying loan qualifications related to age, disability, income, and desired improvements. This shall be done in consultation with appropriate stakeholders.
- Develop an uncomplicated application form and provide assistance to applicants in filling out the application.
- Review loan applications and approve or deny these applications, approving applications until funds are no longer available. Definitions for eligible improvements established by HCD should be consistent with those established by the Multipurpose Senior Services Program, the Linkages Program, and the CalHOME Program.
- Issue an annual report to be issued by HCD starting in 2005-06.

Protects against fraud by requesting borrower to submit a dated receipt, invoice, or certificate of completion for home improvement work to HCD within six months after the applicant receives the loan.

Status: Held in the Senate Housing and Community Development Committee – Two Year Bill

SB 211 (Dunn) – Residential Care Facilities for the Elderly: Admission Agreements

Makes legislative findings and declarations, including:

- It is in the best interest of the residents of Residential Care Facilities for the Elderly (RCFE's) to ensure that admission agreements used by these facilities do not violate residents' rights.
- It is the intent of the Legislature to establish laws to protect the rights of the residents in and to provide the residents with the information necessary to make informed choices regarding admission agreements in these facilities.

Defines "admission agreement," as including all documents that a resident or his or her representative must sign at the time of, or as a condition of, admission to a licensed RCFE.

Requires RCFE's to make blank copies of its agreement immediately available to the public, subject to the time required for copying and mailing, at cost and upon request. Requires RCFE's to post in a conspicuous location within the facility either a copy of the agreement or a notice of its availability from the facility.

Requires that the agreement be written in clear, coherent language, organized by sections, and printed in black type, in not less than 12-point font, on white paper and on one side of the paper only.

Restricts the agreement from including unlawful waivers of facility liability for the health and safety or personal property of residents. Restricts the agreement from including provisions that the facility knows or should know is deceptive, or in violation of state or federal law.

Requires the agreement to include among other elements:

- A comprehensive description of any items and services provided, such as a monthly fee for room, board, and other items and services;
- A comprehensive description of, and the fee schedule for, all items and services not included in a single fee;
- An indication that the resident will receive a monthly statement itemizing all separate charges incurred by the resident. A facility may assess itemized separate charges only if that separate charge is authorized by the admission agreement. If additional services become available for purchase by the resident after the admission agreement is signed, a list of those services and their costs shall be provided to the resident or their representative. A statement of acceptance or refusal to purchase such services shall be signed and dated by the resident or their representative;
- A comprehensive description of billing and payment policies and procedures;
- The conditions under which rates may be increased; and
- An attached copy of the resident's rights specified by law or regulation.

Requires the agreement to be signed and dated by the resident or representative.

Excludes from these provisions licensees of RCFE's that have obtained a certificate of authority to offer continuing care contracts.
Status: Chapter 409, Statutes of 2003

SB 413 (Speier) – Health Insurance Counseling Fees

Permits the California Department of Aging (CDA) to increase the amount of the fee assessed on a health care service plan for each enrollee to offset the cost of the Health Insurance Counseling and Advocacy Program (HICAP) to not more than $1.20, from a current maximum of $1.

Requires that CDA assess the fee annually on a health care service plan for each enrollee insured under a Medicare supplement contract, including a Medicare Select contract.

Enables HICAP to maintain its full level of funding and to provide seniors with this service, despite the recent loss of federal funding.
Status: Chapter 545, Statutes of 2003

SB 540 (Soto) – Special Services for Residential Care Facilities for the Elderly

Defines "specific health condition" as a condition for which the facility advertises or promotes special care or programs to persons with the affected condition. These conditions may include, but are not limited to, diabetes, dementia, incontinence, and memory loss.

Requires a licensee of a Residential Care Facilities for the Elderly that advertises or promotes special care, programming, or environments for persons with any specific health condition, to provide to each prospective resident a written narrative description of these programs and services prior to admission.

Requires that all reasonable efforts be made to communicate the information to a person who is unable to read it himself or herself, including, but not limited to, reading the description out loud.

Status: Chapter 322, Statutes of 2003

SB 686 (Ortiz) – Liability Insurance for Long-Term Health Care Facilities

Requires an insurer issuing policies of liability insurance to long-term health care facilities, residential care facilities for the elderly, or physicians who provide or oversee the provision of services to residents in those facilities to notify the Department of Insurance (DOI) at least 90 days prior to the date it intends to cease, withdraw, or substantially withdraw from offering liability policies to those facilities or physicians.

Requires each insurer writing liability insurance for the facilities and physicians described above, by a date set by the Insurance Commissioner (IC) but no later than July 1 of each calendar year, to report to the IC specified information regarding liability policies for those facilities or physicians. Provides that the information collected by DOI shall be deemed "official information." Specifies that nothing in this bill shall require individualized information that would identify the amount paid by a specific insurer or facility to be released, however, nothing in this section shall prevent DOI from preparing reports and policy recommendations based on the data collected pursuant to this section.

Permits the IC to authorize the formation of a market assistance program to assist in securing liability insurance for long-term health care facilities, residential care facilities for the elderly, or physicians who provide services to residents in those facilities if the IC finds after a public hearing that such insurance is not readily available in the voluntary insurance market, and that the public interest requires this availability.

Authorizes the IC to also assist in securing insurance for the facilities and physicians described above for which commercial liability insurance is not readily available by forming a risk pooling arrangement as permitted by federal law.

Allows the IC to order the creation of an unincorporated, not-for-profit, temporary joint underwriting association for liability insurance, constituting a legal entity separate and distinct from all of its members. Provides that the purpose of the association is to provide a market for liability insurance on a self-supporting basis, without subsidy from association members.

Provides that this bill shall only be implemented if funds for its purposes are available from the Insurance Fund.

Changes the date by which the Department of Health Services is required to implement, for purposes of reimbursement under the Medi-Cal program a facility-specific rate-setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities from 8/1/05 to 8/1/04 and makes implementation subject to the availability or other funds.
Status: Chapter 899, Statutes of 2003

AB 43 (Daucher) – Chronic Care Integration Program and Pilot Project
Renames the Long-Term Care Integration pilot program as the Chronic Care Integration (CCI) program, and requires the State Department of Health Services (DHS) to administer this new program as an ongoing program instead of a pilot.

Makes various changes to the program relating to financing, site requirements, selection criteria and service requirements for projects

Proposes to shift some of the existing funding for the pilot to the new program where it would qualify for a 50 percent General Fund/50 percent fund match.

Requires DHS to establish a privately operated CCI project in San Diego County if that county elects to participate.

Stipulates that its provisions are to be implemented only to the extent that funds are appropriated in the annual Budget Act or another statute for that purpose.

Clarifies approval and compliance standards required for any program implemented within the CCI program, including the authorized pilot project.

Deletes unnecessary language pertaining to a review process by a program site's advisory committee related to in-home supportive services (IHSS) recipients.

Deletes redundant and expanded language regarding the approval of alternative case management, information, and payrolling systems for IHSS.

Includes geographic managed care programs or plans as possible participants in the CCI program.

Makes technical correction to ensure that, notwithstanding any other provision of this article, costs to the General Fund shall not exceed the amount that would have been expended in the absence of the pilot program.

Changes the effective date of the study from a set date of January 7, 2007 to within three years after the initiation of the operations of the CCI program.

States that for the pilot project for a private entity, the county shall not incur any risks associated with the implementation of the article, effectively transferring risk to the private entity.

Restores Section 14145.3 of the Welfare and Institutions Code, reinserting language regarding the development of at least one alternative model to the Long-Term Care Integration Pilot Program and consultation with an established waiver technical advisory committee.
Status: Vetoed by the Governor

AB 691 (Daucher) – Long-Term Care and Skilled Nursing Facilities: Vaccines
Requires long-term health care facilities, skilled nursing facilities, intermediate care facilities, or nursing facilities to offer immunizations for influenza and pneumococcal disease to residents, aged 65 years or older, between October 1 and April 1 of each year.

Requires each of the specified health care facilities to offer pneumococcal vaccine to all new admittees to the health care facility.

Specifies that the facility will be reimbursed the standard Medi-Cal rate for an immunization provided to a Medi-Cal recipient, unless he or she is also a Medicare recipient whose coverage includes reimbursement for the immunization.

Allows the facility to make the immunizations available without limitation as to the period when the residents receive services at the facility.

Requires the facility to obtain informed consent for the immunization from the resident or, if the person lacks the capacity to make medical decisions, from the person legally authorized to make medical decisions on the resident's behalf.

Requires the health care facility to document in a resident's medical record whether the resident has been offered the vaccines.

Allows a person to decline the immunizations if the vaccine is medically contraindicated, as defined, receipt of the vaccine is against the resident's personal beliefs, or receipt of the vaccine is against the resident's, or their legal representative's, wishes.

Exempts facilities from the requirements under this chapter if there is a shortage of the vaccines or if a resident refuses to pay for the vaccine and no other funding source is available.

Provides that if a health care facility fails to provide an immunization, due to a clerical error, lack of vaccine availability, or lack of patient cooperation, despite a good faith effort, the failure shall not be the basis for issuing a deficiency or citation against the facility's license.
Status: Held on the Assembly Floor for Concurrence – Two Year Bill

AB 1369 (Pavley) - Residential Care Facilities for the Elderly: Automatic External Defibrillators

Requires, commencing January 1, 2005, every residential care facilities for the elderly (RCFEs)with a licensed bed capacity that exceeds 60 persons to purchase, and train personnel in the use of, an automatic external defibrillators (AED) consistent with current state law, as outlined below.

Provides that the training of RCFE personnel and use of AEDs must meet any minimum standards established by the Emergency Medical Services Authority (EMSA).

Provides that all RCFEs must comply with all regulations governing the placement of an AED, to ensure that the AED is maintained and regularly tested according to operation and maintenance guidelines, to ensure that the AED is checked for readiness after each use or at least once every 30 days, whichever is sooner, and to have a written plan that describes the procedures to be followed in the event of an emergency that may involve the use of an AED.

Stipulates that (a) an employee of an RCFE who uses an AED to render emergency care or treatment, or (b) the members of the board of directors of the facility may not be held liable for civil damages resulting from acts or omissions in rendering the emergency care or treatment of a resident by use of an AED, except in the case of personal injury or wrongful death that results from gross negligence or willful or wanton misconduct.

Clarifies that the requirement to render emergency treatment by use of an AED does not authorize its use contrary to a request to forego resuscitative measures, an advance directive, or a do-not-resuscitate (DNR).

Provides that if a resident executes a request to forego resuscitative measures, an advance directive, or a DNR, the resident shall indicate separately, in writing, if he or she does not want facility employees to use an AED if he or she needs emergency care or treatment.
Status: Held under Submission in the Senate Appropriations Committee – Two Year Bill

AIDS/HIV

SB 774 (Vasconcellos) – Hypodermic Needles and Syringes

Permits a pharmacist, who works for a pharmacy that is registered for the Disease Prevention Demonstration Project (DPDP), to furnish without a prescription 30 or fewer hypodermic needles and syringes at any one time to a person 18 years of age or older. Sunsets this provision on December 31, 2007.

Establishes the DPDP, a collaboration between pharmacies and local and state health officials, to evaluate the long-term desirability of allowing licensed pharmacies to furnish or sell non-prescription syringes to prevent the spread of blood-borne pathogens, including HIV and hepatitis C.

Requires the Office of AIDS to convene an uncompensated evaluation advisory panel as specified, to evaluate the effects of this bill, and to provide a report to the Governor and Legislature on or before January 15, 2007. Makes the requirements of this provision subject to the availability of federal or private funds. Requires the report to include, but not be limited to, the effect of non-prescription syringe and needle sales on the following:

- Hypodermic needle and syringe sharing practice among those who inject illegal drugs.
- Rates of disease infection caused by syringe and needle sharing.
- Needlestick injuries to law enforcement officers and waste management employees.
- Drug crime or other crime in the vicinity of pharmacies.
- Safe or unsafe discard of used needles and syringes.
- Rates of injection of illegal drugs.

Requires local health departments to do all of the following:

- Maintain a list of pharmacies within the local health jurisdiction that have registered under the DPDP.
- Provide pharmacies with written information that can be reproduced and provided at the time of furnishing nonprescription syringes and needles that includes: local options for accessing drug treatment; local options for accessing testing and treatment for HIV and hepatitis C; local options for safe disposal including, if available, the locations of authorized needle exchange programs, home-generated sharps consolidation, or medical waste generators for disposal as specified.
- Cooperate with the state Office of AIDS in collection and analysis of data.

Requires a pharmacy, in order to furnish or sell non-prescription syringes, to do all of the following:

- Register with the local health departments and certify that it will provide at the time of furnishing of needles and syringes written or oral information as specified above.
- Store hypodermic needles and syringes so that they are available only to authorized personnel, and not openly available to customers.
- Provide one or more safe syringe disposal programs, as specified.

Status: Vetoed by the Governor

AB 879 (Koretz) - HIV: Post-Exposure Prophylaxis: Task Force

Makes findings and declarations, including that:

- Post-exposure prophylaxis (PEP) was first developed as a means to prevent HIV infections after accidental needle stick exposures by health care workers;
- PEP is used following sexual assaults and in combination with other methods to prevent mother to child transmission;
- Increasingly, PEP is being used to reduce infections following non-occupational exposures;
- Several countries and states have PEP guidelines for the general population; and these guidelines vary substantially.

Requires the Department of Health Services (DHS) Office of AIDS to appoint and convene a task force to develop recommendations for the use of PEP for the prevention of HIV infection in the general population, and requires the task force to review and consider existing PEP guidelines, established by other states and countries. Limits the task force membership to a maximum of ten members, including research scientists, patients who have received PEP treatment, HIV physicians or clinicians, HIV service providers, representatives from the pharmaceutical industry, public health officials, representatives of the Office of AIDS, and health plan representatives.

Requires that a representative of the Office of AIDS serve as the chair of the task force and that a physician member of the task force, designated by DHS, serve as the co-chair. Also requires the co-chair to consult with and advise DHS, and to serve without compensation or reimbursement for expenses.

Requires the task force to be implemented only through existing state resources and permits DHS to seek financial and in-kind assistance for implementation.

Specifies that task force members shall not be compensated or reimbursed for expenses and exempts DHS from the requirements of this bill if DHS is unable to secure uncompensated task force members. Requires DHS to post the recommendations of the task force on its website, and specifies that DHS is not required to print or mail them.
Status: Chapter 746, Statutes of 2003

AB 946 (Berg) – AIDS: Clean Needle and Syringe Exchange

Makes findings and declarations including that:

- AIDS and hepatitis pose an unprecedented public health crisis in California.
- Injection drug users are the second largest group at risk of becoming infected with HIV and are the primary source of heterosexual, female, and perinatal transmission in California.
- The exchange of needles and syringes does not increase drug use, can serve as an important bridge to treatment and recovery from drug abuse, and can curtail the spread of HIV.

Exempts public entities from being subject to criminal prosecution for distributing needles or syringes as part of a locally approved clean needle and syringe exchange project, in the absence of a declaration of a local health emergency.

Authorizes clean needle and syringe exchange programs in any city and county, county, or city upon the action of a county board of supervisors and the local health officer or health commission, or upon the action of the city council, the mayor, and the local health officer.

Requires cities, counties, or cities and counties, in consultation with the Department of Health Services, to authorize the exchange of clean hypodermic needles and syringes, subject to the availability of funding, as part of a network of comprehensive services to combat the spread of HIV and hepatitis.
Status: Vetoed by the Governor

AB 1676 (Dutra) – Human Immunodeficiency Virus: Maternal and Newborn Health

Makes findings and declarations, including that: women, particularly women of color, are the fastest growing population with AIDS in California; universal testing of pregnant women helps decrease the risk of perinatal transmission of Human Immunodeficiency Virus (HIV) to newborns, even in cases where the women receive no prenatal care; maternal transmission of HIV can be reduced further, despite the decrease from 1,760 nationally in 1991 to 280 in 2000; and this year the Center for Disease Control recommended the testing of all pregnant women for HIV.

Requires that a blood specimen of a pregnant woman that is drawn for testing for rhesus (Rh) blood type and hepatitis B also be tested for HIV. Requires a positive test result to be reported to the local health officer.

Provides that HIV testing is not required if the patient has been previously determined to be infected with HIV. Requires certain medical care providers to ensure that the patient is informed of, among other things, the purpose of testing and that the woman has a right to refuse testing. Requires that the testing to be conducted as early as possible during prenatal care and be tested by a method that will ensure the earliest possible results.

Requires that specified providers ensure that the patient receives information and counseling to explain the test results and implications, including any follow-up care necessary.

Requires, by December 31, 2004, the Department of Health Services, in consultation with specified organizations, to develop culturally sensitive informational materials in specified languages, including information on available referral and consultation resources about prenatal HIV treatment.
Status: Chapter 749, Statutes of 2003

ALCOHOL AND DRUGS, PRESCRIPTION DRUGS, AND DIETARY SUPPLEMENTS

SB 151 (Burton) – Prescriptions: Schedule II Controlled Substances
Eliminates the July 1, 2008 sunset date of Controlled Substances Utilization Review and Evaluation System (CURES), administered by the State Department of Justice.

Eliminates, effective July 1, 2004, the requirement that Schedule II controlled substances prescriptions be written on triplicate forms.

Requires, effective January 1, 2005, prescribers of Schedule II controlled substances to meet the same prescription requirements imposed with respect to other controlled substances that may be prescribed.

Requires, effective January 1, 2005, prescriptions for any controlled substances to be issued on a controlled substance prescription form obtained from a security printer that has been approved by the Board of Pharmacy.

Allows prescriptions using either the triplicate or security forms between July 1, 2004 and January 1, 2005

Adds a requirement that Schedule III controlled substances be included in the CURES system. This provision is contingent upon the availability of funds from Department of Justice. Prohibits funds from being appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, or the Osteopathic Medical Board of California Contingent Fund.

Makes it a misdemeanor to counterfeit a controlled substance prescription, knowingly possess a counterfeited controlled substance prescription or obtain under false pretences or fraudulently produce a controlled substance prescription.

Requires, effective January 1, 2005, physicians who dispense prescriptions from their offices to keep a log and submit it to Department of Justice on a monthly basis in either hardcopy or electronic form.
Status: Chapter 406, Statutes of 2003

SB 490 (Alpert) – Emergency Contraception Drug Therapy
Authorizes a pharmacist to furnish emergency contraception drug therapy in accordance with standardized procedures or protocol developed and approved by both the Board of Pharmacy and the Medical Board, in consultation with the American College of Obstetricians and Gynecologists, and other appropriate entities.

Specifies that both the board and the Medical Board of California shall have authority to ensure compliance, and both boards are specifically charged with the enforcement of the provision with respect to their respective licensees. Provides that nothing in these

provisions shall be construed to expand the authority of a pharmacist to prescribe any prescription medication.

Requires a pharmacist, prior to furnishing emergency contraception, to complete a training program of at least one hour of approved continuing education on emergency contraception drug therapy.
Status: Chapter 651, Statutes of 2003

SB 582 (Speier) – Ephedrine Group Alkaloids: Prohibition on Sales of Dietary Supplements

Prohibits the sale or distribution of any dietary supplement products containing ephedrine group alkaloids.

Exempts from the prohibition the following:

- A California licensed health care practitioner who is practicing within his or her scope of practice and who prescribes or dispenses, or both, dietary supplement products containing ephedrine group alkaloids in the course of the treatment of a patient under the direct care of that licensed health care practitioner, except that a licensed health care practitioner shall not prescribe or dispense dietary supplements containing ephedrine group alkaloids for purposes of weight loss, body building, or athletic performance enhancement.
- Dietary supplement products containing ephedrine group alkaloids that are sold or distributed directly to a licensed health care practitioner when the dietary supplement product containing ephedrine group alkaloids is used solely for the purpose of the treatment of patients under the direct care of the health care practitioner.
- Dietary supplement products containing ephedrine group alkaloids that are sold or distributed directly to a licensed pharmacist for resale to a patient for whom the products have been prescribed.
- Dietary supplement products containing ephedrine group alkaloids that are not for resale in California and that are sold or distributed directly to businesses not located in California.

Status: Chapter 903, Statutes of 2003

AB 1739 (Frommer) – Health Care

Requires pharmaceutical manufacturers to give the Department of General Services the Medicaid Best Price for any given drug if the manufacturer wishes that drug to remain on the Medi-Cal Contract Drug list and not require prior authorization for dispensing to Medi-Cal patients.

Changes the name of the California Health Manpower Policy Commission to the California Healthcare Workforce Policy Commission.

Requires the Department of Health Services (DHS) to adopt regulations prescribing the standards for training and testing programs for hemodialysis technician training, certification of hemodialysis technicians, minimum standards for the approval for operating a training program, and DHS enforcement of the regulations.
Status: Failed Passage in the Senate Health and Human Services Committee

CALWORKS
AND OTHER PUBLIC ASSISTANCE PROGRAMS

SB 664 (Kuehl) – Temporary Assistance for Needy Families: Domestic Violence
Makes various legislative findings, including:

- When California enacted the CalWORKs program in 1998, it adopted the Family Violence Option, which is crucial for helping poor women to achieve economic self-sufficiency by addressing the violence in their lives. Despite this adoption, the state did not allocate dollars to fund domestic violence services for CalWORKs recipients as it did for mental health and substance abuse services.
- Because over one-half of CalWORKs recipients are or have been victims of abuse, and because domestic violence is a threat to safe and lasting marriages, a portion of the marriage promotion moneys in the TANF Fund should be allocated to domestic violence prevention and early intervention programs. These funds should be used to develop, expand, or develop and expand programs appropriate for CalWORKs recipients.

Requires the state Department of Social Services (DSS) to allocate an unspecified percentage of marriage promotion moneys in the TANF Fund to county welfare agencies to carry out existing domestic violence services for CalWORKs recipients. The county welfare agencies shall use these funds in a manner consistent with federal guidelines to aid CalWORKs recipients who are domestic violence victims.

Requires DSS to allocate the marriage promotion for the purpose mentioned above consistent with the formula used to distribute each county's CalWORKs program allocation.

Requires each county to use the funds to supplement, and not supplant, health care treatment funds and other funds received for domestic violence services.

Requires DSS to allocate an unspecified percentage of the marriage promotion moneys in the TANF Fund to the Office of Women's Health in the State Department of Health Services for a public education campaign to raise awareness regarding the short and long-term health impacts of domestic violence on victims and children.

Requires that DSS implement the state option available under federal law that provides that a state may certify standards and procedures to ensure that the state screens for and identifies domestic violence.

States that these changes will only be implemented to the extent that federal TANF block grant funds are available for marriage promotion purposes.

Asks that DSS seek any federal approval for any state plan amendment necessary to implement this act.
Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

AB 231 (Steinberg) - Food Stamps and CalWORKs Benefits
Provides that the rules governing the resource value of a motor vehicle under the CalWORKs program shall be aligned with an alternative program allowed under the Federal Food Stamp Program, replacing the current exclusion limit of $4,650.

Requires each county welfare department, to the extent permitted by federal law, to exempt a household from complying with face-to-face interview requirements at initial application and recertification, according to a specified process. Provides that this provision does not limit a county's ability to require an applicant or recipient to make a personal appearance at a county welfare department office if the applicant or recipient no longer qualifies for an exemption or for other good cause.

Eliminates the 5-month limitation on county welfare departments to provide transitional food stamp benefits to households terminating their participation in the CalWORKs program.
Status: Chapter 743, Statutes of 2003

CANCER

SB 1075 (Health and Human Services) – Breast Cancer: Alternatives to Mammography
Requires the Department of Health Services (DHS) to include in any literature that it produces regarding breast cancer information, but not be limited to, all of the following:

- Summarized information on risk factors for breast cancer in younger women, including, but not limited to, information on the increased risk associated with a family history of the disease.
- Summarized information regarding detection alternatives to mammography that may be available and more effective for at-risk women between the ages of 25 and 40 years.
- Information on Web sites of relevant organizations, government agencies, and research institutions where information on mammography alternatives may be obtained.

Specifies that the additional information required by the bill shall be produced consistent with DHS' protocols and procedures regarding the production and dissemination of information on breast cancer, including specified elements.

States that it is the intent of the Legislature that the provisions of this measure apply to information that is distributed by any branch of the department, including, but not limited to, the Cancer Detection Section and the Office of Women's Health, which are charged with providing information about cancer.
Status: Chapter 886, Statutes of 2003

CHILD CARE

AB 366 (Mullin) - Child Care: Substitute Employee Registry
Requires the Department of Social Services (DSS) to operate the substitute employee registry program until January 1, 2007, and authorizes DSS, in its discretion, to operate it after that.

Requires DSS to provide each registry with a facility number.

Allows DSS to limit the program to seven specified counties: Alameda, Contra Costa, Sacramento, Orange, San Francisco, San Mateo, and Santa Clara.

Authorizes DSS to charge participating registries a reasonable annual licensing fee.

Provides that the child care worker shall be registered with the registry, and not with an individual child care facility that temporarily employs the child care worker. Requires the registry to maintain all employee records for a child care worker at its central office subject to inspection or electronic transfer to DSS if requested.

Requires DSS to report to the Legislature, by March 31, 2004, whether state personnel are filling the authorized positions for the substitute child care employee registry pilot program, including the proportion of each person's time allocated to the substitute employee registry project, the number of counties and substitute employee registries participating in the pilot program as of February 28, 2004, and any barriers encountered in the implementation of the pilot program. Requires a copy of any emergency regulations adopted by DSS pursuant to the bill to also be transmitted with the report.
Status: Held on the Assembly Floor for Concurrence - Two Year Bill

AB 529 (Mullin) - Family Day Care Homes
Permits a child attending kindergarten school to be one of the two additional school-aged children allowed to be in care above the licensed capacities of small and large family day care homes. Previous law required any additional school-aged children to be at least 6 years of age.
Status: Chapter 744, Statutes of 2003

AB 1326 (Simitian) - Child Care Subsidies: County of San Mateo: Pilot Project

Creates a five-year child care subsidy pilot program in San Mateo County and specifies the procedures the county must follow in developing and implementing a county child care subsidy plan.

Requires the county, in consultation with the state Department of Education (SDE), to include in this plan an assessment of the county's goals, current child care subsidy structure, and the identification of barriers in the state's child care subsidy system that interfere with local program delivery. Additionally, the bill requires the county to consider a set of specified information for the assessment.

Allows the local policy to supercede state law regarding eligibility criteria, fees, reimbursement rates, and methods of maximizing the efficient use of subsidy funds. (Examples of "maximizing efficient use of funds" would be to allow an agency to convert funds in a direct service contract into a voucher or to allow a school-age-care contractor to provide care for younger children.)

Permits the plan to include the use all sources of funding utilized by direct service contractors for the child care subsidy plan.

Requires the county to establish measurable outcomes to evaluate the success of the program and to provide the State Department of Social Services with an opportunity to review and comment before submission to SDE for approval.

Terminates the pilot project by January 1, 2009, followed by a two-year phase-out of the program.

Status: Chapter 691, Statutes of 2003

AB 1683 (Pavley) - Child Day Care: Licensing Report

Requires the Department of Social Services (DSS), after conducting a site visit at a child day care facility, to post a notice that includes all of the following: the date of the visit, whether the facility was cited for any violations, whether the site visit report is required to be posted [pursuant to below], and contact information for DSS if a person wants to obtain a copy of the report or request other information.

Requires every licensed child day care facility to post a copy of any licensing report that documents a violation of state standards or regulations discovered as a result of a site visit, documents a substantiated complaint, or documents the facility's compliance or noncompliance with an order by DSS to correct a deficiency. The report shall be posted for 30 consecutive days, and shall be posted on or immediately adjacent to the interior side of the main door of the child day care facility. Failure to comply with these requirements will subject the facility to a civil penalty of $100.

Status: Chapter 403, Statutes of 2003

DISABILITIES

SB 577 (Kuehl) – Protection and Advocacy Agencies: Disability Rights

Expands the authority of the state's protective and advocacy agency, Protection and Advocacy, Inc. (PAI), to protect and advocate for the rights of "people with disabilities," rather than only to persons who are developmentally disabled or who are mentally ill, by redefining "disability" to include not only those contained in the governing federal laws but also those within the meaning of the Fair Employment and Housing Act.

Redefines "abuse," "neglect," and "complaint" to conform with federal law.

Specifies the conditions under which PAI may have reasonable unaccompanied access to a facility, its programs, records and recipients of services and the purposes for which access is authorized. Allows the PAI reasonable "unaccompanied" access to facilities and recipients (disabled persons receiving services at the facilities) to investigate abuse or neglect, provide information and training, to monitor rights and safety, and to inspect, view and photograph.

Defines "reasonable unaccompanied access" as access that permits the protection and advocacy agency without undue interference to monitor, inspect, and observe conditions in facilities and programs to meet and communicate with residents and service recipients privately and confidentially on a regular basis, formally or informally, and to review records privately and confidentially in a manner that minimizes interference with the activities of the program or service, that respects residents' privacy interests and honors a request to terminate an interview, and that does not jeopardize the physical health or safety of facility or program staff, residents, service recipients, or protection and advocacy agency staff.

Adds, to the list of disabled persons whose records may be accessed by PAI, any person who is deceased and for whom PAI had received a complaint of abuse or neglect or for whom PAI believed probable cause exists that the person was subjected to abuse or neglect.

Specifies the records accessible to PAI investigating an incident of abuse or neglect, and the records which are protected from disclosure under the provisions of law.

Specifies that access to records be provided no later than three days after PAI makes a request for the records, and that access to the records be provided within 24 hours after the PAI makes a request, if the agency determines there is probable cause to believe that the health or safety of an individual is in serious and immediate jeopardy or in case of death of an individual with disability.

Contains further legislative declarations and finding that the Act shall ensure that protection and advocacy agency services are provided to all persons with disabilities, as defined in state law, and provide the agency in state law with, authority as established by

the federal laws stated in the Developmental Disabilities Assistance and Bill of Rights Act, the Protection and Advocacy for Individuals with Mental Illness Act, and the Protection and Advocacy of Individual Rights Act.
Status: Chapter 878, Statutes of 2003

EMERGENCY MEDICAL SERVICES

SB 108 (Romero) – Emergency Medical Services: Alcohol Fee

Makes various legislative findings, including:

- Emergency medical services are inadequate to properly meet the needs of the residents of California. Alcohol-related incidents on California roads cost over $3 billion per year in monetary costs.
- Alcohol is a factor in nearly one-third of all vehicle crashes in the state, and emergency rooms and trauma centers are the primary medical services providers for those injured in these incidents.
- From July 1, 2000, to June 30, 2001, inclusive, 60% of all patients admitted to emergency rooms and trauma centers in Los Angeles County tested positive for alcohol.

Enacts the Alcohol-Related Emergency Services Reimbursement Act of 2003. Requires the State Board of Equalization (BOE) to collect a five-cent ($0.05) per drink fee from wholesalers located in California who distribute alcoholic beverages to retailers for consumption in the state. The fee is based on 1.50 ounces of distilled spirits, 12 ounces of beer, and 5 ounces of wine.

Requires that all funds collected as a result of the above-described fee be deposited in the Alcohol-Related Emergency Services Reimbursement Trust Fund, newly created in the State Treasury. Requires that BOE be reimbursed for the costs of implementation of the Act.

Makes the following persons and entities eligible for receipt of the funds: local emergency medical services providers, including emergency departments, trauma centers, emergency and oncall physicians, entities that provide initial prehospital emergency medical stabilization services, emergency ambulance transportation, and other emergency medical professionals and entities that meet the qualifications established by the department for reimbursement of expenses incurred in providing services for alcohol-related emergencies.

Defines alcohol-related emergency as an incident that results in the provision of medical services, including transportation, to a victim who is injured as a result of the ingestion of alcohol.

Requires that the Department of Health Services (DHS) adopt regulations that establish criteria to identify incidents and emergencies that qualify as alcohol-related emergencies.

Bestows priority for full reimbursement to persons or entities that are unreimbursed by insurance or the individual patient.

Provides that after two years of implementation, DHS, in consultation with the BOE and governmental entities with information about the status of the alcohol industry, shall evaluate the economic impact of this bill on the alcohol industry, including its impact on jobs and profits in the industry. The evaluation shall be submitted to the Legislature upon completion.

Requires DHS to adopt regulations necessary to implement this chapter.
Status: Held in the Senate Rules Committee – Two Year Bill

SB 476 (Florez) – Emergency Medical Services: Reimbursement and Reserves
Specifies that each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons and hospitals providing disproportionate trauma and emergency medical care services.

Permits each administering agency to maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined in each county.

Provides that the amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse entities according to the reimbursement schedule.

Allows for funding under the seventeen percent portion to be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of the chapter.

Provides that all funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during the year.

Changes the reporting requirements, requiring each county to report to the Legislature on April 15, instead of January 1, of each year. The Emergency Medical Services Authority shall then compile and submit a report to the Legislature. The report is required to cover the preceding fiscal year.

Requires each county's administering officer to solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments.

Allows for the above requirement to be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. Allows the administering officer to instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.
Status: Chapter 707, Statutes of 2003

HEALTH CARE

SB 420 (Vasconcellos) – Medical Marijuana

Finds that certain problems and uncertainties in the Compassionate Use Act of 1996 (Act) have impeded the ability of law enforcement to interpret and enforce the law. Finds lack of enforcement has prevented qualified individuals access to medical marijuana and finds a voluntary identification (ID) card program consistent with the purpose of the act.

States intent of Legislature to clarify the scope and application of the Act and to facilitate prompt ID of qualified patients, promote uniform application of the act, and enhance access of patients to marijuana through collective cultivation. States findings and declarations that (a) a state ID card program will further the goals of the people and the Legislature, and (b) with respect to individuals, the identification system must be wholly voluntary and a patient entitled to the protections of Section 11362.5 of the Health and Safety code need not possess an ID card in order to claim the protections of the Act.

Requires the State Department of Health Services (DHS) to establish and maintain a voluntary program for the issuance of ID cards to patients who satisfy the requirements set out in this bill and who voluntarily apply for the card.

Requires DHS to develop: protocols for county health departments to confirm the accuracy of applications and to protect confidentiality; application forms; distinguishable ID cards for patients and primary caregivers.

Requires county health departments, or another entity designated by the county health department, to provide applications for the ID cards, receive and process applications, maintain records, and issue cards to applicants and primary caregivers.

Exempts patients and caregivers with valid ID cards from arrest for possession, transportation or cultivation for an approved amount of marijuana. States possession of an ID card is not a requirement to claim protection under Section 11362.5 of the Act.

Requires payment of a fee and specifies documentation necessary to obtain a valid ID card to include proof of residency of patient, written documentation by the attending physician on the qualifying condition and a statement that the medical use of marijuana is appropriate; name, address, phone number and license number of the physician; and the name, duties, and photo of primary caregiver.

Permits a legal representative to apply for a card for an individual who lacks the capacity to make medical decisions, and designate him or her to serve as a primary caregiver.

Requires DHS to establish application and renewal fees that are sufficient to cover the expenses by DHS. Authorizes each county health department to charge an additional fee for all county department or designee costs incurred for administering the program. However, upon satisfactory proof of participation and eligibility in the Medi-Cal program, these fees shall be reduced by 50 percent.

Provides that qualified patients or primary caregivers may possess no more than eight ounces of dried marijuana, and, in addition, may also maintain no more than six mature and 12 immature marijuana plants per qualified patient.

States that if a patient or primary caregiver has a doctor's recommendation that this quantity does not meet the patient's medical needs, the patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs.

Provides that cities and counties may retain or enact medical marijuana guidelines allowing patients or their caregivers to exceed the state limits.

Provides that the Attorney General may recommend modifications to the possession or cultivation limits, and that such recommendations shall be made to the Legislature no later than January 1, 2005.

Requires a state or local law enforcement officer to accept an ID card unless the officer has reasonable cause to believe the card is fraudulent.

Restricts the use of medical marijuana in workplaces, correctional facilities, near schools or in other places where smoking tobacco is prohibited.

Prohibits administrative or licensing actions against professionals in compliance with this act. Makes fraudulent use of an ID card punishable by a fine and up to one-year in jail.
Status: Chapter 875, Statutes of 2003

SB 676 (Ortiz) – Tobacco Manufacturers: Health Care Costs of Smoking

Finds and declares that: smoking costs California's economy $15.8 billion annually; direct medical costs of $8.6 billion are associated with smoking; and nearly 17% of Medi-Cal costs are caused by smoking. Finds that the tobacco industry denied, but was aware of, the addictive nature and destructive health effects of tobacco products, and finds it appropriate that the manufacturers be held financially liable for the harm caused by their product.

Imposes a fee of unspecified rate on tobacco manufacturers whose products have contributed to tobacco-related illnesses. The Department of Health Services (DHS) is directed to establish fees for each manufacturer based on the manufacturer's market share and the annual costs to state and local government for the treatment of tobacco-caused

diseases. The fee would be reduced by any amount paid by the manufacturer in tobacco-related taxes, federal legislation or tobacco-related lawsuits. DHS would be required to adjust the fee annually to reflect changes in state costs, manufacturer's market share and tobacco-related taxes and fees.
Status: Held in the Senate Revenue and Taxation Committee – Two Year Bill

AB 561 (Lieber) – Family Planning: Teen Pregnancy
Establishes the Male Involvement Program as a continuing program within the Department of Health Services (DHS) Office of Family Planning with the goal of reducing teenage pregnancy through promotion of primary prevention skills and motivation of adolescent boys and young men. Specifies types of assistance to be offered to local programs, including awareness raising, skill building, and grants to qualifying public or private nonprofit providers.

Establishes the Community Challenge Grant Program as a continuing program within the DHS Office of Family Planning with the goal of reducing teenage pregnancies and teenage single parents, and promoting responsible parenting and the involvement of the biological father. Specifies targeted population groups for the program and that school-based programs shall comply with existing law related to sex education.

Establishes the TeenSMART Program as a continuing program within the DHS Office of Family Planning with the goal of reducing teenage pregnancies and reducing the incidence of sexually transmitted infections. Specifies the types of counseling, outreach, and education services to be provided through the program.

Establishes the Information and Education Program as a continuing program within the DHS Office of Family Planning with the goal of reducing teenage pregnancies through educational programs that equip teens at high risk for pregnancy with the knowledge, understanding, and behavioral skills necessary to make responsible decisions regarding at-risk behavior. Specifies priorities for funding under this program.

Conditions implementation of each program on funding made available from the federal government, in the annual Budget Act or any other statute, or through any combination of these sources of funding.
Status: Chapter 643, Statutes of 2003

HEALTH COVERAGE

SB 2 (Burton/Speier) – Health Care Coverage
Creates the State Health Purchasing Program, which would be administered by the Managed Risk Medical Insurance Board (MRMIB).

Requires specified health benefits to be provided directly by employers or through the program.

Requires MRMIB to arrange health plan coverage for certain employers, who would be required to pay a fee for employee health coverage, except that employers who provide health care coverage directly would receive a credit against the fee.

Requires employees and dependents of large employers to be covered beginning January 1, 2006, while it requires employees of medium employers to be covered beginning January 1, 2007, subject to certain conditions. Small employers are exempted from the requirement to provide coverage and from the fee.

Requires MRMIB to determine the fee to be paid by employers, and provides that the associated employee contributions, which employers would be required to collect from employees, may not exceed 20 percent of the employer fee. The fees, including the employee contributions, would be collected by the State Employment Development Department and would be deposited in the newly created State Health Purchasing Fund. The moneys in the fund would be continuously appropriated to the board for the purposes of the program.

Authorizes MRMIB to coordinate coverage under the program with coverage available under the Medi-Cal program, the Healthy Families Program, and other public programs, and imposes various requirements on the board and DHS in that regard.

Authorizes a loan from the General Fund to MRMIB for startup costs related to the State Health Purchasing Program, subject to appropriation by the Legislature. The bill enacts other related provisions.

Extends the application of these requirements to health care coverage provided directly by employers under the bill, and imposes various other requirements. Because a willful violation of these provisions by health care service plans would be a crime, the bill imposes a state-mandated local program.
Status: Chapter 673, Statutes of 2003

SB 921 (Kuehl) – Single Payer Health Care Coverage

Establishes the California Health Care System to be administered by the newly created California Health Care Agency under the control of an elected Health Care Commissioner.

Makes all California residents eligible for specified health care benefits under the California Health Care System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services.

Prohibits deductibles or copayments during the initial first 2 years of operation of the health care system, but would authorize the commissioner to establish deductibles and copayments thereafter.

Requires the health care system to be operational by January 1, 2006, and would enact various transition provisions. Requires the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Health Care System, which would then assume responsibility for all benefits and services previously paid for with those funds.

Creates a Health Policy Board to establish policy on medical issues and various other matters relating to the health care system. Creates the Office of Consumer Advocacy within the agency to represent the interests of health care consumers relative to the health care system. Creates the Office of Medical Practice Standards within the agency, headed by the chief medical officer, to establish standards of best medical practice, including evaluation of pharmaceuticals and medical and surgical treatment, and in conjunction with that office, creates the Medical Practice Standards Advisory Board with specified advisory duties.

Creates the Office of Inspector General for the California Health Care System within the Attorney General's office, which would have various oversight powers.

Extends the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime.

Enacts other related provisions relative to budgeting, federal preemption, subrogation, collective bargaining agreements, and associated matters.
Status: Held in the Assembly Health Committee – Two Year Bill

AB 923 (Firebaugh) – Sales and Use Tax, Income Taxes: Health Insurance Tax Credit

Repeals, effective January 1, 2004, state sales and use tax exemptions for the following products:

- liquefied petroleum gas purchased for use in producing and harvesting agricultural products;
- farm production equipment and machinery used to produce and harvest agricultural products;
- timber harvesting equipment and machinery;
- diesel fuel used in farming activities and food processing, and
- racehorse breeding stock.

Requires the State Board of Equalization (BOE), in consultation with the State Department of Finance, to estimate the annual increase in the amount of state sales and use tax revenue attributable to repeal of the sales tax exemptions cited above.

Authorizes, effective beginning in the 2004 tax year, a nonrefundable personal income and corporation tax credit capped at the amount estimated by BOE to have been collected

by the state as a result of the sales and use tax exemption repeal, plus the amount of the state Employment Development Department's (EDD) costs to administer the credit allocation process (total amount available). Details of the credit are as follows:

- for purposes of the credit, an "agricultural employee" is defined by reference to the Labor Code as one engaged in agriculture. This definition is intended to include field workers and to exclude administrative and management personnel;
- "qualified taxpayer" is defined as a taxpayer who either employs agricultural employees directly or is a labor contractor who employs agricultural employees for use by farmers;
- in order to be eligible to claim a credit, each qualified taxpayer must pay for at least 80 percent of their agricultural employees' qualified health care coverage and must file a credit application with EDD no later than January 31 of the year following the year for which they wish to claim the credit (e.g., a credit application for the 2004 calendar year must be submitted no later than January 31, 1005);
- the amount of the credit to which each taxpayer is entitled is calculated by EDD, as described immediately below. Credits may be claimed on taxpayers' annual income tax returns. Unused credits may be carried forward for up to five years.

Defines "qualified health care coverage" as follows:

- Any health care coverage that meets the minimum requirements set forth in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.
- A group health insurance policy, as defined in subdivision (b) of Section 106 of the Insurance Code, that covers hospital, surgical, and medical care expenses, provided the maximum out-of-pocket costs for insureds do not exceed the maximum out-of-pocket costs for enrollees of health care service plans providing benefits under a preferred provider organization policy.
- Any Taft-Hartley health and welfare fund or any other lawful collective bargaining agreement which provides for health and welfare coverage for collective bargaining unit or other employees thereby covered.
- Any employer sponsored group health plan meeting the requirements of the federal Employee Retirement Income Security Act of 1974, provided it meets the benefits required under the first and second subparagraph of this paragraph.

Requires EDD to calculate the credit for each qualified employer on a pro rata basis using the total amount paid or incurred during the taxable year by a qualified taxpayer for qualified health care coverage for his or her agricultural employees and/or the employee's dependents relative to the total amount paid or incurred by all qualified taxpayers during the taxable year for qualified health care coverage for agricultural employees and their dependents. The ratio derived from this calculation must then be multiplied by the total amount available for the credit in order to determine the amount of the credit to which each taxpayer is entitled.

Provides that fraudulent credit claims are punishable by jail time of up to one year and a fine of up to $60,000.

Requires the State Franchise Tax Board, with the cooperation of EDD, to report annually to the Legislature regarding utilization of this bill's credit.

Authorizes, effective beginning on January 1, 2004, state sales and use tax exemptions for the purchase of certain items by small farmers. For purposes of this bill, a small farmer is defined as one whose gross receipts from the sale of agricultural products was less than $250,000 during the prior calendar year. Items for which small farmers may claim exemptions include the following:

- farm equipment and machinery and the parts thereof that are purchased for use primarily in producing and harvesting agricultural products;
- diesel fuel purchased for use in farming activities.

Authorizes, from January 1, 2004 through December 31, 2004, a state sales and use tax exemption for the purchase of farm tractors by farmers, for use primarily in producing and harvesting agricultural products.
Status: Held on the Senate Floor – Two Year Bill

HEALTH FACILITIES

SB 143 (Cedillo) – Acute Care Hospitals: Patient Needs
Requires the Department of Health Services (DHS) to adopt regulations on or before January 1, 2010, to establish separate common patient classification or acuity systems to be used by all general acute care hospitals and all acute psychiatric hospitals. Stipulates that these systems shall be used by these hospitals to determine the level of nursing care needed for each category of patient in each unit and on each shift.

Allows DHS to take into account variations among hospitals in operating characteristics that are related to the level and type of nursing care that the patient needs, as well as the specific needs of rural hospitals, while developing these systems and ensuring appropriate patient care.
Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 197 (Burton) – Registered Nurses: Wages and Hours of Employment Violations: Fines
Subjects a for-profit general acute care hospital, as defined, to treble civil penalties for violating meal or rest period provisions for registered nurses.

Establishes findings and declarations that state, among other things, that there is a demonstrated shortage of registered nurses and the shortage is reducing access to necessary and quality health care, and that many nurses are leaving because the work

environment has deteriorated to an unacceptable level. It is in the best interest of the public, hospitals, patients, and registered nurses to strengthen workplace protections for registered nurses.

Status: Amendments taken in the Senate Health and Human Services Committee withdrew the measure out of the committee and sent to the Labor and Industrial Relations Committee

SB 379 (Ortiz) – Statewide Health Planning and Development: Hospitals: Charity Care and Reduced Payment Policies

Requires acute care, acute psychiatric, and special hospitals to develop a charity care and reduced payment policy and to provide notice of the policy to patients at the time of admission, if clinically appropriate, and during the discharge process.

Requires hospitals to post a general description of their charity care and reduced payment policy, including a description of the services that are provided and a description of the financial criteria used to determine eligibility for charity care and reduced payments, in locations that are visible to the public.

Requires the Office of Statewide Health Planning and Development (OSHPD) to develop a uniform charity care and reduced payment application to be used by all hospitals.

Requires hospitals, as part of any billing to a patient, to provide the patient with a notice that includes a statement of charges, and a statement that if the patient does not have health insurance coverage, they may be eligible for Medicare, Healthy Families, Medi-Cal, or charity care or reduced payment.

Requires hospitals, to allow no less than 150 days prior to the commencement of collection activities in order to facilitate payment by public or private third-party payers. Requires hospitals during the 150-day period to: attempt to negotiate a payment plan: attempt to collect payment from any responsible third-party payer; provide information that may assist the patient in obtaining coverage through the Medi-Cal, Healthy Families, or other public program; assist the patient in applying for charity care or reduced payment; and attempt to make a final determination as to whether the patient is eligible for charity care.

Requires hospitals, prior to commencing collection activities against a patient, to provide the patient with information about their rights and about nonprofit credit counseling services, and a statement that they may still obtain care at the hospital.

Requires hospitals to use reasonable efforts to negotiate a payment plan with the patient prior to selling or assigning a patient's account to any party, reporting nonpayment to a credit reporting agency, or commencing civil action against the patient.

Requires hospitals to complete and file charity care reports with OSHPD including, but not limited to: the cost of charity care, the number of persons who received charity care, the number of persons who sought charity care, the type of care received.

Requires hospitals to provide OSHPD with a copy of their charity care and reduced payment policies, eligibility procedures, review process, and procedure for determining reduced payments.
Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 847 (Aanestad) – Health Facilities: Nurse-to-Patient Ratios
Requires, by January 1, 2005, the Department of Health Services (DHS) to evaluate the proposed hospital nurse staffing regulations issued by DHS pursuant to AB 394 (Kuehl) of 1999.

Requires the evaluation to demonstrate the validity of several assumptions or findings, including:
- That raising nurse-to-patient ratios would attract and have, in fact, attracted more nurses to hospitals;
- That there is a sufficient supply of nurses to meet the phased-in 1:5 ratio for medical/surgical units without disruption in access to care;
- That the original fiscal impact estimates of the regulations are substantially accurate;
- That the effects of the initial 1:6 ratio proposed for medical/surgical units have not adversely affected the ability of long-term care providers to hire and retain nursing staff;
- That there have been measurable improvements in patient care sufficient to justify the cost of the 1:6 ratio for medical/surgical units;
- That further measurable improvements in patient care can be expected through the phase-in of the 1:5 requirement, and that the additional improvements in patient care are sufficient to justify the additional costs of the 1:5 nurse-to-patient ratio in medical/surgical units.

Provides that DHS may not impose the 1:5 nurse-to-patient ratio for medical/surgical units unless it is able to demonstrate that any of the following conditions exist:
- There is a sufficient supply of nurses available to meet a 1:5 nurse-to-patient ratio with no loss of bed availability;
- There are measurable improvements to patient care as a result of a 1:5 nurse-to-patient ratio requirement; or
- The cost projected in moving from a 1:6 nurse-to-patient ratio to a 1:5 ratio does not exceed projected revenues.

Provides that if DHS determines that any of the conditions above have been satisfied, DHS may require health facilities to meet the 1:5 nurse-to-patient ratio in medical/surgical units.
Status: Failed Passage in the Senate Health and Human Services Committee – Reconsideration Granted – Two Year Bill

SB 932 (Bowen) – Nonprofit Corporations: Health Facilities

Prohibits the Attorney General from consenting to a health facility agreement or transaction involving the sale, transfer, lease, or other transfer of a nonprofit health care facility to a for-profit corporation or entity, a mutual benefit corporation or entity or another non-profit entity, in which the seller of the facility restricts the type or level of medical services that may be provided at the facility.

Status: Chapter 65, Statutes of 2003

SB 937 (Ducheny) – Licensure and Operation of Clinics

Provides that no application to the Department of Health Services (DHS) is required when a licensed primary care clinic adds a service that is not a special service or remodels an existing clinic site. Requires the primary care clinic to notify DHS at least 60 days before adding the service or remodeling the site.

Requires, instead of authorizes, DHS to issue a license to an applicant to operate a primary care clinic that meets all requirements for licensure except that the clinic's facility does not meet all of the applicable building requirements, other than fire and life safety requirements, if specified conditions have been met.

Permits a primary care clinic that has held a valid and unsuspended license for at least the preceding five years, with no history of repeated or uncorrected violations of law or regulation that pose immediate jeopardy to a patient, to apply to establish an affiliate primary care clinic at an additional site. Requires DHS to issue a license within 30 days of receipt of a completed application. Requires DHS to approve a license to the affiliate clinic without the necessity of first conducting an onsite survey if specified conditions are met.

Permits two or more primary care clinics that are operated by a single nonprofit corporation to consolidate specified administrative functions within the state of California without obtaining DHS approval.

Permits a primary care clinic to establish compliance with minimum construction standards for physical plant adequacy and safety by submitting a written certification from a licensed architect or a written statement from a local building department that the applicable construction is in compliance with these standards and that the individual signing the statement is competent to determine that compliance.

Decreases the frequency of periodic clinic inspections from at least once every two years to at least once every three years. Expands an existing exemption from periodic inspection for certain kinds of clinics to include primary care clinics accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care, or any other accrediting organization recognized by DHS.

States that DHS retains the authority to inspect a primary care clinic as necessary to ensure the quality of care being provided.

Provides that no penalty or fine may be imposed against a primary care clinic or any person acting on behalf of the clinic for a violation of a regulation unless the regulation has been adopted pursuant to state law regarding administrative regulations and rulemaking.

Permits DHS to approve a single program flexibility request on behalf of more than one similarly situated primary care clinic.
Status: Chapter 602, Statutes of 2003

SB 953 (Dunn) – Children's Hospital Bond Act of 2004

Creates the Children's Hospital Bond Act of 2004 and defines the following terms:

- "Committee" is the Children's Hospital Bond Act Finance Committee, consisting of the Controller, Director of Finance, and the Treasurer, or their designated representatives.
- "Fund" is the Children's Hospital Fund, from which bonds shall be issued and sold. "Program" is the Children's Hospital Program.
- "Authority" is the California Health Facilities Financing Authority (CHFFA), located within the Treasurer's Office.
- "Children's Hospital" is those hospitals defined under existing law (Section 10727 or 10728 of the Welfare and Institutions Code).
- "Grant" is the distribution of money in the fund by the authority to children's hospitals for projects.
- "Projects" are the construction, expansion, remodeling, furnishing, or equipping, or the funding, financing, or refinancing, of a children's hospital, or the acquisition of a children's hospital, to be financed or refinanced with funds provided in whole or in part by this act. This may include reimbursement for the costs associated with any of the aforementioned activities. "Project" may also include any combination of one or more of the foregoing undertaken jointly by a participating children's hospital with one or more other participating health institutions.

Provides that the purpose of the program is to improve the health and welfare of California's critically ill children by providing a stable and ready source of funds for capital improvement projects for children's hospitals.

Authorizes CHFFA to award grants to any children's hospital for purposes of funding projects. Requires eighty percent of the total funds available to be awarded to children's hospitals as identified in Section 10727 of the Welfare and Institutions Code [WIC]. Requires twenty percent of the total funds available to be awarded to children's hospitals as identified in WIC Section 10728.

Requires CHFFA to develop an application process for awarding grants to eligible children's hospitals, with the award of grants based on the following factors:

- The extent to which the grant will contribute toward the improvement of child health care and patient outcomes.
- The importance and level of services to vulnerable populations that will be generated.
- Demonstration by the applicant of project readiness and feasibility.

Permits the Bureau of State Audits to conduct periodic audits to ensure that bond proceeds are awarded in a timely fashion and that awardees are using funds in compliance with the act's purpose.

Allows bonds in the total amount of _____ dollars ($___), or so much thereof as is necessary, not including the amount of any refunding bonds, or so much thereof as is necessary, to be issued and sold to provide a fund to be used for carrying out the purposes of the act.

Appropriates moneys from the General Fund in an amount that equals the annual sum necessary to pay the principal of, and interest on, bonds issued and sold, as the principal and interest become due and payable, and the sum necessary to carry out this act, appropriated without regard to fiscal years.

Provides for submission of the bond act to the voters at the next statewide election in accordance with specified law.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 1005 (Dunn) – Hospital Inspections, Deficiencies, and Plans of Corrections

Prohibits advance announcement of a periodic inspection of a health facility.

Requires the Department of Health Services (DHS), if inspecting a hospital jointly with an outside entity (such as the Joint Commission on Accreditation of Healthcare Organizations) that does provide notice in advance of a periodic inspection, to conduct an additional periodic inspection that is not announced in advance to the facility.

Requires DHS to inspect a hospital for compliance with nurse-to-patient staffing ratios during a periodic inspection.

Establishes a new process for DHS to investigate a written or oral complaint involving a hospital, as specified.

Establishes appeals process to dispute the department's determination.

Requires a hospital to correct a deficiency within 180 calendar days. The hospital may request an extension of the period within which to correct the deficiency, except for a violation of nurse-to-patient staffing ratios or any other staffing requirement.

Provides that if a hospital and DHS fail to agree upon a plan of correction within 60 days, and if the deficiency poses a significant hazard to the health or safety of patients, then DHS may devise a plan of correction and order its implementation.

Provides that if any condition within a hospital poses an immediate jeopardy to a patient, DHS may order a reduction in the number of patients, a ban on admission of patients, or the closure of all or part of the unit or units that pose the risk, until the deficiency is corrected. Permits a hospital to appeal such an order to superior court.

Requires an inspection report prepared by DHS inspectors to include a recommended date for reinspection in order to ensure compliance with a plan of correction. The reinspection may not be more than 180 days after the citation of deficiency.

Provides that if a hospital fails to correct a deficiency that poses an immediate jeopardy to a patient within the lesser of 180 days or the time specified in the plan of correction, or within an extension of that time, DHS must assess against the hospital a civil penalty of $50 per patient affected by the deficiency for each day that the deficiency continues past the date of correction, until the deficiency is corrected.

Provides that annual hospital license fees fund the activities of DHS to implement this bill.

States that the provisions of this bill shall not be construed to require the retrofitting of a hospital building built prior to July 1, 2004 to meet current seismic safety standards.
Status: Held on Assembly Floor, Failed Passage, Reconsideration Granted - Two Year Bill

SB 1014 (Aanestad) – Hospital Facilities: Seismic Safety Requirements

Makes inoperative on January 1, 2004 existing provisions of law:

- Requiring the Office of Statewide Health Planning and Development (OSHPD) to develop regulations, standards, and earthquake performance categories pertaining to seismic safety in hospitals and to review and approve seismic evaluation reports, compliance schedules, and construction documents developed by hospitals.

- Requiring the California Building Standards Commission to review and adopt earthquake performance categories, seismic evaluation procedures, and standards and timeframes for upgrading the most critical nonstructural systems within hospitals.

- Requiring hospitals to conduct seismic evaluations and to prepare plans and schedules indicating the steps by which they intend to bring their buildings into substantial compliance with the regulations and standards developed by OSHPD.

- Requiring hospitals to meet the 2008 deadline for replacing, retrofitting, or conversion to nonacute purposes of hospitals at risk of collapse or significant loss of life, and the 2030 deadline for demolition, replacement, retrofitting, or change to

nonacute care use of all buildings not in substantial compliance with regulations and standards developed by OSHPD.

States the intent of the Legislature that legislation to make these provisions operative again be enacted when the fiscal condition of the state's health care safety net is able to sufficiently cover the cost of meeting seismic retrofitting and other requirements without affecting health care delivery and access.
Status: Failed passage in the Senate Health and Human Services Committee - Reconsideration granted – Two Year Bill

AB 232 (Chan) - Statewide Health Planning and Development: Hospitals: Self-Pay Policies
Requires each general acute care hospital, acute psychiatric hospital, and special hospital to develop a self-pay policy specifying how the hospital shall determine the prices to be paid by self-pay patients, as defined.

Requires the self-pay policy to include a section addressing charity care patients.

Requires each hospital to perform various functions in connection with the hospital self-pay policy, including notifying patients of the policy, and attempting to determine the availability of private or public health insurance coverage for each patient.

Specifies billing and collection procedures to be followed by a hospital, its assignee, or billing service. Requires each hospital to submit to the office a copy of the hospital's self-pay application. Authorizes the office to develop a uniform self-pay application to be used by all hospitals. Requires each hospital to provide information to the office, including a copy of the hospital's self-pay policy.

Provides that to the extent that certain of the bill's requirements result in a specified federal determination relating to the hospital's established charge schedule, the requirement in question shall be inoperative with respect to a hospital that is licensed to and operated by a county or public hospital authority, as specified.
Status: Held under Submission in the Senate Appropriations Committee – Two Year Bill

AB 253 (Steinberg) - Health Facilities: Nurse-To-Patient Ratios
Directs the Department of Health Services (DHS) to conduct announced and unannounced hospital inspections to determine compliance with minimum nurse-to-patient staffing ratios.

Requires DHS, upon determination that an immediate jeopardy exists at a hospital to assess a $5,000 fine on that hospital.

Requires DHS, upon determination that a pattern of violation exists relating to nurse-to-patient ratios, to assess a $10,000 fine on the hospital. Authorizes hospitals to appeal the fine.

Defines "pattern of violation" as a hospital that has violated Section 1276.4 four or more times in a continuous six month period. Defines "immediate jeopardy" as a situation in which the hospital's noncompliance with one or more requirements of licensure has caused or is likely to cause serious injury, harm, impairment, or death to a patient.

Requires that the notice of deficiency and the approved plan of correction must be posted in the nurses' station or designated nurses' area of the unit where the deficiency occurred until the hospital has complied with the plan of correction.
Status: Held on the Assembly Floor for Concurrence, Failed Passage, Reconsideration Granted – Two Year Bill

AB 1627 (Frommer) - Payers' Bill of Rights
Requires, beginning July 1, 2004, that a hospital that uses a charge description master to make a written or electronic copy of its charge description master available either by posting an electronic copy on the hospital's web site, or by making one written or one electronic copy available on location. Exempts a small or rural hospital from these requirements.

Requires hospitals to post a notice in various locations informing patients that the chargemaster is available upon request.

Requires a hospital to file a copy of its charge description master annually with the Office of Statewide Health Planning and Development (OSHPD).

Requires hospitals to calculate the percentage increase in their gross revenue due to any price increase for patient services during the prior 12-month period.

Requires each hospital to make available to any person who requests it, and to OSHPD, a list of their average charges for the 25 most commonly used goods, services, or procedures.

Requires OSHPD to compile and publish on its website a list of the ten most common Medicare diagnosis related groups (DRGs) and the average charge for each DRG for each hospital.

Authorizes the Department of Health Services (DHS) to fine a hospital up to $5,000 for a violation of the disclosure and reporting requirements in the bill.

Permits any person to file a claim with DHS alleging a violation of these disclosure requirements. Requires DHS to investigate and inform the complainant of its determination whether a violation has occurred and what action it will take.
Status: Chapter 582, Statutes of 2003

AB 1629 (Frommer) - Office of Statewide Health Planning and Development: Health Facility Data

Requires, effective July 1, 2004, that every organization that operates a hospital to report to Office of Statewide Health Planning and Development(OSHPD) specified financial information for affiliates or entities in California over which the organization exercises control, responsibility, or governance of a material amount of the assets or operations of the entity.

Provides that the reporting elements for affiliates that provide patient care shall include, in addition to specified financial information, patient utilization data consistent with that required to be reported by hospital emergency departments and ambulatory surgery clinics.

Exempts from the definition of "affiliate" a health care service plan, a health insurer, and a risk-bearing organization, such as a medical group, that contracts with a health care service plan.

Provides that affiliates already required to report information to OSHPD shall not be required to prepare duplicate reports.

Requires a hospital reporting data to OSHPD to identify the corporate entity that exercises control over a material amount of the assets or operation of the facility, and requires this corporate entity to report specified financial information to OSHPD, effective July 1, 2004.

Requires OSHPD to periodically review hospital reporting elements, and, in doing so, to consult with associations of health facilities, consumer, labor, and physician membership organizations, the Department of Health Services, the Department of Managed Health Care, and other interested parties.

Directs OSHPD to consider guidelines and other information provided by consumer, labor and health care purchaser organizations when it develops by regulation guidelines for reporting of hospital charity care services.

Directs OSHPD to consult with the Department of Health Services regarding how its health data assists enforcement of staffing ratio requirements in hospitals and skilled nursing facilities.

Authorizes OSHPD to publish, by July 1, 2006, and every year thereafter, a risk-adjusted outcome report for coronary angioplasty surgery for all such surgeries performed in California.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

HEALTH PERSONNEL

SB 143 (Cedillo) – Acute Care Hospitals: Patient Needs

Requires the Department of Health Services (DHS) to adopt regulations on or before January 1, 2010, to establish separate common patient classification or acuity systems to be used by all general acute care hospitals and all acute psychiatric hospitals. Stipulates that these systems shall be used by these hospitals to determine the level of nursing care needed for each category of patient in each unit and on each shift.

Allows DHS to take into account variations among hospitals in operating characteristics that are related to the level and type of nursing care that the patient needs, as well as the specific needs of rural hospitals, while developing these systems and ensuring appropriate patient care.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 197 (Burton) – Registered Nurses: Wages and Hours of Employment Violations: Fines

Subjects a for-profit general acute care hospital, as defined, to treble civil penalties for violating meal or rest period provisions for registered nurses.

Establishes findings and declarations that state, among other things, that there is a demonstrated shortage of registered nurses and the shortage is reducing access to necessary and quality health care, and that many nurses are leaving because the work environment has deteriorated to an unacceptable level. It is in the best interest of the public, hospitals, patients, and registered nurses to strengthen workplace protections for registered nurses.

Status: Amendments taken in Senate Health and Human Services Committee withdrew the measure out of the committee and sent to the Labor and Industrial Relations Committee

SB 250 (Battin) – Mandated Reporters: Clerical and Administrative Staff

Makes two changes in the law governing mandated reporters of child abuse:

- Provides that any licensed or certificated professional who is a mandated reporter could be subject to revocation of the license or certificate if found guilty of failing to report an incident of known or reasonably suspected child abuse and neglect.
- Adds any receptionist, support staff, administrative employee, or volunteer at a hospital, clinic, or health or medical facility to the list of mandated reporters.

Status: This Version Failed Passage in the Senate Health and Human Services Committee – Reconsideration Granted – Amended Version Does Not Pertain to the Committee - Withdrawn

SB 398 (Romero) – Health Care Referral Agencies: Temporary Workers

Redefines healthcare employment agencies as a private, profit or nonprofit agency engaged in referring workers to *a general acute care hospital, an acute psychiatric hospital, or other acute care facility,* extended care facilities, skilled nursing homes, intermediate care facilities, or the distinct part of a facility that provides extended care, skilled nursing home care, or intermediate care. (Those facilities in italics are added by this bill to the current definition.)

Eliminates the exemption from these requirements that is currently allowed to a nurses' registry that charges fees exclusively to employers.

Prohibits a health facility from using an employee on a temporary basis when a permanent employee is available to work. Requires a health facility that uses an employee on a temporary basis to evaluate that employee prior to the employee starting work, again within two days of employment, and thereafter at least as often as permanent employees performing similar work are evaluated.

Requires a health facility that uses an employee on a temporary basis to provide an orientation before that employee starts work.

Changes the fee for a referral agency to the amount sufficient to administer the activities of the Department of Health Services relative to licensing referral agencies.

Prohibits referral agencies from referring on a temporary basis a health care practitioner certified or licensed in California or another state unless that practitioner has a valid license or certificate, issued by California or another state, that is not a temporary or interim license or certificate.

Requires that a referral agency, prior to referring a worker for temporary employment, provide a report of the worker's credentials, prior health care experience, and background check that is not more than 30 days old.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 828 (Figueroa) – Health Facilities: Boutique Hospitals

Provides that the Department of Health Services (DHS) may not issue a license for a boutique hospital unless the applicant hospital agrees to continuously maintain and operate an emergency department that provides either basic or comprehensive emergency medical services 24 hours a day, seven days a week, except when on periodic diversion.

Defines "boutique hospital" as a hospital that:

- Does not continuously maintain and operate an emergency department that provides either basic or comprehensive emergency medical services.
- Where two-thirds or more of inpatient discharges are either classified in one or two diagnosis categories or are for surgical diagnosis-related groups.

Requires DHS to suspend the license of a boutique hospital if the hospital fails to maintain its emergency department as specified.

Excludes from the definition of boutique hospital:

- A special hospital as defined under existing law.
- A hospital specializing in pediatrics, an acute psychiatric hospital, or a hospital specializing in physical rehabilitation.
- An eleemosynary hospital that does not bill patients for services provided.
- A hospital granted a license on or before January 1, 2004.
- A hospital that was under construction or had submitted working drawings to the Office of Statewide Health Planning and Development on or before April 1, 2003.
- A hospital issued a new license in order to be rebuilt to meet state seismic safety standards if the hospital has an emergency department and the new rebuilt hospital will also have an emergency department of the same license category or greater.

Status: Failed Passage in the Assembly Health Committee – Two Year Bill

SB 847 (Aanestad) – Health Facilities: Nurse-to-Patient Ratios

Requires, by January 1, 2005, the Department of Health Services (DHS) to evaluate the proposed hospital nurse staffing regulations issued by DHS pursuant to AB 394 (Kuehl) of 1999.

Requires the evaluation to demonstrate the validity of several assumptions or findings, including:

- That raising nurse-to-patient ratios would attract and have, in fact, attracted more nurses to hospitals;
- That there is a sufficient supply of nurses to meet the phased-in 1:5 ratio for medical/surgical units without disruption in access to care;
- That the original fiscal impact estimates of the regulations are substantially accurate;
- That the effects of the initial 1:6 ratio proposed for medical/surgical units have not adversely affected the ability of long-term care providers to hire and retain nursing staff;
- That there have been measurable improvements in patient care sufficient to justify the cost of the 1:6 ratio for medical/surgical units;
- That further measurable improvements in patient care can be expected through the phase-in of the 1:5 requirement, and that the additional improvements in patient care are sufficient to justify the additional costs of the 1:5 nurse-to-patient ratio in medical/surgical units.

Provides that DHS may not impose the 1:5 nurse-to-patient ratio for medical/surgical units unless it is able to demonstrate that any of the following conditions exist:

- There is a sufficient supply of nurses available to meet a 1:5 nurse-to-patient ratio with no loss of bed availability;
- There are measurable improvements to patient care as a result of a 1:5 nurse-to-patient ratio requirement; or

- The cost projected in moving from a 1:6 nurse-to-patient ratio to a 1:5 ratio does not exceed projected revenues.

Provides that if DHS determines that any of the conditions above have been satisfied, DHS may require health facilities to meet the 1:5 nurse-to-patient ratio in medical/surgical units.
Status: Failed Passage in the Senate Health and Human Services Committee – Reconsideration Granted – Two Year Bill.

SB 1005 (Dunn) – Hospital Inspections, Deficiencies, and Plans of Corrections
Prohibits advance announcement of a periodic inspection of a health facility.

Requires the Department of Health Services (DHS), if inspecting a hospital jointly with an outside entity (such as the Joint Commission on Accreditation of Healthcare Organizations) that does provide notice in advance of a periodic inspection, to conduct an additional periodic inspection that is not announced in advance to the facility.

Requires DHS to inspect a hospital for compliance with nurse-to-patient staffing ratios during a periodic inspection.

Establishes a new process for DHS to investigate a written or oral complaint involving a hospital, as specified.

Establishes appeals process to dispute the department's determination.

Requires a hospital to correct a deficiency within 180 calendar days. The hospital may request an extension of the period within which to correct the deficiency, except for a violation of nurse-to-patient staffing ratios or any other staffing requirement.

Provides that if a hospital and DHS fail to agree upon a plan of correction within 60 days, and if the deficiency poses a significant hazard to the health or safety of patients, then DHS may devise a plan of correction and order its implementation.

Provides that if any condition within a hospital poses an immediate jeopardy to a patient, DHS may order a reduction in the number of patients, a ban on admission of patients, or the closure of all or part of the unit or units that pose the risk, until the deficiency is corrected. Permits a hospital to appeal such an order to superior court.

Requires an inspection report prepared by DHS inspectors to include a recommended date for reinspection in order to ensure compliance with a plan of correction. The reinspection may not be more than 180 days after the citation of deficiency.

Provides that if a hospital fails to correct a deficiency that poses an immediate jeopardy to a patient within the lesser of 180 days or the time specified in the plan of correction, or within an extension of that time, DHS must assess against the hospital a civil penalty of

$50 per patient affected by the deficiency for each day that the deficiency continues past the date of correction, until the deficiency is corrected.

Provides that annual hospital license fees fund the activities of DHS to implement this bill.

States that the provisions of this bill shall not be construed to require the retrofitting of a hospital building built prior to July 1, 2004 to meet current seismic safety standards.
Status: Held on Assembly Floor, Failed Passage, Reconsideration Granted - Two Year Bill

AB 948 (Nunez) - Physicians and Surgeons: Postgraduate Study Fellowship Program

Permits physicians who are not citizens but are legally admitted to the United States to participate in a fellowship program in a specialty or subspecialty field after application to and approval by Medical Board of California (MBC), if the fellowship program is in a medically underserved area in a clinic or hospital licensed by the Department of Health Services or exempt from licensure as specified.

Requires at all times that physicians who participate in fellowships identified in #1 above be under the direction and supervision of a licensed, board-certified physician and surgeon who has an appointment with a medical school in California and is a specialist in the field in which the fellow is to be trained. Requires the supervisor to submit to the MBC his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow.

States that approval of the fellowship program and supervisor is for a period of one year. Permits annual renewal if approved by MBC up to four times.

Requires applicants at the time the application is filed to pay a fee, determined by MBC, based on the cost of operating this program.

Prohibits physicians participating in fellowships under this bill from practicing medicine except as authorized by this bill. Prohibits the time spent under appointment in a clinic pursuant to this bill from being used to meet the requirements for licensure as specified.

States that a United States citizen who has received his or her medical degree from a medical school located in a foreign country is not precluded from participating in any program established pursuant to this bill.

Defines, for purposes of this bill, a medically underserved area as a federally designated Medically Underserved Area, a federally designated Health Professions Shortage Area, and any other area determined by the MBC to be medically underserved.
Status: Chapter 438, Statutes of 2003

AB 1241 (Parra) - Nursing Education Scholarships
Requires the Office of Statewide Health Planning and Development to establish a statewide Associate Degree Nursing Scholarship Pilot Program.

Provides that scholarships under the pilot program shall be available in counties determined to have the most need, based on a county having a registered nurse to population ratio equal to or less than 500 registered nurses per 100,000 individuals; county unemployment rate; and county level of poverty.

Requires scholarship recipients to complete, at a minimum, an associate degree in nursing and work in a medically underserved area in California upon obtaining his or her license from the Board of Registered Nursing.

Requires the pilot Associate Degree Nursing Scholarship Pilot Program to be funded from the Registered Nurse Education Fund; requires the Health Professions Education Foundation to allocate a portion of the moneys in the fund for the pilot program.

Sunsets the pilot program on January 1, 2009.
Status: Chapter 396, Statutes of 2003

IN-HOME SUPPORTIVE SERVICES

AB 632 (Kehoe) - In-Home Supportive Services Providers: Employment Benefits
Provides for the inclusion of those In-Home Supportive Services (IHSS) workers employed through a nonprofit or proprietary agency in the Department of Social Services labor pool for the purpose of paying contributions for workers' compensation coverage.

Allows the employer of record of IHSS workers to negotiate with employee representatives for the purchase of health insurance through the state Public Employees' Medical and Hospital Care Act.

Excludes recipients of IHSS services from enrolling in the CalPERS health care coverage as a family member of an IHSS worker.

Defines "contracting agency" for the purpose of CalPERS as an IHSS employer of record if the employer obtains an advisory opinion by the United States Department of Labor stating that it is an instrumentality of the state as a prerequisite for negotiating health coverage.

Limits state financial participation in any negotiated health insurance benefit pursuant to this bill to that participation set forth in the annual Budget Act.
Status: Chapter 209, Statutes of 2003

AB 1470 (Vargas) - In-Home Supportive Services: Provider Wage And Benefit Increases: Voter Initiative

Makes legislative findings about the difficulty in attracting persons to provide quality IHSS, and the intent to provide an ongoing remedy for these circumstances.

Provides that in any county, the wages and benefits of In-Home Supportive Services (IHSS) providers may be increased by voter initiative to the same extent as may be increased by the board of supervisors, when the following events have occurred:

- The initiative is placed on the ballot of a previously scheduled county election.
- The employer of record and employee organization have exhausted their obligations to meet and confer in good faith, impasse has been reached and impasse procedures have been exhausted.
- After two months of impasse, either party has submitted the dispute to the Public Employee Relations Board or the California State Mediation and Conciliation Services, a mediator has been appointed but was unable to settle the dispute within one month, and the employee organization has requested that the government agency appoint a fact finder to investigate and determine the amount of county moneys available, if any, to fund the proposed increase.
- Within one month of appointment, the fact finder has issued an advisory determination of the amount of additional resources available outside of realignment accounts.
- The parties have met and conferred in good faith for one month over the fact finder's advisory determination but have not reached agreement.

Divides mediation costs equally between the employer of record and the employee organization.

Limits the total cost of wages and benefits provided by voter initiative to the maximum levels provided for state participation in WIC Section 12306.1.

Status: Held under Submission in the Senate Appropriations Committee – Two Year Bill

MEDICAL RESEARCH

SB 133 (Battin) – Human Cloning

Prohibits human reproductive cloning and therapeutic cloning. Therapeutic cloning involves somatic cell nuclear transplantation to produce embryonic stem cells and is closely associated with deriving therapies from stem cell research.

Defines "to clone a human being" as engaging in human asexual reproduction, accomplished by introducing nuclear material from one or more human somatic cells into a fertilized or unfertilized oocyte, which has had its nuclear material removed or inactivated so as to produce a living organism, at any stage of development, that is genetically virtually identical to a previously existing human organism. Defines "asexual

reproduction" as reproduction not initiated by the union of an oocyte and sperm, and "somatic cell" as a diploid cell having a complete set of chromosomes obtained from a human being at any stage of development. Permits all scientific research that is not specifically prohibited by this Act. Prohibited research includes the use of cloning techniques to create human embryonic stem cells.

Eliminates the Department of Health Services' authority to assess penalties for violations of California's human reproductive cloning ban and establishes criminal penalties for violations of up to $1,000,000 for corporations, firms, clinics, hospitals, laboratories, or research facilities and $250,000 for individuals.
Status: Failed Passage in the Senate Health and Human Services Committee – Reconsideration Granted – Two Year Bill

SB 322 (Ortiz) – Human Stem Cell Research Review Council
Requires the State Department of Health Services (DHS), on or before January 1, 2005, to develop guidelines for research involving the derivation or use of human embryonic stem cells in California. The provisions of the bill sunset January 1, 2007.

Permits DHS, in developing these guidelines, to consider guidelines developed or in use in the United States and in other countries, and to contract with a public or private organization, to the extent permitted by state law, for assistance in developing the guidelines.

Requires the Director of DHS, for purposes of developing the guidelines, to establish a 13-member Human Stem Cell Research Advisory Committee with specified membership.

Requires all research projects involving the derivation or use of human embryonic stem cells to be reviewed and approved by an institutional review board (IRB) that is established in accordance with federal regulations. Requires an IRB board, after guidelines are developed by DHS, to consider and apply those guidelines in its review of human embryonic stem cell research projects. Permits an IRB to require modifications to the plan or design of a proposed human embryonic stem cell research project as a condition of approving the research project.

Requires an IRB, at least annually, to conduct a continuing review of human embryonic stem cell research projects reviewed and approved to ensure the research continues to meet IRB standards. Permits an IRB, pursuant to its review, to revoke its prior approval of research and to require modifications to the plan or design of a continuing research project before permitting the research to continue.

Requires each IRB that has reviewed human embryonic stem cell research to report to DHS annually on:
- The number of human embryonic stem cell research projects the IRB has reviewed, and the status and disposition of each of those projects.
- Unanticipated problems or serious continuing investigator noncompliance with the requirements or determinations of the IRB with respect to the review of human

embryonic stem cell research projects, and the actions taken by the IRB to respond to these situations.

Requires DHS to at least annually review reports from IRBs, and permits DHS to revise the guidelines developed as it deems necessary. Requires DHS to annually report to the Legislature on human embryonic stem cell research activity, and requires these annual reports to be compiled from the reports from IRBs.
Status: Chapter 506, Statutes of 2003

SB 771 (Ortiz) - Human Cells: Embryo Registry: Egg Cell Donation

Requires the Department of Health Services (DHS) to establish and maintain an anonymous registry of embryos that are available for research but only to the extent that funds are received by DHS from private or other non-state sources. Authorizes DHS to contract with the University of California, private organizations, or other public entities to establish and administer the registry.

Requires physicians or other health care providers, when providing fertility treatment, to provide a form to the male and female partner, or individual, that sets forth advanced written directives regarding the disposition of embryos, and requires the form to include specified information and choices.

Specifies the information that must be included when providing informed consent for patients who have elected to donate embryos remaining after fertility treatment for research. Requires that this information include statements that:

- Early human embryos will be used to derive human stem cells for research and may be used for human transplantation research.
- All identifiers associated with embryos will be removed. Donors will not receive any subsequent information about the embryo or derived cells.
- Possibly the donated material may have commercial potential and the donor will not receive financial or any other benefits.

Early human embryos donated will not be transferred to a woman's uterus, will not survive the research process, and will be handled as is appropriate for all human tissue used in research.

Defines as "unprofessional conduct" the failure by a health care provider, delivering fertility treatment, to provide a patient with information to allow the patient to make an informed choice regarding the disposition of remaining embryos following treatment.
Status: Chapter 507, Statutes of 2003

SB 778 (Ortiz) – Biomedical Research and Development Act of 2004

Enacts the Biomedical Research and Development Act of 2004 and authorizes the issuance of general obligation bonds in an unspecified amount for the purposes of financing biomedical research and facilities.

Provides for allocation of bond funds into a Biomedical Research Account and a Biomedical Research Facilities Account.

Directs the Department of Human Services (DHS) to use Research Account funds for grants and loans to public or private research companies, universities, institutes, and organizations for biomedical research, including but not limited to research in the fields of cell differentiation, nuclear reprogramming, tissue formation and regeneration, stem cell biology, developmental biology, regenerative medicine, and related fields.

Requires that all funds be awarded on the basis of the research priorities established for the program and the scientific merit of the proposed research and with an emphasis on research that complements, rather than duplicates, research funded by the federal government or other entities.

Allows all research investigators, regardless of affiliation, to have equal access and opportunity to compete for the funds.

Requires all projects, in order to be eligible for funding, to have been reviewed and approved by an institutional review board that meets the requirements of federal law and regulations.

Establishes a Biomedical Research Council comprised of 10 – 13 members to develop the strategic objectives and priorities of the program and to make final recommendations on which research projects are to be funded.

Requires the membership of the Council to consist of scientists with current or past research experience in the fields of research eligible for funding, who would comprise a majority of the members of the Council; at least two representatives of patient advocacy organizations; and at least two representatives of private industry that are conducting or have conducted research in the fields of research eligible for funding.

Requires DHS and the Council to develop policies and procedures to facilitate the translation of research results into commercial and other applications; provides that intellectual property assets developed under the program shall be treated in accordance with state and federal law.

Provides that no more than five percent of the bond proceeds to be used for administrative costs.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

MEDI-CAL, HEALTHY FAMILIES, AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS

SB 24 (Figueroa) – Health Care: Accelerated Enrollment

Establishes a Medi-Cal Prenatal Gateway for pregnant women who receive care at a prenatal care provider's office and are currently eligible for presumptive eligibility, under which presumptive eligibility for Medi-Cal will be established by the submission of eligibility information through an electronic enrollment process.

Permits the State Department of Health Services (DHS), in implementing the Prenatal Gateway, to contract with public and private entities or use existing provider enrollment and payment mechanisms, as specified.

Requires that in implementing the bill, the form used by a provider to collect information about a pregnant woman for purposes of establishing temporary eligibility for Medi-Cal constitute a simplified application for the Medi-Cal program. Requires the form, if necessary, to ensure federal financial participation, to be modified to add only those elements required for federal financial participation and to be as simple as DHS considers practicable.

Establishes a Newborn Hospital Gateway, under which hospitals will submit eligibility information electronically only for infants deemed eligible by federal law for Medi-Cal from birth to age one. The information submitted will establish the eligibility of the infant up to age one without requiring the family submit a follow-up application to maintain one-year enrollment.

Prohibits the Prenatal and Newborn Hospital Gateways from being adopted until sufficient monies are deposited in the Special Funds Account to defray the costs of their development and sufficient new staff, not to exceed a total of three personnel years, funded through non-state General Fund sources, is available.

Creates the Gateway Fund in the State Treasury. Permits monies in the fund to be spent exclusively for purposes of establishing and maintaining the Prenatal Gateway and the Newborn Hospital Gateway. Requires that the fund consist of the following three accounts: the Special Funds Account, the Other Public Funds Account, and the Federal Funds Account.

Requires the Special Funds Account to consist of funds received by the Controller from private foundations and other nongovernmental sources. Prohibits DHS from being responsible for securing those funds. Requires money in this account to be used exclusively for the Prenatal and Newborn Hospital Gateways.

Status: Chapter 895, Statutes of 2003

SB 323 (Soto) – Medi-Cal: Disease Management

Makes findings and declarations, including: health care costs are rising dramatically, largely attributable to chronic diseases; research demonstrates that disease management can improve patient outcomes and decrease costs; disease management is being used in the private health care market; the aged, blind and disabled population accounts for 25 percent of Medi-Cal costs; and beneficiaries and taxpayers will continue to be "shortchanged" until the state adopts disease management within Medi-Cal.

States that it is the policy of the state to provide and encourage the provision of disease management programs and services.

Requires the Department of Health Services (DHS) to develop a strategy for providing Medi-Cal beneficiaries with population-based disease management programs and services, by nationally-accredited disease management organizations.

Requires DHS, within existing resources and as quickly as possible, to adopt a list of diseases eligible for disease management and guidelines for implementing the state's policy, and requires DHS to pay special attention to the following:

- Chronic diseases with high overall costs;
- Co-morbidity among chronic diseases;
- Potential cost-savings from providing disease management to the Medi-Cal fee-for-service population;
- Potential coordination with PERS disease management programs; and
- Providing disease management in both counties with fee-for-service Medi-Cal and counties with Medi-Cal managed care models.

Requires DHS to post on its website a notice stating that work on disease management has been initiated by DHS, including specified details, including a contact at DHS to receive public input.

Urges DHS to recommend either developing a timeline for phasing in various diseases, or developing a plan to provide coverage for a range of chronic diseases simultaneously.

Requires DHS to seek all necessary federal waivers to ensure federal financial participation, and prohibits DHS from providing disease management services until a federal waiver is obtained.

Requires DHS to seek a federal waiver to ensure that the state will share in cost savings that result from Medi-Cal disease management provided to individuals who are dual-eligible for Medi-Cal and Medicare.

Authorizes DHS to seek information and advice from specified agencies, organizations and other entities to speed the delivery of disease management programs.

Authorizes DHS to issue requests for proposals and enter into contracts with disease management organizations.

Requires DHS to report its findings, recommendations, guidelines, disease management delivery and implementation strategy, and progress report on implementing disease management programs to the Governor, Secretary of Health and Human Services, and the Legislature by January 1, 2005.
Status: Held at the Assembly Desk – Two Year Bill

AB 373 (Chu) – Healthy Families Program
Requires, effective July 1, 2004, any Healthy Families Program (HFP) subscriber who affirmatively selects, or is assigned by default to, a federally qualified health center (FQHC), rural health clinic (RHC), or primary care clinic (PCC), as specified, be deemed to have been assigned directly to the center or clinic, and not to any individual provider who performs services on behalf of the center or clinic.

Requires, when an HFP subscriber is assigned to a physician, optometrist or dentist who is an employee of a FQHC, a RHC, or PCC, that the assignment constitutes an assignment to the center or clinic.
Status: Chapter 139, Statutes of 2003

AB 1130 (Diaz) - Health Care Coverage: County Health Initiative Matching Fund
Appropriates $89 million from the County Health Initiative Matching (CHIM) Fund and $164 million from the Federal Trust Fund to fund county health initiatives (CHIs) in the current year.

Deletes a requirement that funds from the CHIM Fund may only be matched with State Children's Health Insurance Program (SCHIP) funds that otherwise reverts to the federal government. Requires that SCHIP funds shall only be available after providing full funding to HFP and other state programs funded through SCHIP, as specified. Requires funds to be appropriated specifically for CHIs.
Status: Chapter 687, Statutes of 2003

AB 1201 (Berg) – Medi-Cal: Subacute Care Services
Requires the Department of Health Services (DHS), when it is terminating or not renewing a health facility's subacute care contract, to notify the facility 30 days before termination.

Requires DHS to provide guidance to a subacute care facility regarding expectations for the transfer of residents when the subacute contract is being terminated. Requires the guidance to consider the need to minimize trauma of a resident due to transfer, and to ensure, prior to any transfer or discharge, that the facility has complied with specified transfer and discharge requirements in state and federal law.

Requires the Medi-Cal Division of DHS to coordinate with the Licensing and Certification Division of DHS in developing the guidance for the protection of residents' transfer rights.

Requires, prior to any transfer, the health facility to continue to provide the subacute level of care required by a resident, and requires the health facility to continue to be paid commensurate with that subacute level of care.

Requires a health facility that has a subacute care services provider contract with DHS under the Medi-Cal program to comply with specified patient transfer and discharge requirements that apply to other skilled nursing facilities.

Requires the facility, before residents are transferred due to any change in the status of the license or operation of the facility, including the termination of the subacute care services provider contract, to comply with the specified transfer and discharge requirements in existing state and federal law.

Requires all of the rights and procedures that apply to the appeal of the transfer or discharge of a nursing facility resident to apply to an appeal of a subacute care patient.

Requires the facility to ensure that each resident and resident's representative is notified of this right to appeal, and requires the notification to be in writing and to be communicated in a language and manner that is understood by the resident or resident's representative.
Status: Chapter 443, Statutes of 2003

AB 1220 (Berg) – Heart Disease

Makes various findings and declarations, including:

- Heart disease is the number one cause of death and disability nationwide.
- This year the economic burden on the nation due to heart disease and stroke is estimated to be over $350 billion.
- A heart disease and stroke prevention and treatment state master plan is needed to reduce the morbidity, mortality, and economic burden of heart disease and stroke in the state. A master plan is a vital sign towards enabling the state to draw down needed federal funds for future activities.

Establishes the Heart Disease and Stroke Prevention and Treatment Task Force (Task Force) within the Department of Health Services (DHS), to be composed of 12 members who have demonstrated interest in heart disease, or stroke, as specified.
Three members appointed by the Speaker of the Assembly, as follows:

- One member representing a volunteer health organization dedicated to research and prevention of heart disease and stroke.
- One practicing physician with expertise in research, prevention, or treatment of stroke victims.
- One hospital administrator.

Three members appointed by the Senate Committee on Rules, as follows:

- One representative of a population disproportionately affected by heart disease and stroke.
- One practicing physician with expertise in research, prevention, or treatment of heart disease.
- One representative of a health care organization.

Six members appointed by the Governor, as follows:

- One heart disease survivor.
- One stroke survivor.
- One registered nurse.
- One representative of a local health department.
- One member of a university facility with expertise in programs intended to reduce the rate of heart disease and stroke.
- One registered dietitian with experience in population based programs.

Requires that the members of the Task Force be appointed on or before March 1, 2004.

Requires the Task Force to create and submit a Heart Disease and Stroke Prevention and Treatment State Master Plan to the Legislature, Governor, and DHS by November 1, 2005 that shall address needed changes to existing law, regulations, programs, services, and policies for the purposes of improving heart disease and stroke prevention and treatment.

Conditions implementation on receipt of private funding in an amount sufficient to fund the entire cost of the operation of the task force and costs associated with completing the requirements imposed by this section, as determined by the department..
Status: Chapter 395, Statutes of 2003

AB 1524 (Richman) – County Health Initiative Matching Fund

Expands the scope of the County Health Initiative Matching (CHIM) Fund's health insurance coverage to include adults who are parents of an eligible child participating in the Health Families Program (HFP) and whose income does not exceed 200% of the Federal Poverty Level, as specified.

Allows local initiatives and county entities to submit proposals to the Managed Risk Medical Insurance Board (MRMIB) for reimbursement of medical, dental, vision or mental health services delivered to adults.

Requires MRMIB and the Department of Health Services to include in the criteria for evaluating county coverage proposals for adults, the extent to which the proposal (1) seeks to pursue assistance from employers in the payment of premiums and whether the

proposal requires, as a condition of parental enrollment, the enrollment of children in the applicant's plan or a competing plan, and (2) offers subscribers a choice of health care service plans or health insurers similar to the choices available to children eligible for the HFP in that county.

Allows parental expansion only if there is money that would otherwise revert to the federal government because it is not needed for the estimated enrollees for Healthy Families or for children's expansion programs under CHIM.
Status: Chapter 866, Statutes of 2003

MENTAL HEALTH

SB 130 (Chesbro) – Mental Health and Care Facilities: Use of Seclusion and Behavioral Restraints

Requires the State Health and Human Services Agency to provide leadership and coordination necessary to reduce the use of seclusion and behavioral restraints in facilities that are licensed, certified, or monitored by the departments that fall within the agency's jurisdiction.

Requires the State Department of Mental Health and the State Department of Developmental Services to develop technical assistance and training programs to support the efforts of facilities operated by these departments to reduce or eliminate the use of seclusion and behavioral restraints in those facilities and to take steps to establish a system of data collection.

Requires that facilities operated by these departments report each death or serious injury of a person occurring during, or related to, the use of seclusion or behavioral restraints.

Authorizes specified facilities to use seclusion and behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to the person or others and requires an initial assessment of each person upon admission for these purposes, and prohibits specified facilities from sing specified types of seclusion and behavioral restraints.

Requires these facilities to conduct reviews for each episode of the use of seclusion or behavioral restraint, to conduct debriefings, and to document the incident.
Status: Chapter 750, Statutes of 2003

SB 372 (Margett) – Involuntary Detention: Grave Disability

Amends the definition of "gravely disabled" within the Lanterman-Petris-Short Act to allow the court to order a conservatorship for those individuals who have been charged with a complaint, pursuant to Section 806 of the Penal Code, as well as those individuals charged with an indictment or information, as long as other provisions of the law are met.
Status: Failed Passage in the Senate Health and Human Services Committee – Reconsideration Granted – Two Year Bill

AB 348 (Chu) - Mental Health: Involuntary Confinement: Psychologists

Permits a psychologist or a psychiatrist, in those situations in which both a psychiatrist and a psychologist have personally evaluated a person, to release a person prior to completion of a 72-hour, 14-day, or 30-day treatment and evaluation hold, if both the psychiatrist and psychologist determine that the person no longer requires evaluation and treatment.

Specifies that, in the event of a disagreement regarding the early release of a person, the person may not be released unless the medical director overrules the decision of the psychiatrist or psychologist opposing the release.

Prohibits psychologists from being held civilly or criminally liable for any action by a person released before the end of a 72-hour, 14-day, or 30-day hold, if the provisions of law relating to the early release of the person have been met. Prohibits psychologists, in addition to psychiatrists, from being held civilly or criminally liable for any action by a person released at the end of the 72-hour, 14-day, or 30-day treatment and evaluation hold.

Status: Chapter 94, Statutes of 2003

AB 376 (Chu) - California Mental Health Planning Council: Composition

Requires that the California Mental Health Planning Council (MHPC) include representatives of direct service providers from both the public and private sectors.

Directs the MHPC to review the provision of mental health services to foster children, to make efforts to reduce the stigma of mental illness, and to work with advocacy organizations to remove barriers to mental health services for children and youth. This set of responsibilities is assigned from the effective date of the bill until January 1, 2007.

Status: Chapter 71, Statutes of 2003

AB 938 (Yee) - Mental Health Professionals: Educational Loan Reimbursement: Funding

Declares the need for licensed mental health providers, particularly in multicultural, linguistically diverse, and medically underserved areas.

Creates the Mental Health Practitioner Education Fund and Licensed Mental Health Provider Education Program within the fund.

Requires the Board of Psychology and the Board of Behavioral Sciences to charge a $10 fee to psychologists, marriage and family therapists, and licensed clinical social workers at the time of biennial license renewal.

Allows, commencing January 1, 2005, any mental health provider who provides direct patient care in a publicly-funded facility or a health manpower shortage area that is multicultural and linguistically diverse, to apply for a grant under the program to reimburse his or her loans related to a career as a licensed mental health service provider.

Requires program participants to enter into a standard contractual agreement to serve in a publicly-funded facility or health manpower shortage area for at least one year. In return, participants are eligible for loan forgiveness not to exceed the amount of educational loans related to a career as a licensed mental health service provider.
Status: Chapter 437, Statutes of 2003

AB 1370 (Yee) - Mental Health: Community Treatment Facilities: Seclusion and Restraints
Requires community treatment facilities to retain at least one full-time registered nurse on staff.

Prohibits the Department of Mental Health from requiring 24-hour on-site licensed nursing staff.

Requires that other nursing staff be available on call to provide nursing services, when necessary, within one hour.

Requires all direct care staff to be trained in first aid, cardiopulmonary resuscitation, emergency intervention techniques, and methods approved by the Community Care Licensing Division of the Department of Social Services.

Sets a sunset date of January 1, 2007 for these provisions.
Status: Chapter 575, Statutes of 2003

ORGAN DONATION

SB 38 (Denham) - Organ and Tissue Donation: Donations to Incarcerated Persons
Requires the forms provided by the Department of Motor Vehicles for the purposes of allowing license applicants to indicate their intent to make an anatomical gift upon death to include a provision allowing the donor to indicate whether he or she desires to prohibit a donation to any person who is incarcerated in a state prison or county jail.
Status: Held in the Senate Health and Human Services Committee – Two Year Bill

SB 112 (Speier) - California Organ and Tissue Donor Registry
Deletes the provisions of law establishing the Registry and Fund.

Authorizes federally established organ procurement organizations to establish a not-for-profit entity that shall be designated the California Organ and Tissue Donor Registrar, which shall establish and maintain the California Organ and Tissue Donor Registry.

Transfers certain related duties of the Agency to the Registrar and makes conforming changes.

Requires the Registrar to submit an annual written report to the Agency Director and the Legislature that includes all of the following: (a) the number of donors on the registry, (b) the changes in the number of donors on the registry, and (c) the general characteristics of donors.

Makes legislative findings and declarations concerning the occurrence of certain conditions that repealed specified related Vehicle Code provisions on July 1, 1999.
Status: Chapter 405, Statutes of 2003

SB 617 (Speier) - Anatomical Gifts: Tissue Banks: Informed Consent

Requires "donees" (defined as hospitals, organ procurement organizations, and tissue banks) to revise informed consent forms and procedures to advise donors or their representatives that tissue banks work with both nonprofit and for profit tissue processors and distributors, that it is possible that donated tissue may be used for cosmetic or reconstructive surgery purposes and that donated tissue may be used for transplants outside of the United States.

Requires the consent process to separately allow the donor or representative to withhold consent for tissues to be used outside of the United States or by for-profit tissue processors and distributors, or for donated skin to be used for cosmetic surgery purposes. Requires donees to provide a copy of the completed consent to the donor or representative.

States that donees shall be deemed to have complied with above by designating tissue that has been donated with specific restrictions for its use. States that once the donee transfers tissue to a separate entity, the donee's responsibility for compliance with any restrictions on the tissue ceases.

Makes violation of the provisions of this bill by licensed health care providers unprofessional conduct; authorizes the Department of Health Services (DHS) to establish standards for license suspension or revocation for failure to comply with the requirements of this bill.

Permits a donor to recover civil penalties ($1,000 to $5,000) plus court costs from an individual or entity that fails to comply with the provisions of this bill. Requires that a separate penalty be assessed for each individual or entity that fails to comply.

Exempts physicians who remove sperm or ova from patients from the notice and informed consent requirements of this bill. Requires DHS to report to the Legislature by January 1, 2004 on the status of its regulations governing tissue banks.

States legislative intent that this bill shall not increase the number of inspections of donees and that the review of informed consent procedures would be incorporated within existing inspection requirements. Stipulates that the requirements of this bill shall be met with DHS' existing resources.
Status: Chapter 464, Statutes of 2003

AB 777 (Dutton) – Anatomical Gifts: Organs: Inquests

Authorizes, explicitly, the county medical examiner or coroner to permit the removal of organs that constitute an anatomical gift from a decedent who died under circumstances requiring an inquest.

Authorizes release of the organs to a qualified organ procurement organization (OPO), when an autopsy is required, if the medical examiner or coroner determines that organ removal will not compromise evidence during an investigation into cause of death.

Requires, upon request from a qualified organ placement organization, that the medical examiner or coroner to be present during the procedure to remove the organs, if the medical examiner or coroner is considering withholding one or more organs for any reason. Provides exception in cases where there is no known next of kin or when a person dies in the custody of a law enforcement agency.

Permits the medical examiner or coroner to request a biopsy of the organs or deny removal of the organs if necessary, and allows, but does not require, the medical examiner or coroner to explain in writing the reasons for the denial and provide the explanation to the OPO.

Requires the OPO to reimburse the county for the costs of the medical examiner or coroner's attendance during the removal of the organs.

Requires the health care professional removing the organs from a decedent, who died under circumstances requiring an inquest, to file a report with the medical examiner or coroner detailing the condition of the removed organs and their relationship, if any, to cause of death.

Specifies that its provisions do not preclude a coroner or medical examiner from permitting the removal of organs for an anatomical gift under any other provision of law.
Status: Chapter 309, Statutes of 2003

PUBLIC HEALTH

SB 201 (Romero) – Radioactive Materials: Transfer of Authority and Imposing Tougher Clean-Up Standards

Repeals the Radiation Control Law and re-enacts those provisions as the Radioactive Materials Management Act.

Transfers authority, jurisdiction, and responsibility for the regulation of radioactive materials and waste from the Department of Human Services (DHS) to the Department of Toxic Substance Control (DTSC).

Transfers staff responsible for the regulation of radioactive materials and waste, up to management level, from DHS to DTSC. Specifies the scientific positions, units, and

branches at DHS which are transferred to DTSC, requires DTSC to perform a job classification review of the positions affected by the bill and requires DTSC to report the Legislature on additional statutory changes needed to effectuate that change.

Requires persons applying for licenses for receipt, possession, or transfer of radioactive materials to submit a disclosure statement which includes specified information on the person's identity, fingerprints, business interests, and past violations of law, requires DTSC to forward fingerprint cards, images and related information to the Department of Justice (DOJ) prior to issuing any licenses, and requires DOJ to provide reciprocal information to DTSC on the criminal history of the applicant.

Prohibits any person from selling, transferring or leasing radioactively contaminated property, other than a former military base, for any subsequent land use until DTSC certifies that the radioactive contamination has been remediated pursuant to the standards, guidance, procedures, and practices established under the federal Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, as amended (CERCLA) (42 U.S.C. Section 9601 et. seq.), also referred to as the federal Superfund Law.

Exempts from the prohibition in above any portion of a radioactively contaminated property that is uncontaminated.
Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 475 (Florez) – Public Freshwater Recreation Areas: Clean Water Standards
Requires posting of a notice at a public saltwater beach where testing and monitoring of water quality and safety has not occurred, because of insufficient funds, informing the public that the local health agency has not tested the water for microbiological contaminants.

Requires the Department of Human Services (DHS) to convene a public advisory group, by March 1, 2004, with specified representation, to advise DHS on the development of minimum standards and regulations for sanitation of freshwater bathing areas.

Requires the regulations to:
- Require testing of waters in "high use or priority public freshwater bathing areas" for microbiological contaminants, which must be conducted on a weekly basis from April 1 to October 31, beginning in 2007.
- Establish protective minimum standards for certain microbiological indicators, in consultation with the State Water Resources Control Board.

Allows a city or county to adopt standards that are stricter than the DHS standards.

Assigns responsibilities and powers to local health officers and environmental health directors, including responsibility to test water, power to restrict use of bathing areas that are out of compliance with standards, power to investigate complaints of noncompliance

with standards, responsibility to inform the administering agency of a bathing area within 24 hours of an adverse action, and the responsibility to report violations of posting, closure, or other restrictions to the district attorney or city attorney.

Provides that any of the above duties on a local agency are mandatory only during a fiscal year that the Legislature has appropriated sufficient funds for local agencies to cover costs in performing the duties, as determined by DHS.

Requires local health authorities to notify the public by posting a notice at a public beach that there are insufficient funds to test the water..
Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 679 (Ortiz) – Restaurants: Nutritional Information
Requires food establishments to provide nutritional content information to customers by either posting the information on a wall and in a conspicuous way, or in the form of a pamphlet which must be accompanied by posting a visible sign at the counter where food is ordered or near the front of the restaurant indicating that nutritional information is available.

Requires the information to be similar to that required on nutritional information labels under federal law.

Limits an enforcement officer's duty, in enforcing this bill, to conduct an inspection in the course of regular health inspections and verifying the food establishment's good faith effort to comply.

Creates an infraction for each violation and permits an enforcement officer to assess a fine ranging from $25 to $250. Limits a food establishment's liability to knowing or negligent failure to comply and provides and exception for an individual franchisee if the franchisee's parent corporation has failed to provide the necessary materials required by the bill.

Defines "large chain" as a chain of restaurants that includes 10 or more franchises or restaurants in California.

Defines "food establishment" as any establishment where food is prepared and sold at a retail level, except for mobile, satellite distribution, or temporary food facilities, open-air barbecue, farmer's markets, or food preparation units.

Makes various findings relating to obesity.
Status: Failed Passage in the Assembly Health Committee, Reconsideration Granted – Two Year Bill

SB 689 (Ortiz) – Healthy Californians Biomonitoring Project

Makes various legislative findings, including:

- Chronic disease has reached epidemic proportions in the United States. An estimated 125 million Americans, or 43 percent of the population, have at least one chronic condition.
- An estimated 85,000 synthetic chemicals are registered for use today in the United States and another 2,000 chemicals are added each year.
- Many of these chemicals are in daily use in cosmetics, hair products, pesticides, food dyes, cleaning products, fuels, and plastics.

Some toxicological screening data exists for only 7 percent of these chemicals and ore than 90 percent of these chemicals have never been tested for their effects on human health.

Establishes the Healthy Californians Biomonitoring Project, to be administered by the Department of Health Services (DHS).

Requires the department, in consultation with an advisory committee, to develop a biomonitoring pilot program, beginning with a pilot using breast milk as a marker of community health in a minimum of three diverse communities throughout the state.

Requires DHS to conduct and complete additional pilot projects, based on models and protocols developed in the first pilot, using other biomonitoring markers, including blood and urine, by January 1, 2007.

Requires DHS to appoint an advisory committee of experts to assist the department in designing and implementing the program.

Creates the Healthy Californians Biomonitoring Fund in the State Treasury, containing revenues collected from an additional tax on the distribution of cigarettes and tobacco products at the rate of 0.5 mills for each cigarette distributed.

Status: Held under Submission in the Senate Appropriations Committee - Two Year Bill

SB 774 (Vasconcellos) – Hypodermic Needles and Syringes

Permits a pharmacist, who works for a pharmacy that is registered for the Disease Prevention Demonstration Project (DPDP), to furnish without a prescription 30 or fewer hypodermic needles and syringes at any one time to a person 18 years of age or older. Sunsets this provision on December 31, 2007.

Establishes the DPDP, a collaboration between pharmacies and local and state health officials, to evaluate the long-term desirability of allowing licensed pharmacies to furnish or sell non-prescription syringes to prevent the spread of blood-borne pathogens, including HIV and hepatitis C.

Requires the Office of AIDS to convene an uncompensated evaluation advisory panel as specified, to evaluate the effects of this bill, and to provide a report to the Governor and Legislature on or before January 15, 2007. Makes the requirements of this provision subject to the availability of federal or private funds. Requires the report to include, but not be limited to, the effect of non-prescription syringe and needle sales on the following:

- Hypodermic needle and syringe sharing practice among those who inject illegal drugs.
- Rates of disease infection caused by syringe and needle sharing.
- Needlestick injuries to law enforcement officers and waste management employees.
- Drug crime or other crime in the vicinity of pharmacies.
- Safe or unsafe discard of used needles and syringes.
- Rates of injection of illegal drugs.

Requires local health departments to do all of the following:

- Maintain a list of pharmacies within the local health jurisdiction that have registered under the DPDP.
- Provide pharmacies with written information that can be reproduced and provided at the time of furnishing nonprescription syringes and needles that includes: local options for accessing drug treatment; local options for accessing testing and treatment for HIV and hepatitis C; local options for safe disposal including, if available, the locations of authorized needle exchange programs, home-generated sharps consolidation, or medical waste generators for disposal as specified.
- Cooperate with the state Office of AIDS in collection and analysis of data.

Requires a pharmacy, in order to furnish or sell non-prescription syringes, to do all of the following:

- Register with the local health departments and certify that it will provide at the time of furnishing of needles and syringes written or oral information as specified above.
- Store hypodermic needles and syringes so that they are available only to authorized personnel, and not openly available to customers.
- Provide one or more safe syringe disposal programs, as specified.

Status: Vetoed by the Governor

SB 875 (Escutia) – Child and Parental Nutrition

Makes findings and declarations, including that: obesity and chronic disease rates in California have skyrocketed over the past 30 years; pregnant women and new mothers are especially at risk for health problems; and young children are suffering from type 2 diabetes, high cholesterol, high blood pressure, heart disease, and cancer due to poor eating habits and lack of physical activity.

Requires the Department of Health Services (DHS) to develop a brochure to educate pregnant women and new parents about the importance of both eating a diet rich in fruits and vegetables and daily physical activity to maintain a healthy lifestyle and prevent chronic diseases.

Requires that this brochure specifically address how proper nutrition and exercise help prevent chronic disease, and the importance of fruits and vegetables in the diet of new mothers.

Requires DHS to include this brochure on their web site.

Requires the brochure to be available in both English and Spanish and to be distributed as follows:

- By DHS to each individual who contacts the BabyCal program and receives a package of information from the program.
- By a provider to each participant in the Access for Infants and Mothers program one time during the participant's pregnancy.

Requires that these activities be implemented only to the extent that federal or private funding is available for this purpose.
Status: Chapter 879, Statutes of 2003

SB 1081 (Health & Human Services Committee) – Blood Donors: State Donor Deferral Register

Deletes from existing law the requirement that the Department of Health Services (DHS) maintain the Donor Deferral Register (DDR).

Deletes requirements that physicians and hospitals report individuals with confirmed AIDS cases and carriers of viral hepatitis to DHS for inclusion of these persons in the DDR and deletes requirements that blood banks and plasma centers report cases of viral hepatitis to DHS for inclusion of these persons in the DDR.

Requires a physician, hospital or other health care provider to report all AIDS cases, HIV infection and viral hepatitis infections, including transfusion-associated cases or infections, to the local health officer with the information required, and within the time frames established by DHS pursuant to existing state regulations, which, among other things, require reporting HIV infections by non-name code.

Requires local health officials, upon receipt of a report of transfusion-associated hepatitis or transfusion-associated HIV or AIDS cases, to identify which blood bank or plasma center is the source of the infectious blood or blood components and report this finding to that blood bank or plasma center. Requires the blood bank or plasma center to investigate the donor source of the infectious blood.

Requires local health officers, instead of county health departments or DHS, to contact all persons with confirmed cases of HIV to suggest appropriate treatment alternatives and for epidemiological studies and follow-up.

Deletes obsolete language relating to blood donors and disease reporting requirements and updates existing donor notification materials required to be signed by the donor regarding testing of the donor's blood.

Includes within the definition of "public entity," a local health officer for purposes of existing law, which grants immunity from liability for an inadvertent, accidental or unintentional disclosure of the results of an HIV test or for any damages resulting from the notification of test results.
Status: Chapter 419, Statutes of 2003

AB 83 (Corbett) – Bottled Water

Transfers the provisions, under current law relating to the licensure and regulation of persons engaged in bottled and vended water activities from the Sherman Law to the Safe Drinking Water Act (SDWA).

Requires bottled water licensees to comply with provisions similar to those imposed on public water systems regarding emergency notification plans, consumer confidence reports (CCRs), and annual inspections.

Revises the annual fee license schedule to reflect cost-based reimbursement and creates the Safe Bottled and Vended Water Account in the General Fund, comprised of fees based on the Department of Health Services' (DHS) costs in conducting these activities, from which moneys would be expended for purposes of administering the above provisions.

Requires DHS, by July 1, 2005, to adopt regulations that establish appropriate penalties for multiple violations, including, but not limited to, written warnings, increased inspection frequency, suspension of license, revocation of license, monetary penalties, or permanent removal of a water-vending machine from service.

Maintains the federal requirements relating to bottled water by requiring that any person who processes, packages, distributes, transfers, or stores bottled water or vended water continue to comply with all manufacturing processes required by federal law.

Requires bottled and vended water to meet all maximum contaminant levels (MCLs) set for public drinking water by DHS in order to ensure that bottled water presents no significant adverse effect on public health.

Requires a licensee to notify DHS and notify consumers as required by DHS, if specified standards are not met or the licensee fails to take certain steps in compliance with the act such as exceedence of any MCL set for public drinking water, failure to carry out any DHS-mandated monitoring, or failure to comply with the conditions of any variance.

Prohibits DHS from issuing a license or a variance to any bottled or vending water operation unless it has an approved emergency notification plan or has been provided an exemption by DHS that serves the "public interest."

Requires each licensee to establish, or utilize, an existing toll-free, multilingual telephone hotline for consumers to request additional information regarding water quality, CCRs, and information from local health departments regarding the quality of bottled water, if applicable. A water vending machine licensee may use a local telephone number instead.

Requires as a condition of licensure, each licensee to prepare a consumer confidence report according to DHS' most recent guidelines, and specifies the contents for the annual CCR, which shall be available to the consumer and posted on DHS' website. The report shall include the source of the bottled or vended water, the definitions of MCLs, primary drinking water standards and public health goals, a report on any regulated contaminant found in the water over the past year, the contact information for additional consumer information, and a disclosure of any variance granted to the licensee by DHS.

Specifies that the CCR must also have information in Spanish, and any other language of a population that exceeds 10 percent of the state's population based on current United States Census data, stressing the importance of the report or offering additional information, as determined to be necessary by DHS.

Specifies certain labeling requirements in both English and Spanish for vended water containers or machines.

Requires bottled water, beginning July 1, 2004, sold at retail or wholesale in this state in a plastic beverage container to place on its label the source of the bottled water and a "California Water Quality Notice" to include the statement telling consumers where they may get more information about the products.

Requires each licensee to reimburse DHS for actual enforcement costs incurred by DHS for specified enforcement actions.

Makes any failure to comply with the inspection provisions a misdemeanor.

Provides that in any civil action brought by DHS for enforcement purposes, the prevailing party shall be awarded litigation costs.

Makes certain findings relating to the differences between the way drinking water is regulated by DHS under the SDWA and the Sherman Law.
Status: Held on the Senate Floor, Failed Passage, Reconsideration Granted - Two Year Bill

REALIGNMENT

AB 1716 (Human Services) – Local Revenue Fund: Allocations

Changes the allocation of sales tax growth revenues within the realignment Local Revenue Fund and establishes a mechanism to restore the base level of funding for each county's social services account in the county's health and welfare trust fund to the level of the 2001-02 fiscal year, for the 2003-04 budget year. States that if there are not sufficient funds in sales tax growth to cover the entire shortfall in the base during 2003-04, that subsequent years' sales tax growth would be used until the entire amount is offset.

Stipulates that it is the intent of the Legislature to develop recommendations on realignment by April 1, 2004, including the best means of financing realigned social services, mental health services and health services to ensure program stability and minimize tension between caseload and non-caseload driven programs.
Status: Chapter 450, Statutes of 2003

SCHOOL HEALTH

SB 267 (Knight) – Abstinence Education

Defines abstinence education program as an educational or motivational program that has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.

Defines abstinence education program as a program that includes the following teachings, among others:

- Abstinence from sexual activity outside marriage as the expected standard for all school-age children.
- Abstinence from sexual activity as the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems.
- A mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity.
- How young people may reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances.

Requires the Department of Human Services (DHS) to develop and implement a program of abstinence education. Requires DHS to implement the abstinence education program in a manner to maximize federal financial participation under all applicable federal law and regulations. Requires DHS to adopt regulations to implement this law.
Status: Failed Passage in the Senate Health and Human Services Committee, Reconsideration Granted – Two Year Bill

TOBACCO

SB 676 (Ortiz) – Tobacco Manufacturers: Health Care Costs of Smoking

Finds and declares that: smoking costs California's economy $15.8 billion annually; direct medical costs of $8.6 billion are associated with smoking; and nearly 17% of Medi-Cal costs are caused by smoking. Finds that the tobacco industry denied, but was aware of, the addictive nature and destructive health effects of tobacco products, and finds it appropriate that the manufacturers be held financially liable for the harm caused by their product.

Imposes a fee of unspecified rate on tobacco manufacturers whose products have contributed to tobacco-related illnesses. The Department of Health Services is directed to establish fees for each manufacturer based on the manufacturer's market share and the annual costs to state and local government for the treatment of tobacco-caused diseases. The fee would be reduced by any amount paid by the manufacturer in tobacco-related taxes, federal legislation or tobacco-related lawsuits. The Department of Human Services would be required to adjust the fee annually to reflect changes in state costs, manufacturer's market share and tobacco-related taxes and fees.

Status: Held in the Senate Revenue And Taxation Committee – Two Year Bill

AB 71 (Jerome Horton) – Tobacco Products: Licensing for Tax Purposes

Creates the California Cigarette and Tobacco Products Licensing Act of 2003 (Act) to provide for the licensure by the Board of Equalization (BOE) of manufacturers, distributors, wholesalers, importers and retailers of cigarette or tobacco products that are engaged in business in California.

Requires a retailer to have and maintain a license to sell cigarettes or tobacco products. A separate license is required for each location owned or controlled by a retailer. Requires a retailer to apply for the license and pay a one-time fee of $100 per license in order to engage in the sale of cigarettes or tobacco products and authorizes the BOE to investigate the background of the applicant and review the application prior to issuing a license.

Requires a wholesaler or distributor to apply for the license, pay an annual fee of $1,000 per license in order to engage in the sale of cigarettes or tobacco products and authorizes the BOE to investigate the background of the applicant and review an application prior to issuing a license.

Requires a manufacturer or importer to apply for a license in order to engage in the sale of cigarettes and authorizes the BOE to conduct an inquiry to determine if the applicant complies with the provisions of the Act. Manufacturers and importers must pay an administration fee of $.01 per package of cigarettes manufactured and shipped into the state or imported into the state during 2001.

Establishes criteria for denying a license application by retailers, distributors and wholesalers that are limited to: (a) suspension or revocation by the BOE of a previous license issued under the Act, (b) felony violations of revenue and taxation code provisions related to the stamping of cigarettes, (c) felony evasion of lawfully determined cigarette or tobacco product taxes, and (d) failure to possess all required permits or licenses required under the Revenue and Taxation Code (for retailers).

Establishes criteria for mandatory revoking of a license for retailers, distributors and wholesalers that are limited to: (a) felony violations of revenue and taxation code provisions related to the stamping of cigarettes, (b) felony evasion of lawfully determined cigarette and tobacco taxes, and (c) previous revocation of a permit or license under any provision of the Revenue and Taxation Code.

Allows the BOE to revoke or suspend a license for any violations of the Act or other Revenue and Taxation Code sections related to cigarette and tobacco products. In addition, the BOE may levy a civil penalty for violations of the Act.

Requires the Bureau of State Audits to conduct a performance audit of the licensing and enforcement provisions of this bill and report to the BOE and the Legislature by July 1, 2006.

Requires BOE to suspend a retailer's license for four convictions of sales to underage buyers within 24 months and to revoke a license for eight violations within 24 months. This provision applies only if the State Department of Health Services survey indicates that underage sales were made to 13 percent or more of its sample. Adds or increases penalties and provides additional enforcement authority to BOE and the state Department of Justice (DOJ).

Requires licensees to retain invoices and/or purchase records for cigarettes and tobacco products for a specified period and make available these invoices for inspection by the BOE or a law enforcement agency. Allows the BOE or a law enforcement agency to seize cigarettes that do not have the proper revenue stamp or for which taxes are due but not paid.

Prohibits manufacturers from selling cigarettes to any distributors, wholesalers or retailer who does not possess a license. Prohibits importers, distributors, wholesaler and retailers from purchasing cigarettes unless they possess a license. Any violations are a misdemeanor.

Creates the Cigarette and Tobacco Products Compliance Fund. All license fees and penalties collected pursuant to this division shall be deposited in the Fund.

Appropriates $11 million from the fund to the BOE with approximately half being available for reimbursement to DOJ for investigation and enforcement assistance.

Requires a manufacturer or importer, as a condition of obtaining a license, to certify that it is a participating manufacturer as defined in the Master Settlement Agreement or is complying with state law for non-participating manufacturers, in particular setting aside a specified amount of money into an escrow account for settling of judgements or claims.

Manufacturers shall provide a listing of all brands to the Attorney General who shall publish on its web site a directory listing of all brand families. A tobacco stamp cannot be affixed to a package of cigarettes that is not listed and the sale or importation of such cigarettes is illegal.

Requires the BOE to report to the Legislature by July 1, 2004, a report on the actual costs incurred by cigarette distributors to apply tax stamps to the product.

Provides that this act does not preempt or supercede any local tobacco control law or ordinance other than those laws or ordinances that are related to the collection of state taxes.

Prohibits stamping or selling of cigarettes made by manufacturers who are not part of the Master Settlement Agreement or payers into the escrow account.
Status: Chapter 890, Statutes of 2003