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California State Assembly

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MIA BONTA
CHAIR

AGENDA

Tuesday, April 16, 2024
1:30 p.m. -- 1021 O Street, Room 1100

Bills heard in file order
Testimony may be limited: 2 witnesses per side, 2 minutes each

1.	AB 1799	Jackson	Public health: annual state of public health in California.
2.	AB 1895	Weber	Public health: maternity ward closures.
3.	AB 1936	Cervantes	Maternal mental health screenings.
4.	AB 1975	Bonta	Medi-Cal: medically supportive food and nutrition interventions.
5.	AB 2063	Maienschein	Health care coverage.
6.	AB 2066	Reyes	The California Food Safety Act.
7.	AB 2072	Weber	Group health care coverage: biomedical industry.
8.	AB 2098	Garcia	California Health Facilities Financing Authority Act: nondesignated hospitals: loan repayment.
9.	AB 2105	Lowenthal	Coverage for PANDAS and PANS.
10.	AB 2119	Weber	Mental health.
11.	AB 2131	Valencia	Certified nurse assistant training programs.
12.	AB 2340	Bonta	Medi-Cal: EPSDT services: informational materials.
13.	AB 2376	Bains	Chemical dependency recovery hospitals.
14.	AB 2434	Grayson	Health care coverage: multiple employer welfare arrangements.
15.	AB 2449	Ta	Health care coverage: qualified autism service providers.
16.	AB 2466	Wendy Carrillo	Medi-Cal managed care: network adequacy standards.
17.	AB 2490	Petrie-Norris	Reproductive Health Emergency Preparedness Program.
18.	AB 2650	Zbur	Licensed adult residential facilities and residential care facilities for the elderly: data collection.
19.	AB 2680	Aguiar-Curry	Alzheimer’s disease.
20.	AB 2775	Gipson	Emergency medical services.
21.	AB 2859	Jim Patterson	Emergency medical technicians: peer support.
22.	AB 2866	Pellerin	Pool safety: State Department of Social Services regulated facilities.
23.	AB 2956	Boerner	Medi-Cal eligibility: redetermination.
24.	AB 2960	Lee	Sexually transmitted diseases: testing.
25.	AB 2995	Jackson	Public health: alcohol and drug programs: definitions.
26.	AB 3149	Garcia	Promotores Advisory and Oversight Workgroup.
27.	AB 3221	Pellerin	Department of Managed Health Care: review of records.
28.	AB 3260	Pellerin	Health care coverage: reviews and grievances.
29.	AB 3271	Joe Patterson	Pupil health: opioid antagonists.
30.	AB 3275	Soria	Health care coverage: claim reimbursement.

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1799 (Jackson) – As Introduced January 8, 2024

SUBJECT: Public health: annual state of public health in California.

SUMMARY: Requires the State Public Health Officer (PHO) to include the impact of racism, if any, on the information and data submitted in their written report to the Governor and the Legislature on the State of Public Health in California.

EXISTING LAW requires the PHO, on or before February 1 of every other year, to submit a report to the Governor and Legislature on the state of public health in California and requires the report to include, among other things, information on health disparities, as specified, and data on the prevalence of morbidity and mortality related to mental illness and substance abuse [Health and Safety Code § 101320.3]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, racism is a public health crisis and any real conversation on public heath must include the impact of racism on the causes of health inequities, health disparities, and disease. The author continues that countless studies show the clear inequality and the negative impacts racism has on health outcomes in the Black community and other communities of color. This bill ensures the Administration and the Legislature are educated on how systemic racism is a root cause of racial and ethnic health inequities that harm the Black community and communities of color. The author concludes that this bill is intended to promote future legislation that is data-driven and will support the elimination of racial disparities in health outcomes.

2) **BACKGROUND.**

   a) **The State of Public Health Report.** SB 184 (Committee on Budget), Chapter 47, Statutes of 2023 requires the PHO, on or before February 1 of every other year, to submit a written report to the Governor and both houses of the Legislature on the state of public health in California, and requires the PHO to present an update annually to the Assembly and Senate Budget Committees, or relevant subcommittees, during legislative budget hearings. SB 184 requires this annual report to include specified data, including: information on public health indicators, health disparities, leading causes of morbidity and mortality, and incidence and prevalence of communicable and non-communicable chronic diseases and conditions, intentional and unintentional injuries, suicide, gun violence, mental illness and substance use disorders. SB 184 requires the Department of Public Health (DPH) to annually seek input from stakeholders, including legislative staff, on the contents of the required report.

   According to DPH, the California State of Public Health Report supported by the Future of Public Health investment. The report uses multiple health measures and data sources to highlight the major trends and disparities in health outcomes across California while

presenting opportunities, partnership, and collaboration to improve population health. This report is part of the broader State Health Assessment and Improvement Plan processes, and joins a host of DPH reports and resources, including the Office of Health Equity's Demographic Report on Health and Mental Health Equity, that contribute to governmental public health's foundational function of surveillance, monitoring, and response, while also providing perspectives on health outcomes and core determinants of health to inform public health action, accountability, and impact.

b) The Inaugural State of Public Health Report. This year, 2024, marks the inaugural State of Public Health Report. The report finds that there have been major improvements in health and well-being over the past 20 years; however, there are significant opportunities to reduce health inequities and address emerging public health concerns, including behavioral health, and the structural and social determinants of health. Some of the key findings include:

i) Racial and ethnic disparities are observed in specific health outcomes and exposures early in life, such as infant and pregnancy-related mortality and Adverse Childhood Experiences (ACEs). Structural racism, living in a high poverty neighborhood, housing insecurity, lack of access to culturally responsive and quality health care, nutrition insecurity, mental health challenges, and substance use are key drivers of poor health outcomes during pregnancy, birth, and childhood.

ii) Infant and pregnancy-related mortality are important indicators of overall community health. Although California has some of the lowest infant and pregnancy-related mortality rates in the nation, Black infants and families experience significant disparities in perinatal outcomes. Infant mortality rates are also significantly higher in neighborhoods with higher rates of poverty.

iii) ACEs are associated with immediate and long-term negative health outcomes, such as behavioral health challenges and chronic disease. American Indian and Alaska Native, Pacific Islander, and Black Californians reported higher rates than other groups.

iv) Congenital syphilis cases reached their highest levels in 30 years in 2022, consistent with national trends. Cases were more common among parents receiving late or no prenatal care, using methamphetamine and injection drugs, experiencing homelessness or unstable housing, and/or having been incarcerated within the prior 12 months.

v) Black males experienced a homicide rate more than eight times greater than the overall rate, and nearly 18 times greater than the overall rate among younger age groups. The homicide death rate for Black young adult males was higher than any cause of death for children, youth, and young adults of all race and ethnic groups. There was also a high homicide burden among Latino individuals (about half of all homicide deaths.

vi) The total number of suicides was highest among white individuals, accounting for 58% of all suicide deaths in California in 2022.

(1) There are a range of factors that can increase risk of suicide death including easy access to lethal means, stigma associated with seeking help, health conditions linked to chronic pain, lack of access to health care and services, job loss or financial problems, bullying, loss of relationships, and social isolation.

(2) Exposure to ACEs is associated with an increased risk for suicide, increasing risk up to 30 times higher for adults who experienced four or more ACEs compared to those who had not experienced ACEs.

vii) Social determinants, such as community conditions, contribute to disparities in cardiovascular disease risk and mortality, including prevalence of risk factors such as obesity and diabetes among households with lower incomes, and Black, Latino, and Pacific Islander individuals.

The State of Public Health Report also highlights that there are over 200 DPH and local programs and initiatives underway to address the health conditions and disparities described throughout the report. The throughline to a successful statewide support for community health and safety is the intentional application of equity-focused prevention and intervention approaches positioned upstream. Some examples include:

(1) Healthy pregnancy and child development such as the California Home Visiting and Women, Infants, and Children programs that link families to social supports, wraparound services, as well as, education (e.g., nutrition and breastfeeding) and coping services.

(2) Culturally responsive health promotion and education that raises awareness, reduces stigma, and catalyzes social norm and behavior change, such as the Children and Youth Behavioral Health Initiative and Opioid Use and Overdose Prevention Initiative.

(3) Community-developed solutions to advance mental health equity, as demonstrated by the California Reducing Disparities Project.

(4) Policy, systems, and environmental change strategies to improve community conditions and increase access to healthy foods, walkable neighborhoods, and limit exposure to tobacco smoke and products (e.g., the California Tobacco Prevention Program and Safe Streets and Roads for All).

(5) Data and surveillance to identify high burden health conditions and effectively allocate resources, as well as, to identify, implement, and evaluate policies and strategies.

(6) Licensing and certifying health care facilities, agencies, and qualified providers to ensure provision of high-quality care.

(7) Trauma-informed and accessible screening, testing, and linkages to care for HIV, sexually transmitted infections, and the hepatitis C virus.

(8) Multisector partnerships and a whole-of-government approach to address complex public health problems and achieve health equity.

c) Health effects of structural racism. A Presidential Advisory published in *Circulation*, the American Heart Association's journal, notes that structural racism inequitably limits opportunities for social, economic, and financial advancement, which in turn results in a complex interplay among race, social determinants, and health that has negative consequences. Structural racism concentrates power among privileged groups and devalues populations whose health needs to be equitably improved, in particular, Black Americans who are also subjected to the ills of anti-Black racism. For example, regardless of socioeconomic position, Black people continue to experience striking disparities in cardiovascular disease (CVD) morbidity and mortality. Higher socioeconomic status does not protect Black people from the impact of structural racism and its health effects. For example, in comparison with college-educated White people, college-educated Black people are more likely to experience unemployment and have lower wealth at every level of income.

The experience of racism results in chronic discrimination, stress, and depression that adversely impact persons from historically marginalized populations. Adverse childhood, and adult experiences, as well, attributable to racism and community violence can result in the phenomenon called toxic stress. Furthermore, excessive activation of the stress response system can lead to long-lasting and cumulative damage to the body and brain. This response is described in the weathering hypothesis, which can be captured using measures of allostatic load, and which has been used to explain the effect of socioeconomic disadvantage on deteriorating health in early adulthood among Black populations. For example, stress and stress-related hormones can cause maladaptive changes in gene expression and structural and functional remodeling of brain regions involved in memory and self-regulation, including the hippocampus, amygdala, and prefrontal cortex.

The COVID-19 pandemic has highlighted the disproportionate consequences of structural racism among persons who are Black, Hispanic/Latino, and American Indian/Alaska Native. They not only make up a higher proportion of essential workers, who are preferentially exposed to this easily transmitted virus, but they also have a higher prevalence of underlying medical conditions that raise the risk for severe reactions, hospitalization, and death attributable to COVID-19.

The intersection between the social determinants of health and disparities by race/ethnicity is rooted in structural racism that results in uneven access to quality schools, good-paying jobs, higher incomes, wealth accumulation, better neighborhoods, health insurance, and quality medical care.

There is a clear and direct association between socioeconomic position and health outcomes. Educational attainment, household income, residential environment, and access to health care help to explain more of the disparities in CVD mortality than traditional cardiovascular risk factors.

On average, individuals from historically marginalized groups, Black, Hispanic/Latino, and American Indian/Alaska Native people, in particular, are more likely to have lower

high school graduation rates, individual and household incomes below the federal poverty level, and lack insurance and regular access to quality primary care, because of structural racism. However, the literature examining structural racism and its effects on health is not sufficient.

3) **SUPPORT.** According to the California Academy of Child & Adolescent Psychiatry, the inclusion of racism as a factor in the state's public health reporting is crucial for developing a comprehensive understanding of the health disparities affecting our communities and for guiding equitable public health strategies and interventions. This bill would ensure that the PHO's report reflects the multifaceted nature of public health challenges in California. By acknowledging the impact of racism, the report can better address the root causes of health disparities, including those related to mental illness and substance abuse, which are of particular concern to our members and the populations they serve.

4) **PREVIOUS LEGISLATION.** SB 184 requires on or before February 1 of every other year, beginning in calendar year 2024, the PHO to submit a written report to the Governor and the Legislature on the state of public health in California.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Child and Adolescent Psychiatry
National Association of Social Workers California

Opposition

None on file.

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1895 (Weber) – As Amended March 18, 2024

SUBJECT: Public health: maternity ward closures.

SUMMARY: Requires a general acute care hospital (GACH) that provides maternity services and determines those services are at risk of closing in the next 12 months to report specified information to the State Department of Health Care Services (DHCS), the Department of Health Care Access and Information (HCAI), the State Department of Public Health (DPH), and the Chairs of the Senate and Assembly Committees on Health. Specifically, **this bill**:

1) Requires a GACH that offers the supplemental service of maternity services that determines those services are at risk of closure in the next 12 months, as determined by the hospital pursuant to the factors described in 3) below, to report the following information to DHCS, HCAI, DPH, the Chairs of the Senate and Assembly Committees on Health:
   a) The number of medical staff and employees working in the maternity ward;
   b) The number of deliveries per month over the past 12 months at the maternity ward;
   c) The number of patients served over the past 12 months who have commercial insurance;
   d) The number of patients served over the past 12 months who had Medi-Cal or Medicare; and,
   e) The hospital's prior and projected performance on financial metrics from the past 12 months.

2) Requires the information provided pursuant to 1) above to be kept confidential to the extent permitted by applicable law.

3) Requires a GACH, when assessing the risk of closure of maternity services, to consider factors, including, but not limited to, financial distress, workforce shortages, decreased demand in services, and birthing volume.

4) Requires HCAI, in conjunction with DPH, to conduct a community impact assessment regarding the closure. Requires the community impact assessment to determine the three closest hospitals offering maternity services in the geographic area, and their distance from the at-risk facility. Requires the community impact assessment to be completed within six months of notice from the hospital that the maternity services are at risk of closure. Requires the community impact assessment to be provided to the public with the public notice described in 5) below.

5) Requires, if the maternity services of a GACH are at risk of closure, the GACH to provide public notice of the potential closure, including the results of the community impact assessment described in 4) above, and the information required in 6) of existing law below. Requires the public notice to be posted on the GACH's internet website 90 days in advance of the proposed closure. Requires the public to be permitted to comment on the potential closure for 60 days after the notice is given, and within this period at least one noticed public hearing shall be conducted by the GACH, and for the GACH to also accept written public comment.

EXISTING LAW:

1) Licenses and regulates hospitals, including GACHs, DPH. Permits GACHs, in addition to the basic services all hospitals are required to offer (medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services), to be approved by DPH to offer special services, including, among other services, an emergency department (ED) and maternity services. [Health and Safety Code [HSC] §1250 and §1255, *et seq*.]

2) Requires EDs, under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and also under similar provisions of state law (state EMTALA), to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay. Federal EMTALA imposes this requirement on any hospital that participates in Medicare. State EMTALA imposes this requirement on any hospital that operates an ED. [42 United States Code §1395dd; HSC §1317]

3) Requires any hospital that provides emergency medical services (EMS) to provide notice of a planned reduction or elimination of the level of EMS to DPH, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital, as soon as possible but not later than 180 days prior to the planned reduction or elimination of emergency services. Requires the hospital to also provide public notice, within the same time limits, in a manner that is likely to reach a significant number of residents of the community serviced by that facility. [HSC §1255.1]

4) Specifies that a hospital is not subject to the notice requirements in 3) above if DPH determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole, or if DPH cites the emergency center for unsafe staffing practices. [HSC §1255.1(c)]

5) Requires a health facility implementing a downgrade or change to make reasonable efforts to ensure that the community served by its facility is informed of the downgrade or closure, including advertising the change in terms likely to be understood by a layperson, soliciting media coverage regarding the change, informing patients of the facility of the impending change, and notifying contracting health plans. [HSC §1255.2]

6) Requires a health facility providing public notice of the proposed closure or elimination of a supplemental service to include the following information:
   a) A description of the proposed closure, elimination, or relocation. Requires the description to be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable;
   b) A description of the three nearest available comparable services in the community. Requires, if the health facility closing these services serves Medi-Cal or Medicare patients, this health facility to specify if the providers of the nearest available comparable services serve these patients;
   c) A telephone number and address for each of the following, where interested parties may offer comments:
      i) The health facility;
      ii) The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility; and,

iii) The chief executive officer. [HSC §1255.25]

7) Permits a health facility license holder, with the approval of DPH, to surrender its license or special permit for supplemental service for suspension or cancellation by DPH. Requires DPH, before approving a downgrade or closure of emergency services, to receive a copy of an impact evaluation by the county to determine impacts of the closure or downgrade on the community. Permits the county to designate the local EMS agency (LEMSA) as the appropriate agency to conduct the impact evaluation. Requires development of the impact evaluation to incorporate at least one public hearing, and requires the impact evaluation and hearing to be completed within 60 days of the county receiving notification of intent to downgrade or close emergency services.
[HSC §1300]

8) Requires a GACH, not less than 120 days prior to closing the facility, or 90 days prior to eliminating a supplemental service, or relocating a supplemental service to a different campus, to provide public notice, containing specified information, of the proposed closure, elimination, or relocation, including a notice posted at the entrance to all affected facilities and a notice to DPH and the board of supervisors of the county in which the health facility is located. [HSC §1255.25]

9) Excludes county facilities from the public notice requirements of 7) above, as county facilities are subject to separate provisions of law requiring counties to provide public notice and public hearings when proposing to eliminate or reduce the level of medical services provided by a county, or when selling or transferring management of these service. This process is known as the Beilenson Act. [HSC §1442.5]

10) Establishes HCAI in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [HSC §127000, *et seq*.]

11) Defines supplemental service to mean an organized inpatient or outpatient service which is not required to be provided by law or regulation. [Section 70067, Article 1, Chapter 1, Division 5, Title 22 of the California Code of Regulations]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal Committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, last November, *CalMatters* published an article on the issue of maternity ward closures. In that story, they found that between 2012 and 2019, at least 19 California hospitals stopped offering labor and delivery services. Six of those hospitals closed completely. That number rose when sixteen more hospitals closed their maternity wards between 2020 and 2022. Under current law, the state is only notified once a decision to close a maternity unit has already been made. Without prior notification, the state has no opportunity to intervene when possible, or consider these facts when making policy and budget decisions.

2) BACKGROUND.

a) Supplemental Services. With some exceptions, GACHs are required to provide eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary. Beyond these basic services, hospitals can be authorized to offer supplemental services, including outpatient services such as emergency services, or inpatient services such as intensive care, cardiovascular surgery, maternity, and a psychiatric unit, among others.

b) Increasing Maternity Unit Closures. On November 15, 2023, *CalMatters* published an investigative story focusing on the increase in maternity unit closures in California, titled "As Hospitals Close Labor Wards, Large Stretches of California Are Without Maternity Care." According to this report, from 2012 to 2019, at least 19 hospitals stopped offering labor and delivery services (six of those were because the hospitals closed completely). In an acceleration, 16 more closed maternity services from 2020 to 2022. By the time of publication, 11 more had announced maternity closures in 2023, including one hospital that completely closed (Madera Community Hospital). *CalMatters* reported that after El Centro Regional Medical Center closed its maternity service in January of 2023, Imperial County was left with only one hospital doing births for the approximately 2,500 babies born every year in Imperial County. In total, according to the *CalMatters* analysis, at least 46 California hospitals have shut down or suspended labor and delivery since 2012, and 27 of those have taken place in the last three years. Twelve rural counties do not have any hospitals delivering babies, and Latino and low-income communities have been hit hardest by losses. *CalMatters* noted that the closures come as the country and state contend with a maternal mortality crisis, with pregnancy-related deaths reaching a ten-year high in 2020 in California.

The *CalMatters* report stated that hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, and declining birth rates. In the past 30 years, the number of births have dropped by half in California, and the birth rate is at its lowest level on record. *CalMatters* noted that the trend is not unique to California, with labor and delivery units closing across the country. Many closures result from hospital systems consolidating maternity care into one location, which hospitals argue can help maintain staff training and provide a higher level of care. According to *CalMatters*, labor and delivery units are often the second-most expensive department for hospitals to run, second only to emergency rooms, and quoted a health researcher as stating that obstetrics units are often unprofitable for hospitals to operate.

As recently as February 8, 2024, Adventist Health Simi Valley announced it was closing its labor and delivery department and neonatal intensive care unit effective May 8, 2024. Adventist stated that births had declined by 25% at the hospital and it could no longer sustain the service. Adventist noted that Ventura County births dropped from 19 per 1,000 in 1990 to 10.5 per 1,000 in 2021.

c) Effects of Maternity Ward Closures. A 2018 study published by the *Journal of the American Medical Association* showed that rural counties not adjacent to urban areas fare the worst with the loss of hospital-based obstetric services. For these counties, maternity ward closures were associated with increases in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year. The latter "emergency

births" in unprepared facilities also occurred in urban-adjacent counties. The Association of State and Territorial Health Organizations notes that the effect of hospital closures goes well beyond isolated negative health consequences, including the exacerbation of poor socioeconomic conditions, job loss, transportation barriers, and overall higher health care costs for disadvantaged communities. A study set for publication in April 2024 shows that obstetric closures have a nuanced impact on communities, depending on the size and rurality of the community. For example, in far northern counties, birthing people take the understood risk of giving birth while making the long drive to their obstetric facility. Others, in more urban communities may face other negative impacts not otherwise revealed without a specific impact assessment.

d) Current Process for Closing an ED Requires an Impact Evaluation. Under existing law, while most supplemental services only require a 90 day notice, hospitals are required to provide at least a 180 day notice prior to a planned reduction or elimination of the level of EMS to DPH, the local health department, and all health plans or other entities under contract with the hospital to provide services to enrollees. A separate provision of law, which permits a hospital to surrender a license or permit with the approval of DPH, specifies that "before approving a downgrade or closure of emergency services," the county or the LEMSA is required to conduct an impact evaluation of the downgrade or closure upon the community, and how that downgrade or closure will affect emergency services provided by other entities. This impact evaluation is required to incorporate at least one public hearing, and must be done within 60 days of DPH receiving notice of the intent to downgrade or close emergency services. Despite the language stating "before approving a downgrade or closure of emergency services," DPH has not interpreted this provision of law as giving them the ability to deny a hospital the ability to close or reduce emergency services, and therefore the impact evaluation is more of a tool to help the community and the local emergency services agency prepare for the reduction or closure.

This bill would implement a similar process, requiring HCAI, in conjunction with DPH, to conduct a community impact assessment regarding the closure of a maternity ward. The author has requested $1.5 million from the General Fund for the staffing and administration of this bill.

3) SUPPORT. American College of Obstetricians and Gynecologists (ACOG), Black Women for Wellness Action Project, California Nurse Midwives Association, and Reproductive Freedom for All California are the cosponsors of this bill. The cosponsors note that GACHs that offer basic and specialty maternity services provide needed obstetric care for most women who are giving birth in California, as well as the rest of the United States. They often provide maternity care in rural and underserved communities, which offers the benefit of keeping women with low- or moderate-risk pregnancies in their local communities. The closure of maternity wards not only diminishes access to essential prenatal and postnatal care but also poses significant risks to the health and safety of expectant mothers and their newborns. Without local access to these vital services, pregnant women are forced to travel long distances for care, which can lead to delays in receiving necessary medical attention. This is particularly concerning in cases of high-risk pregnancies or emergency situations where every moment is crucial. Moreover, the closure of labor and delivery units can exacerbate health disparities, especially in rural and underserved communities. These areas already face significant obstacles in accessing health care services, and the loss of local maternity wards further increases the risk of adverse birth outcomes, including preterm births

and low birth weight. The ripple effects of such closures extend beyond immediate health concerns, impacting the overall well-being and socioeconomic stability of communities.

The cosponsors conclude that requiring facilities to report on the number of births, staffing levels, and fiscal condition will provide valuable data to better understand the challenges the labor and delivery units face and will enable targeted interventions to support the sustainability of labor and delivery units and ensure that every family has access to safe, quality maternal care.

4) **CONCERNS.** The California Hospital Association (CHA) states that they have concerns with this bill. CHA notes that CHA supports transparency and understands the desire for earlier notification on Labor and Delivery (L&D) closures. However, hospitals already provide a 90 day public notification and a 90 day notification to DPH when closing or reducing a service. CHA is concerned that notification of potential closures would exacerbate the existing challenges as health care providers and staff leave their jobs after learning that a facility is at risk of closure and prospective patients would be dissuaded from seeking care at a facility that may close, resulting in diminished patient volume. Hospitals typically do not know 12 months in advance that they may need to close an L&D unit. There are many factors hospitals must consider when making this difficult decision; however, it is often an unforeseen circumstance that ultimately pushes the hospital to decide to close its L&D unit. Finally, CHA states that most of the data that hospitals would be required to report is data that they already report to HCAI on an annual or quarterly basis and is publicly available and a more streamlined approach to reporting could help avoid duplicative data submissions.

5) **RELATED LEGISLATION.** SB 1300 (Cortese) extends the public notice requirement when a health facility eliminates a supplemental service, currently 90 days prior to elimination of the service, to instead be 120 days when it involves the closure of either inpatient psychiatric services or maternity services. Requires a health facility that is eliminating an inpatient psychiatric or maternity supplemental service to complete an impact analysis report prior to providing notice of the proposed elimination of the supplemental service, and requires HCAI to prepare a form for this report and to review and certify the impact analyses. SB 1300 is pending in the Senate Appropriations Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 2037 (Wicks), Chapter 95, Statutes of 2020, increased the period of time when a hospital is required to provide public notice of a proposed closure or elimination of a supplemental service, from 90 days for the closure or downgrading of emergency services and 30 days for all other closures or eliminations of supplemental services, to 180 days prior to the elimination or downgrading of emergency services, 120 days prior to the closure of a hospital, and 90 days prior to the elimination of any other supplemental service.

   b) AB 1014 (O'Donnell) of 2019 would have increased the period of time when a hospital is required to provide public notice of a proposed closure or elimination of a supplemental service, from 90 days for the closure or downgrading of emergency services and 30 days for all other closures or eliminations of supplemental services, to 180 days prior to the closure of a hospital or the elimination or downgrading of emergency services, and 90 days prior to the elimination of any other supplemental service. AB 1014 was vetoed by

the Governor, who stated the following in his veto message: "I agree that hospital closures have vast impacts on communities. However, this bill would not change the fact that the State is not able to force a hospital to stay open when they are financially unable. I am concerned that this bill may exacerbate the financial and patient safety concerns that often lead to closures."

c) AB 2874 (Thurmond) of 2018 would have required any hospital that provides EMS to notify the Attorney General no later than 180 days prior to a planned reduction or elimination of the level of EMS. AB 2874 failed passage on the Assembly Floor.

d) SB 687 (Skinner) of 2017 would have required a nonprofit corporation that operates a health facility that includes a licensed emergency center to obtain the consent of the Attorney General prior to a planned elimination or reduction in the level of EMS provided. SB 687 was vetoed by Governor Brown.

e) AB 2400 (Price), Chapter 459, Statutes of 2008, requires hospitals, not less than 30 days prior to closing a general acute care or acute psychiatric hospital, eliminating a supplemental service, as defined in existing regulations, or relocating the provision of a supplemental service to a different campus, to provide notice to the public and the applicable administering state department.

7) POLICY COMMENTS.

a) Confidential information? This bill requires a hospital to report various information to HCAI when the hospital believes the maternity ward may be at risk of closure, and requires the information to be kept confidential to the extent permitted by law. However, much of the information is already reported to HCAI and is publicly accessible. Moving forward, the author may wish to work with stakeholders and HCAI to ensure that publicly available data is not inadvertently made confidential by the provisions of this bill.

b) Financial distress. This bill requires a hospital, when assessing the risk of closure of maternity services, to consider factors, including, but not limited to, financial distress, workforce shortages, decreased demand in services, and birthing volume. As this bill moves forward, the author may wish to work with stakeholders and HCAI to develop specific metrics to assessment of financial health.

REGISTERED SUPPORT / OPPOSITION:

Support

American College of Obstetricians and Gynecologists District IX (cosponsor)
Reproductive Freedom for All (cosponsor)
California Medical Association
California Women's Law Center
Cleanearth4kids.org
Mee Memorial Healthcare System
San Francisco Women's Political Committee

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1936 (Cervantes) – As Amended April 8, 2024

SUBJECT: Maternal mental health screenings.

SUMMARY: Requires a health plan or insurer's maternal mental health (MMH) program to conduct at least one MMH screening during pregnancy, and at least one additional screening during the first six months of the postpartum period, if determined to be medically necessary and clinically appropriate in the treating provider's judgement.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health and other insurance. [Health and Safety Code (HSC) §1340, *et seq*., Insurance Code (INS) §106, *et seq*.]

2) Establishes as California's essential health benefits (EHBs) benchmark under the federal Patient and Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization contract, existing California health insurance mandates, and the 10 ACA mandated EHBs, including mental health (MH) and substance use disorder (SUD) coverage. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services; and,
   g) Hospice care. [HSC § 1345]

4) Requires health plans to ensure that all services are readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services. [HSC § 1367]

5) Requires every health plan contract and insurance policy that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of MH and SUDs under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72 and INS § 10144.5]

6) Requires health plans and insurers to develop a MMH program designed to promote quality and cost-effective outcomes, developed with sound clinical principals and processes, and to provide, upon request, guidelines and criteria to medical providers including contracting obstetric providers. Encourages health plans and health insurers to improve screening, treatment, and referral to MMH services, include coverage for doulas, incentivize training

opportunities for contracting obstetric providers, and educate enrollees and insureds about the MMH program. [HSC §1367.625 and INS §10123.867]

7) Requires a licensed health care provider who provides prenatal or postpartum care to, by July 1, 2019, ensure that the mother is offered or is appropriately screened for MMH conditions. [HSC §123640]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** The author states that according to the Department of Public Health (DPH), before the onset of the COVID-19 pandemic, one in five women and birthing people in California experienced symptoms of anxiety or depression during pregnancy or the postpartum period. During the pandemic, that figure increased to one in three women and birthing people. Women and birthing people who are Black, Latina, or Native American; or have low incomes; or have experienced hardships in their childhood or during pregnancy are at heightened risk of experiencing MMH issues. Under existing law, women and birthing people are required to be offered at least one screening for MMH conditions during pregnancy and the postpartum period. Unfortunately, implementation of that law often presents the availability of these screenings to be a choice between either during pregnancy or the postpartum period. According to the author, this bill will help more women and birthing people in California receive proper diagnoses if they are experiencing MMH issues by requiring that a screening be offered to women and birthing people at least once during pregnancy, with an additional screening offered during the first six months of the postpartum period. The author concludes that this increased access to screening will help more women and birthing people in California seek and receive the treatment they need to address MMH issues.

2) **BACKGROUND.** According to a California Health Care Foundation blog in 2022, in California, as in the US overall, about one in five mothers / birthing people suffers from MMH issues (also known as "perinatal mood and anxiety disorders"), negatively impacting the mother / birthing person and the child. Despite this high prevalence of MMH issues, the overwhelming majority of mothers / birthing people experiencing MMH symptoms (75%) do not receive treatment.

   a) **MMH Conditions**. MMH conditions are the most common complications of pregnancy and childbirth. They include prenatal and postpartum depression and/or anxiety, bipolar disorder, and in extreme cases, postpartum psychosis. According to DPH's Maternal and Infant Health Assessment, 21% of pregnant and postpartum mothers / birthing people in California are affected. The prevalence is estimated to be even higher in some populations. For example, during pregnancy, maternal depression rates rise to as high as one in two for those on Medicaid. This is significant because Medi-Cal covers 45% of the 400,000 babies born in the state annually. Additionally, in California, Black mothers / birthing people report the highest rates of anxiety and depression, compared to all other races, and anxiety has been found to be more common than depression in the perinatal population. Alarmingly, maternal suicide is a leading cause of maternal mortality in the US; it is most common in the white population and occurs most often between six and 12 months postpartum.

Left undetected and untreated, MMH conditions can lead to negative health outcomes for the mother / birthing person, and can negatively affect the mother-child bond and the child's long-term physical, emotional, and developmental health. Additionally, there can be significant financial costs of untreated MMH conditions (e.g., more use of emergency care services, higher rates of absenteeism at work), an estimated $35,000 for each mother / birthing person–child dyad.

b) Recent California coverage laws. AB 2193 (Maienschein), Chapter 755, Statutes of 2018, establishes a MMH program designed to promote quality and cost-effective outcomes and developed with sound clinical principles and processes. AB 2193 also requires a licensed health care practitioner who provides prenatal or postpartum care for a patient, to offer to screen or appropriately screen a mother for MMH conditions. SB 1207 (Portantino), Chapter 618, Statutes of 2022, further revises the requirements of the MMH program to include quality measures to encourage screening, diagnosis, treatment, and referral. SB 1207 also encourages coverage for doulas, incentivizes training opportunities for contracting obstetric providers, and educates enrollees and insureds about the MMH program. Last year, AB 904 (Calderon), Chapter 349, Statutes of 2023, established a maternal and infant health equity program to address racial health disparities in maternal and infant health outcomes. This bill expands on the existing MMH program to require health plans and insurers to conduct one MMH screening during pregnancy, and at least one additional screening during the first six months of the postpartum period.

3) SUPPORT. The California State Association of Psychiatrists write that screening for perinatal or postpartum depression or other MMH conditions is the first step to detect potential conditions that may have a negative impact during pregnancy or the postpartum period. Because a verified medical diagnostic test has not yet been developed, obstetric and licensed practitioners rely on screening tools, or questionnaires, for detection purposes.

4) RELATED LEGISLATION.

a) AB 2556 (Jackson) requires health plan and insurer's to provide notice to legal guardians related to the benefits of behavioral health and wellness screenings. AB 2556 is pending in Assembly Appropriations Committee.

b) AB 3059 (Weber) requires coverage of human milk. AB 3059 is pending in Assembly Health Committee.

5) PREVIOUS LEGISLATION.

a) AB 904 requires a health plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. Requires the DMHC, in consultation with CDI, to collect data and submit a report describing the doula coverage and the maternal and infant health equity programs to the Legislature by January 1, 2027.

b) SB 1207 revises the requirements of the MMH program to include quality measures to encourage screening, diagnosis, treatment, and referral. Encourages health plans and health insurers to improve screening, treatment, and referral to MMH services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees and insureds about the MMH program.

c) AB 935 (Maienschein) of 2021 would have required health plans and health insurers, including Medi-Cal managed care plans, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a MH consultation program, as specified. AB 935 was held in Assembly Appropriations Committee.

d) AB 1357 (Cervantes) of 2021 would have required DPH, for purposes of a statewide, comprehensive community-based perinatal services program, to develop and maintain on its internet website a referral network of community-based MH providers and support services addressing postpartum depression, prenatal, delivery, and postpartum care, neonatal and infant care services, and support groups, to improve access to postpartum depression screening, referral, treatment, and support services in medically underserved areas and areas with demonstrated need. Governor Newsom vetoed this bill, stating in part:

"AB 1357 is duplicative as there are existing resources available to pregnant and postpartum individuals. The Department of Health Care Services maintains a website that provides information about how individuals can seek mental health services through their local county. State programs such as the Adolescent Family Life Program, Black Infant Health Program, California Home Visiting Program, Perinatal Equity Initiative, and the Comprehensive Perinatal Services Program work to ensure pregnant and postpartum individuals are assessed, informed, linked, and referred to appropriate health and social services, including mental health services. Local health jurisdictions also inform pregnant and postpartum individuals of services and providers that are available and unique to each county. Finally, an individual's source of health coverage, whether it be Medi-Cal, a county mental health plan, or commercial health plan can arrange for care through its local provider network."

e) AB 2193 requires health plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a MMH program, as specified. Requires, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a patient, to offer to screen or appropriately screen a mother for MMH conditions.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists
Mental Health America of California

Opposition

None on file.

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1975 (Bonta) – As Introduced January 30, 2024

SUBJECT: Medi-Cal: medically supportive food and nutrition interventions.

SUMMARY: Adds medically supportive food and nutrition interventions as a covered Medi-Cal benefit. Specifically, **this bill**:

1) Effective July 1, 2026, adds medically supportive food and nutrition interventions as a covered Medi-Cal benefit when medically necessary in treating a patient's medical condition by a health care provider or health care plan, subject to specifications and utilization controls.

2) Requires a Medi-Cal managed care plan to offer at least three of six medically supportive food and nutrition interventions. Requires interventions to be provided for 12 weeks, or longer if deemed medically necessary.

3) Conditions implementation on the issuance of final guidance by the Department of Health Care Services (DHCS) in conjunction with a medically supportive food and nutrition benefit stakeholder advisory workgroup (workgroup), as specified.

4) Defines the following terms:

    a) "Medically supportive food and nutrition intervention" means the seven interventions specified in 4) b) through h) below, that provide nutrient-rich whole food, including any fruit, vegetable, legume, nut, seed, whole grain, low-mercury and high-omega-3 fatty acid seafood, or lean animal protein, used for the prevention, reversal, or treatment of certain health conditions.

    b) "Medically tailored meals (MTM)" means meals that adhere to standards informed by established nutrition guidelines for specific health conditions, as available, and are tailored to a recipient's health conditions by a registered dietitian nutritionist (RDN).

    c) "Medically supportive meals" means meals that follow the federal Dietary Guidelines for Americans and meet general health recommendations.

    d) "Food pharmacy" means medically supportive food paired with additional nutrition supports, typically in a health care setting.

    e) "Medically tailored groceries" means preselected medically supportive food that adheres to standards informed by established nutrition guidelines for specific health conditions, as available, and is tailored to a recipient's health conditions by an RDN.

    f) "Medically supportive groceries" means preselected medically supportive food that follows the federal Dietary Guidelines for Americans and meets general health recommendations.

g) "Produce prescription" means fruits and vegetables, procured in retail settings, such as grocery stores or farmers' markets, via a financial mechanism.

h) "Nutrition supports" includes nutrition education, cooking education and tools, including equipment and materials, and health coaching and behavioral supports based on a recipient's medical conditions, when paired with the interventions described in 4) b) through g) above.

5) For purposes of coverage of medically supportive food and nutrition interventions, requires DHCS to define the qualifying medical conditions for those interventions, including chronic and other conditions that evidence shows are sensitive to changes in diet. Requires DHCS to consult with the workgroup in the development of these qualifying medical conditions.

6) Requires a health care provider, to the extent possible, to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods to the extent possible.

7) Specifies nutrition supports, as defined in 4) h) above, are encouraged to be included with the interventions offered to the patient, but do not count toward the minimum coverage requirements.

8) Requires, on or before July 1, 2025, DHCS to establish a workgroup to assist in developing official guidance related to eligible populations, the duration and dosage of those interventions, rate-setting, the determination of permitted and preferred medically supportive food and nutrition providers, value-based procurement and equitable sourcing of food, and continuing education for health care providers and other medically supportive food and nutrition providers. Requires the workgroup to include providers, farmers, researchers, Medi-Cal consumer advocacy organizations, and at least one knowledgeable stakeholder to represent each of the seven medically supportive food and nutrition interventions described in 4) b) through h) above. Requires the workgroup to meet quarterly or more often as necessary.

9) Requires DHCS to provide 30 calendar days for the workgroup to comment on guidance on the benefit design of the medically supportive food and nutrition interventions before finalizing draft guidance for public comment, and an additional 60 calendar days for public comment on draft guidance before finalizing official guidance.

10) Requires DHCS to issue final guidance on or before July 1, 2026.

EXISTING LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Establishes a schedule of benefits under the Medi-Cal program, which includes federally required and optional Medicaid benefits, subject to utilization controls. [WIC §14132]

3) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act, and requires the implementation of the time-limited CalAIM initiative to support the following goals:

a) Identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health;
b) Transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and,
c) Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC §14184.100]

4) Establishes a CalAIM term of January 1, 2022, to December 31, 2026, inclusive, and any extensions, meaning the CalAIM initiative and its component parts are active, pursuant to federal approval, only during this time frame. [WIC §14184.101]

5) Authorizes medically supportive food and nutrition services, including MTMs, under CalAIM as "Community Supports" that a Medi-Cal managed care plan may elect to cover. Specifies Community Supports are provided "in lieu of" typical Medi-Cal covered services, in accordance with the federally approved CalAIM Terms and Conditions. [WIC §14184.206]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. This bill is sponsored by the Food as Medicine Collaborative and SPUR, a nonprofit public policy organization in the San Francisco Bay area, to expand access to medically supportive food and nutrition interventions. According to the author, unhealthy options like sugary drinks, processed foods, and fast food are too easily available and cleverly marketed towards low-income communities and communities of color. The author argues historical legacies of redlining and other forms of discrimination are a central cause of food injustice. Furthermore, the author notes, access to adequate and nutritious food is critical to preventing and treating chronic conditions. The author indicates this bill will make medically supportive food and nutrition services under Medi-Cal a permanent benefit for all recipients. These services include medically tailored meals, food pharmacies, and produce prescriptions for managing or reversing diet-sensitive health conditions. The author intends this bill to replicate successes seen locally: improvements to a patient's quality of life and health status and significant savings in healthcare costs.

2) BACKGROUND.

a) CalAIM. CalAIM is a collection of major initiatives spearheaded by the DHCS that align with the Administration's program improvement goals, including addressing social drivers of health, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. The majority of CalAIM proposals were put forward in 2021 through two comprehensive applications to the federal government for a "Section 1115 demonstration" and "Section 1915(b) waiver"—both named for the sections of the Social Security Act that authorize state and federal flexibility with Medicaid program rules to implement specific initiatives. DHCS received federal approval on December 29, 2021, for both the demonstration and waiver, effective through December 31, 2026, subject to Special Terms and Conditions (STC) that govern the state's implementation of the initiatives.

b) Community Supports. One component of CalAIM that addresses social drivers of health is called Community Supports. Community Supports are services that can be provided by Medi-Cal managed care plans as cost-effective alternatives to traditional medical services or settings. DHCS has a pre-approved list of 14 Community Supports, based on experience in prior demonstration programs to address health-related social needs. These supports are designed to provide flexibility to address specific needs of complex populations. For instance, home modifications, adaptations, and remediation can support individuals in maintaining or improving their health and reduce emergency department visits and inpatient stays. Similarly, medically supportive food or tailored meals can potentially provide similar health improvements and avoidance of expensive, high-intensity health care services.

Every Medicaid program has a Medicaid State Plan that specifies the benefits and services covered by that program. Community Supports, as defined through CalAIM, are alternative services to those covered under the Medi-Cal State Plan, but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if the state determines they are medically appropriate and cost-effective substitutes or settings for a State Plan service. Cost-effectiveness is measured on an overall population basis; services do not have to be deemed cost-effective for each individual patient.

c) "Food as Medicine" concept. Behaviors related to diet, exercise and smoking are major factors in determining health status and the likelihood of chronic disease. Food as medicine programs aim to leverage targeted interventions to prevent, manage, treat and, in some instances, reverse disease by improving nutrition to help children and adults get well and stay healthy. These programs exist in the context of other food assistance programs, such as the CalFresh Program and the Women, Infants and Children program; other efforts such as the MTMs pilot program (further discussed below); and other state efforts to improve the provision of preventive and outpatient care, as well as non-medical interventions, to maintain health and prevent inpatient admissions and institutionalization.

d) Food and Nutrition Interventions. According to the bill sponsors, the spectrum of medically supportive food and nutrition interventions includes: MTMs, medically supportive meals, food pharmacies, medically tailored groceries, medically supportive groceries, produce prescriptions, and nutrition supports when paired with food provision. The sponsors indicate providing the full spectrum of food-based services allows a medical provider to match the acuity of a patient's condition to the intensity of the intervention.

The proposed benefit is structured to be flexible by providing a choice of interventions to Medi-Cal managed care plans. Medically *tailored* meals and groceries are more targeted at a particular health condition, while medically *supportive* meals and groceries are more generically "healthy foods," including any fruit, vegetable, legume, nut, seed, whole grain, low-mercury and high-omega-3 fatty acid seafood, and lean animal protein. In addition to these two broad categories, nutrition support can be paired with the food benefit. For instance, a cooking class could be offered to demonstrate how to prepare seasonal vegetables that are offered in a "food pharmacy" set in a community clinic.

e) **MTMs Pilot Program**, SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, authorized the MTM Pilot Program, which launched on April 1, 2018, in eight counties. DHCS oversees the program and contracted with Project Open Hand for the provision of services. The pilot was planned to run for four years with a total budget of $6 million, and an evaluation is being conducted to determine the impact of the MTM program on hospital, emergency department, and skilled nursing facility admissions. The program has served three MTMs per day for 12 weeks to 1,413 eligible beneficiaries with congestive heart failure during the four-year period.

f) **Cost Considerations for adding Food Interventions as a Medi-Cal Benefit**. As noted above, Community Supports are currently authorized through a demonstration program and the offer of Community Supports is subject to specific rules. Specifically, because Community Supports must overall be medically appropriate and cost-effective substitutes or settings for the State Plan service, this imposes a cost-benefit calculation on the provision of Community Supports. Making services a benefit, versus a Community Support offered through a temporary demonstration project, will result in broader eligibility for services. This could add to program costs significantly for the provision of the benefit and could result in significant offsetting health care cost savings or health improvements as a result of broader coverage. Currently, managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for members. One provider of MTMs through the current Medi-Cal Community Supports indicates the price range is $7 to $12 a meal. According to the sponsors, over a third of Medi-Cal beneficiaries is expected to have one or more of the medical diagnoses currently included in the bill, as discussed in the section below under "Eligibility." However, a medical condition would not automatically translate into meeting the medical necessity criteria for the intervention. DHCS could also establish additional criteria. The rollout would likely have a ramp-up period as providers expand capacity.

g) **Current MTMs/Medically-Supportive Food Community Support.** DHCS's January 2023 "Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide" includes the following description of the Community Support:

i) **Description/Overview**: Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased member satisfaction.

(1) Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
(2) MTMs: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
(3) MTMs are tailored to the medical needs of the member by a Registered Dietitian or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

(4) Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.
(5) Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for members (e.g., MTMs, groceries, food vouchers, etc.).

ii) Eligibility:
(1) Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, HIV, cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders;
(2) Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or,
(3) Individuals with extensive care coordination needs.

iii) Restrictions/Limitations
(1) Up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary;
(2) Meals that are eligible for or reimbursed by alternate programs are not eligible; and,
(3) Meals are not covered to respond solely to food insecurities.

Community supports are to supplement and not supplant services received by the Medi-Cal beneficiary through other state, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

iv) Licensing/Allowable Providers. Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services:
(1) Home delivered meal Providers;
(2) Area Agencies on Aging;
(3) Nutritional Education Services to help sustain healthy cooking and eating habits;
(4) Meals on Wheels Providers; and,
(5) Medically-Supportive Food & Nutrition Providers.

h) Evidence of Effectiveness. DHCS has presented findings that MTMs are effective in improving health. According to DHCS, one study found a 17% reduction in patients with poorly controlled diabetes when patients were providing diabetes appropriate MTMs. Other research on MTM delivery among older adults found that 79% of individuals who had fallen in the past did not fall again during the study period compared to 46% in the control group, a 33-point increase in fall prevention. Finally, a 2014 study on MTMs recipients with diabetes, HIV, and comorbid conditions found a 50% increase in medication adherence among recipients. Studies have also found double-digit percentage point decreases in emergency department visits, inpatient admissions, and 30-day hospital readmissions among MTM recipients.

On November 8, 2023, the Public Health Institute (PHI) announced the results of a study of the "Healthy Food Rx" program in Stockton, California, which delivered free recipe-based food boxes to approximately 450 participants' homes and provided hands-on education about managing their diabetes through nutrition, over a 12-month period. PHI found that Healthy Food Rx participants had clinically significant decreases in A1C levels (a common measure of blood sugar used to manage diabetes), improved diabetes self-management, and improved overall diet quality and food security.

A 2022 article in *JAMA (Journal of the American Medical Association) Network Open* titled, "Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US," used a microsimulation model to study the impact of national implementation of MTM access for patients with diet-related diseases and limited instrumental activities of daily living who have Medicaid, Medicare, or private insurance. This economic evaluation among 6.3 million eligible US adults found that national implementation of MTMs for patients with diet-sensitive conditions and activity limitations could potentially be associated with 1.6 million averted hospitalizations and net cost savings of $13.6 billion annually from an insurer perspective.

3) **SUPPORT.** Numerous community-based organizations, including food and chronic disease advocacy organizations, consumer advocates, and food banks, support this bill. Food for People, the Food Bank for Humboldt County, cites cost savings, improved health, and food justice in supporting this bill. The Food As Medicine Collaborative, a cosponsor of the bill, asserts along with a large coalition of supporters that transitioning medically supportive food and nutrition interventions from optional services under a time-limited waiver in healthcare to covered Medi-Cal benefits will improve health outcomes, advance health equity across California, reduce avoidable healthcare costs and support the prevention, not just the treatment, of chronic conditions.

4) **PREVIOUS LEGISLATION.**

   a) AB 1644 (Bonta) of 2023 was similar to this bill and was held on the suspense file of the Assembly Appropriations Committee.

   b) AB 1085 (Maienschein) would have required DHCS to seek federal approval to add housing support services, which are currently Community Supports, as a Medi-Cal benefit. AB 1085 was vetoed by Governor Newsom based on cost concerns.

   c) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, established statutory authority for various aspects of the CalAIM initiative, including authority to provide "ILOS", which was later renamed as "Community Supports."

   d) SB 97 authorized the MTM Pilot Program.

   e) AB 3118 (Bonta) of 2020 would have created a Medi-Cal pilot program in Alameda County to provide a "medically supportive food assistance" benefit for a Medi-Cal beneficiary who has a chronic health condition, as specified, for a three-year period, and requires DHCS to evaluate the pilot and make recommendations for its expansion or

continuation. AB 3118 was held on the Suspense File of the Assembly Appropriations Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

California Food Is Medicine Coalition (cosponsor)
SPUR (cosponsor)
AARP
AIDS Healthcare Foundation
Alameda County Board of Supervisors
Alameda County Community Food Bank
Alameda-Contra Costa Medical Association
Almond Alliance
American College of Obstetricians and Gynecologists, District IX
American Diabetes Association
American Pistachio Growers
Asian Pacific Islander Forward Movement
Association of Regional Center Agencies
Black Equity Collective
CA4Health
California Black Health Network
California Black Power Network
California Chronic Care Coalition
California Food and Farming Network
California Health Coalition Advocacy
California Immigrant Policy Center
California Kidney Care Alliance
California Medical Association
California Reparations Task Force Members Dr. Cheryl Grills, Lisa Holder, and Don Tamaki
California Retired Teachers Association
California WIC Association
California-Hawaii State Conference of the NAACP
Catalyst California
Ceres Community Project
City and County of San Francisco
City of Long Beach
Contra Costa Health Services
County Health Executives Association of California (CHEAC)
Culver City Democratic Club
Educate. Advocate.
Equal Justice Society
Food for People, the Food Bank for Humboldt County
Fresenius Medical Care North America
Fresh Approach
Glide
Greater Sacramento Urban League
Harbor Christian Church

Health Access California
Indivisible Ca: StateStrong
LeadingAge California
Livefree California
Marin Food Policy Council
Meals on Wheels California (UNREG)
Meals on Wheels San Francisco
Pesticide Action Network North America
Purfoods, LLC A/k/a Mom's Meals
Rising Communities
Roots of Change
Sacramento Food Policy Council
San Diego Hunger Coalition
San Francisco-Marin Food Bank
Second Harvest Food Bank of Orange County
Second Harvest of Silicon Valley
The Praxis Project
Veggielution
Western Center on Law & Poverty, INC.

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2063 (Maienschein) – As Introduced February 1, 2024

SUBJECT: Health care coverage.

SUMMARY: Extends the sunset for pilot programs for risk bearing organizations (RBOs) as described under 8) below of Existing Law and authorized by the Department of Managed Health Care (DMHC) to operate from December 31, 2025 to December 31, 2027. Extends the deadline for DMHC to report the pilot program findings to the Legislature from January 1, 2027 to January 1, 2029.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans, and, which, among other duties, ensures the financial stability of health plans under the Knox-Keene Health Care Service Plan Act of 1975 (KKA). [Health and Safety Code (HSC) §1340*, et seq.*]

Licensure Requirements

2) Defines a health plan as:
   a) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees; or,
   b) Any person, whether located within or outside of California, who solicits or contracts with a subscriber or enrollee in California to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee. [HSC § 1345]

3) Makes it unlawful for any person to engage in business as a health plan in California or to receive advance or periodic consideration in connection with a plan from, or, on behalf of persons in California, unless such person has first secured from the DMHC Director a license, then in effect, as a plan or unless such person is exempted, as specified. [HSC §1349]

4) Establishes requirements for applicants for KKA licensure as a health plan or specialized health plan including disclosure of provider contracts, a statement describing the plan, method of providing health care services and physical facilities, financial statements, marketing methods, service area, procedures and programs for internal quality review, and other provisions. [HSC § 1351]

5) Requires a health plan to demonstrate that it is fiscally sound and has assumed full financial risk on a prospective basis for the provision of covered health care services, as specified. [HSC § 1375.1]

6) Requires health plans, if a plan maintains capitation or risk sharing contracts, to ensure that each contracting provider has the administrative and financial capacity to meet its contractual

obligations. Defines RBO as a professional medical corporation or other form of corporation controlled by physicians that delivers, furnishes or otherwise arranges for or provides health care services that does all of the following: a) contracts directly with a health plan or arranges for healthcare services for health plan enrollees; b) receives compensation for those services on any capitated or fixed periodic basis; and, c) is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of health plans that are covered under the capitation or fixed periodic payment arrangement. [HSC §1375.4]

7) Permits the DMHC Director to exempt from the KKA any class of persons or plan contracts if the DMHC Director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the KKA, and that the regulation of the persons or plan contracts is not essential to the purposes of the KKA. Authorizes DMHC to exempt certain plans from the KKA, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, policy subdivision, or public joint labor management trust that satisfies specified criteria. Exempts any county-operated pilot program contracting with the State Department of Health Care Services, as specified. [HSC § 1343]

Pilot Program

8) Allows the DMHC Director, no later than May 1, 2021, to authorize, until December 31, 2025, one pilot program in northern California, and one pilot program in southern California, whereby providers approved by the DMHC may undertake risk-bearing arrangements with a voluntary employees' beneficiary association (VEBA), as defined, with enrollment of greater than 100,000 lives, or a trust fund that is a welfare plan, as defined, and a multiemployer plan, as defined, with enrollment of greater than 25,000 lives if all of the following criteria are met:
   a) The purpose of the pilot program is to demonstrate the control of costs for health care services and the improvement of health outcomes and quality of service when compared against a sole fee-for-service (FFS) provider reimbursement model;
   b) The VEBA or trust fund has entered into a contract with one or more health care providers under which each provider agrees to VEBA employees' beneficiary association or trust fund;
   c) Each risk-bearing provider is registered as a RBO, as specified, and applies if the provider accepts professional capitation and is delegated the responsibility for the processing and payment of claims;
   d) Each global risk-bearing provider holds or will obtain in conjunction with the pilot program application a limited or restricted license, as specified;
   e) Each risk-bearing provider continues to comply with applicable financial solvency standards and audit requirements, including, but not limited to, financial reporting on a quarterly basis, during the term of the pilot program;
   f) Require the VEBA or trust fund to be responsible for providing all of the following:
      i) Basic health care services;
      ii) Prescription drug benefits;
      iii) Continuity of care;
      iv) Standards for network adequacy and timely access to care, including, but not limited to, access to specialty care;

v) Language assistance programs;
vi) A process for filing and resolving consumer grievances and appeals, including, but not limited to, independent medical review;
vii) Prohibitions against deceptive marketing;
viii) Member documents that include a description of the benefit coverage, any applicable copays, how to access services, and how to submit a grievance; and,
ix) Mechanisms for resolving provider disputes, including an appeals process.

g) Require the contract between the VEBA or trust fund and each health care provider to include all of the following:
i) Provisions dividing financial responsibility between the parties and defining which party is financially responsible for services rendered, including arrangements for member care should a global or risk-bearing provider become insolvent;
ii) A delegation agreement;
iii) Requirements regarding utilization review or utilization management;
iv) Provisions stating the RBO, limited licensee, or restricted licensee, as applicable, has the organizational and administrative capacity to provide services to covered employees, and that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management, including the disclosure of the percentage of risk assumed in relation to its total risk-based business;
v) Requirements regarding the submission of claims by providers and the timely processing of provider claims, including a guarantee that the VEBA or trust fund will indemnify any outstanding unpaid provider claim in the event of the insolvency of a participating provider to the pilot program;
vi) Require the health care provider to comply with the VEBA or trust fund's requirements for all of the following:
(1) Continuity of care;
(2) Language assistance; and,
(3) Consumer grievances and appeals, including, but not limited to, independent medical review.
vii) Prohibit the term of each contract between the VEBA or trust fund and a health care provider from exceeding the period of the pilot program;
viii) Require each VEBA or trust fund, participating in the pilot program, to submit an application to DMHC. Allows the DMHC to select up to two qualified participants for the pilot program; and,
ix) Specify that each health care provider that has entered into a contract with the VEBA or trust fund is a party to the pilot program application submitted to the DMHC. Requires the application to include a copy of each contract between the VEBA or trust fund and a participating health care provider.

9) Requires the VEBA or trust fund and each health care provider participating in the pilot program to agree to collect and report to the DMHC, in each year of the pilot program, in a manner and frequency determined by DMHC, information regarding the comparative cost savings when compared to FFS payment, performance measurements for clinical patient outcomes, and enrollee satisfaction. Authorizes the DMHC to require additional reporting, not subject to the Administrative Procedure Act.

10) Requires the participating VEBA or trust fund to report on a quarterly basis to the DMHC any complaint lodged by a participating enrollee in their respective pilot programs, along with a description of the response and resolution.

11) Requires the DMHC, after the termination of both pilot programs, and before January 1, 2027, to submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot programs compared to FFS payment models, including data on consumer and provider grievances, appeals, and independent medical reviews. Allows the DMHC to authorize a public or private agency to prepare the report.

12) Sunsets 8) to 11) above on January 1, 2028.

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, labor union trusts cannot utilize value-based payment mechanisms with the provider networks in their self-funded plan networks. This results in higher health care costs that could be avoided. Independent, impartial research on health care cost drivers and delivery system reform conducted by the U.C. Berkeley School of Public Health and the Integrated Healthcare Association consistently show that the solution to rising health care costs is to increase the percentage of health care that is delivered through clinically integrated providers that share the financial risk with health plans, government and employer payers. The author concludes that to date, this kind of health care financing and delivery model has been used in the fully-insured employer-sponsored HMO, Medicare Advantage and Medi-Cal Managed Care market segments.

2) **BACKGROUND.**

   a) **California's regulation of health insurance.** The business of health insurance in California is subject to a complex patchwork of federal and state regulations. Different rules apply depending on whether insurance coverage is purchased directly by individuals or on behalf of a group, as in job-based health insurance. There are essentially three relevant regulatory frameworks for health insurance and they are DMHC, the California Department of Insurance, and the federal Department of Labor for regulation of self-insured employee health benefit plans.

      The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from enforcing state laws relating to private sector employee benefit plans established by employers or other sponsors in order to provide health coverage. In general, ERISA requirements for employee health benefit plans are less far-reaching than the state regulations that apply to insurance carriers. Since self-insured employee benefit plans are subject only to ERISA, consumers covered by self-insured plans can have fewer consumer protections than those covered through fully insured plans that are required to comply with California's consumer protection laws.

      An arrangement established pursuant to a collective bargaining agreement may be a single employer or multiemployer plan. A Taft-Hartley trust is a multiemployer plan that, in addition to being established or maintained under or pursuant to one or more collective bargaining agreements, also meets criteria outlined in the Labor-Management Relations Act of 1947 (referred to as the Taft-Hartley Act). Plans established or maintained under or pursuant to collective bargaining agreements may be governed by both the Taft-

Hartley Act and ERISA. VEBAs and trust funds are authorized participants in this bill's pilot program.

b) DMHC Licensure Requirements. According to DMHC's Annual Report, in 2022, 97 full service health plans licensed by the DMHC provided health care services to more than 29.7 million Californians. DMHC assesses and monitors health plan networks and delivery systems for compliance with the KKA, and evaluates compliance through onsite surveys of health plan operations performed every three years. Surveys examine health plan processes related to access, utilization management, quality improvement, continuity and coordination of care, language access and enrollee grievances and appeals.

i) Risk Arrangements. According to a 2018 State Health and Value Strategies report, the KKA is the legal framework through which health care entities in the state are governed. The long-standing practice of providers accepting financial risk in California, and the bankruptcies of large provider groups in the 1990s, led DMHC to adopt prescriptive regulations governing health plans and provider RBOs. The KKA requires licensure by DMHC of health plans that accept global risk, defined as risk for both institutional and professional services, for the provision of health care services. The primary forms of risk arrangements include capitation, risk pools, withholds and stop-loss arrangements. Capitation is a set amount of money received by or paid to a provider on a per member per month basis rather than on the level of health care services provided. DMHC is also authorized to exempt entities from KKA requirements under certain circumstances.

ii) Risk Regulations. DMHC finalized regulations seeking to clarify the level of financial risk that would trigger health plan licensure. The regulations proposed different categories of licensure, including "full" and "restricted." Traditional health insurance plans would be required to obtain a full license to operate. Entities that accept global risk as a subcontractor to a fully-licensed health plan could obtain a restricted license. A restricted licensee would not be subject to rules concerning marketing and enrollment. Entities that have a small market share and/or operate in well-served areas could be granted an exemption from California's licensure requirements as those dynamics reduce the risk of disrupting the delivery of care in the event of insolvency.

iii) RBOs. An entity in California that only takes financial risk within the scope of its professional license (e.g., primary care capitation) is required to register as an RBO. DMHC retains limited oversight of RBOs; most of the direct oversight is delegated to the health plans with which RBOs contract. RBOs are required to submit quarterly and annual reports to DMHC so the DMHC can evaluate their financial condition. The pilot program in this bill authorizes RBOs to contract with VEBAs or a trust fund.

3) AB 1124 PILOT PROGRAM. AB 1124 (Maienschein), Chapter 266, Statutes of 2020, authorizes DMHC, to establish two pilot programs that allow healthcare providers to undertake risk-bearing arrangements. According to the author, the two pilot programs were expected to begin no later than May 1, 2021, with a sunset date of January 1, 2028. However, due to COVID-19, the pilot program experienced a two-year delay. This bill extends the sunset date of the AB 1124 pilot program from January 1, 2028, to January 1, 2030. It

introduces a two-year pilot program extension, allowing approved applicants, like VEBA, to continue their direct contracting program without any unnecessary interruptions. The author states that securing approval for the extension is imperative, especially considering that as of January 1, 2024, 5,000 members enrolled, and disrupting the process prematurely could lead to adverse outcomes. According to DMHC, Southern California Schools VEBA was authorized to participate in the pilot program located in southern California on December 10, 2021, for implementation effective January 1, 2022.

4) **SUPPORT.** California Schools VEBA, sponsor of this bill, writes that over 5,000 members are enrolled in this pilot and the extension in this bill is imperative to prevent avoidable disruptions in care and to the direct contracting pilot programs approved by the DMHC. California Schools VEBA is a 501(c)(9) non-profit trust that currently services more than 90 participating employers and over 150,000 members, throughout Southern California. In 2019, the VEBA Resource Center was launched to help members assess, identify and remove barriers to achieving optimal health and provide quality health care for its members and lower costs for their employers. America's Physician Groups writes that the Office of Health Care Affordability (OHCA) recently released a draft provider alternative payment model standard for review and adoption by California's Health Care Affordability Board. The standard supports the very purpose of the pilot; to move away from a costly, fragmented fee-for-service payment model to one that emphasizes pay-for-quality patient care outcomes.

5) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans, write that this arrangement sets a dangerous precedent and does not provide the important consumer protections that licensed health plans must extend to their enrollees under the KKA. It bears reminding that the DMHC promulgated regulations in October 2019 to address concerns regarding the financial solvency of existing RBOs. As of September 2023, there were 18 RBOs that were on Corrective Action Plans for failure to meet financial solvency requirements. Furthermore, the DMHC, in four years, has not taken any meaningful steps to enact the program. California's KKA licensed health plans are tightly regulated and comply with a wide array of requirements that protect the market and health service consumers. Among other things, fully licensed health plans must meet stringent financial solvency requirements, ensure timely access to care, implement consumer grievance processes, and participate in independent medical reviews. The opposition concludes that considering the enactment of the OHCA and its ongoing work to lower health costs, plus given the state's deficit, there is no compelling need to eliminate the critical role of fully licensed health plans in order to continue exploring pilot projects.

6) **RELATED LEGISLATION.**

   a) AB 2434 (Grayson) authorizes an association of employers to offer a large group health plan contract or insurance policy to small group employer members of the association, consistent with ERISA, if certain requirements are met, including that the association was established before January 1, 1966, and is the sponsor of a multiple employer welfare arrangement, and that the contract or policy includes coverage of employees of an association member in the engineering, surveying, or design industry. AB 2434 is pending in Assembly Health Committee.

b) AB 2072 (Weber) deletes the sunset date of January 1, 2026, for the authorization of an association of biomedical industry employers to offer a large group plan to small group members of the association, thereby authorizing these plans and policies indefinitely. AB 2072 is pending in Assembly Health Committee.

7) PREVIOUS LEGISLATION.

a) AB 1124 (Maienschein), Chapter 266, Statutes of 2020, authorizes the DMHC Director, no later than May 1, 2021, to authorize two pilot programs, one in northern California and one in southern California, under which providers approved by DMHC may undertake risk-bearing arrangements with a VEBA, or a trust fund. Repeals these provisions on January 1, 2028.

b) AB 1249 (Maienschein) was substantially similar to AB 1124 and was vetoed by Governor Newsom who stated in part:

"This bill would authorize a pilot program that would exempt risk-bearing provider groups taking on global risk from full licensure under the KKA. This proposed pilot project would undermine the fundamental purpose of the KKA by permitting such entities to operate in the State without providing the strong consumer protections guaranteed under the KKA."

REGISTERED SUPPORT / OPPOSITION:

Support

California Schools VEBA (sponsor)
America's Physician Groups
American Federation of Teachers Guild Local 1931
California Federation of Teachers AFL-CIO
Sharp Rees-Stealy Medical Group
Sweetwater Union High School District

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2066 (Reyes) – As Amended April 8, 2024

SUBJECT: The California Food Safety Act.

SUMMARY: Prohibits, commencing January 1, 2027, a person or entity from using methylene chloride (MC) in the process of decaffeinating coffee. Prohibits the sale, delivery, distribution, holding or offer for sale in commerce coffee that has been decaffeinated in a process using MC. Makes a violation of these provisions punishable by a civil penalty not to exceed $5,000 for a first violation and not to exceed $10,000 for each subsequent violation, upon an action brought by the Attorney General, a city attorney, a county counsel, or a district attorney.

EXISTING LAW:

1) Establishes the Sherman Food, Drug and Cosmetics Law, administered by the California Department of Public Health (DPH), which regulates the packaging, labeling, and advertising of drugs and devices, including dietary supplements. [Health & Safety Code (HSC) § 109875-111929.4]

2) Defines food as:
   a) Any article used or intended for use for food, drink, confection, condiment, or chewing gum by man or other animal; and,
   b) Any article used or intended for use as a component of any article designated in a) above. [HSC § 109935].

3) Defines color additive as a substance that satisfies both of the following requirements: a) it is a dye, pigment, or other substance made by a process of synthesis or similar artifice, or extracted, isolated, or otherwise derived, with or without intermediate or final change of identity, from a vegetable, animal, mineral, or other source; and, b) when added or applied to a food, drug, device, or cosmetic, or to the human body or any part of the body, it is capable, alone or through reaction with any other substance, of imparting color to the food, drug, device, or cosmetic, or to the human body or the part of the human body, to which it is added or applied. [HSC § 109895]

4) Defines food additive as any substance, the intended use of which results or may reasonably be expected to result, directly or indirectly, in the substance becoming a component of the food or otherwise affecting characteristics of the food. [HSC § 109940]

5) Permits DPH whenever public health or other considerations in this state require, to adopt, upon its own motion, or upon the petition of any interested party, regulations that prescribe tolerances, included but not limited to zero tolerances, for poisonous or deleterious substances, food additives, pesticide chemicals, or color additives. Authorizes DPH to prescribe the conditions under which a food additive or a color additive may be safely used and may grant exemptions for a food additive or color additive when it is to be used solely for investigational or experimental purposes. Requires a petitioner to furnish data, as specified. [HSC § 110070]

6) Requires DPH, in adopting regulations under 5) above, to consider specified factors, including the probable consumption and effect of the substance in the diet of man or any other animal and safety factors, as specified. [HSC § 110075]

7) Requires all food additive regulations and any amendments to the regulations adopted pursuant to the federal Food, Drug, and Cosmetic Act (FDCA) in effect on November 23, 1970, or adopted on or after that date, are the food additive regulations of this state. Permits DPH, by regulation, to prescribe conditions under which a food additive may be used in this state whether or not these conditions are in accordance with the regulations adopted pursuant to the FDCA. [HSC § 110085]

8) Establishes within the California Environmental Protection Agency, the Office of Environmental Health Hazard Assessment (OEHHA) to protect and enhance the health of Californians and the state's environment through scientific evaluations that inform, support and guide regulatory and other actions. [HSC §59000 *et. seq*.]

9) Establishes, through the initiative process, Proposition 65, commonly known as the Safe Drinking Water and Toxic Enforcement Act of 1986, which requires businesses to provide warnings to Californians about significant exposures to chemicals that cause cancer, birth defects, or other reproductive harm. Specifies that these chemicals can be in the products that Californians purchase, in their homes or workplaces, or that are released into the environment. Prohibits California businesses from knowingly discharging significant amounts of listed chemicals into sources of drinking water. Requires California to publish a list of chemicals known to cause cancer, birth defects or other reproductive harm. Requires this list to be updated at least once a year, and now includes approximately 900. [HSC § 25249.5 - 25249.14]

EXISTING FEDERAL LAW:

1) Establishes the federal Food, Drug, and Cosmetic Act (FDCA), which among various functions regulates food, dietary supplements, and cosmetics. [21 United States Code (U.S.C.) §310 *et.seq*.]

2) Defines food additive as any substance the intended use of which results or may reasonably be expected to result, directly or indirectly, in its becoming a component or otherwise affecting the characteristic of any food (including any substance intended for use in producing, manufacturing, packing, processing, preparing, treating, packaging, transporting, or holding food; and including any source of radiation intended for any such use); if such substance is not generally recognized as safe or sanctioned prior to 1958 or otherwise excluded from the definition of food additives, as specified. [Title 21 Code of Federal Regulations (CFR) §170.3]

3) Defines color additive as any material that is a dye, pigment or other substance that when added or applied to a food, drug, or cosmetic or to the human body that imparts color. [Title 21 CFR §70.3]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill seeks to protect against the use of MC, a carcinogenic chemical solvent, in the manufacturing process of decaffeinated coffee. The author highlights that the United States Environmental Protection Agency (EPA) banned the use of MC as a solvent due to its advertise impacts on workers and OEHHA includes MC on its Proposition 65 list because it can cause cancer. The author contends that this is of concern for pregnant people, who switch from caffeinated to decaffeinated coffee, assuming it is safe to consume. According to OEHHA, MC can pass from mother to baby. The author contends that there are safer methods to decaffeinate coffee, and that MC should not be ingested or utilized in the decaffeination process, due to its carcinogenic risks. The author concludes that this bill seeks to protect coffee consumers and make decaffeinated coffee safer, in particular for those who are pregnant and those with pre-existing health conditions.

2) **BACKGROUND.**

   a) **MC.** According to the EPA, MC, which is also called Dichloromethane, is a volatile chemical that is produced and imported into the United States, with use estimated at over 260 million pounds per year. MC is a solvent used in a variety of industries and applications, such as adhesives, paint and coating products, pharmaceuticals, metal cleaning, chemical processing, and aerosols. Certain paint strippers, aerosol paints, and adhesives, as well as other metal cleaning products, can contain MC. MC is also used as solvent in the process to decaffeinate coffee.

   b) **How does MC exposure occur?** Because of its volatility, it is found mostly in air, and the predominant exposure for the general population occurs from inhalation (primarily from industrial emissions and consumer product use). In 1996, the national average concentration of MC in outdoor air was 0.47 micrograms per square meter (μg/m3). Indoor inhalation exposures can result from using consumer products containing MC such as adhesives, spray shoe polishes, paint and adhesive removers, and building materials and furnishings. Average indoor air concentrations collected from urban, suburban, and rural residences between 1990 (after the 1989 ban on hairspray) and 2005 ranged from 0.4 to 3.5 μg/m3. Concentrations of MC in food and water are small compared to concentrations in air; thus, oral exposures are low. Drinking-water mean concentrations are generally less than one part per billion (ppb), which is below the 5 ppb maximum contaminant level (MCL). MC releases to drinking-water sources are estimated to range between 0.3 and 2.4% of total environmental releases, much lower than the 86–95% estimate for atmospheric releases, with releases to land accounting for 2–12%. Dermal absorption of MC has been demonstrated in animals and in humans making this pathway another potential exposure pathway of concern, particularly in occupational settings without adequate protective gear and with improper use of consumer products (e.g., paint strippers). High indoor air concentrations of MC have been reported in occupational settings, where the largest numbers of workers are potentially exposed to the chemical during metal cleaning, industrial paint stripping, and tasks using ink solvents. Drinking-water mean concentrations are generally less than one part per billion (ppb), which is below the 5 ppb MCL.

   c) **Links between MC and cancer.** In their 2020 risk evaluation of MC, the EPA stated that most of the human data on lung cancer and MC exposure are not conclusive and most do

not show an association with MC. The EPA stated that in animal studies, MC produced large, statistically significant increases in lung tumor incidences in male and female mice exposed by inhalation. When looking at ingestion of MC, there was also some evidence for production of lung tumors in mice by oral exposure to MC. Researchers reported a nonsignificant dose-related trend for higher incidences of pulmonary adenomas in male, but not female, mice in an oral gavage study that was, however, terminated at 64 weeks due to high mortality. A two-year drinking water study did not find any increase in lung tumor incidence in male or female mice. Lung tumors were not increased by MC in rats or hamsters by inhalation or oral exposure. Data from oral animal studies also identified nervous system effects that include sensorimotor and neuromuscular changes after acute and short-term exposure as well as excitability, autonomic effects, decreased activity and convulsions (one rat) after short-term exposure.

d) Regulations related to MC.

i) EPA regulations. In March 2019, EPA issued a final rule to prohibit the manufacture (including import), processing, and distribution of MC in all paint and coating removers for consumer use. EPA states that they took this action because of the acute fatalities that have resulted from exposure to the chemical. In November 2022, EPA released a final revised risk determination finding that MC as a whole chemical substance presents an unreasonable risk of injury to health under its conditions of use. In May 2023, the EPA proposed prohibiting manufacturing, processing, and distribution of MC for all consumer uses, prohibit most industrial and commercial uses of MC, create strict workplace protections to ensure that for the remaining uses, workers will not be harmed by MC use; and require manufacturers (including importers), processors, and distributors to notify companies to whom MC is shipped of the prohibitions and to maintain records.

ii) California. Recently, the OEHHA added MC to its Prop. 65 list. Per OEHHA's website, MC exposure occurs by breathing in MC in the air and skin contact with products that contain MC. OEHHA's website also states that during pregnancy, MC can pass from mother to baby.

e) MC in decaffeinated coffee. MC is used in the process of decaffeinating green coffee and tea. Green coffee beans are steamed to open their "pores" and make caffeine more accessible. The beans are rinsed with a mixture of water and MC, which bonds to and removes caffeine. The liquid solution (now containing the caffeine originally in the beans) is removed. Caffeine is extracted from the solution for use in other products, and nearly 100% of the liquid is captured and reused to decaffeinate more coffee beans. Decaffeinated coffee beans are dried and roasted at approximately 400˚ Fahrenheit or higher, which is two to four times higher than the evaporation point of MC.

f) FDA Petition.

i) The Environmental Defense Fund, Breast Cancer Prevention Partners, Center for Environmental Health, the Environmental Working Group, and Lisa Lefferts, an environmental health consultant, submitted a petition to amend food additive regulations to eliminate the agency-approved uses of MC among other solvents. Since 1958, the FDCA has stated that "no [food] additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal, or if it is found, after tests which are appropriate for the evaluation of the safety of food additives, to induce

cancer in man or animal . . .” (21U.S.C. § 348(c)(3)(A)). This requirement, known as the Delaney Clause, is a bright line drawn by Congress that carcinogens are not safe to use in food. This statutory requirement has not been altered in the intervening half-century. The petitioners claim that MC as has been found to induce cancer in humans or animals, and it is not safe pursuant to the Delaney Clause.

ii) The National Coffee Association responded to this filing stating the following: MC used as a processing aid to decaffeinate coffee does not trigger the Delaney Clause because: (1) there is no evidence supporting the assertion that MC induces cancer when ingested in decaffeinated coffee; and, (2) experts (including FDA) have not conducted appropriate tests to evaluate whether MC is found to induce cancer when used as a food additive in decaffeinated coffee. Thus, FDA is not required to—and should not—delist MC for use as a food additive. Under the FDCA, the FDA cannot approve a food additive unless data establishes that the food additive is safe for its intended use. The FDCA requires FDA to consider, among other factors, the probable consumption of the additive, the cumulative effect the additive may have in the diet of humans or animals, and safety factors that experts recognize as appropriate for the use of animal experimentation data. If FDA determines that a food additive is safe, it means that there is a “reasonable certainty in the minds of competent scientists that the substance is not harmful under the intended conditions of use.”

g) Studies on MC concentrations in decaffeinated coffee. Studies conducted in 1977, 1984, 1987, and 1989 analyzed samples of decaffeinated coffee. Collectively, these studies demonstrate that the concentration of MC in decaffeinated roasted coffee or decaffeinated instant coffee is often below the limit of detection (≤50 ppb) and, at most, is detected at ~9,000 ppb (equivalent to ~9 ppm), which remains below the FDA limit of 10 ppm. Additionally, based on the samples available, MC concentrations in decaffeinated instant coffee (maximum of 0.91 ppm) are lower than in decaffeinated roasted coffee. Clean Label Project, sponsors of this bill, conducted a study of MC levels in decaffeinated coffee samples in 2022. The samples they studied found trace amounts of MC. All test results were below the regulatory limits.

h) Methods to decaffeinate coffee.

i) The direct solvent method. This technique typically utilizes MC, coffee oil, or ethyl acetate. The liquid solvent is circulated through a bed of moist, green coffee beans, removing some of the caffeine; the solvent is then recaptured in an evaporator, and the beans are washed with water. Residues of the solvent are removed from the coffee to trace levels by steaming the beans. Often this process utilizes batch processing--that is, solvent is added to the vessel, circulated and emptied several times until the coffee has been decaffeinated to the desired level. Solvents are used because they are generally more precisely targeted to caffeine than is charcoal, leaving behind nearly all the non-caffeine solids. The more caffeine-specific solvents, such as MCs, can extract 96 to 97 % of the caffeine.

ii) The Swiss Water Process. The Swiss Water Process is based solely on water and carbon filtration. The coffee beans are first immersed in hot water to extract their caffeine and flavorful components. The initial beans are then discarded, and the resulting flavor-rich water (called “green coffee extract”) is passed through a carbon filter that is sized to capture only the large caffeine molecules. The decaffeinated green coffee extract is then used to wash and filter the next batch of beans. Caffeine is thereby filtered from the beans without recourse to chemical agents and without the

beans losing many of their flavorful components. This is the primary method used to decaffeinate organic coffee beans. This method does not utilize MC.

iii) **Supercritical Carbon Dioxide method.** Finally, the supercritical carbon dioxide method uses carbon dioxide (CO2) under high temperatures and pressure to act like both a gas and a liquid. This supercritical CO2 reaches into the crevices of coffee beans like a gas but dissolves caffeine like a liquid. After the beans have been soaked in water (a process that expands cell structures and makes it easier to extract the caffeine molecules), they are exposed to supercritical CO2 for several hours. The caffeinated CO2 liquefies and evaporates, and the beans are then processed. Because this method leaves the carbohydrates and proteins intact, there is less change in taste as a result of decaffeination. This method does not utilize MC.

i) **MC in decaffeinated coffee.** More research is needed regarding the specific health impacts of MC used in the coffee decaffeination process on human health. Generally, decaffeinated coffee is associated with a lower risk of mortality. Drinking decaffeinated coffee is not associated with an increase in the risk of cancer.

i) **Liver cancer and other liver diseases.** Perhaps one of the most well-known and scientifically rigorous prospective cohort studies in the world is the UK Biobank Study. Comparing 384,818 coffee drinkers and 109,767 non-coffee drinkers who were followed for a median of 10.7 years, the UK Biobank Study results showed substantially lower risks of hepatocellular carcinoma (liver cancer), chronic liver diseases, and death due to chronic liver diseases among coffee drinkers. The associations for decaffeinated, instant and ground coffee individually were similar to all types combined.

ii) **Hepatocellular carcinoma.** The European Prospective Investigation into Cancer (EPIC) Study, another major prospective cohort study of nearly 500,000 individuals, also found a lower risk of hepatocellular carcinoma in those who consumed decaffeinated coffee, although this decrease was not statistically significant. In another case-control study in Italy, there were no significant associations between decaffeinated coffee intake and risk of liver cancer. A meta-analysis of 18 cohort studies and eight case-control studies found that decaffeinated coffee intake was associated with a decreased risk of hepatocellular carcinoma in humans, even when there was pre-existing liver disease.

iii) **Breast Cancer.** Prospective epidemiologic studies have found no evidence for an increased risk of breast cancer among those who drink decaffeinated coffee. A meta-analysis of 37 studies found no association between decaffeinated coffee intake and breast cancer risk. These studies included millions of participants, tens of thousands of whom developed breast cancer. Therefore, they had ample statistical power to detect even minimal increased risks, yet none declared an increased risk of breast cancer in those who consumed decaffeinated coffee.

iv) **Non-Hodgkin Lymphoma (NHL).** The results of the Women's Health Initiative Observational Study, a prospective study that followed more than 74,000 women for 18 years, found no association between decaffeinated coffee consumption and the risk of NHL. More than 850 women developed NHL in this study, yet there was no observable association with decaffeinated coffee intake. These results are similar to those found in a previous case-control study.

v) **Lung cancer.** A meta-analysis of epidemiologic studies concluded that drinking decaffeinated coffee was associated with lower risk of lung cancer, although the numbers were relatively small. A 2016 study found there was a slight increase in the

risk of lung cancer among both caffeinated and decaffeinated coffee drinkers, but the point estimate for this increased risk was smaller among decaffeinated coffee drinkers than among caffeinated coffee drinkers, making it unlikely that any effect was attributable to decaffeination. The authors conclude that: "it is likely that the remaining association is due to residual confounding by smoking." Another combined analysis of prospective studies published in 2021, which including the aforementioned study, found a slightly increased risk of lung cancer among both caffeinated and decaffeinated coffee drinkers yet the authors caution that "these findings should not be assumed to be causal because of the likelihood of residual confounding by smoking, including passive smoking, and change of coffee and tea consumption after study enrollment."

3) **SUPPORT.** Clean Label Project (CLP), the sponsor of this bill, states that MC is a volatile, nonflammable, chlorinated hydrocarbon and colorless chemical solvent. It was commonly used as a solvent in paint removers, in the manufacturing of pharmaceuticals and as a degreasing agent for industrial use. CLP continues that MC is a carcinogen that has been banned by the EPA for industrial uses due to adverse health impacts to workers. CLP states Japan and Korea have banned coffee decaffeinated using MC, and Canada requires such coffee to be labeled. CLP further states the EPA has determined the use of MC to be hazardous and poses an unreasonable risk to human health. CLP continues that the OEHHA found MC to be a cancer risk and has placed it on the Prop 65 list. CLP states it is often pregnant women and people with high blood pressure that drink decaffeinated coffee. CLP continues that the State of California's evaluation of MC concluded that during pregnancy, MC can pass from mother to baby. CLP states that there are safer decaffeination processes are in use today, such as processes use water or air methods to decaffeinate coffee. CLP concludes there is no justification for using this known carcinogen to decaffeinate coffee.

4) **OPPOSITION.** The National Coffee Association (NCA) opposes this bill. NCA argues that this bill contradicts: a) scientific determinations by the European Union, the United States, and food safety authorities around the world, all of which have authorized European Method decaf as safe; and, b) the overwhelming weight of independent scientific evidence, which demonstrates that drinking European Method decaf, like all coffee, is associated with numerous significant health benefits, including increased longevity and decreased risk of multiple cancers. The majority of decaffeinated coffee has been made using the European Method for more than 50 years. In this method, a mixture of water and MC is used to remove caffeine from green, unroasted coffee beans. It is not added to finished decaffeinated coffee. Because caffeine is removed before coffee beans are roasted at extremely high temperatures (well above the evaporation temperature for MC), data show that any minute traces of MC are either undetectable or otherwise present at infinitesimal levels, well below the safe standard of 10 ppm set by FDA. The majority of decaffeinated coffee is made using the European Method because it is safe, retains flavor, effectively removes more than 97% of caffeine, and conserves energy and water. All decaffeination methods rely on chemistry to extract caffeine naturally found in coffee beans. Other decaffeination methods are much less widely available and more expensive than the European Method. Banning European Method decaf would leave only a minority of decaffeinated coffee on the market, increase prices, and restrict Californians' access to a safe product associated with health benefits.

5) **RELATED LEGISLATION.**

i) AB 2365 (Haney) adds kratom products to the Sherman Food, Drug, and Cosmetic Law. Prescribes specified quantities of alkaloids present in kratom products, establishes labeling and packaging requirements, and requires that kratom products be registered with DPH annually, which would include certification by a laboratory specifying that the product meets certain qualifications. Prohibits the sale of kratom leaf and kratom products to those under 18 years of age. AB 2365 passed the Assembly Committee on Health with a 15-0 vote on April 9, 2024 and is pending in the Assembly Committee on Environmental Safety and Toxic Materials.

j) AB 1830 (Arambula) requires a manufacturer of corn masa flour (CMF) to add folic acid at a level not to exceed 0.7 milligrams of folic acid per pound of CMF and to include a declaration of folic acid on the nutrition label in accordance with applicable federal law. AB 1830 is on the Assembly Floor.

6) **PREVIOUS LEGISLATION.** AB 418 (Gabriel), Chapter 328, Statutes of 2023, prohibits a person or entity, commencing January 1, 2027, from manufacturing, selling, delivering, distributing, holding, or offering for sale, in commerce a food product for human consumption that contains any of the following substances: Brominated vegetable oil; Potassium bromate; Propylparaben; or Red dye 3. AB 418 makes a violation of its provisions punishable by a civil penalty not to exceed $5,000 for a first violation and not to exceed $10,000 for each subsequent violation, upon an action brought by the Attorney General, a city attorney, a county counsel, or a district.

7) **DOUBLE REFERRAL.** This bill is double-referred, upon passage of this Committee, it will be referred to the Assembly Committee on Judiciary.

8) **SUGGESTED AMENDMENTS.** To allow sufficient time for manufacturers and retailers to transition, the author may wish to amend this bill to delay implementation to January 1, 2032.

REGISTERED SUPPORT / OPPOSITION:

Support

Clean Label Project (sponsor)
A Voice for Choice Advocacy
Breast Cancer Prevention Partners
California Health Coalition Advocacy
California Nurses for Environmental Health and Justice
Cleanearth4kids.org
Educate. Advocate.
Environmental Working Group
Facts: Families Advocating for Chemical & Toxics Safety
Physicians for Social Responsibility - San Francisco Bay Area Chapter
Reproductive Freedom for All
SEE (Social Eco Education)

Opposition

Alliance of Coffee Decaffeinators
American Beverage Association
American Chemistry Council
California Chamber of Commerce
California Grocers Association
California League of Food Producers
California Manufacturers and Technology Association
California Restaurant Association
California Retailers Association
Consumer Brands Association
National Coffee Association

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2072 (Weber) – As Introduced February 5, 2024

SUBJECT: Group health care coverage: biomedical industry.

SUMMARY: Repeals the sunset in existing law for the authorization of an association of employers to offer a large group health plan or insurance policy to small group employer members of the association consistent with the federal Employee Retirement Income Security Act of 1974 (ERISA), including that the association is a sponsor of a multiple employer welfare arrangements (MEWAs), and who are employed by an association member in the biomedical industry with operations in California.

EXISTING FEDERAL LAW:

1) Establishes, pursuant to federal law, ERISA, which sets minimum standards for most voluntarily established pension and health plans in private industry, including Taft-Hartley Multi-Employer Health and Welfare Plans. Exempts these plans from state insurance regulation. [29 United States Code (U.S.C.) §1144]

2) Defines, in federal law, the terms "employee welfare benefit plan" and "welfare plan" to mean any plan, fund, or program which established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, the following: a) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services; or, b) any benefit, as described (other than pensions on retirement or death, and insurance to provide such pensions). [29 U.S.C. §1002(1)]

3) Defines in federal law, MEWA to mean an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit in 2) above to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, as specified. [29 U.S.C. §1002(1)]

4) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges, federal financial assistance in the form of premium assistance or cost sharing reductions to specified eligible individuals, and coverage of essential health benefits (mandated coverage of 10 benefit categories, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness and chronic disease management, and pediatric services). [42 U.S.C. 300gg, *et seq*.]

EXISTING STATE LAW:

5) Establishes, in state government, the California Health Benefit Exchange, referred to as Covered California, as an independent public entity not affiliated with an agency or department, and requires Covered California to compare and make available through selective contracting health insurance for individuals and small business purchasers as authorized under the ACA. [Government Code §100500-100522]

6) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (KKA) and California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

7) Permits the DMHC Director to exempt from the KKA any class of persons or plan contracts if the DMHC Director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the KKA, and that the regulation of the persons or plan contracts is not essential to the purposes of the KKA. [HSC § 1343]

8) Defines a health plan as:
   a) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees; or,
   b) Any person, whether located within or outside of California, who solicits or contracts with a subscriber or enrollee in California to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee. [HSC § 1345]

9) Requires health coverage through an association that is not related to employment to be considered individual coverage. Specifies that the status of each distinct member of an association determines whether that member's association is individual, small group, or large group health insurance coverage. [HSC §1357.503 and INS §10753.05]

10) Prohibits employer group health benefit plans from being issued, marketed, or sold, directly or indirectly through any arrangement, to a sole proprietorship or partnership without employees. Requires only individual health benefit plans to be sold to any entity without employees. Revises the definition of eligible employee for purposes of all small employer health plan contracts and health insurance policies to exclude sole proprietors or their spouses, and partners or their spouses. [HSC §1357 and INS §10755]

11) Authorizes an association of employers to offer a large group health plan contract or health insurance policy to small group employer members of the association, consistent with the ERISA, if all of the following requirements are met:
   a) The association is headquartered in California, was established prior to March 23, 2010, has been in continued existence since, and is a bona fide association or group of employers that may act as an employer under ERISA. The association is the sponsor of a MEWA, and the MEWA is fully insured, headquartered in California, and is in full compliance with all applicable state and federal laws;

b) The MEWA has offered a large group health plan contract or health insurance policy since January 1, 2012, in connection with an employee welfare benefit plan;
c) The large group health plan contract or insurance policy offers to employees a level of coverage having an actuarial value greater than or equivalent to the platinum level of coverage available through Covered California and covers essential health benefits (EHBs), as specified;
d) The large group health plan contract or insurance policy includes coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California;
e) The large group health plan contract or insurance policy offers only fully insured benefits through an insurance contract with an insurance carrier licensed by CDI or with a health maintenance organization licensed by DMHC;
f) Association members purchasing health coverage have a minimum of four full-time common law employees and are current employer members of the association sponsoring the plan. Employer members subsidize employee premiums by at least 51%;
g) The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan;
h) The participating employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits;
i) Membership in the association is open solely to employers, and the participating employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the large group health plan contract or insurance policy, both in form and substance;
j) The large group health plan contract or insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health status or claims of any person;
k) An employer otherwise eligible is not excluded from participating in a MEWA, or offering or renewing the large group health plan contract or insurance policy based on health status or claims of any employee or dependent;
l) The MEWA at all times covers at least 101 employees; and,
m) The association and MEWA files an application for registration with the DMHC or CDI on or before June 1, 2022.

12) Prohibits, on or after January 1, 2022, a health plan or insurer from marketing, issuing, amending, renewing, or delivering large employer health care coverage to a MEWA that provides any benefit to a resident of California unless the MEWA is registered and complies with 10) above, or has an application pending. Requires DMHC or CDI to determine whether the MEWA is in compliance. Sunsets on January 1, 2026. [HSC §1357.503 and INS §10753.05]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill is critical for small biomedical companies to attract top talent in a very competitive labor market. It continues to allow small life science companies to join together in a fully insured multiple-employer agreement (as allowed by ERISA) under specified conditions, including that benefits offered must be actuarially equivalent to the platinum level of the California Health Benefit Exchange. The plan also must be offered through an insurance carrier licensed by the State. The author concludes that this bill allows small emerging companies to compete with global biopharmaceutical or medical device companies for talent by not asking an employee to sacrifice quality of health coverage for the opportunity to work at a small, innovative company, the very companies that are fueling California's expanding economy.

2) **BACKGROUND.**

   a) **Association Health Plans (AHPs).** The California Health Care Foundation (CHCF) in a March 2021 Issue Brief writes that under federal law, AHPs are a type of MEWA established or maintained to provide insurance coverage for medical, surgical, hospital care, or other benefits in the event of sickness. AHPs are insurance arrangements that allow small businesses, associations, and self-employed workers to organize together to purchase health care coverage, potentially obtaining lower-priced coverage by spreading risk and negotiating on behalf of a larger set of enrollees. AHPs have long been offered and regulated in the state of California. California law established requirements for small group reform that applied to AHPs, including criteria for guaranteed issue, standard rating rules, defined risk corridors, specific age bands, and the number of geographic regions for the small group insurance market. In 2010, the ACA changed the rating rules and benefit coverage requirements in the individual and small group markets, and led to the establishment of Covered California. Through Covered California, individuals and employees of participating small businesses can enroll in subsidized and unsubsidized health coverage.

      In 2018, according to CHCF, efforts to unwind key provisions of the ACA included the U.S. Department of Labor (DOL) new regulation for AHPs that made it easier for small employers to organize for the purpose of accessing health insurance typically available only to large groups. Proponents of the DOL rule argued that AHPs promote competition in increasingly consolidated insurance markets and provide more affordable options in the face of ever-escalating and unaffordable health insurance premiums. By allowing a more restrictive benefit design, such plans could also be attractive to small groups with a lower-risk profile. Such groups could design products that do not cover the EHBs as required for individual and small group plans under the ACA but instead comply with less stringent ERISA consumer protections. Opponents of the DOL rule argued that such plans would create adverse selection by driving higher-risk individuals into the state or federal health insurance marketplace options, increasing costs and ultimately undermining the stability of those risk pools. Premiums for the small group market are determined by a community rating methodology whereby the claims experience across the small group segment is pooled to determine health insurance premiums and annual rate increases.

According to a January 2018 paper authored by the Center on Health Insurance Reforms at Georgetown University, the primary purpose of the DOL rule is to allow more groups of small businesses and self-employed individuals to form AHPs so that they can offer coverage that is regulated under federal law as large-group coverage, and avoid ACA requirements such as EHBs, premium rating restrictions, the single risk pool requirement and risk adjustment. At that time, an analysis by Avalere Health indicated that individual and small group markets would see premiums rise, over a five-year period, 2.7% to 4% in the individual market and .1% to 1.9% in the small group market relative to current law because healthier enrollees would shift into AHPs. Avalere estimated 2.4 million to 4.3 million would switch to AHPs. In 2018, Covered California released a report indicating that this policy change along with another one related to short-term policies could cause an increase in premiums in 2019 of 0.3% to 1.3%. Together with the elimination of the individual mandate penalties (it should be noted that California subsequently enacted a state individual mandate), premium costs could go up by 12% to 32% in total in 2019.

b) SB 1375. In response to the 2018 DOL rule, California enacted SB 1375, Chapter 700, Statutes of 2018, to prohibit fully-insured MEWA from selling large group coverage to small employers. SB 1375 protects the state's individual and small group markets from potential adverse selection by specifying that the status of each distinct member of an association determines whether that member's association coverage is individual, small group, or large group health coverage. In other words, if a member in the association is a small group, then the member would need to meet existing small group requirements in California law (i.e., small group premium rating restrictions).

The DMHC issued a 2019 All Plan Letter (APL) to remind health plans, solicitors, brokers and others that in California, group coverage may not be sold to individual subscribers directly or "indirectly through any arrangement." California law significantly limits the extent to which employers and individuals may join together to purchase health care coverage as an association. As such, notwithstanding the DOL rule, individuals (including sole proprietors without employees) may purchase individual coverage only, regardless of whether they are in an association. Similarly, small employers may purchase small group coverage only, regardless of whether that coverage is sold through an association.

c) SB 1375 Exemptions. In 2021, two bills were enacted to create two narrow exceptions to the general rule in SB 1375 that plans are barred from selling large group coverage to small employers and individuals through a MEWA. SB 255 (Portantino), Chapter 725, Statutes of 2021, exempts one MEWA that provides health coverage for freelance filming crews in the television commercial production industry. Eligibility requirements of the large group contract is required to provide coverage for employees and their dependents, who are employed in designated job categories on a project-by-project basis for one or more employers with no single project exceeding six months in duration. SB 718 (Bates), Chapter 736, Statutes of 2021, exempts a MEWA that provides health coverage for individuals in the biomedical industry. SB 718 requires the large group health plan to include coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California. The provisions related to SB 718 will sunset on January 1, 2026. This bill deletes the sunset in SB 718.

d) Recent Proposed Federal Rule. Late last year, the DOL issued a proposed rule that would rescind the 2018 DOL rule designed to expand the formation and use of AHPs. According to a recent Health Affairs article, in the preamble to its proposed rule, DOL describes its "extensive experience" with unscrupulous promoters and operators of MEWAs. Compared to traditional health insurers, MEWAs have disproportionately suffered from financial mismanagement and abuse, leaving enrollees and providers with significant financial liabilities. Under ERISA, an association can only sponsor an employee health benefit plan when it is acting as an employer. Such plans can only be offered through genuine employment-based arrangements. In its proposed rule, DOL argues that the 2018 DOL rule loosening the business purpose, commonality of interest, and working owner standards do not align with the text and intent of ERISA. The agency also notes that the 2018 DOL rule would have increased adverse selection in the individual and small-group insurance markets. DOL further notes that the 2018 DOL rule would have enabled AHPs to offer coverage not subject to the ACA's EHB standard, enabling them to offer only "skinny" plans that leave workers underinsured. These federal rules are pending.

3) **SUPPORT.** Biocom California, sponsor of this bill, writes that Biocom California established a health plan trust, specifically for its small and medium sized life science companies. Biocom works on behalf of more than 1,7000 members. The plan's benefits are high-quality and are available to not just the most experienced scientists but to all qualified employees of an enrolled company – including entry-level clerks and administrative assistants. SB 718 was introduced in 2021 because the biomedical industry's high-quality health plan was swept into the DMHC's regulatory action to reign in lower-quality health plans pursuant to prior legislation. The safeguards included in the 2021 bill have proven effective – the health plan trust has remained stable, it has not resulted in significant flight from the small employer group market, while still providing cost-effective, high-quality health insurance to small life science companies and their employees. Given this, this bill removes the January 1, 2026 sunset date so that the members of the biomedical small employer health plan trust can continue to offer its health plan to its employees. Without the certainty of knowing that their health plan will continue to exist past 2025, due to the sunset included in SB 718, it is difficult for small and medium sized biomedical companies to properly plan. Most small biomedical companies operate on extremely thin margins, making certainty of affordable, high-quality care in the long term critical to their success.

4) **RELATED LEGISLATION.** AB 2434 (Grayson) seeks a similar exemption to this bill for an association member in the engineering, surveying, or design industry. AB 2434 is pending in Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

a) SB 718 until January 1, 2026, an association of employers to offer a large group health plan contract or insurance policy to small group employer members of the association consistent with ERISA if certain requirements are met, including that the association is the sponsor of a MEWA that has offered a large group health plan contract or insurance policy since January 1, 2012, in connection with an employee welfare benefit plan under ERISA, provides a specified level of coverage, and includes coverage for common law employees, and their dependents, who are employed by an association member in the biomedical industry with operations in California.

b) SB 255 authorizes an association of employers to offer a large group health plan contract or insurance policy consistent with ERISA if certain requirements are met, including that the association is headquartered in this state, is a MEWA as defined under ERISA, and was established as a MEWA prior to March 23, 2010, and has been in continuous existence since that date. Includes coverage for employees, and their dependents, who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding 6 months in duration, and who, in the course of that employment, are not covered by another group health care service plan contract or insurance policy in which the employer participates.

c) SB 129 (Pan), Chapter 241, Statutes of 2019, requires annual health plan and insurer enrollment reporting to include enrollment data for products sold inside and outside of Covered California, any other business lines, and MEWAs; and requires DMHC and CDI to publicly report annual enrollment data no later than April 15th of each year.

d) SB 1375 deletes sole proprietors, partners of a partnership, and the spouses of sole proprietors and partners from the definition of "eligible employee" and provides that, with respect to a sole proprietorship that consists only of the sole proprietor and his or her spouse, or a partnership that consists solely of partners and their spouses, that the sole proprietor or the partner, as applicable, and the spouses of those persons, are not considered employees for purposes of determining eligibility for small employer coverage. Prohibits employer group health plans and employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement, and requires that only individual health care service plans and individual health benefit plans be sold to any entity without employees. Revises the definition of a small employer to include any small employer, as defined, who purchases coverage through any arrangement, except as specified.

6) SUGGESTED AMENDMENTS. As this bill seeks an exemption to existing law enacted in response to actions at the federal level to undermine the protections of the ACA, the committee may wish to consider including a sunset on this bill to allow regulators an opportunity to analyze and report to the Legislature on the impacts to the health care insurance market and compliance with existing law.

REGISTERED SUPPORT / OPPOSITION:

Support

Biocom California (sponsor)
California Small Manufacturers Trust

Opposition

None on file.

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2098 (Garcia) – As Amended March 21, 2024

SUBJECT: California Health Facilities Financing Authority Act: nondesignated hospitals: loan repayment.

SUMMARY: Extends the repayment requirements for nondesignated public hospitals participating in a California Health Facilities Financing Authority (CHFFA) loan program. Specifically, **this bill**:

1) Requires CHFFA to extend the repayment period as described in 2) below for nondesignated public hospitals participating in the loan program authorized under the Budget Act of 2022.

2) Requires a nondesignated public hospital participating in the loan program described in 1) above to be required to begin monthly repayments on the loan 24 months after the date of that loan, and to discharge the loan within 72 months of the date of that loan. Requires the monthly payments to be amortized over the term of the loan, at 0% interest. Prohibits a prepayment penalty.

3) Prohibits this bill be construed to amend or otherwise affect the requirements of, or the authorities conferred to implement, the loan program described in 1) above.

4) Defines, for purposes of this bill, "nondesignated public hospital" to mean a public hospital as that term is defined in existing law for purposes of Medi-Cal rate stabilization, excluding those affiliated with county health systems.

EXISTING LAW:

1) Establishes Department of Health Care Access and Information (HCAI) in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [Health and Safety Code (HSC) § 127000, *et seq.*]

2) Establishes CHFFA within the office of the State Treasurer to be the State's vehicle for providing financial assistance to public and non-profit health care providers through loans, grants, and tax-exempt bonds. [Government Code (GOV) § 15430 *et seq.*]

3) Defines "health facility," for purposes of CHFFA eligibility, to mean a facility, place, or building that is licensed, accredited, or certified and organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, or physical, mental, or developmental disability, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, including, but not limited to, a general acute care hospital (GACH) that is a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. [GOV § 15432]

4) Authorizes CHFFA to make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between CHFFA and the participating health institution to refinance indebtedness incurred by that participating health institution or a participating health institution that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with that participating health institution, in connection with projects undertaken or for health facilities acquired or for working capital. [GOV § 15432 (j)]

5) Authorizes CHFFA, if a participating health institution seeking financing for a project that does not meet the guidelines with respect to bond rating, to give special consideration, on a case-by-case basis, to financing the project if the participating health institution demonstrates to the satisfaction of CHFFA the financial feasibility of the project, and the performance of significant community service. [GOV § 15438.5]

6) Specifies, for or the purposes of 4) above, a participating health institution that performs a significant community service is one that contracts with Medi-Cal or that can demonstrate, with the burden of proof being on the participating health institution, that it has fulfilled at least two of the following criteria:

    a) On or before January 1, 1991, has established, and agrees to maintain, a 24-hour basic emergency medical service open to the public with a physician and surgeon on duty, or is a children's hospital that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital. Prohibits this criterion from being utilized in a circumstance where a small and rural hospital has not established a 24-hour basic emergency medical service with a physician and surgeon on duty or will operate a designated trauma center on a continuing basis during the life of the revenue bonds issued by the authority;
    b) Has adopted, and agrees to maintain on a continuing basis during the life of the revenue bonds issued by CHFFA, a policy, approved and recorded by the facility's board of directors, of treating all patients without regard to ability to pay, including, but not limited to, emergency room walk-in patients;
    c) Has provided and agrees to provide care, on a continuing basis during the life of the revenue bonds issued by the authority, to Medi-Cal and uninsured patients in an amount not less than 5% of the facility's adjusted inpatient days as reported on an annual basis to HCAI; and/or,
    d) Has budgeted at least 5% of its net operating income to meeting the medical needs of uninsured patients and to providing other services, including, but not limited to, community education, primary care outreach in ambulatory settings, and unmet nonmedical needs, such as food, shelter, clothing, or transportation for vulnerable populations in the community, and agrees to continue that policy during the life of the revenue bonds issued by CHFFA. [*Id*.]

7) Establishes the Distressed Hospital Loan Program (DHLP) until January 1, 2032, which will provide interest free cashflow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals. Requires HCAI to administer the DHLP and to enter into an interagency agreement with CHFFA to implement the DHLP. [HSC §129381]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, hospitals and health care providers are still facing extremely high levels of inflation, and for the district and municipal hospitals already experiencing financial challenges, repaying these loans at this time is pushing some to the brink of financial insolvency. The author concludes that by giving these hospitals an additional four years to repay the loans, we can ensure that vital services will be available to patients when and where they need it.

2) **BACKGROUND.**

   a) **CHFFA.** CHFFA administers various loan programs for public and non-profit hospitals. In order to meet the requirements for CHFFA financing, an institution must be a public hospital, a private non-profit corporation, or an association authorized by the laws of California to provide or operate a health facility and undertake the financing or refinancing of a project. Generally, non-profit, licensed health facilities in the State of California including adult day health centers, community clinics, developmentally disabled centers, and drug and alcohol rehabilitation centers are eligible for financing. Applicants must be approved by a resolution of the CHFFA Members at a regularly scheduled public meeting. In addition to initial eligibility, CHFFA requires borrowers to comply with its Bond Issuance Guidelines per bond rating category and provide loan security provisions and bond covenants that correspond with its rating. Savings resulting from issuance of tax-exempt bonds for borrowers must be transferred to the consuming public via lower or contained costs for delivery of health services.

   b) **CHFFA "Bridge" loans.** During the pandemic district and municipal hospitals were struggling with staffing shortages, supply shortages, and increased expenses. The Department of Health Care Services (DHCS) also transitioned its Medi-Cal managed care program from a Fiscal Year to Calendar Year and this impacted the timing of Medi-Cal supplemental programs, delaying over a $100 million of payments annually. The District Hospital Leadership Forum (DHLF), the sponsor of this bill, worked with the Legislature on two $40 million loan programs, accomplished through budget actions in 2021 and 2022, administered by CHFFA to "bridge" some of the cash flow gap for those hospitals most in need. These interest free loans had a two-year repayment term as it was expected that hospitals would exit the pandemic and return to a better fiscal situation. Payments on the first round of loans, implemented in the 2021 budget bill are coming due this year, and are not affected by the provisions of this bill.

      This bill seeks to change the loan repayment terms for the loans awarded in the 2022 budget bill, to 24 months after the date of the loan, and to discharge the loan within 72 months of the date of that loan, similar to the DHLP.

   c) **DHLP.** AB 112 (Committee on Budget), Chapter 6, Statutes of 2023, established the DHLP, until January 1, 2032, which will provide interest free cashflow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals. The DHLP is jointly administered by

HCAI and CHFFA. The following hospitals received a total of $300 million in financial support:

i) Beverly Hospital $5 million*;
ii) Dameron Hospital Association $29 million;
iii) El Centro Regional Medical Center (El Centro) $28 million;
iv) Hayward Sisters Hospital, dba St. Rose Hospital $17.65 million;
v) Hazel Hawkins Memorial $10 million (HH subsequently declared bankruptcy and declined it loan award);
vi) John C. Fremont Healthcare District $9.35 million;
vii) Kaweah Delta Health Care District $20.75 million;
viii) Madera Community Hospital $2 million**;
ix) Martin Luther King, Jr. Community Hospital $14 million;
x) Palo Verde Hospital $8.5 million;
xi) Pioneers Memorial Healthcare District $28 million;
xii) Ridgecrest Regional Hospital $5.5 million;
xiii) San Gorgonio Memorial Healthcare District $9.8 million;
xiv) Sonoma Valley Hospital $3.1 million;
xv) TriCity Medical Center $33.2 million; and,
xvi) Watsonville Community Hospital $8.3 million.

* Beverly Hospital in Montebello was awarded a $5 million dollar bridge loan to cover operational costs while the hospital was purchased out of bankruptcy, which they subsequently declined.

** Madera Community Hospital, which has been closed since December 2022 and filed for bankruptcy in March 2023, received a $2 million bridge loan to cover basic operational costs for the facility while working with potential partners to reopen. On April 8, 2024, it was announced that Madera was approved for a $57 million DHLP loan, and that the Department of Public Health approved a Change of Management Application filed by American Advanced Management, Inc.

The loans are at zero-interest and are repayable over 72 months, with an initial 18-month grace period at the beginning of the loan term. The program will sunset on December 31, 2031. HCAI and CHFFA received 30 applicants for the program, however, not all hospitals were awarded funds. During the extensive loan application review process, HCAI considered a diverse set of criteria. Hospitals that demonstrated the greatest levels of financial distress, at-risk of closing in the near term, and had a well-founded plan to remain open and provide services and care, were prioritized and issued loans through the program. Hospitals that did not receive funds from the program demonstrated less financial distress when compared to other hospitals that applied. Many of the district hospitals that received bridge loans, also received DHLP funds.

d) Imperial County Hospitals. The Assembly Budget Subcommittee No. 1 on Health hearing held an Oversight Hearing on Hospital Financing and Closures on March 11, 2024. The University of California (UC) San Diego Health CEO's testimony gave insight into the situation specifically with rural hospitals like those in Imperial County, the author of this bill's district. Patty Maysent testified that "Forty-five percent of Imperial County residents have Medi-Cal coverage, among the highest in the state, and health care providers are reimbursed at 25 to 35 cents on the dollar. Low reimbursement rates from

Medi-Cal and Medicare, coupled with financial losses during COVID and the need to take out debt to meet its 2020 seismic requirements put El Centro on the brink of closure at the end of 2022. Leadership at the time decided to close obstetrical services and prepare for potential bankruptcy.

"To prevent the hospital from closing, UC San Diego Health agreed to assume day-to-day operational, clinical, and financial management in February 2023. Since then and with support from the state, the city of El Centro, and the management team, El Centro is on track to achieve positive cash flow by the end of this year. El Centro team could not have accomplished this turn-around without the $28 million loan the hospital received from the DHLF. Those funds are being leveraged to complete the construction required to achieve California's 2030 mandated seismic compliance, to pay down bond principal and interest, to help fund necessary investments in an electronic medical records system and other capital equipment, and to fund payroll. By the end of this year, El Centro will be a fully seismically-compliant hospital and will be on the path to financial stability. That said, the future of the hospital and health care in general in Imperial County depend on needed growth, physician and workforce recruitment and development, and other investments so patients do not have to leave Imperial Valley to receive care such as cancer treatment, critical care, or cardiology interventions. Loan forgiveness will help El Centro maintain the financial stability it needs to continue serving the Imperial Valley community."

3) **SUPPORT.** DHLF is the sponsor of this bill and states that because so many district and municipal hospitals are on the brink of financial insolvency, nearly half of the DHLP loans and available funds were allocated to support district and municipal hospitals. Unfortunately, since the public health emergency, California's district and municipal hospitals have liquidated their reserves and now are facing significant financial distress—struggling with rising inflation and increased labor costs. Given that district and municipal hospitals only represent 8% of hospitals statewide, qualifying for this level of support with short-term loans provides a real-time assessment of the financial status for these providers and the inherent risk of access to health care in the communities they serve. DHLF concludes that these public safety net hospitals need more time to repay the CHFFA bridge loans and this provides them with the much-needed lifeline, and is asking the legislature for support to extend the repayment term of CHFFA bridge loans issued to district and municipal hospitals to match the term of the DHLP.

4) **RELATED LEGISLATION.** AB 3275 (Soria) requires a health care service plan or health insurer to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within 10 business days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within five business days that the claim is contested or denied. AB 3275 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

   a) AB 412 established the DHLP, until January 1, 2032, which will provide interest free cashflow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals. Requires HCAI to administer the DHLP and to enter into an interagency agreement with CHFFA to implement the DHLP.

b) AB 1131 (Garcia) of 2023 would establish the Hospitals First Revolving Fund, administered by the HCAI, to offer grants and low-cost loans to hospitals in rural and medically underserved communities to prevent the closure of a hospital or facilitate the reopening of a closed hospital. AB 1131 was held in the Assembly Appropriations Committee.

c) SB 45 (Roth) would have established the California Acute Care Psychiatric Hospital Loan Fund within CHFFA and would continuously appropriate moneys in that fund to CHFFA to provide loans to qualifying county or city and county applicants for the purpose of building or renovating acute care psychiatric hospitals, psychiatric health facilities, or psychiatric units in GACHs, as defined. Requires CHFFA to develop an application for county or city and county applicants by January 1, 2025. SB 45 was held in the Assembly Appropriations Committee.

6) DOUBLE REFERRAL. This bill is double referred. Upon passage of this Committee, it will be referred to the Assembly Committee on Budget.

REGISTERED SUPPORT / OPPOSITION:

Support

District Hospital Leadership Forum (sponsor)
California Hospital Association

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2105 (Lowenthal) – As Introduced February 5, 2024

SUBJECT: Coverage for PANDAS and PANS.

SUMMARY: Requires a health plan contract or health insurance policy to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) as prescribed or ordered by the treating physician and surgeon. Specifically, **this bill**:

1) Requires a health plan contract or insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of PANDAS and PANS prescribed or ordered by the treating physician and surgeon. Includes antibiotics, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin (IVIg) therapy.

2) Prohibits coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits provided by the contract or policy.

3) Specifies that any required authorization for PANDAS and PANS be provided in a timely manner that is appropriate for the severity of an enrollee or insured's condition.

4) Prohibits a health plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the enrollee or insured was diagnosed with or received treatment for their condition under a different diagnostic name, including autoimmune encephalopathy.

5) Prohibits a health plan or insurer from limiting coverage of immunomodulating therapies for PANDAS or PANS in a manner that is inconsistent with the treatment recommendations pursuant to 6) below, and from requiring a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies pursuant to this bill.

6) Specifies that coverage for PANDAS and PANS adhere to the treatment recommendations developed by a consortium of medical professionals convened to research, identify, and publish clinical practice guidelines and evidence-based standards for the diagnosis and treatment of those disorders.

7) Requires, for billing and diagnostic purposes, PANDAS and PANS to be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services (CMS) create and assign a specific code or codes for PANDAS and PANS. Authorizes, after the creation of that code or codes, PANDAS and PANS to be coded as autoimmune encephalitis, PANDAS, or PANS. Provides that if

PANDAS or PANS is known by a different common name in the future, it may be coded under that name and requires this bill to apply to that disorder or syndrome.

8) Exempts specialized health plan contract or insurance policy that covers dental or vision benefits or a Medicare supplement policy from the provisions of this bill.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

2) Establishes as California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization contract, existing California health insurance mandates, and the 10 ACA mandated benefits. [HSC §1367.005 and INS §10112.27]

3) Defines "basic health care services" as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services; and,
   g) Hospice care. [HSC §1345]

4) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services to:
   a) Be developed with involvement from actively practicing health care providers;
   b) Be consistent with sound clinical principles and processes;
   c) Be evaluated, and updated if necessary, at least annually;
   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,
   e) Be available to the public upon request. [HSC §1363.5 and INS §10123.135]

5) Requires reviews, for purposes of Independent Medical Review (IMR), to determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee or insured and any of the following:
   a) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
   b) Nationally recognized professional standards;
   c) Expert opinion;
   d) Generally accepted standards of medical practice; or,
   e) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious. [HSC §1374.33 and INS §10169.3]

6) Requires every health plan or insurer to provide an external, IMR to examine the plan or insurer's coverage decisions regarding experimental or investigational therapies for an individual with a life-threatening or seriously debilitating condition, as specified. [HSC §1370.4 and INS §10145.3]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, despite published PANDAS/PANS treatment guidelines that established the standard of care in 2017, insurers have continued to adhere to their own policy statements forbidding authorization of immune-focused treatments like IVIg. As a result, effective treatments are denied routinely without real consideration. Reviewers working for insurers are often nurses or pharmacists, not physicians, and even when an insurer engages the service of a physician to determine authorization, the physician reviewer generally lacks experience in this complex, uncommon, and devastating disorder. A typical delay in receiving IVIg due to insurance denials is measured in months, if not years. Meanwhile, most PANS/PANDAS sufferers cannot attend school or require intensive academic accommodations such as home hospital school. They may be hospitalized medically or psychiatrically, resulting in more cost and unnecessary suffering. They may accumulate permanent neurological damage. This last sad fact has led to the establishment of the POND Brain Bank at Georgetown University, where the brains of seven deceased young PANDAS/PANS patients are now contributing to scientific knowledge. Eleven states have passed legislation similar to this bill since 2017. Without legislation, insurers have shown no willingness to grant timely and medically indicated treatment to PANS/PANDAS children. The author concludes that as a result, families continue to suffer unnecessarily and the state continues to incur costs related to special education and parental loss of employment and productivity.

2) **BACKGROUND.** According to the California Health Benefits Review Program (CHBRP), PANDAS/PANS are terms used to describe a subset of children with symptoms that include a sudden onset of a collection of neuropsychiatric symptoms co-occurring with obsessive-compulsive disorder (OCD) and/or tic disorders usually following an infection. PANDAS, currently classified as a subset of PANS, is hypothesized by some to be triggered by an autoimmune response to Group A Streptococcal (Strep) bacteria (which cause Strep throat or soft tissue infections). More specifically, some research hypothesizes that the body's immune system may produce antibodies (known as cross-reactive antibodies) that create a dysfunctional autoimmune response following a Group A Strep infection, which may result in a range of conditions, including rheumatic fever which affects the heart valves. These cross-reactive antibodies may occur in the brain, where the autoimmune response is thought to result in sudden onset of neuropsychiatric symptoms such as OCD, tic disorders, and other psychiatric symptoms that also present in children diagnosed with PANDAS. However, according to CHBRP, findings from other studies run counter to this hypothesis. Two prospective, blinded case-control studies have shown no observable temporal relationship between Group A Strep infection and the clinical exacerbations (i.e., worsening or increase in symptoms) associated with patients who met published diagnostic criteria for PANDAS. PANS is hypothesized to be triggered by causes other than Group A Streptococcus infection. Much remains unknown about PANDAS and PANS and controversy remains regarding whether PANDAS differs enough from pediatric OCD or tic disorders and other

neuropsychiatric disorders to warrant a different diagnostic category. The body of research related to PANDAS and PANS is small (number of studies and sample sizes among studies) compared with many other diseases and conditions.

Prevalence. PANDAS/PANS has been primarily described in children between the ages of three and 12 years; however, the exact prevalence and age distribution of PANDAS/PANS is unknown. Because OCD is a required symptom for the diagnosis of PANDAS and PANS, it is thought their prevalence can be estimated as a subset of the prevalence of pediatric OCD. Epidemiological research estimates that 0.5% to 5% of children in the United States are affected by OCD. PANDAS/PANS is uncommon and despite the first publication on the topic occurring in 1998, it remains unfamiliar to much of the clinical community. Clinicians commonly involved in diagnosing PANDAS/PANS may include a family physician, pediatrician, pediatric nurse practitioner, pediatric neurologist, pediatric psychiatrist, neurodevelopmental pediatrician, pediatric rheumatologist, and pediatric allergist/immunologist. Despite the wide variety of clinicians listed, many are unfamiliar with the syndromes and how to diagnose or treat them. CHBRP notes that there are ~10 PANDAS/PANS clinics nationwide with two located in California (Stanford and UCLA).

Due to the lack of diagnostic laboratory or imaging tests specific to PANDAS/PANS, and the overlap of symptoms with multiple conditions, the diagnostic process for these syndromes is challenging. PANS has no specific diagnostic or billing codes; an International Classification of Diseases, Tenth Revision code for PANDAS exists. This bill requires the use of the codes for autoimmune encephalitis until national billing codes for PANDAS/PANS diagnostic process relies primarily on a clinical diagnosis in conjunction with laboratory testing to rule out conditions with similar symptoms such as pediatric autoimmune encephalitis, other pediatric infection-triggered autoimmune neuropsychiatric disorders (e.g., childhood acute neuropsychiatric syndromes, Sydenham chorea, neuropsychiatric lupus, etc.), Tourette syndrome, and pediatric OCD. Misdiagnosis and children's suppression of behaviors during diagnostic visits also make accurate diagnosis challenging. The clinical diagnosis focuses on a detailed medical history to define sudden onset, possible relation to recent infections, and documentation of current symptoms.

Barriers. Barriers for the diagnosis and treatment of PANDAS/PANS include the lack of evidence on effective treatment options. The lack of clinicians familiar with PANDAS and PANS contributes to long distance travel (and associated travel expenses) for families seeking care. PANDAS/PANS symptoms overlap with symptoms of other conditions, thus the lack of a definitive test and reliance on a differential diagnosis can lead to delayed diagnosis. Misdiagnosis, and children's suppression of behaviors during assessments are also treatment barriers in PANDAS/PANS. Treatment for moderate-to-severe PANDAS/PANS generally requires pediatric specialists, and ideally, coordinated care among treating clinicians who may be in different care settings. For patients with mild or moderate cases, weekly therapy with cognitive behavioral therapy (CBT), or outpatient daily therapy may be prescribed, but due to pediatric behavioral health workforce shortages in California, both may be difficult to access. For patients with more severe cases, space in inpatient day programs or hospitalizations, where treatment may last from one week to months, may be difficult to obtain due to California's shortage of pediatric psychiatric care clinicians and inpatient and treatment beds.

IMR. In 2023, CHBRP reviewed the state's IMR determinations since the implementation of the ACA in California and found 29 related to coverage of treatment for PANDAS, PANS, and autoimmune encephalitis. All determinations were specific to coverage of IVIg. A total of 15 IMRs overturned the decision of the health plan for enrollees requesting coverage for IVIg, based on the refractory nature of the patient's condition and sufficient evidence showing lack of improvement following first-line therapies. The health plans' decisions were upheld in 14 instances where enrollees requested coverage of IVIg either due to insufficient medical evidence and/or lack of clinical evidence supporting the patient's diagnosis.

Clinical Guidelines. CHBRP used the guidelines developed by the PANDAS Physicians Network, the PANDAS/PANS Clinical Research Consortium, and Nordic Pediatric Immunopsychiatry Group in its analytic approach to AB 907 (Lowenthal) of 2023 which was substantially similar to this bill. CHBRP notes that this bill requires coverage of PANDAS and PANS to adhere to treatment recommendations in clinical practice guidelines and evidence-based standards; the guidelines developed by the groups mentioned above are consensus guidelines. Evidence-based guidelines make statements that are informed by a systematic review of the evidence and an assessment of the benefits and harms of alternative options. Consensus guidelines are developed by an independent panel of experts with experience in the condition(s), usually multidisciplinary, convened to review the research literature in an evidence-based manner for the purpose of advancing the understanding of an issue, procedure or method. The key difference between the development of the two types of guidelines appears to be that when the evidence is of high quality, some guideline panels rely on the evidence review to guide their recommendations and the process is evidence-based. However, when the evidence is very limited and hence of low quality or very low quality, some guideline panels rely primarily on clinical experience and the process is consensus-based. CHBRP found clinical practice guidelines from three different organizations; all recognize the syndromes' range of severity (mild, moderate, severe) and recommend similar, but not perfectly aligned, treatments.

a) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP reviewed AB 907 (Lowenthal) of 2023, which is substantially similar to this bill, and states the following in its analysis:

   i) Enrollees covered. At baseline, 100% of enrollees with health insurance that would be subject to this bill have coverage that includes diagnostic tests associated with PANDAS/PANS recommended by various guidelines for diagnosing PANDAS/PANS. At baseline, 100% of enrollees with health insurance that would be subject to this bill have coverage that includes some, but not all, treatments for PANDAS/PANS. Coverage by type of treatment varies substantially. For example, CHBRP found that 100% of enrollees have health insurance that includes antibiotics commonly used for PANDAS/PANS and some oral prescription immunomodulatory medications including steroids and nonsteroidal anti-inflammatory medications (NSAIDs). CHBRP finds that 0% of enrollees have coverage for intravenous immunomodulating therapies, including plasma exchange,

B-cell modulators (rituximab), and IVIg therapy. Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective. Postmandate, 100% of enrollees with health insurance subject to this bill would have coverage for all diagnostic tests and treatments included under this bill.

ii) **Impact on expenditures.** This bill increases total net annual expenditures by total net annual $2,990,000 or total net annual 0.0020% for enrollees with DMHC-regulated plans (including DMHC-regulated Medi-Cal) and CDI-regulated policies. Premiums for enrollees in individual plans purchased through Covered California would increase by a total of $69,000 in annual expenditures.

(1) **Medi-Cal**. For this analysis, CHBRP has included potential impacts on Medi-Cal beneficiaries. In addition to the expected increase of $1.47 million in premiums, CHBRP is estimating for the 8.8 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans (a figure that represents a 0.005% increase in premiums), it seems reasonable to assume that a population proportional increase of $370,000 would occur for the 2.0 million beneficiaries enrolled in county organized health systems managed care.

(2) **CalPERS.** For enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.001% ($0.01 per member per month, or $83,000 total increase in expenditures).

(3) **Uninsured.** Since the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of this bill.

iii) **EHBs.** This bill would not require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California.

iv) **Medical effectiveness.** CHBRP analyzed the strength of evidence for the effectiveness of antibiotics, psychotropic medications, CBT, plasma exchange, IVIg and other immunomodulating medications addressed by this bill, specifically, for children affected by PANDAS/PANS. Overall, the evidence is insufficient or inconclusive that any of these treatments are effective at reducing prominent symptoms, such as OCD symptoms, tics, or eating restrictions, for pediatric patients with PANDAS/PANS. The body of research on PANDAS and PANS is small (number of studies and sample sizes of available studies) compared with many other diseases and conditions. Additional studies involving controlled clinical trials, larger sample sizes, and clear eligibility criteria are necessary to determine which treatments are effective for children with PANDAS/PANS. More specifically, CHBRP found insufficient evidence on the effectiveness of CBT, psychotropics, NSAIDs, corticosteroids, plasma exchange, rituximab, mycophenolate mofetil, and vitamin D in reducing or eliminating the prominent symptoms associated with PANDAS/PANS. CHBRP found inconclusive evidence on the effectiveness of antibiotics and IVIg in reducing or eliminating the prominent symptoms associated with PANDAS/PANS.

v) **Utilization.** CHBRP estimates that at baseline, 15,410 enrollees use diagnostic tests for PANDAS/PANS. Given that 100% of enrollees already have baseline coverage, CHBRP estimates no changes in utilization for these diagnostic tests. At baseline, CHBRP estimates that 670 enrollees have a PANDAS/PANS diagnosis. Given that 100% of enrollees already have baseline coverage for these medications and behavioral health therapies such as CBT, CHBRP estimated no changes in

utilization of these specific medications and CBT services postmandate. CHBRP estimates that IVIg, rituximab, and plasma exchange have extremely limited use at baseline. CHBRP estimates that average annual utilization of IVIg among all enrollees with PANDAS/PANS would increase to 0.7 infusion therapy sessions per year. This results in an estimated 90 enrollees with moderate or severe PANDAS/PANS utilizing IVIg at least once per year, with greater expected utilization among those with severe PANDAS/PANS. CHBRP estimated no change in the use of plasma exchange services given their low availability and the lack of evidence of their effectiveness in PANDAS/PANS.

vi) **Public health.** In the first year postmandate, the public health impact of this bill is unknown due to insufficient and inconclusive evidence regarding the effectiveness of treatments for PANDAS/PANS.

vii) **Long-term impacts**. Utilization of diagnostic tests and treatments for PANDAS/PANS is expected to be similar in the long term as utilization in the first 12 months postmandate. However, should evidence about the effectiveness of new diagnostic tests or treatments such as IVIg become more conclusive, for example, from more evidence from larger randomized controlled clinical trials, more physicians may prescribe these treatments. Cost impacts are expected to also be similar to those projected in the first 12 months postmandate.

viii) **Other states.** There are 10 states, including Arkansas, Delaware, Illinois, Indiana, Kansas, Maryland, Massachusetts, Minnesota, New Hampshire, and Rhode Island, that mandate at least temporary coverage of treatment for PANDAS and PANS. Minnesota's law is most similar to this bill, describing the same set of treatments that may be recommended by a health care professional for PANDAS and PANS. In 2023, 12 states in addition to California (Arkansas, Connecticut, Georgia, Illinois, Maine, Massachusetts, Missouri, New York, Oregon, Rhode Island, Texas, and West Virginia) introduced legislation related to PANDAS and PANS. According to the author, eleven more states have pending legislation this year.

3) **SUPPORT.** The Northwest PANDAS/PANS Network writes that this bill will ensure access to medical care that is required for children with PANDAS/PANS. Oregon has approved and now provides IVIg treatment coverage for PANDAS/PANS. This decision was made after a 15-month review process for the inclusion of coverage for Medicaid recipients. The Oregon bill was passed which mandates private and commercial insurers provide the same coverage and received unanimous and bi-partisan support. Most PANDAS/PANS families cannot afford to pay privately for the care and treatments that are so often denied by insurers. Instead, they are forced to watch their child be crippled by psychiatric distress, losing parts of their childhood they will never get back. No parent should face such a tragedy that is preventable when access to treatment is available. Children Now writes that **c**urrently, insurers automatically deny treatment for severe PANS requiring IVIg, based on their own policy statements claiming it is experimental or not medically necessary. These statements contrast with recommendations published in 2017 by experts across the nation, including Stanford University. IVIg meets the definition of medical necessity as defined by California Insurance Code. If it was experimental (which it is not), it would also meet the test for experimental treatments that insurers are required to cover. Unfortunately, less than 1% of denied families will appeal these denials. By the time IVIg is needed, the child's situation is urgent, and overwhelmed families are unable to carry out the intensive, slow appeals process. Children Now states that this multi-step, multiple-month process is inappropriate when a child's brain is severely inflamed. Insurance denials prolong suffering, risk permanent

neurologic and mental health disability, and shift the burden to California taxpayers who pay for special education, unemployment, disability, and lost productivity

4) **OPPOSITION.** The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) oppose mandates for health plans and insurers to cover specific services, as well as bills that eliminate cost sharing and limit utilization management, which have similar cost impacts as coverage mandates. Moreover, they will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. CAHP, ACLHIC, and ACLHIC write that state mandates increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates.

5) **RELATED LEGISLATION.** SB 1290 (Roth) expresses the intent of the Legislature to review California's EHBs benchmark plan and establish a new benchmark plan for the 2027 plan year. SB 1290 is pending in Senate Health Committee.

6) **PREVIOUS LEGISLATION.** AB 907 was substantially similar to this bill and vetoed by Governor Newsom, who stated in part:

> "While I support the author's goal of ensuring that children with PANS and PANDAS receive the treatment they need in a timely manner, this bill creates a disease-specific mandate and contains provisions that would be duplicative of existing laws for timely access standards and grievance processes through the DMHC and CDI. Further, this bill removes the medical necessity requirement, which is a standard condition for health plans in determining coverage of specific services."

7) **AUTHOR'S AMENDMENTS.** To address one of the concerns raised by the Governor's veto of AB 907, the author wishes to amend this bill to clarify that medically necessary is as defined by current clinical practice guidelines published in peer-reviewed medical literature, or put forth by organizations comprised of expert treating clinicians.

8) **COMMENT.** As this bill moves forward, the Committee may wish to recommend to the author to engage the Administration as soon as possible to address the veto of AB 907 from last year.

REGISTERED SUPPORT / OPPOSITION:

Support

California Coalition for PANS/PANDAS Advocacy (sponsor)
California Children's Hospital Assn
California Federation of Teachers Afl-cio
California Life Sciences
California Medical Association
California Teamsters Public Affairs Council
Children Now

Educate. Advocate.
Los Angeles County Medical Association
Memorialcare Health System
Moleculera Labs
Northwest Pandas/pans Network (NWPPN)
Sag Aftra

Opposition

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2119 (Weber) – As Amended March 18, 2024

SUBJECT: Mental health.

SUMMARY: Strikes outdated terminology from existing law in relation to mental health and replaces with person-first terminology. Specifically, **this bill**:

1) Replaces the following terms throughout various Welfare and Institutions Code (WIC) sections, Chapter titles and Article titles:

   a) "Mentally ill person, child, or minor" with "person, child, or minor with a mental health condition;"

   b) "Seriously emotionally disturbed" with "serious emotional disturbance;"

   c) "Seriously emotionally disturbed children and youth" with "children and youth with serious emotional disturbance;"

   d) "Seriously mentally ill person" with "person, child or adolescent with a serious mental health condition;"

   e) "Seriously and persistently mentally ill adults" with "adults with a serious and persistent mental illness;"

   f) "Severely mentally ill person, elderly persons, or children and youth" with "Person, elderly persons, or children and youth with a severe mental health condition;"

   g) "Severely and persistently mentally disabled person" with "person with a severe and persistent mental health condition;"

   h) "Gravely disabled" as "person with a grave disability;"

   i) "Mentally disabled" and "mentally disordered" with "persons with a mental health disability;"

   j) "Homeless mentally disabled persons" with "persons who are homeless with a mental health disability;"

   k) "Suffering from" with "experiencing;"

   l) "Disorder or defect" with "disorder or condition;"

   m) "Frequent failures" with "have not been successful;"

   n) "Prolonged suffering" with "worsening of symptoms and the condition over time;" and,

   o) "Abuse" with "use and misuse."

2) Makes related technical and non-substantive changes.

EXISTING LAW:

1) Establishes the Department of State Hospitals (DSH) with jurisdiction over the execution of the laws relating to care and treatment of persons with mental health disorders under the custody of the DSH. Grants the Department of Health Care Services (DHCS) jurisdiction over the execution of the laws relating to the care, custody, and treatment of persons with mental health disorders. [WIC §4000, *et seq.*]

2) Establishes the Lanterman-Petris-Short Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in county-designated facilities. [WIC §5000, *et seq*.]

3) Establishes the Children's Civil Commitment and Mental Health Treatment Act of 1988 to provide evaluation and treatment of minors with mental health disorders, with particular priority given to seriously emotionally disturbed children and adolescents, safeguard the rights to due process for minors and their families, and to prevent severe and long-term mental disabilities among minors through early identification, effective family service interventions, and public education. [WIC §5585, *et seq*.]

4) Establishes the Bronzan-McCorquodale Act to organize and finance community mental health services for those with mental health disorders in every county through locally administered and controlled community mental health programs. [WIC §5600, *et seq*.]

5) Establishes the Adult and Older Adult Mental Health System of Care Act to encourage each county to implement a system of care for adults and older adults with serious mental illness. [WIC §5800, *et seq*.]

6) Requires DHCS, in coordination with counties, to establish a program to prevent mental illnesses from becoming severe and disabling. Requires the program to emphasize improving timely access to services for underserved populations. [WIC §5840]

7) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of Mental Health Services Act, made up of 16 members appointed by the Governor, and the Legislature, as specified. [WIC §5845 and §5846]

8) Establishes the Children's Mental Health Services Act to establish an interagency system of care for children with serious emotional and behavioral disturbances that provides comprehensive, coordinated care. [WIC §5850, *et seq*.]

9) Organizes and finances mental health services in skilled nursing facilities designated as institutions for mental disease. [WIC §5900, *et seq*.]

10) Authorizes a minor within the jurisdiction of juvenile court, with the advice of counsel, to make voluntary application for inpatient or outpatient mental health services. [WIC §6552]

11) Defines "integrated children's services programs" as a coordinated children's service system, operating as a program that is part of a department or DHCS initiative that offers a full range of integrated behavioral social, health, and mental health service. [WIC §18986.4]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, research shows that the presence of stigma reduces the likelihood of individuals accessing and staying with treatment and being on a path to recovery. The author continues that communities of color not only seek mental health services at lower rates – but when they do, it is increasingly difficult to find providers of color. The author concludes that we need to ensure that all individuals facing a mental or behavioral health issue, feel empowered to seek treatment and do not get discouraged by the misperceptions surrounding mental health.

2) **BACKGROUND.**

   a) **Prevalence of mental health disorders in California.** A 2022 publication from the California Health Care Foundation, entitled "Mental Health in California" reported that nearly one in seven California adults experiences a mental illness, and one in 26 has a serious mental health condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level. Despite major investments and policy shifts to bolster mental health treatment in recent years, close to two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes reported that they didn't receive any treatment. These barriers to care are an issue of equity. A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly five million, or 16%, of Black Americans reported having a mental illness. However, only one in three Black adults who needs mental health care receives it. Similarly, a 2021 study by the University of California Los Angeles Center for Health Policy Research found that almost half of Latino adults who had a perceived need for mental health services experienced an unmet need for care.

   b) **Stigmatizing Terminology.** Research shows that stigmatizing language is one of many barriers to seeking treatment for a substance use or mental health disorder. Slang, medically inaccurate, and non-person first terms can invite negative judgments about individuals with mental health disorders including deeming them unpredictable, dangerous, and untrustworthy. This stigma burdens individuals and can adversely impact their self-esteem, symptom severity, and willingness to seek treatment.

      The American Psychological Association (APA) provides guidance on preferred language for talking about mental health, stressing the importance of the words we use and the power they have to reduce stigma. This guidance urges the use of person-first

language and avoiding derogatory terms that can increase stigma and negative bias. The APA discourages use of terms such as “suffering” or “victim” when discussing those who have mental health needs, and advocates for phrasing like “person with a mental health disorder,” explaining that shifting to person-first language demonstrates that the mental health condition is only one aspect of a person’s life, not the defining characteristic.

3) **SUPPORT.** The County Behavioral Health Directors Association of California (CBHDA) are the sponsors of this bill stating that one in five adults in the United States live with mental illness, and mental health conditions are the world’s leading cause of disability, yet a significant amount of stigma persists around mental health conditions and treatment. CBHDA continues that stigma surrounding health conditions in language and statute reflects societal attitudes that lead to discrimination in obtaining housing, accessing health services and treatment, education, and employment opportunities. CBHDA concludes that as California continues to prioritize the mental and emotional wellbeing of its residents, modernizing statutory language will help challenge the harmful stigma and stereotypes associated with mental health conditions.

4) **RELATED LEGISLATION.** 2995 (Jackson) strikes outdated terminology from existing law in relation to substance use disorder and replaces with person-first terminology. AB 2995 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

   a) AB 248 (Mathis), Chapter 797, Statutes of 2023, strikes the terms "handicapped," "mentally retarded persons," "mentally retarded children," and "retardation" and instead uses the terms “individuals with intellectual, developmental disabilities,” “impaired,” or “disability” throughout code.

   b) AB 1130 (Berman), Chapter 21, Statutes of 2023, updates various provisions of code to replace use of the term “addict” with the term “person with substance use disorder.”

   c) AB 1096 (Luz Rivas), Chapter 296, Statutes of 2021, strikes the offensive and dehumanizing term "alien" used to describe a person who is not a citizen or national of the United States where it appears in multiple California Code sections and, replaces it with other terms that do not include the word "alien."

REGISTERED SUPPORT / OPPOSITION:

Support

County Behavioral Health Directors Association California (sponsor)
Steinberg Institute

Opposition

None on file.

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2131 (Valencia) – As Amended March 18, 2024

SUBJECT: Certified nurse assistant training programs.

SUMMARY: Requires the Department of Public Health (DPH) to prepare, maintain, and publish at least twice a year, an updated list on its internet website of approved training programs for nurse assistant certification, aggregated by the language in which the test was taken. Requires DPH, no later than December 31, 2025, to provide, or contract with an approved vendor to provide a nurse assistant certification examination that includes the option to take the written and oral competency examination in Spanish.

EXISTING LAW:

1) Requires certain health facilities, including skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), to be licensed by DPH. [Health and Safety Code (HSC) §1250, et. seq.]

2) Defines a "certified nurse assistant (CNA)" as any person who holds themselves out as a CNA and who, for compensation, performs basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients, and is certified as having completed training requirements in existing law. Prohibits CNA services from including any services which may only be performed by a licensed person and requires those services to be performed under the supervision of a registered nurse (RN) or a licensed vocational nurse. [HSC §1337]

3) Requires a SNF or ICF to adopt an approved training program that meets standards established by DPH. Requires the training program to consist of at least an orientation program to be given to newly employed nurse assistants prior to providing direct patient care in SNFs or ICFs and a precertification training program consisting of at least 60 hours of training, as specified. [HSC §1337.1]

4) Places the following requirements on the 60 hours of training:

    a) At least two hours of the 60 hours of training to address the special needs of persons with developmental and mental disorders, including intellectual disability, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness;
    b) At least two hours to address the special needs of persons with Alzheimer's disease and related dementias;
    c) A minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing specified courses; and,
    d) A minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations. [*Ibid.*]

5) Requires the precertification training program, in addition to the 60 hours of training, to consist of at least 100 hours of supervised and on-the-job training clinical practice. Permits the 100 hours to consist of normal employment as a nurse assistant under the supervision of

either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training. Requires at least four hours of the 100 hours of supervised clinical training to address the special needs of persons with developmental and mental disorders, including intellectual disability, cerebral palsy, epilepsy, Alzheimer's disease and related dementias, and Parkinson's disease. [*Ibid.*]

6) Authorizes DPH to approve an online or distance learning nurse assistant training program that complies with the following requirements:
   a) Provide online instruction in which the trainees and the approved instructor are online at the same or similar times and which allows them to use real-time collaborative software that combines audio, video, file sharing, or any other forms of approved interaction and communication;
   b) Require the use of a personal identification number or personal identification information that confirms the identity of the trainees and instructors, including, but not limited to, having trainees sign an affidavit attesting under penalty of perjury to their identity while completing the program;
   c) Provide safeguards to protect personal information;
   d) Include policies and procedures to ensure that instructors are accessible to trainees outside of the normal instruction times;
   e) Include policies and procedures for equipment failures, student absences, and completing assignments past original deadlines;
   f) Provide a clear explanation on its Internet website of all technology requirements to participate and complete the program; and,
   g) Provide DPH with statistics about the performance of trainees in the program, including, but not limited to, exam pass rate and the rate at which trainees repeat each module of the program, and any other information requested by DPH regarding trainee participation in and completion of the program. [HSC §1337.16]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill ensures better accessibility to individuals looking to be a CNA by requiring the written and oral portion of the CNA competency exam to be offered in Spanish. The author concludes that making the exam available in one of the most commonly spoken languages other than English in California, will create more linguistically competent care for California patients with limited English proficiency, help build the workforce pipeline to one that is more reflective of our population and address the critical workforce shortages.

2) BACKGROUND.

a) CNAs. An applicant for certification as a CNA must be at least sixteen years of age, have successfully completed a training program approved by DPH, which includes an examination to test the applicant's knowledge and skills related to basic patient care services, and obtain a criminal record clearance. CNAs provide basic care to patients under the supervision of a RN or a Licensed Practical Nurse (LPN). CNAs are sometimes referred to as nurse aides, patient care technicians, or nursing assistants. Some of their essential responsibilities include:

i) Turning or Repositioning Patients: CNAs help patients change positions to prevent bedsores and improve comfort;
ii) Gathering Supplies for the RN or Medical Doctor: They assist in preparing materials needed for medical procedures;
iii) Checking and Charting Vital Signs: CNAs monitor patients' blood pressure, heart rate, temperature, and other vital signs;
iv) Answering Patient Calls/Bells: They respond to patient requests for assistance;
v) Bathing, Feeding, and Dressing Patients: CNAs help with daily hygiene tasks;
vi) Measuring and Recording Patient Food/Liquid Intake: They track the amount of food and fluids consumed; and,
vii) Assisting Patients with Elimination: They assist patients with toileting needs.

CNAs play an important role in maintaining patient well-being and act as a liaison between nurses and patients. They work in various healthcare settings, including hospitals, SNFs, long-term residential facilities, rehabilitation centers, and adult daycare centers.

b) Workforce shortages. According to July 2022 *Journal of Nurse Regulation,* "Nursing Workforce Challenges in the Post-pandemic World," examining the pre- and post-COVID-19 pandemic literature on nursing turnover found that since the pandemic's onset, there has been a significant increase in nurse turnover intention. A 16-study synthesis of nurse burnout literature during the pandemic found high levels of emotional exhaustion and depersonalization, as well as reduced feelings of personal accomplishment. The same study also identified risk factors for burnout, including decreased social support, working in hospitals with inadequate and insufficient material and human resources, and increased workload. According to the Premier Nursing Academy, RNs and LPNs who are short-staffed often delegate more tasks to CNAs, increasing CNAs mental and physical fatigue which can eventually lead to burnout. A 2018 study indicates that approximately one-third of nurses' experience some level of burnout, and burnout rates may be as high as 50% for CNAs. Burnout can lead to poor job performance and, for many, leaving the profession.

c) Need for cultural competency in the workforce. According to the Latino Policy & Politics Institute Latino Data Hub, individuals who are limited English proficient make up 28.1% (4,055,000) of the Latino population in California. Studies show that rates of misdiagnosis and complications arise when the patients and healthcare professionals do not speak the same language. An April 2023 study, "Barriers in Healthcare for Latinx Patients with Limited English Proficiency," found that Latinos who report limited English proficiency experience discrimination, feel distrust in the healthcare setting, and face poorer health outcome than non-Latino whites. Low healthcare satisfaction and medical mistrust have been well demonstrated in the Latino community. These challenges lead to later hospital presentation, low healthcare utilization, and poor outcomes.

Massachusetts approved legislation allowing CNAs to take their written tests in Spanish and Chinese beginning in 2024.

3) SUPPORT. SEIU California State Council (SEIU California) is the sponsor of this bill and states that to build the CNA workforce and to ensure our growing and diverse population of

older adults receives linguistically competent care, California must recognize its valuable caregivers with limited English proficiency (LEP). Latino individuals aged 65+ are projected to more than double from 1.4 million in 2020 to 2.9 million in 2040. Of those aged 65+ in California, an estimated 17% speak Spanish, and 64% of them say that they speak English less well. While many CNA training programs provide translated versions of the approved DPH materials during training, the CNA exam is only offered in English. This language barrier dissuades experienced care providers with LEP from pursuing CNA certification. By expanding the CNA exam test language to Spanish, the potential worker pool would expand dramatically, allowing the state to measure the impact of providing testing in preferred languages. There is precedent in several other states that allow for the CNA exam to be offered in Spanish.

Current law requires DPH to prepare and maintain a list of CNA training programs that includes information on whether the program is currently offering training, how many individuals a program has trained, and the average pass rate of the program. This detailed information on the training programs is absent from the DPH website and it instead only displays a list of 400+ training programs with business name, physical address, and phone number. Those interested in joining the workforce are given an overwhelming number of options, with little context on which program is right for them. SEIU California concludes that publishing the list online with success metrics and training availability will increase accessibility for those looking to become a CNA and allow individuals to make better-informed decisions.

California Association of Health Facilities (CAHF) supports this bill and states that SNFs continue to face a historic workforce crisis brought on by the pandemic. According to the Bureau of Labor Statistics, the sector has lost nearly 229,000 caregivers (or more than 14% of its workforce) since February 2020, the worst job loss among all health care sectors. The lack of available staff has forced more than 60% of nursing homes nationwide to limit new patient admissions – impacting hospitals that are seeking to free up precious beds and preventing seniors from accessing the care they need. CAHF concludes that by providing more information about where to get CNA training and requiring the exam be offered in Spanish, this bill will expand access to the CNA training, education and certification to individuals desiring to enter the profession.

4) PREVIOUS LEGISLATION.

a) SB 525 (Durazo), Chapter 890, Statutes of 2023, enacts a phased in multi-tiered statewide minimum wage schedule for health care workers employed by covered healthcare facilities, as defined; requires, following the phased-in wage increases, the minimum wage for health care workers employed by covered healthcare facilities to be adjusted, as specified; provides a temporary waiver of wage increases under specified circumstances; and establishes a 10-year moratorium on wage ordinances, regulations, or administrative actions for covered health care facility employees, as specified.

b) AB 2850 (Rubio), Chapter 769, Statutes of 2018, permits SNFs, ICFs, or educational institutions to conduct the 60 classroom hours of training for CNAs in an online or distance learning course format, as approved by DPH.

REGISTERED SUPPORT / OPPOSITION:

Support

SEIU California (sponsor)
California Association of Health Facilities
LeadingAge California

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2340 (Bonta) – As Amended April 4, 2024

SUBJECT: Medi-Cal: EPSDT services: informational materials.

SUMMARY: Requires the Department of Health Care Services (DHCS) to take specified actions in DHCS's implementation of federal regulations requiring states to share informational materials about early and periodic screening, diagnostic, and treatment (EPSDT) services with Medi-Cal beneficiaries under 21 and their families. Specifically, **this bill**:

1) Requires DHCS, per federal regulation, to use clear and nontechnical language in preparation of written informational materials that effectively explain and clarify the scope and nature of the EPSDT benefit, and requires DHCS, in implementing this federal regulation, to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries.

2) Authorizes DHCS to standardize informational materials for use by DHCS and Medi-Cal managed care plans, as deemed appropriate by DHCS.

3) Requires DHCS to, in consultation with stakeholders, regularly review the informational materials to ensure materials are up-to-date.

4) Requires DHCS, for purposes of Medi-Cal beneficiaries under the fee-for-service (FFS) delivery system, or a Medi-Cal managed care plan, for purposes of Medi-Cal beneficiaries under the managed care delivery system, to provide informational materials to youth and their parents or guardians, as applicable, within 60 calendar days after that beneficiary's initial Medi-Cal eligibility determination and annually thereafter.

5) Requires informational materials to include content designed for youth, and requires this information to be delivered to a Medi-Cal eligible beneficiary who is 12 years of age or older but under 21 years of age.

6) Defines EPSDT services to include all age-specific assessments and services listed under, and codifies current state policy that covers services on, the "Bright Futures" periodicity schedule issued by the American Academy of Pediatrics (AAP), and any other medically necessary assessments and services that exceed those listed by AAP and Bright Futures.

EXISTING FEDERAL LAW: Defines EPSDT to include vision, dental, hearing and other screening and preventive services at regular intervals, as well as such other diagnostic and treatment services federally allowable under Medicaid to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not those services are covered under the Medicaid State plan. [Title 42 U.S. Code § 1396d(r)]

EXISTING FEDERAL REGULATION: Requires state Medicaid agencies to:

1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals or their families about EPSDT.

2) Using clear and nontechnical language, provide information about the following:
   a) The benefits of preventive health care;
   b) Services available under EPSDT and where and how to obtain those services;
   c) Costs of care; and,
   d) Coverage of transportation and scheduling assistance.

3) Effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language.

4) Provide assurance to the federal Centers for Medicare and Medicaid Service (CMS) that processes are in place to effectively inform individuals, generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter. [42 Code of Federal Regulations § 441.56]

EXISTING STATE LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Establishes a schedule of benefits under the Medi-Cal program, which includes federally required and optional Medicaid benefits, subject to utilization controls. [WIC §14132]

3) Establishes EPSDT as a Medi-Cal benefit for any individual under 21 years of age is covered, consistent with the requirements of federal law, as specified. [WIC §14132(v)]

FISCAL EFFECT: Unknown. This bill has not yet been reviewed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, despite the Medi-Cal entitlement to early and periodic screening and preventive health care services, California lags far behind other states in providing regular, preventive health care to Medicaid-enrolled infants and children. Prior to 2020, California ranked 40th nationwide for utilization of children's preventive services, or 10 percentage points below the national average. During the COVID-19 pandemic, this utilization fell dramatically. Unfortunately, the author indicates, utilization has not recovered post-pandemic, and in fact it has continued to decline. The author notes this is unacceptable, and behind the statistics are the lives of vulnerable children.

When we miss the mark, the author argues, we miss opportunities to provide these children the screening, early intervention, and treatment they need to stay healthy. The author states we must reverse this trend, and that one common-sense thing we can do is ensure every eligible child and family receives timely, relevant, and user-friendly information about the comprehensive children's health care services that are recommended and covered by Medi-Cal. This alone will not address the crisis in children's preventive care, the author notes, but

it will set the long-term foundation for greater success by ensuring the informational materials are meaningful, culturally concordant, and provided timely, and include materials that speak directly to the needs of youth and encourage them to seek preventive health care and other health care they need.

2) BACKGROUND.

a) EPSDT and Children's Preventive Health Services in Medi-Cal. Federal law establishes an entitlement to the EPSDT benefit, forming the foundation for children's coverage under Medicaid. State law provides limited direction to DHCS on how to implement EPSDT. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. Under EPSDT, Medi-Cal covers periodic screening assessments for infants, children, and adolescents under 21 years of age, as specified in the AAP Bright Futures® preventive healthcare periodicity schedule. The AAP Bright Futures® periodicity schedule provides clear, comprehensive guidance on recommended services at each well-child visit, corresponding to each age milestone up to age 21. For instance, it specifies developmental screening is recommended at well-child visits occurring at nine months, 18 months, and 30 months of age.

Each state must adopt an evidence-based schedule of recommended screening and preventive services as a component of EPSDT services; this bill defines EPSDT services to include all age-specific assessments and services listed under the most current AAP Bright Futures® periodicity schedule, consistent with current practice.

EPSDT is an expansive entitlement for children. In addition to screening, vision, dental, hearing and other preventive services, coverage also includes such other diagnostic and treatment services federally allowable under Medicaid to "correct or ameliorate defects and physical and mental illnesses and conditions," whether or not those services are covered under the Medicaid State plan. Limits, such as caps on the number of covered visits, on EPSDT services are not allowed when those services are medically necessary.

b) Bureau of State Audits (BSA) Audit. In March 2019, BSA released an audit entitled "Department of Health Care Services - Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," regarding DHCS' oversight of the delivery of preventive services to children in Medi-Cal. BSA found the following:

- **i)** An annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services;
- **ii)** Many of the state's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services;
- **iii)** Limited provider access is due, in part, to low Medi-Cal reimbursement rates;
- **iv)** States with higher utilization rates offer financial incentive programs that California could implement, but it would likely require additional funding;
- **v)** DHCS delegates responsibilities to ensure access and use of children's preventive services to managed care plans, but it does not provide effective guidance and oversight;
- **vi)** DHCS does not provide adequate information to plans, providers, and beneficiaries about the services it expects children to receive;

vii) DHCS does not ensure that plans regularly identify and address underutilization of children's preventive services; and,
viii) DHCS has not followed up on plans' efforts to mitigate cultural disparities in the usage of preventive services.

On April 30, 2019, the Joint Legislative Audit Committee and Assembly Committee on Health held a joint hearing to review the audit report and the DHCS response. On November 4, 2019, the Assembly Committee on Health and Senate Committee on Health held a joint informational hearing to review findings and recommendations related to the audit, as well as the standard Six Month Auditee Implementation Progress Report.

c) Follow-Up Audit Findings. On September 3, 2022, the BSA issued a follow-up audit to the original 2019 audit, titled "Department of Health Care Services Is Still Not Doing Enough to Ensure That Children in Medi-Cal Receive Preventive Health Services." The BSA found DHCS made progress in implementing the 2019 audit's recommendations, but it had yet to fully implement eight of the 14 recommendations. According to data analyzed by the BSA, from fiscal years 2018–19 through 2020–21, less than half of all children in Medi-Cal received all required preventive services, leaving an average of 2.9 million children per year missing at least some preventive services. BSA found in fiscal year 2020–21, less than 42% of children received the required number of preventive services, which compares unfavorably to a pre-pandemic level of almost 48% in fiscal year 2018–19.

The audit noted concerns related to DHCS doing limited outreach and not distributing outreach materials during the COVID-19 pandemic as well as continued concerns about the accuracy of provider directories. The audit also notes DHCS approved nearly 10,500 exceptions related to managed care time and distance standards for pediatric services.

d) DHCS Response to the September 2022 Audit; Current Efforts. As noted, DHCS fully implemented six of the audit recommendations and seven more recommendations are partially implemented. In their audit responses, DHCS also cites a number of ongoing initiatives to improve children's health care in Medi-Cal. Some of the initiatives have been implemented and others are in development. DHCS notes the March 2022 brief, "Medi-Cal's Strategy to Support Health and Opportunity for Children and Families" (Strategy), is a forward-looking policy agenda for children and families enrolled in Medi-Cal, intended to unify common threads of existing and newly proposed child and family health initiatives, and solidify DHCS' accountability and oversight of children's services. A number of these strategies are supportive of ensuring continued focus on children's health and increasing utilization of children's preventive services. They include:

i) A new leadership structure at DHCS, including a "child health champion;"
ii) Implementing a new population health management strategy to ensure plans identify and serve children in need of care coordination;
iii) Increasing pediatric and maternity care performance standards for managed care plans;
iv) Support school partnerships by requiring plans to provide Medi-Cal services, including preventive services and adolescent health services, provided in schools or by school-affiliated health providers, as well as an all-payer fee schedule for behavioral health services provided at schools;

v) Streamline DHCS pediatric dashboards to enhance transparency and increase usability;
vi) Enhance and sustain payments to pediatric providers to increase use of key preventive and screening services for children and families;
vii) Implement expanded postpartum eligibility for 12 months and new maternal and child-focused benefits, including dyadic, community health worker, and doula services, and clarify family therapy coverage;
viii) Launch Enhanced Care Management for children; and,
ix) Conducting an education and outreach campaign regarding EPSDT for enrollees, providers, and managed care plans to support families (further discussed below).

With respect to vi), above, DHCS has proposed in the 2024 Governor's Budget to increase rates to 100% of Medicare for procedure codes utilized for evaluation and management for primary care and specialty office visits, preventative services, and care management; obstetric services; non-specialty mental health services; vaccine administration; and vision (optometric) services; and to apply additional equity adjustment payments. These increased payments are posited to increase health care provider participation in Medi-Cal, which may assist children and families gain greater access to providers like pediatricians.

e) 2023 Audit on Children's Access to Behavioral Health in Medi-Cal. In November 2023, the BSA issued another audit, this time related to children's access to behavioral health care in Medi-Cal. BSA found many Medi-Cal managed care plans are unable to provide children with timely access to behavioral health care, as well as weaknesses in the way DHCS and Department Managed Health Care measure timely access. BSA recommended different ways to monitor compliance, and recommended, among other things, that DHCS revise its agreements with managed care plans to require them to demonstrate efforts to recruit new providers to underserved areas and to implement a policy outlining when noncompliance with standards justifies financial penalties. DHCS acknowledged and agreed with many of the recommendations and is in process of researching feasibility and incorporating the recommendations into new and ongoing measurement and compliance monitoring activities over the next couple of years.

f) Children Now Report Card. In their recently issued 2024 California Children's Report Card that measures numerous aspects of children's well-being, Children Now gave California a D for preventive screenings, D+ for health care access and accountability, and a D+ in supporting mental health. Overall, outside of health care coverage where California receives an A-, the report card paints a fairly dire picture of children's access to and utilization of health care. Children Now indicates, for instance, only one in four California children in Medi-Cal receive important blood lead and developmental screenings, California's kids are dangerously behind on routine vaccinations, and California lags far behind national benchmarks for Medi-Cal care usage.

g) Comparative Data for Infants and Toddlers Well-Child Visits. According to recent state data downloaded from Centers for Medicare and Medicaid Services data portal on children's preventive care measures, California's numbers continue to raise alarm. For instance, 2022 data for a key metric measured as part of the Child Core Set of federally required quality metrics, "Percentage of Children who had Six or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life," indicates California's percentage was

36.8%, while the median rate across 48 reporting states was 57.5%. California's rate lagged far below the 51.3% cutoff for the bottom quartile for this metric.

Percentage of Children who had Six or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life (Selected Comparisons of State Medicaid Program Data)	
Connecticut	77.4
New York	66.7
Florida	59.4
Median	57.5
Bottom Quartile	51.3
California	**36.8**
Source: Data.cms.gov	

Although this is a common quality metric, it should be noted it does not measure how many children received *all recommended care* (e.g., the number of well-child visits that are recommended). Specifically, the AAP Bright Futures schedule recommends a first week visit (three to five days old); visits at one, two, four, six, nine, 12, and 15 months old—a total of eight visits in the first 15 months. The metric is slightly more forgiving, in that it measures the percentage who had at least six visits.

For another key metric, the "Percentage of Children who had Two or More Well-Child Visits with a Primary Care Practitioner during the 15th to 30th Months of Life," California ranks below the median of 65.1%.

Percentage of Children who had Two or More Well-Child Visits with a Primary Care Practitioner during the 15th to 30th Months of Life (Selected Comparisons of State Medicaid Program Data)	
Connecticut	82.3
New York	78.2
Florida	72.1
Median	65.1
Bottom Quartile	60.4
California	**62.4**
Source: Data.cms.gov	

h) "Medi-Cal for Kids and Teens" EPSDT Education and Outreach Campaign. As noted above, DHCS's Strategy document included an education and outreach campaign. DHCS notes it is designed to supplement work DHCS has undertaken to advance EPSDT awareness and close gaps and disparities in care that have grown particularly egregious during the COVID-19 public health emergency. The Strategy indicates, as part of this campaign, that DHCS intends to coordinate with a range of child-serving stakeholders, including other state and local agencies and many others, to deliver targeted messaging related to prevention and early intervention services available under EPSDT. DHCS notes training, technical assistance, policy guidance, and model communications to enhance understanding of EPSDT will be available to plans, providers, and these child-serving

stakeholders.

In February 2023, DHCS released a consumer-tested outreach toolkit that includes brochures specific to Medi-Cal services for children and teens under EPSDT that are intended to be shared annually with beneficiaries, as well as a "Know Your Rights Guide" detailing what actions beneficiaries can take if they are denied services. DHCS has designed and distributed the materials under the name "Medi-Cal for Kids and Teens" to refer to coverage and requirements that apply to Medi-Cal beneficiaries under 21 pursuant to EPSDT. These written materials also include a brochure designed specifically for teens and young adults.

i) **Guidance to Managed Care Plans.** DHCS issued All-Plan Letter (APL) 19-010 in 2019 and an updated letter in 2023, APL 23-005, to clarify and provide guidance to Medi-Cal managed care plans, on their obligations to provide health services under EPSDT. These plans provide coverage to the vast majority of Medi-Cal enrolled children. According to APL 23-005, plans are required to publish the DHCS materials and a related "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter on their websites. Plans may include their logo on the DHCS supplied outreach and education brochures, but cannot make any other changes to the brochures or letter. Beginning in 2023, plans are required to mail these DHCS supplied outreach and education materials consisting of the age appropriate material and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter to Members under the age of 21 on an annual basis. For new members, plans are required to mail the materials within seven calendar days of enrollment in the plan. Plans were required to mail out the first set of materials to existing Members beginning June 1, 2023. For 2023, DHCS will translate the brochures and letter into DHCS's threshold languages.

   Beginning in 2024 and on an annual basis by January 1 of each calendar year, plans are required to mail or share electronically DHCS supplied materials for existing members under the age of 21. For new Members, plans are required to mail or share electronically, DHCS supplied materials within seven calendar days of enrollment in the plan. Starting in January 2024, plans are also required to ensure all their network providers complete EPSDT-specific training no less than every two years.

j) **Requirements of this Bill**. Given the need to communicate ongoing with youth and families about the importance of regular preventive care and other covered services as their needs change, the author indicates this bill would codify the ongoing distribution of informational materials to ensure the outreach and education effort is ongoing and not limited to a one-time campaign. It further specifies materials must be shared with all children and youth and their families annually ongoing. Federal regulations and current Medi-Cal managed care contracts require a process to inform families who have not utilized EPSDT services; the DHCS APL discussed above also requires plans to share these materials annually but allows plans to share these materials electronically after 2024. This bill also requires youth-specific materials be developed and shared with youth, consistent with current practice.

   Federal regulations also require a combination of written and oral methods to *effectively* inform all EPSDT eligible individuals (or their families) about the EPSDT program, using clear and non-technical language, including for those who do not understand English. Accordingly, this bill requires DHCS to test the quality, clarity, and cultural

concordance of translations of the informational materials with Medi-Cal beneficiaries to ensure Medi-Cal is clearly communicating with California's diverse populations.

3) **SUPPORT.** This bill is supported by children's advocates, health care providers, a mental health advocacy organization and health consumer advocacy organization. Children Now writes in support that California policymakers must ensure that every young child receives required routine health screenings in a timely way and that disparities in children's health are addressed, and that this bill will ensure the regular delivery of relevant, high-quality, timely and culturally concordant informational materials about EPSDT covered services. The California Dental Association writes that early detection and prevention are essential in preventing dental disease and the informational materials about EPSDT covered services to will help increase awareness and utilization. The Children's Partnership writes in support to uplift the importance of the bill's requirements related to youth-specific, and also shares additional ideas about improving access to EPSDT services, including guaranteeing stable coverage through multi-year continuous enrollment, redirecting penalties from child-related health plan performance to a designated fund for children's health care access, and providing EPSDT training and leveraging culturally concordant community partners, such as community health workers, promotoras, or community health representatives to directly educate and assist families connect with preventive and mental health care for their children.

4) **RELATED LEGISLATION.**

a) AB 2237 (Aguiar-Curry) streamlines the transfer of specialty mental health services for children and youth who move across county lines. AB 2237 was heard by the Assembly Health Committee on April 9, 2024, and it passed out on a vote of 16-0.

b) AB 2466 (Carrillo) is intended to address children's access to care in Medi-Cal by tightening requirements under which Medi-Cal managed care plans can request alternative access standards for network adequacy, establishing more stringent compliance standards for time and access standards, and related items. AB 2466 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

a) AB 1202 (Lackey) of 2023 would have required DHCS to prepare a public report including information on each Medi-Cal managed care plan's network adequacy of pediatric primary care, data on beneficiaries, and reporting on DHCS' efforts to improve access. AB 1202 was vetoed by Governor Newsom on concerns the reporting was duplicative with current and pending DHCS efforts.

b) SB 1287 (Hernandez), Chapter 855, Statutes of 2017, codified medical necessity for EPSDT in alignment with federal law.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association for Health Services At Home
California Dental Association
Children Now

Coalition for Adequate Funding for Special Education
National Health Law Program
Steinberg Institute
The Children's Partnership
The Council of Autism Service Providers
Western Center on Law & Poverty, Inc.

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2376 (Bains) – As Amended March 21, 2024

SUBJECT: Chemical dependency recovery hospitals.

SUMMARY: Expands the definition of "chemical dependency recovery services (CDRS)" to include medications for addiction treatment and medically managed voluntary inpatient detoxification. Deletes the requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital (GACH) or acute psychiatric hospital (APH), and instead would authorize those facilities to provide CDRS as a supplemental service within the same building or in a separate building on campus that meets specified structural requirements of a freestanding chemical dependency recovery hospital (CDRH). Deletes the requirements for chemical dependency services to be provided in a hospital building that provides only CDRS, or has been removed from general acute care use.

EXISTING LAW:

1) Licenses and regulates health facilities, which are facilities licensed for the treatment of individuals who are admitted for a period of 24 hours or longer, by the Department of Public Health (DPH), including GACHs. [Health & Safety Code (HSC) §1250, *et seq*.]

2) Establishes CDRHs, licensed by DPH, to provide 24-hour inpatient care for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs and includes the following basic services: patient counseling, group therapy, physical conditioning, family therapy, outpatient services, and dietetic services. Requires each CDRH to have a medical director who is a physician licensed to practice in this state. [HSC §1250.3]

3) Permits CDRH services to be provided in a freestanding facility, within a hospital building that only provides chemical recovery service, or within a distinct part, as defined. Defines "distinct part" as an identifiable unit of a hospital or a freestanding facility accommodating beds, and related services, including, but not limited to, contiguous rooms, a wing, a floor, or a building that is approved by DPH for a specific purpose. [*Ibid.*]

4) Requires a separately licensed CDRH that is not a distinct part of a GACH to have agreements with one or more GACHs providing for 24-hour emergency service and pharmacy, laboratory, and any other services that DPH requires. [*Ibid.*]

5) Requires all beds in a CDRH to be designated for CDRS. Requires chemical dependency recovery beds to be used exclusively for alcohol or other drug dependency treatment, or both alcohol and other drug dependency treatment. [*Ibid.*]

6) Exempts all freestanding CDRHs from seismic requirements. [HSC §1275.2]

7) Makes a Legislative declaration that significant cost reductions can be achieved by CDRHs when architectural requirements established by DPH encourage a flexible and open construction approach that significantly reduces capital construction costs, and programs are

designed to provide comprehensive inpatient treatment while permitting substantial flexibility in the use of qualified personnel to meet the specific needs of the patients of the CDRH. [HSC §1250.3]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, as a family physician and an addiction medicine specialist, she knows we need to use every tool available to help people with substance use disorders (SUDs), and it is particularly critical to intervene early in the progression of the disease. The author states that California's emergency rooms (ERs) see over a million patients annually who have a SUD. While the vast majority of hospitals in the state now offer medication treatment for addiction in their emergency departments (EDs), only a handful are licensed to provide chemical dependency recovery services (CDRS), in part because California law significantly restricts where those services can be offered within existing hospitals. This bill will give hospitals the flexibility to use their existing campuses and facilities to provide inpatient addiction treatment, increasing the likelihood that patients who need ongoing help will receive it.

2) **BACKGROUND.**

   a) **Need for addiction treatment in California.** According to an April 2023 California Health Policy Strategies policy brief, "Fatal Overdoses in California: 2017-2021," overdoses killed nearly 11,000 people in California in 2021, a 54% increase over 2015. Overdose disproportionately impacts vulnerable populations. Since 2017, deaths have risen among teenagers (15 to 19) by 370%; and Black and Latinx Californians by 200%. Currently, 5.3 million Californians have a SUD, but only 10% receive treatment. According to the *Journal of Emergency Medicine*, the ER is often the only source of healthcare for patients from historically marginalized backgrounds.

   b) **Access to SUD Treatment.** According to Department of Health Care Access and Information data, over 1.1 million individuals who presented in a California ED were diagnosed with a SUD in 2021; this is about one in seven visits. More than half are Medi-Cal beneficiaries.

      In 2015, research conducted at the Yale School of Medicine showed that if patients in opioid withdrawal were immediately started on the medication buprenorphine in the ED, as opposed to being referred elsewhere to start treatment at a later date, the likelihood they'd remain in treatment 30 days later doubled.

   c) **CalBridge.** Through the State Opioid Response, the Behavioral Health Pilot Project, and the CalBridge Behavioral Health Navigator Program, CalBridge has engaged 276 of the state's 331 EDs to become the single most significant source of new medication assisted treatment (MAT) initiations in 2020 to 2022. These EDs now serve approximately 50,000 patients annually. Through this work, California has implemented the most significant and fastest expansion of ED MAT in the country.

A January 2024 study in the *Journal of the American Medical Association (JAMA),* "Emergency Department Access to Buprenorphine for Opioid Use Disorder," shows that when patients are offered treatment from the ED setting, 85% accept it. Another *JAMA* study has shown that patients who begin treatment from the ED are nearly twice as likely to be in treatment after 40 days compared with those who did not receive treatment. Increasing the ability of a patient to begin their addiction treatment in the hospital will decrease the likelihood that the patient will reenter their community and experience an overdose.

Untreated addiction is a major driver of both health care costs and mortality. A February 2019 review by the US Government Accountability Office found that adults who have untreated addiction and behavioral health challenges have significantly higher health care costs than adults overall, in particular related to ED visits that could have been prevented with earlier treatment.

d) CDRHs. CDRH are the medical model facilities that treat those with SUDs, versus the Department of Health Care Services' licensed residential treatment facilities, which are the nonmedical, social model. CDRHs allows the most comprehensive range of chemical dependency (CD) services including inpatient medical withdrawal management to longer term CD rehabilitation/residential, to intensive CD outpatient programs. According to information provided by the author, there are only ten licensed CDRHs in the state, and many are not located near acute care hospitals.

This bill will allow hospitals to establish CDRS within the same building as other acute care is provided, provided the facility meets existing state codes that govern acute care delivery.

3) SUPPORT. CA Bridge (CB), a program of the Public Health Institute, supports this bill and states that they have supported the largest and fastest expansion of medication for addiction treatment in 85% of California's EDs'. CB's work supporting addiction treatment from the ED has helped them understand and identify gaps in treatment throughout the hospital landscape and healthcare system. CB states that this bill will support patients in entering treatment in a non-stigmatizing manner from the hospital rather than forcing them to leave the hospital to wait to enter treatment. Many patients who present to the hospital needing treatment are unhoused, have unstable housing, or need extra time in a safe place until a treatment bed becomes available in their community. CB concludes that this bill will make it easier for hospitals to support patients in entering treatment without experiencing a gap that would threaten their ability to enter and succeed in treatment.

4) PREVIOUS LEGISLATION. AB 2096 (Mullin), Chapter 233, Statutes of 2022, permits CDRH services to be co-located as a distinct part with other services or distinct parts of its parent facility, as specified. Permits CDRH services to be provided within a hospital building that has been removed from general acute care use.

REGISTERED SUPPORT / OPPOSITION:

Support

Public Health Institute

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2434 (Grayson) – As Amended March 11, 2024

SUBJECT: Health care coverage: multiple employer welfare arrangements.

SUMMARY: Authorizes an association of employers to offer a large group health plan contract or health insurance policy to small group employer members of the association, consistent with Employee Retirement Income Security Act of 1974 (ERISA), if certain requirements are met, including that the association was established before January 1, 1966, and is the sponsor of a multiple employer welfare arrangement (MEWA), and that the contract or policy includes coverage of employees of an association member in the engineering, surveying, or design industry. Specifically, **this bill**:

1) Authorizes an association of employers to offer a large group health plan contract or health insurance policy to small group employer members of the association, consistent with the ERISA, as amended, if all of the following requirements are met:

    a) The association was established prior to January 1, 1966, has been in continuous existence since that date, and is a bona fide association or group of and the association is the sponsor of a MEWA;

    b) The MEWA is fully insured as described, and is in full compliance with all applicable state and federal laws;

    c) The MEWA has offered a large group health care service plan contract or insurance policy since January 1, 2012, in connection with an employee welfare benefit plan under ERISA;

    d) The large group health plan contract or insurance policy offers to employees a level of coverage having an actuarial value equivalent to, or greater than, the platinum level of coverage, and provides coverage for essential health benefits (EHBs), as specified;

    e) The large group health plan contract or insurance policy includes coverage of common law employees, and their dependents, who are employed by an association member in the engineering, surveying, or design industry and whose employer has operations in California; the large group health plan or insurer offers only fully insured benefits through an insurance contract with a health plan licensed by the Department of Managed Health Care (DMHC) or health insurer licensed by the California Department of Insurance (CDI);

    f) Association members purchasing health coverage have a minimum of two full-time common law employees and are current employer members of the association sponsoring the MEWA. Employer members of the association subsidize employee premiums by at least 51%;

g) The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan;

h) The participating member employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits;

i) Membership in the association is open solely to employers, and the participating member employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the MEWA, and the large group health plan contract or insurance policy, both in form and substance;

j) The large group health plan contract or insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents, as specified;

k) The MEWA at all times covers at least 101 employees; and,

l) The association and the MEWA file applications for registration with the DMHC or CDI on or before June 1, 2025.

2) Requires an association and MEWA that timely register with the DMHC or CDI prior to June 1, 2025, and that are found to be in compliance with this bill, to annually file evidence of ongoing compliance with this bill with the DMHC or CDI, in a form and manner set forth by the DMHC or CDI.

3) Specifies that an association and MEWA that have registered with DMHC or CDI and fails to show ongoing compliance in their annual filing is subject to the restrictions in existing law (prohibiting the association from offering a large group contract or policy).

4) Prohibits on or after June 1, 2025, a health plan from marketing, issuing, amending, renewing, or delivering large employer health plan coverage or policy to any association or MEWA that provides any benefit to a resident in this state unless the association and MEWA have registered with the DMHC or CDI.

EXISTING FEDERAL LAW:

1) Establishes, pursuant to federal law, ERISA, which sets minimum standards for most voluntarily established pension and health plans in private industry, including Taft-Hartley Multi-Employer Health and Welfare Plans. Exempts these plans from state insurance regulation. [29 United States Code (U.S.C.) §1144]

2) Defines, in federal law, the terms “employee welfare benefit plan” and “welfare plan” to mean any plan, fund, or program which established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, the following: a) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship

funds, or prepaid legal services; or, b) any benefit, as described (other than pensions on retirement or death, and insurance to provide such pensions). [29 U.S.C. §1002(1)]

3) Defines in federal law, MEWA to mean an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit in 2) above to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, as specified. [29 U.S.C. §1002(1)]

4) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges, federal financial assistance in the form of premium assistance or cost sharing reductions to specified eligible individuals, and coverage of EHBs. [42 U.S.C. 300gg, *et seq*.]

EXISTING STATE LAW:

1) Establishes, in state government, the California Health Benefit Exchange, referred to as Covered California, as an independent public entity not affiliated with an agency or department, and requires Covered California to compare and make available through selective contracting health insurance for individuals and small business purchasers as authorized under the ACA. [Government Code §100500-100522]

2) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (KKA) and CDI to regulate health insurers. [Health and Safety Code (HSC) §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

3) Permits the DMHC Director to exempt from the KKA any class of persons or plan contracts if the DMHC Director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the KKA, and that the regulation of the persons or plan contracts is not essential to the purposes of the KKA. [HSC § 1343]

4) Defines a health plan as:

    a) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees; or,
    b) Any person, whether located within or outside of California, who solicits or contracts with a subscriber or enrollee in California to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee. [HSC § 1345]

5) Requires health coverage through an association that is not related to employment to be considered individual coverage and the status of each distinct member of an association to determine whether that member's association is individual, small group, or large group health insurance coverage. [HSC §1357.503 and INS §10753.05]

6) Prohibits employer group health benefit plans from being issued, marketed, or sold, directly or indirectly through any arrangement, to a sole proprietorship or partnership without employees. Requires only individual health benefit plans to be sold to any entity without employees. Revises the definition of eligible employee for purposes of all small employer health plan contracts and health insurance policies to exclude sole proprietors or their spouses, and partners or their spouses. [HSC §1357 and INS §10755]

7) Authorizes an association of employers to offer a large group health plan contract or health insurance policy to small group employer members of the association, consistent with the ERISA, if all of the following requirements are met:

   a) The association is headquartered in California, was established prior to March 23, 2010, has been in continued existence since, and is a bona fide association or group of employers that may act as an employer under ERISA. The association is the sponsor of a MEWA, and the MEWA is fully insured, headquartered in California, and is in full compliance with all applicable state and federal laws;
   b) The MEWA has offered a large group health plan contract or health insurance policy since January 1, 2012, in connection with an employee welfare benefit plan;
   c) The large group health plan contract or insurance policy offers to employees a level of coverage having an actuarial value greater than or equivalent to the platinum level of coverage available through Covered California and covers EHBs, as specified;
   d) The large group health plan contract or insurance policy includes coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California;
   e) The large group health plan contract or insurance policy offers only fully insured benefits through an insurance contract with an insurance carrier licensed by CDI or with a health maintenance organization licensed by DMHC;
   f) Association members purchasing health coverage have a minimum of four full-time common law employees and are current employer members of the association sponsoring the plan. Employer members subsidize employee premiums by at least 51%;
   g) The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan;
   h) The participating employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits;
   i) Membership in the association is open solely to employers, and the participating employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the large group health plan contract or insurance policy, both in form and substance;
   j) The large group health plan contract or insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health status or claims of any person;
   k) An employer otherwise eligible is not excluded from participating in a MEWA, or offering or renewing the large group health plan contract or insurance policy based on health status or claims of any employee or dependent;
   l) The MEWA at all times covers at least 101 employees; and,

m) The association and MEWA files an application for registration with the DMHC or CDI on or before June 1, 2022.

8) Prohibits, on or after January 1, 2022, a health plan or insurer from marketing, issuing, amending, renewing, or delivering large employer health care coverage to a MEWA that provides any benefit to a resident of California unless the MEWA is registered and complies with 10) above, or has an application pending. Requires DMHC or CDI to determine whether the MEWA is in compliance. Sunsets on January 1, 2026. [HSC §1357.503 and INS §10753.05]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the American Council of Engineering Companies California (ACEC) represents California's engineering land surveying, and design firms and exists in a federation with ACEC chapters in every state and under the national ACEC parent organization. In 1965, ACEC created the Life/Health Trust (LHT), which provides a way for ACEC's small business members to secure high value, high quality healthcare. Although in existence since 1965, the LHT was not grandfathered in at the time of SB 1375 (Hernandez), Chapter 700, Statutes of 2018, and will no longer be allowed to offer coverage to California employees of firms with under 100 employees beyond 2024. This will have a profound impact on each individual LHT enrollee's healthcare expenses. This bill will create a specific exemption for the LHT akin to those granted in 2021, allowing the LHT to continue serving small businesses beyond 2024. The author concludes that the exemption will include certain guardrails, ensuring that the coverage provided to these small member firms is in line with the ACA requirements.

2) **BACKGROUND.**

   a) **Association Health Plans (AHPs).** The California Health Care Foundation (CHCF) in a March 2021 Issue Brief writes that under federal law, AHPs are a type of MEWA established or maintained to provide insurance coverage for medical, surgical, hospital care, or other benefits in the event of sickness. AHPs are insurance arrangements that allow small businesses, associations, and self-employed workers to organize together to purchase health care coverage, potentially obtaining lower-priced coverage by spreading risk and negotiating on behalf of a larger set of enrollees. AHPs have long been offered and regulated in the state of California. California law established requirements for small group reform that applied to AHPs, including criteria for guaranteed issue, standard rating rules, defined risk corridors, specific age bands, and the number of geographic regions for the small group insurance market. In 2010, the ACA changed the rating rules and benefit coverage requirements in the individual and small group markets, and led to the establishment of Covered California. Through Covered California, individuals and employees of participating small businesses can enroll in subsidized and unsubsidized health coverage.

      In 2018, according to CHCF, efforts to unwind key provisions of the ACA included the U.S. Department of Labor (DOL) new regulation for AHPs that made it easier for small employers to organize for the purpose of accessing health insurance typically available

only to large groups. Proponents of the DOL rule argued that AHPs promote competition in increasingly consolidated insurance markets and provide more affordable options in the face of ever-escalating and unaffordable health insurance premiums. By allowing a more restrictive benefit design, such plans could also be attractive to small groups with a lower-risk profile. Such groups could design products that do not cover the EHBs as required for individual and small group plans under the ACA but instead comply with less stringent ERISA consumer protections. Opponents of the DOL rule argued that such plans would create adverse selection by driving higher-risk individuals into the state or federal health insurance marketplace options, increasing costs and ultimately undermining the stability of those risk pools. Premiums for the small group market are determined by a community rating methodology whereby the claims experience across the small group segment is pooled to determine health insurance premiums and annual rate increases.

According to a January 2018 paper authored by the Center on Health Insurance Reforms at Georgetown University, the primary purpose of the DOL rule is to allow more groups of small businesses and self-employed individuals to form AHPs so that they can offer coverage that is regulated under federal law as large-group coverage, and avoid ACA requirements such as EHBs, premium rating restrictions, the single risk pool requirement and risk adjustment. At that time, an analysis by Avalere Health indicated that individual and small group markets would see premiums rise, over a five-year period, 2.7% to 4% in the individual market and .1% to 1.9% in the small group market relative to current law because healthier enrollees would shift into AHPs. Avalere estimated 2.4 million to 4.3 million would switch to AHPs. In 2018, Covered California released a report indicating that this policy change along with another one related to short-term policies could cause an increase in premiums in 2019 of 0.3% to 1.3%. Together with the elimination of the individual mandate penalties (it should be noted that California subsequently enacted a state individual mandate), premium costs could go up by 12% to 32% in total in 2019.

b) SB 1375. In response to the 2018 DOL rule, California enacted SB 1375 to prohibit fully-insured MEWA from selling large group coverage to small employers. In California, small group businesses include any business with at least one but no more than 100 full time employees. SB 1375 protects the state's individual and small group markets from potential adverse selection by specifying that the status of each distinct member of an association determines whether that member's association coverage is individual, small group, or large group health coverage. In other words, if a member in the association is a small group, then the member would need to meet existing small group requirements in California law (i.e., small group premium rating restrictions).

The DMHC issued a 2019 All Plan Letter (APL) to remind health plans, solicitors, brokers and others that in California, group coverage may not be sold to individual subscribers directly or "indirectly through any arrangement." California law significantly limits the extent to which employers and individuals may join together to purchase health care coverage as an association. As such, notwithstanding the DOL rule, individuals (including sole proprietors without employees) may purchase individual coverage only, regardless of whether they are in an association. Similarly, small employers may purchase small group coverage only, regardless of whether that coverage is sold through an association.

c) **SB 1375 Exemptions**. In 2021, two bills were enacted to create two narrow exceptions to the general rule in SB 1375 that plans are barred from selling large group coverage to small employers and individuals through a MEWA. SB 255 (Portantino), Chapter 725, Statutes of 2021, exempts one MEWA that provides health coverage for freelance filming crews in the television commercial production industry. Eligibility requirements of the large group contract is required to provide coverage for employees and their dependents, who are employed in designated job categories on a project-by-project basis for one or more employers with no single project exceeding six months in duration. SB 718 (Bates), Chapter 736, Statutes of 2021, exempts a MEWA that provides health coverage for individuals in the biomedical industry. SB 718 requires the large group health plan to include coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California. The provisions related to SB 718 will sunset on January 1, 2026.

d) **Recent Proposed Federal Rule.** Late last year, the DOL issued a proposed rule that would rescind the 2018 DOL rule designed to expand the formation and use of AHPs. According to a recent Health Affairs article, in the preamble to its proposed rule, DOL describes its "extensive experience" with unscrupulous promoters and operators of MEWAs. Compared to traditional health insurers, MEWAs have disproportionately suffered from financial mismanagement and abuse, leaving enrollees and providers with significant financial liabilities. Under ERISA, an association can only sponsor an employee health benefit plan when it is acting as an employer. Such plans can only be offered through genuine employment-based arrangements. In its proposed rule, DOL argues that the 2018 DOL rule loosening the business purpose, commonality of interest, and working owner standards do not align with the text and intent of ERISA. The agency also notes that the 2018 DOL rule would have increased adverse selection in the individual and small-group insurance markets. DOL further notes that the 2018 DOL rule would have enabled AHPs to offer coverage not subject to the ACA's EHB standard, enabling them to offer only "skinny" plans that leave workers underinsured. These federal rules are pending.

3) **SUPPORT.** ACEC California, sponsor of this bill, seeks to permit the ACEC LHT to continue offering health insurance coverage beyond 2024 to ACEC small business members in California. ACEC California represents nearly 600 engineering and land surveying firms and over 25,000 professionals who are involved in all aspects of the design, construction, and repair of California's residential, commercial, industrial, and public works infrastructure. ACEC California exists in a federation within the larger ACEC organization, which represents 600,000 design professionals and 6,000 design firms nationwide; 87% of ACEC membership are small businesses with fewer than 100 employees. In 1965, ACEC created the LHT so that employees of ACEC's small business membership could have access to affordable, high-quality health insurance. The LHT has continuously offered these policies in every state and D.C. and as of January 2024 nearly 11,000 Californians receive their health insurance through the LHT. Without this bill, beginning January 1, 2025, employees of ACEC California's small business members will lose access to the LHT and be forced to look for coverage elsewhere. The sponsors conclude that this will immediately and significantly increase their monthly healthcare expenses and will put small design firms at a competitive disadvantage to large firms, which can more easily negotiate with insurers for quality coverage at an affordable rate, both when bidding on public works projects and also when attracting talent.

4) RELATED LEGISLATION.

a) AB 2072 (Weber) deletes the sunset from SB 718. AB 2072 is pending in Assembly Health Committee.

b) AB 2063 (Maienschein) extends the sunset of two pilot programs authorized by DMHC under which providers may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. AB 2063 is pending in Assembly Health Committee.

5) PREVIOUS LEGISLATION.

a) SB 718 authorizes, until January 1, 2026, an association of employers to offer a large group health plan contract or insurance policy to small group employer members of the association consistent with ERISA if certain requirements are met, including that the association is the sponsor of a MEWA that has offered a large group health plan contract or insurance policy since January 1, 2012, in connection with an employee welfare benefit plan under ERISA, provides a specified level of coverage, and includes coverage for common law employees, and their dependents, who are employed by an association member in the biomedical industry with operations in California.

b) SB 255 authorizes an association of employers to offer a large group health plan contract or insurance policy consistent with ERISA if certain requirements are met, including that the association is headquartered in this state, is a MEWA as defined under ERISA, and was established as a MEWA prior to March 23, 2010, and has been in continuous existence since that date. Includes coverage for employees, and their dependents, who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding 6 months in duration, and who, in the course of that employment, are not covered by another group health care service plan contract or insurance policy in which the employer participates.

c) SB 129 (Pan), Chapter 241, Statutes of 2019, requires annual health plan and insurer enrollment reporting to include enrollment data for products sold inside and outside of Covered California, any other business lines, and MEWAs; and requires DMHC and CDI to publicly report annual enrollment data no later than April 15th of each year.

d) SB 1375 deletes sole proprietors, partners of a partnership, and the spouses of sole proprietors and partners from the definition of "eligible employee" and provides that, with respect to a sole proprietorship that consists only of the sole proprietor and his or her spouse, or a partnership that consists solely of partners and their spouses, that the sole proprietor or the partner, as applicable, and the spouses of those persons, are not considered employees for purposes of determining eligibility for small employer coverage. Prohibits employer group health plans and employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement, and requires that only individual health care service plans and individual health benefit plans be sold to any entity without employees. Revises the definition of a small employer to include any small

employer, as defined, who purchases coverage through any arrangement, except as specified.

6) **SUGGESTED AMENDMENTS.** As this bill seeks an exemption to existing law enacted in response to actions at the federal level to undermine the protections of the ACA, the committee may wish to consider including a sunset on this bill to allow regulators an opportunity to analyze and report to the Legislature on the impacts to the health care insurance market and compliance with existing law.

REGISTERED SUPPORT / OPPOSITION:

Support

Aliquot
American Council of Engineering Companies of California
ArcSine Engineering
Associated Transportation Engineers
Aurum Consulting Engineers
Base Consulting
Bethel Engineering
BKF Engineers
Blackburn Consulting
Bowman & Williams
Brooks Ransom
Buehler
C2G/Civil Consultants Group, Inc.
Cabrinha. Hearn & Associates
California Geotechnical Engineers Association
Capo
CE2 Corp
Christian Wheeler
Civil Engineering Associates
CMAG Engineering
Coast Surveying, INC.
Coleman Engineering
Cornerstone Earth Group
Cornerstone Structural Engineering
Degenkolb Engineers
DES Architects + Engineers
Elevate Environmental Consultants
Fargen Surveys
Forell Elsesser Engineers
Grice Engineering
Groza Construction
Guida Surveying INC.
Hanagan Land Surveying
HD Geosolutions

HMH Engineers
Hogan Land Services
Howard Carter Associates
Ifland Engineers
International Bridge Technologies
IWalk, INC.
Jackson & Sands Engineering
Joseph C. Truxaw and Associates, INC.
Kurt Fischer Structural Engineering
Kyler Engineering
Lane Engineers
Mesiti-Miller Engineering, INC.
Michael K. Nunley & Associates, INC.
Mid Pacific Engineering, INC.
MNS Engineers
MSO Technologies, INC.
North Coast Engineering
Owens Design
Polaris Land Surveying, INC.
QK INC.
R&s Tavares Associates
Rasmussen Land Surveying, INC.
Rinne & Peterson, INC.
RKA Consulting Group
Romig Engineers
RRM Design Group
Sharrah Dunlap Sawyer, INC.
Talas Engineering
Tanner Pacific, INC.
Towill
TRC Parkitects
Watry Design, INC.
Whitson Engineers
Wilson Ihrig
Yamabe and Horn Engineering, INC.
ZT Consulting Group

Opposition

None on file.

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2449 (Ta) – As Introduced February 13, 2024

SUBJECT: Health care coverage: qualified autism service providers.

SUMMARY: Expands the definition of qualified autism service (QAS) provider to also mean a person who is certified by a national entity, such as the Qualified Applied Behavior Analysis (QABA) Credentialing Board, with a certification that is accredited by the American National Standards Institute (ANSI) in addition to the certifications in 4)c)i) below under existing law as it relates to the coverage of behavioral health treatment (BHT) for pervasive developmental disorder (PDD) or autism.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health and other insurers. [Health and Safety Code (HSC) §1340, *et seq*., Insurance Code (INS) §106, *et seq*.]

2) Requires every health plan contract and health insurance policy that provides hospital, medical, or surgical coverage to cover BHT for PDD or autism. Requires the coverage to be provided in the same manner and to be subject to the same requirements as provided in California's mental health parity law. [HSC §1374.73 and INS §10144.51]

3) Defines BHT for purposes of 2) above as professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with PDD or autism and that meet specified criteria regarding the treatment plan, the professionals who can prescribe (physicians and psychologists) and supervise treatment, and administer a treatment plan. Defines BHT to mean specified services provided by, among others, a qualified autism service professional (QASP) or qualified autism service paraprofessional (QASPP) supervised and employed by a QAS provider. [HSC §1374.73 and INS §10144.51]

4) Defines the following BHT providers:
   a) QASP to mean an individual that meets specified criteria, including is supervised by a QAS provider; provides treatment pursuant to a treatment plan developed and approved by a QAS provider; is either a behavioral service provider as specified in regulations or a clinical provider as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology; has training and experience in providing services for PDD or autism; and, is employed by the QAS provider responsible for the autism treatment plan;
   b) Defines a QASPP an unlicensed and uncertified individual who meets specified criteria, including supervision by a QAS provider or QASP at a level of clinical supervision that meets professionally recognized standards of practice, provides treatment and implements services pursuant to a treatment plan developed and approved by the QAS provider; and meets the education and training qualifications described in regulations; and,
   c) Defines a QAS provider to mean either of the following:

i) A person who is certified by a national entity, such as the Behavior Analyst Certification Board (BACB), with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for PDD or autism, provided the services are within the experience and competence of the person who is nationally certified; or,
ii) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist in the Business and Professions Code, who designs, supervises, or provides treatment for PDD or autism, provided the services are within the experience and competence of the licensee. [HSC §1374.73(c) and INS §10144.51(c)]

5) Requires the treatment plan to have measurable goals over a specific timeline that is developed and approved by the QAS provider for the specific patient being treated. Requires the treatment plan to be reviewed no less than once every six months by the QAS provider and modified whenever appropriate, and requires the QAS provider to do all of the following:
   a) Describes the patient's behavioral health impairments or developmental challenges that are to be treated;
   b) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan or insurer's goal and objectives, and the frequency at which the patient's progress is evaluated and reported;
   c) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating PDD or autism; and,
   d) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. [HSC §1374.73(c)(1)(C) and INS §10144.51(c)(1)(C)]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill is a critical piece of legislation aimed at ensuring that individuals with autism receive the highest quality of care from QAS providers. By establishing clear standards and qualifications, we can guarantee consistent and effective care for those in need, regardless of their background or location. The author concludes that this bill not only supports the well-being of individuals with autism but also promotes a more equitable and efficient healthcare system**.**

2) **BACKGROUND.** According to the California Health Benefits Review Program (CHBRP), autism spectrum disorder (ASD) is a developmental disability characterized by deficits in social interactions and communication, sensory processing, stereotypic (repetitive) behaviors or interests, and sometimes cognitive function. The symptoms of ASD fall along a continuum, ranging from mild impairment to profound disability. ASD diagnoses are often made early in life, as individuals often demonstrate symptoms in early childhood. ASD can sometimes be detected by the age of 18 months, with reliable diagnoses by age two. The cause (or causes) of ASD remain unknown, and research into genetic etiology, as well as environmental factors, continues to be explored. There is no cure for ASD; however, there is

evidence that treatment, including BHT, may improve some symptoms. California law requires BHT coverage.

a) SB 946. SB 946 (Steinberg and Evans), Chapter 650, Statutes of 2011, imposes a set of rules regarding BHT that health plans and health insurers in California must cover for individuals with autism and PDD. SB 946 also identifies the required qualifications of individuals who provide BHT, and permits individuals who are not licensed by the state to provide BHT, as long as the detailed criteria set forth in the bill are met. SB 946 required the DMHC to convene an Autism Advisory Task Force (Task Force) by February 1, 2012, to develop recommendations regarding medically necessary BHT for individuals with autism or PDD, as well as the appropriate qualifications, training and supervision for providers of such treatment. SB 946 also required the Task Force to develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing BHT must meet in order to obtain licensure from the state.

b) Task Force. The Task Force was charged with making recommendations to inform state policymaking and guide future recommendations addressing specified subjects and develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing autism services must meet in order to secure a license from the state. The Task Force reached consensus on 54 of 55 recommendations and approved one recommendation by a vote of the majority. The Task Force concluded that all "top level" (undefined) providers should be licensed by the state, and set forth a process for establishing a new professional license for "Licensed Behavioral Health Practitioner." The Task Force recommended that the license requirement not take effect until three years after the license is established, and an interim commission be formed to implement the new license until a board is able to do so. The Task Force also recommended all providers of autism services be registered with the state's TrustLine Registry or comparable system as a condition of employment by service organizations and contracting with health plans and health insurers. TrustLine uses the criminal history background check system to check the fingerprints of applicants, and checks for evidence of additional criminal records. Two attempts at establishing licensing for BHT providers were made in 2016 and 2015, however, neither bill was successful.

c) Provider Qualifications. Existing law requires a QAS Provider, QASP, or QASPP to meet specific education and training requirements. Numerous attempts since the passage of SB 946 have attempted to make changes to these provider types. Most recently, SB 805 (Portantino), Chapter 635, Statutes of 2023, expanded the criteria for a QASP to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, who must also meet the criteria established by the Department of Development Services (DDS) for a Behavioral Health Professional. This bill expands the criteria for a QASP provider. Current law defines a QAS provider as a person who is certified by a national entity, such as the BACB, with a certification that is accredited by the National Commission for Certifying Agencies. According to the BACB website, the BACB is a nonprofit corporation that was established in 1998 to meet professional certification needs identified by behavior analysts, governments, and consumers of behavior-analytic services. The BACB’s mission is to protect consumers of behavior-analytic services by systematically establishing, promoting, and disseminating professional standards.

This bill adds the QABA Credentialing Board as a national entity that may certify a QAS provider, and authorizes the certification to be accredited by ANSI. It should be noted that SB 562 (Portantino) from 2021, among other changes, included the expansion included in this bill. According to the QABA website, QABA is an internationally-accredited credentialing agency dedicated to ensuring the highest standard of care among professionals providing ABA services and was established 2012 to meet the growing need for more credentialed professionals providing ABA services.

d) Disparities in Access to BHT for ASD. According to CHBRP, treatments for ASD include a number of modalities that are based on a variety of theoretical models. Studies of children with ASD consistently show that children from low income, less educated, and more rural families are less likely to receive BHT than their higher income, better educated, and urban counterparts. One study revealed that parents with a lower educational level accessed less intensive therapies compared to parents with higher educational levels who accessed higher intensity services. A similar pattern was observed with geographic location with children in rural areas accessing less intensive services and individual treatment. Another study using data from the 2009/2010 National Survey of Children with Special Health Care Needs indicated that parents of Latino and black children with ASD were 45% less likely than whites to report that providers spent adequate time with their children, and were about 40% less likely to feel that their child's special needs provider was sensitive to their values and customs. Latino children in families whose primary language was not English also were less likely to utilize BHT. CHBPR notes, in its analysis of SB 562 (Portantino) of 2021, QAS provider shortages are less well documented, but literature suggests that provider shortages create unique barriers to BHT for low-income and rural families. For example, interviews with stakeholders in five states with autism insurance mandates, including California, reported that families were better able to access treatment services after the mandates were enacted, but that both consumer advocates and insurance companies reported shortages of licensed providers. To further complicate matters, stakeholders reported that low insurance reimbursement rates discourage QAS providers from accepting private insurance. CHBRP's literature review found three of six studies on geographic variation in age of autism diagnosis (the start of autism treatment services) identified barriers for rural compared to urban families.

3) SUPPORT. The QABA Credentialing Board, sponsors of this bill, write that including the QABA Credentialing Board and its three credentials parallel to the BACB represents fair trade. QABA is internationally accredited by ANSI, the golden standard for accreditation in the U.S. ANSI is the only accrediting body in the U.S. that is equivalent to higher education accreditation as they perform validation on paper and onsite visits. In 2023, QABA certified 302 people in California. There are 2,179 certificants in California. Funding sources such as Tricare, Magellan, Blue Shield of California, Blue Shield Promise, Kaiser and more include QABA credentials. QABA knows this bill would positively impact those individuals that already hold a certification from our credentialing board, and allow them to continue practicing ABA. QABA concludes that this bill will also provide continuity of care for families who are already receiving services from QABA Providers.

4) OTHER. ANSI submitted a letter providing additional background for consideration. The ANSI National Accreditation Board is a wholly owned subsidiary of ANSI and the largest multi-disciplinary accreditation body in the western hemisphere, with more than 2,500

organizations accredited in approximately 80 countries. ANSI coordinates the private sector standardization system for the United States. Member standards developers impact businesses in nearly every sector: from acoustical devices to construction equipment, from roads and bridges to energy distribution, and healthcare.

Accreditation is a key component of an effective standardization system, assuring industry and governmental decision-makers that credentialing organizations are competent and their results can be trusted. ANSI concludes that the standard has been recognized by several U.S. federal agencies as a critical requirement for personnel certification bodies that offer certification in areas related to public health, environment, and national security.

5) **OPPOSITION.** The California Association for Behavior Analysis (CalABA) writes that this bill contradicts widely accepted standards and best practices in credentialing practitioners in health care and other human services. Those standards call for credentialing bodies to be independent from other organizations, with a governance structure that prevents financial and other conflicts of interest. They also require the credentialing body to do the following for each credential it issues: a) conduct job or occupational task analyses to identify the knowledge and competencies required to practice the profession; b) specify prerequisites (degrees, coursework, and experiential training) for taking a professional examination in the subject matter; c) develop and manage a valid, reliable, and secure examination; d) specify requirements for maintaining the credential; and, e) ensure transparency about all of the above as well as outcomes of the credentialing programs. The large majority of national entities that credential practitioners in health care and other human services professions are nonprofit organizations. CalABA contends that according to information on its website and elsewhere, the QABA Board does not have the characteristics of national credentialing bodies in behavioral health and related professions. The Council of Autism Service Providers (CASP) write that the educational and experiential requirements of the QABA credential are significantly less stringent than those of the BCBA credential. QABAs receive no required training in the concepts, principles and theoretical underpinnings of the science of behavior analysis and QABA coursework may be obtained from third party vendors and is not required to be obtained through accredited university programs, or verified course sequences, further lessening the quality of the education received by QABA credentialed individuals. CASP concludes that QABA is a for-profit entity and potential disadvantages of for-profit professional credentialing entities are lack of transparency and conflicts of interest.

6) **RELATED LEGISLATION.** AB 1977 (Ta) prohibits a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025 from requiring an enrollee or insured previously diagnosed with PDD or autism to be reevaluated or review a new behavioral diagnosis to maintain coverage for BHT for PDD or autism. AB 1977 is pending in Assembly Health Committee.

7) **PREVIOUS LEGISLATION.**

   a) SB 805 (Portantino), Chapter 635, Statutes of 2023, expands the criteria for a QASP to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as specified. Requires those positions to meet the criteria for a Behavioral Health Professional, as provided. Requires DDS to adopt regulations, on or before July 1, 2026, to address the use of Behavioral Health Professionals and Behavioral Health Paraprofessionals in BHT

group practice. Requires DDS to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these positions to provide behavioral intervention services, as specified.

b) SB 562 (Portantino) of 2021 would have revised the definition of BHT to require the services and treatment programs provided to be based on behavioral, developmental, relationship-based, or other evidence-based models. Would have expanded the definitions of QAS provider, QASP, QASPP and specifically, would have added the QABA Credentialing Board accredited by ANSI. Would have prohibited using the lack of parent or caregiver participation, implementation of an alternative plan, or the setting, location, or time of treatment as a reason to deny or reduce coverage for medically necessary services. SB 562 was vetoed by Governor Newsom, in part:

"Early diagnosis of ASD and subsequent participation in evidence-based intervention and therapies, provided by licensed and certified individuals, make all the difference in an individual's long-term health outcomes. Research finds that Black and Latino children are often misdiagnosed and diagnosed later with ASD than their White peers. It is incumbent upon us to ensure that any intervention is medically-necessary, evidence-based and grounded in research that is conducted to reduce disparities.

This bill proposes to change the existing evidence-based standard by requiring coverage of therapies where there is insufficient, or only emerging, evidence to assess the impact of the interventions. Furthermore, the bill proposes changes to professional standards by expanding the types of individuals who can serve as qualified autism service professionals, which could result in long-term ramifications for individuals with ASD who receive the services.

While the bill's intent is laudable, expanding access to certain therapies and interventions must be grounded in evidence-based practices and be provided by qualified professionals. I encourage the author to continue discussions related to the expansion of provider types and changes to professional standards through a formal licensing scheme that includes clinical expertise and administrative oversight to address qualification standards for practitioners, to ensure equity and quality of care, and provide effective consumer protection, as I expressed when I vetoed a similar bill in 2019."

c) AB 1074 (Maienschein), Chapter 385, Statutes of 2017, requires a QASP or QASPP to be supervised by a QAS provider for purposes of providing BHT. Require a QASP and a QASPP to be employed by a QAS provider or an entity or group that employs QAS providers. Authorizes a qualified autism service professional, as specified, to supervise a qualified autism service paraprofessional. Revises the definition of a QASP to, among other things, specify that the BHT provided by the QASP may include clinical case management and case supervision under the direction and supervision of a QAS provider.

d) AB 1715 (Holden) of 2016 would have established the Behavior Analyst Act, which provides for the licensure, registration, and regulation of behavior analysts and assistant behavior analysts, and requires the California Board of Psychology, until January 1, 2022, to administer and enforce the Act. AB 1715 died in the Senate Business, Professions and Economic Development Committee.

e) SB 479 (Bates) of 2015 would have established the Behavior Analyst Act which requires a person to apply for and obtain a license from the Board of Psychology prior to engaging in the practice of behavior analysis, as defined, either as a behavior analyst or an assistant behavior analyst, and meet certain educational and training requirements. SB 479 died in the Assembly Appropriations Committee.

f) AB 2041 (Jones) of 2014 would have required that a regional center classify a vendor as a behavior management consultant or behavior management assistant if the vendor designs or implements evidence-based BHT, has a specified amount of experience in designing or implementing that treatment, and meets other licensure and education requirements. AB 2041 died in the Senate Appropriations Committee.

g) SB 946 requires until July 1, 2014, health plans and health insurance policies to cover BHT for PDD or autism, requires health plans and insurers to maintain adequate networks of autism service providers, established a task force in DMHC, and makes other technical changes to existing law regarding HIV reporting and mental health services payments.

h) AB 1453 (Monning), Chapter 854, Statutes of 2012, and SB 951 (Hernandez), Chapter 866, Statutes of 2012, established California's essential health benefits.

i) AB 1205 (Berryhill) of 2011 would have required the Board of Behavioral Sciences to license behavioral analysts and assistant behavioral analysts, on and after January 1, 2015, and included standards for licensure such as specified higher education and training, fieldwork, passage of relevant examinations, and national board accreditation. AB 1205 was held in the Assembly Appropriations Committee on the suspense file.

8) POLICY COMMENTS.

a) Provider Networks. As CHBRP noted above, disparities in access to BHT services persist and this bill may expand the number of providers in a health plan's network.

b) Licensing. Current law requires specified providers to meet the education, training, and experience qualifications described in existing law and specified regulations. This bill authorizes additional qualifications to meet the criteria of a QAS provider under health insurance coverage. While DMHC and CDI are tasked with regulating health plans and health insurers, these entities may not be the appropriate entities to provide oversight of provider qualifications. Without a board supervised licensing scheme, it is difficult to measure the quality of care of BHT providers and ensure appropriate consumer safety protections. As this bill moves forward, the author should consider a proposal that would require a state agency to conduct an analysis on the appropriate oversight of BHT providers, including how to measure quality of care. Alternatively, the author could consider the Committee on Business and Professions sunrise process for the purpose of assessing requests for new or increased occupational regulation.

REGISTERED SUPPORT / OPPOSITION:

Support

Qualified Applied Behavior Analysis Credentialing Board (sponsor)

A Change in Trajectory
Autism Behavior Services INC.
Autism Business Association
Autism Society of California
California Psychological Association
DIR/Floortime Coalition of California
Greenhouse Therapy Center

Opposition

California Association for Behavior Analysis
The Council of Autism Service Providers

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2466 (Wendy Carrillo) – As Amended March 18, 2024

SUBJECT: Medi-Cal managed care: network adequacy standards.

SUMMARY: Implements a number of recommendations from a state audit related to improving monitoring and oversight of the accuracy of provider networks and timely access to care in Medi-Cal managed care. Specifically, **this bill**:

1) Deems a Medi-Cal managed care plan out of compliance with appointment time standards if either:
   a) Fewer than 85% of the network providers, pursuant to new evaluation standards imposed by this bill, for a specific network had a non-urgent or urgent appointment available within the appointment time standards; or,
   b) The Department of Health Care Services (DHCS) receives information establishing that the Medi-Cal managed care plan was unable to deliver timely, available, or accessible health care services to enrollees. Authorizes DHCS to consider any of the following factors in evaluating whether each instance identified is part of a pattern of noncompliance that is reasonably related:
      i) Each instance is a violation of the same appointment time standard;
      ii) Each instance involves the same network;
      iii) Each instance involves the same provider group or subcontracted plan;
      iv) Each instance involves the same provider type;
      v) Each instance involves the same network provider;
      vi) Each instance occurs in the same region;
      vii) The number of enrollees in the Medi-Cal managed care plan's network and the total number of instances identified as part of a pattern;
      viii) Whether each instance occurred within the same 12-month period; or,
      ix) Whether each instance involves the same category of health care services.

2) Requires, effective for contract periods commencing on or after July 1, 2025:
   a) The annual report measuring plan compliance with the time or distance and appointment time standards to measure all of the following:
      i) Compliance separately for new and returning patients;
      ii) Compliance with a 48-hour urgent care standard for behavioral health appointments; and,
      iii) Compliance with access standards for new and returning patients.
   b) Annual evaluations by DHCS measuring plan compliance with the time or distance and appointment time standards to be performed using a direct testing method, which may include, but need not be limited to, a "secret shopper" method, and requires, similar to a) above, compliance for both new and follow-up appointments as well as using a 48-hour urgent care standard. Requires the evaluation to also utilize a method for accounting for and reporting the number of providers who are unavailable or unreachable for purposes of the evaluation.

   c) DHCS's annual reports summarizing evaluation findings and corrective action plans (CAPs) to report information on unavailable or unreachable providers and how each plan will utilize this information to regularly maintain or update its provider directories.

3) Specifies failure to comply with 1) or 2) above can result in contract termination or the issuance of sanctions pursuant to existing law.

4) Changes, from at least every three years to annually, the frequency of alternative access standards request submissions made by Medi-Cal managed care plans when they cannot meet the time and distance standards. Requires the request to explain efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard, including documentation of efforts to recruit new providers into its network. Requires DHCS to consider the reasonableness and effectiveness of the mitigating efforts as part of the renewal decision.

5) Requires, effective for contract periods commencing on or after July 1, 2025, as part of the federally required external quality review organization (EQRO) review of Medi-Cal managed care plans, the following data to be categorized, in addition to the categories established in current law, as follows:
   a) The number of requests for alternative access standards in the plan service area for time and distance, to be categorized by new and returning patients; and,
   b) Number of allowable exceptions for the appointment time standard, if known, to be categorized by urgent and non-urgent appointment types and by new and returning patients.

6) Requires any CAP imposed on a Medi-Cal managed care plan by DHCS for failure to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause, to be monitored by DHCS and progress reported publicly no less than annually for the duration of the plan of correction.

7) Defines the terms "timely" and "accurate network provider data," for purposes of a compliance evaluation of provider data, such that the submission of such data must occur no less than annually and must include information related to unavailable or unreachable providers.

EXISTING LAW:

1) Requires a Medi-Cal managed care plan to maintain a network of providers that are located within specified time and distance standards for specified services. [Welfare and Institutions Code (WIC) §14197 (b)]

2) Establishes time or distance standards for primary care (adult and pediatric), dental services, and obstetrics and gynecology, as 10 miles or 30 minutes from the beneficiary's place of residence; a standard for hospitals that is 15 miles or 30 minutes from the beneficiary's place of residence; and other standards for specialists (adult and pediatric), pharmacy services, outpatient mental health and substance use disorder services, and opioid treatment programs. [WIC §14197(b)(1)]

3) Requires Medi-Cal managed care plans to comply with appointment availability standards developed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and its regulations. [WIC §14197(d)(1)(A)]

4) Allows, if a Medi-Cal managed care plan cannot meet the time and distance standards set forth in statute, the plan to submit to DHCS a request for alternative access standards, in the form and manner specified by DHCS. [WIC §14197(f)(3)]

5) Allows DHCS, upon request of a Medi-Cal managed care plan, to authorize alternative access standards for the established time or distance standards if either of the following occur:
   a) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard; or,
   b) DHCS determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access. [WIC §14197(f)(2)]

6) Allows DHCS to authorize a Medi-Cal managed care plan to use clinically appropriate synchronous video telehealth as a means of demonstrating compliance with time or distance standards. [WIC §14197(e)]

7) Requires the plan to close out any CAP deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network. [WIC §14197(f)(3)(D)]

8) Requires measurement of compliance with time or distance and appointment time standards separately for adult and pediatric services for primary care, behavioral health, and core specialist services. [WIC §14197(g)(1)]

9) Sunsets the time and distance and appointment availability standards on January 1, 2026. [WIC §14197(l)]

10) Requires an EQRO review of Medi-Cal managed care plans annually and requires the EQRO to compile specified data, for the purpose of informing the status of implementation of the time, distance, and appointment time requirements. [WIC §14197.05; 42 Code of Federal Regulations §438.364]

11) Grants the Director of DHCS the power and authority to take one or more of the following actions against a Medi-Cal managed care plan for specified findings of noncompliance, including with time, distance, appointment time, provider network adequacy, and a number of related standards:
   a) Suspend enrollment and marketing activities;
   b) Impose a CAP;
   c) Require the contractor to suspend or terminate contractor personnel or subcontractors;
   d) Impose civil penalties in various amounts up to $100,000 ;
   e) Impose monetary sanctions of up to $25,000 for a first violation, $50,000 for a second violation, and up to $100,000 for each subsequent violation; or,
   f) Various other actions. [WIC §14197.7 (d), (e), (f)]

12) Requires, by July 1, 2025, DHCS to adopt any regulations necessary to implement penalties and sanctions. [WIC §14197.7 (r)(2)]

13) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Act. [HSC §1340, *et seq.*]

14) Requires a Knox Keene Act-licensed health plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service plan, to comply with specified timely access requirements. [HSC §1367.03]

15) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:

    a) Waiting times for appointments, including primary and specialty care physicians;
    b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,
    c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC §1367.03]

16) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency or care, and the requirements of law governing utilization review. [HSC §1367.03]

17) Authorizes regulations to be issued by DMHC related to timely access to care. [Title 28 of the California Code of Regulations, including Sections 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70.]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, last fall, a report from the State Auditor showed that California is falling short when it comes to providing timely access to behavioral health appointments for young people on Medi-Cal. The author argues the report found a clear need for DHCS to monitor the compliance of health plans with statutory timely access standards to eliminate the long-standing disparities in access and mental health outcomes for the state's low-income children and youth enrolled in Medi-Cal. The author concludes this bill makes fixes to improve those metrics, ensuring that California's most vulnerable young people receive the services they need. This bill is sponsored by The Children's Partnership (TCP) & National Health Law Program (NHeLP) to improve managed care plan accountability with an overall goal of shorter wait times for behavioral health appointments for young people in Medi-Cal.

2) BACKGROUND.

a) Managed Care. According to the Medicaid and Children's Health Insurance Program Payment and Access Commission (MacPAC), a federal entity that tracks and advises on Medicaid policy, managed care is the primary Medicaid delivery system in more than

half the states. States have incorporated managed care into their Medicaid programs for a number of reasons, including more control and predictability over future costs, opportunities for improved care management, and greater ability to institute accountability and systematic monitoring of performance, access, and quality. However, given managed care plans are paid on a capitated basis (an agreed-upon amount per-member, per-month), it is important for payers to also monitor plans and hold them accountable to ensure plan members are able to access recommended and needed care. As the federal government has allowed states more flexibility to expand managed care in their Medicaid programs, it has concurrently implemented more monitoring and accountability requirements.

b) Network Adequacy Standards. Accordingly, in 2016, the federal Centers for Medicare and Medicaid Services (CMS) adopted a major new regulation requiring states to develop and enforce network adequacy standards, including time and distance standards for different provider types. California already had standards in place for Knox-Keene Act-licensed plans. To implement the required changes, the Legislature established network adequacy requirements for Medi-Cal managed care plans (including Denti-Cal plans), county mental health plans that provide specialty mental health services, and county Drug Medi-Cal-Organized Delivery System (DMC-ODS) plans, through AB 205 (Wood), Chapter 738, Statutes of 2018.

AB 205 established maximum time and distance standards for specialists, based on the county population density. For example, plans have to maintain a network of specialists who are up to 15 miles or 30 minutes from the beneficiary's place of residence in nine major urban counties (such as Alameda, Los Angeles, and San Francisco), but can have a standard that is up to 60 miles or 90 minutes from the beneficiary's place of residence for 13 rural counties (such as Alpine, Colusa, and, Trinity), as shown in the chart below:

Time and Distance Standards in AB 205 for Specialists and Outpatient Mental Health

Category	Population Density	# of Counties	Counties	Standard
Rural	< 50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra , Siskiyou, Tehama, Tuolumne, Trinity	60 miles/90 minutes
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, Yuba	45 miles/75 minutes
Medium	201 to 600 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura	30 miles/60 minutes
Dense	≥ 600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara	15 miles/30 minutes

AB 205 also required plans to make available appointments within specified timeframes for physicians, with different timeframes depending upon whether the visit is urgent and whether the visit is with a specialist, using the current Knox-Keene Act standards for physicians and mental health providers. Prior to AB 205, these standards did not apply to county mental health plans or DMC-ODS plans. Those standards are as follows:

Urgent Appointments	Time
For services that do not need prior approval	48 hours
For services that do need prior approval	96 hours

Non-urgent appointments	Wait Time
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a non-MD mental health provider	10 business days
Appointment for a services to diagnose/treat a health conditions	15 business days

Pursuant to All-Plan Letter 23-001, if a plan is able to cover at least 85% of the members in a ZIP code and they can show that they have additional capacity through the use of telehealth providers to serve the remaining members, the plan would be deemed compliant with time or distance standards and no alternative access request is required.

Medi-Cal managed care plans, as well as private health plans licensed by the Knox-Keene Act, are also required to ensure must also ensure provider capacity through reporting on provider-enrollee ratios, such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks must include one primary care provider for every 2,000 beneficiaries.

c) Alternative Access Requests. DHCS can allow, upon request by a Medi-Cal managed care plan, "alternative access requests" from the time and distance standards if:

i) The requesting plan has exhausted all other reasonable options to obtain providers to meet the applicable standard; or,

ii) DHCS determines that the requesting plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

Plan requests for alternative access standards are typically likely based one or more of the following:

i) The lack of providers in an area (such as in rural parts of the state);

ii) Specialists providers for complex cases where beneficiaries would need to travel to because of the expertise of the particular provider (for example, children's hospitals, university teaching hospitals and cancer centers); or,

iii) Providers who are within a plan's area but who do not contract with Medi-Cal plans, typically because of plan rates paid to providers, plan contract terms, or an unwillingness to participate in Medi-Cal.

d) Monitoring. According to MacPAC, federal law establishes two direct oversight and monitoring requirements for Medicaid programs: States must develop, implement and update a managed care quality strategy that includes access standards and procedures for monitoring and evaluating the quality and appropriateness of care and services, meets the standards set by CMS, and is subject to monitoring by CMS; and states must conduct an annual external independent review of the quality of and access to services under each managed care contract.

As part of implementation of the 2016 regulations, DHCS created a monitoring plan to monitor compliance with contractual requirements that includes a number of different methods. DHCS explains that, for example, for plans, DHCS will conduct a telephonic timely access survey through its EQRO. DHCS will provide the EQRO with provider network data and the EQRO will randomly select a statistically significant sample of providers, by plan operating area, to survey wait times for beneficiaries to next appointment. These surveys will be conducted quarterly. DHCS also notes the following:

- **i)** DHCS conducts compliance audits and reviews of plans both annually and triannually, depending on plan type, to determine the plans' compliance with state and federal requirements, including, but not limited to: network adequacy, provider monitoring, provider directories, and access standards;
- **ii)** In order to ensure network adequacy standards are meaningful, DHCS will hold plans to the standards and enforce corrective action if they fail to meet them;
- **iii)** DHCS has established processes to work with the plans on monitoring and oversight issues. If DHCS identifies that a plan is struggling to meet network adequacy requirements, DHCS will provide technical assistance to the plan. When necessary, a CAP may be imposed. Moreover, if a plan does not come into compliance with the CAP, DHCS may impose a financial penalty or sanction;
- **iv)** DHCS continually seeks improvement in its monitoring program to further drive quality, such as improving the provider network data collected;
- **v)** DHCS will review provider network directories on a monthly basis as required by the federal regulation; and,
- **vi)** Starting with the 2022 contract year, CMS requested DHCS submit an Annual Network Certification for each contracting managed care plan, including Medi-Cal managed care plans and county-administered specialty mental health service plans.

Finally, CMS is in the process of updating its regulations on access to care monitoring, and released a notice of proposed rulemaking last spring. These pending federal rules may require a "secret shopper" approach for appointment time surveys and a 90% compliance threshold for the percentage of appointments that meet timely access standards.

e) Enforcement. DHCS has increased oversight and expectations on managed care plans and has stepped up enforcement in recent years. Assembly Bill 1642 (Wood), Chapter 465, Statues of 2019, provides DHCS with the authority to increase monetary sanctions for various types of violations, including, among other things, violations of contract provisions, failure to demonstrate network adequacy, and failure to meet certain performance levels. In 2022, DHCS sanctioned 11 plans. On February 14, 2023, DHCS issued sanction notices to another 11 plans and on December 22, 2023, DHCS announced sanctions on 22 plans due to poor performance on quality and required immediate action. DHCS notes more than half of plans fell below Minimum Performance Levels (MPL) for

immunization rates, well-infant and well-child visits, breast cancer screenings, and cervical cancer screenings, leaving significant room for improvement in children's and women's preventive services. Sanctions ranged from $25,000 to $437,000 based on various factors, including how many Medi-Cal members were impacted, the degree to which a plan fell below MPL, and the degree of improvement or decline from the previous measurement year. LA Care, a large plan, was sanctioned $890,000 in 2022. Plans were also required to take specified actions to improve quality.

Although state law authorizes DHCS to levy sanctions for noncompliance with network adequacy standards, the sanctions discussed above were largely related to plans' inability to meet quality performance benchmarks, not failures to demonstrate network adequacy.

f) State Audits on Children's Access to Health Care in Medi-Cal. In March 2019, the Bureau of State Audits (auditor) released an audit entitled "Department of Health Care Services - Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," regarding DHCS' oversight of the delivery of preventive services to children in Medi-Cal. The auditor found, among other things, that many of the state's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services. On September 3, 2022, the auditor issued a follow-up audit to the original 2019 audit, titled "Department of Health Care Services Is Still Not Doing Enough to Ensure That Children in Medi-Cal Receive Preventive Health Services." The auditor found DHCS made progress in implementing the 2019 audit's recommendations, but it had yet to fully implement some recommendations, including one related to the lack of pediatric providers. Specifically, the auditor recommended that DHCS identify where more Medi-Cal providers are needed and request additional funding from the Legislature to increase the number of providers in those identified areas. DHCS indicated it does not plan to implement that recommendation, citing its belief that broader workforce recruitment is beyond DHCS' purview.

In its response to the 2022 audit recommendation DHCS indicates it plans to have an external evaluator conduct an access assessment by reviewing the various components of access, comparing managed care plan networks and access to care with commercial and Medicare Advantage markets. Through the assessment, DHCS aims to compare access in Medi-Cal managed care to access for Californians who receive health coverage through the commercial or Medicare Advantage markets. DHCS explains this will allow it to assess if any barriers to access are a reflection of systematic problems across the entire health care system, such as issues related to workforce pipeline, or if access barriers are specific to Medi-Cal. In addition, the assessment will track different levels of access to help determine whether issues exist at the managed care level (network adequacy), provider level (scheduling practices, responsiveness to member scheduling requests, etc.) or both. DHCS indicates the results of the assessment will be shared with CMS in March 2026.

g) 2023 Audit on Children's Access to Behavioral Health in Medi-Cal. In November 2023, the auditor issued another audit, this time related to children's access to behavioral health care in Medi-Cal. The auditor found many Medi-Cal managed care plans are unable to provide children with timely access to behavioral health care, as well as weaknesses in the way DHCS and DMHC measure timely access. The auditor recommended different ways to monitor compliance, and recommended, among other

things, that DHCS revise its agreements with managed care plans to require them to demonstrate efforts to recruit new providers to underserved areas and to implement a policy outlining when noncompliance with standards justifies financial penalties. DHCS acknowledged and agreed with many of the recommendations and is in process of researching feasibility and incorporating the recommendations into new and ongoing measurement and compliance monitoring activities over the next couple of years. Specific audit recommendations, and their relationship to provisions of this bill, are discussed below.

h) How This Bill Addresses Specific Audit Recommendations.

i) Data on appointment times; compliance thresholds. The auditor recommends DHCS set a compliance threshold for the percentage of appointments that meet timely access standards. This bill sets such a standard, at 85%. It also specifies factors DHCS should consider in establishing a pattern of noncompliance.

ii) Methodological issues in surveys and thresholds. The auditor pointed out a number of methodological limitations in the state's measurement of appointment times, including the following related to timely access surveys:

(1) Surveys were measuring compliance with a 96-hour standard, not the 48-hour standard that applies for services that do not need prior approval pursuant to state law.

(2) Survey data may have been biased by the surveyor transparently telling the provider the reason for the call, versus collecting data through a "secret shopper" oversight approach;

(3) Non-responsive providers were excluded from data reporting and the reporting was not qualified or adjusted to account for this exclusion, which likely gave the wrong impression about provider availability, because a significant proportion of providers were non-responsive; and,

(4) Surveys do not differentiate between appointment times for new versus existing patients, which may be significantly longer, nor did they differentiate between adult versus pediatric.

This bill requires the measurement of compliance separately for new and returning patients and compliance with a 48-hour urgent care standard for behavioral health appointment. It also requires annual evaluations by DHCS evaluating plan compliance with the time or distance and appointment time standards to be performed using a direct testing method, which may include, but need not be limited to, a "secret shopper" method. Finally, it requires DHCS to utilize a method for accounting for and reporting the number of providers who are unavailable or unreachable for purposes of the evaluation.

iii) Oversight of CAPs. The auditor recommended DHCS should demonstrate that it has followed up with county mental health plans and Drug Medi-Cal programs on CAPs that continue to be deficient in timely access or other network adequacy standards. This bill requires any plan of correction to be monitored by DHCS and progress reported publicly no less than annually for the duration of the plan of correction.

iv) **Provider capacity.** The auditor recommended DHCS should develop a new methodology for calculating non-specialty outpatient behavioral health provider-to-member ratios, as well as other recommendations related to improving the accuracy of how providers are counted as contributing to the adequacy of a provider network. These are not specifically addressed by the bill. DHCS has indicated that it is addressing this recommendation administratively.

The auditor also recommended DHCS should revise its agreements with plans that do not meet time and distance standards to require them to demonstrate efforts to recruit new providers to underserved areas. This bill requires, as part of DHCS's approval of requests for alternative access standards, requests to be made annually and requires plans to explain efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard, including documentation of efforts to recruit new providers into its network. It also requires DHCS to consider the reasonableness and effectiveness of the mitigating efforts as part of its decision to renew the standard.

v) **Enforcement**. The auditor recommends DHCS develop and implement a policy outlining when noncompliance with network adequacy standards by a Medi-Cal managed care plan, county mental health plan, or county Drug Medi-Cal program justifies financial penalties. This bill reinforces that DHCS can assess sanctions for noncompliance with various standards and lays out factors DHCS should consider in assessing financial penalties.

3) **SUPPORT.** A large coalition of children's, health, health consumer, behavioral health and legal advocates and providers support this bill. The California Alliance of Child and Family Services writes in support that legislative changes would ensure that Medi-Cal managed care plans are held accountable for taking actionable efforts to recruit new providers and deploy mitigation strategies to meet timely access standards for behavioral health appointments, particularly those with an urgent need. Cosponsors NHeLP and TCP write they are cosponsoring this bill to implement strategies that better ensure compliance with existing timely access standards and provide greater accountability for Medi-Cal managed care and county behavioral health plans not meeting those standards, especially for children and youth accessing Medi-Cal covered behavioral health care.

4) **OPPOSITION.** California Association of Health Plans (CAHP) and Local Health Plans of California (LHPC) oppose this bill on similar grounds. LHPC writes that while they appreciate the bill's intent, they believe it will undermine processes underway by DHCS to address many of the same concerns that the bill attempts to confront and that it may not align with existing standards. LHPC notes DHCS outlined, in their audit response, several planned or active actions that they are taking to address the findings and recommendations within the report, including analyzing the feasibility of including a "secret shopper" approach within timely access surveys and identifying the steps necessary to operationalize changes to the survey approach, as well as including implementation of monitoring for new and existing patients. Additionally, in their response DHCS acknowledges that they have already begun to explore in partnership with the DMHC compliance thresholds that align across managed care delivery systems.

CAHP and LHPC share their concern about the provision in the bill increasing the appointment time threshold to 85%. CAHP explains that currently, managed care plans are required to meet a threshold of 70%, although many of Med-Cal managed care plans are currently exceeding that threshold. However, CAHP points out, establishing a base compliance rate of 85% will be very problematic for plans operating in rural and underserved communities. Rural and underserved areas of the state already lack the available workforce needed to serve the needs of these communities. For example, CAHP notes, providers in many of these communities are only in the office/clinic/hospital once or twice a week. This creates inherent difficulties scheduling members with those providers within the existing timeframes. CAHP respectfully requests this provision be amended to align with the DMHC compliance thresholds to create consistency across delivery systems.

LHPC points out that the frequency in which Medi-Cal managed care plans are required to submit renewals for previously approved Alternative Access Standard (AAS) requests was modified in statute in 2022 from annually to every three years. LHPC explains this change acknowledges that large changes in provider availability across the state are unlikely to occur within one years' time, and a triennial process was more appropriate to revisit changes in provider availability and therefore the need for an AAS. LHPC states the reversion back to annual submission creates an unnecessary administrative burden on Medi-Cal managed care plans and DHCS. LHPC argues local plans are committed to developing, recruiting, and retaining providers into network, demonstrated through many local plans' community investment activities; however, these efforts take time and considerable resources. LHPC states allowing plans to submit AAS request renewals every three years will allow local plans the time and focus necessary to strengthen network capacity.

LHPC and CAHP conclude that the bill may be premature, and that it may circumvent the work being done on these issues.

5) RELATED LEGISLATION.

a) AB 2340 (Bonta) requires DHCS to take specified actions in DHCS's implementation of federal regulations requiring states to share informational materials about early and periodic screening, diagnostic, and services with Medicaid beneficiaries under 21 years of age. AB 2340 is pending in the Assembly Health Committee.

b) AB 236 (Holden) requires health plans and insurers to annually audit and delete inaccurate provider listings, and subjects a health plan or insurer to administrative penalties if it fails to meet prescribed benchmarks for accuracy, as specified. AB 236 is pending referral in the Senate.

6) PREVIOUS LEGISLATION.

a) AB 1202 (Lackey) of 2023 would have required DHCS to prepare a public report including information on each Medi-Cal managed care plan's network adequacy of pediatric primary care, data on beneficiaries, and reporting on DHCS' efforts to improve access. AB 1202 was vetoed by Governor Newsom on concerns the reporting was duplicative with current and pending DHCS efforts.

b) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, extends from January 1, 2023, to January 1, 2026, time, distance, and appointment time standards

for specified services to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner. Authorizes DHCS to allow a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the time or distance standards, and as part of an alternative access standard request, and authorizes DHCS to develop policies for granting credit, as specified. Makes changes to the frequency of alternative access standards request submissions made by Medi-Cal managed care plans when they cannot meet the time and distance standards, and requires the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network.

c) AB 1642 increases the maximum civil penalty amounts in existing law for Medi-Cal managed care plans. Broadens the bases for the DHCS to levy sanctions against plans, and broadens DHCS authority to find noncompliance beyond medical audits. Includes county mental health plans and Drug Medi-Cal organized delivery system in the plan penalty provisions. Requires penalty revenue to be deposited into the General Fund for use, and upon appropriation by the Legislature, to address workforce issues in the Medi-Cal program and to improve access to care in the Medi-Cal program. Requires plans seeking exceptions from appointment travel time standards to include a description of how the plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time and distance standards. Requires DHCS to evaluate and determine whether the resulting time and distance is reasonable to expect a beneficiary to travel to receive care.

d) AB 205 implements federal rules establishing network adequacy requirements for Medi-Cal managed care plans.

7) **POLICY COMMENTS.** With the transition of the overwhelming majority of the Medi-Cal population to managed care and evidence of poor utilization of services and access to care issues in Medi-Cal, it is critical the state implement robust monitoring, oversight, and, where necessary, enforcement. The auditor's recent report raised numerous issues and questions about the state's ability to accurately monitor and oversee compliance with time and distance and appointment time requirements, with negative results for beneficiaries who have difficulty getting timely access to care despite plans showing they meet standards "on paper," This bill addresses many of the audit's important and reasonable recommendations. However, the author may encounter challenges balancing the timing and content of changes through legislation with the significant work ongoing administratively to improve processes in response to the audit. Final federal regulations expected out this year that address some of these issues may also require the author to respond quickly to conform as needed. The opposition also raises reasonable issues that are worth further consideration, for instance, the importance of consistency across Medi-Cal and commercial delivery systems. The author may wish to continue engaging with DHCS and stakeholders, including the opposition, to mitigate these issues while establishing a firm statutory foundation for improving oversight of access to care for Medi-Cal beneficiaries.

8) **TECHNICAL AMENDMENTS.** The Committee has, in discussion with the author and sponsor, identified minor amendments to correct and clarify code references to align with the author's intent:

a) In Section 14197.7, subdivision (e): apply the definitions of "timely" and "accurate network provider data" only to the failure to submit timely and accurate network provider data, not to all the provisions of subdivision (e).

b) In Section 14197, subdivision (g): Correct a reference within the paragraph that creates a report that measures compliance for new and returning patients and a 48-hour urgent care standard. This report should relate to the plan's compliance with the time or distance and appointment time standards, not compliance with health care services from a health care provider or a facility located outside of the time or distance standards. In addition, the bill includes two requirements to measure compliance for new and returning patients. Amendments will correct this by removing one of the duplicative requirements.

REGISTERED SUPPORT / OPPOSITION:

Support

AARP
Access Reproductive Justice
Alliance for Children's Rights
APLA Health
California Alliance of Child and Family Services
California School-based Health Alliance
Children Now
Courage California
Didi Hirsch Mental Health Services
Friends Committee on Legislation of California
Mental Health America of California
National Center for Youth Law
National Health Law Program
The Children's Partnership
The Leukemia & Lymphoma Society
Western Center on Law & Poverty, Inc.

Opposition

California Association of Health Plans
Local Health Plans of California

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2490 (Petrie-Norris) – As Amended April 1, 2024

SUBJECT: Reproductive Health Emergency Preparedness Program.

SUMMARY: Establishes the Reproductive Health Emergency Preparedness Program (RHEPP), upon appropriation by the Legislature, to expand and improve access to reproductive and sexual health care in emergency departments (EDs). Requires the Department of Health Care Access and Information (HCAI) to award grants and administer the RHEPP in collaboration with a California-based organization to serve as the grant administrator, trainer, and technical assistance provider. Specifically, **this bill**:

1) Establishes RHEPP for the purpose of expanding and improving access to reproductive and sexual health care in EDs across California.

2) Requires the RHEPP to be administered by HCAI, in collaboration with a California-based organization to serve as the grant administrator, trainer, and technical assistance provider. Requires the organization chosen to have experience providing funding, training, and technical assistance for hospital EDs related to abortion, contraception, pregnancy emergencies, and pregnancy loss. Requires the organization to coordinate directly with hospitals that apply to participate in the program.

3) Requires funds awarded pursuant to the RHEPP to be awarded to increase access to timely, evidence-based treatment of pregnancy loss and miscarriage, contraception, emergency contraception, medical and surgical abortion.

4) Requires HCAI to award grants on a competitive basis and to establish minimum standards, funding schedules, and procedures for awarding grants that take into consideration efforts identified to increase access to reproductive and sexual health care in EDs.

5) Authorizes awardees receiving grants pursuant to RHEPP to use those funds for, but not be limited to, any of the following:
   a) Providing medically accurate education, clinical guidelines and algorithms, and training tools to ED providers, including materials that correct common misinformation about abortion and other reproductive health care;
   b) Supporting clinical fellowships to serve as local champions working in EDs;
   c) Providing mentorship and coaching services;
   d) Piloting the delivery of medication abortion (MA) in EDs electing to provide these services; and,
   e) Training ED providers in MA and manual or other aspiration techniques for the management of pregnancy loss and abortion in EDs electing to provide these services.

6) Makes the provisions of this bill operative upon appropriation by the Legislature. Provides that this bill will remain in effect only until January 1, 2030, and as of that date is repealed.
7) Finds and declares that EDs in hospitals are essential access points for pregnant people, and that RHEPP will work to improve and expand access to the full spectrum of sexual and

reproductive health care in California's EDs, including abortion and full-spectrum miscarriage care in EDs choosing to provide these services.

EXISTING LAW:

1) Establishes the Reproductive Privacy Act, which prohibits the state from denying or interfering with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman. [Health and Safety Code (HSC) §123460, *et seq*.]

2) Replaces the Office of Statewide Health Planning and Development with HCAI and requires HCAI to conduct a number activities related to workforce development, health planning, and data collection and dissemination related to pharmaceutical prices and health care payments. [HSC §127000, *et seq*.]

3) Establishes the Department of Health Care Services (DHCS) to administer the Medi-Cal program, which provides comprehensive medical coverage to low-income persons, and the Family Planning, Access, Care, and Treatment program, which provides comprehensive clinical family planning services and sexually transmitted disease screening and treatment to low income persons. [Welfare and Institutions Code (WIC) §14000, et seq., WIC §14132, et seq.]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, reproductive freedom is under assault in this country, and this assault is not limited to abortion rights. Other states have also attacked birth control access, In vitro fertilization, and have even prosecuted women who have suffered miscarriages. Due to all of these factors, patients have been increasingly forced to travel to neighboring states to receive life-saving reproductive care – with many coming to California. The author states that for many Californians, an ED serves as the most accessible source of medical care for pregnant people, due to a lack of health insurance and shortages of primary care providers, obstetricians & gynecologists (OBGYNs), and reproductive health clinics. The author contends that the majority of EDs are inadequately trained and ill equipped to meet reproductive health needs. This puts those seeking care – including miscarriage care, abortion care, pregnancy emergencies, and more – at increased risk. The author states that as a national leader in reproductive freedom, health, and justice, California has a duty to ensure both our EDs and healthcare workforce are fully equipped to manage pregnancy related emergencies.

2) **BACKGROUND.** According to the Center for Disease Control and Prevention (CDC), a legal induced abortion is defined as an intervention performed by a licensed clinician that is intended to terminate an ongoing pregnancy. Ending a pregnancy with medications is an option for women who are less than ten weeks pregnant and would like to have an abortion at home with a less invasive procedure. The CDC reports that a total of 629,898 abortions were reported nationally from 49 reporting areas in 2019. From 2018 to 2019, the total number of abortions increased 2%, and from 2010 to 2019, the total number of reported abortions decreased 18%. In 2019, women in their 20s accounted for more than half of abortions

(56.9%). By contrast, adolescents under 15 years (0.2%) and women over 40 (3.7%) years accounted for the lowest percentages of abortions. In 2019, 79.3% of abortions were performed at or less than nine weeks' gestation, and nearly all (92.7%) were performed at or less than 13 weeks gestation. In 2019, the highest proportion of abortions were performed by surgical abortion at or less than 13 weeks gestation (49.0%), followed by early medication abortion at or less than nine weeks' gestation (42.3%). In 2018, the most recent year for which data were reviewed for pregnancy-related deaths, two women died as a result of complications from legally induced abortion.

a) **Abortion Access.** According to the Guttmacher Institute, in 2017, there were 1,587 facilities providing abortion in the U.S., representing a 5% decrease from the 1,671 facilities in 2014. Sixteen percent of facilities in 2017 were abortion clinics (i.e., clinics where more than half of all patient visits were for abortion), 35% were nonspecialized clinics, 33% were hospitals and 16% were private physicians' offices. Sixty percent of all abortions were provided at abortion clinics, 35% at nonspecialized clinics, 3% at hospitals and 1% at physicians' offices. In 2017, 89% of U.S. counties had no clinics providing abortions. Some 38% of reproductive-age women lived in those counties and would have had to travel elsewhere to obtain an abortion. Of patients who had an abortion in 2014, one-third had to travel more than 25 miles one way to reach a facility.

b) **California data.** According to the Guttmacher Institute, in 2017, 132,680 abortions were provided in California, though not all abortions that occurred in California were provided to state residents. There was a 16% decline in the abortion rate in California between 2014 and 2017, from 19.5 to 16.4 abortions per 1,000 women of reproductive age. Abortions in California represent 15.4% of all abortions in the U.S. There were 419 facilities providing abortion in California in 2017, and 161 of those were clinics. These numbers represent a 6% increase in clinics from 2014, when there were 512 abortion-providing facilities overall, of which 152 were clinics. In 2017, some 40% of California counties had no clinics that provided abortions, and 3% of California women lived in those counties.

c) **Abortion training.** Abortion is normal and a common healthcare procedure, yet many healthcare professionals receive no or limited training in abortion care while in school. Only 6% of national family medicine programs guarantee their residents abortion training, and in nursing and midwifery, abortion training is even less accessible. Only 6% of national Family Medicine programs guarantee their residents abortion training, and within nursing, midwifery, and other healthcare professions, abortion training is even less accessible. Nineteen percent of Family Medicine programs in California offer opt-out abortion training as part of their residency program. California has 64 Family Medicine programs, of those 12 offer opt-out abortion training.

d) **ED services and access.** According to a 2017 Guttmacher Institute study, "Abortion Incidence and Service Availability in the United States," an ED serves as the most accessible source of medical care for many pregnant people, due to a lack of health insurance and shortages of primary care providers, OBGYNs and reproductive health clinics. Many patients go to the ED for prenatal care, sexually transmitted infections, or sexual assault. Yet most ED providers are not well trained in these areas and depend on OB-GYNs, who are in increasingly short supply in many rural hospitals. Many Californians, especially lower-income, rural, and patients of color already struggle to

obtain the full spectrum of reproductive health care near where they live. Forty percent of California counties do not have an abortion provider, creating a maldistribution of trained providers that are concentrated in the metropolitan areas of our state. These regions often also have primary care and OB-GYN provider shortages.

e) Budget ask. The author of this bill has requested a $4 million augmentation from the Budget Committee to fund this bill.

3) SUPPORT. TEACH (Training in Early Abortion for Comprehensive Healthcare) is a cosponsor of this bill and states that in June 2022, the U.S. the Supreme Court overturned *Roe v. Wade*, leaving the right to abortion up to individual states. As of today, 18 states have enacted total bans or severe restrictions on abortion, and it's anticipated more states will follow. The negative impact of abortion bans goes beyond access to abortion care, it also affects those who experience pregnancy loss and complications. With limited options, patients are often referred to, or seek care from, emergency medical professionals who are not properly trained or equipped to meet miscarriage, contraception, and abortion-related reproductive health needs. With the increase of telehealth medication abortion and self-medicated abortions, ED services also become a critical point of access. TEACH notes that RHEPP would support EDs with the necessary tools and skills building for providers, to help them better serve people who have been traditionally excluded from the healthcare system. As a result of the program, EDs will be better equipped to provide pregnancy loss and miscarriage treatment, contraception, emergency contraception, medication and/or procedural abortion to patients who need it.

Reproductive Freedom for All California (formerly NARAL Pro-Choice California), is a cosponsor of this bill and states that EDs should be equipped to manage a wide range of reproductive health emergencies to not place an undue burden on patients without access to other modes of medical care. Further, as more states ban abortion, which includes miscarriage management, California will continue to see an increase in out of state patients seeking life-saving reproductive healthcare. As a national leader in reproductive freedom, health, and justice– California has a duty to ensure both our emergency departments and reproductive healthcare workforce are fully equipped to manage pregnancy related emergencies.

4) OPPOSITION. The California Catholic Conference (CCC) is opposed to this bill and states that they strongly affirm that women deserve excellent, compassionate healthcare, especially when facing pregnancy loss and pregnancy emergencies. CCC notes that they are also always opposed to the violence of abortion. However, reducing the emergency needs of women to abortion and contraception at the expense of every other kind of reproductive healthcare will only worsen gender biases and the outcomes for women's and maternal health. CCC contends that comprehensive reproductive and sexual health understands the totality of the person, including the physiological, nutritional, endocrine, cardiovascular, and psychological needs of women across the lifespan. CCC notes that contraception is free, over-the-counter, and widely available. Abortion is already free and ubiquitous in California - performed by doctors, nurse practitioners, midwives, and physician assistants, at 400 facilities, on college campuses, and via telehealth and a dozen sources by mail. Pushing unwanted abortion on our communities is exploitative and is reproductive coercion. CCC explains that women in maternity care deserts cannot find are enough doctors who can safely monitor them through

pregnancy and deliver their infants. CCC points to the following statistics:

a) One in 4 California women receives inadequate prenatal care;
b) Forty-six maternity wards have closed since 2012, half in the last three years;
c) Doctors are assisting at hundreds of births per year;
d) The average OBGYN age is 51, with most retiring by 59;
e) Rural California counties have no OBGYN; and,
f) Maternal mortality has doubled in California, with astonishingly high rates for Black and Native mothers.

CCC concludes that California is failing at reproductive healthcare that women need, and lawmakers need to ensure parity for the choices of pregnant and parenting women as they pursue motherhood.

5) RELATED LEGISLATION. AB 2670 (Schiavo and Holden) requires the Department of Public Health to develop an awareness campaign to publicize the internet website "abortion.ca.gov" to the general public, health care providers, health care professional associations and societies, health care employers, and local public health officers and health departments.

6) PREVIOUS LEGISLATION.

a) AB 1918 (Petrie-Norris), Chapter 561, Statutes of 2022, establishes the California Reproductive Health Service Corps program within HCAI to reduce the debt burden of current and future health care professionals dedicated to providing reproductive health care in underserved areas of California.

b) AB 2091 (Mia Bonta), Chapter 628, Statutes of 2022, prohibits compelling a person to identify or provide information that would identify an individual who has sought or obtained an abortion in a state, county, city, or other local criminal, administrative, legislative, or other proceeding.

c) AB 2134 (Akilah Weber), Chapter 562, Statutes of 2022, establishes the California Reproductive Health Equity Program within HCAI to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services.

d) AB 2223 (Wicks), Chapter 629, Statutes of 2022, prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a pregnant person who is exercising their reproductive rights.

e) SB 1301 (Sheila Kuehl), Chapter 385, Statutes of 2002, enacts the Reproductive Privacy Act, which provides that every individual possesses a fundamental right of privacy with respect to reproductive decisions, including the fundamental right to choose or refuse birth control, and the fundamental right to choose to bear a child or obtain an abortion.

REGISTERED SUPPORT / OPPOSITION:

Support

Reproductive Freedom for All (cosponsor)
Training in Early Abortion for Comprehensive Health Care (cosponsor)
Access Reproductive Justice
American Atheists
American College of Obstetricians and Gynecologists District IX
Black Women for Wellness Action Project
California Medical Association
If/when/how: Lawyering for Reproductive Justice
National Health Law Program
Women's Foundation California

Opposition

California Catholic Conference

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