California State Assembly

HEALTH

MIA BONTA
CHAIR

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AGENDA

Tuesday, April 23, 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

SPECIAL ORDER OF BUSINESS FROM 3:00 PM TO 4:00 PM

1.	AB 2200	Kalra	Guaranteed Health Care for All.

REGULAR ORDER OF BUSINESS

2.	AB 2064	Jones-Sawyer	Community Violence Interdiction Grant Program.
3.	AB 2075	Alvarez	Resident Access Protection Act.
4.	AB 2101	Rodriguez	Statewide strategic stockpile.
5.	AB 2115	Haney	Controlled substances: clinics.
6.	AB 2180	Weber	Health care coverage: cost sharing.
7.	AB 2198	Flora	Health information.
8.	AB 2271	Ortega	St. Rose Hospital.
9.	AB 2348	Rodriguez	Emergency medical services.
10.	AB 2352	Irwin	Behavioral health and psychiatric advance directives.
11.	AB 2383	Wendy Carrillo	State Department of Developmental Services: services for children with developmental disabilities: training programs.
12.	AB 2467	Bauer-Kahan	Health care coverage for menopause.
13.	AB 2563	Essayli	Newborn screening program.

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14.	AB 2574	Valencia	Alcoholism or drug abuse recovery or treatment facilities.
15.	AB 2613	Zbur	Jaqueline Marie Zbur Rare Disease Advisory Council.
16.	AB 2637	Schiavo	Health Facilities Financing Authority Act.
17.	AB 2668	Berman	Coverage for cranial prostheses.
18.	AB 2670	Schiavo	Awareness campaign: abortion services.
19.	AB 2726	Flora	Specialty care network: telehealth and other virtual services.
20.	AB 2756	Boerner	Pelvic Floor and Core Conditioning Pilot Program.
21.	AB 2767	Santiago	Financial Solvency Standards Board: membership.
22.	AB 2786	Bonta	Mobile farmers' markets.
23.	AB 2789	Wallis	Marriage: change of name.
24.	AB 2843	Petrie-Norris	Health care coverage: rape and sexual assault.
25.	AB 2893	Ward	The Shared Recovery Housing Residency Program.
26.	AB 2914	Bonta	Health care coverage: essential health benefits.
27.	AB 2942	Villapudua	Novel Allogeneic Adipose Cell-Based Viral Therapies Clinical Trials Grant Program.
28.	AB 3045	Ta	Birth certificate: decorative Asian Zodiac heirloom birth certificate.
29.	AB 3059	Weber	Human milk.
30.	AB 3156	Joe Patterson	Medi-Cal managed care plans: exemption from mandatory enrollment.
31.	AB 3245	Joe Patterson	Coverage for colorectal cancer screening.
32.	HR 58	Jackson	Access to care.

RECONSIDERATION VOTE ONLY

33.	AB 2960	Lee	Sexually transmitted diseases: testing.

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2200 (Kalra) – As Amended April 9, 2024

SUBJECT: Guaranteed Health Care for All.

SUMMARY: Creates the California Guaranteed Health Care for All Act. Establishes in state government the California Guaranteed Health Care for All program, or CalCare, to be governed by the CalCare Board (board). Specifies that every state resident is eligible and entitled to enroll as a CalCare member. Prohibits a member from being required to pay a fee, payment, or other charge for enrolling in or being a CalCare member. Entitles individuals enrolled for CalCare benefits to have payments made by CalCare to a participating provider for the health care items and services if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition. Provides that a health care provider or entity is qualified to participate as a CalCare provider, as specified. Requires the CalCare board to adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services. Requires CalCare to establish a single standard of care, therapeutic, and effective care for all state residents. Establishes an Office of Health Equity (Office) within CalCare. Authorizes the CalCare board to seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare. Creates the CalCare Trust Fund and requires the CalCare board to annually prepare a budget that specifies a budget for all expenditures to be made for covered health care items and services. Specifies the intent of the Legislature to enact legislation that would develop a revenue plan, taking into considerations anticipated federal revenue available for CalCare. Specifically, **this bill**:

Governance

1) Requires CalCare to be governed by an executive board, known as the CalCare board, consisting of nine voting members who are residents of California. Requires the board to be an independent public entity not affiliated with an agency or department. Requires, of the members of the board, five to be appointed by the Governor, two to be appointed by the Senate Committee on Rules, and two to be appointed by the Speaker of the Assembly. Requires the Secretary of the California Health and Human Services Agency (CHHSA) or the Secretary's designee to serve as a nonvoting, ex officio member of the board.

2) Requires a member of the board, other than an ex officio member, to be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules to be for a term of five years, and the initial appointment by the Speaker of the Assembly to be for a term of two years. Allows these members to be reappointed for succeeding four-year terms.

3) Requires appointments by the Governor to be subject to confirmation by the Senate. Allows a member of the board to continue to serve until the appointment and qualification of the member's successor. Requires vacancies to be filled by appointment for the unexpired term. Requires the board to elect a chairperson on an annual basis.

4) Requires each person appointed to the board to have demonstrated and acknowledged expertise in health care policy or delivery. Requires appointing authorities to also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care and the diversity of various regions within the state.

5) Requires appointments to the board to be made as follows:
   a) Two health care professionals who practice medicine. At least one to be a practicing physician or medical doctor;
   b) One registered nurse;
   c) One public health professional;
   d) One mental health professional;
   e) One member with an institutional provider background;
   f) One representative of a not-for-profit organization that advocates for individuals who use health care in California;
   g) One representative of a labor organization; and,
   h) One member of the committee under 15) below to serve on a rotating basis to be determined by the committee.

6) Requires each member of the board to have the responsibility and duty to meet the requirements of this bill and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through CalCare, and to ensure the operational well-being and fiscal solvency of CalCare.

7) Requires the appointment authorities to, in making appointments to the board, take into consideration the racial, ethnic, gender, and geographical diversity of the state so that the board's composition reflects the communities of California.

8) Prohibits a member of the board or of the staff of the board from being employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health care professional, institutional provider, or group practice while serving on the board or on the staff of the board, except board members who are practicing health care professionals may be employed by an institutional provider or group practice. Prohibits a member of the board or of the staff of the board from being a board member or an employee of a trade association of health professionals, institutional providers, or group practices while serving on the board or on the staff of the board. Allows a member of the board or of the staff of the board to be a health care professional if that member does not have an ownership interest in an institutional provider or a professional health care practice.

9) Specifies a board member is to receive compensation for service on the board. Authorizes a board member to receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board.

10) Prohibits a member of the board from making, participate in making, or in any way attempting to use the member's official position to influence the making of a decision that the member knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the member or a person in the member's immediate family, or on either of the following:
   a) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without

regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months before the decision is made; or,

b) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

11) Prohibits liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this bill.

12) Requires the board to hire an executive director to organize, administer, and manage the operations of the board. Exempts the executive director from civil service and serves at the pleasure of the board.

13) Subjects the board to the Bagley-Keene Open Meeting Act, except authorizes the board to hold closed sessions when considering matters related to litigation, personnel, contracting, and provider rates.

14) Authorizes the board to adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act.

15) Requires the board to convene a CalCare Public Advisory Committee (committee) to advise the board on all matters of policy for CalCare. Requires the committee to consist of members who are residents of California.

16) Requires members of the committee to be appointed by the board for a term of two years. Allows for reappointment for succeeding two-year terms.

17) Requires committee members to be as follows:
    a) Four health care professionals;
    b) One registered nurse;
    c) One representative of a licensed health facility;
    d) One representative of an essential community provider;
    e) One representative of a physician organization or medical group;
    f) One behavioral health provider;
    g) One dentist or oral care specialist;
    h) One representative of private hospitals;
    i) One representative of public hospitals;
    j) One individual who is enrolled in and uses health care items and services under CalCare;
    k) Two representatives of organizations that advocate for individuals who use health care in California, including at least one representative of an organization that advocates for the disabled community; and,
    l) Two representatives of organized labor, including at least one labor organization representing registered nurses.

18) Requires the board to, in convening the committee, make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

19) Requires committee members to serve without compensation, but to be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and to receive one hundred fifty dollars ($150) for each full day of attending meetings of the committee. Defines full day of attending a meeting to mean presence at, and participation in, not less than 75% of the total meeting time of the committee during any particular 24-hour period.

20) Requires the committee to meet at least once every quarter, and to solicit input on agendas and topics set by the board. Requires all meetings of the committee to be open to the public, pursuant to the Bagley-Keene Open Meeting Act.

21) Requires the committee to elect a chairperson to serve for two years and to be reelected for an additional two years.

22) Prohibits committee members, or their assistants, clerks, or deputies, from using for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

23) Requires the board to have all powers and duties necessary to establish and implement CalCare. Requires the board to provide, under CalCare, comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

24) Requires the board, to the maximum extent possible, to organize, administer, and market CalCare and services as a single-payer program under the name "CalCare" or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. Requires the board to, in implementing this bill, avoid jeopardizing federal financial participation in the programs that are incorporated into CalCare and to take care to promote public understanding and awareness of available benefits and programs.

25) Requires the board to consider any matter to effectuate the provisions and purposes of this bill. Prohibits the board from having executive, administrative, or appointive duties except as otherwise provided by law.

26) Requires the board to designate the executive director to employ necessary staff and authorize reasonable, necessary expenditures from the CalCare Trust Fund to pay program expenses and to administer CalCare. Requires the executive director to hire or designate another to hire staff, as specified. Requires the executive director, or the executive director's designee, to give preference in hiring to all individuals displaced or unemployed as a direct result of the implementation of CalCare, including as set forth in 42) below.

27) Requires the board to do or delegate to the executive director all of the following:
    a) Determine goals, standards, guidelines, and priorities for CalCare;
    b) Annually assess projected revenues and expenditures and ensure the financial solvency of CalCare;
    c) Develop CalCare's budget pursuant to 231) below to ensure adequate funding to meet the health care needs of the population, and review all budgets annually to ensure they

address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices to address disparities;

d) Establish standards and criteria for the development and submission of provider operating and capital expenditure requests pursuant to 133) below;
e) Establish standards and criteria for the allocation of funds from the CalCare Trust Fund 230) below;
f) Determine when individuals may begin enrolling in CalCare. Requires an implementation period that begins on the date that individuals may begin enrolling in CalCare and ends on a date determined by the board;
g) Establish an enrollment system that ensures all eligible California residents, including those who travel out of state, those who have disabilities that limit their mobility, hearing, vision, or mental or cognitive capacity, those who cannot read, and those who do not speak or write English, are aware of their right to health care and are formally enrolled in CalCare;
h) Negotiate payment rates, set payment methodologies, and set prices involving aspects of CalCare and establish procedures thereto, including procedures for negotiating fee-for-service (FFS) payment to certain participating providers pursuant 260) below;
i) Oversee the establishment, as part of the administration of CalCare, of the committee pursuant to 15) above;
j) Implement policies to ensure that all Californians receive culturally, linguistically, and structurally competent care, pursuant 191) below to, ensure that all disabled Californians receive care in accordance with the federal Americans with Disabilities Act and the federal Rehabilitation Act of 1973, and develop mechanisms and incentives to achieve these purposes and a means to monitor the effectiveness of efforts to achieve these purposes;
k) Establish standards for mandatory reporting by participating providers and penalties for failure to report, including reporting of data pursuant to 47) below and to 100) below;
l) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services;
m) Ensure the establishment of policies that support the public health;
n) Meet regularly with the committee;
o) Determine an appropriate level of, and provide support during the transition for, training and job placement for persons who are displaced from employment as a result of the initiation of CalCare pursuant to 42) below;
p) In consultation with the Department of Managed Health Care (DMHC), oversee the establishment of a system for resolution of disputes and a system for independent medical review (IMR) pursuant to 90) below;
q) Establish and maintain an internet website that provides information to the public about CalCare that includes information that supports choice of providers and facilities and informs the public about meetings of the board and the committee;
r) Establish a process that is accessible to all Californians for CalCare to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of CalCare; and,
s) Annually prepare a written report on the implementation and performance of CalCare functions during the preceding fiscal year, that includes, at a minimum:
    i) The manner in which funds were expended;
    ii) The progress toward and achievement of the requirements of this title;
    iii) CalCare's fiscal condition;
    iv) Recommendations for statutory changes;

v) Receipt of payments from the federal government and other sources;
vi) Whether current year goals and priorities have been met;
vii) Future goals and priorities; and,
viii) Requires the report to be transmitted to the Legislature and the Governor, on or before October 1 of each year and to be made available to the public on the internet website of CalCare, as specified.

28) Allows the board to do or delegate to the executive director all of the following:

a) Negotiate and enter into any necessary contracts, including contracts with health care providers and health care professionals;

b) Sue and be sued;

c) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state;

d) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation; and,

e) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of CalCare.

29) Prohibits a carrier from offering benefits or cover health care items or services for which coverage is offered to individuals under CalCare. Allows a carrier to offer benefits to cover health care items or services that are not offered to individuals under CalCare.

30) Allows a carrier to offer either of the following:

a) Benefits to or for individuals, including their families, who are employed or self-employed in the state, but who are not residents of the state. Applies to a carrier except as otherwise prohibited by federal law; or,

b) Benefits during the implementation period to individuals who enrolled or may enroll as members of CalCare.

31) Prohibits a person from being a board a member unless the person is a member of CalCare, except the ex officio member, after the end of the implementation period.

32) Requires board, no later than two years after the effective date of this bill, to develop proposals for the following:

a) In consultation with the Advisory Committee on Public Employees' Retirement System Health Benefits established under 43) below, accommodating employer retiree health benefits for people who have been members of the Public Employees' Retirement System, but live as retirees out of the state; and,

b) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state before the implementation of CalCare and live as retirees out of the state.

33) Requires the board to develop a proposal for CalCare coverage of health care items and services currently covered under the workers' compensation system, including whether and how to continue funding for those item and services under that system and how to incorporate experience rating.

34) Authorizes the board to contract with not-for-profit organizations to provide both of the following:

a) Assistance to CalCare members with respect to selection of a participating provider, enrolling, obtaining health care items and services, disenrolling, and other matters relating to CalCare; and,

b) Assistance to a health care provider providing, seeking, or considering whether to provide health care items and services under CalCare.

35) Establishes in state government an Advisory Commission on Long-Term Services and Supports (commission), to advise the board on matters of policy related to long-term services and supports for CalCare.

36) Requires the advisory commission to consist of eleven members who are residents of California. Requires, of the members of the advisory commission, five to be appointed by the Governor, three to be appointed by the Senate Committee on Rules, and three to be appointed by the Speaker of the Assembly. Requires the members of the advisory commission to include all of the following:
a) At least two people with disabilities who use long-term services and supports;
b) At least two older adults who use long-term services and supports;
c) At least two providers of long-term services and supports, including one family attendant or family caregiver;
d) At least one representative of a disability rights organization;
e) At least one representative or member of a labor organization representing workers who provide long-term services and supports;
f) At least one representative of a group representing seniors; and,
g) At least one researcher or academic in long-term services and supports.

37) Requires, in making appointments pursuant to 36) above, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly to make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the diversity of the population of people who use long-term services and supports, including their race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographic location, and socioeconomic status.

38) Allows a member of the advisory commission to continue to serve until the appointment and qualification of that member's successor. Requires vacancies to be filled by appointment for the unexpired term. Requires members of the advisory commission to be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules to be for

a term of five years, and the initial appointment by the Speaker of the Assembly to be for a term of two years. Allows these members to be reappointed for succeeding four-year terms.

39) Requires vacancies that occur to be filled within 30 days after the occurrence of the vacancy, and to be filled in the same manner in which the vacating member was initially selected or appointed. Requires the CHHSA Secretary to notify the appropriate appointing authority of any expected vacancies on the long-term services and supports advisory commission.

40) Requires members of the advisory commission to serve without compensation, but to be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies. Requires members to also receive one hundred fifty dollars ($150) for each full day of attending meetings of the advisory commission. Defines full day of attending a meeting to mean presence at, and participation in, not less than 75% of the total meeting time of the advisory commission during any particular 24-hour period.

41) Requires the advisory commission to meet at least six times per year in a place convenient to the public. Requires all meetings of the advisory commission to be open to the public, pursuant to the Bagley-Keene Open Meeting Act. Requires the advisory commission to elect a chairperson who shall serve for two years and who may be reelected for an additional two years. Prohibits the advisory commission members or any of their assistants, clerks, or deputies from using for personal benefit any information that is filed with, or obtained by, the advisory commission and that is not generally available to the public.

42) Requires the board to provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for program assistance to individuals employed or previously employed in the fields of health insurance, health care service plans, or other third-party payments for health care, individuals providing services to health care providers to deal with third-party payers for health care, individuals who may be affected by and who may experience economic dislocation as a result of the implementation of this bill, and individuals whose jobs may be or have been ended as a result of the implementation of CalCare, consistent with otherwise applicable law. Specifies assistance described to include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits, and education benefits.

43) Requires the board to establish an Advisory Committee on Public Employees' Retirement System Health Benefits to provide input, including recommendations, to the board on matters of policy related to public employee retiree health benefits and CalCare, including all of the following:
    a) Processes to obtain approval of CalCare as a health benefits plan under public pension or retirement systems;
    b) Recommendations to the Legislature and Governor to provide tax or other accommodations for people who have accrued retiree health benefit contributions under public employees' retirement systems;
    c) Recommendations to, and coordination with, public employee retirement system boards to fully integrate beneficiaries into CalCare;
    d) Processes to change or phase out health benefits under public employees' retirement systems to fully integrate beneficiaries into CalCare; and,

e) Federal approvals that may support transition of Medicare plans under public employees' retirement systems to CalCare.

44) Requires the board to appoint the members of the advisory committee during the implementation period. Requires appointments to be made by a majority vote of the voting members of the board. Requires the board to aim for broad representation, including, at a minimum, the following representatives of public sector labor organizations, the Public Employees' Retirement System, the State Teachers' Retirement System, the University of California Retirement System, and locally administered public pension or retirement systems when appointing members to the advisory committee. Requires one-half of the committee members, at a minimum, to be representatives of public sector labor organizations.

45) Requires each appointed member to serve at the discretion of the board and may be removed at any time by a majority vote of the voting members of the board.

46) Prohibits advisory committee members from having access to confidential, nonpublic information that is accessible to the board and office. Requires instead, the advisory committee to only have access to information that is publicly available. Neither the board nor the office to disclose any confidential, nonpublic information to the advisory committee members. Requires advisory committee members to receive reimbursement for travel and other actual costs. Requires the advisory committee to meet at least four times per year in a place convenient to the public. Subjects all meetings of the advisory committee to be open to the public, pursuant to the Bagley-Keene Open Meeting Act. Requires the board to consider input, including recommendations, from the advisory committee, along with public comments, in the board's deliberation and decisionmaking.

47) Requires the board to utilize the data collected pursuant to the existing Health Data and Advisory Council Consolidation Act to assess patient outcomes and to review utilization of health care items and services paid for by CalCare.

48) Provides that the board require and enforce the collection and availability of all of the following data to promote transparency, assess quality of care, compare patient outcomes, and review utilization of health care items and services paid for by CalCare, As applicable to the type of provider, which shall be reported to the board and, as applicable, the Department of Health Care Access and Information (HCAI) or the Medical Board of California (MBC):
   a) Inpatient discharge data, including severity of illness and risk of mortality, with respect to each discharge;
   b) Emergency department, ambulatory surgical center, and other outpatient department data, including cost data, charge data, length of stay, and patients' unit of observation with respect to each individual receiving health care items and services;
   c) For hospitals and other providers receiving global budgets, annual financial data, including all of the following:
      i) Community benefit activities, including charity care, as specified, provided by the provider in dollar value at cost;
      ii) Number of employees by employee classification or job title and by patient care unit or department;
      iii) Number of hours worked by the employees in each patient care unit or department;
      iv) Employee wage information by job title and patient care unit or department;
      v) Number of registered nurses per staffed bed by patient care unit or department;

vi) A description of all information technology, including health information technology and artificial intelligence, used by the provider and the dollar value of that information technology; and,
vii) Annual spending on information technology, including health information technology, artificial intelligence, purchases, upgrades, and maintenance.

d) Risk-adjusted and raw outcome data, including:
   i) Risk-adjusted outcome reports for medical, surgical, and obstetric procedures selected by the HCAI pursuant existing law; and,
   ii) Any other risk-adjusted outcome reports that the board may require for medical, surgical, and obstetric procedures and conditions as it deems appropriate, and,

e) A disclosure made by a provider of unearned rebates, refunds, and discounts pursuant to existing law.

49) Requires the MBC to collect data for the outpatient surgery settings that the MBC regulates that meets the Ambulatory Surgery Data Record requirements of existing law, and to submit that data to the CalCare board.

50) Requires the board to make that data available as required under 51) below.

51) Requires the board to make all disclosed data collected publicly available and searchable through an internet website and through the HCAI public data sets.

52) Requires the board to make available data collected through CalCare to the HCAI and the CHHSA, consistent with this bill and otherwise applicable law, to promote and protect public, environmental, and occupational health consistent with state and federal privacy laws.

53) Requires the board to, before full implementation of CalCare, and, for providers seeking to receive global budgets or salaried payments under 133) below, as applicable, before the negotiation of initial payments, the board provide for the collection and availability of the following data:
   a) The number of patients served;
   b) The dollar value of the care provided, at cost, for all of the following categories of HCAI data items:
      i) Patients receiving charity care;
      ii) Contractual adjustments of county and indigent programs, including traditional and managed care; and,
      iii) Bad debts or any other unpaid charges for patient care that the provider sought, but was unable to collect.

54) Requires the board to regularly analyze information reported under this section and to establish rules and regulations to allow researchers, scholars, participating providers, and others to access and analyze data for purposes consistent with this bill, without compromising patient privacy.

55) Requires the board to establish regulations for the collection and reporting of data to promote transparency, assess patient outcomes, and review utilization of services provided by physicians and other health care professionals, as applicable, and paid for by CalCare.

56) Requires the board to, in implementing 47) above, utilize data that is already being collected pursuant to other state or federal laws and regulations whenever possible.

57) Provides that data reporting required by participating providers under 47) above to supplement the data collected by the HCAI and prohibits modifying or altering other reporting requirements to governmental agencies.

58) Prohibits the board from utilizing quality or other review measures established under 47) above for the purposes of establishing payment methods to providers.

59) Allows the board to coordinate and cooperate with the HCAI or other health planning agencies of the state to implement the requirements of 47) above.

60) Requires the board to establish and use a process to enter into participation agreements with health care providers and other contracts with contractors. Exempts contract entered into pursuant to this bill from the Public Contract Code, and from the review or approval of the Department of General Services (DGS). Requires the board to adopt a CalCare Contracting Manual incorporating procurement and contracting policies and procedures to be followed by CalCare. Requires the policies and procedures in the manual to be substantially similar to the provisions contained in the State Contracting Manual.

61) Provides that the adoption, amendment, or repeal of a regulation by the board to implement 60) above, including the adoption of a manual and any procurement process conducted by CalCare in accordance with the manual, is exempt from the rulemaking provisions of the Administrative Procedure Act.

62) Prohibits CalCare, a state or local agency, or a public employee acting under color of law from providing or disclosing to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

63) Prohibits law enforcement agencies from using CalCare moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of a requirement that individuals register with the federal government or a federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act.

64) Requires the board to, on or before July 1, ____, conduct and deliver a fiscal analysis to determine both of the following:
    a) Whether or not CalCare may be implemented; and,
    b) If revenue is more likely than not to be sufficient to pay for program costs within eight years of CalCare's implementation.

65) Authorizes the board to contract with one or more independent entities with the appropriate expertise or coordinate with other state agencies to conduct the fiscal analysis.

66) Requires the board deliver, and upon request present, the fiscal analysis to the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, the Chair of the Senate Committee on Appropriations, and the Chair of the Assembly Committee on Appropriations.

Eligibility and Enrollment

67) Provides that every resident of the state be eligible and entitled to enroll as a member of CalCare.

68) Prohibits a member from being required to pay a fee, payment, or other charge for enrolling in or being a member of CalCare.

69) Prohibits a member from being required to pay a premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits under CalCare.

70) Authorizes a college, university, or other institution of higher education in the state to purchase coverage under CalCare for a student, or a student's dependent, who is not a resident of the state.

71) Allows an individual entitled to benefits through CalCare to obtain health care items and services from any institution, agency, or individual participating provider.

72) Requires the board to establish a process for automatic CalCare enrollment at the time of birth in California.

73) Provides that all residents of this state, no matter what their sex, race, color, religion, ancestry, national origin, disability, age, previous or existing medical condition, genetic information, marital status, familial status, military or veteran status, sexual orientation, gender identity or expression, pregnancy, pregnancy-related medical condition, including termination of pregnancy, citizenship, primary language, or immigration status, are entitled to full and equal accommodations, advantages, facilities, privileges, or services in all health care providers participating in CalCare.

74) Prohibits a participating provider, or an entity conducting, administering, or funding a health program or activity pursuant to this bill, from discriminating based upon the categories described in 73) above in the provision, administration, or implementation of health care items and services through CalCare. Includes the following:
    a) Exclusion of a person from participation in or denial of the benefits of CalCare, except as expressly authorized by this title for the purposes of enforcing eligibility standards in 67) above;
    b) Reduction of a person's benefits; and,
    c) Any other discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity pursuant to this bill.

75) Applies personal rights penalties in existing law for the actual damages, any amount that may be determined by a jury, or a court sitting without a jury, up to a maximum of three times the amount of actual damage but in no case less than four thousand dollars ($4,000), and any attorney's fees that may be determined by the court in addition thereto, suffered by any person denied the rights, as specified.

76) Specifies that a participating provider or entity is in violation of 74) above if the complaining party demonstrates that any of the categories listed in 73) above was a motivating factor for any health care practice, even if other factors also motivated the practice.

Benefits

77) Entitles individuals enrolled for benefits under CalCare to have payment made by CalCare to a participating provider for the health care items and services in 79) below, if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition.

78) Requires the determination of medical necessity or appropriateness to be made by the member's treating physician or by a health care professional who is treating that individual and is authorized to make that determination in accordance with the scope of practice, licensing, the program standards, as established, and by the board, and other laws of the state.

79) Specifies covered health care benefits for members to include all of the following categories of health care items and services:
   a) Inpatient and outpatient medical and health facility services, including hospital services and 24-hour-a-day emergency services;
   b) Inpatient and outpatient health care professional services and other ambulatory patient services;
   c) Primary and preventive services, including chronic disease management;
   d) Prescription drugs, biological products, and all contraceptive items approved by the United States Food and Drug Administration;
   e) Medical devices, equipment, appliances, and assistive technology;
   f) Mental health and substance abuse treatment services, including inpatient and outpatient care;
   g) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services;
   h) Comprehensive reproductive care, including abortion, contraception, and assistive reproductive technology, maternity care, and newborn care;
   i) Pediatrics;
   j) Oral health, audiology, and vision services;
   k) Rehabilitative and habilitative services and devices, including inpatient and outpatient care;
   l) Emergency services and transportation;
   m) Early and periodic screening, diagnostic, and treatment services as defined in federal law;
   n) Comprehensive gender-affirming health care;
   o) Necessary transportation for health care items and services for persons with disabilities or who may qualify as low income;
   p) Long-term services and supports described in Section 100636, including long-term services and supports covered under Medi-Cal or the federal Children's Health Insurance Program (CHIP);
   q) Care coordination; and,
   r) Any additional health care items and services the board authorizes to be added to CalCare benefits.

80) Includes all the following under the categories of covered health care items and services of 79) above:
   a) Prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for their use by an individual;
   b) Child and adult immunizations;
   c) Hospice care;

d) Care in a skilled nursing facility;
e) Home health care, including health care provided in an assisted living facility;
f) Prenatal and postnatal care;
g) Podiatric care;
h) Blood and blood products;
i) Dialysis;
j) Community-based adult services as defined;
k) Dietary and nutritional therapies determined appropriate by the board;
l) Therapies that are shown by the National Center for Complementary and Integrative Health in the National Institutes of Health to be safe and effective, including chiropractic care and acupuncture;
m) Health care items and services previously covered by county integrated health and human services programs;
n) Health care items and services previously covered by a regional center for persons with developmental disabilities; and,
o) Language interpretation and translation for health care items and services, including sign language and braille or other services needed for individuals with communication barriers.

81) Includes all health care items and services required to be covered under the following provisions, without regard to whether the member would be eligible for or covered by the source referred to:
a) CHIP;
b) Medi-Cal;
c) The federal Medicare program;
d) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (KKA);
e) Health insurers, as defined in the Insurance Code; and,
f) All essential health benefits (EHBs) mandated by the federal Patient Protection and Affordable Care Act (ACA) as of January 1, 2017.

82) Prohibits health care items and services covered under CalCare from being subject to prior authorization or a limitation applied through the use of step therapy protocols.

83) Entitles individuals enrolled for benefits under CalCare to have payment made by CalCare to an eligible provider for long-term services and supports, in accordance with the standards established in this bill, for care, services, diagnosis, treatment, rehabilitation, or maintenance of health related to a medically determinable condition, whether physical or mental, of health, injury, or age, that either:
a) Causes a functional limitation in performing one or more activities of daily living or in instrumental activities of daily living; or,
b) Is a disability, as defined in federal law, that substantially limits one or more of the member's major life activities.

84) Requires the board to adopt regulations that provide for the following:
a) The determination of individual eligibility for long-term services and supports under 83) above;
b) The assessment of the long-term services and supports needed for an eligible individual; or,

c) The automatic entitlement of an individual who receives or is approved to receive disability benefits from the federal Social Security Administration under the federal Social Security Disability Insurance program to the long-term services and supports under 83) above.

85) Requires long-term services and supports provided in 83) above to do all of the following:
   a) Include long-term nursing services for a member, whether provided in an institution or in a home- and community-based setting;
   b) Provide coverage for a broad spectrum of long-term services and supports, including home- and community-based services, other care provided through noninstitutional settings, and respite care;
   c) Provide coverage that meets the physical, mental, and social needs of a member while allowing the member the member's maximum possible autonomy and the member's maximum possible civic, social, and economic participation;
   d) Prioritize delivery of long-term services and supports through home- and community-based services over institutionalization;
   e) Unless a member chooses otherwise, ensure that the member receives home- and community-based long-term services and supports regardless of the recipient's type or level of disability, service need, or age;
   f) Have the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the member's needs;
   g) Be provided in a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity;
   h) Provide long-term services and supports that are of equal quality and equitably accessible across geographic regions; and,
   i) Ensure that long-term services and supports provide recipients the option of self-direction of service, as specified, from either the recipient or care coordinators of the recipient's choosing.

86) Requires the board to consult the advisory commission established in 35) in developing regulations to implement 84) above.

87) Requires the board to, on a regular basis and at least annually, evaluate whether the benefits under CalCare should be expanded or adjusted to promote the health of members and California residents, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science.

88) Prohibits the board from removing or eliminating covered health care items and services under CalCare as listed in this bill.

89) Requires the board to establish a process by which health care professionals, other clinicians, and members may petition the board to add or expand benefits to CalCare.

90) Requires the board to establish a process by which individuals may bring a disputed health care item or service or a coverage decision for review to the IMR System established in DMHC. Defines the following:
   a) Coverage decision as the approval or denial of health care items or services by a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for items and services furnished under CalCare from a

participating provider, substantially based on a finding that the provision of a particular service is included or excluded as a covered item or service under CalCare. A "coverage decision" does not encompass a decision regarding a disputed health care item or service; and,

b) Disputed health care item or service as a health care item or service eligible for coverage and payment under CalCare that has been denied, modified, or delayed by a decision of a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for health care items and services furnished under CalCare from a participating provider, in whole or in part, due to a finding that the service is not medically necessary or appropriate. A decision regarding a disputed health care item or service relates to the practice of medicine, including early discharge from an institutional provider, and is not a coverage decision.

Health Care Delivery

91) Qualifies a health care provider or entity to participate as a provider in CalCare if the health care provider furnishes health care items and services while the provider, or, if the provider is an entity, the individual health care professional of the entity furnishing the health care items and services, is physically present within the State of California, and if the provider meets all of the following:
   a) The provider or entity is a health care professional, group practice, or institutional health care provider licensed to practice in California;
   b) The provider or entity agrees to accept CalCare rates as payment in full for all covered health care items and services;
   c) The provider or entity has filed with the board a participation agreement described in x) below; and,
   d) The provider or entity is otherwise in good standing.

92) Requires the board to establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under CalCare for members who require out-of-state health care services while the member is temporarily located out of the state.

93) Prohibits a provider or entity from being qualified to furnish health care items and services under CalCare if the provider or entity does not provide health care items or services directly to individuals, including the following:
   a) Entities or providers that contract with other entities or providers to provide health care items and services. Prohibits these entities or providers from being considered a qualified provider for those contracted items and services.
   b) Entities that are approved to coordinate care plans under the Medicare Advantage program as of January 1, 2020, but do not directly provide health care items and services.

94) Authorizes a health care provider qualified to participate to provide covered health care items or services under CalCare, as long as the health care provider is legally authorized to provide the health care item or service for the individual and under the circumstances involved.

95) Requires the board to establish and maintain procedures for members and individuals eligible to enroll in CalCare to enroll onsite at a participating provider.

96) Requires a participating provider to accept onsite enrollment of members and eligible individuals under the procedures established.

97) Requires the board to establish and maintain procedures and standards for members to select a primary care provider, which may be an internist, a pediatrician, a physician who practices family medicine, a gynecologist, a physician who practices geriatric medicine, or, at the option of a member who has a chronic condition that requires specialty care, a specialist health care professional who regularly and continually provides treatment to the member for that condition, and other participating providers.

98) Provides that a referral from a primary care provider is not required for a member to see a participating provider.

99) Allows a member to choose to receive health care items and services under CalCare from a participating provider, subject to the willingness or availability of the provider, and consistent with the provisions of this title relating to discrimination, and the appropriate clinically relevant circumstances and standards.

100) Requires a health care provider to enter into a participation agreement with the board to qualify as a participating provider under CalCare.

101) Requires a participation agreement between the board and a health care provider to include provisions for at least the following, as applicable to each provider:
   a) Health care items and services to members to be furnished by the provider without discrimination, as required by 69) above. Prohibits the provision of a type or class of health care items or services that are outside the scope of the provider's normal practice.
   b) Prohibits a charge to be made to a member for a covered health care item or service, other than for payment authorized by this title. Provides that, except as described in 119) below, a contract not be entered into with a patient for a covered health care item or service.
   c) Requires the provider to follow the policies and procedures in the CalCare Contracting Manual established 61) above.

102) Requires the provider to furnish information reasonably required by the board and shall meet the reporting requirements of 47) above and 193 below for at least the following:
   a) Quality review by designated entities.
   b) Making payments, including the examination of records as necessary for the verification of information on which those payments are based.
   c) Statistical or other studies required for the implementation of this bill.
   d) Other purposes specified by the board.

103) Prohibits the provider from employing or using an individual or other provider that has had a participation agreement terminated for cause to provide covered health care items and services if the provider is not an individual.

104) Requires the provider to submit bills and required supporting documentation relating to the provision of covered health care items or services within 30 days after the date of providing those items or services if the provider is paid on a FFS basis for covered health care items and services.

105) Requires the provider to submit information and any other required supporting documentation reasonably required by the board on a quarterly basis that relates to the provision of covered health care items and services and describes health care items and services furnished with respect to specific individuals.

106) Requires the provider to, if the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, disclose the following to the board:
   a) Any case mix indexes, diagnosis coding software, procedure coding software, or other coding system utilized by the provider for the purposes of meeting payment, global budget, or other disclosure requirements under this bill; and,
   b) Any case mix indexes, diagnosis coding guidelines, procedure coding guidelines, or coding tip sheets used by the provider for the purposes of meeting payment or disclosure requirements under this bill.

107) Prohibits the provider from, if the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, doing the following:
   a) Use proprietary case mix indexes, diagnosis coding software, procedure coding software, or other coding system for the purposes of meeting payment, global budget, or other disclosure requirements under this bill;
   b) Require another health care professional to apply case mix indexes, diagnosis coding software, procedure coding software, or other coding system in a manner that limits the clinical diagnosis, treatment process, or a treating health care professional's judgment in determining a diagnosis or treatment process, including the use of leading queries or prohibitions on using certain codes;
   c) Provide financial incentives or disincentives to physicians, registered nurses, or other health care professionals for particular coding query results or code selections; and,
   d) Use case mix indexes, diagnosis coding software, procedure coding software, or other coding system that make suggestions for higher severity diagnoses or higher cost procedure coding.

108) Requires the provider to comply with the duty of patient advocacy and reporting requirements described in 192) below.

109) Provides that if the provider is not an individual, the provider to ensure that a board member, executive, or administrator of the provider is not receiving compensation from, own stock or have other financial investments in, or receive services as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

110) Provides that if the provider is a not-for-profit hospital, as specified, the hospital to submit to the board the community benefits plan developed pursuant existing law.

111) Requires health care items and services to members to be furnished by a health care professional while the professional is physically present within the State of California.

112) Prohibits the provider from entering into risk-bearing, risk-sharing, or risk-shifting agreements with other health care providers or entities other than CalCare.

113) Does not limit the formation of group practices.

114) Authorizes a participation agreement to be terminated with appropriate notice by the board for failure to meet the requirements of this bill or may be terminated by a provider.

115) Requires a participating provider to be provided notice and a reasonable opportunity to correct deficiencies before the board terminates an agreement, unless a more immediate termination is required for public safety or similar reasons.

116) Requires the procedures and penalties under the Medi-Cal program for fraud or abuse pursuant existing law to apply to an applicant or provider under CalCare. Defines the following:
   a) Applicant as an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the board to participate as a provider in CalCare; and,
   b) Provider as an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to CalCare program members.

117) Prohibits a person from discharging or otherwise discriminating against an employee on account of the employee or a person acting pursuant to a request of the employee for any of the following:
   a) Notifying the board, executive director, or employee's employer of an alleged violation of this bill, including communications related to carrying out the employee's job duties;
   b) Refusing to engage in a practice made unlawful by this title, if the employee has identified the alleged illegality to the employer;
   c) Providing, causing to be provided, or being about to provide or cause to be provided to the provider, the federal government, or the Attorney General information relating to a violation of, or an act or omission the provider or representative reasonably believes to be a violation of, this bill;
   d) Testifying before or otherwise providing information relevant for a state or federal proceeding regarding this bill or a proposed amendment to this bill;
   e) Commencing, causing to be commenced, or being about to commence or cause to be commenced a proceeding under this bill;
   f) Testifying or being about to testify in a proceeding;
   g) Assisting or participating, or being about to assist or participate, in a proceeding or other action to carry out the purposes of this bill; and,
   h) Objecting to, or refusing to participate in, an activity, policy, practice, or assigned task that the employee or representative reasonably believes to be in violation of this bill or any order, rule, regulation, standard, or ban under this bill.

118) Allows an employee covered by this section who alleges discrimination by an employer in violation to 117) above to bring an action governed by the rules and procedures, legal burdens of proof, and remedies applicable under the False Claims Act, or an action against unfair competition, as specified.

119) Prohibits the rights and remedies in 118) above from being waived by an agreement, policy, form, or condition of employment or preempting or diminishing any other law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination. Defines the following:
   a) Employer as a person engaged in profit or not-for-profit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and who is subject to liability for violating this bill; and,
   b) Employee as an individual performing activities under this bill on behalf of an employer.

120) Prohibits an institutional or other health care provider with a participation agreement in effect from billing or entering into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is a covered benefit through CalCare.

121) Allows an institutional or other health care provider with a participation agreement in effect to bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is not a covered benefit through CalCare if the following requirements are met:
   a) The contract and provider meet the requirements specified in 122) and 124) below;
   b) The health care item or service is not payable or available through CalCare; and,
   c) The provider does not receive reimbursement, directly or indirectly, from CalCare for the health care item or service, and does not receive an amount for the health care item or service from an organization that receives reimbursement, directly or indirectly, for the health care item or service from CalCare.

122) Requires a contract described in 121) above to be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the health care item or service is furnished pursuant to the contract, and to not be entered into at a time when the individual is facing an emergency health care situation.

123) Requires a contract described in 121) above to clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:
   a) Prohibits the individual from submitting a claim or request that the provider submit a claim to CalCare for the health care item or service;
   b) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service;
   c) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service; and,
   d) The individual understands that the provider is providing services outside the scope of CalCare.

124) Requires a participating provider that enters into a contract described in 120) above to have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, to be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. Requires the affidavit to identify the provider who is to furnish the noncovered health care item or service, state that the provider will not

submit a claim to CalCare for a noncovered health care item or service provided to a member, and be signed by the provider.

125) Requires all of the following to apply if a provider signing an affidavit described in 124) above knowingly and willfully submits a claim to CalCare for a noncovered health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract:
   a) A contract described 120) to be void;
   b) A payment to not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period to be remitted to CalCare, plus interest; and,
   c) A payment received by the provider from the member, CalCare, or other payer for a health care item or service furnished during the period described in 125)b) above to be remitted to the payer, and damages to be available to the payer pursuant to existing law.

126) Allows an institutional or other health care provider with a participation agreement in effect to bill or enter into a private contract with an individual ineligible for benefits under CalCare for a health care item or service. Requires the institutional or other health care provider to report to the board, on an annual basis, aggregate information regarding services furnished to ineligible individuals consistent with 63) above.

127) Allows an institutional or other health care provider without a participation agreement in effect to bill or enter into a private contract with an individual eligible for benefits under CalCare for a health care item or service that is a covered benefit through CalCare only if the contract and provider meet the requirements specified in 128) and 129) below.

128) Requires a contract described in 127) above to be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the item or service is furnished pursuant to the contract, and to not be entered into at a time when the individual is facing an emergency health care situation.

129) Requires a contract described in 127) above to clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:
   a) The individual understands that the individual has the right to have the health care item or service provided by another provider for which payment would be made under CalCare;
   b) The individual shall not submit a claim or request that the provider submit a claim to CalCare for the health care item or service, even if the health care item or service is otherwise covered under CalCare;
   c) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service;
   d) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service; and,
   e) The individual understands that the provider is providing services outside the scope of CalCare.

130) Requires a provider that enters into a contract described in 127) above to have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. Requires the affidavit to identify the provider who is to furnish the health care item or service, state that the provider will not submit a claim to CalCare for a health care item or service provided to a member during a two-year period beginning on the date the affidavit was signed, and be signed by the provider.

131) Requires all of the following apply if a provider who signed an affidavit described in 130) above knowingly and willfully submits a claim to CalCare for a health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract described in an affidavit signed:
   a) A contract described in 127) above to be void;
   b) Prohibits a payment from being made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period be remitted to CalCare, plus interest; and,
   c) A payment received by the provider from the member, CalCare program, or other payer for a health care item or service furnished during the period described in 131) b) to be remitted to the payer, and damages to be available to the payer pursuant to existing law.

132) Allows an institutional or other health care provider without a participation agreement in effect to bill or enter into a private contract with an individual for a health care item or service that is not a benefit under CalCare.

Payment for Health Care Items and Services

133) Requires the board to adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services provided to members under CalCare by participating providers. Requires all payment rates under CalCare to be reasonable and reasonably related to all of the following:
   a) The cost of efficiently providing health care items and services;
   b) Ensuring availability and accessibility of CalCare health care services, including compliance with state requirements regarding network adequacy, timely access, and language access; and,
   c) Maintaining an optimal workforce and the health care facilities necessary to deliver quality, equitable health care.

134) Requires payment for health care items and services to be considered payment in full.

135) Prohibits a participating provider from charging a rate in excess of the payment established through CalCare for a health care item or service furnished under CalCare and from soliciting or accepting payment from any member or third party for a health care item or service furnished under CalCare, except as provided under a federal program.

136) Does not preclude CalCare from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

137) Requires the board to pay to each institutional provider a lump sum to cover all operating expenses under a global budget as set forth in 147) below. Requires an institutional provider receiving a global budget payment to accept that payment as payment in full for all operating expenses for health care items and services furnished under CalCare, whether inpatient or outpatient, by the institutional provider, no later than the beginning of each fiscal quarter during which an institutional provider of care, including a hospital, skilled nursing facility, and chronic dialysis clinic, is to furnish health care items and services under CalCare.

138) Allows a group practice, county organized health system, or local initiative to elect to be paid for health care items and services furnished under CalCare either on a FFS basis under 169) below or on a salaried basis.

139) Requires a group practice, county organized health system, or local initiative that elects to be paid on a salaried basis to negotiate salaried payment rates with the board annually, and requires the board to pay the group practice, county organized health system, or local initiative at the beginning of each month.

140) Allows the board to determine whether a group practice, county organized health system, or local initiative may elect to be paid on an hourly or other time-based rate for certain health care items and services furnished under CalCare, including primary and preventive care and care coordination.

141) Requires health care items and services provided to members under CalCare by individual providers or any other providers not paid under 137) or 138) above to be paid for on a FFS basis under 169) below.

142) Requires capital-related expenses for specifically identified capital expenditures incurred by participating providers to meet the requirements under 174) below.

143) Requires payment methodologies and payment rates to include a distinct component of reimbursement for direct and indirect costs incurred by the institutional provider for graduate medical education, as applicable.

144) Requires the board to adopt, by regulation, payment methodologies and procedures for paying for out-of-state health care services.

145) Specifies that this bill does not regulate, interfere with, diminish, or abrogate a collective bargaining agreement, established employee rights, or the right, obligation, or authority of a collective bargaining representative under state or local law; nor does it not compel, regulate, interfere with, or duplicate the provisions of an established training program that is operated under the terms of a collective bargaining agreement or unilaterally by an employer or bona fide labor union.

146) Requires the board to determine the appropriate use and allocation of the special projects budget for the construction, renovation, or staffing of health care facilities in rural, underserved, or health professional or medical shortage areas, and to address health disparities, including those based on race, ethnicity, national origin, primary language use,

age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

147) Requires an institutional provider's global budget to be determined before the start of a fiscal year through negotiations between the provider and the board. Requires the global budget to be negotiated annually based on the payment factors described in 150) below.

148) Requires an institutional provider's global budget to be used only to cover operating expenses associated with direct care for patients for health care items and services covered under CalCare. Prohibits an institutional provider's global budget from being used for capital expenditures, and capital expenditures and being included in the global budget.

149) Requires the board, on a quarterly basis, to review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and to determine whether adjustment to the institutional provider's payment is warranted.

150) Requires a payment negotiated pursuant to 147) above to take into account, with respect to each provider, all of the following:
   a) The historical volume of services provided for each health care item and service in the previous three-year period;
   b) The actual expenditures of a provider in the provider's most recent Medicare cost report for each health care item and service, or other cost report that may otherwise be adopted by the board, compared to the following:
      i) The expenditures of other comparable institutional providers in the state;
      ii) The normative payment rates established under the comparative payment rate systems pursuant to 165) below, including permissible adjustments to the rates for the health care items and services;
      iii) Projected changes in the volume and type of health care items and services to be furnished;
      iv) Employee wages and compensation;
      v) The provider's maximum capacity to provide health care items and services;
      vi) Education and prevention programs;
      vii) Health care workforce recruitment and retention programs, including programs to maintain optimal staffing levels of health care workers as established by the board and to maintain mandatory minimum safe registered nurse-to-patient ratio regulations adopted pursuant to existing law;
      viii) Permissible adjustments to the provider's operating budget from the previous fiscal year due to factors including an increase in primary or specialty care access, efforts to decrease health care disparities in rural or medically underserved areas, a response to emergent conditions, and proposed changes to patient care programs at the institutional level; and,
      ix) Any other factor determined appropriate by the board; and,
   c) In a rural or medically underserved area, the need to mitigate the impact of the availability and accessibility of health care services through increased global budget payment.

151) Prohibits a payment negotiated pursuant to 147) above or payment methodology from doing any of the following:

a) Take into account capital expenditures of the provider or any other expenditure not directly associated with furnishing health care items and services under CalCare;
b) Be used by a provider for capital expenditures or other expenditures associated with capital projects;
c) Exceed the provider's capacity to furnish health care items and services covered under CalCare;
d) Be used to pay or otherwise compensate a board member, executive, or administrator of the institutional provider who has an interest or relationship prohibited under 100) above or 192) below; and,
e) Take into account relief pending appeal granted to a provider under 158) above.

152) Allows the board to negotiate changes to an institutional provider's global budget based on factors not prohibited under this bill.

153) Requires compensation costs for an employee, contractor employee, or subcontractor employee of an institutional provider receiving a global budget to meet the compensation cap established federal law and its implementing regulations, except that the board may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that those exceptions are needed to ensure CalCare continued access to needed skills and capabilities.

154) Prohibits payment to an institutional provider from allowing a participating provider to retain revenue generated from outsourcing health care items and services covered under CalCare, unless that revenue was considered part of the global budget negotiation process. Requires payment to apply to revenue from outsourcing health care items and services that were previously furnished by employees of the participating provider who were subject to a collective bargaining agreement. Defines "operating expenses" of a provider to include the following:
   a) The costs associated with covered health care items and services under CalCare, including the following:
      i) Compensation for health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider;
      ii) Pharmaceutical products administered by health care professionals at the institutional provider's facility or facilities;
      iii) Purchasing supplies;
      iv) Maintenance of medical devices and health care technologies, including diagnostic testing equipment, except that health information technology that is not necessary to comply with data collection and reporting requirements under this title or otherwise required by law and artificial intelligence shall be considered capital expenditures, unless otherwise determined by the board;
      v) Incidental services necessary for safe patient care;
      vi) Patient care, education, and preventive health programs, and necessary staff to implement those programs;
      vii) Occupational health and safety programs and public health programs, and necessary staff to implement those programs for the continued education and health and safety of clinicians and other individuals employed by the institutional provider;
      viii) Infectious disease response preparedness, including the maintenance of a one-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, and contact tracing; and,

ix) Recruitment, retention, and training of health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider, including programs to maintain optimal staffing levels of health care workers as established by the board and to maintain mandatory minimum safe registered nurse-to-patient ratio regulations adopted pursuant to existing law; and,

b) Administrative costs of the institutional provider.

155) Requires the board to consider a request for interim payment, filed by an institutional provider that is subject to the payments or global budget, based on the following:
   a) The overall financial condition of the institutional provider, including bankruptcy or financial solvency;
   b) Excessive risks to the ongoing operation of the institutional provider;
   c) Justifiable differences in costs among providers, including providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations;
   d) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the provider. Those factors may include:
   e) Natural disasters;
   f) Outbreaks of epidemics or infectious diseases;
   g) Unanticipated facility or equipment repairs or purchases;
   h) Significant and unanticipated increases in pharmaceutical or medical device prices; and,
   i) Public health emergencies.
   j) Changes in state or federal laws that result in a change in costs; and,
   k) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

156) Requires the board to establish uniform written procedures under which it reviews requests for interim payment pursuant to 155) above, including procedures to provide immediate payment in the event of a public health emergency.

157) Requires the board, to, on a quarterly basis, review the global budget and payments to institutional providers that are not-for-profit or governmental entities and may initiate an interim payment review under 155) above.

158) Requires the board to consider an appeal of payments, the global budget, or a determination of a request for interim payment, filed by an institutional provider that is subject to the payment or global budget.

159) Requires the payments set and global budget negotiated by the board to be paid to the institutional provider to stay in effect during the appeal process, subject to relief pending appeal under this subdivision.

160) Requires the board to have the power to grant interim relief based on fairness. Requires the board to develop regulations governing interim relief. Requires the board to establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by an institutional provider. Requires a decision on interim relief to be granted within one month of the filing of an interim relief appeal. Requires an institutional provider

to certify in its interim relief appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the institutional provider has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those described 155) above.

161) Allows the board to delegate the conduct of a hearing to an administrative law judge, to issue a proposed decision with findings of fact and conclusions of law.

162) Authorizes the administrative law judge to hold evidentiary hearings and to issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted payment or global budget, within four months of the filing of the appeal.

163) Allows the board to, within 30 days of receipt of the proposed decision by the administrative law judge, approve, disapprove, or modify the decision, and to issue a final decision for the appealing institutional provider.

164) Requires a final determination by the board to be subject to judicial review pursuant to existing law.

165) Requires the board to use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations described in 150) above. Requires the board to update the comparative payment rate system annually.

166) Requires the board to use only the operating base payment rates under each Medicare prospective payment system with applicable adjustments to develop the comparative payment rate system.

167) Prohibits the comparative rate system from including value-based purchasing adjustments or capital expenses base payment rates that may be included in Medicare prospective payment systems.

168) Requires the board to take into account the appropriate Medicare prospective payment system from the most recent year to determine what operating base payment the institutional provider would have been paid for covered health care items and services furnished the preceding year with applicable adjustments, excluding value-based purchasing adjustments, based on the prospective payment system, in the first year that global budget payments are available to institutional providers, and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for an institutional provider.

169) Requires the board to engage in good faith negotiations with health care providers' representatives under 260) below to determine rates of FFS payments for health care items and services furnished under CalCare.

170) Provides for a rebuttable presumption that the Medicare FFS rates of reimbursement constitute reasonable FFS payment rates. Requires the fee schedule to be updated annually.

171) Prohibits payments to individual providers under this article from including payments to individual providers in salaried positions at institutional providers receiving global budgets

under 147) above or individual health care professionals who are employed by or otherwise receive compensation or payment for health care items and services furnished under CalCare from group practices, county organized health systems, or local initiatives that receive payment under CalCare on a salaried basis.

172) Requires the board to ensure that the fee schedule compensates physicians and other health care professionals at a rate that reflects the value for health care items and services furnished to establish the FFS payment rates.

173) Allows the board to mitigate the impact of the availability and accessibility of health care services through increased individual provider payment in a rural or medically underserved area.

174) Requires the board to adopt, by regulation, payment methodologies for the payment of capital expenditures for specifically identified capital projects incurred by not-for-profit or governmental entities that are health facilities pursuant existing law.

175) Requires the board to prioritize allocation of funding under 174) above to projects that propose to use the funds to improve service in a rural or medically underserved area, or to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status. Requires the board to consider the impact of any prior reduction in services or facility closure by a not-for-profit or governmental entity as part of the application review process.

176) Requires health care facilities and governmental entities to apply to the board in a time and manner specified by the board for the purposes of funding capital expenditures 174) above. Requires all capital-related expenses generated by a capital project to have received prior approval from the board to be paid under CalCare.

177) Requires approval of an application for capital expenditures to be based on achievement of the program standards described in 191) below.

178) Prohibits the board from granting funding for capital expenditures for capital projects that are financed directly or indirectly through the diversion of private or other non-CalCare program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

179) Prohibits a participating provider from using operating funds or payments from CalCare for the operating expenses associated with a capital asset that was not funded by CalCare without the approval of the board.

180) Prohibits a participating provider from doing either of the following:
   a) Use funds from CalCare designated for operating expenses or payments for capital expenditures; or,
   b) Use funds from CalCare designated for capital expenditures or payments for operating expenses.

181) Allows a margin generated by a participating provider receiving a global budget under CalCare to be retained and used to meet the health care needs of CalCare members.

182) Prohibits a participating provider from retaining a margin if that margin was generated through inappropriate limitations on access to health care, compromises in the quality of care, or actions that adversely affected or are likely to adversely affect the health of the persons receiving services from an institutional provider, group practice, or other participating provider under CalCare.

183) Requires the board to evaluate the source of margin generation.

184) Prohibits a payment under CalCare, including provider payments for operating expenses or capital expenditures, taking into account, include a process for the funding of, or be used by a provider for any of the following:
   a) Marketing, which does not include education and prevention programs paid under a global budget;
   b) The profit or net revenue, or increasing the profit, net revenue, or financial result of the provider;
   c) An incentive payment, bonus, or compensation based on patient utilization of health care items or services or any financial measure applied with respect to the provider or a group practice or other entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider;
   d) A bonus, incentive payment, or incentive adjustment from CalCare to a participating provider;
   e) A bonus, incentive payment, or compensation based on the financial results of any other health care provider with which the provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship;
   f) A bonus, incentive payment, or compensation based on the financial results of an integrated health care delivery system, group practice, or other provider; or,
   g) State political contributions.

185) Requires the board to establish and enforce penalties for violations of 180) above, consistent with the Administrative Procedure Act.

186) Requires penalty payments collected for violations of 180) above to be remitted to the CalCare Trust Fund for use in CalCare.

187) Requires the board to, in consultation with the DGS, the Department of Health Care Services (DHCS), and other relevant state agencies, negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. Requires negotiations by the board to be on behalf of the entire CalCare program. Requires a state agency to cooperate to provide data and other information to the board.

188) Requires the board to, in consultation with the DGS, the DHCS, the CalCare Public Advisory Committee, patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals, establish a prescription drug formulary system. Requires the board to do all of the following:
   a) Promote the use of generic and biosimilar medications;

b) Consider the clinical efficacy of medications;
c) Update the formulary frequently and allow health care professionals, other clinicians, and members to petition the board to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary; and,
d) Consult with patient advocacy organizations, physicians, nurses, pharmacists, and other health care professionals to determine the clinical efficacy and need for the inclusion of specific medications in the formulary.

189) Prohibits the prescription drug formulary system from requiring a prior authorization determination for coverage under CalCare and from applying treatment limitations through the use of step therapy protocols.

190) Requires the board to promulgate regulations regarding the use of off-formulary medications that allow for patient access.

Program Standards

191) Requires CalCare to establish a single standard of safe, therapeutic, and effective care for all residents of the state by the following means:
   a) The board to establish requirements and standards, by regulation, for CalCare and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:
      i) The scope, quality, and accessibility of health care items and services;
      ii) Relations between participating providers and members; and,
      iii) Relations between institutional providers, group practices, and individual health care organizations, including credentialing for participation in CalCare and clinical and admitting privileges, and terms, methods, and rates of payment.
   b) The board to establish requirements and standards, by regulation, under CalCare that include provisions to promote all of the following:
      i) Simplification, transparency, uniformity, and fairness in the following:
         (1) Health care provider credentialing for participation in CalCare;
         (2) Health care provider clinical and admitting privileges in health care facilities;
         (3) Clinical placement for educational purposes, including clinical placement for prelicensure registered nursing students without regard to degree type, that prioritizes nursing students in public education programs;
         (4) Payment procedures and rates; and,
         (5) Claims processing.
      ii) In-person primary and preventive care, efficient and effective health care items and services, quality assurance, and promotion of public, environmental, and occupational health;
      iii) Elimination of health care disparities;
      iv) Nondiscrimination pursuant to x) above Section 100631;
      v) Accessibility of health care items and services, including accessibility for people with disabilities and people with limited ability to speak or understand English;
      vi) Providing health care items and services in a culturally, linguistically, and structurally competent manner; and,

vii) Prevention-oriented care.

c) The board to establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with CalCare health care items and services and ancillary services currently provided by other programs, including Medicare, the ACA, and federally matched public health programs;

d) A participating provider to furnish information as required by HCAI pursuant to 47) above) and 100) above, and to existing law, and permit examination of that information by the board as reasonably required for purposes of reviewing accessibility and utilization of health care items and services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of CalCare or for protection and promotion of public, environmental, and occupational health;

e) The board to use the data furnished under this title to ensure that clinical practices meet the utilization, quality, and access standards of CalCare. The board to not use a standard developed under 191) above for the purposes of establishing a payment incentive or adjustment under CalCare;

f) To develop requirements and standards and making other policy determinations under this chapter, the board to consult with representatives of members, health care providers, health care organizations, labor organizations representing health care employees, and other interested parties; and,

g) The board to coordinate with the Office, HCAI, and DMHC to do both of the following:
   i) Monitor participating providers for, and establish procedures related to, compliance with the requirements and standards established under this section; and,
   ii) Establish programs, including special projects under 239) below, to ensure or manage CalCare member access to in-person primary and preventive care, efficient and effective health care items and services, and quality care.

192) Provides that a participating provider has a duty to act in the exclusive interest of the patient as part of a health care practitioner's duty to advocate for medically appropriate health care for their patients pursuant to existing law. Applies to a health care professional who may be employed by a participating provider or otherwise receive compensation or payment for health care items and services furnished under CalCare.

193) Specifies that an individual's treating physician, or other health care professional who is authorized to diagnose the individual in accordance with all applicable scope of practice and other license requirements and is treating the individual, is responsible for the determination of the medically necessary or appropriate care for the individual; and, a participating provider or health care professional who may be employed by a participating provider or otherwise receive compensation or payment for health care items and services furnished under CalCare from a participating provider or other person participating in CalCare to use reasonable care and diligence in safeguarding an individual under the care of the provider or professional and shall not impair an individual's treating physician or other health care provider treating the individual from advocating for medically necessary or appropriate care under this section.

194) Provides that a health care provider or health care professional violates the duty under 192) above, for any of the following:
   a) Having a pecuniary interest or relationship, including an interest or relationship disclosed under 195) below, that impairs the provider's ability to provide medically necessary or appropriate care;

b) Accepting a bonus, incentive payment, or compensation based on any of the following:
   i) A patient's utilization of services;
   ii) The financial results of another health care provider with which the participating provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship, or of a person that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider; and,
   iii) The financial results of an institutional provider, group practice, or person that contracts with, provides health care items or services under, or otherwise receives payment from CalCare; and,
c) Having a board member, executive, or administrator that receives compensation from, owns stock or has other financial investments in, or serves as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

195) Requires a participating provider to report, at least annually, to HCAI all of the following:
   a) A beneficial interest required to be disclosed to a patient pursuant existing law;
   b) A membership, proprietary interest, coownership, or profit-sharing arrangement, required to be disclosed to a patient pursuant to existing law;
   c) A subcontract entered into that contains incentive plans that involve general payments, including capitation payments or shared risk agreements, that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions;
   d) Bonus or other incentive arrangements used in compensation agreements with another health care provider or an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider; and,
   e) An offer, delivery, receipt, or acceptance of rebates, refunds, commission, preference, patronage dividend, discount, or other consideration for a referral made in exception to existing law.

196) Allows the board to adopt regulations as necessary to implement and enforce this section and to adopt regulations to expand reporting requirements under this bill. Defines person to mean an individual, partnership, corporation, limited liability company, or other organization, or any combination thereof, including a medical group practice, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer.

197) Allows an individual's treating physician, nurse, or other health care professional, in implementing a patient's medical or nursing care plan and in accordance with their scope of practice and licensure, to override health information technology or clinical practice guidelines, including standards and guidelines implemented by a participating provider through the use of health information technology, including electronic health record technology, clinical decision support technology, and computerized order entry programs.

198) Requires an override described in 197) above to, in the independent professional judgment of the treating physician, nurse, or other health care professional, meet all of the following requirements:

a) The override is consistent with the treating physician's, nurse's, or other health care professional's determination of medical necessity or appropriateness or nursing assessment;
b) The override is in the best interest of the patient; and,
c) The override is consistent with the patient's wishes.

199) Establishes, within CalCare, the Office. Requires the HCAI Director to be the director of the office and to carry out all functions of that position, including enforcement.

200) Requires the office to be responsible for coordination and collaboration across the programs and activities of CalCare and the CHHSA with respect to ensuring health equity under CalCare and other health programs of the CHHSA.

201) Requires the office to do all of the following:
   a) Support the board through data collection and analysis of, and recommendations to address, all of the following:
      i) The disproportionate burden of disease and death by race, ethnicity, national origin, primary language use, immigration status, age, disability, sex, including gender identity and sexual orientation, geographic location, socioeconomic status, incarceration, housing status, and other population-based characteristics;
      ii) Barriers to health, including barriers relating to income, education, housing, food insecurity, employment status, working conditions, and conditions related to the physical environment;
      iii) Barriers to health care access, including lack of trust and awareness, lack of transportation, geography, hospital and service closures, lack of health care infrastructure and facilities, lack of health care professional staffing and recruitment, disparities in quality of care received, and disparities in utilization of care;
      iv) Inequitable distribution of health care services, including health care professional shortage areas, medically underserved areas, medically underserved populations, and trends in hospital closures and service reductions;
      v) Discrimination in health care settings and the use of racially biased or other discriminatory practice guidelines, health care technologies, and algorithms; and,
      vi) Increasing access to high-quality primary health care, particularly in medically underserved areas and for medically underserved populations;
   b) Ensure that analysis and data collected are made publicly available and allow for the analysis of cross-sectional information on people's identities;
   c) Support the board through the development and coordination of programs and recommendations to enhance health equity in California, including programs and recommendations on all of the following:
      i) Improving the provision of culturally, linguistically, and structurally competent care;
      ii) Increasing diversity in the health care workforce;
      iii) Ensuring sufficient health care professionals and facilities to meet the health care needs across the state;
      iv) Ensuring equitable access and distribution of health care professionals and facilities to meet the health care needs across the state;
      v) Recruitment and retention of a health care workforce that meets the cultural, linguistic, and other needs of Californians; and,
      vi) Recruitment and retention of a health care workforce in rural and medically underserved areas.

d) Develop, coordinate, and provide recommendations on programs that expand the number of primary health care providers and practitioners, including primary care physicians, registered nurses, and dentists, in the state;
e) Develop, coordinate, and provide recommendations on targeted programs and resources for federally qualified health centers, rural health centers, community health centers, and other community-based organizations that provide primary care in the state;
f) Conduct ongoing research and evaluation on health equity and access to primary care in California;
g) Support the board and the CalCare Public Advisory Committee through data collection and analysis and recommendations to develop, propose, and review special projects under x) below Section 100677;
h) Adopt and promulgate regulations for the purpose of carrying out 199) above; and,
i) Establish advisory or technical committees, as necessary.

202) Allows the office to enter into exclusive or nonexclusive contracts on a bid or negotiated basis for purposes of implementing 199) above, including hiring staff and consultants, through the procurement authority and processes of HCAI, facilitating and conducting meetings, conducting research and analysis, and developing the required reports. Exempts, until January 1, 2026, contracts entered into or amended from the Public Contract Code, and the State Administrative Manual, from the review or approval of any division of DGS.

Federal Health Programs and Funding

203) Authorizes the board to seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare consistent with this bill.

204) Authorizes the board to apply for a federal waiver or federal approval as necessary to receive funds to operate CalCare pursuant 203) above, including a waiver under Section 18052 of Title 42 of the United States Code.

205) Requires the board to apply for federal waivers or federal approval pursuant to 203) above by January 1, 2026.

206) Requires the board to apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the ACA, and any other federal programs or laws, as appropriate, that are necessary to enable all CalCare members to receive all benefits under CalCare through CalCare, to enable the state to implement this bill, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the CalCare Trust Fund, created pursuant to 221) below, and to use those funds for CalCare and other provisions under this bill.

207) Requires the board to, to the fullest extent possible, negotiate arrangements with the federal government to ensure that federal payments are paid to CalCare in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

Requires the state to direct the funding and moneys to CalCare to the extent any federal funding is not paid directly to CalCare.

208) Allows the board to require members or applicants to provide information necessary for CalCare to comply with any waiver or arrangement under this bill. Prohibits information provided by members to the board for the purposes of 206) above from being used for any other purpose.

209) Allows the board to take any additional actions necessary to effectively implement CalCare to the maximum extent possible as an independent single-payer program consistent with this bill. States the intent of the Legislature to establish CalCare, to the fullest extent possible, as an independent agency.

210) Allows the board to take actions consistent with 203) above to enable CalCare to administer Medicare in California. Requires CalCare to be a provider of supplemental insurance coverage and to provide premium assistance for drug coverage under Medicare Part D for eligible members of CalCare.

211) Allows the board to waive or modify the applicability of any provisions of this title relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under 203) above or to maximize the federal benefits to CalCare under this bill.

212) Allows the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Prohibits enrollment in a federally matched public health program or Medicare from causing a member to lose a health care item or service provided by CalCare or diminish any right the member would otherwise have.

213) Requires the board, by regulation, to increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the ACA.

214) Authorizes the board to act under this 213) above, upon a finding approved by the Director of Finance and the board that the action does all of the following:
    a) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the ACA;
    b) Will not diminish any individual's access to a health care item or service or right the individual would otherwise have;
    c) Is in the interest of CalCare; and,
    d) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

215) Allows the board to require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare to enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare.

216) Requires a member who is eligible for benefits under Medicare to enroll in Medicare, including Parts A, B, and D, as a condition of continued eligibility for health care items and services under CalCare.

217) Requires the board to provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under federal law, limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services (CMS) and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare Advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to CalCare.

218) Requires the member to provide, and authorize CalCare to obtain, any information or documentation required to establish the member's eligibility for that subsidy if the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under federal law. Requires the board to attempt to obtain as much of the information and documentation as possible from records that are available to it.

219) Requires the board to make a reasonable effort to notify members of their obligations under 218) above. Requires the member to be notified in writing that the member has 60 days to provide the required information after a reasonable effort has been made to contact the member. Allows the member's coverage under CalCare to be suspended until the issue is resolved if the required information is not provided within the 60-day period. Prohibits information provided by a member to the board for the purposes of 218) above from being used for any other purpose.

220) Requires the board to assume responsibility for all benefits and services paid for by the federal government with those funds.

221) Creates the CalCare Trust Fund in the State Treasury for the purposes of this bill to be administered by the CalCare Board. Requires all moneys in the fund to be continuously appropriated without regard to fiscal year for the purposes of this bill. Allows any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year to be carried forward to the next succeeding fiscal year.

222) Prohibits moneys deposited in the fund from being loaned to, or borrowed by, any other special fund or the General Fund, a county general fund or any other county fund, or any other fund.

223) Requires the board to establish and maintain a prudent reserve in the fund to enable it to respond to costs including those of an epidemic, pandemic, natural disaster, or other health emergency, or market-shift adjustments related to patient volume.

224) Prohibits the board or staff of the board from utilizing any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

225) Requires all interest earned on the moneys that have been deposited into the fund to be retained in the fund and used for purposes consistent with the fund.

226) Requires the fund to consist of all of the following:
   a) All moneys obtained pursuant to legislation enacted as proposed under 258) below;
   b) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the ACA;
   c) The amounts paid by the DHCS that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the ACA for health benefits that are equivalent to health benefits covered under CalCare;
   d) Federal and state funds for purposes of the provision of services authorized under federal law that would otherwise be covered under CalCare; and,
   e) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care items or services for services and benefits covered under CalCare. Requires payments to the fund pursuant to 221) above to be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this bill.

227) Requires all federal moneys to be placed into the CalCare Federal Funds Account, which is hereby created within the CalCare Trust Fund.

228) Requires moneys in the CalCare Trust Fund to only be used for the purposes established in this bill.

229) Requires, before the delivery of the fiscal analysis required pursuant to 65) above:
   a) Moneys in the CalCare Trust fund to not be used for startup and administrative costs to implement 23) above; and,
   b) Moneys in the CalCare Trust Fund to be used to design and commission the fiscal analysis required pursuant to 65) above.

230) Allows moneys in the CalCare Trust Fund to be used for startup and administrative costs to implement 23) above after delivery of the fiscal analysis required pursuant to 65) above.

231) Requires the board annually to prepare a budget for CalCare that specifies a budget for all expenditures to be made for covered health care items and services and to establish allocations for each of the budget components under 232) below that cover a three-year period.
232) Requires the CalCare budget to consist of at least the following components:
   a) An operating budget;
   b) A capital expenditures budget;
   c) A special projects budget;

d) Program standards activities;
e) Health professional education expenditures;
f) Health care workforce recruitment and retention expenditures;
g) Administrative costs; and,
h) Prevention and public health activities.

233) Requires the board to allocate the funds received among the components described in 232) above to ensure the following:
   a) The operating budget allows for participating providers to meet the health care needs of the population;
   b) A fair allocation to the special projects budget to meet the purposes described in a reasonable timeframe;
   c) A fair allocation for program standards activities; and,
   d) The health professional education expenditures component is sufficient to meet the need for covered health care items and services.

234) Specifies the operating budget described in 232) above to be used for payments to providers for health care items and services furnished by participating providers under CalCare.

235) Requires the capital expenditures budget described in 232) above to be used for the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term services and supports under CalCare, and other capital expenditures.

236) Specifies the special projects budget described in 232) above to be used for the payment to not-for-profit or governmental entities pursuant to 239) below.

237) Requires at least 1% of the budget to be allocated to programs providing transition assistance pursuant to 42) above for up to five years following the date on which benefits first become available under CalCare.

238) Requires up to 1% of the budget to be allocated to programs providing health care workforce education, recruitment, and retention pursuant to 271) below during the implementation period and for at least five years following the date on which benefits first become available under CalCare.

239) Requires the special projects budget described in 232) above to be used for the payment to not-for-profit entities that are health facilities pursuant to existing law or governmental entities for the construction or renovation of health care facilities, major equipment purchases, staffing in a rural or medically underserved area, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

240) Authorizes the special projects budget to be used to increase payment to providers in a rural or medically underserved area to mitigate the impact of the payments on the availability and accessibility of health care services.

241) Authorizes an agency of the state, a city, a county, a city and county, or another political subdivision of the state or a not-for-profit entity that is a health facility pursuant to existing law to submit an application to the board for payment from the special projects budget for a special project under 239) above.

242) Requires the board to develop criteria to evaluate applications for payment from the special projects budget for special projects in consultation with the CalCare Public Advisory Committee, the office, the California Health Facilities Financing Authority, HCAI, DHCS, DMHC, the Department of Public Health (DPH), and other relevant state agencies.

243) Requires the criteria to evaluate applications to consider factors, including if the special project will support a health facility in a rural or medically underserved area, and if the special project will address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

244) Requires the criteria to evaluate applications to also be used for identification and monitoring of health facilities at risk of understaffing in rural or medically underserved areas and of populations experiencing health disparities.

245) Authorizes the board to issue a request for applications for a special project paid under 241) above in consultation with the office.

246) Allows the CalCare Public Advisory Committee to develop and recommend the board issue a request for applications for a special project paid under 241) above.

247) Requires an applicant for payment from the special projects budget to provide the board with financial, demographic, and other information regarding the proposed health care service area as determined by the board, in a format determined by the board, to review an application to receive payment from the special projects budget for a special project.

248) Requires an applicant for payment from the special projects budget to submit a plan to the board detailing the projected uses of the proposed payment and strategies proposed to address a health disparity or other qualifying need identified by the board.

249) Requires the board to determine the application process and methodology for approval and distribution of payments from the special projects budget.

250) Requires the board to evaluate if there is a reasonable likelihood that it will address a health disparity or other qualifying need identified by the board in reviewing a plan submitted by an applicant for payment from the special projects budget under 239) above.

251) Requires the board to provide public notice of an application submitted under 239) above and post a copy of the applicant's plan submitted on its internet website.

252) Requires the board to make its application process and methodology publicly accessible on its internet website.

253) Requires the board to provide a preliminary report to the applicant of the board's initial review of the application and provide public notice of the preliminary report within 90 days of receipt of a complete application for a payment from the special projects budget for a special project.

254) Requires the board to provide the public the opportunity to provide written comment on a preliminary report of an application for payment from the special projects budget for a special project.

255) Requires the CalCare Public Advisory Committee to conduct at least one public hearing to receive public input and comment on the application before the board approves an application for payment from the special projects budgets for a special project.

256) Requires the CalCare Public Advisory Committee to provide a recommendation to the board on the approval of an application submitted to the board.

257) Requires the board to have the authority to determine service provision requirements or other conditions in approving, and for the duration of, special projects payments to health facilities or that support health facilities. Requires the board to consider the impact of any changes to the health facilities service delivery on access to medical care in making its determination.

258) States the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. Specifies the intent of the Legislature to consult with appropriate officials and stakeholders in developing the revenue plan.

259) State the intent of the Legislature to enact legislation that would require all state revenues from CalCare to be deposited in an account within the CalCare Trust Fund to be established and known as the CalCare Trust Fund Account.

Transition

260) Allows an individual who meets all of the following to be eligible to enroll as a member of CalCare during the implementation period:
   a) The individual meets the eligibility standards established by the board under 67) above; and,
   b) The individual is 55 years of age or older, 18 years of age or younger, or is currently enrolled in Medicare or Medicaid during the implementation period.

261) Requires the board to ensure that all persons enrolled, or who seek to enroll, in a health plan during the implementation period are protected from disruptions in their care during the implementation period, including continuity of care with current health care teams.

262) Prohibits a carrier, during the implementation period, from ending coverage for a CalCare member until the end of the implementation period except as expressly agreed upon under the terms of the plan.

263) Prohibits a carrier from imposing any exclusion or limitation of coverage on the basis of a person's disability, complex medical need, or chronic condition during the implementation period.

264) Applies to a carrier except as otherwise prohibited by federal law.

265) Requires the board to consult with the Advisory Commission on Long-Term Services and Supports, communities and advocacy organizations of persons living with disabilities, and other patient advocacy organizations to ensure that CalCare coverage during the implementation period takes into account the continuity of care for persons with disabilities, complex medical needs, or chronic conditions.

266) Require the board to provide for continuation of benefits under CalCare until the end of the period of stay in the case of inpatient hospital services and extended care services during a continuous period of stay that began before the end of the implementation period, and that had not ended as of the end of the implementation date.

267) Requires the board to, during the implementation period, establish and maintain procedures that, to the greatest extent possible, provide for the following:
   a) Automatic enrollment in CalCare of individuals who are eligible to enroll in CalCare during the implementation period; and,
   b) Automatic enrollment in CalCare of individuals who will become eligible to enroll in CalCare after the end of the implementation period.

268) Requires the board to, during the implementation period, establish and maintain procedures for individuals who will become eligible to enroll in CalCare after the end of the implementation period to select a primary care provider under 68) above.

269) Requires the board to, during the implementation period to the greatest extent possible, establish and maintain procedures for individuals who are currently members of an integrated health care delivery system to automatically select participating providers in the individual's integrated health care delivery system care team as their primary care provider upon enrollment in CalCare.

270) Allows a person who is eligible to receive CalCare benefits during the implementation period to opt to maintain coverage outside of CalCare, including private health care coverage or coverage offered through the California Health Benefit Exchange, until the end of the implementation period.

271) Requires the board to provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for programs to address health care workforce education, recruitment, and retention to meet health workforce demands under CalCare, including programs implemented during the implementation period.

272) Requires the board to coordinate with the CalCare Public Advisory Committee, the office, HCAI, the Labor and Workforce Development Agency, CHHSA, and health care professional licensing boards, including the Board of Registered Nursing, MBC, and

Dental Board of California, to implement programs and policies related to health care workforce education, recruitment, and retention.

273) Requires the board to establish a CalCare Health Workforce Working Group to provide input, including recommendations, to the board and Secretary of Labor and Workforce Development on issues related to health care workforce education, recruitment, and retention, including all of the following:
   a) Programs and measures to expand clinical education capacity at California community colleges providing associate degree programs in health professions, including through programs to ensure the fair and equitable distribution of clinical placement at clinical education sites among approved health professions education programs and through programs to recruit and retain clinical faculty;
   b) Data collection and analysis and recommendations on health workforce attrition from direct care positions, including on moral distress and moral injury, safe staffing, and gaps in active California health professions licensees and those working in direct care;
   c) Identification and prioritization of geographical areas or populations in the state with unmet primary care or other health care needs, including access and availability of family physicians, primary care clinics, and registered nurses;
   d) Programs and measures to retain health care workforces, including public loan repayment assistance programs, minimum safe staffing requirements, investments in personal protective equipment, and occupational safety and health programs;
   e) Programs and measures to support expansion of graduate medical education programs and assistance for medical residents;
   f) Career ladders into health professions for ancillary and allied health workers, including licensed vocational nurses, certified nursing assistants, medical technicians, behavioral health technicians, health navigators, and community health workers;
   g) Career technical education pathways toward an associate degree at a California community college in a health professions education program; and,
   h) Programs to address barriers to health professions, including student debt levels, tuition assistance, childcare or other support, and debt-free residency or mentorship programs.

274) Requires the board to appoint the members of the CalCare Health Workforce Working Group. Requires appointments to be made by a majority vote of the voting members of the board. Requires the board to, when appointing members to the working group, aim for broad representation, including, at a minimum, all of the following:
   a) Representatives of health professions and other health care workers, including specialties for primary care and behavioral health, physicians, registered nurses, and ancillary services;
   b) Representatives of labor organizations representing health care workers; Representatives of California community colleges, graduate medical education and training programs, and nursing education programs;
   c) Representatives of consumer and patient groups; and,
   d) Representatives of health care providers, including hospitals, nonacute care providers, and medical groups.

275) Requires each appointed member of the CalCare Health Workforce Working Group to serve at the discretion of the board and may be removed at any time by a majority vote of the voting members of the board.

276) Prohibits working group members from having access to confidential, nonpublic information that is accessible to the board and office. Requires, instead, the working group to only have access to information that is publicly available. Specifies that neither the board nor the office disclose any confidential, nonpublic information to the working group members.

277) Requires the working group members receive reimbursement for travel and other actual costs.

278) Requires the working group to meet at least four times per year in a place convenient to the public and all meetings of the advisory commission to be open to the public, pursuant to the Bagley-Keene Open Meeting Act.

279) Requires the board to consider input, including recommendations, from the working group, along with public comments, in the board's deliberation and decisionmaking.

Collective Negotiation by Health Care Providers with CalCare

280) Authorizes health care providers to meet and communicate for the purpose of collectively negotiating with CalCare on any matter relating to CalCare FFS rates of payment for health care items and services or procedures related to FFS payment under CalCare.

281) Provides that collective negotiations does not allow a strike of CalCare by health care providers.

282) Provides that collective negotiations does not allow or authorize terms or conditions that would impede the ability of CalCare to comply with applicable state or federal law.

283) Requires collective negotiation to meet all of the following requirements:
   a) A health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with CalCare;
   b) A health care provider may communicate with a health care provider's representative;
   c) A health care provider's representative is the only party authorized to negotiate with CalCare on behalf of the health care providers as a group; and,
   d) A health care provider can be bound by the terms and conditions negotiated by the health care provider's representative.

284) Specifies that collective negotiations does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

285) Specifies that collective negotiations does not affect or limit collective action or collective bargaining on the part of a health care provider with the health care provider's employer or any other lawful collective action or collective bargaining.

286) Requires a health care provider's representative to file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance before engaging in collective negotiations with CalCare on behalf of health care providers.

287) Requires a person who acts as the representative of negotiating parties to pay a fee to the board to act as a representative. Requires the board, by regulation, to set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board.

288) Specifies that collective negotiation does not authorize competing health care providers to act in concert in response to a health care provider's representative's discussions or negotiations with CalCare, except as authorized by other law.

289) Prohibits a health care provider's representative from negotiating an agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by a health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

290) Applies the definitions to 280) to 289) above:
   a) Health care provider as a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to existing law and who is either of the following:
      i) An individual who practices that profession as a health care professional or as an independent contractor; or,
      ii) An owner, officer, shareholder, or proprietor of a health care group practice that has elected to receive FFS payments from CalCare pursuant to 133) above.
   b) A health care provider licensed, certified, registered, or authorized to practice a health care profession pursuant to existing who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.
   c) Health care provider's representative as a third party that is authorized by a health care provider to negotiate on their behalf with CalCare over terms and conditions affecting those health care providers.

Operative Date

291) Prohibits CalCare from being operative until the date the CHHSA Secretary notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that the secretary has determined that the CalCare Trust Fund has the revenues to fund the costs of implementing this bill.

292) Requires the CHHSA to publish a copy of the notice on its internet website.

293) Requires the CHHSA Secretary to make a notification pursuant to 291) above.

294) Includes severability clause that if any provision of this bill or its application is held invalid, that invalidity not affect other provisions or applications that can be given effect without the invalid provision or application.

295) Makes findings and declarations that specified sections of this bill imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of the California Constitution; and, to demonstrate the interest protected by this limitation and the need for protecting that

interest, it is necessary for that information to remain confidential. In order to protect private, confidential, and proprietary information.

Definitions

296) Defines the following:
   a) Activities of daily living as basic personal everyday activities including eating, toileting, grooming, dressing, bathing, and transferring
   b) Advisory commission as the Advisory Commission on Long-Term Services and Supports;
   c) The ACA as the federal Patient Protection and Affordable Care Act, and any amendments to, or regulations or guidance issued under, those acts;
   d) Allied health practitioner as a group of health professionals who apply their expertise to prevent disease transmission and diagnose, treat, and rehabilitate people of all ages and in all specialties, together with a range of technical and support staff, by delivering direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Includes audiologists, occupational therapists, social workers, and radiographers;
   e) Board as the CalCare Board;
   f) CalCare or "California Guaranteed Health Care for All" means the California Guaranteed Health Care for All program;
   g) Capital expenditures as expenses for the purchase, lease, construction, or renovation of capital facilities, health information technology, artificial intelligence, and major equipment, including costs associated with state grants, loans, lines of credit, and lease-purchase arrangements;
   h) Carrier as either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under existing law, licensed by the DMHC;
   i) Committee as the CalCare Public Advisory Committee;
   j) County organized health system as a health system implemented pursuant to existing law;
   k) Essential community provider as a provider, as defined in federal law, that serves predominantly low-income, medically underserved individuals and that is one of the following:
      i) A community clinic, as defined;
      ii) A free clinic, as defined;
      iii) A federally qualified health center, as defined;
      iv) A rural health clinic, as defined; and,
      v) An Indian Health Service Facility, as defined;
   l) Federally matched public health program as the state's Medi-Cal program and the federal CHIP under federal law;
   m) Fund as the CalCare Trust Fund;
   n) Global budget as the payment negotiated between an institutional provider and the board under 147) above;
   o) Group practice as professional corporation under existing law that is a single corporation or partnership composed of licensed doctors of medicine, doctors of osteopathy, or other licensed health care professionals, and that provides health care items and services primarily directly through physicians or other health care professionals who are either employees or partners of the organization;

p) Health care professional as a health care professional licensed pursuant existing law, who, in accordance with the professional's scope of practice, may provide health care items and services under this title;
q) Health care item or service as a health care item or service that is included as a benefit under CalCare;
r) Health professional education expenditures as expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities;
s) Home- and community-based services as an integrated continuum of service options available locally for older individuals and functionally impaired persons who seek to maximize self-care and independent living in the home or a home-like environment, which includes the home- and community-based services that are available through Medi-Cal pursuant to the home- and community-based waiver program under federal law;
t) Implementation period as the period under 23) above is subject to special eligibility and financing provisions until it is fully implemented under that section;
u) Institutional provider as an entity that provides health care items and services and is licensed pursuant to any of the following (as defined and licensed under existing law):
    i) A health facility;
    ii) A clinic;
    iii) A long-term health care facility;
    iv) A county medical facility;
    v) A residential care facility for persons with chronic, life-threatening illness;
    vi) An Alzheimer's daycare resource center;
    vii) A residential care facility for the elderly;
    viii) A hospice;
    ix) A pediatric day health and respite care facility;
    x) A mental health care provider; and,
    xi) A federally qualified health center.
v) Instrumental activities of daily living as activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community;
w) Integrated health care delivery system;
x) Local initiative as a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries, including the entities established in existing law;
y) Long-term services and supports as long-term care, treatment, maintenance, or services related to health conditions, injury, or age, that are needed to support the activities of daily living and the instrumental activities of daily living for a person with a disability, including all long-term services and supports as defined, home- and community-based services, additional services and supports identified by the board to support people with disabilities to live, work, and participate in their communities, and those as defined by the board;
z) Medicaid or medical assistance as a program that is one of the following:
    i) The state's Medi-Cal program under Title XIX of the federal Social Security Act; or,
    ii) The federal CHIP under Title XXI of the federal Social Security Act;

aa) Medically necessary or appropriate as the health care items, services, or supplies needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, or disease, or its symptoms, and that meet accepted standards of medicine as determined by a patient's treating physician or other individual health care professional who is treating the patient, and, according to that health care professional's scope of practice and licensure, is authorized to establish a medical diagnosis and has made an assessment of the patient's condition;

bb) Medicare as Title XVIII of the federal Social Security Act and the programs thereunder;

cc) Member as an individual who is enrolled in CalCare;

dd) Out-of-state health care service as a health care item or service provided in person to a member while the member is temporarily, for no more than 90 days, and physically located out of the state under either of the following circumstances:

i) It is medically necessary or appropriate that the health care item or service be provided while the member physically is out of the state; or,

ii) It is medically necessary or appropriate, and cannot be provided in the state, because the health care item or service can only be provided by a particular health care provider physically located out of the state;

ee) Participating provider as an individual or entity that is a health care provider qualified under 91) that has a participation agreement pursuant to 100) above in effect with the board to furnish health care items or services under CalCare;

ff) Prescription drugs as prescription drugs as defined in existing law;

gg) Resident as an individual whose primary place of abode is in this state, without regard to the individual's immigration status, who meets the California residence requirements adopted by the board pursuant to 1) above. Requires the board to be guided by the principles and requirements set forth in the Medi-Cal program; and,

hh) Rural or medically underserved area as the same meaning as a "health professional shortage area" in federal law.

297) Prohibits this bill from preempting a city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this bill.

298) Specifies that to the extent any law is inconsistent with this bill or the legislative intent of the California Guaranteed Health Care for All Act, this bill apply and prevail, except when explicitly provided otherwise by this bill.

299) Makes various findings and declarations including the following:

a) To establish the California Guaranteed Health Care for All program to provide universal health care coverage for every Californian, funded by broad-based revenue;

b) To work to obtain waivers and other approvals relating to Medi-Cal, the federal CHIP, Medicare, the ACA, and any other federal programs pertaining to the provision of health care so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the CalCare Trust Fund;

c) Under those waivers and approvals, those funds would be used for health care coverage that provides health care benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums;

d) Those programs would be replaced and merged into CalCare, which will operate as a true single-payer program;

e) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of funding from federally matched public health programs and other federal health programs in CalCare;
f) Even if other programs, including Medi-Cal or Medicare, may contribute to paying for care, it is the goal of this act that the coverage be delivered by CalCare, and, as much as possible, that the multiple sources of funding be pooled with other CalCare program funds; and,
g) It is the intent of the Legislature to provide universal health care coverage with greater benefits and access to providers than existing health coverage plans, including for Californians who primarily receive care through an integrated health care delivery system, that is free at the point of service and does not have deductibles, coinsurance, premiums, or other cost-sharing.

EXISTING FEDERAL LAW:

1) Establishes the Medicaid program to enable each state to furnish medical assistance on behalf of individuals whose income and resources are insufficient to meet the costs of necessary medical services. Requires states to submit a state plan for medical assistance describing the coverage of mandatory and optional populations and benefits. [42 United States Code (USC) §1396, *et seq*.]

2) Establishes CHIP to allow states to provide free or low-cost health coverage to low-income children and pregnant women whose income is too high for Medicaid coverage. Requires states to submit a state child health plan in order to receive payment for health coverage under CHIP. [42 USC §1397aa, *et seq*.]

3) Authorizes the Department of Health and Human Services (DHHS) Secretary to waive Medicaid state plan requirements (with the exception of citizenship and requirements of another agency) to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program. [42 USC §1315]

4) Establishes state health insurance exchanges through the ACA to sell qualified health plans (QHPs) with standard benefit designs to eligible individuals with or without premium assistance and cost sharing reductions. Limits eligibility for premium assistance and cost-sharing reductions to individuals who earn between 100-400% of the federal poverty level (FPL) or 100-250% FPL respectively and who do not have minimum essential coverage (MEC), are lawfully present and are not incarcerated. [42 USC §18031 et seq.; 26 CFR §1.36B-2.]

5) Authorizes waivers for state innovation under which states can seek federal approval to waive major provisions of the ACA, including the requirement for Exchanges, QHPs, premium tax credits and cost-sharing reductions, the individual mandate and the employer responsibility requirement, provided federal requirements for comprehensive benefits, affordability, and comparable coverage are met and the state proposal does not increase the federal deficit. [42 USC §18052]

6) Establishes, pursuant to federal law, the Medicare program, which provides coverage for seniors and certain persons with disabilities. Authorizes the federal Secretary of DHHS, to

develop and engage in experiments and demonstration projects for specified purposes, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations. [42 USC §1395, *et seq*.; §1395b-1]

7) Creates within CMS a Center for Medicare and Medicaid Innovation (CMMI), the purpose of which is to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under those programs. [42 USC §1315a]

8) Penalizes employers with 50 or more full time or full-time equivalent employees who do not offer MEC to their employees. [26 USC §4980H]

EXISTING STATE LAW:

1) Designates HCAI as the state agency that collects health facility data for use by all state agencies, including various financial data reports. [Health and Safety Code (HSC) §128730, *et seq*.]

2) Requires HCAI to convene a Health Care Equity Measures Advisory Committee (Advisory Committee) to assist and advise the HCAI Director in reviewing and amending the appropriate measures that align with the health equity measures developed by CMS at the hospital-, hospital system-, and integrated system-level related to access, quality, and outcomes, including any relevant Agency for Healthcare Research and Quality's Quality Indicators, that hospitals are required to report in their annual equity reports. [HSC § 127372]

3) Requires hospitals to prepare an annual equity report. Requires the annual equity report to include an analysis of health status and access to care disparities for patients on the basis of age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and payor. [*Id*]

4) Requires a hospital to annually submit the equity report to HCAI. Requires a hospital to annually post the equity report on its website, as specified. Requires data and information included in annual equity reports to be reported to the extent information is available and disclosed in a manner that protects the personal information of patients pursuant to state and federal privacy laws. [HSC § 127373]

5) Provides HCAI the authority to establish the Health Care Payments Data Program to collect health care data from health plans, health insurers, government agencies and others. [Health and Safety Code (HSC) §8.5]

6) Establishes the Office of Health Care Affordability (OHCA) within HCAI. Identifies OHCAs three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. Requires OHCA to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board. [HSC §127501]

7) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code § 14000, et seq.]

8) Establishes the DMHC to regulate health plans under the KKA. [HSC §1340*, et seq*.]

9) Establishes as California's EHBs benchmark under the ACA, the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits, including prescription drug coverage. [HSC §1367.005]

10) 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]

11) Requires reviews, for purposes of IMR, to determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee 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]

12) Requires health plans to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. [HSC §1367]

13) Requires, if a health plan that provides coverage for prescription drugs or a contracted physicians group fails to respond to prior authorization, or step therapy exception request, as specified, within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed request form, the request is deemed granted. [HSC §1367.241]

14) Establishes Covered California (or Exchange) as an independent entity in state government not affiliated with any state agency or department, governed by a five-member board. Requires the Covered California Executive Board to establish and use a competitive process to select participating carriers and other contractors, and to make health insurance available to individuals and small businesses as authorized under the ACA. [Government Code (GOV) §100500 -100522]

15) Creates the Affordability Fund to be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs operated by Covered California. [GOV §100520.5]

16) Requires Covered California to develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. Requires the options to be reported to the Legislature, Governor, and the Healthy California for All Commission (HCFA) on or before January 1, 2022, for consideration in the 2022–23 budget process. [GOV §100520.5]

17) Requires, under the Minimum Essential Coverage (MEC) Individual Mandate (state mandate requiring health coverage), for each month beginning on or after January 1, 2020, a California resident to be enrolled in and maintain MEC for that month, and for any person who qualifies as a spouse or dependent of the resident except as provided below:

    a) An individual who has in effect a certificate of exemption for hardship or religious conscience issued by Covered California for that month;
    b) An individual who is a member of a health care sharing ministry, as specified for that month;
    c) An individual who is incarcerated for that month, other than incarceration pending the disposition of charges;
    d) An individual who is not a citizen or national of the US and is not lawfully present in the US for that month;
    e) An individual who is a member of an Indian tribe, as defined, during that month;
    f) An individual for whom that month occurs during a period living abroad, as described;
    g) An individual who is a bona fide resident of a possession of the U.S., as specified;
    h) An individual who is a bona fide resident of another state for that month; and,
    i) An individual who is enrolled in limited or restricted scope coverage under the Medi-Cal program or another health care coverage program administered by and determined to be substantially similar to limited or restricted scope coverage by DHCS for that month. [GOV §100705]

18) Requires an Individual Shared Responsibility Penalty to be imposed for failure to meet the requirement of the MEC Individual Mandate. [GOV §100705]

19) Establishes the HCFA as an independent body to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians. Requires the HCFA to submit a report to the Legislature and Governor by February 1, 2021, that that includes options for key design considerations for a unified financing system, including, but not limited to, a single-payer financing system. [HSC §1002, repealed on Jan. 1, 2022 by HSC §1005]

20) Requires all meetings to be conducted in the open of multimember state bodies that are created by statute. [GOV §11120, 11121]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, today's U.S. health care system is a complex, fragmented multi-payer system that leaves wide gaps in coverage and access to care, poses significant issues of affordability, and has growing health disparities. Despite health care spending in the U.S. far exceeding other high-income, industrialized countries that offer a publicly financed single-payer system, we consistently report worse health outcomes and disparities among vulnerable populations. CalCare will begin the process of creating a universal single-payer system of health care for every California resident. This bill would enact a comprehensive framework of governance, benefits, program standards, and health care cost controls, and will allow California to begin consolidating existing health care programs, obtain necessary federal waivers and determine any future public financing. Also known as CalCare, this is a meaningful step towards building a transformative and equitable health care payment system that will guarantee comprehensive health care and achieve health care justice for all. The author states that we cannot afford to let our health care status quo persist and CalCare would actually save money. The HCFA found that under a single-payer model, California will save between $32 billion to $213 billion over 10 years compared to the current system. With a single-payer system, these savings will be redirected to patients and allow the state to make strategic investments in our health care to improve access to care and dismantle health inequities. By guaranteeing health care for all Californians and establishing a payment system that eliminates waste and aligns reimbursements with the actual cost of care, we can make tremendous progress on health care as a human right. Transforming our complex, inequitable health care system will not be easy and will not happen overnight. The author concludes that this bill is the first necessary step that will lay the policy foundation for single-payer so the state can submit federal waivers and determine a just financing plan that puts the health of California before profits.

   a) **California Health Insurance Coverage.** In 2022, according to the California Health Care Foundation (CHCF), California health insurers covered 35.9 million enrollees. Of those, 14.1 million were commercial enrollees, 16.1 million were public managed care enrollees, and 5.8 million were enrolled through administrative services only arrangements for self-insured employers.

   b) **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.

      In California, regulation and oversight of fully insured employee health benefit plans is split between two state departments, the DMHC and the California Department of Insurance (CDI). DMHC primarily regulates health maintenance organizations (HMOs), but also has jurisdiction over some preferred provider organization (PPO) plans. CDI has jurisdiction over all other types of health insurance, including plans that offer traditional health insurance products, such as indemnity plans, and some PPO plans.

      There are essentially three relevant regulatory frameworks for health insurance state regulation by DMHC, by CDI, and regulation of self-insured employee health benefit plans by the federal Department of Labor.

c) Uninsured. California's implementation of the ACA significantly reduced the number of uninsured in the state. In 2012, there were 6.5 million Californians who were uninsured. Recently, the state has undertaken additional initiatives to extend health care coverage to more Californians. Between 2016 and 2020, the state expanded comprehensive Medi-Cal coverage to include income-eligible undocumented residents who are under the age of 26. Beginning in May 2022, the state further expanded eligibility for comprehensive Medi-Cal coverage to income-eligible undocumented residents over the age of 49. As part of the 2022-23 Budget Act, the Legislature approved expanding eligibility to income-eligible undocumented residents between the ages of 26 through 49 beginning no later than January 1, 2024. At full implementation, over 700,000 undocumented residents between the ages of 26 through 49 are expected to enroll in comprehensive Medi-Cal.

According to a March 2023 Policy Brief by the University of California Los Angeles Center for Health Policy Research and University of California Berkeley Labor Center (Labor Center) entitled "California's Uninsured in 2024: Medi-Cal Expands to all low-income adults but half a million undocumented Californians lack affordable coverage options," after the January 1, 2024 Medi-Cal expansion, California's uninsured population will decrease to a record low of 2.57 million under the age of 65. Close to one million undocumented Californians will have gained access to Medi-Cal through the expansions to children, young adults, older adults and now adults ages 26 to 49. The policy brief specifies that out of the 2.57 million uninsured: 230,000 are eligible for Covered California coverage above the 400% FPL; 540,000 are eligible for Covered California coverage under the 400% FPL; 570,000 are eligible for employer coverage; 710,000 are eligible for Medi-Cal and 520,000 are undocumented and not eligible for Medi-Cal or Covered California, and without an offer of employer coverage. Californians who are low-income, Latinos, or adults age 19 to 49 are more likely to be uninsured.

According to the Labor Center, undocumented Californians will continue to be excluded from Covered California under federal policy and are currently excluded from purchasing coverage through Covered California and from receiving ACA subsidies that help make coverage more affordable for other Californians. Despite the lack of financial help, the Labor Center projects 110,000 undocumented Californians will pay the full cost of individual market coverage. While others enroll in employer coverage, undocumented workers are offered affordable employer coverage at a lower rate than their counterparts with citizenship or documentation. According to the Labor Center, the health coverage needs of this group warrant particular attention because they remain categorically excluded from enrolling in Covered California and cannot receive federal subsidies to make coverage more affordable.

d) Health care spending. According to OHCA, health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015. Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020. For the third consecutive year, the 2022 CHCF California Health Policy Survey found that half of Californians (49%) – and fully two-thirds of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months. Among those who reported skipping or delaying care due to cost, about half reported that their conditions worsened as a result. OHCA states that to create a sustainable health care system, the rate of health care

spending needs to align with a target percentage, such as the statewide economic growth rate. An analysis of health care spending in California identified a range of contributors to high health care costs, including overtreatment and administrative complexity, and estimated that California could save between $58 and $73 billion per year by eliminating waste and improving efficiency.

e) Affordability concerns. According to the Labor Center, since 2008, premiums for job-based family health coverage in California have grown by 49% on average; but real median wages have remained stagnant. For example, single coverage premiums averaged $8,712 per year in 2018, equivalent to $4 per hour for someone working 40 hours per week and for family coverage, the average annual premium was $20,843 which is equivalent to $10 per hour work for a full-time worker, which is $2 less per hour than the current $12 minimum wage for employers with more than 25 employees. In addition to premium costs, consumers are also facing higher out-of-pocket spending.

For most people with job-based coverage, the largest health-related expenditure in any given year will be the cost of premiums. The total premium cost is usually split between the employer and the worker; on average in 2022 California workers paid 30% of the cost of family coverage and employers paid 70%. Despite this nominal division of costs, economic theory posits that workers pay the entire cost of premiums in forgone wages, and in practice the entire cost of coverage is included when calculating workers' total compensation. As health care premiums have increased, so has the amount workers' pay for their coverage. Not only has the dollar amount increased, but employers have also increased the premium share paid by workers. In 2002, California workers in the private sector paid 15% of the cost of single premiums ($446 on average) and 24% of the cost of family premiums ($4,193 on average). In 2022, private-sector workers paid both higher amounts and a higher share of the premium: an average of 19% of the cost of single coverage ($1,448) and 30% of the cost of family premiums ($6,755).

f) OHCA. In 2022, the California Health Care Quality and Affordability Act (SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022) established OHCA within HCAI. Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal. OHCA will collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a new Health Care Affordability Board. To ensure a balanced approach to slow spending growth, OHCA will monitor system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability. Through cost and market impact reviews, OHCA will analyze transactions that are likely to significantly impact on market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will then coordinate with other state agencies to address consolidation as appropriate.

g) California's Recent Attempts to Enact Single Payer.

i) Background on the Creation of the HCFA. On August 23, 2017, Speaker Rendon created the Assembly Select Committee on Health Care Delivery Systems and

Universal Coverage (Select Committee) to hold hearings to develop plans for achieving universal health care in California, in part as a response to SB 562 (Lara) of 2017. SB 562 would have created a universal health care system in California. The Select Committee held six days of hearings on various topics including cost containment efforts, achieving better access and greater value in California's health care system, implementation considerations and options for universal coverage. The Select Committee also published a report and included recommendations for achieving universal coverage in California.

AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, established the Council on Health Care Delivery Systems (Council) as an independent body to develop a plan that includes options for advancing progress toward achieving a health care delivery system that provides coverage and access through a unified financing (UF) system for all Californians, based on one of the Select Committee's recommendations. AB 1810 was subsequently amended by SB 104 (Committee on Budget), Chapter 67, Statutes of 2019, and renamed the Council into the HCFA and charged HCFA with developing a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a UF system, including, but not limited to, a single-payer financing system, for all Californians. SB 104 required the HCFA to submit a report to the Legislature and the Governor with, among other things, an analysis of California's existing health care delivery system and options to transition to a UF system, including a single-payer financing system.

In April 2022, the HCFA issued its final report and endorsed a UF system. The report pointed to the variety of methods that other countries use to achieve UF, some, such as Canada and the United Kingdom, which land squarely within the definition of single payer, while others, such as Germany or the Netherlands, which rely on health insurance that is highly regulated. The financial analysis done in connection with the report found that without a shift to UF, health care spending in California is estimated to increase by $158 billion over nine years, which is a 30% increase over base line spending. The total cost of a UF system would depend on a number of key design decisions including eligibility and enrollment, covered benefits and services, patient cost-sharing, provider payment, purchasing arrangements and role for intermediaries, care coordination, and cost containment measures. In some areas, such as the decision to use risk-based capitation (e.g. managed care plan) versus a direct payment model, no consensus was reached by the HCFA. A number of scenarios using both a direct payment to providers model and a health plan model, and using different options that included (or not) an expansion of long-term services and supports and included (or not) income-related cost-sharing were discussed. Almost every option resulted in considerable savings compared to the baseline health expenditure of $517 billion per year with the exception of scenarios that both expanded long-term services and supports and contained zero cost-sharing for consumers.

This bill includes some of the following: i) requires the board to engage in good faith negotiations with health care providers to determine rates of FFS payments; ii) requires the board to pay to each institutional provider (hospital, skilled nursing facility, and chronic dialysis clinic) a lump sum to cover all operating expenses under global budget; iii) includes long-term services and supports; and, iv) prohibits a

CalCare member from paying a premium, copayment, coinsurance, deductible, or any other form of cost sharing.

h) Federal Waivers. This bill states intent language with respect to a revenue plan. The HCFA report found that UF cannot be accomplished in California without federal support. Commissioners disagreed about whether federal participation could be accomplished through existing Medicare, Medicaid, and ACA waiver authority, or whether changes in federal law would be required. Waiver authority allows a state to ignore certain federal program rules for experimental or demonstration projects which are generally required to cost no more than what the federal government would have spent on the program without the waiver. SB 770 (Wiener), Chapter 412, Statutes of 2023, directs the CHHSA Secretary to research, develop, and pursue discussions of a federal waiver framework in consultation with the federal government with the objective of a health care system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The *LA Times* writes that this bill could help California obtain a waiver that could allocate federal Medicaid and Medicare funds to be used for what could eventually become a single-payer system that would cover every California resident and be financed entirely by state and federal funds.

i) Other States. In 2011, under Governor Shumlin, Vermont enacted Green Mountain Care, the first state level single-payer health care system in the country. On December 17, 2014, Vermont abandoned Green Mountain Care, citing the measure's cost. At that time, according to the governor's financial models, financing the system would have required an 11.5% payroll tax on all businesses in Vermont and a sliding-scale, income-based premium assessment of up to 9.5%. Then Governor Shumlin indicated: "These are simply not tax rates that I can responsibly support or urge the Legislature to pass. In my judgment, the potential economic disruption and risks would be too great to small businesses, working families and the state's economy."

2) SUPPORT. The California Nurses Association (CNA), sponsor of this bill, writes this bill establishes a system that provides a single standard of high-quality care for every California resident regardless of ability to pay or medical condition, without being tied to a job or immigration status, and regardless of whether an insurance company deems them to be profitable. Every single day, CNA members, as nurses, witness too many patients forgo needed medications, procedures, or care because they cannot afford the costs. Nurses watch as insurance corporations refuse to cover care that is required for the health and well-being of their patients, overriding the professional judgment of health care workers who can do little to intervene when our patients do not get the care that they need. As a result, nurses see patients come to the emergency room with advanced stages of illness or disease that could have been prevented if they had access to treatment earlier. High costs and poor health outcomes persist because access to an insurance plan is not the same as guaranteed health care for all. CNA states that California must do better. The system now is beholden to the corporate interests that determine who gets treatment and what treatment they get. It is deeply inefficient and unsustainable because it prioritizes short-term financial returns rather than long-term investments in our health. The current system is unaffordable for California and for patients. CNA writes that the only way to solve the health care crisis and to heal California's health care system is to pass this bill and enact the single-payer health care

system of CalCare now. The HCFA estimated that it costs California hospitals, doctors, and other providers about $85 billion each year in insurance related administrative costs, not including the costs for patients and employers to navigate the complex web of private insurers and public program. CNA writes that even with the planned expansion of Medi-Cal, an estimated 2.6 million Californians will remain uninsured. Millions more with insurance coverage are unable to afford care due to increasing copays, deductibles, and out-of-pocket costs. This bill would improve and expand upon Medicare and Medi-Cal by consolidating existing health care programs into a single, streamlined health system to cover everyone living in California and providing comprehensive benefits to all. The HCFA found that under a single-payer model, with no cost sharing for patients and long-term care for all, California would save between $32 billion to $213 billion over ten years compared to our current system. By moving to the single-payer system of CalCare, we would transform the profit-driven health insurance system into a health care system that prioritizes patient care. CalCare would create the necessary infrastructure to target and begin to dismantle the health inequities that our current unjust system is built upon. CNA concludes the only way we can guarantee that every person living in California receives the health care they need with a single standard of excellent care is by adopting a single-payer, CalCare system for all.

3) **SUPPORT IN CONCEPT.** Health Access California (HAC) writes that a progressively financed system, where what we pay for health care is based on what we can afford, not on how sick we are or what job we happen to have, and where the tax structure is also progressive, capturing unearned income and wealth while not relying on regressive payroll taxes to finance it. Health care is expensive, and employer health benefits are notably regressive in terms of income. The regressivity is especially stark in high deductible plans where the sick by definition pay more than the healthy. In addition, the cost of a health plan is thousands of dollars, which can be a third or a half of a low-income worker's annual income. The ACA made strides in addressing the regressivity of health benefits by providing Medi-Cal to all legal residents below or around the poverty level, and significant but still insufficient income-based affordability assistance to those under 400% of the FPL. Additional federal and state subsidies have taken some additional steps to the single-payer goal of a government guarantee that nobody has to spend more than a percentage of their income on health care. Depending on how the taxes to finance the single payer system are structured, a single payer system could finally assure that those who can afford the most are paying the most toward the cost of financing the health system and that individuals pay based on a sliding scale based on income, both earned and unearned, or extraordinary wealth. The ACA and existing California law now puts a minimum standard on benefits and a maximum ceiling on cost-sharing, but more work is needed to assure people can get care when they need it and that they can afford that care. A well-managed single-payer system has tools for managing costs and streamlining operations and administration far greater than any individual insurer or provider. HAC appreciates the work of the author in looking at how other countries negotiate or set rates, with his previous bill AB 3087 (Kalra) of 2018 and this current proposal. Our current fragmented system creates confusion, and while the ACA filled in many gaps, there is more to do. Having a "single payer" would avoid the continuing complications with regard to the churn between coverage types, as people shift from one employer to another job, between Medi-Cal income levels and those of Covered California, and age from their parents' coverage or into Medicare. HAC concludes that the administrative costs of so many payers include not just the overhead of the insurance industry, but the imposed burden on providers of navigating the many billing systems of multiple insurers and payers.

4) **OPPOSITION.** The California Association of Health Plans and the Association of California Life and Health Insurance Companies (collectively "insurers") writes that this bill ignores and destroys progress, and instead creates a massive new government- run program with no ability for consumers to opt-out or choose their own coverage. Single payer faces huge procedural hurdles in the form of receiving federal waivers, passing massive tax increases and garnering support for a constitutional amendment; all of which will have a significant impact on the state budget. According to the insurers, this proposal would include eliminating or weakening voter-approved constitutional protections for school funding and public safety, threatening funding for public schools and community colleges, hiking the state's voter-approved constitutional spending limit by hundreds of billions of dollars a year – putting at risk California's financial health. With single payer, supply in health care provision often fails to meet demand leading to long wait times, cost increases and provider shortages – as seen in single payer systems abroad. In the U.K.'s single payer system, 120,000 patients died in 2022 while on wait lists for care. In Canada, the median wait time between a referral from a general practitioner to a specialist procedure is 27.7 weeks. In contrast, the average wait time to see a specialist under our current system in the U.S. is 26 days.

   The California Hospital Association (CHA) writes that this bill would face fiscal pressures to keep costs low while overpromising benefits. As a result, appointment wait times would increase, necessary treatments rationed, and patient choice stifled. California's hospitals recognize that shortcomings in access and affordability remain as part of the health care system. While this bill does not reflect the right approach, CHA looks forward to collaborating with the Legislature and governor to develop solutions that constructively and meaningfully enhance health care access and outcomes for all Californians.

   The California Medical Association (CMA) contends that this bill contemplates consolidating Medi-Cal, Medicare, private insurance and the Covered California exchange into a single health insurance product (CalCare) provided by the state — without the constitutional protections that are essential to ensuring that an adequate, guaranteed supply of resources will be allocated to ensure its viability. Unlike the federal government which may carry debt and finance a program of this magnitude with some uncertainties, California must pass a balanced budget and could create a situation where CalCare could face uncertain financing in tough deficit years (like this one). Without these needed protections and given the volatility of California's tax revenue from year to year, a single-payer program could default to a system that it is unable to provide timely access to quality care for the beneficiaries it would cover. CMA agrees that a system should cover the vast amount of benefits, with limited co-pays, quick patient appointments and at a fraction of the cost of the current system. However, those decisions cannot be made in a vacuum and are not without fiscal consequences or tradeoffs. CMA concludes until we know how much money can be generated and contributed to this program, we cannot begin to discuss the specifics.

   The America's Physician Groups (APG) write that this bill expressly prohibits the use of information technology and clinical practice guidelines, in favor of individual licensees' professional judgement. APG have been uniquely responsible for the care of millions of patients across the country under an accountable model for the past several decades and they have pioneered the use of best clinical practices guidelines to standardize care approaches, focus on evidence-based medicine, improve patient outcomes and decrease variation in medical practice. Clinical variation involves the overuse, underuse, different use and waste of healthcare practices and services with varying outcomes. It has been associated with poorer

health outcomes, increased costs, disparities in care and increased burden on the public health system. This bill further defines "medically necessary and appropriate" based on the subjective determination of each licensed provider rendering services. Building accountable systems of patient care that decrease variation in medical practice involves peer-supported oversight, use of clinical practice guidelines and intensive use of information technology. It is also highly dependent upon provider payment mechanisms other than pure FFS. According to APG, this bill restricts payment of physician practices to two models, either FFS or salaried. Independent physicians may only be paid on a FFS basis. In combination, these factors dismantle the best elements of the California healthcare delivery system and replace it with outdated, obsolete 1950's style, cottage-industry healthcare delivery.

5) PREVIOUS LEGISLATION.

a) SB 770 (Wiener), Chapter 412, Statutes of 2023, requires the CHHSA Secretary to research, develop and pursue discussions of a waiver framework in consultation with the federal government with the objective of creating a health care system that incorporates specified features and objectives. Requires the CHHSA Secretary, in developing the waiver framework, to engage stakeholders to provide input on topics related to discussions with the federal government and key system design issues identified by the HCFA for further analysis. Requires the CHHSA Secretary, no later than January 1, 2025, to provide an interim report to the chairs of the Assembly and Senate Budget and Health Committees that details the agency's policy priorities and preliminary analysis of issues related to the federal discussions, as well as a summary of the input received date through the stakeholder engagement process. Requires the CHHSA Secretary, no later than January 1, 2025, to propose statutory language to the chairs of these committees authorizing the development and submission of application to the federal government for waivers necessary to implement the UF.

b) AB 1690 (Kalra) of 2023 stated the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state. AB 1690 was held in the Assembly Rules Committee.

c) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2202, establishes OHCA within HCAI. Identifies OHCAs three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. Requires OHCA to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board.

d) AB 1400 (Kalra) of 2021 would have established the California Guaranteed Health Care for All or CalCare as California's single-payer health care coverage program. AB 1400 died on the Assembly Floor.

e) ACA 11 (Kalra) of 2021 would have imposed an annual tax of 2.3% on businesses that have at least $2 million in annual revenue; a 1.25% tax on payroll for companies with at least 50 employees; a one percent tax for those employers who pay employees at least $49,900. ACA 11 would also have included a series of tax hikes on wealthier people, starting with a 0.5% levy on the income of people who make at least $149,509 per year and ending at a 2.5% income tax for people who make more than $2.48 million per year.

ACA 11 would have permitted the Legislature to pass a statute that increases any or all of the tax rates by a majority vote; and would have authorized the Legislature, upon an economic analysis determining insufficient amounts to fund these purposes, to increase any or all of these tax rates, as specified. ACA 11 was never referred to a committee and died at the Assembly Desk.

f) SB 562 (Lara and Atkins) of 2017 would have enacted the Healthy California program, which would have required the provision of comprehensive universal single-payer health care coverage system for all California residents. SB 562 died in Assembly Rules Committee. Speaker Rendon at that time called SB 562 "woefully incomplete" and instead created the Select Committee (described above).

g) SB 810 (Leno) of 2011 and SB 810 (Leno) of 2009 would have established the California Healthcare System and failed passage on the Senate Floor in 2012. SB 810 (Leno) of 2009 was not taken up on the Assembly Floor.

h) SB 840 (Kuehl) of 2007 was similar to SB 2009 and was vetoed by Governor Schwarzenegger. In his veto message, the Governor cited a Legislative Analyst's Office analysis that estimated the bill to cost $210 billion in its first full year of implementation and cause annual shortfalls of $42 billion, and he could not support a bill that placed an annual shortfall of over $40 billion on California's economy.

i) SB 1014 (Kuehl) of 2007 would have imposed a payroll tax to fund the single payer system. SB 1014 was heard in the Senate Revenue and Taxation Committee but no vote was taken.

j) SB 921 (Kuehl) of 2003 would have established the California Health Care System to be administered by the newly created California Health Care Agency under the control of an elected Health Care Commissioner. Would have made all California residents eligible for specified health care benefits under the California Health Care System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services was never heard in the Assembly Appropriations Committee. SB 921 was held in the Assembly.

6) AUTHOR'S AMENDMENTS. The author is proposing to amend this bill as follows:

a) Revise the Governor's board appointments to four;

b) Revise the board to two patient advocacy seats and merge the public health and mental health seat;

c) Revise conflict of interest provisions for the board;

d) Address generic drug as a substitute;

e) Include a reference to the OHCA spending target;

f) Add language about prevention-oriented care to the Office of Health Equity responsibilities;

g) Add intent language to existing patient rights and protections and reference to the IMR process;

h) Add a provision allowing individual providers to petition for interim review of payments;

i) Add a provision allowing workers and their representatives to petition for review of a global budget payment; and,

j) Delete county-organized health plans and local initiatives.

7) COMMENTS.

a) Federal issues. HCFA noted that many factors affect California's ability to take independent action to reorganize health care finance and delivery including: i) California would need to grapple with federal law and regulation related to Medicare and Medicaid; ii) address limitations under the Employee Retirement Income Security Act of 1974 (ERISA) on the state's ability to impose requirements on employer benefit program (self-funded employers not subject to state law); and, iii) navigate existing constrains on how California raises and spends revenue. This bill provides that every resident of this state is eligible and entitled to enroll in CalCare. California law with respect to insurance regulation is pre-empted under ERISA from regulating employer sponsored benefits. Additionally, this bill requires the board to establish requirements and standards by regulation, to the extent authorized by federal law, to replace and merge with CalCare health care items and services and ancillary services currently provided by other programs, including Medicare, the ACA, and federally matched public health programs. As noted above by CHCF, in 2022, there were 5.8 million people were enrolled through administrative services only arrangements for self-insured employers. As this bill moves forward, the author should consider any unintended consequence to employer sponsored coverage and whether or not CalCare may cause a shift to ERISA plans, diluting the intent of CalCare to provide coverage to all residents of California.

b) Consumer Protections in Existing law. To address concerns raised that other similar single payer systems have long wait times as raised by the insurers above, the author may wish to consider the following consumer-oriented requirements:

i) Network adequacy. According to CHCF, network adequacy standards are commonly used as a regulatory tool to ensure that health plans contain a network of health care providers adequate for enrollees to access medically necessary services in a timely manner. California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:

(1) Timely Access. Timely Access Laws and Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally include the following standards for appointment availability:

(a) *Urgent care without prior authorization*: **within 48 hours**;

(b) *Urgent care with prior authorization*: **within 96 hours**;

(c) *Non-urgent primary care appointments*: **within 10 business days;**

(d) *Non-urgent specialist appointments*: **within 15 business days;**

(e) *Non-Urgent mental health appointments*: **within 15 business days** for psychiatrist, **within 10 business days** for non-physician MH provider; and,

(f) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

(2) Geographic Access. Health plans are also generally required to ensure geographic access such that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be **located within 15 miles or 30 minutes** from work or home. Health plans must also ensure provider capacity 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 should include **one PCP for every 2,000 beneficiaries.**

ii) Appeals. Another consumer right is the right to know why a health plan denies a service or treatment, and the right to file a grievance if the consumer disagrees. Health plans are required to have grievance and appeals systems to assist consumers in resolving these issues. A robust grievance program also allows health plans to track and trend grievances for the purpose of uncovering systemic problems, thereby providing the opportunity for quality improvement. The author should consider a similar framework that allows CalCare members to complain about the quality of care or lack of timely or geographic access to CalCare providers.

iii) Other consumer protections. In addition to other consumer protections under the KKA, there are other consumer protections under Medicare, Medicaid, or the Lanterman-Petris-Short (LPS) Act. As such, the author should consider adding additional intent language as follows:

This title does not diminish or eliminate any of the rights and protections afforded Californians by the Medicare and Medicaid program under state and federal law or the LPS Act in state law.

c) Health Information Exchange. The CHHSA Data Sharing Agreement (DSA) is California's first-ever statewide data sharing agreement that governs the safe exchange of health and social services information by defining a common set of terms, conditions, and obligations—promoting whole person care and ensuring that the medical care, behavioral health and social services systems in California are able to work together and securely share information pertinent to a patient's health and wellbeing. Most health care providers were required to sign the DSA by January 31, 2023, however, it should be noted that full compliance has not been reached. This bill should mandate all CalCare health care providers to participate in the DSA to ensure the goals of the DSA are achieved.

d) Fiscal Solvency. This bill authorizes the board to do many things under this bill, including the ability to add benefits; to establish requirements and standards for CalCare

and health care providers when establishing a single standard of safe, therapeutic and effective care for all state residents; and, to increase an individual's eligibility for any federal financial support related to Medicare or the ACA. While this bill requires the CalCare Executive Director to annually submit a report to the Legislature on the implementation and performance of CalCare functions, should this board consider the value of existing state resources from any of the departments under the CHHSA, for example, a review of the fiscal solvency of CalCare? As this bill moves forward, the author should consider whether or not this bill has the appropriate oversight by the Legislature or other state agencies to ensure successful implementation.

e) Role of current regulatory authorities and agencies. The fate of existing regulators and independent agencies are unclear under this bill. The author may wish to address the value of these state agencies and the role each plays to ensure relevant oversight and enforce consumer protections in the provision of health care coverage. As this bill moves forward, the author should consider adding specific enforcement language, including providing the board the authority to develop a framework for investigating potential violations of this bill.

f) State Constitutional Issues. There are two state constitutional issues that must be addressed if California is to implement a single-payer program. Proposition 4 of 1979 established a constitutional state spending limit that is known as the "Gann Limit." The original Gann Limit was later modified by two ballot measures: Proposition 98 of 1988 and Proposition 111 of 1990. Proposition 98 of 1988, as modified by Proposition 111 of 1990, constitutionally guarantees a minimum level of funding for K-12 schools and community colleges. Thus, any taxes/revenues raised to support this bill would be subject to the requirements of the Gann limit and Proposition 98 and may require a voter initiative.

g) Cost Containment. This bill contains certain cost containment provisions, including establishing a global budget for institutional providers, and giving the board the authority to negotiate prices for prescription drugs, medical supplies and other health care items. However, this bill also relies on a FFS payment mechanism and although it uses 100% of Medicare FFS as the reasonable basis for payment, under a FFS payment, providers would each be paid separately for each test, procedure or treatment. This bill further defines "medically necessary and appropriate" based on the treating physician. A 2016 CHCF blog writes that in California, most physician organizations contracting with HMOs also generally receive per-member, per-month payments, or capitation, so they are accountable and generally rewarded for the health of a defined patient population. This organizational model is consistent with the overall goal of CMS and other purchasers to drive more care and payments through so-called alternative payment models that aim to deliver high-quality, affordable, patient-centered care. These are the essential characteristics of high-value care. Even using the Medicare payment rate system, the cost of health care will continue to rise. It is important for the Committee to evaluate whether this bill includes sufficient cost containment mechanisms to identify and address cost drivers in the system, ensure it eliminates waste and fraud, and evaluate the price of health care while improving quality and care. As this bill moves forward, the author should consider whether periodic review of the program's reimbursement structures for fiscal and other impacts can be addressed.

REGISTERED SUPPORT / OPPOSITION:

Support

California Nurses Association
ACLU California Action
AIDS Healthcare Foundation
Alameda County Homeless Action Center
Alex Rechsteiner Painting
Alliance for Boys and Men of Color
Asian/Pacific Islanders for Calcare
Black Lives Matter - Los Angeles
Butte County Health Care Coalition
Cal Red Berets
California Alliance for Retired Americans
California Conference of Machinists
California Faculty Association
California Federation of Interpreters
California Federation of Teachers AFL-CIO
California Immigrant Policy Center
California Labor Federation, AFL-CIO
California OneCare
California Pan - Ethnic Health Network
California School Employees Association
California State Northridge Young Democratic Socialists of America
California Teachers Association
Cleanearth4kids.org
Coalition to Abolish Slavery and Trafficking (CAST)
Community Health Councils
Conference of California Bar Associations
Council Member Mateo Bedolla, City of Tracy
County of Santa Clara
Culver City Democratic Club
Democratic Socialists of America - San Luis Obispo
DSA-Santa Barbara
East Valley Indivisibles
Educators for Single-payer
Federation of Retired Union Members
Feel the Bern Democratic Club, Los Angeles
Feel the Bern San Fernando Valley Democratic Club
Focus Strategies
Gray Panthers of San Francisco
Green Party of California
Green Party of Santa Clara County CA
Health Access California
Health Care 4 US (HC4US)
Health Care for All - California

Healthy California Now
Hire Survivors Hollywood
Hollywood4CalCare
Holy Faith Episcopal Church
Human Agenda
Humboldt Progressive Democrats
Indivisible Ca: Statestrong
Indivisible Sacramento
Indivisible Westside Los Angeles
Initiate Justice Action
Inland Equity Partnership
International Association of Machinists & Aerospace Workers Local Lodge 1484
Iranian American Democrats of California
Katharine Gale Consulting
Labor Today International, INC.
Long Beach Gray Panthers
Midnight Books
NorCal Resist
Parivar Bay Area
Peace and Freedom Party of California
Peninsula DSA
Physicians for A National Health Program -- Bay Area Chapter
Pride At Work South Bay Chapter
Sacramento Democratic Socialists of America
Sacramento; City of
San Diego Snahp Chapter
San Gabriel Valley Neighbors for Peace and Justice
San Gabriel Valley Progressives
Santa Clara County Single Payer Health Care Coalition
Santa Cruz for Bernie
Santa Monica Democratic Club
Socialists for CalCare
South Bay Community Land Trust
South Bay Indigenous Solidarity
South Bay Progressive Alliance
Southern Alameda County Progressive Democrats
Stanislaus County Democratic Central Committee
Techequity Collaborative
Thai Community Development Center
The National Tai Chi Chuan Association
Therapists for Single Payer
Trade Show Temps
Unite Here Local 11
Unite-Here, AFL-CIO
United Democrats of Southern Solano County
Western Center on Law & Poverty, INC.
White People 4 Black Lives

Opposition

Acclamation Insurance Management Services
African American Farmers of California
Agricultural Council of California
Alameda Chamber of Commerce
Allied Managed Care
America's Physician Groups
American Composites Manufacturers Association
American Petroleum and Convenience Store Association
American Pistachio Growers
American Property Casualty Insurance Association
Antelope Valley Chambers of Commerce
Associated General Contractors
Associated General Contractors San Diego
Association of California Life & Health Insurance Companies
Bay Area Council
Blue Shield of California
Brea Chamber of Commerce
Building Owners and Managers Association of California
Business Council San Joaquin County
California Agents & Health Insurance Professionals (CAHIP)
California Agricultural Aircraft Association
California Apple Commission
California Asian Pacific Chamber of Commerce (CAPCC)
California Association of Health Plans
California Association of Highway Patrolmen
California Association of Winegrape Growers
California Attractions and Parks Association
California Beer and Beverage Distributors
California Blueberry Association
California Blueberry Commission
California Builders Alliance
California Building Industry Association
California Business Properties Association
California Business Roundtable
California Cable and Telecommunications Association
California Cattlemen's Association
California Chamber of Commerce
California Children's Hospital Association
California Correctional Peace Officers Association Benefit Trust
California Cotton Ginners and Growers Association
California Dental Association
California Financial Services Association
California Fresh Fruit Association
California Fuels and Convenience Alliance
California Hispanic Chamber of Commerce
California Hospital Association
California Independent Petroleum Association (CIPA)

California Land Title Association
California Landscape Contractor's Association
California Landscape Contractors Association
California League of Food Producers
California Lodging Industry Association
California Manufacturers & Technology Association
California Medical Association
California New Car Dealers Association
California Pool & Spa Association
California Retailers Association
California Rice Commission
California Strawberry Commission
California Taxpayers Association
California Walnut Commission
California Women for Agriculture
Can Manufacturers Institute
Carlsbad Chamber of Commerce
Cemetery and Mortuary Association of California
Chino Valley Chamber of Commerce
Cigna
Coalition of Small and Disabled Veteran Businesses
Construction Employers' Association
Corona Chamber of Commerce
Dairy Institute of California
Danville Area Chamber of Commerce
Department of California Marine Corps League
El Dorado County Chamber of Commerce
El Dorado Hills Chamber of Commerce
Elevance Health
Elk Grove Chamber of Commerce
Family Business Association of California
Flasher Barricade Association
Folsom Chamber of Commerce
Fontana Chamber of Commerce
Fountain Valley Chamber of Commerce
Fresno Chamber of Commerce
Garden Grove Chamber of Commerce
Gateway Chambers Alliance
Gilroy Chamber of Commerce
Greater Coachella Valley Chamber of Commerce
Greater Conejo Valley Chamber of Commerce
Greater Grass Valley Chamber of Commerce
Greater High Desert Chamber of Commerce
Greater Riverside Chambers of Commerce
Greater San Fernando Valley Chamber of Commerce
Greater Stockton Chamber of Commerce
Health Net
Hollywood Chamber of Commerce
Housing Contractors of California

Imperial Valley Regional Chamber of Commerce
Independent Lodging Industry Association.
Innovating Commerce Serving Communities
Kaiser Permanente
LA Cañada Flintridge Chamber of Commerce and Community Association
Laguna Niguel Chamber of Commerce
Lincoln Area Chamber of Commerce
Long Beach Area Chamber of Commerce
Los Angeles Area Chamber of Commerce
Mammoth Lakes Chamber of Commerce
Manhattan Beach Chamber of Commerce
Manteca Chamber of Commerce
Metal Finishing Association of Northern California
Metal Finishing Association of Southern California
Mission Viejo Chamber of Commerce
Murrieta Wildomar Chamber of Commerce
NAIOP California
National Electrical Contractors Association (NECA)
National Federation of Independent Business
Newport Beach Chamber of Commerce
Nisei Farmers League
North San Diego Business Chamber
Norwalk Chamber of Commerce
Oceanside Chamber of Commerce
Olive Growers Council of California
Orange County Business Council
Palos Verdes Peninsula Chamber of Commerce
Paso Robles Templeton Chamber of Commerce
Peace Officers Research Association of California (PORAC)
Pleasanton Chamber of Commerce
Rancho Cordova Area Chamber of Commerce
Redondo Beach Chamber of Commerce
Rocklin Area Chamber of Commerce
Roseville Area Chamber of Commerce
Sacramento Black Chamber of Commerce
Sacramento Regional Builders Exchange (SRBX)
San Diego Regional Chamber of Commerce
San Juan Capistrano Chamber of Commerce
San Mateo Area Chamber of Commerce
San Pedro Chamber of Commerce
San Ramon Chamber of Commerce
Santa Ana Chamber of Commerce
Santa Maria Valley Chamber of Commerce
Shasta; County of
Shingle Springs/Cameron Park Chamber of Commerce
Silicon Valley Leadership Group
Simi Valley Chamber of Commerce
South Bay Association of Chambers of Commerce
Southwest California Legislative Council

Torrance Area Chamber of Commerce
Tulare Chamber of Commerce
United Chamber Advocacy Network
United Contractors
Vacaville Chamber of Commerce
Valley Industry and Commerce Association (VICA)
Ventura Chamber of Commerce
Walnut Creek Chamber of Commerce & Visitors Bureau
Waste Management
West Coast Lumber & Building Material Association
West Hollywood Chamber of Commerce
West Ventura County Business Alliance
Western Agricultural Processors Association
Western Growers Association
Western Manufactured Housing Communities Association
Western Plant Health Association
Whittier Area Chamber of Commerce
Word & Brown
Yuba Sutter Chamber of Commerce

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

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2064 (Jones-Sawyer) – As Amended March 21, 2024

SUBJECT: Community Violence Interdiction Grant Program.

SUMMARY: Redirects money saved by closing prisons to community violence interdiction programs. Specifically, **this bill**:

1) Creates the Community Violence Interdiction Grant Program to provide funding to programs for community-driven solutions to decrease violence in neighborhoods and schools, to be administered by the California Health and Human Services Agency (CHHSA).

2) Defines eligible programs as including, but not limited to, the following:
   a) Evidence-based, focused-deterrence collaborative programs that conduct outreach to targeted gangs and offer supportive services in order to preemptively reduce and eliminate violence and gang involvement;
   b) Programs that create and enhance recreation- and health-based interventions for youth during peak times of violence;
   c) Programs that implement evidence-based interventions for pupils impacted by trauma for the improvement in the health and well-being of the youth and school and community stability;
   d) Youth diversion programs that promote positive youth development by relying on responses that prevent a youth's involvement or further involvement in the justice system; and,
   e) The creation and operation of school-based health centers.

3) Requires grants to be made on a competitive basis, with preference to cities and local jurisdictions disproportionately impacted by violence and gang involvement, and with preference to community-based organizations that serve those jurisdictions.

4) Requires CHHSA to work with stakeholders to ensure the program is geographically diverse and effectively targeted, and requires applicants seeking funding to demonstrate how they will prioritize specified populations of underserved pupils most impacted by trauma.

5) Creates a continuously appropriated fund (Community Violence Interdiction Grant Fund) for purposes of the grant program.

6) Requires, beginning July 31, 2025, and each fiscal year thereafter, the Director of Finance and the Legislative Analyst's Office (LAO) to calculate the savings that accrued to the state from the closure of state prisons during the preceding fiscal year, requires these calculations be averaged to determine a final amount, and requires the Controller to transfer the final amount from the General Fund to the fund described in 5) above, to fund the grant program.

EXISTING LAW:

Youth Reinvestment Grant Program (YRGP)

1) Establishes the YRGP within the Board of State and Community Corrections (BSCC) for the purpose of granting funds, as specified. [Welfare and Institutions Code (WIC) § 1450]

2) Requires that a specified percentage of funds be allocated for the purpose of implementing diversion programs for children throughout local jurisdictions that are trauma-informed, evidence-based, and culturally relevant, among other things. [WIC § 1454 (a),(b)]

3) Provides that BSCC is responsible for oversight and accountability of the program and that it must track funding, provide guidance to programs, and contract with a research firm to conduct a statewide evaluation of the grant, as specified. [WIC § 1455]

4) Establishes the Office of Youth and Community Restoration (OYCR) in the CHHSA, whose mission is to promote trauma responsive, culturally informed services for youth involved in the juvenile justice system that support their successful transition to adulthood and help them become responsible, thriving, and engaged members of their communities. [WIC § 2200 (a),(b)]

5) Requires all juvenile justice grant administration functions in the BSCC to be moved to the OYCR no later than January 1, 2025. [WIC § 2200 (h)]

California Violence Intervention Program (CalVIP)

6) Establishes CalVIP, to be administered by the BSCC. [Penal Code (PEN) § 14131(a)]

7) States that the purpose of CalVIP is to improve public health and safety by supporting effective community gun violence reduction initiatives in communities that are disproportionately impacted by community gun violence. [PEN § 14131 (b)]

8) States CalVIP grants must be used to develop, support, expand, and replicate evidence-based community gun violence reduction initiatives, including, without limitation, hospital-based violence intervention programs, evidence-based street outreach programs, and focused-deterrence strategies that seek to interrupt cycles of community gun violence and retaliation in order to reduce the incidence of homicides, shootings, and aggravated assaults. [PEN § 14131 (c)]

Medi-Cal Community Health Worker (CHW)/Violence Prevention Professional Benefit

9) Establishes the Medi-Cal Program, administered by the Department of Health Care Services (DHCS), to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [WIC §14000 *et seq*.]

10) Establishes a schedule of benefits under the Medi-Cal program. [WIC §14132]

11) Establishes CHW services as a Medi-Cal benefit and requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit. [WIC §14132.36]

12) Defines CHW to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. States that CHWs include other nonlicensed health workers, including violence prevention professionals. Requires a CHW's lived experience to align with and provide a connection to the community being served. [WIC § 18998]

Proposition 64 Youth Education, Prevention, Early Intervention and Treatment Fund

13) Allocates revenue from taxes on cannabis. [Revenue and Taxation Code (RTC) §34019]

14) Allocates, after other specified disbursements, 60% of the remaining cannabis tax funds to the Youth Education Prevention, Early Intervention and Treatment Account to fund programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. [RTC §34019 (f)(1)]

School-Based Health Centers

15) Establishes the Public School Health Center Support Program (PSHCSP) within the State Department of Public Health (DPH), in collaboration with the California Department of Education to perform specified functions, including providing technical assistance to school based health centers on effective outreach and enrollment strategies to identify children who are eligible but not enrolled in specified health care programs; serve as a liaison between organizations on prevention services, primary care, and family health; and, to provide technical assistance to facilitate and encourage the establishment, retention or expansion of health centers. [Health and Safety Code (HSC) § 124174.2]

16) Requires DPH to establish a grant program, contingent upon appropriation, within the PSHCSP to provide technical assistance, and funding for the expansion, renovation, and retrofitting of existing school health centers and the development of new health centers, as specified. Makes available planning grants, facilities grants, and start-up grants. [HSC § 124174.6]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, by advancing sensible legislation and budget items to improve public safety and advance justice and equity, the Legislature has decreased the number of incarcerated people in California. The author argues it is imperative that the resulting savings be reinvested into effective strategies proven to further reduce crime and violence. Accordingly, the author states, this bill will capture the savings from the closure of prisons and reinvest those funds in programs with proven success. By keeping the funding within our crime prevention budget rather than sending it back to the General Fund, the author intends to send a message about the value of these programs and that our efforts to reduce crime are continuous.

2) BACKGROUND.

a) Violence as a Public Health Issue. According to the federal Office of the Assistant Secretary for Health, United States Department of Health and Human Services (OASH), addressing exposure to crime and violence as a public health issues means implementing community-based strategies focused on building resilience, reducing susceptibility to violence, and creating protective environments. For instance, the federal Community Preventive Services Task Force, a federal entity that reviews the evidence basis for community-based prevention programs, recommends universal school-based programs that focus on building emotional self-awareness and control skills, social problem-solving, and teamwork skills to reduce or prevent violent behavior among school-aged children. Hospital-based violence intervention program that involve screening and intensive case management have also been proven successful and cost-effective in reducing escalation and recurrence of violent injury.

The OASH administers the Healthy People 2030 initiative, which is a set of 10-year, measurable public health objectives. Violence-related objectives include:

i) Reducing the rate of minors and young adults committing violent crimes;
ii) Reducing non-fatal physical assault injuries; and,
iii) Reducing firearm-related deaths.

DPH established a Violence Prevention Initiative (VPI), with the purpose of elevating violence as a departmental priority, integrating and aligning efforts across multiple DPH programs, and framing the public health governmental role in addressing violence. DPH emphasizes public health approaches work "upstream" to address underlying causes to prevent violence from happening in the first place. According to DPH, the public health approach to violence prevention focuses on the following four-step process:

i) Define and monitor the problem – Analyze data such as the number of violence-related injuries and deaths;
ii) Identify risk and protective factors – These can increase or decrease the likelihood of a person becoming a victim or perpetrator of violence;
iii) Develop and test prevention strategies – Use data and findings from evaluation and research as an evidence-based approach to program planning; and,
iv) Assure widespread dissemination of effective practices – Share best practices through networking, training, and technical assistance.

The VPI appears to have been active until 2020. The VPI has conducted surveys, published reports and data briefs, and hosted a statewide convening in 2018.

b) Current Public Safety-Focused Efforts on Violence Prevention.

i) CalVIP. CalVIP provides grant funding for initiatives to reduce community gun violence, to communities disproportionately impacted by such violence. Funding is awarded to qualifying cities, counties, and community-based organizations on a competitive basis. The program was established in 2017 to replace a gang-related prevention and intervention program that began in 2007, and was narrowed to focus on community gun violence specifically through AB 762 (Wicks), Chapter 421,

Statutes of 2023.

State law requires CalVIP grants be used to support, expand and replicate evidence-based violence reduction initiatives, including but not limited to:

(1) Hospital-based violence intervention programs;
(2) Evidence-based street outreach programs; and,
(3) Focused deterrence strategies.

These initiatives must be primarily focused on providing violence intervention services to the small segment of the population that is identified as at high risk of perpetrating or being victimized by community gun violence in the near future. According to the BSCC, historically, CalVIP has been allocated approximately $9 million annually. In 2021, the state Budget Act also provided a one-time augmentation of $200 million across three fiscal years (2021-22, 2022-23, and 2023-24) to enhance CalVIP.

ii) YRGP. The goal of the YRGP is to divert youth from contact with the juvenile justice system by funding grantees that provide evidence-based, culturally relevant, trauma-informed, and developmentally appropriate programs to youth. Programs funded by the YRGP provided mental health referrals, mentoring, counseling, pro-social activities, restorative justice activities, and educational supports to participating youth.

The YRGP was enacted in the Budget Act of 2018 and related trailer bill, which included an initial $37.3 million appropriation for the program. The 2019 Budget Act augmented funding by an additional $5 million. According to the final evaluation reports from two rounds of grant funding, $40.9 million has now been disbursed. According to the statewide evaluation findings, grantees funded by the program reported positive outcomes for participating youth, many of whom had no further contact with the juvenile justice system during the reporting period. AB 2267 (Jones-Sawyer), which is pending hearing in the Assembly Appropriations Committee, would re-establish the YRGP and designate the OYCR to administer it. However, there is no additional funding proposed for the program.

c) Current Health-Focused Efforts on Violence Prevention and Youth Development. In addition to funding focused violence prevention strategies, this bill would allocate funding to more generic supports such as recreation- and health-based interventions that offer alternatives to violence, evidence-based interventions for pupils impacted by trauma to improve health and well-being, youth diversion programs that promote positive youth development, and creation and operation of school-based health centers. There are several efforts administered by California state health departments that seek to support youth by enhancing school-based health, youth development and other protective factors in disadvantaged communities.

i) Medi-Cal Coverage of Violence Prevention Services. CHW services, defined to include violence prevention services, were added as a Medi-Cal benefit starting July 1, 2022. The benefit was codified through AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022. Key provisions relevant to violence prevention include:

(1) CHW services are defined to include those delivered by a variety of non-licensed public health workers, including violence prevention professionals;
(2) CHWs can address issues that include but are not limited to a number of diseases, conditions, and topics, including domestic violence and violence prevention; and,
(3) CHW services include health education; navigation to health care and other community resources that address health-related social needs; screening and assessment to identify the need for services; and individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence.

CHW services became a benefit in July 2022; however, billing data shows little utilization so far. Because billing for violence prevention services would be subsumed under the reported utilization for CHW services overall, it is unknown whether the limited services billed so far reflect any billing for violence prevention services.

ii) Prop 64-Funded "Elevate Youth California." In November 2016, Proposition 64 (Prop 64) was passed by voters allowing adults aged 21 years or older to possess and use cannabis for non-medical purposes. Prop 64 created new taxes, the revenues of which are deposited into the California Cannabis Tax Fund. Current law allocates, after other specified disbursements, 60% of the remaining California Cannabis Tax Fund to be deposited into the Prop 64 Youth Education Prevention, Early Intervention and Treatment Account. Funds are then disbursed to DHCS, which in turn allocates funds to Elevate Youth California, a statewide program that makes grants with a specific focus on youth ages 12 to 26 living in communities disproportionately impacted by the war on drugs. These grants focus on empowering youth to create policy and system changes through civic engagement; youth development, peer support, and mentoring programs; using evidence-based and/or community-defined practices that help individuals and communities cope with adversity and heal trauma; and harm reduction and public health solutions that create resiliency and prevent substance use disorder. DHCS projects a 2023-24 allocation of $371 million for these programs.

iii) School-Based Health Centers. A school-based health center is a health center that provides age-appropriate, clinical health care services on-site or near a school. Services are provided by qualified health professionals and organized through school, community, and health provider relationships. AB 2560 (Ridley-Thomas), Chapter 334, Statutes of 2006, established the PSHCSP, which requires DPH to provide technical assistance to school-based health centers and to establish a state liaison to school-based health centers. Further, SB 564 (Ridley-Thomas), Chapter 381, Statutes of 2008, created a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing centers and the development of new centers. However, the grant program was contingent on an appropriation for this program's purpose and, according to DPH, the PSHCSP was not established due to lack of such an appropriation. However, the legislation referenced above created a statutory framework for this grant program, which could be leveraged if funding was made available. AB 2052 (Jones-Sawyer), currently pending in the Assembly Education Committee, makes various changes to the framework of this grant program. DPH also facilitates a quarterly statewide School-Based Health Center Collaborative Workgroup.

iv) **Activity Stipends for Foster Youth.** DHCS has submitted to the federal government a request for approval of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration. Among other proposals included in the demonstration application, DHCS proposes to develop a new stipend for children involved with the child welfare system to be used for activities and supports to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful physical and mental health effects of trauma.

d) Prison Closures and Cost Savings. According to the LAO's analysis of the California Department of Corrections and Rehabilitation (CDCR) 2024-25 budget proposal, the prison population has declined significantly in recent years and is expected to remain low through June 2028. The LAO notes that in 2021, CDCR completed a multiyear drawdown of people housed in contractor-operated prisons made possible by the declining prison population. Since 2021, the administration has also deactivated a number of other facilities and yards. The LAO notes CDCR estimates that these deactivations resulted in ongoing General Fund savings totaling about $620 million annually. Deactivation also allowed the state to avoid funding infrastructure repairs that would otherwise have been needed to continue operating these facilities—for example, the state was able to avoid a water-treatment project in one prison, estimated in 2018 to cost $32 million, which would have been necessary to comply with drinking water standards. The administration currently plans to deactivate Chuckawalla Valley State Prison in Blythe by March 2025.

e) Focus of This Bill and Relationship to Existing Efforts. This bill's intent is to allocate funding, in an annual amount equal to the amount the state is saving on an ongoing basis due to the closure of state prisons, to various grants focused on youth, with an end goal of violence prevention. Some components of the grant program created by this bill may overlap with existing efforts, while other components appear complimentary to existing programs. Specifically:

i) **Diversion**. This bill could fund diversion programs that promote positive youth development to prevent a youth's involvement or further involvement in the justice system. This is similar to the goals of the YRGP, as described above, although it could be construed as broader because it could fund so-called "primary prevention," or preventing a youth's involvement with the justice system prior to any such contact. In addition, as noted above, the YRGP is currently unfunded.

ii) **School-Based Health Centers**. This bill could fund creation and operation of school-based health centers. As noted above, another unfunded grant program already exists to support the creation and operation of such centers, the framework of which could be leveraged if funding was available.

iii) **Evidence-Based Violence Prevention**. This bill could fund evidence-based, focused-deterrence collaborative programs that conduct outreach to targeted gangs and offer supportive services in order to preemptively reduce and eliminate violence and gang involvement. This component appears to align with the activities that have been funded through CalVIP.

iv) **Interventions Not Addressed by Existing Efforts**. Eligible programs that could be do not appear to be specifically addressed by existing efforts include: (1) programs that create and enhance recreation- and health-based interventions for youth; and, (2) programs that implement evidence-based interventions for pupils impacted by trauma. The latter may be implemented to some extent at the discretion of local educational agencies, and may be addressed at the state level to some extent by population-based mental health prevention programs that are to be administered by DPH under the provisions of Proposition 1, which recently passed in March 2024. Otherwise, youth development and recreation programs are largely funded at the discretion of local communities and non-profit community-based organizations, pursuant to the availability of philanthropic, organizational or local funds.

3) **SUPPORT.** The Greater Sacramento Urban League, the bill's sponsor, writes in strong support that they recognize the importance of reinvesting savings from prison closures into programs that prevent incarceration on the front end, promoting safer communities and reducing the need for future prison beds. The Alliance for Reparations, Reconciliation, and Truth (ARRT), an alliance of several of the bill's other supporters, writes in support that establishing the Community Violence Interdiction Program with redirected savings from the closure of state prisons is a sensible preventive solution to expand the care-based supports and services communities need to decrease violence in their neighborhoods and schools. The ARRT indicates this bill grants California the opportunity to commit to repairing the harm it helped create by reimagining safety with a sensible preventive solution to expand the care-based supports and services communities need to decrease violence in their neighborhoods and schools.

4) **RELATED LEGISLATION.**

a) AB 2267 (Jones-Sawyer) re-establishes the YRGP and designate the OYCR to administer it. AB 2267 is pending hearing in the Assembly Appropriations Committee.

b) AB 2052 (Jones-Sawyer) makes various changes to the framework of a grant program within the PSHCSP. AB 2052 is pending in Assembly Education Committee.

5) **PREVIOUS LEGISLATION.**

a) AB 762 (Wicks) changes the purpose of CalVIP, as well as the eligibility requirements for the grant, and makes the program permanent. Removes the sunset date of January 1, 2025, and allows the CalVIP to operate indefinitely.

b) AB 912 (Jones-Sawyer), of 2023, would have reestablished the YRGP and provided for additional related grants, contingent upon appropriation. AB 912 was vetoed by the Governor, who cited cost pressure and the need to consider spending in the budget.

c) AB 2697 (Aguiar-Curry) added CHW services as a covered benefit under Medi-Cal.

d) AB 1929 (Gabriel), Chapter 154, Statutes of 2022, added violence prevention services, as defined, as a covered benefit under Medi-Cal. AB 166 (Gabriel) of 2019, was similar and was vetoed by Governor Newsom, who stated the 2019 Budget Act provided $30 million in the General Fund for the CalVIP.

e) AB 1454 (Jones-Sawyer), Chapter 584, Statutes of 2019, revises and recasts the YRGP by increasing the maximum grant award from $1,000,000 to $2,000,000 and allowing nonprofit organizations to apply for grants through the program.

f) AB 1603 (Jones-Sawyer), Chapter 735, Statutes of 2019, codified CalVIP and the authority and duties of BSCC in administering the program.

6) POLICY COMMENTS. As this bill moves forward and the author continues to refine its provisions, the Committee offers the following suggestions for the author's consideration:

a) The calculation of savings from prison closures could be clarified to align with the intent to allocate the "running total" of the cumulative state funds saved due to prison closures, which would grow over the years as more prisons were closed. The current bill language could be construed this way, but could also be construed to mean if there were no closures in the preceding fiscal year, there would be no funding allocated.

b) Some of the goals of the grant program established by the bill might be accomplished more efficiently by leveraging existing programs and efforts within BSCC, OCR, or DPH, versus funding a new program.

c) The Medi-Cal violence prevention services benefit has not been heavily utilized; if funding is allocated for violence prevention, allocating one-time funds to build up infrastructure for community-based organizations that offer violence prevention services to bill Medi-Cal could help create a long-term sustainable funding stream, which leverages federal matching funds ongoing, to support these programs.

REGISTERED SUPPORT / OPPOSITION:

Support

Black Equity Collective
California Black Power Network
California Reparations Task Force Members Dr. Cheryl Grills, Lisa Holder, and Don Tamaki
Catalyst California
Greater Sacramento Urban League
Livefree California
Santa Monica Democratic Club

Opposition

None on file.

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

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2075 (Alvarez) – As Amended April 10, 2024

SUBJECT: Resident Access Protection Act.

SUMMARY: Grants a resident of a long-term care (LTC) facility the right to in-person, onsite access to a visitor and health care and social services providers during any public health emergency (PHE) in which visitation rights of residents are curtailed by a state or local order. Specifically, **this bill**:

1) Requires, at the discretion of the resident or their representative, a visitor and health care and social services providers to have the right to enter the resident's dwelling and provide private support or care. Authorizes the LTC facility to limit the access of a visitor or health care and social services provider within the LTC facility to the resident and to the areas in which the resident resides or receives care, consistent with the state or local order.

2) Requires a LTC facility to allow a resident to have their visitor and health care and social services provider be physically present, consistent with the same hours of visitation required when there is no PHE.

3) Requires, during a PHE, a resident of a LTC facility to have the right to leave the facility on outings subject to a state or local government order prescribing the safety protocols governing their outing and return. Prohibits these safety protocols from exceeding what is required of staff.

4) Authorizes a LTC facility to require visitors and health care and social services providers to adhere to safety protocols not greater than required of facility staff during a PHE for the duration of their visit. Requires the LTC facility to provide personal protective equipment (PPE) and testing resources to each visitor, to the extent that those resources have been made readily available to the LTC facility by state or local entities for their use. States that the provision of PPE and testing resources to visitors is not intended to inhibit access to emergency supplies for staff. Allows visitors to use their own supplies so long as they meet or exceed the minimum standards set forth by state or local order.

5) Requires a LTC facility to provide safety protocols required of care staff, visitors, and health and social services providers during a PHE to the residents, resident representatives, and visitors in writing.

6) Requires the facility to provide the required safety protocols in the individual's primary or preferred language, if made available to the facility by state or local entities. Requires changes in safety protocols to be communicated, as soon as practically possible, to the residents, resident representatives, and visitors in writing in the individual's primary or preferred language, if made available to the facility by state or local entities.

7) Requires, if the individual is hearing impaired or vision impaired, the LTC facility to provide the required protocols in an accessible format, if made available to the facility by state or

local entities.

8) Prohibits a LTC facility from requiring visitors and health care and social services providers to adhere to safety protocols that have not been communicated as set forth in 5), 6) and 7), above. Specifies that this requirement does not preclude a LTC facility from informing a visitor upon their arrival of updated protocols or recent changes in protocols that impact their role as a visitor.

9) Authorizes a state or local government order to supersede the provisions of this bill during a declared state of emergency, local emergency, health emergency, or local health emergency, to limit the number of visitors or health care and social services providers who may simultaneously visit a resident, except for compassionate care visits, or require visitors or health care and social services providers to follow the same safety protocols required of facility staff. Authorizes a state or local government order to state the terms by which visitors or health care and social services providers can demonstrate their proficiency to follow the same safety protocols required of staff. Prohibits this from otherwise being suspended, superseded, or modified.

10) Specifies, that for purposes of civil penalties, a violation of this bill constitutes a class "B" violation for long-term health care facilities, or is subject to a civil penalty for residential care facilities for the elderly (RCFE).

11) Provides that this bill does not supersede or otherwise limit the statutory, regulatory, or other legal authority of government surveyors and inspectors, the LTC ombudsman, patient advocates, law enforcement officials, and other officials to access LTC facilities or residents in accordance with state or federal law.

12) Requires every residential facility to abide by the provisions of the Resident Access Protection Act.

13) Requires every RCFE to abide by the provisions of the Resident Access Protection Act.

EXISTING LAW:

1) Provides for the licensure of health facilities, including LTC facilities, skilled nursing facilities (SNFs), intermediate care facilities (ICF), and congregate living health facilities, by the Department of Public Health (DPH). [Health and Safety Code (HSC) §1250, *et seq.*]

2) Defines a "SNF" as a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. [HSC §1250(c)]

3) Establishes a civil penalty structure for LTC facilities, including SNFs and ICFs, categorized into "AA," "A," and "B" violations:
   a) "A" violations are those which DPH determines the violation presents either imminent danger of death or serious harm, or a substantial probability that death or serious harm to residents would result;

b) "AA" violations (the most severe) are those that meet the criteria for a class "A" violation that DPH determines was a substantial factor (as defined) in the death of a resident of an LTC facility; and;
c) "B" violations are those that DPH determines have a direct or immediate relationship to the health, safety, or security of LTC facility residents. [HSC §1424]

4) Provides for the licensure of community care facilities by the Department of Social Services (DSS), which includes residential facilities and adult day programs, among other categories. "Residential facility" is defined as any family home, group care facility, or similar facility determined by DSS, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual. Defines, in regulations, "adult residential facility" to mean any facility of any capacity that provides 24-hour-a-day nonmedical care and supervision to persons 18 years of age through 59 years of age. [HSC §1500 et seq., §1502, 22 California Code of Regulations §80001(a)(5)]

5) Licenses and regulates RCFEs as a separate category within the licensing structure of DSS, as a housing arrangement chosen voluntarily by persons 60 years of age or over, where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided for persons. [HSC §1569 et seq.]

6) Establishes the Office of the Long-Term Care Ombudsman Program (LTC Ombudsman) within the California Department of Aging, pursuant to a grant from the federal government under the Older Americans Act, as specified, to hear, investigate, and resolve complaints made by or on behalf of patients or residents of long-term care facilities relating to matters that may affect the health, safety, welfare, and rights of these patients or residents. [Welfare and Institutions Code (WIC) §9700, *et seq*.]

7) Permits representatives of the LTC Ombudsman to have the right to enter LTC facilities and have unescorted, unhindered movement within them for the purposes of identifying, hearing, investigating, and resolving complaints, observing and monitoring conditions of residents and facilities, speaking confidentially with residents, and providing services to assist residents in protecting their health, safety, welfare, and rights. Requires entry to be provided at any time deemed necessary and reasonable by the LTC ombudsman. [WIC §9722]

8) Establishes the California Emergency Services Act, which provides the Governor with the authority to proclaim a state of emergency, and provides the Governor, during a state of emergency, with complete authority over all agencies of the state government and the right to exercise within the area all police power vested in the state by the Constitution and laws of California, and in exercising these powers, gives the Governor the authority to promulgate, issue, and enforce such orders and regulations as he deems necessary. Permits the Governor to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, where the Governor determines that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency. [Government Code (GOV) §8625, §8627, and §8571]

9) Defines three conditions of emergency for purposes of the Emergency Services Act, including a "state of war emergency," "local emergency" that is within the territorial limits of

a city or county, and a "state of emergency" which could be caused by air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, plant or animal infestation or disease, or an earthquake or other conditions, which are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county or city and require the combined forces of a mutual aid region or regions to combat. [GOV §8558]

10) Gives the State Public Health Officer (PHO), as the director of DPH, broad authority to detect, monitor, and prevent the spread of communicable disease in the state, including to adopt and enforce regulations requiring strict or modified isolation, or quarantine, for any of the contagious, infectious, or communicable diseases, if in the opinion of DPH, the action is necessary for the protection of the public health. [HSC §120130, *et seq.*]

11) Permits the PHO or a local health officer (LHO), appointed by a county, to declare a health emergency or a local health emergency, respectively, whenever there is a hazardous waste spill or whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent. Permits the PHO or the LHO to take specified actions during a health emergency or a local health emergency. [HSC §101080]

12) Requires LHOs knowing or having reason to believe that any case of reportable diseases, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, to take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases. [HSC §120175

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, COVID-19 cost the lives of millions of Americans and irrevocably disrupted the lives of millions more. One subset of Californians impacted were residents of LTC Facilities whose loved ones were prohibited by state and local authorities from visiting them. To understand the full extent of the impact, the Legislature commissioned a work study group composed of state agencies and stakeholders representing public health officials, long-term care facility operators and residents, and consumer advocates to create recommendations for the legislature to incorporate that threads the needle allowing visitation in Long-Term Care Facilities while maintaining public health. The work group concluded that this separation had a huge impact on resident's well-being, and they gave a set of recommendations that balanced public health safety concerns and the need to ensure visitation rights for residents. The author concludes that this bill recognizes the importance loved ones play in the mental and physical health of Long-Term Care residents by codifying these recommendations

2) **BACKGROUND.**

   a) **Limitation on visitation.** At the beginning of the COVID-19 pandemic, after an outbreak at a nursing home in Washington that was followed by outbreaks in nursing homes elsewhere, the Centers for Medicare and Medicaid Services (CMS) issued guidance in March of 2020 that restricted all visitors to nursing homes, without an exception for LTC

ombudsmen. Over the course of this pandemic, the guidance from CMS, as well as guidance from DPH and DSS, evolved in response to changing conditions. By June, DPH sent out an All Facilities Letter (AFL) permitting facilities not experiencing an outbreak to permit LTC ombudsman in the facility. On August 25, DPH sent out an AFL updating the guidance to require facilities to permit LTC ombudsmen to enter regardless of whether or not there is a COVID-19 outbreak, after being screening for fever and COVID-19 symptoms and wearing appropriate PPE. Vaccination clinics began for LTC residents in December 2020, followed by a sharp decline in COVID-19 cases and deaths. CMS lifted restrictions on visitors to nursing homes on March 10, 2021, allowing for responsible indoor visitation at all times and for all residents, with certain exceptions for facilities in counties with high positivity rates and low vaccination rates. Under current DPH guidance, visitors to SNFs are required to show proof of vaccination or a negative test for indoor visitation, but notes that LTC ombudsmen are not visitors and are not subject to vaccination or testing requirements when they are on site conducting state business. DSS also requires proof of vaccination or negative test result for indoor visitation to RCFEs, and similarly exempts LTC ombudsman representatives from those requirements.

b) Concerns over restrictions on visitations. In September 2020, CMS convened the Coronavirus Commission on Safety and Quality in Nursing Homes (Commission), which released a report addressing safety and quality in nursing homes in relation to the PHE. The Commission found that while restrictions on visitation protected the physical health of residents, these restrictions created substantial harm, including loneliness, anxiety, and depression among residents, and distress for families who were unable to assess the well-being and safety of loved ones. The Commission concluded that visitation is a vital resident right and recommended updated in-person guidance to enable safe visitation.

c) LTC Working Group. AB 178 (Ting), Chapter 45, Statutes of 2022, was a Budget bill that, among other provisions, commissioned a workgroup to "develop recommendations regarding best policies and practices for LTC facilities during public health emergencies, including, but not limited to, visitation policies. During their discussions, workgroup members weighed the following concepts:

- **i)** Balance, referring to the relationship between the need for public health protection and the physical health, mental health, and advocacy needs of residents, their families, their friends, and others during emergencies, including their individual rights and autonomy;
- **ii)** Parity, referring to similarities or differences in visitation requirements that a facility requires for visitors, outside professional staff, and facility staff;
- **iii)** Regionalism, referring to differences among regions of California; and,
- **iv)** Equity, referring to the imperative to ensure equity in visitation access, with consideration for ageism, ableism, and barriers for historically marginalized communities.

The working group made several recommendations, including that in a state of emergency in which a local or state order curtails visitation due to a legitimate public health or safety risk, that a "Resident-Designated Support Person" (RDSP) be able to conduct in-person visits with LTC-facility residents subject to the same safety protocols as LTC facility staff. Many of the recommendations of the LTC Workgroup are included in this bill.

3) **SUPPORT.** California Advocates for Nursing Home Reform (CANHR) are the sponsors of this bill and state that it is nearly impossible to understate the importance of visitation in LTC facilities. These facilities are home to over 250,000 Californians, who enjoy the company of family, friends, and other visitors just as anyone else does. The ability to host visitors and share personal moments with loved ones is a key to making long term care facilities more homelike. Aside from the obvious psychological benefits that visitation and in-person companionship provide, visitation is often vital to the well-being of residents. CANHR also notes that visitors provide direct care that is not only supplemental to that provided by the facility staff, but essential to residents' health and safety. Visitors provide food and feeding assistance; help with grooming, toileting, and exercise; turning and repositioning for skin integrity; and myriad other care services. In addition, visitors' observations, supervision, and advocacy ensure residents are getting their basic care delivered as needed. CANHR concludes that when these caregivers were barred from facilities, the subsequent loss was devastating, making 2020-2022 the worst years in the history of long term care.

4) **OPPOSE UNLESS AMENDED.** The Health Officers Association of California, and the County Health Executives Association of California are oppose unless amended to this bill and request the removal of provocative declarative language, the section prohibiting quarantine, and language limiting health officer authority to protect Californians in times of serious threat. They also request the addition of language to ensure onsite access to a visitor is done in a manner consistent with state and local public health guidance. LHOs recognize the importance of designated support persons to the health and well-being of long-term care facility residents. In addition to protecting communities from infectious diseases, public health also strives to create an environment in which everyone has access to health and wellbeing, including mental and physical wellness. Health officer orders at both the state and local level are not issued lightly and aim to use the least restrictive means of preventing disease. The COVID-19 pandemic was unprecedented and public health officials worked tirelessly to protect communities from the spread of disease, often while facing harsh criticism and even harassment. Supplies were limited, health care resources were strained, and the number of cases and deaths were increasing at rapid rates. Any actions taken to limit visitation in long-term care facilities were not intended to be punitive, but instead issued out of care and concern for the health and well-being of vulnerable residents.

5) **RELATED LEGISLATION.** AB 2549 (Gallagher) Establishes the Patients' Visitation Rights Act, which requires DPH, not later than January 1, 2026, to provide specific clinical guidance related to safe visitation during a pandemic event for hospitals, as defined. AB 2549 is pending in the Assembly Appropriations Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 1855 (Nazarian), Chapter 583, Statutes of 2022, prohibits a SNF or RCFE, under any circumstances and notwithstanding any other law, from denying entry to a long term care ombudsman, unless the Governor has declared a state of emergency related to an infectious disease and the ombudsman is positive for, or showing symptoms of, the disease that is the reason for the state of emergency.

   b) AB 2546 (Nazarian) would have enacted the Resident-Designated Support Persons Act, granting residents of LTC facilities the right to in-person, onsite access to a minimum of two designated support person during any PHE, as defined, in which the residents'

visitation rights are curtailed by a state or local order. AB 2546 was subsequently amended to address a different subject matter.

7) **DOUBLE REFERRAL.** This bill is double-referred, it passed the Assembly Committee on Aging and Long-Term Care with a vote of 5 to 0 on April 16, 2024.

8) **SUGGESTED AMENDMENTS:** As currently drafted, this bill supersedes a state or local government order during a declared state of emergency, local emergency, health emergency, or local health emergency **to limit** the number of visitors or health care and social services providers who may simultaneously visit a resident. This could be interpreted to allow visitors to enter a LTC facility that is being evacuated. The Committee may wish to amend this bill to clarify that this bill shall not be interpreted to allow visitors to enter a long-term health facility during an evacuation, or in the event there are first responders on-site who refuse entry to the facility.

REGISTERED SUPPORT / OPPOSITION:

Support

AARP
Alzheimer's Association State Policy Office
Association of Regional Center Agencies
CA Virtual Resident Council
California Advocates for Nursing Home Reform
California Assisted Living Association
California Association of Long Term Care Medicine
California Coalition on Family Caregiving
California Continuing Care Residents Association (CALCRA)
California Long Term Care Ombudsman Association (CLTCOA)
California Office of The State Long-Term Care Ombudsman
California Retired Teachers Association
Consumer Attorneys of California
Essential Caregivers Coalition
Gray Panthers
Gray Panthers of San Francisco
Inland Coalition on Aging
Inland Empire/Riverside County CNAS
Justice in Aging
Office of The State Long-Term Care Ombudsman
Retired Public Employees Association
Wise and Healthy Aging

Opposition

None on file

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

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2101 (Rodriguez) – As Amended April 15, 2024

SUBJECT: Statewide strategic stockpile.

SUMMARY: Requires the State Department of Public Health (DPH), in coordination with the Office of Emergency Services (Cal OES), medical health operational area coordinators (MHOACs), regional disaster and medical health coordinators and specialists, and other state agencies, to establish a statewide strategic stockpile. Specifically, this bill:

1) Requires DPH, in coordination with Cal OES to establish guidelines for procurement, management, and distribution of medicine, vaccines, and dental and medical supply items in the stockpile from DPH.

2) Authorizes DPH to contract with private entities for the procurement of supplies for, and management and distribution of, the stockpile. Authorizes DPH to contract for the reservation of supplies stored by a private entity for the stockpile, and the distribution of those supplies, consistent with this bill and policies established by the DPH.

3) Requires the guidelines to take into account all of the following:

    a) The various types of items that may be required during a pandemic or other health emergency, including, but not limited to, natural disasters, man-made disasters, and mass casualty events;
    b) The shelf life of each item that may be obtained from DPH and how to restock a portion of each item to ensure the procurements are unexpired;
    c) The amount of each type of item required for a sustained health emergency;
    d) Lessons learned from previous pandemics and state emergencies, including, but not limited to, supply procurement, management, provider eligibility, distribution, and restock;
    e) Geographical distribution of stockpile storage or the location of any contracted entity's storage facilities responsible for management and distribution of items determined to be necessary for the stockpile;
    f) Guidance on the timely restocking of items distributed from the stockpile;
    g) Guidance on how to establish policies and standards for stockpile surge capacity to ensure that hospitals and emergency providers have access to an adequate supply of any relevant item during a pandemic or other health emergency; and,
    h) The policies and funding that would be required for the state to establish the stockpile.
        i) Requires the guidelines established in this bill to include guidance on distribution from any procurement is to be prioritized in the event that there is insufficient resources to meet the needs of providers or employers of providers, including consideration of all of the following:
        The provider or employer is in a location with a high share of low-income residents;
        ii) The provider or employer is in a medically underserved area, as designated by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA);

iii) The provider or employer disproportionately serves a medically underserved population, as designated by HRSA;
iv) The provider or employer is in a county with a high infection rate or high hospitalization rate related to the declared emergency;
v) Requires DPH to annually report to the Legislature, the Assembly Committee on Emergency Management and the Senate Committee on Governmental Organization the amount of items in the stockpile, the amount of items from the stockpile that have been used, the amount of anticipated future usage, the status of existing contracts with private entities that fulfill the procurement guidelines, the types and amount of items reserved through private entities, and plans to access items reserved by private entities for an emergency; and,
vi) Requires the report to be submitted in compliance with existing law.

EXISTING LAW:

1) Requires DPH and Cal OES to procure, maintain, and deploy a personal protective equipment (PPE) specific stockpile for use during an emergency, upon appropriation. [Health and Safety Code (HSC) § 131021]

2) Requires the establishment of guidelines for the PPE stockpile, as specified, upon appropriation. [HSC § 131021]

3) Establishes a Personal Protective Equipment Advisory Committee for the PPE stockpile, as specified, upon appropriation. [HSC § 131021]

4) Requires DPH to develop a plan with recommendations and guidelines for counties to use in the case of a significant air quality event, such as a wildfire, which must include policies on whether counties should have stockpiles of respiratory protection and other protective equipment and devices available for distribution. [HSC § 107250]

5) Requires the Department of Industrial Relations and DPH to adopt regulations setting requirements for determining 45-day surge capacity levels for health care employer inventories [Labor Code (LAB) § 6403.1]

6) Requires employers with workers in the public or private sector that provide direct patient care in a general acute care hospital to supply PPE and maintain a stockpile, as specified, comprised of three months' worth of their normal consumption of PPE. [LAB § 6403.3]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California is a disaster prone state, and as we continue to face these emergencies, ensuring we have the necessary supplies to support our residents is imperative. The author contends by codifying the state strategic stockpile and enabling DPH to develop clear guidelines for procuring, managing, and distributing these essential supplies, we demonstrate our clear commitment to preparation. Stockpiles are like emergency toolkits, giving us what we need right away when trouble hits. The author continues with COVID-19, catastrophic wildfires, and other emergencies reminding us why readiness matters, this stockpile isn't just a good idea; it's essential for

keeping everyone in California safe. The author states that as the Legislature considers potentially defunding the state's early pandemic detection efforts, having a robust stockpile is even more critical for ensuring our readiness to tackle crises head-on.

2) BACKGROUND.

a) Strategic National Stockpile. The Strategic National Stockpile (SNS) is part of the federal medical response infrastructure and can supplement medical countermeasures needed by states, tribal nations, and territories during public health emergencies. The supplies, medicines, and devices for lifesaving care contained in the stockpile can be used as a short-term, stopgap buffer when the immediate supply of these materials may not be available or sufficient. The SNS is separate from California's stockpile. Items may be requested from the SNS by the Governor or their designee.

b) The State Stockpile. DPH refers to the items stockpiled as their inventory, which is maintained by DPH and Cal OES. According to DPH, the state inventory "includes various types of PPE such as face masks, N-95 respirators, gowns, and gloves as well as COVID-19 testing supplies and a small quantity of COVID-19 pharmaceuticals." Depending on decisions made by the Governor (noted in the court rulings section), Misoprostol may be stockpiled once again. Due to the lack of appropriation for SB 275 (discussed in the history section), DPH points to the interactions through resource requests from the COVID-19 pandemic as what directed policy decisions. This includes interactions with MHOACs, Regional Disaster Medical Health Coordinators and Specialists (RDMHSs), and other non-public health and medical sectors which required PPE. They also based guidelines on priorities from the SNS. Cal OES oversees the Logistics and Commodity Taskforce, which is comprised of DPH, the Department of General Services, and CalOES. In lieu of the unfunded Personal Protective Equipment Advisory Committee, this taskforce makes recommendations and provides operational support for acquiring and disbursing the stockpiled items.

Cal OES and DPH are jointly responsible for adding, dispersing, and rotating items through their own warehouses. Historically, DPH is responsible for distributing to public health entities while Cal OES distributes items to all other relevant organizations. Cal OES houses the majority of the PPE while DPH largely manages testing supplies, pharmaceuticals, and over the counter products. Requests are made through MHOAC, RDMHS and forwarded to DPH's Medical Health Coordination Center, who tasks the appropriate office for fulfilment. There is also communication with the Administration for Strategic Preparedness and Response and SNS staff at the federal level regarding the contents. According to DPH, "Public Health leadership may request medical countermeasures, to include PPE from the SNS, however these resources are prioritized nationwide and may not sufficiently offset state needs."

When asked to provide a recommendation for what types, and the amount, of items are needed for the stockpile, DPH responded with their March 3, 2020 to April 3, 2020 emergency outbreak situation response data. During this period early in the pandemic, the following resources were distributed from the state stockpile:

i) 24,700,020 N95 respirators;
ii) 2,713,500 procedure masks;
iii) 1,996,500 gloves;

iv) 398,492 surgical/isolation gowns;
v) 408,192 face shields;
vi) 116,400 goggles; and,
vii) 637,068 bottles of hand sanitizer.

c) Stockpiling in Response to Court Rulings. The state's stockpile not only supplements the SNS but also reflects California's priorities. In 2023, California secured an emergency stockpile of 250,000 pills of Misoprostol, a commonly used abortion pill, in response to an extremist Texas Court ruling which aimed to block access nationwide. California also negotiated an option to purchase up to an additional 1.75 million pills for the same base price of roughly 43 cents per pill. All of the purchased pills were distributed as of March, 2024. With the Supreme Court placing a hold on the Texas Court ruling while they heard arguments and draft their decision, the pressure to make a decision on stockpiling the drug further was relieved. However, the Supreme Court decision is expected in June so California will need to decide whether to resupply this stockpile.

d) PPE issues. As of late 2023, the Associated Press reports at least 15 states (not including California) were forced to dispose of significant amounts of PPE because they failed to properly manage their stockpiles after the height of the pandemic. For example, Ohio trashed nearly $29 million worth of expired gowns, masks, gloves, and other materials; Rhode Island shredded 829 tons of PPE for recycling; Wisconsin trashed 1.7 million masks and 1 million gowns, and Maryland trashed $93 million worth of PPE. Even states that made an extensive effort to distribute their expiring PPE, such as Washington, Nevada, and Pennsylvania, were unable to find enough beneficiaries prior to the expiration dates and sent the PPE to landfills.

While California is not listed in this report, the issues these states have with expired PPE is similar to what our state experienced at the beginning of the pandemic with 21 million, expired N95 masks stockpiled.

3) SUPPORT. The California Nurses Association (CNA) states in support of this bill that California's medical supply stockpile is critical to ensure the health of it's population, as well as ensuring that the states values are protected. CNA notes for example that maintaining adequate medical stockpiles will guarantee that nurses and all health care workers have the proper PPE should the country experience another pandemic, natural or human-caused disaster. CNA further states that as other states ban reproductive rights, California maintains common medications that protect a woman's right to make decisions over her own body. As a statewide strategic stockpile is critical, management of these supplies is equally important to ensure that equipment is ready for use in emergencies. CNA further notes that when the Covid-19 pandemic spread throughout California, the state found the majority of it's stockpile of PPE to be expired, California scrambled to replace critical equipment that were now in high demand with low inventory available forcing the state to pay premium prices for ventilator masks, gowns and other medical supplies. CNA cites a 2020 study by the Berkeley Labor Center which found California can save millions in maintained statewide stockpile. CNA concludes that as California faces budget deficits, it would be sound economic investment to maintain a statewide strategic stockpile in the event of a major disaster to avoid a situation of low availability of medical supplies.

4) PREVIOUS LEGISLATION.

a) AB 228 (Wilson) of 2023 would have required DPH and Cal OES to establish an infant formula stockpile, upon appropriation. AB 228 was held in the Assembly Committee on Appropriations.

b) AB 2537 (Rodriguez), Chapter 313, Statutes of 2020, requires employers, as defined, to maintain a stockpile of specified PPE for specified workers in an amount equal to three months of normal consumption.

c) SB 275 (Pan), Chapter 301, Statutes of 2020, requires DPH and Cal OES to procure, maintain, and deploy a PPE stockpile for use during an emergency.

5) DOUBLE REFERRAL. This bill is double referred; it passed the Assembly Committee on Emergency Management with a vote of 7-0 on April 8, 2024.

6) SUGGESTED AMENDMENTS. The author may wish to consider amending this bill to clarify that if DPH authorizes a contracted private entity to distribute items from the stockpile, DPH is to specify the distribution of the supplies and not the private entity.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Medical Product Suppliers
California Nurses Association
California Teachers Association
Healthcare Distribution Alliance (HDA)

Opposition

None on file.

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

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2115 (Haney) – As Amended April 1, 2024

SUBJECT: Controlled substances: clinics.

SUMMARY: Authorizes nonprofit or free clinics to dispense methadone to relieve acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Eases restrictions on participation in narcotic treatment programs. Specifically, **this bill**:

1) Authorizes a nonprofit or free clinic to dispense a Schedule II controlled substance if the substance being dispensed is a narcotic drug for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment consistent with federal regulations.

2) Subjects a nonprofit or free clinic dispensing a Schedule II controlled substance to the specified labeling, recordkeeping, and packaging requirements.

3) Permits any health care provider to conduct a medical evaluation of a patient prior to admittance to a detoxification or maintenance treatment program, if it is verified by a narcotic treatment program practitioner as true and accurate and it is transmitted in accordance with all applicable privacy laws.

4) Permits a narcotic treatment program to authorize a patient to decline laboratory testing for disease or to authorize a patient to complete that testing within two weeks of the date of admittance to the program.

5) Prohibits a narcotic treatment program from denying a patient maintenance treatment due to the length of time a person has been addicted to opiates.

6) Specifies that a patient receiving maintenance treatment is not precluded from receiving medication for opiate use disorder by refusing to participate in counseling services.

7) Requires a narcotic treatment program practitioner to update a patient's treatment plan annually.

8) Prohibits the initial dose of methadone provided to a patient in a narcotic treatment program from exceeding 50 milligrams unless the practitioner finds sufficient medical rationale that a higher dose is clinically indicated. Requires the practitioner to document that rationale in the patient's records.

9) Requires a decision to dispense take-home doses of narcotic replacement therapy medications to be determined by a medical practitioner. Requires the medical practitioner to consider, among other pertinent factors, all of the following criteria:

a) The absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

b) The regularity of attendance for supervised medication administration;

c) The absence of serious behavioral problems that endanger the patient, the public, or others;

d) The absence of known recent diversion activity;

e) Whether take-home medication can be safely transported and stored; and,

f) Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

10) Prohibits a decision to dispense take-home medication to be contingent on the length of time a patient has participated in treatment. Enables a patient eligible for take-home medication to receive up to a seven-day take-home supply of medication. Permits, after 15 days of treatment, a patient to receive up to a two-week take-home supply of medication, and after 31 days in treatment a 28-day take-home supply of medication.

11) Specifies that a medical practitioner is not required to restrict a patient's take-home medication privileges if that patient's monthly bodily specimen has tested positive for illicit drugs in two consecutive months.

12) Specifies that in restoring a patient's take-home medication privileges, a practitioner is not required to impose any requirement that the patient's monthly bodily specimen test negative for illicit drugs for any specified period of time.

13) Permits a patient to be absent from a maintenance treatment program for up to 30 days, without contacting the program.

14) Requires the Department of Health Care Services (DHCS) to review existing regulations promulgated pursuant to this bill and remove outdated, stigmatizing language and obsolete references.

EXISTING LAW:

1) Defines "dispense" as the furnishing of drugs or devices upon a prescription from a physician, nurse practitioner, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor acting within the scope of their practice. [Business and Professions Code (BPC) §4024]

2) Defines "controlled substance" as any substance included in the exhaustive "Standards and Schedules" list of the Health and Safety Code. [BPC §4021]

3) Classifies methadone as a Schedule II controlled substance. [Health and Safety Code (HSC) §11055(c)(14)-(15)]

4) Authorizes methadone and other specified medications to be used for narcotic replacement therapy and medication-assisted treatment by licensed narcotic treatment programs. [HSC §11839.2]

5) Requires DHCS to license narcotic treatment programs to use narcotic replacement therapy in the treatment of addicted persons whose addiction was acquired or supported by the use of a narcotic drug or drugs, not in compliance with a physician and surgeon's legal prescription. [HSC §11839.3]

6) Defines "community clinic" as a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. Requires in a community clinic, any charges to the patient to be based on the patient's ability to pay, utilizing a sliding fee scale. [HSC §1204(a)(1)(A)]

7) Defines "free clinic" to mean a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. Prohibits a free clinic from charging directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. [HSC §1204(a)(1)(B)]

8) Authorizes the following clinics to purchase drugs at wholesale for administration or dispensing, under the direction of a physician and surgeon, to patients registered for care at the clinic: a licensed nonprofit community clinic or free clinic; a primary care clinic owned or operated by a county; a clinic operated by a federally recognized Indian tribe or tribal organization; a clinic operated by a primary care community or free clinic that is operated on separate premises from a licensed clinic; a student health center operated by a public institution of higher education; and a nonprofit multispecialty clinic. [BPC §4180(a)(1)]

9) Requires each clinic to keep records of the kind and amounts of drugs purchased, administered, and dispensed. Requires records to be available and maintained for a minimum of three years for inspection by all specified personnel. [BPC §4180(a)(2)]

10) Requires each clinic location to be licensed and requires clinics to notify the Board Of Pharmacy of address changes. [BPC §4180(b)]

11) As a condition of licensure, requires each clinic to comply with all applicable laws and regulations of the California Department of Public Health (DPH) relating to the drug distribution service to ensure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation occur in a manner that is consistent with the promotion and protection of the health and safety of the public. [BPC §4181(a)]

12) Specifies that the dispensing of drugs in a clinic can only be done by a physician, pharmacist, or other person lawfully authorized to dispense drugs, and only in compliance with all applicable laws and regulations. [BPC § 4181(b)]

13) Requires clinics to retain a consulting pharmacist to approve policies and procedures and to certify in writing quarterly that the clinic is, or is not, operating in compliance with the requirements of the Pharmacy Law. [BPC §4192]

14) Prohibits a Schedule II controlled substance from being dispensed by a clinic, although a physician may dispense a schedule II drug to the extent permitted by law. [BPC §4184]

EXISTING STATE REGULATIONS:

1) Requires the medical director of a narcotic treatment program to conduct a medical evaluation, as specified, or document their review and concurrence of a medical evaluation conducted by the physician extender before admitting an applicant to detoxification or maintenance treatment. [California Code of Regulations (CCR) §10270(a)]

2) Requires applicants to have a confirmed documented history of at least one year of addiction to opioids to be accepted as patients for maintenance treatment. [CCR §10270(d)(1)]

3) Requires the primary counselor at a narcotic treatment program to, upon completion of the initial treatment plan, arrange for the patient to receive a minimum of 50 minutes of counseling services per calendar month. [CCR §10345(a)]

4) Authorizes the medical director to adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month, and requires documentation of rationale for the medical order to adjust or waive counseling services in the patient's treatment plan. [CCR §10345(e)]

5) Requires the primary counselor at a narcotic treatment program to evaluate and update the patient's maintenance treatment plan whenever necessary or at least once every three months from the date of admission. [CCR §10305(f)]

6) Specifies that a patient’s first-day dose of methadone cannot exceed 30 milligrams unless the dose is divided and the initial portion of the dose is 30 milligrams or less and the subsequent portion is administered to the patient separately after a period of observation as prescribed by the medical director or program physician. [CCR §10355(d)(1)]

7) Specifies that the total dose of methadone for the first day cannot exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the patient's opioid abstinence symptoms, and documents in the patient's record the basis for their determination. [CCR §10355(d)(2)]

8) Specifies that methadone may only be provided to a patient as take-home medication if the medical director or program physician has determined, in their clinical judgment, that the patient is responsible in handling narcotic medications, is adhering to program requirements, and has documented their rationale in the patient's record. Requires rationale to be based on consideration of the following criteria:

    a) Absence of use of illicit drugs and abuse of other substances, including alcohol;

    b) Regularity of program attendance for replacement narcotic therapy and counseling services;

    c) Absence of serious behavioral problems while at the program;

    d) Absence of known criminal activity, including the selling or distributing of illicit drugs;

e) Stability of the patient's home environment and social relationships;

f) Length of time in maintenance treatment;

g) Assurance that take-home medication can be safely stored within the patient's home; and,

h) Whether the rehabilitative benefit to the patient derived from decreasing the frequency of program attendance outweighs the potential risks of diversion. [CCR §10370(a)]

9) Requires narcotic treatment programs to adhere to the following methadone take-home medication schedules:

a) Step I Level - Day 1 through 90 of continuous maintenance treatment, the medical director or program physician may grant the patient a single dose of take-home supply of medication per week. The patient must attend the program at least six times per week for observed ingestion.

b) Step II Level - Day 91 through 180 of continuous maintenance treatment, the medical director or program physician may grant the patient not more than a two-day take-home supply of medication per week. The patient must attend the program at least five times per week for observed ingestion.

c) Step III Level - Day 181 through 270 of continuous maintenance treatment, the medical director or program physician may grant the patient not more than a three-day take-home supply of medication per week. The patient must attend the program at least four times per week for observed ingestion.

d) Step IV Level - Day 271 through one year of continuous treatment, the medical director or program physician may grant the patient not more than a six-day take-home supply of medication per week. The patient must attend the program at least one time per week for observed ingestion.

e) Step V Level - After one year of continuous treatment, the medical director or program physician may grant the patient not more than a two-week supply of medication. The patient must attend the program at least two times per month for observed ingestion.

f) Step VI Level - After two years of continuous treatment, the medical director or program physician may grant the patient not more than a one-month take-home supply of medication. The patient must attend the program at least one time per month for observed ingestion. [CCR §10375(a)]

10) Requires the medical director or program physician to restrict a patient’s take-home medication privileges by moving the patient back at least one step level on the take-home medication schedule for any of the following reasons:

a) Patients on step level schedules I through V who have submitted at least two consecutive monthly body specimens which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results;

b) Patients on step level schedule VI who have submitted at least two monthly body specimens within the last four consecutive months which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results;

c) Patients, after receiving a supply of take-home medication, are inexcusably absent from or miss a scheduled appointment with the program without authorization from the program staff; or,

d) The patient is no longer a suitable candidate for take-home medication privileges as presently scheduled, based on consideration of specified criteria. [CCR §10390(a)(1)]

11) Specifies that if a patient in maintenance treatment misses appointments for two weeks or more without notifying the program, the patient's treatment must be terminated by the medical director or program physician and the discharge must be noted in the patient's record. Requires if the discharged patient returns for care and is accepted into the program, the patient to be readmitted as a new patient and documentation for the new readmission to be noted in the patient's record. [CCR §10300(b)]

EXISTING FEDERAL REGULATIONS:

1) Authorizes a practitioner who is registered with the federal Drug Enforcement Administration (DEA) as a narcotic treatment program and is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of narcotic drugs to administer and dispense (but not prescribe) a narcotic drug listed in any schedule to a narcotic dependent person for the purpose of maintenance or detoxification treatment. [Code of Federal Regulations (CFR) §1306.07(a)]

2) Authorizes a practitioner who is not registered with the DEA to conduct a narcotic treatment program to dispense (but not prescribe) narcotic drugs, in accordance with applicable Federal, State, and local laws related to controlled substances, to a person or for one person’s use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both). [CFR §1306.07(b)]

3) Prohibits more than a three-day supply of narcotic drug medication from being dispensed while arrangements are being made for referral for treatment, and prohibits such emergency treatment from being renewed or extended. [CFR §1306.07(b)]

4) Authorizes a practitioner to administer or dispense (including prescribe) any Schedule III, IV, or V narcotic drug approved by the Food and Drug Administration (FDA) specifically for use in maintenance or detoxification treatment to a narcotic dependent person if the practitioner complies with specified requirements. [CFR §1306.07(d)]

5) Requires opioid treatment programs (OTP) to maintain current procedures designed to ensure that patients are admitted to treatment by qualified personnel who have determined, using accepted medical criteria, that the person meets diagnostic criteria for a moderate to severe opioid use disorder (OUD); the individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose. [CFR §8.12(e)(1)]

6) Requires an OTP to require each patient to undergo an initial medical exam comprised of a screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with medications for OUD (MOUD) and a full history and examination, to determine the patient's broader health status, with lab testing as determined to be required by an appropriately licensed practitioner. Specifies that a patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications. [CFR §8.12(f)(2)(i)]

7) Requires the screening examination and full examination to be completed by an appropriately licensed practitioner. Requires if the practitioner is not an OTP practitioner, the screening examination to be completed no more than seven days prior to OTP admission. Requires where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, to be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner. [CFR §8.12(f)(2)(ii)]

8) Specifies that a full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP. Authorizes the full exam to be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws. [CFR §8.12(f)(2)(iii)]

9) Requires a patient’s care plan to be reviewed and updated to reflect responses to treatment and recovery support services, and adjustments made that reflect changes in the context of the person's life, their current needs for and interests in medical, psychiatric, social, and psychological services, and current needs for and interests in education, vocational training, and employment services. [CFR §8.12(f)(4)(i)]

10) Specifies that patients refusal of counseling cannot not preclude them from receiving MOUD. [CFR §8.12(f)(5)(i)]

11) Requires the initial dose of methadone for each new patient enrolled in an OTP to be individually determined and requires the following to be considered: the type(s) of opioid(s) involved in the patient's OUD, other medications or substances being taken, medical history, and severity of opioid withdrawal. Prohibits the total dose for the first day from exceeding 50 milligrams unless the OTP practitioner finds sufficient medical rationale, including but not limited to if the patient is transferring from another OTP on a higher dose that has been verified, and documents in the patient's record that a higher dose was clinically indicated. [CFR §8.12(h)(3)(ii)]

12) Specifies that OTP decisions on dispensing MOUD to patients for unsupervised use must be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which patients may receive unsupervised medication doses, the medical director or program medical practitioner must consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

a) Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

b) Regularity of attendance for supervised medication administration;

c) Absence of serious behavioral problems that endanger the patient, the public or others;

d) Absence of known recent diversion activity;

e) Whether take-home medication can be safely transported and stored; and,

f) Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health. [CFR §8.12(i)(2)]

13) Authorizes during the first 14 days of treatment, the take-home supply of methadone to be limited to seven days. From 15 days of treatment, the take-home supply is limited to 14 days. From 31 days of treatment, the take-home supply provided to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up and the rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record. [CFR §8.12(i)(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, we need to dismantle barriers to methadone access, such as the regulatory restrictions, negative stigma, and a lack of understanding by the public. The author continues that untreated drug addiction has been a devastating and deadly epidemic and ensuring that individuals suffering from opioid addiction have easy access to methadone treatment is essential in reducing the rates of overdose deaths. The author argues that by fostering a more supportive environment, we can encourage those struggling with addiction to seek help without fear of judgment. The author concludes that this bill will transform California from a state with the most restrictive methadone laws into a state that leads in accessibility for methadone treatment by providing the most meaningful update of California's methadone laws in over a decade, and bring us in line with federal methadone standards.

2) **BACKGROUND.** California is facing an overdose epidemic. According to a California Health Care Foundation report, 9% of Californians have met the criteria for a substance use disorder (SUD) within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a ten-fold increase in fentanyl related deaths between 2015 and 2019. DPH's Opioid Overdose Dashboard reported 7,385 deaths related to "any" opioid overdose in 2022, with 6,473 (87.7%) of those deaths fentanyl related.

   a) **Fentanyl.** Fentanyl is a potent synthetic opioid drug approved by the FDA for use as an analgesic and anesthetic. It is approximately 50 times stronger than heroin and 100 times

stronger than morphine. First developed in 1959, it was introduced in the 1960s as an intravenous anesthetic. Fentanyl is legally manufactured and distributed in the United States; however, there are two types of fentanyl: pharmaceutical fentanyl and illicitly manufactured fentanyl. Both are considered synthetic opioids. Pharmaceutical fentanyl is prescribed by doctors to treat severe pain, especially after surgery and for advanced-stage cancer. Most recently, cases of fentanyl-related overdoses are linked to illicitly manufactured fentanyl that is distributed through illegal drug markets for its heroin-like effect. It is often added to other drugs because of its extreme potency, which makes drugs cheaper, more powerful, more addictive, and more dangerous.

b) Methadone. Methadone is an opioid medication that is used to treat OUD in conjunction with behavioral health therapies. It reduces opioid cravings and withdrawal and limits the effects of opioids. As a full opioid agonist, methadone works by activating opioid receptors in the brain, though its effects are slower and long-lasting, preventing the same euphoric effect associated with other opioids. Nonetheless, while methadone is generally safe and effective when taken as prescribed, it can be misused and overdose and death are possible. As a Schedule II drug, methadone is highly regulated. Methadone is frequently marketed under the brand names Dolophine and Methadose, among others.

c) OTP & Methadone Regulations. Federal regulations on OTPs, which include those that dispense methadone, are governed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the DEA. These regulations are designed to ensure the safe and effective provision of medication-assisted treatment (MAT) for individuals with OUD. OTPs must adhere to stringent federal requirements regarding program operations, patient care, staff qualifications, and security measures to prevent diversion and misuse of controlled substances like methadone. Recent changes in federal regulations have focused on enhancing access to MAT and reducing barriers to treatment. One significant change includes the expansion of telehealth services for OTPs, allowing patients to receive counseling and medication management remotely, particularly beneficial during the COVID-19 pandemic.

Additionally, there has been an emphasis on increasing flexibility in take-home medication doses. The federal Easy Medication Access and Treatment for Opioid Addiction Act, as incorporated into a short-term funding bill signed in 2020, directs the DEA to revise its regulations "so that practitioners . . . are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)." Accordingly, the DEA expanded and revised this regulation in August 2023 to allow non-physician practitioners to prescribe narcotic drugs under the "Three Day Rule" or the "72-Hour Rule."

The Three Day Rule for methadone dispensing by physicians regulates the frequency at which methadone can be dispensed to patients in OTPs. According to this rule, physicians are allowed to dispense up to a 72-hour supply of methadone to patients who are stable in their treatment. This means that patients who have been consistently adherent to their treatment plan and have shown progress in their recovery may receive a three-day supply of methadone at a time, rather than needing to visit the clinic daily for their dose. Certain criteria must be met for a patient to qualify for extended take-home doses, such as negative drug screens and compliance with program requirements.

The primary goal of the Three Day Rule is to increase flexibility and convenience for patients in methadone treatment programs while ensuring the safe and effective management of their addiction. Allowing for dispensing of methadone by clinics to alleviate acute withdrawal symptoms, coupled with arrangements for referral to narcotic treatment programs and the relaxation of participation restrictions, draws on the principles of harm reduction and patient-centered care. By allowing clinics to dispense methadone for symptom relief, individuals in distress can access immediate support, potentially reducing the likelihood of relapse and overdose deaths. This approach emphasizes the importance of mitigating harm associated with opioid use while respecting individual autonomy and dignity. Research published in *Lancet Public Health* supports this shift in practice. A study synthesizing the effects of COVID flexibilities on take home doses of methadone found that take home doses were associated with a lower probability of treatment discontinuation, with patients reporting feelings of pride, liberation, stability, and reduced stigma. Providers also noted greater adherence to treatment and improved autonomy and motivations to change amongst their patients.

This bill would allow patients in California to take full advantage of the Three Day Rule by authorizing nonprofit or free clinics to dispense methadone to relieve acute withdrawal symptoms while arrangements are being made for referral for treatment. The clinic would be required to comply with specified labeling recordkeeping, and packaging requirements, including the use of childproof containers. The author believes this authority will improve health outcomes for patients in need of treatment and improve the likelihood of linkage to a treatment program. These changes aim to improve treatment retention, reduce the burden on patients, and promote better outcomes in opioid addiction treatment programs, while maintaining stringent oversight to ensure the safety and effectiveness of MAT.

3) **SUPPORT.** The San Francisco Department of Public Health (SFDPH) is sponsoring this bill, stating that patients face multiple barriers to accessing methadone for the treatment of OUD, as it can only be dispensed in a limited number of situations. SFDPH continues that the DEA recently increased the situations when methadone can be provided and now allows clinics to dispense 72 hours of methadone while referring a person to an OTP. SFDPH argues that current California law does not fully align with this new DEA flexibility, but this bill will address this issue and allow clinics to dispense 72 hours of methadone while referring a person to a methadone clinic. SFDPH concludes that overall, this change would lower the barrier to patients receiving opioid withdrawal management services, improve linkage to longer term treatment at methadone clinics, and reduce ongoing opioid use and overdose risk.

4) **SUPPORT WITH AMENDMENTS.** The California Association of Alcohol and Drug Program Executives (CAADPE) supports the intent of this bill and believes it can be strengthened greatly with amendments. CAADPE argues that this bill should be amended to limit the dispensing of medication-assisted treatment to one episode per patient, with a maximum duration of three days to ensure patient and community safety, and mitigate the risks of diversion, misuse, and potential overdose. CAADPE also requests the author to establish a robust tracking or reporting process to systematically gather relevant data. CAADPE also requests the inclusion of a requirement to query the Controlled Substance Utilization Review and Evaluation System database, explicit provisions regarding storage requirements, and explicit mention of entities qualified to dispense MAT, which are already requirements under current law.

5) **RELATED LEGISLATION.** SB 1468 (Ochoa Bogh) requires each health professional licensing board that licenses a prescriber to develop informational and educational material regarding the "Three Day Rule" in order to ensure prescriber awareness of existing medication-assisted treatment pathways to serve patients with substance use disorder. SB 1468 is pending in the Senate Appropriations Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 663 (Haney), Chapter 539, Statutes of 2023, allows county-operated mobile pharmacies to carry and dispense buprenorphine and buprenorphine/naloxone combination medications for the treatment of OUD and authorizes the operation of multiple mobile units within one jurisdiction.

   b) AB 816 (Haney), Chapter 456, Statutes of 2023, authorizes a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine, as specified.

7) **DOUBLE REFERRAL.** This bill is double referred, it passed the Assembly Committee on Business and Professions with a 17-0 vote on April 16, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

San Francisco Department of Public Health (sponsor)
Supervisor Joel Engardio, San Francisco Board of Supervisors
California Society of Addiction Medicine
County of San Diego
County of Santa Clara
HealthRIGHT 360
Mothers Against Drug Addiction and Deaths
R Street Institute
San Francisco Community Clinic Consortium
San Mateo County Board of Supervisors
Smart Justice California, a Project of Tides Advocacy
Steinberg Institute

Opposition

None on file.

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

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2180 (Weber) – As Amended April 10, 2024

SUBJECT: Health care coverage: cost sharing.

SUMMARY: Requires a health plan, insurer, or pharmacy benefit manager (PBM) to apply any amounts paid by the enrollee, insured, or third party patient assistance program (PAP) towards the enrollee or insured's cost sharing requirement for those who have a chronic disease or terminal illness. Specifically, **this bill**:

1) Requires a health plan, insurer, or PBM that administers pharmacy benefits for a health plan or insurer to apply any amounts paid by either the enrollee or insured or PAP to the enrollee or insured's cost sharing requirement, to the extent permitted by federal law, and consistent with existing law relating to prescription drug discount prohibitions. Limits requirements to only those enrollees or insureds who have a chronic disease or terminal illness.

2) Requires a health plan or insurer to include expenditures for any item or service covered by the health plan or insurer, and include within a category of essential health benefits (EHBs) when calculating an enrollee or insured's overall contribution to the annual limitation on cost sharing set forth in existing federal law.

3) Specifies that if under federal law, 1) above would result in health savings account (HSA) ineligibility, this requirement to apply for HSA-qualified high deductible health plans (HDHP) with respect to the deductible of a policy after the enrollee or insured has satisfied the minimum deductible under federal law, except with respect to items or services that are preventive care, as specified.

4) Exempts provisions of this bill from self-insured employer plans governed by the Employee Retirement Income Security Act of 1974.

5) Defines the following:

    a) Cost-sharing requirement as any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including a limitation subject to federal law, required by, or on behalf of, an enrollee or insured in order to receive a specific health care service, including a prescription drug, covered by a health plan contract or insurance policy;

    b) PBM as a person or business that administers the prescription drug or device program of one or more health plans or insurers on behalf of a third party in accordance with a pharmacy benefit program. Includes any agent or representative of a PBM hired or contracted by the PBM to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a PBM;

    c) PAP to include, but is not limited to, manufacturer or charitable cost-sharing or copay assistance programs that provide financial assistance intended to assist patients in paying their out-of-pocket (OOP) cost-sharing obligations for prescription drugs. Third-party

PAP does not include discounts, product vouchers, or coupons that provide a percentage-based discount off the list price of a prescription drug;

d) Chronic disease as conditions that have a tendency to last one year or more and require ongoing medical attention or limit activities of daily living or both; and,

e) Terminal illness as a medical condition that is life-limiting and expected to result in death.

EXISTING LAW:

1) Establishes 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 EHB benchmark, the Kaiser Small Group Health Maintenance Organization, existing California mandates, and 10 Patient Protection and Affordable Care Act mandated benefits, including prescription drugs. [HSC §1367.005 and INS §10112.27]

3) Prohibits, with respect to an individual or group health plan contract or health insurance policy that covers EHBs, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days from exceeding $250; for a product with an actuarial value at or equivalent to a Bronze level, limits cost sharing to not more than $500 for a supply of up to 30 days; and for a HDHP the $250 or $500 limits apply only after an enrollee's deductible is met. [HSC §1342.73 and INS §10123.1932]

4) Requires a health plan or health insurer that reports rate information, as specified, to report information no later than October 1 of each year that demonstrates the overall impact of drug costs on health care premiums. [HSC §1356.243 and INS §10123.205]

5) Requires health plans and insurers, for all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, to report:
   a) The 25 most frequently prescribed drugs;
   b) The 25 most costly drugs by total annual plan spending; and,
   c) The 25 drugs with the highest year-over-year increase in total annual plan spending. [HSC §1356.243 and INS §10123.205]

5) Requires DMHC and CDI to compile the information from 5) above into a report for the public and Legislators where the data is aggregated and does not reveal information specific to individual plans. Requires the report to be published on DMHC's and CDI's website. [HSC §1356.243 and INS §10123.205]

6) Defines a PBM as a person, business, or other entity that, pursuant to a contract with a health plan, manages the prescription drug coverage provided by the health plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network

pharmacies, and controlling the cost of covered prescription drugs. [HSC §1385.001]

7) Requires a health plan that contracts with a PBM to require the PBM to comply with specified requirements including register with DMHC and exercise good faith and fair dealing in the performance of its duties. [HSC §1385.004 and §1385.005]

8) Requires the failure by a health plan to comply with PBM contractual requirements to constitute grounds for disciplinary action. Requires the DMHC Director, as appropriate, to investigate and take enforcement action against a health plan that fails to comply with these requirements and to periodically evaluate contracts between health plans and PBMs to determine if any audit, evaluation, or enforcement actions should be undertaken by DMHC. [HSC §1385.006]

9) Prohibits a person who manufactures a prescription drug from offering in the state a discount, repayment, product voucher, or other reduction in an individual's OOP expenses associated with his or her health insurance, health plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for a prescription drug if a lower cost generic drug is covered under the individual's health insurance, health plan, or other health coverage on a lower cost-sharing tier that is designated to be therapeutically equivalent as indicated by the United States Food and Drug Administration's (FDA) "Approved Drug Products with Therapeutic Equivalence Evaluations." [HSC §132000]

10) Exempts from 9) above, the a single-tablet drug regimen for treatment or prevention of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) that is as effective as a multitablet regimen, unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally effective or more effective and is more likely to result in adherence to the drug regimen; and, an individual who has completed any applicable step therapy or prior authorization requirements for the branded prescription drug as mandated by the individual's health insurer, health plan, or other health coverage from the prohibition in 9) above. [HSC §132004]

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 will have California join 16 other states and Puerto Rico in banning the copay accumulator programs. These programs are used by health insurers and PBMs to prevent copay assistance given to patients from counting towards their deductible and maximum OOP spending. This practice reduces the cost to payers while placing an extreme financial burden on patients, who then are forced to pay OOP to reach their full deductibles or forego their life-saving medications because they can't afford it. Copay assistance is provided by drug manufacturers, charitable foundations and other third parties to help patients pay for their prescriptions, sometimes saving them thousands of dollars. However, health plans and PBMs are keeping the value of the copay assistance, turning the help given to patients into more profit for themselves. The author concludes that this bill would ban the practice of copay accumulator programs to lift the burden from patients

2) BACKGROUND.

a) Prescription Drug Spending and SB 17 DMHC Report. According to the DMHC, health plans paid almost $1.3 billion more on prescription drugs in 2022 than in 2021, the highest year-over-year increase since SB 17 (Hernandez), Chapter 603, Statutes of 2017, reporting began. The cost of prescription drugs continues to impact the affordability of health care overall, with health plans paying about $12.1 billion for prescription drugs in 2022. SB 17 requires health plans in the commercial market to annually report their prescription drug costs to the DMHC. This report looks at the impact of the cost of prescription drugs on health plan premiums and compares this data across the reporting years. The DMHC considers the total volume of prescription drugs prescribed by health plans and the total cost paid by health plans for these drugs, on both an aggregate spending level and a per member per month basis and compares the annualized data. The DMHC also analyzes how the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year increase in total annual spending impacted health plan premiums over the course of the last four years. The most recent report notes the following key findings:

i) Health plans paid about $12.1 billion for prescription drugs in 2022, an increase of almost $1.3 billion, or 12.3%, from 2021. Since 2017, prescription drug costs paid by health plans increased by $3.4 billion or 39%;

ii) Prescription drugs accounted for 14.2% of total health plan premiums in 2022, an increase from 13.3% in 2021;

iii) Total prescription drug costs increased by 12.3% in 2022, whereas total medical expenses increased by 7.9%. Overall, total health plan premiums increased by 4.4% from 2021 to 2022;

iv) Manufacturer drug rebates totaled approximately $2.068 billion, up from $1.674 billion in 2021 and $1.437 billion in 2020. This represents about 17.1% of the $12.1 billion spent on prescription drugs in 2022;

v) While specialty drugs accounted for only 1.6% of all prescription drugs dispensed, they accounted for 64% of total annual spending on prescription drugs;

vi) Generic drugs accounted for 88.9% of all prescribed drugs but only 14.4% of the total annual spending on prescription drugs;

vii) Brand name drugs accounted for 9.5% of prescriptions and constituted 21.6% of the total annual spending on prescription drugs;

viii) For the second year, the Pfizer and Moderna COVID-19 vaccines were amongst the most frequently prescribed brand name drugs and the most costly brand name drugs. Also, this is the first year which shows COVID-19 tests amongst the brand name drugs with the highest year-over-year increase in total spending; and,

ix) The primary drugs that are driving the increase in the total prescription drug cost spending for 2022 are in the specialty and brand name drug categories. In particular, several drugs used in the management of diabetes or weight loss and biological

immunological drugs have risen in the rankings or appeared on the top 25 lists for the first time and are among the most expensive and rapidly expanding drugs.

b) Cost sharing structures. According to the California Health Benefits Review Program (CHBRP), payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, deductibles, and out-of-pocket maximums (OOPMs) (but do not include premium expenses). Definitions of each are as follows:

- **i) Deductible**: The enrollee is responsible for paying the full cost of covered benefits subject to the deductible until the full value of the deductible is paid by the enrollee. The enrollee's payments towards the deductible accumulate over the course of the plan or policy year. For example, if an enrollee has a $750 deductible, and uses four $250 services that are subject to the deductible throughout the course of the year, the enrollee would pay for the first three services ($250 x 3 = $750) in full. At that point, the deductible would be met and a different form of cost sharing such as a copayment or coinsurance may be applied to the fourth visit, depending on the plan or policy.
- **ii) Copayment**: A copayment is a flat dollar amount paid by the enrollee per service for services subject to a copayment. Copayments may be applied on their own or to services subject to a deductible after the deductible is met. Copayments are often higher for brand drugs, particularly when a lower-cost bioequivalent generic is available, to discourage their use.
- **iii) Coinsurance**: Coinsurance is the percentage of the total cost of a service that will be paid by the enrollee. For example, on a $250 service subject to a 10% coinsurance, the enrollee cost sharing would be $25. Coinsurance may be applied on its own or to services subject to deductible after the deductible is met.
- **iv) OOPM**: The annual OOPM is the maximum an enrollee will spend on cost sharing for covered services in the form of deductibles, copayments, and coinsurance during the plan/policy year. For plans and policies available through Covered California, OOPMs for in-network EHBs are applicable. In 2024, the OOPM limit for self-only coverage is $9,450. If an enrollee has a high-cost hospital stay in the first month of their plan/policy year (whether or not that plan or policy includes a deductible) and reaches their OOPM, the enrollee will not have any other cost sharing for covered services for the remaining 11 months of the plan/policy year.

There are varieties of cost-sharing mechanisms that can be applicable to covered benefits. Some health insurance benefit designs incorporate higher enrollee cost sharing to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits. Annual OOPMs for covered benefits limit annual enrollee cost sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits. Under current law, some health plans and insurers may design their pharmacy benefit to not allow payments made in association with pharmaceutical drug discount cards or by PAPs from counting towards an enrollee's copayment, coinsurance, or OOPM.

This bill instead mandates that all such payments would count towards the enrollee's cost-sharing responsibility.

c) Copay accumulator programs. Copayment adjustment programs are a type of pharmacy benefit design that offset the impacts of certain pharmaceutical financial assistance; they operate by prohibiting the contributions made by a third party from counting towards the enrollee's OOPM. They may be designed to target specific drugs. Copayment adjustment programs are used to encourage the use of lower-cost prescription drugs, drive down drug prices, and reintroduce price sensitivity to enrollees who use financial assistance for OOP costs. There are two types of copayment adjustment programs: copay accumulator programs and copay maximizer combination programs.

- **i) Copay accumulator programs**: Prohibit any amounts collected at the point of sale when using financial assistance from a third party for a prescription drug from counting towards their deductible or annual OOPM; and,
- **ii) Copay maximizer programs:** Amounts collected at the point of sale when using financial assistance from a third party for a prescription drug do not count towards their deductible or annual OOPM; however, the cost share is adjusted to an amount that maximizes the value of the financial assistance from a third party and applied throughout the benefit year.

d) Federal guidance on PAPs. According to CHBRP, the Office of Inspector General (OIG) is a federal agency with a mission to provide objective oversight to promote efficiency, effectiveness, economy, and integrity of U.S. Department of Health and Human Services programs, and reduce waste, fraud, and abuse. The OIG has published guidance on the operation of nonprofit organizations offering financial assistance for prescription drugs in an effort to allow for the provision of medically necessary drugs to financially needy patients, and ensure the assistance is provided in a manner that does not conflict with the federal anti-kickback statute or other laws. As part of this effort, pharmaceutical manufacturers are prohibited from influencing enrollees' drug choices through independent charity organizations; to help prevent this from happening, pharmaceutical manufacturers may not control which drugs an independent charities may offer to patients. The OIG is also concerned about the influence of nonprofit organizations providing financial assistance for prescription drugs on overall drug prices. OIG guidance states that although the agency recognizes that a patient prescribed an expensive drug may have a greater need for financial assistance than a patient prescribed a less expensive alternative, the OIG is concerned that limiting cost-sharing support from these organizations to expensive products may steer patients in a manner that is costly to federal health care programs and may even facilitate increases in drug prices. OIG guidance also specifies that the cost of the particular drug for which the patient is applying for assistance is not an appropriate stand-alone factor in determining individual financial need.

- **i) Federal regulations on copayment adjustment programs.** In July 2021, the Centers for Medicare & Medicaid Services' (CMS) final rule on copayment adjustment programs deferred to states regarding their regulation for health plans sold on the exchanges and in nongrandfathered individual and group health plans sold off exchanges. Health plans and insurers were authorized to count payments associated with drug manufacturer financial assistance towards an enrollee's cost-sharing limits but were not mandated to do so unless the state regulates them otherwise. The 2021 federal rule encouraged, but did not require, health plans and policies to disclose the use of copayment accumulator programs on websites, brochures, plan documents, and

other materials. In September 2023, the U.S. District Court for the District of Columbia vacated, or set aside, this rule. An appeal from the federal government was withdrawn. The federal rule which allows insurers to stop applying the value of prescription drug coupons towards an enrollee's maximum OOP costs in situations where a generic medication is available and medically appropriate, in order to encourage generic use and result in lower drug spending, applies in the marketplace today.

ii) **Medicare.** CMS allows for PAPs to provide assistance to Medicare Part D (prescription drug) enrollees; however, they must operate "outside the Part D benefit." In other words, the payments made by a pharmaceutical patient assistance program do not count towards a Part D beneficiary's true OOP cost. CMS uses the true OOP calculation to determine whether a beneficiary has reached the threshold for catastrophic coverage under the Part D benefit, after which Medicare covers all Part D drugs for the remainder of the calendar year.

e) **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 this bill and states the following in its analysis:

i) **Assumptions:** PBMs typically only work with specialty pharmacies, which they either own or have exclusive contracts with, on implementation of copayment adjustment programs. CHBRP assumes that this bill would only impact specialty drugs, which are typically high-cost brand-name drugs. Specialty drugs come in various forms and may be billed under either the pharmacy benefit, medical benefit, or both. The timing of claims processing for specialty drugs varies significantly between those on the pharmacy versus medical benefit. Specialty drugs billed on the pharmacy benefit are processed in real time. In contrast, the billing system for medical benefit drugs is more complex, making it difficult to track claims and, therefore, track payments. In addition, claims for medical benefit drugs can take several weeks to process with third-party insurance. Because of this, it is difficult for PBMs to include medical benefit drugs in copayment adjustment programs. Thus, CHBRP assumes that specialty drugs administered in a medical setting are already compliant and this bill would only impact specialty drugs on the pharmacy benefit. CHBRP also considered how trends in biosimilars might impact assumptions for this bill. The interaction of biosimilar availability and adoption on this bill is potentially mixed. Considerations include the extent to which biosimilars are available from multiple manufacturers, the extent to which biosimilars impact drug prices (including rebates) as well as total member cost-sharing requirements, and the extent to which biosimilars are available and even preferred on formularies developed by PBMs. Biosimilars are a type of biologic medication and may be available at a lower cost than the original biologics (which include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins).

ii) **Enrollees covered.** CHBRP estimates the number of specialty prescriptions filled that have drug copay assistance (117,000) would not change due to this bill in the first

year. This represents approximately 11,000 enrollees who will be impacted by this bill. Similarly, the average unit cost (for a 30-day fill) for specialty medications of $7,964 would not change from baseline to postmandate.

iii) **Impact on expenditures.** Postmandate, some enrollees would reach their OOPM earlier in the year as a result of this bill and would utilize services that they would not have used prior to enactment of the mandate; these additional services would be fully paid for by the health plans/insurers. Overall, this bill would increase total net annual expenditures for the first year by $24,714,000, or 0.02%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $52,745,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $28,031,000 decrease in enrollee expenses for covered and/or noncovered benefits. It should be noted that total net annual expenditures for the second year identifies an increase of $94,953,000.

Changes in premiums as a result of this bill would vary by market segment. Among DMHC-regulated plans, large-group premiums would increase by 0.03%, individual market premiums would increase by 0.03%, and CalPERS would increase by 0.01%. However, DMHC-regulated small-group premiums would increase by 0.12%. In the CDI-regulated market, the large-group market would face the smallest increase (0.12%), while individual (0.16%) and small group (0.17%) would have the highest increase across all markets.

CHBRP estimates this bill would result in enrollees in non-CalPERS commercial plans in all markets to pay less in OOP expenses. On average, DMHC-regulated large-group enrollees would experience a $0.10 reduction in enrollee expenses on the low end, with small-group DMHC-regulated enrollees experiencing a $0.48 decrease in enrollee expenses on the high end. For CDI-regulated enrollees, those with small-group ($0.92 decrease) and individual market ($0.68 decrease) policies would see the largest reduction in OOP expenses, while enrollees in large-group policies would experience $0.48 in reduced enrollee expenses on average. Overall, enrollee expenses would decrease by $28,031,000 across all markets. Due to the decreases in cost sharing, measurable public health impacts at the population level may occur if it results in increased adherence to a prescription drug.

(1) CalPERS. Postmandate, for enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% ($0.0066 per member per month, $429,000 total increase in expenditures).

(2) Covered California. Postmandate, premiums for enrollees in individual plans purchased through Covered California would increase by less than 0.01% (approximately $180,000 increase in total expenditures).

(3) Number of Uninsured in California. CHBRP expects no measurable change in the number of uninsured persons due to the enactment of this bill.

iv) **EHBs.** This bill does not appear to exceed the EHB definition, as all health plans and insurance carriers in California are already required to cover outpatient prescription drugs.

v) **Long-term impacts**. In the longer term, CHBRP anticipates that this bill would incentivize manufacturers to increase funding to drug copay assistance through nonprofit organizations. Manufacturers would stand to benefit from increased drug copay assistance because by removing barriers to patient access to high-cost

medications, manufacturers may increase the overall demand for specialty medications. Health plans and insurers may respond by removing specific high-cost specialty drugs that have therapeutic equivalent drugs from their formulary. Off-formulary drugs are not considered covered benefits, and therefore this bill would not apply to these drugs.

vi) **Cost impacts**. One key aspect of this bill is the degree to which patients may be willing to switch to alternative therapies when presented with an opportunity to reduce OOP expenditures. Drug copay assistance may influence patient behavior, as patients with drug copay assistance may be less likely to search for lower-cost, alternative treatment options. Furthermore, these programs may even minimize or eliminate cost sharing for all other medical services throughout the year if the OOPM is reached. The presence of these programs may have the long-term potential to encourage patients to continue a specific therapy even as less costly, equivalent therapies become available. Therefore, these programs may have the potential to increase overall costs for drugs over time. Another key consideration of this bill is the degree to which the mandate impacts patients with chronic disease versus terminal diseases. Due to the ongoing nature of treatments for chronic disease, the potential for higher utilization is greater for medications for chronic conditions than those for terminal diseases. CHBRP also notes that this bill may address inequalities because of the current consequences of cost sharing on low-income patients. At baseline, some patients may face financial hardships in order to receive needed treatments or even postpone treatment if nonprofit organizations have insufficient drug copay assistance to meet patient demand. Assuming this bill leads to an influx of additional financial contributions from pharmaceutical manufacturers and other organizations to copay assistance programs, the mandate may benefit those who would otherwise suffer financial hardship and may reduce health care disparities amongst lower income populations with commercial insurance. In addition, postmandate, some patients may no longer be compelled to pay up front for their prescriptions, as this bill eliminates the requirement to cover the deductible and OOPM for these patients, through drug copay assistance and a card processed by the PBM at the point of sale. This would benefit those who would otherwise suffer financial hardship, and may reduce health care disparities amongst lower-income populations with commercial insurance. In Year 2 (2026), CHBRP assumes that this factor would lead to increased utilization. It stands to reason that in the long run, this bill may improve the health status of patients who would not have otherwise received treatment.

vii) **Other states**. Massachusetts has also banned the use of discounts or other reductions for prescription drugs when a generic equivalent is available. Twenty states, including Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia, and the District of Columbia and Puerto Rico have enacted legislation banning copayment adjustment programs.

3) **SUPPORT.** The ALS Association, California Rheumatology Alliance, Cystic Fibrosis Research Institute, Hemophilia Council of California and Sickle Cell Disease Foundation (cosponsors) write that many Californians with chronic and terminal conditions rely on PAPs to afford their vital medications when there is no generic equivalent available to help them manage their complex or serious conditions and avoid costly health complications. Copay assistance provided from third-party sources for specific medications should not be confused

with discounts, product vouchers or coupons that are available for general use and yield a percentage-based discount off the list price of a prescription drug. Unfortunately, nearly half of California-regulated commercial health plans and PBMs have copay accumulator policies, which are often obscurely stated in patients' annual health plan benefit summaries, to prevent copay assistance from counting towards patients' annual deductibles and maximum OOP cost-sharing. Moreover, health plans and PBMs are increasingly moving therapies covered through the pharmacy benefit to the medical benefit, which typically has a much higher copay and thus further increases the financial burden on patients who depend on such therapies. According to the co-sponsors, commercial health plans and PBMs that utilize copay accumulators are turning the financial copay assistance for medications intended to help patients in need into a financial windfall for themselves since they collect the third-party source payments made on patients' behalf while also requiring these patients to pay their full annual OOP cost-share obligations, thereby double dipping. The adverse effect of copay accumulators is to nullify the financial relief that eligible patients would normally receive from participating in PAPs, putting these patients in greater harm when they discover that they can no longer afford their vital medications and raising overall health care costs due to unnecessary complications. This is also a health equity issue since copay accumulators have a disproportionate impact on the most vulnerable patients, including the underinsured and individuals with chronic or terminal conditions who often rely on multiple treatments to manage their illness and who have a higher OOP health care spend year-after-year than healthier patients. The co-sponsors conclude that this bill will ensure that patients who rely on costly treatments no longer must choose between filling their prescriptions or paying for other necessities.

4) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans (collectively "opposition") write that everyone should be able to get the medications they need at a cost they can afford. But drug prices continue to rise with no end in sight, and hardworking families feel the consequences every day. Prescription drug costs now represent over 22 cents out of every dollar of premium spent on health care. Drug manufacturers acknowledge their drugs are unaffordable for patients, but rather than choose to lower their prices for everyone, they point to their PAPs which offer copay coupons. Coupons are offered only to a narrow set of patients, for a narrow selection of drugs, and often only for a limited time. Once the patient hits their deductible, drugmakers discontinue the patient's coupons. According to the opposition, this scheme allows drugmakers to keep their underlying prices hidden from patients, while keeping their costs extremely high for employers and consumers who end up paying much more in premiums and cost-sharing. The federal government considers copay coupons illegal kickbacks in federal health care programs like Medicare and Medicaid because these coupons induce a patient to use a specific drug. To counter the market manipulation from coupons, health plans and insurers have worked together with employers to develop programs to hold drug companies accountable, to shed light on these pricing schemes, and keep costs low for Californians. Such programs help restore the balance in the system by allowing patients to use manufacturer coupons to save money at the pharmacy counter, but does not count the amount the drug manufacturer has paid for the drug (through the coupon) towards the patient's deductible or OOPM. Legislation like this bill that bans these programs by requiring health plans and insurers to count third-party payments towards an enrollee's cost sharing obligations will eliminate incentives for drug companies to lower prices. The opposition concludes that as a result, drug companies will make more money

while California families and businesses continue to foot the bill through higher premiums, higher OOP expenses, and higher federal insurance subsidies.

5) **RELATED LEGISLATION.** SB 966 (Wiener) requires a PBM, as defined by the bill, to apply for and obtain a license from the Board of Pharmacy (board) to operate as a PBM. Requires a PBM, on or before April 1, 2027, and annually thereafter, to file with the board a report containing specified information. Prohibits the report from disclosure to the public. Requires the board, on or before August 1, 2027, and annually thereafter, to submit a report to the Legislature based on the reports submitted by licensees, and requires the board to post the report on the board's internet website. Imposes specified duties, including prohibiting a PBM from deriving income from PBM services, except as specified. SB 966 was recently amended in Senate Business, Professions and Economic Development Committee and is pending in Senate Health Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 874 (Weber) of 2023 was similar to this bill but was never heard in Assembly Health Committee.

   b) SB 873 (Bradford) of 2023 would have required an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. Would have required DMHC and CDI to submit an annual report on the impact of these provisions to the appropriate policy committees of the Legislature, as specified. SB 873 was held on suspense in the Assembly Appropriations Committee.

   c) AB 948 (Berman), Chapter, Statutes of 2023, makes permanent existing law provisions that prohibit the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days or $500 for bronze products, except as specified.

   d) AB 933 (Daly) of 2021 is substantially similar to SB 873 and was held on suspense in the Assembly Appropriations Committee.

   e) AB 290 (Wood), Chapter 862, Statutes of 2019, requires a health plan or an insurer that provides a policy of health insurance to accept payments from specified third-party entities, including an Indian tribe or a local, state, or federal government program. Requires a financially interested entity, as defined, other than those entities, that is making a third-party premium payment, to provide that assistance and to perform other related duties, including disclosing to the plan or the insurer the name of the enrollee or insured, as applicable, for each plan or policy on whose behalf a third-party premium payment will be made. Requires each plan or insurer to provide to the appropriate department information regarding premium payments by financially interested entities and reimbursement for services to providers, and would set forth standards governing the reimbursement of financially interested providers, including, but not limited to, chronic dialysis clinics, that meet certain criteria. Requires reimbursement to contracted providers to be the higher of the Medicare reimbursement rate or the rate determined pursuant to an independent dispute resolution process, as prescribed.

f) AB 315 (Wood), Chapter 905, Statutes of 2018, requires health plans that contract with PBMs to register with the DMHC.

g) AB 265 (Wood), Chapter 611, Statutes of 2017, prohibits prescription drug manufacturers from offering discounts or other reduction in an individual's OOP expenses associated with his or her insurance coverage, if a lower cost therapeutically equivalent generic drug is available. Specifies a number of exceptions that allow discounts even if a lower cost therapeutically equivalent generic drug is available.

h) SB 17 (Hernandez), Chapter 603, Statutes of 2017, requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to DMHC and CDI. Requires DMHC and CDI to compile specified information into a consumer-friendly report that demonstrates the overall impact of drug costs on health care premiums. Requires drug manufacturers to notify specified purchasers, in writing at least 90 days prior to the planned effective date, if it is increasing the wholesale acquisition cost of a prescription drug by specified amounts. Requires drug manufacturers to notify the the Department of Health Care Access and Information (HCAI) three days after FDA approval when introducing a new drug to market, as specified. Requires drug manufacturers to provide specified information to HCAI related to the drug's price.

7) **AMENDMENTS.** The Committee is recommending the following amendments to address some of the potential unintended consequences raised by the CHBRP analysis:

a) Add a sunset and authorize the regulators to conduct an analysis of this bill and its impact to consumers and whether or not the Legislature should eliminate the sunset;

b) Update SB 17 reporting to include PAPs;

c) Require notices to enrollees on the availability of the PAP during the contract period; and,

d) Limit this bill to prescription drugs.

8) COMMENTS.

a) Specialty Drugs. As part of this analysis, CHBRP assumed that compliance with this mandate will impact only specialty medications, as PBMs rely on specialty pharmacies to handle pricing adjustments at point-of-sale to administer these programs. As the recent SB 17 report pointed out, the cost of specialty drugs continues to be a driver of overall health care costs. In the second year of implementation, total net annual expenditures is $94,953,000. As drafted, there is nothing in this bill that guarantees or controls how much manufacturers could increase their prices. To address concerns that PAPs may facilitate increased in drug prices, should this bill be amended such that PAPs must be applied towards the enrollee's OOPM only if there is no generic equivalent and consistent with AB 265 which prohibits prescription drug coupons when there is a generic available?

b) Prescription Drug Coupons. This bill, as introduced, excluded general manufacturer coupons. Recent amendments now specify, "third-party patient assistance program does not include discounts, product vouchers, or coupons that provide a percentage-based

discount off the list price of a prescription drug." Since this language is different from CHBRP's current analysis, the Committee may wish to request an updated analysis to reflect the current language of this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

ALS Association (cosponsor)
California Rheumatology Alliance (cosponsor)
Cystic Fibrosis Research Institute (cosponsor)
Hemophilia Council of California (cosponsor)
Sickle Cell Disease Foundation (co-sponsor)
AIDS Healthcare Foundation
Aim At Melanoma Foundation
Aimed Alliance
Alliance for Gout Awareness
Alliance for Patient Access
American Cancer Society Cancer Action Network INC.
American Diabetes Association
Arthritis Foundation
Association for Clinical Oncology
Association of Northern California Oncologists
Association of Women in Rheumatology (AWIR)
California Academy of Physician Assistants
California Black Health Network
California Chapter American College of Cardiology
California Chronic Care Coalition
California Life Sciences
California Medical Association
California Pharmacists Association
California Retired Teachers Association
California Society of Dermatology & Dermatologic Surgery
California Society of Plastic Surgeons
California Urological Association
Cancer Support Community San Francisco Bay Area
Center for Inherited Blood Disorders
Central California Hemophilia Foundation
Children's Hospital Los Angeles
Children's Specialty Care Coalition
Chronic Care Policy Alliance
Chronic Disease Coalition
Community Oncology Alliance (COA)
Crohns and Colitis Foundation
Cystic Fibrosis Foundation
Everylife Foundation for Rare Diseases
Global Healthy Living Foundation
Head
Hemophilia Federation of America

Hemophilia Foundation of Northern California
Hemophilia Foundation of Southern California
HIV + Hepatitis Policy Institute
ICAN, International Cancer Advocacy Network
Infusion Access Foundation (IAF)
International Foundation for Autoimmune and Inflammatory Arthritis
Looms for Lupus
Lung Cancer Foundation of America
Lungevity Foundation
Lupus and Allied Diseases Association, INC.
Medical Oncology Association of Southern California
Movement Disorders Policy Coalition
National Bleeding Disorders Foundation
National Health Law Program
National Infusion Center Association (NICA)
National Multiple Sclerosis Society, Ms-can
National Psoriasis Foundation
Oncology Nursing Society
Osteopathic Physicians and Surgeons of California
Rady Children's Hospital San Diego
Spondylitis Assocation of America
Support Fibromyalgia Network
The AIDS Institute
The Defeating Epilepsy Foundation
The Hemophilia Association of San Diego County
UCSF Adult Hemophilia Treatment Center
Vision Health Advocacy Coalition
We Win Foundation

Opposition

America's Health Insurance Plans (AHIP)
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Pharmaceutical Care Management Association

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Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2198 (Flora) – As Introduced February 7, 2024

SUBJECT: Health information.

SUMMARY: Exempts health plans or insurers offering dental or vision benefits from the requirements to establish and maintain application programming interfaces (API) pursuant to 6) below under existing law.

EXISTING LAW:

1) Establishes under federal law, the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA covered entity may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails. [45 Code of Federal Regulations §164.500, *et. seq*.]

2) Defines electronic health record (EHR) as an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. [42 United States Code §17921]

3) Defines, for purposes of the Confidentiality of Medical Information Act, medical information to mean any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. Defines individually identifiable information to mean that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity. [Civil Code §56, *et. seq*.]

4) Requires the California Health and Human Services Agency (CHHSA), on or before July 1, 2022, to establish the Data Exchange Framework (Framework) and include a single data-sharing agreement and common set of policies and procedures that will leverage and advance national standards for information exchange and data content, and that will govern and require health information exchange (HIE) among health care entities and government agencies in California. [Health and Safety Code (HSC) §130290]

5) 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. [HSC §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

6) Requires, commencing January 1, 2024, health plans and health insurers to establish and maintain API (patient access API, provider directory API, and payer-to-payer exchange API), as described by the federal regulations, for the benefit of enrollees, insureds, and contracted providers. Authorizes the DMHC or CDI to require a health plan or insurer to establish and maintain provider access API and prior authorization support API if and when the final rules are published by the federal government. [HSC §1374.196 and INS §10133.12]

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 needed to clarify dental and vision plans are not subject to APIs as prescribed by federal regulations, and it is largely a clean-up measure since the federal regulations that prompted California action do not include commercial standalone dental. The author concludes that this bill will clarify and update California law to align with federal law.

2) **BACKGROUND.** According to a 2021 California Health Care Foundation report, entitled "Why California Needs Better Data Exchange: Challenges, Impacts, and Policy Options for a 21st Century Health System," the efficient, effective, and equitable delivery of care is vital to the well-being of all Californians and is necessary for a strong and vibrant economy. Information must easily be exchanged among medical, behavioral, social services, and public health professionals to allow them to make informed decisions that impact the lives of every resident. Access to this kind of critical information is limited, with the exchange of health data confined to a subset of clinical patient information shared mostly among larger clinics and hospitals that have federally certified EHR technologies.

   a) **Federal Action**. In 2009, President Obama signed the American Recovery and Reinvestment Act of 2009, which included the Health Information Technology for Economic and Clinical Health (HITECH) Act. Among other provisions, the HITECH Act provides eligible hospitals and health care professionals with financial incentives through Medicare and Medicaid financing to adopt, implement and upgrade certified EHRs, and for "meaningful use" of certified EHRs. In 2015, Congress declared a national objective to achieve widespread HIE through interoperable certified EHR technology nationwide by December 31, 2018 through the Medicare Access and the Children's Health Insurance Program Reauthorization Act of 2015. Patient health information is regulated under state law and federal law and regulation not only to protect the privacy of personal health information, but also to allow information to be shared between health care providers for treatment purposes, and to incentivize the adoption of certified EHR technology that fosters health information sharing. In 2016, the Cures Act further promoted the adoption use of EHR technology. The Cures Act contained multiple provisions, including provisions regarding the interoperability of health records. In addition, the Cures Act prohibits "information blocking" and contains provisions to facilitate patient access to their electronic health information by encouraging partnerships between health information networks, health care providers, and other stakeholders to offer access through secure, user-friendly software. The goal of the federal rules implementing the Cures Act are to drive the electronic access, exchange, and use of health information, to inject competition into the health care delivery system by addressing both technical barriers and business practices that impede the secure and appropriate sharing of data,

with a central purpose of the rule being to facilitate patient access to their electronic health information on their smartphone.

b) Federal APIs. The Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule (CMS Interoperability Rule) requires Medicare Advantage organizations, Medicaid Fee-for-Service (FFS) Programs, Medicaid managed care plans, Children's Health Insurance Program (CHIP) FFS programs, CHIP managed care entities, and Qualified Health Plan issuers on the Federally-Facilitated Exchanges (FFEs) to implement API technology to advance health data exchange. The CMS Interoperability Rule builds on CMS' previous rule by outlining requirements for additional information that certain payers must provide via the Patient Access API and new requirements for certain payers to implement three additional APIs: Provider Access API, Payer-to-Payer API, and Prior Authorization API. The APIs finalized must meet certain technical standards to drive interoperability and increase provider and patient access to health information, for example, allowing patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice. According to a 2022 *Harvard Business Review* article, "Standardized APIs Could Finally Make It Easy to Exchange Health Records," APIs support the ability of an application from one developer to read and write data from another developer's application. The article further notes that using APIs to unlock EHR data could give people easy, efficient access to their own data to help them understand their health and make more informed choices.

c) SB 1419. SB 1419 (Becker), Chapter 888, Statutes of 2021, requires health plans, beginning January 1, 2024, to establish and maintain API for the benefit of enrollees and contracted providers to facilitate patient and provider access to health information as applicable under federal rules. Specifically, SB 1419 required patient, provider directory, and payer to payer exchange API. SB 1419 applied these requirements to all health plans and insurers, including dental and vision plans.

A DMHC December 13, 2023 All Plan Letter (APL) notes that these APIs are to be in accordance with standards published in a final rule issued by CMS and published in the Federal Register, and align with federal effective dates, including enforcement delays and suspensions. Pursuant to existing law, the DMHC Director is authorized to exempt health plans from compliance, if the DMHC Director finds the action to be in the public interest and not detrimental to the protection of enrollees. The DMHC APL further states, given the pending federal guidance related to APIs, the DMHC Director exempts health plans from compliance with the January 1, 2024, effective date in SB 1419, and extends the effective date to January 1, 2025 to align with potential federal proposals.

This bill clarifies that health plans or insurers offering dental or vision benefits are excluded from the API provisions of SB 1419. According to the author and sponsors of this bill, at this time, federal guidance does not include dental or vision plans. Additionally, the author states that based on the Senate legislative analysis of SB 1419, the intent of that bill was to incorporate into California law the requirements of the federal Interoperability Regulations. Since CMS did not include dental and vision plans in the federal regulations, and SB 1419 was intended to implement federal regulations at the state level, the author suggests the California's Legislature did not contemplate inclusion of dental and vision plans.

d) Dental exemptions. The California Association of Dental Plans (CADP), sponsor of this bill, cite to 2020 and 2024 federal guidance noting that the requirements proposed in federal regulations do not apply to issuers offering only stand-alone dental plans (SADPs) on the FFEs. In contrast to qualified health plan issuers of medical plans, according to CADP, issuers offering only SADPs offer enrollees access to a unique and specialized form of medical care. CMS references the exclusion of dental plans throughout the preamble in both the 2020 and 2024 API regulations. CMS explains that dental information would be: i) of limited use; ii) costly to develop; and, iii) could drive dental plans away from marketplace participation. In addition, language specifically excluding SADPs in the FFEs is directly incorporated into the final regulations. CADP contends that the proposed standards and health information technology (HIT) investment would be overly burdensome for SADP issuers as related to their current enrollment and premium intake and could result in SADP issuers no longer participating in FFEs, which would not be in the best interest of enrollees.

e) Department of Health Care Services (DHCS) 2022 APL. In a DHCS 2022 APL, DHCS writes that the CMS Interoperability Rule requires dental managed care plans (DMCPs) to implement and maintain a secure, standards-based Patient Access API and a publicly-accessible, standards-based Provider Directory API that can connect to mobile applications, provider electronic health records, or practice management systems. DMCP must also comply with the requirements of federal regulations, and the public reporting and information blocking components of the CMS Interoperability Rule to the extent these requirements are applicable to DMCPs. DHCS provided the following information to the DMCPs:

- **i) Patient Access API**. DMCP must implement the Patient Access API that can connect to provider EHRs and practice management systems. The Patient Access API must permit third-party applications to retrieve, with the approval and at the direction of a member or member's authorized representative, data specified in the United States Core Data for Interoperability through the use of common technologies and without special effort from the member. Additionally, DMCPs must tailor these member educational resources to best meet the needs of their member populations, including literacy levels, languages spoken, conditions, etc. as required; and,
- **ii) Provider Directory API**. DMCPs must implement and maintain a publicly accessible standards-based Provider Directory API as described, and meet the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of provider directory information to particular persons or organizations. DMCPs are required to update the provider directory on a weekly basis after the DMCP receives the provider information, or is notified of a change.

3) SUPPORT. CADP, sponsor of this bill, writes that APIs are a set of rules or protocols that let software applications communicate with each other to exchange data, features, and functionality. While SB 1419 codified federal regulations into California law, it failed to capture the exclusion of commercial dental and vision plans. CMS excluded commercial dental plans from the API requirements in the preamble to the CMS Interoperability Rule regulation and further explained dental information would be of limited use, costly to develop, and could drive dental plans away from the marketplace.

4) **OPPOSE UNLESS AMENDED.** The California Dental Association requests the amendments to this bill that align with federal regulations by including the same dental plans specified in the federal regulations and additionally to apply the provider access and prior authorization API requirements to stand alone dental plans, as it would be beneficial for patients and providers alike to have access to the information these APIs would provide.

5) **OPPOSITION.** Health Access California states that APIs are critical to the facilitation of HIE amongst providers for better care and for patients. In 2022, California launched its Framework to facilitate the secure exchange of health and social services information, to help give providers a clear understanding of a consumers' health history, to deliver better, whole-person care. While the federal interoperability requirements excluded dental and vision plans, California law rightly included dental and vision benefits and plans in the API requirements. This bill not only excludes dental and vision health plans from the API requirements, but specifically dental and vision benefits, inclusive of those benefits for enrollees enrolled in full-service health plans like Kaiser. Exempting dental and vision benefits from these requirements would undermine our goal of whole person care. The California Pan Ethnic Health Network writes that this bill ensures dental and vision plans are meeting API requirements, providing physicians and patients with seamless access to all data needed to provide high-quality patient care. AB 1419 ensures these standards apply equally to public and commercial dental and vision plans and will make it easier for dental plans to participate in California's HIE, should California require this in the future. As an essential health benefit under the Patient Protection and Affordable Care Act, dental plans and benefits must not be exempted from these important consumer requirements.

6) **PREVIOUS LEGISLATION.**

   a) SB 582 (Becker) from 2023 was substantially similar to this bill with respect to the API exemption and was vetoed by Governor Newsom in large part due to another provision as it relates to EHRs and as premature given the work of CHHSA's Framework.

   b) SB 1419 requires, beginning January 1, 2024, health plans and health insurers to establish and maintain API, as described by the federal regulations, for the benefit of enrollees, insureds, and contracted providers.

   c) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes the Framework and requires by July 1, 2022, in consultation with members of the Stakeholder Advisory Group, the CHHSA to finalize a data sharing agreement. Specifies that the Framework defines the parties that will be subject to these new data exchange rules and sets forth a common set of terms, conditions, and obligations to support secure, real-time access to and exchange of health and social services information, in compliance with applicable federal, state, and local laws, regulations, and policies.

   d) SB 371 (Caballero) of 2021 would have required any federal funds CHHSA receives for HIT and the exchange to be deposited in the California Health Information Technology and Exchange Fund. Would have authorized CHHSA to use the fund to provide grants to health care providers to implement or expand health information technology and to contract for direct data exchange technical assistance for safety net providers. Would have required a health information organization to be connected to the California Trusted Exchange Network and to a qualified national network. Would have required a health

care provider, health system, health care service plan, or health insurer that engages in HIE to comply with specified federal standards. SB 371 was never heard in Assembly Health Committee.

e) SB 441 (Galgiani) of 2019 would have enacted the California Interoperability Enforcement Act to regulate EHR vendors operating in California and require the office to review federal law and policy for opportunities to regulate EHR vendors and to establish an interoperability enforcement structure. SB 441 was scheduled but not heard in the Senate Health Committee.

f) SB 853 (Committee on Budget), Chapter 717, Statutes of 2010, authorizes the state to contract with a qualified nonprofit entity to operate a federally-funded HIE. Establishes a process for a nonprofit entity to implement a statewide collaborative process for expanding capacity for electronic HIE, as well as, establishes the parameters and requirements of entering into a contract with a nonprofit entity.

g) SB 337 (Alquist), Chapter 180, Statutes of 2009, authorizes CHHSA to apply for federal HIT and exchange funding and, if no application is made by a certain date, requires selection of a state-designated qualified nonprofit agency for the purposes of submitting an application for federal HIT and exchange funding.

7) **COMMENT.** California's Framework is an initiative with purpose to accelerate and expand HIE among health care entities, government agencies, and social service programs throughout the state. At this time, dental plans are not required to participate in the Framework. This bill seeks to exempt dental plans from establishing and maintaining APIs, with goals to advance health data exchange. At a time when we should be encouraging connectivity, lessen provider administrative burden, and increase patient access to records, should we stifle this type of potential for data sharing? The author is committed to incorporating a threshold provider compliance provision in this bill to delay implementation for dental and vision plans until a number of contracted providers are utilizing EHRs.

8) **AUTHOR AMENDMENTS.** To address concerns exempting dental from existing health plan requirements, the author is proposing the following amendments:

a) Delete the dental and vision exemption to instead delay implementation of commercial stand alone dental and vision plans to align with federal timelines of at least 2027; and,
b) Exempt smaller, regional plans from the requirements of existing law.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Dental Plans (sponsor)

Opposition

California Pan - Ethnic Health Network
Health Access California

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