California State Assembly

HEALTH

MIA BONTA
CHAIR

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AGENDA

Tuesday, June 25, 2024
1:30 p.m. -- 1021 O Street, Room 1100

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

1.	AJR 16	Low	Sunscreen: ingredients and filters.
2.	HR 105	Dixon	Opioid Abuse Awareness.
3.	HR 107	Waldron	Behavioral Health Care.
4.	SB 803	Becker	Heal Our Heroes Act.
5.	SB 945	Alvarado-Gil	The Wildfire Smoke and Health Outcomes Data Act.
6.	SB 954	Menjivar	Sexual health.
7.	SB 966	Wiener	Pharmacy benefits.
8.	SB 1033	Menjivar	Medi-Cal cost reporting: private duty nursing and congregate living health facilities.
9.	SB 1061	Limón	Consumer debt: medical debt.
10.	SB 1099	Nguyen	Newborn screening: genetic diseases: blood samples collected.
11.	SB 1238	Eggman	Lanterman-Petris-Short Act: designated facilities.
12.	SB 1258	Dahle	Medi-Cal: unrecovered payments: interest rate.
13.	SB 1290	Roth	Health care coverage: essential health benefits.
14.	SB 1339	Allen	Step-down care.
15.	SB 1354	Wahab	Long-term health care facilities: payment source and resident census.
16.	SB 1423	Dahle	Medi-Cal: critical access hospitals.
17.	SB 1432	Caballero	Health facilities: seismic standards.
18.	SB 1511	Health	Health omnibus.

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AJR 16 (Low) – As Introduced April 18, 2024

SUBJECT: Sunscreen: ingredients and filters.

SUMMARY: Urges the United States (U.S.) Congress to explore policy options to improve the timeliness of the U.S. Food and Drug Administration (FDA)'s approval pathways for sunscreen ingredients and filters. Specifically, **this resolution**:

1) States the following:
   a) The FDA has not approved a new ingredient or filter for use in sunscreen in over 20 years. Consequently, there has been little improvement or innovation in the U.S. sunscreen composition for decades, leaving Americans vulnerable to skin cancer, which remains, by far, the most common form of cancer in the U.S.;

   b) In the U.S., sunscreen manufacturers currently have access to 16 ultraviolet (UV) filters to create sunscreen products. Comparatively, European nations have up to 30 approved UV filters for consumer product companies to formulate a variety of sunscreen products;

   c) The lack of approved UV filters in America severely hampers the ability to bring forward a broader selection of sunscreen products that help protect Americans from skin cancer and the harmful effects of overexposure to the sun. With more ingredients and filters to choose from, overseas sunscreen manufacturers are able to create more innovative and stronger forms of protection against harmful ultraviolet rays. Americans have fewer choices in their sunscreen options, and, therefore, notably poorer protection from ultraviolet rays;

   d) In 2014, Congress passed the Sunscreen Innovation Act to address the regulatory backlog preventing Americans from accessing advanced, effective sunscreens that are widely available in the rest of the world, and have been for years. Still, the FDA is taking too long to approve nonprescription (OTC) ingredients and filters that are safe and widely available to the rest of the world; and,

   e) Current requirements require a significant amount of time and resources, akin to a new drug application, to complete and do not allow for the use of 21st century nonanimal testing or alternatives for assessing the safety and effectiveness of products that are currently utilized by the FDA's Center for Food Safety and Applied Nutrition, and other countries throughout the world.

2) Resolves the following:
   a) That the Assembly and the Senate of the State of California, jointly, That the Legislature of the State of California urges the United States Congress to explore policy options to improve the timeliness of the FDA's approval pathways for sunscreen ingredients and filters; and,

b) That the Chief Clerk of the Assembly transmit copies of this resolution to the President and Vice President of the U.S., to the Speaker of the House of Representatives, to the Majority Leader of the Senate, and to each Senator and Representative from California in the Congress of the United States.

FEDERAL LAW defines "sunscreen" to mean a drug containing one or more sunscreen active ingredients; and defines "sunscreen active ingredient" to mean an active ingredient that is intended for application to the skin of humans for purposes of absorbing, reflecting, or scattering ultraviolet radiation. [Title 21, United States Code § 360fff]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS RESOLUTION.** According to the author, it is time for the FDA to provide Californians and all Americans with the resources needed to protect themselves and their families from the harmful effects of the sun. The author contends that by advocating for policy changes, we can ensure Americans have access to the best possible protection against the sun's harmful rays and safeguard public health and the health of future generations.

2) **BACKGROUND.**

   a) **UV Rays.** According to the University of Texas MD Anderson Cancer Center, Most UV radiation from sunlight is absorbed by the atmosphere, but two kinds of UV rays do break through. They are called Ultraviolet A (UVA) and Ultraviolet B (UVB) radiation. UVA radiation makes up 95% of the all the UV rays that make it to the Earth's surface. UVA penetrates deep into our skin and can even pass through glass. UVA damages the collagen and elastin in the skin and also generates free radicals. Free radicals avidly attack macromolecules such as protein, lipid, RNA and DNA, altering their structure and interfering with their function. UVB radiation makes up only 5% of the UV rays from the sun, but it is very high energy. UVB damages skin cells and causes DNA mutations that can eventually lead to melanoma and other types of skin cancer.

   b) **Sunscreen filters.** Sunscreen UV filters are the active ingredients in sunscreen that prevent sunburn, decrease the risk of skin cancer, and mitigate early skin aging. Skin cancer is the most common form of cancer in the U.S. According to the American Academy of Dermatology Association, it is estimated that 9,500 Americans are diagnosed with skin cancer every day and one in five Americans will develop skin cancer in their lifetime. Effective and long-lasting sunscreen can decrease the risk of skin cancers, with regular daily use reducing the risk of developing skin cancer by up to 50%.

   c) **FDA regulation of sunscreen.** Sunscreens have been regulated by FDA since the 1970s. Sunscreens are classified by the FDA as over-the-counter drug products, which means sunscreens require more stringent safety, stability, compatibility, and efficacy testing than what is required for cosmetics products like skincare and makeup. The UV filters that give sunscreens their protective abilities are considered "active ingredients." Only FDA-approved UV filters can be included in U.S. sunscreen products and the FDA's UV filter OTC Monograph of active sunscreen ingredients. OTC Monograph is a "rule book" for each therapeutic category that establishes conditions, such as active ingredients, uses,

doses, labeling, and testing. Approving a UV filter as an active ingredient can be time-consuming and expensive. It requires extensive safety, toxicology, and efficacy testing, which is done either on animals or on humans. Once products have passed all necessary tests and are deemed FDA-approved UV filters, only then can they be labeled as sunscreens.

d) Progress on the approval of sunscreen ingredients and filters.

i) The Sunscreen Innovation Act. The Sunscreen Innovation Act (SIA) was enacted on November 26, 2014, to provide an alternative process for reviewing the safety and effectiveness of nonprescription sunscreen active ingredients. The SIA supplemented the regulation of the FDA's Time and Extent Application (TEA) with new statutory procedures. TEAs are responsible for assessing marketing timelines and scopes to determine eligibility. The SIA also required the FDA to establish timeframes to review TEAs for OTC drugs other than sunscreen active ingredients. The SIA ended at the end of Fiscal Year 2022.

ii) 2019 FDA proposed rule. In 2019, FDA issued a proposed rule on sunscreens, which proposed to revise the requirements for sunscreen active ingredients; maximum sun protection factor (SPF) levels; broad spectrum requirements (protection against both ultraviolet A and B rays); and dosage forms (for example, cream, lotion, or spray), among other things. The proposed rule also included updates on how sunscreens are labeled to make it easier for consumers to identify key information. The 2019 proposal aimed to bring sunscreens up to date with the latest science, including new information showing that certain sunscreen ingredients can be absorbed through the skin into the body. The FDA is now using this proposed order to efficiently transition our ongoing consideration of the appropriate requirements for OTC sunscreens from the previous rulemaking process to the new order process that the 2020 Coronavirus Aid, Relief, and Economic Security Act (CARES) Act created.

iii) The CARES Act. In response to the COVID-19 pandemic, Congress enacted the CARES Act. Most of its provisions focused on economic relief to individuals, families, businesses, and other groups. However, the CARES Act also reformed and modernized how the FDA regulates certain OTC Monograph drugs, specifically sunscreen. The CARES Act replaced the rulemaking process for OTC Monograph drugs with an administrative order process for issuing, revising, and amending the OTC Monographs. The administrative order process gives the FDA new tools to help revise the OTC Monographs if science changes, innovation progresses, new data becomes available, or emerging safety signals arise.

iv) 2021 FDA actions. On September 24, 2021, FDA took steps aimed at improving the quality, safety, and efficacy of sunscreens as part of its implementation of new authorities for certain OTC drugs. FDA posted the deemed final order for sunscreens which sets the current requirements for marketing OTC sunscreen products. FDA also posted the proposed order for sunscreens to amend and revise this deemed final order for OTC sunscreens products. The proposed order reflects FDA's proposed requirements for OTC sunscreen products for the future. The proposed order is a proposal and does not "take effect" until it is finalized. A 45-day public comment period began when FDA issued the proposed order. After reviewing and considering

the comments, FDA will issue a final order that will include an effective date. The CARES Act specifies that the effective date for the final order cannot be earlier than one year after issuance of the final order.

This resolution urges Congress to explore policy options to improve the timeliness of the FDA's approval pathways for sunscreen ingredients and filters.

v) **Comparisons to sunscreens in other countries**. . Many consumers have reported sunscreens available in other countries, primarily countries within European Union (EU), Australia, and Japan, are more effective and less expensive. The European Commission regulates sunscreens as cosmetics, which allows more flexibility in which active ingredients sunscreen manufacturers can use to protect against UVA rays. The EU has 34 UV filters approved for use in sunscreens, compared to 16 in the U.S. In countries subject to European Commission regulations, manufacturers voluntarily comply with a recommendation that all sunscreens offer UVA protection at least one-third as potent as the SPF. For example, if a product advertises SPF 30, its UVA protection must be at least SPF 10.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
HR 105 (Dixon) – As Introduced June 10, 2024

SUBJECT: Opioid Abuse Awareness.

SUMMARY: Requests the Governor, the California Health and Human Services Agency, the Department of Health Care Services (DHCS), Department of Corrections and Rehabilitation, and other relevant state entities to further prioritize increasing public and provider awareness of the health risks associated with opioid abuse. Requests DHCS to increase public and provider awareness of non-opioid pharmacological therapies to treat pain. Encourages the health care community to educate themselves and their patients as to the societal, fiscal, and health benefits of non-opioid therapies to treat pain. Encourages state agencies, within existing resources, to pursue opportunities and collaborate to protect access to non-opioid alternatives for people or entities providing, assisting, seeking, or obtaining such non-opioid alternatives for the treatment of pain in California. Makes findings and declarations including that the opioid crisis has devastated communities within California, that the federal Centers for Disease Control and Prevention (CDC) issued updated guidance emphasizing that non-opioid therapies are at least as effective as opioids for many common types of pain, and that awareness of and access to non-opioid pharmacological treatments for pain are vitally important to California's efforts to combat the opioid crisis, and use of these treatments should be considered by doctors when addressing a patient's pain.

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS RESOLUTION.** According to the author, the opioid crisis continues to plague California. The author continues that many of those addicted to illicit and extremely harmful drugs, first began their dependence on drugs with a legal prescription for opioids to treat acute pain. The author argues that as medical science continues to evolve, and new non-opioid treatments become accessible, the state's health agencies and our medical professionals should be educated on their availability and use. The author concludes that pain is very real for many patients, and providing non-opioid pharmacological treatments for them is an important component of stemming the tide on the opioid crisis.

2) **BACKGROUND.** California is facing an overdose epidemic. According to a 2022 California Health Care Foundation report "Substance Use in California: Prevalence and Treatment," 9% of Californians have met the criteria for a substance use disorder (SUD). While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with a 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 10-fold increase in fentanyl related deaths between 2015 and 2019.

   a) **Fentanyl.** Fentanyl is a potent synthetic opioid drug approved by the United States (US) Food and Drug Administration 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 1960's as an intravenous anesthetic. Fentanyl is legally manufactured and distributed in the US; 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) **CDC Guidance on Non-Opioid Therapies.** In November 2022, the CDC released their "Clinical Practice Guideline for Prescribing Opioids for Pain," providing guidelines for clinicians providing pain care for patients 18 and over. The guidance states that non-opioid therapies are at least as effective as opioids for many common types of acute pain. The guidance further states that non-opioid therapies are preferred for subacute and chronic pain. Non-opioid therapies can be pharmacologic, such as topical or oral non-steroidal anti-inflammatory drugs, or non-pharmacologic, such as ice, heat, exercise therapy, and acupuncture. The CDC recommends that clinicians should maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate and only consider opioid therapy if benefits are anticipated to outweigh risks to the patient. The CDC continues that before starting opioid therapy, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

REGISTERED SUPPORT / OPPOSITION:

Support

California Life Sciences

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
HR 107 (Waldron) – As Introduced June 12, 2024

SUBJECT: Behavioral Health Care.

SUMMARY: Urges the state of California to address established practices and investments by creating a statewide minimum standard for behavioral health (BH) care that emphasizes prevention and early intervention. Proposes this minimum standard of care to give equal access to a variety of interrelated elements of prevention and care, regardless of where individuals reside and who insures them. States that to be successful in addressing the BH crisis, strategies must mirror those made in primary health care, where the goal is prevent BH conditions and detect early warning signs as soon as possible. States the concept of "flipping the triangle" in mental health (MH) care seeks to invert the existing model, by prioritizing early prevention rather than crisis management, establishing a baseline for prevention and early intervention, identifying gaps in service, and ensuring equitable access and consistent quality of care across counties and across plans. Resolves that the Assembly recognizes the importance of "flipping the triangle" in the MH care model. Makes findings and declarations about the prevalence of BH conditions in California and California's investment in reactive responses to BH challenges rather than prevention and intervention.

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS RESOLUTION.** According to the author, California faces a MH crisis, with one in seven adults experiencing BH challenges, and two-thirds not receiving treatment. The author continues that this resolution calls to "flip the triangle" of resource allocation in BH care, by prioritizing prevention and early intervention, ensuring equitable access to treatment. The author argues that a proactive approach reduces the need for acute care, overall improving health outcomes. The author concludes that by establishing a statewide minimum standard, this resolution seeks to create a more effective and fair BH care system for all Californians.

2) **BACKGROUND.**

   a) **Prevalence of MH disorders in California.** A 2022 publication from the California Health Care Foundation (CHCF), entitled "Mental Health in California" reported that nearly one in seven California adults experiences a mental illness, and one in 26 has a serious MH condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level. Despite major investments and policy shifts to bolster MH treatment in recent years, close to two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes reported that they didn't receive any treatment. These barriers to care are an issue of equity. A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly 5 million, or

16%, of Black Americans reported having a mental illness. However, only one in three Black adults who needs MH care receives it. Similarly, a 2021 study by the University of California Los Angeles Center for Health Policy Research found that almost half of Latino adults who had a perceived need for MH services experienced an unmet need for care.

b) Prevalence of Substance Use Disorder (SUD) in California. A 2022 publication from CHCF, entitled "Substance Use in California: Prevalence and Treatment" reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a 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 10-fold increase in fentanyl related deaths between 2015 and 2019. The California Department of Public Health'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.

c) Modernizing California's MH System. In March 2023, Governor Newsom announced in his plan to modernize California's MH system. With the passage of Proposition 1 on the March 2024 ballot, several new initiatives will be undertaken to:

i) Build thousands of new BH beds in state-of-the-art residential settings to house Californians with mental illness and substance use disorders, which could serve over 10,000 people every year in residential-style settings that have on-site services, including some locked facility beds;

ii) Provide more funding specifically for housing for homeless veterans;

iii) Recast the Mental Health Services Act as the BH Services Act (BHSA). leading to approximately $1 billion every year in local assistance for housing and residential services for people experiencing mental illness and substance use disorders, and allowing BHSA funds to serve people with substance use disorders; and,

iv) Include new accountability and oversight measures for counties to improve performance.

d) "Flip the Triangle." According to a National Institutes of Health study "Flip the Triangle: using quality improvement methods to embed a positive behaviour support approach on a medium secure forensic ward for men with intellectual disabilities" the "flip the triangle" quality improvement project aimed to develop a model of care and culture in London's Shoreditch Ward by flipping the attention and effort of staff to increase focus on positive and proactive interventions to manage and prevent challenging behaviors before they occur. The project team reported a 95% increase in positive and proactive interventions. The project team reported this shift had a significantly positive impact on the ward culture and the care of patients with intellectual disabilities and recommended the approach to be shared with other services.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 803 (Becker) – As Amended June 17, 2024

SENATE VOTE: Not relevant.

SUBJECT: Heal Our Heroes Act.

SUMMARY: Creates the Heal our Heroes Act which establishes the Psychedelic-Assisted Facilitation Pilot Program (pilot program) in the City and County of San Francisco, the County of San Diego, and the County of Santa Cruz. Specifically, **this bill**:

1) Establishes the pilot program. Permits the public health officers (PHOs) of the City and County of San Francisco, the County of San Diego, and the County of Santa Cruz to create programs to approve entities within their jurisdictions to establish and operate psychedelic-assisted facilitation centers. Requires PHOs of authorizing jurisdictions to consult with experts in psilocybin or psilocin facilitation on program design.

2) Requires PHOs of authorizing jurisdictions to provide law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting.

3) Requires the PHO of the authorizing jurisdiction to collect all of the following:

    a) The total number of participants;

    b) The demographic information of each participant; and,

    c) Reports on outcomes, including any serious adverse events.

4) Requires the PHO of the authorizing jurisdiction to submit a report on the collected data with recommendations for changes to the program to the Legislature no later than January 1, 2027.

5) Requires authorized jurisdictions to issue permits to facilitators. Requires facilitators to be licensed physicians and surgeons.

6) Requires entities, in order to be approved to operate a psychedelic-assisted facilitation center, to at a minimum:

    a) Provide a hygienic space to consume the psychedelic under supervision of trained staff;

    b) Provide sterile consumption supplies and provide secure disposal services;

    c) Monitor participants and provide care as necessary;

    d) Provide access or referrals to substance use disorder (SUD) treatment services, primary medical care, mental health services, and social services;

    e) Provide reasonable security of the center location;

f) Establish operating procedures for the center, including, but not limited to, standard hours of operation, training standards for staff, a minimum number of personnel required to be onsite during those hours of operation, and the maximum number of individuals who can be served at one time;

g) Establish a plan for staff and workplace safety; and,

h) Establish an emergency response plan.

7) Requires psychedelic-assisted facilitation centers to only administer psilocybin or psilocin as authorized by this bill. Prohibits a psychedelic-assisted facilitation center from possessing or administering any other psychedelic substance, unless otherwise authorized by law.

8) Requires psychedelic-assisted facilitation centers to only administer psychedelics to persons who:

a) Are a veteran or former first responder;

b) Are 21 years of age or older; and,

c) Have passed a suitability screening.

9) Permits only facilitators with a permit to administer a psychedelic at a psychedelic-assisted facilitation center. Prohibits administration outside of a facilitated session at a psychedelic-assisted facilitation center.

10) Limits authorizing jurisdictions to five psychedelic-assisted facilitation centers.

11) Permits an individual with an issued permit to cultivate a spore or mycelium or other material with the intent to cultivate psilocybin or psilocin for the purpose of the pilot program.

12) Prohibits the distribution or sale of psilocybin or psilocin in this state without a certificate of analysis from an independent testing laboratory that has been certified by the state that confirms both of the following:

a) The product is a batch of psilocybin or psilocin that was tested by the independent testing laboratory; and,

b) The tested sample of the batch did not contain contaminants that are unsafe for human or animal consumption.

13) Limits authorizing jurisdictions to three permits to cultivate.

14) Creates liability protections for persons involved in the activities of a psychedelic-assisted facilitation center, as specified.

15) States legislative findings and declarations on the mental health challenges of veterans and first responders and emerging research on psychedelic treatment.

16) Repeals the provisions of this bill on January 1, 2028.

EXISTING FEDERAL LAW:

1) Makes it unlawful for any person to knowingly or intentionally possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of their professional practice, or as otherwise specified. [21 United States Code (U.S.C.) § 844]

2) Makes it unlawful to knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance. [21 U.S.C. § 856 (a)]

3) Makes it unlawful to manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally renting, leasing, profiting from, or making available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance. [21 U.S.C. § 856, (b)]

EXISTING STATE LAW:

1) Establishes the Uniform Controlled Substances Act which regulates controlled substances and defines an opiate as any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. [Health and Safety Code (HSC) § 11020]

2) Lists controlled substances into five "schedules" intended to list drugs in decreasing order of harm and increasing medical utility or safety and provides penalties for the possession of and the engagement in commerce of a controlled substances. Includes in Schedule I the most serious and heavily controlled substances, with Schedule V being the least serious and most lightly controlled substances. [HSC § 11054-11058]

3) Classifies several hallucinogenic substances including Dimethyltryptamine (DMT), ibogaine, mescaline, psilocybin, and psilocin as Schedule I substances. [HSC § 11054(d)]

4) Prohibits the possession of several specified controlled substances. [HSC §11350(a)]

5) Makes it is unlawful to possess any device, instrument, or paraphernalia used for unlawfully injecting or smoking specified controlled substances, except as specified. [HSC §11364(a)]

6) Makes it unlawful for any person to deliver, furnish, or transfer, possess with intent to deliver, furnish, or transfer, or manufacture with the intent to deliver, furnish, or transfer, drug paraphernalia, knowing that it will be used to plant, propagate, cultivate, grow, harvest, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance. [HSC §11364.7]

7) Makes it unlawful to visit or to be in any room or place where specified controlled substances are being unlawfully smoked or used with knowledge that such activity is occurring. [HSC §11365(a)]

8) Provides that the possession of methamphetamine and other specified controlled substances is unlawful. [HSC §11377(a)]

9) Makes it unlawful for a person to transport, import into this state, sell, furnish, administer, or give away, or offer to transport, import into this state, sell, furnish, administer, or give away, or attempt to import into this state or transport specified controlled substances, including psilocybin and psilocyn. [HSC § 11379]

10) Makes it unlawful for a person to agree, consent, or in any manner offer to unlawfully sell, furnish, transport, administer, or give specified controlled substances, including psilocybin and psilocyn. [HSC §11382}]

11) Provides that it is unlawful to be under the influence of specified controlled substances. [HSC §11550(a)]

12) Makes it unlawful for a person who, with the intent to produce psilocybin or psilocin, cultivates any spores or mycelium capable of producing mushrooms or other material which contains such a controlled substance. [HSC §11390]

13) Makes it unlawful to transport, import into this state, sell, furnish, give away, or offer to transport, import into this state, sell, furnish, or give away any spores or mycelium capable of producing mushrooms or other material which contain psilocybin or psilocin. [HSC § 11391]

FISCAL EFFECT: None.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is a practical measure aimed at improving mental health support for California's veterans and first responders. The author argues that research shows that when used with proper screening and support, psychedelics can significantly help those struggling with mental health and addiction disorders. The author continues that as public interest in these treatments grows, surveys suggest more people are turning to unregulated sources for access. The author concludes that this bill takes an evidence-based approach to providing safe access to these promising treatments. California has a responsibility to provide quality care for its heroes, and this bipartisan effort will make a real impact on those who serve our state and country.

2) BACKGROUND.

a) Psychedelics. Psychedelics, also known as hallucinogens, are a diverse group of drugs that alter a person’s perception or awareness of their surroundings. Some hallucinogens are found in plants and fungi and some are synthetically produced. According to the National Institute on Drug Abuse, hallucinogens are commonly split into two categories: classic hallucinogens and dissociative drugs. Both types can cause hallucinations, and dissociative drugs can cause the user to feel disconnected from their body or environment. Hallucinogens can be consumed in a variety of ways, including swallowed as tablets, pills, or liquid, consumed raw or dried, snorted, injected, inhaled, vaporized, smoked, or absorbed through the lining of the mouth using drug-soaked pieces of paper.

Common hallucinogens include lysergic acid diethylamide (LSD), Dimethyltryptamine (DMT), psilocybin, peyote, mescaline, and ketamine.

Many hallucinogenic substances, including LSD, DMT, mescaline, and psilocybin are classified as Schedule I substances under the state's Uniform Controlled Substances Act. Schedule I substances are defined as those controlled substances having no medical utility and that have a high potential for abuse. There is research, however, that indicates that many of these substances have therapeutic benefits. (Davis et. al, "Effects of Psilocybin-Assisted Therapy on Major Depressive Disorder", *JAMA Psychiatry* (2020); D'Souza et al., "Exploratory Study of the Dose-Related Safety, Tolerability, and Efficacy of Dimethyltryptamine (DMT) in Healthy Volunteers and Major Depressive Disorder," Neuropsychopharmacol (2022); Köck et al., "A Systematic Literature Review of Clinical Trials and Therapeutic Applications of Ibogaine," *Journal of Substance Abuse Treatment* (2022)).

In recent years, the U.S. Federal Drug Administration (FDA) has designated psilocybin as a "breakthrough therapy" to treat severe depression. (Saplakoglu, "FDA Calls Psychedelic Psilocybin a 'Breakthrough Therapy' for Severe Depression," Live Science (Nov. 25, 2019). The "breakthrough therapy" designation is "a process designed to expedite the development and review of drugs that are intended to treat a serious condition and preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over available therapy on a clinically significant endpoint."

While research on hallucinogenic substances is promising, their use is not without risk. Hallucinogens included in this bill are associated with significant harms. The absence of adequate reporting systems to track these harms hampers the ability to quantify them, however, a review of the medical literature, demonstrates these drugs contribute to non-trivial risks for individuals and the public health. Case reports document adverse effects of psilocybin and other hallucinogens including acute panic *(Nordic Council of Ministries, 2009; Riley and Blackman, 2008; van Amsterdam et al., 2011)*, risk of physical self-harm *(Allen et al., 1991; Schwartz and Smith, 1988; van Amsterdam et al., 2011)*, self-harm resulting in death, including in cases with no known medical or psychiatric history *(Honyiglo et al., 2019)*, medical help-seeking *(Allen et al., 1991; Nordic Council of Ministries, 2009; Mowry et al., 2014)*, and enduring negative psychological or psychiatric problems *(Allen et al., 1991; Nordic Council of Ministries, 2009; Nielen et al., 2004; Espiard et al., 2020; Hendin et al., 2021)*.

b) California and Federal Drug Schedules. California and Federal drug schedules closely mirror each other. Both have five schedules intended to list drugs in decreasing order of harm and increasing medical utility or safety and provides penalties for possession of and engaging in the commerce of controlled substances. Schedule I includes the most serious and heavily controlled substances, with Schedule V being the least serious and most lightly controlled substances. The drugs on each schedule are largely consistent.

Schedule I – The drug has a high potential for abuse; the drug has no currently accepted medical use in treatment in the United States (US); there is a lack of accepted safety for use of the drug under medical supervision.

Schedule II – The drug has a high potential for abuse; the drug has a currently accepted

medical use in treatment in the U.S. or a currently accepted medical use with severe restrictions; abuse of the drug may lead to severe psychological or physical dependence.

Schedule III – The drug has potential for abuse less than the drugs or other substances in Schedule I and II; the drug has a currently accepted medical use in treatment in the U.S.; abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV – The drug has a low potential for abuse relative to the drugs in Schedule III; the drug has a currently accepted medical use in the U.S.; abuse of the drug may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

Schedule V – The drug has a low potential for abuse relative to the drugs or other substances in IV; the drug has a currently accepted medical use in treatment in the U.S.; abuse of the drug may lead to limited physical dependence of psychological dependence relative to the drugs or other substances in Schedule IV.

c) Criminal Under Federal Law: State authorization does not nullify federal drug laws, and the substances this bill authorizes for use in the pilot program remain illegal under federal law. As a result, PHO authorization for approved facilitators and facilities to use psilocybin and psilocin would not prevent the federal government from shutting down those facilities. Likewise, state authorization does not provide immunity from federal criminal proceedings, if federal law enforcement was inclined to pursue them.

For example, federal law provides, "It shall be unlawful for any person knowingly or intentionally to possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of his professional practice," or as otherwise specified. Federal law also makes it unlawful to do either of the following:

i) Knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, **o**r using any controlled substance; or,

ii) Manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

This means the facilitators and centers proposed in this bill would still be illegal under federal law.

d) Reform Efforts Related to Psychedelics: Though most psychedelic drugs remain federally controlled, some states and the District of Columbia have decriminalized possession or deprioritized enforcement of laws against the substances. According to a 2022 *JAMA Psychiatry* article "Psychedelics Drug Legislative Reform and Legalization in the US," 25 states have considered 74 bills. Nearly all specified psilocybin (67), and many also included methylenedioxymethamphetamine (MDMA) (27). While bills varied

in their framework, most proposed decriminalization (43), of which few delineated medical oversight (10 of 43) or training and/or licensure requirements (15 of 43).

In 2019, voters in Denver approved a measure to make the personal use and possession of psilocybin by adults 21 years of age and older the lowest law enforcement priority and to prohibit the city from spending resources to impose criminal penalties related to such conduct. That same year, the Oakland City Council passed a resolution prohibiting the use of city funding "to assist in the enforcement of laws imposing criminal penalties for the use and possession of entheogenic plants by adults" and specifies that investigating people for growing, buying, distributing or possessing those substances "shall be amongst the lowest law enforcement priority for the City of Oakland." Similarly, a resolution passed by the Santa Cruz City Council in 2020 made the personal possession and use of entheogenic plants and fungi a low priority for law enforcement. Additional jurisdictions have passed similar measures since 2020.

In 2020, Oregon voters approved Measure 109, the Psilocybin Services Act, which directed the Oregon Health Authority to create a state-licensed, psilocybin-assisted therapy program over a two-year period. In implementing Measure 109, Oregon had to determine how to license and regulate the manufacturing, transportation, delivery, sale and purchase of psilocybin products as well as the provision of psilocybin services. Following the two-year development period for psilocybin services, the state began taking license applications on January 2, 2023. Psilocybin services refers to preparation, administration, and integration sessions provided by a licensed facilitator. Psilocybin services are available to individuals aged 21 and older and do not require a prescription or medical referral. The psilocybin products consumed must be cultivated or produced by a licensed psilocybin manufacturer and can only be provided to a client at a licensed psilocybin service center during an administration session.

In 2021, Texas adopted House Bill 1802, which directed their Department of State Health Services to, in collaboration with the Texas Medical Board, conduct a study to evaluate the therapeutic efficacy of alternative therapies, including the use of MDMA, psilocybin, and ketamine in the treatment of mental health and other medical conditions including, depression, anxiety, post-traumatic stress disorder, bipolar disorder, chronic pain, and migraines. The evaluation should include a determination of whether alternative therapies are effective in treating the mental health and other medical conditions described in the bill and to compare the efficacy of the alternative therapies with the efficacy of treatments currently used for those conditions.

In 2022, Colorado voters approved Proposition 122 which, among things, decriminalized the personal possession and use of psilocybin, psilocyn, DMT, ibogaine and mescaline for adults aged 21 and older. The measure additionally establishes a program for licensed "healing centers" to administer psilocybin and psilocyn to adults by licensed professionals, and creates a regulatory framework for the manufacture, cultivation, testing, storage, transport, transfer, delivery, sale, and purchase of the covered substances between healing centers and other permitted entities.

e) FDA Draft Guidance on Clinical Trials with Psychedelic Drugs. On June 23, 2023, FDA published draft guidance to highlight fundamental considerations to researchers investigating the use of psychedelic drugs for potential treatment of medical conditions,

including for psychiatric conditions or SUDs. This is the first FDA draft guidance that presents considerations to industry for designing clinical trials for psychedelic drugs.

There has been growing interest in the therapeutic potential of psychedelic drugs in recent years. They are being evaluated for use in the potential treatment of conditions such as depression, post-traumatic stress disorder, SUDs and other conditions. However, designing clinical studies to evaluate the safety and effectiveness of these compounds presents a number of unique challenges that require careful consideration.

"Psychedelic drugs show initial promise as potential treatments for mood, anxiety and SUDs. However, these are still investigational products. Tiffany Farchione, M.D., director of the Division of Psychiatry in the FDA's Center for Drug Evaluation and Research said that "sponsors evaluating the therapeutic potential of these drugs should consider their unique characteristics when designing clinical studies. By publishing this draft guidance, the FDA hopes to outline the challenges inherent in designing psychedelic drug development programs and provide information on how to address these challenges. The goal is to help researchers design studies that will yield interpretable results that will be capable of supporting future drug applications."

The purpose of the draft guidance is to advise researchers on study design and other considerations as they develop medications that contain psychedelics. Within the draft guidance, the term psychedelics refers to "classic psychedelics," typically understood to be drugs such as psilocybin and LSD that act on the brain's serotonin system, as well as "entactogens" or "empathogens" such as MDMA.

The FDA draft guidance describes basic considerations throughout the drug development process including trial conduct, data collection, subject safety and new drug application requirements. For example, psychedelic drugs may produce psychoactive effects such as mood and cognitive changes, as well as hallucinations. As a result, there is the potential for abuse of these drugs, which is a drug safety issue that requires careful consideration and putting sufficient safety measures in place for preventing misuse throughout clinical development. For psychedelics that are currently Schedule I controlled substances, the draft guidance notes that activities associated with investigations under an Investigational New Drug Application must comply with applicable Drug Enforcement Administration regulatory requirements.

The evidentiary standard for establishing effectiveness of psychedelic drugs is the same as for all other drugs. However, there are unique factors investigators may need to consider when designing their clinical trials if those trials are to be considered adequate and well-controlled. The draft guidance also addresses the role of psychotherapy in psychedelic drug development, considerations for safety monitoring and the importance of characterizing dose-response and the durability of any treatment effect.

3) **SUPPORT**. Law Enforcement Action Partnership (LEAP) supports this bill, stating it will pose little risk to public safety, and will not increase recreational psychedelic consumption, as it does not decriminalize the sale, possession, or use of psychedelics outside of the therapeutic, regulated pilot program. LEAP continues that millions of military veterans and first responders are struggling with serious mental health challenges and therapy, daily medication, and other coping mechanisms help some people get by — but for many, these

tools aren't working. LEAP argues that this bill would promote the safe use and continued research of psychedelic assisted therapy. LEAP continues that in the wake of an unaddressed mental health crisis, rampant opioid overdoses, and police and veteran suicides caused by PTSD, this bill would offer hope.

4) **DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Committee on Public Safety

5) **RELATED LEGISLATION**.

   a) AB 941 (Waldron) requires the California Health and Human Services Agency to convene a workgroup to study and make recommendations on the establishment of a framework governing psychedelic-assisted therapy. Requires the workgroup to send a report to the Legislature containing those recommendations on or before January 1, 2026. Makes, contingent upon the Legislature enacting a framework governing psychedelic-assisted therapy, the use of hallucinogenic/psychedelic substances for psychedelic-assisted therapy lawful. AB 941 is currently pending in the Senate Health Committee.

   b) SB 1012 (Wiener) would have established the Regulated Psychedelic Facilitators Act and Regulated Psychedelic-Assisted Therapy Act administered by three new state entities: a Division of Regulated Psychedelic-Assisted Therapy; a Board of Regulated Psychedelic Facilitators and; a Regulated Psychedelic Substances Oversight Committee, each of which is required to undertake significant regulatory efforts to determine, define, and establish standards for psychedelic facilitation in California. SB 1012 was held on the Senate Appropriations Suspense file.

6) **PREVIOUS LEGISLATION**.

   a) SB 58 (Wiener) of 2023 would have decriminalized possessing, preparing, obtaining, transferring, as specified, or transporting of, specified quantities of psilocybin, psilocyn, DMT, ibogaine, and mescaline, for personal use or facilitated or supported use, as defined, by and with persons 21 years of age or older. SB 58 was vetoed by Governor Newsom whose veto message stated in part:

      "California should immediately begin work to set up regulated treatment guidelines - replete with dosing information, therapeutic guidelines, rules to prevent against exploitation during guided treatments, and medical clearance of no underlying psychoses. Unfortunately, this bill would decriminalize possession prior to these guidelines going into place, and I cannot sign it. I urge the legislature to send me legislation next year that includes therapeutic guidelines."

   b) SB 519 (Wiener) of 2022 was substantially similar to SB 58. SB 519 died on the Assembly inactive file.

   c) SB 57 (Wiener) of 2022 would have authorized the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention program for adults supervised by healthcare professionals or other trained staff where people who use drugs can safely consume drugs and get access or

referrals SUD treatment services, primary medical care, mental health services, and social services. SB 57 was vetoed by Governor Newsom whose veto message stated in part:

> "I have long supported the cutting edge of harm reduction strategies. However, I am acutely concerned about the operations of safe injection sites without strong, engaged local leadership and well-documented, vetted, and thoughtful operational and sustainability plans. The unlimited number of safe injection sites that this bill would authorize - facilities which could exist well into the later part of this decade - could induce a world of unintended consequences. It is possible that these sites would help improve the safety and health of our urban areas, but if done without a strong plan, they could work against this purpose. These unintended consequences in cities like Los Angeles, San Francisco, and Oakland cannot be taken lightly. Worsening drug consumption challenges in these areas is not a risk we can take."

d) AB 362 (Eggman) of 2020 would have authorized the City and County of San Francisco to approve entities to operate an overdose prevention program for adults supervised by healthcare professionals or other trained staff where people who use drugs can safely consume drugs and get access to referrals to addiction treatment. AB 362 was never heard in the Senate Health Committee.

e) AB 2495 (Eggman) of 2016 would have decriminalized conduct connected to use and operation of an adult public health or medical intervention facility that is permitted by state or local health departments and intended to reduce death, disability, or injury due to the use of controlled substances. SB 294 was heard for testimony and returned to the desk.

7) POLICY CONCERNS.

a) Lack of oversight, standards, and framework. This bill authorizes the PHOs in San Francisco, Santa Cruz, and San Diego counties to establish a psychedelic-assisted facilitation pilot program. PHOs are physicians appointed by each county to support their mandate to "take measures as may be necessary to preserve and protect the public health." PHOs have over 170 distinct duties and are granted broad authority to prevent disease, including the authority to issue public health orders and declare local health emergencies. While PHOs are physicians, their duties are focused on public health. It is highly unlikely that these officers have the background, experience, and capacity to single-handedly establish and operate an experimental pilot program. This premise is especially concerning given that there is zero role for local or state government in establishing or overseeing the pilot programs in this bill.

b) Program design lacks clarity. To establish the pilot program, PHOs only need to fulfill one requirement: consult with experts in psilocybin or psilocin facilitation on program design. Prior to approving an entity to operate a psychedelic-assisted facilitation center under the pilot, this bill simply requires a PHO to hold a public meeting to provide "local law enforcement officials, local public health officials, and the public with an opportunity to comment." The final requirement on a PHO is to collect data and provide a single report to the Legislature on: the total number of participants, demographic information of each participant, and reports on outcomes, including any serious adverse events.

This limited framework leaves a number of questions and concerns unaddressed. The PHO is not required to do anything with the commentary provided during the public meeting. Beyond design, the PHO is not required to consult with experts or researchers throughout the pilot to observe, assess, or adjust the pilot as needed. The PHO is not required to collaborate with, seek approval from, or even notify any local or state officials before establishing the pilot program. There are no minimum standards or planning processes to ensure consistency across the pilot programs in the three counties. Under this bill, there would be no analysis of the pilot programs to meaningfully inform local or state government on outcomes and support future legislative efforts on psychedelics.

c) **Scarce health and safety standards.** In addition to establishing the pilot program, this bill empowers the PHO to approve psychedelic-assisted facilitation centers for operation. In order for an entity to be approved, they must demonstrate a minimum set of services, including to provide a hygienic space for psychedelic consumption, to monitor participants and provide care "as necessary," and to establish an emergency response plan. Leaving the demonstration of operability up to the facilities is of great concern. There is no requirement for the facilities to meet health or safety standards required of other health facilities, no minimum clinical staffing for medical care and intervention, no required services to be provided onsite outside of facilitation, and no required partnerships with law enforcement or emergency services. There is no one designated to manage the day-to-day oversight of facilities after they're approved, no requirement to monitor activities and outcomes throughout the pilot, no requirement to report adverse events as they happen, and no tools for shutting down a facility that's found to be harming participants.

d) **Cultivation with no regulation.** This bill also permits a PHO to issue three permits to cultivate a spore or mycelium or other material with the intent to cultivate psilocybin or psilocin. There are no guidelines on who can be a cultivator – no age limits, experience, or expertise required. This bill does require the psilocybin or psilocin to be independently tested by a laboratory to confirm that it did not contain contaminants that are unsafe for human or animal consumption, but beyond that there are no parameters as to where cultivation can and cannot happen, or what a safe environment is for cultivation. There is no limit on how much psilocybin or psilocin each permittee can cultivate, no limit on how much each facilitation center can purchase. And again, there is no requirement that local or state government is informed of the granting of a cultivation permit, no continual oversight of cultivators, and no requirement to monitor or report activities related to cultivation.

e) **Patient safety concerns.** To be qualified to participate in the pilot, an individual must meet three requirements: be a veteran or former first responder, be 21 years of age or older, and pass a "suitability screening." A suitability screening, as defined in this bill, is not required to be completed by a physician and, beyond pregnancy or breastfeeding, does not identify conditions or markers that would make a participant ineligible for psychedelic-assisted treatment. The use of psychedelics can negatively impact the well-being of individuals and are specifically contraindicated for individuals who have a personal or family history of primary psychotic or affective disorders like Schizophrenia or Bipolar 1, depression, as well as for people with significant trauma histories. For example, psychedelics could lead to reliving traumatic experiences, and opening up repressed traumatic memories that can lead to significant emotional upheaval. Because of

these significant contraindications, there should be thorough physical and mental health screenings, completed by clinicians, to thoroughly assess the appropriateness of an individual's participation in this pilot. This bill is also silent on what happens after facilitation to monitor and assess a patient's outcomes and state of being. At a minimum there should be required post-facilitation physical and mental health assessments, none of which is specified in this bill.

Additionally, despite the findings in this bill citing the varied mental health challenges that burden first responders and veterans, there are no specified conditions that make a participant eligible for psychedelic-assisted treatment. No post-traumatic stress disorder, depression, anxiety, or any mental health diagnosis is necessary to participate. Without a defined diagnosis, how would a facilitator know what they are treating, testing, monitoring, and assessing? If the goal is to ensure that individuals, particularly those with certain conditions are able to safely access these substances for treatment and therapy, that should be made clear much like it is under California's medicinal cannabis laws. Lastly, there are no dosage guidelines or limitations in the bill – leaving the door open for improper facilitation and treatment.

f) Unclear urgency. The current contents of this bill were introduced on June 6, 2024 and subsequently amended on June 17, 2024. This late introduction provides policy committees less than 3.5 weeks to hear, amend, and vote on legislation that would authorize the use of experimental, federally illegal, treatment on veterans and first responders. In the short time this Committee had to review the bill it identified extensive health concerns, but this analysis does not cover the varied concerns that have been raised by other committees and stakeholders. If there was more time, this Committee is confident even more concerns would arise.

There has been no clear urgency demonstrated as to why the Legislature must rush such a consequential bill through the process. The proponents of this bill have pointed to the Governor's veto message of SB 58 (Wiener) as their direction to move swiftly on this issue. However, the Governor's veto clearly stated his desire for legislation "to set up regulated treatment guidelines - replete with dosing information, therapeutic guidelines, rules to prevent against exploitation during guided treatments, and medical clearance of no underlying psychoses." As noted in the policy comments above, such guidelines are absent in this bill and left to localities to establish.

g) Conclusion. This narrative does not encompass all of the Committee's concerns in these regards, but demonstrates the significant lack of parameters and guardrails in this bill. The proponents of this bill have stated that local control is a key element for a pilot program, arguing that locals need to be able to make it work for their own community. But local control cannot come at the expense of patient safety. This bill is authorizing the therapeutic use of psychedelic substances that are not being utilized under the strict parameters of clinical research have nor have they been subjected to the rigorous drug approval process of the FDA. Safeguards need to be in place to ensure that each pilot program is established and run in a manner that is safe for participants, scientifically sound, meeting local and state health standards, and is producing conclusions of value for the state.

REGISTERED SUPPORT / OPPOSITION:

Support

Law Enforcement Action Partnership

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 945 (Alvarado-Gil) – As Amended June 13, 2024

SENATE VOTE: 38-0

SUBJECT: The Wildfire Smoke and Health Outcomes Data Act.

SUMMARY: Requires California Department of Public Health (DPH), the California Department of Forestry and Fire Protection (CAL FIRE), and the Wildfire and Forest Resilience Task Force (WFRTF) to coordinate and integrate existing wildfire smoke and health data to provide information on the negative health impacts of wildfire smoke and to evaluate the effectiveness of wildfire mitigation efforts on health outcomes in California. Requires DPH, in consultation with CAL FIRE and WFRTF, to create and manage a wildfire smoke and health data platform before July 1, 2026. Creates the Wildfire Smoke and Health Administration Fund (Fund), upon appropriation, for the purpose of collecting, managing, and improving wildfire smoke and health data. Specifically, **this bill**:

1) Requires DPH, CAL FIRE, and WFRTF to coordinate and integrate existing wildfire smoke and health data, including data from local, state, and federal agencies, open source data and other external data, to provide information on the negative health impacts of wildfire smoke and to evaluate the effectiveness of wildfire mitigation efforts on health outcomes in California.

2) Requires DPH, in consultation with CAL FIRE and WFRTF, to develop the following:
   a) Protocols for data sharing, documentation, quality control, and promotion of open-source platforms and decision support tools related to wildfire smoke and health data;
   b) Regularly updated data products that track air pollution concentrations attributable to wildfire smoke, population exposure to smoke, and cases of adverse health outcomes attributable to smoke;
   c) Smoke data products that include estimates of smoke impacts by individual wildfires;
   d) Methodological guidelines for estimating smoke air pollutant concentrations and counts of adverse health impacts attributable to wildfire smoke;
   e) Methodologies to estimate smoke emissions from human-made materials; and,
   f) Smoke emission inventories that include emission estimates from developed landscapes that are burned by wildfire.

3) Requires DPH, CAL FIRE, and WFRTF to create and manage a statewide integrated wildfire smoke and health data platform before July 1, 2026 that does all of the following:
   a) Integrates existing wildfire smoke and health data information from multiple autonomous databases managed by federal, state, and local agencies and academia using consistent and standardized formats;
   b) Integrates the data products, methodological guidelines, methodologies, and smoke emission inventories described in provision 2) b), d), e), and f), above;
   c) Provides documentation of data quality and data formats through metadata;
   d) Adheres to data protocols developed by state agencies pursuant to 2) above; and,
   e) Is able to receive both spatial and time series data from various sources.

4) States that state agencies can disseminate, manage, or publish data on this subject separately from the platform.

5) Creates the Fund, upon appropriation, to DPH, CAL FIRE and WFRTF, to support wildfire smoke and health data management and collection.

6) Directs the Department of Finance to develop a standardized agreement for the Fund to allow for voluntary donations from individuals, government entities, corporations, business, or other organizations.

EXISTING LAW:

1) Establishes DPH to protect the public's health and helps shape positive health outcomes for individuals, families, and communities. Specifies functions of DPH includes infectious disease control and prevention, food safety, environmental health, laboratory services, patient safety, emergency preparedness, chronic disease prevention and health promotion, family health, health equity, and vital records and statistics. [Health and Safety Code (HSC) § 131000]

2) Establishes the California Air Resources Board (CARB) as the state agency charged with coordinating efforts to attain and maintain ambient air quality standards, to conduct research into the causes of and solution to air pollution. [HSC § 39003]

3) Requires DPH to develop a plan with recommendations and guidelines for counties to use in the case of a significant air quality event caused by wildfires or other sources. Requires the plan to establish policies and procedures for: respiratory protection and other protective equipment and devices; providing information to residents on what to do if the air quality index hits a significant threshold; providing information to residents regarding the health impacts of inhaling air pollution during a significant air quality event caused by wildfires or other sources; developing prevention strategies to assist residents in avoiding inhalation of air pollutants; and, disseminating information to the public. [HSC §107250]

4) Establishes the WFRTF to support the state’s resilience to wildfires. [Executive Order No. B-52-18]

5) Requires the WFRTF, the California Natural Resources Agency (CNRA), the California Environmental Protection Agency (CalEPA), the Office of Planning and Research, CAL FIRE, in coordination with the relevant lead federal, state, local, and tribal agencies, to develop a comprehensive implementation strategy to track and ensure the achievement of the goals and key actions identified in the state’s “Wildfire and Forest Resilience Action Plan.” Requires on or before January 1, 2023, and annually thereafter until January 1, 2048, WFRTF to submit a report to the appropriate policy and budget committees of the Legislature on progress made in achieving the goals and key actions identified in the state’s “Wildfire and Forest Resilience Action Plan,” on state expenditures made to implement these key actions, and on additional resources and policy changes needed to achieve these goals and key actions. Requires on or before January 1, 2026, and every five years thereafter, WFRTF, or its successor to update the state’s “Wildfire and Forest Resilience Action Plan.” [Public Resources Code § 4771]

6) Establishes the Wildfire Forecast and Threat Intelligence Integration Center (Center) to collect, assess, and analyze fire weather data, atmospheric conditions, and other threat indicators that could lead to catastrophic wildfire and to reduce the likelihood and severity of wildfire incidents that could endanger the safety of persons, property, and the environment by developing and sharing intelligence products related to fire weather and fire threat conditions for government decision makers. Requires the Center to coordinate wildfire threat intelligence and data sharing among federal, state, and local agencies, tribal governments, utilities and other service providers, academic institutions, and nongovernmental organizations [Government Code. (GOV) § 8586.7]

7) Establishes the Office of Wildfire Technology Research and Development within CAL FIRE to study, test, and advise, regarding procurement of emerging technologies and tools in order to more effectively prevent and suppress wildfires within the state. [GOV § 8586.8]

FISCAL EFFECT: According to the Senate Appropriations Committee, DPH estimates ongoing annual costs of $1,310,000 starting in 2025-26, and potential additional limited-term costs of $880,000 for information technology, CAL FIRE estimates costs of $354,000 in year one, $254,000 in year two, and $238,000 annually thereafter for state administration, and WFRTF estimates no fiscal impact. Further, creation of the Fund would result in cost pressures to the General Fund if special fund revenues are not sufficient to cover the costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, amidst California's escalating wildfires fueled by climate change, the crucial necessity for effective forest management strategies is becoming increasingly evident. The author contends that, as these fires rage with unparalleled ferocity, endangering ecosystems, livestock, public health, and human lives, it is imperative to gather comprehensive data on the health effects of wildfire smoke, particularly considering the heightened vulnerability of outdoor workers who experience increased inhalation of wildfire smoke due to the nature of their duties. The author concludes that by requiring DPH, CAL FIRE, and WFRTF to create, operate, and maintain a statewide integrated wildfire smoke and health data platform, the state can bridge concerted efforts and mobilize action from both state authorities and the medical community to confront this critical, time-sensitive issue.

2) **BACKGROUND**.

   a) **California Wildfire Prevalence and Climate Change.** According to a 2023 study conducted at UCLA and published in the *International Journal of Wildland Fire,* dry air and record-breaking temperatures linked to climate change have led to more frequent and severe fires in California. Additional research funded by the National Integrated Drought Information System, indicate that summer burned areas in northern and central California have increased fivefold during 1996 to 2021 compared to 1971 to 1995. Additionally, 10 of the largest California wildfires have occurred in the last 20 years—five of which occurred in 2020 alone. CARB reports that because of the growth in extreme fires, 25% of the state's population now live in high fire-risk areas. As of June 18, 2024, there have been 2,103 wildland fires with more than 66,055 acres burned.

   b) **Wildfire Smoke.** Wildfires release a variety of particles and gases, including fine and coarse particles, greenhouse gases, reactive compounds, such as carbon monoxide and

nitrogen oxides, and volatile organic compounds, such as formaldehyde and benzene. Particulate matter (PM), especially fine particles ($PM_{2.5}$), is the main pollutant of concern from wildfire smoke due to its ability to penetrate deep into the lungs and bloodstream, affecting vital organs throughout the body. Wildfire smoke contains a variety of other pollutants, including chemicals listed as Hazardous Air Pollutants by the U.S. Environmental Protection Agency (U.S. EPA) and Toxic Air Contaminants by the Office of Environmental Health Hazard Assessment (OEHHA) within CalEPA. If fires reach more urban areas, other toxic chemicals can be released from the burning of household or industrial materials, like plastics, pesticides, and hazardous waste.

c) Wildfire Smoke and Health

i) According to "Wildfire Smoke, Considerations for California's Public Health Officials", developed by DPH and CARB, a growing body of scientific evidence links wildfire smoke exposure to various adverse health effects. Wildfire smoke exposure risks vary by age, being higher in childhood, lower in young adults, and increasing in middle and older age due to more prevalent heart, lung, and metabolic diseases. Pregnancy is a particularly vulnerable period for both the pregnant person and the fetus. High-risk groups also include individuals with preexisting heart and lung conditions, socially vulnerable people (e.g., the unhoused), outdoor workers, immunocompromised individuals, and those recovering from COVID-19. The report states that public health authorities should focus on reducing wildfire smoke exposure for these groups and educate them on smoke information, air filtration, and mitigation measures. The primary health threat from wildfire smoke is PM, which can cause respiratory issues like coughing and difficulty breathing. Studies have linked PM exposure to higher risks of premature death, and aggravated respiratory and cardiovascular diseases, including asthma, chronic obstructive pulmonary disease, bronchitis, pneumonia, heart attacks, cardiac arrhythmias, heart failure, and strokes.

ii) California Wildfire Smoke and Air Pollution Health Burden Mapping Dashboard. The California Wildfire Smoke and Air Pollution Health Burden Mapping Dashboard provides an in-depth look at the health impacts of air pollution and wildfire smoke from 2008 to 2016. Developed by DPH in collaboration with the Sequoia Foundation, CalEPA, and Sonoma Technology, Inc., this dashboard was partially funded by a grant from CAL FIRE's Forest Health Research Program, as part of California Climate Investments. The dashboard maps excess emergency department visits from respiratory or cardiovascular conditions attributed to exposures to particle pollution. The particle pollution data measures concentration of $PM_{2.5}$ on all days and on days affected by wildfire smoke. Each map showcases the exposure and health impact at the zip code level. The health burden can be further examined by race/ethnicity and age group. The dashboard is based on data in the publication, *Wildfires and the Changing Landscape of Air Pollution-related Health Burden in California*.

iii) California Climate Adaptation Strategy. AB 1482 (Gordon), Chapter 603, Statutes of 2015, required CNRA to create a Climate Adaptation Strategy (Strategy) and to update the Strategy every three years. The first Strategy was developed in 2017. According to CNRA, the 2024 draft builds on the evolved approach of the 2021 Strategy. Specifically, the 2021 Strategy and this 2024 draft outline the state's key

climate resilience priorities, includes specific and measurable actions, and serves as a framework for collective efforts across sectors and regions in California. The 2024 draft is open for public comment through July 12, 2024. One goal of the Strategy is to improve understanding of climate impacts on California's communities, including what drives vulnerability, and to increase the collection, analysis, and reporting of data on climate-related health impacts, especially the health impacts from cascading climate risks, such as heat and wildfire smoke exposure. To fulfill this goal, three success metrics were identified and assigned to specific agencies:

(1) The Health and Human Services Agency (CalHHS) is to add indicators, models, and tools to DPH's Climate Change and Health Vulnerability Indicators for California data visualization platform and update the platform annually.
(2) OEHHA is to provide a bibliography with plain language summaries of health outcome and epidemiological studies that examine human health impacts of climate-related stressors, to be updated biennially.
(3) OEHHA is to incorporate indicators of impacts on human health in the Indicators of Climate Change in California report, as data becomes available, starting in 2026 and updated every four years thereafter.

d) Evaluation of Wildfire Mitigation Efforts

i) California's Wildfire and Forest Resilience and Action Plan (Plan). The Plan was published in January 2021 and is designed to strategically accelerate efforts to restore the health and resilience of California forests, grasslands, and natural places. The Plan also includes efforts to reduce the health impacts of smoke by launching the "Smoke Ready California" campaign, releasing the California Smoke Spotter App, and enhancing the prescribed fire reporting system. Furthermore, the Plan highlights research grants distributed by CAL FIRE to evaluate the efficacy of forest management actions, improve model predictions, and improve research capacity in the state. Additional research topics outlined in the plan include evaluation of the following:

(1) The total cost of uncontrolled wildfire, including the health costs of increased air pollution, loss of economic output, lost school days, environmental damages, and other impacts.
(2) The effectiveness and trade-offs between alternative management strategies to reduce wildfire risk, increase carbon storage, improve biodiversity, improve water and air quality, and provide regional economic benefits.
(3) The human health impacts of smoke from prescribed and uncontrolled fires.

ii) California Wildfire and Landscape Interagency Treatment Dashboard. In 2022 WFRTF released the beta version of the California Wildfire and Landscape Interagency Treatment Dashboard. The Dashboard is a first-of-its-kind online platform that displays the location and size of federal and state wildfire and landscape resilience treatments throughout the state.

e) California Council on Science and Technology (CCST) and Blue Forest Report Recommendations. In September 2023 CCST and Blue Forest issued a report that examined the connections between forest management, wildfire smoke, and human health. Data for the report was collected through interviews with health sector organizations in

California and a review of the scientific literature. The report shows that that improving the health of California's forests can reduce the risk of wildfire and benefit people's health. Specifically, the report highlights four key takeaways:

i) Wildfire smoke impacts human health and health sector organizations' workforces, operations, and ability to provide services, yet the costs are largely unquantified. Quantifying these costs would enable state and local health sector organizations to make informed decisions regarding budgeting, resource allocation, and response.

ii) Many interviewed health sector organizations see value in future engagement with forest management to mitigate adverse outcomes and costs associated with wildfire smoke, but require avenues for collaboration and more information on the potential benefits of forest management to human health and the health sector.

iii) Comprehensive statewide or locally specific information on the adverse human health impacts of wildfire smoke are not readily available but could be generated from additional analysis of existing data resources. The data and methodologies to support the above understanding require thoughtful, forward-looking, collaborative, coordinated research design that is informed by use cases appropriate for California.

iv) A small but growing body of research suggests that management to improve forest health can be tailored to reduce total smoke impacts and benefit human health. Informed prioritization of management strategies that promote forest resilience and human health across California's many landscapes will benefit from filling data gaps relating the costs and efficacy of various treatments under different conditions.

f) Current Air Quality Standards and Data Reporting.

i) Federal Air Quality Standards. The federal Clean Air Act requires the U.S. EPA to establish air quality standards for major pollutants. Primary standards must protect public health and regulatory air monitoring is used to assure these standards are met throughout the U.S. The U.S. EPA has established National Ambient Air Quality Standards for six major air pollutants (also called "criteria air pollutants"), PM, ozone, sulfur dioxide, nitrogen dioxide, carbon monoxide, and lead. There are two primary standards for $PM_{2.5}$, a 24-hour standard, for short-term exposure, and an annual standard, for long-term exposure.

ii) State Air Quality Standards. Implementing air quality standards is the joint responsibility of U.S. EPA and states. States are responsible for developing enforceable state implementation plans to achieve and maintain air quality that meets national standards. State and local agencies are also responsible for air monitoring. CARB is the state agency responsible for air quality standards in California. The California Ambient Air Quality Standards, established by CARB, are more stringent than national standards and include additional pollutants like sulfates, hydrogen sulfide, vinyl chloride, and visibility-reducing particles.

iii) Air Quality Index and AirNow. The official U.S. Air Quality Index (AQI) communicates information about air quality, including health impacts, to the public. The AQI is a standardized, color-coded system that is applied to major air pollutants, including particle pollution ($PM_{2.5}$ and PM_{10}) and ozone. The averaging period for the

AQI is 24 hours for PM and eight hours for ozone. Each color on the AQI represents a different level of concern with regards to air quality based on a measurement of air pollutants.

iv) **AirNow.** AirNow is a website and app that reports on air quality using the AQI. AirNow is a partnership of the U.S. EPA; National Oceanic and Atmospheric Administration; National Park Service; National Aeronautics and Space Administration; U.S. Centers for Disease Control and Prevention; and tribal, state, and local air quality agencies. Agencies across the country send monitoring data to AirNow for inclusion in the data maps. The AirNow website also provides information on potential health impacts related to poor air quality.

3) **SUPPORT**. The California Farm Bureau, the sponsor of this bill writes that, "While the state has invested billions of dollars for the first time in developing a cohesive strategy to promote resilient forests, including the adaption of prescribed burning, there is little data available to understand how wildfire fuels mitigation investments are impacting health outcomes across the state in communities impacted by smoke events... This missing data leaves policy holders without complete information about the true costs of these massive fires, and the direct human health benefits and health cost controls that comes from investing in wildfire fuels mitigation. This bill will empower policy makers and stakeholders with data to fully understand the value of those investments."

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

5) **RELATED LEGISLATION**.

a) SB 1014 (Dodd) of 2024 requires the Deputy Director of Community Wildfire Preparedness and Mitigation within the Office of the State Fire Marshal, on or before January 1, 2026, and every three years thereafter, to prepare a Wildfire Risk Mitigation Planning Framework sufficient to quantitatively evaluate wildfire risk mitigation actions, as provided. SB 1014 is pending in Assembly Natural Resources Committee.

b) SB 1029 (Min) of 2024 would have required the Department of Conservation to submit a report to the Legislature that evaluates the impact and effectiveness of the Regional Forest and Fire Capacity program every five years, beginning December 31, 2028. SB 1029 was held on the suspense file in Senate Appropriations Committee.

c) AB 2344 (Petrie-Norris) of 2024 would have required, on or before July 1, 2025, and every July 1 thereafter, WFRTF to post on its website information about specified state, federal, and other publicly funded fire prevention grant programs, for each fiscal year in which the Legislature appropriated program funding or program projects occurred in the state. AB 2344 was held on the suspense file in Assembly Appropriations Committee.

d) SB 436 (Dodd) of 2023 would have required CalOES to prepare a Wildfire Risk Mitigation Planning Framework, a Wildfire Risk Baseline and Forecast, and a Wildfire Mitigation Scenarios Report, each to be released and updated on a specified schedule. SB 436 was returned to the Secretary of Senate pursuant to Joint Rule 56.

6) AB 788 (Petrie-Norris) of 2023 would have required WFRTF, on or before July 1, 2024, and annually thereafter, to compile and post on its internet website specified information relating to certain state and federal grant programs related to fire prevention, as provided. AB 788 was held on the suspense file in Senate Appropriations Committee.

7) PREVIOUS LEGISLATION.

a) AB 2538 (Robert Rivas) of 2022 would have required CalOES to ensure the California State Warning Center integrates, upon the next update to CalOES's emergency plan, a plan to provide targeted alerts for public health dangers, including smoke from wildfires. AB 2538 was held on the suspense file in Assembly Appropriations Committee.

b) AB 619 (Calderon), Chapter 412, Statutes of 2021, required DPH to develop a plan with recommendations and guidelines for counties to use in case of a significant air quality event caused by wildfires or other sources. Required a county, in advance of the next update to its emergency plan, to use the plan developed by DPH but allowed a county to incorporate its existing process, as specified.

c) SB 456 (Laird), Chapter 387, Statutes of 2021, renamed the Forest Management Task Force to WFRTF. Required WFRTF to develop a comprehensive implementation strategy to track and ensure the achievement of the goals and key actions identified in the WFRTF's Plan. Required specified annual reporting by WFRTF related to the progress achieving the goals and key actions in the Plan.

d) AB 73 (Robert Rivas), Chapter 322, Statutes of 2021, expanded the definition of essential workers to include agricultural workers for the purpose of accessing the personal protective equipment stockpile for emergencies. Directed the Division of Occupational Safety and Health to review and update the content of wildfire smoke training in existing regulations. Required training provided by employers to be in a language and manner readily understandable by employees.

e) SB 109 (Dodd), Chapter 239, Statutes of 2021, established the Office of Wildfire Technology Research and Development within CAL FIRE as well as the Wildfire Technology Research and Development Review Advisory Board, consisting of nine specified members.

f) ACR 33 (Friedman), Chapter 111, Statutes of 2021, stated the Legislature's commitment to improving wildfire outcomes in California by investing in science-based wildfire mitigation strategies that will benefit the health of California forests and communities.

g) SB 209 (Dodd), Chapter 405, Statutes of 2019, required Cal OES and CAL FIRE to jointly establish and lead the California Wildfire Forecast and Threat Intelligence Integration Center to take specified actions to create situational awareness of conditions that could result in catastrophic wildfires.

h) AB 464 (Cristina Garcia) of 2019 would have required CARB to include "catastrophic wildfire" in their air pollution inventory. AB 464 was held in the Senate Environmental Quality Committee.

8) **POLICY COMMENTS.** Given the wide array of tools, data, and resources available through multiple federal and state agencies to track and study wildfires and wildfire mitigation efforts, the author may wish to consider limiting the scope of the bill by removing provisions related to the measurement of smoke and the evaluation of wildfire mitigation efforts. Further, given the extensive range of health outcomes related to wildfire smoke, both short-term and long-term, the author may wish to provide guidance on what specific health outcomes should be included in the data platform and how often the data platform should be updated. The author may wish to use the California Wildfire Smoke and Air Pollution Health Burden Mapping Dashboard, previously developed by DPH, as an example.

REGISTERED SUPPORT / OPPOSITION:

Support

California Farm Bureau Federation (sponsor)
Amador Water Agency
American Red Cross California Chapter
Bear Yuba Land Trust
California Cattlemen's Association
California Farm Bureau Federation
California Forest Watershed Alliance
California Medical Association
California Society for Respiratory Care
California Special Districts Association
Community Action to Fight Asthma
County of Placer
CPCA Advocates, Subsidiary of The California Primary Care Association
Eastern Sierra Land Trust
El Dorado Irrigation District
Feather River Land Trust
Humboldt Redwood Company LLC
Megafire Action
Mountain Counties Water Resources Association
Nevada; County of
Placer Land Trust
Sierra Business Council
Sierra Consortium
Sierra County Land Trust
Sierra Foothill Conservancy
Sierra Nevada Alliance
Truckee Donner Land Trust
Union of Concerned Scientists
Upper Mokelumne River Watershed Authority

Opposition

None on file.

Analysis Prepared by: Natalie Pita / HEALTH / (916) 319-2097

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 954 (Menjivar) – As Amended June 3, 2024

SENATE VOTE: 29-9

SUBJECT: Sexual health: contraceptives.

SUMMARY: Requires all public high schools to make condoms available to students by the start of the 2025-26 school year, and to provide information to students on the availability of condoms as well as other sexual health information; prohibits public schools from preventing a school-based health center (SBHC) from making condoms available and easily accessible to students; and prohibits retail establishments from refusing to provide nonprescription contraception to a person solely on the basis of age. Specifically, **this bill**:

Health and Safety Code (HSC) provisions:

1) Prohibits a retail establishment from refusing to furnish nonprescription contraception to a person solely on the basis of age by any means, including, but not limited to, requiring the customer to present identification to demonstrate their age. Exempts a violation of this prohibition from penalties for violating the Sherman Law as described in 1) of existing law, below.

2) Defines "retail establishment" as any vendor that, in the regular course of business, furnishes nonprescription contraception at retail directly to the public, including, but not limited to, a pharmacy, grocery store, or other retail store.

3) Specifies that the prohibition in 1) above does not apply to the refusal to furnish nonprescription contraception on the basis of age if, under other provisions of federal or state law, the contraception is subject to restrictions on the basis of age.

Education Code (EC) provisions:

1) Requires each public school serving students in grades nine to 12 to make internal and external condoms available to all students free of charge by the start of the 2025-26 school year to prevent and reduce unintended pregnancies and sexually transmitted infections (STIs).

2) Requires schools to place condoms in a minimum of two locations on school grounds where they are easily accessible to students during school hours without requiring assistance or permission from school staff.

3) Requires schools to inform students of the availability and location of the free condoms at the beginning of each school year through existing school communication channels.

4) Requires public schools to prominently post at least one notice regarding the availability of free condoms in appropriate areas that are accessible to, and commonly frequented by, students, and requires the notice to include all of the following:

a) The contact information, including an email address and telephone number, for a designated individual responsible for maintaining the supply of condoms;
b) Information that abstinence from sexual activity and injection drug use is the only certain way to prevent human immunodeficiency virus (HIV) and other STIs and that abstinence from sexual intercourse is the only certain way to prevent unintended pregnancy;
c) Information directing pupils to where they can find information about how to use condoms properly; and,
d) Information on how to access local resources and students' legal rights to access local resources for sexual and reproductive health care such as testing and medical care for HIV and other STIs and pregnancy prevention and care, as well as local resources for assistance with sexual assault and intimate partner violence.

5) Requires a public school, upon request, to provide the notice in 4) above in an accessible format to ensure all students, including but not limited to those with visual disabilities, are able to access the notice.

6) Requires public schools serving students in grades seven to 12 to allow the distribution of condoms during the course of educational or public health programs and initiatives, including any of the following:

a) Community organizations or other entities providing instruction on the California Healthy Youth Act;
b) Pupil peer health programs, clubs, or groups;
c) Pupil health fairs conducted on campus; and,
d) SBHC staff.

7) Requires the governing board or body of a public school to designate one employee at each schoolsite to implement the requirements of 1) to 6) of the EC provisions above.

8) Makes the implementation of these provisions contingent upon an appropriation for this purpose.

9) Authorizes a state agency, the California Department of Education (CDE), or a public school to accept gifts, grants, and donations from any source for the support of a public school carrying out the provisions of this bill, including, but not limited to, the acceptance of condoms from a manufacturer or wholesaler.

10) Encourages public schools to explore partnerships with local health jurisdictions, community health centers, nonprofit organizations, and the Department of Public Health (DPH) to comply with the requirements of this bill.

11) Prohibits a public school serving students in grades seven to 12, a school district, the CDE, or a county office of education (COE), from preventing a SBHC from making internal and external condoms available and easily accessible to pupils at the SBHC site.

12) Requires the CDE to monitor compliance with the provisions of this bill as part of its annual compliance monitoring of state and federal programs.

13) Defines "public school" to include a school operated by a school district, COE, or a charter school.

14) Defines "local health jurisdiction" as a county health department or combined health department in the case of counties acting jointly or city health department.

15) Defines "school-based health center" as a center or program, located at or near a public school, that provides age-appropriate health care services at the program site or through referrals.

EXISTING LAW:

1) Enacts the Sherman Food, Drug and Cosmetic Law (Sherman Law), which provides broad authority for DPH to enforce requirements related to food, cosmetics, drugs, and home medical devices. [HSC §109875, et seq.]

2) Establishes the California Healthy Youth Act to provide pupils with the knowledge and skills necessary to protect their sexual and reproductive health from HIV and other sexually transmitted infections and from unintended pregnancy, and, among other things, to ensure that pupils receive integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention instruction, and provide educators with clear tools and guidance to accomplish that objective. (EC §51930)

3) Requires each school district to ensure that all students in grades seven to 12 receive comprehensive sexual health education and HIV prevention at least once in junior high or middle school and once in high school. Requires this instruction to include information about the value of delaying sexual activity while also providing medically accurate information on other methods of preventing HIV and other sexually transmitted infections and pregnancy, as well as information about the effectiveness and safety of all Food and Drug Administration approved contraceptive methods in preventing pregnancy, including, but not limited to, emergency contraception. (EC §51934)

4) Requires school districts, at the beginning of each school year, or, for a pupil who enrolls in a school after the beginning of the school year, at the time of that pupil's enrollment, to provide parents and guardians with a notice:

    a) About instruction in comprehensive sexual health education and HIV prevention education and research on pupil health behaviors and risks planned for the coming year;
    b) Advising the parent or guardian that the educational materials used in sexual health education are available for inspection;
    c) Advising the parent or guardian whether the comprehensive sexual health education or HIV prevention education will be taught by school district personnel or by outside consultants; and,
    d) Advising the parent or guardian that the parent or guardian has the right to excuse their child from comprehensive sexual health education and HIV prevention education and that in order to excuse their child they must state their request in writing to the school district. (EC § 51938)

FISCAL EFFECT: According to the Senate Committee on Appropriations, the bill's requirement for schools to provide condoms for free to students in grades nine through 12 would be contingent upon an appropriation, resulting in Proposition 98 General Fund cost pressure in the low millions of dollars in Proposition 98 General Fund each year. A precise amount would ultimately depend on how many condoms schools decide to make available. There could also be one-time cost pressures of an unknown amount to buy and install tamper-proof dispensers and post the notices with specified information.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, we cannot continue ignoring the STI epidemic among our youth when some high schools and retailers are enacting dangerous policies that deny them the ability to protect themselves. The author continues that this bill aims to safeguard the health and futures of high school students statewide by increasing equitable access to condoms while also increasing fiscal responsibility. The author contends that investing in prevention is a fraction of the cost compared to the millions California spends on the treatment of STIs every year.

2) **BACKGROUND**.

   a) **Sexual Health of Young People in California.** Sexual health is influenced by complex factors including biology, socioeconomics, community environments, relationships with family and peers, media, and access to health care and education. According to 2019 Centers for Disease Control and Prevention (CDC) data, it is estimated that although young people ages 15-24 make up 13% of the U.S. population, they represent around 27% of the sexually active population and account for around 53% of all new STI cases each year. According to KidsData.org, in 2018, more than 48,000 new chlamydia and gonorrhea infections were reported among teens ages 15-19 statewide. STIs, in particular, pose a major threat to sexual health—despite being largely preventable and curable—and disproportionately impact youth. According to the National Academies of Sciences, Engineering, and Medicine, the lifetime direct medical costs associated with STIs acquired in a single year among U.S. young people ages 15-24 have been estimated at $4.2 billion.

      Among infectious diseases that must be reported to the U.S. government, chlamydia and gonorrhea are the most common, with young people ages 15-24 having the highest rates of infection when compared with other age groups. Nationwide, African American/Black youth experience especially high rates of chlamydia and gonorrhea; in 2021, Black youth ages 15-19 were diagnosed with chlamydia at more than five times the rate for white youth of the same age, and with gonorrhea at nearly 12 times the rate of their white peers. If untreated, chlamydia and gonorrhea can lead to chronic pain, pelvic inflammatory disease, infertility, and adverse reproductive outcomes.

   b) **Sexual Health Education in California.** AB 329 (Weber), Chapter 398, Statutes of 2015, requires school districts, COEs, and the state special schools provide comprehensive sexual health education and HIV prevention education to all students at least once in middle school and at least once in high school. The EC defines comprehensive sexual health education as "education regarding human development and sexuality, including education on pregnancy, contraception, and STIs" and HIV

prevention education as "instruction on the nature of HIV and acquired immune deficiency syndrome (AIDS), methods of transmission, strategies to reduce the risk of HIV infection, and social and public health issues related to HIV and AIDS." Parents are afforded the right to opt their child out of a portion, or all, of the instruction and schools are required to notify parents and guardians of this right.

c) Condom Use and Access. Condoms are an effective method to prevent STIs, HIV, and pregnancy. According to the CDC, condom use among sexually active high school students decreased from 60% in 2011 to 52% in 2021.

i) Barriers to Condom Access. According to information provided by Essential Access Health, the sponsor of this bill, a survey conducted by TeenSource among California teens from December 2023-January 2024 found that 68% of teens indicated they do not have access to condoms in schools and 98% of respondents agreed that more sexually active teens would use condoms if they were easier to obtain. Approximately 92% of youth said schools should make condoms available.

Young people face multiple barriers to accessing condoms such as cost and lack of transportation to visit a store or health care provider to get condoms. According to information provided by the author and sponsors, young people have also reported being shamed, harassed, and discriminated against at some pharmacies and retailers while attempting to buy condoms, including being asked to show an I.D or denied service because they appeared to be "too young" despite the fact that there are no age requirements for condom purchases.

This bill includes a provision in the Sherman Law prohibiting retail establishments from refusing to provide nonprescription contraception to a person solely on the basis of age. This bill exempts a violation of this prohibition from penalties for violating the Sherman Law.

ii) School-based condom availability programs (CAPS). CAPs have existed since the early 1990s in high schools as one strategy to prevent unplanned pregnancy and to reduce the transmission of STIs and HIV. These programs make condoms available to students in places like the school nurse office, school-based health centers (SBHCs), classrooms, and vending machines. While some programs include things like advertisements for CAPs, most program descriptions do not include such detail. In general, most programs provide condoms to students free of charge and are implemented simultaneously with other sexual health promotion strategies (e.g., sexual health education, or HIV/STI testing and referral to treatment). A systemic review of school-based condom availability programs published in *AIDS and Behavior* in 2018 found that students in schools with CAPs were more likely to have obtained condoms than students in schools without CAPs.

According to Essential Access Health, some California high schools distribute free condoms to students, including schools in the Los Angeles and San Francisco Unified School Districts, in an effort to curb STI rates and reduce unintended pregnancy. However, not all schools do so, leaving youth in other regions – including regions with some of the highest rates of STIs and pregnancies among youth – without equitable access to condoms and preventive health resources. In 2020, Vermont

became the first state in the country to require middle and high schools to make free condoms readily available to students.

This bill requires all public high schools to make condoms available to students by the start of the 2025-26 school year, and to provide information to students on the availability of condoms as well as other sexual health information.

3) **SUPPORT**. According to Essential Access Health, teens have long reported facing multiple barriers to accessing condoms that deter them from seeking and securing the resources they need to protect themselves against STIs and unintended pregnancy. Essential Access Health continues that when barriers remain, youth with low-incomes are often left without the option to regularly utilize condoms to help protect their health and prevent an unintended pregnancy from occurring. Essential Access Health contends that increasing condom accessibility is a safe, low-cost intervention that provides young people with the resources they need while saving state dollars in the short and long-term. Essential Access Health further states that the scope of the STI epidemic requires bold action and that to reduce public health disparities and provide greater access to a preventive and cost saving tool we must ensure that California youth have equitable access to condoms.

4) **OPPOSITION**. The California Family Council writes in opposition to this bill, "This bill promotes a hookup culture that's a perfect petri dish for STIs to spread. The only certain method to reduce STIs is to encourage teens to develop self-control, which limits the number of sexual partners. This whole problem disappears if you promote a culture that treats sex as a special and intimate act to be shared in a monogamous, committed marriage."

5) **DOUBLE REFERRAL**. This bill is double referred; it passed the Assembly Education Committee with a vote of 5-0 on June 12, 2024.

6) **RELATED LEGISLATION**. SB 541 (Menjivar) of the 2023-24 Session was substantially similar to this measure. This bill was vetoed by the Governor, who stated, in part:

> While evidence-based strategies, like increasing access to condoms, are important to supporting improved adolescent sexual health, this bill would create an unfunded mandate to public schools that should be considered in the annual budget process.

7) **PREVIOUS LEGISLATION**.

   a) AB 2482 (Calderon), Chapter 933, Statutes of 2022, establishes the Wellness Vending Machine Pilot Program, until July 1, 2029, that requires the California State University and the California Community Colleges to establish at five campuses of their respective segments at least one vending machine that dispenses wellness products, including condoms. Additionally requests that the University of California establish at any number of its campuses at least one vending machine that dispenses wellness products.

   b) AB 2312 (Lee) of 2022 would have prohibited a retail establishment from refusing to furnish nonprescription contraception solely on the basis of age and would have required a $25,000 penalty for the retail establishment for each violation. AB 2312 was not heard in the Assembly Health Committee.

c) AB 329 makes instruction in sexual health education mandatory, revises HIV prevention education content, expands topics covered in sexual health education, requires this instruction to be inclusive of different sexual orientations, and clarifies parental consent policy.

REGISTERED SUPPORT / OPPOSITION:

Support

Essential Access Health (cosponsor)
Black Women for Wellness Action Project (cosponsor)
California School-Based Health Alliance (cosponsor)
Generation Up (cosponsor)
URGE: Unite for Reproductive & Gender Equity (cosponsor)
Voters of Tomorrow (cosponsor)
Access Reproductive Justice
ACLU California Action
AIDS Healthcare Foundation
Alameda County Board of Supervisors
Alliance for Children's Rights
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
American Nurses Association/California
APLA Health
Asian Americans Advancing Justice-Southern California
Bienestar Human Services
Buen Vecino
California Academy of Preventive Medicine
California Association for Health, Physical Education, Recreation & Dance
California Coalition for Youth
California Latinas for Reproductive Justice
California Legislative LGBTQ Caucus
California Nurse-Midwives Association
California Pan - Ethnic Health Network
California Primary Care Association
California Teachers Association
California Women's Law Center
Children Now
Christie's Place
Citizens for Choice
Community Health Councils
Courage California
Equality California
Glide
Health Officers Association of California
Indivisible CA: Statestrong
Junior Leagues of California State Public Affairs Committee
Los Angeles LGBT Center

Los Angeles Trust for Children's Health
Maternal and Child Health Access
National Center for Youth Law
National Health Law Program
Period @ Irvine, CA
Planned Parenthood Affiliates of California
Raizes Collective
Reproductive Freedom for All California
Sacramento LGBT Community Center
San Francisco AIDS Foundation
San Francisco Unified School District
SF Black and Jewish Unity Coalition
The Children's Partnership
The Los Angeles Trust for Children's Health
The Source LGBT+ Center
Training in Early Abortion for Comprehensive Health Care
Women's Foundation California
Women's Health Specialists
Young Invincibles

Opposition

California Baptist for Biblical Values
California Family Council
Concerned Women for America
Lighthouse Baptist Church
Real Impact.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 966 (Wiener) – As Amended June 18, 2024

SENATE VOTE: 39-0

SUBJECT: Pharmacy benefits.

SUMMARY: Establishes licensure and regulation requirements for pharmacy benefit managers (PBMs) under the California Department of Insurance (CDI). Requires initial license and renewal fees to be collected into the PBM Account in the Insurance Fund. Adds reporting requirements to existing prescription drug data reporting, including the aggregate amount of rebates received by the PBM for each drug. Prohibits spread pricing from being offered in PBM contracts and policies. Specifically, this bill:

CDI Licensure and Regulation of PBMs

1) Requires CDI to license and regulate PBMs. Grants CDI the authority to enforce this bill, as specified.

2) Requires PBMs that provide services in this state to, no later than January 1, 2027, apply for a license to operate as a PBM from CDI. Requires a PBM to maintain its license in good standing.

3) Requires an application for a PBM license to be submitted in a form and manner determined by CDI and to be signed by an officer or individual responsible for the conduct or affairs of the PBM verifying that the contents of the application form and any attachments are correct. Requires the application to include all of the following:
   a) A nonrefundable application fee in an amount established by CDI under 11) below;
   b) A list of every health plan or health insurer on behalf of which the PBM contracts with a pharmacy or a pharmacy services administration organization to provide health services to individuals covered by the health plan or health insurer;
   c) A statement indicating all jurisdictions where the applicant has an application pending or has been registered, licensed, or otherwise certified to transact business as a PBM;
   d) A statement indicating whether either of the following has occurred:
      i) The PBM or any individual responsible for the conduct of the affairs of the PBM has had a PBM certificate of authority or license denied or revoked for cause in another state; or,
      ii) Any individual responsible for the conduct of the affairs of the PBM has been convicted of, or has entered a plea of guilty or nolo contender to a felony without regard to whether adjudication was withheld;
   e) A copy of a power of attorney duly executed by the PBM if not domiciled in this state, appointing CDI, CDI's successors in office, and CDI's authorized deputies as the attorney of the PBM in and for this state, on whom process in any legal action or proceeding against the PBM on a cause of action arising in this state may be served;
   f) The names, addresses, official positions, and professional qualifications of each individual who is responsible for the conduct of the affairs of the PBM;

g) A copy of a recent financial statements showing the PBM's assets, liabilities, and sources of financial support that CDI determines are sufficient to show that the PBM is financially viable. If the PBM's financial statements are prepared by an independent accountant public accountant, a copy of the most recent regular financial statement satisfies the requirement to show financial viability unless CDI determines that additional or more recent financial information is required for the proper administration of this bill;
h) A document providing the names, addresses, dates of birth, social security numbers, official positions, and professional qualifications of each individual who owns, legally or the information as to each person beneficially, 10% or more in equity in the entity interested therein or any person with management or control over the PBM;
i) A copy of all basic organizational and governing documents of the PBM, including, but not limited to, the articles of incorporation, bylaws, articles of association, trade name certificate, and other similar documents and all amendments to those documents;
j) A description of the PBM, its services, facilities, and personnel;
k) A document in which the PBM confirms that its business practices and each ongoing contract comply with this bill; and,
l) Any other relevant information required by CDI.

4) Requires the individual responsible for the conduct or affairs of the PBM and any of the organization's partners, members, controlling persons, officers, directors, and managers to comply with the background check requirements as required by the CDI Commissioner.

5) Requires a PBM to file a notice of the modification with CDI within 30 days after a significant modification of the information or documents submitted pursuant to 2) above.

6) Subjects an applicant for a PBM license or licensed PBM to existing law relating to the business of insurance.

7) Prohibits a PBM from operating in this state unless it is licensed pursuant to this bill.

8) Does not abrogate compliance by a PBM with any applicable requirements of existing law.

9) Specifies that a violation of this bill constitutes an unfair practice, as specified.

10) Entitles the CDI Commissioner to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this bill and to recover attorney's fees and costs incurred in remedying each violation.

11) Requires a PBM license applicant to pay the initial application fee as determined by CDI and to be renewed every two years and is nontransferable.

12) Requires a renewing applicant to submit to CDI both of the following:
a) A renewal application in a form and manner determined by CDI that is signed by an officer or individual responsible for the conduct or affairs of the PBM verifying that the contents of the renewal form are correct; and,
b) A renewal schedule and fee as determined by CDI.

13) Requires a PBM license to expire if a complete renewal filing and fee is not received by the due date established by CDI.

14) Allows the application for renewal of an expired license to be filed after the expiration date and until that same month and day of the next succeeding year. Requires the fee for a renewal application under this bill to be the fee specified in 15) below and a delinquent fee in the amount specified for a one-year period in 15) below for the filing. Subjects each licensee to payment of delinquent fees under this bill.

15) Provides an application fee of dollars ($), and for each year of the two-year license term thereafter, a renewal fee of dollars ($_). Authorizes the CDI Commissioner to increase or decrease fees, and schedule fees and charges, as specified.

PBM Reporting Requirements

16) Requires PBMs to, on or before July 1, 2028, and on or before each July 1 thereafter, file with CDI a report that contains all of the information required by 14) of existing law below from the preceding calendar year.

17) Requires CDI to, on or before January 1, 2029, and on or before each January 1 thereafter, prepare a report based on the information received by CDI pursuant to 16) above and to publish the report on its internet website. Requires the report to contain aggregate data and to exclude any information that CDI determines would cause financial, competitive, or proprietary harm to a PBM.

18) Requires a PBM to, on or before July 1, 2027, and on or before each July 1 thereafter, report to CDI all of the following information:
    a) A list of the 50 costliest drugs, the 50 most frequently prescribed drugs, and the 50 highest revenue-producing drugs, grouped by generic, brand, specialty, and other. Requires the PBM to report both of the following, for each drug that falls into the above categories:
        i) The pharmacy type used to fill the drug prescription, such as integrated, chain, independent, specialty, and mail order pharmacies; and,
        ii) Pricing and rebate information, including the net price paid, the amount of rebate the PBM receives from the manufacturer, the amount of rebate the PBM passes to the health plan or health insurer, the amount the health plan or insurer pays the PBM, and the amount the PBM pays the pharmacy.
    b) For each list in 18) a) above, all of the following:
        i) The aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each drug;
        ii) The aggregate amount of rebates received by the PBM for each drug;
        iii) Any administrative fees received from the pharmaceutical manufacturer or labeler;
        iv) The aggregate of payments, or the equivalent economic benefit, made by the PBM to pharmacies owned or controlled by the PBM for each drug;
        v) The aggregate of payments made by the PBM to pharmacies not owned or collected by the PBM for each drug;
        vi) Deidentified claims level information in electronic format that allows the CDI Commissioner to sort and analyze the following information for each claim, whether the claim required prior authorization; and,
        vii) The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point of sale and retroactive charges. Deems data as confidential pursuant to 21) below.

c) All of the following information in the aggregate:
   i) The purchasers with which the PBM contracts, the scope of services provided to the purchasers, and the number of enrollees, insureds, and plan members served;
   ii) PBM revenue, including revenue from manufacturers, purchasers, and other revenue; and,
   iii) PBM expenses, including payments to pharmacies, claims processing, special programs, administration, and other expenses.

19) Requires CDI to compile the information reported pursuant to 18) above into a report for the public and Legislature that demonstrates the overall impact of PBMs on drug costs. Requires the data in the report to be aggregated and to not reveal information specific to individual purchasers.

20) Requires CDI to, on or before January 1, 2029, and on or before each January 1 thereafter, publish the report on its internet website and include as part of the public meeting, as required. Allows CDI to consolidate reports.

21) Deems information submitted to CDI, except for the reports required pursuant to 17) and 19) above, confidential and not disclosed to the public pursuant to the California Public Records Act. Provides that this bill does not prevent disclosure to the Attorney General (AG) to investigate, prosecute, or defend any legitimate legal claim or cause or action, or to use the reports in any court or proceeding of law.

22) Defines a specialty drug as one that exceeds the threshold for a specialty drug under the Medicare Part D program for purposes of the reporting requirements under this bill.

PBM Prohibitions

23) Prohibits a PBM from imposing any requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs.

24) Prohibits discrimination pursuant to 23) above that includes all of the following:
   a) Terms or conditions applied to nonaffiliated pharmacies based on their status as a nonaffiliated pharmacy;
   b) Refusing to contract with or terminating a contract with a nonaffiliated pharmacy on the basis that the pharmacy is a nonaffiliated pharmacy or for reasons other than those that apply equally to affiliated pharmacies;
   c) Retaliation against a nonaffiliated pharmacy based on its exercise of any right or remedy under this bill; and,
   d) Reimbursing a nonaffiliated pharmacy less for a pharmacy service than the PBM would reimburse an affiliated pharmacy for the same pharmacy service.

25) Specifies that this bill does not preclude a PBM or a purchaser of PBM services from establishing a network of contracting or participating pharmacies.

26) Prohibits a PBM from doing any of the following:
   a) Require an enrollee or insured to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network;

b) Financially induce an enrollee, insured, or prescriber to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network;
c) Require a retail nonaffiliated pharmacy to transfer a prescription to a retail affiliated pharmacy if there are nonaffiliated pharmacies in the network. Does not prevent a purchaser or PBM from offering and communicating to enrollees or insured' financial incentives to use a particular pharmacy, such as lower copays or costs for a prescription when the prescription is dispensed;
d) Unreasonably restrict an enrollee or insured from using a particular contracted retail pharmacy for the purpose of receiving pharmacist services covered by the enrollee's or insured's contract or policy;
e) Communicate to an enrollee or insured verbally, electronically, or in writing that the enrollee or insured is required to have a prescription dispensed at, or pharmacy services provided by, a particular affiliated pharmacy or pharmacies if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network; and,
f) Deny a nonaffiliated contract pharmacy the opportunity to participate in a PBM network as preferred participation status if the pharmacy is willing to accept the same terms and conditions that the PBM has established for affiliated pharmacies as a condition of preferred network participation status.

27) Disallows a contract issued, amended, or renewed on or after January 1, 2025, between a nonaffiliated pharmacy and a PBM from prohibiting the retail pharmacy from offering either of the following as an ancillary service of the retail pharmacy:
a) The delivery of a prescription drug by mail or common carrier to a patient or personal representative on request of the patient or personal representative if the request is made before the drug is delivered; or,
b) The delivery of a prescription to a patient or personal representative by an employee or contractor of the retail pharmacy.

28) Prohibits the retail pharmacy, except as otherwise provided in a contract described in 27) above, from charging a PBM for the delivery service described in 27) above. Does not prohibit the use of remote pharmacies, secure locker systems, or other types of pickup stations if those services are otherwise permitted by law.

29) Requires contracts entered into pursuant to this bill to be open for inspection by CDI.

30) Prohibits a PBM from requiring more than one accreditation from an independent accrediting organization for pharmacists and pharmacies to dispense specialty drugs and requires a PBM to make every effort to ensure that enhanced standards are not imposed to dispense specialty drugs beyond those related to the safety and competency necessary to comply with requirements for dispensing specified medications and providing optimal patient care.

31) Requires the PBM to disclose the amount and types of the PBM fees to the health insurer or health plan.

32) Requires a PBM to use a passthrough pricing model.

33) Requires a PBM to pass 100% of all prescription drug manufacturer rebates received to the health plan, health insurer, or program, if the contractual arrangement delegates the negotiation

of rebates to the PBM, for the sole purpose of offsetting defined cost sharing, deductibles, and coinsurance contributions and reducing premiums of enrollees or insureds.

34) Specifies that this bill does not preclude a health insurer or health plan from paying performance bonuses to a PBM based on savings to the health plan or health insurer that affects rated paid by the enrollee and insured or subscriber and policy holder, as long as the performance bonus is not based or contingent on any of the following:
   a) The acquisition cost or any other price metric of a drug;
   b) The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the PBM, that is retained by the pharmacy manager;
   c) The amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the PBM from patients or other persons on behalf of a patient; and,
   d) Compensation arrangements governed by this bill to be open for inspection by CDI.

35) Prohibits a PBM from making or permitting any reduction of payment for pharmacist services by a PBM or a health insurer or health plan directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including without limitation generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.

36) Prohibits a claim or aggregate of claims for pharmacist services from being directly or indirectly retroactively denied or reduced after adjudication of the claim or aggregate of claims unless any of the following have occurred:
   a) The original claim was submitted fraudulently;
   b) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; and,
   c) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

37) Prohibits a PBM from reversing and resubmitting the claim of a contract pharmacy under any of the following circumstances:
   a) Without prior written notification to the contract pharmacy;
   b) Without just cause or attempt to first reconcile the claim with the pharmacy; or,
   c) More than 90 days after the claim was first affirmatively adjudicated.

38) Prohibits a PBM from charging a pharmacy or pharmacist a fee to process a claim electronically.

39) Prohibits the termination of a contract with a nonaffiliated pharmacy from releasing the PBM from the obligation to make a payment due to the pharmacy for an affirmatively adjudicated claim unless payments are withheld because of an investigation relating to insurance fraud.

40) Prohibits a PBM from retaliating against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of a right or remedy under this bill. Includes, as prohibited retaliation, any of the following:
   a) Terminating or refusing to renew a contract with the pharmacist or pharmacy;
   b) Subjecting the pharmacist or pharmacy to increased audits; and,
   c) Failing to promptly pay the pharmacist or pharmacy money owed by the PBM to the pharmacist or pharmacy.

41) Prohibits a PBM from, except as permitted under existing law, unreasonably obstructing or interfering with a patient's right to timely access a prescription drug or device that has been legally prescribed for that patient at a contract pharmacy of their choice.

42) Prohibits a PBM from making, disseminating, or causing or permitting the use of an advertisement, promotion, solicitation, representation, proposal, or offer that is known to be, or reasonably should be known to be, untrue, deceptive, or misleading.

43) Authorizes CDI to investigate referrals provided by the Board of Pharmacy (BoP).

44) Prohibits a PBM, commencing January 1, 2025, from conducting spread pricing. Prohibits any subsequent amendment or renewal of that contract from containing spread pricing if a preexisting contract between a PBM and a health plan or health insurer authorizes spread pricing. Voids any spread pricing terms on and after January 1, 2028.

45) Prohibits a PBM from entering into, amending, enforcing, or renewing a contract on or after January 1, 2025, with manufacturers who do business in California that expressly or implicitly restrict, or implements implicit or express exclusivity for, those manufacturers' drugs, medical devices, or other products.

46) Prohibits a PBM from entering into, amending, enforcing, or renewing a contract on or after January 1, 2025, with pharmacies or pharmacy administrative services organizations who do business in California that expressly or implicitly restrict, or impose implicit or express exclusivity on, nonaffiliated pharmacies' ability to contract with employers, insurers, and health plans.

Enforcement

47) Authorizes CDI to, in addition to any of the grounds listed in 1) above, deny, suspend, or revoke the license of a PBM if the CDI finds that any of the following are true:
    a) The PBM has violated a statute or regulation applicable to the PBM;
    b) The PBM has refused to be examined or to produce its accounts, records, and files for examination by CDI, or an individual responsible for the conduct of affairs of the PBM has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination required by the CDI;
    c) The PBM has, without just cause, exhibited a pattern or practice of refusing to pay proper claims or perform services arising under its contracts or has, without just cause, caused enrollees or insureds to accept less than the amount due them;
    d) The PBM is required under this chapter to have a license and fails to continue to meet the qualifications for licensure during its active licensure;
    e) The PBM failed to file a timely report as required by 16) above; and,
    f) The PBM is not financially viable.

48) Requires a hearing pursuant to this bill to be conducted in accordance with the Administrative Procedure Act (APA), as specified.

49) Authorizes CDI to examine or audit any books and records of a PBM to determine if the PBM is in compliance with this bill. Requires a PBM to pay for reasonable expenses for any examinations or audits conducted pursuant to this bill. Requires payments to be deposited into the PBM Account. Requires examinations conducted by CDI to be pursuant to the same

examination authority of CDI relative to insurers. Provides that PBMs have the same rights as insurers.

50) Allows CDI to produce and disclose publicly an examination report describing any act or omission committed by a PBM that violates this division.

51) Requires CDI to establish a retention schedule for all records, books, papers, and other data on file with the CDI related to the enforcement of this bill.

52) Prohibits CDI from ordering the destruction or other disposal of a record, book, paper, or other data that is required to be filed or kept on file with CDI during the retention period.

53) Specifies that existing law relating to examinations by the CDI Commissioner does not prevent disclosure of information and data acquired during an examination to the AG to investigate, prosecute, or defend any legitimate legal claim or cause of action, or to use the information and data in any court or proceeding of law. Authorizes CDI to provide to the AG information related to competition and obtain an opinion from a consultant or consultants with the expertise to assess the competitive impact of the matter.

54) Requires a PBM to have a duty and obligation to the health plan of the enrollee or subscriber or insurer of the insured or policyholder, and to perform its services with care, skill, prudence, diligence, and professionalism, and for the best interests of the health plan or insurer.

55) Requires a PBM to disclose to a health insurer or health plan information of clinical efficacy and clinical evidence regarding the inclusion, exclusion, or limitation of prescription drugs in the formulary.

56) Requires any PBM that this bill applies to be liable for restitution to any enrollee or insured harmed by the violation, in addition to any other penalty provided by law.

57) Entitles the AG to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this bill and to recover attorney's fees and costs incurred in remedying each violation. Specifies that this bill does not alter or abrogate the CDI's authority to enforce this provision.

58) Subjects any person that violates this bill to an injunction and liable for a civil penalty of not less than one thousand dollars ($1,000) or more than seven thousand five hundred dollars ($7,500) for each violation to be assessed and recovered in a civil action brought by the AG.

59) Specifies that a violation of specified provisions is an act of unfair competition within the meaning of the Business and Professions Code (BPC) and nothing in this bill limits any other statutory or common law rights or remedies, including liability pursuant to the Unfair Competition Law.

60) Prohibits an action from being brought in the name of the people of the State of California that seeks relief under this bill pursuant to the Unfair Competition Law of the BPC without the written consent and permission of the AG. Specifies that this bill does not alter or abrogate the CDI's authority to enforce this provision.

61) Provides for the remedies or penalties provided by this bill to be cumulative to each other and to the remedies or penalties available under all other laws of this state.

PBM Fines and Penalties Account

62) Requires, beginning on or after January 1, 2026, the fines and administrative penalties collected to be deposited into the PBM Fines and Penalties Account, which is established in the General Fund.

PBM Account

63) Requires, no earlier than January 1, 2026, the fees for a PBM initial license and renewal application to be sufficient to fund CDI's duties in relation to responsibilities under this bill, but in no case exceed the reasonable regulatory cost to administer this bill. Requires fees received under this bill to be deposited into the PBM Account, created in the Insurance Fund, and to be subject to an annual appropriation each fiscal year for the support of CDI related to the licensing and regulation of PBMs.

Other CDI Provisions

64) Construes any activity conducted by a PBM, as defined in this bill, as the business of insurance.

65) Requires CDI to adopt regulations necessary to implement this bill, and subject to the following:
    a) Allows, until January 1, 2028, necessary regulations for the purpose of implementing this bill to be adopted as emergency regulations in accordance with the APA. Deems the adoption of emergency regulations pursuant to this bill to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare;
    b) Requires an emergency regulation adopted pursuant to this bill to be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by CDI within five years of the initial adoption of the emergency regulation; and,
    c) Requires a regulation adopted pursuant to this bill to be discussed by CDI during at least one public stakeholder meeting before CDI adopts the rule or regulation.

66) Requires CDI to establish procedures for receiving, investigating, tracking, and publicly reporting consumer complaints against PBMs.

67) Requires CDI to publish on its internet website a record of consumer complaints against a PBM that have been determined by CDI to be justified. Prohibits complaint data from being published unless it has been provided to the PBM in accordance with existing law requiring the CDI Commissioner to provide to the insurer a description of any complaint against the insurer.

68) Prohibits the authority of the AG to maintain or restore competitive markets and prosecute state and federal antitrust and unfair competition violations from being narrowed, abrogated, or otherwise altered by this bill.

69) Adds a 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.

70) Finds and declares that this bill, which adds 16) and 49) above to the Insurance Code, 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 Section 3 of Article I of the California Constitution. Makes findings to demonstrate the interest protected by this limitation and the need for protecting the confidentiality of information received by state agencies from PBMs, as necessary to be presumptively confidential, except as otherwise provided by law.

Definitions

71) Defines the following for purposes of this bill:
   a) Affiliated pharmacy as a contract pharmacy that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, a PBM;
   b) Claim as a request for payment for administering, filling, or refilling a drug or for providing a pharmacy service or a medical supply or device to an enrollee or insured;
   c) Contract pharmacy as a retail pharmacy or other pharmacy that contracts directly or through a pharmacy services administration organization with a PBM;
   d) Financially viable means that either of the following conditions is met:
      i) The PBM has received an unqualified opinion from an independent public accountant; or,
      ii) If an independent public accountant opinion is not obtained, the PBM remains solvent after adjusting for goodwill and intangible assets.
   e) Nonaffiliated pharmacy as a contract pharmacy that directly, or indirectly through one or more intermediaries, does not control, is not controlled by, and is not under common control with, a PBM;
   f) Passthrough pricing model means a payment model used by a PBM in which the payments made by the health care service plan or health insurer client to the PBM for the covered outpatient drugs are both of the following:
      i) Equivalent to the payments the PBM makes to a pharmacy or provider for those drugs, including any contracted professional dispensing fee between the PBM and its network of pharmacies. That dispensing fee would be paid if the pharmacy benefits plan or program was making the payments directly; and,
      ii) Passed through in their entirety by the health plan or health insurer client or by the PBM to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.
   g) Pharmacist services as products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy;
   h) PBM fee as a fee that covers the cost of providing one or more PBM services and that does not exceed the value of the service or services actually performed by the PBM. Requires the value of the service or services to be based on the value to the health insurer or health plan;
   i) PBM service as all of the following:
      i) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

ii) Managing any aspect of a prescription drug benefit, 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 the prescription drug benefit, contracting with pharmacies, controlling the cost of covered prescription drugs, managing or providing data relating to the prescription drug benefit, or the provision of services related thereto;
iii) Performing any administrative, managerial, clinical, pricing, financial, reimbursement, data administration, or reporting, or billing service; and,
iv) Other services as CDI defines in regulation;

j) PBM as a person, business, or other entity that, either directly or indirectly, manages the prescription drug coverage, including, but not limited to, the following: clinical or other formulary or preferred drug list development or management; the processing and payment of claims for prescription drugs, the negotiation or administration of rebates, discounts, payment differentials, or other incentives; for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular 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 pharmacies; and controlling the cost of covered prescription drugs. Does not include the following:
   i) A health plan that is part of a fully integrated delivery system in which enrollees primarily use pharmacies that are entirely owned and operated by the health plan, and the health plan's enrollees may use any pharmacy in the health plan's network that has the ability to dispense the medication or provide the services;
   ii) An entity providing services pursuant to a contract authorized by the Labor Code under Workers' Compensation and Insurance;
   iii) A health plan, or its contracted provider, as defined; or,
   iv) A health insurer.
k) Pharmacy services administration organization as an entity that provides contracting and other administrative services relating to prescription drug benefits to pharmacies;
l) Rebate as a formulary discount or remuneration attributable to the use of prescription drugs that is paid by a manufacturer or third party, directly or indirectly, to a PBM after a claim has been adjudicated at a pharmacy. Does not include a fee, including a bona fide service fee or administrative fee, that is not a formulary discount or remuneration;
m) Spread pricing as the model of prescription drug pricing in which a PBM charges a health plan or health insurer a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy; and,
n) Third party as a person that is not an enrollee, insured, or PBM.

Health Plan and Insurance PBM Provisions

72) Prohibits a health plan contract or insurance policy issued, amended, or renewed on or after January 1, 2025, that provides prescription drug coverage from calculating an enrollee or insured's cost sharing at an amount that exceeds the actual rate paid for the prescription drug.

73) Prohibits any contract or policy or any subsequent amendment or renewal of an existing contract or policy, commencing January 1, 2025 from authorizing spread pricing.

Prescription Drug Reporting

74) Requires health plans or insurers, in addition to prescription drug reporting set forth in 6) of existing law below of the 25 most frequently prescribed drugs, most costly drugs by total annual plan spending, and 25 drugs with the highest year over year increase to also report all of the following:
   a) The aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each drug;
   b) The aggregate amount of rebates received by the PBM for each drug;
   c) Any administrative fees received from the pharmaceutical manufacturer or labeler;
   d) The aggregate of payments, or the equivalent economic benefit, made by the pharmacy benefit manager to pharmacies owned or controlled by the PBM for each drug; and,
   e) The aggregate of payments made by the PBM to pharmacies not owned or collected by the PBM for each drug.

EXISTING LAW:

Health Plan and Health Insurance

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans in the Health and Safety Code; CDI to regulate health insurers under the Insurance Code. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Establishes as California's Essential Health Benefits (EHBs) benchmark, the Kaiser Small Group Health Maintenance Organization, existing California mandates, and federal Patient and Protection Affordable Care Act mandated benefits, including prescription drugs. [HSC §1367.005 and INS §10112.27]

3) Requires health plans to maintain the following:
   a) Complete drug formulary or formularies, including a list of prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over other drugs;
   b) Records developed by the pharmacy and therapeutic committee of the health plan that fully describe the reasoning behind formulary decisions; and,
   c) Health plan arrangements with entities that are associated with activities of the health plan to encourage formulary compliance or otherwise manage prescription drug benefits. [HSC §1367.005]

4) Requires a plan or insurer that provides EHBs to allow an enrollee or insured to access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration (FDA) or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Permits a nongrandfathered individual or small group health plan contract or insurance policy to charge an enrollee or insured a different cost sharing for obtaining a covered drug at a retail pharmacy, but requires all cost sharing to count toward the annual limitation on cost sharing. [HSC §1367.42 and INS §10123.201]

5) 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]

6) 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. [*Ibid*.]

7) Requires DMHC and CDI to compile the information from 5) and 6) 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. [*Ibid*.]

PBM Registration Under the DMHC

8) 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]

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

10) 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]

11) Establishes a pilot project in Riverside and Sonoma Counties, effective January 1, 2020, to assess the impact of health plan and PBM prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies. Specifies the following:

   a) Prohibit a health plan, pursuant to the pilot project, from prohibiting, or permitting any delegated PBM to prohibit, a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or PBM allows that amount to be dispensed through a pharmacy owned or controlled by the plan or PBM, unless the prescription drug is subject to restricted distribution by the FDA or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy; and,
   b) Require health plans subject to the pilot project, on or before July 1, 2020, to report annually to DMHC information and data relating to changes, if any, to costs and

utilization of prescription drugs attributable to the prohibition of contract terms in 12) a) above. [HSC §1368.6]

Board of Pharmacy

12) Provides for the licensure and regulation of pharmacists and pharmacies by the BoP. [BPC §4200, *et seq*.]

13) Requires a PBM that reimburses a contracting pharmacy for a drug on a maximum allowable cost basis to do the following, among other provisions related to maximum allowable cost:
    a) Include in a contract, initially entered into, or renewed on its scheduled renewal date, on or after January 1, 2016, with the contracting pharmacy information identifying any national drug pricing compendia or other data sources used to determine the maximum allowable cost for the drugs on a maximum allowable cost list; and,
    b) Make available to a contracting pharmacy, upon request, the most up-to-date maximum allowable cost list or lists used by the PBM for patients served by that pharmacy in a readily accessible, secure, and usable web-based format or other comparable format. [BPC §4440]

14) Establishes audits of pharmacy benefits by BoP and requires PBMs to disclose, upon the request of the purchaser, the following information with respect to prescription product benefits specific to the purchaser, on a quarterly basis:
    a) The aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each therapeutic category of drugs containing three or more drugs, as outlined in the EHBs;
    b) The aggregate amount of rebates received by the PBM by therapeutic category of drugs containing three or more drugs, as outlined in the EHBs. Requires the aggregate amount of rebates to include any utilization discounts the PBM receives from a pharmaceutical manufacturer or labeler;
    c) Any administrative fees received from the pharmaceutical manufacturer or labeler;
    d) Whether the PBM has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a purchaser's employees, insureds, or enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement;
    e) Prescription drug utilization information for the purchaser's enrollees or insureds that is not specific to any individual enrollee or insured;
    f) The aggregate of payments, or the equivalent economic benefit, made by the PBM to pharmacies owned or controlled by the PBM;
    g) The aggregate of payments made by the PBM to pharmacies not owned or collected by the PBM; and,
    h) The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, and the application of those amounts collected pursuant to the contract with the purchaser. [BPC §4441]
15) Prohibits a PBM from including in a contract with a pharmacy network provider or its contracting agent a provision that prohibits the provider from informing a patient of a less costly alternative to a prescribed medication. [*Ibid.*]

FISCAL EFFECT: According to the Senate Appropriations Committee:

1) Unknown likely significant fiscal impact ranging in the high hundreds of thousands to low millions of dollars for CDI to license PBMs (Insurance Fund and PBM Fund). CDI would likely require Insurance Fund or other fund support until it establishes and collects fee revenue sufficient to support the ongoing administration and enforcement operations of the PBM licensure program. Costs to CDI will likely include additional staff resources to develop regulations, establish the licensing framework, provide additional consumer service support to address complaints received from the public and the BoP, and to intake information from PBMs and publish required reports. There will also likely be additional enforcement and legal costs to ensure compliance with licensure requirements and prohibitions. Other costs may include informational technology resources to build infrastructure to support licensing or complaint intake systems. PBM license fee revenue may offset CDI's costs. It is unknown at what level fees would need to be set for CDI to recoup its administrative and enforcement costs.
2) DMHC reports ongoing annual costs of approximately $51,000 beginning in Fiscal Year 2025-26 to its Office of Financial Review for additional workload related to revising reporting templates, reviewing health plan filings, and compiling data for annual reporting and compliance requirements (Managed Care Fund).
3) Unknown, potentially significant workload cost pressures to the courts to adjudicate cases brought by the AG against PBMs engaged in specified prohibited activities and practices (Trial Court Trust Fund, General Fund).

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill reins in the worst abuses by PBMs. This bill will protect consumer choice, provide transparency on prescription drug prices, and improve our healthcare system by ensuring that PBMs are appropriately regulated. Vertical integration and a lack of oversight have allowed some PBMs to engage in unfair business practices that undermine healthcare access and drive up the cost of prescription drugs. By raising fees and lowering reimbursement rates, PBMs are making it hard for many independent pharmacies to stock vital medications, and forcing many of them to close. The complete lack of oversight has also allowed some PBMs to steer patients toward pharmacies they own, pocket large portions of the rebates they negotiate with drug manufacturers, and make misleading statements to customers. The author concludes that this bill fills that regulatory gap by requiring that all PBMs be licensed by CDI and disclose basic information regarding their business practices to the state.

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 most recent report of 2022 data 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) 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) PBM History. According to the National Academy for State Health Policy, regulating PBMs is a legislative priority for states to lower prescription drug costs. Between 2017 and 2023, laws regulating PBMs accounted for more than half of all enacted prescription drug legislation.

According to the California Health Benefits Review Program (CHBRP), PBMs have evolved significantly over recent decades. PBMs went from primarily processing prescription claims (which was largely an administrative function) in the late 1960s to serving as gatekeeper to outpatient prescriptions through active management of formularies and pharmacy networks. The first generation PBMs were heavily focused on developing innovations that allowed them to keep costs down for employers/health plans and for patients. CHBRP states that PBMs also play a role in pricing as they negotiate directly with drug manufacturer but reveal little about how those savings are passed onto consumers. The current formulary-for-rebate arrangement between PBMs and manufacturers is a form of selective contracting that has been employed in the provision

of health care since the 1980s. During the 1990s, the focus of PBMs shifted from pharmaceutical claims management to more complex business models with a diversified portfolio of services, including the use of incentives to modify consumer behavior, and disease management programs. Today, PBMs use their buying power, combined with utilization management strategies, to lower the total cost of pharmaceuticals. PBMs have consolidated significantly in recent years and there are now three large PBMs — CVS, Express Scripts, and Optum — that account for 80% of the market.

c) Existing California PBM law. PBMs play a major role in negotiating the prices of prescription drugs, creating and managing formularies, and several other functions key to the management of pharmacy benefits for millions of Californians. However, despite a PBM's interaction with most major players, including drug manufacturers, health plans and insurers, and pharmacies, very little is known about those relationships. AB 315 (Wood), Chapter 905, Statutes of 2018, establishes a regulatory structure for PBMs, and provides for the registration of PBMs to the DMHC. AB 315 requires DMHC, by July 1, 2019, and in collaboration with other agencies, departments, advocates, experts, health plan representatives, and other entities and stakeholders that it deems appropriate, to convene a Task Force on PBM Reporting to determine what information related to pharmaceutical costs, if any, it should require to be reported by health plans or their contracted PBMs, in addition to reporting required in existing law.

i) 2020 AB 315 Task Force Report. In 2019, the DMHC facilitated a series of public Task Force meetings to develop the recommendations contained in this report. The report noted that the PBM marketplace appears to be highly concentrated, with the top three PBMs representing approximately 75% of covered lives in California. Some suggest that this concentration is evidence of a stable and functioning market, whereas others believe it is evidence that the largest PBMs have a stranglehold on the market and therefore wield too much negotiating power. Stakeholders attending the Task Force meetings asserted that dominant PBMs may negotiate higher rebates only to keep the bulk of the rebate. By not passing the rebate on to health plans, consumers may be adversely affected by higher costs. Market concentration is seen not only across the marketplace, but also vertically within the supply chain. Some PBMs own their own pharmacies, referred to as an "integrated pharmacy." This may result in misaligned incentives, as a PBM may favor an integrated pharmacy even if competing pharmacies have lower costs. Additionally, the Task Force heard from pharmacy representatives who stated PBMs may improperly utilize prescription information to steer patients who are prescribed high-cost drugs to the PBM's integrated pharmacies. Some PBMs and health plans have common ownership which could lead to PBMs increasing drug costs to rival health plans. The Task Force recommended gathering data to increase transparency and understand how PBMs impact the cost of prescription drugs, including gathering information on PBMs, including revenue and expense information, to determine PBM market impact and the value PBMs provide to consumers.

ii) Pilot Project. AB 315 also established a pilot project, effective January 1, 2020, in Riverside and Sonoma counties to assess the impact of health plan and PBM prohibitions on the dispensing of certain amounts of prescriptions drugs by network retail pharmacies. During the pilot project, health plans and PBMs were required to permit prescription drugs to be dispensed at all network pharmacies in the same

quantities that are dispensed at pharmacies owned or controlled by the health plans or PBMs. The most commonly dispensed prescription drugs were generic drugs for maintenance of chronic conditions, such as high cholesterol and hypothyroidism and frequently dispensed in 90-day supplies. The total prescription cost for the six health plans was approximately $170.7 million, of which 9.1%, or approximately $15.6 million, was attributed to the impacted drugs. Given that costs were reduced during the pilot project, it appears that the average costs paid to non-owned or non-controlled pharmacies were lower than those paid to health plan or PBM owned or controlled pharmacies. It should be noted that the public health emergency related to the COVID-19 pandemic occurred not long after the start of the pilot project and likely impacted the number prescriptions filled at network pharmacies, particularly in the first year.

d) Federal Report on PBM regulation to Address Prescription Drug Spending. The United States Government Accountability Office (GAO) published a March 2024 report indicating that prescription drug spending by private health plans climbed to nearly $152 billion in 2021, an 18% increase from 2016. Health plans generally rely on PBMs to process claims, develop pharmacy networks, and negotiate rebates from drug manufacturers. However, some researchers and stakeholders have questioned certain PBM practices, such as PBMs retaining a share of the rebates and use of spread pricing. According to the GAO, PBMs receive compensation from health plans for their services in a variety of ways. Health plans may opt for an administrative fee contract, where they pay the PBM directly for all the services provided. Alternatively, health plans may elect to use a spread pricing option. Under spread pricing, the health plan pays the PBM a set price for each prescription filled, and the PBM retains the difference between the price paid by the health plan and the price paid to the pharmacy as a form of compensation. Additionally, PBMs may retain a portion of manufacturer rebates to offset the fees health plans would otherwise pay.

In response, all 50 states having enacted at least one PBM-related law between 2017 and 2023. The GAO reviewed states' regulation of PBMs, many of which are similar to the provisions of this bill. These laws include pharmacy reimbursement, transparency, through licensing and reporting, and pharmacy network and access requirements. One of the lessons learned includes providing regulators with broad regulatory authority was more effective than enacting specific statutory provisions as doing so allowed regulators to address emerging issues without new legislation, according to regulators from one state. Some regulators also stressed the need for robust enforcement of PBM laws and effective penalties to enforce them.

3) SUPPORT. The California Pharmacists Association, California Chronic Care Coalition, San Francisco AIDS Foundation, and Los Angeles LGBT Center, cosponsors, write that while the initial purpose of PBMs was to negotiate contracts on behalf of their clients (health plans), there is now an inherent conflict of interest and lack of transparency in how they operate. PBMs are squarely in the middle of negotiating prices, demanding rebates, and driving formulary decisions—controlling virtually every aspect of prescription drug program. The self-dealing nature of PBMs is on full display when they steer patients to their company-owned mail-order, community and special pharmacies, all of which calls into question the ability of PBMs to fairly represent the employers, providers, and patients they purport to serve. The cosponsors write that the only healthcare entities that have seemingly avoided

transparency and oversight are PBMs. By providing transparency and oversight of PBMs, the following harmful practices can be subject to scrutiny and, in some cases, prohibited:

a) **Rebate Pumping**: PBMs favoring higher-cost drugs on a formulary because the PBM can negotiate a higher rebate, which PBMs retain as profit;

b) **Spread Pricing**: PBMs charge the health plan a higher cost than what it pays to the pharmacy. This can lead to higher costs for the plan sponsor, which in turn can increase premiums and co-pays for patients;

c) **Claw-backs**: After a prescription is filled, PBMs retroactively recoup the difference between a patient's copay and the actual price of a drug when the copay amount is higher. The cosponsors write that it is important to note that the PBMs require a pharmacy to collect a copay from a patient that is set by the PBM. If the patient copay imposed by the PBM is higher than the ultimate reimbursement to the pharmacy, the PBM claws back the excess copay from the pharmacy, keeping it as a profit;

d) **Rebate retention**: PBMs retain a portion of the drug manufacturer rebate as profit instead of returning full amount to the consumer or health plan; and,

e) **Patient Steering**: PBMs require patients to transfer prescriptions to the PBM-owned mail-order or community pharmacies or the consumer faces higher copay amounts for their medications.

4) **SUPPORT IF AMENDED.** The Association of Northern California Oncologists, the Medical Oncology Association of Southern California and the Association for Clinical Oncology request amendments to extend this bill's protections for pharmacists from patient steering to physicians, in order to better enable California's oncologists to provide the best care possible to California's cancer patient population.

5) **OPPOSE UNLESS AMENDED.** San Diego Regional Chamber of Commerce (SD Chamber) contends that this bill seeks to limit pharmacy network design by prohibiting health plans from using preferred pharmacies. When health plans use preferred pharmacies they obtain cost savings, which are then passed on to plan holders, including employers and employees, in the form of lower premiums or expanded benefits. Limiting pharmacy network design for health plans can drive up premiums and will simply increase revenue for a small number of pharmacies. Additionally, SD Chamber writes that restrictions on specialty network design can lead to diminished patient safety as plans could use unaccredited pharmacies that do not meet high standards for specialty drug storage and dispensing.

   The California State Pipe Trades Council, California State Association of Electrical Workers and Western States Council of Sheet Metal Workers seek amendments to allow both spread pricing and pass-through contracts to be considered on the basis that health plans and health plan sponsors often ask for spread pricing contracts when issuing their request for proposals to compare different PBM payment models and determine which one best suits their needs.

6) **OPPOSITION**. Various organizations representing the California Alliance for Prescription Affordability write that PBMs have proven to be the only entity helping to negotiate and drive prescription drug costs and this bill puts pharmacy profits ahead of California's small

businesses, their employees and families, and will make the postpandemic recovery that much more difficult, if not impossible, in the years ahead.

The Pharmaceutical Care Management Association (PCMA) writes that prohibiting employers and health plan sponsors from choosing how to compensate PBMs based on the savings they provide will encourage drug manufacturers to raise their prices. If plan sponsors are unable to incentivize lower costs, and are prohibited from encouraging PBMs to negotiate against drug manufacturers, ultimately, costs will increase. PCMA contends that banning performance-based contracts would cause an overall increase in health premiums in California. While PCMA is not opposed to licensure or to the overall policy objective of the state collecting and analyzing aggregated protected PBM data, PCMA wants to ensure the data is meaningful, useful, and practical. PCMA also notes that PBMs do not engage in the business of insurance and are third party administrators that do not take on financial risk like insurance companies and the result of this could cause CDI issuing regulations exempt from the Employee Retirement Income Security Act of 1974 (ERISA). PCMA concludes that this bill goes far beyond licensing and regulating of PBMs and will disrupt how health plans, employers, and unions choose to manage and pay for prescription drug benefits and will lead to higher costs for payers and patients in California.

7) **RELATED LEGISLATION**. AB 2180 (Weber) would have required a health plan, health insurance policy, or PBM that administers pharmacy benefits for a health plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program for prescription drugs toward the enrollee's or insured's cost-sharing requirement, and would have only applied those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness. AB 2180 was held in the Assembly Appropriations Committee.

8) **PREVIOUS LEGISLATION**.

   a) AB 913 (Petrie-Norris) of 2023 would have required the BoP to license and regulate PBMs that manage the prescription drug coverage provided by a health plan or health insurer, except as specified. Would have set forth various duties of PBMs, including requirements to file a report with the BoP. AB 913 was never heard in the Assembly Business and Professions 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. SB 873 was held in the Assembly Appropriations Committee.

   c) AB 948 (Berman), Chapter 820, Statutes of 2023, makes permanent existing law 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; and, requires a non-grandfathered individual or small group plan contract or insurance policy to use specified definitions for each tier of a drug formulary. Prohibits a copayment or percentage coinsurance from exceeding 50% of the cost to the plan and require a plan or insurer to ensure that the enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are

on the formulary, if there is a generic equivalent to a brand name drug. Deletes biologics from the tier four definition in existing law.

d) AB 524 (Skinner) of 2021 would have prohibited a health plan, a health insurer, or the agent thereof from engaging in patient steering, as specified. Would have defined "patient steering" to mean communicating to an enrollee or insured that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy, as specified, or offering group health care coverage contracts or policies that include provisions that limit access to only pharmacy providers that are owned or operated by the health care service plan, health insurer, or agent thereof. Governor Newsom vetoed AB 524 stating in part:

"While offering consumers a choice in pharmacies within their health plan or insurer networks is a worthwhile goal, the bill lacks clarity in key areas which may render it subject to misinterpretation or a lack of enforceability. It is unclear what business relationships between health plans, insurers, and their agents are intended to be affected because the bill does not define "agent" or "corporate affiliate." Furthermore, it is unclear what it means to "limit an enrollees' (or insureds') access" to certain pharmacy providers.

It is necessary to define these terms and concepts so appropriate oversight and enforcement may occur, particularly in light of the complexity of the contracting arrangements and benefit designs at issue. Finally, it is important to ensure that efforts to address these concerns do not have the unintended consequence of interfering with the ability of health plans and insurers to coordinate care and contain pharmaceutical costs for California's consumers."

e) AB 1803 (Committee on Health), Chapter 114, Statutes of 2019, requires a pharmacy to inform a customer at the point of sale for a covered prescription drug whether the retail price is lower than the applicable cost-sharing amount for the prescription drug, except as specified, and, if the customer pays the retail price, requires the pharmacy to submit the claim to the customer's health plan or health insurer beginning January 1, 2020.

f) AB 315 requires PBMs to register with the DMHC, to exercise good faith and fair dealing, and to disclose, upon a purchaser's request, information with respect to prescription product benefits, as specified.

g) SB 17 requires health plans and insurers that offer commercial products and file rate information with the DMHC or CDI to annually report specific information related to the costs of covered prescription drugs.

9) DOUBLE REFERRED. This bill is double-referred; upon passage of this Committee, this bill will be referred to the Assembly Judiciary Committee.

10) AMENDMENTS. As this bill moves forward, the author has agreed to the following amendments:

a) The following technical amendments:

i) At INS § 17000(r): Does not include **~~either of~~** the following:

ii) At INS § 17010(c)(4)(B): nolo contender**e**; and,

iii) At INS § 17050(d)(2): The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the PBM, that is retained by the pharmacy **benefit** manager;

b) The following substantive amendment:

i) At INS § 17045: A pharmacy benefit manager shall not require more than ~~one~~ **two** accreditation from an independent accrediting organization for pharmacists and pharmacies to dispense specialty drugs and shall make every effort to ensure that enhanced standards are not imposed to dispense specialty drugs beyond those related to the safety and competency necessary to comply with requirements for dispensing specified medications and providing optimal patient care.

11) POLICY COMMENTS.

a) Regulatory Oversight of Health Insurance in California. In California, regulation and oversight of health insurance is split between two state departments – DMHC and CDI. According to data from the California Health Care Foundation, as of 2022, DMHC enrollees represent 13.2 million commercial lives whereas CDI insureds represent 0.8 million lives.

i) Existing regulatory authority. One of the threshold issues for this bill is whether or not CDI is the appropriate state regulator given existing law requiring PBM registration under the DMHC. The Legislature should consider whether existing law should be expanded to include not just licensure and oversight of health plans by DMHC, but to third-party entities, like PBMs, that contract with health plans.

ii) Costs to implement this bill. While this bill establishes a PBM Account with fees to fund CDI's duties in relation to responsibilities under this bill, the Senate Appropriations Committee notes a significant fiscal impact ranging in the high hundreds of thousands to low millions of dollars for CDI to license PBMs, as described above. It is unknown whether or not CDI will have the capacity to handle this expansion given the significant resources required by this bill.

Should this bill be amended to require PBM licensure by DMHC considering the number of lives covered by the DMHC versus CDI and the potential expansion of existing law?

b) Broad Regulatory Authority. Every arrangement that PBMs make with manufacturers, employers, and insurers is secret and proprietary, and these arrangements can make it difficult to examine PBM contracts. A regulatory framework, as established in this bill, will authorize the state to examine the kinds of deals PBMs are making. One of the lessons learned from the GAO report cited above, is that providing broad authority allows regulators the flexibility to address emerging issues and to avoid potential unintended consequences to consumers.

i) Prescription Drug Pricing. From a consumer perspective and as the Congressional Committee on Oversight and Accountability noted, the focus of the pharmaceutical marketplace should be on the patient. Greater transparency is needed to determine the

impact PBMs tactics are having on patients. This bill can be strengthened by allowing the regulator to study the contract terms between PBMs and their clients to understand the actual costs of pharmaceuticals to health plans and their enrollees prior to implementing some of the prohibitions codified in this bill.

ii) **PBM Reimbursement.** As drafted, this bill sets forth PBM reimbursement methods, specifically prohibiting spread pricing and allowing for passthrough payments. While this bill allows for PBM performance bonuses, it is unclear how this provision can be interpreted given the number of prohibitions and definitions in this bill. As noted by the opposition, health plans or purchasers ask for options to compare different PBM payment models to determine which one best suits their needs. One of the goals of the Office of Health Care Affordability is to promote high-value health system performance and promote the shift from fee-for-service payments to alternative payment models that provide financial incentives for equitable, high-quality, and cost-efficient care. Can this bill be interpreted to limit the options available to purchasers and the financial incentives for PBMs to negotiate lower prescription drug prices for their clients?

Without a broader regulatory approach, it is unclear whether this bill will reduce overall pharmaceutical spending. The Legislature may need to consider which reforms, along with changes to PBM reimbursement, will bring value to the health care system.

REGISTERED SUPPORT / OPPOSITION:

Support

California Pharmacists Association (cosponsors)
California Chronic Care Coalition (cosponsors)
San Francisco AIDS Foundation (cosponsors)
Los Angeles LGBT Center (cosponsors)
Insurance Commissioner Ricardo Lara / California Department of Insurance
AIDS Healthcare Foundation
Alliance for Patient Access
ALS Association; the
American Diabetes Association
Axis Advocacy
Biocom California
California Farmworker Foundation
California Health Collaborative
California Life Sciences
California Medical Association
California Society of Health System Pharmacists
California State Association of Psychiatrists (CSAP)
Cystic Fibrosis Research, INC. (CFRI)
Hemophilia Council of California
International Bipolar Foundation
International Foundation for Autoimmune & Autoinflammatory Arthritis
National Association of Chain Drug Stores
National Community Pharmacists Association (UNREG)

National Multiple Sclerosis Society
National Psoriasis Foundation
North East Medical Services
Pharmaceutical Research and Manufacturers of America
San Francisco Marin Medical Society
Spondylitis Association of America
United Nurses Associations of California/Union of Health Care Professionals

Opposition

Abate-a-weed
America's Health Insurance Plans (AHIP)
American GI Forum Foundation
American Muslims for Coalition for Change
Angel's Foundation
Association of California Life & Health Insurance Companies
Bell Gardens Chamber of Commerce
Black Business Association
Brea Chamber of Commerce
California Alliance for Prescription Affordability (CAPA)
California Association of Health Plans
California Clothing Recylcers
California Delivery Association
California El Salvadoran Chamber of Commerce
California Hispanic Chamber of Commerce
California Muslim Action Network
California State Association of Electrical Workers
California State Pipe Trades Council
Cerna Home Care
CJ Basso & Associates
Coalition for Small and Disabled Veteran Businesses
Coalition of California Chambers Orange County
Community Church Oakland
Corinthian Baptist Church
Crisp Catering
Cypress Chamber of Commerce
Defisal Foundation
Dublin Chamber of Commerce
Energías Del Corazón Foundation
Ephesian Missionary Baptist Church
Ethnos Church
Evergreen Missionary Baptist Church
Faith Action for All
First Union Baptist Church
Flasher Barricade Association
Gary Mckinsey Strategies
Granite Bay Benefits
King Courier
Latin Business Association

Law Offices of James E. Mahoney, Jr.
Los Angeles Civil Rights Association
M&l Brothers Foundation
Marina Chamber of Commerce
Martinez Communications
Menifee Bicycles
Mount Gilead Baptist Church
Orange County Hispanic Chamber of Commerce
Pharmaceutical Care Management Association
Pro Small Biz CA
Professional Small Business Services, INC.
Proyecto 555 Foundation
Sal's Mexican Restaurant
San Juan Capistrano Chamber of Commerce
Seabreeze Books & Charts
Shalom International
Slavic-American Chamber of Commerce
Spaces Renewed
Sperantia
Strategies for Your Success
The Row LA - the Church Without Walls
Tournament Advisors LLC
Vournas Coffee Trading Company
Western Pacific Roofing Company
Western States Council Sheet Metal, Air, Rail and Transportation

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1033 (Menjivar) – As Amended May 16, 2024

SENATE VOTE: 38-0

SUBJECT: Medi-Cal cost reporting: private duty nursing and congregate living health facilities.

SUMMARY: Requires the Department of Health Care Services (DHCS) to develop and submit to the Legislature, by January 10, 2026, a study of the costs of operating a congregate living health facility (CLHF), and an estimate of the cost of increasing Medi-Cal rates of private duty nursing (PDN) services to pediatric patients to 87% and 100%, of the corresponding Medicare rate.

EXISTING LAW:

1) Licenses and regulates CLHFs by the California Department of Public Health (DPH), which are defined as residential homes with a capacity of no more than 18 beds (with specified exceptions for larger facilities) that provide inpatient care that is generally less intense than that provided in a general acute care hospital (GACH), but more intense than that provided in a skilled nursing facility, and that includes medical supervision, 24-hour skilled nursing care, pharmacy, dietary, social, recreational, and at least one of the following types of services:
   a) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent;
   b) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Defines terminal illness as a life expectancy of six months or less; or,
   c) Services for persons who are catastrophically and severely disabled, which is defined as a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom services such as speech, physical, and occupational therapy are being provided. [Health and Safety Code (HSC) §1250(i)]

2) Requires a CLHF to have a noninstitutional, homelike environment. [HSC §1250(i)(5)]

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

4) Establishes a schedule of benefits under the Medi-Cal program, which includes home health care services as well as all medically necessary services covered under the federal early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21 years of age. [WIC §14132, §14059.5]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown costs to DHCS for state administration (General Fund and federal funds).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, both CHLFs and PDN services play a vital role in providing care for individuals with highly complex medical conditions. While CLHFs provide a residential setting for meeting the acute medical care needs of patients with catastrophic and sports-related accidents, amyotrophic lateral sclerosis (ALS), muscular dystrophy, stroke, and work-related injuries, PDN in Medi-Cal is specialized, continuous skilled nursing care in the home for children with complex medical illnesses. The author indicates CLHFs have not received a rate increase since they were created as a pilot program in 1983, while increases in the cost of nursing services have made current PDN payment rates uncompetitive. The author concludes that estimates of the cost of providing CLHF services and the costs of increasing PDN rates to a more competitive level will inform potential rate adjustments to allow CLHFs to remain open and sustain their services, and allow children with significant medical needs to access the PDN care they are authorized and entitled to receive.

2) **BACKGROUND**. CLHFs and PDN are both home and community-based alternatives to hospitalization, providing a high level of care to individuals with significant medical needs and/or severe disabilities.

   a) **CLHFs**. A licensed CLHF is a residential medical option for individuals requiring more intensive medical care than a skilled nursing facility, but less than that provided in an acute care hospital. The level of care that CLHFs provide is considered "subacute," however, in contrast to subacute care facilities, CLHFs are six to18 bed residential homes that provide care in a homelike setting. CLHFs provide the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, and recreational. In addition, a CLHF must provide at least one type of the following services: services for persons who may be ventilator-dependent; services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both; or, services for persons who are catastrophically and severely disabled. The CLHF Association states, with the exception of individual contracts with managed care plans to care for a patients being discharged from an acute care hospital, CLHFs are only reimbursed through the Home and Community-Based Alternatives (HCBA) Medi-Cal Waiver.

      The HCBA waiver is a program implemented under a federally approved waiver of Medicaid program rules, which allows states to develop creative home- and community-based alternatives for individuals who would otherwise require care in a nursing facility or hospital. To receive care in a CLHF, patients are most often discharged from a GACH and must meet Medi-Cal and HCBA eligibility requirements and be approved by a HCBA Waiver Agency.

      The daily rate that Medi-Cal pays for care to residents in a CLHF under the HCBA Waiver is $490 per day. According to the CLHF Association, this rate is the same that was originally set for CLHFs when they were established in the 1980s and has never been adjusted. A provision in a prior version of this bill, which was removed, would have raised Medi-Cal commensurate with the cost study for CLHFs.

      According to the CLHF Association, only 229 Medi-Cal patients are currently receiving CLHF care under the HCBA waiver. Although DHCS has received federal approval to grant additional waiver slots, enrollment is limited by the total number of slots available

and eligible individuals are placed on a waiting list until slots are available. Individuals under 21 years of age, individuals transitioning from similar waiver programs, or individuals who have been residing in a health care facility for at least 60 days are prioritized for enrollment into the HCBA waiver.

b) Private Duty Nursing. According to federal Medicaid regulations, PDN is provided at a Medi-Cal recipient's home, under the direction of their doctor, to an individual who requires more individual and continuous care than is available from a visiting nurse. Under federal and state law, Medi-Cal eligible children under age 21 are entitled to all of the services they need through the requirement of EPSDT, including PDN. Under the PDN benefit, a child under age 21 is authorized for a specific number of nursing hours based on medical need, usually from four to 24 hour per day. However, anecdotally, many families experience profound difficulty securing the authorized number of PDN hours that are medically necessary for their children.

In 2018, a class-action lawsuit was filed against DHCS for failure to ensure that children receive the PDN hours they are authorized to receive. In 2019, the parties settled with DHCS, agreeing, among other things, to designate Medi-Cal managed care plans and other entities as case management service providers for affected class members to ensure that they receive in-home nursing care.

While not part of the settlement agreement, a rate increase also went into effect in 2019. However, cosponsor California Association for Health Services at Home (CAHSAH), which represents licensed home health agencies that provide PDN services, states the value of these static Medi-Cal reimbursement rates have eroded over time given recent significant wage growth, and consequently there are not enough in-home nurses to care for the medically fragile children who are able to leave the hospital. PDN positions tend to be filled largely by licensed vocational nurses (LVNs). According to a 2023 study commissioned by CAHSAH, "Estimating the Cost of Caring for Children with Complex Medical Conditions During a Nursing Shortage," the LVN wage supported by the current Medi-Cal rate had significantly eroded by 2022, such it was below the 25th percentile LVN wage in the state.

c) Medi-Cal Rates. According to DHCS, historically, Medi-Cal rates for most outpatient provider types are not updated annually and are only periodically adjusted through the state budget process. According to a handout produced by the Legislative Analyst's Office (LAO) for a May 6, 2024, joint hearing of the Assembly Budget Subcommittee #1 on Health and Assembly Health Committee, the state has not had a formal, consistent process for adjusting rates once initially set. The LAO notes, in the absence of such a policy, the budget condition has been a driving factor of rate adjustments. AB 119 (Committee on Budget), Chapter 13, Statutes of 2023, reauthorized a tax on managed care organizations (MCOs) licensed by the Department of Managed Health Care or contracted with the Medi-Cal program to generate funds for the Medi-Cal program, including to increase provider rates. The tax rate was increased through early budget action to generate additional funding via SB 136 (Committee on Budget and Fiscal Review), Chapter 6, Statutes of 2024. MCO tax revenues have supported increased provider rates for primary care, maternal care, and mental health care, effective January 1, 2024. Additional rate increases were planned as part of the MCO tax expenditure plan

proposed by DHCS in January 2024, however, these additional rate increase proposals were withdrawn in the May Revision to the Governor's Budget to help address a projected budget deficit. The outcome of these additional proposed rate increases are unknown pending final budget decisions. Notably, the January 2024 expenditure plan addressed several provider types, pursuant to the authorizing statute, but did not propose rate increases for CLHFs or PDN services.

For new benefits and services added by Medi-Cal, DHCS generally sets the fee-for-service Medi-Cal rate at 80% of the equivalent Medicare rate. Medicare rates are a common benchmark to which Medicaid payment levels are compared, both in California and across Medicaid programs nationwide. If there is no Medicare equivalent rate, DHCS commonly considers a variety of other factors when setting rates, such as available cost information, wage information, and payment rates of other payers.

d) Cost Considerations for CLHF and PDN Rates. One unique aspect of CLHF and PDN services is that both provider types are generally less-costly alternatives to hospital care. If CLHF and PDN services are inaccessible, the intense clinical needs of Medi-Cal enrollees do not go away; on the contrary, individuals may be cared for in a more costly setting such as a GACH. It is unlikely that each individual who lacks access to a CLHF or to PDN services would be admitted to a hospital to receive care, but the 2023 study commissioned by the CAHSAH, referenced in b) above, modeled outcomes overall with respect to PDN provided to eligible children. According to the study, lack of in-home nursing drives up costs through delayed hospital discharges, increased length of stay waiting for adequate home nursing coverage, increased likelihood of readmission within 90 days, and overall increased likelihood of hospital admissions for children who are being cared for at home but receiving an inadequate number of hours. The study estimated net cost savings of $175 million annually if Medi-Cal rates for PDN were increased by 40% and the higher rates led to more children being served by PDN as an alternative to costly hospital care.

3) SUPPORT. This bill is cosponsored by the CLHF Association, which states that CLHFs have never received a rate adjustment in the 40 years these facilities have existed. While the maximum daily rate for a CLHF has been $490 for more than 40 years, the costs of skilled labor, medical equipment, food, and license fees have long surpassed the daily rate. The CLHF Association notes that licensing fees alone have increased by more than 700% in that time. A number of individual CLHF providers make similar arguments in support.

Cosponsor CAHSAH writes that because of stagnant Medi-Cal reimbursement rates for PDN services, home health agencies have been unable to compete with hospitals and other facilities that are paying large sign-on bonuses to nurses. PDN wages have frozen, compelling many private duty nurses to seek employment elsewhere and crippling the ability of home health agencies to recruit and retain an adequate supply of professionals to meet the demand.

Supporters Disability Rights California (DRC), who served as counsel in the 2018 class action lawsuit, writes that despite federal and state law requirements to cover PDN services, children are tragically prevented from returning home from the hospital, or forced to go

without needed care, due to wholly inadequate reimbursement rates. They state it is particularly difficult in urban areas like the Bay Area where they have clients who cannot find a nurse for even a portion of the hours needed. DRC argues leaving such children without any nursing services is a clear violation of federal and state law. They also state that beyond the legal requirement and moral imperative of providing these services to children, increasing rates would save money.

4) RELATED LEGISLATION.

a) SB 1492 (Menjivar) would have included PDN as an expenditure category under the MCO tax revenue expenditure plan. SB 1492 was held on the suspense file of the Senate Appropriations Committee. Simultaneously, provisions requiring an estimate of the cost of increasing PDN rates were included in SB 1033.

b) SB 1423 (Dahle) requires DHCS to develop a rate methodology for critical access hospitals to ensure participating hospitals are reimbursed at a minimum of 100% of the projected and reasonable costs for Medi-Cal covered inpatient, outpatient, and emergency department services. SB 1423 is pending in the Assembly Health Committee.

c) AB 2303 (Carrillo) requires DHCS to develop a minimum wage add-on as an alternative payment methodology to increase rates for federally qualified health center and rural health center services covered under the Medi-Cal program to account for the increase in minimum wage, subject to an appropriation. AB 2303 is pending in the Assembly Health Committee.

d) AB 2342 (Lowenthal) requires DHCS to provide an annual supplemental payment to each critical access hospital that operates on an island at least ten miles offshore that is still within the jurisdiction of the state (i.e., Catalina Island Health). AB 2342 is pending in the Assembly Health Committee.

5) PREVIOUS LEGISLATION. AB 1211 (Maienschein), Chapter 483, Statutes of 2015, increased the maximum capacity of CLHFs, except those that are specifically permitted to have larger capacities due to meeting specified exemptions, from 12 to 18 beds.

6) AMENDMENTS. The author and sponsor have noted the lack of a Medicare equivalent rate for PDN services, and have agreed to add the following language to the bill to ensure a cost estimate can be made using an alternative benchmark rate. The language includes factors DHCS commonly considers in rate-setting when there is no equivalent Medicare rate for a particular service.

(c) If there is no available rate for corresponding services under the federal Medicare Program, the cost estimate described in subdivision (a) shall be calculated as follows:

(1) The department shall calculate an alternative benchmark rate, utilizing appropriate methodologies used for other Medi-Cal services with no Medicare equivalent, including, but not limited to, consideration of all of the following:

(A) Analysis of current rates and reimbursement methodology.
(B) A rate scan of current rates in appropriate comparison states.
(C) Stakeholder engagement.

(D) A review of industry standards.
(E) Provider cost information.
(F) Publicly available data from the United States Bureau of Labor Statistics occupation wage studies and other similar sources of wage data.

(2) The cost estimate described in subdivision (a) shall estimate the cost of raising the Medi-Cal rates of private duty nursing services provided to pediatric patients to 87 percent of, and to 100 percent of the alternative benchmark rate developed pursuant to paragraph (1).

REGISTERED SUPPORT / OPPOSITION:

Support

Agape Congregate Living
Allwell Residential Care
Archwood House CLHF, Inc.
Aveanna Healthcare
Avenida Living Home INC
California Association for Health Services At Home
Care Home by RNs Congregate Living Health Facility
Caresource Congregate Living
Children's Specialty Care Coalition
Community Care Solutions, INC
Congregate Living Health Facility Association
Connected Living INC
Covina CLHF Corporation
Elderly Care Everywhere
Home of Compassion, Inc.
Los Angeles Congregate Living
Majesticare Health and Rehab Center of Moorpark
Maxim Healthcare Services
Optimum Care
Prime Home Health
Senior Congregate Living INC
Sunflower CLHF
Sunshine 1 Congregate Home, Inc.
Sunshine Lovely, INC
Team Select Home Care
The Community Home, INC.
The Eden CLHF
White Oak Congregate Facility, LLC

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1061 (Limón) – As Amended June 19, 2024

SENATE VOTE: 31-8

SUBJECT: Consumer debt: medical debt.

SUMMARY: Prohibits a consumer credit reporting agency or an investigative consumer reporting agency from making a consumer credit report or an investigative consumer report containing information about medical debt, as defined. Prohibits a person who uses a consumer credit report in connection with a credit transaction from using medical debt listed on the report as a negative factor when making a credit decision. Requires a hospital to maintain all records relating to money owed to the hospital by a patient or a patient's guarantor, as specified. Specifically, **this bill**:

1) Prohibits a consumer credit reporting agency from making any consumer credit report containing medical debt.

2) Prohibits a person who uses a consumer credit report in connection with a credit transaction from using a medical debt listed on the report as a negative factor when making a credit decision.

3) Prohibits a person from furnishing information regarding a medical debt to a consumer credit reporting agency.

4) Specifies that a medical debt is void and unenforceable if a person knowingly violates the provisions of this bill by furnishing information regarding the medical debt to a consumer credit reporting agency.

5) Declares that on or after July 1, 2025, it is unlawful to enter into a contract creating a medical debt that does not include the following term: "A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code (CIV) from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

6) Deems a contract entered into on or after July 1, 2025, that does not include the term described in 5) above as void and unenforceable.

7) Deems a violation of this bill by a person holding a license or permit issued by the state to be a violation of the law governing that license or permit.

8) Specifies that 4) and 5) above not apply to a debt secured by real property.

9) Prohibits an investigative consumer reporting agency from making or furnishing any investigative consumer report containing medical debt.

10) Prohibits a noncontracting ground ambulance provider (or a ground ambulance provider of an uninsured patient or self-pay patient), or an entity acting on its behalf, including a debt buyer or assignee of the debt, from reporting adverse information to a consumer credit reporting agency, in addition to starting a civil action against the enrollee for a minimum of 12 months after the initial billing regarding amounts owed by the enrollee or insured, pursuant to 9) of existing law below.

11) Prohibits a noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, from reporting adverse information to a consumer credit reporting agency, in addition to starting civil action against the enrollee or insured for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee or insured, pursuant to 6) of existing law below.

12) Prohibits a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency or debt buyer, from doing either of the following:

    a) Reporting adverse information to a consumer credit reporting agency; or,

    b) Commencing civil action against the patient for nonpayment before 180 days after initial billing.

13) Requires a hospital to maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for five years, including, but not limited to, all of the following:

    a) Documents related to litigation filed by or on behalf of the hospital or any subsequent holder of the debt, including, but not limited to, a debt buyer;

    b) A contract by which a hospital assigns or sells medical debt to a third party; and,

    c) A list, updated at least annually, of every person, including the person's name and contact information, that meets at least one of the following criteria:

        i) The person is a debt collector to whom the hospital sold or assigned a debt that a patient of the hospital owed the hospital; or,

        ii) The person is retained by the hospital to pursue litigation for debts owed by patients on behalf of the hospital.

14) Defines the following for purposes of this bill:

    a) Medical debt as a debt related to, in whole or in part, a transaction, account, or balance arising from a medical service, product, or device.

    b) Medical debt does not include any of the following:

        i) Debt charged to a credit card unless either of the following applies:

            (1) The credit card is issued under an open-end or closed-end plan offered specifically for the payment of medical services, products, or devices; or,

(2) The credit card allows for deferred interest purchases of a medical service, product, or device.

ii) A loan secured by real property unless either of the following applies:

(1) The lender marketed the loan as being for the purpose of paying for a medical service, product, or device; or,

(2) At the time the loan was made, the lender had actual knowledge that the borrower intended to use the proceeds of the loan to pay for a medical service, product, or device.

c) Medical service, product, or device, for purposes of this bill, does not include cosmetic surgery, as defined, and includes, but is not limited to, all of the following:

i) Any service, drug, medication, product, or device sold, offered, or provided to a patient by either of the following:

(1) A person or facility licensed under the Health and Safety Code (HSC), as specified; or,

(2) A person licensed under Business and Professions Code, as specified;

ii) Initial or subsequent reconstructive surgeries, as defined, and followup care deemed necessary by the attending physician and surgeon;

iii) Initial or subsequent prosthetic devices, as defined, and followup care deemed necessary by the attending physician and surgeon; and,

iv) A mastectomy, as defined.

EXISTING LAW:

1) Establishes the Department of Managed Health Care to regulate health plans and the California Department of Insurance to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Requires health plans and health insurers to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; including ambulance and ambulance transport services and out of area coverage; and, hospice care. [HSC § 1345, INS § 10112.281]

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

4) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health

plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services. [HSC § 1367]

5) Requires contracts between providers and health plans to be in writing and prohibits, except for applicable copayments and deductibles, a contracted provider from invoicing or balance billing a health plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the health plan or the health plan's capitated provider for any covered benefit. Prohibits a provider, in the event that a contract has not been reduced to writing, or does not contain the prohibition above, from collecting or attempting to collect from the subscriber or enrollee sums owed by the health plan. Prohibits a contracting provider, agent, trustee, or assignee from taking an action against a subscriber or enrollee to collect sums owed by the health plan. [HSC § 1367.03]

6) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2017, to provide that if an enrollee or insured receives covered services from a contracting health facility, as defined, at which, or as a result of which, the enrollee or insured receives covered services provided by a noncontracting individual health professional, as defined, the enrollee or insured would be required to pay the noncontracting individual health professional only the same cost sharing required if the services were provided by a contracting individual health professional, which would be referred to as the "in-network cost-sharing amount." Prohibits an enrollee or insured from owing the noncontracting individual health professional at the contracting health facility more than the in-network cost-sharing amount if the noncontracting individual health professional receives reimbursement for services provided to the enrollee or insured at a contracting health facility from the health care service plan or health insurer. [HSC § 1371.9 and INS § 10112.8]

7) Establishes, pursuant to 6) above, a payment rate for covered services provided by noncontracting health professionals at contracting facilities, which is the greater of the average of a health plan or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services. [HSC § 1371.31 and INS § 10112.82]

8) Requires a health plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. Prohibits a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and prohibits a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. Requires a plan or insurer to reimburse for ground ambulance services at the rate established or approved by the governing board of the local government having jurisdiction for that area or subarea, including an exclusive operating area, as specified. [HSC § 1371.56 and INS § 10126.66]

9) Requires a noncontracting ground ambulance provider to only advance to collections the in-network cost-sharing amount, as determined by the plan or insurer, that the enrollee failed to pay. Prohibits a noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, from reporting adverse information to a

consumer credit reporting agency or commence civil action against the enrollee or insured for a minimum of 12 months after the initial billing regarding amounts owed by the enrollee or insured. Prohibits a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, from using wage garnishments or liens on primary residences as a means of collecting unpaid bills. [HSC § 1371.56(c) and INS § 10126.66(c)]

10) Establishes the Consumer Credit Reporting Agencies Act, which regulates consumer credit reports and consumer credit reporting agencies. Prohibits a consumer credit reporting agency from making any consumer credit report containing any of the following items of information, including bankruptcies; suits and judgments; unlawful detainer actions; paid tax liens; accounts placed for collection; and, records of arrest, indictment, information, misdemeanor complaint, or conviction of a crime, as specified. Prohibits these items of information from being reported if at any time it is learned that in the case of a conviction a full pardon has been granted, or in the case of an arrest, indictment, information, or misdemeanor complaint a conviction did not result. [CIV § 1785.13]

11) Prohibits an investigative consumer reporting agency from making or furnishing any investigative consumer report containing specified items of information, similar to 10) above. [CIV § 1786.18]

12) Establishes the Department of Health Care Access and Information (HCAI) to, among other things, collect health information to help make health care more effective and affordable. [HSC §127000]

13) Prohibits a hospital from selling patient debt to a debt buyer, as defined, unless all of the following apply:
    a) The hospital has found the patient ineligible for financial assistance or the patient has not responded to any attempts to bill or offer financial assistance for 180 days;
    b) The hospital includes contractual language in the sales agreement in which the debt buyer agrees to return, and the hospital agrees to accept, any account in which the balance has been determined to be incorrect due to the availability of a third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care or financial assistance;
    c) The debt buyer agrees to not resell or otherwise transfer the patient debt, except to the originating hospital or a tax-exempt organization, as described, or if the debt buyer is sold or merged with another entity;
    d) The debt buyer agrees not to charge interest or fees on the patient debt; and,
    e) The debt buyer is licensed as a debt collector by the Department of Financial Protection and Innovation (DFPI). [Health and Safety Code §127425]

14) Requires a hospital to have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency, or debt buyer. [*Ibid*.]

15) Requires a hospital to establish a written policy defining standards and practices for the collection of debt, and to obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. Authorizes the hospital to consider only income and monetary assets, in determining the amount of a

debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy. [*Ibid.*]

16) Requires a hospital to, at time of billing, provide a written summary, which includes the same information concerning services and charges provided to all other patients who receive care at the hospital. [*Ibid*.]

17) Requires a hospital to send a patient a notice with all of the following information before assigning a bill to collections:

    a) The date or dates of service of the bill that is being assigned to collections or sold;
    b) The name of the entity the bill is being assigned or sold to;
    c) A statement informing the patient how to obtain an itemized hospital bill from the hospital;
    d) The name and plan type of the health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information;
    e) An application for the hospital's charity care and financial assistance; and,
    f) The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made. [*Ibid*.]

FISCAL EFFECT: According to the Senate Appropriations Committee, the Department of Justice estimates ongoing costs of $394,000 for state staffing resources (Unfair Competition Law Fund). Unknown, potential ongoing General Fund costs for the DFPI for state administration. HCAI anticipates no fiscal impact.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, removing medical debt from consumer credit reports will improve the lives of millions of Californians dealing with purported past-due medical expenses. Medical debt differs from other categories of consumer debt in several ways. First, medical debt is often non-discretionary – consumers have limited or no choice in the nature and timing of medical services they require to support their health and well-being. Second, the amounts of medical debt reported to credit bureaus contain inaccuracies at significantly higher rates than other forms of consumer debt, often driven by mistakes in billings, reimbursements, or insurance disputes. And, third, medical debt is less predictive of a consumer's willingness and ability to pay future credit obligations than other forms of consumer debt. The author also states that medical debt disproportionately affects low-income consumers, Black and Latino communities, and young people, all of whom already face structural barriers to achieving financial well-being.

   According to the author, this bill will not relieve many burdens associated with medical debt. This bill does not forgive debts, nor does it restrict collection practices related to medical debt. But this bill will help to lift the credit scores of people who have been inaccurately and unfairly saddled with medical debts on their credit reports, opening opportunities for access to healthier financial products, better housing, and more employment opportunities. The author concludes that without a robust health care system that covers necessary and often lifesaving medical expenses in a timely, accurate and comprehensive manner, medical debt should not be included on consumer credit reports.

2) **BACKGROUND**. A 2021 Study on the "Impact of Financial Assistance Programs on Health Care Utilization," found that almost half of individuals with medical debt intentionally avoided seeking care. According to the United States Census Bureau, medical debt means that households have less money to spend on other essential items, such as food and housing. People with medical debt, or at risk of accumulating medical debt, may also forgo needed medical care or treatment. Medical debt can also lead to bankruptcy.

   a) **Health Care Affordabilit**y. A February 2024 *CalMatters* article writes that health care spending in California reached $405 billion in 2020 and $10,299 per person, according to federal data. According to the Office of Health Care Affordability (OHCA), between 2015 and 2020, per capital health spending grew each year an average of 5.2%, outpacing wages. The UC Berkeley Labor Center states that health care affordability has deteriorated over the past two decades in California due to rising premiums along with increasingly common and increasingly large deductibles for job-based coverage. Taken together, these trends in premium and deductible growth result in health care taking up a larger and larger share of household income. This has consequences for Californians' health and financial well-being: a significant portion of California adults, with any type of insurance including those without insurance, reported that in the last 12 months they or a family member had delayed or postponed care due to cost (52%), had problems paying or couldn't pay any medical bills (27%), or had some type of medical debt (36%).

      In February 2024, the California Health Care Foundation (CHCF) reported that nearly four in 10 Californians (38%) report having any kind of medical debt. Californians who report any kind of medical debt (78%) are more likely to report skipping care due to cost than Californians who report no medical debt (38%). Californians with low incomes (52%) are more likely to report any type of medical debt than those with higher incomes (34%). Black (53%) and Latino/x Californians (46%) are more likely to report debt than white (33%) or Asian Californians (28%). Californians who speak Spanish (59%) are more likely to say they have medical debt than those who speak English (38%) or Chinese (20%). Californians with low incomes are more likely to have each type of medical debt than Californians with higher incomes. The most often reported type of medical debt for Californians overall and across income groups is medical or dental bills that they have put on a credit card and are paying off. Among Californians who report medical debt, 18% owe $5,000 or more, with 10% reporting $5,000 to $10,000, 4% reporting $10,000 to $25,000, and 4% reporting $25,000 or more. According to CHCF, the amount of medical debt owed was similar across Californians by income, race/ethnicity, and language spoken.

   b) **Medical Credit Cards.** A May 2023 Consumer Financial Protection Bureau report describes how financial institutions are generating a growing number of financing mechanisms for families and individuals struggling to pay their out-of-pocket healthcare expenses. The report provides an overview of medical credit cards and loans used for services and procedures for basic medical treatment and emergency health care and key findings include:

      i) Medical credit cards and loans used to be restricted to paying for elective procedures. In recent years, these products have been also offered for basic medical treatment and emergency health care and are growing in scope. These products are often offered by

a trusted doctor or nurse in doctor's offices or hospitals when their patients are under significant stress;

ii) Medical financing companies market their products to healthcare providers by touting their products' cost-saving features and that patients can pay for more expensive medical care that may not be covered by their insurance. However, when these products are offered by medical providers, patients appear not to fully understand the terms of the products and sometimes end up with credit they are unable to afford;

iii) Many medical credit cards offer people deferred interest, or springing interest, terms for a time period of between six and eighteen months. If someone has a remaining balance after the designated promotional period, they are charged all the interest that would have accrued since their original purchase date. These products are typically more expensive than other forms of payment due to the higher interest payments; and,

iv) Patients who should be eligible to receive reduced or free care through a financial assistance program or their insurance plan may instead be signed up for a medical card or loan. Many people would be better off without these products for two reasons:

(1) The financial burden can be higher and their ability to challenge an inaccurate bill is complicated when they are working through a third party financial institution; and,

(2) The terms of credit for medical credit cards and financing plans can vary greatly in terms of annual percentage rates (APRs), length of the special financing period, and other terms. The APR of the typical medical credit card is 26.99%; currently, the mean APR for all general purpose credit cards is approximately 16%.

3) **SUPPORT**. The Attorney General, California Low-Income Consumer Coalition, Consumer Federation of CA, CALPIRG, California Nurses Association, Health Access California, and the National Consumer Law Center (cosponsors) write that medical debt does not belong on credit reports at all. Medical bills are often unexpected, overwhelming, and incomprehensible. Medical debt is not like other types of debt, and is often incurred involuntarily and inadvertently by people who need health care. Medical debt may also be riddled with problems such as billing errors and disputes with insurers over liability for accounts. California can protect its consumers from all of these negative effects of medical debt by adopting this bill. This bill specifically prohibits credit reporting agencies from including medical debt on credit reports and requires that medical debt contracts include provisions preventing medical debt information from being shared with credit reporting agencies. To enforce the exclusion of medical debt on credit reports, this bill makes medical debt void if it is knowingly shared with a credit reporting agency. Despite the large portion of Californians with medical debt, and the increasing number of debt collection lawsuits by hospitals, there is little data about the number of and type of lawsuits or the demographics of the patients the lawsuits are against. According to the cosponsors, this bill will improve information collection as well as our understanding about these lawsuits and the patients being sued, and help to inform policymaking.

4) **OPPOSE UNLESS AMENDED.** The California Hospital Association (CHA) seeks amendments to the provisions of this bill as it relates to "litigation documents related to litigation" and "or any subsequent holder of the debt" for clarity as CHA is unclear of what

documents should be included and notes that hospitals are no longer in ownership over debt once a debt is sold. Various organizations representing original lenders doing business in California, including the California Chamber of Commerce and California Bankers Association, seek an amendment to define medical debt as debt that is owed directly to a medical provider or facility based on the Consumer Financial Protection Bureau. The lenders write that by including credit card products and secured debts in this bill, this bill is likely to result in significant non-medical debts being hidden from lenders, therefore causing lenders to provide more credit, and more debt, to consumers who cannot afford it.

5) **OPPOSITION**. The Consumer Data Industry Association (CDIA) writes that suppressing medical debt from a credit report will likely cause greater risk to a consumer's credit history, will increase risk to lenders and creditors, and has the potential to result in less credit or higher interest rates to the consumers in California. In addition, language requiring non-reporting to credit reporting agencies is preempted by the Federal Fair Credit Reporting Act. CDIA states that any legislation which attempts to suppress the reporting of this information in its entirety, could have severe unintended consequences. Failure to include medical debt in its entirety means that credit reports are less accurate and therefore less reliable for scoring models. A safe and sound credit economy needs a reliable credit reporting system. CDIA states that suppression of credit reporting leads to increased inaccurate credit files, reduces the reliability of credit scores, and adds greater risk and uncertainty into the lending process.

6) **TRIPLE REFERRAL**. This bill is triple referred; it passed the Assembly Committee on Judiciary June 18, 2024 by an 8-1 vote and upon passage in this Committee it will be referred to the Assembly Committee on Banking and Finance.

7) **PREVIOUS LEGISLATION**.

   a) AB 716 (Boerner), Chapter 454, Statutes of 2023, requires an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. Prohibits a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and prohibits a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. Requires a plan or insurer to reimburse for ground ambulance services at a rate established or approved by the governing board of the local government having jurisdiction for that area or subarea, including an exclusive operating area, as specified.

   b) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, 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.

8) **AMENDMENTS**. As this bill moves forwarded, the author is committed to amending this bill as follows:

a) Clarify that a hospital maintain documents related to litigation filed by the hospital itself and require that a hospital include a provision in any contract with a debt collector that requires the debt collector to maintain documents and records related to litigation for five years; and,

b) Exempt from "medical debt" instances when a health insurer makes a payment directly to the insured, and require the health insurer to provide a specified notice to the insured related to the conditions that make the debt reportable to a consumer credit reporting agency.

REGISTERED SUPPORT / OPPOSITION:

Support

Attorney General Rob Bonta (cosponsor)
California Low-Income Consumer Coalition (cosponsor)
Consumer Federation of CA (cosponsor)
CALPIRG (cosponsor)
California Nurses Association (cosponsor)
Health Access CA (cosponsor)
National Consumer Law Center (cosponsor)
AARP
ACLU California Action
American Cancer Society Cancer Action Network INC.
Asian Resources, INC
California Labor Federation
California Low-income Consumer Coalition
California Pan-Ethnic Health Network
California State Council of Service Employees International Union (SEIU California)
CAMEO - California Association for Micro Enterprise Opportunity
Consumer Federation of America
Consumer Protection Policy Center/USD School of Law
County of Santa Clara
Courage California
East Bay Community Law Center
Friends Committee on Legislation of California
Los Angeles County Department of Public Health
Maternal and Child Health Access
National Health Law Program
National Multiple Sclerosis Society
NextGen California
Public Law Center
Rising Communities (formerly Community Health Councils)
Small Business Majority
Solano County Democratic Central Committee
The Leukemia & Lymphoma Society

Opposition

Consumer Data Industry Association

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1099 (Nguyen) – As Amended June 11, 2024

SENATE VOTE: 37-0

SUBJECT: Newborn screening: genetic diseases: blood samples collected.

SUMMARY: Requires the California Department of Public Health (DPH), commencing July 1, 2026, and each July 1 thereafter, to provide a report to the Legislature that includes specified information regarding the collection of residual screening specimens stored at the California Biobank. Requires DPH to make the report available on its website. Requires specified fee revenue to fund DPH's reporting requirement. Specifically, **this bill**:

1) Requires DPH, commencing July 1, 2026, and each July 1 thereafter, to provide a report to the Legislature, and to post the report on its website, that includes each of the following:

    a) The total number of any residual screening specimens stored at the California Biobank;
    b) The number of new residual screening specimens collected the previous calendar year;
    c) The number of inheritable conditions identified by the original screening tests the previous calendar year;
    d) The number of projects utilizing specimens from the California Biobank;
    e) The number of published research studies where biospecimens from the California Biobank were used or referenced and the potential public health benefits from the research;
    f) The number of specimens provided by the California Biobank for each research project;
    g) The number of screening tests waived for religious purposes the previous calendar year; and,
    h) The number of residual screening specimens destroyed at the request of a parent or adult the previous calendar year.

2) Requires the fee revenues in existing law below to fund DPH's reporting requirement pursuant to this bill.

3) Makes technical changes to existing law.

EXISTING LAW:

1) Establishes the Birth Defects Monitoring Program (BDMP) within DPH to operate statewide to accomplish the following:

    a) To provide information on the incidence, prevalence, and trends of birth defects, stillbirths, and miscarriages;
    b) To provide information to determine whether environmental hazards are associated with birth defects, stillbirths, and miscarriages;
    c) To provide information as to other possible causes of birth defects, stillbirths, and miscarriages;

d) To develop prevention strategies for reducing the incidence of birth defects, stillbirths, and miscarriages; and,
e) To conduct interview studies about the causes of birth defects. [Health and Safety Code (HSC) § 103825 – 103855]

2) Requires DPH to establish a genetic disease unit to coordinate all DPH programs in the area of genetic disease that will promote a statewide program of information, testing, and counseling services; and, have the responsibility of designating tests and regulations to be used in executing the California Newborn Screening Program (CNSP). [HSC §125000]

3) Requires DPH to establish a program for the development, provision, and evaluation of genetic disease testing, and may provide laboratory testing facilities or make grants to, contract with, or make payments to, any laboratory that it deems qualified and cost effective to conduct testing or with any metabolic specialty clinic to provide necessary treatment with qualified specialists. The program shall provide genetic screening and followup services for persons who have the screening. [HSC §125000]

4) Requires DPH to include in the CNSP screening for phenylketonuria, fatty acid oxidation, amino acid, organic acid disorders, congenital adrenal hyperplasia, severe combined immunodeficiency, adrenoleukodystrophy, and any other disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the federal Recommended Uniform Screening Panel or state law is amended, whichever is later. [HSC §125000, 12501]

5) Requires birth attendants to provide pregnant women, prior to the estimated delivery date, with a copy of DPH's informational material entitled "Important Information for Parents." Requires perinatal licensed health facilities to provide the same to women admitted for delivery if she has not already received it and to translate or read the material in a language she understands if she cannot read it. [Title 17 California Code of Regulations (CCR) §6504, 6504.2]

6) Authorizes the parent or guardian of a newborn child to opt out of the CNSP if they object to a test on the ground that the test conflicts with their religious beliefs or practices. Requires parents or guardians who opt out to sign a refusal form approved by DPH and provided by the physician or birth attendant. Requires the form to be translated or read in a language understood by the parent or guardian if they cannot read the form. [HSC §125000; 17 CCR §6501.2]

7) Requires perinatal health facilities to collect the CNSP blood spot specimen when a newborn is between 12 and 48 hours old, with certain exceptions, and send such specimen to a CNSP laboratory on the same or next business day. For infants not born in a perinatal licensed health facility, but admitted to such a facility, the facility is required to obtain a specimen within 48 hours of admission and send it to a CNSP laboratory on the same or next business day. For infants neither born nor admitted to a perinatal licensed health facility after birth, the out-of-hospital provider is required to collect the CNSP specimen when a newborn is between 12 and 48 hours old, unless a religious objection is executed, and sent to a CNSP laboratory on the same or next business day. [17 CCR §6505]

8) Requires county registrars of births to provide a copy of the CNSP informational material to each person registering the birth of a newborn that occurred outside of a perinatal health facility when the newborn was not admitted to such a facility within the first 30 days of age. Requires the county registrar of birth to notify the local health officer and DPH of this birth, and requires the local health department to make every reasonable effort to obtain CNSP specimens. Permits local health departments, with permission from DPH, to terminate efforts to obtain the CNSP specimen after 30 days. [17 CCR §6505, 6507.1]

9) Requires DPH to provide the following forms for the administration of the CNSP: the California Newborn Screening Test Request Form (CDPH-4409) and the Notification of Registration of Birth Which Occurred Out of a Licensed Health Facility (CDPH-4460). [17 CCR §6501.5]

10) Requires CNSP results to be available to individuals over 18 years of age or the individual's parent or guardian. Requires results to be held as a confidential medical record, except for data compiled without reference to the identity of any individual and for research purposes, provided that the research has first been reviewed and approved by an institutional review board, as specified. Requires any disclosure of information to preserve the anonymity of the persons tested unless the person has given written consent to disclose the information. [HSC §124980; 17 CCR §6502.1]

11) Requires DPH to charge a fee for newborn screening and follow-up services, and requires the amount of the fee to be periodically adjusted in order to meet the costs of the CNSP. [HSC §125000]

12) Requires DPH to charge a fee for prenatal screening to support the pregnancy blood sample storage, testing, and research activities of the BDMP. Creates the BDMP Fund as a special fund in the State Treasury. Requires the fee revenues that are collected to be deposited into the fund and made available upon appropriation by the Legislature to support the pregnancy blood sample storage, testing, and research activities of the BDMP. [HSC §124977]

13) Requires DPH to establish fees in an amount that do not exceed the costs of administering the BDMP, which DPH is required to collect from researchers who have been approved by DPH. Requires these moneys to be used for the costs related to data management, including data linkage and entry, blood collection, storage, retrieval, processing, inventory, and shipping. [HSC §124991]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, the California Biobank contains blood specimens from roughly 20 million Californians, including specimens of whole blood from about 99% of the infants born in California since 1983. DPH has retained, stored, and for a fee, made them available to researchers to use. The author states that there has never been any report from or audit of the California Biobank that has been available to the Legislature or to the public. The author argues Californians deserve to know how their DNA is being used by private and public researchers.

2) BACKGROUND.

a) California Biobank Program (CBP). CBP represents the combined biospecimen and data resources of two DPH and monitoring programs, the California Genetic Disease Screening Program (GDSP) and the California Birth Defects Monitoring Program (CBDMP). GDSP administers both the CNSP and the Prenatal Screening Program, one of the largest and most comprehensive screening programs in the world. GDSP screens approximately 500,000 newborns each year for over 80 genetic and congenital disorders and over 350,000 pregnant women for Down syndrome, trisomy 18 and neural tube defects. The CBDMP administered by the GDSP, began tracking birth defects in 1983, and is recognized as a model for birth defects surveillance. CBDMP maintains a registry of data on children with serious major malformations. The CBP has been mandated to make specimens and data available to researchers for the following approved purposes: to identify risk factors for children's and women's diseases; to develop and evaluate screening tests; to develop and evaluate screening strategies; and, to develop and evaluate treatments.

b) Emerging Genetic Privacy Concerns. In April of 2018, police arrested Joseph James DeAngelo, alleging that he was the "Golden State Killer" suspected of at least 13 murders, 50 rapes, and 100 burglaries in California between 1974 and 1986. The break in the case arose from law enforcement's use of publicly available genetic data supplied to the freely accessible genealogical database GEDMatch, to which users upload their genetic data received from direct-to-consumer genetic tests in order to identify familial matches among other users. Using the killer's DNA profile collected from a rape kit, investigators submitted the killer's genetic information to GEDMatch and identified 10 to 20 relatives who shared the killer's great-great-great grandparents. Investigators then reconstructed a family tree using this information, ultimately identifying two prime suspects, one of which was exonerated by a family member's submitted genetic data; the other, DeAngelo, was a genetic match with the killer. Since that time, various articles, including a local news story and an academic article, have raised genetic privacy concerns regarding the Biobank's retention of specimens.

This bill seeks to increase transparency by requiring DPH to report to the Legislature information regarding the use of specimens from the California Biobank by outside researchers, including, among other things, the number of published research studies where specimens from the California Biobank were used and the potential public health benefits.

3) SUPPORT. According to California Health Coalition Advocacy (CHCA), the sponsor of this bill, each year in California, hundreds of thousands of newborn screenings are performed to detect genetic conditions. In addition, hundreds of thousands of prenatal screenings are performed to evaluate risk of certain birth defects, and pregnant mothers have the option to allow residual blood samples to be stored and used for research. CHCA continues that California indefinitely stores the residual blood samples in the California Biobank and makes them available to third party researchers, and in the case of newborn residual samples, without the consent of parents. CHCA contends that the genetic material of mothers and children is being stored and used for research for public health purposes, but there is no transparency into: what research is being conducted, what entities are utilizing the residual blood samples, or what specific public health benefits have been achieved. CHCA concludes

that this bill would ensure that the public has access to information about the activities of the California Biobank by requiring DPH to annually prepare a report, deliver a copy of the report to the Legislature, and post the report on their website.

4) **RELATED LEGISLATION**. SB 1250 (Nguyen) applies the requirements of SB 41 as described in 5)b) of previous legislation below to the CNSP and any contracts entered into before the implementation date, beginning on January 1, 2025. SB 1250 was not heard in the Senate Judiciary Committee.

5) **PREVIOUS LEGISLATION**.

a) SB 625 (Nguyen) of 2023 would have required DPH to permit the parent or legal guardian to opt out of the retention or use of the newborn child's blood sample for medical research. SB 625 would have prohibited any residual screening specimen from being released to any person or entity for law enforcement purposes or to establish a database for forensic identification. SB 625 would have authorized a parent or guardian of a minor child, and the child, once they are at least 18 years of age, to request that DPH destroy the residual screening specimen or retain the specimen, but not use it for research purposes. SB 625 would have further required DPH to prepare a separate standard informational acceptance form with a space for the parent or legal guardian of the newborn child to provide a signed and dated written acknowledgment of receipt of the informational brochure and would have required the form to be maintained in the mother's medical file, as specified. SB 625 was held on the Senate Appropriations Committee suspense file.

b) SB 41 (Umberg), Chapter 596, Statutes of 2021, established the Genetic Information Privacy Act, which requires direct-to-consumer genetic testing companies to provide consumers with information regarding the company's policies and procedures for the collection, use, and disclosure of genetic data and to obtain a consumer's express consent for collection, use, or disclosure of a consumer's genetic data. CNSP was specifically exempted.

c) SB 980 (Umberg) of 2020 was substantively similar to SB 41 as described in b) above. SB 980 was vetoed by the Governor who found the broad language of the bill could interfere with laboratories' mandatory requirement to report COVID-19 test outcomes to local public health departments who report that information to DPH.

d) AB 170 (Gatto) of 2015 would have required DPH to provide information about genetic testing and to obtain a signed form, as specified, from a parent or guardian of a newborn child regarding the collection of blood samples, as specified. AB 170 would have allowed parents and guardians, and individuals at least 18 years of age, to request, as specified, that blood samples not be used for medical research, or to be destroyed, or both, as specified. AB 170 was not heard in Senate Health Committee.

e) SB 222 (Padilla) of 2014 would have enacted the Genetic Information Privacy Act, which would have required an individual's written authorization prior to the collection of genetic information for testing, analysis, retention, or disclosure. SB 222 was held in the Senate Appropriations Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

California Health Coalition Advocacy (sponsor)
A Voice for Choice Advocacy
American Nurses Association/California
Educate. Advocate.
National Association of Pediatric Nurse Practitioners (NAPNAP)
Oakland Privacy

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1238 (Eggman) – As Amended April 18, 2024

SENATE VOTE: 39-0

SUBJECT: Lanterman-Petris-Short Act: designated facilities.

SUMMARY: Expands the definition of "designated facility" or "facility designated by the county for evaluation or treatment" for purposes of an involuntary hold. Specifically, **this bill**:

1) Expands the definition of "designated facility" or "facility designated by the county for evaluation and treatment" to include facilities that meet both of the following:

    a) Have appropriate services, personnel, and security to safely treat individuals being held involuntarily; and,

    b) Are licensed or certified as any of the following:

        i) A facility licensed by the Department of Public Health (DPH) as a skilled nursing facility (SNF);
        ii) A facility licensed by the Department of Health Care Services (DHCS) as a mental health rehabilitation center (MHRC);
        iii) A facility licensed or certified by DPH or DHCS as capable of providing treatment at American Society of Addiction Medicine levels of care 3.7 to 4.0; or,
        iv) A facility licensed by the Department of Social Services (DSS) as a social rehabilitation facility (SRF) with a mental health (MH) program certification from DHCS.

2) Prohibits the provisions in this bill from being interpreted to preclude a MH facility or substance use disorder (SUD) facility from treating either a MH or severe SUD as a primary condition if the facility is appropriate to provide those treatment services.

3) Permits a county to designate a facility for the purpose of providing one or more of the following services:

    a) Providing evaluation and treatment for the initial involuntary detention of up-to 72 hours;
    b) Providing intensive treatment for an initial up-to 14 days, following the 72 hour detention;
    c) Providing additional intensive treatment, following the initial up-to 14 days for an additional up-to14 days for suicidal persons;
    d) Providing additional intensive treatment, following the initial up-to 14 days for an additional up-to 30 days; or,
    e) Providing postcertification treatment, following the expiration of the 14 day period of intensive treatment not to exceed an additional 180 days when the individual continues substantially to be a danger to self or others, as specified.

4) Permits a county to designate a facility, as is appropriate and based on capability, to provide one or more types of treatment without designating the facility to provide all the possible treatments.

5) Requires DHCS to ensure that designated facilities are reimbursed for evaluation and treatment of standalone severe SUDs at reimbursement rates equivalent to those provided for evaluation and treatment of MH disorders.

6) Requires DHCS to authorize licensed MHRCs to admit clients who are only diagnosed with a severe SUD.

7) Permits DHCS to implement, interpret, or make specific the provisions in this bill, in whole or in part, by means of information notices, provider bulletins, or other similar instructions, until the time regulations are adopted.

EXISTING LAW:

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

2) Defines "gravely disabled," for purposes of evaluating and treating an individual who has been involuntarily detained or for placing an individual in conservatorship, as a condition in which a person, as a result of a MH disorder, a severe SUD, or both, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. [WIC §5008]

3) Requires the phrase "a danger to himself or herself or others, or gravely disabled" throughout the LPS Act to refer also to the condition of being a danger to self or others, or gravely disabled, as a result of the use of controlled substances rather than by a MH/SUD. [WIC §5342]

4) Defines a "designated facility" or "facility designated by the county for evaluation and treatment" as a facility that is licensed or certified as a MH treatment facility or a hospital, as specified, by DPH, and includes a licensed psychiatric hospital, a licensed psychiatric health facility (PHF), and a certified crisis stabilization unit (CSU). [WIC §5008]

5) Defines "PHF" as a facility licensed by DHCS that provides 24-hour inpatient care for people with MH disorders that includes, but is not limited to, the following basic services: psychiatry; clinical psychology; psychiatric nursing; social work; rehabilitation drug administration; and, appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. Prohibits PHFs from admitting and treating patients when the primary diagnosis is chemical dependency, chemical

intoxication, or chemical withdrawal. [Health and Safety Code (HSC) §1250.2, WIC §4080, and 22 California Code of Regulations (CCR) §77113(a)(3)]

6) Requires MHRCs to be licensed only by DHCS subsequent to application by counties, county contract providers, or other organizations. Requires DHCS to conduct annual licensing inspections of MHRCs. Prohibits an MHRC from admitting any person who is nonambulatory, who requires a level or levels of medical care not provided, who would be appropriately served by an acute psychiatric hospital (APH), or who is diagnosed only with a SUD or eating disorder. [WIC §5675 and 9 CCR §784.26(d)]

7) Provides for the licensure of health facilities, including SNFs, by DPH, and 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)]

8) Requires DSS to license SRFs, which are defined as any residential facility that provides social rehabilitation services for no longer than 18 months in a group setting to adults recovering from MH disorders who temporarily need assistance, guidance, or counseling. [HSC §1502]

FISCAL EFFECT: According to the Senate Appropriations Committee there are unknown, ongoing General Fund costs for DHCS for state administration.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, last year this Legislature passed SB 43 (Eggman), Chapter 637, Statutes of 2023, to amend the LPS Act by modernizing the definition of "gravely disabled." The author continues that thousands of Californians are suffering with severe mental illness and SUDs and it is our obligation to ensure appropriate facilities and services are made available to give them the treatment they need. The author argues that this bill is necessary to ensure that counties have the necessary authorized facilities, appropriate reimbursement, and policy guidance from the state to both implement SB 43, and provide the appropriate care to these Californians.

2) **BACKGROUND**.

   a) **LPS Act involuntary detentions.** The LPS Act provides for involuntary detentions for varying lengths of time for the purpose of evaluation and treatment, provided certain requirements are met, such as that an individual is taken to a county-designated facility. Typically, one first interacts with the LPS Act through a "5150" hold initiated by a peace officer or other person authorized by a county, who must determine and document that the individual meets the standard for a 5150 hold. A county-designated facility is authorized to then involuntarily detain an individual for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The professional person in charge of the county-designated facility is required to assess an individual to determine the appropriateness of the involuntary detention prior to admitting the individual. Subject to various conditions, a person who is found to be a danger to self or others, or gravely disabled, can be subsequently involuntarily detained for an initial up-to 14 days for intensive treatment, an additional 14 days (or up to an additional 30 days in counties that have opted to provide

this additional up-to 30 day intensive treatment episode), and ultimately a conservatorship, which is typically for up to a year and may be extended as appropriate.

Throughout this process, existing law requires specified entities to notify family members or others identified by the detained individual of various hearings, where it is determined whether a person will be further detained or released, unless the detained person requests that this information is not provided. Additionally, a person cannot be found to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or others who indicate they are both willing and able to help. A person can also be released prior to the end of intensive treatment if they are found to no longer meet the criteria or are prepared to accept treatment voluntarily.

b) County-designated facilities vs. non-designated facilities (NDFs). Individual counties are responsible for determining whether general acute care hospitals (GACHs), PHFs, APHs, and other licensed facilities qualify to be designated facilities for evaluating and treating individuals placed in involuntary detentions. DHCS is responsible for the approval of designated facilities as determined by the counties. Counties generally have the discretion to implement how facilities are designated, but facilities are required to uphold proper care of the patient and a patient's civil rights throughout the process of detention. As one example, Los Angeles County (LAC) has strict guidelines that designated facilities must meet. Every three years, facilities are re-evaluated for designation. If there are complaints about a designated facility, LAC has the authority to inspect patient medical records and issue corrective action plans to the designated facilities. If designated facilities do not comply, LAC can revoke designation. While the intent of the LPS Act is for authorized individuals to take those whom have been placed on a 5150 hold to a designated facility, if one does not exist, or a person is suffering another condition that requires immediate emergency medical services, the person is transported to the nearest facility, which is often an emergency department that is in an NDF. Pursuant to existing law, NDFs are permitted to involuntarily detain an individual who meets grave disability criteria, as outlined in the LPS Act, for more than eight, but less than 24, hours for evaluation and treatment, until the individual is either safely released or transferred to a designated facility.

c) Recent changes to the LPS Act. SB 43 expanded the definition of "gravely disabled" to also include a condition in which a person, as a result of a severe SUD, or a co-occurring mental health and SUD, is unable to provide for their personal safety or necessary medical care, in addition to the inability to provide for basic personal needs of food, clothing, and shelter. Upon its passage and signature by Governor Newsom, all but two counties (San Francisco and San Luis Obispo) indicated they would take advantage of a provision in the law permitting counties to defer implementation of the expanded definition until January 1, 2026.

As the County Behavioral Health Directors noted in their letter of concern on SB 43, the treatment, workforce, and housing capacity needed to support implementation was not addressed in that bill. Stakeholders also desired DHCS to issue a bulletin to clarify SB 43, which it had not done until March 25, 2024. In its Behavioral Health Information Notice (BHIN) No. 24-011, DHCS reiterates the prohibition for PHFs and MHRCs to admit those with primary SUDs, as well as the lack of DHCS's authority in the new law to approve the designation of new categories of facilities for the evaluation and treatment

of individuals on involuntary detentions for grave disability due only to a severe SUD. The BHIN did state, however, that, currently, GACHs, APHs, and CSUs could treat patients with only a severe SUD if the facilities have distinct part units providing chemical dependency recovery as a supplemental service and the CSU complies with specified regulations.

d) Prevalence of SUD in California. A 2022 publication from the California Health Care Foundation, entitled "Substance Use in California: Prevalence and Treatment" reported that substance use in California is widespread with over half of Californians over age 12 years reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a 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 10-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.

e) Shortage of treatment beds in California. According to a 2021 RAND report, California requires 50.5 inpatient psychiatric beds per 100,000 adults: 26.0 per 100,000 at the acute level and 24.6 per 100,000 at the subacute level, or 7,945 and 7,518 beds, respectively. At the community residential level, the estimated need is 22.3 beds per 100,000 adults. RAND estimated that California has a total of 5,975 beds at the acute level (19.5 per 100,000 adults) and 4,724 at the subacute level (15.4 per 100,000 adults), excluding state hospital beds. If state hospital beds are included, these figures increase to 7,679 (25.1 per 100,000 adults) and 9,168 beds (29.9 per 100,000 adults), respectively. RAND also observed large regional variation. For example, excluding state hospitals, acute bed capacity ranged from 9.1 beds per 100,000 adults in the Northern San Joaquin Valley to 27.9 beds per 100,000 adults in the Superior county region. For subacute bed capacity, regional estimates ranged from 7.4 to 31.8 beds per 100,000 adults. At the community residential level, RAND estimated that California has a total of 3,872 beds (12.7 per 100,000 adults). California has a shortfall of approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults) and a shortage of 2,796 beds at the subacute level (9.1 additional beds required per 100,000 adults), or 4,767 subacute and acute beds combined, excluding state hospital beds. If state hospitals were included in this estimate, the shortage of acute inpatient beds would shrink to 267, and there would be no observable shortage in beds at the subacute level. Separately, RAND estimated a shortage of 2,963 community-based residential beds.

f) Lack of evidence supporting involuntary SUD treatment. This bill is intended to close the gap in facility capacity left by SB 43. But this gap may be due to a lack of evidence-based models for compulsory SUD care. According to a review of studies on involuntary SUD treatment, "The effectiveness of compulsory drug treatment: A systemic review," the majority of studies evaluating compulsory treatment failed to detect any significant positive impacts on drug use or criminal recidivism over other approaches, and found that some studies suggest potential harms. In Massachusetts, where general law permits the involuntary commitment of individuals with SUD, the state's department of public health found that those who received involuntary treatment were 2.2 times more likely to die of

opioid-related overdoses than those who received voluntary treatment. A June 2020 statement from the World Health Organization (WHO) urged the permanent closure of compulsory SUD treatment facilities, stating "there is no evidence that compulsory drug detention and rehabilitation centers are beneficial." The WHO further urged a transition to evidence-informed systems that are aligned with international guidelines and principles of drug dependence treatment, drug use, and human rights.

3) **SUPPORT**. The Big City Mayors coalition, representing the 13 largest cities, are sponsoring this bill stating that while last year's reforms to the LPS Act focused on eligibility and the definition of "gravely disabled," other state codes now need to be updated to provide successful implementation. The Big City Mayors continue that this bill seeks to update licensing and reimbursement regulations to make sure facilities providing behavioral health treatment, including substance use treatment, have the authorities and funding mechanisms in place to treat this population. The Big City Mayors argue that this bill would also give DHCS the necessary authorities to provide implementing regulations for these updated behavioral health laws. The Big City Mayors conclude that we have reached a crisis point of seriously mentally ill Californians languishing in our communities and this bill will make improvements across the continuum of care and better position California to provide the services and care that our constituents expect and desperately seek. The California State Association of Psychiatrists (CSAP) are also sponsors of this bill and argue that it would allow for licensed professionals to more accurately and comprehensively provide for the needs of individuals experiencing a substantial risk of serious harm due to a mental health or SUD and help to provide dignity and treatment to those who are the most difficult to reach. CSAP concludes that this bill is in line with other recent legislative actions pertaining to the LPS Act.

4) **OPPOSITION**. ACLU California Action is opposed to this bill, stating that it would increase risk of overdose death, perpetuate racial disparities, overburden our already strained mental health system, and allow state administrative agencies to make major changes to the behavioral health system before engaging in the regulatory rulemaking process, thwarting important procedures for soliciting public feedback. The ACLU continues that expanding involuntary behavioral health facilities and treatment will disproportionately cause harm and death to people of color, particularly Black people, who are civilly committed at much higher rates than their white counterparts. In other states that involuntarily commit individuals for SUD, research has shown that Black people are overrepresented because they are less likely to have access to sufficient voluntary substance use disorder treatment services in their community. The ACLU also opposes this bill's approach to reducing public input and adherence to accepted rulemaking processes by allowing DHCS to "implement, interpret, or make specific this act, in whole or in part, by means of information notices, provider bulletins, or other similar instructions, until the time regulations are adopted." The ACLU argues that this provides an unjustifiable workaround without any enforceable guardrails to the regulatory rulemaking process, which has comprehensive public notice and comment requirements, allowing DHCS to issue guidance without a public process soliciting input from those most impacted.

5) **OPPOSED UNLESS AMENDED**. SEIU California is opposed to this bill unless amended to address their concerns that this bill would negatively impact the successful implementation of SB 43 and would put existing patients in the proposed expansion of designated facilities at risk of harm. SEIU acknowledges the bill's reference to all future facilities needing to have

"appropriate services, personnel, and security to safely treat individuals," but are concerned this language does not go far enough. SEIU argues that it lacks specificity and definition to guarantee readiness of facilities, nor does it reflect dialog with stakeholders on appropriateness of settings to guarantee the best clinical outcomes. SEIU also states that the needs of those who may be involuntarily detained may go well beyond the immediate event or episode that led to the individual being held involuntarily. SEIU requests that the bill is amended to better reflect these realities and include language on how designated facilities will meet these needs, including how continuity of care and care coordination will be maintained for those already in a program of care for a medical or behavioral need. SEIU continues that clear accountability and oversight is needed to ensure that data, patient outcomes, and trends are being tracked over time to identify where facility, staffing, and/or policy level changes are needed. Lastly, SEIU argues that to guarantee implementation success, this bill should be amended such that stakeholder engagement is clearly identified.

6) RELATED LEGISLATION.

a) SB 1017 (Eggman) would have required DHCS, in consultation with DPH and DSS, to develop a solution to collect, aggregate, and display information about beds in specified facilities to identify the availability of inpatient and residential MH or SUD treatment. SB 1017 was held on the Senate Appropriations Committee suspense file.

b) SB 1319 (Wahab) permits a SNF, that is applying to provide therapeutic behavioral health programs in a physically separate unit of a SNF and is required to receive approvals from multiple departments, to apply simultaneously to those departments, and requires those departments to work jointly to develop processes to allow applications to be reviewed simultaneously to minimize the total approval time for all departments. SB 1319 is currently pending in the Assembly Health Committee.

7) PREVIOUS LEGISLATION.

a) SB 43, among other things, expands the definition of "gravely disabled," for purposes of involuntarily detaining an individual under the LPS Act, to include an individual with a severe SUD, or a co-occurring mental health disorder and a severe SUD, or chronic alcoholism, who is unable to provide for food, clothing, shelter, personal safety or necessary medical care.

b) SB 363 (Eggman) of 2023 was substantially similar to SB 1017, except it required the creation of a database instead of a solution. SB 363 was held on the Assembly Appropriations Committee suspense file.

c) SB 1227 (Eggman), Chapter 619, Statutes of 2022, modifies the LPS Act to allow a second 30-day intensive treatment hold for a person who has been certified as "gravely disabled" on top of the existing 72 hour, 14 day, and 30 day treatment holds; the second 30-day treatment hold must be approved by a court pursuant to a petition filed by the professional in charge of the intensive treatment, as specified.

8) PROPOSED TECHNICAL AMENDMENTS. The author's office has received proposed technical amendments from DHCS, which DHCS states will provide them with the comprehensive authority to carry out the author's goal of permitting PHFs and MHRCs to

admit individuals diagnosed only with a severe SUD for purposes of involuntary treatment. The Committee may wish to adopt some of DHCS' proposed amendments, including provisions to:

a) Amend the definition and various code sections related to PHFs to explicitly authorize PHFs to admit people diagnosed only with severe SUDs, upon approval by DHCS.

b) Explicitly authorize MHRCs to admit clients diagnosed only with severe SUDs, upon approval by DHCS.

c) Require PHFs and MHRCs, as a condition of approval by DHCS, to offer medications for addiction treatment (MAT) or have an effective referral process in place for MAT treatment. Require MAT policies to align with existing standards for other SUD providers as defined in SB 184 (Committee on Budget), Chapter 47, Statutes of 2022.

d) Strike facilities that DHCS does not feel are appropriate for individuals with SUD from the list of those who can be designated, including SNFs, SRFs, and facilities licensed or certified by DPH or DHCS as capable of providing treatment at American Society of Addiction Medicine levels of care 3.7 to 4.0.

e) Add new facilities to the list of those who can be designated, including PHFs, psychiatric residential treatment facilities, CSUs, GACHs, APHs, hospitals operated by the US Department of Veteran Affairs, and chemical dependency recovery hospitals.

f) Revise language regarding reimbursement to instead direct DHCS to issue guidance regarding Medi-Cal reimbursement for covered Medi-Cal services provided to an individual receiving involuntary SUD treatment.

g) Make various technical and clarifying changes.

9) PROPOSED COMMITTEE AMENDMENTS. The amendments proposed by DHCS do not address the entirety of concerns raised by various stakeholders. Given this historic expansion of the LPS Act and lack of evidence-based models for involuntary SUD care there are legitimate concerns about the outcomes of the implementation of SB 43 and this bill. This is especially important given the existing disproportionality of Black and Latinx individuals involuntarily detained and conserved in California. Based on an analysis from the Department of Healthcare Access and Information, Black and Latinx Californians were 57.2% and 154.5%, respectively, more likely to be placed on a 5150 hold compared to their white counterparts. The Committee may wish to further amend the bill to address gaps and concerns left unaddressed by language proposed by DHCS, including amendments to:

a) Require DHCS, in consultation with pertinent stakeholders, to establish updated regulations for the purpose of developing standards for designated facilities who are involuntarily admitting and treating persons. The regulations should, at a minimum, include:

i) Minimum SUD service requirements with sufficient SUD staff to maintain programs, treatment setting services, and safety measures;

ii) Standards for offering MAT or an effective referral process to other MAT providers;

iii) Length of stay standards consistent with evidence-based care for SUD disorders;

iv) Discharge planning for SUD disorder services;

v) Privacy and data sharing requirements;

vi) Process for transitioning and assisting licensed facilities and centers to updated regulatory requirements; and,

vii) Systems of public accountability and oversight that include, but are not limited to, readiness to meet, and ongoing maintenance of, required standards for staffing, facilities, and care established pursuant to this section.

b) Require DHCS to adopt regulations by December 31, 2027.

10) **REMAINING POLICY CONCERNS.** Some stakeholders still question whether this bill, as proposed to be amended, will be enough to ensure that counties can successfully and safely implement SB 43. This bill is authorizing, not requiring, certain facilities to provide involuntary SUD services. Some stakeholders question whether there is enough incentive and support in this bill to create the bed capacity needed to implement SB 43. Additionally, this bill only authorizes facilities to provide involuntary treatment for severe SUDs, even though these facilities may admit and treat both involuntary **and** voluntary mental health patients with a range of diagnoses. This raises a few questions and concerns. What happens if an involuntary SUD patient becomes voluntary, but wants to stay at the same facility? Would they be required to leave? What if a patient is on an involuntary MH hold but needs SUD services, would those be available to them? This bill isn't requiring these facilities to provide any type of SUD services. But if they want and have the capacity to provide them wouldn't that be something to encourage given our state's significant shortage of treatment beds? The author is strongly encouraged to continue conversations with stakeholders and DHCS to ensure this bill is structured in a way that will fully meet the needs of patients across the state and those who are charged with serving them.

REGISTERED SUPPORT / OPPOSITION:

Support

Big City Mayors Coalition (cosponsor)
California State Association of Psychiatrists (cosponsor)
Mayor London Breed, City of San Francisco
Alameda County Families Advocating for the Seriously Mentally Ill
California Chapter of the American College of Emergency Physicians
California Hospital Association
California Medical Association
Cedars Sinai
County of San Diego
National Alliance on Mental Illness (NAMI-CA)
Psychiatric Physicians Alliance of California
Sharp Healthcare

Opposition

ACLU California Action
Cal Voices
Disability Rights California
Mental Health America of California

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1258 (Dahle) – As Amended April 8, 2024

SENATE VOTE: 37-0

SUBJECT: Medi-Cal: unrecovered payments: interest rate.

SUMMARY: Allows the Department of Health Care Services (DHCS) to waive the interest that would otherwise accrue when DHCS seeks to recover an overpayment made to a Medi-Cal provider, under specified circumstances. Specifically, **this bill** allows DHCS to waive the interest, as part of a repayment agreement entered into with a Medi-Cal provider, if the unrecovered overpayment occurred four or more years before the issuance of the first statement of account status or demand for repayment, after taking into account the following factors:

1) The importance of the provider to the health care safety net in the community in which the provider provides services to patients;

2) The impact of the repayment amounts on the fiscal solvency of the provider;

3) The ability of the provider to repay the overpayment amounts;

4) Whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider; and,

5) Whether waiving the interest would jeopardize the availability of federal funding.

EXISTING LAW:

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

2) Requires DHCS to audit providers for amounts paid for services provided to Medi-Cal beneficiaries. Requires DHCS to establish an administrative appeal process for providers to review grievances or complaints arising from the findings of an audit or examination. [WIC §14170, §14171]

3) Requires interest to apply against any unrecovered overpayment due to DHCS from a provider following an audit or examination, or any payment recovered by a provider who prevails in an audit appeal, and for the interest rate to be the higher of the following:

    a) The rate equal to the monthly average received on investments in the Surplus Money Investment Fund (SMIF) during a specified timeframe; or,
    b) Simple interest at the rate of 7% per annum. [WIC §14171]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, potential annual interest loss (General Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, revenue margins of community health clinics are narrower than they have ever been. Some medical providers are having to shut down or reduce services because of ongoing funding challenges while caring for patients. The author asserts small clinics shouldn't be hostage for payment errors four or more years old. The author concludes this bill is crucial to ensure that providers are able to reliably serve and treat their community while fulfilling their financial obligations to the state.

2) **BACKGROUND**. Current law specifies if recovery of a disallowed payment has been made by the department, DHCS collects the overpayment with interest. A provider who prevails in an appeal is entitled to interest at the same rate. The current rate is equal to the monthly average received on investments in the SMIF, or simple interest at the rate of 7%, whichever is higher. A higher interest rate presumably incentivizes accuracy in billing and prompt repayment.

   a) **SMIF**. Monies of various funds deposited in the State Treasury are transferred for investment purposes in the SMIF. For all of the participating special funds, the State Treasurer invests any cash balances that exceed the special fund's immediate cash needs. The average rate received on investments fluctuates significantly.

   b) **Medi-Cal Payment Recovery Activities**. The Overpayments Program is a section within DHCS's Third Party Liability and Recovery Division, which is responsible for enforcing fiscal compliance with Medi-Cal laws and regulations for Medi-Cal providers and beneficiaries. The program's primary function is to recover funds due to the Medi-Cal program. DHCS's Audits and Investigations Division, other auditing and legal agencies, and Medi-Cal fiscal intermediaries refer overpayment cases to the program.

      When a provider overpayment is identified, providers are sent notices of overpayments by the fiscal intermediaries or demand-for-payment letters by the auditing organization. These letters also notify the provider of their appeal rights. Providers may request that the Overpayments Program work with them to develop a repayment agreement that allows repayment over a period of time, rather than paying the overpayment in full at once.

      If the provider does not pay voluntarily, DHCS will withhold a provider's Medi-Cal claims payment until the debt is satisfied. DHCS also may take steps to initiate an offset of state income tax refunds, pursue civil actions in small claims court, or refer the case to the Attorney General's Office to secure a judgment against the beneficiary's assets and/or record a real property lien. The provider has 60 days from receiving the notice of overpayment to pay in full or establish a repayment agreement before DHCS begins to take these actions.

   c) **Overpayment Interest Rate.** Through the 2012-13 Budget, the interest rate on overpayment was changed from the SMIF rate to either the SMIF rate or simple interest of 7% per year, whichever is higher. DHCS proposed trailer bill legislation in 2012 to make this change because extremely low SMIF rates at that time offered little incentive for providers to pay their obligations in a timely manner. This resulted in additional cost pressures on the General Fund, given the state's borrowing rate and other factors at the

time. This bill would allow DHCS to waive interest on past overpayments, after considering a number of factors.

3) **SUPPORT**. California Chapter of the American College of Emergency Physicians writes in support that a large portion of income to emergency physician groups comes from Medi-Cal; fines or interest associated with disallowed payments can have a disproportionate impact on emergency department physicians. Elderly Care Everywhere writes that interest accrued on unrecovered overpayments can be a significant burden, particularly for providers who are part of the health care safety net in their communities.

4) **PREVIOUS LEGISLATION**.

   a) AB 515 (Mathis) of 2019 was similar to this bill. AB 515 was vetoed by Governor Newsom who stated in his veto message that the bill "fails to distinguish between overpayments due to provider fraud and abuse and those caused by Medi-Cal policy changes or DHCS error that are not the fault of a billing provider. In addition, it does not make the option for DHCS to waive interest subject to the availability of federal funding. . . I encourage the author to work with DHCS on future legislation that will specify the circumstances under which interest may be waived, and make those conditions subject to the availability of federal funding, in order to protect the State General Fund." This bill addresses the veto message by including "whether waiving the interest would jeopardize the availability of federal funding" in the consideration of whether to waive interest.

   b) AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, the 2012 health budget trailer bill, among other provisions, requires DHCS to assess interest against Medi-Cal provider overpayments at the SMIF rate or 7% per year, whichever is higher. AB 1467 also requires DHCS to pay interest at the same rate to a provider who prevails in an appeal of a payment disallowed by DHCS.

REGISTERED SUPPORT / OPPOSITION:

Support

California Chapter of the American College of Emergency Physicians
California Medical Association
Elderly Care Everywhere

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1290 (Roth) – As Introduced February 15, 2024

SENATE VOTE: 39-0

SUBJECT: Health care coverage: essential health benefits.

SUMMARY: Expresses the intent of the Legislature to review California's essential health benefits (EHBs) benchmark plan and establish a new EHB plan for the 2027 plan year. Limits the current benchmark to plan years on or before the 2027 plan year.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans 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 under the federal Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization (HMO) contract, existing California health insurance mandates, and the 10 ACA mandated benefits. Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC §1367.005 and INS §10112.27]

3) Defines "basic health care services" as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
   g) Hospice care. [HSC §1345]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, California's EHBs are based upon the same 2014 benchmark plan established when California first implemented the ACA. Updates were adopted in 2015 (effective in 2017) to incorporate the federal definition of habilitative, to base pediatric vision benefits on the Federal Employees Dental and Vision Insurance

Program (CHIP) vision plan, and to base pediatric dental benefits on the Children's Health Insurance Program benefits. California's benchmark does not include coverage for hearing aids, infertility treatment, adult dental, chiropractic, or nutritional counseling, among other benefits. The author states that inclusion of any of these benefits in California's EHBs requires the state to update our benchmark plan through a stakeholder process and to notify the federal Centers for Medicare and Medicare Services by May of 2025, in order for those benefits to be in place for the 2027 plan year. This bill will help begin the review process, which requires actuarial analysis, and a stakeholder process to inform the options for policymakers, and ultimately codify any changes to California's benchmark plan. The author concludes that any added health insurance mandates outside of this process require the state to pay for or "defray" the added costs of insurance mandates not included in the benchmark.

2) **BACKGROUND**.

a) ACA and federal requirements. Enacted in March 2010, the ACA provides the framework, policies, regulations and guidelines for the implementation of comprehensive health care reform by the states. The ACA expands access to quality, affordable insurance and health care. As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions. These aspects of the ACA, along with tax credits for low and middle income people buying insurance on their own in new health benefit exchanges, make it easier for people with preexisting conditions to gain insurance coverage. Additionally, the ACA requires health plans sold in the individual and small group markets to offer a comprehensive package of items and services, known as EHBs. The federal government gave each state the authority to choose its "benchmark" plan.

b) California's Current EHB benchmark plan. The federal Department of Health and Human Services (DHHS) define EHBs based on state-specific EHB benchmark plans. The base-benchmark plan California selected for 2014 (Kaiser Foundation Health Plan Small Group HMO 30 plan) was the largest plan by enrollment in one of the three largest small-group insurance products in the state's small-group market. According to the California Health Benefits Review Program (CHBRP), California chose to supplement this plan with the pediatric oral benefit from its CHIP, and the pediatric vision benefits from a federal plan to create the EHB-benchmark plan. Additionally, California chose to define habilitative services and required that these services be provided "under the same terms and conditions applied to rehabilitative services."

c) Health insurance mandates. The ACA establishes that while states are permitted to require coverage of benefits in addition to those considered EHBs, they must defray the cost of providing those state-mandated benefits, either by paying the enrollee directly or by paying the qualified health plan (offered on Covered California). For California, it is unclear which entity or person would be responsible for the determination of whether a benefit mandate requires defrayal. According to CHBRP, federal guidance established the "state" as the entity that would identify when a state benefit mandate exceeds EHBs; however, the state entity would be subject to federal oversight. However, California has not yet officially determined who or which agency would be the responsible party for determining whether a benefit exceeds EHBs. It should be noted that since the passage of the ACA and the selection of the Kaiser benchmark plan, no legislation has been signed into law that exceeded the EHBs and required the state to defray the cost of that service.

Last year, SB 635 (Menjivar) of 2023 would have required hearing aids for children and was vetoed by Governor Newsom as exceeding EHBs.

New health benefit mandates do not require defrayal when they do not exceed the state's definition of EHBs. According to CHBRP, state rules around service delivery method (such as telemedicine), provider types, cost sharing, or reimbursement methods are not considered state benefit mandates that would trigger the requirement for the state to defray the costs even though plans and policies in a state must comply with these requirements.

States adopting a new benchmark plan or revising the existing plan, will not result in triggering defrayal. It should be noted that premiums (what consumers pay) may increase as a result of setting a new benchmark plan.

d) New Benchmark Selection. In late 2023, DHHS published a proposed rule that would, among other things, allow states to mandate new benefits without exceeding EHB or triggering the requirement that the state cover the costs of those new benefits (as explained below), if the state adopts a new benchmark plan that includes the new benefits. If enacted, this rule change would allow California to adopt a new benchmark plan that requires health plans to cover new benefits (such as hearing aids for children) without also incurring the state cost for those benefits for Covered California enrollees.

According to the DMHC, federal law dictates the process a state must follow when selecting a new benchmark plan. These requirements include the following:

- **i)** The state must select a benchmark plan that provides a scope of benefits equal to or greater than the scope of benefits provided by a "typical employer plan." This sets the floor for the generosity of the benefits. The benchmark plan also cannot exceed the generosity of the state's most generous "comparison plan." This sets the ceiling for the generosity of the benefits. The state must submit to DHHS an actuarial certification and report affirming the selected benchmark plan meets these floor and ceiling requirements;
- **ii)** The benefits in the proposed benchmark plan cannot be "unduly" weighted toward any particular category of benefits, must provide benefits for diverse segments of the population, and cannot include discriminatory benefit designs;
- **iii)** The state must submit a formulary drug list in a format and manner specified by DHHS;
- **iv)** The state must provide reasonable public notice regarding the proposed new benchmark plan and must give the public a reasonable time to comment on the proposed plan; and,
- **v)** The state must notify DHHS of the selected new benchmark plan and submit supporting documentation, including the required actuarial certification and report, "by the first Wednesday in May of the year that is two years before the effective date" of the new benchmark plan. Based on these time frames, the earliest that California could have a new benchmark plan in place is for plan year 2027.

3) SUPPORT. The National Health Law Program (NHeLP) writes that the new benchmarking process requires the state to establish a transparent process where stakeholders can provide input about potential new benefits. The state must also conduct an actuarial analysis

certifying that the resulting plan does not exceed the value of the most generous typical employer plan in the state, as defined in federal regulations. For this reason, NHeLP concludes that it is important that states begin the process with sufficient time and in advance of the anticipated effective plan year. Children Now and Let California Kids Hear are writing to strongly support a policy solution that will permanently close coverage gaps and ensure that all children in California have access to affordable and comprehensive health insurance that meets all of their health needs.

4) **SUPPORT IF AMENDED.** The California Dental Association urges the consideration of including adult dental services as an EHB in the updated benchmark plan.

5) **COMMENT.** CDI provided comments on potential changes to the EHB benchmark plan and offered recommendations to consider when the Legislature chooses a new benchmark plan. CDI recommends that at a minimum, manual and power wheelchairs, walkers, hospital beds, respiratory equipment such as oxygen systems, and power operated scooters should be added to EHBs. CDI recommends that the Legislature consider adding external prosthetic and orthotic devices required to replace the function of all or part of an organ or extremity, rigid and semi-rigid orthotic devices required to support or correct a defective body part, and special footwear for foot disfigurement, to EHBs. CDI also recommends hearing aids, infertility, eyeglasses, expansion of home health visits, and routine dental services.

6) **RELATED LEGISLATION**.

   a) AB 2914 (Bonta) is substantially similar to this bill. AB 2914 is pending in the Senate Health Committee.

   b) AB 2753 (Ortega) includes durable medical equipment, as specified, under EHBs coverage of rehabilitative and habilitative services and devices. AB 2753 is pending in the Senate Health Committee.

7) **PREVIOUS LEGISLATION.**

   a) SB 635 would have required health aid coverage for enrollees or insureds under 21 years of age. Governor Newsom vetoed SB 635, stating in part, that the Department of Health Care Services has developed a comprehensive plan to increase provider participation and program enrollment for the Hearing Aid Coverage for Children Program.

   b) AB 1157 (Ortega) of 2023 was substantially similar to AB 2753 (Ortega) and was held in Senate Appropriations Committee.

   c) SB 729 (Menjivar) of 2023 would have required large and small group health plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. SB 729 was held on the Assembly Appropriations Suspense file.

REGISTERED SUPPORT / OPPOSITION:

Support

California Chiropractic Association

Children Now
Crohns and Colitis Foundation
Health Access California
Let California Kids Hear Coalition
National Health Law Program
Western Center on Law & Poverty, INC.

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1339 (Allen) – As Amended June 17, 2024

SENATE VOTE: 38-0

SUBJECT: Step-down care.

SUMMARY: Requires the Department of Health Care Services (DHCS), by January 1, 2027, in consultation with relevant state and county agencies and stakeholders to establish a voluntary certification program for "supportive community residences." Requires a referring entity, as defined, to provide information relating to the license or certification status of a step-down care facility when informing an individual options for step-down care covered by the individual's health insurance. Specifically, **this bill**:

1) Requires DHCS, by January 1, 2027, in consultation with relevant state and county agencies and stakeholders to establish a voluntary certification program for "supportive community residences."

2) Defines "supportive community residence" as a residence providing community-based, nonclinical housing for adults with a substance use disorder (SUD), mental health (MH) diagnosis, or dual diagnosis seeking a cooperative living arrangement as a transitional or long-term residence during the process of recovery. Requires supportive community residences to provide peer supports, services navigation, and physical design features that support an individual in the process of recovery from a SUD, MH diagnosis, or dual diagnosis. Clarifies that supportive community residences include, but are not limited to, "recovery residences," as defined in existing law, that serve people in recovery for a SUD in an alcohol and drug-free environment.

3) Requires the certification program to include all of the following:

    a) Standards and procedures for operation of the certification program that consider, at a minimum, all of the following:

        i) Types of certifications needed for the various types of supportive community residences;

        ii) Nationally recognized standards of operation;

        iii) Target populations and diversity of communities served;

        iv) Evidence-based, trauma-informed, and culturally sensitive environments;

        v) Tenant rights and protections;

        vi) Access to, and security of, residents' medication;

        vii) Services navigation;

viii) Peer supports;

ix) Cleanliness, privacy, physical design, and safety;

x) Relocation assistance;

xi) Data reporting requirements;

xii) Harm reduction and abstinence models; and,

xiii) Screening and intake assessments and procedures.

b) Methods for filing and investigating complaints within a reasonable timeframe;

c) Procedures for periodic monitoring, onsite inspections, demonstration of successful outcomes, and enforcement of compliance with laws and regulations governing supportive community residences;

d) Penalties for supportive community residences that do not remediate deficiencies within a designated timeframe, conditions under which a supportive community residence may be decertified, and the means by which a supportive community residence may regain certification; and,

e) Technical assistance to assist owners, operators, house managers, and other supportive community residence staff with respect to the following:

i) Developing an understanding of the applicable regulations and statutes;

ii) Completing the application process for certification;

iii) Answering questions regarding day-to-day operation; and,

iv) Implementation of harm reduction principles, accommodation of medication-assisted treatment, and outcome data tracking and reporting.

4) Requires DHCS to create and maintain a searchable online database of certified facilities that meets the following requirements:

a) To preserve privacy, does not provide the address or specific location of a supportive community residence other than the city, ZIP Code, or both;

b) Provides telephone and email contact information;

c) Provides a record of any substantive and validated complaints filed against a supportive community residence, findings after investigation of those complaints, and the time it took from the date of filing until the complaint is resolve; and,

d) Updated monthly in order to reflect all new certifications or updated certification status for supportive community residences.

5) Prohibits a supportive community residence from providing any licensable services onsite, including, but not limited to, incidental medical services.

6) Permits DHCS to charge a fee for certification of supportive community residences in an amount not to exceed the reasonable cost of administering the program and not exceeding $2,000. Requires certification to be valid for two years.

7) Permits DHCS to charge a fee for recertification in an amount not to exceed the reasonable cost of administering the program and not exceeding $500.

8) Establishes the Supportive Community Residence Program Fund in the State Treasury. Requires all fees collected in accordance with this program to be deposited into the fund. Requires the moneys in the fund to be available upon appropriation by the Legislature for the purposes of supporting the certification activities of DHCS.

9) Defines a "referring entity" as a state or local entity, or a state-licensed or state-certified entity that discharges, directs, or provides a list of one or more residential or inpatient step-down care options for adults with a SUD or MH diagnosis. A referring entity includes, but is not limited to, an adult treatment facility, a general acute care hospital or acute psychiatric hospital, psychiatric health facilities, a chemical dependency recovery hospital, a licensed community care facility, certified supportive community residences, MH rehabilitation centers, crisis stabilization units, short-term residential therapeutic programs, skilled nursing facilities with special treatment programs, and county behavioral health agencies.

10) Defines a "step-down care facility" as a supportive community residence, any residential or inpatient licensed alcoholism or drug abuse recovery or treatment facility, or any residential or inpatient licensed community care facility serving adults with mental health or SUDs.

11) Requires a referring entity, when informing an individual with a SUD, MH diagnosis, or dual diagnosis of one or more options for a step-down care facility that is covered by the individual's health insurance, to provide the following information:

    a) The license or certification number of the step-down care facility; and,

    b) The contact information for the licensing or certifying agency.

12) Requires a referring entity, when informing an individual with a SUD, MH diagnosis, or dual diagnosis of one or more options for a step-down care facility that is not covered by the individual's health insurance, to first verify any license or certification the step-down care facility claims to hold.

13) Requires a referring entity to report to the appropriate state agency any suspected fraudulent license or certification identified during verification.

14) Requires health care service plans and disability insurers that provide coverage for MH and SUDs and that credential step-down care facilities to provide those services for its networks

to assess and verify the qualifications of a step-down care facility within 60 days after receiving a completed facility credentialing application. Requires, upon receipt of the application by the credentialing department, the health care service plan or disability insurer to notify the applicant within seven business days to verify receipt and inform the applicant whether the application is complete.

15) Makes legislative findings and declarations about SUD and MH diagnoses, the shortage of treatment beds, the lack of state standards and oversight for residential homes serving people with SUD and MH diagnoses, and the need to improve access to quality community-based and non-institutional settings.

EXISTING LAW:

1) Grants DHCS the sole authority in state government to license alcoholism or drug abuse recovery or treatment facilities (RTFs). [Health and Safety Code (HSC) §11834.01]

2) Defines "alcoholism or drug abuse RTF" as any, place or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. [HSC §11834.02]

3) Defines a "recovery residence" (RR) as a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a SUD and that does not require licensure by DHCS or does not provide licensable services, as specified, including residential dwellings commonly referred to as "sober living homes," "sober living environments," or "unlicensed alcohol and drug free residences." [HSC §11833.05]

4) Prohibits any person, firm, partnership, association, corporation, or local governmental entity from operating, establishing, managing, conducting, or maintaining an alcoholism or drug abuse RTF to provide recovery, treatment, or detoxification services without first obtaining a current valid license from DHCS. [HSC §11834.30]

5) Prohibits, under the Fair Employment and Housing Act, discrimination against any person in any housing accommodation on the basis of race, color, religion, sex, marital status, national origin, ancestry, familial status, or disability. Specifies that discriminatory land use regulations, zoning laws, and restrictive covenants are unlawful acts. [Government Code §12900 et seq.]

6) Establishes the Department of Managed Health Care to regulate health plans and California Department of Insurance to regulate health insurance. [Health and Safety HSC §1340, *et seq*. and Insurance Code (INS) §106, *et seq*.]

7) Establishes as California's essential health benefits (EHBs) benchmark under the Patient protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the ten ACA mandated benefits, including MH and SUD coverage. [HSC §1367.005 and INS §10112.27]

8) Requires every health plan contract and insurance policy that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of MH and SUDs

under the same terms and conditions applied to other medical conditions, as specified. [HSC §1374.72 and INS §10144.5]

FISCAL EFFECT: According to the Senate Appropriations Committee, there are unknown, ongoing costs for DHCS for state administration. Certification fees collected would be deposited into a newly created Supportive Community Residence Program Fund to support DHCS's costs. Additional unknown, ongoing costs to counties to administer duties as a "referring entity." Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

COMMENTS:

1) **PURPOSE OF THIS BILL**. A constituent of the author, a 26 year old aerospace engineer named Brandon Nelson, suffered a psychotic break in January 2018. According to the author, over several weeks Brandon was transferred between facilities as his condition fluctuated between more and less stable. The author continues that the last of those facilities delayed providing Brandon's prescription and meeting with a psychiatrist, and left him unsupervised and alone in his room. Within 24-hours, Brandon committed suicide. The author states that the facility had been operating fraudulently and without a valid state license, and Brandon's case is just one example of the MH care system failing to adequately protect vulnerable Californians. The author continues that the number of MH providers and beds are projected to decline over the next decade which has exacerbated the increase in number of people seeking MH support from sober living homes and other non-medical residential facilities. The author argues that the state does not regulate these institutions and reporting reveals a system suffused with fraud, abuse, and neglect. The author concludes that this bill protects patients by creating greater accountability and oversight within the MH system and empowering people with MH diagnoses or SUDs to make more informed decisions about their care.

2) **BACKGROUND**.

   a) **Prevalence of SUD in California.** A 2022 publication from the California Health Care Foundation, entitled "Substance Use in California: Prevalence and Treatment," reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a 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 10-fold increase in fentanyl related deaths between 2015 and 2019. The California Department of Public Health'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.

   b) **Alcohol and Drug Treatment Facility Licensing and Certification.** DHCS has sole authority to license RTFs in the state. Licensure is required when at least one of the following services is provided: detoxification; group sessions; individual sessions; educational sessions; or, alcoholism or other drug abuse recovery or treatment planning.

Additionally, facilities may be subject to other types of permits, clearances, business taxes, or local fees that may be required by the cities or counties in which the facilities are located.

As part of their licensing function, DHCS conducts reviews of RTF operations every two years, or as necessary. DHCS's Substance Use Disorder Compliance Division checks for compliance with statute and regulations to ensure the health and safety of RTF residents and investigates all complaints related to RTFs, including deaths, complaints against staff, and allegations of operating without a license. DHCS has the authority to suspend or revoke a license for conduct in the operation of an RTF that is inimical to the health, morals, welfare, or safety of either an individual in, or receiving services from, the facility or to the people of the State of California.

AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, requires other non-residential, outpatient alcohol or other drug programs be certified by DHCS. Certification is required when at least one of the following is provided: outpatient treatment services; recovery services; detoxification; or medications for addiction treatment. DHCS does not license alcohol and drug RRs with six or less beds that don't provide licensable services, known as RRs.

c) RRs. An RR is a residence for people in recovery from substance abuse. It may serve as support for individuals undergoing treatment but it does not provide treatment or care, whether medical or nonmedical. The state laws and licensing requirements that govern treatment and care facilities do not currently include RRs. Therefore, the state does not keep any list of registered RRs, conduct inspections of RRs, or perform any of the other activities associated with licensing facilities. An RR may be completely self-governed or have formal on-site management, but in the latter case, the managers' duties relate to the administration of the house rather than the tenants or their recovery (as in "case management"). The tenants of an RR pay rent and abide by house rules, which always include maintenance of sobriety and participation in a self-help program. Multiple studies have shown the effectiveness of this kind of environment as a support for people transitioning out of drug or alcohol treatment. The effectiveness of sober living as one component of a person's successful recovery program is not controversial. The California Research Bureau estimates that there are at least 12,000 sober living beds in the state to serve an eligible population of between 25,000 and 35,000 individuals. If an RR is providing any licensable services then it must obtain a valid RTF license from DHCS.

DHCS's Drug Medi-Cal-Organized Delivery System waiver permits counties to use RRs in their continuum of services if they adhere to the following guidelines: the RR does not provide SUD services that would require licensure by DHCS; all residents of an RR are actively engaged in medically necessary recovery support services to be provided off-site; each county develops guidelines for contracted RR entities; and, the county provides monitoring and oversight of the RR.

d) Harm Reduction. According to the National Institutes of Health (NIH) website, harm reduction is a strategy that aims to reduce the harms associated with certain behaviors. When applied to SUDs, harm reduction accepts that a continuing level of drug use (both legal and illegal) in society is inevitable and defines objectives as reducing adverse consequences. It emphasizes the measurement of health, social, and economic outcomes,

as opposed to the measurement of drug consumption. Harm reduction has evolved over time, from its initial identification in the 1980s, as an alternative to abstinence-only focused interventions for adults with SUDs. At the time, it was recognized that abstinence was not a realistic goal for those with SUDs. In addition, those individuals who were interested in reducing, but not eliminating, their use were excluded from programs that required abstinence. NIH's website states there is persuasive evidence that harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors. For example, areas that have introduced needle-exchange programs have shown mean annual decreases in HIV prevalence compared with those areas that have not introduced needle-exchange programs. Access to and use of methadone maintenance programs are strongly related to decreased mortality, both from natural causes and overdoses, which suggests that these programs have an impact on overall socio-medical health. The most recent addition to the harm reduction continuum is that of safe consumption spaces, which have been successfully implemented in over 100 sites around the world.

e) MH Parity. The Federal MH Parity law requires, if health plans include services for MH and SUDs as part of their benefits, the provision of MH services under the same terms and conditions as other medical services. The ACA also specified coverage of the 10 EHBs, including MH and SUD treatment services and preventive and wellness services. According to a 2015 *Health Affairs* Health Policy Brief, the ACA went beyond existing federal law by mandating coverage instead of requiring parity only if coverage is provided.

SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers to provide full coverage for the treatment of all MH conditions and SUDs. SB 855 also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. SB 855 applies to all state-regulated health plans and insurers that provide hospital, medical, or surgical coverage, and to any entity acting on the plan or insurer's behalf. A health plan cannot limit benefits or coverage for MH or SUD treatments or services when medically necessary.

3) **SUPPORT**. Share! Collaborative Housing is sponsoring this bill, stating that this bill seeks to certify supportive community residencies and place them appropriately in the continuum of care. SHARE! Collaborative Housing argues that there is a need for this high-road model to be codified into a legal definition, so as to discourage bad actors from preying on unsuspecting and vulnerable populations

4) **OPPOSITION.** The California Consortium of Addiction Programs and Professionals (CCAPP) opposes this bill, stating they support many of the bill's goals but have major structural issues with recent amendments. CCAPP highlights concerns with the definition of "step-down care," stating that RRs don't provide care and redefining them as places where people are given care would assuredly lead to its rezoning in all jurisdictions, eliminating this important housing resource for thousands of people. CCAPP also raises various questions to the provisions of this bill regarding referring entities, arguing that this bill poses more questions than it answers.

5) RELATED LEGISLATION.

a) AB 2479 (Haney) adds requirements for recovery housing to Housing First. AB 2479 is currently pending in the Senate Housing Committee.

b) AB 2574 (Valencia) requires an organization that operates, conducts, owns, or maintains a certified program or a licensed facility to disclose to the department whether the licensee, or a general partner, director, or officer of the licensee owns or has a financial interest in a recovery residence and whether it has contractual relationships with entities that provide recovery services to clients of certified programs or licensed facilities if the entity is not a part of a certified program or a licensed facility. AB 2574 is currently pending in the Senate Appropriations Committee.

c) AB 2893 (Ward) Requires DHCS to establish a certification process for recovery homes and adds a standard for recovery homes that meets the state's Housing First requirements. AB 2893 is currently pending in the Senate Health Committee.

d) SB 1438 (Niello) changes the core components of Housing First to allow the eviction of a resident for the use of drugs or alcohol if children are housed in the same location, and include "recovery housing" programs, as specified. SB 1438 is currently pending in the Senate Housing Committee.

e) SB 913 (Umberg) would have permitted a city attorney of a city in which housing units are located or a district attorney, if the units are located in the unincorporated area of the county, to enforce parts of DHCS licensing laws, as specified. Would have required DHCS to adopt a process that permits a city or county to conduct announced and/or unannounced site visits to facilities licensed by DHCS and to sober living homes/RRs that do not require DHCS licensure. SB 913 was held on the Senate Appropriation Committee suspense file.

f) SB 1334 (Newman) defines an RR, for purposes of licensing RTFs, as a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a SUD, does not require DHCS licensure, and does not provide licensable services, and clarifies that an unlicensed RR may provide services to its residents, including, but not limited to, dining, housekeeping, security, transportation, and recreation. Exempts RRs from being required to be licensed RTFs if the facility does not offer recovery services, as defined, and would allow residents of an RR to actively participate in recovery services outside of the home. Requires RRs to be operated as a separate business from a licensed RTF and require RRs to maintain separate agreements with each resident for the housing and services it provides SB 1334 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 1696 (Sanchez) of 2021 would have required any government entity that contracts with a privately owned RR to provide recovery services to require the RR to comply with specified requirements. AB 1696 was vetoed by the Governor.

b) SB 349 (Umberg), Chapter 15, Statutes of 2022, creates the California Ethical Treatment for Persons with Addiction Act to provide protection for SUD treatment clients and their

families. Imposes requirements and proscribed unlawful acts relating to marketing and advertising with respect to treatment provide. Requires treatment providers to adopt a client bill of rights for persons seeking treatment for SUD, and to make the bill of rights available to all-clients and prospective clients; a treatment provider to maintain records of referrals to or from a RR, as specified and, provides that acts made unlawful by the bill be subject to a civil fine of up to $20,000 per violation.

c) AB 1158 (Petrie Norris), Chapter 443, Statutes of 2021, requires an RTF licensed by DHCS serving more than six residents to maintain specified insurance coverages, including commercial general liability insurance and employer's liability insurance. Requires a licensee serving six or fewer residents to maintain general liability insurance coverage. Requires any government entity that contract with privately owned RR or RTF serving more than six residents to require the contractors to, at all times, maintain specific insurance coverage.

d) AB 1098 (Daly) of 2021 would have created the Excellence in Recovery Residence Housing Act. Would have required the Secretary of the California Health and Human Services Agency to develop and publish on the DHCS internet website consensus-based guidelines and nationally recognized standards for counties to use to promote the availability of high-quality RR housing for individuals with a SUD and to dissuade the use of contracting with, or referral to, RRs that do not meet these guidelines and standards. AB 1098 was held on the Assembly Appropriations Committee suspense file.

7) POLICY COMMENTS. Recent author's amendments require insurers to verify licensure or certification status of a step-down care facility before credentialing the facility to provide services in its networks. These amendments also require referring entities, when informing an individual about a step-down care facility, to verify and then provide the individual a facility's license or certification number. The amendments raise the following questions:

a) What is step-down care, and is it a covered service? This bill defines "step-down care" as: a supportive community residence, any licensed RTF, or any residential or inpatient licensed community care facility serving adults with MH or SUDs. A supportive community residence, as defined in this bill, is nonclinical housing that is prohibited from providing any licensable services. California's MH parity laws only mandate the coverage of medically necessary treatment, so it is unlikely that housing in a supportive community residence would be covered and credentialed by insurers in the state. The definition of "step-down care" also includes all licensed RTFs and community care facilities. Licensed facilities are required to identify their level of care as they provide treatment, so it is unclear how these are "step-down care" in nature.

There are significant differences between licensed facilities and supportive community residences. Including these terms in the same definition may be confusing for insurers, consumers, and regulators. The author is encouraged to work with stakeholders and the relevant state departments to ensure that the step-down care provisions of this bill are appropriately tailored to what is actually covered by insurers in the state.

b) What does certification mean for referral? The certification program in this bill is completely voluntary and gives DHCS authority to charge up to $2,000 for certification. Given that supportive community residence models, such as RRs, can currently operate without state certification or licensure, there is a likelihood that many won't pursue

certification under this bill. Simultaneously, this bill requires referring entities to verify the licensure or certification of a step-down care facility. The language as drafted leaves a few questions unanswered. What happens if a supportive community residence doesn't seek voluntary certification, are they excluded from referral by the laundry list of facilities and programs detailed in this bill? What would this mean for individuals seeking a supportive community residence in an area where there are no certified residences or available certified beds? Is the goal to give preferential referral to certified residences? The author may wish to clarify these provisions of the bill to ensure intent is clear and implementation is possible.

c) **Same sponsor, different goals?** Lastly, AB 2893 (Ward) shares the same sponsor as this bill and is also aiming to define supportive community residences and create a certification program to enable these residences to be eligible for state funding under housing first requirements. However, neither the definitions of supportive community residences nor the certification processes in these parallel bills are aligned. The authors and sponsor are strongly encouraged to work together to align their bills and avoid unnecessarily directing DHCS to create two separate certification programs for housing with the same name and purpose.

8) **DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, it will be referred to the Assembly Committee on Housing and Community Development.

REGISTERED SUPPORT / OPPOSITION:

Support

Share! Collaborative Housing (sponsor)
California State Association of Psychiatrists
Steinberg Institute

Opposition

California Consortium of Addiction Programs and Professionals

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1354 (Wahab) – As Amended June 17, 2024

SENATE VOTE: 30-9

SUBJECT: Long-term health care facilities: payment source and resident census.

SUMMARY: Imposes requirements to increase accountability for and compliance with existing law, regulation, and policy related to nondiscrimination of payer source for admissions to, discharges from, and transfers within or from long-term health care facilities (LTC facilities). Specifically, **this bill**:

1) Requires a skilled nursing facility (SNF) participating as a Medi-Cal provider to make publicly available its current daily resident census and nurse staffing data by meeting either of the following conditions:
   a) The facility posts on its website the facility's current daily resident census and nurse staffing data; or,
   b) Upon request by telephone, the facility provides the data through either or both of the following ways based on the preference of the requestor: verbally, within 24 hours; or by email within two business days. Allows the facility to comply with the request to provide data by email by emailing a photo of its posted data.

2) Defines "current daily resident census" and "nurse staffing data" as data required to be posted by the facility pursuant to federal regulations, as specified, that corresponds to a given day, in the case data is posted on a website pursuant to 1) a) above, or the day a request is made pursuant to 1) b) above.

3) Specifies the reporting requirement established by 1) above does not preclude the provision of any information by a LTC facility otherwise required by state or federal law.

4) Exempts a failure to comply with 1) above from specified penalties and misdemeanor charges.

5) Requires the addition of the following statement to the written notice required to be provided when a resident is involuntarily transferred or discharged from a LTC facility:

   "At the time of admission, this facility is an enrolled provider with the following: ____ Medi-Cal ____ Medicare.

   If we participate in Medi-Cal, you will not be discharged from the facility or transferred within the facility, solely as a result of changing your manner of purchasing the services from private payment or Medicare to Medi-Cal, except for a potential transfer within the facility from a private room to a semiprivate room.

   If we participate in Medi-Cal, you may be eligible for the Long-Term Care Medi-Cal program to help pay for your stay in the facility. For more information, refer to the attached notice DHCS 7077, Notice Regarding Standards for Medi-Cal Eligibility, from

the State Department of Health Care Services. Medi-Cal, Medicare, or a private payor may require that the resident pay a copayment, coinsurance, or a deductible, all of which the facility considers to be the resident's share of cost."

6) Requires a LTC facility participating as a Medi-Cal provider to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. Specifies this applies to, but is not limited to, admission practices, room selection and placements except as otherwise specified in law, and meal provision.

7) Makes a technical conforming change.

EXISTING FEDERAL LAW:

1) Prohibits nursing facilities that participate in the Medicaid or Medicare program from requesting or requiring oral or written assurance that residents or potential residents state that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. [42 Code of Federal Regulations (CFR) §483.15]

2) Prohibits nursing facilities that participate in the Medicaid or Medicare program from transferring or discharging a resident from the facility unless under one of the following conditions:
   a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
   b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
   c) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
   d) The health of individuals in the facility would otherwise be endangered;
   e) The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility. Specifies that for a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or,
   f) The facility ceases to operate. [*Ibid.*]

3) Requires nursing facilities that participate in Medicaid or Medicare to post the following information on a daily basis:
   a) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift, as specified; and,
   b) Resident census.

   Requires posting of nurse staffing data on a daily basis at the beginning of each shift. Requires data to be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors. Requires a facility, upon oral or written request, to make nurse staffing data available to the public for review at a cost not to exceed the community standard. Requires a facility to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. [42 CFR §483.35(g)]

EXISTING STATE LAW:

1) Licenses and regulates health care facilities by the California Department of Public Health (DPH), including SNFs. [Health and Safety Code (HSC) §1250 *et seq.*]

2) Defines LTC facilities, in part, as SNFs, intermediate care facilities (ICFs), and congregate living health facilities. [HSC §1418]

3) Requires all contracts of admission to LTC facilities to state that except in an emergency, a resident cannot be involuntarily transferred within, or discharged from, the facility unless the resident is given reasonable notice in writing and transfer or discharge planning as required. Requires the written notice to state the reason for the transfer or discharge, and requires the facility to immediately notify the Office of the State Long-Term Care Ombudsman (LTC Ombudsman) in every case of involuntary discharge, as specified. [HSC §1599.78]

4) Requires an LTC facility, if a resident is notified in writing of a facility-initiated transfer or discharge, to also send a copy of the notice to the local LTC Ombudsman at the same time the notice is provided to the resident. Requires the facility, if the resident is subject to a facility-initiated transfer to a general acute care hospital on an emergency basis, to provide a copy of the notice to the LTC Ombudsman as soon as practicable. [HSC §1439.6]

5) Regulates contracts of admission to LTC facilities, and requires that SNFs, ICFs, and nursing facilities use a standard admission agreement developed and adopted by DPH. [HSC §1599.60, *et seq.*]

6) Regulates involuntary transfers and discharges from LTC facilities. Prohibits a contract of admission from listing any ground for involuntary transfer or discharge of the resident except those grounds which are specifically enumerated in either federal or state law. [HSC §1599.76]

7) Requires every contract of admission to a LTC facility that participates in Medi-Cal to state that the facility may not transfer or seek to evict any resident solely as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal. [*Ibid.*]

8) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code (WIC) §14000, *et seq.*]

9) Establishes a schedule of benefits under the Medi-Cal program, which includes LTC services, as specified. [WIC §14132]

10) Prohibits a LTC facility that participates as a Medi-Cal provider from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal, except that a facility is permitted to transfer a resident from a private room to a semi-private room. [WIC §14124.7]

11) To the extent not prohibited by federal law, prohibits a Medi-Cal provider from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. [WIC §14124.10]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, one of the most disturbing violations of state and federal laws is the pervasive discrimination against Medi-Cal beneficiaries who need nursing home care. The author cites examples of calling nursing home after nursing home for a loved one who is on Medi-Cal and not being able to find one, and meanwhile, if the person is on Medicare, a place can be found right away. Medicare reimbursement rates are higher than Medi-Cal rates; the author declares that, therefore, discriminating against Medi-Cal residents has become the standard way nursing homes try to increase their profits. Participation in the Medi-Cal program is voluntary; facilities who participate must sign a provider agreement certifying under penalty of perjury that they will adhere to all state and federal laws, which include a prohibition against Medi-Cal discrimination. This bill seeks to tighten and improve accountability to current nondiscrimination requirements in order to make it easier for Medi-Cal members seeking LTC services to find a LTC placement, and to prevent inappropriate discharges of Medi-Cal members.

2) **BACKGROUND**.

   a) **Insurance-Based Discrimination.** Insurance-based discrimination refers to inequitable treatment that patients receive from health care providers because of the type of insurance they have, or because they do not have insurance. Many health care providers and institutions routinely provide differential access to services based on insurance status. For instance, many providers can choose whether to accept Medicaid or uninsured patients and can choose whether to contract with Medicaid managed care plans. Patients may experience different appointment availability and overall access to care depending on their insurance status.

      According to "Insurance-Based Discrimination Reports and Access to Care Among Nonelderly US Adults, 2011–2019," a peer-reviewed 2023 study published in the *American Journal of Public Health* of survey data from 4,000 adults aged 18 to 64 years who reported their experiences with insurance-based discrimination:

      i) Research consistently shows dramatically higher rates of insurance-based discrimination among people with public rather than private insurance;

      ii) Research also consistently demonstrates that reports of insurance-based discrimination are tied to delayed and forgone care, lack of confidence in getting needed care, reports of poor-quality care, and receipt of suboptimal care; and,

      iii) Compared with adults with private insurance (4% on average), insurance-based discrimination was five or six times higher for adults with public insurance (21% on average) and about seven times higher for adults with no insurance (27% on average).

The study recommends monitoring insurance-based discrimination and enforcing nondiscrimination policies.

b) Existing Nondiscrimination Protections Based on Insurance Status. Despite insurance-based discrimination being fairly common, some health care providers and institutions are bound by nondiscrimination protections that apply as a condition of participation in Medicare and Medicaid (Medi-Cal in California). Since Medicare and Medicaid pay for the vast majority of patient days in SNFs, these facilities are bound by rules that apply as a condition of participation in these programs.

Medi-Cal provider agreements include language prohibiting discrimination "against Medi-Cal beneficiaries in any manner, including, but not limited to, admission practices, room selection and placement, [and] meals provision," as well as requiring a provider to "agree that it shall provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public." This bill codifies these non-discrimination protections as they apply to LTC facilities.

In addition, state law prohibits a LTC facility that participates as a Medi-Cal provider from seeking to evict out of the facility, or transfer within the facility, a resident as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal, except the law explicitly permits a facility to transfer a resident from a private room to a semi-private room. Finally, state law prohibits a Medi-Cal provider from discriminating against a Medi-Cal patient on the basis of the source of payment for services covered by Medi-Cal.

c) Recent DPH Guidance Reiterates Nondiscrimination Rules. Pursuant to federal regulations, SNFs must provide residents with equal access to quality care regardless of diagnosis, severity of condition, or payment source. This requirement was cited in a December 22, 2023, All-Facilities Letter (AFL) 23-37 issued by DPH, among other requirements, to reiterate nondiscrimination protections and expectations under state and federal rules. AFL 23-37 also reminded SNFs that:

- **i)** Both federal and state regulations limit the circumstances under which a SNF can initiate a transfer or discharge, thus protecting SNF residents from facility-initiated transfers and discharges that would violate those regulations;
- **ii)** Discharges of residents admitted for short-term rehabilitation who communicate they are not ready to leave the facility may be investigated for discrimination; and,
- **iii)** SNFs may not seek to transfer or discharge residents solely due to a change in their source of payment, e.g., Medicare to Medi-Cal, or to open a bed for residents with insurance coverage that provides a higher rate of reimbursement.

d) Experience from the Field. Cosponsor California Advocates for Nursing Home Reform (CANHR) asserts that Medi-Cal discrimination has long been a problem in LTC facilities despite the prohibitions on discrimination noted above. CANHR indicates Medi-Cal discrimination in these facilities manifests in two primary ways: admissions and discharge decisions.

i) **Admissions**. CANHR asserts that in admissions, nursing homes uniformly refuse to admit residents from anywhere other than a hospital, given that hospital stays trigger lucrative Medicare coverage that is only available for a benefit period of 100 days.

ii) **Discharges**. CANHR asserts Medi-Cal discrimination results in residents being chased out and subject to unsafe, inappropriate discharges the instant their Medicare coverage ends and they switch to Medi-Cal reimbursement.

According to CANHR, the standard business plan of nursing home chains is to maximize the number of residents on Medicare and minimize the number on Medi-Cal, and this is evident when viewed at a broad level despite difficulty conclusively demonstrating discrimination on a case-by-case basis. CANHR cites, for instance, the difficulty in finding placements for 681 residents affected by the closure of a SNF called Laguna Honda in 2022. Although nursing home resident census data that was available at the time showed that hundreds of nursing home beds were available in the City of San Francisco alone, CANHR notes 14,480 calls made by Laguna Honda staff seeking placements led to only 41 successful transfers, 35 of which were to a single facility.

By codifying nondiscrimination provisions of the provider agreement, informing individuals as they are admitted of their rights to not be discharged or transferred from the facility based on insurance status, and improving access to information about average daily census and nurse staffing, this bill seeks to increase compliance with nondiscrimination rules, improve the ability of Medi-Cal enrolled individuals to find SNF placements, and reduce inappropriate transfers and discharges.

3) **SUPPORT**. Numerous disability, aging, and consumer rights advocacy organizations support this bill, asserting that despite antidiscrimination laws, for decades, nursing homes have found numerous ways of discriminating to reduce their Medi-Cal population and free beds up to make way for more lucrative private pay or Medicare residents. Supporters note the situation has prompted DPH to publish an AFL reminding facilities of their obligation to provide the same level of care and accommodation to all residents, regardless of their payment source. Cosponsor Office of the State LTC Ombudsman states this bill would address the growing problem of systemic discrimination faced by Medi-Cal beneficiaries by SNFs that often refuse their admission or terminate their services when their payment source is switched to Medi-Cal.

4) **RELATED LEGISLATION**. SB 1033 (Menjivar) requires a study on reimbursement of licensed congregate living health facilities and private duty nursing services. SB 1033 is pending in this Committee.

5) **PREVIOUS LEGISLATION**.

a) AB 1309 (Reyes), Chapter 835, Statutes of 2023, requires nursing homes, within 48 hours of giving a required written notice of an involuntary transfer or discharge, to provide the resident with a copy of certain discharge-related documents, including a description of specific needs that cannot be met when the basis of the transfer or discharge is because the resident's needs cannot be met in the facility.

b) AB 895 (Holden), Chapter 577, Statutes of 2022, requires SNFs and residential care facilities for the elderly to provide a written notice to a prospective resident, or their representative, that includes the contact information for the local LTC ombudsman, and links to specified websites governing licensing and quality of care.

c) AB 133 (Committee on Budget), Chapter 143, Statutes of 2022, health trailer bill that, among other things, requires an LTC facility to timely comply with a hearing decision that finds that the facility improperly transferred, discharged, or refused to readmit a resident. Allows DHCS to assess penalties of $750 a day for each calendar day the facility fails to comply with the hearing decision.

d) AB 940 (Weber), Chapter 274, Statues of 2017, requires a LTC facility to notify the local LTC ombudsman when a resident is notified in writing of a facility-initiated transfer or discharge from the facility.

e) SB 526 (Alquist) of 2005, among other things, would have prohibited SNFs from discriminating on the source of payment against a current or prospective Medi-Cal recipient and required that applicants for admission to a SNF be admitted on a first come, first serve basis. SB 526 was referred to the Senate Health Committee and was not heard.

REGISTERED SUPPORT / OPPOSITION:

Support

Office of the State Long-Term Care Ombudsman (cosponsor)
California Advocates for Nursing Home Reform (cosponsor)
AARP
Alameda County Democratic Central Committee
Association of Regional Center Agencies
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Alliance for Retired Americans
California Long Term Care Ombudsman Association (CLTCOA)
California Retired Teachers Association
Disability Rights California
Elderly Care Everywhere
Imperial County Long-Term Care Ombudsman Program
Justice in Aging
Long Term Care Services of Ventura Co, Ombudsman

Opposition

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1423 (Dahle) – As Amended May 16, 2024
AS PROPOSED TO BE AMENDED

SENATE VOTE: 38-0

SUBJECT: Medi-Cal: critical access hospitals.

SUMMARY: Requires the Department of Health Care Services (DHCS) to convene a Rural Hospital Technical Advisory Group, consisting of representatives, as specified, to discuss and provide recommendations on Medi-Cal reimbursement and other issues related to the financial viability of small, rural, or critical access hospitals (CAHs). Specifically, **this bill**:

1) Requires DHCS, during the 2025 calendar year, to convene a Rural Hospital Technical Advisory Group (advisory group), consisting of representatives from small, rural, and CAHs, statewide hospital trade associations representing general acute care hospitals, statewide or regional organizations representing rural communities, individuals with specific relevant expertise in hospital finance, Medicaid reimbursement, rural health care delivery, or related areas, and other affected stakeholders as the department deems appropriate, for the following purposes:

    a) To analyze the continued ability of small, rural, and CAHs to remain financially viable under existing Medi-Cal reimbursement methodologies applicable to the array of covered Medi-Cal services provided by small, rural, and CAHs in both the fee-for-service (FFS) and managed care delivery systems. Requires this to include, at a minimum, consideration of the costs incurred by small, rural, and CAHs in serving Medi-Cal beneficiaries and the extent to which current reimbursement methodologies reimburse for those costs;

    b) To provide recommendations on changes to existing Medi-Cal reimbursement methodologies or the implementation of successor reimbursement methodologies, or both, to ensure sufficient access to covered Medi-Cal services in the rural communities served by small, rural, and CAHs and to promote the continued financial viability of these hospitals; and,

    c) To analyze the contribution of Medi-Cal reimbursement to the overall financial viability of small, rural, and CAHs, and identify, as appropriate, any other key contributors to the financial challenges of small, rural, and CAHs. Allows DHCS to engage stakeholders, researchers, and other state departments, including but not limited to, the Department of Managed Health Care (DMHC), the Department of Health Care Access and Information (HCAI), and the Department of Public Health, in this effort.

2) Requires the advisory group to be convened, at a minimum, on a bimonthly basis through the end of the 2025 calendar year.

3) Requires DHCS, by March 31, 2026, and in consultation with the advisory group, to report to

the Legislature on the findings and recommendations arising out of the meetings. Requires this to include, at a minimum:

a) Recommendations for successor reimbursement methodologies applicable to public or private small, rural, and CAHs, or both;
b) Identification of any existing reimbursement methodologies that would be replaced by such successor methodologies;
c) Any considerations for obtaining the necessary federal approvals for such changes;
d) Any conforming statutory changes necessary to effectuate such recommendations; and,
e) An assessment of the contribution of Medi-Cal reimbursement to the overall financial viability of small, rural, and CAHs, and any other key contributors to financial challenges of small, rural, and CAHs, as appropriate, as well as any recommendations identified by DHCS that relate to these other key contributors.

4) Defines "Small, rural, or CAH" to mean a licensed general acute care hospital that meets at least one of the following criteria:

a) Is designated by the State Department of Public Health as a CAH, and certified as such by the Secretary of the United States Department of Health and Humans Services under the federal Medicare Rural Hospital Flexibility Program; or,
b) Has fewer than 25 licensed general acute care beds and is located in a Medical Service Study Area defined as having a Rural or Frontier designation status.

EXISTING LAW:

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

2) Makes hospitals designated as a CAH by DHCS, and certified as such by the federal Department of Health and Human Services, eligible for supplemental payments for Medi-Cal covered outpatient services. [WIC §14105.17]

3) Subjects the supplemental payments in 2) above to federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of the payments. Requires the supplemental payments to be apportioned among CAHs based upon their number of Medi-Cal outpatient visits. [WIC §14105.17]

4) Establishes a Hospital Quality Assurance Fee (HQAF) supplemental payment program, defines private hospitals as eligible recipients of payments through the program, and exempts specified small and rural hospitals from payment of fees associated with the program. [WIC §14169.50]

FISCAL EFFECT: This bill, as proposed to be amended, has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, California hospitals, especially rural CAHs, are suffering. The author points out that the state has the most heavily regulated business environment in the nation, so providing essential services to those in need is extremely difficult. The 37 CAHs in California serve the state's most vulnerable and disadvantaged people. Financial pressures, such as an increase in Medi-Cal patients, labor expenses, and building regulations are severely limiting the ability of these hospitals to continue providing essential care. The author asserts that many of these hospitals are on the verge of closing and will be forced to shut down because they simply are not able to operate at a loss anymore. Although a prior version of this bill would have implemented a cost-based reimbursement methodology for CAHs, this bill as proposed to be amended will instead allow for a comprehensive consideration of the fiscal challenges of CAHs, engage stakeholders and technical experts to inform a Medi-Cal reimbursement design that is sustainable, and identify and provide recommendations to address other contributors to the financial challenges of these hospitals. With this information and engagement, the author concludes we can take proactive measures to prevent financial distress while maintaining critical services.

2) **BACKGROUND**.

   a) **CAHs**. The federal Medicare program allows for certification of hospitals as CAHs if they meet particular criteria established in federal regulations. These requirements include:

      i) The hospital is located in a state with a State Medicare Rural Hospital Flexibility Program and has been designated by the state as a CAH;
      ii) The hospital is located in a rural area or an area that is treated as rural and is more than 35 miles from the nearest hospital or more than 15 miles in areas with mountainous terrain or only secondary roads; and,
      iii) The hospital has no more than 25 inpatient beds, an average length of stay of 96 hours or less per patient for acute inpatient care, and has 24-hour emergency care services seven days a week.

      The federal Medicare program pays 101% of a CAH's reasonable costs for most inpatient and outpatient services. According to the federal Health Resources and Services Administration, there are currently 37 CAHs in California.

   b) **Hospital Access.** Hospital locations and services emerged from and continue to evolve based on community demand, public and private investment, and regional health care market environments. Most hospitals are private entities, and state regulation is focused on whether a hospital meets licensure, staffing and quality standards—not where a hospital operates or what services they offer. Some states require review and approval of health facilities, bed capacity, and services through a "Certificate of Need" process to encourage rational allocation of health resources, but in California such decisions are generally market-based or a result of local public or nonprofit investment. The financial health of hospitals is monitored by HCAI through mandatory data reporting, however, there is no state oversight entity tasked with monitoring or guiding the geographic availability of hospitals nor ensuing financial viability of hospitals in areas that have limited access, such as rural areas. The state does have a program to assist small and rural hospitals to comply with seismic requirements, and recently launched a loan

program for distressed hospitals pursuant to AB 112 (Committee on Budget), Chapter 6, Statutes of 2023.

DMHC network adequacy standards for licensed health plans require plans to include an in-network hospital within 30 minutes or 15 miles of enrollee's residence. However, in many cases, health plans can apply for exemptions from this requirement in rural areas by requesting "alternative access standards," based on evidence and good-faith efforts to include available providers in their network.

c) Impact of Rural Hospital Closures. According to an August 2019 National Bureau of Economic Research paper, "Impact of Rural and Urban Hospital Closures on Inpatient Mortality," 92 rural hospitals closed in California from 1995 to 2011. The paper found that mortality rates rose nearly 6% when a rural hospital closed. However, the closings of urban hospitals did not have a similar impact. In rural areas, ambulances have to travel further to patients after a hospital closes.

According to the California Hospital Association, sponsor of this bill, one-fifth of California's rural hospitals stopped offering obstetric services between 2011 and 2021, and 40% of California's rural hospitals stopped offering chemotherapy between 2014 and 2022. CHA notes when a rural hospital closes, those in poor health, seniors, and people experiencing poverty suffer the most. According to a report by the California Health Care Foundation (CHCF), hospitals are often an important source of employment opportunities in rural parts of the state, and financial insolvency may have serious impacts on regional labor markets.

d) Hospital Financial Distress. A number of hospitals in California, primarily those in rural areas but also some independent hospitals in urban areas, are in financial distress. According to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 600 rural hospitals across the country are at risk of closing in the near future due to persistent financial losses on patient services and low financial reserves. Of these, 200 are at "immediate risk of closing," including six in California, according to CHQPR. CHQPR does not release names, and hospitals in general avoid publicizing financial distress, because it could lead to staff leaving and exacerbating the hospital's situation.

According to an April 6, 2023 article in *CalMatters*, among hospitals that have publicly talked about their troubles or attributed reductions in services and staff to their finances are Mad River Community Hospital in Arcata, Kaweah Health Medical Center in Visalia, El Centro Regional Medical Center in Imperial County, and Beverly Community Hospital in Montebello. Madera Community Hospital in central California closed in January 2023. Catalina Island Health, a CAH, also presented on its financial distress publicly this year, and according to an April 12, 2024, *Los Angeles Times* article, L.A. Care, a local Medi-Cal managed care plan, provided a $2 million emergency grant to keep the hospital afloat.

According to CHA, California's 37 CAHs have seen their operating margin drop by a frightening eight percentage points from 2019 to 2023. CHA notes that small remote hospitals face bigger challenges than ever, and asserts that when there isn't a large enough population of privately insured patients to offset the cost of treating low-income Medi-Cal and Medicare enrollees, small hospitals lose money.

Not all California hospitals are in financial trouble; some are doing quite well financially. According to a recent study commissioned by CHCF, while both the average and median profitability for all hospitals remained positive for all but one quarter of 2020–22, those in the bottom quartile of financial performance were losing money throughout that period and had an average margin of -8% in the fourth quarter of 2022. The top quartile boasted total margins averaging 14% throughout that period.

Contrary to common assertions, the study found that the "payer mix" – the proportion of inpatient discharges paid by Medi-Cal, Medicare, and private payers—did not explain the low margins. Notably, these low-margin hospitals were no more dependent on Medi-Cal or Medicare than the average hospital. The average hospital in California has a payer mix (based on inpatient discharges) of 40% Medicare and 32% Medi-Cal. The sample of low-margin hospitals had a payer mix of 42% Medicare and 31% Medi-Cal. Nearly 20% of the lowest margin hospitals had a private payer mix of 50% or more. Furthermore, based on HCAI financial disclosures and Medicare cost reports, the study concludes that payment-to-cost ratios are least favorable for Medicare lines of business, and that supplemental payment streams significantly improve Medi-Cal payment-to-cost ratios.

The study also concluded that while many of California's hospitals appear to have come through the most acute phases of the COVID-19 pandemic on sound financial footing, significant and fundamental challenges persist, and policymakers must confront the long-term sustainability of the underlying business model for hospital-based services in various parts of the state. A hospital's status as financially viable is unique to each hospital in their particular region. The specific type and location of a facility determine eligibility for some federal and state supplemental payment streams. A facility's size, competitive environment, and system-membership status impact the payment rates it can negotiate. Hospitals may or may not have an efficient underlying cost structure and have varying degrees of control over their costs.

e) Medi-Cal Hospital Reimbursement for CAHs. Medi-Cal hospital reimbursement is complicated and multi-layered. First, hospitals receive different types of Medi-Cal payment depending on whether the patient they are treating is enrolled in a managed care plan or in FFS Medi-Cal. Second, hospitals also deliver care in different settings—inpatient, outpatient, and nursing facilities— and different reimbursement mechanisms apply to these three types of care within each of the two delivery systems (FFS and managed care). Third, a hospital's status as designated public hospital, district hospital, or private hospital determines how a hospital is paid and eligibility for supplemental payments. Finally, CAHs are treated separately for purposes of certain types of payments.

Broadly speaking, hospital payments are comprised of both "base rate"—e.g., the type of payment that may correspond to an itemized bill for an episode of service—as well as supplemental payments. The term "supplemental payments" has become somewhat of a misnomer, as these payments have grown in recent years to comprise a large proportion of many hospitals' total Medi-Cal revenue.

Designated public hospitals, which include county-administered and University of California hospitals, have a reimbursement methodology that is highly specific to this class of hospital. The majority of hospitals, i.e., private hospitals or other public (district)

hospitals, are paid through similar mechanisms with respect to the "base rate," but differ in their eligibility for and participation in various Medi-Cal supplemental payment programs. Medi-Cal reimbursement mechanisms that currently apply to CAHs are described below.

i) Inpatient. In FFS Medi-Cal, inpatient services are reimbursed via a mechanism called diagnosis-related group (DRG). Within the DRG system, CAHs are eligible for a CAH-specific rate, a prospective rate that is projected to cover 95% of their costs, with costs aggregated across the class of CAHs as a whole and not on a per-hospital basis.

With respect to base rates for Medi-Cal inpatient services in Medi-Cal managed care, rates are negotiated between plans and CAHs; however, the Medi-Cal FFS rate often serves as a benchmark in these negotiations.

With respect to supplemental payments, a CAH is eligible for payments based on whether it is a district hospital or a private hospital. CAHs that are district hospitals participate in two inpatient supplemental payment programs, the District Hospital Directed Payment Program and the District Hospital Quality Improvement Program. CAHs that are private hospitals participate in the HQAF supplemental payment program.

ii) Outpatient, Including Emergency Services. Outpatient services are reimbursed similarly for CAHs as for most other public and private hospitals, with rates paid according to the Medi-Cal fee schedule in FFS Medi-Cal, and rates negotiated with managed care plans in Medi-Cal managed care. The supplemental payment programs noted above that apply to district and private hospitals, respectively, also have an outpatient component, meaning the total supplemental payments are based on the volume of outpatient services at each hospital, in addition to inpatient.

A fiscal and policy consideration with respect to increasing payments for hospital outpatient services is that these services also tend to be available outside of a hospital, sometimes at a lower cost, given the higher overhead costs of operating outpatient services as part of a hospital or hospital system. From an economic standpoint, significantly increasing payments for hospital outpatient services could incentivize hospital-based outpatient services over provision of the same services in a physician office, ambulatory surgery center, or other lower-cost location. On the other hand, many rural areas also lack these other options.

iii) Long Term Care Services. About half of CAHs also administer distinct-part nursing facilities (DP-NFs) that provide skilled nursing care.

In FFS Medi-Cal, DP-NF rates are facility-specific and are established on a quasi-cost basis, based on a facility's prior year cost reports with an inflation adjustment, with some limits on costs. Skilled nursing services provided in a DP-NF are generally paid at a much higher rate than for standalone skilled nursing facilities. Long-term services and supports (LTSS), including skilled nursing facility care, was recently "carved in to" managed care. This means Medi-Cal managed care plans became responsible for the provision of these services. During the transitional period of this carve-in of

skilled nursing facility services, managed care plans must pay at least at the FFS rate level through December 31, 2025. On or after January 1, 2026, subject to federal approval, DHCS is authorized to continue requiring this payment level at its discretion, or allow payments to be determined subject to negotiation.

Supplemental payments are also available for nursing facility services provided by CAHs that participate in the district hospital supplemental payment programs. The HQAF that applies to private hospitals, including CAHs, does not provide supplemental payments for nursing facility services.

This bill will provide a forum to assess the adequacy of these current reimbursement methodologies and levels to cover the cost of caring for Medi-Cal beneficiaries, as well as other key contributors to hospitals' financial challenges and provide related recommendations, as warranted.

3) **SUPPORT.** CHA is the sponsor of this bill and argues CAHs need a strategy for long-term, sustainable funding to stabilize their finances and support their ability to care for patients in rural communities. CHA notes in support that proposed amendments that would create a Technical Advisory Group will maintain and extend the work that started this year to save hospitals. CHA supports the development of an advisory group at the DHCS to evaluate and make recommendations on the financial stability of CAHs. DHCS will then submit a report to the Legislature with recommendations to improve the financial stability of these vulnerable hospitals.

REGISTERED SUPPORT / OPPOSITION:

Support (Prior Version)

California Hospital Association (sponsor)
Adventist Health
Antelope Valley Medical Center
Banner Lassen Medical Center
Barton Memorial Hospital
California Fresh Fruit Association
Fairchild Medical Center
John C Fremont Healthcare District
Los Angeles County
Marshall Medical Center
Mee Memorial Healthcare System
Plumas District Hospital
Providence
Sohum Health

Opposition (Prior Version)

None on file.

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1432 (Caballero) – As Amended June 18, 2024

SENATE VOTE: 37-0

SUBJECT: Health facilities: seismic standards.

SUMMARY: Requires the Department of Health Care Access and Information (HCAI) to grant an extension of the 2030 deadline for substantial compliance with seismic safety regulations or standards to January 1, 2033, for any hospital building for which the hospital owner submits its seismic compliance plan, and Nonstructural Performance Category (NPC)-5 Evaluation Report, to HCAI by specified dates. Authorizes a hospital to propose a final compliance date that extends up to five years beyond January 1, 2033, but no later than January 1, 2038. Specifically, **this bill**:

Extensions

1) Requires HCAI to grant an extension of the deadline for substantial compliance with the 2030 seismic safety regulations or standards to January 1, 2033, with respect to any hospital building for which the hospital owner submits the following items to HCAI by the dates specified below:

    a) The hospitals' seismic compliance plan, no later than January 1, 2026; and,

    b) The hospitals' NPC-5 Evaluation Report no later than July 1, 2025.

2) Requires, in instances involving functional contiguous grouping of hospital buildings, as described in 3) of existing law below (Structural Performance Category (SPC) -1 Buildings at risk of collapse), a single building containing all of the basic services, or at least one building within the contiguous grouping of hospital buildings, that has received a building permit to be evaluated and classified as a Nonconforming, SPC-2 building (which are not a collapse hazard). Requires the classification to be submitted to, and accepted by HCAI. Exempts the identified building from NPC-5 reporting, if the hospital agrees that the basic service or services that were provided in that building will be provided, on or before January 1, 2033, as follows:

    a) Moved into an existing conforming SPC-3, SPC-4, or an SPC-5 and NPC-4 or NPC-5 building;

    b) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-4 building; or,

    c) Continued in the building if the building is retrofitted to an SPC-5 and NPC-4 or NPC-5 building.

3) Requires, on or before January 1, 2026, the hospital to submit to HCAI an attestation that the board of directors of that hospital is aware that the hospital building is required to be in

substantial compliance with seismic safety regulations that a hospital remain operational by January 1, 2030, and is seeking an extension of the deadline.

4) Authorizes, for purposes of 1) above, a hospital to propose a final compliance date that extends up to five years beyond January 1, 2033, but no later than January 1, 2038. Makes any seismic compliance plan that extends past January 1, 2033, subject to HCAI's approval pursuant to 5) below. Requires a hospital, if HCAI does not grant approval for the extended seismic compliance plan or approves a final seismic compliance date that is sooner than the seismic compliance plan submitted by the hospital, to submit a revised seismic compliance plan.

5) Authorizes HCAI, in addition to the extension provided pursuant to 1) above, to grant an additional extension of the deadline for substantial compliance with seismic safety requirements to remain operational after an earthquake, of up to five years upon a demonstration by the owner of any of the following:

   a) The complexity of the hospital's seismic compliance plan detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline; or,

   b) Demonstration that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals within a reasonable proximity.

      i) Requires HCAI, in determining the duration of the extension granted pursuant to this provision, to consider the impact on access to necessary medical care during seismic related construction, particularly for beneficiaries of the Medi-Cal program, and to consider the availability of any of the following services in the community served by the hospital:

         (1) Coronary care services;

         (2) Emergency medical services;

         (3) Intensive care services;

         (4) Pediatric services;

         (5) Perinatal services;

         (6) Psychiatric services;

         (7) Complex respiratory and ventilator weaning services; and,

         (8) Any other specialized service that HCAI determines is necessary to maintain access to medically necessary care for the community.

   c) The hospital owner demonstrates and HCAI finds a lack of financial capacity, including the cost to borrow the funds to complete construction to substantially comply with the seismic safety regulations by the January 1, 2033 deadline.

d) HCAI determines, by means of a health impact assessment, that removal of the building or buildings from service may diminish significantly the availability or accessibility of health care services in the community.

6) Requires as a condition of approval of any extension pursuant 1), a hospital owner to, as applicable, submit to HCAI:

   a) The hospital building plans and extension schedule that includes building permitting, construction commencement and completion;

   b) A construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. Requires the timeline to include the projected construction start date, the projected construction completion date, and identification of the contractor. Requires HCAI and the hospital to, using the projected construction start and completion date, to identify at least two major milestones relating to the seismic compliance plan that will be used as the basis for determining whether the hospital is making adequate progress towards meeting the subject hospital's seismic compliance deadline. Authorizes HCAI to grant an adjustment to the extensions of time approved pursuant to 1) above or the milestones agreed upon pursuant to this provision, or both, as necessary to deal with contractor, labor, or material delays, or with acts of God, or with governmental entitlements, experienced by the hospital, up to the final compliance date of January 1, 2038. Requires, if one or more adjustments is granted, the hospital to submit a revised seismic compliance plan, including but need not be limited to, a revised construction schedule.

7) Requires, in instances involving functional contiguous grouping of hospital buildings, as defined in 3) of existing law below (SPC-1 buildings at risk of collapse), a single building containing all of the basic services, or at least one building within the contiguous grouping of hospital buildings, that has received a building permit, to be evaluated and classified as a nonconforming, SPC-2 building. Requires this classification to be submitted to, and accepted by, HCAI. Requires the identified building to be exempt from NPC-5 reporting requirements if the hospital agrees that the basic service or services that were provided in that building will be provided, on or before January 1, 2033, as follows:

   a) Moved into an existing conforming SPC-3, SPC-4, or an SPC-5 and NPC-4 or NPC-5 building.

   b) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-4 building; or,

   c) Continued in the building if the building is retrofitted to an SPC-5 and NPC-4 or NPC-5 building.

8) Requires HCAI, prior to granting an extension past January 1, 2033, pursuant to 5) above, to do all of the following:

   a) Provide public notice of a hospital's request for an extension of the deadline. Requires the notice, at a minimum, to be posted on HCAI's internet website alongside the hospital's seismic compliance plan, and to include the facility's name and identification number, the length of the extension, the status of the request, and the beginning and ending dates of the comment period, and to advise the public of the opportunity to submit

public comments. Requires HCAI to also include, in plain language, the purpose of seismic safety requirements, the structural and nonstructural risk level for each building included in the compliance plan, and the hospital's compliance history;

b) Provide copies of any publicly available material submitted by the hospital in support of their extension, upon request, to interested parties within 10 working days to allow interested parties to review and provide comment within the 45-day comment period; and,

c) Allow the public to submit written comments on the extension proposal for a period of not less than 45 days from the date of the public notice prior to HCAI approving, denying, or modifying any extension request submitted pursuant to 5) above.

9) Requires HCAI, beginning on January 1, 2028, and annually thereafter, to post on its internet website, along with the approved compliance plans, its decision to grant or deny any extensions pursuant to 1) above, of the deadlines for substantial compliance with the seismic safety regulations. Requires this posting report to include detailed data on facilities that have been both granted and denied extensions, along with the reasoning behind each determination. Requires HCAI to notify the county board of supervisors, the city council, and the Assembly and Senate representative in writing and electronically if a hospital within their district has been granted or denied an extension.

Regulations and public notice

10) Requires HCAI, on or before January 1, 2026, to adopt regulations and standards, or revise existing regulations and standards, or both, to extend the deadlines for meeting the 2030 structural performance and nonstructural performance requirements. Deems regulatory submissions made by HCAI to the California Building Standards Commission pursuant to this bill to be emergency regulations and to be adopted as such. Deems the adoption of these regulations to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare.

11) Requires HCAI to annually post on the its internet website a list of hospitals that have secured an extension to the 2030 seismic compliance deadline pursuant to 1) above and hospitals that have secured a delay to the seismic compliance deadline pursuant to 5) above.

Compliance plans

12) Requires, as a condition of securing an additional extension of time pursuant to subdivision 1) or 5) above, or both, an owner of an acute care inpatient hospital building that does not substantially comply with the 2030 seismic safety regulations or standards as of the effective date of this bill, to submit a seismic compliance plan to HCAI no later than January 1, 2026, in a form and manner determined by HCAI. Requires each seismic compliance plan to include the following:

a) An inventory of each acute care inpatient service that is provided in any hospital building that is rated SPC-2;

b) Requires for each hospital building that does not substantially comply the 2030 seismic safety requirements as of the effective date of this bill that is planned for retrofit or replacement, the plan to identify:
   i) Whether the hospital owner intends to retrofit the SPC-2 building to SPC-4D, or rebuild the building to SPC-5;
   ii) The project number or numbers assigned by HCAI, if any, for retrofit or rebuilding;
   iii) The projected construction start date or dates, and projected construction completion date or dates, if available;
   iv) The estimated costs to substantially comply with the 2030 SPC and NPC requirements;
   v) The most recent project status and approvals; and,
   vi) The number of inpatient beds and patient days, by type of unit and type of service provided in the building;

c) For each hospital building that does not substantially comply with the 2030 seismic safety requirements as of the effective date of this bill that is planned to be removed from acute care inpatient service, the plan to identify:
   i) The projected date or dates the building will be removed from inpatient service;
   ii) The inpatient services currently delivered in the building;
   iii) The number of inpatient beds and patient days, by type of unit and type of service provided in the building;
   iv) The planned uses of the building to be removed from service; and,
   v) Whether the inpatient services and beds currently provided in the building will be relocated to a new or retrofitted building, and any corresponding building sites or project numbers associated with such planned relocation;

d) For each facility for which one or more hospital buildings are planned to be removed from inpatient service, any net change in the number of inpatient beds, by type of unit and type of service, taking into account beds provided in buildings to be removed from inpatient service, beds provided in buildings to be retrofitted or replaced, and beds provided in any other buildings used for acute care inpatient services by the facility; and,

e) The planned final configuration of all buildings on the hospital campus depicting how each building will comply with the 2030 seismic safety requirements, whether by retrofit or rebuild, and the type of services that will be provided in each building.

13) Requires an owner of a general acute care hospital to annually update HCAI, in a form and manner determined by HCAI, with any changes or adjustments to its seismic compliance plan submitted pursuant to this bill.

14) Requires, on or before July 1, 2025, HCAI to issue guidance for calculating the estimated costs of compliance. Requires, to the extent possible, guidance to be limited to calculating the estimated costs required for seismic safety compliance, including any construction related to maintaining service levels or related financing costs. Requires this guidance to specify, at a minimum, the types of costs to be included in the estimate.

15) Requires HCAI to post seismic compliance plans submitted pursuant to 12) above on its internet website within 90 calendar days of receipt to facilitate the public comment. Requires seismic compliance plans to be removed after the comment period for review and approval

by HCAI, and once approved, to be reposted as an approved plan, including any changes. Requires subsequent revisions to a hospital's compliance plan to be posted on HCAI's internet website along with the approved compliance plan.

Transfer plans

16) Requires an acute care inpatient hospital with one or more hospital buildings classified as SPC-2 as of the effective date of this bill to submit a Patient Alternate Care Sites and Transfer Plan to HCAI, in a form and manner determined by HCAI, no later than January 1, 2026. Requires the plan to address continued care for the hospital's patients following a seismic event through alternate care sites on the hospital campus and transfers to other health care facilities. Requires the plan to include all of the following:
    a) The number of patients that could potentially be affected by SPC-2 buildings on the hospital campus;
    b) Locations on the hospital campus that could be utilized as alternate care sites for the hospital's patients, including but not limited to, other inpatient or outpatient units, temporary structures, and areas not typically used for patient care;
    c) The capacity for transfers to other hospitals or other appropriate care settings in the subject hospital's service area, and description of how the hospital would transfer and transport any patients to such sites;
    d) A description of the hospital's process for communicating the following information to employees affected by the seismic event, and their bargaining representatives, if applicable:
        i) The request for waivers from law or normal operations from the Department of Public Health (DPH) and the Emergency Medical Services Authority (EMSA), if any;
        ii) The timeline for the use of any requested or utilized DPH and EMSA waivers, if applicable;
        iii) A timeline for repairs and reopening of the SPC-2 building, if available;
        iv) Updates and revisions to the timeline for repairs and reopening of the SPC-2 building, if available;
        v) The use of alternate care sites, if applicable; and,
        vi) The availability of open or temporary positions within the hospital or hospital system.

17) Requires the hospital, in developing its plan required pursuant to 16) above, to consult with the medical health operational area coordinator, the local emergency medical services authority, and other county entities and other hospitals within the subject hospital's service area, as appropriate.

18) Requires the hospital to submit updates to the plan required by 16) above, if any, on an annual basis to HCAI, in a form and manner determined by HCAI. Specifies that as of the date the hospital no longer has one or more buildings classified as SPC-2, the hospital will no longer be required to submit annual updates.

Reporting

19) Requires HCAI, on or before January 1, 2029, to provide the Legislature with a report to include both of the following:

a) An analysis of each cost estimate analysis submitted by an owner of an acute care inpatient hospital; and,
b) An estimate of the total statewide cost to retrofit each SPC-2 building to SPC-4D and NPC-5, or rebuild to SPC-5 and NPC-5, in order to comply with the 2030 seismic safety requirements. Requires HCAI, in estimating the total statewide cost, to consider the hospital-specific cost estimates, and authorizes HCAI to consider other sources HCAI deems appropriate.

20) Requires the HCAI Director to provide the Office of Health Care Affordability (OHCA) Board, and the Health Care Affordability Advisory Committee, with the report described in 19) above on the same date as it is provided to the Legislature. Requires the HCAI Director to present the major findings of the report during at least one meeting of the OHCA Board and the OHCA Advisory Committee within six months of the submission of the report to the Legislature.

21) Requires HCAI, in consultation with the California Health Facilities Financing Authority, to submit to the Legislature by January 1, 2028, a Hospital Construction Financing Overview report which includes the following, at a minimum:
a) An inventory of current federal, state, and local financing programs and funding opportunities that are potentially available to an owner of an acute care inpatient hospital for purposes of funding construction costs associated with meeting the 2030 seismic safety requirements, including, but not limited to, the amount of funding available, any costs associated with accessing associated financing, and the eligibility, application, and reporting requirements for each program or opportunity inventoried; and,
b) Options and recommendations for new or expanded financing programs and funding opportunities that could be made available for hospital construction costs associated with meeting the 2030 seismic safety requirements including, but not limited to, state infrastructure funds, grants, no-cost or low-cost loans, and general obligation bond financing. Requires HCAI, in making its recommendations, to consider the impact of escalating construction costs and the ongoing ability of hospitals to pay debt service.

Stakeholder workgroup

22) Requires HCAI, on or before January 1, 2028, to convene a stakeholder workgroup to facilitate input on how the 2030 seismic safety requirements impact ongoing access to health care services at the local and regional levels, including, but not limited to, consideration of potential changes to the inpatient services available as a result of the 2030 requirements, such as the reduction, suspension, and closure of inpatient service lines in the subject locality or region.

23) Requires the stakeholder convening to include, at a minimum, representatives for hospitals, physicians, workers, consumers, and counties.

24) Requires HCAI, on or before July 1, 2028, to provide a report to the Legislature detailing any findings and recommendations arising out of the stakeholder convening.

25) Prohibits HCAI from extending any deadlines for SPC-1 buildings unless authorized in another statute.

26) Updates requirements for hospitals to post information in the lobby regarding hospital buildings that do not comply with 2030 seismic safety requirements, and to provide annual notices to local officials regarding the non-compliance pursuant to 6) of existing law below.

EXISTING LAW:

1) Licenses and regulates health facilities, including general acute care hospitals, by DPH. [Health and Safety Code (HSC) §1250, et seq.]

2) Establishes the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (Seismic Safety Act), to ensure that hospital buildings are constructed to resist the forces generated by earthquakes and requires HCAI to propose building standards for earthquake resistance and to provide independent review of the design and construction of hospital buildings. [HSC §129675, et seq.]

3) Establishes timelines for hospital compliance with seismic safety standards, including a requirement that buildings posing a significant risk of collapse and a danger to the public (referred to as SPC-1 buildings) be rebuilt or retrofitted to be capable of withstanding an earthquake, or removed from acute care service, by January 1, 2008 (which has been extended for various hospitals to various dates). [HSC §130060]

4) Requires hospitals to be capable of continued operation following an earthquake by January 1, 2030. [HSC §130065]

5) Requires the owner of a hospital whose building does not substantially comply with the January 1, 2030 seismic safety requirement described in 4) above, to submit to HCAI, by January 1, 2020, an attestation that the board of directors of that hospital is aware that the hospital building is required to meet this requirement. [HSC §130066]

6) Requires, before January 1, 2024, the owner of an acute care inpatient hospital that includes a building that does not substantially comply with the 2030 seismic safety regulations or standards to post in any lobby or waiting area generally accessible to patients or the public a notice provided by the HCAI that the hospital is not in compliance with the seismic safety requirements. Requires the notice to be posted until the time the owner receives notification from the department that it meets the 2030 seismic safety requirements. [HSC §130066.5]

7) Establishes the Small and Rural Hospital Relief Program within HCAI for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals. Requires HCAI to provide grants to small, rural, and critical access hospitals that meet certain criteria, including that seismic safety compliance imposes a financial burden on the applicant that may result in hospital closure. [HSC §130075, §130076, §130078]

8) Establishes the OHCA within HCAI. Requires the Director of HCAI be the Director of OHCA and to carry out all functions of that position, including enforcement. Makes OHCA responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets. [HSC §127501]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown costs for HCAI for state administration (Hospital Building Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, over the past few decades, nearly all hospitals have spent billions to ensure their buildings will remain standing after a major earthquake, protecting patients and workers. Unfortunately, after supporting communities through the COVID- 19 pandemic, California hospitals experienced new financial and operational challenges, leaving many in financial distress. The author states that this bill will extend the 2030 seismic compliance deadline, enhance disaster planning in the event of an earthquake, and create new reporting requirements to enhance transparency and accountability. The author concludes that without an extension, access to care will be jeopardized as all hospitals struggle to meet the 2030 seismic compliance deadline.

2) **BACKGROUND**. The original Seismic Safety Act was passed in 1973, following the 1971 San Fernando Valley (also known as Sylmar) earthquake, and required all new hospital construction to meet seismic safety standards. The Seismic Safety Act did not apply to existing buildings with the expectation that older buildings would be replaced with conforming buildings over time. By the time of the Northridge earthquake in 1994, however, 80% of hospital beds were still in pre-1973 non-conforming buildings. The Northridge earthquake caused significant structural damage to a number of hospitals, with at least two hospitals needing to be evacuated. What also became apparent in the Northridge earthquake was that nonstructural damage was also a threat to patient safety, with damage to heating and ventilation systems and sprinklers, forcing evacuations.

   Following the Northridge earthquake, the Legislature updated the Seismic Safety Act with SB 1953 (Alquist), Chapter 740, Statutes of 1994, which required HCAI (at that time Office of Statewide Health Planning and Development) to establish earthquake performance categories for hospitals. SB 1953 also established a January 1, 2008 deadline by which general acute care hospitals must be retrofitted or replaced so that they do not pose a risk of collapse in the event of an earthquake (which has been repeatedly extended by subsequent legislation for most hospitals), and a January 1, 2030, deadline by which they must be capable of remaining operational following an earthquake.

   Specifically, SB 1953 required HCAI to create SPCs, as well as NPCs for "nonstructural systems that are critical to providing basic services to hospital inpatients and the public after a disaster." Each hospital building receives both an SPC and an NPC rating. According to HCAI, the SPC requirements can be thought of as protecting the skeleton, while NPC requirements ensure the organs and other tissues that are necessary for a human body to function will remain safely attached to the skeleton. It is important to note that a licensed facility, or hospital, is often made up of several buildings on its campus. Many hospitals may have one or more buildings that are 2030 compliant, while other buildings still need to be retrofitted, replaced, or changed to a use that is not associated with acute care services.

   a) **Description of SPC ratings.** Following the enactment of SB 1953, HCAI adopted regulations that initially created five SPC ratings, with a sixth category (SPC-4D) added more recently. The SPC ratings are as follows:

i) **SPC-1** – These are pre-1973 buildings (built prior to the adoption of the Seismic Safety Act standards) that are at significant risk of collapse and that represent a danger to the public. These buildings were originally required to be brought up to SPC-2 level or removed from service by 2008, but there have been a number of extensions. Most recently, AB 2190 (Reyes), Chapter 673, Statutes of 2018, provided for an extension until July 1, 2022 for hospitals that plan to replace or retrofit to SPC-2, and up to January 1, 2025 for hospitals that plan to retrofit to SPC 4D or replace with a new SPC-5 building.

ii) **SPC 2** – These are also pre-1973 buildings, but were in substantial compliance with pre-1973 California Building Standards Codes, and while they may not be repairable or functional following an earthquake, they will not significantly jeopardize life. These buildings are permitted to remain in service only until January 1, 2030, at which point they need to have been replaced by an SPC-5 building, have the acute care services relocated to a conforming building (SPC-3, 4, or 5), or be retrofitted to SPC-4D.

The following categories are 2030 compliant, and can continue operating indefinitely:

iii) **SPC-3** – These buildings are in compliance with the original 1973 Seismic Safety Act, but were constructed under a permit issued prior to October 25, 1994, and utilized steel movement-resisting frames. These buildings may experience structural damage during an earthquake, which does not significantly jeopardize life, but may not be repairable or functional following strong ground motion.

iv) **SPC-4** – These are buildings constructed in compliance with the Seismic Safety Act under building permits issued between 1973 and 1989, but may experience structural damage, which may inhibit the ability to provide services to the public following strong ground motion.

v) **SPC-4D** – This is a new category created to allow SPC 2 buildings to be retrofitted to a standard that is 2030 compliant. Because SPC 2 buildings were constructed prior to 1973, they can never reach SPC 3, 4 or 5, since these categories required construction to have started after the adoption of the 1973 standards. SPC 4D became effective on January 1, 2017.

vi) **SPC-5** – These are buildings constructed after 1989, and are considered reasonably capable of providing services to the public following strong ground motion.

b) **Description of NPC ratings**. The NPC requirements, unlike SPC requirements, are cumulative, and not different options. For example, a hospital is first required to achieve NPC-2, which ensures that the nonstructural components that are necessary for a safe evacuation are braced and anchored. Next, a hospital is required to achieve NPC-3 status, which ensures that at a minimum the critical care areas are able to continue to function following an earthquake, and so on. The NPC standards are as follows:

i) **NPC-1** – The building does not meet any bracing and anchorage requirements.

ii) **NPC-2** – The following systems in the building are braced or anchored according to the California Building Standards Code: communications systems, emergency power supply, bulk medical gas systems, fire alarm systems, and emergency lighting equipment and signs in the means of egress**. Hospitals had to meet at least the NPC-2 standard by January 1, 2002.**

iii) **NPC-3** – This standard requires NPC-2 compliance, plus specified additional bracing and anchorage requirements in critical care areas, clinical laboratory services spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas. Hospitals had to meet this standard by January 1, 2008, unless an extension or exemption was approved**. Extensions generally tracked the extensions given to SPC 1 buildings, so some buildings are not required to achieve NPC-3 until January 1, 2024.**

iv) **NPC-4** – This standard requires NPC-3 compliance, plus all architectural, mechanical, electrical systems, components and equipment, and hospital equipment to meet bracing and anchorage requirements. **Hospitals are required to meet this standard by January 1, 2024 or 2030 depending on the building's seismic risk category and extension request requirements.**

v) **NPC-4D** – This is a new category assigned to existing hospital buildings that are in compliance with NPC-3 requirements, and have additionally achieved one of three levels with regards to emergency preparedness. NPC-4D became effective on January 1, 2017. **Hospitals are required to meet this standard by January 1, 2030.**

vi) **NPC-5** – This final standard requires the hospital building to meet NPC-4 or NPC-4D, plus have onsite supplies of water and holding tanks for sewage and liquid waste, sufficient to support 72 hours of emergency operations, which are required to be integrated into the plumbing systems. Additionally, an onsite emergency system, as defined in the California Electrical Code, must be incorporated in the building electrical system for critical care areas, and the system is required to provide for radiological service and onsite fuel supply for 72 hours of acute care operation. **Hospitals are required to meet this standard by January 1, 2030.**

c) **Building code requirements account for regional variation of seismic risk.** According to HCAI, compared to rest of the nation, California, in general, has high seismicity throughout the state. Parts of the state have **very high** seismicity in areas of close proximity to the major earthquake faults. Other areas of the state still have **high** seismicity. Additionally, each facility has a seismicity value based on their location. This location-specific seismic value is used to evaluate and design buildings at that site. Therefore, the evaluation for a building located in an area with a very high seismicity value will require a stronger building that can resist stronger earthquakes when compared to the evaluation for a building in a high seismicity value area. The evaluation based on location-specific seismicity values addresses the narrow differences in seismicity levels in California. Therefore, an SPC-2 building near a fault will need to be stronger to be life-safe than an SPC-2 building located significantly farther away from a fault line.

d) **Status of hospital seismic safety compliance**. According to HCAI, as of February of 2024, there are a total of 3,340 buildings at 410 licensed hospital facilities that are subject

to the seismic safety standards. All have achieved at least the SPC-2 standard that allows them to remain in service until 2030 except for 41 buildings spread across 20 hospital facilities. In some cases, there are no plans to retrofit or rebuild, and the hospital has either already taken them out of service but it is not reflected in the data yet, or there are plans to take them out of service prior to the January 1, 2025 deadline. It is unclear how many of the remaining out-of-compliance buildings are expected to remain in service, but are in jeopardy of missing the January 1, 2025 deadline for retrofit or replacement projects.

Regarding the 2030 deadline for buildings to achieve SPC-3, 4, 4D or 5, there are still 658 buildings, spread across 251 licensed hospitals, that have an SPC-2 rating and will need to either be retrofitted to SPC-4D, replaced with an SPC-5 building, or removed from acute care service. Of the 658 SPC-2 buildings, 151 have SPC-4D upgrade projects submitted. It is unclear how many of these 151 SPC-2 building upgrade projects will be in construction. The SPC-4D option has only been available since 2017; it is not known whether that will be utilized for the remaining buildings, or whether hospitals will choose to construct new replacement buildings.

Regarding NPC compliance, the vast majority of buildings have not yet met 2030 standards. More than half of all hospital buildings are still NPC-2. Only about 6% of all hospital buildings have achieved NPC-5 and are fully 2030 compliant. Another 34% have met NPC-4 requirements. The deadline to submit NPC construction projects is January 1, 2026, followed by an NPC construction permit deadline of January 1, 2028.

e) Previous California Hospital Association (CHA) proposal focused on emergency services. In the summer of 2021, the Newsom Administration released budget trailer bill language, with the support of CHA, to delay the 2030 deadline to 2037, and to only require that it apply to buildings that house an emergency department, and those areas and services necessary to support emergency medical services following a disaster, as specified. The Legislature did not adopt this budget language.

f) RAND report on estimated costs of seismic compliance. CHA commissioned the RAND Corporation to update a prior estimate of the cost of future seismic safety compliance with a particular focus on the 2030 deadline. RAND published its report in 2019, and estimated that collectively, California hospitals faced (at that time) a range of $34 billion to $143 billion in compliance costs, depending on assumptions regarding retrofit versus new construction and future cost escalation. RAND stated that a significant proportion of hospitals were already experiencing some degree of financial distress, and the burden of future compliance is likely to exacerbate this stress.

g) Administration Technical Assistance (TA) on this bill and AB 869 (Wood). On May 28, 2024, HCAI reached out to the authors and committee staff with suggested TA for these bills. The TA document included HCAI's "Seismic Compliance Principles," which are as follows:

i) Any hospital that can comply with the seismic safety standards by 2030 should be encouraged/incentivized to do so. A blanket 2033 extension may result in hospitals capable of meeting the 2030 deadline recalibrating their activities to the new 2033 deadline;

ii) Extensions should only be given based on demonstrated need and all hospitals must have a clear plan for compliance. Accountability mechanisms are vital to ensure progress; and,

iii) Seek to support those hospitals that truly need support versus providing another extension for those hospitals that have chosen not to invest in the safety of the California hospitals that they own and operate.

The Administration/HCAI TA on this bill would not grant an automatic extension, and limits the **possibility** of a seismic extension to up to three years, or at most five years beyond the January 1, 2030 deadline. A hospital would be required to first submit a seismic compliance plan to demonstrate that the extension is necessary to deal with contractor, labor, or material delays, or with acts of God, or with governmental entitlements, or other external forces beyond the hospital's control. The AB 869 TA applies to small, rural, district and financially distressed hospitals, and would allow HCAI to approve extensions of up to three years, or at most five years beyond January 1, 2030.

3) **SUPPORT**. This bill is supported by numerous individual hospitals and sponsored by CHA who states that after more than two decades of work and billions of dollars spent, nearly all hospitals will be able to withstand a major earthquake. Now, hospitals must comply with a different standard by 2030 that requires them to be fully operational after a major earthquake or close their doors to patient care. CHA contends that while hospitals are working to comply with this requirement, many will not meet the 2030 deadline. CHA states that this bill provides all hospitals with an initial three-year extension to 2033, upon submission of a seismic compliance plan and Non-Structural Performance Evaluation report to HCAI, and provides up to an additional five-year extension, at the discretion of HCAI, depending on hospitals' submission of information regarding the complexity of a construction project, financial capability to support seismic compliance, and/or the impact on access to care in the community. CHA also notes that this bill requires all hospitals to strengthen their disaster plans to ensure patients continue to receive the care they need during and after a disaster, and workers have a clear picture of the patient care plan following an earthquake.

CHA notes that in addition, this bill seeks greater partnership between hospitals and the state to comply with the law. Understanding the significant impact that construction would have on access to hospital care will be critical, and this proposal would require HCAI's Office of Statewide Hospital Planning and Development to provide TA to hospitals to assist in the development of construction plans, convene community stakeholders, and report findings to the Legislature to understand the impact of seismic-related construction on hospital services and patient access to care.

CHA contends that extending this deadline would ensure that seismic compliance can be approached in a systematic way that preserves access to care, and concludes that a transparent and comprehensive understanding of the scope, scale, and cost of seismic compliance is essential for the state to support its work to ensure safe, operational hospitals, to minimize disruption of patient care for all Californians, and to prevent the mandatory closure of hospitals on Jan. 1, 2030.

4) **OPPOSITION**. A coalition of labor organizations including, California Labor Federation, AFL-CIO, AFSCME California, California Nurses Association, California Professional

Firefighters, California Teamsters Public Affairs Council, NUHW, Professional Engineers in California Government, SEIU, California, UNITE HERE!, and United Nurses Association of California/Union of Health Care Professionals are opposed to this bill. The coalition notes that in 1994, the California Legislature passed, and Republican Governor Pete Wilson signed, the law requiring that California hospitals be operational after an earthquake. This legislation was a compromise between those who sought immediate protection in the wake of an earthquake that closed numerous hospitals, and forced hospital workers to evacuate patients, including newborn babies, in the dark down staircases to parking lots. The coalition states that this requirement to be operational after a major quake has been delayed and modified numerous times in the decades since. For example, the standards for small and rural hospitals were modified to reflect their risk. Similarly, hospitals that rebuilt to this higher standard were not required to retrofit to meet the lower standard of "collapse-hazard" but subject to evacuation post-quake. However, these modifications have all held true to the goal that California's hospitals need to be operational and ready to serve their communities following a major earthquake. The coalition contends that, currently, almost all hospital buildings in California are no longer at risk of collapsing in an earthquake. However, as many as one in four hospital buildings would still need to be evacuated and closed after a major quake. The remaining non-structural requirements have been met by some but not all hospitals: these include basic safety standards such as elevators and electricity, water and sewage, and other components essential to delivering hospital care.

The coalition laments that instead of meeting 2030 seismic standards, hospitals have used their significant profits to consolidate the health care industry and pursue patients who have medical debt. Medical debt in Los Angeles County alone equals almost $3 billion, and hospitals drive people into medical debt every day. The coalition continues that California hospitals have known for 30 years that they face the requirement to be fully operational after a major seismic event. Almost all hospitals are no longer at risk of collapsing but remain at risk of being non-functional as well as needing to be evacuated after an earthquake.

The coalition states that their organizations appreciate the recent TA shared by HCAI on this bill, and that the amendments are a step in the right direction in the decades-long effort to get hospitals to come into compliance with the 2030 seismic standards. One of the coalition's most significant concerns with this bill as it is currently in print is that it grants hospitals a blanket extension without any mechanism to evaluate need or merit. The TA lays out a pathway for hospitals to get or be denied an extension based on objective factors and expert analysis. That is a good start, but more requirements are needed to ensure the safety of patients, workers, and the public in the event of a major earthquake. The coalition encourages considering the maintenance of patient services as part of an extension, and states they would also like to see additional transparency on hospital building plans and accountability, such as a state monitor for hospitals that miss a deadline on the hospital board, among other accountability mechanisms. The coalition concludes that California's working families expect their hospitals to take care of them after an earthquake, California's health care workers stand ready to do so, just as they did during the pandemic, and they oppose the unrelenting efforts of hospital management to put the safety of patients and workers at risk.

5) RELATED LEGISLATION.

a) AB 869 (Wood**)** expands eligibility for grants for single- and 2-story hospitals in rural areas with less than 80 beds. Requires grants under the program to provide hospitals with

funds to secure an SPC-4D assessment for purposes of planning for, and estimating the costs of, compliance with 2030 seismic safety standards. Delays the requirement to meet those standard until January 1, 2033. Authorizes financially distressed health care districts to apply to HCA for grants for the purposed of meeting the 2030 seismic safety standards, and delays the requirement to meet those standards until January 1, 2032 for a health care district that qualifies for a grant. AB 869 in pending in the Senate Health Committee.

b) SB 1447 (Durazo) Grants Children's Hospital Los Angeles (CHLA) a three-year extension, to January 1, 2033, of the seismic safety requirement that hospitals be capable of continued operation following a major earthquake. Permits CHLA to request an additional extension, up to January 1, 2038, if it meets certain specified criteria. SB 1447 is currently pending in the Assembly Appropriations Committee.

c) SB 759 (Grove) of 2023 would have extended the seismic safety deadline for hospitals to be capable of continued operations following an earthquake, from January 1, 2030 to January 1, 2040. SB 759 was never heard in Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 1471 (Pellerin), Chapter 304, Statutes of 2023, extended the dates for compliance with seismic safety requirements for three buildings on the campus of Santa Clara Valley Medical Center, with the latest deadline being July 1, 2026.

b) AB 1882 (Robert Rivas), Chapter 584, Statutes of 2022, requires owners of general acute care hospital (GACH) buildings that are not compliant with the January 1, 2030 seismic safety requirement to remain operational following a major earthquake, to submit annual status updates to various entities, including the county board of supervisors, any labor union that represents workers in a building that is not January 1, 2030 compliant, the local office of emergency services, and the medical health operational area coordinator; and, requires hospitals to post in any lobby or waiting area of a hospital building that is not compliant with the January 1, 2030 seismic requirement a notice that the hospital is not in compliance.

c) AB 2404 (Luz Rivas), Chapter 592, Statutes of 2022, permits HCAI to waive the requirements of the Seismic Safety Act for Pacifica Hospital of the Valley in Los Angeles County if the hospital submits a plan that proposes compliance by January 1, 2025, HCAI accepts the plan based on it being feasible, and the hospital reports to HCAI on a quarterly basis on its progress to timely complete the plan.

d) AB 2904 (Bonta) of 2022 would have extended the January 1, 2030 seismic safety requirement for Alameda Hospital until January 1, 2032. AB 2904 was vetoed by the Governor, who stated that any consideration of an extension must be contemplated across all communities and across all types of facilities in a holistic manner.

e) SB 564 (Cortese), Chapter 388, Statutes of 2021, permits HCAI to grant an extension of the seismic safety requirement that hospitals be capable of remaining standing following a major earthquake, until a maximum of December 31, 2024, for two hospitals owned by the County of Santa Clara.

f) AB 1527 (Ting), Chapter 1527, Statutes of 2021, permits HCAI to extend the seismic requirements for Seton Medical Center in Daly City until July 1, 2023.

g) SB 758 (Portantino) of 2020, among other provisions, would have extended the 2030 hospital seismic compliance deadline to January 1, 2037. SB 758 was amended in the Assembly Appropriations Committee when it came off the Suspense File, to reduce the extension to January 1, 2032. SB 758 was not taken up on the Assembly Floor.

h) AB 2190 (Reyes), Chapter 673, Statutes of 2018, provided for an extension of the January 1, 2020, hospital seismic safety deadline of up to 30 months (until July 1, 2022) for hospitals that plan to replace or retrofit a building to at least the 2020 standard of SPC-2, and up to five years (January 1, 2025) for hospitals that plan to rebuild to SPC-4D or SPC-5 standards that meet 2030 standards.

i) AB 908 (Dababneh), Chapter 350, Statutes of 2017, permitted Providence Tarzana Medical Center in Los Angeles to request an additional extension, until October 1, 2022, of the seismic safety requirement that hospital buildings be rebuilt or retrofitted in order to be capable of withstanding an earthquake.

j) AB 81 (Wood), Chapter 63, Statutes of 2015 permitted a hospital in the City of Willits to request an eight-month deadline extension of a seismic safety requirement that hospitals be rebuilt or retrofitted to be capable of withstanding an earthquake, which it was required to meet by January 1, 2015, so that this hospital could have until September 1, 2015.

k) AB 2557 (Pan), Chapter 821, Statutes of 2014, permitted a hospital located in the Counties of Sacramento, San Mateo, or Santa Barbara or the City of San Jose, that had received an additional extension of the January 1, 2008, seismic safety requirements under specified provisions of existing law to January 1, 2015, to request an additional extension until September 1, 2015, in order to obtain either a certificate of occupancy or a construction final from the HCAI.

l) SB 90 (Steinberg), Chapter 19, Statutes of 2011, allowed a hospital to seek an extension for seismic compliance for its SPC-1 buildings of up to seven years based on the following elements: the structural integrity of the building, the loss of essential hospital services to the community if the hospital closed, and financial hardship.

m) SB 499 (Ducheny), Chapter 601, Statutes of 2009, required all GACHs that have SPC-1 buildings to report to HCAI by November 1, 2010, and annually thereafter, on the status of their compliance with the seismic safety deadlines.

n) SB 306 (Ducheny), Chapter 642, Statutes of 2007, amended the Seismic Safety Act to permit hospitals to delay compliance with the July 1, 2008 seismic retrofit deadline, and the 2013 extension, to the year 2020, by filing a declaration with HCAI that the owner lacks financial capacity to comply with the law.

o) SB 1661 (Cox), Chapter 679, Statutes of 2006, authorized an extension of up to an additional two years for hospitals that had already received extensions of the January 1,

2008 seismic safety compliance deadline if specified criteria were met, and required specified hospital reports to be posted on the HCAI website.

7) **POLICY COMMENTS**. As noted above, HCAI has provided TA for this bill, signaling the direction the Administration would like the bill to take moving forward. The author and sponsors have accepted a few of the proposed amendments, and are continuing to have discussions with the Administration about this TA. However, there is no agreement on some of the more substantive changes that the Administration has requested, most notably, whether or not all hospitals will be given an across the board three-year delay of the 2030 seismic safety requirements. Moving forward the author will need to work with the author of AB 869, which seeks to provide a path for rural, district and critical access hospitals to meet the 2030 seismic requirements, and the Administration, to craft legislation that ensures the safety of patients and workers, and that hospitals will remain operational following an earthquake.

8) **AMENDMENTS**.

   a) **Recent amendment unclear.** In order to qualify for the automatic three-year extension in this bill, hospitals are required to submit an NPC-5 evaluation report by July 1, 2025. Recent amendments to this bill described in 2) of what the bill does, above, according to the sponsor, are intended to clarify that a hospital does not have to submit the NPC-5 evaluation report for a building that the hospital is not intending to bring into seismic compliance, and instead intends to relocate the acute care services from that building into a seismically compliant building before the newly extended seismic compliance deadline. However, the language is modeled on, and cross-references, existing law specific to the older seismic requirement that hospitals just remain standing. By re-using this language, it appears to be requiring these buildings to obtain a building permit, and to require HCAI to re-evaluate and classify certain buildings as SPC-2, neither of which seems consistent with the author's intent. The Committee may wish to clarify this language so the intent is more clear.

   b) **Reporting requirements.** This bill requires HCAI to submit a report to the Legislature and OHCA with an analysis of each cost estimate analysis submitted by an owner of an acute care inpatient hospital and an estimate of the total statewide cost to retrofit and/or rebuild noncompliant buildings in order to comply with the 2030 seismic safety requirements. OHCA's statute does not give it authority to consider seismic compliance for purposes of setting cost targets, and as such, the Committee recommends striking references to OHCA, and the reporting requirement from this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

California Hospital Association (sponsor)
Banner Lassen Medical Center
Calexico Wellness Center
California Human Development
California Special Districts Association
Center for Employment Training
Central Valley Opportunity Center

Coalicion de Buena Salud y Bienestar
Comite Civico del Valle
Community Health System
County of Humboldt
Farmworkers Institute of Education & Leadership Development
First Day Foundation, Inc.
Fresno Chamber of Commerce
Greater Conejo Valley Chamber of Commerce
Huntington Health
La Cooperativa Campesina de California
LA Downtown Medical Center
Los Amigos de la Communidad
Marjaree Mason Center
Private Essential Access Community Hospitals
Proteus, Inc.
Providence
San Bernardino County
San Bernardino Mountains Community Hospital District
San Diego Regional Chamber of Commerce
Southwest California Legislative Council
United Hospital Association
University of California

Opposition

AFSCME CA
California Labor Federation, AFL-CIO
California Nurses Association
California Professional Firefighters
California Teamsters Public Affairs Council
NUHW
Professional Engineers in California Government (PECG)
SEIU California State Council
United Nurses Association of California/Union of Health Care Professionals
UNITE HERE!

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

Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1511 (Committee on Health) – As Amended June 17, 2024

SENATE VOTE: 37-0

SUBJECT: Health omnibus.

SUMMARY: Makes non-controversial changes to a number of provisions of existing law contained in the Health and Safety Code (HSC) and the Welfare and Institutions Code (WIC). Specifically, **this bill**:

1) Changes the reporting deadline for primary care clinics' annual utilization reports (AUR) from February 15 to March 15.

2) Extends the deadline, from January 1, 2024 to January 1, 2026, for skilled nursing facilities (SNFs) to come into compliance with a requirement to have an alternative source of power for no fewer than 96 hours during a power outage.

3) Makes death record indices created for purposes of preventing fraud available to all of the following:
   a) Health plans and insurers, including Medi-Cal managed care plans;
   b) A physician organization, as specified, including physician group practices; and,
   c) A licensed health facility, as specified, including hospitals, nursing facilities, intermediate care facilities of various types, congregate living health facilities, correctional treatment centers, and hospice facilities.

4) Requires the California Department of Public Health (DPH) to regularly notify specified licensing entities of instances in which registration data indicates that physicians or funeral establishments are repeatedly failing to comply with existing law related to the fetal death registration process.

5) Clarifies that general acute care hospitals (GACHs) are required to permit patients who have a chronic condition to use medicinal cannabis when they are also terminally ill.

6) Clarifies that any reference to "group contract" in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) does not include a Medi-Cal managed care contract between a health plan and Department of Health Care Services (DHCS) to provide benefits to beneficiaries of the Medi-Cal program.

7) Extends the deadline, from June 30, 2026 to December 31, 2031, for California Health Facilities Finance Authority (CHFFA) and Department of Health Care Access and Information (HCAI) to use funds allocated for administrative costs of the Distressed Hospital Loan Program (DHLP).

8) Clarifies that all Medi-Cal Local Education Agency Billing Option Program (LEA BOP) state administrative activities are funded under a 5% cap on expenses that may be withheld from program funds for such activities.

9) Revises several provisions of existing law to reflect a recently updated definition of "gravely disabled," which added severe substance use disorder (SUD) as a primary and/or standalone condition, as well as to add the inability of an individual to provide for their own personal safety or necessary medical care.

10) Requires a commercial health plan to accept the state's right to recovery for payments for Medi-Cal services from Medi-Cal managed care plans and Medi-Cal's federal waiver programs.

11) Prohibits a commercial health plan from denying a claim submitted by the Medi-Cal program, a provider, or a Medi-Cal managed care plan for services rendered to a Medi-Cal recipient with private health coverage for failure to obtain a prior authorization for the service.

12) Requires a commercial health plan to respond to a request for payment for services rendered by the Medi-Cal program to a Medi-Cal recipient within 60 days by either making payment on the claim or submitting in writing a request for additional information necessary to process the claim or an explanation for the denial of the claim.

13) Establishes a time limit for third parties on refunds to three years from the date of service.

14) Make other technical, clarifying changes, including renumbering a code section to correct a clerical error.

EXISTING LAW:

1) Licenses and regulates clinics, including primary care clinics and specialty clinics, by DPH. [HSC §1200, *et seq*.]

2) Defines a PCC as either a "community clinic," which is required to be operated by a non-profit corporation and to use a sliding fee scale to charge patients based on their ability to pay; or a "free clinic," which is also required to be operated by a non-profit but is not allowed to directly charge patients for services rendered or for any drugs, medicines, or apparatuses furnished. [HSC §1204]

3) Requires every clinic holding a license to file with HCAI an AUR with the following information relating to the previous calendar year:
   a) Number of patients served and descriptive information, including, but not limited to, age, gender, race, and ethnic background of patients;
   b) Number of patient visits by type of service, including all of the following:
      i) Child health and disability prevention screens, treatment, and followup services;
      ii) Medical services;
      iii) Dental services; and,
      iv) Other health services.
   c) Total clinic operating expenses;

d) Gross patient charges by payer category;
e) Deductions from revenue by payer category, bad debts, and charity care charges; and,
f) Additional information as may be required by the HCAI or DPH. [HSC §1216]

4) Requires a SNF to have an alternative source of power, as defined, to protect resident health and safety, as defined, for no fewer than 96 hours during any type of power outage. Requires a facility to comply with its requirements by January 1, 2024. [HSC §1418.22]

5) Establishes the State Registrar within DPH, and requires the State Registrar to arrange and permanently preserve birth, death, and marriage certificates in a systematic manner and prepare and maintain comprehensive and continuous indices of all certificates registered. [HSC §102230]

6) Requires the State Registrar to prepare and maintain separate noncomprehensive indices of all California birth, death, and nonconfidential marriage records for purposes of law enforcement or preventing fraud. Makes birth, death, and marriage record indices prepared available to certain entities for specified purposes, including, government, law enforcement, and financial entities, for specified purposes, including law enforcement and prevention of fraud. [*Ibid*.]

7) Includes, in noncomprehensive death record indices for the purpose of preventing fraud: first, middle, and last name, place of death, mother's maiden name, sex, social security number, date of birth, place of birth, date of death, and father's last name. [*Ibid*.]

8) Requires each fetal death in which the fetus has advanced to or beyond the 20th week of uterogestation to be registered with the local registrar of births and deaths of the district in which the fetal death was officially pronounced within eight calendar days of the event and prior to any disposition of the fetus. Establishes a process by which the funeral director, physician in attendance of the delivery, and coroner prepare a fetal death certificate and register it with the local registrar. [HSC §102950, *et seq*.]

9) Requires certain health facilities, including GACHs, SNFs, hospice facilities, and home health agencies, to permit terminally ill patients to use medicinal cannabis within the facility. Requires these same facilities, with the exception of GACHs, to permit patients over 65 years of age with a chronic disease to use medicinal cannabis within the facility. [HSC §1649.2]

10) Establishes the Knox-Keene Act to require the Department of Managed Health Care (DHMC) to execute laws related to health plans and health plan business including, but not limited to, laws to ensure that health plans provide enrollees with access to quality health care services and protect and promote interests of enrollees. [HSC §1340, *et seq.]*

11) Defines "Group contract," under DMHC regulation, to means a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group. [HSC §1345]

12) Establishes the DHLP Fund to provide loans to not-for-profit hospitals and public hospitals in significant financial distress to prevent the closure or facilitate the re-opening of a closed hospital. Requires CHFFA and HCAI to co-administer the program. [HSC §129385]

13) Establishes the Medi-Cal program, administered by DHCS, which provides medical coverage to low income persons. [WIC §14000, *et seq*.]

14) Requires DHCS to amend the Medicaid state plan regarding the billing option for services by LEAs to ensure that schools are reimbursed for all eligible services they provide. [WIC §14115.8]

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

16) Defines "gravely disabled," for purposes of evaluating and treating an individual who has been involuntarily detained or for placing an individual in conservatorship, as a condition in which a person, as a result of a MH disorder, a severe SUD, or a co-occurring MH disorder and a severe SUD (MH/SUD), is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. [WIC §5008]

17) Licenses, under the Department of Consumer Affairs, physicians and funeral establishments [Business and Professions Code §2000, *et seq*.; §7615, *et seq*.]

18) Permits the Medi-Cal program, when providing or paying for health care services to a person with private health coverage, to subrogate the rights that person has against the carrier of the private health coverage for the health care services provided or paid for. [WIC § 10022]

19) Requires entities providing private health coverage to accept the state's right of recovery for services provided through the Medi-Cal program to a person with private health coverage. [WIC §10022]

FISCAL EFFECT: According to the Senate Committee on Appropriations:

1) Unknown, potential General Fund costs for DPH to review fetal death registrations.

2) Unknown, potential costs for the DHCS for state administration regarding claims for Medi-Cal enrollees with private health coverage (General Fund and federal funds).

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is an omnibus measure meant to implement non-controversial and non-substantive changes to a number of statutes in the HSC, as well as WIC.

2) BACKGROUND.

a) Annual Reporting Deadline for Primary Care Clinic Data. SB 779 (Stern), Chapter 505, Statutes of 2023, enacted the Primary Care Clinic Data Modernization Act, which

creates new reporting requirements for the AUR for primary care clinics. The AUR, which must be submitted to HCAI annually, includes various types of data and information, including all mergers and acquisitions, a detailed labor report, a detailed workforce development report, and a report of quality and equity measures. According to CPCA Advocates, the advocacy affiliate of the California Primary Care Association, , which sought a later reporting deadline for the AUR through negotiations on SB 779, parties agreed at that time to push the reporting deadline later, however, due to timing and the inclusion of other amendments, the change was not made in that bill.

This bill changes the annual deadline for submission of the AUR from February 15 to March 15. CPCA notes the new March 15 deadline would give the health centers more time to complete the AUR, which would assist clinics to comply with the requirement, particularly in light of a federal data report which is also due annually on February 15.

b) Two-Year Delay for Compliance with 96-Hour Generator Requirement. AB 2511 (Irwin), Chapter 788, Statutes of 2022, requires a SNF, by January 1, 2024, to have an alternative source of power for no fewer than 96 hours during any type of power outage. According to the California Association of Health Facilities (CAHF) that represents SNFs, compliance will result in new mandated costs for facilities that need to purchase and install generators, transfer switches, electrical panels and new heating, ventilation and air conditioning systems that are compatible with the required generators. In many cases, CAHF notes, the locations of the existing generators are not sufficiently sized and will require engineering solutions. The Governor's signing message for AB 2511 noted the bill did not include workable timelines, and encouraged the author and stakeholders to engage with HCAI, in order for implementation to reflect a more realistic timeframe for facilities to come into compliance.

This bill would delay implementation of the requirement to have 96 hours of backup power by two years, from January 1, 2024, to January 1, 2026.

c) Making Death Indices Available to Health Plans and Providers. The State Registrar within DPH, in addition to organizing and preserving birth, death, and marriage certificates, creates public and nonpublic indices of these records to assist other entities to enforce the law and prevent fraud. Dr. Neil Wenger, et al. published a research letter in the *JAMA Internal Medicine* journal in 2023 titled, "Consequences of a Health System Not Knowing Which Patients are Diseased." In the journal article, the authors investigated what proportion of active patients a health system is unaware are deceased, as well as encounters with these patients after death. The letter found 19% of deceased patients were marked alive in the electronic health record (EHR) system, and 80% had outreach, such as postcards or phone calls about upcoming appointments or preventive care. According to the Senate Health Committee, health plans and providers should have access to nonpublic death indices so these entities can update their EHRs. The research letter notes that not knowing who is dead hinders effective health management, billing, advanced illness interventions, and measurement. The letter notes nonpublic death data lacks specificity necessary to validate a death for purposes of an EHR.

This bill would require death record indices to made available to certain entities, including health plans, health insurers, physician organizations, and health facilities.

d) Fetal Death Registration. The California State Auditor (CSA) recently conducted an audit on DPH's fetal death and stillbirth registration process. In the audit, CSA found that local registration of fetal deaths in California took an average of three times longer than the legal period of eight calendar days from the delivery. Delays in the process prevent families from obtaining a burial permit until the local registrar approves the fetal death certificate. The fetal death registration process begins with the physician in attendance, who has 15 hours to provide relevant medical data and their signature on the fetal death certificate. The coroner, if reviewing a fetal death, must then state their findings and other medical data on the certificate, as well as sign it, within three days of examining the fetus. The funeral director then has eight days to obtain required information outside of medical or health data and register it with the local registrar. The local registrar and DPH examine the certificates they receive and obtain further information as necessary, with the local registrar and are then required to issue a burial permit. There is currently no accountability in place for these parties to fulfill their responsibilities within their legally required time frame.

This bill implements one of CSA's recommendations: Requiring DPH to regularly notify licensing entities of instances in which registration data indicates that physicians or funeral establishments are repeatedly failing to comply with existing law related to the fetal death registration process.

e) Correction to Compassionate Access to Medical Cannabis Act. SB 302 (Stern), Chapter 484, Statutes of 2023, expanded the Compassionate Access to Medical Cannabis Act by expanding the type of facilities where medicinal cannabis was permitted and by permitting patients over 65 years of age with a chronic disease to have access to their medical cannabis in addition to the terminally ill. DPH provided amendments to the author that were adopted on September 7, 2023, one of which prohibits GACHs from allowing patients with a chronic disease to use medical cannabis. However, this amendment created ambiguity, as it does not distinguish between patients who only have a chronic condition, and those who have both a chronic condition and a terminal illness. Senator Stern submitted a letter to the journal at the end of session last year to clarify that creating this ambiguity was not his intent, and that legislation in 2024 would correct the ambiguity created by the September 7, 2023 amendments. This bill allows access for patients with a chronic condition if they also have a terminal illness.

f) Defining "Group contracts" to Exclude Medi-Cal Managed Care. The Knox-Keene Act references "group contracts" for health coverage, causing stakeholders to routinely ask DMHC as to whether the statutory reference to "group contracts" also includes contracts between health plans and the DHCS to provide Medi-Cal managed care plan services to Medi-Cal beneficiaries. This bill specifies the definition does not include Medi-Cal managed care plans.

g) Administrative Funding for DHLP. The California State Treasurer requests a deadline extension for the utilization of administrative funds allocated for the DHLP by CHFFA and HCAI. AB 112 (Assembly Committee on Budget), Chapter 6, Statutes of 2023, established the DHLP to provide loans to not-for-profit hospitals and public hospitals in significant financial distress. The bill authorizes CHFFA and HCAI to co-administer the DHLP, including issuing loans to the appropriate hospitals. In addition to the approval and distribution of loans by CHFFA and HCAI, CHFFA staff also plans to assist in the

collecting and monitoring of payments as well as ensuring compliance with loan conditions and terms from the hospitals. CHFFA also anticipates a reasonable likelihood of requiring outside counsel to help with highly specialized bankruptcy proceedings. These factors would extend the responsibility of CHFFA's administrative duties for at least another 72 months, or until at least 2030. However, the funds for administrative costs available will only be accessible for encumbrance or expenditure until June 30, 2026.

This bill will extend the deadline for expenditure of administrative funds until December 1, 2031.

h) LEA BOP. LEA BOP is a voluntary local program that allows LEAs, including school districts, county offices of education, and direct-funded charter schools, to seek federal reimbursement for Medi-Cal covered services. Prior to AB 483 (Muratsuchi and Wood), Chapter 527, Statutes of 2023, the amount that Medi-Cal/LEA BOP payments could be withheld to fund DHCS administrative costs was capped in statute at $1.5 million, and budget bill language (BBL) provided an additional $1 million set-aside to fund program activities. AB 483 amended existing law, striking the $1.5 million in statute and replacing it with a cap of no more than 5% of the total federal Medicaid LEA BOP payments (5% admin cap). The 5% cap was intended to fund LEA BOP program activities broadly, replacing both the $1.5 million statutory set-aside and the supplemental $1 million set-aside in BBL. However, the amended language was inadvertently too narrow because it limited the use of funds under the 5% admin cap to activities specified within the specific section, which did not specify all LEA BOP program activities. This left DHCS unclear about whether it can use funds under the 5% admin cap for the program functions not included in that section.

This bill clarifies that DHCS is authorized to use the funds under the 5% administrative cap to fund all LEA BOP administrative activities.

i) Conforming Language for Change in "Gravely disabled" Definition. SB 43 (Eggman), Chapter 637, Statutes of 2023, expanded the definition of "gravely disabled" to include a condition in which a person, as a result of a severe SUD, or a co-occurring MH/SUD, is additionally unable to provide for their personal safety or necessary medical care, for the purposes of the LPS Act. However, some sections in the LPS Act still reference the previous definition of "gravely disabled" that only cited a MH disorder, or a person's inability to provide for their food, clothing, or shelter.

This bill updates several related code sections to conform to the new definition of "gravely disabled" instituted by SB 43.

j) Changes to Medi-Cal Third-Party Liability (TPL) Laws. Under federal law, if a Medicaid enrollee has another source of health care coverage for a service paid for by Medicaid, the state is obligated to pursue payment from that source for the service. DHCS ensures that the Medi-Cal program is the payer of last resort by identifying and recovering costs from liable third parties, such as commercial insurance policies and Medicare. This bill addresses several TPL-related issues:

i) **Federal Conformity**. When Medi-Cal covers the services first and DHCS seeks recovery of payment, third-party payers sometimes deny DHCS's claims based on a lack of prior authorization. The federal Consolidated Appropriations Act (CAA) of 2022 requires states to enact laws that prohibit third-party payers (outside of Medicare plans) from denying payment to the Medicaid program solely on the basis that the item or service did not receive prior authorization under the third-party payer's rules. Under the CAA, the responsible third party must treat payment by the state Medicaid program as if the authorization was made by them. The CAA also requires states to have prompt payment standards by requiring third parties to respond within 60 days of receiving the Medicaid agency's claim. California law has yet to reflect these federal rules and this bill codifies them.

ii) **Clarifying Authority for TPL Payment Recovery**. California delegates TPL responsibilities to Medi-Cal managed care plans for Medi-Cal covered services provided to plan enrollees. According to current contracts with DHCS, a Medi-Cal managed care plan retains monies recovered from other plans through TPL post-payment recovery activities. Current law references DHCS and providers as entities who seek TPL payment recovery. This bill clarifies managed care plans are also authorized to seek TPL payment recovery.

Current law only explicitly requires commercial plans to accept the state's rights of payment recovery for services for which payment is made under the state plan (the state's Medicaid contract with the federal government). However, many services are authorized and paid for under federal waiver authority, which is technically a separate authority than the state plan. This bill also clarifies commercial plans must accept the state's rights of payment recovery for services for which payment is made under a federal waiver.

iii) **Establishing a Deadline for Refund Requests**. Liable third parties sometimes pay claims without appropriately reviewing them beforehand to meet required time frames, which can lead to plans requesting refunds en masse, sometimes years later, based on a post hoc review. This bill would limit the ability to third parties to request a refund for an erroneously paid claim no later than three years from the date the payment was made to DHCS.

k) **Duplicate Code Section**. In 2021, two bills inadvertently added a section of law to the HSC with the same number (HSC 1367.34). To correct this clerical error, this bill moves and renumbers Section 1 of SB 428 (Hurtado), Chapter 641, Statutes of 2021, which requires commercial health plans to cover adverse childhood experience screenings, to HSC 1367.37.

3) **SUPPORT**. The California Hospital Association writes in support of the provision extending the expenditure deadline for administrative support for the DHLP.

CPCA Advocates, the advocacy affiliate of the California Primary Care Association, writes in support of the bill, and in particular in support of the provision changing the reporting deadline for the AUR from February to March 15. According to CPCA Advocates, this technical change, changing the reporting date from February 15th to March 15th, will allow primary care clinics to focus on each critical report to ensure the data gets completed in a

comprehensive and timely manner.

California Association of Health Facilities and LeadingAge California write in support of the provision extending the deadline for compliance with AB 2511 (Irwin) regarding generator capacity for SNFs.

4) PREVIOUS LEGISLATION.

a) SB 306 (Pan), Chapter 486, Statutes of 2021, requires health plans and insurers to provide coverage for home test kits for sexually transmitted diseases and the laboratory costs for processing those kits that are deemed necessary by a health care provider, and enacts an identically numbered code section as SB 428 (Hurtado), as described in 2) k) above.

b) SB 302 (Stern), Chapter 484, Statutes of 2023, expands the Compassionate Access to Medical Cannabis Act, or Ryan's Law, to include patients over 65 years of age with a chronic disease in specified health care facilities.

c) AB 112 (Assembly Committee on Budget), Chapter 6, Statutes of 2023, creates the Program and requires CHFFA and HCAI to jointly administer it.

d) SB 43 (Eggman), Chapter 637, Statutes of 2023, expands the definition of "gravely disabled" to include a condition in which a person, as a result of a severe substance use disorder, is unable to provide for their personal safety or necessary medical care in the LPS Act.

e) AB 483 (Muratsuchi and Wood), Chapter 527, Statutes of 2023, requires DHCS to complete audits of a Medi-Cal LEA BOP claim and notify the LEA of the findings within 18 months of the date that the Cost and Reimbursement Comparison Schedule is submitted.

f) SB 779 (Stern), Chapter 505, Statutes of 2023, enacted the Primary Care Clinic Data Modernization Act, which creates new reporting requirements for all primary care clinics, including intermittent clinics, to report various types of data to HCAI, including all mergers and acquisitions, a detailed labor report, a detailed workforce development report, and a report of quality and equity measures.

5) AMENDMENTS. Nonpublic death indices include sensitive information, including first, middle, and last name, place of death, mother's maiden name, sex, social security number, date of birth, place of birth, date of death, and father's last name. This bill does not specify the purpose of providing this data to health plans and providers nor limit the reason for the availability of such data. Amendments will specify the reason for access to nonpublic death data records and limit the use of such data by adding language to HSC 102230 (c)(6) as follows:

(6) The death record indices prepared pursuant to this subdivision shall be made available to all of the following***, for the sole purpose of verifying a death to promote accuracy of patient records used for patient care, reporting and quality improvement***:

(A) A health care service plan […]

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Health Facilities
California Hospital Association
CPCA Advocates, Subsidiary of the California Primary Care Association
LeadingAge California

Opposition

None on file.

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