California State Assembly

HEALTH

MIA BONTA
CHAIR

AGENDA

Tuesday, April 22, 2025
1:30 p.m. -- 1021 O Street, Room 1100

SPECIAL ORDER OF BUSINESS

1.	AB 669	Haney	Substance use disorder coverage.
2.	AB 384	Connolly	Health care coverage: mental health and substance use disorders: inpatient admissions.
3.	AB 510	Addis	Health care coverage: utilization review: appeals and grievances.
4.	AB 512	Harabedian	Health care coverage: prior authorization.
5.	AB 539	Schiavo	Health care coverage: prior authorizations.
6.	AB 574	Mark González	Prior authorization: physical therapy.

BILLS HEARD IN FILE ORDER

7.	AB 220	Jackson	Medi-Cal: subacute care services.
8.	AB 302	Bauer-Kahan	Confidentiality of Medical Information Act.
9.	AB 348	Krell	Full-service partnerships.
10.	AB 350	Bonta	Health care coverage: fluoride treatments.
11.	AB 371	Haney	Dental coverage.
12.	*AB 424	Davies	Alcohol and other drug programs: complaints.
13.	AB 425	Davies	Certification of alcohol and other drug programs.
14.	*AB 463	M. Rodriguez	Emergency medical services: dogs and cats.
15.	AB 543	Mark González	Medi-Cal: street medicine.
16.	AB 573	Rogers	Cigarette and tobacco products: licensing and enforcement.
17.	AB 592	Gabriel	Business: retail food.
18.	AB 645	Carrillo	Emergency medical services: dispatch.
19.	*AB 676	Jeff Gonzalez	Medi-Cal: unrecovered payments: interest rate.
20.	AB 785	Sharp-Collins	Community Violence Interdiction Grant Program.
21.	AB 835	Calderon	Medi-Cal: skilled nursing facility services.
22.	*AB 870	Hadwick	Children’s services.
23.	*AB 894	Carrillo	General acute care hospitals: patient directories.

* Proposed Consent

24.	AB 910	Bonta	Pharmacy benefit management.
25.	AB 955	Alvarez	Mexican prepaid health plans: individual market.
26.	*AB 960	Garcia	Patient visitation.
27.	AB 974	Patterson	Medi-Cal managed care plans: enrollees with other health care coverage.
28.	AB 1088	Bains	Public health: kratom.
29.	AB 1242	Nguyen	Language access.
30.	AB 1267	Pellerin	Consolidated license and certification.
31.	*AB 1288	Addis	Registered environmental health specialists.
32.	AB 1328	M. Rodriguez	Medi-Cal reimbursements: nonemergency ambulance transportation.
33.	AB 1356	Dixon	Alcohol and other drug programs.
34.	AB 1415	Bonta	California Health Care Quality and Affordability Act.
35.	*AB 1419	Addis	California Health Benefit Exchange: automatic health care coverage enrollment.
~~36.~~	~~AB 1429~~	~~Bains~~	~~Behavioral health reimbursement.~~ **Pulled by Author**
37.	AB 1460	Rogers	Prescription drug pricing.
38.	AB 1487	Addis	Public health: the Two-Spirit, Transgender, Gender Nonconforming, and Intersex Wellness and Equity Fund.

* Proposed Consent

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 220 (Jackson) – As Introduced January 8, 2025

SUBJECT: Medi-Cal: subacute care services.

SUMMARY: Requires a health facility providing pediatric or adult subacute care services under the Medi-Cal program to submit a specified form to request authorization for these services, and prohibits a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity. Requires the Department of Health Care Services (DHCS) to develop and implement procedures, and specifies DHCS may impose sanctions, to ensure that a Medi-Cal managed care plan complies with the aforementioned requirements.

EXISTING LAW:

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

2) Establishes a schedule of benefits under the Medi-Cal program, which includes subacute care services. [WIC § 14132 (c)]

3) Establishes the subacute care program as a Medi-Cal benefit available to patients in health facilities who meet subacute care criteria. Requires DHCS to establish level of care criteria and appropriate utilization controls for patients eligible for the subacute care program. [WIC § 14132.25]

4) Defines pediatric subacute services as health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. [*Ibid.*]

5) Requires medical necessity for pediatric subacute care services to be substantiated in one of five specifically enumerated ways, for instance, requiring a tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day. [*Ibid.*]

6) Specifies that the medical necessity determination outlined in 5) above is intended solely for the evaluation of a patient who is potentially eligible and meets the criteria to be transferred from an acute care setting to a subacute level of care. [*Ibid.*]

7) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act as a set of Medi-Cal transformation initiatives, and requires implementation of the CalAIM initiative to support a number of goals, including transitioning and transforming the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility. [WIC § 14184.100]

8) Establishes a CalAIM term of January 1, 2022, to December 31, 2026, inclusive, and any extensions. [WIC § 14184.101]

9) Under CalAIM, commencing January 1, 2024, and subject to federal approval and the availability of federal matching funds, requires DHCS to include, or continue to include, institutional long-term care services, which is defined to include subacute and pediatric subacute facility services, as capitated benefits in Medi-Cal managed care. Specifies reimbursement requirements during a two-year transitional period ending December 31, 2025. [WIC § 14184.201 (c) and (g)]

10) Mirrors statutory requirements for Medi-Cal subacute care in regulations. [Title 22, Code of California Regulations § 51124.5 and § 51124.6]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill is crucial for enhancing the care and support provided to patients who require subacute medical services. The author asserts care for medically fragile children with disabilities is being delayed and denied by managed care plans. The author concludes this bill is a vital step toward improving patient outcomes by ensuring patients receive services aligned with their medical needs within an appropriate facility.

2) **BACKGROUND.**

   a) **Subacute Care**. In Medi-Cal, adult subacute care is defined as a level of care needed by a patient who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility. Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding, and complex wound management care.

      Pediatric subacute care is defined in statute as a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Pediatric subacute care facilities care for children who have experienced illnesses and injuries resulting from, for instance, congenital birth defects, neurologic injuries, cardiac and respiratory illness seizure disorders, or premature birth complications. As an example of the type of patients who are seen in a pediatric subacute care facility, a hypothetical patient would be a ten year-old child with developmental delay across several domains, who is dependent on a ventilator, wears hearing aids, is wheelchair dependent and is in recovery from a spinal surgery and has corresponding wound care needs.

   b) **Managed Care Transition**. Prior to January 1, 2024, adult and pediatric subacute care services were “carved out” of Medi-Cal managed care, meaning they were provided as a separate, fee-for-service benefit contracted and paid for directly by DHCS. As a component of the CalAIM initiative, effective January 1, 2024, a number of institutional long-term care services, including adult and pediatric subacute care services, were “carved in” to Medi-Cal managed care. This means Medi-Cal managed care plans are now responsible for contracting with these facilities and paying them for medically necessary subacute care services. Plans also took on the role of reviewing prior authorization requests for subacute care services.

According to DHCS, the stated goals of the carve-in of subacute care services into managed care are as follows:

i) Standardize subacute care services coverage under managed care statewide.

ii) Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.

iii) Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in subacute care.

DHCS has conducted significant stakeholder engagement and has provided training for providers and managed care plans to prepare for and troubleshoot aspects of this transition.

c) DHCS Guidance on Subacute Care. On September 16, 2024, DHCS issued "*All-Plan Letter 24-010*" to provide updated guidance on the transition of subacute care to Medi-Cal managed care. DHCS specifies plans must determine medical necessity consistent with definitions in current statute and regulation discussed in Existing Law, above. DHCS further specifies that members in need of adult or pediatric subacute care services are to be placed in a health care facility that provides the level of care most appropriate to the member's medical needs, as outlined in the managed care plan contract and as documented by the member's provider. DHCS requires, effective January 1, 2024, all plans in all counties to expedite prior authorization requests for members who are transitioning from an acute care hospital to a subacute care facility. DHCS also requires plans to make all authorization decisions in a timeframe appropriate for the nature of the member's condition, and requires all authorization decisions to be made within 72 hours after the plan receives relevant information needed to make an authorization decision

3) SUPPORT. The sponsor of this legislation, Totally Kids Rehabilitation Center, writes in support that medical necessity criteria for subacute care services is well-established, particularly for pediatric subacute care. The sponsor explains that prior to the transition to Medi-Cal managed care, DHCS used a simple form with a checklist in the fee-for-service (FFS) Medi-Cal program to establish medical necessity, and the determination was straightforward: if a facility provided medical chart information that verified a child met one of a number of criteria specified in statute, medical necessity was established. With the recent inclusion of these services into Medi-Cal managed care, the sponsor explains this process has grown so complicated and burdensome that their facility had to hire two additional case managers to handle the demands of managed care plans.

California Association of Health Facilities (CAHF) writes in support that as California transitioned from a FFS model to the Medi-Cal managed care model, plans in essence became case managers determining when, how, and if pediatric patients receive care without proper training and knowledge of long-term care regulations and laws (LTC). CAHF argues this bill will streamline the authorization process for patients needing subacute care while ensuring they receive the appropriate, adequate care they deserve, and return case management to the appropriate authority. Other organizations representing individuals with disabilities, consumers, and specialty care providers also support this bill.

4) **RELATED LEGISLATION.** Other legislation seeks to address prior authorization in Medi-Cal and various specific pressure points related to DHCS's transition of populations and services into managed care.

   a) AB 517 (Krell), pending in the Assembly Appropriations Committee, would prohibit DHCS from requiring certain criteria to be met prior to Medi-Cal payment for repair of complex rehabilitation technology, generally powered wheelchairs and related mobility products.

   b) AB 835 (Calderon), pending in this committee, would address contracting delays between Medi-Cal managed care plans and skilled nursing facilities (SNFs) related to the carve-in of SNF services into managed care by requiring plans to pay SNFs specified "directed payments" retroactively regardless of a facility's status as a network (contracted) provider with the plan.

   c) AB 974 (Patterson), pending in this committee, would implement several changes to help beneficiaries enrolled in commercial health coverage and who use Medi-Cal as a payer of last resort to maintain their providers as they transition from FFS Medi-Cal to Medi-Cal managed care.

   d) A large number of other bills this year are seeking to address various issues related to prior authorization and utilization review in the commercial market and Medi-Cal program, which consumers and providers say impedes access to care in various ways. These bills include: AB 384 (Connolly), AB 510 (Addis), AB 512 (Harabedian), AB 539 (Schiavo), AB 574 (Mark González), and AB 669 (Haney), which are all pending in the Assembly Health Committee, and SB 306 (Becker), which is pending in the Senate Health Committee.

5) **PREVIOUS LEGISLATION.**

   a) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes statutory authority for various aspects of the CalAIM initiative, including the carve-in of institutional LTC services into Medi-Cal managed care.

   b) AB 667 (Mitchell), Chapter 294, Statutes of 2011, updated and codified medical necessity criteria for pediatric subacute care in Medi-Cal.

6) **POLICY COMMENT**. Pursuant to CalAIM, DHCS has been transitioning numerous services, as well as Medi-Cal enrolled populations, into managed care. Although this transition has certain benefits and streamlines aspects of the Medi-Cal program from the state perspective, it has not come without tradeoffs in other parts of the system. In addition to various administrative issues related to the transition itself, from a provider perspective, working within the managed care system often increases complexity and administrative burden as compared to providing Medi-Cal services through FFS. Specifically, in order to provide services to Medi-Cal enrollees, providers must continue to be enrolled with DHCS but also be credentialed by, maintain contracts with, bill, and receive payment from a large number of plans, versus dealing with DHCS as a single entity.

   In the case of pediatric subacute care in particular, providers argue that the process of demonstrating medical necessity has become unnecessarily complex and administratively

burdensome, even though medical necessity criteria, in the case of pediatric subacute care, are clearly laid out in statute. Administrative processes and documentation requirements to demonstrate medical necessity are not standardized across plans, meaning plans may require slightly different forms of proof or have different means to accept this information.

There is a careful balance between providing plans sufficient authority to coordinate care and tethering plans to a rigid standard. It is not clear whether Medi-Cal is striking the right balance as the state transitions more services to managed care overall. It is worth considering the value in creating more standardization for services like subacute care in particular, as this bill proposes, where medical necessity standards are more clearly laid out in statute and there is little room for differing interpretations. Conversely, this bill's more narrow and rigid approach risks being too prescriptive in statute.

As this bill moves forward, the author is encouraged, at a minimum, to seek technical assistance from DHCS to re-draft the bill language to refer to a standardized prior authorization form or process without referencing a specific numbered form in statute (this bill currently specifies "*form DHCS 6200*" and "*form DHCS 6200a*"). Because forms can change, statute should avoid referencing specific numbered forms when possible. Further, the author should consider, and seek DHCS and stakeholder input on, replacing this bill's more specific language with a more general approach of providing DHCS with broader authority and direction to standardize prior authorization and medical necessity where DHCS judges there is an overall benefit to doing so. This approach would allow more DHCS flexibility and discretion to address individual circumstances with appropriate nuance and to keep requirements up to date without making additional statutory changes.

REGISTERED SUPPORT / OPPOSITION:

Support

Totally Kids Rehabilitation Hospital (sponsor)
California Alliance of Child and Family Services
California Association of Health Facilities
California Hospital Association
CANHR
Children's Healthcare of Northern California
Children's Specialty Care Coalition
District Hospital Leadership Forum
The Arc and United Cerebral Palsy California Collaboration
One individual

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 302 (Bauer-Kahan) – As Introduced January 23, 2025

SUBJECT: Confidentiality of Medical Information Act.

SUMMARY: Requires a provider of health care, health care service plan (health plan) or contractor to disclose medical information when specifically required by California law. Revises disclosure requirements relating to court orders and search warrants, as specified. Deletes existing authorizations to disclose medical information pursuant to an express authorization by a patient, enrollee, or subscriber. Specifically, **this bill**:

1) Requires a provider of health care, health plan, or contractor to disclose medical information if the disclosure is compelled by:

    a) A California state court pursuant to an order of that court or a court order from another state based on another state's law, as long as that law does not interfere with California law, including, but not limited to, the Reproductive Privacy Act;

    b) A search warrant lawfully issued to a governmental law enforcement agency, including a warrant from another state based on another state's law, as long as that law does not interfere with California law, including, but not limited to, the Reproductive Privacy Act; or,

    c) When otherwise specifically required by California law.

2) Deletes exceptions allowing disclosure of medical information pursuant to an express authorization by a patient, enrollee, or subscriber under the following conditions:

    a) To share, sell, use for marketing, or otherwise for a purpose not necessary to provide health care services to the patient; or

    b) To a person or entity that is not engaged in providing direct health care services to the patient or the patient's provider of health care or health plan or insurer or self-insured employer.

EXISTING LAW:

1) Establishes under federal law, the Health Information Portability and Accountability Act of 1996 (HIPAA), which sets standards for privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA covered entity may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails. [Title 45, Code of Federal Regulations § 164.500, *et. seq*.]

2) Prohibits, under the Confidentiality of Medical Information Act (CMIA), a health care provider, a health care service plan, a contractor, a corporation and its subsidiaries and

affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as expressly authorized by the patient, enrollee, or subscriber, as specified, or as otherwise required or authorized by law. States that a violation of these provisions that results in economic loss or personal injury to a patient is a crime. [Civil Code (CIV) § 56, *et. seq*.]

3) Defines, for purposes of the CMIA, medical information to mean any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health app information, mental or physical condition, or treatment. [CIV § 56.05(i)]

4) Prohibits health care providers, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. [CIV § 56.10(a)]

5) Establishes the Reproductive Privacy Act, which provides that the state cannot deny or interfere with a women's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman, and makes legislative findings and declarations that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions, and that every woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion, as specified. [Health & Safety Code 123460 *et seq*.]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill ensures that patients' medical information is not being used as a commodity. The author states that technology companies are increasingly expanding into the healthcare space by developing new communication tools using artificial intelligence. The author continues that these companies rely on private medical information for marketing purposes and to train and refine their systems. The author notes that current law requires entities to obtain consent from patients regarding the use, sharing and sale of their medical information. The author argues that patients are often asked to consent without being provided a clear understanding of what they are giving permission for. The author states that this bill updates the CMIA in two important ways. First, it removes an exemption that allows health care entities to share or sell medical information for purposes other than to provide health care services to patients, if they obtain consent from the patient and prohibits the disclosure of medical information regarding a patient to any entity that is not engaged in providing direct health care services. Second, the bill also updates the exemptions to information sharing by prohibiting the sharing of medical information with a court or law enforcement entity outside of California unless they have either obtained a California court order or have a court order that does not contradict California's laws.

2) **BACKGROUND.** HIPAA is a federal law that sets national standards for protecting sensitive health information from disclosure without patient's consent. CMIA is a state law that adds to federal law, further protecting the confidentiality of individually identifiable

medical information obtained by health plans, health care providers, and their contractors. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health and reproductive health information.

a) **Federal law and guidance**. According to the U.S. Department of Health and Human Services Agency (HHSA), the HIPAA protects the privacy and security of medical and other health information when it is transmitted or maintained by covered entities (health plans, most health care providers, health care clearinghouses) and business associates (people and companies that provide certain services for covered entities). This information is referred to as protected health information (PHI), and it includes individually identifying information, such as name, address, age, social security number, and location, as well as information about health history, any diagnoses or conditions, current health status, and more. The HIPAA Rules apply only when PHI is created, received, maintained, or transmitted by covered entities and business associates.

b) **State law.** In California, protection for PHI comes from a combination of both federal and state law. HIPAA sets the baseline, but in enacting HIPAA Congress expressly provided that stronger state health privacy laws could also be enforced. Under this authority CMIA provides enhanced protections for Californian's PHI. According to the California Health Care Foundation, the legal doctrine of preemption – the overriding of state law by federal law on the same subject – is relatively simple in the area of health information privacy. Under HIPAA it is explicit that state regulations that are more protective of patient rights than HIPAA's are enforceable. For California, that means to the extent that HIPAA and CMIA provide different, but not conflicting protections, both apply. It also means that when the provisions of either law are more protective than the other's on the same matter, the more stringent rule will set the legal standard.

3) **SUPPORT.** Oakland Privacy supports this bill, stating that California has been engaged in an ongoing process to protect Californians and visitors to the state who are engaging in activities legal under California law that have been criminalized in other states and sometimes by federal authorities. Oakland Privacy continues that among those activities are some medical procedures including the medical termination of pregnancy, or abortion, and gender-affirming medical care. Oakland Privacy notes that it is possible that other medical procedures will also become subject to divergences between California law and the laws of other states. Oakland Privacy continues that when that happens, it is important that state law clearly indicate what is to happen when other jurisdictions try to enforce their laws outside their boundaries. Oakland Privacy states that this bill also relates to the complex question of consumer consent. Oakland Privacy contends that the long privacy policies to which we are all subjected are supposed to explain what people need to know for meaningful consent, but the length, frequency and legal jargon of such documents has caused them to largely fail at that purpose. Oakland Privacy states that people just don't read them. Oakland Privacy continues that with all of the factors in play, sometimes the simple yes/no I consent/I don't consent checkbox is simply not sufficient to empower people to protect themselves. Oakland Privacy concludes that at a minimum, we should ensure that consent processes are maximally robust and that it is made clear to people when they are getting medical care that they do not have to grant consent and that their medical care will not be delayed or impaired if they withhold consent.

4) **OPPOSED UNLESS AMENDED.** The California Hospital Association (CHA) is opposed to this bill unless it is amended. According to CHA, this bill would eliminate a patient's right to require that their health information be sent directly to a third party of their choosing, in violation of federal law. CHA states that the federal Health Information Technology for Economic and Clinical Health Act requires a hospital, doctor, or other HIPAA covered entity to comply with a patient's direction to transmit their health information to another person. CHA continues that HIPAA preempts state law to the extent that HIPAA gives the patient more control over their own health information than state law does. But CHA argues that the proposed changes in this bill to Civil Code Sections 56.10 (d) and (e), if enacted, would be preempted by federal law, rendering them invalid. CHA continues that even if HIPAA did not preempt the proposed revisions to Civil Code, individuals must be allowed to require hospitals and doctors to transmit their health information (or the health information of their deceased family member) directly to entities that are not listed in Civil Code. CHA gives the example that patients often ask that their medical record be transmitted to the Social Security Administration so they can qualify for Social Security disability benefits. Similarly, a person making a claim for accidental death benefits may need to submit their deceased spouse's medical record to an accidental death insurance company. CHA concludes that these are but two examples illustrating why patients must have control over their medical records.

5) **PREVIOUS LEGISLATION.**

   a) AB 2089 (Bauer-Kahan), Chapter 690, Statutes of 2022, amends the CMIA to include mental health application (app) information. Defines mental health app information as information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in existing law, collected by a mental health digital service; and, mental health digital service as a mobile-based application or internet website that collects mental health app information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer. Deems any business that offers a mental health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider, as specified. Requires any business that offers a mental health digital service to provide to the health care provider information regarding how to find data breaches reported, as specified, on the Attorney General's website.

   b) AB 2091 (Bonta), Chapter 628, Statutes of 2022, prohibits compelling a person to identify or provide information that would identify or that is related to an individual who has sought or obtained an abortion in a state, county, city, or other local criminal, administrative, legislative, or other proceeding if the information is being requested based on another state's laws that interfere with a person's right to choose or obtain an abortion or a foreign penal civil action, as defined. Prohibits a provider of health care, a health care service plan, a contractor, or an employer from releasing medical information that would identify an individual or related to an individual seeking or obtaining an abortion in response to a subpoena or a request or to law enforcement if that subpoena, request, or the purpose of law enforcement for the medical information is based on, or for the purpose of enforcement of, either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. AB 2091 also prohibits issuance of a subpoena if the submitted foreign subpoena relates to a foreign penal civil

action and the submitted foreign subpoena would require disclosure of information related to sensitive services, as defined.

c) AB 1184 (Chiu), Chapter 190, Statutes of 2021, revises and recasts provisions to require a health care service plan (health plan) or health insurer, effective July 1, 2022, to accommodate requests for confidential communication of medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual. Prohibits a health plan or health insurer from requiring a protected individual, as defined, to obtain the policyholder, primary subscriber, or other enrollee or insured's authorization to receive health care services or to submit a claim, if the protected individual has the right to consent to care. Requires the health plan or health insurer to direct all communications regarding a protected individual's receipt of sensitive health care services directly to the protected individual, and prohibits the disclosure of that information to the policyholder, primary subscriber, or any plan enrollees or insureds without the authorization of the protected individual, as provided. Expands the definition of sensitive services to identify all health care services related to mental health, reproductive health, sexually transmitted infections, substance use disorder, transgender health, including gender affirming care, and intimate partner violence, and includes services, as specified.

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

6) COMMITTEE AMENDMENTS. HIPAA allows states to strengthen PHI protections under state law; however, it is unclear if this bill, as drafted, strengthens or weakens patient rights. HIPAA expressly grants individuals the right to direct the transmission of their information to other people or entities. This bill broadly revokes an individual’s right to authorize the release of their information to people or entities that aren’t engaged in providing direct health care services to the patient. According to background submitted to the committee, this bill is based on a personal experience the author had with a consent/release form she was presented to sign. The author argues that patients are often asked to consent to release their information without being provided a clear understanding of what they are giving permission for. While the author’s goal is to ensure patients have a full understanding of what they are releasing their PHI for and to limit the release of PHI to third parties who may be inappropriately using it for purposes of artificial intelligence or other technological pursuits, this broad revocation of a patient’s right to transmit their information could have unintended consequences. For example, some stakeholders have indicated this bill could limit a patient’s ability to authorize the release of their PHI to government entities and schools for purposes of determining eligibility for benefits and programs, clinical trials, medical research, and more. This bill also brings into question if individuals should be barred from releasing their PHI for purposes of advancing technology if they so choose. The committee may wish to amend this bill to narrow the scope of limiting PHI sharing and preserve necessary pathways for patients to authorize the release of their own PHI.

REGISTERED SUPPORT / OPPOSITION:

Support

American College of Obstetricians & Gynecologists – District IX
Oakland Privacy
Privacy Rights Clearinghouse

Opposition

One individual

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 348 (Krell) – As Amended April 10, 2025

SUBJECT: Full-service partnerships.

SUMMARY: Establishes specific criteria that would make a person with a serious mental illness (SMI) presumptively eligible for a full-service partnership (FSP). Specifically, **this bill**:

1) States that an individual with an SMI is presumptively eligible for an FSP if they meet one or more of the following criteria:

    a) They are currently experiencing unsheltered homelessness, as described by federal regulations;

    b) They are transitioning to the community after six months or more in a secured treatment or residential setting, including, but not limited to, a mental health rehabilitation center, institution for mental disease, secured skilled nursing facility, or out-of-county placement;

    c) The have experienced two or more emergency department visits related to an SMI or a psychiatric event in the last six months;

    d) They are transitioning to the community after six months or more in the state prison or county jail; or,

    e) They have experienced two or more arrests in the last six months.

2) States that a county would not be required to enroll an individual who meets these criteria if doing so would exceed the county's FSP funding through the Behavioral Health Services Act (BHSA).

3) States that an individual with an SMI is not ineligible for enrollment in FSP solely because their primary diagnosis is a substance use disorder (SUD).

4) Makes Legislative findings and declarations relative to FSPs.

EXISTING LAW:

1) Establishes a 1% tax on incomes over one-million dollars for the provision of behavioral health services. [Revenue and Taxation Code (RTC) § 17043]

2) Establishes the Behavioral Health Services Fund to receive the tax revenue from 1) above. [RTC § 19602.5]

3) Requires the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) to report biennially to the Legislature the outcomes for those receiving community mental health services under an FSP and provide recommendations for improving FSPs. [Welfare and Institutions Code (WIC) § 5845.8]

4) Specifies that the Mental Health Services Act (MHSA) can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by majority vote. [Section 18 of Proposition 63 of 2004]

5) Requires counties to complete a three-year integrated plan for behavioral health services with community stakeholder engagement and a public hearing on the proposed plan held by the local behavioral health board. Requires counties to complete annual updates to the integrated plans and permits intermittent updates, as necessary, but does not require a stakeholder engagement process for annual or intermittent updates. [WIC § 5963.03]

Inoperative July 1, 2026:

6) Establishes the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and create integrated service plans for mentally ill children, adults, and seniors. [WIC § 5892]

7) Requires each county mental health program (CMHP) to prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the Department of Health Care Services (DHCS) based on available unspent MHSA funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements. [WIC § 5847]

Operative July 1, 2026:

8) Requires counties to spend their portion of BHSA dollars as follows: 30% for housing interventions, 35% for FSPs, and 35% for Behavioral Health Services and Supports (BHSS), and defines these service categories. Requires counties to spend half of the housing category on those experiencing chronic homelessness, with an emphasis on those in encampments, and 51% of the BHSS category on early intervention, with 51% of that focused on youth 25 and younger. Allows counties some flexibility to move up to 7% from one expenditure category to another with approval from DHCS. [WIC § 5892]

9) Requires each county to establish an FSP program to provide: mental health, supportive, and substance use disorder treatment services; specific treatment models, such as Assertive Community Treatment (ACT), high fidelity wraparound, and other evidence-based treatment models specified by DHCS; assertive field-based initiation for substance use disorder treatment services; outpatient behavioral health services; ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services; service planning; and housing interventions. [WIC § 5887(a)]

10) Requires FSP services to utilize a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports in a streamlined and coordinated manner to reduce any barriers to services. Requires FSP services to support the individual in the recovery process, reduce health disparities, and be provided for the length of time identified during the service planning process. Requires FSP programs to employ community-defined evidence practices, as specified by DHCS. [WIC § 5887(b)-(c)]

11) Requires counties to prioritize BHSA services for the following populations:

    a) Eligible adults and older adults who: are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the justice system; are reentering the community from a state prison or county jail; are at risk of conservatorship; or are at risk of institutionalization; and,

    b) Eligible children and youth who are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the juvenile justice system; are reentering the community from a youth correctional facility; are in the child welfare system; or are at risk of institutionalization. [WIC § 5892]

FISCAL EFFECT: This bill is keyed non-fiscal.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California is continuing to invest in mental health assistance for those most in need, yet we continue to run into red tape. The author states that this bill ensures Californians with the highest need can access the fast, effective, and consistent care that will change their lives. The author says that FSPs are shown to be extremely beneficial for those suffering from severe mental illness, who have interacted with the criminal justice system and have a history of housing instability. The author argues that streamlining access to FSPs for this population will lead to better health outcomes.

2) **BACKGROUND.**

    a) **BHSA Implementation.** Passed by California voters in the 2024 statewide primary election, Proposition 1 revised and recast the MHSA as the BHSA, with a focus on expanding access to SUD treatment and changing how the money from the act is used. Many of the major policy changes won't be in effect until July 2026 when the new county plans become effective. Since the passage of the BHSA, DHCS and the California Health and Human Services Agency have been collaborating with counties, providers, tribal leaders, and other stakeholders to prepare for implementation. In February 2025, DHCS released the final version of the BHSA County Policy Manual Module 1, which reflects feedback received through public listening sessions, comments, and engagement forums. The manual is being released in multiple phases called "modules." Once completed, it will be a comprehensive guide for all involved parties to implement the requirements detailed in the BHSA. Module 2 was released in April 2025, focusing on FSPs, BHSA fiscal policies, BHSS (including early intervention), and documentation requirements for clinical BHSA services. A draft of Module 3 regarding guidance for completing the county integrated plan was released for public comment at the same time.

    The BHSA also requires programs established under each of the three county expenditure categories (housing interventions, FSPs, and BHSS) to prioritize services for those who meet priority population criteria. These priority populations are children and youth who: are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the juvenile justice system; are reentering the community from a youth correctional facility; are in the child welfare system; or are at risk of institutionalization. Priority populations also include adults and older adults who:

are chronically homeless, experiencing homelessness, or at risk of experiencing homelessness; are in, or at risk of being in, the justice system; are reentering the community from a state prison or county jail; are at risk of conservatorship; or are at risk of institutionalization.

b) Full-Service Partnerships. Regulations currently require CMHPs to direct the majority of Community Services and Supports funds (76% of county MHSA funds) to FSP services, which generally are thought of as "whatever it takes" services that may include:

i) Mental health treatment, including alternative and culturally specific treatments, peer support, supportive services to assist the client and the client's family, wellness centers, needs assessments, and crisis intervention and stabilization services;

ii) Non-mental health services and supports like food, clothing, housing, and cost of health care treatment; and,

iii) Wrap-around services to children through the development of expanded family-based services programs.

Under the BHSA, 35% of county BHSA funds must be dedicated to FSPs. The BHSA codified standardized, evidence-based practices for models of treatment for FSPs including ACT and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by DHCS.

c) BHSOAC FSP Innovation Project. In 2019, the BHSOAC (then the MHSOAC) partnered with several local behavioral health departments and a non-profit consultant, Third Sector, to explore strategies to emphasize outcomes through the design and delivery of FSP services. One of the identified goals of that project was to increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.

RAND then evaluated the multi-county innovation project and reported that the participating counties acknowledged that the absence of standardized definitions for their populations created difficulties in understanding who is eligible for FSP programs. As part of the project, counties successfully developed standardized definitions for key populations: individuals experiencing homelessness, those with justice system involvement, and those at risk of experiencing homelessness and justice system involvement. Healthy Brains Global Initiative also completed a report in partnership with the MHSOAC on FSPs, and reported that some family members had their adult children repeatedly arrested before gaining access to an FSP.

d) BHSOAC FSP Report. SB 465 (Eggman), Chapter 544, Statutes of 2021, requires the BHSOAC to report to the Legislature biennially on FSP enrollees, outcomes, and recommendations for strengthening FSPs to reduce incarceration, hospitalization, and homelessness. The first report was released in January 2023, and identified three primary concerns: data quality challenges for assessing effectiveness of FSPs, counties not appearing to meet minimum spending requirements, and insufficient technical assistance and support to ensure effectiveness. The BHSOAC shared the draft 2025 report at its

February 2025 meeting and it recommends, among many other things, "Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one."

e) **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).** The state is currently implementing several interconnected behavioral health reforms. According to DHCS, the BH-CONNECT initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a new five-year Medicaid section 1115 demonstration, state plan amendments to expand coverage of Evidence-Based Practices (EBPs) available under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide. Beginning January 1, 2025, counties may opt to offer services like ACT, FACT, coordinated specialty care for first episode psychosis, individual placement and support supported employment, Community Health Worker services, and clubhouse services. ACT and FACT are also required as part of FSPs under the BHSA.

   On April 11, 2025, DHCS released BH-CONNECT guidance via Behavioral Health Information Notice (BHIN) 25-009. The BHIN states "Prior authorization is required prior to billing the bundled rate for ACT or FACT. Behavioral Health Plans are responsible for implementing or delegating prior authorization requirements and communicating those requirements to county-operated and county-contracted provider organizations. While awaiting prior authorization for ACT or FACT, the provider organization must ensure that the member continues to have access to medically necessary components of ACT or FACT that do not require prior authorization."

3) **SUPPORT.** The Steinberg Institute (SI) is co-sponsoring this bill and states it is a necessary step to get life-saving and stabilizing behavioral health care to the Californians who need it most. SI argues that though funding has existed for FSPs for more than two decades, the individuals most at risk of continued system involvement are not being prioritized for enrollment due to a lack of clarity in eligibility criteria. SI concludes that this bill is a fiscally responsible, evidence-based solution that maximizes California's behavioral health investments, and ensures BHSA funding reaches the people who need it most, reducing homelessness, unnecessary hospitalizations, incarceration, and system cycling.

   The California Behavioral Health Association (CBHA) is also co-sponsoring this bill and states inconsistency in eligibility processes between counties and complex administrative hurdles create artificial barriers to access. CBHA notes that FSPs are one of the most effective interventions for stabilizing individuals with SMI and complex social needs, and research shows this model significantly reduces incarceration, lowers hospitalization rates, and helps people stay housed and engaged in care. CBHA concludes that this bill ensures all available resources are allocated effectively to reach the highest risk individuals.

   Californians for Safety and Justice (CSJ) supports this bill stating that the standardized criteria in this bill create a consistent, statewide approach to prioritizing access to intensive behavioral health services for those who need them most. CSJ says that these criteria do not require counties to enroll individuals beyond their existing FSP funding levels and, instead, ensure that resources are targeted to reach those most in need.

The California District Attorneys Association (CDAA) supports this bill and states far too often, individuals with serious mental illness experience significant delays or denials in accessing essential services due to administrative hurdles. CDAA argues this bill seeks to solve this issue by streamlining the process between incarceration and out-of-custody treatment/services by creating presumptive eligibility for an individual with serious mental illness transiting to the community after six months or more in prison or county jail. Ensuring individuals receive the intensive, wraparound support they need will reduce the risk of hospitalization, increase housing stability, and minimize involvement in the criminal justice system.

The National Alliance on Mental Illness California (NAMI-CA) also supports this bill and states FSPs are among California's most effective tools for stabilizing individuals with complex mental health needs. These programs provide wraparound services—housing, crisis interventions, employment support—that are proven to reduce hospitalization, incarceration, and chronic homelessness. NAMI-CA argues despite their success, access to FSPs remains inconsistent due to fragmented eligibility criteria and burdensome administrative processes. As a result, too many individuals are left in crisis without care. NAMI-CA says this bill directly addresses this gap by creating presumptive eligibility for individuals with serious mental illness.

4) **OPPOSE UNLESS AMENDED.** The County Behavioral Health Director's Association (CBHDA) opposes this bill unless amended stating concerns it broadens the scope of who will be eligible to be placed in a FSP when counties are currently using a portion of BHSA funding to stand up FSPs. Additionally, there is preexisting criteria for priority populations to be eligible for FSPs from DHCS and the populations identified in this bill, such as those with SMI experiencing homelessness, are already considered a priority population for FSPs, making the need for presumptive eligibility redundant to what is already in statute. CBHDA is requesting amendments to align presumptive eligibility with the current BHSA requirements.

5) **PREVIOUS LEGISLATION.**

   a) SB 326 (Eggman), Chapter 790, Statutes of 2023, recasts the MHSA as the BHSA and modifies state and local spending requirements, including the establishment of the FSP program in statute, and creates additional oversight and reporting requirements for counties.

   b) SB 465 (Eggman), Chapter 544, Statutes of 2021, requires the BHSOAC to report biennially to the Legislature the outcomes for those receiving community mental health services under an FSP and to make recommendations to strengthen FSPs to reduce incarceration, hospitalization, and homelessness.

6) **POLICY COMMENTS.**

   a) **Is updating the BHSA premature?** The updated expenditure requirements and standardization of FSPs under the BHSA become operative July 1, 2026 pursuant to Proposition 1, however counties are already beginning their planning process and working with DHCS as it releases its new policy manual in multiple modules. Module 2 was released this spring focusing on FSPs, BHSA fiscal policies, BHSS (including early intervention), and documentation requirements for clinical BHSA services. Adding a new

requirement to the law, which would take effect on January 1, 2026, may provide little time for counties to integrate the changes into their plans. There is also ongoing implementation of a separate but related state program, BH-CONNECT, which could affect the ultimate impacts of this bill. While there may be benefits to providing certain populations with presumptive eligibility, it may be premature given that these programs have not yet started in the new structure under the BHSA.

b) Will presumptive eligibility result in better outcomes? The bill states that a county would not be required to enroll an individual who meets these presumptive eligibility criteria if doing so would exceed the county's FSP funding through the BHSA. However, the bill could still result in a loss of county discretion when enrolling clients in an FSP. Many of the populations of focus under the BHSA are those that are already more challenging to reach, so functionally prioritizing one participant based on objective presumptive eligibility criteria when another participant may be experiencing similar conditions and challenges and be more willing to engage in treatment could present difficult treatment decisions. Also, adding specific numbers of arrests or emergency department visits as criteria could incentivize family members to seek out these interventions for their loved ones dealing with behavioral health issues, which are the exact interventions that FSPs seek to reduce.

7) AMENDMENTS.

a) Following conversations with the committee about the concern of incentivizing the arrest of individuals to get them in to treatment, the author is proposing striking the presumptive eligibility criteria requiring a minimum number of arrests or emergency department visits, and adding presumptive eligibility for a person with five or more detainments under WIC § 5150 in the last five years.

b) The author also proposes clarifying that enrollment of a presumptively eligible individual under this bill be contingent upon the recommendation of a licensed behavioral health clinician, based on their professional assessment of the individual's mental health needs and appropriateness for enrollment, and documenting this recommendation in the individual's clinical record.

c) The committee may wish to align the presumptive eligibility definition with existing BHSA standards of care, and clarify that counties are not required to enroll an individual if it would conflict with their contractual obligations under Medi-Cal or court orders.

REGISTERED SUPPORT / OPPOSITION:

Support

California Behavioral Health Association (Co-Sponsor)
Steinberg Institute (Co-Sponsor)
California Association of Alcohol and Drug Program Executives, INC.
California Big City Mayors Coalition
California District Attorneys Association
California Hospital Association
California Pan - Ethnic Health Network
California Peer Watch

Californians for Safety and Justice
Corporation for Supportive Housing
Courage California
Drug Policy Alliance
Ella Baker Center for Human Rights
Housing California
Mental Health America of California
National Alliance on Mental Illness (NAMI-CA)
National Alliance to End Homelessness
Occupational Therapy Association of California
Sacramento County Probation Association
Smart Justice California, a Project of Tides Advocacy
Vera Institute of Justice
Four individuals

Opposition

None on file

Analysis Prepared by: Logan Hess / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 350 (Bonta) – As Introduced January 29, 2025

SUBJECT: Health care coverage: fluoride treatments.

SUMMARY: Expands coverage for fluoride varnish for children in a primary care setting in commercial health plans and insurance policies, clarifies Medi-Cal coverage for the same, and modifies Medi-Cal coverage policy to allow reimbursement when the varnish is physically applied by nonclinical personnel otherwise authorized by law to apply it. Specifically, **this bill**:

1) Requires health plans and insurers to cover the application of fluoride varnish in the primary care setting for children under 21 years of age.

2) Clarifies that Medi-Cal covers the application of fluoride varnish in the primary care setting for children under 21 years of age.

3) Requires the Department of Health Care Services (DHCS) to establish and promulgate a billing policy that allows a Medi-Cal enrolled provider who is authorized to apply and bill for the application of fluoride varnish to be reimbursed for that service, if the fluoride varnish is physically applied by a person who is both of the following:

    a) Employed by the Medi-Cal enrolled provider or working in a contractual relationship with the Medi-Cal provider; and,

    b) Otherwise authorized under existing law to apply fluoride varnish.

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

EXISTING STATE LAW:

Medi-Cal

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

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

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

4) Specifies EPSDT services also include all age-specific assessments and services listed under the most current periodicity schedule by the American Academy of Pediatrics (AAP) and Bright Futures, and any other medically necessary assessments and services that exceed those listed by AAP and Bright Futures. [WIC § 14149.95]

5) Requires coverage of the application of fluoride, or other appropriate fluoride treatment as defined by DHCS, and other prophylaxis treatment for children 17 years of age. [WIC § 14132 (q)]

6) Required DHCS to establish a list of performance measures to ensure the Medi-Cal dental fee-for-service program meets quality and access criteria required by the department; specifies performance measures shall be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment; and requires the measures established by the department to monitor the dental fee-for-service program for children shall include, but not be limited to, a number of preventive measures that include number of applications of dental sealants and fluoride varnishes. [WIC § 14132.915]

Commercial Coverage

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

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

9) Codifies federal ACA provisions, in state law, to require a group or individual non-grandfathered health insurance policy to, at a minimum, provide coverage for and not impose any cost-sharing requirements for evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF), as periodically updated. [HSC § 1367.002 and INS § 10112.2]

Public Health and School-Based Oral Health Programs

10) Authorizes, within a public health setting or a public health program that is created or administered by a federal, state, or local governmental entity, any person to apply topical fluoride, including fluoride varnish to the teeth of individuals who are being served in that setting or program, according to the prescription and protocol issued and established by a physician or dentist. [Health and Safety Code (HSC) § 104762]

11) Requires pupils of public and private elementary and secondary schools, except pupils of community colleges, to be provided the opportunity to receive within the school year the topical application of fluoride, including fluoride varnish, or other decay-inhibiting agent to the teeth in the manner approved by the department. Specifies that the program of topical application must be under the general direction of a dentist licensed in the state, and that

topical application of fluoride may include, according to the prescription and protocol established by the dentist, self-application or application by another person. [HSC § 104830]

12) Requires the county health officer of each county to organize and operate a program so that treatment is made available to all persons specified in 11) above, and to determine how the cost of such a program is to be recovered. Providers that to the extent that the cost to the county is in excess of that sum recovered from persons treated, the cost shall be paid by the county in the same manner as other expenses of the county are paid. [HSC § 104840]

13) States that, in enacting the requirements of 11) and 12) above, it is the intent of the Legislature to provide a means for the eventual achievement of the topical application of fluoride or other decay-inhibiting agent to the teeth of all school pupils in California, and acknowledges that this treatment is not a substitute for regular professional dental care. [HSC § 104865]

14) Makes legislative findings about the burden of dental disease in children and the importance of oral health and prevention, and establishes a framework for a voluntary, locally administered community dental disease prevention program. [HSC § 104770]

15) Establishes, within the California Department of Public Health (DPH), the Office of Oral Health. [HSC § 131051]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, fluoride varnish is a safe, inexpensive, and effective dental intervention that can help prevent tooth decay. However, current Medi-Cal policy, as printed in the Medi-Cal provider manual, is unnecessarily restrictive. First, Medi-Cal policy requires a qualified health professional to "hold the brush" when applying fluoride varnish, making it more difficult and costly to incorporate into primary care and public health settings. So while schools and public health settings may offer additional opportunities for the application of fluoride varnish, and even though many types of non-clinical staff can be authorized to apply the varnish, Medi-Cal will only cover this service if a qualified health professional applies the varnish. Medi-Cal policy guidance is also unclear that medically necessary fluoride varnish in the primary care setting is currently covered by Medi-Cal for all children under 21 under federal EPSDT requirements. In addition, the author indicates commercial insurance only covers fluoride varnish in the primary care setting for children under the age of five, which leaves out other children who could benefit from this preventive intervention.

   A 2018 survey by the California Department of Public Health (DPH) found that 61% of California children in third grade experienced dental caries, which is significantly higher than the national median. Furthermore, according to a 2020-21 National Survey of Children's Health, 14.8% of California's children had decayed teeth or cavities in the prior 12 months. Only two states, Wyoming and Louisiana, ranked worse than California on this metric, while the best-performing states had under 9%. This data demonstrates the need to remove barriers so our children can more effectively access this proven treatment to help prevent tooth decay.

The author states this bill will enhance coverage of fluoride varnish in the primary care setting, which will encourage more pediatric providers to incorporate into their workflow. This bill will also make it easier for dental, medical, and school-based care providers to offer fluoride varnish by ensuring Medi-Cal will pay for the service when a nonclinical provider applies it, according to the prescription and protocol issued and established by a physician or dentist, as allowed under existing law. In an era where settled science on the effectiveness and safety of fluoride is being questioned, the author argues, California should expand this cost-effective intervention to prevent cavities and promote good oral health for our children.

2) **BACKGROUND.** As discussed below, the California Health Benefits Review Program (CHBRP) reviewed this bill and reported on its key impacts, including utilization, cost, and public health impact of the Medi-Cal and commercial insurance mandate. A portion of the background information presented below is also based on the findings of the CHBRP report.

   a) **Children's Oral Health in California.** Untreated dental cavities or carious lesions resulting from dental caries can lead to pain, sensitivity, abscesses, and subsequent tooth loss. Among young children, it can further lead to delayed eruption or malformation of permanent teeth. Dental caries is the most common chronic condition in the pediatric population in the United States. As noted above, the 2018 survey (Smile Survey) by DPH found that 61% of California children in third grade experienced dental caries, higher than the national median of 53%. Among children with Medi-Cal, 7% reported missing two or more school days in the last year due to dental caries; 5% of children with employment-based insurance reported missing two or more school days in the last year due to dental caries.

      There is a documented connection between income and rate of dental caries with children from lower-income families experiencing higher rates of dental caries than their counterparts from higher-income families. In California, the Smile Survey estimated that children in lower-income households had almost two times greater prevalence of tooth decay than their counterparts from higher-income households (72% vs. 41%, respectively). The Smile Survey also estimated disparities in rates of dental caries by socioeconomic level and race. Third-grade Latino children had experienced the highest rate of dental caries (72%), followed by Black (59%), and Asian (50%) and other races (50%). White California children in third grade had the lowest rate of dental caries among all races/ethnicities (40%). Geographic variation in dental caries was estimated through the Smile Survey with the highest prevalence occurring in the San Joaquin Valley, Los Angeles County, and Central Coast (76%, 65%, and 64%, respectively) and the lowest prevalence in the Sacramento and Bay Area regions (46% and 45%, respectively).

   b) **Fluoride Varnish.** Fluoride is a mineral that helps to prevent cavities and to heal early cavities. Tooth enamel, the outermost covering of the tooth that protects the teeth from wear and tear and cavities, naturally cycles through a demineralization and remineralization process. The demineralization process occurs when bacteria in the mouth produce lactic acid from fermenting carbohydrates and dissolves the tooth's mineral content, resulting in a carious lesion (soft spot) or a cavity. Remineralization of the tooth occurs through saliva production as well as foods and water that contain minerals like fluoride, phosphate, and calcium.

Fluoride varnish is made of an adhesive that contains 5% sodium fluoride or 2.25% fluoride ion and is used to maintain high fluoride contact with the tooth for approximately 12 hours (usually overnight) before being brushed off. The application, which requires minimal training, averages less than 2 minutes to "paint" the tops and sides of teeth using a small brush. Varnish dries more quickly than other topical fluoride gels and foams, which reduces potential for swallowing the fluoride and prevents adverse events like nausea and vomiting from swallowing. Fluoride varnish has not been associated with harms that can be caused by excessive fluoride exposure, such as dental fluorosis.

c) Recommendations for Fluoride Varnish. The California Oral Health Plan 2018–2028 (Plan) issued by the DPH Office of Oral Health highlights the application of fluoride varnish in primary care and community-based settings as a key preventive strategy. Specifically, the Plan seeks to increase the number of Medi-Cal beneficiaries under six years of age receiving, in any 12-month period, a dental disease prevention protocol by primary care medical providers that includes the application of fluoride varnish. The Plan also seeks to improve the performance of school-based and school-linked fluoride programs.

A number of professional organizations have issued recommendations related to fluoride varnish:

i) The American Dental Association (ADA) recommends the application of fluoride varnish every three to six months for patients at elevated risk of dental caries. ADA states that patients at *low risk* of dental caries "may not need additional topical fluoride other than over-the-counter fluoridated toothpaste and fluoridated water."

ii) Similar to the ADA, the American Academy of Pediatric Dentistry encourages professionally applied fluoride treatments for all individuals at risk for dental caries.

iii) The American Academy of Pediatrics (AAP) recommends that primary care clinicians apply fluoride varnish every 3 months (for high caries risk) and 6 months (for low caries risk) for all children from the age of primary tooth eruption through age 5 years. Well-child visits are the most common type of visit in a medical setting where fluoride varnish is applied. AAP recommends seven pediatric visits in the first year of life, three pediatric visits in the second year of life, and annual visits between three and 21 years of age.

iv) USPSTF provided a recommendation in 2021, with an evidence grade of "B," that primary care clinicians apply fluoride varnish to pediatric patients beginning at primary tooth eruption and up to age 5 years. For children aged 5 to 17 years, the USPSTF found *insufficient evidence* to assess the effectiveness of *routine application* (i.e., application for every child in this age range) of fluoride varnish by primary care clinicians. Insufficient evidence is not evidence of a lack of effectiveness; it generally means the issue has not been studied enough to provide a basis for USPSTF to issue a recommendation that all members of a specified population should receive a specific preventive intervention. USPSTF recommendations do not address whether interventions are medically necessary or effective for *individual* patients.

In a manner similar to this bill, since 2008, MassHealth, Massachussetts' Medicaid program, has covered the application of fluoride varnish in a medical setting by

physicians and other qualified health professionals to at-risk members ages 21 and younger, in an effort to deliver preventive oral health services to high-risk children.

d) School-Based and Community Programs. In addition to fluoride varnish applied in a clinical setting, fluoride varnish may also be applied to children through school- or community-based dental programs. These programs are typically organized by county health departments and are funded through the county health departments, grants, or donations. For example, Alameda County's Office of Dental Health provides preventive dental services including fluoride varnish to all third grade students enrolled in select elementary schools. These services are typically not billed to Medi-Cal. However, because they are voluntary, have no designated funding, and rely on county or school district personnel prioritizing these programs, these population-based programs are not universally accessible.

To facilitate the delivery of school- and community-based programs, AB 667 (Block), Chapter 119, Statutes of 2009, permits any person working in a public health setting or a public health program that is created or administered by a federal, state, or local governmental entity to apply fluoride varnish or other topical fluoride to a person being served in that setting or program, in accordance with a prescription and protocol established by a dentist or physician. As a result of AB 667, nonclinical individuals such as teachers, parents, promotoras, and community health workers are permitted to apply varnish under the law. However, Medi-Cal will not reimburse an enrolled medical or dental provider if the application of varnish is done at their direction but physically applied by such nonclinical personnel, despite the 2009 state law authorizing nonclinical personnel to apply varnish. According to dental providers who have attempted to piece together funding to support school- and community-based fluoride programs, this limitation in Medi-Cal reimbursement poses a major barrier to financial sustainability.

e) Medi-Cal. Medi-Cal covers fluoride varnish in the dental and medical setting, as described below:

i) Dental Setting. Fluoride varnish is covered as a preventive Medi-Cal dental benefit (reimbursable to a dental professional), for both children and adults. Under a Pay-for-Performance Initiative for Preventive Care in the Medi-Cal Dental program, Medi-Cal also pays a supplemental bonus for topical application of fluoride varnish for all children under 21, with a higher bonus for application for children ages 0-5.

ii) Medical Setting. Medi-Cal provides preventive services benefits in accordance with USPSTF A and B recommendations and the Bright Futures/AAP Periodicity Schedule. On that basis, consistent with those recommendations described in c) above, Medi-Cal covers the application of fluoride varnish when provided in a medical setting for Medi-Cal beneficiaries ages zero to five.

However, Medi-Cal is also subject to federal requirements under EPSDT. Under EPSDT, if a child has a medical necessity for fluoride varnish in a medical setting, Medi-Cal would be obligated to cover the service regardless of the age of the child. The Medi-Cal provider manual, however, does not provide guidance on billing for ages six to 20 in a medical setting.

According to the Medi-Cal provider manual describing dental benefits for children that are billable in a medical setting, CPT® code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) is reimbursable only for children through five years of age, up to three times a year. The manual further specifies that "When the procedure is delegated to them and follows a protocol established by the attending physician, *nurses, physicians and other medical personnel* are legally permitted to apply fluoride varnish." This definition does not allow other, nonclinical personnel to apply fluoride varnish, which is also addressed by this bill.

DHCS has implemented quality improvement programs to increase uptake of fluoride varnish and other preventive dental services. Specifically, DHCS adopted a performance benchmark that establishes minimum performance target levels for fluoride varnish for Medi-Cal beneficiaries.

f) Commercial Coverage. Similar to Medi-Cal coverage requirements, California law requires commercial plans and insurers to cover the following preventive services without cost sharing or prior authorization:

i) The USPSTF A and B recommendations; and,

ii) The Health Resources and Services Administration (HRSA)–supported comprehensive guidelines for infants, children, and adolescents, which include the Bright Futures Recommendations for Pediatric Preventive Health Care.

Coverage of fluoride varnish applied in medical settings for children age five years and younger is thus required because of the AAP and USPSTF's applicable recommendations, as noted in c) above.

g) CHBRP Analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernández), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits (EHBs), and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP's analysis of the insurance mandate portion of this bill includes the following:

i) Enrollees covered. CHBRP assumes that 100% of enrollees have coverage for fluoride varnish when applied in a primary care setting for enrollees aged zero to five years in accordance with state and federal law. For fluoride varnish applied to enrollees aged 6 to 20 years in medical settings, CHBRP estimates approximately 1.5% of enrollees in commercial/CalPERS plans and policies and 17% of Medi-Cal beneficiaries have coverage at baseline. Postmandate, all enrollees would have coverage for fluoride varnish provided in a medical setting for children aged 20 years and younger.

ii) Utilization.

(1) Medi-Cal. Among Medi-Cal beneficiaries, approximately 1,063,000 are aged zero to five years and 3,738,000 are aged 6 to 20 years. At baseline, there are approximately 115,500 billed applications of fluoride varnish among enrollees aged zero to five years and 9,000 billed applications of fluoride varnish among enrollees aged 6 to 20 in medical settings. Postmandate, CHBRP assumes utilization of fluoride varnish among enrollees aged zero to five years would not increase because this service is fully covered at baseline; for enrollees aged 6 to 20 years, CHBRP estimates utilization would increase by 112,800 applications for a total of 121,800 applications being billed in the first year.

(2) Commercial. In commercial/CalPERS plans and policies, there are approximately 771,000 enrollees aged zero to five years and 2,577,000 enrollees aged 6 to 20 years. At baseline, there were approximately 16,600 billed applications of fluoride varnish among enrollees aged zero to five years and 700 billed applications of fluoride varnish among enrollees aged 6 to 20. Postmandate, CHBRP assumes utilization of fluoride varnish among enrollees aged zero to five years would not increase because this service is fully covered at baseline. For enrollees aged 6 to 20 years, CHBRP estimates there would be approximately 27,800 billed applications of fluoride varnish in the medical setting in the first year.

(3) Barriers to Increasing Utilization. CHBRP notes the change in utilization is limited by barriers beyond insurance coverage, such as clinician knowledge about obtaining and applying fluoride varnish, difficulties integrating oral health screening and fluoride varnish application into the workflow, clinician hesitancy due to perceived harms of the varnish, concerns about inadequate or rejected reimbursement, and inadequate office visit time and parent hesitancy. CHBRP notes that one quality improvement study in Contra Costa County found that even with concentrated support for implementing fluoride varnish program in the clinic, significant training of primary care practitioners and clinic workflow revisions were required for successful implementation. Ultimately, in this study, these challenges were addressed through training and workflow innovations, resulting in 95% of children receiving fluoride varnish sustained over the 2-year follow-up period.

iii) Impact on expenditures. CHBRP finds the average unit cost of fluoride varnish application is $33.77 in commercial/CalPERS plans and policies and $18.55 in Medi-Cal. CHBRP estimates this bill would increase total net annual expenditures in California by $3,242,000 or 0.002% overall. Estimates of potential future-year savings are described in Long-Term Impacts, below.

(1) Commercial. Within Department of Managed Health Care (DMHC)-regulated commercial/CalPERS plans and CDI-regulated commercial policies, premiums would increase between 0.0007% and 0.0009% or between $0.006 PMPM and $0.007 per-member, per-month (PMPM).

(2) Medi-Cal. For Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS, per-member per-month costs paid by the state to managed care plans would increase by less than 0.01% or $0.02 PMPM.

(3) CalPERS. Within DMHC-regulated commercial/CalPERS plans and CDI-regulated commercial policies, premiums would increase between 0.0007% and 0.0009% or between $0.006 PMPM and $0.007 PMPM.

(4) Out of Pocket Costs. CHBRP assumes cost-sharing would not be charged because fluoride varnish would be applied during a well-child visit.

(5) Other considerations. CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of this bill, no measurable impact on enrollment in publicly funded insurance programs, and no reduction in fluoride varnish applied to enrollees in the dental setting as a result of the increased benefit coverage.

iv) EHBs. CHBRP finds this bill would not exceed the definition of EHBs in California because this bill would expand existing benefit coverage (i.e., it covers an existing benefit for an additional age range) and does not create a new coverage requirement.

v) Medical effectiveness. Overall, CHBRP found strong evidence of the medical effectiveness of fluoride varnish. Because this bill is specific to primary care (medical) settings, CHBRP examined evidence of fluoride varnish delivered in various settings. CHBRP finds, for primary and permanent teeth, strong evidence that fluoride varnish is effective in improving oral health outcomes, such as the prevention of tooth decay and caries, compared to no fluoride varnish, among children younger than 18 years.

vi) Public health. CHBRP estimates a limited but positive public health impact. Dental cavities generally take one to two years to develop; therefore, in the first year postmandate, the number of cavities averted would be low. CHBRP notes that, despite very limited impact in the short term, at the person-level, some children may see a reduction in cavities or tooth loss that would have otherwise occurred, as well as potential reductions in cascading consequences such as pain, lost school days, lost workdays for caregivers, and additional dental work.

vii) Long-term impacts. The long-term public health impact associated with this bill (reduction in dental caries, associated health and quality of life impacts, and related disparities) may be greater than the first year postmandate due to the expected time course for fluoride to prevent dental caries as well as potential reductions in clinician barriers (as discussed in ii) (3) above). CHBRP notes obtaining successful reimbursement for fluoride varnish claim submissions could motivate the adoption of a standardized workflow that incorporates oral health assessments at well-child visits (which is an AAP recommendation) among more medical offices and clinics. This could lead to a modest increase in utilization rates if barriers to application are reduced. For example, primary care clinician behavior may change over time due to greater awareness of opportunity for reimbursement for fluoride varnish application.

viii) **Cavities Averted and Cost Savings**. CHBRP finds this bill could potentially result in a reduction of 5,800 cavities among the 27,100 new users aged six to 20 years with commercial/CalPERS coverage and a reduction of 24,200 cavities among the 112,800 new users aged 6 to 20 years with Medi-Cal. This would potentially result in a reduction in expenditures for commercial dental insurers and enrollees of $660,000 and a reduction in expenditures for the Medi-Cal dental program of $1,508,000 over a 4-year period.

ix) **Community Fluoridation**. CHBRP notes that the long-term impact of AB 350 also could be affected by the availability of community water fluoridation, which is an established public health strategy for improving population oral health. Community water fluoridation programs provide topical and systemic-based fluoride through the contact with teeth when drinking fluoridated water as well as absorption through the digestive process. CHBRP notes across California's 3,056 water districts, 415 districts implemented a fluoridation program which serves about 22.8 million Californians. The remaining districts serve about 17 million Californians. Should some water districts rescind their community water fluoridation program in the future, CHBRP would expect that the public health impact of this bill might increase as individual prevention efforts (fluoride varnish, using fluoride toothpaste) become the primary prevention tool against dental caries rather than these individual efforts coupled with fluoridated water.

3) **SUPPORT.** A large number of dental providers; consumer, health, and children's advocates, community-based organizations and foundations, and the Dental Hygiene Board of California write in support of this bill. Supporters state that allowing more children to benefit from topical fluoride varnish application could lead to overall improved oral health outcomes for a higher number of children and youth and keep them in school ready to learn.

   Children Now and the California Dental Association, co-sponsors of this bill, write in support that cavities are the most common chronic, yet largely preventable condition, experienced by children. Co-sponsors note untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing and learning, and that unfortunately, in California, fewer than half of children in the Medi-Cal program have annual dental visits where topical fluoride varnish could be applied. Co-sponsors write that primary care and public health settings such as schools offer additional access points for the application of fluoride varnish for children enrolled in Medi-Cal. AAP California states the expansion of fluoride varnish as a covered benefit under Medi-Cal for children under 21 years of age will enhance access to preventive dental treatments for low-income families who might otherwise struggle to afford care.

4) **OPPOSITION.** California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) write in opposition to this bill, noting current guidelines mandate coverage for children aged zero to five years and this bill would expand coverage in commercial and Medi-Cal. Additionally, CAHP and ACLHIC note the fiscal ramifications of $3.2 million statewide are significant at a time when California is grappling with rising health care costs. CAHP and ACLHIC also argue the age range referenced in the bill does not fully align with the pediatric dental standards that were established under the ACA, which covers pediatric dental service as an EHB until a child reaches 19.

5) PREVIOUS LEGISLATION.

a) AB 2340 (Bonta), Chapter 564, Statutes of 2024, clarifies EPSDT services also include all age-specific assessments and services listed under the most current periodicity schedule by the AAP and Bright Futures, and any other medically necessary assessments and services that exceed those listed by AAP and Bright Futures.

b) ACR 10 (Weber), Res. Chapter 16, Statutes of 2023, recognized February 2023 as Children's Dental Health Month and specified basic preventive treatments like fluoride varnish, dental sealants, and community water fluoridation can all help prevent cavities in primary teeth.

c) AB 667 authorizes a dental assistant to apply topical fluoride when operating in a school-based setting or a public health program created or administered by a federal, state, county, or local governmental entity under the general direction of a licensed dentist of physician. Allows any person, within a public health setting or a public health program that is created or administered by a federal, state, or local government entity, to apply topical fluoride, including fluoride varnish, to the teeth of individual as who are being served in that setting of program, according to the prescription and protocol issued and established by a physician or dentist.

d) SB 653 (Chang), Chapter 130, Statutes of 2020, expanded the scope of practice for registered dental hygienists (RDHs) and RDHs in alternative practice, including allowing an RDH to provide, without supervision, fluoride varnish to a patient.

6) AMENDMENTS. As noted above, CHBRP assumes cost-sharing would not be charged because fluoride varnish would be applied during a well-child visit. To conform to CHBRP's analytical assumptions, to be consistent with the current-law prohibition on cost-sharing for fluoride varnish in the primary care medical setting for children ages zero to five, and to prevent families from facing unexpected costs associated with a cost-sharing for a preventive benefit delivered at a well-child visit, the author proposes to amend this bill to prohibit the application of cost-sharing for the expanded coverage of fluoride varnish.

Staff also suggests amendments to clarify that, consistent with the intent of the bill and the CHBRP analysis, primary care setting means a setting where services would be billed as a medical benefit, such as a pediatrician's or family physician's office or in a community- or school-based setting overseen a physician or clinic instead of by a dentist. Fluoride varnish are billed by dental professionals under a separate pediatric dental benefit.

REGISTERED SUPPORT / OPPOSITION:

Support

California Dental Association (sponsor)
Children Now (sponsor)
American Academy of Pediatrics, California
Asian Resources, Inc.
Association of Regional Center Agencies
California Association of Orthodontists
California Dental Hygienists' Association

California Pan - Ethnic Health Network
California School-based Health Alliance
California Society of Pediatric Dentistry
California State PTA
Care 2 U Oral Care Administrative Services
Center for Oral Health
Children's Choice Dental Care
County of Sacramento
Dental Hygiene Board of California
Dientes Community Dental Care
Everychild Foundation
First 5 Monterey County
First 5 Nevada County
First 5 San Bernardino
LA Best Babies Network
Latino Coalition for a Healthy California
Nicos Chinese Health Coalition
State Council on Developmental Disabilities
The Los Angeles Trust for Children's Health
Western Center on Law & Poverty
Two individuals

Opposition

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

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 371 (Haney) – As Amended March 13, 2025

SUBJECT: Dental coverage.

SUMMARY: Requires a health care service plan (health plan) or health insurer, if they pay a contracting dental provider directly for covered services, to pay a non-contracting dental provider directly for covered services if the non-contracting provider submits a written assignment of benefits (AOB) form signed by the enrollee. Requires a health plan or health insurer offering dental services to meet specified timely and geographic access requirements. Specifically, **this bill**:

1) Requires a health plan or health insurer, if they pay a contracting dental provider directly for covered services, to pay a non-contracting dental provider directly for covered services if the non-contracting provider submits a written AOB form signed by the enrollee.

2) Requires a non-contracting dental provider, before accepting an AOB, to disclose the following information to an enrollee:

    a) That the provider is a non-contracting dental provider;

    b) That the enrollee may experience lower out-of-pocket costs if services are rendered by a contracting network dentist; and,

    c) An estimate of what the planned treatment would cost and the enrollee's portion of the cost.

3) Requires a health plan or health insurer to provide notice to an enrollee that the out-of-network cost may count towards their annual or lifetime maximum, as applicable and that payment was sent to the provider.

4) Requires a dental plan or insurer to provide a predetermination or prior authorization to the dental provider. Prohibits the dental plan or insurer from reimbursing the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

5) Shortens existing timely access requirements, requiring a health plan or health insurer offering dental services to offer:

    a) Urgent appointments within 48 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

    b) Non-urgent appointments within 18 business days of the request for appointment; and,

    c) Preventive dental care appointments within 20 business days of the request for appointment.

6) Requires dentists to be available within 15 miles or 30 minutes from an enrollee's residence or workplace.

7) Requires information reported by a dental plan or insurer to the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to include comprehensive information regarding the dental provider networks that each dental provider serves, including the plan's self-insured network. Specifies comprehensive information includes the number of covered lives per line of business, including self-insured, third party, or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, requires the departments to review the adequacy of an entire dental provider network, as reported by the health care service plans, including the portions of the network serving plans and insurers not regulated by the department.

8) Specifies that the provisions of this bill do not apply to Medi-Cal managed care plans.

9) Defines AOB as the transfer of reimbursement or other rights provided for under a plan or insurance contract to a treating provider for services or items rendered to an enrollee.

EXISTING LAW:

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

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

   a) Waiting times for appointments, including primary and specialty care physicians;

   b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,

   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC § 1367.03]

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

4) Requires CDI to promulgate regulations applicable to health insurers to ensure access to health care in a timely manner, and designed to ensure adequacy of the number of locations of institutional facilities and professional providers, adequacy of number of professional providers, and license classifications, consistent with standards of good health care and clinically appropriate care, and that contracts are fair and reasonable. [INS § 10133.5]

5) Requires, in designing the regulations, CDI to consider regulations promulgated by DMHC and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. [INS § 10133.5]

6) Requires, for a plan or insurer offering coverage for dental services, urgent dental appointments to be offered within 72 hours of a request, non-urgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request. [HSC § 1367.03 and INS § 10133.54]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, too many Californians are struggling to find a dentist near their home or work, and even when they do, insurance companies are forcing them to pay out of pocket for care that should be covered. The author states that we can put a stop to these unfair practices by ensuring that everyone gets the dental care they need without any unnecessary obstacles or hidden costs. The author argues that this bill will require dental insurance companies to ensure patients can access in-network care within a reasonable distance from their home or workplace. The author continues that this bill will also ban insurers from making patients pay upfront for covered services and will require them to report network adequacy data.

2) **BACKGROUND.**

   a) **Dental insurance.** According to the California Health Benefits Review Program (CHBRP), the majority of dental benefit plans are "fully insured" and regulated at the state level by DMHC or CDI. The Affordable Care Act helped California expand Medi-Cal eligibility and offer dental benefits to newly eligible adult enrollees (the "expansion population"). Additionally, all Covered California health insurance plans offer embedded pediatric dental coverage at no extra cost. For adults, a dental plan can be added to health plan purchases. Dental insurance commonly divides oral health services into the following categories: preventive and diagnostic, basic restorative services, major restorative services, and orthodontics. Preventive and diagnostic services are typically the most generous in terms of coverage. Basic restorative services include the treatments for common dental problems and are generally straightforward and nonsurgical in nature, such as simple extractions and basic root canals. Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. Coverage for major restorative services can be limited in many dental plan designs and products.

      Dental plans, like health plans, come in various models including Preferred Provider Organization (PPO) plans. In a PPO arrangement, the health insurer contracts with a network of providers who agree to accept lower fees and/or to control utilization. Enrollees in a PPO plan receive a higher level of benefits if they go to a preferred provider than if they go to a non-preferred or non-contracted provider.

   b) **AOB.** A core function of dental insurance is the development of a network of dental providers who agree to treat patients covered by the plan. Dentists who contract with a dental plan will agree to terms about reimbursement rates, cost-sharing, benefits covered, and other details. Contracting dentists are then listed as participating provider by the insurance plan and have access to the patient network covered by the plan. Contracting dentists are also able to bill the dental plan directly for services while patients are responsible for paying any cost-sharing amounts detailed under their coverage.

Patients under a PPO plan may seek services from non-contracted providers. The patients may seek an AOB, which is an arrangement where a patient requests that their plan payments be made directly to a designated person or facility, such as a dentist, physician, or hospital. In the context of this bill, an AOB would apply to non-contracting dentists. Under AOB, a patient may permit a non-contracting dentist to bill the dental plan directly and collect authorized reimbursement from the plan. The patient is on the hook to pay the dentist the remaining balance of their bill. Under AOB non-contracting dentists aren't required to limit their rates to contractual levels, meaning the patient may pay higher cost-sharing amounts. For example, a plan may cover a filling for $100 with the patient paying 20%. A contracted dentist would then be able to collect $80 from the plan and $20 from the patient. However, if that patient had an AOB with a non-contracting dentist who charges $150 for a filling, the dentist would collect $80 from the dental plan and $70 from the patient. If an AOB was not in place the dentist would not be able to directly bill the insurer, meaning the patient would be balance billed for the full $150 and have to seek reimbursement for $80 from their dental plan.

c) Network Adequacy Requirements. Network adequacy standards are utilized to ensure that plans contain and maintain a network of providers adequate for enrollees to access medically necessary in a timely manner. In California, state law sets forth various network adequacy requirements on plans and insurers, including the following:

i) Timely Access to Care. State law requires that plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally provide dental plan members the right to appointments within the following time frames:

(1) Urgent care **within 72 hours**;

(2) Non-urgent care **within 36 business days**; and

(3) Preventive dental care **within 40 business days.**

For comparison, health plan members have the right to appointments within the following time frames:

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

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

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

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

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

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

ii) Geographic Access. Health plans are also generally required to ensure geographic access, meaning there are a sufficient number of providers located within a

reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be **located within 15 miles or 30 minutes** from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include **one PCP for every 2,000 beneficiaries**.

3) **SUPPORT.** The California Dental Association (CDA), sponsor of this bill, states that Californians are increasingly finding it difficult to locate in-network dentists. CDA continues that this challenge is not due to a shortage of dentists but rather a result of dental plans failing to offer adequate networks for consumers. CDA states that current California law mandates that DMHC and CDI assess the network adequacy of commercial dental plans to ensure they have enough providers to meet the needs of their enrollees. CDA argues that undermining this oversight is the fact that roughly half of Californians with commercial dental plans have a plan that is self-insured by their employer, known as ERISA plans, which fall outside of state regulatory oversight, and are not included in the network adequacy assessments, despite serving a significant number of patients. CDA continues that in addition to this loophole in the state's oversight, while medical insurance plans are held to stringent time and distance standards, dental plans are not subject to the same requirements. CDA further argues that due to limited in-network options, many patients are forced to seek care from out-of-network providers but some dental plans refuse to honor a patient's AOB. CDA states that patients should not be penalized for choosing to see an out-of-network dentist, especially when their plan fails to provide an adequate network. CDA concludes that this bill will ensure that patients receive better value from their dental coverage, both in terms of benefits and accessibility.

4) **OPPOSITION.** Delta Dental of California (Delta Dental) opposes this bill, stating that it threatens to increase consumer costs and reduce dental networks thereby reducing access to affordable dental care. Delta Dental continues that this bill proposes to reduce the current appointment wait time standards by half and they have concerns that more restrictive appointment wait times do not take into account the dental workforce shortage that is affecting California – particularly in rural areas. Delta Dental states that the DMHC applies existing regulatory time and distance standards to dental plans and the regulations allows for plans to request a waiver to these requirements in exchange for an alternate standard approved by the regulator, which is especially crucial in areas of California where there is a shortage of dental health professionals. Delta Dental argues that the reporting requirements including a dental plan's self-insured population are an overreach as state law does not cover self-insured business regulated under ERISA. Lastly, Delta Dental states that the ability to receive direct payment for covered services is one of the primary reasons dentists join a carrier's network and agree to lower their usual fees from what they would otherwise normally charge. Delta Dental argues that AOB erodes the value of direct reimbursement for those dentists who do contract and agree to discount their fees in return for higher patient volume, another reason providers join networks.

5) PREVIOUS LEGISLATION.

a) AB 1048 (Wicks), Chapter 557, Statutes of 2023 prohibits, after January 1, 2025, a plan or health insurer from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision in large group contracts and policies, or a preexisting condition provision in any contracts or policies. Requires health plan contracts and insurance policies covering dental services to be subject to premium rate reviews.

b) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or substance use disorder (SUD) providers that is within 10 business days of the prior appointment.

c) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

d) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

e) AB 1579 (Campos) of 2012, would have required a health plan or health insurer that pays a contracting dental provider directly for covered services rendered to an enrollee or insured to also pay a non-contracting dental provider directly for covered services rendered to an enrollee or insured where the provider submits a written assignment of benefits signed by the enrollee or insured, or their legal representative. AB 1579 was held in the Senate Health Committee.

f) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services.

6) POLICY COMMENTS. Some opposing groups argue that that the ability to receive direct payment for covered services is the primary reason dentists choose to participate in carrier networks, agreeing to lower their fees in exchange for streamlined reimbursement. Delta Dental estimates that the AOB provisions of this bill could lead to a five to 15% reduction in network participation, which would mean enrollees would face an additional $235 million to $700 million in out-of-pocket costs annually. However, the true impact of an AOB mandate is unclear. The California Association of Dental Plans (CADP) states that many of their

members offer AOB as a business decision, although they argue that it should not be mandated for all plans. The author and sponsors shared a report with the committee from the George Washington University (GWU) titled "*Analysis of the Impact of Dental AOB Laws*," which was published after multiple states passed their own AOB laws. The GWU report examined the impact of AOB laws on the number of total dentists participating in PPO networks in four states, Tennessee, New Jersey, Mississippi, and South Dakota. The report found that the number of total participating dentists in PPO networks did not decline, but actually rose following the adoption of AOB laws.

This committee asked Delta Dental for data on the impact of AOB laws on their networks in other states that have passed similar laws, but have not received such data at the time of publishing this analysis.

It's important to note that if an AOB mandate were to be enacted, patients would no longer be burdened with passing payment between their dental plan and provider. Removing patients from the middle of such transactions would align with recent state and federal efforts to limit patient exposure to balance billing from their health plan. When a consumer enrolls in a PPO they are generally making a conscious choice to pick a plan with more flexibility to see out-of-network providers, even if it costs more. While some opposition groups have noted that this bill erodes consumer protections, this bill does not give PPO consumers any more ability to see an out-of-network provider than they already do. In fact, this bill would provide consumers with more disclosure and notification about the cost impact of going out-of-network than they would without an AOB. Making these trade-offs more clear to patients should be considered a step forward.

While the impact of AOB on the dental plan market is an important consideration that the Legislature should continue to question, it is important to also center the patient experience when considering the context of this bill.

7) PROPOSED AMENDMENTS.

a) To address concerns with the ability to meet time and distance requirements in rural areas, the committee may wish to amend the bill to clarify that existing geographic access standards, including waivers and flexibilities that DMHC and CDI provide, would also apply to dental networks.

b) The committee may also wish to remove references to self-insured plans in the reporting requirements to ensure that these provisions do not conflict with ERISA.

REGISTERED SUPPORT / OPPOSITION:

Support

California Dental Association (sponsor)
American Federation of State, County and Municipal Employees, AFL-CIO
California Association of Orthodontists
California Dental Hygienists' Association
California Hospital Association
California Medical Association (CMA)
California Pan - Ethnic Health Network

California Society of Pediatric Dentistry
California State Council of Service Employees International Union (SEIU California)
Union of American Physicians and Dentists

Oppose

Association of California Life & Health Insurance Companies
Bay Area Council
California Association of Dental Plans (CADP)
California Association of Health Plans
California Chamber of Commerce
Delta Dental of California
Los Angeles County Business Federation (BIZFED)

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 384 (Connolly) – As Amended March 17, 2025

SUBJECT: Health care coverage: mental health and substance use disorders: inpatient admissions.

SUMMARY: Prohibits a health care service plan (health plan), health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health (MH) and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. Specifically, **this bill**:

1) Prohibits a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for MH and SUDs from requiring prior authorization for an enrollee or insured to be admitted to medically necessary 24-hour inpatient settings for MH and SUDs.

2) Prohibits a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for MH and SUDs from requiring prior authorization for medically necessary health care services provided to an enrollee or insured while admitted to 24-hour inpatient care.

3) Prohibits the Medi-Cal program from requiring prior authorization for admission to medically necessary 24-hour inpatient settings for MH and SUDs. Prohibits prior authorization for medically necessary health care services provided to a beneficiary while admitted to 24-hour inpatient care.

4) Grants enforcement powers to the Department of Managed Health Care (DMHC), Department of Insurance (CDI), and Department of Health Care Services (DHCS).

5) Defines "24-hour care in inpatient settings" to include all of the following:

    a) A general acute care hospital and a rural general acute care hospital;
    b) An acute psychiatric hospital;
    c) A psychiatric health facility;
    d) A chemical dependency recovery hospital; and
    e) A psychiatric residential treatment facility.

EXISTING LAW:

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

2) Establishes California's Essential Health Benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance

Organization. Establishes existing California health insurance mandates and the 10 ACA mandated benefits, including MH and SUD coverage. [HSC § 1367.005 and INS § 10112.27]

3) Requires every disability insurance policy and health plan 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]

4) Defines medically necessary treatment of MH or SUD including that the service or product is in accordance with generally accepted standards of MH or SUD care, clinically appropriate in terms of type, frequency, extent, site, and duration. [HSC § 1374.72 and INS §10144.5]

5) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review (UR) criteria on current generally accepted standards of MH and SUD care, as specified. Requires medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with MH and SUDs to be conducted in accordance with the requirements in 6) below. [HSC §1374.72 and INS §10144.5]

6) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the UR criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs on current generally accepted standards of MH and SUD care, as specified. Requires a health plan or insurer to apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty in conducting UR of all covered health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs in children, adolescents, and adults. [HSC § 1374.721 and INS § 10144.52]

7) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for UR or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

9) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

10) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee (in writing) within two business days of the decision. Prohibits, in the case of concurrent review, discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC § 1367.01 and INS § 10123.135]

11) 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.]

12) Establishes a schedule of benefits under the Medi-Cal program, including inpatient services. [WIC § 14132]

13) 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. [WIC §5000, *et seq*.]

FISCAL EFFECT: Unknown. This bill has yet to be analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, in a MH emergency, every second counts. The author states that prior authorizations create delays by forcing doctors to justify their decisions regarding a patient's medical care to an insurance company. The author continues that during a MH crisis, these delays can have severe and life-altering consequences. The author concludes that this bill, the Mental Health Protection Act, ensures that Californian's who are hospitalized for a MH or SUD emergency receive immediate care with no unnecessary delays.

2) **BACKGROUND.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is

medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

a) **Overall impact of prior authorization.** In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

b) **Cost impacts.** One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low value or medically unnecessary care is delivered. Behavioral health, particularly applied behavioral analysis, was identified by health plans/insurers as a leading fraud risk.

c) **Access to and utilization of care.** Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between five to 15% of all covered medical services and 16 to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out of pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

d) **Administrative burden.** According to the American Medical Association (AMA), prior authorization leads to substantial administrative burdens for physicians, taking time away from direct patient care while costing practices money. AMA's 2024 physician survey on prior authorization found that on average, physicians and their staff spend 13 hours each week completing prior authorizations and 40% of physicians have staff who work exclusively on prior authorization. One in three physicians reported that prior authorization requests are often or always denied and 93% reported that prior authorization leads to care delays for their patients. 89% of physicians reported that prior authorization somewhat or significantly increases physician burnout.

e) **Prevalence of SUD in California.** A 2024 publication from Health Management Associates and the California Health Care Foundation (CHCF) titled, "*Substance Use Disorder in California — a Focused Landscape Analysis"* reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 and 2021. 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. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

f) **Prevalence of MH in California.** A 2022 publication from CHCF, entitled "*Mental Health in California"* reported that nearly one in seven California adults experience a mental illness, and one in 26 has a serious mental health condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level. A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly five million, or 16%, of Black Americans reported having a mental illness. However, only one in three Black adults who needs 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.

3) **SUPPORT.** The California Behavioral Health Association (CBHA), co-sponsor of this bill, states that in the midst of a national MH crisis, it is critical to reduce the bureaucratic obstacles that prevent patients from receiving care in a timely manner. CBHA notes that one-third of all inpatient hospitalizations in California involve behavioral health diagnoses. CBHA continues that the state has experienced a 40% spike in hospitalizations for young people with MH emergencies over the last decade. CBHA argues that immediate treatment

upon admission is vital to protecting the well-being of patients who may face life threatening conditions.

The California State Association of Psychiatrists (CSAP), another co-sponsor of this bill, states that when prior authorization is used during these crisis situations, doctors must justify their decisions regarding a patient's care by communicating clinical information with an insurer. CSAP continues that that this lengthy administrative process forces doctors to divert significant amounts of time and focus away from patient care, delaying that patient from receiving vital medical services. CSAP argues that in MH emergencies, the consequences of delayed treatment can be severe, particularly during an inpatient mental health case when an individual is hospitalized for a serious psychiatric condition.

4) **OPPOSITION.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, citing concerns with the implications of including residential treatment facilities in the bill's definition of inpatient settings. CAHP and ACLHIC state that residential treatment centers fundamentally differ from acute care hospitals and other inpatient facilities. CAHP and ACLHIC note that while they operate as 24-hour centers, they are not locked units and do not provide constant medical treatment. CAHP and ACLHIC argue this differentiation is crucial, as it raises significant concerns regarding potential waste, fraud, and abuse within these facilities. CAHP and ACLHIC continue that there has been an increasing trend of legislative efforts aimed at regulating these facilities due to ongoing issues of misconduct, inadequate oversight, and exploitative practices. Additionally, CAHP and ACLHIC find it troubling that the bill lacks clarity regarding whether concurrent or retrospective review of services rendered is permissible. CAHP and ACLHIC argue this ambiguity could lead to additional complications in ensuring appropriate healthcare delivery and safeguarding against unnecessary costs.

5) **RELATED LEGISLATION.**

a) AB 510 (Addis) would require, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 is currently pending in the Assembly Health Committee.

b) AB 512 (Harabedian) would shorten the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. AB 512 is currently pending in the Assembly Health Committee.

c) AB 539 (Schiavo) would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is currently pending in the Assembly Health Committee.

d) AB 574 (Mark González) would prohibit a health plan or health insurer from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy (PT). Would require a PT provider to verify an individual's coverage and disclose their share of the cost of care, as specified. Would require a PT provider to obtain written consent for costs that may not be covered by the individual's plan, as specified. AB 574 is currently pending in the Assembly Health Committee.

e) AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would prohibit concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 is currently pending in the Assembly Health Committee.

f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 516 (Skinner), of 2024, would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization. SB 516 was not heard in the Assembly Health Committee.

b) AB 1451 (Jackson), of 2023, would have required a health plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency MH and SUD without preauthorization. AB 1451 was vetoed by Governor Newsom who stated in part:

"I share the author's concern regarding the importance of accessible behavioral health services statewide, as evidenced by the billions of dollars we have invested to enhance access to timely and necessary behavioral health care, as well as the programs and reforms implemented to improve our delivery system. Existing law already prohibits prior authorization for emergency care, and requires mental health and substance use disorder services to meet timely access standards. The requirements in this bill would result in significant costs in the tens of millions of dollars, to the state General Fund and to consumers through health plan premium increases. These impacts should be considered as part of the annual budget process."

c) SB 238 (Wiener), of 2023, would have required a health plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the IMR System, as specified, if the decision is to deny, modify, or delay specified services relating to MH or SUD conditions for an enrollee or insured up to 26 years of age. SB 238 was held on the Assembly Appropriations suspense file.

d) SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

e) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

f) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or SUD providers that is within 10 business days of the prior appointment.

g) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's MH Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

7) POLICY COMMENTS.

a) Best approach for addressing issues with UR and UM. This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes at the systemic level by speeding up processing times, reducing the overall volume of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

b) Definition of inpatient care. The author and sponsors of this bill provided this committee with detailed examples of prior authorization delaying patient access to inpatient MH and SUD emergencies. Examples ranged from Medi-Cal patients facing delays in access due to their managed care plan requiring prior authorization for all mental health hospitalizations, patients getting stuck in EDs as they awaited approval for transfer to an appropriate inpatient facility, and even patients under LPS conservatorship who were denied access to their judicially mandated care. While there is a wide scope of situations where patients faced barriers to necessary inpatient care due to prior authorization, the list of facilities defined under "inpatient care" in this bill may be unintentionally narrow and exclude some patients from benefiting from its provisions. For example, SB 1238 (Eggman) Chapter 644, Statutes of 2024, expanded the types of facilities that can hold and treat patients for MH and SUD under the LPS Act, yet not all of these facilities are encompassed in the definition under this bill. The author and

sponsors may wish to work with stakeholders to ensure their definition is all-encompassing, or at least not limiting, the application of this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

California Behavioral Health Association (co-sponsor)
California State Association of Psychiatrists (co-sponsor)
California Academy of Child and Adolescent Psychiatry
California Chapter of the American College of Emergency Physicians
California Hospital Association
California Peer Watch
Hemophilia Council of California
National Alliance on Mental Illness
Providence St. Joseph Health
The Kennedy Forum
United Hospital Association

Opposition

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

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 424 (Davies) – As Amended March 19, 2025

SUBJECT: Alcohol and other drug programs: complaints.

SUMMARY: Requires the State Department of Health Care Services (DHCS), when it receives a complaint against a licensed alcohol or other drug recovery or treatment facility (RTF), or a complaint alleging that a facility is unlawfully operating without a license, to provide the complainant with a notice that the complaint has been received within 10 days of receipt and provide them notice that the complaint has been closed, including whether DHCS found the facility to be in violation of relevant laws or regulations.

EXISTING LAW:

1) Establishes DHCS as the sole licensing authority for RTFs. Permits new licenses to be issued for a period of two years and requires DHCS to conduct onsite program visits for compliance at least once during the two-year licensing period. [Health and Safety Code (HSC) § 11834.01]

2) Requires DHCS to adopt the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and requires a licensee to maintain those standards with respect to the level of care to be provided by the licensee. [HSC § 11834.015]

3) Defines RTF to mean a premises, place, or building that provides residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or addiction, and who need alcohol, drug, or alcohol and drug recover, treatment, or detoxification services. [HSC § 11834.02]

4) Permits DHCS to issue a license to operate an RTF upon receipt of a completed written application, fire clearance, and licensing fee, and determination that the facility meets applicable requirements and regulations. [HSC § 11834.09(a)]

5) Requires DHCS to terminate application review and an applicant to submit a new application upon failure to submit the written application, fire clearance, and payment of the required licensing fee in a timely manner. [HSC § 11834.09(b)]

6) Requires DHCS to deny an application for licensure if the applicant fails to demonstrate compliance with the requirements in 4) above. [HSC § 11834.09(c)]

7) Requires that initial licenses for a new alcohol or other drug recovery or treatment facility to be provisional for one year and permits DHCS to revoke the provisional license for good cause and prohibits a licensee from reapplying for an initial license for five years following a revocation of a provisional license. Defines “good cause” to mean failure to operate in compliance with the statutes and regulations relating to treatment facilities. [HSC § 11834.09(d)]

8) Requires, if a facility intends to provide incidental medical services, evidence of a valid license of a physician and surgeon who will provide or oversee those services, and any other information deemed appropriate by DHCS. Defines "incidental medical services" as services that follow the community standard of practice and are not required to be performed in a licensed clinic or licensed health facility, and includes obtaining medical histories, monitoring health status, testing associated with detoxification from alcohol or drugs, and overseeing patient self-administered medications. [HSC §§ 11834.025-11834.026]

9) Authorizes DHCS to assess civil penalties on facilities that provide alcohol or drug use recovery, treatment, or detoxification services without a license. [HSC § 11834.15]

10) Prohibits a person, firm, partnership, association, corporation, or local governmental entity from operating, establishing, managing, conducting, or maintaining an RTF without first obtaining a current valid license. [HSC § 11834.30]

11) Requires DHCS to conduct a site visit to investigate an allegation of a facility operating without a license and, if evidence is found supporting this allegation, requires the employee or agent to submit the findings to DHCS and, with DHCS authorization, send notice to the facility containing a date to cease providing services, the civil penalty that will be assessed for any days services are provided beyond that date, and that the case will be referred for civil proceedings if services continue. Requires the employee or agent to also inform the facility of state licensing requirements. [HSC § 11834.31]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill will help to create transparency when someone files a complaint regarding a substance use treatment facility. The author states this bill will require a notice be sent, within ten days of filing, to the complainant by DHCS informing them the complaint was received and, at the close of the investigation, a second notice will be sent to the complainant informing them if the facility was found to be in violation. The author argues that with times to close complaint investigations being so high, yet coming down, it's important for people to know that they are still being heard by those in charge of their protection.

2) **BACKGROUND.**

   a) **Prevalence of Substance Use Disorder (SUD) in California.** A 2024 publication from Health Management Associates and the California Health Care Foundation titled, "*Substance Use Disorder in California — a Focused Landscape Analysis"* reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 to 2021. 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. According to the DPH's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

b) Alcohol and Drug Treatment Facility Licensing. 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 checks for compliance with statute and regulations (Title 9, Chapter 5, California Code of 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 contrary 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.

c) State Audit. In October 2024, the State Auditor released a report assessing the licensing of residential RTFs by DHCS. Key findings from the audit include:

i) Southern California contains a greater concentration of treatment facilities serving six or fewer residents (small facilities) than other parts of the state. However, state law allows facilities to be located near each other and have the same legal owners.

ii) DHCS consistently reviewed the 26 license applications that were assessed, and the application process is generally the same for all facilities. However, of the 26 compliance inspections of operating facilities that were reviewed, DHCS conducted only half of them on time.

iii) DHCS also took longer than its target of 30 to 60 days to investigate complaints against treatment facilities. For instance, it took more than a year to complete 22 of the 60 investigations reviewed in the audit. Additionally, DHCS did not always follow up on unlicensed facilities that it found were unlawfully advertising or providing services. SB 35 and SB 329 in "Related Legislation" below respond to this issue.

Based on these findings, the audit makes several operational recommendations to DHCS, including the following:

i) Provide management with information about the timeliness of compliance inspections and implement processes for notifying responsible staff of upcoming compliance inspections.

ii) Implement guidelines that specify the length of time analysts should take to complete key steps in the investigation process.

iii) Develop and implement a follow-up procedure when it has substantiated allegations of an unlicensed facility providing services.

In response to the audit, DHCS has made several operational changes. According to the State Auditor's website, DHCS will create and implement new protocols and processes as well as schedule and conduct the appropriate trainings to ensure supervisors are closely tracking the programs in need of inspections within their two-year windows. DHCS will also begin using a new digital platform to complete onsite inspection reports, which will aid DHCS in sending providers reports more quickly, thereby improving the rate at which assignments are completed. Also, in August 2024, DHCS revised its Complaints Operations Manual to clarify the requirement for case assignment within 10 days and updated the complaint intake process.

d) DHCS Complaint Process. According to DHCS, the Licensing and Certification Division (LCD) oversees and conducts complaint investigations against California's alcohol and other drug (AOD) recovery and treatment programs. This includes general allegations against a program, allegations of unlicensed or uncertified activity, and client deaths that occur at licensed facilities. LCD also investigates allegations of misconduct by registered or certified AOD counselors that work at licensed AOD programs.

Upon receiving a complaint via phone, email, fax, mail, or online, DHCS establishes whether the complaint is within its jurisdiction. If DHCS receives a complaint that does not fall under its jurisdiction, it sends a letter to the complainant informing them that it does not investigate that type of complaint. If the complaint is under DHCS jurisdiction. it is logged, assigned a complaint number, and a high, medium or low-level designation. Receipt of a complaint is acknowledged through written communication with the complainant. Upon opening a complaint, complainants are asked if they would like a Public Records Act (PRA) request opened on their behalf. If they have the request opened, they would receive a copy of the report via email through the PRA process; only then would the complainant be notified with the outcome of their complaint.

Once assigned, an analyst will contact the program in question, review documents and records relevant to the complaint, and, if necessary, conduct an on-site visit to gather evidence, inspect facilities, and conduct interviews. An investigative report is issued, outlining whether an allegation was substantiated, and if any additional findings were discovered throughout the course of the investigation. If any deficiencies are identified and substantiated, programs may be subject to a Notice of Deficiency, requiring a Corrective Action Plan or Verification of Correction and civil penalties for failure to respond timely to a Notice of Deficiency.

Deficiencies can result in departmental action to suspend or revoke a program's licensure. If no deficiencies are found, the complaint report would be issued with allegations marked as "not substantiated," and no additional deficiencies would be indicated on the report.

3) SUPPORT. The League of California Cities (Cal Cities) is sponsoring this bill and says in support that a lack of timely communication creates frustration for both residents and local governments and that cities report that constituents and staff frequently contact DHCS for updates, diverting staff time away from critical investigations. Cal Cities continues that by

improving communication, this bill would help cities stay informed and support a more transparent oversight process.

Several cities support the bill and say that residential recovery housing provides a wide range of benefits to some of California's most vulnerable residents, and it is critical that their needs are prioritized over profits. These cities argue that this bill promotes better monitoring and regulation of alcohol and drug recovery facilities within its jurisdiction, ensuring they adhere to state standards and provide safe environments for clients.

The Orange County Employees Association (OCEA) supports this bill and says that it will enhance the process for individuals who file complaints against licensed alcohol or other drug recovery or treatment facilities. OCEA argues this bill ensures that complainants are informed in a timely manner, which promotes a sense of confidence and trust in the regulatory system. Additionally, the requirement to notify complainants upon the closure of their complaints and provide information on whether a violation was found will significantly increase transparency and improve public confidence in the department's work.

4) RELATED LEGISLATION.

a) AB 3 (Dixon) would exempt an RTF from being considered a residential use of property if multiple single-family dwellings are being used as a licensed or unlicensed RTF, they share an owner, a director, programs, or amenities with another facility, and any of the dwellings are within 300 feet of that facility, or if a single-family dwelling being used as an RTF shares an owner, a director, programs, or amenities with another facility that is commercially owned, operated, and licensed that is located anywhere in the state. AB 3 is pending in the Assembly Health Committee.

b) AB 425 (Davies) would require DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for certified AOD programs. A certified program would be required to maintain those standards. AB 425 is pending the Assembly Health Committee.

c) AB 492 (Valencia) would require DHCS to notify a city or county, in writing, of the issuance of a new license to an alcohol or other drug recovery or treatment facility within the local government's jurisdiction. AB 492 is pending in the Assembly Appropriations Committee.

d) AB 1356 (Dixon) would require an RTF to submit a report within 60 days of the death of a resident that describes the follow-up action plan that was implemented and provides any relevant information that was not known at the time of the initial incident or that was known but was not provided to the department in the initial report. AB 1356 is pending in the Assembly Health Committee.

e) SB 35 (Umberg) would require DHCS to initiate an investigation into unlicensed operation of an RTF within 10 days of receiving the allegation and complete the investigation within 60 days of initiating the investigation. The bill would require an employee or agent to provide the notice within 10 days of submitting their findings to DHCS and to conduct a follow up site visit to determine whether the facility has ceased providing services. SB 35 would authorize these provisions to be enforced by the city attorney of a city in which the facility is located, or by the county counsel or the county

behavioral health agency if the facility is located in the unincorporated area of the county, if DHCS fails to initiate or conclude the investigation in accordance with these time limits. SB 35 is pending in the Senate Health Committee.

f) SB 43 (Umberg) would require all programs certified and all facilities licensed, no later than July 15, 2026, and annually each July 15 thereafter, to submit to the department a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year. This bill is pending in the Senate Health Committee.

g) SB 329 (Blakespear) would require DHCS to assign a complaint under its jurisdiction regarding an RTF to an analyst for investigation within 10 days of receiving the complaint and to complete an investigation within 60 days of assigning the complaint, unless specified circumstances exist, and notify the complainant if the investigation is not able to be completed within 60 days. SB 329 is pending in the Senate Appropriations Committee.

5) PREVIOUS LEGISLATION.

a) AB 2081 (Davies), Chapter 376, Statutes of 2024, requires entities licensed or certified by DHCS to include on their websites and intake paperwork a disclosure stating an individual may check DHCS's website to confirm any actions taken against the entity.

b) AB 2121 (Dixon) of 2024 would have required an RTF to confirm that it is located more than 300 feet from any other RTF or any community care facility, as specified, and would have required the department to notify in writing the city or the county in which the facility is located of the issuance of a license. This bill was not set for hearing in the Assembly Health Committee.

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 recovery residence or RTF serving more than six residents to require the contractors to, at all times, maintain specific insurance coverage.

6) POLICY COMMENT. According to DHCS, upon opening a complaint, complainants are asked if they would like a PRA Request opened on their behalf. They would then receive a copy of the final report via email through the PRA process. DHCS also notes the establishment of a new online platform in 2025, Survey 123, which provides on-demand public access to AOD treatment program licensing and certification reports and the findings of DHCS complaint investigations. Given this existing process for receiving the disposition of a complaint, the author may wish to continue working with DHCS to determine whether this additional statutory requirement is necessary or if internal processes can be improved.

REGISTERED SUPPORT / OPPOSITION:

Support

League of California Cities (Sponsor)
Advocates for Responsible Treatment
Association of California Cities - Orange County (ACC-OC)
Capo Cares
City of Buena Park
City of Huntington Beach
City of Laguna Niguel
City of Lathrop
City of Los Alamitos
City of Manteca
City of Mission Viejo
City of Newport Beach
City of Thousand Oaks
City of Villa Park
Orange County
Orange County Employees Association
8 individuals

Opposition

None on file

Analysis Prepared by: Logan Hess / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 425 (Davies) – As Introduced February 5, 2025

SUBJECT: Certification of alcohol and other drug programs.

SUMMARY: This bill would require the State Department of Health Care Services (DHCS) to adopt the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for alcohol or other drug (AOD) programs certified by the DHCS, and would require certified programs to maintain those standards. Specifically, **this bill**:

1) Requires DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for certified AOD programs and requires a program to maintain those standards with respect to the level of care to be provided.

2) Requires DHCS to adopt regulations by January 1, 2026.

3) Permits DHCS to implement, interpret, or make specific the provisions of this bill by means of plan or provider bulletins, or similar instructions until regulations are adopted.

4) Makes Legislative findings and declarations regarding the importance of meeting or exceeding ASAM criteria.

EXISTING LAW:

1) Establishes DHCS as the sole certifying authority for AOD programs. Requires new certifications to be issued for a period of two years to programs meeting statutory and regulatory requirements. [Health and Safety Code (HSC) § 11832]

2) Exempts specific settings from the certification requirement, including but not limited to: licensed adult alcoholism or drug abuse recovery or treatment facilities (RTF), clinics licensed by the State Department of Public Health (DPH), community care facilities licensed by the State Department of Social Services, public elementary and secondary schools, and county jails and state correctional institutions, including juvenile justice facilities. [HSC § 11832.3]

3) Requires an entity applying for certification to submit a written application, a certification fee, an initial application fee, and any other documentation specified by DHCS. [HSC § 11832.4]

4) Specifies the conditions under which DHCS may issue a certification, terminate review of an application, or deny certification. [HSC § 11832.5]

5) Requires certified programs to adopt policies and procedures consistent with statute and regulations that address, at a minimum: admission and discharge, client rights, services, medications, and staff and client code of conduct. Requires programs to either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place, as defined. [HSC § 11832.8 and § 11832.9]

6) Requires DHCS to conduct onsite visits for compliance at least once during each certification period. [HSC § 11832.12]

7) Establishes DHCS as the sole licensing authority for RTFs. Permits new licenses to be issued for a period of two years and requires DHCS to conduct onsite program visits for compliance at least once during the two-year licensing period. [HSC § 11834.01]

8) Requires DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and requires a licensee to maintain those standards with respect to the level of care to be provided by the licensee. [HSC § 11834.015]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill raises the minimum standard of treatment for certified substance use disorder (SUD) facilities in California. The author argues that the bill will standardize treatment, but will also help to increase retention rates for treatment. By codifying evidence-based standards we set a strong baseline of expectations for the care our patients should receive.

2) BACKGROUND.

a) Prevalence of Substance Use Disorders (SUD) in California. A 2024 publication from Health Management Associates and the California Health Care Foundation titled, "*Substance Use Disorder in California — a Focused Landscape Analysis"* reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 and 2021. 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. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

b) ASAM. ASAM established a six dimension assessment (the ASAM criteria) and a corresponding continuum of care with five broad levels of care (zero to four). Current law requires DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed RTFs and requires licensees to maintain those standards with respect to the level of care. DHCS has adopted the ASAM treatment criteria as the standard of care required of all licensed RTFs. To ensure that all licensed facilities are capable of delivering care consistent with the ASAM treatment criteria and meet all of DHCS' requirements, DHCS has developed a level of

care (LOC) designation program for RTFs. The levels of care for residential facilities are as follows:

i) Clinically Managed Low-Intensity Residential – ASAM 3.1/ DHCS 3.1

ii) Clinically Managed Residential Withdrawal Management – DHCS 3.2

iii) Clinically Managed Population-specific Low-intensity Residential – ASAM 3.3/ DHCS 3.3

iv) Clinically Managed High-Intensity Residential – ASAM 3.5/ DHCS 3.5

DHCS also notes in a disclaimer on their licensing website: "An approval for a DHCS LOC Designation does not guarantee eligibility for an ASAM LOC Certification. However, an approved residential ASAM LOC Certification is sufficient to meet the DHCS requirement. Licensees must directly contact ASAM to obtain information regarding its certification process and requirements to obtain ASAM LOC Certification."

ASAM also has lower LOCs, which would be the basis for the AOD certification requirements under this bill. Those levels are as follows:

i) Early Intervention – ASAM 0.5, Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder.

ii) Outpatient Services – ASAM 1, Less than nine hours of service/week (for adults) for recovery or motivational enhancement therapies/strategies.

iii) Intensive Outpatient – ASAM 2.1, nine or more hours of service/week (for adults) to treat multidimensional instability.

iv) Partial Hospitalization – ASAM 2.5, 20 or more hours of service/week for multidimensional instability not requiring 24-hour care.

c) 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.

Prior to January 1, 2025, AOD programs were permitted to seek certification from DHCS. Under AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, certification is now a requirement for many alcohol and drug programs, with exceptions for various licensed facility types, such as schools, jails, and prisons. DHCS certification regulations contain a frequency of service standard for outpatient services as a maximum of nine hours per week and intensive outpatient with a 9-19 hour per week range, similar to the ASAM designation.

3) **SUPPORT.** The City of Los Alamitos states in support of the bill that it will improve public health, ensure high-quality care for residents, and effectively utilize resources to address substance use challenges within the community. Los Alamitos states it is committed to policies that improve the quality of life for its constituents and overall health of the community and this bill aligns with that goal.

4) **RELATED LEGISLATION.**

a) AB 423 (Davies) would require a business-operated recovery residence to register its location with DHCS and defines that term as a recovery residence in which a business, in exchange for compensation, provides more than one service beyond those of a typical tenancy arrangement to more than one occupant, including, but not limited to, drug testing, supervision, scheduling, rule setting, rule enforcement, room assignment, entertainment, gym memberships, transportation, laundry, or meal preparation and coordination. AB 423 is pending in the Assembly Health Committee.

b) AB 492 (Valencia) would require DHCS to notify a city or county, in writing, of the issuance of a new license to an alcohol or other drug recovery or treatment facility within the local government's jurisdiction. AB 492 is pending in the Assembly Appropriations Committee.

c) AB 1356 (Dixon) would require an RTF to submit a report within 60 days of the death of a resident that describes the follow-up action plan that was implemented and provides any relevant information that was not known at the time of the initial incident or that was known but was not provided to the department in the initial report. AB 1356 is pending in the Assembly Health Committee.

d) SB 35 (Umberg) would require DHCS to initiate an investigation into unlicensed operation of an RTF within 10 days of receiving the allegation and complete the investigation within 60 days of initiating the investigation. The bill would require an employee or agent to provide the notice within 10 days of submitting their findings to DHCS and to conduct a follow up site visit to determine whether the facility has ceased providing services. SB 35 would authorize these provisions to be enforced by the city attorney of a city in which the facility is located, or by the county counsel or the county behavioral health agency if the facility is located in the unincorporated area of the county, if DHCS fails to initiate or conclude the investigation in accordance with these time limits. SB 35 is pending in the Senate Health Committee.

e) SB 43 (Umberg) would require all programs certified and all facilities licensed, no later than July 15, 2026, and annually each July 15 thereafter, to submit to DHCS a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year. This bill is pending in the Senate Health Committee.

f) SB 329 (Blakespear) would require DHCS to assign a complaint under its jurisdiction regarding an RTF to an analyst for investigation within 10 days of receiving the complaint and to complete an investigation within 60 days of assigning the complaint, unless specified circumstances exist, and notify the complainant if the investigation is not able to be completed within 60 days. SB 329 is pending in the Senate Appropriations Committee.

5) PREVIOUS LEGISLATION.

a) AB 2081 (Davies), Chapter 376, Statutes of 2024, requires entities licensed or certified by DHCS to include on their websites and intake paperwork a disclosure stating an individual may check DHCS's website to confirm any actions taken against the entity.

b) AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, prohibits a program from offering alcohol and other drug treatment recovery services without certification, and establishes procedures for: certification, inspections of certified programs, and for revocation of certification from noncompliant programs.

c) SB 823 (Hill) Chapter 781, Statutes of 2018, requires DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and requires a licensee to maintain those standards with respect to the level of care to be provided by the licensee.

6) COMMITTEE AMENDMENTS. The committee may wish to delay the requirement of DHCS to adopt regulations to January 1, 2027. As written, the bill would require regulations to be adopted on the same day that the law takes effect, January 1, 2026.

REGISTERED SUPPORT / OPPOSITION:

Support

Advocates for Responsible Treatment
Association of California Cities - Orange County (ACC-OC)
City of Los Alamitos
City of Villa Park
Orange County Board of Supervisors
Five individuals

Opposition

None on file

Analysis Prepared by: Logan Hess / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 463 (Michelle Rodriguez) – As Amended April 2, 2025

SUBJECT: Emergency medical services: dogs and cats.

SUMMARY: Authorizes a private ambulance owner, or a person who operates ambulances owned or operated by a fire department of a federally recognized Indian tribe, to transport a police canine, or a search and rescue dog, as defined, that is injured in the line of duty to a veterinary clinic or similar facility if there is no other person requiring medical attention or transport at that time. Specifically, **this bill**:

1) Authorizes a paramedic or an emergency medical technician (EMT) to provide emergency medical care to a police canine or search and rescue dog that is injured in the line of duty while the police canine or search and rescue dog is being transported to a veterinary clinic or similar facility, and would exempt that person from civil or criminal liability if they act in good faith to provide emergency medical care to an injured police canine or search and rescue dog while the police canine or search and rescue dog is being transported to a veterinary clinic or similar facility.

2) Clarifies that an emergency responder may provide basic first aid care to an injured police canine or search and rescue dog to the extent that the provision of care is not prohibited by the responder's employer, and that the responder is not subject to criminal prosecution for a violation of the provisions described in 4) in existing law below.

EXISTING LAW:

1) Authorizes any person to provide emergency medical care to a police canine injured in the line of duty. [Business and Professions Code (BPC) § 4827]

2) Defines "search and rescue dog" to mean a dog that is officially affiliated with, or sponsored by, a governmental agency and that has been trained and approved as a search and rescue dog, or that is currently registered and approved for search and rescue work with a search and rescue team affiliated with the California Emergency Management Agency (now the Governor's Office of Emergency Services). Includes a dog that is in training to become registered and approved for that work. [Civil Code § 54.25]

3) Defines "police canine" to mean a canine that is owned, or the service of which is employed, by a state or local law enforcement agency, a correctional agency, a fire department, a special fire district, or the State Fire Marshal for the principal purpose of aiding in the detection of criminal activity, flammable materials, or missing persons, the enforcement of laws, the investigation of fires, or the apprehension of offenders. [Health and Safety Code § 1317.05]

4) Exempts a paramedic or an EMT who acts in good faith to provide emergency medical care to an injured police canine immune from criminal or civil liability. [*Ibid.*]

5) Makes it unlawful for any person to practice veterinary medicine unless the person holds a valid license, as specified, subject to specified exemptions, including that an emergency

responder may provide basic first aid to dogs and cats, as defined, to the extent that the provision of that care is not prohibited by the responder's employer. [BPC § 4800 *et seq.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, police canines are more than just working animals, they are dedicated partners in law enforcement, risking their lives to protect officers and the public. These highly trained dogs serve on the front lines, tracking dangerous suspects, detecting illegal substances, and shielding their handlers from harm. Their presence saves lives, yet when they are critically injured in the line of duty, their access to lifesaving emergency care is often delayed due to outdated legal restrictions. The risks these canines face are not hypothetical, they are real and frequent. The author notes that in Los Angeles, three police canines were recently wounded during a violent standoff, each requiring urgent medical attention. In Vacaville, a K-9 was shot while confronting an armed suspect, a stark reminder that these animals face the same dangers as their human counterparts. Yet, when these heroes are injured, emergency medical personnel are often prohibited from providing immediate care or even transporting them to a veterinary hospital. Instead, officers must scramble to find alternative means of transport, wasting precious minutes that could mean the difference between life and death. The author states that this is unacceptable. Police canines are not expendable assets; they are valued members of law enforcement who deserve the same urgency and access to care as any first responder injured in the line of duty. The author concludes that we cannot continue to turn a blind eye to the gaps in current law that force these animals to suffer when help is within reach.

2) **BACKGROUND.** The author provided numerous press articles regarding the transport of injured canines across the country. Oftentimes, an ambulance provider is called and asked to transport an injured canine to a veterinarian. Committee staff conducted an informal survey of several canine officers and was told that most canine handlers currently just "scoop and run" an injured canine and drive it themselves in the back of their car to whatever veterinarian facility is closest.

   a) **Medical care for police canines.** The National Police Dog Foundation is a charity that assists with the purchase, training, and medical care for canines. According to their website, there are over 14 veterinarians who volunteer to provide discounted medical care for canines in California, most of them located in the southern portion of the state.

   b) **Police canines killed or injured.** An internet website, the "*Officer Down Memorial Page*" tracks K-9s killed in the line of duty. The site has data broken down by state, listing over 35 fatalities in California, with the oldest entry dating back to 1980. There does not appear to be any publicly collected data available regarding the number of K-9s injured in the line of duty. A 2025 article published online in the journal *Police Practice and Research* titled, *"Police K-9 line-of-duty deaths and heatstroke 2000–2023,"* notes that research focusing on the deaths of police canine officers is almost nonexistent. In one of the only existing studies on the topic, published in the *Contemporary Justice Review* in 2019 found that, of the 96 police canine fatalities analyzed between 2011 and 2015, roughly a quarter of deaths were the result of gunfire. However, the leading cause of death during this time was heat exhaustion (30.2%), localized in the southern US during the hotter months of the year.

c) Other states. Colorado enacted legislation in 2014 which granted limited authority to emergency medical service providers to voluntarily provide "pre-veterinary emergency care" to certain domesticated animals. In 2017, Illinois passed legislation substantially similar to this bill.

3) SUPPORT. The California State Sheriffs' Association (CSSA) supports this bill and states that police canines play a vital role in law enforcement, assisting officers in detecting contraband, tracking suspects, and protecting their handlers. These highly trained animals often face dangerous situations in the line of duty, putting them at risk of serious injury. However, despite their critical role, emergency medical personnel are often restricted in their ability to provide immediate care or transport for injured police canines. CSSA notes that this bill will explicitly authorize licensed ambulance operators to transport injured police canines when no human patients require immediate assistance, while allowing paramedics and EMTs to provide emergency medical treatment to injured police canines at the scene or during transport without legal barriers. CSSA concludes that this proposal ensures that police dogs—who often suffer injuries in the line of duty—can receive faster medical attention.

4) PREVIOUS LEGISLATION.

a) SB 1305 (Glazer), Chapter 900, Statutes of 2018, permits an emergency responder to provide basic first aid, as specified, to a dog or a cat, without being in violation of the Veterinary Medicine Practice Act.

b) AB 1776 (Steinorth), Chapter 272, Statutes of 2018, authorized the County of San Bernardino to collaborate with the Inland Counties Emergency Medical Agency to conduct a pilot project that commenced on January 1, 2019. Permitted the transportation of police dogs injured in the line of duty to facilities capable of providing veterinary medical services, provided certain conditions were met. AB 1776 mandated the Inland Counties Emergency Medical Agency to collect specified data regarding the pilot project and to submit a report to the Legislature by January 1, 2022. These provisions were repealed on January 1, 2022.

5) AMENDMENTS. In order to address concerns raised by the California Veterinary Medical Association, the author is proposing to amend this bill as follows:

a) To change references to "emergency medical care" to "basic first aid;" and,

b) To change the terms "paramedic" and "emergency medical technician" to "emergency responder." These changes make the bill consistent with other provisions of existing law.

The author is also proposing to make changes to the liability provisions of the bill to clarify that the emergency responder who acts in good faith ***and not for compensation*** is not subject to criminal or civil liability ***for any injury to the canine.***

REGISTERED SUPPORT / OPPOSITION:

Support

California Ambulance Association
California State Sheriffs' Association

Mono County Board of Supervisors
Riverside County Sheriff's Office
One individual

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 510 (Addis) – As Amended April 10, 2025

SUBJECT: Health care coverage: utilization review: appeals and grievances.

SUMMARY: Requires, upon request, an appeal or grievance regarding a decision by a health care service plan (health plan) or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. Specifically, **this bill**:

1) Requires, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or peer health care professional.

2) Requires, upon a request for review, a health plan or health insurer to directly and expeditiously connect the requesting health care provider with a peer physician or peer health care professional, without requiring the requesting provider to communicate with any additional employees or individuals acting on behalf of the health plan or health insurer.

3) Requires a review to occur within two business days of the request. Requires, if the enrollee faces an imminent and serious threat to their health, a review to occur in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 24 hours after the request.

4) Requires a prior authorization request to be deemed approved and supersede any prior delay, denial, or modification if a health plan or insurer fails to meet the review timelines in 2) and 3) above.

5) Permits an appeal or grievance review to be performed by a contracted specialist reviewer, provided the reviewer is a peer physician or peer health care professional.

6) Permits, if the provider requesting review is not a physician, the appeal or grievance to be reviewed by a peer health care professional.

7) Defines "peer health care professional" as a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider.

8) Defines "peer physician" as a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider.

EXISTING LAW:

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

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (UR) or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

4) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

5) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee (in writing) within two business days of the decision. Prohibits, in the case of concurrent review, discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC § 1367.01 and INS § 10123.135]

6) Requires, if a health plan or health insurer that provides coverage for prescription drugs or a contracted physicians group fails to respond to a prior authorization, or step therapy exception request, as specified, within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed request form, that the request be deemed granted. [HSC § 1367.241 and INS § 10123.191]

7) Allows for appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing an internal appeal pursuant to federal law and any subsequent rules or regulations issued thereunder. [INS § 10123.201]

8) Establishes, in DMHC and CDI, the Independent Medical Review System (IMR) which reviews disputed health care services that a plan, or one of its contracting entities, or insurer determines is not medically necessary or is experimental or investigational. [HSC §§ 1374.30 - 1374.36 and INS § 10169]

9) Requires every health plan to establish and maintain a grievance system approved by DMHC under which enrollees may submit their grievances and complaints to the plan. Permits enrollees to submit those grievances to DMHC after undergoing the plan's internal process for at least 30 days, unless the case involves imminent and serious threat, severe pain, potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a contract or any other case where DMHC determines early review is warranted. Requires to the extent required by federal law and any subsequent rules or regulations, an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of a health plan's cancellation, rescission, or nonrenewal of an enrollee's or subscriber's coverage. [HSC § 1368]

10) Requires under federal law a group health plan and a health insurance issuer offering group or individual health insurance coverage to implement an effective appeals process for appeals of coverage determinations and claims, including an internal claims appeal process with notices in a culturally and linguistically appropriate manner, of available internal and external appeals process. Establishes processes for internal and external reviews. [42 U.S.C. § 300gg-19]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, it is vital that health care decisions be made by professionals who understand the complexities of a patient's condition. The author continues that this bill will require that appeals of prior authorization denials be performed by a provider of the same or similar specialty. The author concludes that this will protect patient rights and ensure access to a fair, transparent process that prioritizes health over profits.

2) **BACKGROUND.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

   a) **Overall impact of prior authorization.** In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue

denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

b) Cost impacts. One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low value or medically unnecessary care is delivered. Behavioral health, particularly applied behavioral analysis, was identified by health plans/insurers as a leading fraud risk.

c) Access to and utilization of care. Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between five to 15% of all covered medical services and 16% to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out of pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

d) Administrative burden. According to the American Medical Association (AMA), prior authorization leads to substantial administrative burdens for physicians, taking time away from direct patient care while costing practices money. AMA's 2024 physician survey on prior authorization found that on average, physicians and their staff spend 13 hours each week completing prior authorizations and 40% of physicians have staff who work exclusively on prior authorization. One in three physicians reported that prior authorization requests are often or always denied and 93% reported that prior authorization leads to care delays for their patients. 89% of physicians reported that prior authorization somewhat or significantly increases physician burnout.

e) Antiquated systems. According to CHBRP, many aspects of prior authorization workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. Contributing to the resource intense process is the type of technology (or lack of) used by providers and plans. Although many providers have transitioned to electronic health records (EHRs), for some providers, the cost to do

so is prohibitive. Additionally, not all EHRs easily communicate with other EHRs, thereby still requiring a person to manually transfer information from one system to another. In light of these challenges, there are ongoing state and federal efforts to improve data sharing across health care entities to improve processes like prior authorization.

In January of 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule. This rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. The rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care. Impacted payers are required to implement certain provisions by January 1, 2026 and meet remaining requirements by January 1, 2027.

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) and required CalHHS to finalize a data sharing agreement by July 1, 2022. The DxF defines the entities that will be subject to these new data exchange rules and sets forth a common set of terms, conditions, and obligations to support secure, real-time access to and exchange of health and social services information, in compliance with applicable federal, state, and local laws, regulations, and policies. DxF is not a new technology or centralized data repository, it is an agreement across health and human services systems and providers to share information safely. Many health care entities were required to participate beginning January 2024. Remaining entities are required to participate by January 2026.

3) **SUPPORT.** The California Medical Association (CMA), sponsor of this bill, states that too often, health plans deny a physician's treatment request, and the individuals reviewing these decisions and appeals lack the requisite clinical expertise to assess the physician's recommendation properly. CMA continues that when a health plan representative lacks the appropriate specialization, physicians must spend even more time seeking to educate health plan representatives on basic medical details regarding the underlying condition and fighting for their recommended treatment. CMA states that as a result, physicians report that their patient care and appointments are disrupted. CMA argues that this bill would ensure that treating physicians have the right to have their appeals of prior authorization denials, delays, or modifications expeditiously reviewed by a peer of the same or similar specialty, upon request. CMA continues that this bill would state that if a health plan is unable to satisfy this requirement, then after two days the prior authorization request being appealed is approved. CMA concludes that this common-sense change to the prior authorization process will help ensure that patients can more swiftly receive the care they need and help physicians spend more time treating patients and less time navigating inefficient administrative hurdles.

4) **OPPOSSED UNLESS AMENDED.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC), are opposed to this bill unless amended. CAHP and ACLHIC state they share the goal of ensuring timely access to necessary health care services for patients, but believe the current language of this bill creates significant operational challenges and unintended consequences that could ultimately hinder, rather than help, the efficient delivery of quality care. CAHP and ACLHIC continue that their primary concerns include a problematic specialty matching requirement,

unrealistic and unworkable review timelines, the potential for compromised quality of review, and unintended consequences with automatic approvals. CAHP and ACLHIC request amendments that: mandate all appeals be submitted electronically by providers, require all necessary clinical information be included in the appeal, limit the specialty matching requirement to services that are requested outside the standard of care, remove the timeframes, approval mandate, and communication restrictions in the bill, specify that if a plan makes a "good faith effort" to schedule a peer-to-peer review they are not automatically out of compliance, and delay the implementation date of the bill.

5) RELATED LEGISLATION.

a) AB 384 (Connolly) would prohibit a health plan, health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 is currently pending in the Assembly Health Committee.

b) AB 512 (Harabedian) would shorten the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. AB 512 is currently pending in the Assembly Health Committee.

c) AB 539 (Schiavo) would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is currently pending in the Assembly Health Committee.

d) AB 574 (Mark González) would prohibit a health plan or health insurer that provides coverage for physical therapy (PT) from requiring prior authorization for the initial 12 treatment visits for a new episode of care for PT.

e) AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would prohibit concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 is currently pending in the Assembly Health Committee.

f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 999 (Cortese) of 2024 would have required a health plan or disability insurer to comply with UR determination requirements related to mental health and substance use disorder treatment. SB 999 was held on suspense in the Assembly Appropriations Committee.

b) SB 516 (Skinner) of 2024 would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization. SB 516 was not heard in the Assembly Health Committee.

c) SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

d) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

e) SB 999 (Cortese) of 2022 was similar to this bill. SB 999 was vetoed by Governor Newsom who stated in part:

"I share the author's goal of ensuring that patients are able to receive the behavioral health care they need, when they need it. Two years ago, I signed SB 855 (Wiener), Chapter 151, Statutes of 2020, a landmark update to California's MH parity statutes. SB 855 and forthcoming regulations implementing the law seek to address the issues targeted by this bill by requiring the use of unbiased MH and SUD clinical standards in coverage reviews and mandating the appropriate training and oversight of staff performing those reviews. Implementation of SB 855 is underway, and the industry is in the process of adapting to California's stringent new requirements. As such, this bill is premature and unnecessary at this time."

f) AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. Would have defined clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 was vetoed by Governor Newsom who stated in part:

"Health plans and health insurers should make every effort to streamline UM processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing IMR requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes."

g) AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of the 30 health care services for which prospective review was most frequently requested. AB 1268 was held on suspense in the Assembly Appropriations Committee.

7) **TECHNICAL AMENDMENTS.** The committee may wish to amend this bill to make technical, clarifying changes.

8) **POLICY COMMENTS.**

   a) **Alignment with data solutions.** As noted in the background of this analysis, many aspects of the UR workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. The peer-to-peer review timelines in this bill will be difficult to meet if providers and plans are still relying on outdated information sharing systems. The author and sponsors may wish to work with stakeholders to ensure that this bill is aligned with ongoing state and federal efforts to improve data sharing and technological connectivity between patients, providers, and payers to ensure that the timelines it is setting can be met.

   b) **Best approach for addressing issues with UR and UM.** This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes at the systemic level by speeding up processing times, reducing the overall volume of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (sponsor)
AARP
Alliance of Catholic Health Care, Inc.
ALS Association
American Academy of Pediatrics, California
American College of Obstetricians & Gynecologists - District IX
Association for Clinical Oncology
Association of Northern California Oncologists
California Academy of Child and Adolescent Psychiatry
California Advocates for Nursing Home Reform
California Association for Health Services At Home
California Chapter American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Chronic Care Coalition
California Hospital Association
California Nurses Association
California Orthopedic Association
California Podiatric Medical Association

California Psychological Association
California Radiological Society
California Retired Teachers Association
California Rheumatology Alliance
California Society of Pathologists
California Society of Plastic Surgeons
California State Association of Psychiatrists (CSAP)
Crohns and Colitis Foundation
District Hospital Leadership Forum
Medical Oncology Association of Southern California
Mental Health America of California
Saint Agnes Medical Center
Stanford Health Care
Steinberg Institute
The Kennedy Forum
U.S. Pain Foundation
United Hospital Association
Western Center on Law & Poverty

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 512 (Harabedian) – As Amended April 11, 2025

SUBJECT: Health care coverage: prior authorization.

SUMMARY: Shortens the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. Specifically, **this bill**:

1) Requires decisions based on medical necessity to approve, modify, or deny requests by a provider prior to the provision of health care services to be made in a timely fashion that does not exceed 48 hours for standard requests or 24 hours for urgent requests upon the health plan or health insurer's receipt of the information reasonably necessary and requested by the health plan or health insurer to make the determination.

2) Defines "urgent" to mean the enrollee or insured's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or that the normal timeframe for the decision-making process for standard requests would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.

EXISTING LAW:

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

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (UR) or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

4) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

5) Requires decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to be made in a timely fashion that does not to exceed five business days from the health plan or health insurer's receipt of the information reasonably necessary and requested by the plan to make the determination. Requires, in cases where the review is retrospective, the decision to be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and be communicated to the provider in a manner that is consistent with current law. [HSC § 1367.01 and INS § 10123.135]

6) Requires decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services, to be made in a timely fashion appropriate for the nature of the enrollee or insured's condition, not to exceed 72 hours when an individual's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. [HSC § 1367.01 and INS § 10123.135]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, delays in prior authorization create unnecessary barriers to timely medical care, leading to worsened patient outcomes, increased healthcare costs, and provider burnout. The author continues that this bill ensures that health insurers make prior authorization decisions within 48 hours instead of five days for standard requests and 24 hours instead of 48 hours for urgent cases, reducing delays that prevent patients from receiving necessary treatment. The author concludes that by streamlining the process, the bill improves access to care, lowers avoidable healthcare expenses, and allows providers to focus on patient needs

2) **BACKGROUND.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

    a) **Overall impact of prior authorization.** In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization

is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

b) Cost impacts. One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low value or medically unnecessary care is delivered. Behavioral health – particularly applied behavioral analysis – was identified by health plans/insurers as a leading fraud risk.

c) Access to and utilization of care. Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between 5% to 15% of all covered medical services and 16% to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out-of-pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

d) Administrative burden. According to the American Medical Association (AMA), prior authorization leads to substantial administrative burdens for physicians, taking time away from direct patient care while costing practices money. AMA's 2024 physician survey on prior authorization found that on average, physicians and their staff spend 13 hours each week completing prior authorizations and 40% of physicians have staff who work exclusively on prior authorization. One in three physicians reported that prior

authorization requests are often or always denied and 93% reported that prior authorization leads to care delays for their patients. 89% of physicians reported that prior authorization somewhat or significantly increases physician burnout.

e) Antiquated systems. According to CHBRP, many aspects of prior authorization workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. Contributing to the resource intense process is the type of technology (or lack of) used by providers and plans. Although many providers have transitioned to electronic health records (EHRs), for some providers, the cost to do so is prohibitive. Additionally, not all EHRs easily communicate with other EHRs, thereby still requiring a person to manually transfer information from one system to another. In light of these challenges, there are ongoing state and federal efforts to improve data sharing across health care entities to improve processes like prior authorization.

In January of 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule. This rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. The rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care. Impacted payers are required to implement certain provisions by January 1, 2026 and meet remaining requirements by January 1, 2027.

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) and required CalHHS to finalize a data sharing agreement by July 1, 2022. The DxF defines the entities that will be subject to these new data exchange rules and sets forth a common set of terms, conditions, and obligations to support secure, real-time access to and exchange of health and social services information, in compliance with applicable federal, state, and local laws, regulations, and policies. DxF is not a new technology or centralized data repository, it is an agreement across health and human services systems and providers to share information safely. Many health care entities were required to participate beginning January 2024. Remaining entities are required to participate by January 2026.

3) SUPPORT. The California Medical Association (CMA), sponsor of this bill, states that burdensome prior authorization processes contribute to more adverse effects on patient care outcomes, especially when they result in delays in treatment. CMA continues that adding to these delays are the sluggish response times by health plans to prior authorization requests. CMA states that California currently has some of the slowest response timelines in the nation – 5 business days for non-urgent requests and 72 for urgent requests. CMA argues that these slow-moving response times lead to delays that negatively impact patient health. CMA continues that current prior authorization timelines are inadequate for many patients, and delays can cause unnecessary suffering, increased healthcare costs due to complications from postponed treatment, and administrative burdens on physicians. CMA concludes that by shortening response timelines, this bill ensures that health plans respond to a prior authorization request in a timelier manner, avoiding unnecessary delays to crucial medical

care that have resulted in unnecessary pain, the worsening of patients' illnesses and in some cases even death.

4) **OPPOSSED UNLESS AMENDED.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, they state they share the goal of ensuring timely access to medically necessary care, but believe the proposed timelines are operationally burdensome, will negatively impact the health care system, and will lead to the exact opposite goal the bill is trying to achieve. CAHP and ACLHIC highlight operational challenges an unintended consequences with this bill, including increased administrative burden on providers, potential for increased denial rates, and increased cost of health care. CAHP and ACLHIC suggest alternative approaches to this bill, including mandating that all authorization requests be submitted electronically, requiring clinically complete requests, excluding prescription drug authorizations, and delaying the implementation date.

5) **RELATED LEGISLATION.**

   a) AB 384 (Connolly) would prohibit a health plan, health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 is currently pending in the Assembly Health Committee.

   b) AB 510 (Addis) would require, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 is currently pending in the Assembly Health Committee.

   c) AB 539 (Schiavo) would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is currently pending in the Assembly Health Committee.

   d) AB 574 (Mark González) would prohibit a health plan or health insurer that provides coverage for physical therapy (PT) from requiring prior authorization for the initial 12 treatment visits for a new episode of care for PT.

   e) AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would prohibit concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 is currently pending in the Assembly Health Committee.

   f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 516 (Skinner) of 2024, would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization. SB 516 was not heard in the Assembly Health Committee.

b) SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

c) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

d) AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. Would have defined clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 was vetoed by Governor Newsom who stated in part:

"Health plans and health insurers should make every effort to streamline UM processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing IMR requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes."

e) AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of the 30 health care services for which prospective review was most frequently requested. AB 1268 was held on suspense in the Assembly Appropriations Committee.

7) PROPOSED AMENDMENTS. Current law sets forth identical timelines for prior authorization and concurrent review requests. This bill only updates timelines for prior authorization requests, leaving longer concurrent review timelines in statute. This split in review timelines may create unintended consequences. When timelines for prior authorization become shorter than those for concurrent review, health plans may shift to lean on concurrent reviews for denials if they have a longer period to do so. This could lead to an increase in denials of coverage during or after receipt of services, which would be burdensome to consumers who would have to grapple with either discontinuing or being responsible for paying for a treatment plan they have already started. The committee may wish to amend this bill to shorten timelines for both prior authorization and concurrent reviews, keeping them consistent as they are under existing law.

8) POLICY COMMENTS.

a) Alignment with data solutions. As noted in the background of this analysis, many aspects of the UR workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. While there is no doubt that shortening UR timelines will improve patient access to care and reduce provider burden, the timelines in this bill will be difficult to meet if providers and plans are still relying on outdated information sharing systems. The author and sponsors may wish to work with stakeholders to ensure that this bill is aligned with ongoing state and federal efforts to improve data sharing and technological connectivity between patients, providers, and payers to ensure that the timelines it is setting can be met.

b) Best approach for addressing issues with UR and UM. This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes through systemic level changes such as speeding up processing times, reducing the overall volume of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (sponsor)
AARP
Alliance of Catholic Health Care, Inc.
ALS Association
American Academy of Pediatrics, California
American Diabetes Association
Association for Clinical Oncology
Association of Northern California Oncologists
California Academy of Child and Adolescent Psychiatry
California Chapter American College of Cardiology
California Chronic Care Coalition
California Hospital Association
California Orthopedic Association
California Retired Teachers Association
California Rheumatology Alliance
California Society of Plastic Surgeons
California State Association of Psychiatrists
Medical Oncology Association of Southern California

Mental Health America of California
Saint Agnes Medical Center
Stanford Health Care
U.S. Pain Foundation
United Hospital Association

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 539 (Schiavo) – As Introduced February 11, 2025

SUBJECT: Health care coverage: prior authorizations.

SUMMARY: Requires a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval.

EXISTING LAW:

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

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (UR) or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

4) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, while prior authorization delays and denials continue to climb, so too do the harms to patients. What's worse, the author continues, is insurance companies are looking to artificial intelligence to speed up the denial process while suggesting it leads to positive patient experiences, and increased safety and affordability. The author notes that the data is clear, insurers are using prior authorization to deny care and boost profits. The author continues this bill reduces health care administrative

costs and speeds up patient access to care by extending the duration of an approved prior authorization by a health plan to one year. The author argues this approach will remove unnecessary bureaucratic delays, reduce the burden on physicians and patients, and help prevent lapses in vital life-saving care, especially for those with chronic illnesses, due to having to seek frequent approval for their care. The author concludes this is one step that California can take to re-center patients, as opposed to health insurance profits, and reduce the harm caused by prior authorization delays.

2) **BACKGROUND.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay, or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

   a) **Overall impact of prior authorization.** In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

   b) **Cost impacts.** One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low-value or medically unnecessary care is delivered.

Behavioral health, particularly applied behavioral analysis, was identified by health plans/insurers as a leading fraud risk.

c) **Access to and utilization of care.** Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between 5% to 15% of all covered medical services and 16% to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out of pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

d) **Administrative burden.** According to the American Medical Association (AMA), prior authorization leads to substantial administrative burdens for physicians, taking time away from direct patient care while costing practices money. AMA's 2024 physician survey on prior authorization found that on average, physicians and their staff spend 13 hours each week completing prior authorizations and 40% of physicians have staff who work exclusively on prior authorization. One in three physicians reported that prior authorization requests are often or always denied and 93% reported that prior authorization leads to care delays for their patients. 89% of physicians reported that prior authorization somewhat or significantly increases physician burnout.

e) **Antiquated systems.** According to CHBRP, many aspects of prior authorization workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. Contributing to the resource intense process is the type of technology (or lack of) used by providers and plans. Although many providers have transitioned to electronic health records (EHRs), for some providers, the cost to do so is prohibitive. Additionally, not all EHRs easily communicate with other EHRs, thereby still requiring a person to manually transfer information from one system to another. In light of these challenges, there are ongoing state and federal efforts to improve data sharing across health care entities to improve processes like prior authorization.

   In January of 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule. This rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. The rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care. Impacted payers are required to implement certain provisions by January 1, 2026 and meet remaining requirements by January 1, 2027.

   AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) and required CalHHS to finalize a data sharing agreement by July 1, 2022. The DxF defines the

entities that will be subject to these new data exchange rules and sets forth a common set of terms, conditions, and obligations to support secure, real-time access to and exchange of health and social services information, in compliance with applicable federal, state, and local laws, regulations, and policies. DxF is not a new technology or centralized data repository, it is an agreement across health and human services systems and providers to share information safely. Many health care entities were required to participate beginning January 2024. Remaining entities are required to participate by January 2026.

3) **SUPPORT.** The California Medical Association (CMA), sponsor of this bill, states that many conditions require ongoing treatment plans that benefit from strict adherence and recurring prior authorization requirements can lead to disruptions in care delivery and threaten a patient's health. CMA shares that according to an AMA survey, 88% of physicians reported that prior authorizations interfere with continuity of care for patients and 78% of physicians reported that prior authorization can lead to treatment abandonment, inevitably leading patients to seek more expensive forms of care, including emergency room visits and even unexpected hospitalization. CMA continues that the current standard for an approved prior authorization request is about 60 to 90 days, which leads to physicians having to submit multiple requests for the same services, even when the treatment plan has not changed since the initial claim. Adding to the frustration of physicians and patients is that identical claims submitted weeks apart will have different outcomes, one that is approved while the other is denied. CMA argues that these arbitrary delays disrupt a patient's treatment plan and interfere with continuity of care. CMA concludes that by extending the duration of approved prior authorizations to one year, this bill reduces inefficient administrative burdens on providers, addresses redundancies in the current approval process, and ensures that patients have access to the care they need without delays or interference from health plans.

4) **OPPOSED UNLESS AMENDED.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) are opposed to this bill unless it is amended. CAHP and ACLHIC state that while it is vitally important to maintain appropriate checks-and-balances in health care, it is equally important to embrace solutions. To address their concerns and ensure that this bill does not negatively impact patient care and the responsible use of health care resources, CAHP and ACLHIC recommend amendments to: mandate that all authorization requests be submitted electronically by providers, require authorizations to be clinically complete, limit the validity period to a maximum of six months, limit the validity period to specific treatments/drugs for certain chronic conditions, exempt certain treatments and drugs, specify that the validity timeline is based on the expected course of treatment or clinically appropriate timeline associated with the service, clarify the impact of eligibility termination, and delay the implementation date of the bill.

5) **RELATED LEGISLATION.**

   a) AB 384 (Connolly) would prohibit a health plan, health insurer, or the Medi-Cal program, from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings for mental health and substance use disorders and for any medically necessary services provided while admitted for that care. AB 384 is currently pending in the Assembly Health Committee.

b) AB 510 (Addis) would require, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 is currently pending in the Assembly Health Committee.

c) AB 512 (Harabedian) would shorten the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. AB 512 is currently pending in the Assembly Health Committee.

d) AB 574 (Mark González) would prohibit a health plan or health insurer from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy (PT). Would require a PT provider to verify an individual's coverage and disclose their share of the cost of care, as specified. Would require a PT provider to obtain written consent for costs that may not be covered by the individual's plan, as specified. AB 574 is currently pending in the Assembly Health Committee.

e) AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient substance use disorder (SUD) stay. Would prohibit concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 is currently pending in the Assembly Health Committee.

f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 516 (Skinner) of 2024 would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization. SB 516 was not heard in the Assembly Health Committee.

b) SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

c) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

d) AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. Would

have defined clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 was vetoed by Governor Newsom who stated in part:

"Health plans and health insurers should make every effort to streamline UM processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing IMR requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes."

e) AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of the 30 health care services for which prospective review was most frequently requested. AB 1268 was held on suspense in the Assembly Appropriations Committee.

7) **PROPOSED AMENDMENTS.** Short authorization periods can lead to disruptions in patient treatment and administrative burden for physicians. However, unnecessarily long authorization periods could lead to the overutilization of unnecessary care. Not all conditions will need a year of treatment, such as infections like strep throat or viruses like influenza. The committee may wish to amend this bill to specify that a prior authorization is valid for one year or throughout the course of prescribed treatment, if that is less than one year.

8) **POLICY COMMENT.** This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes through systemic level changes such as speeding up processing times, reducing the overall volume of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (sponsor)
ALS Association
American Diabetes Association
Association for Clinical Oncology
Association of Northern California Oncologists
California Academy of Child and Adolescent Psychiatry
California Chapter American College of Cardiology

California Chronic Care Coalition
California Orthopedic Association
California Podiatric Medical Association
California Radiological Society
California Retired Teachers Association
California Rheumatology Alliance
California Society of Plastic Surgeons
California State Association of Psychiatrists
Children's Specialty Care Coalition
Crohn’s and Colitis Foundation
Hemophilia Council of California
Medical Oncology Association of Southern California
Mental Health America of California
U.S. Pain Foundation
Western Center on Law & Poverty

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 543 (Mark González) – As Amended April 8, 2025

SUBJECT: Medi-Cal: street medicine.

SUMMARY: Requires the Department of Health Care Services (DHCS) to implement a Medi-Cal presumptive eligibility (PE) program for persons experiencing homelessness (PEH). Requires a Medi-Cal managed care (MCMC) plan that elects to offer Medi-Cal covered services through a street medicine provider to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a street medicine provider, regardless of the beneficiary's network assignment. Requires the single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs developed by DHCS to include the means for the applicant to indicate if they are a PEH at the time of application or redetermination. Specifically, **this bill**:

Presumptive Eligibility for PEH

1) Requires DHCS to implement a PE program for PEH.

2) Requires the PE benefits provided under this bill to be full-scope Medi-Cal benefits without a share of cost.

3) Requires DHCS, upon implementation of the PE for PEH, to issue a declaration stating that implementation of the program has commenced.

4) Permits an enrolled Medi-Cal provider, including, but not limited to, a health facility or a clinic, including in the capacity of a street medicine provider or otherwise, to make a PE determination for a PEH.

MCMC Plan Option for Street Medicine and Requirements for Direct Access Option if Implemented by MCMC Plans for a PEH

5) Permits a Medi-Cal managed care plan to elect to offer Medi-Cal covered services through a street medicine provider pursuant to this bill.

6) Requires a MCMC that elects to offer Medi-Cal covered services through a street medicine provider to allow:

    a) A Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a street medicine provider, regardless of the beneficiary's network assignment, such as primary care provider (PCP) or independent practice association (IPA) assignment; and,

    b) A street medicine provider enrolled in the Medi-Cal program to directly refer a Medi-Cal beneficiary who is experiencing homelessness for covered services, including specialist, diagnostic services, medications, durable medical equipment (DME), transportation, or other medically necessary covered services, within the appropriate network of the MCMC plan or IPA.

7) Requires the MCMC plan or IPA to create referral and authorization mechanisms in order to facilitate the referrals described above.

8) Permits a MCMC plan, in implementing direct access requirements, to establish reasonable requirements governing participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to Medi-Cal beneficiaries who are experiencing homelessness.

9) Requires a MCMC plan to provide a Medi-Cal beneficiary with the ability to inform the MCMC plan online, in person, or via telephone that the beneficiary is experiencing homelessness.

10) Requires DHCS to inform a MCMC plan if a Medi-Cal beneficiary has indicated that they are experiencing homelessness based on information furnished on the Medi-Cal application.

11) Requires DHCS, in the case of a Medi-Cal beneficiary who is experiencing homelessness and who receives services within the fee-for-service (FFS) delivery system, to reimburse a street medicine provider enrolled in the Medi-Cal program for providing Medi-Cal covered services.

Data Sharing and Medi-Cal Applications

12) Requires DHCS to ensure that the Medi-Cal program and the California Statewide Automated Welfare System (CalSAWS, which is the county statewide eligibility system) mutually share data on the status of Medi-Cal applicants or beneficiaries who are PEH, including through codes relating to unsheltered status.

13) Requires the coordination described above to enable a person applying for the Medi-Cal program to identify that they are a PEH, including if that person applies for various public social services programs through a centralized internet website or other mechanism. Requires this provision to be implemented in accordance the Single Streamlined Application for insurance affordability programs in 15) below.

14) Requires the data shared to be made available to DHCS, CalSAWS, and, as applicable, the corresponding MCMC plan.

15) Requires the single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs developed by DHCS to include the means for the applicant to indicate if they are a PEH at the time of application or redetermination (this is known as the “Single Streamlined Application”).

16) Defines, for purposes of this bill, a PEH as a person who is “homeless” by reference to a definition used by the federal Department of Housing and Urban Development (HUD) in an existing federal regulation.

17) Defines, for purposes of this bill, a “street medicine provider” to mean a licensed medical provider, including, but not limited to, a physician and surgeon, osteopathic physician and surgeon, physician assistant, nurse practitioner, or certified nurse-midwife, who conducts patient visits outside of the four walls of health facilities, clinics, or other locations, and instead provides care directly on the street, in environments where persons experiencing

unsheltered homelessness might be, such as living in a car, recreational vehicle, encampment, abandoned building, or other outdoor areas.

18) Makes various legislative findings and declarations about the health status of PEH, street medicine, and policy barriers in delivering health care services to this population.

EXISTING LAW:

1) 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*.]

2) Makes adults and parents with incomes up to 138% of the federal poverty level (FPL) eligible for Medi-Cal, and makes children with incomes up to 266% of the FPL eligible for Medi-Cal, including providing full-scope Medi-Cal benefits to undocumented children and young adults through age 25. [WIC § 14005.30, § 14005.60, § 14005.26]

3) Requires a single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs known as the "Single Streamlined Application" to be developed by DHCS, in consultation with Covered California, to be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents. [WIC § 15926]

4) Permits, under federal Medicaid regulation, if the state agency provides Medicaid during a PE period to children or to pregnant women, the agency to also apply PE to other groups of individuals, including parents and caretaker relatives, and individuals aged 19 through 64, based on the income standard established by the state. [Title 42, Code of Federal Regulations, § 435.1100 *et seq*.]

5) Requires, in areas specified by the director for expansion of the MCMC program under particular MCMC models where DHCS is contracting with a plan, an applicant or beneficiary to be informed of the health care options available regarding methods of receiving Medi-Cal benefits. (This process is referred to as the "Health Care Options" process.) [WIC § 14087.305]

6) Requires each Medi-Cal beneficiary to be informed that if they fail to make a choice, they will be assigned to, and enrolled in, a plan. [*Ibid*.]

7) Requires the Medi-Cal beneficiary to indicate their choice, in writing, from among the available plans in the region and their choice of PCP or clinic contracting with the selected plan. [*Ibid*.]

8) Requires, if a beneficiary or eligible applicant does not choose a PCP or clinic, or does not select any PCP who is available, the plan that was selected by or assigned to the beneficiary to ensure that the beneficiary selects a PCP or clinic within 30 days after enrollment or is assigned to a PCP within 40 days after enrollment. [*Ibid*.]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, every person in our community deserves compassionate, comprehensive care—this includes the 187,000 people living on the streets in California. PEH face severe health risks and a mortality rate ten times higher than the general population—largely due to barriers in accessing health care. Evidence-based models like street medicine have proven to significantly improve access to health care, reduce hospitalizations, enhance chronic disease management, and increase housing placements. To address the ongoing homelessness crisis, we must respond with innovation and solution rooted in humane solutions that work, such as street medicine. The author concludes that these are not just programs; they are lifelines.

2) **PERSONS EXPERIENCING HOMLESSNESS**. A long-standing way that California and the rest of the United States have estimated the number of people experiencing homelessness is through a point-in-time count. Because the count is only a snapshot of people experiencing homelessness on one given night in a year (typically in late January) and those conducting the count may miss individuals who are hidden from view at the time (such as people sleeping in a secluded area), the homelessness data collected is an undercount. In January 2024 (the most recently available data), 187,000 people were counted as homeless in California—an all-time high, and 36,000 (24%) more than were counted in January 2019. Two-thirds of those counted were unsheltered (such as people living on the street or in a park). The other one-third were identified as "sheltered homeless," meaning they were spending the night in an emergency shelter or other temporary housing. California has 12% of the total population in the U.S. but accounts for about one-quarter of the country's homelessness count.

   A California Health Care Foundation Issue Brief titled "*Homelessness and Health Care: Lessons and Policy Considerations from the COVID-19 Pandemic"* cited studies that people who are homeless have higher rates of illness and die on average 12 years sooner than the general US population, that people living in shelters are more than twice as likely to have a disability compared to the general population, and community survey data indicate that over one-quarter of people experiencing homelessness have severe mental illness and nearly 35% have a chronic substance use disorder. The Issue Brief stated that chronic disease such as diabetes, heart disease, respiratory tract conditions, dental disease, and HIV/AIDS are found at high rates among the homeless population, placing people experiencing homelessness at higher risk of serious illness from COVID-19. Additionally, PEH who contract COVID-19 are two to four times more likely to require critical care and two to three times as likely to die compared to the general population.

3) **DHCS POLICY ON STREET MEDICINE.** Existing DHCS policy for street medicine is published in guidance. DHCS All-Plan Letter (APL) 24-001 is the most recent guidance to date. This guidance is for MCMC plans on opportunities to utilize street medicine providers to address clinical and non-clinical needs of their Medi-Cal members experiencing unsheltered homelessness. Under APL 24-001, the utilization of street medicine providers is voluntary for MCMC plans, but if a plan offers street medicine, it must meet the requirements of the APL.

   Street medicine providers are required to verify the Medi-Cal eligibility of individual they encounter in the provision of health care services. Street medicine providers rendering

services to Medi-Cal eligible individuals are to bill Medi-Cal FFS or the plan if the provider is contracted, based on the eligibility of the individual. If a street medicine provider is a federally qualified health center (FQHC), the APL indicates the FQHC can be reimbursed at their applicable Prospective Payment System rate when such services are provided outside the four walls of the clinic and where the beneficiary is located.

4) **PE.** This bill requires, to the extent that FFP is available, DHCS to implement a PE program for PEH. PE is a federal Medicaid option that permits time-limited coverage in lieu of a full Medicaid application. California has elected to implement several PE programs, which provide qualified individuals immediate temporary Medi-Cal coverage based on the individual's self-attested preliminary information. Qualified PE providers approved by DHCS make PE determinations under the following programs:

   a) Breast and Cervical Cancer Treatment Program;

   b) Child Health and Disability Prevention Program (known as "CHDP Gateway");

   c) Every Woman Counts;

   d) PE for Pregnant Women (PE4PW); and,

   e) Hospital PE.

   The provider-based PE process enables eligible applicants to receive immediate access to temporary, no-cost Medi-Cal while the individual applies for permanent Medi-Cal coverage or other health coverage. DHCS allows qualified Hospital PE providers to determine PE under the Hospital PE program off the premises of hospitals and clinics, such as in mobile clinics, street teams or other locations. The Hospital PE Provider submits the individual's information via the Hospital PE Medi-Cal Application online portal and eligibility is determined in real-time. Similarly, PE4PW program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application.

   The advantages of extending PE to PEH is that PE provides immediate access to care and enables continuity of care, facilitates enrollment in coverage by establishing new/additional points of entry to coverage, offers streamlined enrollment and mitigates potential Medi-Cal eligibility processing delays.

5) **APPLICATION MODIFICATION.** Under the Patient Protection and Affordable Care Act (ACA) and state law, an individual has the option to apply for insurance affordability programs (Medi-Cal and Covered California) in person, by mail, online, by telephone, or by other commonly available electronic means. There are multiple Medi-Cal applications, including a joint application for Medi-Cal, CalWORKS and CalFRESH (known as the "SAWS-2 Plus"), and an ACA-required "Single Streamlined Application" for insurance affordability programs. The automated state eligibility and enrollment system for Covered California and Medi-Cal is known as the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The single streamlined application is required by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents.

The SAWS-2 Plus application asks the question "Are you homeless?" with instructions to the applicant to let the county know right away if the individual is a PEH so the county can help the applicant figure out an address to use to accept their application and receive notices from the county about the person's case. This joint application also asks the question because there are additional services available through CalWORKs and Cal FRESH. There are multiple policy reasons for including such a question on the Medi-Cal application.

a) PEH may be receiving mail at a location that they do not visit regularly (such as a charity or social services/welfare office) and MCMC plans and providers could be made aware that attempting to contact the individual via mail may result in a delayed or non-response, and that other forms of communication would be more effective;

b) An affirmative answer to the question will identify beneficiaries as a PEH who will have "direct access" to health care providers treating PEH outside the four walls of a health care provider's office;

c) MCMC plans would be aware of PEH in determining auto-assignment of a beneficiary to a primary care physician or a clinic; and,

d) MCMC plans could enroll the PEH in additional benefits currently available in MCMC (case management) and under California Advancing and Innovating Medi-Cal (CalAIM), such as enhanced case management and community supports.

6) SUPPORT. This bill is jointly sponsored by the California Street Medicine Collaborative and the University of Southern California (USC), which write that this bill takes essential steps to ensure that Medi-Cal-eligible individuals who are unhoused can receive life-saving medical care without unnecessary administrative delays. The sponsors note that the mortality rate among people experiencing homelessness is ten times higher than that of housed individuals and continues to rise at an alarming rate. The sponsors state that, despite the scale of this crisis, existing health care systems fail to provide adequate access to primary and specialty care for unhoused individuals. Although over 70% of people experiencing homelessness are enrolled in Medi-Cal, only 8% have access to a primary care provider, compared to 82% of the general population. The sponsors state this is not due to a lack of insurance, but rather systemic barriers, including lack of identification, network-based restrictions on referrals, and prolonged Medi-Cal eligibility redeterminations, that prevent them from receiving the care they need. Without access to primary care, people experiencing homelessness are forced to rely on emergency departments and crisis services at much higher rates.

The sponsors point to studies that show that unhoused individuals have twice the length of hospital stays compared to housed patients and spend 740% more days in the hospital, at 170% higher costs per day. In addition, the sponsors note that studies have shown that street medicine inpatient consult services have reduced hospital stays from eleven days to eight days among homeless patients and decreased 30-day readmission rates from 37% to 10%, and that providing medical care outside of traditional facilities significantly improves housing placements.

The sponsors state this bill tackles the barriers preventing unhoused individuals from receiving timely, appropriate care by ensuring access to medically necessary services when a street medicine provider determines that a patient needs specialty care, diagnostics, or DME.

The sponsor states MCMC plans frequently deny these referrals solely due to network assignment restrictions. This bill prohibits MCMC plans from denying necessary care based only on network assignment, ensuring that unhoused individuals are not left without critical medical interventions simply because they receive care outside of a traditional clinic.

In addition, this bill would allow street medicine providers to immediately enroll eligible individuals in Medi-Cal through the use of PE, thus eliminating the bureaucratic delays that currently leave patients without coverage while awaiting an eligibility determination or initial enrollment. Finally, this bill would require the creation of a homelessness identifier code in Medi-Cal and public assistance systems. The sponsors state the lack of a specific identifier for homelessness within Medi-Cal and California's welfare system leads to missed opportunities to connect eligible individuals to essential services and causes additional administrative burden and inefficiency. The sponsors conclude that this bill is a necessary and long overdue reform that ensures people experiencing homelessness can access the health care to which they are entitled—without preventable delays, denials, or administrative barriers.

7) **OPPOSE UNLESS AMNEDED.** Several Los Angeles-based FQHCs and provider groups write taking an oppose unless amended position, including the Community Clinic Association of Los Angeles County (CCALAC). CCALAC and these entities write that they are opposed to this bill unless it is amended to address the need for reliable communication and sharing of information between providers as part of the MCMC model when street medicine providers provide medical care to beneficiaries on the street. Given the role and responsibilities of primary care providers with regard to their assigned patients, it is crucial they are informed when another provider renders care or services to their patients to enable outreach, monitoring, and follow-up care.

8) **PREVIOUS LEGISLATION.** AB 369 (Kamlager) contained provisions similar to this bill in allowing direct access to street medicine providers, requiring applications for insurance affordability programs to ask about whether the applicant was a PEH, and to establish a PE program. AB 369 was vetoed by Governor Newsom. In his veto message, the Governor stated that creating a "carve out" for PEH, on the eve of the CalAIM transformation, will cut out these patients from services that are being created specifically to support their health, housing stability, and overall well-being. The Governor stated he is directing DHCS to identify any interim gaps that can be imminently addressed and act quickly to close these gaps, and that such actions may include providing temporary resources to street medicine providers across the state, providing additional technical assistance to street medicine providers who seek to provide services through managed Medi-Cal, and promptly implementing the CalAIM opportunities that will soon be rolling out.

REGISTERED SUPPORT / OPPOSITION:

Support

California Street Medicine Collaborative (co-sponsor)
University of Southern California (co-sponsor)
Adventist Health
California Chapter of the American College of Emergency Physicians
California Hospital Association
California Pan-Ethnic Health Network

California State Association of Counties
California State Association of Psychiatrists
California Street Medicine Collaborative
Capital Compassion
Coalition to Abolish Slavery and Trafficking
Corporation for Supportive Housing
County Behavioral Health Directors Association
Courage California
Downtown Women's Center
Drug Policy Alliance
Elica Health Centers
Healthcare in Action (HIA)
Heritage Clinic
Homeless Outreach Program Integrated Care Systems
Housing California
Kings Tulare Homeless Alliance
LA Family Housing
LifeLong Medical Care
Liver Coalition of San Diego
National Alliance to End Homelessness
National Health Care for the Homeless Council
National Healthcare & Housing Advisors
PATH (People Assisting the Homeless)
Sacramento Street Medicine
San Ysidro Health
SCAN Group
Shasta Community Health Center
Silverlake Community Church
Smart Justice California, a Project of Tides Advocacy
SoCal Street Medicine
St. Joseph Center
Street Medicine Institute
The People Concern
The Steinberg Institute
UC Riverside School of Medicine
Venice Community Housing Corporation
Wellness Equity Alliance
Western Center on Law & Poverty, Inc.
Whole Person Care Clinic
Seven Individuals

Opposition

None on file

Analysis Prepared by: Scott Bain / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 573 (Rogers) – As Amended March 28, 2025

SUBJECT: Cigarette and tobacco products: licensing and enforcement.

SUMMARY: Requires a tobacco retailer to pay a fee to cover the reasonable regulatory costs of the California Department of Tax and Fee Administration (CDTFA), not to exceed $600, for the issuance or renewal of a license to sell those tobacco products. Requires the Legislative Analyst (LAO), on or before December 1, 2027, and again on or before December 1, 2029, in collaboration with specified agencies, to prepare and submit reports to the Legislature on the adequacy of funding for the tobacco retailer licensing program and the rate of inspection of retailers. Repeals those reporting requirements on January 1, 2034. Specifically, **this bill**:

1) Requires a tobacco retailer to submit a fee, to cover the reasonable regulatory costs of CDTFA, not to exceed $600, with each application for the issuance or renewal of a license. Requires an applicant that owns or controls more than one retail location to pay a separate fee for each location.

2) Requires the LAO, on or before December 1, 2027, and again on or before December 1, 2029, in collaboration with the CDTFA and the Department of Public Health (DPH), including, but not limited to, the Office of Youth Tobacco Enforcement, to prepare and submit a report to the Legislature on the adequacy of funding for the tobacco retailer licensing program and the rate of inspection of retailers. Requires, to the extent data is available, the report to include, but not be limited to:

    a) Strategies and tools to bolster coordination and efficiency between state and federal agencies and local authorities regarding enforcement of all tobacco laws and to ensure state compliance with the federal Synar regulations requiring no more than a 20% retailer violation rate;

    b) Data and recommendations about whether the annual licensing fees are set at appropriate levels to maintain an effective licensing and enforcement program and attain a reasonable reduction in the availability of flavored tobacco products;

    c) Costs for transport, storage, and disposal of hazardous waste, universal waste, and other waste arising from seizures of tobacco products; and,

    d) An evaluation of whether prior violations of analogous federal and local laws regarding the sale of tobacco products to minors should be considered when considering escalating penalties for violations of state laws regarding the sale of tobacco products to minors.

3) Authorizes the LAO, to prepare the reports required by this bill, to request information from any state or local agency involved in enforcement of laws regulating retailers.

4) Requires the reports required by this bill to be submitted in compliance with existing law, and to not include any personally identifiable information. Makes this provision inoperative on December 1, 2033, and repealed on January 1, 2034.

5) Repeals a duplicative provision of code that authorizes CDTFA to seize illegal flavored tobacco products or tobacco product flavor enhancers if CDTFA discovers that a retailer sells, offers for sale, or possesses with the intent to sell or offer for sale, those products, and deems the seized products as forfeited.

6) Defines "package" to mean the individual packet, box, or other container of flavored tobacco products or tobacco product flavor enhancers that are normally sold or intended to be sold at retail. "Package" does not include containers that contain smaller packaging units of flavored tobacco products or tobacco product flavor enhancers, including, but not limited to, cartons, cases, bales, or boxes.

7) Makes the following findings and declarations:

   a) As state agencies ramp up efforts to enforce California's flavored tobacco laws, the scale and frequency of enforcement activities is critical. As of September 2024, prohibited flavored e-cigarettes comprised 39.8% of total e-cigarette sales in California;

   b) While the proportion of California youth and young adult tobacco users who report that it is easy to access flavored tobacco products in retail stores has declined since implementation of the ban, over 70% still believe it is easy to access these products. Nearly 90% of California high school e-cigarette users report using flavored e-cigarettes; and,

   c) In 2024, California tobacco retailers still sold tobacco to underage buyers at a rate of 18.9%. Regular compliance inspections are proven to reduce youth access to tobacco products.

   d) That this bill strikes a balance between reporting essential information to the Legislature to ensure adequate funding for the cigarette and tobacco product retailer licensing program while protecting the privacy of individuals.

EXISTING LAW:

1) Establishes DPH to protect the public's health and help shape positive health outcomes for individuals, families and communities. Establishes the California Tobacco Control Branch within DPH, which leads statewide and local health programs, services and activities that promote a tobacco free environment. [Health and Safety Code (HSC) § 131056]

2) Requires CDTFA, under the Cigarette and Tobacco Products Licensing Act, to administer a statewide program to license cigarette and tobacco product manufacturers, importers, distributors, wholesalers, and retailers. Prohibits selling tobacco products without a valid license, and makes violations punishable as a misdemeanor. Retailers are required to obtain a separate license for each retail location that sells cigarettes and tobacco products and pay to an annual license fee. [Business and Professions Code (BCP) § 22970 *et seq.*]

3) Requires DPH to establish and develop a program to reduce the availability of "tobacco products," as defined, to persons under 21 years of age through authorized enforcement activities, as specified, pursuant to the Stop Tobacco Access to Kids Enforcement Act (STAKE Act). [BCP § 22952]

4) Requires all persons engaging in the retail sale of tobacco products to check the identification of tobacco purchasers, to establish the age of the purchaser, if the purchaser reasonably appears to be under 21. [BPC § 22956]

5) Permits an enforcing agency, as specified, to assess civil penalties against any person, firm, or corporation that sells, gives, or in any way furnishes to another person who is under 21 any tobacco product, instrument, or paraphernalia that is designed for the smoking or ingestion of tobacco products, as specified, ranging from $400 to $6,000 for a first, second, third, fourth, or fifth violation within a five-year period. [BPC § 22958]

6) Permits an enforcing agency to assess civil penalties against any person, firm, or corporation that sells, gives, or in any way furnishes to another person who is under 21, except for military personnel 18 years of age or older, any tobacco product, instrument, or paraphernalia that is designed for the smoking or ingestion of tobacco products ranging from $400 to $6,000 for a first, second, third, fourth, or fifth violation within a five-year period. [BPC § 22958]

7) Prohibits a tobacco retailer, or any of the tobacco retailer's agents or employees, from selling, offering for sale, or possessing with the intent to sell or offer for sale, a "flavored tobacco product," as defined, or a "tobacco product flavor enhancer," and authorizes an enforcing agency (DPH, the California Attorney General, or a local law enforcement agency) to assess civil penalties against any person or entity that violates this provision. [HSC § 104559.5]

8) Requires DPH, in addition to the civil penalties in 6) above, upon the assessment of a civil penalty for the third, fourth, or fifth violation, to notify CDTFA of the violation. Requires CDTFA to assess a civil penalty of $250 and suspend or revoke a retailer's license. [*Ibid.*]

9) Defines "flavored tobacco product" as any tobacco product that contains a constituent that imparts a characterizing flavor. Defines "tobacco product flavor enhancer" as a product designed, manufactured, produced, marketed, or sold to produce a characterizing flavor when added to a tobacco product. [*Ibid.*]

10) Defines "characterizing flavor" to mean a distinguishable taste or aroma, or both, other than the taste or aroma of tobacco, imparted by a tobacco product or any byproduct produced by the tobacco product. Includes, but are not limited to, tastes or aromas relating to any fruit, vanilla, chocolate, honey, candy, cocoa, dessert, alcoholic beverage, menthol, mint, wintergreen, herb, or spice. Prohibits a tobacco product from being determined to have a characterizing flavor solely because of the use of additives or flavorings or the provision of ingredient information and instead, it is the presence of a distinguishable taste or aroma, or both, that constitutes a characterizing flavor.

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, despite recent efforts by the Legislature to pass comprehensive laws banning access to flavored tobacco products, these products are still getting into the hands of young people at an alarmingly high rate. Even though they are illegal, flavored e-cigarettes still comprise almost 40% of total e-cigarette

sales in California. In 2024, 18.9% of California tobacco retailers still sold tobacco to underage buyers. Nationwide, 90% of middle school and high school e-cigarette users report preferring flavored products. Clearly, more must be done to bring retailers into compliance with the law and protect young people from getting hooked on tobacco products. The author states that CDTFA is tasked with enforcing the flavored tobacco ban on the retail level, but they have limited resources and only inspect about 11% of retailers every year. This bill provides CDTFA with more funding to maintain and enhance tobacco enforcement operations by increasing the state tobacco retailer license annual fee from $265 to $600. Currently, CDTFA relies on an annual allocation from the Cigarette and Tobacco Products Compliance Fund and a portion of its own budget to fund enforcement activities. Providing more funding from the retail license fee will provide a reliable funding source from which CDTFA can build out inspection and enforcement operations. This bill also commissions a study on the enforcement of tobacco laws amongst local, state and federal agencies to make recommendations for greater collaboration and efficiency. The author concludes that this will help guide future policy efforts to eliminate access to these dangerous and addictive products.

2) **BACKGROUND.** In 2022, California voters upheld the state law, SB 793 (Hill), Chapter 34, Statutes of 2020, which prohibits a tobacco retailer, or any of the tobacco retailer's agents or employees, from selling, offering for sale, or possessing with the intent to sell or offer for sale, most flavored tobacco products including flavored e-cigarettes and menthol cigarettes, as well as tobacco product flavor enhancers in retail locations. The following year, Governor Newsom signed into law AB 935 (Connolly), Chapter 135, Statutes of 2023, which strengthens the enforcement of the flavored tobacco retail law and broadening the definition of a retail location. In 2024, SB 1230 (Rubio), Chapter 462, Statutes of 2024 was signed into law. This bill increased STAKE Act penalties for retailers who sell to minors and strengthened CDTFA's enforcement authority by allowing them to seize illegal flavored tobacco products found during inspections. Last year, Governor Newsom signed AB 3218 (Wood), Chapter 849, Statutes of 2024, which required the creation of the Unflavored Tobacco List by the California Attorney General to clearly define which products are legally allowed to be sold by retailers, wholesalers, distributors and delivery sellers in California. The law also updates existing definitions in law and increases penalties on retailers who possess or sell illegal flavored tobacco products.
The CDTFA is responsible for ensuring that tobacco retailers comply with the state's tobacco excise tax and licensing laws. CDTFA was recently given additional authority to seize illegal flavored tobacco products.

   a) **Youth and flavored tobacco products**. A 2024 study by the Centers for Disease Control and Prevention found that, among middle school and high school students who currently use e-cigarettes, nearly 9 in 10 use flavored e-cigarettes. Illegal flavored e-cigarettes still comprise 39.8% of total e-cigarette sales in California. Disposable e-cigarettes represent 90.9% of sales of prohibited flavored e-cigarettes in California. In 2024, California tobacco retailers still sold tobacco to underage buyers at a rate of 18.9%.

      In addition to CDTFA, the Office of Youth Enforcement in DPH, the Department of Justice and local entities all play a role in enforcing the flavored tobacco law and restricting youth access. However, there is currently no systemic cooperation amongst the various enforcement agencies. This bill requires LAO to complete a study of the tobacco retailer enforcement landscape and make recommendations for better

coordination among the enforcing agencies, as well as an appropriate fee to ensure maximum compliance by all of California's retailers.

b) Demographics of tobacco use. African-American youth and young adults have significantly lower prevalence of cigarette smoking than Hispanics and whites, and although the prevalence of cigarette smoking among African-American and white adults is the same, African-Americans smoke fewer cigarettes per day. On average, African-Americans initiate smoking at a later age compared to whites; however, they are more likely to die from smoking-related diseases than whites.

American Indian/Alaska Native youth and adults have the highest prevalence of cigarette smoking among all racial/ethnic groups in the U.S, however, it is important to note that some American Indians use tobacco for ceremonial, religious, or medicinal purposes. Regional variations in cigarette smoking exist among American Indians/Alaska Natives, with lower prevalence in the Southwest and higher prevalence in the Northern Plains and Alaska.

Hispanic/Latin adults generally have lower prevalence of cigarette smoking and other tobacco use than other racial/ethnic groups, with the exception of Asian-Americans. However, prevalence varies among sub-groups within the Hispanic population. For example, 50% of Cuban men and more than 35% of Cuban women report smoking 20 or more cigarettes per day, and Mexican men and women are less likely than other Hispanic/Latinx groups to report that they smoke 20 or more cigarettes per day.

Although Asian-Americans, Native-Hawaiians, and Pacific-Islanders are often combined together as one group in survey data due to smaller numbers of the individual groups surveyed, they are actually three distinct groups. Cigarette smoking among Asian-American/Pacific-Islander adults is lower than other racial ethnic groups, however, prevalence among Asian sub-groups varies and can be higher than that of the general population.

Like many other minority groups, the LGBTQ+ community has been the target of tobacco industry marketing for several decades. As a result, smoking rates are disproportionately higher among LGBTQ+ individuals than the general population. About one in four LGBTQ+ adults smoke cigarettes compared with about one in six heterosexual/straight adults. More than twice as many LGBTQ+ students report having smoked a cigarette before the age of 13 compared to heterosexual students.

c) Tobacco harms. Cigarette smoking causes more than 480,000 deaths each year in the United States (U.S.), or nearly one in five deaths. Smoking causes more deaths each year than the following causes combined: Human immunodeficiency virus, illegal drug use, alcohol use, motor vehicle injuries, and firearm-related incidents. More than 10 times as many U.S. citizens have died prematurely from cigarette smoking than have died in all the wars fought by the United States. Smoking causes about 90% (or nine out of 10) of all lung cancer deaths. More women die from lung cancer each year than from breast cancer. Smoking causes about 80% (or eight out of 10) of all deaths from chronic obstructive pulmonary disease. Cigarette smoking increases the risk for death from all causes in men and women. In California, smoking-related health care costs $13.29 billion per year and smoking-related losses in productivity totals $10.35 billion per year.

d) Flavored tobacco ban enforcement and funding. There are approximately 30,000 tobacco retailers in California. Currently CDTFA inspects about 3,300 a year (11% of tobacco retailers). According to CDTFA absent additional funding of the state tobacco license, those inspection numbers will continue to decline.

Effective January 1, 2025, AB 3218 (Wood), Chapter 849, Statutes of 2024 and SB 1230 (Rubio), Chapter 462, Statutes of 2024 enacts the Unflavored Tobacco Product List and includes enforcement authority for flavored tobacco products and tobacco product flavor enhancers. To address the workload associated with the passage of AB 3218 and SB 1230, CDTFA is requesting $3.5 million in 2025-26 from the Cigarette and Tobacco Products Compliance Fund (Compliance Fund), for the implementation and ongoing administration of the Cigarette and Tobacco Products Licensing Program. Once CDTFA evaluates the actual impact resulting from the legislation, particularly regarding enforcement, CDTFA will recommend and request the necessary resources such as fee adjustments and additional spending authority. At this point, CDTFA states it has identified workload costs of $3.3 million in 2024-25, $5.5 million in fiscal year 2025-26 and 2026-27, and $3.1 million in 2027-28 and ongoing from the Compliance Fund. Resources for implementation work of $3.3 million in 2024-25 and $2 million in 2025-26, will be absorbed by CDTFA, thereby reducing the request for the identified workload costs. As per CDTFA's analysis of AB 3218, lower than expected penalty revenues may create pressure to increase licensing fees or obtain other General Fund support. This bill will address that issue.

3) SUPPORT. The American Cancer Society Cancer Action Network, the American Heart Association, American Lung Association, and the Campaign for Tobacco-Free Kids are the co-sponsors of this bill, and were cosponsors of SB 793 (Hill), which restricts the sale of flavored tobacco products. The co-sponsors note that SB 793 is critical to reducing youth tobacco use since eight out of 10 youth who have ever used tobacco started with a flavored product. However, like any law, it can only be effective if fully enforced, and this will provide necessary funding to maintain CDTFA's flavored tobacco product seizure and enforcement operations.

The co-sponsors point to the fact that last year, the Governor signed AB 3218 and SB 1230, which strengthen enforcement of the flavored tobacco law. AB 3218 requires the Attorney General to establish a list of unflavored tobacco products to simplify enforcement of the flavor ban. Both AB 3218 and SB 1230 authorize CDTFA to seize and destroy flavored tobacco products discovered during existing inspections of locations where tobacco products are sold. CDTFA is currently only able to visit 11% of tobacco retailers each year. Without additional funding of the state tobacco license, those inspection numbers will continue to decline. This bill will increase the state tobacco retailer license annual fee to $600 to sustain the compliance program and provide CDTFA with more resources to remove illegal tobacco products from the market. The bill will also commission a study that would bring much-needed clarity to California's tobacco law enforcement landscape and make recommendations on how to improve coordination and efficiency amongst California's various tobacco enforcement agencies.

The co-sponsors argue that despite implementation of SB 793 in December 2022, flavored illegal tobacco products, especially flavored e-cigarettes, still remain on store shelves and illegal flavored e-cigarettes make up nearly 40% of total e-cigarette sales in California. The

co-sponsors conclude that this bill provides CDTFA with more resources to sustain current flavored tobacco product seizure and enforcement operations and enhance the agency's ability to identify bad actors who repeatedly sell illegal products.

4) PREVIOUS LEGISLATION.

a) AB 3218 requires the California Attorney General (AG) to establish and maintain on its website a list of tobacco product brand styles that lack a characterizing flavor, known as the "Unflavored Tobacco List" (UTL). Requires any brand style not on the UTL to be deemed a flavored tobacco product. Permits the AG to deny inclusion of a tobacco product on the UTL.

b) SB 1230 enacts the Strengthen Tobacco Oversight Programs and Seize Illegal Tobacco Products Act, which increases civil penalties on retailers who violate the STAKE Act, and authorizes the CDTFA to seize flavored tobacco products or tobacco product flavor enhancers that violate the flavored tobacco products ban.

c) SB 793 prohibits a tobacco retailer, or any of its agents or employees from selling, offering for sale, or possessing with the intent to sell or offer for sale, a flavored tobacco product or a tobacco product flavor enhancer. Exempts from this prohibition the sale of Hookah water pipes and flavored shisha tobacco products, pipe tobacco, and premium cigars.

REGISTERED SUPPORT / OPPOSITION:

Support

American Cancer Society Cancer Action Network Inc. (co-sponsor)
American Heart Association (co-sponsor)
American Lung Association of California (co-sponsor)
Campaign for Tobacco Free Kids (co-sponsor)

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 574 (Mark González) – As Amended March 10, 2025

SUBJECT: Prior authorization: physical therapy.

SUMMARY: Prohibits a health care service plan (health plan) or health insurer that provides coverage for physical therapy (PT) from requiring prior authorization for the initial 12 treatment visits for a new episode of care for PT. Specifically, **this bill**:

1) Prohibits a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for PT from requiring prior authorization for the initial 12 treatment visits for a new episode of care for PT.

2) Requires a PT provider to verify the enrollee or insured's coverage and disclose cost sharing, including the maximum out-of-pocket expense the enrollee or insured may be charged per visit if the health plan or health insurer denies coverage for services rendered. Requires the disclosure to encourage the enrollee or insured to contact the plan or insurer for coverage information and indicate that by signing the separate written consent, the enrollee or insured does not give up any applicable rights. Requires the PT provider to disclose if they are not in-network with the enrollee or insured's plan.

3) Requires, for costs that may not be covered by the enrollee or insured's contract, the PT provider to obtain separate written consent that includes a written estimate of the cost of care for which the enrollee or insured is responsible if coverage is denied or otherwise not applicable. Requires the consent document and cost estimate to be provided in the language spoken by the enrollee or insured.

4) Specifies that this bill does not apply to Medi-Cal managed care plans.

5) Defines "new episode of care" as treatment for a new or recurring condition for which the enrollee has not been treated by the provider within the previous 90 days and is not currently undergoing active treatment.

EXISTING LAW:

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

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (UR) or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

c) Be evaluated, and updated if necessary, at least annually;

d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

4) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, barriers to medically necessary PT present significant challenges for patients seeking to recover. The author states that such barriers can negatively impact patient outcomes and hinder the effective delivery of health care. The author shares an example that patients in chronic pain may be forced to rely on painkillers while waiting for authorization to proceed with prescribed PT. The author continues that some insurers base prior authorization and UR decisions on provider profiles or computer algorithms rather than the patient's specific medical needs. The author argues that currently there is no practical accountability for insurers or third-party UM companies when a denied or delayed PT treatment results in negative patient outcomes. The author continues that these delays and denials frequently lead to reductions in the frequency and duration of prescribed treatments. The author concludes that the appeals process is often lengthy, making it untimely for patients in need of care.

2) **BACKGROUND.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

   a) **Overall impact of prior authorization.** In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care

system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

b) Cost impacts. One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low value or medically unnecessary care is delivered. Behavioral health, particularly applied behavioral analysis, was identified by health plans/insurers as a leading fraud risk.

c) Access to and utilization of care. Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between 5% to 15% of all covered medical services and 16% to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out of pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

3) SUPPORT. The California Physical Therapy Association (CPTA), sponsor of this bill, states that an increasing number of health plans, insurers and third-party administrators are using computer algorithms and automated systems for decision-making over the care their beneficiaries may receive. CPTA continues that such practices often have no basis in research and are inconsistent with community standards of care for the symptoms and diagnoses presented by patients and seem more directed toward limiting the number of visits patients may obtain. CPTA states that these practices create barriers and challenges for patients by delaying access to medically necessary care and increasing the administrative burden required to navigate prior authorization, unnecessary reviews, and manage appeals. CPTA notes that research studies indicate that delays in treatment can result in poorer outcomes for patients. CPTA cites a recent study of patients with neck pain which showed

that delays in access to PT increased overall health care costs, as well as reliance upon opioids as a treatment alternative. CPTA shared another study of patients with low back pain which showed that early referral to PT resulted in lower utilization and overall costs. CPTA continues that the 12 PT visits defined in this bill are consistent with research and studies indicating that most conditions resolve within this treatment range. CPTA states that more serious conditions necessitate further treatment, and it is logical for a plan or insurer in those instances to monitor the development of such conditions more closely in determining medical necessity for ongoing care. Doing so at earlier intervals, according to CPTA, only results in unnecessary administrative burdens on providers and delays in patient treatment intervals.

4) **OPPOSITION.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, stating that prior authorization protocols promote safe, effective and affordable care for plan enrollees while ensuring that patients receive the right care, at the right time, from the right provider. CAHP and ACLHIC continue that this bill would undermine this process by allowing PT providers to provide their patients with up to 12 visits without any oversight or review by the patient's health plan or primary care physician. CAHP and ACLHIC argue that in essence, this policy change would grant unfettered access to this particular service, restricting the health plan or insurer's ability to determine if the treatments and visits are medically necessary or follow the standard clinical guidelines. CAHP and ACLHIC continue that without this assessment, they are concerned that patients may receive unnecessary and/or inappropriate treatments or therapies that are not tailored to their specific needs. CAHP and ACLHIC conclude that they believe this bill will unnecessarily increase administrative costs, decrease affordability, and potentially lead to unneeded and unnecessary care delivery for their members.

5) **RELATED LEGISLATION.**

   a) AB 384 (Connolly) would prohibit a health plan, health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 is currently pending in the Assembly Health Committee.

   b) AB 510 (Addis) would require, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 is currently pending in the Assembly Health Committee.

   c) AB 512 (Harabedian) would shorten the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. AB 512 is currently pending in the Assembly Health Committee.

   d) AB 539 (Schiavo) would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is currently pending in the Assembly Health Committee.

   e) AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would prohibit concurrent or

retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 is currently pending in the Assembly Health Committee.

f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 516 (Skinner) of 2024 would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization. SB 516 was not heard in the Assembly Health Committee.

b) AB 931 (Irwin) of 2023 was substantially similar to this bill. AB 931 was vetoed by Governor Newsom, who stated in part:

"Beginning January 1, 2025, this bill would prohibit a health plan or insurer from requiring prior authorization for the initial 12 physical therapy treatment visits for a new episode of care. The bill would also require that, prior to treatment, the provider verify an enrollee's coverage and disclose the enrollee's cost sharing, maximum out-of-pocket expense per visit, and whether the provider is in-network for the enrollee.

I appreciate the author's intent to increase access to physical therapy treatment. However, prior authorization, when applied appropriately, can be an important tool to contain health care costs, protect patients from unanticipated billing, and ensure medically necessary care. Further, existing law requires health plans to provide appointments within a timely access minimum standard, even when prior authorization is required."

c) SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

d) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

7) POLICY COMMENT. This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes at the systemic level by speeding up processing times, reducing the overall volume

of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

REGISTERED SUPPORT / OPPOSITION:

Support

California Physical Therapy Association (sponsor)
Benicia Bay Physical Therapy
California Chronic Care Coalition
70 individuals

Opposition

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

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 592 (Gabriel) – As Amended April 8, 2025

SUBJECT: Business: retail food

SUMMARY: Extends the sunset date of a current authorization that allows the Department of Alcohol Beverage Control (ABC), to permit licensees to exercise license privileges in an expanded license area authorized pursuant to a COVID-19 Temporary Catering Authorization, as defined, from July 1, 2026 to January 1, 2029. Makes current provisions in law operative indefinitely that permit a permitted food facility to prepare and serve food as a temporary satellite food service without obtaining a separate permit or submitting written operating procedures, as defined. Authorizes a permanent food facility to use open windows, folding doors, or non-fixed store fronts during hours of operation. Specifically, **this bill**:

1) Extends the sunset date of provisions in 3) of Existing Law below which allow ABC licensees to exercise license privileges in an expanded license area authorized pursuant to a COVID-19 Temporary Catering Authorization approved in accordance with the Fourth Notice of Regulatory Relief issued by ABC on May 15, 2020. A COVID-19 Temporary Catering Authorization authorizes the on-sale consumption of those alcoholic beverages for which the licensee has on-sale privileges on property adjacent to the licensed premises, under the control of the licensee from July 1, 2026 to January 1, 2029.

2) Removes a sunset date in current law (July 1, 2026) and makes operative indefinitely provisions which require a local jurisdiction that has not adopted its own ordinance on the issue to reduce the number of otherwise required parking spaces to accommodate an outdoor expansion of a business to mitigate COVID-19 indoor dining restrictions.

3) Removes a sunset date in current law (July 1, 2026) and makes operative indefinitely provisions which permit food facilities within any local jurisdiction that is subject to retail food operation restrictions related to COVID-19 to prepare and serve food as a temporary satellite food service without obtaining a separate satellite food service permit or submitting written operating procedures, as specified.

4) Requires, on and after January 1, 2026, each permanent food facility to be in a building consisting of permanent floors, walls, and an overhead structure that meet the minimum standards as prescribed by the California Retail Food Code (CRFC). Requires a permanent food facility to be fully enclosed during hours of nonoperation. Authorizes a permanent food facility to use open windows, folding doors, or non-fixed store fronts during hours of operation, as specified.

EXISTING LAW:

1) Establishes ABC and grants it exclusive authority to administer the provisions of the Alcoholic Beverage Control Act (Act) in accordance with laws enacted by the Legislature. This involves licensing individuals and businesses associated with the manufacture, importation, and sale of alcoholic beverages and the collection of license fees for this purpose. Provides, under the Act, for the issuance of various alcoholic beverage licenses,

including the imposition of fees, conditions, and restrictions in connection with the issuance of those licenses. [Business and Professions Code (BPC) § 23000, et.seq]

2) Defines an "on-sale" license as authorizing the sale of all types of alcoholic beverages: namely, beer, wine, and distilled spirits, for consumption on the premises (such as at a restaurant or bar). An "off-sale" license authorizes the sale of all types of alcoholic beverages for consumption off the premises in original, sealed containers. [BPC § 23393, § 23394, § 23396 and § 23399]

3) Authorizes, until July 1, 2026, the ABC, for a period of 365 days following the end of the state of emergency proclaimed by the Governor on March 4, 2020, in response to the COVID-19 pandemic, to permit licensees to exercise license privileges in an expanded license area authorized pursuant to a COVID-19 Temporary Catering Authorization approved in accordance with the Fourth Notice of Regulatory Relief issued by ABC. [BPC § 25750.5]

4) Authorizes, notwithstanding any other law, if ABC determines that any licensee is found to be abusing the relief provided by 3), or if the licensee's actions jeopardize public health, safety, or welfare, ABC to summarily rescind the relief as to that licensee at any time. [*Ibid.]*

5) Provides that until July 1, 2026, to the extent that an outdoor expansion of a business to mitigate COVID-19 pandemic restrictions on indoor dining interferes with required parking for existing uses, a local jurisdiction that has not adopted an ordinance that provides relief from parking restrictions for expanded outdoor dining areas must reduce the number of required parking spaces for existing uses by the number of spaces that the local jurisdiction determines are needed to accommodate an expanded outdoor dining area. [Government Code (GOV) § 65907]

6) Extends to July 1, 2026, the authorization for a permitted food facility within any local jurisdiction that is subject to retail food operation restrictions related to a COVID-19 public health response to prepare and serve food as a temporary satellite food service without obtaining a separate satellite food service permit or submitting written operating procedures, as specified. [Health and Safety Code (HSC) § 114067]

7) Establishes the CRFC to provide for the regulation of retail food facilities. Establishes health and sanitation standards at the state level through the CRFC, while enforcement is charged to local agencies, carried out by the 58 county environmental health departments, and four city environmental health departments (Berkeley, Long Beach, Pasadena, and Vernon). (HSC § 113700, et.seq.)

8) Defines a "food facility" to mean an operation that stores, prepares, packages, serves, or provides food for human consumption at the retail level, as specified. Includes in the definition of food facility private and public school cafeterias, commissaries, mobile food facilities, temporary food facilities, vending machines, catering operation, fishermen's market, and host facility. (HSC § 113789)

9) Defines a "satellite food service" to mean a remotely located food service operation that is conducted on the same property as, in reasonable proximity to, and in conjunction with and by, a fully enclosed permanent food facility. Specifies that satellite food service does not include remote food service operations located within a fully enclosed permanent food facility. (HSC § 113899)

10) Requires permanent food facilities to be fully enclosed in a building consisting of permanent floors, walls, and an overhead structure that meet prescribed minimum standards. (HSC § 114266)

11) Authorizes, under state planning and zoning laws, the legislative body of any city or county to adopt ordinances that regulate zoning within its jurisdiction, as specified. Under that law, authorizes variances and conditional use permits to be granted if provided for by the zoning ordinance. [GOV § 65850, *et seq.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, community restaurants are the heart and soul of California, offering vibrant and diverse dining experiences. The author continues that these beloved restaurants are not just places to eat, but they are also hubs of culture and connection. The author notes that after the devastating impact of the COVID-19 pandemic, many are still struggling to stay afloat. The author continues that rising costs, escalating labor costs, and inflation continue to threaten their existence. The author concludes that this bill is a lifeline for these essential small businesses, providing much-needed relief by cutting through unnecessary red tape and simplifying regulations.

2) **BACKGROUND.**

   a) **Impact of COVID on restaurants.** On March 4, 2020, Governor Newsom proclaimed a State of Emergency regarding the COVID-19 pandemic, and asked all restaurants statewide to suspend dine-in service and only allow take-out or delivery food service. Many businesses sought authorization to expand outdoor dining areas, either in their parking lots, streets, or other designated spaces, while following guidelines for safety and hygiene.

   According to the Assembly Committee on Governmental Organization's analysis of this bill, on March 15, 2020, ABC issued its Fourth Notice of Regulatory Relief to address state's COVID-19 State of Emergency. These notices were intended to assist eligible hospitality businesses to reopen in a manner consistent with local and state health and safety directives. The notice created the COVID-19 Temporary Catering Authorization (TCA), which authorized the on-site consumption of those alcoholic beverages for which the licensee has on-sale privileges on property that is adjacent to the licensed premises and that is under the control of the licensee. The TCA allowed designated ABC businesses to maintain operations and generate income through alternative means during periods when in-person dining was restricted or limited.

   On June 3, 2021, ABC issued its Eighth Notice of Regulatory Relief, which extended a number of the previous reliefs until December 31, 2021. Included in that was an extension of the COVID-19 Temporary Catering Authorization. A qualified business is required to apply to ABC and include a diagram which clearly identifies where the requested area is in relation to the existing licensed premise. Prior to submitting an application, the licensee was responsible for, among other things, ensuring they have the legal authority to use the area requested, ensuring that the temporary expansion request has the approval of local agencies, and ensuring the temporary expansion request is being

made in accordance with applicable city, county, and state guidelines regarding social distancing and the legality of the business being open for in-person service. The temporary authorization may be further canceled by ABC for disturbance of the quiet enjoyment of nearby residents and upon objection by local law enforcement. ABC has issued approximately 11,000 COVID-19 temporary authorizations.

The provisions of this bill focused on extending the authorization of ABC licensees to exercise license privileges in an expanded license area authorized pursuant to a COVID-19 Temporary Catering Authorization approved in accordance with the Fourth Notice of Regulatory Relief were analyzed by the Assembly Committee on Governmental Organization.

b) California Retail Food Code. The portion of the HSC known as the CRFC contains the structural, equipment, and operational requirements for all California retail food facilities. Provisions of the CRFC are primarily enforced by 62 local environmental health regulatory agencies. DPH's Food and Drug Branch plays a supporting role in the enforcement of the CRFC by providing technical expertise to evaluate processes and procedures and to answer technical and legal inquires for local agencies, industry and consumers.

c) Satellite Food Service. CRFC requires a permanent food facility to obtain a permit to operate a satellite food service or operation. Satellite food service is a remotely located food service operation that is conducted on the same property as, in reasonable proximity to, and in conjunction with and by, a fully enclosed permanent food facility. Examples of satellite operations are the food service in booths, on the street or in other locations on the same property or fairly close to where the food is prepared at a fully licensed facility like a restaurant or a catering operation. As part of the process of obtaining a permit, a permanent food facility is required to submit to the local enforcement agency written standard operating procedures that include specified information including all food products that will be handled and dispensed; process or methods or food preparation and handling; how food would be transported to and from the permanent food facility and satellite food service.

This bill permanently extends a provision in existing law that allows a permitted food facility within any local jurisdiction that is subject to retail food operation restrictions related to a COVID-19 public health response to prepare and serve food as a temporary satellite food service without obtaining a separate satellite food service permit or submitting written operating procedures and requires the permitted food facility to maintain the written operating procedures onsite for review, upon request, by the local jurisdiction.

d) Permanent Food Facilities. Existing law requires permanent food facilities to be fully enclosed. This bill makes that requirement inoperative as of January 1, 2026 and allows, commencing January 1, 2026, permanent food facilities to use open windows, folding doors, or nonfixed store fronts during hours of operation while requiring permanent food facilities to be fully enclosed during nonoperating hours.

According to the California Association of Environmental Health Administrators, the reason for enclosure is to protect the open food from outside contamination that could occur from an unenclosed food preparation area. This could be contamination from dust

and debris during windy days, flies getting into the rear food prep areas and landing on food and food contact surfaces contaminating them, and the introduction of vectors such as cockroaches or rats into a food facility that would then lead to an infestation and subsequent closure of the facility. Limited food preparation has controls in place to reduce these impacts which is why limited food prep can be conducted in a facility with open windows or front walls, as long as the main full preparation kitchen is properly enclosed. Limited food preparation allows a wide variety of food to be served from an unenclosed food facility. The most common type seen in permanent food facilities is for bar or beverage service, where the bar is open to the outside, and the main kitchen is closed off with a secondary barrier/door and proper pass thru windows as provided in code. Limited food preparation allows for the slicing of prewashed produce, serving food from a steam table to customers as long as the steam table has lids that are replaced when not actively serving food and the food was made in the main enclosed kitchen under proper temperature control, and cooking of food on a flat grill that was pre-portioned in the enclosed prep area and then served directly to a customer's plate.

The author intends to allow restaurants to utilize an "open kitchen" concept to create an inviting and open-air atmosphere as part of the overall dining experience for customers.

3) **SUPPORT.** The California Restaurant Association (CRA) is the sponsor of this bill and states that this bill will help community restaurants and the overall hospitality climate in the following ways: by allowing for the preparation and service of a food as a temporary satellite food service without obtaining a separate satellite food service permit; by enabling restaurants to take full advantage of local outdoor dining expansion opportunities; and, by extending the ABC's regulatory relief, allowing a streamlined approval process for the option to serve alcohol in these spaces. CRA continues that each of these elements help support existing and future expanded outdoor dining spaces by creating a pathway for restaurants to be properly permitted- and to better provide food and drink services in closer proximity to these expanded outdoor spaces. CRA concludes that this bill contains some of the most successful elements of early pandemic policy responses- and allows those policies to continue in order to play a critical role in helping restore economic vitality to downtown cores hollowed out by the pandemic or impacted by recent natural disasters.

4) **OPPOSITION.** According to the California Alcohol Policy Alliance, this bill would make the "regulatory relief" measures intended to support bars during COVID-19 lockdowns permanent. CAPA states that the economic urgency that made these measures critical has passed. The consequences, however, remain, including an elevated alcohol-mortality rate, repeated injuries as cars collide with hastily erected extended service structure, and a supercharging of neighborhood disruption as blocks are given over solely to the sale of alcohol. CAPA states that research shows that delivery options have mainly added to the daily consumption of individuals already at risk of causing harm to themselves and their communities. CAPA notes that they have opposed these measures from the outset, and have been chagrinned to find many of their fears realized over the ensuing years. CAPA concludes that the solution is not to make these "emergency" measures permanent, it is to take serious stock of alcohol harm in local communities.

5) RELATED LEGISLATION.

a) AB 342 (Haney) would authorize, beginning January 1, 2026, an on-sale licensee, or their agent or employee, to sell or give alcoholic beverages until 4 a.m. on Fridays, Saturdays, or state holidays within a hospitality zone, defined to include a Hospitality Zone and a Special Event Hospitality Zone, as specified. Authorizes the ABC to issue an additional serving hour's license that authorizes an on-sale licensee, or their agent or employee, to sell or give alcoholic beverages within the timeframes described above in a hospitality zone, as specified. AB 342 would further authorize an additional service hours license to be used by a licensed premises in a Hospitality Zone if a local governing body, as defined, of the city or county, as applicable, in which the licensed premises is located adopts a resolution that meets certain requirements and submits the resolution to the ABC. AB 342 is pending in the Assembly Committee on Governmental Organization.

b) SB 395 (Wiener) would authorize the issuance of up to 20 additional new original on-sale general licenses, as specified, for bona fide public eating places located within a designated retail district in the City and County of San Francisco, as defined. SB 395 would further require ABC to follow specified procedures concerning the issuance of these licenses, and would authorize ABC to designate these licenses as on-sale general for special use. SB 395 is pending in the Senate Committee on Governmental Organization.

6) PREVIOUS LEGISLATION.

a) AB 1217 (Gabriel), Chapter 569, Statutes of 2023 extends, among other things, until July 1, 2026 the authority of the ABC to permit licensees to exercise license privileges in an expanded license area authorized pursuant to a COVID-19 Temporary Catering Authorization approved in accordance with the Fourth Notice of Regulatory Relief issued by ABC on May 15, 2020. Permits food facilities until July 1, 2026 to operate a temporary satellite food service without needing to obtain a separate permit.

b) SB 76 (Wiener), Chapter 700, Statutes of 2023 authorizes specified licensees in the City and County of San Francisco to allow consumers to leave the licensed premises with open containers of alcoholic beverages for consumption off the premises within an entertainment zone, as specified. Makes various changes to the music venue license, as specified.

c) SB 793 (Wiener), Chapter 468, Statutes of 2022 authorizes ABC to issue a music venue license that would allow the licensee to sell beer, wine, and distilled spirits for consumption on the premises in a music entertainment facility, as defined.

d) SB 930 (Wiener) of 2022 would have, beginning January 1, 2025, and before January 2, 2028, required the ABC to conduct a pilot program that issues an additional hours license to an on-sale licensee located in a qualified city (cities of Palm Springs, West Hollywood and the City and County of San Francisco), authorizing the licensee to serve alcoholic beverages at the licensed premises between the hours of 2 a.m. and 4 a.m. on Saturdays and Sundays and specified holidays, and between the hours of 2 a.m. and 3 a.m. on all other days, upon completion of specified requirements. SB 930 failed passage on Assembly Floor.

e) AB 61 (Gabriel), Chapter 651, Statutes of 2021 authorizes the ABC, for 365 days from the date the Covid-19 pandemic state of emergency proclaimed by the Governor is lifted, to allow licensees to continue to exercise license privileges in an expanded licensed area authorized pursuant to a COVID-19 Temporary Catering Authorization, as provided. In addition, the bill authorizes a permitted food facility to prepare and serve food as a temporary satellite food service without obtaining a separate permit for up to one year after the end of the state of emergency declared in response to the COVID-19 pandemic or until January 1, 2024, whichever comes first.

f) SB 314 (Wiener), Chapter 656, Statutes of 2021 authorizes ABC, for 365 days from the date the Covid-19 state of emergency is lifted, to allow licensees to continue to exercise license privileges in an expanded licensed area authorized pursuant to a Covid-19 temporary catering authorization, as provided. Allows a licensed manufacturer to share a common licensed area with multiple licensed retailers, as specified. Increases the number of times, from 24 to 36 in a calendar year, that the ABC can issue a caterer's permit for use at any one location.

g) AB 831 (Committee on Health), Chapter 155, Statutes of 2021 makes a variety of clarifying and technical changes to the provisions of law governing retail food facilities.

h) SB 389 (Dodd), Chapter 657, Statutes of 2021 authorizes, until December 31, 2026, specified on-sale licensees that operate a bona fide public eating place to sell distilled spirits for off-sale consumption for which their license permits on-sale consumption if the beverages are in manufacturer-prepackaged containers, and ordered and picked up by the consumer. Authorizes a licensee to sell the alcoholic beverages, except beer, for off-sale consumption for which their license permits on-sale consumption when the beverages are not in manufacturer-prepackaged containers if specified conditions are met.

7) **POLICY COMMENT.** The author has expressed the intent to allow for open kitchens with service openings from counter height to ceiling to create an inviting environment for consumers and to support restaurant businesses. As the bill moves through the process, the author may wish to consider working with DPH and environmental health stakeholders to ensure food safety. Additionally, with regard to removal of the sunset date of the provisions allowing food facilities within any local jurisdiction that is subject to retail food operation restrictions related to COVID-19 to prepare and serve food as a temporary satellite food service without obtaining a separate satellite food service permit or submitting written operating procedures, it appears that this provision would apply to the extent that COVID-19 restrictions are in place. Given the author's goal to allow these provisions to continue permanently, the author may wish to consider an amendment to clarify this intent.

8) **DOUBLE REFERRAL.** This bill is double referred, it passed the Assembly Committee on Governmental Organization with an 18-0 vote on April 2, 2025.

REGISTERED SUPPORT / OPPOSITION:

Support

Asian Business Association
Bavel Restaurant
Bestia Restaurant

Cal Asian Chamber of Commerce
California Attractions and Parks Association
California Downtown Association
California Restaurant Association
California Travel Association (CALTRAVEL)
Cameo - California Association for Micro Enterprise Opportunity
Central City Association
Central City Association of Los Angeles
Downtown San Diego Partnership
El Dorado County Chamber of Commerce
El Dorado Hills Chamber of Commerce
Elk Grove Chamber of Commerce
Folsom Chamber of Commerce
Golden Gate Restaurant Association (GGRA)
Hiho
Inclusive Action for The City
Independent Hospitality Coalition
Jon & Vinny's
Latino Restaurant Association
Lincoln Chamber of Commerce
Los Angeles Area Chamber of Commerce
Los Angeles County Business Federation (BIZ-FED)
Los Angeles County Business Federation (BIZFED)
Matu
Oceanside Chamber of Commerce
Public Counsel
Rancho Cordova Chamber of Commerce
Rocklin Area Chamber of Commerce
Roseville Area Chamber of Commerce
Rossoblu
Rustic Canyon
Sacramento Mayor Kevin McCarty
Sacramento Metro Chamber of Commerce
Saffy's
San Deigo Regional Chamber of Commerce
San Diego County Lodging Association
San Marcos Chamber of Commerce
Shingle Springs/Cameron Park Chamber of Commerce
Streets for All
Superfine Playa
Sushi Nozawa
The Greater Los Angeles Hospitality Association
Uovo
Valley Industry & Commerce Association
West Hollywood Chamber of Commerce
Yuba Sutter Chamber of Commerce

Oppose

Alcohol Justice
California Alcohol Policy Alliance
California Council on Alcohol Problems (CCAP)

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 645 (Carrillo) – As Amended March 24, 2025

SUBJECT: Emergency medical services: dispatch.

SUMMARY: Requires the Emergency Medical Services Authority (EMSA) to develop, and, after approval by the Emergency Medical Services Commission (Commission), to adopt minimum standards for emergency medical dispatcher (EMD) training. Requires a public safety dispatcher or telecommunicatior to complete that training. Specifically, **this bill**:

1) Requires EMSA to develop and, after approval by the Commission, adopt minimum standards for EMD training.

2) Requires a public safety dispatcher or public safety telecommunicator to complete EMD training that complies with the minimum standards adopted by EMSA.

3) Defines, for purposes of this bill, "public safety dispatcher or public safety telecommunicator" to mean an individual employed by a public safety agency, as the initial first responder, whose primary responsibility is to receive, process, transmit, or dispatch emergency and nonemergency calls for law enforcement, fire, emergency medical, and other public safety services by telephone, radio, or other communication device, and includes an individual who promotes from this position and supervises individuals who perform these functions.

EXISTING LAW:

1) Establishes the Warren-911-Emergency Assistance Act, which requires every public agency to have in operation a telephone service which automatically connects a person dialing the digits "911" to an established public safety answering point. Defines public agency to include the state, any city or county, or any public district that provides or has authority to provide firefighting, police, ambulance, or other emergency services. Prohibits these provisions of law from prohibiting or discouraging the formation of multijurisdictional or regional systems. [Government Code (GOV) § 53100, *et seq*.]

2) Requires every 911 system to include police, firefighting, and emergency medical and ambulance services. Requires every 911 system, in those areas in which a public safety agency provides ambulance emergency services, to include such public safety agencies. Permits 911 systems to incorporate private ambulance services. [GOV § 53110]

3) Establishes the 11-member State 911 Advisory Board, comprised of the Chief of the Public Safety Communications Division, representatives from the California Highway Patrol, California Police Chiefs Association, California State Sheriffs' Association, and the California Fire Chiefs Association among others. Requires board members to have at least two years of experience as a Public Safety Answering Point (PSAP) manger or county coordinator. Requires the Board to advise on various subjects, including training standards for county coordinators and PSAP managers. [GOV § 53115.1 and § 53115.2]

4) Establishes the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (EMS Act) to provide for a statewide system for emergency medical services (EMS), and establishes EMSA, which is responsible for the coordination and integration of all state activities concerning EMS, including the establishment of minimum standards, policies, and procedures. [Health and Safety Code (HSC) § 1797*, et seq*.]

5) Requires a public safety agency implementing an EMD program to be subject to the review and approval of the local EMS agency, and to perform "911" call processing services and operate the program in accordance with applicable state guidelines and regulations and the policies adopted by the local EMS agency. [HSC § 1797.223 (c)]

6) Establishes the 19-member Commission on Emergency Medical Services (Commission), within the California Health and Human Services Agency (HHSA). Defines the duties of the Commission to include reviewing regulations, standards, and guidelines developed by EMSA; advising EMSA on a data collection system; advising on emergency facilities and services, emergency communications, medical equipment, personnel training, and various aspects of the EMS system; and, to make recommendations for further development of the EMS system. [HSC § 1799, § 1799.2, § 1799.50]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, public safety dispatchers play a critical role in emergency response, yet there is no statewide requirement ensuring they are equipped with the training necessary to provide life-saving guidance during medical emergencies. The author states that this bill addresses this gap by requiring EMD training for dispatchers, ensuring they can deliver effective pre-arrival instructions and allocate appropriate resources. In emergencies like cardiac arrest or choking—especially in rural areas where response times are longer—trained dispatchers can make the difference between life and death. According to the American Heart Association, immediate CPR can double or triple survival rates. The author notes that EMD protocols also improve dispatchers' ability to assess medical situations accurately, ensuring resources are deployed efficiently. The author concludes that by establishing statewide training standards, this bill improves emergency response, reduces strain on EMS, and aligns California with 18 other states that mandate EMD certification.

2) BACKGROUND.

a) EMS. While EMSA is the lead agency and centralized resource to oversee emergency and disaster medical services, day-to-day EMS system management is the responsibility of the local EMS agencies (LEMSAs). California has 33 LEMSA systems that provide EMS for California's 58 counties. Regional systems are usually comprised of small, more rural, less-populated counties and single-county systems generally exist in the larger and more urban counties. There are seven regional EMS agencies comprised of 32 counties and 26 single-county local EMS agencies.

The EMS Act comprehensively regulates emergency medical care in California. Enacted in 1980, the Act provides for the creation of emergency medical procedures and protocols, certification of emergency medical personnel, and coordination of emergency

responses by fire departments, ambulance services, hospitals, specialty care centers, and other providers within the local EMS system.

b) 911. The Warren 911 Act authorizes cities and counties to form contracts regulating the implementation of a 911 system. The basic structure of the 911 system is designed to ensure that when a person dials 911, a law enforcement agency serving as a primary PSAP receives 911 requests from the area where the person is calling. If a 911 caller requests emergency medical assistance, the primary PSAP may retain the caller if it directly provides EMS dispatch, or may transfer the caller to a secondary PSAP for emergency medical response. The medical secondary PSAP can be a public agency, public/private partnership, or private EMS provider designated or recognized by the LEMSA as serving the entire EMS area or portion of the EMS area.

c) Dispatch. There are approximately/over 6,000 911 dispatchers in California. In more urban areas, 911 dispatcher services are usually divided, with police departments having their own dispatch center, and fire and EMS departments having another. In more rural areas with dispersed populations, emergency dispatch services tend to be unified under a centralized public communication center. The Commission on Peace Officer Standards and Training certifies a Public Safety Dispatchers' Basic Course, which is the entry-level training requirement for dispatchers employed as law enforcement focused dispatchers.

d) Emergency Medical Dispatcher Standards. EMSA is currently developing standards for EMD training and for the provision of pre-arrival emergency care instructions (emergency medical care advice given over the telephone by EMDs to persons at the scene of a medical emergency for the provision of emergency care until qualified prehospital medical care personnel arrive at the scene and take over care of the patient). EMSA is also working with experts to evaluate the status of EMS communications systems in California and to develop a state plan for EMS communications systems. Responsibilities for emergency medical dispatcher standards and EMS communications systems planning and development include the following:

i) Development of statewide training standards for EMDs;

ii) Development of statewide standards for the provision of pre-arrival emergency care instructions;

iii) Provision of technical assistance to emergency medical dispatch agencies and dispatchers;

iv) Assessment of EMS communications systems; and,

v) Development of a state EMS communications plan.

According to EMSA, large urban dispatch centers which already do EMD will have little trouble meeting a standard, but there will be work and associated cost for secondary urban and most rural centers to meet a newly defined training standard based on national EMD standards.

Currently, EMSA regulations have no defined EMD training requirements or standard. However, EMSA plans to begin the regulations needed for dispatchers within the next 12 months.

3) **SUPPORT.** California Ambulance Association (CAA) is the sponsor of this bill and states that it seeks to enhance emergency response effectiveness by requiring all public safety dispatchers to complete EMD training. CAA notes that this will ensure that dispatchers have the skills and resources needed to provide life-saving pre-arrival instructions and dispatch appropriate emergency personnel. CAA notes that, in life-threatening situations such as cardiac arrest or choking, immediate intervention is crucial. CAA states that according to the American Heart Association, only 46% of individuals experiencing cardiac arrest receive bystander CPR before emergency responders arrive, significantly reducing their chances of survival. CAA contends that EMD training provides dispatchers with structured protocols to give life-saving pre-arrival instructions. Dispatchers can guide callers through critical interventions such as CPR or the Heimlich maneuver, increasing survival rates.

4) **OPPOSITION.** The Riverside County Sheriff's Office (RSO) is opposed to this bill and states that they strongly believe public safety dispatchers handling EMS call should be required to undergo training regulated by EMSA. However, RSO dispatchers do not dispatch EMS calls, this is the sole responsibility of Cal-Fire in their county. RSO concludes that in their opinion, it is a waste of tax dollars and burden their already short-handed staff by requiring more training they do not need and will never use.

   The California Chapter of the National Emergency Number Association (CALNENA) is opposed to this bill and states that requiring law enforcement agencies or other primary PSAPs that do not provide medical instructions to have their dispatchers EMD certified would be unnecessary, expensive, and overly burdensome. Many leading medical dispatch protocols require quality assurance, continuing education, and a minimum call volume that law enforcement dispatchers would be unable to meet. Staffing is always a challenge in 9-1-1 centers and the requirement to send all dispatchers in the state to several days of training would put an unnecessary burden on local, state, and federal agencies alike.

   CALNENA states that further, they remain concerned about statutory direction that establishes a statewide framework for EMD training for dispatch centers that are processing EMS calls. Decisions about appropriate first response services are best determined at the local level, according the unique structure and arrangement of first responders within their own communities and commensurate with the jurisdictions and responsibilities of responding agencies (sheriff, police, CHP, fire, EMS, JPAs, etc.) and the way they partner to provide emergency response.

5) **PREVIOUS LEGISLATION.**

   a) SB 438 (Hertzberg), Chapter 438, Statutes of 2019 prohibited a public agency from entering into a contract for 911 call processing services unless the contract is with another public agency, with specified exceptions.

   b) SB 1250 (McGuire) of 2015 would have required every local public agency to establish within its jurisdiction a basic emergency telephone system that includes, at a minimum, police, firefighting, and emergency medical and ambulance services. AB 1250 was held in the Assembly Rules Committee.

6) AMENDMENTS. The author is proposing to amend this bill to clarify the EMD training requirement only applies to medical dispatchers, not law enforcement, and to tie the timing of implementation of the training requirements to the completion of the EMSA standards discussed above.

REGISTERED SUPPORT / OPPOSITION:

Support

California Ambulance Association (sponsor)
Ambuserve
Amwest Ambulance
City Ambulance of Eureka
Lifewest Ambulance
Medic Ambulance
Norcal Ambulance
Sierra Emergency Medical Services Alliance

Opposition

California Chapter of the National Emergency Number Association
Riverside County Sheriff's Office

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 669 (Haney) – As Amended April 10, 2025

SUBJECT: Substance use disorder coverage.

SUMMARY: Prohibits concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient substance use disorder (SUD) stay. Prohibits concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Prohibits retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Prohibits prior authorization for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. Specifically, **this bill**:

1) Prohibits concurrent or retrospective review of medical necessity for in-network services and benefits for the first 28 days of an inpatient SUD stay. Specifies medical necessity is determined by the enrollee's physician and consistent with existing standards defined in law.

2) Permits concurrent review of in-network health care services and benefits for day 29 thereafter of inpatient SUD care. Requires a request for approval of inpatient care beyond the first 28 days to be submitted for concurrent review before the expiration of the initial 28 day period. Requires a request for approval of inpatient care beyond a period that is approved under concurrent review to be submitted within the period that was previously approved.

3) Prohibits a health care service plan (health plan) or health insurer from initiating concurrent review for inpatient SUD care more frequently than two-week intervals after the initial 28 days. Requires, if a health plan or health insurer determines that continued inpatient SUD care in a facility is no longer medically necessary, the health plan or insurer to provide written notice to the enrollee and enrollee's physician of its decision and the right to file an expedited internal appeal of the determination within 24 hours.

4) Requires a health plan or health insurer to review and make a determination of an appeal submitted pursuant to 3) above within 24 hours and communicate the determination to the enrollee and the enrollee's physician. Requires, if the determination is to uphold the denial, that the enrollee and enrollee's physician have the right to file an expedited appeal with the Department of Managed Health Care (DMHC) or Department of Insurance (CDI). Requires, if the health plan or health insurer's determination is upheld and it is determined that continued inpatient SUD care is not medically necessary, the health plan or health insurer to remain responsible for providing benefits for inpatient care through the day following the date the determination is made. Requires the enrollee to only be responsible for any applicable copayment, deductible, and coinsurance for the stay through the final date of coverage.

5) Prohibits an enrollee from being discharged or released from the inpatient facility, until all internal and DMHC or CDI appeals are exhausted. Requires costs incurred after the day following the date of determination until the day of discharge to be paid for by the facility or provider, excluding applicable enrollee cost sharing.

6) Prohibits concurrent or retrospective review of medical necessity or any other utilization management (UM) review of in-network services and benefits for outpatient SUD visits.

7) Prohibits retrospective review of medical necessity for the first 28 days of in-network services and benefits for intensive outpatient or partial hospitalization SUD services. Specifies medical necessity is determined by the enrollee's physician.

8) Requires concurrent review of in-network intensive outpatient or partial hospitalization services for SUD after 29 days. Specifies medical necessity determinations utilize the American Society of Addiction Medicine (ASAM) criteria and guidelines.

9) Requires in-network services and benefits for outpatient, intensive outpatient, and partial hospitalization SUD services to be provided to all enrollees with a SUD diagnosis. Prohibits the presence of additional related or unrelated diagnoses from being used to reduce or deny benefits.

10) Prohibits prior authorization or other prospective UM requirements for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. Prohibits the presence of additional related or unrelated diagnoses from being used to reduce or deny benefits.

11) Specifies that the provisions of this bill do not apply to a county Drug Medi-Cal organized delivery system.

EXISTING LAW:

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

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

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

4) Defines medically necessary treatment of MH or SUD including that the service or product is in accordance with generally accepted standards of MH or SUD care, clinically appropriate in terms of type, frequency, extent, site, and duration. [HSC § 1374.72 and INS § 10144.5]

5) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review (UR) criteria on current generally accepted standards of MH and SUD care, as specified. Requires medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with MH and SUDs to be conducted in accordance with the requirements in 6) below. [HSC § 1374.72 and INS § 10144.5]

6) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the UR criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs on current generally accepted standards of MH and SUD care, as specified. Requires a health plan or insurer to apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty in conducting UR of all covered health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs in children, adolescents, and adults. [HSC § 1374.721 and INS § 10144.52]

7) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for UR or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

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

9) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

10) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee (in writing) within two business days of the decision. Prohibits, in the case of concurrent review, discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC § 1367.01 and INS § 10123.135]

11) Requires every health plan to establish and maintain a grievance system approved by DMHC under which enrollees may submit grievances to the plan. Requires a plan's response to also comply with federal requirements. Requires, in regulations, that a plan's grievance system be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authohrity to administrer and resolve the plan's grievance system. Defines

grievance as a written or oral expression of dissatisfaction regarding the plan and/or provider. [HSC § 1368]

12) Allows for appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing an internal appeal pursuant to federal law and any subsequent rules or regulations issued thereunder. [INS § 10123.201]

13) Establishes, in DMHC and CDI, the Independent Medical Review System (IMR) which reviews disputed health care services that a plan, or one of its contracting entities, or insurer determines is not medically necessary or is experimental or investigational. [HSC § 1374.30-1374.36 and INS § 10169]

14) Requires, if there is an imminent and serious threat to the health of the insured or enrollee, all necessary information and documents to be delivered to an IMR organization within 24 hours of approval of the request for review. Requires the use of medical and scientific evidence from specified sources. [INS § 10145.3, § 10169 and HSC § 1370.4]

15) Requires CDI or DMHC to expeditiously review IMR requests and immediately notify the insured or enrollee if the request has been approved, in whole or in part, and, if not, the reasons for the denial. Requires the insurer or plan to promptly issue a notification to the insured or enrollee, after submitting all of the required material to the IMR organization, including an annotated list of documents submitted and offer the insured or enrollee the opportunity to request copies of those documents. Requires any request for IMR not approved by CDI or DMHC to be treated as an immediate request for CDI or DMHC to review the grievance. [HSC § 1374.31 and INS § 10169.1]

16) Requires, upon receipt of information and documents related to a case, the IMR medical professional reviewer or reviewers to promptly review all pertinent medical, provider reports, or any other information provided. Requires, if reviewers request information from any of the parties, a copy of the request and the response to be provided to all of the parties. [HSC § 1374.33 and INS § 10169.3]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, insurance companies are denying addiction treatment, not based on medical need, but on their own bottom line. The author states that insurers use corporate review panels to rubber-stamp denials, even when real doctors say treatment is still necessary. The author continues that this means families who pay every month for insurance are left without care when they need it most. The author notes that research shows that longer treatment stays lead to better recovery outcomes, yet insurers frequently cut off coverage after just a few days. The author continues that more than 40% of opioid overdose deaths occur within two weeks of early treatment discharge, highlighting the deadly consequences of premature insurance denials. The author argues that this bill closes this loophole by stopping insurance companies from cutting off addiction treatment early based on their own insurer-appointed reviewers' recommendations.

2) BACKGROUND.

a) Prevalence of SUD in California. A 2024 publication from Health Management Associates and the California Health Care Foundation titled, *"Substance Use Disorder in California — a Focused Landscape Analysis"* reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 and 2021. 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. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

b) Levels of SUD care. ASAM developed a set of criteria that treatment providers can use in the assessment of a person to help determine the most appropriate level of care. ASAM established a six dimension assessment (the ASAM criteria) and a corresponding continuum of care with five broad levels of care (zero to four). These guidelines are the most comprehensive and widely-used criteria to determine placement in treatment, as well as patients' transfer and discharge from treatment programs. The ASAM levels of care include:

i) Level 1 - outpatient treatment, consists of treatment for substance use that is less than 9 hours a week. Level 1 is appropriate for people with less severe disorders, or as a step-down from more intensive services.

ii) Level 2.1 - intensive outpatient services, consists of at least 9 and no more than 20 hours per week of treatment. These programs typically offer medical care 24 hours a day by phone or within 72 hours in person.

iii) Level 2.5 - partial hospitalization, which is at least 20 hours a week but is less than 24-hour care. This level of care provides structure, and daily oversight for people who need daily monitoring, but not 24/7 care.

iv) Level 3.1 - clinically managed low-intensity residential treatment, residential services at this level consist of a setting, such as a group home, where people live. However, treatment is only required to be 5 hours per week, which helps people with such topics as relapse management.

v) Level 3.3 - clinically managed high-intensity and population-specific services, which are programs targeted for providing treatment designed to move at a slower pace, for people with cognitive functioning issues, including people with traumatic brain injuries, the elderly, or people with developmental disabilities.

vi) **Level 3.5 - clinically managed residential services,** which are designed for people with serious psychological or social issues who need 24-hour oversight and are at risk of imminent harm.

vii) **Level 3.7 - medically managed high-intensity inpatient treatment,** for people who need intensive medical or psychological monitoring in a 24-hour setting but do not need daily physician interaction.

viii) **Level 4 - 24-hour nursing care and daily physician visits,** people in this level of care need daily physician monitoring, along with 24-hour oversight.

While ASAM provides assessment criteria and levels of care, there is no standard set of days that a person is recommended to undergo SUD treatment. The appropriate duration for an individual will depend on the type and degree of their SUD. However, addiction research has shown that remaining in treatment for an adequate amount of time is critical to improving outcomes. The National Institute on Drug Abuse (NIDA) states that research indicates most individuals need at least three months of SUD treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. According to the NIDA, recovery from SUD is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur and should signal a need for treatment to be reinstated or adjusted. The NIDA recommends that strategies be pursued to keep patients in treatment.

c) **UM and UR.** UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Concurrent review occurs throughout the course of a patient's treatment. Concurrent review is intended to enable a plan to scrutinize the necessity for the plan, level, and setting of care while care is being delivered. Retrospective review occurs after care was delivered and after the bill for that care was submitted. Retrospective review seeks to confirm that the care that was delivered was appropriate and provided at the most efficient and effective level.

d) **Impact of UM on SUD care.** There is limited data and evidence of the impact of UM on access to care. In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization, a type of UM, is used in California. CHBRP found that evidence is limited as to the extent in which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

While evidence is limited, there is increasing scrutiny from the public and press on the impact of UM on patients' ability to maintain access to medically necessary care – especially for SUD. A recent Calmatters article, "*He wanted to live. After his insurance rejected coverage, he died of a fentanyl overdose,"* tells the story of Ryan Matlock, who despite being recommended 90 days at an inpatient treatment facility by his physician, found his coverage revoked after just a three day stay. Despite pleas with his health plan and submitting an appeal of their denial, Matlock was discharged early. Within days of being discharged, Matlock passed away of an overdose.

Patients who are denied treatment authorization can first appeal to their health plans; this can involve a review of available records as well as a peer-to-peer review that includes a phone conversation between the patient's clinician and a reviewer working on behalf of the health plan. Under state law, if a patient's issue has not been resolved or they are not satisfied with the decision of their plan after 30-days, they are able to pursue IMR through DMHC or CDI, in which outside experts review cases for the state and determine whether a health plan rightfully denied treatment. The entire grievance process can be time consuming and onerous for patients to navigate. However, according to CalMatters when state regulators do get involved, they overwhelmingly side with patients. For 2023 and the first eight months of 2024, in appeals related to residential treatment denials, DMHC overturned health plans' medical necessity decisions 76% of the time.

e) Other state efforts to protect access to SUD care. Several states have implemented laws that ensure a protected period of access to SUD treatment. New Jersey passed legislation in 2017 that prohibits concurrent or retrospective review for 28 days of inpatient SUD treatment, restricts the usage of prior authorization for certain SUD treatment services, and enacts patient protections throughout appeal processes. The author and sponsors state this bill is heavily modeled off New Jersey's law. New York prohibited prior authorization for SUD treatment and concurrent review for the first 28 days of inpatient SUD treatment through laws passed in 2017 and 2019. Massachusetts, Delaware, Illinois, and Washington State have similarly passed laws that prohibit or limit an insurer's ability to utilize UM to deny or terminate various types of SUD treatment.

3) SUPPORT. The Addiction Treatment Advocacy Coalition (ATAC), a co-sponsor of this bill, states that AB 669 is designed to ensure that those seeking treatment for SUD are provided adequate treatment days based upon the opinion of the treating physician. ATAC continues that this bill ensures that patients will not be prematurely discharged, resulting in potential relapses, or dangerous overdoses. ATAC notes that this bill does not require a specific level or duration of treatment, which is the purview of the in-network treating physician. ATAC states that the treating physician is best equipped to determine the required care of the patient and in California both the provider and the health insurer are required to follow ASAM criteria, an objective national standard, in determining the appropriate level of care and length of treatment. ATAC continues that the treatment plan developed by the in-network treatment provider will determine the course of treatment for the first 28 days of the treatment episode. ATAC concludes that those seeking treatment for SUD need our support to ensure their episode of care is not arbitrarily ended by a health insurer during early recovery.

4) OPPOSITION. The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, citing concerns

about the implications of removing accountability within the system without improving the quality of care. CAHP and ACLHIC state that if passed, this bill could result in a system where individuals are placed in higher-level inpatient or residential care treatment settings for longer than necessary. CAHP and ACLHIC continue that this bill fails to contemplate the issue of provider quality, including the potential for patients to be subjected to non-evidence-based treatments. CAHP and ACLHIC argue this is particularly troubling given the vulnerability of this population and the general need for clinical care oversight in an area of healthcare where licensure and oversight standards are often less stringent. CAHP and ACLHIC state that rather than addressing these concerns, this bill would make it nearly impossible for health plans/insurers to prevent patients from falling victim to the unscrupulous practices of some substance-use rehabilitation-related facilities, that are putting patients at risk and driving up the cost of care. CAHP and ACLHIC continue that eliminating the plans/insurer's ability to review prescription drugs for addiction treatment in outpatient settings would significantly limit a plan's ability to substitute cost effective generic alternatives in place of costly brand-name drugs which will inevitably drive up the cost of care without providing any measurable improvement to the quality of care the patient is receiving.

5) RELATED LEGISLATION.

a) AB 384 (Connolly) would prohibit a health plan, health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 is currently pending in the Assembly Health Committee.

b) AB 510 (Addis) would require, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 is currently pending in the Assembly Health Committee.

c) AB 512 (Harabedian) would shortens the timeline for prior authorization requests to be no longer than 48 hours for standard requests or 24 hours for urgent requests. AB 512 is currently pending in the Assembly Health Committee.

d) AB 539 (Schiavo) would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is currently pending in the Assembly Health Committee.

e) AB 574 (Mark González) would prohibit a health plan or health insurer that provides coverage for physical therapy (PT) from requiring prior authorization for the initial 12 treatment visits for a new episode of care for PT.

f) SB 306 (Becker) would prohibit a health plan or health insurer, or an entity with which the plan or insurer contracts, from imposing prior authorization or prior notification for one calendar year on a covered service that was approved 90% or more of the time in the prior calendar year. SB 306 is currently pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 238 (Wiener) of 2023, would have required a health plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the IMR System, as specified, if the decision is to deny, modify, or delay specified services relating to MH or SUD conditions for an enrollee or insured up to 26 years of age. SB 238 was held on the Assembly Appropriations suspense file.

b) AB 1451 (Jackson) of 2023, would have required a health plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency MH and SUD without preauthorization. AB 1451 was vetoed by Governor Newsom who stated in part:

"I share the author's concern regarding the importance of accessible behavioral health services statewide, as evidenced by the billions of dollars we have invested to enhance access to timely and necessary behavioral health care, as well as the programs and reforms implemented to improve our delivery system. Existing law already prohibits prior authorization for emergency care, and requires mental health and substance use disorder services to meet timely access standards. The requirements in this bill would result in significant costs in the tens of millions of dollars, to the state General Fund and to consumers through health plan premium increases. These impacts should be considered as part of the annual budget process."

c) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or SUD providers that is within 10 business days of the prior appointment.

d) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's MH Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

7) TECHNICAL AMENDMENTS. The committee may wish to adopt technical amendments to help clarify the provisions of this bill.

8) POLICY COMMENT. This committee is reviewing a number of bills aiming to address the problems that current UR and UM processes create in terms of access to care and physician burden. The volume of bills introduced on the topic demonstrate the level of Legislative determination to improve UR and UM processes for Californians. However, there is a divide on how to best approach such improvements. Some bills aim to address UR and UM processes through systemic level changes such as speeding up processing times, reducing the

overall volume of services that require prior authorization, or extending authorization periods. Others aim to tackle problems at a more individual level by removing or altering UM and UR processes for specific services or conditions. While there is a clear need and desire for progress on improving the UR and UM experience, the Legislature will need to consider what the best approach is for all Californians. Altering structural processes? Or removing barriers for priority services and conditions?

REGISTERED SUPPORT / OPPOSITION:

Support

A New Path (co-sponsor)
Addiction Treatment Advocacy Coalition (co-sponsor)
California Behavioral Health Association (co-sponsor)
California Consortium of Addiction Programs and Professionals (co-sponsor)
Addiction Recovery Communities of California
Advanced Therapeutic Services
Anaheim Family Chiropractic
Asana Recovery
Aton Center
Beginnings Treatment Centers
Breathe Life Healing Centers
California Alliance for State Advocacy
California Hospital Association
California Recovery Center
Cambridge Healthcare Management Services, LLC
Community Social Model Advocates, Inc.
Covenant Hills Treatment Center
Davis Healthcare Management Group
Design for Changes
Drug Policy Alliance
Experience Recovery
First Responder Wellness
First Steps Recovery
Healthcare Services, Inc.
Iris Healing Retreat
JMG Investments, Harmony Place
LA Fuente Hollywood Treatment Center
Mission Recovery Home
Mountain Vista Farm
New Found Life Treatment Center
New U Therapy
Oceanrock Health
Orange County Recovery Collaboration
Pacific Sands Recovery Center
Peninsula Health Center
R.E.S.T.
Safe & Sound
Socal Detox

South Coast Counseling
Stairway Recovery
Sun Street Centers
Sustain Recovery
The Lakes Treatment Center
The Purpose of Recovery
United Hospital Association
Valley Restoration Center
Young People in Recovery
10 individuals

Opposition

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

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 676 (Jeff Gonzalez) – As Amended April 9, 2025

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

SUMMARY: Requires 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:**

1) Requires DHCS to waive the interest, as part of a repayment agreement entered into with a Medi-Cal provider, if the overpayment occurred four or more years ago and, in DHCS's sole discretion, DHCS determines that all of the following apply:

    a) The provider has demonstrated to DHCS a substantial impact of the repayment amounts on the fiscal solvency of the provider;

    b) The provider has demonstrated to DHCS that the overpayment was caused by a policy change or DHCS error and was not caused by the provider; and,

    c) Waiving the interest will not jeopardize the availability of federal funding.

2) Specifies DHCS's right to recover payments if a provider defaults on a payment or seeks bankruptcy protection.

3) Specifies that DHCS's determination whether or not to exercise its discretion is not subject to judicial review, except through a writ of mandate to rectify an abuse of discretion.

4) Authorizes DHCS to implement the bill through non-regulatory guidance, such as a provider bulletin.

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 state's Surplus Money Investment Fund (SMIF) during a specified timeframe; or,

b) Simple interest at the rate of 7% per annum. [WIC § 14171]

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

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, hospitals and clinics across the state are facing budget shortages and those in rural areas are especially vulnerable. The author argues it is not fair nor is it in the best interest of our communities to require providers to pay additional money to the state due to no fault of their own. The author concludes that this bill is about equity, fairness, and ensuring healthcare access to those who need it most.

2) **BACKGROUND**. Current law specifies when DHCS pursues recovery of a Medi-Cal overpayment, DHCS collects the overpayment with interest. Similarly, a provider who prevails in an appeal is entitled to receive interest on any amount due from the state 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 providers to be accurate and timely in billing and, when applicable, repayment.

   a) **Surplus Money Investment Fund**. 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 state's fiscal intermediary 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 budget 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. This bill would require DHCS to waive interest on certain past overpayments if certain factors are met.

3) **SUPPORT**. The California Chapter of the American College of Emergency Physicians writes in support of this bill, noting that a large portion of income to emergency physician groups comes from Medi-Cal and any fines or interest associated with disallowed payments can have a disproportionate impact on emergency department physicians.

4) **PREVIOUS LEGISLATION**.

   a) SB 1258 (Dahle) of 2024 was similar to this bill, except it would have *authorized* DHCS to waive interest based on DHCS's consideration of several factors, versus this bill's approach of *requiring* to waive the interest if certain criteria are met. SB 1258 was held on the suspense file of the Assembly Appropriations Committee.

   b) AB 515 (Mathis) of 2019 was similar to SB 1258. 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 requiring interest be waived only if doing so will not jeopardize the availability of federal funding; it also limits the application to overpayments caused by a policy change or departmental error, versus on error or fraud on the part of the provider.

   c) 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 Orthopedic Association

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 785 (Sharp-Collins) – As Amended April 9, 2025

SUBJECT: Community Violence Interdiction Grant Program.

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

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

2) Defines eligible programs as including, but not limited to, the following:

    a) Evidence-based, focused-deterrence collaborative programs that conduct outreach to targeted gangs and offer supportive services in order to preemptively reduce and eliminate violence and gang involvement;

    b) Programs that create and enhance recreation- and health-based interventions for youth during peak times of violence;

    c) Programs that implement evidence-based interventions for pupils impacted by trauma for the improvement in the health and well-being of the youth and school and community stability;

    d) Youth diversion programs that promote positive youth development by relying on responses that prevent a youth's involvement or further involvement in the justice system; and,

    e) The creation and operation of school-based health centers.

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

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

5) Creates the Community Violence Interdiction Grant Fund for purposes of the Program, and makes the fund available upon appropriation by the Legislature to CalHHS for purposes of the Program.

6) Requires, beginning July 31, 2026, and each fiscal year thereafter, the Director of Finance and the Legislative Analyst's Office (LAO) to calculate the savings that accrued to the state from the closure of state prisons during the preceding fiscal year, requires these calculations be averaged to determine a final amount, and requires the Controller, upon appropriation by

the Legislature, to transfer the final amount from the General Fund to the fund described in 5) above, to fund the Program.

EXISTING LAW:

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

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

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

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

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

California Violence Intervention Program (CalVIP)

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

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

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

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

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

10) Establishes a schedule of benefits under the Medi-Cal program, including violence prevention services, as defined as “evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury,

trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes." [WIC § 14132(ag)]

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

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

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

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

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

School-Based Health Centers

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

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

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, by advancing sensible legislation and budget items to improve public safety and advance justice and equity, the Legislature has decreased the number of incarcerated people in California. The author argues it is imperative that the resulting savings be reinvested into effective strategies proven to further reduce crime and violence. Accordingly, the author states, this bill will capture the savings from the closure of prisons and reinvest those funds in programs with proven success. By keeping the

funding within our crime prevention budget rather than sending it back to the General Fund, the author intends to send a message about the value of these programs and that our efforts to reduce crime are continuous.

2) BACKGROUND.

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

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

i) Reducing the rate of minors and young adults committing violent crimes;

ii) Reducing non-fatal physical assault injuries; and,

iii) Reducing firearm-related deaths.

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

i) Define and monitor the problem – Analyze data such as the number of violence-related injuries and deaths;

ii) Identify risk and protective factors – These can increase or decrease the likelihood of a person becoming a victim or perpetrator of violence;

iii) Develop and test prevention strategies – Use data and findings from evaluation and research as an evidence-based approach to program planning; and,

iv) Assure widespread dissemination of effective practices – Share best practices through networking, training, and technical assistance.

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

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

i) **CalVIP**. CalVIP provides grant funding for initiatives to reduce community gun violence, to communities disproportionately impacted by such violence. Funding is awarded to qualifying cities, counties, and community-based organizations on a competitive basis. The program was established in 2017 to replace a gang-related prevention and intervention program that began in 2007, and was narrowed to focus on community gun violence specifically through AB 762 (Wicks), Chapter 421, Statutes of 2023.

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

(1) Hospital-based violence intervention programs;

(2) Evidence-based street outreach programs; and,

(3) Focused deterrence strategies.

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

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

The YRGP was enacted in the Budget Act of 2018 and related trailer bill, which included an initial $37.3 million appropriation for the program. The 2019 Budget Act augmented funding by an additional $5 million. According to the final evaluation reports from two rounds of grant funding, $40.9 million has now been disbursed. According to the statewide evaluation findings, grantees funded by the program reported positive outcomes for participating youth, many of whom had no further contact with the juvenile justice system during the reporting period. AB 2267 (Jones-Sawyer) of 2024 which was held on the suspense file of the Assembly Appropriations Committee, would have reestablished the YRGP and designated the OYCR to administer it. However, at this time it is unfunded.

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

youth by enhancing school-based health, youth development and other protective factors in disadvantaged communities.

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

   (1) CHW services are defined to include those delivered by a variety of non-licensed public health workers, including violence prevention professionals;

   (2) CHWs can address issues that include but are not limited to a number of diseases, conditions, and topics, including domestic violence and violence prevention; and,

   (3) CHW services include health education; navigation to health care and other community resources that address health-related social needs; screening and assessment to identify the need for services; and individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence.

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

ii) **Prop 64-Funded "Elevate Youth California."** In November 2016, Proposition 64 (Prop 64) was passed by voters allowing adults aged 21 years or older to possess and use cannabis for non-medical purposes. Prop 64 created new taxes, the revenues of which are deposited into the California Cannabis Tax Fund. Current law allocates, after other specified disbursements, 60% of the remaining California Cannabis Tax Fund to be deposited into the Prop 64 Youth Education Prevention, Early Intervention and Treatment Account (YPEIETA). Funds are then disbursed to DHCS, which in turn allocates funds to Elevate Youth California, a statewide program that makes grants with a specific focus on youth ages 12 to 26 living in communities disproportionately impacted by the war on drugs. These grants focus on empowering youth to create policy and system changes through civic engagement; youth development, peer support, and mentoring programs; using evidence-based and/or community-defined practices that help individuals and communities cope with adversity and heal trauma; and harm reduction and public health solutions that create resiliency and prevent substance use disorder. According to the Governor's proposed 2025-26 Budget, DHCS estimates an allocation of $323 million in 2024-25 and $281 million in 2025-26 for the YEPEITA.

iii) **School-Based Health Centers.** A school-based health center is a health center that provides age-appropriate, clinical health care services on-site or near a school. Services are provided by qualified health professionals and organized through school, community, and health provider relationships. AB 2560 (Ridley-Thomas), Chapter 334, Statutes of 2006, established the PSHCSP, which requires DPH to provide technical assistance to school-based health centers and to establish a state liaison to school-based health centers. Further, SB 564 (Ridley-Thomas), Chapter 381, Statutes

of 2008, created a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing centers and the development of new centers. However, the grant program was contingent on an appropriation for this program's purpose and, according to DPH, the PSHCSP was not established due to lack of such an appropriation. However, the legislation referenced above created a statutory framework for this grant program, which could be leveraged if funding was made available.

d) Prison Closures, Cost Savings, and Unknown Impact of Proposition 36. According to the LAO's analysis of the California Department of Corrections and Rehabilitation (CDCR) 2024-25 budget proposal, the prison population has declined significantly in recent years and is expected to remain low through June 2028. Last year, the LAO noted that in 2021, CDCR completed a multiyear drawdown of people housed in contractor-operated prisons made possible by the declining prison population. Since 2021, the administration has also deactivated a number of other facilities and yards. The LAO notes CDCR estimates that these deactivations resulted in ongoing General Fund savings totaling about $620 million annually. Deactivation also allowed the state to avoid funding infrastructure repairs that would otherwise have been needed to continue operating these facilities—for example, the state was able to avoid a water-treatment project in one prison, estimated in 2018 to cost $32 million, which would have been necessary to comply with drinking water standards.

However, in February 2025 the LAO estimated that Proposition 36, which was approved by the voters in November 2024 and increased punishment for various theft and drug crimes, could increase the state prison population by a few thousand people.

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

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

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

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

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

3) **SUPPORT.** Greater Sacramento Urban League (GSUL), Youth Forward, and other organizations write in support, indicating that over the last few decades, the Legislature has passed numerous bills supporting criminal justice reform, resulting in a major reduction in the prison population and the shutdown of multiple prisons. Supporters argue that reinvesting into programs will prevent incarceration, and that since 2021, three planned prison closures have resulted in $450 million in annual ongoing savings and an additional $170 million in ongoing savings was generated by deactivating six facilities at different prisons. Initiate Justice Action writes in support that this bill seeks to address the root causes of harm and crime in our community.

4) **PREVIOUS LEGISLATION.**

a) AB 2064 (Jones-Sawyer) of 2024 would have established the Community Violence Interdiction Grant Program (CVIGP). This bill is a reintroduction of AB 2064, which was held on the suspense file of the Senate Appropriations Committee.

b) AB 2267 (Jones-Sawyer) of 2024 would have re-established the YRGP and designated the OYCR to administer it. AB 2267 was held on the suspense file of the Assembly Appropriations Committee.

c) AB 2052 (Jones-Sawyer) of 2024 would have made various changes to the framework of a grant program within the PSHCSP. AB 2052 was held on the suspense file of the Assembly Appropriations Committee.

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

e) AB 762 (Wicks), Chapter 241, Statutes of 2023, changes the purpose of CalVIP, as well as the eligibility requirements for the grant, and makes the program permanent. Removes the sunset date of January 1, 2025, and allows the CalVIP to operate indefinitely.

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

g) AB 1929 (Gabriel), Chapter 154, Statutes of 2022, adds violence prevention services, as defined, as a covered benefit under Medi-Cal. AB 166 (Gabriel) of 2019, was similar and

was vetoed by Governor Newsom, who stated the 2019 Budget Act provided $30 million in the General Fund for the CalVIP.

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

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

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

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

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

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

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Child and Adolescent Psychiatry
California Public Defenders Association (CPDA)
California Youth Empowerment Network
Californians for Safety and Justice
Chinese for Affirmative Action/AACRE
Ella Baker Center for Human Rights
Greater Sacramento Urban League
Initiate Justice
Initiate Justice Action
Sacramento LGBT Community Center
The Los Angeles Trust for Children's Health
Youth Forward

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 835 (Calderon) – As Amended March 13, 2025

SUBJECT: Medi-Cal: skilled nursing facility services.

SUMMARY: Removes a requirement that a skilled nursing facility (SNF) provider be a network provider (contracted with a health plan) to receive payments under the Medi-Cal Workforce and Quality Incentive Program (WQIP) for SNFs. Requires WQIP payments to be retroactively calculated and paid based on the total number of days, effective July 9, 2024, during which the facility provided services to Medi-Cal beneficiaries, regardless of whether the facility was a network provider.

EXISTING LAW:

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

2) Establishes a schedule of benefits under the Medi-Cal program, including nursing facility services. [WIC § 14132 (c)]

3) Establishes, through the Medi-Cal Long-Term Care Reimbursement Act, the methodology for SNF reimbursement in the Medi-Cal program. [WIC § 14126.033]

4) Requires, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the WQIP, which includes the following provisions:

    a) Authorizes a network provider furnishing SNF services to a Medi-Cal managed care enrollee to earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified, in addition to other certain payments.

    b) Requires DHCS, in consultation with stakeholders, to establish the methodology, parameters, and eligibility criteria for the directed payments, including milestones and metrics that network providers of SNF services must meet in order to receive a directed payment, with at least two of these milestones and metrics tied to workforce measures.

    c) Sets the amount of performance-based WQIP directed payments to target an aggregate amount of $280 million for the 2023 calendar year, and requires DHCS to set the amount, 2024 through 2026 calendar years, at a total based on the prior year's target plus an annual growth factor specified in existing law. [WIC § 14126.024]

5) Specifies rules related to state-directed payments under Medicaid managed care, including a provision that was recently and specifically updated to allow state-directed payments to be directed to non-network providers. [Title 42, Code of Federal Regulations § 438.6(c)]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, SNFs are an essential element of the healthcare landscape for Medi-Cal patients, who are more likely to be elderly, chronically ill, or disabled. This bill is intended to allow SNFs to receive compensation from the WQIP when providing care to a Medi-Cal beneficiary even if the beneficiary is receiving care outside of their healthcare network, as allowed under federal regulation. The author argues that SNFs need to remain viable so they continue providing care to our most vulnerable and that this bill ensures SNFs are compensated fairly.

2) **BACKGROUND**.

   a) **SNF Reimbursement**. AB 186 (Committee on Budget), Chapter 46, Statutes of 2022, a health-related budget trailer bill, included significant reforms to Medi-Cal SNF reimbursement methodology. The intent of the reforms was to establish a long-term funding framework that assures the long-term financial viability of SNFs while creating incentives for SNFs to improve quality of care, advance equity, and invest in workforce. In addition to updating the basic reimbursement structure for SNFs, AB 186 established the WQIP as an incentive program, as well as the SNF Accountability Sanctions Program that imposes monetary sanctions on facilities that fail to meet quality or equity measures.

   b) **Workforce and Quality Incentive Program.** Pursuant to AB 186, a total amount of $280 million for calendar year 2023 was allocated to be distributed through the WQIP. Funding for 2024, 2025, and 2026 is calculated based on applying a growth factor to the prior year's total amount. The WQIP payments are calculated based on a facility's performance on a variety of staffing, clinical, and equity metrics. These metrics include, for instance, staff turnover, nursing hours, residents experiencing a fall with major injury, and the completeness of racial and ethnic data.

      The WQIP is a fixed dollar amount allocation per year, and allowing facilities to receive payments for non-contracted days does not increase or otherwise affect the total amount of WQIP dollars available from the program. DHCS is currently in the process of calculating payments for the 2024 performance year.

   c) **Medicaid State-Directed Payments**. The WQIP is a federally approved Medicaid (Medi-Cal in California) "state-directed payment" program. Generally, when a state contracts with managed care plans to administer medical benefits, the state pay the plans a per-member, per-month rate and the plans reimburse health care providers at negotiated rates. When state-directed payments are distributed by a Medi-Cal managed care plan, however, payments are made to certain providers subject to certain state-defined and federally approved calculations and criteria for receiving payments.

      State law limits WQIP payments to "network providers," meaning managed care plans are required to distribute these payments only to providers with whom they have contracted to be a part of the plan's network. According to the California Association of Health Facilities (CAHF), the sponsor of this bill, there are a number of reasons facilities may not be in contract with a particular plan but still may be providing care to that plan's members. For instance, there may be delays in reaching agreement on a contract, the facility may be located in a different county than the plan and therefore not receive a

large number of patients who are enrolled in that plan, or the plan or a facility may decide for business reasons it is not in their interest to contract with the other.

d) Recent Federal Regulatory Change. In a May 10, 2024, regulatory update, the federal Centers for Medicare and Medicaid Services (CMS) relaxed its rules related to state-directed payments to providers within Medicaid managed care. In the narrative accompanying the final rule, CMS described its proposal to remove the term ‘‘network’’ from the descriptions of state-directed payment arrangements, thereby allowing these payments to be made to non-network providers. Prior to this regulatory change, federal regulations specified that certain types of directed payments must be limited to ‘‘network providers.” In making this change, CMS noted that limiting state-directed payments arrangements to network providers has proven to be too narrow and has created an unintended barrier to states’ and CMS’s policy goals to ensure access to quality care for beneficiaries.

This bill changes statute to remove the limitation to network providers, as allowed by this recent federal regulatory change.

3) SUPPORT. CAHF, this bill’s sponsor, writes in support that this bill helps to remedy an arbitrary rule omitted by CMS and will help provide timely payments. CAHF asserts that the statutory limitation was put into place based on DHCS’s understanding that federal law prohibited directed payments to non-network providers, and the 2024 federal rule from CMS explicitly states that SNF providers are not required to be “in-network” to qualify for payments. CAHF argues that by restricting WQIP payments to solely “in-network” providers contracted with Medi-Cal managed care plans, the state unfairly penalizes providers who care for Medi-Cal beneficiaries outside of formal contracts with managed care plans, denying quality payments earned for qualifying Medi-Cal services and making it more challenging to determine eligible patient care days. CAHF concludes this bill will help SNF qualify for WQIP payments and reduce current barriers to efficient, quick calculations and distributions of WQIP payments to Medi-Cal providers.

4) PREVIOUS LEGISLATION. AB 186 updated SNF reimbursement rules and established the WQIP.

5) POLICY COMMENT. As this bill moves forward, the author and sponsor may wish to engage with Medi-Cal managed care plans and DHCS to consider the extent to which removing the requirement to be a network provider to receive WQIP payments could create a disincentive for SNFs to contract with plans. In general, to support the Medi-Cal program’s overall transition to managed care, it is important for the state to support managed care plans’ ability to build and maintain provider networks. On the other hand, as the author and sponsor point out, each plan contract imposes some administrative burden, there have been contracting delays associated with the transition to managed care, and there are a number of reasons a particular facility may be delivering care as a non-network provider.

The author is also encouraged to engage with DHCS on the feasibility of receiving federal approval for, and implementing this change to, the WQIP program on a retroactive basis.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Health Facilities
LeadingAge California

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 870 (Hadwick) – As Introduced April 21, 2025

SUBJECT: Children's services.

SUMMARY: Authorizes counties with a total population under 2,000 persons (Alpine County) to designate another county to administer the California Children's Services (CCS) program, if that county agrees and otherwise meets the standards set forth by the Department of Health Care Services (DHCS), and neither county is a "Whole Child Model" county (a county where CCS services are provided through managed care plans).

EXISTING LAW:

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

2) Establishes CCS, administered by DHCS, under which individuals under the age of 21 who have eligible medical conditions established in regulation and meet financial requirements, are eligible to receive medically necessary services and treatments. [Health and Safety Code (HSC) § 123800, *et seq*.]

3) Establishes medical and financial eligibility for the CCS program. [HSC § 123830; Title 22, California Code of Regulations §§ 41515.1-41518.9; and HSC §123870]

4) Prohibits CCS covered services from being be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994 until January 1, 2022, except for contracts entered into for county organized health systems (COHS) or a Regional Health Authority in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa. [WIC § 14094.3]

5) Authorizes DHCS to establish a "Whole Child Model" (WCM) program for Medi-Cal enrolled children who are also enrolled in CCS in specified counties. [WIC § 14094.4]

6) Requires the board of supervisors of each county to designate the county department of public health or the county department of social welfare as the designated agency to administer the CCS program. [WIC § 123850]

7) Authorizes counties with total population under 200,000 persons to administer the county CSS program independently or jointly with DHCS and requires counties with a total population in excess of 200,000 persons to administer the county CCS program independently. [*Ibid*.]

FISCAL EFFECT: This bill is keyed non-fiscal.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, Alpine County is the smallest county in California, with a total population of roughly 1,200 residents and a single public health nurse who manages their CCS program. The author indicates that when the single nurse is unavailable, the program comes to a halt as no one else in the county has the credentials to administer the CCS program, which could leave sick and/or physically handicapped children without services. Recently, when this employee was out on extended leave, Alpine County worked with neighboring El Dorado County to ensure continued administration of CCS. Although no current residents of Alpine County are enrolled in CCS, the county must maintain infrastructure to administer CCS. This bill would authorize such an arrangement as a sustainable long-term solution for a very small county that struggles to maintain sufficient resources to administer the CCS program.

2) **BACKGROUND.**

   a) **CCS**. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions (e.g., severe genetic diseases, chronic medical conditions, infectious diseases producing major complications, and traumatic injuries) who are income eligible or otherwise unable to afford catastrophic health care costs. Nearly 200,000 California children are enrolled in CCS, and the majority of these children are also enrolled in Medi-Cal.

   b) **CCS Program Administration.** In counties with populations greater than 200,000 (independent counties), county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care. For 27 smaller, more rural counties with populations under 200,000 (dependent counties), DHCS provides medical case management and eligibility and benefits determination through its regional offices located in Sacramento and Los Angeles, while dependent counties interact directly with families to perform some functions. According to a 2023 overview published by DHCS outlining state and local responsibilities for CCS in dependent counties, each county is assigned to a specific levels of responsibility for eligibility determinations, case management and other functions. The overview indicates Alpine County retains responsibility for CCS financial and residential program eligibility determinations and less complex CCS case management procedures and liaison functions.

   c) **CCS and Medi-Cal Managed Care.** In most counties, children who are eligible for both Medi-Cal and the CCS program are enrolled in Medi-Cal managed care and receive CCS-covered services through the CCS program on a fee-for-service basis. However, in counties whose Medi-Cal services are provided through County Organized Health Systems (a single managed care plan authorized at the county level) counties assume full financial responsibility, with some exceptions. In addition, SB 586 (Hernandez, Chapter 625, Statutes of 2015) authorized DHCS to establish the Whole Child Model, in which both Medi-Cal and most CCS services would be covered and paid for by the Medi-Cal managed care plan. AB 113 (Committee on Budget), Chapter 42, Statutes of 2023, expanded DHCS's authority to implement Whole Child Model programs in Butte,

Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa, and San Benito Counties, no sooner than January 1, 2025.

This bill has been recently amended to address concerns from specialty care providers with respect to potentially designating a Whole Child Model counties to perform CCS functions on behalf of another county. Specifically, it was amended to allow a county under 2,000 people to designate a neighboring county to provide services only if both counties are not Whole Child Model counties. Neither Alpine nor El Dorado, the county Alpine would seek to contract with, are Whole Child Model counties at this time.

3) **SUPPORT.** This bill is supported by Alpine County and a number of county-based organizations, including the California Health Executives Association of California (CHEAC). According to CHEAC, this bill would enable the smallest county in the state to partner with a willing county for program administration to ensure quality care for all CCS-eligible children.

4) **RELATED LEGISLATION.** AB 1450 (Hoover), pending in this committee, would define "advanced practice provider" as a nurse practitioner, physician assistant, or certified registered nurse anesthetist that meets certain criteria, would allow such providers to be "paneled" (to be a qualified service provider) in the CCS program, and would specify various requirements related to these providers.

5) **PREVIOUS LEGISLATION.**

   a) AB 113 authorizes DHCS, no sooner than January 1, 2025, to establish a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a managed care plan in additional counties.

   b) SB 424 (Durazo) would have addressed a number of issues in the CCS program, including codifying CCS-eligible conditions, increasing payment rates and creating a grant program for hospitals, and prohibiting the expansion of the Medi-Cal managed care Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in specified counties. SB 424 was referred to the Assembly Health Committee and not heard, and was later amended to a different subject matter.

   c) SB 586 (Hernández, Chapter 625, Statutes of 2015) authorized DHCS to establish the Whole Child Model.

REGISTERED SUPPORT / OPPOSITION:

Support

Alpine County
California State Association of Counties (CSAC)
County Health Executives Association of California (CHEAC)
Health Officers Association of California
Rural County Representatives of California (RCRC)

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 894 (Carrillo) – As Amended March 24, 2025

SUBJECT: General acute care hospitals: patient directories.

SUMMARY: Requires a general acute care hospital (GACH) to inform a patient, at the time of admitting, or at the earliest time possible in cases of patient incapacity or an emergency treatment circumstance, that the patient may restrict or prohibit the use or disclosure of protected health information in the hospital's patient directory by using a separate document or having hospital personnel verbally inform the patient, as specified. Specifically, **this bill**:

1) Requires a GACH to inform a patient, at the time of admitting, or at the earliest time possible in cases of patient incapacity or an emergency treatment circumstance, that the patient may restrict or prohibit the use or disclosure of protected health information in the hospital's patient directory, in either of the following manners:

    a) Using a separate document that only includes information regarding the hospital's directory and the included protected health information. The separate document shall include check boxes for the patient to mark whether they authorize or restrict or prohibit use or disclosure of the protected health information in the hospital's patient directory; or,

    b) Having hospital personnel verbally inform the patient.

2) Requires the information provided pursuant to a) above, to be made available or provided in the top five languages, other than English, in the hospital's service area.

EXISTING LAW:

1) Licenses and regulates health facilities, including GACHs, by the Department of Public Health (DPH). Defines GACH to mean a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Permits GACHs, in addition to the basic services all hospitals are required to offer, to be approved by DPH to offer special services, including, among other services, an emergency department (ED). [Health and Safety Code (HSC) § 1250 and § 1255 *et seq*.]

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

3) Requires every health care provider, health care service plan, pharmaceutical company, or contractor who creates, maintains, preserves, stores, abandons, destroys, or disposes of medical information to do so in a manner that preserves the confidentiality of the information. Requires any provider of health care, health care service plan, pharmaceutical company, or contractor who negligently creates, maintains, preserves, stores, abandons, destroys, or disposes of medical information to be subject to the remedies and penalties, as specified. Requires an electronic health records (EHR) system or electronic medical record system to do the following:

    a) Protect and preserve the integrity of electronic medical information; and,

    b) Automatically record and preserve any change or deletion of any electronically stored medical information. [CIV § 56.101]

4) Authorizes a "covered entity," (including a hospital), under federal regulations, to use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. Authorizes the covered entity to orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure. [Section 164.510 of Title 45 of the Code of Federal Regulations]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, in a time where personal safety and privacy are more critical than ever, we must take immediate action to protect those who are most at risk. The current practice of listing patients' personal information in hospital directories, often without their full understanding, can lead to exposing individuals to threatening situations. Those facing sensitive circumstances, such as immigration issues, domestic violence, and human trafficking, deserve to feel protected when seeking health treatment. The author states that this bill will give vulnerable patients the power to make an informed choice about whether their personal information should be accessible, ensuring that they are not put in a potentially dangerous situation. The author argues that we must send a clear message to our most marginalized Californians that their right to privacy and safety is a top priority, regardless of their background. The author concludes, that as lawmakers, it is our responsibility to guarantee that every patient seeking treatment can safely do so.

2) **BACKGROUND.**

    a) **Sensitive areas.** In 2011, the director of Immigration and Customs Enforcement (ICE) issued an internal memo directing officers to generally refrain from conducting enforcement actions, such as arrests, interviews, searches, and surveillance, at sensitive areas. These protected areas included hospitals, churches, and schools. However, on January 21, 2025, the Department of Homeland Security rescinded this policy. In response, on January 27th, 2025, the California Hospital Association released a statement addressing the Department's decision. One of their key recommendations was for hospitals to better inform patients of their right to opt-out of the patient directory, a crucial measure for safeguarding their privacy. To achieve this, hospitals were advised to

either provide a separate document outlining this option or to have admitting personnel verbally notify patients.

b) Impact of "policing patients." In the past few years, states such as Florida and Texas have enacted policies that erode trust in healthcare and put healthcare facilities in the position of policing patients. Florida hospitals that accept Medicaid are now mandated to collect data on patients' immigration status, and Texas public hospitals are mandated to collect data on costs they incur to provide emergency and inpatient care for undocumented immigrants. This is despite evidence that immigrants don't use as much healthcare as U.S.-born people, and actually subsidize the healthcare of U.S. residents through their payment of insurance premiums and taxes.

According to a January 2025 Kaiser Family Foundation (KFF) brief, *"Key Facts on Health Coverage of Immigrants,"* as of 2023, there were 47.1 million immigrants residing in the U.S., including 22.4 million noncitizen immigrants and 24.7 million naturalized citizens, who each accounted for about 7% of the total population. Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. One in four children has an immigrant parent, including over one in ten (12%) who are citizen children with at least one noncitizen parent. Overall, research shows that immigrants use less health care than U.S.-born citizens. Lower use of health care among immigrants likely reflects a combination of them being younger and healthier than their U.S.-born counterparts as well as them facing increased barriers to care including a higher uninsured rate, language access challenges, and immigration-related fears.

A KFF analysis of 2021 medical expenditure data shows that, on average, annual per capita health care expenditures for immigrants are about two-thirds of those who are U.S.-born citizens ($4,875 vs. $7,277). Recent research further finds that, because immigrants, especially undocumented immigrants, have lower health care use despite contributing billions of dollars in insurance premiums and taxes, they help subsidize the U.S. health care system and offset the costs of care incurred by U.S.-born citizens.

3) RELATED LEGISLATION. SB 81(Arreguín) would prohibit, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise required, a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for immigration enforcement. Prohibits, to the extent permitted by state and federal law, and to the extent possible, a provider of health care, health care service plan, contractor, or employer from allowing access to a patient for immigration enforcement. SB 81 is pending in the Senate Health Committee.

4) PREVIOUS LEGISLATION.

a) SB 1184 (Cortese) Chapter 993, Statutes of 2022 authorizes a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator pursuant to a written authorization.

b) AB 3013 (Koretz) Chapter 833, Statutes of 2006 amends the Confidentiality of Medical Information Act (CMIA) to better conform to confidentiality provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). Preserves the ability of general acute care hospitals to make specified disclosures.

5) AMENDMENTS. The author is proposing to amend this bill to clarify that the notification documents can be either paper or digital.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 910 (Bonta) – As Amended April 10, 2025

SUBJECT: Pharmacy benefit management.

SUMMARY: Requires a pharmacy benefit manager (PBM) to hold a fiduciary duty in the performance of its contracted duties to a health plan. Requires a PBM and any affiliated entities to pass 100% of all prescription drug manufacturer rebates received to the health plan for the sole purpose of offsetting cost-sharing, including copayments, deductibles, and coinsurance contributions, and reducing premiums of enrollees. Prohibits a PBM and any affiliated entity from deriving income from spread pricing, as defined. Prohibits a PBM and any affiliated entity from deriving income from PBM services provided to a health plan except for income derived from a bona fide service fee. Requires a PBM to report to the Department of Managed Health Care (DMHC) specified information, including a list of the 100 most costly drugs, the 100 most frequently prescribed drugs, the 100 highest revenue-producing drugs, and PBM revenue and expenses. Requires DMHC to compile the information reported into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums, to determine PBM's impact on the market, the impact of rebates on pharmacy costs, the impact of PBM relationships with affiliated entities, and the value PBMs provide to consumers. Specifically, **this bill**:

1) Requires a health plan that contracts with a PBM for management of any or all of its prescription drug coverage to:

    a) Require the PBM to hold a "fiduciary duty" in the performance of its contractual duties to a health plan and carry out that duty in accordance with state and federal law. The fiduciary duty requirement replaces the existing law requirement that the PBM "exercise good faith and fair dealing" in the performance of its contractual duties with the health plan;

    b) Require the PBM to remit 100% of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to the utilization of drugs or drug spending under the health plan to the health plan for the sole purpose of offsetting cost sharing, including copayments, deductibles, and coinsurance contributions, and reducing the premiums of enrollees; and;

    c) Prohibit the PBM from entering into any contract for PBM services on behalf of a health plan with an affiliated entity unless 100% of rebates, fees, alternative discounts, and other remuneration received under that contract that are related to the utilization of drugs or drug spending under the health plan are remitted to the health plan by the entity providing the PBM services.

2) Defines an "affiliated entity" as any of the following:

    a) An applicable group purchasing organization (GPO), drug manufacturer, distributor, wholesaler, rebate aggregator or other purchasing entity designed to aggregate rebates, or associated third party;

b) Any subsidiary, parent, affiliate, or subcontractor of a group health plan, entity that provides PBM services on behalf of a group health plan, or any entity described in a); or,

c) Any other entity as designated by the DMHC.

3) Defines a GPO to mean a GPO, including an out-of-state or international organization that is affiliated with or under common ownership or control with an entity that provides PBM services.

4) Defines "rebates" to mean:

a) Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer by a PBM, any affiliate, or any subcontractor, including, but not limited to, any GPO, directly or indirectly related to the purchase or utilization of any prescription drug by eligible members regardless of how the compensation or remuneration is categorized, including, but not limited to, incentive rebates, credits, market share incentives, promotional allowances, commissions, educational grants, market share of utilization, drug pull-through programs, implementation allowances, clinical detailing, rebate submission fees, and administrative or management fees; and,

b) Any bona fide fees, including manufacturer administrative fees or corporate fees that a PBM, any affiliate, or any subcontractor, including, but not limited to, any GPO, receives from a pharmaceutical manufacturer for administrative costs including, but not limited to, formulary placement or access.

5) Excludes from the definition of "rebates" pharmacy purchase discounts and related service fees a PBM, any affiliate, or any subcontractor receives from pharmaceutical companies that are attributable to or based on the purchase of product to stock, or the dispensing of products from a PBM's affiliated mail order and specialty drug pharmacies.

6) Requires a PBM, as a condition of the existing law requirement to register with DMHC, to also comply with all of the following:

a) Requires a PBM, GPO, and any affiliated entity to pass 100% of all prescription drug manufacturer rebates received to the health plan for the sole purpose of offsetting cost sharing, including copayments, deductibles, and coinsurance contributions, and reducing premiums of enrollees;

b) Prohibits a PBM, GPO, and any affiliated entity from deriving income from spread pricing. Defines "spread pricing" to mean the model of prescription drug pricing in which a PBM manager charges a health plan a contracted price for prescription drugs which differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy; and,

c) Prohibits a PBM, GPO and any affiliated entity from deriving income from PBM services provided to a health plan in this state, except for income derived from a bona fide service fee.

7) Requires the amount of any PBM bona fide service fee to be set forth in the agreement between the PBM and the health plan.

8) Defines a "bona fide service fee" to mean a fee that is equal to the fair market value of a bona fide itemized service that is actually performed on behalf of an entity that the entity would otherwise perform or contract for in the absence of the service arrangement, and that is not passed on in whole or in part to a client or customer, whether or not the entity takes title to the drug.

9) Prohibits a PBM fee charged by or paid to a PBM by a health plan from being directly or indirectly based or contingent upon 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 pharmacy benefit manager or its affiliates; and,

    c) The amount of premiums, deductibles, cost sharing, or other fees charged, realized, or collected by the PBM or its affiliates from a patient or other persons on behalf of a patient.

10) Prohibits the above provisions from precluding a health plan from paying flat performance bonuses to a PBM that are both of the following:

    a) Not connected to the price of a drug; and,

    b) Related to services actually performed by the PBM for a plan.

11) Requires compensation arrangements governed by the above-described provisions to be open for inspection and audit by the DMHC.

12) Requires the existing application form for a PBM registration with DMHC to also require the PBM manager to submit the name, address, and relationship of any affiliated entity and GPO in which the PBM has ownership, control, financial interest, or a contractual relationship.

13) Requires a PBM contracting with a health plan to report the information below to the DMHC no later than October 1 of each year, beginning October 1, 2026.

14) Requires a PBM to report, 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, all of the following:

    a) A list of the 100 most costly drugs;

    b) The 100 most frequently prescribed drugs;

    c) The 100 highest revenue-producing drugs, grouped by generic, brand, specialty, and other;

    d) 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 for the prescription drug, the amount of rebate the PBM, GPO, and any affiliated entity receives from the manufacturer, the amount of rebate the PBM passes on to the health plan, the amount the health plan pays the PBM, and the amount the PBM pays the pharmacy.

15) Requires the information provided to additionally include all of the following:

a) The aggregate wholesale acquisition costs (WAC) from a pharmaceutical manufacturer or labeler for each drug;

b) The aggregate amount of rebates received by the PBM, GPO, and any affiliated entity 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 PBM to pharmacies owned or controlled by the PBM for each drug;

e) The aggregate of payments made by the PBM to pharmacies not owned or collected by the PBM for each drug; and,

f) 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.

16) Requires the PBM to also report all of the following information to the DMHC:

a) The health plans with which the PBM, GPO, and any affiliated entity contracts, the scope of services provided to the health plan, and the number of enrollees served by the PBM;

b) The PBM's revenue, including revenue from manufacturers, health plans, pharmacies, its affiliated entities, and other revenue; and,

c) The PBM's expenses, including payments to pharmacies, claims processing, special programs, administration, and other expenses.

17) Requires DMHC to compile the information reported pursuant to the above-described provisions into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums, to determine PBM market impact, the impact of rebates on the pharmacy costs, the impact of PBM relationships with GPO and affiliated entities, and the value PBMs provide to consumers.

18) Requires the data in the report to be aggregated and prohibits the data from revealing information specific to individual PBMs.

19) Defines, for purposes of the reporting requirements, a "specialty drug" as one that exceeds the threshold for a specialty drug under the Medicare Part D program.

20) Requires DMHC, by January 1 of each year, beginning January 1, 2027, to publish on its internet website the report required above.

21) Requires DMHC, after DMHC publishes the required report, to include the report as part of the public meeting required pursuant to a specified provision of existing law.

22) Requires DMHC, except for the required report, to keep confidential all of the information provided to the DMHC, and requires the information to be exempt from disclosure under the California Public Records Act.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans in the Health and Safety Code under the Knox-Keene Act, and requires the California Department of Insurance (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) Defines a "PBM" in the Knox-Keene Act to mean 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. Excludes form this definition a health plan licensed under the Knox-Keene Act or any individual employee of a health plan its contracted provider performing the above-described services. [HSC § 1385.001]

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

4) 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]

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

COMMENTS:

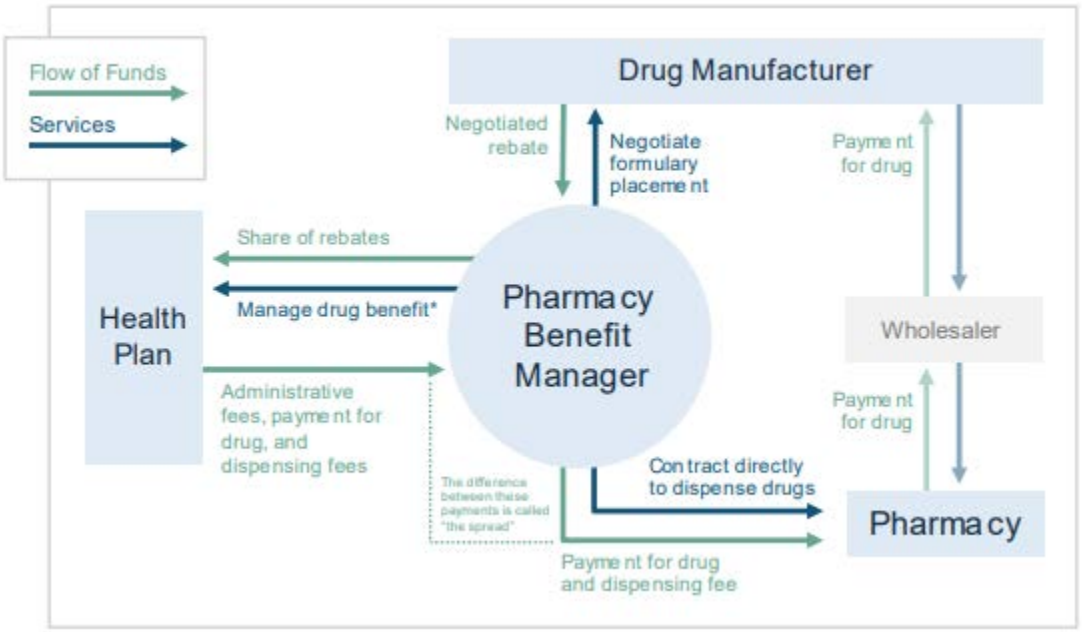
1) **PURPOSE OF THIS BILL**. According to the author, this bill strengthens state oversight of PBMs and reins in practices that impact the cost of prescription drugs for consumers. The author notes that prescription drug spending is growing faster than any other health care cost, as spending on drugs in California alone has increased 56% since 2017. Over half of Californians say they skip or delay care, including prescription drugs, due to the cost. PBMs are companies that are contracted to act as middlemen who administer prescription drug benefits and exercise significant control over which drugs are available, where they are available, and importantly how much they cost. For example, PBMs earn money on rebates they negotiate directly with pharmaceutical companies. The author states that this practice can incentive the coverage of more expensive brand-name drugs at an increased cost for

consumers and health plans. PBMs also engage in spread pricing, where they charge a health plan a higher price than what they pay to the pharmacy and then pocket the difference. The author states this bill requires PBMs to act in the financial interest of their health plan clients, prohibits spread pricing, and requires PBMS to pass through 100% of rebates for the purpose of reducing consumer costs. This bill also requires PBMs to be paid a bona fide service fee, ensuring that their earnings are solely derived from the services they are performing on behalf of Californians. Lastly this bill requires PBMs to report information on their drug costs, revenues, and expenses, shining a light on PBM practices and helping the state better assess their impact on rising prescription drug costs.

2) **PRESCRIPTION DRUG SPENDING AND SB 17 REPORT**. SB 17 (Hernandez), Chapter 603, Statutes of 2017 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 cost of prescription drugs continues to impact the affordability of health care overall, with health plans paying about $13.6 billion for prescription drugs in 2023 (minus $2.6 billion in rebates). Prescription drug costs have increased at a higher rate compared to medical expenses and health plan premiums. Total prescription drug costs increased by 10.8% in 2023, whereas total medical expenses increased by 4% and health plan premiums increased by 6.2% from 2022 to 2023. Prescription drugs accounted for 15.1% of total health plan premiums in 2023, compared to 14.3% in 2022. Specialty drugs (a drug with a plan negotiated monthly cost prior to rebate that exceed the dollar threshold for a specialty drug under Medicare Part D) and brand name drugs were the primary drivers of the increase in total prescription drug-cost spending for 2023. Specialty drugs account for only 2% of all prescriptions dispensed but accounted for 65.8% of total annual spending on prescription drugs. In contrast, generic drugs accounted for 89.2% of all prescriptions but only 12.7% of the total annual spending on prescription drugs. According to the DMHC, health plans paid almost $1.3 billion more on prescription drugs in 2023 than in 2022. Since 2017, total prescription drug costs paid by health plans increased by $4.9 billion or 56%.

3) **BACKGROUND ON THE DRUG SUPPLY CHAIN AND PBMS.** The drug supply chain refers to the process through which prescription drugs move from their development and manufacture to being made available for patient use. Pharmaceutical companies or contract manufacturers research, develop and produce drugs. Drugs are then packaged according to regulatory requirements. Wholesalers and distributors are entities that purchase drugs in bulk from manufacturers and then sell them to pharmacies, hospitals, clinics, and other health care providers. Pharmacies and hospitals are the final points of distribution where patients obtain their prescribed drugs, either through retail pharmacies (community pharmacies or “independents”) chain pharmacies, mail order pharmacies or health care facilities such as hospitals and skilled nursing facilities. Pharmacists dispense medications prescribed by a health care provider (such as a physician, nurse practitioner, or podiatrist) who is authorized to prescribe medications.

PBMS operate in the middle of the prescription drug supply chain, as shown in the graphic below:



Source: Manatt October 26, 2023 Presentation *Understanding PBM Reform: A Guide to Federal PBM Reform Legislation*

PBMs manage the prescription drug benefit on behalf of third-party payers (health plans, insurers, self-insured employers, labor trusts, Medicare and Medicaid, and state and local governments). PBMs role varies by payer, but major PBM functions are as follows:

a) **Claims processing**. PBMs process claims for prescription medications submitted by pharmacies to third-party payers for reimbursement.

b) **Negotiate Drug Prices and Discounts.** PBMs negotiate with pharmaceutical manufacturers for discounts, rebates, and pricing structures to reduce the cost of prescription drugs. PBMs do this by leveraging their purchasing power, representing large groups of patients (from plans/insurers, self-insured employers, health plans, labor trusts, etc.), to secure lower prices for drugs.

c) **Formularies.** Formularies are lists of preferred medications that PBMs establish and manage on behalf of third-party payers. They determine which drugs are covered and at what level of cost-sharing for a patient. PBMs evaluate drugs based on factors such as cost, clinical effectiveness, and safety when deciding which drugs to include on the formulary.

d) **Pharmacy Networks.** PBMs contract with pharmacies to establish pharmacy networks. The pharmacy network determines where patients can fill prescriptions. PBMs negotiate payment rates with pharmacies, determining how much pharmacies are paid for dispensing medications. Pharmacies are typically paid a contracted amount for the drug (the “ingredient cost”) and a fee for filling the drug (a “dispensing fee”).

e) **Utilization Management**. PBMs steer patients toward lower-cost drugs (generic or preferred brand medications) and use step therapy or prior authorization to ensure that less expensive or clinically appropriate treatments are used first. PBMs also monitor drug utilization (how and when patients use their medications). These programs are aimed at ensuring drugs are prescribed appropriately, avoid overuse, underuse, or misuse, and optimize treatment. Medication therapy management programs help identify potential issues, such as drug interactions or incorrect dosing.

f) **Specialty Medications.** Specialty medications are often high-cost drugs for complex or chronic conditions. PBMs manage the distribution and cost of these medications by negotiating prices, managing distribution through specialty pharmacies, and implementing programs that ensure proper use.

g) **Drug Delivery and Mail Order Pharmacies.** Many PBMs operate their own mail-order pharmacies, so patients can obtain their medications via mail or delivery.

PBMs role over time has changed significantly as third-party coverage of prescription drugs has expanded. PBMs were originally established to set reimbursement rates, process claims, and pay pharmacies on behalf of payers. PBMs are increasingly vertically integrated, with several large PBMs being owned by or affiliated with pharmacy chains, insurance companies, and health care providers. According to a Congressional Research Service (CRS) 2023 publication, in 2022, the three largest PBMs (CVS Caremark, part of CVS Health, which owns Anthem; Express Scripts, which is owned by Cigna; and OptumRx, which is owned by UnitedHealthcare) processed a large majority of prescription drug claims in the United States. PBMs have also acquired mail order pharmacies and specialty pharmacies.

This gives PBMs considerable leverage with health payers, pharmacies, and drug manufacturers. Because of the significant behind-the-scenes impact PBMs have on the amount payers pay for drugs, how much pharmacies are reimbursed and which drugs are available to patients, PBMs have faced growing scrutiny at the state and federal level.

5) **REGISTRATION REQUIREMENT FOR PBMs**. AB 315 (Wood), Chapter 905, Statutes of 2018, among other provisions, requires health plans to require PBMs they contract with to register with the DMHC. PBMs pay an initial registration application fee of $3,500 and DMHC bills for time spent reviewing the PBM's responses at a variable hourly rate up to $500, with fees to review an initial registration application capped at $4,000. Fourteen PBMs are registered with DMHC. If an enrollee has an issue related to their outpatient prescription drug coverage where a plan is contracting with a PBM to administer the benefit, DMHC has regulatory jurisdiction over the health plan.

6) **PBM REIMBURSEMENT.** This bill requires a PBM and any affiliated entities to pass 100% of all prescription drug manufacturer rebates received to the health plan for the sole purpose of offsetting cost-sharing, including copayments, deductibles, and coinsurance contributions, and reducing premiums of enrollees. In addition, this bill prohibits a PBM and any affiliated entity from deriving income from spread pricing, as defined. Instead, PBMs, would derive income from bona fide service fees, which would be required to be set forth in the agreement between the PBM and the health plan. In addition, a health plan could pay a flat performance bonuses to a PBM, provided it is not connected to the price of a drug and is instead related to services actually performed by the PBM for a plan.

According to the CRS report, PBMs contracts with payers can specify different methods of compensation, including administrative fees for claims processing and other services. Where allowed, PBMs may engage in a practice known as spread pricing, whereby the PBM generates profit by reimbursing a pharmacy at a lower rate than the amount the PBM is paid by the health payer. PBMs may also generate fees for dispensing drugs through retail and mail-order pharmacies. Some contracts allow PBMs to keep a portion of savings generated from negotiations with drug manufacturers, rather than passing on such savings to the health payer. PBMs also generate revenue by dispensing drugs from their own mail-order and specialty drug pharmacies, rather than through contracted health plan network pharmacies.

A 2023 JAMA Health Forum Special Communication (JAMA article) titled "*Pharmacy Benefit Managers History, Business Practices, Economics, and Policy"* states that rebate retention incentivizes the PBM to maximize rebates, even if doing so results in offering a preferred formulary position to drugs with higher list prices, and spread pricing contracts incentivize PBMs to squeeze lower costs out of their pharmacy networks. The JAMA article states these strategies create an environment that favors larger PBMs with more negotiating leverage, incentivizing horizontal integration through mergers and acquisitions. The same dynamics also create an incentive toward vertical integration with PBM-owned or PBM-affiliated pharmacies, particularly for high-cost specialty pharmaceuticals, which have a massively disproportionate impact on total drug spending.

The JAMA article states that drug manufacturers in competitive therapeutic areas may have an incentive to offer, and some PBMs may have an incentive to accept, a high-list-price and high-rebate strategy. The JAMA article states a PBM may prefer products with high list prices for which it can negotiate high rebates, rather than comparable drugs with lower list prices and smaller rebates, if the PBM retains some percentage of the rebates and its contract with the plan sponsor does not require 100% pass-through. The JAMA article states these pricing incentives have led multiple manufacturers, such as Amgen and Viatris, to launch the same drug products at different list prices (a low-price product with no rebate and a higher-price version with rebates) to appeal to different purchasers. Although it seems counterintuitive that any purchaser would prefer a higher price, both companies expect the high-list-price/high-rebate option to be more attractive to PBMs that retain some of the rebate.

7) **FIDUCICARY DUTY**. This bill requires a health plan that contracts with a PBM for management of any or all of its prescription drug coverage to require the PBM to hold a fiduciary duty in in the performance of its contractual duties to a plan. A fiduciary relationship is one where one of the parties is in duty bound to act with the utmost good faith for the benefit of the other party. A fiduciary assuming that role cannot take advantage from their acts relating to the interest of the other party without the latter's knowledge or consent. A fiduciary duty is a higher standard than the requirement in existing law that a PBM "exercise good faith and fair dealing" in the performance of its contractual duties.

   The National Academy of State Health Policy's (NASHP) "Model Act Relating to Pharmacy Benefit Manager" would require a PBM to have a fiduciary duty to a health carrier client and to discharge that duty in accordance with the provisions of state and federal law so that PBMs have a legal responsibility to protect the financial interests of their health plan clients.

The Purchaser Business Group on Health (PBGH) has called on Congress to include a fiduciary duty requirement on PBMs, stating that, as employers, PBGH believes the ultimate backstop to end present and future PBM industry abusive practices is to hold PBMs to the exact standard that employers face under the federal Employee Retiree Income Security Act (ERISA). PBGH states that, without requiring PBMs to function as fiduciaries, the large companies that control much of the prescription drug market will likely continue to develop revenue-driven strategies that enable them to thwart the spirit and letter of the law.

Similarly, the University of Southern California (USC) Leonard D. Schaeffer Institute for Public Policy & Government Service July 2024 blog post titled "*A Patient-Focused, Evidence-Driven Approach to PBM Reform*" outlines five principles that should be the foundation for comprehensive and sustainable PBM reform. One of the principles is that that PBMs have a fiduciary responsibility to their clients. In Congressional testimony, one of the authors of the USC paper stated the benefit of such a requirement would be to align PBMs' priorities with their clients' goals, and end practices that enrich the PBM at the client's expense. For example, a fiduciary duty should prevent a PBM from preferring a high-cost branded version of a drug over its low-cost generic to collect rebates or fees based on the drug's list price.

8) **FEDERAL EFFORTS TO REIN IN PBM PRACTICES**. PBMs have been the subject of growing national, bipartisan attention in recent years. The Federal Trade Commission (FTC) issued a series of interim reports criticizing PBM practices in 2024. These reports lay out concerns with many of the issues this bill aims to address, including a lack of transparency and business practices such as spread pricing and profiting from negotiating rebates with manufacturers in return for preferential tier placement of specific drugs. The FTC's reports were followed by a lawsuit against the three largest PBMs, Caremark Rx, Express Scripts and Optum Rx, which focuses on PBM practices as they narrowly relate to insulin access. The new FTC chair under the Trump Administration has confirmed that they plan to continue the pursuit of this lawsuit. Several Congressional bills have proposed sweeping reforms to PBM practices in both the Medicare, Medicaid and the commercial markets, and the language in this bill is in part modeled on some of those provisions.

9) **SUPPORT.** Blue Shield of California (BSC) writes in support that this bill would put an end to harmful business practices employed by PBMs, GPOs, and their affiliated entities, often seen under common ownership by for-profit, vertically integrated health care companies. BSC states that health care costs are far outstripping wage growth, creating an unsustainable reality for consumers, taxpayers, and businesses, and that while PBMs were created to lower prescription drug prices for consumers by purchasing at scale and making more efficient administrative functions, PBMs have strayed from that function, morphing into yet another opaque profit center in the system without corresponding value to consumers. BSC states that what was once a straightforward aggregation of purchasing power, has morphed into a complex and convoluted system that is designed to have the appearance of "savings", even though consumers and health plans, who PBMs are supposed to serve, end up paying remarkably more (sometimes over 1,000% more) for prescription drugs than their acquisition cost.

BSC states it made the decision to utilize smaller transparent companies to administer its various pharmaceutical management functions with the goal of securing the lowest price possible for consumers without hidden markups, costs, or fees. BSC states this bill closely

tracks with the policies that were part of the 2024 bi-partisan Congressional end of year continuing resolution funding package, which, amongst other provisions, sought to eliminate the widely recognized bad business practices that PBMs and their affiliated entities engage in, but those provisions were ultimately excluded due to unrelated issues. BSC concludes that this bill is a critical reform that will pick up the pieces from the federal bi-partisan collaboration and will ensure that consumers know what they pay for and will get an honest, fair deal on the prescription drugs they need.

10) **OPPOSE UNLESS AMENDED.** The Pharmaceutical Care Management Association (PCMA) writes that it agrees with DMHC regulation and does not have concerns with the 100% rebate pass through requirement, but argues this bill does nothing to address drug affordability and fails to extend transparency to other entities in the drug supply chain.

    PCMA expresses concerns with the definitions in this bill and the contracting limitations imposed on health plans and PBMs, which PCMA argues would limit how health plans and employers manage and pay PBMs and would severely hinder the ability for these entities to offer affordable and accessible prescription drug benefits to Californians. PCMA argues 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, and result in a financial windfall for the pharmaceutical industry. PCMA states the current pay-for-PBM-performance model has effectively worked in numerous industries and helps PBMs deliver prescription drug savings to patients and plan sponsors year after year. Many health plans and employers prefer contracting options that allow the PBM to keep a small portion of the drug company rebates, or discounts. This bill would limit these highly valued contracting options.

    In addition, PCMA objects to the ban on the use of spread pricing contracts, arguing spread pricing enables health plans and employers to better manage their total drug spend with greater certainty. Additionally, PCMA argues state-imposed fiduciary duties make no sense in the context of a detailed, negotiated, arm's length contract, and parties can make the PBM a fiduciary if they so desire, but they chose not to. Finally, PCMA writes that it agrees with the author's focus on transparency for PBMs, it encourages the author to expand the transparency requirements in the bill to capture the full drug supply chain, as outlined in the Governor's veto of SB 966 last year.

11) **OPPOSITION.** CalAsian Chamber of Commerce (CAC) writes in opposition to this bill, arguing it believes this bill would significantly increase costs for employers and workers while reducing the quality of pharmacy benefits. CAC's key concerns are the eliminating of performance-based arrangements that create financial incentives for PBMs to achieve the lowest possible prescription drug costs, with shared savings or other common arrangements, and the prohibition against spread pricing and limiting contract structures. CAC concludes that this bill will increase health care costs, stating that, without performance incentives, prescription drug costs will likely rise, ultimately burdening employers and patients.

12) **RELATED LEGISLATION.** SB 41 (Wiener) contains multiple provisions dealing with PBMs, including requiring a PBM to reimburse a pharmacy the cost of a prescription drug in an amount that is no less than the National Average Drug Acquisition Cost (NADAC) for that drug at the time of the pharmacy's dispensing of that drug, or another benchmark if that drug if the drug does not appear on the NADAC index. Requires a PBM to pay a pharmacy a

dispensing fee that is no less than the dispensing fee that is paid by Medi-Cal. Requires PBMs to be licensed and regulated by the California Department of Insurance, and it would prohibit a health plan or health insurer that provides prescription drug coverage from calculating an enrollee's or insured's cost sharing at an amount that exceeds the actual rate paid for the prescription drug. Prohibits a contract between a PBM and a health plan or health insurer from authorizing spread pricing. Requires a plan or insurer to include additional information in its annual prescription drug data reporting, including the aggregate amount of rebates received by the PBM for each drug.

13) PREVIOUS LEGISLATION.

a) SB 966 (Wiener) of 2024 was similar to SB 41. In his veto message, Governor Newsom indicated he believes that PBMs must be held accountable to ensure that prescription drugs remain accessible throughout pharmacies across California and available at the lowest price possible, but he was not convinced that SB 966's expansive licensing scheme will achieve such results. He directed the California Health and Human Services Agency to propose a legislative approach to gather much needed data on PBMs next year, which can be considered in conjunction with data from our entire health care delivery system. The Governor stated California needs more granular information to fully understand the cost drivers in the prescription drug market and the role that PMBs play in pricing, and that California should collect comprehensive information from the pharmacy delivery system about the total cost of care for providing individual prescription drug products, including but not limited to wholesale acquisition costs, fees, payments, discounts, and rebates paid to and received by PBMs. The Governor stated that these next steps, together with the CalRx program and the Office of Health Care Affordability's work, will offer a multi-pronged approach to improving affordability of prescription drugs in California.

b) AB 2180 (Weber) of 2024 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.

c) AB 913 (Petrie-Norris) of 2023 would have required the Board of Pharmacy (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 not heard in the Assembly Business and Professions Committee.

d) 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.

e) 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.

f) 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."

g) 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.

h) AB 315 (Wood), Chapter 905, Statutes of 2018 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.

REGISTERED SUPPORT / OPPOSITION:

Support

Blue Shield of California

Opposition

CalAsian Chamber of Commerce

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 955 (Alvarez) – As Amended April 10, 2025

SUBJECT: Mexican prepaid health plans.

SUMMARY: Expands the population that a Mexican health plan that is licensed by the Department of Managed Health Care (DMHC) can provide employer-sponsored group coverage to include individuals legally employed in San Diego and Imperial counties and for their dependents, but only if an employer also provides alternative health care coverage through either a full-service health plan or health insurer that is not a Mexican health plan. Mexican health plans cover the delivery of health care services wholly in Mexico, except for delivery of emergency and urgent care services provided out of area. Under existing law, Mexican health plans can only offer this employer-based coverage to legally employed employees who are Mexican nationals in those two counties, and their dependents.

EXISTING LAW:

1) Requires, if a prepaid health plan operating lawfully under the laws of Mexico elects to operate a health plan in California, the plan to apply for licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act by filing an application for licensure in the form prescribed by DMHC and verified by an authorized representative of the applicant. [Health and Safety Code (HSC) § 1351.2]

2) Requires the prepaid health plan to be subject to the Knox-Keene Act and the rules adopted by the DMHC director as determined by the director to be applicable. [*Ibid*.]

3) Requires the application to be accompanied by a fee prescribed by existing law, and the plan to demonstrate compliance with specified requirements, including:

    a) The prepaid health plan is constituted and operating lawfully under the laws of Mexico and, if required by Mexican law, is authorized as an Insurance Institution Specializing in Health by the Mexican Insurance Commission.

    b) The prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of Mexican nationals legally employed in the Imperial and San Diego Counties, and for the benefit of their dependents regardless of nationality, that pays for, reimburses the cost of, or arranges for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of emergency and urgent care services provided out of area. Defines "out of area" to mean coverage while an enrollee is anywhere outside the service area of the plan, and to also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

    c) Solicitation of plan contracts in California is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in California, each of which is authorized to offer and sell plan group contracts.

d) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area, as required by a specified provision of existing law.

e) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of the Knox-Keene Act and the rules or orders of the director. Requires the DMHC director to require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

f) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under California law or in an account of a national bank located in California.

g) The prepaid health plan maintains a tangible net equity (TNE) as required by the Knox-Keene Act and the rules of the DMHC director, as calculated under United States generally accepted accounting principles, of at least $1 million. Permits, in lieu of an amount in excess of the minimum TNE of $1 million, the prepaid health plan to demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may, accept.

h) Requires the prepaid health plan to also maintain a fidelity bond and a surety bond as required by a specified provision of existing law and the rules of the DMHC director.

i) The prepaid health plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the DMHC director in the form and at the time and place requested by the director.

j) The prepaid health plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. Requires the prepaid health plan to agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States are required to apply.

k) The prepaid health plan agrees that disputes arising from the group contracts involving group contract holders and providers of health care services in the United States are subject to the jurisdiction of the courts of California and the United States.

l) The prepaid health plan employs or designates a medical director who holds an unrestricted license to practice medicine in this state issued by the Medical Board of California or the Osteopathic Medical Board for urgent and emergency out of area health care services. Permits the prepaid health plan, for health care services that are to be provided or delivered wholly in Mexico, to employ or designate a medical director operating under the laws of Mexico. [HSC § 1345 and § 1351.2]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill is a significant legislative proposal that seeks to expand access to health care for employees in San Diego and Imperial Counties. By eliminating the restriction that currently allows only "Mexican nationals" to access prepaid health plans licensed by the DMHC in Mexico, this bill opens the door for all employees in these regions. This inclusive approach not only facilitates greater health care access for a broader segment of the workforce but also acknowledges the unique needs of the local community. With health care facilities like those operated by SIMNSA (SIMNSA is a Mexican health plan operating under the provisions of existing law) open seven days a week, this bill promises to enhance health care accessibility for vulnerable populations on both sides of the border, setting a precedent for a health system that truly serves the needs of all its constituents.

2) **BACKGROUND.** Two Mexican prepaid health plans (SIMNSA and Medi-Excel) are licensed by the DMHC under the Knox-Keene Act to offer group coverage to California employers for employees employed in San Diego or Imperial counties who are Mexican nationals (and their dependents) for health care services provided or delivered wholly in Mexico, except for the provision or delivery of emergency and urgent care services provided out of area.

   SIMNSA was licensed by DMHC as a Mexican health care service plan in January 2000. SIMNSA sells employer-sponsored coverage for Mexican nationals employed in San Diego and Imperial Counties and their dependents, irrespective of the dependent's nationality. SIMNSA's network is in Mexico, but SIMNSA covers emergency and urgent care anywhere in the world. All non-emergency and non-urgent care must be rendered within the plan's network in Mexico. SIMNSA's Knox-Keene plan enrollment as of December 2023 was 59,375 individuals.

   Medi-Excel received its Knox-Keene license in August 2012, and became operational on December 1, 2012, serving San Diego and Imperial Counties. The plan contracts with urgent care centers in the United States and offers employer-based group to both the large and small group markets. Medi-Excel's Knox-Keene plan enrollment as of December 2023 was 16,258 individuals.

   Existing law requires the Mexican health plans plan to be subject to the Knox-Keene Act and the rules adopted by the DMHC director as determined by the director to be applicable. Both plans operate with exemptions from certain provisions of the Knox-Keene Act and its associated regulations. DMHC indicates it reviews Knox-Keene Act provisions in terms of what applies to emergency or urgent care services received in California because DMHC has no jurisdiction over health care services provided in Mexico. DMHC indicates it generally exempts Mexican health plans from certain statutory and regulatory requirements, such as continuity of care requirements, independent medical review (IMR) processes for experimental or investigational therapies, and standing referral to specialist requirements.

   The DMHC also conditionally exempts Mexican health plan licensees from certain Knox-Keene Act statutes and regulations. For example, existing law and regulation requirements for utilization management, continuity of care, referrals, readily accessible services consistent with good professional practice, telehealth, grievances, quality of care and utilization review, and IMR apply only to emergency and urgent care services. DMHC

indicates Mexican health plans must maintain policies, procedures, and systems necessary to ensure compliance with these provisions with respect to emergency and urgent care services. DMCH indicates specified geographic service area, provider network adequacy filing requirements and timely access requirements apply to plans only with respect to provision of emergency and urgent care services provided out of area, while other specified requirements do not apply. Coverage of outpatient patient prescription drugs applies with respect to urgent care services and as otherwise consistent with federal law and guidance.

Mexican health plans are offered in conjunction with US-based plans. For example, HealthNet's Salud HMO y Mas Gold plan provides coverage in the United States and in Mexico through SIMNSA's network providers in northern Mexico. The premiums and cost-sharing for stand-alone Mexican health plans are considerably cheaper than US-based plans. For example, the premium for a 35 year old in the HealthNet Salud HMO y Mas small group product is $473.69 a month, the premium for a stand-alone small group Anthem Blue Cross Gold Priority Select HMO 30 plan for a 35 year old is $493.56 a month, as compared to a small group MediExcel Gold 250/35 HMO plan premium of $135.81 a month for a 35 year old.

3) **SUPPORT.** This bill is sponsored by SIMNSA and supported by an individual small employer, a church, the California Schools Volunteer Employee Benefits Association, and a chamber of commerce. SIMNSA argues this bill enables all employees working in San Diego and Imperial counties to access Mexican health plans, and this inclusive approach not only facilitates greater health care access for a broader segment of the workforce but also acknowledges the unique needs of the local community. SIMNSA states health care access has become a pressing issue for many residents in these counties as many employees along the border are monolingual Spanish speakers or possess limited English proficiency, which makes navigating the health care system a daunting task, and this is amplified by the necessity of using family members as interpreters.

Other supporters state the rising cost of health care in California has driven many employees throughout the San Diego and Imperial region to seek medical services across the border. In response, many employers offer prepaid Mexican health plans to their employees today. However, existing law allows only Mexican nationals working in San Diego and Imperial counties and their dependents to access licensed Mexican health plans. Supporters state this bill solves this health care access issue by removing the "Mexican nationals" restriction, allowing all employees in these counties to access prepaid, licensed health plans in both Mexico and California. Supporters conclude this bill is a practical, common-sense solution to a growing bi-national health care issue.

4) **PREVIOUS LEGISLATION.**

a) SB 1658 (Peace), Chapter 1025, Statutes of 1998 authorizes prepaid health plans licensed in Mexico to apply for licensure in California under Knox-Keene Act to sell Mexican health plans exclusively to Mexican citizens legally working in California, and their dependents.

b) SB 1347 (Ducheny), Chapter 491, Statutes of 2004, would have expanded to the ability of Mexican health plans licensed under the Knox-Keene Act to provide coverage to "persons" legally employed in California (and their dependents). The final version of SB 1347 which became law changed the population who can be served by these plans from

legally employed “Mexican citizens” to legally employed “Mexican nationals” in San Diego and Imperial counties, and their dependents.

5) **AMENDMENT**. Following discussions, the amount of the TNE required in existing law is proposed for an increase from the existing amount of at least $1 million to be at least $2.3 million. TNE is a financial requirement under the Knox-Keene Act that is a measure of a health plan’s financial solvency to ensure a health plan has enough tangible assets to cover its liabilities. The TNE requirement for a Mexican health plans is required by statute to be at least $1 million. This amount was established in law by the original authorizing statute in 1998 and has not been increased since that time.

6) **POLICY QUESTION.**

   a) **TRADE OFF**. This bill poses a trade-off. Mexican health plans offer are a more affordable option and provide access to services in Mexico. On the one hand, this bill would allow these plans to serve more individuals, and some employees may prefer to receive a lower premium and copayment health plan option through their job-based coverage. In addition, employees who are Spanish speaking only or possess limited English proficiency may prefer receiving health care in Mexico for multiple reasons, including because the health care is more culturally competent, health care facilities are located right across the border in Tijuana, and interpreters are not needed. In addition to the benefit to individual employees, the lower premium cost of Mexican health plans could potentially force more price competition on US health plans and providers in the US-Mexico border region.

   On the other hand, because Mexican health plans only offer a limited scope of services in this county, enrollees with severe or chronic conditions requiring on-going access to primary and specialist care providers, labs and pharmacies may be less willing to travel to Mexico to receive on-going care, particularly if they live in the northern parts of the two counties. This could affect the insurance risk pool of US-based plans if the expanded option to enroll in Mexican health plans results in healthier or individuals who anticipate less need for medical care enrolling in large numbers in Mexican health plans. In addition, because Mexican health plans are considerably cheaper than US plans, larger employers with 50 or more full-time employees would be to reduce their employer contribution to employee premiums while still meeting Affordable Care Act affordability requirements. Finally, offering this coverage more broadly will likely result in more border crossings to receive health care services at a time when federal immigration enforcement has tightened.

REGISTERED SUPPORT / OPPOSITION:

Support

SIMNSA (sponsor)
Advantage Printing Inc.
Belellano Insurance Services
California Schools Volunteer Employee Benefits Association
First Christian Church
Otay Mesa Chamber of Commerce

One individual

Opposition

None on file

Analysis Prepared by: Scott Bain / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 960 (Garcia) – As Introduced February 20, 2025

SUBJECT: Patient visitation.

SUMMARY: Requires a health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed unless specified conditions are met, including, but not limited to, that the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of the visitor, a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility. Specifically, **this bill**:

1) Requires a health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed unless any of the following conditions apply:

    a) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of the visitor, a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility;

    b) Requires, if circumstances require the health facility to restrict visitor access to the facility due to health or safety concerns, the health facility to develop alternate visitation protocols that allow visitation to the greatest extent possible while maintaining patient, visitor, and staff health and safety;

    c) Specifies the provisions in 1) do not require a health facility to permit a visitor who is violent or potentially violent to enter the facility or visit a patient, and states that it is the intent of the Legislature that this provision ensures liberal visitation rights for patients with demonstrated dementia needs while at the same time recognizing hospitals' obligations to provide a safe environment for patients, staff, and visitors; and,

    d) The delivery of medical care would be impeded by the presence of the family or friend caregiver.

2) Authorizes a health facility to require visitors to adhere to personal protective equipment and requires the facility to provide personal protective equipment and testing resources to each visitor, to the extent that those resources have been made readily available to the facility by state or local entities for this purpose. States that the provision of personal protective equipment and testing resources to visitors is not intended to inhibit access to emergency supplies for staff, and allows visitors to use their own supplies so long as they meet or exceed the minimum standards required by the facility for its own staff.

3) Specifies that this bill does not prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including age of visitors, supervision of minor visitors, and number of visitors.

4) States that this bill does not create any new civil or criminal liability, including, but not limited to, liability for any illness, infection, or injury experienced by a patient or visitor on the part of a facility that complies with its requirements.

EXISTING LAW:

1) Establishes the Department of Public Health (DPH), which, among other functions, licenses and regulates health facilities. Defines a "health facility" to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

    a) General Acute Care Hospitals (GACHs), which means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services;

    b) Acute psychiatric hospital, which means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders;

    c) Skilled nursing facility (SNF), which means 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;

    d) Intermediate care facility (ICF), which means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care;

    e) ICF/developmentally disabled habilitative, which means a facility with a capacity of four to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care;

    f) Special hospital, which means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity (there are currently no licensed special hospitals in California);

    g) ICF/developmentally disabled, which means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services;

h) ICF/developmentally disabled-nursing, which means a facility with a capacity of four to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care;

i) Congregate living health facility, which means a residential home with a capacity of no more than 18 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, and recreational;

j) Correctional treatment center, which means a health facility operated by the Department of Corrections and Rehabilitation (DCR), the DCR Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by DCR, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services;

k) Nursing facility, which means a health facility that is certified to participate as a provider of care either as a SNF in the federal Medicare Program or Medicaid Program, or both;

l) ICF/developmentally disabled-continuous nursing, which means a homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care; and,

m) Hospice facilities. [Health and Safety Code (HSC) § 1250 *et seq.*]

2) Requires a health facility to allow a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child to visit, unless one of the following is met:

a) No visitors are allowed;

b) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility; or,

c) The patient has indicated to health facility staff that the patient does not want this person to visit. [HSC § 1261]

3) Prohibits the provisions of 2) above from being construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. [*Ibid.*]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, people with dementia rely heavily on friends and family caregivers to be their voice, to help them maintain a good quality of life,

and to remain a part of our communities. When visiting the hospital, people with dementia need to have access to a friend and family caregiver throughout the duration of their stay. Caregivers are an essential part of a dementia care team, and restricting access will cause harm to people with dementia. The author argues, not only do they provide emotional and physical support, but they provide information, facilitate communication, and ensure the needs of the person with dementia are advocated for and met during the hospital stay. They are also the person who will continue to provide and support the health care of the person after they leave the hospital. The author concludes they should be treated as a valuable member of the support team, instead of being restricted to standard visitation hours.

2) **BACKGROUND.** According to the Alzheimer's Association, dementia is an overall term for a particular group of symptoms. The characteristic symptoms of dementia are difficulties with memory, language, problem-solving, and other thinking skills that affect a person's ability to perform everyday activities. Changes to the brain cause dementia, and many different brain changes can lead to dementia. Alzheimer's is the most common cause of dementia, accounting for an estimated 60% to 80% of cases. Most individuals also have the brain changes of one or more other causes of dementia. This is called mixed pathologies, and if recognized during life, is called mixed dementia. Nearly seven million Americans are living with Alzheimer's. By 2050, this number is projected to rise to nearly 13 million. Alzheimer's disease was the fifth-leading cause of death among people age 65 and older in 2021. An estimated 6.9 million Americans age 65 and older are living with Alzheimer's in 2024. Seventy-three percent are age 75 or older. About one in nine people age 65 and older (10.9%) has Alzheimer's. Almost two-thirds of Americans with Alzheimer's are women. Older Black Americans are about twice as likely to have Alzheimer's or other dementias as older whites. Older Hispanics are about one and one-half times as likely to have Alzheimer's or other dementias as older whites.

   a) **Federal Law.** The Patient Bill of Rights, established as part of the Patient Protection and Affordable Care Act, as well as federal regulations outlining a hospitals' ability to receive Medicaid payments, require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

      i) Inform each patient (or support person, where appropriate) of their visitation rights, including any clinical restriction or limitation on such rights;

      ii) Inform each patient (or support person, where appropriate) of the right, subject their consent, to receive the visitors whom they designate, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and their right to withdraw or deny such consent at any time;

      iii) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability; and,

      iv) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

b) Hospital stays. A 2020 literature review titled, *"What are the needs of people with dementia in acute hospital settings, and what interventions are made to meet these needs? A systematic integrative review of the literature,"* noted that hospitalization of people with dementia often leads to an increase in behavioural and psychological symptoms in dementia, risk of poor outcomes, higher incidence of harm, and further cognitive decline. A prospective cohort study of 10,014 hospital admissions revealed that among people with a dementia diagnosis, delirium occurred in 45.8% during the hospital stay. Consequences for people with dementia admitted to hospital include higher mortality rates, increased likelihood of falls, functional decline, spatial disorientation, possible malnutrition and dehydration, increased reliance on caregivers, depression, and delirium. Additionally, they may experience more pain, thirst, fear, and over-stimulation than people without a cognitive impairment while in hospital, partly due to their impaired ability to communicate.

3) SUPPORT. The Alzheimer's Association (AA) supports this bill and states that the policy in this bill is a critical support for patients with dementia. This provides them with a sense of familiarity which reduces anxiety. It will decrease the risk that patients become agitated and minimizes the likelihood that they get confused or disoriented. This accommodation is needed while patients are in what can feel like an unfamiliar environment. This item supports the patient's emotional wellbeing, which is closely linked to outcomes in their physical health. AA concludes that this bill requires a health facility to allow a patient with demonstrated dementia needs to have access to people who bring them comfort with reasonable provisions to assist facilities with implementation.

AARP California supports this bill and states that hospital stays can be stressful and overwhelming for anyone, and patients with Alzheimer's or dementia needs – who experience twice as many hospital stays per year as other older adults – are particularly vulnerable in these situations. They may find themselves confused, frightened, and unable to communicate their needs. While people with dementia are likely to experience further cognitive decline during hospitalization, it is also known that the presence of family or friend caregiver can help patients with communication, meeting urgent needs, assisting with eating, and washing, and providing emotional support. AARP notes that as an organization they have long highlighted the value of consumer and family caregiver engagement and empowerment in all health care settings. However, caregivers are often restricted in accompanying people with dementia throughout hospital stays. AARP concludes that his bill would ensure that people with dementia have access to a friend or family caregiver while hospitalized.

4) RELATED LEGISLATION. AB 92 (Gallagher) would establish Dianne's Law, which would require health facilities to develop alternate visitation protocols that allow visitation to the greatest extent possible when circumstances require the facility to restrict visitor access to the facility due to health or safety concerns. The bill would prevent a health facility from prohibiting in-person visitation in end-of-life situations unless the patient has indicated to the health facility staff that the patient dies not want the person to visit. AB 92 is pending in Assembly Health Committee.

5) PREVIOUS LEGISLATION.

a) AB 2075 (Alvarez) of 2024, would have granted a resident of a Long Term Care (LTC) facility the right to in-person, onsite access to a designated support person and health care and social services provider during any public health emergency in which visitation rights of residents are curtailed by a state or local order. AB 2075 was held in the Senate Appropriations Committee.

b) AB 2549 (Gallagher) of 2024, would have established the Patients' Visitation Rights Act, which required DPH, not later than January 1, 2026, to provide specific clinical guidance related to safe visitation during a pandemic event for hospitals, as defined. AB 2549 was vetoed by Governor Gavin Newsom, who stated, in part: "I believe there are many benefits to in-person visitation for people in health facilities who are sick, in recovery, or simply require a higher level of care. During the COVID-19 pandemic, state and local officials worked with public health and infectious disease experts to evaluate the risks and benefits of in-person interactions, and these standards were updated regularly as personal protective equipment, testing, and vaccines became available. California established a locally-driven response, where counties with fewer risks had higher flexibilities. This bill instead proposes a facility-by-facility approach. I am concerned that requiring facilities to develop individual, alternative protocols will result in confusion and create different access to patients based on each facility's management, rather than public health recommendations."

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

d) AB 2546 (Nazarian) of 2022 would have enacted the Resident-Designated Support Persons Act, granting residents of LTC facilities the right to in-person, onsite access to a minimum of two designated support person during any public health emergency, as defined, in which the residents' visitation rights are curtailed by a state or local order. AB 2546 was subsequently amended to address a different subject matter.

6) AMENDMENTS. As currently drafted this bill grants the ability to request more liberal visitation policies of health facilities for patients' with dementia. The Committee may wish to amend this bill as follows:

a) To apply the ability to request reasonable visitation policies to any patient with physical, intellectual, and/or developmental disabilities and patients with cognitive impairment, including dementia, or another disability; and,

b) To narrow the provisions of this bill to apply only to general acute care hospitals.

REGISTERED SUPPORT / OPPOSITION:

Support

A Voice for Choice Advocacy

AARP
California Commission on Aging
One individual

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 974 (Patterson) – As Amended March 24, 2025

SUBJECT: Medi-Cal managed care plans: enrollees with other health care coverage.

SUMMARY: Implements several changes to help beneficiaries enrolled in commercial health coverage and who use Medi-Cal as a payer of last resort to maintain their providers as they transition from fee-for-service (FFS) Medi-Cal to Medi-Cal managed care. Specifically, this bill:

1) Limits administrative and contracting requirements for providers when billing Medi-Cal managed care plans, for services provided to beneficiaries for whom the Medi-Cal program is a payer of last resort.

2) Specifies that a Medi-Cal managed care plan may require a letter of agreement under certain circumstances, for situations described in 1) above.

3) Requires the Department of Health Care Services (DHCS) to solicit input from stakeholders regarding the coordination of payment for services between Medi-Cal enrollees' other commercial health care coverage and their Medi-Cal managed care plans, with a specific emphasis on Medi-Cal recipients who receive regional center services.

4) Requires DHCS to provide an update on the topic addressed by this bill during the first Medi-Cal Managed Care Advisory Committee of 2026, to report on the bill's implementation annually until 2029 and to issue guidance or take other actions it deems necessary to provide sufficient clarity on this topic.

EXISTING LAW:

1) Establishes an entitlement to services for individuals with developmental disabilities under the Lanterman Developmental Disabilities Services Act (Lanterman Act). [Welfare and Institutions Code Section (WIC) § 4500, *et seq*.]

2) Establishes a system of nonprofit regional centers throughout the state to identify needs and coordinate services for eligible individuals with developmental disabilities and requires the Department of Developmental Services (DDS) to contract with regional centers to provide case management services and arrange for or purchase services that meet the needs of individuals with developmental disabilities, as defined. [WIC § 4620 *et seq*.]

3) Requires a regional center to identify and pursue all possible sources of funding for consumers receiving regional center services, including Medi-Cal and private entities, to the maximum extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer. [WIC § 4646]

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

5) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act as a set of Medi-Cal transformation initiatives, and requires the implementation of the time-limited CalAIM initiative to support a number of goals, including transitioning and transforming the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility. [WIC § 14184.100]

6) Authorizes DHCS to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, with certain exceptions. [WIC § 14184.200]

7) Prohibits a person having private health care coverage to receive the same health care items or services furnished or paid for by a publicly funded health care program. [WIC § 10020 (a)]

8) Requires a carrier of private health care coverage to reimburse a publicly funded health care program for the cost incurred in rendering health care paid for by the public program, to the extent of the benefits provided under the terms of the policy for the items provided or the services rendered. [WIC § 10020 (c)]

9) Requires health plans and other entities to provide to DHCS beneficiary information and access to real-time, electronic eligibility verification, in a format provided by the department, for purposes of cost avoidance. [WIC § 14124.90]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, children and adults with developmental disabilities have been faced with a dilemma of choosing between their existing insurance and medical team, and access to their enrolled regional center. The author notes the transition to a "managed care" approach for serving these individuals has caused confusion with the delivery of their healthcare, requiring families to request an exemption from DHCS to keep their existing medical teams. The author notes his office has been working closely with DHCS and while DHCS indicates families should not have to make these difficult decisions, the author asserts transition to managed care for this population has been rocky. Furthermore, the author notes the requirement to get approved for exemptions has caused anxiety and uncertainty for this vulnerable population that seeks specialized services through regional centers in conjunction with private-pay insurance.

The author states this bill is intended to ensure that individuals and their medical teams do not have to complete lengthy, 40-page exemption documents multiple times per year. The author notes that if DHCS fixes the acknowledged problem, this bill would not be necessary, and expresses a desire to resolve this issue after working on it for three years.

2) BACKGROUND. Medi-Cal provides benefits through both a FFS and managed care delivery system. Medi-Cal is also the payer of last resort if services can be covered by another payer, such as an individual's other health coverage (OHC), which may be through a private commercial health plan. If an individual has OHC, DHCS must ensure the OHC pays for any services covered by that health plan or insurer prior to Medi-Cal paying for services,

and seek to recover costs from third parties like OHC that may be liable for payment of such costs.

Individuals with developmental disabilities who receive services from a regional center, and need a higher level of care, such as home and community-based services, are generally required to enroll in Medi-Cal as a "generic resource" if they are eligible. This is true even if they have other health coverage, because the regional center is a "payer of last resort," even after Medi-Cal. This means the regional center must ensure Medi-Cal or other entities pays for services to which an individual may be entitled, prior to funding those services from the regional center budget. As a condition of accepting regional center services, an individual must enroll in Medi-Cal so they can access Medi-Cal covered services that are not available under their private health plans, such as In-Home Supportive Services (IHSS), a Medi-Cal benefit that provides nonmedical personal care services.

Some children with more significant intellectual and developmental disabilities who are eligible for regional center services can become eligible for Medi-Cal through a process called "Institutional Deeming." This is a special Medi-Cal eligibility rule that considers only the personal income and resources of a person under the age of 18 who meets the disability-related criteria for a special Medi-Cal program called the Home and Community-Based Services Developmental Disabilities Waiver.

Through "Institutional Deeming" and enrollment in the aforementioned Waiver, a child may obtain Medi-Cal benefits for needed services regardless of their family's income. Children who receive Medi-Cal eligibility through this process are likely to be in families with higher incomes and therefore have commercial health insurance that covers most of their medical services.

Because receipt of regional center services obligates families to enroll their children in Medi-Cal even if they are already enrolled in OHC, and because Medi-Cal has strict rules requiring OHC to pay for any services the OHC is financially liable for, families in this situation may confront sometimes confounding "coordination of benefits" issues between their commercial OHC and Medi-Cal. Providers of these services are faced with similar challenges with respect to appropriately billing and receiving payment from OHC and Medi-Cal, and this has apparently worsened as children have transitioned from FFS Medi-Cal, which is administered directly by DHCS, to a number of different managed care plans.

This bill was prompted by complaints from individuals who indicated they were losing access to providers contracted with their private OHC, because of this transition of their Medi-Cal from FFS to managed care. More detailed background on several of these components is provided below.

a) Medi-Cal is the Payer of Last Resort. Federal law requires state Medicaid programs to take reasonable measures to ascertain the legal liability of third parties, including other health plans and insurers, to pay for services covered under Medicaid. A beneficiary is required to utilize their private coverage prior to their Medi-Cal benefits when the same service or benefit is available under the beneficiary's private health coverage. When this occurs, Medi-Cal will be secondary to the other health coverage, covering allowable costs not paid by the primary insurance (for instance, copayments) up to the Medi-Cal rate.

b) Regional Centers. Pursuant to the Lanterman Act, some individuals with developmental disabilities or related risk factors qualify for services offered through 21 regional centers contracted with the state DDS. Regional centers serve as fixed points of contact in the community for consumers and their families to access services and supports. Regional center staff assist consumers to obtain necessary services and supports from "generic agencies," like state agencies that offer health benefits, and purchase other services as necessary. They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled.

c) Mandatory Transition to Managed Care. Over the last several years, most of the Medi-Cal population has transitioned from FFS into Medi-Cal managed care. Under CalAIM initiative, several additional eligibility groups have been transitioned into managed care in 2022 and 2023 on a mandatory basis. Prior to CalAIM, enrollment into the FFS delivery system or the managed care delivery system was based upon specific geographic areas, the health plan model, and/or the aid code that a beneficiary is determined to qualify for. DHCS introduced mandatory enrollment in managed care as part of CalAIM to guarantee a similar beneficiary experience across counties, and to simplify, standardize, and streamline Medi-Cal program administration.

Mandatory managed care enrollment means that Medi-Cal beneficiaries who were enrolled in FFS, and were either excluded from managed care or able to choose managed care on a voluntary basis, are now required to enroll in a managed care plan. Beneficiaries with OHC who do not have Medicare transitioned on January 1, 2022, while beneficiaries who are dually eligible for Medi-Cal and Medicare transitioned effective January 1, 2023.

Certain exceptions remain in statute. These include, for instance, individuals eligible for only restricted-scope Medi-Cal benefits, those made eligible on the basis of a "share of cost," meaning they their income is not low enough to qualify for full-scope Medi-Cal without a share of cost, and those made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, during the relevant period of presumptive eligibility. Individuals who are Native American and youth in the foster system are also exempt from managed care enrollment.

d) Maintaining Providers during an Individual's Transition to Managed Care. State law provides additional, temporary exceptions whereby individuals who transition to a managed care plan can retain relationships with their providers who are not contracted providers with the plan.

i) Medical Exemption Request (MER). Beneficiaries can file a MER to request a temporary exemption from enrollment into a managed care plan only until the member's medical condition has stabilized to a level that would enable the member to transfer to a network provider of the same specialty without deleterious medical effects. Members may get a medical exemption if a member has a complex medical condition, as defined in regulation.

ii) Continuity of Care. Members transitioning from Medi-Cal FFS to a Medi-Cal managed care plan may request continuity of care from their plan to remain with their

current FFS provider for up to 12 months after the enrollment date with the managed care plan. The plan must honor the continuity of care request if the following conditions are met: the individual can establish a pre-existing relationship exists with that provider; the plan has no quality concerns with the provider; and the plan and provider can agree to a rate.

Anecdotally, some of the individuals whose experience has prompted this bill have applied for and been deemed eligible for MERs, but a MER is a temporary, not permanent, exemption from managed care enrollment.

Once an individual is stabilized and/or continuity of care has run its course, for individuals *without* OHC who rely on Medi-Cal to pay their health care costs, an individual may be required to change providers to a provider in the Medi-Cal managed care plan's network. The situation for an individual *with* OHC is further described below.

e) How Medi-Cal Managed Care Interacts with OHC. Most private plans have cost-sharing like copayments or coinsurance, which Medi-Cal will pay on behalf of the Medi-Cal enrollee when an individual has OHC. Medi-Cal prohibits billing patients for cost-sharing. Providers must bill Medi-Cal to recover the cost-sharing amount owed by the Medi-Cal enrollee.

Prior to the transition to managed care, a provider would bill Medi-Cal FFS directly for services not covered by their patient's OHC, or to request reimbursement for cost-sharing required by the patient's OHC.

However, once an individual is enrolled in Medi-Cal managed care, an individual's provider must bill the individual's Medi-Cal managed plan for copayments or other costs not covered by the OHC, instead of billing DHCS. These providers must therefore interact with Medi-Cal managed care plans, even if the provider is not in the network of a Medi-Cal managed care plan and the service is primarily being billed to the OHC. Billing multiple plans may be more complicated for the provider, who must validate and bill the appropriate plan instead of simply billing DHCS for all Medi-Cal claims. Furthermore, DHCS's contracts prohibit Medi-Cal managed care plans from paying claims for services provided to a member with OHC, without proof that the provider has first exhausted all sources of other payment. Administrative processes and documentation requirements to provide such proof are not standardized across plans, meaning plans may require slightly different forms of proof or have different portals or means to accept this information.

Anecdotally, according to the bill's author and affected constituents, these billing requirements have created friction between certain patients, providers, and managed care plans with the recent expansion of mandatory enrollment into Medi-Cal managed care.

f) Can Individuals With OHC Keep Their Providers when Their Medi-Cal Services Transition from FFS to Managed Care? Individuals who rely on OHC as a primary payer for their health care should be able to maintain their providers who are paid primarily by the OHC. The providers should be able to simply bill the Medi-Cal managed care plan instead of FFS Medi-Cal for any allowable costs not covered by the OHC.

According to DHCS, if an individual is seeing providers contracted with their OHC who are billing the OHC for services, and Medi-Cal is only paying for other allowable costs

such as the patient copayment, the provider is able to bill the Medi-Cal managed care plan for the copayment, even if the provider is not contracted with that plan. This guidance is reflected in a fact sheet published by DHCS, titled "*Overview of Mandatory Managed Care Enrollment*." The fact sheet also reiterates an individual can keep their OHC when they become mandatorily enrolled into managed care.

However, anecdotally, the fact sheet has not resolved issues for individuals seeking to maintain their team of providers. Some providers may refuse to render services to individuals enrolled in Medi-Cal managed care for a variety of reasons, including the providers' choice to adopt a policy of not engaging with Medi-Cal managed care whatsoever, or a lack of understanding that they are allowed to bill the Medi-Cal managed care plan for allowable costs even if they are not contracted with the plan.

3) **SUPPORT.** Disability Rights California supports this bill, noting consumers often have complex medical and behavioral needs and established relationships/histories with their providers, and difficulties with coordination of benefits negatively impacts the delivery of essential services to these consumers. California State Council on Developmental Disabilities also supports this bill, arguing the process of maintaining one's providers when possible should be seamless and not burden families that are simply trying to care for their children.

4) **PREVIOUS LEGISLATION.**

a) AB 3156 (Joe Patterson) was similar to this bill and was vetoed by Governor Newsom, who stated, "I am supportive of policies that allow Medi-Cal members with other health coverage to continue to see their providers. However, the timelines specified in this bill are not feasible. DHCS has worked extensively to educate Medi-Cal managed care plans (MCPs) on enrollee rights and how providers who are not enrolled in Medi-Cal can still bill Medi-Cal for appropriate services. DHCS will continue to work with MCPs, stakeholders, and patient advocates to address administrative barriers to ensure continuity of care for Medi-Cal enrollees."

This bill does not address the "infeasible timelines" described in the veto message.

b) AB 1608 (Joe Patterson) of 2023 addressed the same issue as this bill, but took the approach of exempting a beneficiary who receives services from a regional center, and uses a Medi-Cal fee-for-service delivery system as a secondary form of health coverage, form enrollment in Medi-Cal managed care. AB 1608 was not heard in the Assembly Health Committee.

c) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes statutory authority for various aspects of the CalAIM initiative, including authority to standardize enrollment of most populations in managed care.

d) AB 203 (Committee on Budget), Chapter 188, Statutes of 2007, establishes in state law a set of federal requirements regarding recovery of costs incurred by Medi-Cal for health care services covered by third-party payers.

REGISTERED SUPPORT / OPPOSITION:

Support

Disability Rights California
California State Council on Developmental Disabilities

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1088 (Bains) – As Amended April 21, 2025

SUBJECT: Public health: 7-Hydroxymitragynine.

SUMMARY: Adds kratom products and products containing 7-hydroxymitragynine (7-OH products), as defined, to the Sherman Food, Drug, and Cosmetic Law (Sherman Law). Prescribes specified quantities of alkaloids present in kratom products and 7-OH products. Prohibits the sale of kratom products and 7-OH products to those under 21 years of age. Requires the packaging of kratom products and 7-OH products to be child resistant and prohibits the sale and manufacture of a kratom product or 7-OH product that is attractive to children. Specifically, **this bill:**

1) Defines, for purposes of this section, the following terms:

    a) "7-OH product" to mean a product containing 7-hydroxymitragynine.

    b) "Attractive to children" to mean any of the following:

        i) Use of images that are attractive to children, including but not limited to images of any of the following, accept as part of required health warnings:

            (1) Cartoons, toys, or robots;

            (2) Any real or fictional humans;

            (3) Fictional animals or creatures; and,

            (4) Fruits or vegetables, except when used to accurately describe ingredients or flavored contained in a product.

        ii) Likeness to images, characters, or phrases that are popularly used to advertise to children;

        iii) Imitation of candy packaging or labeling, or other packaging and labeling of cereals, sweets, chips, or other food products typically marketed to children;

        iv) The terms "candy" or "candies" or variants in spelling such as "kandy" or "kandee";

        v) Brand names or close imitation of brand names of candies, cereals, sweets, chips, or other food products typically marketed to children;

        vi) Any other image or packaging that is easily confused with commercially available foods that do not contain kratom and are typically marketed to children;

        vii) Anything else that the State Department of Public Health (DPH) determines in regulation to be attractive to children; and,

viii) Anything else that is attractive to children in light of all relevant facts and circumstances.

c) "Kratom leaf" to mean the leaf of a kratom plant, also known as mitragyna speciosa, any form.

d) "Kratom leaf extract" to mean the material obtained by extraction of kratom leaves by any means.

e) "Kratom product" to mean a product consisting of kratom leaf, kratom leaf extract, or both.

f) "Total kratom alkaloids" to mean the sum of mitragynine, speciociliatine, speciogynine, paynantheine, and 7-hydroxymitragynine in a kratom product.

2) Requires packaging of a kratom product or a 7-OH product offered for retail sale to be child resistant for the life of the product. Specifies that both of the following packages are considered child resistant for the purposes of this bill:

a) A package that has been certified as child resistant under the requirements of the Poison Prevention Packaging Act of 1970 (15 United States Code (USC) § 1471, *et seq*.) and any regulations promulgated pursuant to that act; or

b) Plastic packaging that is at least four mils thick and heat sealed without an easy-open tab, dimple, corner, or flap, provided that the package maintains its child resistance throughout the life of the product.

3) Prohibits an individual, business, or other entity from selling, offering for sale, providing, or distributing a kratom product or 7-OH product to a person under 21 years of age.

4) Requires an online retailer or marketplace of a kratom product or 7-OH product to implement an age-verification system to ensure compliance with 3) above.

5) Prohibits an individual, business, or other entity from selling, offering for sale, providing, or distributing a kratom product or 7-OH product that is attractive to children.

6) Prohibits an individual, business, or other entity from selling, offering for sale, providing, or distributing a kratom product or 7-OH product with a level of 7-hydroxymitragynine that is greater than 2% of the total kratom alkaloids in the product.

EXISTING LAW:

1) Enacts the Sherman Law, enforced by DPH, which provides broad authority for DPH to enforce food safety requirements, including that food is not adulterated, misbranded, or falsely advertised. Food labeling requirements generally adopt federal food labeling laws as the state requirement, including nutrition labeling and allergen labeling, but DPH is permitted, by regulation, to adopt additional food labeling regulations. [Health and Safety Code (HSC) § 109875, *et seq.*]

2) Prohibits any person from engaging in the manufacturing, packing, or holding of any processed food unless the person has a valid registration as a food processing facility from the DPH under the Sherman Law. [HSC § 110460]

3) Establishes penalties for violations of the Sherman Law, including a fine of up to $1,000, or up to $10,000 for repeated violations. [HSC § 111825]

4) Prohibits any manufacturer, wholesaler, retailer, or other person from selling, transferring, or otherwise furnishing a dietary supplement containing either of the following to a person under 18 years of age:

   a) A dietary supplement containing an ephedrine group alkaloid; or

   b) A dietary supplement containing any of the following: androstanediol, androstanedione, androstenedione, norandrostenediol, norandrostenedione, dehydroepiandrosterone. [HSC § 110423.2]

5) Establishes a regulatory structure in DPH, under the Sherman Law, for food, beverage and cosmetic products containing industrial hemp, and limits these products to containing no more than 0.3% concentration of tetrahydrocannabinol (THC). Prohibits industrial hemp from including cannabinoids produced through chemical synthesis. [HSC § 111920 et seq., § 111920 (f)]

6) Enacts the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) to establish a comprehensive system to control and regulate the cultivation, distribution, transport, storage, manufacturing, processing, and sale of both medicinal cannabis and cannabis products, and adult-use cannabis and cannabis products for adults 21 years of age and over, regulated by the Department of Cannabis Control (DCC). [Business and Professions Code § 26000, et seq.]

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

COMMENTS:

1) PURPOSE OF THIS BILL. The author states that as a physician specializing in addiction treatment, she has grown increasingly concerned about the use of Kratom and especially its derivative 7-OH. The author states that we have reached a point where state and federal regulators can no longer ignore these products. The author states that until the federal government does its job, California must act to protect our residents and especially our children. The author concludes that this bill is a reasonable first step to age gate these products as we consider additional regulatory protections to put in place.

   a) BACKGROUND. Kratom (Mitragyna speciosa) is a tree in the coffee family, found in Thailand and neighboring countries. These leaves are crushed and then smoked, brewed with tea, or placed into gel capsules. Kratom has a long history of use in Southeast Asia, where it is commonly known as thang, kakuam, thom, ketum, and biak. Traditionally, in Southeast Asia, people have chewed its leaves or made them into a tea that is used to fight fatigue and improve work productivity. Kratom has also traditionally been used during religious ceremonies and to treat symptoms such as pain and diarrhea, sometimes as a substitute for opium. In this bill, kratom leaf refers to the leaf of a kratom plant. The

alkaloid content refers to the sum of the various alkaloids that are present in the leaf material that contribute the effect of the plant, including mitragynine, paynantheine, speciogynine, speciociliatine, and 7-hydroxymitragynine.

b) Effects of kratom usage. Kratom leaves contain two major psychoactive ingredients, mitragynine and 7-hydroxymitragynine, which interact with opioid receptors in the brain. People who use kratom have reported both stimulant-like effects (increased energy, alertness, rapid heart rate) and effects like those of opioids and sedatives (relaxation, pain relief, confusion). Per the United States Drug Enforcement Administration (DEA), consumption of kratom tree leaves produces a stimulant effect in low doses, and a sedative effect in high doses. Consumption of kratom in high doses can also lead to psychotic symptoms, and psychological and physiological dependence.

According to the National Institutes of Health Center for Complementary and Integrative Health (NCCIH), people may use kratom to try to overcome opioid addiction, kratom itself may have the potential to be addictive. People have reported using kratom to manage opioid withdrawal symptoms and cravings, and researchers are studying whether kratom is helpful for this purpose. However, kratom has not been shown to be safe and effective for this or any other medical use. Regular kratom users may experience withdrawal symptoms if they stop using it.

NCCIH notes that a variety of side effects of kratom have been reported. They include mild effects, such as nausea, constipation, dizziness, and drowsiness, and rare but serious effects such as seizures, high blood pressure, and liver problems. Fatal overdoses from kratom alone appear to be extremely rare. The use of kratom in combination with other drugs has been linked to deaths and severe adverse effects such as liver problems. More research is needed on drug interactions involving kratom.

NCCIH highlights that the long-term effects of kratom use are not well understood. Harmful contaminants such as heavy metals and disease-causing bacteria have been found in some kratom products.

According to the DEA, the abuse of kratom has increased markedly in recent years. Several cases of psychosis resulting from use of kratom have been reported, where individuals addicted to kratom exhibited psychotic symptoms, including hallucinations, delusion, and confusion.

c) Research on kratom use. According to a 2019 study titled, *"Current perspectives on the impact of Kratom use"*, the national poison center reporting database documented 1,807 calls related to kratom exposure from 2011 to 2017. The Centers for Disease Control and Prevention analyzed data on unintentional and undetermined opioid overdose deaths from the State Unintentional Drug Overdose Reporting System. Kratom was detected on postmortem toxicology testing in 152 cases of 27,338 overdose deaths from data collected from 11 states from July 2016 to June 2017 and 27 states from July 2017 to December 2017. Kratom was identified as the cause of death by a medical examiner in 91 of the 152 kratom-positive deaths, but was the only identified substance in just seven of these cases. Presence of additional substances in these seven kratom-only cases cannot be ruled out. The co-occurring substances in the 91 cases where kratom was identified as the cause of death include fentanyl (including analogs), heroin, benzodiazepines, prescription opioids, cocaine, and alcohol. Multi-substance exposures involving kratom,

predominantly in combination with opioids, are associated with a greater odds ratio of admittance to a health care facility and occurrence of a serious medical outcome when compared to kratom-only exposure.

These data highlight that kratom use is associated with a complex population of poly-drug users and especially with opioid use disorder. The data further suggests that a deeper investigation into the toxicity of kratom is needed, especially focusing on drug–herb interactions.

d) Legal Status of Kratom.

i) National level. Kratom is currently legal and accessible online and in stores in many areas of the United States. In 2016, DEA published notice of its intent to place mitragynine and 7-hydroxymitragynine in Schedule I on an emergency basis, which would have criminalized possession of kratom and made distribution a felony. However, after receiving numerous comments from some Members of Congress, advocacy groups, and others, DEA withdrew that notice. DEA has listed kratom as a Drug and Chemical of Concern, but to date has not exercised its authority to schedule kratom or its active compounds under the federal Controlled Substances Act. Even though the DEA has listed kratom as a "drug of concern," kratom and kratom compounds are not listed in the U.S. schedule of controlled substances. The federal Food and Drug Administration (FDA) has not approved kratom as safe and effective for any medical purpose. Under the Federal Food, Drug, and Cosmetic Act (FD+C Act), kratom is considered a new dietary ingredient since it was not marketed as a dietary ingredient in the United States before October 15, 1994; evidence of safety is required for new dietary ingredients.

According to the FDA's webpage, *"FDA and Kratom,"* the FDA has not approved any prescription or over-the-counter drug products containing kratom or its two main chemical components, mitragynine and 7-OH-mitragynine. If a new drug application is submitted for kratom (or one of its components) to treat a specific medical condition, FDA will review the scientific data to determine if a drug product containing kratom (or its components) is safe and effective to treat that specific medical condition. Consistent with FDA's practice with unapproved substances, until the agency scientists can evaluate the safety and effectiveness of kratom (or its components) in the treatment of any medical conditions, FDA will continue to warn the public against the use of kratom for medical treatment. The agency will also continue to monitor emerging data trends to better understand the substance and its components. Kratom is not appropriate for use as a dietary supplement. FDA has concluded from available information, including scientific data, that kratom is a new dietary ingredient for which there is inadequate information to provide reasonable assurance that such ingredient does not present a significant or unreasonable risk of illness or injury and, therefore, dietary supplements that are or contain kratom are adulterated under the federal FD+C Act. Further, FDA has determined that kratom, when added to food, is an unsafe food additive under federal law; food containing an unsafe food additive, such as kratom, is adulterated under federal law. Based on these determinations by FDA, kratom is not lawfully marketed as a dietary supplement and cannot be lawfully added to conventional foods. Therefore, kratom is not lawfully

marketed in the U.S. as a drug product, a dietary supplement, or a food additive in conventional food.

FDA has issued a series of import alerts, most recently in July 2023, authorizing FDA personnel to seize imported kratom products from specified firms without physical inspection. FDA has also seized kratom products manufactured in the United States, including an April 2023 seizure of kratom products worth approximately $3 million from an Oklahoma company.

In October 2023, Members introduced essentially identical bills in both the House and the Senate to "protect access to kratom." According to the Congressional Research Service, these bills would direct the Secretary of Health and Human Services to gather information about kratom and would limit the authority to impose regulations on kratom, including prohibiting requirements on kratom that are more restrictive than those for foods, dietary supplements, or dietary ingredients under the FD+C Act. Each bill would contain a non-preemption clause, which would permit states to either ban or regulate kratom. These bills have not progressed out of committee.

ii) Other States.

(1) Kratom bans: Alabama, Arkansas, Indiana, Rhode Island, Vermont, and Wisconsin currently ban mitragynine and hydroxymitragynine or 7-hydroxymitragynine (kratom's active alkaloids). Legislators in Indiana, Rhode Island, Wisconsin, and Vermont have introduced bills to replace existing bans with regulations that would permit the sale of kratom products.

(2) Age restriction: Arizona, Georgia, Illinois, Minnesota, Nevada, Oklahoma, Texas, and Utah ban sales to persons under 18 years of age.

(3) Strength: Arizona, Oklahoma, Texas, and Utah prohibit sale of products in which 7-hydroxymitragynine is greater than 2% of the total alkaloid content.

(4) Marketing to children: Utah prohibits flavoring or packaging that appeals to children and requires child-safe packaging. West Virginia's recently adopted law requires the commissioner of agriculture to develop similar standards.

e) Kratom in California. Some estimates show that nearly 25% of all kratom sales in the United States are in California. In March 2024, the city of Newport Beach approved an ordinance to prohibit the sale and distribution of kratom. The City of San Diego and Oceanside banned the use and sale of kratom in 2016. It has been reported that some manufacturers have created stronger and more potent kratom concentrates to put into their products. According to a 2023 study titled, "*Kratom availability in California vape shops,*" kratom was available in two-thirds of vape-and-smoke shops throughout California.

f) Attractiveness to children. The Kratom Consumer Advisory Council (KCAC) put out a position statement in October 2024 highlighting their concerns regarding the marketing of kratom products that may appeal to children intentionally or unintentionally. KCAC noted that some products are sold in forms resembling popular candies, such as gummies,

lollipops, chocolate bars, and cookies. These products often feature bright colors, mascots, and flavors that could attract young children or be mistaken for regular candy. KCAC noted that the ease of access to these products and their resemblance to well-known candy items raise concerns about accidental ingestion by younger children. This bill prohibits kratom products sold or distributed from being attractive to children.

g) **What is 7-OH**? According to a 2019 study titled, "*7-Hydroxymitragynine is an Active Metabolite of Mitragynine and a Key Mediator of its Analgesic Effects,"* mitragynine is the major active alkaloid found in kratom, and that it is converted to the much more potent mu-opioid receptor agonist 7-OH in the liver. The study found that brain concentrations of 7-OH are sufficient to explain most or all of the opioid-receptor-mediated analgesic activity of mitragynine. At the same time, mitragynine was found in the brains of mice at very high concentrations relative to its opioid receptor binding affinity, suggesting that it does not directly activate opioid receptors. The results suggest a metabolism-dependent mechanism for the analgesic effects of mitragynine. This bill prohibits the sale of a kratom product or 7-OH product with a level of 7-hydroxymitragynine that is greater than 2% of the total kratom alkaloids in the product.

2) **SUPPORT.** The California Narcotic Officers' Association (CNOA) supports this bill and writes, synthesized 7-hydroxymitragynine (7-OH) products, referred to as "legal morphine," are developed from kratom and have become 30 times more potent than morphine. CNOA continues that 7-OH produces opioid-like effects and can cause fatal overdoses, making their abuse a serious public health and safety concern. CNOA continues other adverse effects of 7-OH include psychotic symptoms, and psychological and physiological dependence. CNOA notes that natural kratom products generally contain no more than 66% of mitragynine as the main alkaloid and 2% of 7-hydroxymitragynine in the alkaloid fraction of the extract. CNOA continues that a number of states including Arizona, Oklahoma, Texas, and Utah have enacted bans on synthetic 7-OH exceeding 2% of total alkaloid content in products. CNOA notes that in California, natural kratom products remain unregulated and unrestricted. CNOA states that any one of any age can purchase kratom and synthesized 7-OH products. CNOA states that this addresses safety concerns about natural kratom and 7-OH products by implementing some common-sense measures to protect the public and our youth by establishing a: minimum age of 21 to purchase; requirement for child-resistant packaging; ban on marketing that appeals to children; limit on 7-OH content not to exceed 2% of the product's total alkaloid content. CNOA concludes that AB 1088 will protect better consumers and our youth from dangerous products that have resulted in addiction and death in our state and across the country.

3) **OPPOSE.** The Holistic Alternative Recovery Trust (HART) opposes this bill on the grounds that a cap of 2% of the total alkaloids allowed in a kratom leaf is so de minimis as to be meaningless when manufacturing a 7-OH product. HART directs readers to their April 1, 2025 letter where they expanded on their concerns. Highlights from the previous letter: HART's belief that exploring the potential applications of 7-OH could contribute to discussions on addressing opioid misuse and strategies; evolving research on 7-OH; and concerns that the percentage cap is a fatally-flawed measure noting that bad actor manufacturers who wish to create a high mg 7-OH product can easily adhere to the percentage cap and add the corresponding amount of mitragynine, thereby releasing a dangerous but compliant product. HART concludes by stating that it hopes that a realistic

approach to regulating 7-OH that is focused on the potential benefits to California consumers.

4) **RELATED LEGISLATION.** AB 8 (Aguiar-Curry) would require an out-of-state hemp manufacturer who produces an industrial hemp product that is a food or beverage for sale in this state to register with the department. States that MAUCRSA does not prohibit a licensee from manufacturing, distributing, or selling products that contain industrial hemp or cannabinoids, extracts, or derivatives from industrial hemp, if the product complies with all applicable state laws and regulations.

5) **PREVIOUS LEGISLATION.**

   a) AB 2365 (Haney) of 2024 would have established the Kratom Consumer Protection Program to provide a regulatory structure for kratom products, as provided. AB 2365 was held on the Senate Appropriations Committee suspense file.

   b) AB 45 (Aguiar-Curry), Chapter 576, Statutes of 2021 establishes a regulatory structure in DPH for food, beverage and cosmetic products containing industrial hemp, and limited these products to containing no more than 0.3% concentration of THC.

   c) SB 94 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2017 establishes a single system of administration for cannabis laws in California, combining the Medicinal Cannabis Regulation and Safety Act with the Adult Use of Marijuana Act to create the Medicinal and Adult-Use Cannabis Regulation and Safety Act.

6) **POLICY COMMENTS.** The author may wish to consider working with DPH to determine the appropriate regulatory structure for kratom at DPH, and continue to work with stakeholders to identify a cap for 7-OH in kratom and 7-OH products and whether milligrams would be an effective form of measurement.

7) **DOUBLE REFERRAL.** This bill is double-referred, upon passage of this committee, it will be referred to the Assembly Committee on Environmental Safety and Toxic Materials.

REGISTERED SUPPORT / OPPOSITION:

Support

Arcadia Police Officers' Association
Brea Police Association
Burbank Police Officers' Association
California Association of School Police Chiefs
California Coalition of School Safety Professionals
California District Attorneys Association
California Narcotic Officers' Association
California Reserve Peace Officers Association
Claremont Police Officers Association
Cleanearth4kids.org
Corona Police Officers Association
Culver City Police Officers' Association
Fullerton Police Officers' Association

Los Angeles School Police Management Association
Los Angeles School Police Officers Association
Murrieta Police Officers' Association
Newport Beach Police Association
Palos Verdes Police Officers Association
Placer County Deputy Sheriffs' Assocation
Pomona Police Officers' Association
Riverside Police Officers Association
Riverside Sheriffs' Association
Santa Ana Police Officers Association

Oppose

Holistic Alternative Recovery Trust
7 individuals

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1242 (Nguyen) – As Amended March 28, 2025

SUBJECT: Language access.

SUMMARY: Revises existing law regarding state agency language survey requirements to require each state agency to conduct an assessment and survey of the language needs of non-English-speaking and limited-English-speaking people, as specified. Requires a state agency to utilize specified information in conducting biennial surveys of each statewide and local office, and in developing and updating an implementation plan that provides a detailed description of how the agency plans to address any deficiencies in meeting current language access requirements. Establishes the position of Language Access Director (LAD), within the California Health and Human Services Agency (CalHHS), to ensure individuals with limited English proficiency and individuals who are deaf or hard of hearing have meaningful access to government programs and services. Specifically, **this bill**:

Findings and Declarations

1) Finds and declares that this bill aligns with Executive Order No. N-16-22, which committed to strengthening equity and language access, and CalHHS' current Language Access Plan (LAP) Guidance Document.

Dymally-Alatorre Provisions

2) Requires every state agency that serves a substantial number of non-English-speaking people and provides materials in English explaining services and also provide materials in any non-English language spoken by a substantial number of the public that is served, to also include persons eligible to be served by the agency.

3) Revises and recasts current state agency survey requirements to require each state agency to conduct an assessment and survey of the language needs of non-English-speaking and limited-English-speaking people and develop and update an implementation plan.

4) Requires a state agency to utilize specified information in conducting the assessment and survey and in developing and updating the implementation plan described in 3) above, including:

    a) The most recent census data from the United States Census Bureau, or recent data from any other relevant data databases, including, but not limited to, both of the following:

        i) English Learner Data, available on the DataQuest reporting system provided by the State Department of Education; and,

        ii) Language Microdata for California, and any other language database that is based on the census and includes limited English proficiency (LEP) by ZIP Code and census tract, available on the Demographic Research Unit (DRU) Data Portal provided by the Department of Finance.

b) Community-level input from various mechanisms, including focus groups, roundtables, and advisory bodies, especially during times of emergencies.

c) Any relevant factors other than those described in a) and b) above, including levels of linguistic isolation and percentages of LEP within each language group.

5) Revises and recasts existing survey requirements within existing law to require each state agency to conduct an assessment of language needs and language survey of each its statewide and local offices every two years to determine the number of non-English-speaking or limited-English-speaking people served or eligible to be served by each statewide and local office broken down by native language based on any of the information described in 3) above to assess the language needs in each of its statewide or local offices service area.

6) Revises and recasts provisions to require the state agency's assessment pursuant to 5) above to the include limited-English-speaking people and people eligible to be served by each statewide and local office based on the information described in 4) above to assess the language needs of non-English-speaking or limited-English-speaking populations in each statewide or local offices service area.

7) Includes contracted video interpretation services serving the language needs of people served by the agency as an available option in the assessment pursuant to 5) above when determining whether the use of other available options in addition to qualified bilingual persons in public contact positions is serving the language needs of the people served by the agency.

8) Authorizes an agency to rely on its most recent survey and language assessment data in developing its implementation plan.

9) Requires the Department of Human Resources (CalHR), when reviewing the results of language need surveys and implementation plans, to also review language assessments. Adds to the following requirements to CalHRs existing report to the Legislature:

a) The report to include each state agency's language assessment, survey results, and implementation plan.

b) The report to be submitted in accordance with existing law.

Language Access Director Provisions

10) Establishes within CalHHS, the LAD to provide critical oversight, accountability, and coordination across various state departments and agencies to ensure individuals with LEP and individuals who are deaf or hard of hearing have meaningful access to government programs and services.

11) Requires the LAD to lead the implementation, monitoring, and periodic updating of LAPs within CalHHS, including both of the following:

i) A LAP for each department and office within CalHHS; and,

ii) CalHHS' LAP Guidance Document.

12) Requires the LAD to coordinate with the language access coordinators from the various departments and offices within CalHHS to implement each departments' and offices' LAP.

13) Requires the LAD to increase the provision of language assistance services, including translation and interpreter services, through various options, which may include, but are not limited to, hiring bilingual staff and contracting with community-based organizations and third-party vendors.

14) Requires the LAD to ensure the use of qualified interpreters and qualified translators for any language assistance provided to persons with LEP or persons who are deaf or hard of hearing.

15) Requires the LAD to ensure each LAP as required by 22) includes all of the following:

    a) Methods to identify individuals with LEP who require language assistance, including both of the following:

        i) A demographic assessment of the department's service population.

        ii) An effective system of recording and utilizing spoken, sign, and written language preferences, including processes to identify the correct linguistic variant.

        iii) Language assistance measures and information about the ways that language assistance will be provided, including all of the following:

            (1) The types of services available, including both of the following:

            (2) How a department or office will provide free sign language interpretation and oral interpretation services in a language and linguistic variant, upon request, for all public contacts, including sight translation of vital documents pursuant to CalHHS' LAP Guidance Document; and,

            (3) How the department or office will use the safe harbor provisions described in pages 47311 and 47319 in Volume 68 of the Federal Register to determine the languages that a vital document is required to be translated into.

    b) How staff can obtain those services.

    c) How to respond to an individual who requires language assistance, including via telephone, written communication, and in-person contact.

    d) Ensuring the competency of qualified interpreters and qualified translators.

    e) Training for staff to ensure they know about policies, procedures, and best practices related to the provision of meaningful language access.

    f) Ensuring staff who have contact with the public are trained to work effectively with in-person, video, and telephone interpreters.

g) Notice for individuals containing the language services that are available at no cost for an individual with LEP or, to the extent that a service area exists, who reside in its service area and are eligible for services.

h) A mechanism to do both of the following:

i) Monitor the implementation of the plan; and,

ii) Update the plan every two years. Requires the update to include whether new documents, programs, services, and activities are required to be made accessible for individuals with LEP and who are deaf or hard of hearing.

16) Authorizes the LAD to consider the following when reviewing a plan for updates:

a) Changed demographics;

b) An analysis of internal and external data;

c) Responses to new and unexpected language needs;

d) Assessment and measures of client satisfaction; and,

e) Capacity-building efforts regarding funding, staffing, and training.

17) Requires the LAD to collect data from the various departments and offices within CalHHS to create the report required in 22) below.

18) Requires the LAD to ensure a document is translated if an individual with LEP submits a written request to CalHHS, or any of its departments or offices, that the document be translated into the individual's preferred language.

19) Requires the LAD to develop a LAP Guidance Document to support the various departments and offices within CalHHS in their development of an LAP.

20) Requires the LAD, commencing no later than January 1, 2027, engage communities with LEP and deaf and hard of hearing communities to assist in expanding access to the programs and services provided by CalHHS and the various departments and offices within the agency, including, but not limited to, by doing all of the following:

a) Conducting targeted outreach to communities who are LEP or deaf and hard of hearing to solicit advice on policies and practices affecting individuals who are eligible for services and benefits from department's and offices' within CalHHS and provide input and feedback to the agency about its LAP and policies;

b) Marketing and promoting those programs and services in a variety languages to the general public and LEP communities; and,

c) Establishing a grant program lasting at least two years to provide funding for community-based organizations working with communities with LEP to provide outreach and education to them and to provide feedback to CalHHS regarding its LAP and policies.

LAPS

21) Requires each department and office within CalHHS to do both of the following:

    a) Develop a LAP; and,

    b) Delegate a coordinator to work with the LAD to achieve the purposes of this division.

22) Requires, commencing November 1, 2027, and every other year thereafter, CalHHS, under the oversight of the LAD, to submit a report for the two prior fiscal years to the Legislature and the relevant policy committees containing the information described below. Requires the report to provide information by fiscal year, including:

    a) Challenges encountered while implementing the various LAPs;

    b) The LAD's efforts to address the problems it encountered, if any;

    c) Lessons learned and best practices;

    d) The number and percentage of individuals with LEP and who are deaf or hard of hearing who use each department's or office's services, listed by language other than English, in comparison to the estimated population with LEP and who are deaf or hard of hearing who are eligible for the department's or office's services, including a description of the methodology or data collection system used to make this determination; and,

    e) The name and contact information for each language access coordinator.

    f) A list of ongoing employee development and training strategies to maintain well-trained multilingual employees and general staff, including a description of both of the following:

        i) Quality control protocols for multilingual employees;

        ii) Language service protocols for individuals with LEP, or who are deaf or hard of hearing, who are in crisis situations;

        iii) A list of goals for the upcoming year and, except for the first year of the report, an assessment of each department's and office's success at meeting the prior year's goals;

        iv) The number of translation requests received and provided, the languages used to translate materials, and which materials were translated and completed during the prior fiscal year; and,

        v) The number of interpretation requests received and the number of interpretation services provided, by language, including services provided in person, by video, and via telephone, for services provided by department and office staff, as well as by contracted vendors.

23) Requires the report to be submitted in accordance with 11) of Existing Law.

24) Requires, commencing no later than January 1, 2027, the LAD to engage communities with LEP and deaf and hard of hearing communities to assist in expanding access to the programs and services provided by CalHHS and the various departments and offices within CalHHS, including, but not limited to, by doing all of the following:

    a) Conducting targeted outreach to communities who are LEP or deaf and hard of hearing to solicit advice on policies and practices affecting individuals who are eligible for CalHHS' department's and offices' services and benefits and provide input and feedback to the agency about its LAP and policies;

    b) Marketing and promoting those programs and services in a variety languages to the general public and LEP communities; and,

    c) Establishing a grant program at least two years to provide funding for CBOs working with communities with LEP to provide outreach and education and provide feedback to CalHHS regarding its language access plan and policies.

Funding Mechanism

25) Requires CalHHS, from funds appropriated in the Budget Act of 2023 (Chapter 12 of the Statutes of 2023), to allocate sufficient funds to implement and carry out the Health and Safety Code provisions of this bill, including the requirement for the departments and offices within the agency to assign a language access coordinator.

Definitions

26) Defines "interpretation" to mean the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account.

27) Defines "limited English proficiency" or LEP to mean individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English, and are eligible to receive language assistance with respect to services, benefits, or challenges encountered.

28) Defines "qualified interpreter" to mean a person who satisfies all of the following:

    a) Demonstrated proficiency in both English and the target language;

    b) Knowledge in both English and the target language of health care and other appropriate terminology and concepts relevant to health care or social services delivery systems;

    c) Adherence to generally accepted interpreter ethics and principles, including, but not limited to, client confidentiality; and,

    d) Specifies that a "qualified interpreter" does not mean a person who provides oral interpretation using a machine or done online, including, but not limited to, providing interpretation using an online, machine-based interpreter service or artificial intelligence, unless a person reviews and appropriately corrects the interpretation before the final interpretation reaches its intended audience.

29) Defines "qualified translator" to mean a person who satisfies all of the following:

    a) Demonstrated proficiency in both English and the target language;

    b) Knowledge in both English and the target language of health care and other appropriate terminology and concepts relevant to health care or social services delivery systems;

    c) Adherence to generally accepted translator ethics and principles, including, but not limited to, client confidentiality; and,

    d) Specifies that a "qualified translator" does not mean a person who makes a translation using a machine or done online, including, but not limited to, making a translation using an online, machine-based translation service or artificial intelligence, unless the person reviews and appropriately revises the translation before the final translation reaches its intended audience.

30) Defines "translation" as the conversion of written text into the corresponding written text in a different language, taking cultural and social context into account. Provides that "translation" does not include the conversion of written text into the corresponding written text in a different language made by a machine or done online, including, but not limited to, through the use of an online, machine-based translation service or artificial intelligence, unless a qualified translator reviews and appropriately revises the translation before the final translation reaches its intended audience.

EXISTING LAW:

1) Establishes CalHHS, which consists of the following departments and offices (hereinafter "departments"): Aging, Child Support Services, Community Services and Development, Developmental Services, Health Care Access and Information, Health Care Services, Managed Health Care, Public Health (DPH), Rehabilitation, Social Services (DSS), State Hospitals, the Center for Data Insights and Innovation, the Emergency Medical Services Authority, the Office of Technology and Solutions Integration, the Office of Law Enforcement Support, the Office of the Surgeon General, the Office of Youth and Community Restoration, and the State Council on Developmental Disabilities. [Government Code (GOV) § 12803, § 12806]

2) Requires, under the Dymally-Alatorre Bilingual Services Act, each state agency, defined as every state office, department, division, bureau, board, or commission directly involved in the furnishing of information or the rendering of services to the public that includes a substantial number of people with LEP, to employ a sufficient number of qualified bilingual persons in public contact positions. Defines "public contact position" as a position determined by the agency to be one, which emphasizes the ability to meet, contact, and deal with the public in the performance of the agency's functions. Allows state agencies to contract for telephone-based interpretation services in addition to employing qualified bilingual persons in public contact positions. [GOV § 7292, § 7297, § 7299.1]

3) Requires any materials explaining services available to the public to be translated into any non-English language spoken by a substantial number of people with LEP served by the agency. Defines substantial number people with LEP as members of a group who

compromise 5% or more of the people served by the statewide or any local office or facility of a state agency. [GOV § 7295, § 7295.2]

4) Requires every state agency which serves a substantial number of non-English-speaking people and which provides materials in English explaining services to also provide the same type of materials in any non-English language spoken by a substantial number of the public served by the agency. [GOV § 7295.2]

5) Requires, whenever notice of the availability of materials explaining services available is given, orally or in writing, notice to be given in English and in the non-English language into which any materials have been translated. [*Ibid*.**]**

6) Provides that 1) and 2) are not be interpreted to require verbatim translations of any materials provided in English by a state agency. [*Ibid*.**]**

7) Requires whenever a state agency finds that any of factors listed in both a) and c) or b) and c) below exist, the state agency to distribute the applicable written materials in the appropriate non-English language through its statewide and local offices or facilities to non-English-speaking persons, or, authorizes as an alternative, the state agency to elect to furnish translation aids, translation guides, or provide assistance, through use of a qualified bilingual person, at its statewide and local offices or facilities in completing English forms or questionnaires and in understanding English forms, letters, or notices:

   a) The written materials, whether forms, applications, questionnaires, letters, or notices solicit or require the furnishing of information from an individual or provide that individual with information;

   b) The information solicited, required, or furnished affects or may affect the individual's rights, duties, or privileges with regard to that agency's services or benefits; or,

   c) The statewide or local office or facility of the agency with which the individual is dealing, serves a substantial number of non-English-speaking persons. [GOV § 7295.4]

8) Defines a "substantial number of non-English-speaking people" as members of a group who either do not speak English, or who are unable to effectively communicate in English because it is not their native language, and who comprise five percent or more of the people served by the statewide or any local office or facility of a state agency. [GOV § 7296.2]

9) Requires each state agency to conduct a language survey and develop and update an implementation plan, as specified. [GOV § 7299.4]

10) Requires CalHR to review the results of the surveys and implementation plans required to be made by 6) above and to compile this data, and provide a report to the Legislature every two years. Requires the report to identify significant problems or deficiencies and propose solutions where warranted. [GOV § 7299.6]

11) Requires any report required or requested by law, or identified in the Legislative Analyst's Supplemental Report of the Budget Act, to be submitted by a state or local agency to a committee of the Legislature or the Members of either house of the Legislature generally, shall instead be submitted as a printed copy to the Secretary of the Senate, as an electronic

copy to the Chief Clerk of the Assembly, and as an electronic or printed copy to the Legislative Counsel. Requires each report to include a summary of its contents, not to exceed one page in length. Requires if the report is submitted by a state agency, that agency to also provide an electronic copy of the summary directly to each member of the appropriate house or houses of the Legislature. Requires notice of receipt of the report to be recorded in the journal of the appropriate house or houses of the Legislature by the secretary or clerk of that house, as provided. [GOV § 9795]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According the author, for the nearly 6.4 million Californians with LEP, language barriers pose a significant challenge to their ability to have meaningful access to quality health care coverage and services. The author states that this bill will close important gaps for those seeking a broad spectrum of health and social services, save the state millions in avoidable costs, bolster the state's ability to meet statutory language requirements, and most importantly, advancing health equity for millions of Californians.

2) **BACKGROUND.** In 2021, Governor Newsom proposed a new Equity-Centered Programs initiative, which was included in the 2021–22 budget. The initiative included a Language Access Policy Framework with an accompanying request of budget resources to support two limited-term positions to develop and implement an agency-wide language access policy and a protocol framework that considers legal compliance, operational aspects of translation and interpretation; bilingual staff testing, classification, and related human resources requirements; and engagement with community stakeholders and partners. The agency-wide policy framework was intended to ensure consistent language access standards across all programs and services and build off an internal Language Access Work Group that had been convened in 2020 to develop a language access policy and operations framework to improve language assistance services by CalHHS departments. The Governor also issued Executive Order No. N-16-22 in September 2022, citing the state's investment to improve language access across health and human services programs and ordering CalHHS to develop recommendations to improve language and communications access to state government services and programs.

   a) **LEP in California.** According to the U.S. Census Bureau, of people older than five years old living in California from 2018 to 2022, 43.9% spoke a language other than English at home, and 17.1% reported they did not speak English "very well." Despite anti-discrimination and language access requirements in federal and state law, not all requirements have been implemented, monitored, or enforced. For example, according to an administrative complaint filed with the U.S. Department of Health and Human Services Office for Civil Rights, local agencies in the counties of Alameda, Los Angeles, Orange, Riverside, and San Bernardino failed to provide individuals with LEP meaningful access to COVID services during the pandemic. This complaint cited poor translations through Google Translate and dependence on volunteer interpreters rather than hiring qualified interpretation staff.

   b) **Association between LEP and Health Care Access**. A 2022 study titled, "*Association Between Limited English Proficiency and Healthcare Access and Utilization in California*," highlighted healthcare disparities experienced by patients with LEP. The

researchers analyzed aggregated data from the 2018 California Health Interview Survey, a large population-based survey. A total of 21,177 participants were included with 8.2% having LEP. Compared to participants with proficient English, LEP participants were less likely to have a usual place to go to when sick other than the emergency room or have a preventive care visit in the past year after adjusting for sociodemographic characteristics.

Another 2020 study titled, "*Implications of language Barriers for Healthcare: A Systematic Review*," found that language barriers are a key cause of miscommunication between medical providers and patients, and negatively affect the quality of healthcare services and patient satisfaction. Hospital medical professionals perceive language barriers to be a source of workplace stress and an impediment to the delivery of high-quality healthcare. Much evidence shows a significant association between workplace stress and lower satisfaction among medical providers. In addition, studies indicate that language barriers contribute to medical professionals' incomplete understanding of patients' situations, delayed treatment or misdiagnoses, poor patient assessment and incomplete prescribed treatment.

c) Federal and State Anti-Discrimination Law. In federal law, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal financial assistance. A U.S. Supreme Court case, *Lau v. Nichols* (1974) later specified that national origin discrimination includes discrimination based on a person's inability to speak, read, write, or understand English. Executive Order 13166, issued by President Clinton in 2000, expanded upon these protections by requiring any organization that receives federal financial assistance to provide meaningful access to programs and activities for persons who are LEP.

In California, the Dymally-Alatorre Bilingual Services Act became law in 1973 to ensure that individuals seeking state government services whose primary language is not English are not precluded from receiving services because of language barriers.

The Dymally-Alatorre Act requires each state agency which serves a substantial number of non-English-speaking people and provides materials in English explaining services to also provide the same materials in any non-English language spoken by a substantial number of the public served by the agency. The current definition of "substantial number of non-English speaking people" includes non- or limited-English speaking people who comprise 5% or more of the people served by the statewide or local office or facility of a state agency. Further, the Dymally-Alatorre Act requires all state departments involved in providing information or services to the public, when five percent of contact with the public is made with non- or limited-English speaking people, to employ a sufficient number of qualified bilingual staff in public contact positions to ensure information and services are provided in the language of the non- or limited-English speaking person.

Dymally-Alatorre also requires each agency to conduct a language survey and develop and update an implementation plan. The California Department of Human Resources (CalHR) provides training and technical support to agencies in conducting the Language Survey and Implementation Plan that identifies public contacts and resources available to ensure an equal level of service is being provided to substantial populations speaking non-English languages. Once the survey is conducted, agencies review their results to determine if they have staffing or written document deficiencies, and they develop a plan

to correct any they find. Each agency has a Language Survey Coordinator that is responsible for communicating the requirements of the Act to the agency and for ensuring that a meaningful survey is conducted. The Language Survey Coordinator also reports the progress on the implementation plan to CalHR. CalHR prepares a report to the Governor and the Legislature that identifies the results of the survey.

d) How does this bill update the Dymally-Alatorre Act? This bill expands the definition of "substantial number of non-English speaking people" to include individuals who are eligible to be served by the agency. The author's intent is to include individuals who may not currently access the agency's services, but are eligible to do so. Further, this bill revises the existing survey requirement by requiring not only a survey of the language needs of non- and limited-English-speaking people but also an assessment utilizing data from the United States Census Bureau or recent data from other relevant databases, community-level input, other relevant factors including linguistic isolation and percentages of LEP within each language group. The author's intent is for each agencies to review this data to get a clearer picture of the needs of LEP individuals.

e) Language Access Policy in California. In May 2023, CalHHS released a memo to department directors outlining a policy based on the work of the initiative and the work group. The policy outlines department-level language assistance plans with the following requirements, regardless of the funding source of the department:

i) Be consistent with the U.S. Department of Justice's 2002 guidance to agencies receiving federal financial assistance regarding Title VI's prohibition against national origin discrimination affecting LEP persons and any applicable federal funding agency;

ii) Address Title VI's analysis for determining reasonable steps to ensure meaningful access for persons with LEP. The analysis includes a weighing of the number of people with limited English eligible to be served by the program and the frequency of contact they would have with the program, the nature and importance of the program or service, and the resources available to the program and the costs of translation services;

iii) Identify and address language access legal requirements specific to that department and its programs and analyze whether the Title VI analysis requires additional language assistance beyond what is otherwise required by state law or the department's programs;

iv) Submit plans to CalHHS by December 1, 2023, and review and update the plans as necessary every two years; and,

v) Post its final, public facing Language Access Plan to the Department or Office's website no later than June 1, 2024.

CalHHS also issued minimum language access standards and required each department's LAP to address how it would meet or exceed the standards:

i) Provide free sign language interpretation and oral interpretation in any spoken language, upon request for all public contact, including sight translation of vital documents by January 29, 2024;

ii) Translate all vital documents intended for use statewide, including essential public website content, into at least the top five threshold languages spoken by persons with LEP in California, per the most recent available Census data (currently Spanish, Chinese, Tagalog, Vietnamese, and Korean). Vital documents and essential public website content are to be identified by each department within its Language Assistance Plan. Essential public website content includes one or more introductory web pages with basic information about the department and its programs and non-English taglines advising of the availability of free oral interpretation services and written translations. Essential public website content is also to be provided in American Sign Language video clips;

iii) Identification and translation of vital documents into the top five languages is to be completed by June 1, 2024; and,

iv) CalHHS and the Language Access Work Group are to reevaluate the list of statewide threshold languages and the feasibility of adding more than five within one year and then every two years thereafter.

The policy memo additionally stated that CalHHS Language Access Work Group would issue guidance to CalHHS departments to support the development of their LAPs and that DSS would administer additional funds for interpretation and translation activities to supplement CalHHS departments' existing language services capacity.
Departments and offices under CalHHS have posted LAPs to their websites.

f) How does this bill change language access policy beyond Dymally Alatorre? This bill codifies the requirement for each department or office within CalHHS to develop an LAP and requires each department or office to delegate a coordinator to work with the LAD to fulfill the requirements of this bill.

Further, this bill creates the Language Access Director position to lead the implementation, monitoring, and periodic updating of Language Access Plans within CalHHS.

This bill requires, commencing November 1, 2027, CalHHS under the oversight of the LAD to submit a report for the two prior two fiscal years to the Legislature and the relevant policy committees containing specified information relating to the implementation of the LAPs.

This bill further requires the LAD to engage communities with LEP and deaf and hard of hearing communities to assist in expanding access to the programs and services provided by CalHHS and the various departments and offices within CalHHS, including conducting targeted outreach to solicit feedback and input, marketing and promoting programs and services in a variety of languages, and establishing a grant program to provide funding for community-based organizations working with communities with LEP to provide outreach and education to community members, as well as provide feedback to CalHHS regarding its LAP and policies.

In terms of a funding source, this bill requires CalHHS to allocate sufficient funds appropriated from the Budget Act of 2023 to carry out the provisions of this bill. The author is referring to the $40 million API Health Equity Allocation.

g) **Federal Actions.** President Trump signed an executive order designating English as the official language of the U.S., the first such designation in the country's history. The order rescinds the Clinton-era policy requiring agencies to provide assistance programs for people with LEP. However, the order allows agencies to voluntarily keep those support systems in place.

3) **SUPPORT.** Asian Health Services is the sponsor of this bill and states, to address these language access barriers and increase access for communities who are LEP, this bill would establish a Language Access Director within CalHHS provide oversight, accountability, and coordination across CalHHS' departments and offices and oversee the implementation of CalHHS' and its department's and office's LAPs to ensure individuals with LEP and individuals who are deaf or hard of hearing can access the state's health and human services programs and services. AHS continues that this bill would ensure guardrails for the use of AI for language access by requiring human review when using machine, online or AI-generated interpretation and translation services for all programs and services under CalHHS. AHS further notes that this bill would also amend the Dymally-Alatorre Bilingual Services Act to improve the determination of language assistance provided by state and local agencies through recommending the use of relevant data, community engagement and input, and other relevant factors. AHS states that while the state has made strides in promoting language equity, many vital public health and human services remain inaccessible to Californians who speak less commonly spoken languages, putting their health, safety, and dignity at risk. AHS concludes that this bill is a critical health equity bill that will help ensure all Californians, not just English speakers, receive the services and support they are entitled to.

4) **RELATED LEGISLATION.**

a) AB 843 (Garcia) requires a health care service plan or health insurer to take reasonable steps to provide meaningful access to each individual with LEP, including companions with LEP, eligible to receive services or likely to be directly affected by the plan or insurer's programs and activities. AB 843 passed the Assembly Health Committee with a vote of 13-0.

b) AB 667 (Solache) would, beginning July 1, 2026, require certain boards under the jurisdiction of the Department of Consumer Affairs to permit an applicant who cannot read, speak, or write in English to use an interpreter to interpret the English written and oral portions of the license examination, if the applicant meets all other requirements for licensure, as specified. AB 667 would require an interpreter to satisfy specified requirements, including not having the license for which the applicant is taking the examination, and would prohibit the assistance of an interpreter under certain circumstances, including when English language proficiency is required for the license. AB 667 would also require those boards to post on their internet websites that an applicant may use an interpreter if they cannot read, speak, or write in English, the examination is not offered in their preferred language, and they meet all other requirements for licensure. AB 667 passed Committee on Business & Professions with a vote of 15-0.

5) PREVIOUS LEGISLATION.

a) AB 2155 (Ting) of 2024 would have required DSS to establish and administer a Bilingual-Oriented Social Equity Services Grant Program to distribute funding to community-based organizations that provide social services to pay a differential to services professionals who can communicate in a language other than English as part of their job duties. AB 2155 was held on the Assembly Appropriations Committee suspense file.

b) SB 1016 (Gonzalez) Chapter 873, Statutes of 2024, requires DPH and DSS, whenever collecting demographic data as to the ancestry or ethnic origin of California residents for specified reports, to use separate collection and tabulation categories for each major Latino group, Mesoamerican Indigenous nation, and Mesoamerican Indigenous language group, as specified.

c) SB 1078 (Min) of 2024 would have established the Office of Language Access within CalHHS to lead the development, monitoring, and updating of state department LAPs, maintain a website with language access information and resources, and submit a report to the Legislature on language access issues within CalHHS departments. SB 1078 was held on suspense in the Assembly Appropriations Committee.

d) AB 1084 (Nguyen) of 2023 was substantially similar to AB 2155. AB 1084 was held on the Assembly Appropriations Committee suspense file.

e) AB 135 (Committee on Budget) Chapter 85, Statutes of 2021, requires, among other things, that DSS administer an enhanced language access and cultural competency initiative for individuals with developmental disabilities and their caregivers that includes identification of vital documents and internet content for translation, regular and periodic language needs assessments to determine threshold languages for translation, and coordinating and streamlining of interpretation and translation services.

f) AB 1531 (Salas) of 2019 would have lowered the calculation, from 5% to 3%, for determining the threshold languages for a state agency. AB 1531 was held on the Assembly Appropriations Committee suspense file.

g) AB 2253 (Ting) Chapter 469, Statutes of 2014, requires CalHR to issue orders to compel a state agency to comply with the Dymally-Alatorre Bilingual Services Act, requires agencies to translate and make accessible information about submitting language access complaints on their websites and as available forms in offices, requires each state agency to conduct a bilingual services survey, and revised how threshold languages are determined by state agencies.

6) POLICY COMMENT. Regarding the bill's funding mechanism, the author may wish to work with CalHHS and departments and offices who were allocated this funding to inquire about the status of these funds. The author also indicates she is pursuing a $10M budget request.

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

REGISTERED SUPPORT / OPPOSITION:

Support

Asian Health Services (sponsor)
A.B.L.E. Community Development Foundation
AAPI Equity Alliance
AARP
ACC Senior Services
Access California
Active San Gabriel Valley
API Forward Movement
Asian Americans Advancing Justice-southern California
Asian Americans for Community Involvement
Asian Immigrant Women Advocates
Asian Pacific Fund
Asian Pacific Islander American Public Affairs Association (APAPA)
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Asian Resources, Inc.
Association for Chinese Families of the Disabled
Buen Vecino
California Healthy Nail Salons Collaborative
California LGBTQ Health and Human Services Network
California Pan - Ethnic Health Network
California State Council of Service Employees International Union (SEIU California)
Center for Asian Americans in Action
Central Valley Pacific Islander Alliance
Children Now
Chinatown Community Development Center
Chinese Culture Foundation of San Francisco
Clinica Monseñor Oscar A. Romero
Coalition for Humane Immigrant Rights (CHIRLA)
Community Clinic Association of Los Angeles County (CCALAC)
Community Health Initiative of Orange County
Community Youth Center of San Francisco
Courage California
CPCA Advocates, Subsidiary of the California Primary Care Association
Disability Rights California
Diversity in Health Training Institute
Empowering Pacific Islander Communities (EPIC)
F.O.U. Movement
Hawaii Daughters Guild
Healthy Contra Costa
Healthy House Within a Match Coalition
Hmong Innovating Politics
Initiate Justice
Korean Community Center of the East Bay
Korean Community Services
Kutturan Chamoru Foundation

Latino Coalition for a Healthy California
Le Gafa
Little Tokyo Service Center
Marshallese Youth of Orange County Myoc
National Pacific Islander Education Network
Nicos Chinese Health Coalition
North East Medical Services (NEMS)
Northeast Valley Health Corporation
Nourish California
Oakland Asian Cultural Center
OC Action
Omid Multicultural Institute for Development
Orange County Asian and Pacific Islander Community Alliance, Inc. (OCAPICA)
Orange County Herald Center
Pacific Asian Counseling Services
Pacific Islander Collective San Diego
Pacific Islander Health Partnership
Racial and Ethnic Mental Health Disparities Coalition
Regional Pacific Islander Taskforce
Richmond Area Multi-Services, INC.
San Francisco Community Health Center
South Asian Network
Southeast Asia Resource Action Center
Southern California Pacific Islander Community Response Team (SOCAL PICRT)
The Black Alliance for Just Immigration
The Cambodian Family
The Children's Partnership
The Fresno Center
The Young S.A.M.O.A.
United Latino Voices of Contra Costa County
Vision Y Compromiso
Vital Access Care Foundation
Western Center on Law & Poverty
14 individuals

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1267 (Pellerin) – As Amended March 26, 2025

SUBJECT: Consolidated license and certification.

SUMMARY: Requires, beginning January 1, 2027, the State Department of Health Care Services (DHCS) to offer a consolidated license for adult alcohol or other drug recovery or treatment facilities (RTFs) and certification for alcohol and other drug (AOD) programs that allows the holder to operate more than one facility and more than one facility type within the same geographic location. Specifically, **this bill**:

1) Requires DHCS, beginning January 1, 2027, to offer a consolidated license and certification that allows the holder to operate more than one facility that requires a license, a program that requires a certification, or a combination thereof, that the holder operates within the same geographic location.

2) Defines "same geographic location" as the physical location where clients are generally colocated, intermingle, reside, or receive services in one building or multiple buildings within 1,000 feet of each other.

3) Requires the consolidated license and certification process to include, at a minimum, all of the following:

    a) A unified, single application to fully license and certify all of the facilities and programs the applicant operates within the same geographic location that require a license or certification;

    b) A streamlined process to review an application for a consolidated license and certification;

    c) A unified inspection and oversight of all of the facilities and programs operated under a consolidated license and certification;

    d) Minimum standards for a consolidated license and certification that are the same as if an applicant had applied and operated under separate licenses and certification for each of its facilities and programs; and,

    e) A phase-in period for facilities and programs operating under different licenses and certifications to obtain a consolidated license and certification.

4) Authorizes DHCS to promulgate regulations and impose a charge to implement a consolidated license and certification.

EXISTING LAW:

1) Establishes DHCS as the sole licensing authority for RTFs. Permits new licenses to be issued for a period of two years and requires DHCS to conduct onsite program visits for compliance

at least once during the two-year licensing period. [Health and Safety Code (HSC) § 11834.01]

2) Requires DHCS to adopt the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and requires a licensee to maintain those standards with respect to the level of care to be provided by the licensee. [HSC § 11834.015]

3) Defines RTF to mean a premises, place, or building that provides residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or addiction, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. [HSC § 11834.02]

4) Requires, if a facility intends to provide incidental medical services (IMS), evidence of a valid license of a physician and surgeon who will provide or oversee those services, and any other information deemed appropriate by DHCS. Defines “incidental medical services” to mean services that follow the community standard of practice and are not required to be performed in a licensed clinic or licensed health facility, and includes obtaining medical histories, monitoring health status, testing associated with detoxification from alcohol or drugs, and overseeing patient self-administered medications. [HSC §§ 11834.025-11834.026]

5) Establishes DHCS as the sole certifying authority for alcohol or other drug programs. Requires new certifications to be issued for a period of two years to programs meeting statutory and regulatory requirements. [HSC § 11832]

6) Exempts specific settings from the certification requirement, including but not limited to: licensed adult alcoholism or drug abuse recovery or treatment facilities, clinics licensed by the State Department of Public Health (DPH), community care facilities licensed by the State Department of Social Services, public elementary and secondary schools, and county jails and state correctional institutions, including juvenile justice facilities. [HSC § 11832.3]

7) Requires an entity applying for certification to submit a written application, a certification fee, an initial application fee and any other documentation specified by DHCS. [HSC § 11832.4]

8) Specifies the conditions under which DHCS may issue a certification, terminate review of an application, or deny certification. [HSC § 11832.5]

9) Requires certified programs to adopt policies and procedure consistent with statute and regulations that address, at a minimum: admission and discharge, client rights, services, medications, and staff and client code of conduct. Requires programs to either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place, as defined. [HSC § 11832.8 and § 11832.9]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, California's current fragmented licensing and certification system for substance use disorder (SUD) treatment providers

creates significant administrative redundancies. As a result, SUD treatment providers must secure separate approvals for each distinct program category, such as outpatient certification, residential license and certification, and Narcotic Treatment Program (NTP) licensing. The author argues this bill will remove administrative redundancies, decrease operational costs, and free up resources to be used for direct patient care. The author concludes addressing this heavy administrative load is one step toward addressing the state's growing behavioral health crisis.

2) BACKGROUND.

a) Prevalence of SUD in California. A 2024 publication from Health Management Associates and the California Health Care Foundation titled, "*Substance Use Disorder in California — a Focused Landscape Analysis"* reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 to 2021. 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. According to the DPH Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

b) Alcohol and Drug Treatment Facility Licensing. 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 (Title 9, Chapter 5, California Code of 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 contrary 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.

IMS are optional services provided at a facility by a health care practitioner, or staff under the supervision of a health care practitioner, to address medical issues associated with detoxification, treatment, or recovery services. IMS must be provided at the facility in compliance with the community standard of practice. IMS does not include general

primary medical care or medical services required to be performed in a licensed health facility. IMS are defined in statute and include the following:

i) Obtaining medical histories;

ii) Monitoring health status;

iii) Testing associated with detoxification from alcohol or drugs;

iv) Providing alcoholism or drug abuse recovery or treatment services;

v) Overseeing patient self-administered medications; and,

vi) Treating substance abuse disorders, including detoxification.

c) Local facility approvals. When licensing residential facilities, DHCS requires a fire clearance from the local fire authority. Both residential and outpatient programs must obtain and provide proof of this clearance, which is requested directly from the fire authority within the city where the program is licensed. Current state law and regulations do not require any other additional local approvals beyond a fire clearance for residential facilities.

d) AOD Program Certification. Prior to January 1, 2025, programs were permitted to seek certification from DHCS. Under AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, certification is now a requirement for many AOD programs, with exceptions for various licensed facility types, schools, jails, and prisons. Programs were required to apply for certification no later than January 1, 2024. As of March 2025, DHCS reported that it certifies 1,055 outpatient facilities and 989 licensed facilities, for a total of 2,044 certified facilities. If DHCS finds evidence that a program is providing treatment, recovery, detoxification, or medication-assisted treatment services without a certification, DHCS must issue a written notice to the program stating that it is operating in violation of the law, and any person or entity found to be operating without certification may be subject to an assessment of civil penalties of two thousand ($2,000) dollars per day and will be barred from applying for initial certification for a period of five years from the date of the violation notice.

3) SUPPORT. California Association of Alcohol and Drug Program Executives (CAADPE) is the sponsor of this bill and says in support that it takes a critical step in ensuring that Californians struggling with SUDs can access treatment more efficiently by streamlining the licensing and certification process for SUD treatment facilities. By reducing administrative barriers, CAADPE argues this bill will help expand access to essential services, improving health outcomes while ensuring that resources are directed toward patient care rather than excessive regulatory compliance. CAADPE states that DHCS estimates approximately 50% of the workforce in SUD treatment programs is allocated to administrative tasks, diverting valuable resources away from direct patient care. CAADPE argues the current regulatory framework requires SUD treatment providers to obtain separate licenses and certifications for each facility or program, even when they are located in close proximity exacerbates these administrative costs and creates barriers to providing care. This fragmented approach results to unnecessary costs, duplicative inspections, and delays in expanding treatment services to

meet growing demand. CAADPE concludes that this bill aligns with other recent reforms to expand access to care.

The Drug Policy Alliance (DPA) also supports the bill, stating California faces an ongoing behavioral health crisis, with demand for SUD treatment services far exceeding available capacity. DPA cites the 2022 National Survey on Drug Use and Health finding that approximately 2.9 million California adults meet the criteria for a SUD, yet only a fraction receive treatment due to administrative and financial barriers. DPA also cites DHCS data suggesting that 70% of counties report urgently needing residential treatment services, 75% of counties cite a lack of available SUD residential beds specifically for youth patients, and 38% of counties do not have any residential SUD treatment facilities.

4) **OPPOSITION.** The City of Mission Viejo opposes the bill stating it could result in inconsistent regulatory standards and blur distinctions between facility levels of care, undermining the safety and quality of services for clients—many of whom are among the most vulnerable in our communities. Mission Viejo argues that local agencies and counties rely on clear licensing categories to coordinate care, enforce accountability, and ensure providers are meeting appropriate standards. Mission Viejo further argues that this bill fails to clarify how consolidated licensing would affect local permitting, zoning compliance, and enforcement authority, and that these ambiguities may result in unintentional consequences, including reduced local input and oversight, delays in approvals, and gaps in service coordination.

5) **RELATED LEGISLATION.**

a) AB 255 (Haney) would authorize state programs to fund supportive-recovery residences, a new type of residence that will satisfy housing first principles, be specifically designed to support substance use recovery, emphasize abstinence, and offer permanent housing only. Requires the state to conduct periodic monitoring and prohibits a resident from being evicted for relapse. Requires a resident seeking to leave or at risk of eviction be provided assistance in accessing housing operated with harm-reduction principles that is also permanent housing. AB 255 is pending in the Assembly Housing and Community Development Committee.

b) AB 425 (Davies) would require DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for certified AOD programs. A certified program would be required to maintain those standards. AB 425 is pending the Assembly Health Committee.

c) AB 492 (Valencia) would require DHCS to notify a city or county, in writing, of the issuance of a new license to an RTF within the local government's jurisdiction. AB 492 is pending in the Assembly Appropriations Committee.

d) AB 877 (Dixon) would require the Department of Managed Health Care, the Department of Insurance, and the DHCS to prepare and send one letter to each chief financial officer of a health care service plan, health insurer, or Medi-Cal managed care plan that provides coverage for substance use disorder in residential facilities to include a statement informing the plan or insurer that substance use disorder treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions. AB 877 is pending in the Assembly Health Committee.

e) AB 1037 (Elhawary) would update several SUD licensing and public health laws by expanding those authorized to receive opioid antagonists and eliminate the requirement that they receive training, and require DHCS to offer a combined application for entities to be licenses as an RTF and to provide IMS. AB 1037 is pending in the Assembly Judiciary Committee.

f) SB 43 (Umberg) would require all programs certified and all facilities licensed, no later than July 15, 2026, and annually each July 15 thereafter, to submit to DHCS a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year. SB 43 is pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 2081 (Davies), Chapter 376, Statutes of 2024, requires entities licensed or certified by DHCS to include on their websites and intake paperwork a disclosure stating an individual may check DHCS's website to confirm any actions taken against the entity.

b) AB 2121 (Dixon) of 2024 would have required an RTF to confirm that it is located more than 300 feet from any other RTF or any community care facility, as specified, and would have required the department to notify in writing the city or the county in which the facility is located of the issuance of a license. AB 2121 was not set for hearing in the Assembly Health Committee.

c) AB 381 (Davies), Chapter 437, Statutes of 2021, requires licensed RTFs to have at least two unexpired doses of naloxone on site and to have one staff member on premises that is trained to administer.

d) 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 recovery residence or RTF serving more than six residents to require the contractors to, at all times, maintain specific insurance coverage.

e) SB 992 (Hernández), Chapter 784, Statutes of 2018, requires programs licensed or certified by DHCS to disclose business relationships with recovery residences, prohibits RTFs from denying admission solely on the basis of an individual having a MAT prescription, and requires RTFs to develop relapse plans.

7) AMENDMENTS. The author proposes amending this bill to clarify that the consolidated license and certification applications are not available to facilities located in areas zoned exclusively for residential use.

8) POLICY COMMENT. The intent of the author is that the consolidated application fee not lead to a reduction in resources for DHCS to carry out its licensing and certification functions. Should this bill move forward, the author may wish to consider strategies for ensuring that the ability of larger facilities to consolidate their application does not lead to a disproportionate fee increase for those facilities or programs that cannot take advantage of the consolidation.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Alcohol and Drug Program Executives, INC. (Sponsor)
California Behavioral Health Association
Drug Policy Alliance

Opposition

City of Mission Viejo

Analysis Prepared by: Logan Hess / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1288 (Addis) – As Amended April 10, 2025

SUBJECT: Registered environmental health specialists.

SUMMARY: Makes various changes to the scope, education, training, and examination of registered environmental health specialists (REHS) and environmental health specialist (EHS) trainees as well as to the Environmental Health Specialist Registration Committee. Specifically, **this bill**:

REHS Scope of Practice

1) Includes body art and medical waste in the scope of practice of REHS.

REHS Educational Requirements

2) Revises the educational requirements for the registration of an REHS by striking the references to basic science and replacing with a reference to science courses designated for science or clinical health care degrees by the educational institution as prescribed in Existing Law 5) below.

3) Specifies that three of the required science courses must include a laboratory in options I and II as prescribed in Existing Law 5) below.

4) Adds a bachelor's degree in environmental health from a National Environment Science & Protection Accreditation Council (EHAC) approved institution as an acceptable option under Option V of Existing Law 5) below.

5) Deletes the requirement that basic science coursework be equal to what is acceptable in an approved environmental health degree program within options I to V of Existing Law 5) below.

EHS Training

6) Updates the definition of an EHS trainee to include the requirement that they are engaged in an approved environmental health training plan.

7) Revises and recasts the environmental health training elements to require training in at least three of the following primary elements:

    a) Food safety;

    b) Solid waste;

    c) Liquid waste;

    d) Water quality;

e) Housing and institutions;

f) Recreational Health;

g) Body art; and,

h) Hazardous materials or other Certified Unified Program Agency elements.

8) Revises and recasts existing law to allow additional training content to include any other primary element listed above or any of the following secondary elements: air sanitation, safety and accident prevention, land development and use, disaster sanitation, radiation, milk and dairy products, noise control, occupational health, medical waste and vector control.

9) Requires training in the selected primary elements to not be less than 20% of the total required training hours.

10) Requires additional training to not be less than 40% of the total required training hours.

EHS Trainee Supervision

11) Deletes the daily frequency of the training log required by Existing Law 9) below and clarifies that the log is required to be maintained by the local director of environmental health or the director's designee.

12) Deletes the requirement that the training log required by 9) in Existing Law below covering elements and hours of all training kept by EHS trainees is to be verified by their trainer or supervisor on a weekly basis.

13) Extends the period of time that an environmental health specialist trainee is authorized to work under the supervision of a REHS from three years to five years.

REHS Examination

14) Defines "examination" as a written professional examination prescribed by the Department of Public Health (DPH), administered in person or online, for registration as an REHS.

15) Changes the process after failure of the REHS examination as follows:

a) Deletes the current requirement that an applicant who twice fails to pass the written REHS examination is ineligible to be reexamined a third time until at least one year has elapsed from the date of the second examination;

b) Deletes the requirement that an applicant who fails the third examination is ineligible to take the examination a fourth time until two years have elapsed from the date of the third examination;

c) Deletes the prohibition for an applicant to take the examination more frequently than once in two years; and,

d) Instead prohibits an applicant who fails to pass the written examination from being eligible to be reexamined until 90 days have elapsed from the date of the previous examination.

REHS Committee

16) Changes the executive officer of the Environmental Health Specialist Registration Committee from the Chief of the Environmental Planning and Local Health Services Branch to the State Environmental Health Director and makes technical, clarifying changes to the terminology used in those and related provisions to distinguish local directors of environmental health from the State Environmental Health Director.

17) Revises the education members of the committee from two members from environmental health faculty from California universities and colleges to two members from environmental health or public health faculty, with at least one from environmental health faculty.

18) Deletes the prohibition on the two public health members from being engaged in the field of environmental health in the five years preceding their appointment and instead prohibits the public members from being currently engaged within the field of environmental health or profession regulated by the committee of which they are members.

19) Eliminates the prohibition on a committee member serving more than two successive terms.

20) Deletes the requirement that a committee member serve until one year after the expiration of their term and requires a committee member to serve until the appointment and qualification of their successor.

21) Increases the frequency of REHS meetings from at least twice annually to at least quarterly and specifies that the committee is authorized to meet in person or virtually.

22) Includes updating transcript review guidelines in the business of the committee.

23) Changes the quorum requirement of the REHS Committee from six members to a simple majority of the filled committee seats.

24) Authorizes the Chairperson of the REHS Committee to cancel a meeting, at their discretion, if there is insufficient business to warrant convening a scheduled meeting.

25) Specifies that the REHS Committee is required to keep a record of its meetings.

REHS Registry of REHS Specialists and REHS Trainees

26) Requires DPH to make its registry of all registered environmental health specialists and all environmental health specialist trainees publicly available on its internet website within 90 days of the administration of an examination.

EXISTING LAW:

1) Provides for the certification of REHS by DPH, and establishes application, examination, and renewal fees for this certification. [Health and Safety Code (HSC) § 10615]

2) Defines the scope of practice for a registered environmental health professionals to include, but not be limited to, the prevention of environmental health hazards and the promotion and protection of the public health and the environment in specified areas, including, among others, food protection, housing, and hazardous materials management. [*Ibid.*]

3) Authorizes a local health department to employ an REHS to enforce public health laws, as specified. [HSC § 106625]

4) Authorizes an environmental health specialist (EHS) trainee to work under the supervision of a registered environmental health specialist for a period not to exceed three years. [*Ibid*.]

5) Prescribes the requirements for an REHS to be a bachelor's degree from a DPH approved educational institution or an educational institution of collegiate grade listed in the directory of accredited institutions of postsecondary education compiled by the American Council on Education, with coursework as specified. [HSC § 106635]

6) Requires all EHS trainees to complete a basic training period in an approved environmental health training program. Requires the training period include training in at least six elements, with three of the elements selected from the following basic elements:

   a) Food protection;

   b) Solid or liquid waste management, or both;

   c) Water supply;

   d) Housing and institutions;

   e) Bathing places;

   f) Vector control; and,

   g) Hazardous materials management or underground tank program, or both. [HSC § 106665]

7) Authorizes the remaining three elements to include any other basic element or any of the following elements: air sanitation, safety and accident prevention, land development and use, disaster sanitation, electromagnetic radiation, milk and dairy products, noise control, occupational health, and rabies and animal disease control. [*Ibid*.]

8) Requires a daily log for the certification of the EHS trainee to be maintained by the local director of environmental health. [HSC § 106665]

9) Requires a daily log covering elements and hours spent of all training to be kept by the environmental health specialist trainees, and verified by the trainer or supervisor on a weekly basis. [HSC § 106665]

10) Requires training in each of three basic elements to not be less than 20% of the total required training hours. Requires time spent in the remaining three elements be not less than 40% of the total required training hours. Requires the employer to designate the methods, elements, and types of training or experience for the remaining time required for entrance to the

registered environmental health specialist examination, as specified. Authorizes the specified training to be cumulative and scheduled at the discretion of the employing agency over this period. [HSC § 106670]

11) Prohibits an applicant who twice fails to pass the written REHS examination from being eligible to be reexamined a third time until at least one year has elapsed from the date of the second examination. Prohibits an applicant who fails the third examination from being eligible to take the examination a fourth time until two years have elapsed from the date of the third examination. Prohibits thereafter the examination from being taken more frequently than once in two years. Requires reapplication to be made by submitting a new application with the required fee. [HSC § 106670]

12) Requires an Environmental Health Specialist Registration Committee (EHSRC) to be appointed to advise and to make recommendations to DPH. [HSC § 106675]

13) Prescribes the membership of the committee, including members with experience as local directors of environmental health, and the Chief of the Environmental Planning and Local Health Services Branch, who serves as executive officer in a nonvoting role. [*Ibid*.]

14) Prohibits the two public members of the committee from being engaged at any time within five years immediately preceding their appointments in pursuits that lie within the field of environmental health or the profession regulated by the committee of which they are members. [HSC § 106675]

15) Prescribes the terms of the committee members, as specified, and authorizes a committee member to serve no more than two successive terms, and further requires each member to serve on the committee until the appointment and qualification of their successor or until one year has elapsed since the expiration of the term for which they were appointed, whichever is later. [HSC § 106680]

16) Requires the Environmental Health Specialist Registration Committee to meet at least twice annually and at other times as it may determine to evaluate applications for registration as environmental health specialists, to review and update examinations to prepare and recommend reports relative to the administration of this article, and to transact all other business as necessary. [HSC § 106685]

17) Requires six members to constitute a quorum of the EHSRC. [HSC § 106685]

18) Requires DPH to maintain a current registry of all REHS and all EHS trainees in the state. [HSC § 106690]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, Registered Environmental Health Specialists (REHS) play a critical role in protecting public health. The author states that REHS help ensure that the places we eat, the water we drink, and the places we live comply with health and safety standards so that we can enjoy our daily lives free from hazards caused by unsanitary or dangerous conditions. The author contends that this bill provides much-

needed updates to the REHS trainee experience that will help retain and train skilled, science-focused professionals. The author states that this bill will strengthen California's public health organizational infrastructure, improve regulatory efficiency, and ensure that these professionals have the training and experience necessary to not just succeed, but also excel in their official positions once they pass their exams. The author concludes that evolving health and safety conditions require a workforce that can evolve with them and this will help our REHS meet those challenges head on.

2) BACKGROUND.

a) What do REHS do? A REHS is a professional who is responsible for protecting public health and the environment by ensuring compliance with laws and regulations related to environmental health. This may include inspecting and enforcing regulations related to food safety, water and air quality, and hazardous waste management. REHSs also play a crucial role in educating the public and businesses about environmental health issues and providing guidance on how to maintain a healthy and safe environment. REHS' may work in a variety of settings, including government agencies, private businesses, and non-profit organizations.

b) The REHS program. The REHS program is administered by the Environmental Management Branch of DPH. The REHS program ensures that REHSs have met prescribed education, training, and experience requirements and have passed a comprehensive examination reflective of the demands encountered within the environmental health profession. According to DPH's website, the minimum requirements include a Bachelor's degree from a four year college including 30 semester units of basic science coursework (courses must be for "science" or "biology" majors); up to 18 months experience depending on education and training typically at a local county environmental health department; and, passage of a comprehensive exam held three times a year in the Sacramento and Los Angeles areas.

c) REHS Ad Hoc Committee. According to information provided by the California Conference of Directors of Environmental Health (CCDEH, co-sponsor of this bill), at the beginning of January 2025, CCDEH convened an Ad Hoc Committee to review the REHS statutes and build consensus on changes which would modernize the code and ease hiring hurdles at the local level. The 20-member committee is comprised of eight voting members (two members from each of CCDEH's four geographic regions); the CCDEH Executive Committee and partner organizations, including the County Health Executives Association of California, California Conference of Local Health Officers, and the California Environmental Health Association. The committee met weekly and moved systemically through the code, identifying sections that are producing hurdles to hiring and proposing new language to minimize the hurdles. Proposed changes were taken back to the environmental health (EH) directors in each region for approval which the voting members then used to cast their votes to recommend the changes to the CCDEH Executive Council proposed by this bill.

d) CCDEH Survey. The CCDEH Ad Hoc Committee conducted a survey in February 2025 of EH Directors to better understand hiring obstacles. Sixty-one percent of EH Directors responded to the survey. The number of trainees employed by jurisdictions ranged from zero to 56 with the most frequent number being four. Eighty-four percent of jurisdictions

reported hiring REHSs within the last five years, with the number of hired trainees ranging from 0 to 46. The median number of trainees hired by jurisdictions was 3.5. However, 18% of jurisdictions reported having to release trainees in the last five years because trainees could not pass the REHS exam; the number of released trainees ranged from one to six. Two jurisdictions reported being able to re-assign trainees to other positions. Respondents were asked to identify the primary reasons that trainees could not pass the REHS exam; the top reasons were:

i) REHS exam is not reflective of REHS real-world job tasks;

ii) Trainee struggled with test-taking in general; and,

iii) Trainee was not personally committed to preparing for the exam.

e) Ad Hoc Committee Recommendations. According to the CCDEH Ad Hoc Committee, its findings suggest a variety of changes in REHS statute and DPH implementation in order to increase to address the REHS workforce shortage, including the below**.**

i) Modernize REHS exam procedures so that it is easier for trainees to take the test, including increasing exam frequency, removing restrictions which limit the number of times a trainee can take the exam; and modernizing the testing procedure by moving from a pen-and-paper test to an online test.

This bill allows applicants to retake the exam 90 days after failing it in order to provide trainees with more frequent opportunities to take the exam.

ii) Update the form and content of the REHS exam to be more reflective of current REHS duties and topic areas and restructure the exam so it can be administered online.

This bill updates the lists of primary and secondary training plan topics and maintains the requirement for a training log but remove the 'daily' frequency. The author's intent is to allow jurisdictions to better align their on-the-job training programs (dictated by statute) with job tasks and REHS exam topics and enable better preparation of trainees for the exam.

iii) Improve the operating efficiency of the REHS Committee which advises DPH on exam content, educational requirements, and oversees REHS disciplinary actions.

This bill makes various updates to the REHS Committee with the intent of improving its operating efficiency. One of the changes is the increased frequency of the committee meetings from at least twice a year to at least quarterly, which the author and sponsors contend would allow the committee to make more timely decisions on REHS Exam content. Another change is revised definition of a quorum to make it a simple majority of seated members, which the author and sponsors suggest would make it easier to achieve a quorum.

Additionally, while existing law requires DPH to maintain a current registry of all REHS and environmental health specialist trainees, this bill further requires DPH to

post the REHS registry within 90 days of each exam, with the intent of providing jurisdictions with timely access to the list of people who have passed the REHS Exam.

iv) **Update local REHS training requirements by increasing the number of environmental health topics which can be covered during required training hours.**

This bill revises and recasts the environmental health training elements to require training in at least three of the following primary elements, as well as any other primary element or any of the secondary elements. This bill further requires training in the selected primary elements to not be less than 20% of the total required training hours and requires additional training to not be less than 40% of the total required training hours

v) **Clarify educational requirements by allowing a larger number of college graduates with science degrees to be eligible for the REHS exam.**

Statute prescribes the educational requirements for prospective registered environmental health specialists. This bill revises the educational requirements for the registration of an REHS by striking the references to basic science and replacing it with a reference to science courses designated for science or clinical health care degrees by the educational institution in order to meet the previously stated intent and adds a bachelor's degree in environmental health from a National Environment Science & Protection Accreditation Council approved institution as an acceptable option under Option V of existing law as prescribed.

f) **What is the challenge with the existing employment period for a REHS trainee?** According to information provided by the author and sponsors, the current three-year maximum employment period for environmental health specialist trainees is creating significant recruitment and retention challenges for local health and environmental health departments. There are limited opportunities to take the state-administered exam required to become an REHS, and trainees who fail the required exam within this period must be released from employment or reassigned, leading to a loss of qualified, science-based staff. This has forced local departments across the state to release their trainees, in which they have invested a substantial amount of time, money, and effort, from employment if they cannot pass the exam within three years. This bill extends the maximum training period from three years to five years to provide more time for trainees to prepare for and pass the exam and makes updates to the certification and training process with the intent of helping to retain the skilled environmental health professionals needed to protect public health.

g) **Scope of REHS.** This bill clarifies that body art and medical waste is within the scope of practice of registered environmental health specialists.

3) **SUPPORT.** The County Health Executives Association of California (CHEAC) and California Association of Environmental Health Administrators (CAEHA) are the co-sponsors of this bill and state that certification for the REHS program is administered by DPH. The program ensures that certified REHS's have met adequate education, training and experience requirements and have passed a comprehensive state examination. While working

towards certification, individuals may be employed as a REHS trainee by local health/environmental health departments for up to three years. However, limited examination offerings and strict time limitations governing how often a trainee may take the exam have resulted in trainees being reassigned or released – even if they wish to continue to pursue a career as a certified REHS. The current state exam passage rate averages around 60%. The co-sponsors note that this bill supports strengthening and sustaining the REHS workforce pipeline by extending the time needed to pass the REHS exam, increasing REHS testing opportunities, enhancing local training plans, and modernizing REHS educational requirements. They continue that this bill also provides more opportunities for entry-level employees to continue their careers with local health departments/environmental health departments.

4) **POLICY COMMENT.** This bill changes the requirement for REHS Program applicants from completing specified quantities of units from basic science courses to instead completing specified quantities of units from science courses designated by the educational institution for science or clinical degrees. Given variances between educational institutions, their curriculum, and how they designate science courses for science or clinical health care degrees, this language appears to require interpretation by DPH and could prompt regulations. As this bill moves forward, the author and sponsors should consider continuing to work with DPH to ensure the effective implementation of this proposal.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County
American Federation of State, County and Municipal Employees, AFL-CIO
Butte County Public Health Department
California Environmental Health Association
California State Association of Counties (CSAC)
California State Council of Service Employees International Union (SEIU California)
Contra Costa County
County Health Executives Association of California (CHEAC)
Del Norte County Department of Health and Human Services
El Dorado County Environmental Management Department
Environmental Health Services of the County of San Luis Obispo
Health Officers Association of California
Humboldt County
Kings County Department of Public Health
Lassen County
Los Angeles County Department of Public Health
Monterey County
Monterey County Health Department
Rural County Representatives of California (RCRC)
Sacramento County
San Diego County
San Mateo County Board of Supervisors
Sierra County Public Health
Sonoma County Department of Health Services

Tulare County Health and Human Services Agency
Urban Counties of California (UCC)
Yolo County

Opposition

None on file

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1328 (Michelle Rodriguez) – As Amended April 10, 2025

SUBJECT: Medi-Cal reimbursements: nonemergency ambulance transportation.

SUMMARY: Requires Medi-Cal fee-for-service (FFS) reimbursement for nonemergency ambulance transportation services to be in an amount equal to the amount set forth in the federal Medicare ambulance fee for the corresponding level of service, beginning on January 1, 2026. Makes the rate increase subject to an appropriation by the Legislature. Specifically, **this bill**:

1) Requires Medi-Cal FFS reimbursement for nonemergency ambulance transportation services to be in an amount equal to the amount set forth in the federal Medicare ambulance fee schedule established pursuant to a specified provision of federal law, for the corresponding level of service.

2) Requires this Medi-Cal reimbursement increase to begin on January 1, 2026, and to be subject to an appropriation made by the Legislature to fund, in whole or in part, the reimbursement levels.

3) Requires the nonemergency ambulance transportation services reimbursement to be adjusted by the Geographic Practice Cost Index under the federal Centers for Medicare and Medicaid Services, specific to the area of California in which the services are provided.

4) Requires Department of Health Care Services (DHCS) to maximize federal financial participation (FFP) in implementing this bill to the extent allowable, and requires DHCS to claim FFP to the extent that DHCS determines it is available.

5) Requires DHCS, to the extent that FFP is unavailable, to implement this bill using state funds, if appropriated.

6) States legislative intent that the appropriation described above be sufficient to fund the reimbursement levels in whole.

7) Permits DHCS to implement, interpret, or make specific this bill, in whole or in part, by means of plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action pursuant to the Administrative Procedures Act.

8) Defines “nonemergency ambulance transportation services” to mean nonemergency medical transportation services, as described in a specified provision of Medi-Cal regulations, which are conducted by ground ambulance. Excludes from the definition of “nonemergency ambulance transportation services” emergency medical transport services, as defined in a specified provision of existing law.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which health care services are provided to qualified low-income persons. [Welfare & Institutions Code (WIC) § 14000, *et seq*.]

2) Establishes a schedule of benefits under the Medi-Cal program, which includes emergency and non-emergency medical transportation. [WIC § 14132]

3) Requires, pursuant to state Medi-Cal regulation, all nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's or podiatrist's prescription and prior authorization except as provided in 6) below [Title 42, California Code of Regulations § 51326].

4) Permits, when the service needed is of such an urgent nature that written authorization could not have reasonably been submitted beforehand, the medical transportation provider to request prior authorization by telephone, and requires such telephone authorization to be valid only if confirmed by a written request for authorization. [*Ibid.*]

5) Requires transportation to be authorized only to the nearest facility capable of meeting the patient's medical needs. [*Ibid.*]

6) Exempts nonemergency transportation services from prior authorization when provided to a patient being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility. [*Ibid.*]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is critical because it will help ensure that Medi-Cal patients can receive the transports they often desperately need. This bill accomplishes this important goal by raising the reimbursement rate for an industry that has been hurting for two decades. Without an increase, ambulance services will continue to degrade in rural and impoverished communities. The author concludes that this would leave a significant gap in the healthcare system and negatively affect the patients and communities who need the transports the most.

2) BACKGROUND. Non-emergency medical transportation **(**NEMT) is transportation by ambulance, wheelchair van, or litter van for beneficiaries who cannot use public or private transportation to get to and from covered Medi-Cal services, and who need assistance to ambulate. This bill applies to rates for NEMT via ambulance transport. NEMT is available to all beneficiaries when their medical and physical condition does not allow them to travel by bus, passenger car, taxicab, or another form of public or private transportation. Services must be prescribed by a health care provider.

3) AMERICAN AMBULANCE ASSOCIATION SURVEY, MEDICARE, AND MEDI-CAL RATES. According to the American Ambulance Association's (AAA) 2025 State Medicaid Rate Survey, the national average Medicaid reimbursement for ambulance transport is $259.91. California's average rate is $111.07, a difference of $148.84 per transport (AAA 2025 Survey).

Medi-Cal base ambulance rates (including nonemergency ambulance transportation rates) were reduced in 2008 and again in 2013 (by 10%) pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. The 10% reduction took effect for ground

nonemergency ambulance providers for dates of service on or after September 5, 2013 but was not applied retroactively back to June 2011. The AB 97 rate reduction for non-emergency medical transportation providers was repealed by SB 184 (Committee on Budget), Chapter 47, Statutes of 2022, the 2022 health budget trailer bill.

As shown in the chart below, Medicare and Medi-Cal rates differ substantially in the dollar amount of base rates, with Medicare paying much higher base rates. Unlike Medicare, Medi-Cal pays augmentations that Medicare does not, such as an additional payment amount for services at night, for wait times, the use of electrocardiogram (EKG or ECG) or oxygen, or for an extra attendant and for a patient needing a wheelchair.

Medicare and Medi-Cal Rates				
Service Provided	Reimbursement Code	Medicare Rate	Medi-Cal Rate	Percentage Increase to Medi-Cal Rates
Basic Life Support (BLS) Non-Emergency Response	A0428	$ 318.87	$ 107.16	198%
Advance Life Support (ALS) Non-Emergency Response	A0426	$ 380.24	$ 107.16	255%
Mileage	A0425	$ 8.97	$ 3.55	153%

4) **MANAGED CARE ORGANIZATION TAX AND PROPOSITION 35**. The Legislative Analyst's Office (LAO) February 26, 2025 publication titled "*The 2025-26 Budget – MCO Tax and Proposition 35*" describes the state's Managed Care Organization (MCO) tax, the legislatively adopted spending plan, and the voter-approved MCO spending plan changes made by Proposition 35. The LAO states the MCO tax currently generates more than $12 billion in gross revenue annually, but less than $8 billion in net revenue is available to the state to spend. This is because of a state arrangement that covers each health plan's cost of paying the tax on Medi-Cal enrollment. The Legislature most recently renewed the MCO tax in the 2023-24 budget, extending it through the end of 2026. As part of this renewal, the Legislature notably increased the size of the tax. As a result, the increase reflected substantially more federal funding to the state. With a much larger tax in place, the Legislature also changed how it used the MCO tax. The legislative plan still primarily focused on the Medi-Cal program, but with two key uses:

   a) **Supporting Existing Medi-Cal Program (Offsetting General Fund Spending)**. A portion of MCO tax revenue was to support existing service levels in the Medi-Cal program—the historic use of the MCO tax. This use would continue freeing up General Fund spending for other purposes.

   b) **Supporting Augmentations**. The remaining portion of MCO tax revenue was to support health program augmentations—a new use of MCO tax funds. Most were increases for Medi-Cal provider rates, such as rates for physician and hospital services, and also including non-emergency medical transportation. Beginning January 1, 2026, rate

increases were authorized for non-emergency medical transportation in an amount expected to be $13 million in 2025-26 and $25 million in 2026-27 and annually thereafter, to support these rate increases. A few augmentations also supported certain health programs outside of Medi-Cal, such as workforce initiatives at the University of California (UC) and the Department of Health Care Access and Information (HCAI).

When the Legislature adopted its revised MCO tax spending plan in 2024-25, the trailer bill included trigger language ending the planned augmentations in the event voters approved Proposition 35. Voters subsequently approved Proposition 35 in November 2024, ending the state's previous spending plan and discontinued several legislative augmentations made using MCO funds. Proposition 35 made the MCO permanent under state law and created new rules around how to spend the resulting MCO tax revenue.

5) **SUPPORT.** This bill is sponsored by the California Ambulance Association (CAA), which represents the interests of emergency and non-emergency ambulance service providers. CAA states SB 159 (Committee on Budget), Chapter 40, Statutes of 2024, the health budget trailer bill provided funding through the MCO tax to fund inter-facility transports, aiming to address long-standing gaps in Medi-Cal reimbursement. However, later in 2024, Proposition 35 altered the distribution of funds and effectively nullified those changes and allocations. CAA states this reversal exposed a critical flaw in current law: the Medi-Cal reimbursement rate for non-emergency and inter-facility ambulance transports has not been updated since 1999. CAA states that, for over two decades, providers have operated under a stagnant rate structure that no longer reflects the true cost of care, which jeopardizes timely patient transfers, straining hospital systems, and placing vulnerable patients at risk. CAA states the erosion of inter-facility transport services is already being felt across California. In many of the state's most vulnerable and rural communities, inter-facility providers have ceased operations altogether. Even in urban areas, access is shrinking, resulting in dangerous gaps in care. Without a reliable transport network, patients are losing access to life-sustaining treatment, while ambulance offload delays and emergency system strain continue to escalate.

   CAA argues that, if this trend continues, the consequences will be far-reaching. Non-emergency ambulance transportation is a vital link in California's continuum of care, especially for seniors, people with disabilities, and low-income patients who rely on timely transport for dialysis, chemotherapy, rehabilitation, and safe transfers between hospitals and skilled nursing facilities. Delays or disruptions in these services lead to avoidable hospital readmissions, worsened health outcomes, longer patient offload delays, and increased reliance on emergency departments already stretched thin. This growing gap in access threatens the equity and quality of California's health care delivery system and directly undermines the state's broader Medi-Cal transformation and public health goals. CAA states this bill is a critical step toward reversing this trend by raising the Medi-Cal reimbursement rate for inter-facility transports, which will bring long-overdue relief to an industry that has gone two decades without an update.

   The California Chapter of the American College of Emergency Physicians (Cal-ACEP) writes that emergency departments (EDs) are not staffed with all specialists on site 24 hours a day seven days a week. Cal-ACEP states that it is common for a patient to seek care in an ED and, after a medical screening exam and initial care by an emergency physician, need specialty care not available in that hospital. In these instances, the emergency physician will transfer the patient to another facility with the necessary specialist, but the timeliness of the

transfer is partially dependent on the availability of appropriate transportation. Ambulance services are not bound to the federal Emergency Medical Treatment and Active Labor Act for the purposes of inter-facility transport and can decline to provide transportation if there is not a guarantee of payment. Emergency physicians across California see the effects of delayed transfers on the patients they treat. Patients' conditions can deteriorate while ED physicians are working to coordinate a transfer to an appropriate facility. Cal-ACEP states this bill is an important step towards increasing access to transfers for California's most vulnerable by ensuring that inter-facility transfers are appropriately reimbursed.

6) PREVIOUS LEGISLATION.

a) AB 55 (Rodriguez) of 2023 would have established a "workforce adjustment" supplemental Medi-Cal payment for emergency and non-emergency ambulance services, to establish overall payment for ambulance services at 80% of the lowest maximum allowance established by the federal Medicare Program for the applicable base rate and mileage rate for the transportation service in the ZIP Code of the point of pickup for ambulance services provided by private medical transportation providers who raise wages for several classes of employees. Specified the new payments are in addition to base Medi-Cal payments and "add-on" payments made through an existing supplemental payment program. AB 55 was held on the Assembly Appropriations suspense file.

b) AB 2436 (Mathis) would have required DHCS to establish payment rates for Medi-Cal ground ambulance services based on changes in the Consumer Price Index-Urban. AB 2436 was held on the Assembly Appropriations Committee suspense file.

7) POLICY COMMENTS.

a) Budget Issue. The Committee should consider whether imposing new ongoing GF costs for nonemergency ambulance transportation services is a priority in an uncertain budget time, and whether this should be considered through the budget process.

b) Reimbursement Level. This bill proposes the Medi-Cal reimbursement be at 100% of the Medicare level. As drafted, it is unclear whether the existing add-ons that Medi-Cal reimburses (such as electrocardiograms, oxygen and others) would continue to apply on top of the new rates that are tied to Medicare. In addition, the increases to existing Medi-Cal base rate amounts would be significant, increasing the current Advance Life Support and Basic Life Support Medi-Cal rates by 198% and 255% respectively, and increasing the mileage rate by 153%. In addition, tying the Medi-Cal rate to 100% of Medicare is out of step with most other Medi-Cal payments. For instance, according to Kaiser Family Foundation's 2019 Medicaid-to-Medicare Fee Index for physician services, California's physician rates were at about 73% of Medicare's rates.

Last session, AB 55 (Rodriguez) was amended in the Assembly Health Committee to establish overall payment for ambulance services at 80% of the lowest maximum allowance established by the federal Medicare Program for the applicable base rate and mileage rate for the transportation service in the ZIP Code of the point of pickup. The author may wish to consider increasing the reimbursement rate in this bill to 80% of the applicable Medicare rate.

c) **Amendment to Apply Rate Increase to Medi-Cal managed care (MCMC) plans.** As drafted, this bill increases FFS Medi-Cal rates. However, over 95% of Medi-Cal enrollment is enrolled in MCMC plans. Following discussions, the author is proposing to apply the Medi-Cal FFS rate increase to MCMC plans.

REGISTERED SUPPORT / OPPOSITION:

Support

California Ambulance Association (sponsor)
California Chapter of the American College of Emergency Physicians
County of Sacramento

Opposition

None on file

Analysis Prepared by: Scott Bain / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1356 (Dixon) – As Introduced February 21, 2025

SUBJECT: Alcohol and other drug programs.

SUMMARY: Requires a licensed alcohol or other drug (AOD) recovery or treatment facility (RTF) to submit a report to the State Department of Health Care Services (DHCS) within 60 days of an incident involving the death of a resident that describes the follow up action plan that was implemented and provides any relevant information that was not known at the time of the initial incident or that was known but was not provided to DHCS in the initial report.

EXISTING LAW:

1) Requires DHCS' RTF death investigation policy to be designed to ensure that a resident's death is addressed and investigated in a timely manner. Requires a licensed RTF to report to DHCS, at a minimum, the following: the time, location, and nature of the event or incident; a list of immediate actions that were taken, including persons contacted; and a description of the follow up action that is planned, including, but not limited to, steps taken to prevent a future death. [Health and Safety Code (HSC) § 11830.01]

2) Specifies that a telephonic report, containing the event or incident and all the information in 1) above that is known at the time, must be submitted within one working day of the incident. Specifies that a written report containing this information must be submitted within seven calendar days of the incident. [HSC § 11830.01(c)-(d)]

3) Establishes DHCS as the sole licensing authority for RTFs. Permits new licenses to be issued for a period of two years and requires DHCS to conduct onsite program visits for compliance at least once during the two-year licensing period. [HSC § 11834.01]

4) Defines RTF to mean a premises, place, or building that provides residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or addiction, and who need alcohol, drug, or alcohol and drug recovery, treatment, or detoxification services. [HSC § 11834.02]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill will require a facility which offers a drug and alcohol program to provide a subsequent report to DHCS within 60 days of the death a resident at the facility with updated information on the events surrounding the resident's death and on the facilities follow-up action plan to prevent future incidents occurring. The author states that this bill provides a practical solution to strengthen the DHCS's death investigation policy, provide DHCS with the necessary information to properly regulate and oversee facilities which offer drug and alcohol programs, and improve the safety of those residents within the facilities who are receiving treatment.

2) BACKGROUND.

a) Prevalence of Substance Use Disorders (SUD) in California. A 2024 publication from Health Management Associates and the California Health Care Foundation, titled "*Substance Use Disorder in California — a Focused Landscape Analysis*" reported that approximately 9% of Californians ages 12 years and older met the criteria for SUD in 2022. According to the report, the prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015. While the health care system is moving toward acknowledging SUD as a chronic illness, only 6% of Americans and 10% of Californians ages 12 and older with an SUD received treatment for their condition in 2021. More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021, and the total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 to 2021.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. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California.

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 to 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 recovery residences with six or fewer beds that don't provide licensable services.

c) State Audit. In October 2024, the State Auditor released a report assessing the licensing of residential RTFs by DHCS. Key findings from the audit include:

i) Southern California contains a greater concentration of treatment facilities serving six or fewer residents (small facilities) than other parts of the state. However, state law allows facilities to be located near each other and have the same legal owners.

ii) DHCS consistently reviewed the 26 license applications that were assessed, and the application process is generally the same for all facilities. However, of the 26 compliance inspections of operating facilities that were reviewed, DHCS conducted only half of them on time.

iii) DHCS also took longer than its target of 30 to 60 days to investigate complaints against treatment facilities. For instance, it took more than a year to complete 22 of the 60 investigations reviewed in the audit. Additionally, DHCS did not always follow up on unlicensed facilities that it found were unlawfully advertising or providing services. SB 35 and SB 329 in Related Legislation below respond to this issue.

Based on these findings, the audit makes several operational recommendations to DHCS, including the following:

i) Provide management with information about the timeliness of compliance inspections and implement processes for notifying responsible staff of upcoming compliance inspections;

ii) Implement guidelines that specify the length of time analysts should take to complete key steps in the investigation process; and,

iii) Develop and implement a follow-up procedure when it has substantiated allegations of an unlicensed facility providing services.

In response to the audit, DHCS has made several operational changes. According to the State Auditor’s website, DHCS will create and implement new protocols and processes as well as schedule and conduct the appropriate trainings to ensure supervisors are closely tracking the programs in need of inspections within their two-year windows. DHCS will also begin using a new digital platform to complete onsite inspection reports, which will aid DHCS in sending providers reports more quickly, thereby improving the rate at which assignments are completed. Also, in August 2024, DHCS revised its Complaints Operations Manual to clarify the requirement for case assignment within 10 days and updated the complaint intake process.

d) DHCS Complaint Process. According to DHCS, the Licensing and Certification Division (LCD) oversees and conducts complaint investigations against California's AOD recovery and treatment programs. This includes general allegations against a program, allegations of unlicensed or uncertified activity, and client deaths that occur at licensed facilities. LCD also investigates allegations of misconduct by registered or certified AOD counselors that work at licensed AOD programs.

Upon receiving a complaint via phone, email, fax, mail, or online, DHCS establishes whether the complaint is within its jurisdiction. If DHCS receives a complaint that does not fall under its jurisdiction, it sends a letter to the complainant informing them that it does not investigate that type of complaint. If the complaint is under DHCS jurisdiction. it is logged, assigned a complaint number, and a high, medium or low-level designation. Receipt of a complaint is acknowledged through written communication with the complainant. Upon opening a complaint, complainants are asked if they would like a Public Records Act (PRA) request opened on their behalf. If they have the request

opened, they would receive a copy of the report via email through the PRA process; only then would the complainant be notified with the outcome of their complaint.

Once assigned, an analyst will contact the program in question, review documents and records relevant to the complaint, and, if necessary, conduct an on-site visit to gather evidence, inspect facilities, and conduct interviews. An investigative report is issued, outlining whether an allegation was substantiated, and if any additional findings were discovered throughout the course of the investigation. If any deficiencies are identified and substantiated, programs may be subject to a Notice of Deficiency, requiring a Corrective Action Plan or Verification of Correction and civil penalties for failure to respond timely to a Notice of Deficiency.

Deficiencies can result in DHCS action to suspend or revoke a program's licensure. If no deficiencies are found, the complaint report would be issued with allegations marked as "not substantiated," and no additional deficiencies would be indicated on the report.

3) **SUPPORT.** Orange County supports this bill stating it is a commonsense solution to strengthen the DHCS's death investigation policy, provide DHCS with the necessary information to properly regulate and oversee facilities which offer drug and alcohol programs, and improve the safety of those residents within the facilities who are receiving treatment.

Capo Cares also supports this bill stating that it treats deaths at licensed facilities with the seriousness they warrant. Capo Cares says the public should be able to expect that any deaths are thoroughly investigated, that causes are determined, and that where neglect or abuse is apparent, steps are taken to ensure that harmful facilities are closed and that safeguards are put in place to prevent further harm or even more deaths.

4) **RELATED LEGISLATION.**

a) AB 424 (Davies) would require DHCS to provide, within 10 days of the receipt of a complaint from a member of the public against an RTF, or a complaint alleging that a facility is unlawfully operating without a license, notice to the person filing the complaint that the it has been received and to provide them notice that the complaint has been closed and whether DHCS found the facility to be in violation. AB 424 is pending in the Assembly Health Committee.

b) SB 35 (Umberg) would require DHCS to initiate an investigation into unlicensed operation of an RTF within 10 days of receiving the allegation and complete the investigation within 60 days of initiating the investigation. Requires an employee or agent to provide the notice within 10 days of submitting their findings to DHCS and to conduct a follow up site visit to determine whether the facility has ceased providing services. Authorizes these provisions to be enforced by the city attorney of a city in which the facility is located, or by the county counsel or the county behavioral health agency if the facility is located in the unincorporated area of the county, if DHCS fails to initiate or conclude the investigation in accordance with these time limits. SB 35 is pending in the Senate Health Committee.

c) SB 43 (Umberg) would require all programs certified and all facilities licensed, no later than July 15, 2026, and annually each July 15 thereafter, to submit to the department a

report of all money transfers between the program or facility and a recovery residence during the previous fiscal year. SB 43 is pending in the Senate Health Committee.

d) SB 329 (Blakespear) would require DHCS to assign a complaint under its jurisdiction regarding an RTF to an analyst for investigation within 10 days of receiving the complaint and to complete an investigation within 60 days of assigning the complaint, unless specified circumstances exist, and notify the complainant if the investigation is not able to be completed within 60 days. SB 329 is pending in the Senate Appropriations Committee.

5) PREVIOUS LEGISLATION.

a) AB 2081 (Davies), Chapter 376, Statutes of 2024, requires entities licensed or certified by DHCS to include on their websites and intake paperwork a disclosure stating an individual may check DHCS's website to confirm any actions taken against the entity.

b) AB 381 (Davies), Chapter 437, Statutes of 2021, requires licensed RTFs to have at least two unexpired doses of naloxone on site and to have one staff member on premises that is trained to administer.

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 contracts with privately owned recovery residence or RTF serving more than six residents to require the contractors to, at all times, maintain specific insurance coverage.

d) SB 992 (Hernández), Chapter 784, Statutes of 2018, requires programs licensed or certified by DHCS to disclose business relationships with recovery residences, prohibits RTFs from denying admission solely on the basis of an individual having a medication for assisted treatment prescription, and requires RTFs to develop relapse plans.

6) COMMITTEE AMENDMENTS. Given that there may be no additional need for specific follow up if there is no deficiency found in the facility's plan and response to an incident involving a death, the committee may wish to amend this bill to require the follow up requirement within 60 days of a completed investigation rather than the incident itself, and require the submission of follow up actions contingent upon the finding of a deficiency by DHCS.

REGISTERED SUPPORT / OPPOSITION:

Support

Capo Cares
County of Orange

Opposition

None on file

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Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1415 (Bonta) – As Introduced February 21, 2025

SUBJECT: California Health Care Quality and Affordability Act.

SUMMARY: Adds private equity groups and hedge funds to the types of entities required to report to the Office of Health Care Affordability (OHCA) on pending health care transactions. Defines and adds "health systems," as well as entities that own other providers such as hospitals and physician groups, to the definition of provider under OHCA, and similarly defines and adds "management services organizations" (MSOs) to the definition of health care entity, thereby subjecting these newly defined entities to data reporting, health care cost targets, and notification about pending health care transactions under OHCA's authority. Specifically, **this bill**:

1) Defines the following terms:

    a) A "health system" as including:

        i) A hospital system;

        ii) A combination of one or more hospitals and one or more physician organizations; or,

        iii) A combination of one or more hospitals, one or more physician organizations, or one or more health care service plans or health insurers.

    b) A "hedge fund" as a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of the strategies used to manage the funds, as specified.

    c) A "private equity group" as an investor or group of investors who primarily engage in the raising or returning of capital and who invest, develop, dispose of, or purchase any equity interest in assets, as specified. Exempts specified entities from the definition.

    d) An MSO as an entity that provides administrative services or support for a provider, including, but not limited to, utilization management, billing and collections, customer service, provider rate negotiation, and network development.

2) Adds an MSO as a "health care entity," which makes them subject to data reporting, health care cost targets, and notification requirements that currently apply to health care entities.

3) Adds a health system as a "provider," which makes them subject to data reporting, health care cost targets, and notification requirements that currently apply to providers.

4) Adds an entity that owns, operates, or controls a provider, as defined, as a provider, which makes such an entity subject to data reporting, health care cost targets, and notification requirements that currently apply to providers.

5) Requires a private equity group, hedge fund, or any newly created business entity created for the purpose of entering into agreements or transactions with a health care entity, to notify OHCA of pending health care transactions, as specified.

EXISTING LAW:

1) Establishes the California Health Care Quality and Affordability Act, which creates OHCA within the Department of Health Care Access and Information (HCAI). Identifies OHCA's 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 (Board). [Health and Safety Code (HSC) § 127500 *et seq*.]

2) Requires the Board to collect and analyze data from existing and emerging public and private data sources that allow OHCA to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions, as specified. [HSC § 127501 (c)(4)]

3) For purposes of OHCA's activities:

    a) Defines "health care entity" as any of the following: a payer (generally plans and insurers), fully integrated delivery system (a system where physicians, facilities, and a health plan is integrated), or a provider.

    b) Defines "provider" as any of the following: a physician organization; health facility such as a hospital, clinic, and ambulatory surgery center or accredited outpatient setting; clinical laboratory; and imaging facility. [HSC § 127500.2]

4) Requires the Board to develop, apply, and enforce cost growth targets as follows:

    a) Requires the Board to establish an enforceable statewide health care cost growth target percentage (cost growth target) per calendar year, based on a methodology that is transparent and publicly available, that considers economic indicators or population-based measures and is periodically updated. [HSC § 127502 (a) and (b)]

    b) Requires cost growth targets to promote affordability while maintaining quality and equitable care; include consideration of the impact on persons with disabilities and chronic illness; promote the stability of the health care workforce, including workforce development; and be adjusted to account for cost growth due to projected growth in organized labor costs, as specified. [HSC § 127502 (c)]

    c) Allows the Board to define sectors and adjust cost growth targets for sectors, as specified. [HSC § 127502 (b) and (l)]

    d) Requires the board to apply and enforce cost growth targets for compliance, beginning with targets that apply for the 2026 calendar year. [HSC § 127502]

e) Exempts the adoption of cost growth targets from the Administrative Procedures Act. [HSC § 127502 (n)]

f) Authorizes OHCA to take progressive enforcement actions to enforce cost growth targets, including providing technical assistance, compelling public testimony by the health care entity, requiring performance improvement plans, and assessing administrative penalties, as specified. Allows OHCA to assess administrative penalties when an entity fails to report data or is otherwise non-compliant, as specified. [HSC § 127502.5 (a) and (h)]

g) Authorizes the Board to consider standards to advance the stability of the health care workforce in the setting of cost targets or in the approval of performance improvement plans. [HSC §127506]

5) Requires OHCA to collect and publicly report information on health care transactions, as follows:

a) Requires OHCA to monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. [HSC § 127507(a)]

b) Requires OHCA to promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. [HSC § 127507 (a)]

c) Requires OHCA to prospectively analyze transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. [HSC § 127507 (a)]

d) Requires OHCA to adopt regulations specifying the threshold for material changes that warrant a notification. [HSC § 127507 (c)]

e) Requires OHCA to conduct a cost and market impact review if it finds a material change, as specified, is likely to have a risk of a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers, and authorizes OHCA to conduct a cost and market impact review under other specified circumstances, including for transactions reviewed and referred to OHCA by another state agency. Allows OHCA to recoup reimbursement from the health care entity for the cost of the cost and market impact review. [HSC § 127507.2]

6) Requires a health care entity to provide OHCA with written notice of agreements or transactions to sell or otherwise transfer control of the health care entity, as specified, to one or more entities, subject to certain specified exemptions for transactions involving counties or entities subject to review by other state agencies. Requires notice be provided 90 days prior to entering into the agreement or transaction. [HSC § 127507 (c)]

7) Specifies OHCA is entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of the requirement specified in 6), above, to report on health care transactions, in addition to any legal remedies, as specified, and entitles OHCA to recover any cost incurred in remedying violations. [HSC § 127507.6]

8) Establishes definitions and requirements related to health care spending targets, including data submission to OHCA. [Title 22, California Code of Regulations (CCR) §§ 97445-99749]

9) Establishes definitions and requirements related to "material change transactions" involving health care entities and pre-transaction review. [Title 22, CCR §§ 97431-97432]

10) Provides for the licensure and regulation of physicians and surgeons by the Medical Board of California (MBC) pursuant to the Medical Practice Act (Act) and Osteopathic Medical Board of California pursuant to the Osteopathic Act. [Business and Professions Code (BPC) § 2000 et seq. and BPC §§ 2450-2459.7.]

11) Prohibits the "corporate practice of medicine" by requiring a license to practice medicine and stating, with certain narrow exceptions, that corporations and other artificial legal entities shall have no professional rights, privileges, or powers. [BPC § 2502 and § 2400]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, health care costs continue to rise, placing an increasing burden on families, employers, and our state's budget. That is exactly why the Legislature created OHCA—to ensure California is not just expanding access to care, but also making it affordable and sustainable. Under its existing authority, OHCA can review health care transactions involving private equity and hedge funds, however, only the health care entities involved are required to provide notice and documentation to OHCA for their cost and market impact review. OHCA cannot collect information from the private equity groups and hedge funds directly. The author notes that private equity and hedge fund transactions in health care have accelerated, and between 2019 and 2023, private equity transactions of health care providers in California totaled $4.31 billion, roughly one-third of all health care deals. Like other health care mergers, private equity and hedge fund transactions drive up prices for consumers, and have resulted in negative impacts on quality and access for consumers, with little regulation or oversight. By directly requiring private equity groups and hedge funds to file notices of material change transactions, this bill allows OHCA to conduct a more thorough review of the proposed transactions and their potential impact on market competition, access, affordability, quality, and even the health care workforce.

The author states that this bill will also help OHCA capture the transactions that impact health care market competition by adding health systems, and health care entities owned, operated, or controlled by other corporate entities to the definition of providers, and MSOs to

the definition of health care entities. By including health systems and MSOs as health care entities, this authorizes OHCA to collect data from health systems and MSOs, as well as subject both to spending cost-growth targets. The author concludes that as health care costs continue to grow, it is important we give OHCA the tools it needs to provide California and the Legislature with the information we need to understand and control rising health care costs.

2) BACKGROUND.

a) Health Care Costs and Cost Growth. The U.S. is a clear outlier in international comparisons of health care spending. Health spending is closely associated with a country's wealth, but according to the most recent Peterson-KFF Health System Tracker, even compared to wealthy countries, the U.S. spends about twice as much per person on health care than other wealthy countries. Health expenditures per person in the U.S. were $12,555 in 2022, which was over $4,000 more than any other high-income nation.

Health care cost growth has also significantly outpaced inflation in the United States. Since 2000, the price of medical care, including services provided as well as insurance, drugs, and medical equipment, has increased by 121.3%. In contrast, prices for all consumer goods and services rose by 86.1% in the same period. Generally, prices paid by private insurance are higher and rise more quickly than prices paid by public payers. [1]

b) Impact of High Health Costs and Cost Growth. High health care costs pose a burden for Californians. A 2024 survey conducted for the California Health Care Foundation (CHCF) found:

i) More than half of Californians overall (53%), and nearly 3 in 4 Californians with low incomes (74%), say they skipped or postponed care due to cost in the past year;

ii) More than a quarter of Californians (28%), and nearly half of Californians with low incomes (46%), report trouble paying medical bills;

iii) Close to 4 in 10 Californians (38%), and over half of Californians with low incomes (52%), report having medical debt; and,

iv) Eighty-two percent of Californians and 91% of Californians with low incomes say it's "extremely" or "very" important to reduce what people pay for health care.[2]

In addition to posing a burden on individuals, high and growing health care costs for insurance premiums are burdensome for employers that provide employer-sponsored insurance benefits. Labor organizations and researchers have also noted that growing health care costs for those who receive employer-sponsored insurance can crowd out wage growth for workers. A 2024 study published in JAMA Network Open, "*Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings*

[1] How does health spending in the U.S. compare to other countries? - Peterson-KFF Health System Tracker
[2] The 2024 CHCF California Health Policy Survey

Inequality Among US Families" found increasing health care premiums over several decades were likely associated with reduced annual earnings as well as increased income inequality. The article estimates that if the cost of employer-sponsored insurance had remained at the same proportion of the 1988 average compensation package, the median U.S. family with employer-sponsored insurance could have earned nearly $9,000 more in annual wages in 2019. In fact, labor organizations point out the actual impact on wages is even higher than the $9,000 estimated in the 2024 study, because the study does not account for the explosion in out-of-pocket costs. This trend toward higher out-of-pocket costs requires workers to fund a growing sum of their health care costs out of the portion of their compensation that is ostensibly received as wages. Out-of-pocket costs for insured individuals have risen as individuals and employers seek more affordable premiums. Plans with higher deductibles, copayments, and coinsurance have lower monthly premiums, but health care consumers face high and often unaffordable costs when they go to seek care.

Differential impacts by race also emerged in the study, because health care premiums as a percentage of compensation were significantly higher for non-Hispanic Black and Hispanic families than for non-Hispanic white families, meaning premium cost growth has a disproportionate impact on crowding out wage growth for these groups.[3]

A January 2024 report issued by the University of California, Berkeley Labor Center, "*Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability*," notes trends of higher premiums coupled with more common and larger deductibles have resulted in a serious erosion of job-based coverage affordability. In California, 77% of private-sector workers enrolled in coverage through their job had a deductible in 2022, up from just 33% in 2002. In 2022, the average deductible was $1,808 for single coverage and $3,659 for family coverage among private sector employer sponsored insurance.[4]

c) Why are Costs so High and Growing? A seminal article published in Health Affairs in 2003, "*It's the Prices, Stupid: Why the United States Is So Different from Other Countries*," showed that the U.S. spends significantly more on health care than any other country. However, on most measures of health services use, the United States was below the median for wealthy, developed peer countries. This suggested that the difference in spending is caused mostly by higher prices for health care goods and services in the U.S. This conclusion has been borne out by more recent studies, including a 2019 update to the original article in Health Affairs, and a 2018 study in JAMA, "*Health Care Spending in the United States and Other High-Income Countries*." The 2018 study also found the U.S. spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. The

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[3] Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families | Health Policy | JAMA Network Open | JAMA Network
[4] Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability

study concludes prices and administrative costs appeared to be the major drivers of the difference in overall cost between the U.S. and other high-income countries.[5]

The significantly higher cost of health care and overall outlay on health care in the U.S, as compared to peer countries, does not translate to better health outcomes overall. In 2023, Americans had a life expectancy of 78.4 years, compared to an average of 82.5 among peer countries. The U.S. also tends to significantly lag peer counties on other standard measures.[6] Although California performs slightly better on some health behaviors and outcome measures than the national average, this is likely more related to differences in targeted public health and clinical quality interventions, such as the state's groundbreaking tobacco control program and the California Maternal Quality Care Collaborative initiative, than what Californians spend on health care.[7],[8]

d) Excess Spending. In a 2020 report commissioned by CHCF, "*Getting to Affordability: Spending Trends and Waste in California's Health Care System*," an estimated 20% to 25% of all health care spending in California is "excess spending." This would equate to roughly $81 to $101 billion annually, according to estimates of state expenditures in 2020. The report estimates over 70% of all excess spending results from three factors: administrative complexity, pricing and market inefficiencies, and failure in care delivery and inadequate prevention.[9] This suggests there are significant cost efficiencies that could be found in the delivery of health care that could moderate high prices and cost growth without reducing health care access and quality. One of the key approaches to capture these efficiencies is to address market distortions that raise prices without corresponding health or other public interest benefits.

e) Consolidation and Concentration in California Health Care Markets. Because health care is paid for through many different public and private payers like Medicare, Medi-Cal, and commercial plans like UnitedHealthcare and Blue Shield, the market power of any one of these payers to negotiate lower prices with providers is limited. In a highly consolidated market of health care providers, negotiating fair prices is made even more difficult. Market concentration, including hospital and physician consolidation, has been proliferating in the state along with price acceleration, according to a 2019 CHCF report titled, "*Sky's the Limit: Health Care Prices and Market Consolidation in California*." As market concentration rises, so do prices.

The level of market concentration is also a major factor in the price differences between northern California, where markets are more concentrated, and southern California, where markets are more competitive. These price differences persist when accounting for cost of living and other regional cost factors. The average price of a cesarean delivery in

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[5] Health Care Spending in the United States and Other High-Income Countries | Health Care Economics, Insurance, Payment | JAMA | JAMA Network
[6] World Health Statistics- 2024
[7] Trends in lung cancer and cigarette smoking: California compared to the rest of the United States - PMC
[8] CA-PMSS California Pregnancy-Related Deaths, 2008-2016
[9] Getting to Affordability: Spending Trends and Waste in California's Health Care System - California Health Care Foundation

San Diego was just over $20,000, compared with an average price of just over $30,000 in San Francisco. The Integrated Healthcare Association estimated, for instance, that if all Californians with commercial and Medicare insurance received care at the same cost as in San Diego, total costs to the state would decrease by an estimated $11 billion annually.

According to a 2024 article by KFF, "*Ten Things to Know About Consolidation in Health Care Provider Markets*," a substantial body of research shows that consolidation has led to higher health care prices. The evidence that consolidation leads to higher prices is strongest for hospitals, though studies that have evaluated physician and hospital-physician consolidation have also tended to find that they are associated with higher prices. While consolidation can theoretically reduce fragmentation and improve efficiency, it also makes providers subject to sophisticated business strategies of a larger organization that may seek to use disproportionate market power to charge prices beyond what would be viable in a competitive marketplace.

The state has taken some action to address concerns about high prices and anticompetitive behavior that has been enabled by market concentration. In March 2018, California Attorney General Xavier Becerra brought a civil antitrust action against Sutter Health and its affiliates for using their market power in Northern California to increase prices for its health care services. In late 2019, Sutter agreed to pay $575 million to settle the lawsuit, and also agreed to restrictions on out-of-network charges and practices viewed by the state as anticompetitive.[10] Sutter Health operates as a health system that includes multiple hospitals as well as outpatient clinics, specialty care centers and other types of health care providers.

In addition to market concentration through horizontal integration, such as when a hospital system has disproportionate market power in a geographic location, vertical mergers occur when there is consolidation between entities that offer different services along the same supply chain, such as when a hospital or health plan acquires a physician practice.

f) Increasing Commercialization and the Role of Private Equity, and Hedge Funds in Health Care. A number of factors have made it increasingly difficult for health care providers to continue to financially sustain the operation and management of facilities and practices independently, and trends of commercialization, integration, and consolidation of health care entities have accelerated over the past three decades.[11]

Market pressure, and various opportunities to increase profits or valuation of health care assets, with or without investment-related financial incentives, have contributed to this trend. In some cases, practices and facilities face competition from neighboring providers who have received infusions of investment capital to improve infrastructure and capabilities, or to expand their service locations. Well-intended policy goals, including seeking better coordination and integration of care, requirements for meaningful use of

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[10] Ibid.
[11] Ten Things to Know About Consolidation in Health Care Provider Markets | KFF

electronic health records and health data-sharing, and an increased focus on the collection and improvement of quality metrics have also contributed to this trend, as providers have sought to either join forces or procure additional technology and administrative support to comply with new requirements.

i) Private Equity in Health Care. Health care is many things to many people, but to investors, it is a business. Private equity is a form of corporate ownership that often entails relying on loans to acquire a business, taking it private if not so already, and attempting to increase its value with the goal of selling it at a profit in three to seven years. Private equity firms that rely on buyouts typically acquire a majority stake (i.e. more than 50% ownership) in mature businesses, in contrast to venture capital investors,[12] which tend to acquire a minority stake in start-ups and early-stage ventures.

The CHCF report, "*Private Equity in Health Care: Prevalence, Impact and Policy Options for California and the U.S*," found in California, acquisitions of health care providers totaled $4.31 billion dollars between 2019-2023 and represented roughly a third of all health care deals (307 of 875 deals). Private equity firms now own approximately 8% of all private hospitals in the U.S. and approximately 6% of private hospitals in California. Furthermore, the report reviews evidence and concludes that private equity acquisition of health care service providers is associated with:

(1) Higher costs for patients and insurers;

(2) Lower patient satisfaction;

(3) Mixed changes to operating costs;

(4) Mixed to worse quality of care; and,

(5) Worse financial outcomes for entities being acquired.[13]

ii) Effects of Private Equity on Health Care. According to "*Private Equity Investments in Massachusetts Health Care and State Policy Opportunities*," a July 2024 policy brief issued by the Massachusetts Health Policy Commission (HPC), a growing body of research suggests that private equity ownership can affect health care spending, quality, and access. The HPC, an independent state agency with a similar charge as OHCA, finds that private equity investments have been most active among behavioral health providers, home health and hospice providers, and certain specialty providers, including dentistry and physical therapy. According to HPC, these sectors share a common characteristic of being relatively fragmented and thus may present attractive targets for consolidation.

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[12] HPC Policy Brief: Private Equity Investments in Massachusetts Health Care and State Policy Opportunities
[13] Private Equity in Health Care: Prevalence, Impact and Policy Options for California and the U.S. - California Health Care Foundation

(1) Effects of Private Equity on Utilization, Prices, and Consolidation. Researchers have examined the impact of private equity investments on spending in nursing homes, ambulatory surgical centers, hospitals, and physician practices, with most finding that private equity investments are associated with increased utilization and higher prices.

A national study on physician practices found private equity acquisition was associated with statistically significant price increases for nearly all specialties studied, but the increases were particularly high in markets where a single private equity firm had 30% or more market share in a given physician specialty. Regarding the impact on quality, the evidence is more mixed but indicates concerns with quality. One study that reviewed over 660,000 hospitalizations at 51 private equity–acquired hospitals, "*Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*," found that private equity acquisition of hospitals was associated with a 25.4% increase in hospital-acquired conditions, such as falls and central line associated bloodstream infections, despite serving a lower-risk patient population compared to control hospitals. A National Bureau of Economic Research working paper, "*Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes*," concluded that going to a private equity-owned nursing home increased an individual's short-term mortality by 11%.[14]

One common strategy private equity firms employ is to consolidate providers through a series of mergers and acquisitions. [15]A 2020 Journal of American Medicine article, "*Private Equity Acquisitions of Physician Medical Groups Across Specialties*," notes that private equity has started to play a role in consolidation in recent years. One study found that private equity firms acquired 355 physician practices (1,426 sites and 5,714 physicians) from 2013 to 2016.

(2) Effects of Private Equity on Health Care Access. Private equity's impact on health care is not limited to spending and quality. For instance, evidence shows private equity-owned providers may shift patient mix to favor commercial patients with higher reimbursement rates, which can create access barriers for other patients, particularly those with lower incomes. A 2022 study on urology practices found that Medicaid acceptance was considerably lower at private equity-affiliated practices (52.1%) compared to non-private equity affiliated practices (66%). [16]

In addition, because of the incentive structures of many private equity transactions, if a private equity firm is unable to meet aggressive profit growth targets, transactions can end in closures or bankruptcies. Private equity investors

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[14] Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes | NBER:
[15] Private Equity in Health Care: Prevalence, Impact and Policy Options for California and the U.S. - California Health Care Foundation.
[16] Access to Urological Care for Medicaid-Insured Patients at Urology Practices Acquired by Private Equity Firms - PubMed

aim to produce high returns on investments on a short timeline and enjoy a number of tax advantages, such as the ability to deduct interest payments from taxable income, which encourages private equity's heavy reliance on debt. In a leveraged buyout, a common financial strategy employed by private equity firms, the firm uses a small portion of equity from its fund and a large portion of debt to finance the acquisition, using the company it is buying as collateral. If the investment fails to produce the desired return on investment over a three to seven year timeframe, assets can be sold off to pay off the debt. In the case of a hospital or health facility, this could result in a closure of a facility or services. One analysis across industries found that large companies acquired by private equity firms through leveraged buyouts had a rate of bankruptcy within 10 years that was 10 times higher than controls.[17]

iii) **Limited Public Transparency of Private Equity Transactions.** According to a report by KFF, "*Gaps in Data About Hospital and Health System Finances Limit Transparency for Policymakers and Patients*," [18] there is little transparency and public reporting on private equity. This makes it challenging for regulators, researchers, and the public to track their activities and evaluate the impact of their investments, such as understanding which regions and types of providers private equity groups are invested in, and how this is evolving. Private equity firms and the companies they acquire frequently use complex corporate structures, which further complicates transparency efforts.

g) **MSOs and Relationship with Private Equity**. According to the Massachusetts HPC, partially because of the increasing administrative and technological complexity of delivering health care, providers have increasingly contracted with MSOs to provide varying levels of technical and administrative support. MSOs provide practice management and administrative support services to and on behalf of many health care providers, both non-profit and for-profit. MSOs can provide a wide array of nonclinical services, ranging from billing, provision of information technology services, and space rental, to employment of nonclinical staff and payer negotiations. Outsourcing these tasks can improve operational efficiency and alleviate administrative burden for clinicians, which can be particularly beneficial for smaller provider groups. However, in recent years, MSOs have been increasingly used by for-profit entities, including private equity firms, to become involved in health care practices without violating states' rules regarding the "corporate practice of medicine." In California, the ban on the corporate practice of medicine has historically prevented unlicensed individuals, organizations, and corporations from employing physicians, to address "conflict between the professional standards and obligations" of medical professionals "and the profit motive of the corporate employer."[19]

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[17] Leveraged buyouts and financial distress
[18] Gaps in Data About Hospital and Health System Finances Limit Transparency for Policymakers and Patients | KFF
[19] The Corporate Practice of Medicine in a Changing Healthcare Environment

The MSO model allows corporations, including private equity, to indirectly invest in health care by purchasing providers' nonclinical assets and providing nonclinical services. Even with a focus on nonclinical areas, MSOs can nonetheless have a significant impact on health care market functioning, patient care, and prices. For example, MSOs may create extensive provider networks that negotiate jointly with insurers, increasing the bargaining leverage of those providers relative to insurers and leading to higher prices. For example, a 2022 study published in JAMA Internal Medicine, "*Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners*" found that prices increased 26.0% for anesthesiologists contracted with private equity-backed MSOs, compared to 12.9% for anesthesiologists contracted with MSOs without private equity investment.[20]

h) Health Systems. Hospitals, clinics, physician groups, and even health plans often operate as part of an affiliated "health system." Although this term is used colloquially and among health systems that are comprised of these individual entities, there is no existing statutory definition of what constitutes a health system nor what level of affiliation makes an individual hospital or other provider part of a health system. However, they generally share some of operational and financial integration, and may be under common ownership, make system-level strategic plans, pool capital to make investments, and share administrative resources.

i) OHCA Recent History and Activities. OHCA and its governing Health Care Affordability Board (the Board) were established through the California Health Care Quality and Affordability Act (the Act), which was contained in a health-related budget trailer bill, SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022. Per SB 184, OHCA is charged with three key duties:

i) Slow Spending Growth: OHCA collects, analyzes, and publicly reports data on total health care expenditures, and enforces spending targets set by OHCA's Board. On April 24, 2024, the Board established a base 3% cost growth target for 2029, meaning a health care entity is subject to progressive enforcement if the entity's costs exceed the 3% target. The target was set based on the average annual rate of change in historical median household income growth from 2002-2022. The 3% cost growth target will be phased in between 2025 and 2029, with 2026 being the first year in which a cost growth target of 3.5% will be enforced. Health care entities, as defined in the law and described further below, are subject to the statewide cost growth target unless they are subject to a more specific "sector target" that is defined by OHCA.

ii) Promote High Value: OHCA promotes, measures, and publicly reports performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities, with consideration for minimizing administrative burden and duplication. OHCA is currently seeking public comment

[20] Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners - PMC

on its proposed OHCA Quality and Equity Measure Set. Pursuant to statute, OHCA is also pursuing other goals to promote access and value. Specifically, the Board approved primary care investment benchmarks in October 2024, approved Alternative Payment Model Standards and Adoption Goals in June 2024, and adopted its initial set of Workforce Stability Standards in June 2024.

iii) **Assess Market Consolidation:** OHCA analyzes transactions that are likely to significantly impact market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Health care entities that are party to a transaction are required to submit "Material Change Notices" to OHCA, and OHCA may conduct a cost and market impact review if a transaction is likely to have a significant effect on costs, competition, or the state's ability to meet spending targets. OHCA received its first transaction notification in April 2024, and has not yet required a cost and market impact review for any of the noticed transactions. However, OHCA states it is conducting an "Investigative Study of Hospital Market Competition in Monterey County" and plans to issue a public report later in 2025.

j) **Effect of this Bill and Rationale for Various Provisions.** This bill updates the Act to collect information about various actors in the health care space and, in some cases, subject them to cost growth targets. The additions appear generally consistent with the stated intent of the Legislature in creating OHCA. Specifically, the Legislature expressed intent for OHCA to have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs. The Legislature also expressed intent to increase transparency on health care mergers, acquisitions, and corporate affiliations that may impact market competition and affordability for consumers and purchasers. The intent of this bill is to update the Act based on the experience of OHCA so far, by including additional, relevant actors that evidence shows can affect health care spending but were not included in OHCA's authorizing statute.

i) **Defining MSOs as Health Care Entities Under the Act.** Under the Act, a "health care entity" is any of the following: a payer, including public and private plans and insurers; a fully integrated delivery system (a system where physicians, facilities, and a health plan is integrated, i.e., Kaiser Permanente); or a provider. A "provider" is any of the following: a physician organization; health facility like a hospital, clinic, and ambulatory surgery center or accredited outpatient setting; clinical laboratory; or imaging facility.

Health care entities have a number of responsibilities under the Act. Specifically, they must:

(1) Report health care spending data to OHCA;

(2) Comply with statewide or specific, sector-based cost growth targets; and,

(3) Notify OHCA if they are a party to a material change transaction.

This bill defines MSOs as health care entities under the Act, which will subject them to the above requirements. MSOs are added as health care entities because, as discussed above, MSOs can have significant influence on all aspects of health care outside of direct clinical care, and research has found that private-equity backed MSOs can lead to significant increases in costs. Under current law, a private equity acquisition of an MSO, regardless of the size and scope of the transaction, is not reportable to OHCA. This bill would require MSOs, as health care entities, to report such a pending transaction, and would also require private equity to similarly report the transaction and related information to OHCA.

Because of the significant role MSOs play in health care, OHCA sought to include MSOs under the definition of "health care entity" through a recent OHCA regulation on promoting competition in health care markets. However, the Office of Administrative Law concluded that current statute does not authorize OHCA to include MSOs. This bill would provide such authority.

ii) **Defining New Providers Under the Act.** In addition to adding MSOs as health care entities, this bill adds two new "providers" under the Act: (A) a health system and (B) an entity that owns, operates, or controls another provider defined in the Act. As described above, "health care entity" is defined to also include providers. Accordingly, these new providers, as defined in the bill, will also be subject to the requirements above that apply to health care entities (reporting, cost growth targets, and notification about transactions).

This bill adds "health system" to ensure information is collected at the health system level, which, as discussed above, represents an organization of multiple individual providers with a meaningful level of financial integration. Health systems can take many different forms. A health system would include two or more individual providers already subject to OHCA requirements. Therefore, OHCA would likely issue regulations to clarify and harmonize current requirements on providers with the requirements that apply at the health system level.

In written comments submitted to the Health Care Affordability Board in 2024, this bill's sponsor, Health Access, indicated most state analyses of hospital revenues and spending looks at individual facilities, but the focus on individual facilities rather than systems or groups of entities underestimates how revenue is transferred from an individual facility or facilities into the health system or related group of entities. For instance, Health Access notes, reserves can be used to finance further consolidation and to earn investment revenue, and it is important to understand the financial status of these hospitals and other entities at the system level.

This bill would also add "an entity that owns, operates, or controls another provider" to address complex corporate structures that could otherwise evade the rules that apply to providers.

iii) **Defining Private Equity and Hedge Funds, and Requiring Them to Notify OHCA of Planned Acquisitions.** Currently, health care entities must provide OHCA

with written notice of material change transactions, with limited exceptions, 90 days prior to entering into an agreement. These notification requirements apply to a health care entity who is a party to, or a subject of, a material change transaction, but they currently do not apply to non-health care entities who are party to a transaction with a health care entity. OHCA's regulations on Material Change Transactions and Pre-Transaction Review define the contents of the public notice, and include questions about the organization of the entity, history of transactions, planned or expected changes associated with the transaction, community impacts on health care services, potential impact on whether the entity accepts Medi-Cal, and other items.

Based on the evidence linking private equity and hedge fund acquisitions of health care entities with increased prices, as well as concerns about the potential impact of these transactions on quality and access, requiring private equity and hedge funds to also report on planned transactions would ensure consistency between parties to the transaction and allow OHCA to conduct a more comprehensive analysis of the potential impact of the transaction. This bill also defines private equity and hedge fund for the purposes of the Act.

3) **SUPPORT.** Health Access, sponsor of this bill, notes AB 1415 will allow OHCA to keep up with trends in the health care market that impact consumer affordability, including increasingly complex health care mergers, and rising costs for consumers facing an affordability crisis. Health Access argues OHCA has already started reviewing mergers and has found that there are transactions skirting OHCA oversight, because it does not have specific statutory authority to review mergers involving MSOs and the private equity and hedge fund side of health care deals. In addition, because hospitals often function as part of larger systems, Health Access argues, this bill will appropriately allow OHCA to examine large systems like Adventist, Salinas Valley, or Sutter at the system level with their combined market power, not just a collection of individual hospitals.

Coalition for Patient Centered Care (CPCC), a diverse, national group of healthcare industry stakeholders who oppose private equity's acquisition of and influence over independent physicians, argues in support of this bill that private equity is focused on maximizing investor profits rather than advocating for patients, and that private equity firms have been particularly active in acquiring independent physician groups. CPCC believes this minor, commonsense change to reporting will allow the OHCA to be able to look more closely at the impact of private equity ownership on the provision of healthcare and to look at related cost trends.

The California Physicians Alliance supports this bill because it enhances OHCA's oversight capabilities, particularly concerning MSOs and private equity firms involved in health care transactions.

Service Employer International Union (SEIU) California, UNITE HERE, and other labor organizations write in strong support of this bill, arguing that OHCA needs additional authority to assess rising role of MSOs, private equity firms and hedge funds in driving costs. Labor unions note the critical importance of reining in health care costs. National Union of Healthcare Workers, representing over 19,000 California healthcare workers, writes in

support that on a daily basis, their members see the adverse effects mergers and out-of-control healthcare costs have on patients, such as inability to afford care and reductions in needed services.

4) **OPPOSITION.** California Hospital Association (CHA) and individual hospitals oppose this bill. CHA expresses overall opposition to OHCA's current actions and argues a proposed expansion is premature. In addition, CHA asserts this bill would enable OHCA to single out additional organizations for inequitable treatment by expanding the definition of health care providers to include hospital and health systems. Furthermore, hospitals express concern this bill would expand OHCA's ability to slow down and potentially derail health care partnerships and investments that are essential in saving distressed providers.

   Newport Healthcare, which administers 49 mental health treatment programs in California, writes in opposition to this bill because it requires OHCA to review various transactions. They believe it will possibly lead to imposing cost targets for other health care entities similar to those that are being debated at OHCA. Newport Healthcare is concerned this bill will discourage health care investment and innovation.

   The Long Beach Area Chamber of Commerce opposes this bill, arguing the broad definition of MSOs risks capturing entities that do not directly influence patient care and citing concerns that transaction reporting will increase compliance burdens, which could discourage new entrants into the market and reduce investment in California's health care sector.

5) **OPPOSE UNLESS AMENDED.** The American Investment Council writes in opposition to this bill unless it is amended to address its concerns, including ambiguity in market impact thresholds for transaction reporting and the inclusion of MSOs as health care entities. AIC also points out that definitions explicitly target private equity groups and hedge funds, and that oversight and reporting requirements disproportionately target certain investor types, creating an uneven regulatory landscape.

   America's Physician Groups (APG) also opposes the bill unless amended to address the inclusion of MSOs as health care entities. APG argues the broad definition of MSOs would add hundreds of business entities that do not directly provide health care services to OHCA oversight, and asserts the application of cost targets to MSOs would result in a "double jeopardy" situation where providers could be subject to two cost targets simultaneously.

6) **CONCERNS.** California Association of Health Plans and the Association of California Life and Health Insurance Companies express concerns with, and seek clarification about, the bill's addition of new provider types, specifically citing the potential inclusion of health plans and insurers as part of a health system, as well as the role and parameters of MSOs within the bill's framework.

   California Medical Association applauds the intent of the bill in increasing transparency and addressing medical costs, however, they express concern about the bill's inclusion of MSOs as health care entities, and specifically with the precedent of subjecting entities that do not directly provide patient care, such as MSOs, to the cost targets under OCHA. CMA also seeks clarification that the definition of "health system" does not inadvertently capture a

physician group with 25 or less physicians, as these smaller physician groups were intentionally exempted from cost sharing targets under OCHA.

7) RELATED LEGISLATION.

a) SB 351 (Cabaldon), pending in the Senate Business and Professions Committee, would prohibit a private equity group or hedge fund, as defined, involved in any manner with a physician or dental practice doing business in this state from interfering with the professional judgment of physicians or dentists in making health care decisions and exercising power over specified actions, including, among other things, making decisions regarding coding and billing procedures for patient care services. Would prohibit a private equity group or hedge fund from entering into an agreement or arrangement with a physician or dental practice if the agreement or arrangement would enable the person or entity to engage in the prohibited actions described above. Would render void and unenforceable specified types of contracts between a physician or dental practice and a private equity group or hedge fund that explicitly or implicitly include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation, or from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund, as specified. Would entitle the Attorney General to injunctive relief and attorney's fees and costs for the enforcement of these provisions, as specified.

8) PREVIOUS LEGISLATION.

a) AB 3129 (Wood) of 2024 would have required a private equity group or hedge fund to provide written notice to, and obtain the written consent of, the Attorney General prior to a transaction with a health care facility, except for hospitals, provider groups except dermatology, or, a provider if the private equity group or hedge fund has been involved in a transaction within the last seven years with a health care facility, provider group or provider. Would have prohibited a private equity group or hedge fund involved in any manner with a physician, psychiatric, or dental practice doing business in this state, including as an investor, or as an investor or owner of the assets, from interfering with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions; or, exercising control over, or be delegated the power to do other activities, as specified.

AB 3129 was vetoed by Governor Newsom, who stated OHCA was created as the responsible state entity to review proposed health care transactions, and it would be more appropriate for the OHCA to oversee these consolidation issues as it is already doing much of this work. AB 1415 addresses some of the same reporting issues addressed by AB 3129, and appears consistent with the veto message of AB 3129 by providing OHCA the authority to review private equity group or hedge fund transactions.

b) AB 616 (Rodriguez) of 2023 would have established the Medical Group Financial Transparency Act and authorized the disclosure of audited financial reports and

comprehensive financial statements of physician organizations of 50 or more physicians and physician organizations that are part of a fully integrated delivery system, collected by OHCA, and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care. AB 616 was vetoed by Governor Newson, who stated the policy was premature, given OHCA was in its initial stages of implementation.

c) 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.

d) AB 1130 (Wood) of 2021 would have established OHCA. AB 1130 was referred to the Senate Committee on Health and not heard. Provisions similar to those included in AB 1130 were later codified and OHCA was established in 2022 through SB 184, as noted in c) above.

9) AMENDMENTS. To address stakeholder concerns and technical drafting issues, and to tailor the bill more narrowly to the authority OHCA needs to properly assess and promote competitive markets in California, the author proposes to amend the bill as follows:

a) Definition of "Health system." Clarify the definition of health system to define "hospital" and to clarify a health system is comprised of at least a hospital and at least one other *provider*, instead of a hospital and at least one *physician organization*.

This change clarifies which hospitals are included and clarifies that the definition does not include physician organizations of under 25 persons, which are not considered "providers" under OHCA.

b) Narrow Requirements for MSOs and Other "Controlling" Entities to Reporting on Material Change Transactions and Data Collection Only. A "health care entity" and "provider" defined under OHCA are automatically required to submit data, meet cost growth targets, and report "material change transactions." The following amendments will narrow the application of the bill for MSOs and entities described in ii), below, such that cost growth targets would no longer apply to MSOs and entities described in ii), below. With these amendments, MSOs and the entities would be treated similarly to private equity and hedge funds under the bill, i.e., they would be subject to reporting on material change transactions. OHCA would also retain authority to collect data, but OHCA would not require data submission from all MSOs. Rather, they would do so in a limited and targeted fashion, such as when providers affiliated with MSOs do not comply with their cost growth targets.

i) Strike the addition of an MSO as a health care entity;

ii) Strike the addition of "*An entity that owns, operates, or controls [a provider], regardless of whether it is currently operating, providing health care services, or has a pending or suspended license,*" to the definition of a provider; and,

iii) Require MSOs and entities described in ii) above to report to OHCA on "material change transactions."

iv) Authorize OHCA to collect data from MSOs.

c) Minor, Conforming, and Technical Changes. Amendments add MSOs to the types of organizations on which OHCA is required to conduct ongoing research and evaluation to ensure the OHCA statute includes the entities that significantly affect health care cost, quality, equity, and workforce stability. Amendments also make other necessary conforming, and technical changes.

REGISTERED SUPPORT / OPPOSITION:

Support

Health Access California (sponsor)
Asian Resources, Inc.
California LGBTQ Health and Human Services Network
California Nurses Association
California Pan - Ethnic Health Network
California Physicians Alliance
California State Council of Service Employees International Union (SEIU California)
CALPIRG
CFT - a Union of Educators & Classified Professionals, AFT, AFL-CIO
Coalition for Patient-centered Care
Courage California
Economic Security California Action
National Union of Healthcare Workers (NUHW)
Northern California Carpenters Regional Council
Small Business Majority
Unite Here International Union, AFL-CIO

Opposition

California Hospital Association
Dignity Health
Long Beach Area Chamber of Commerce
Newport Healthcare
United Hospital Association
University of California

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1419 (Addis) – As Amended March 24, 2025

SUBJECT: California Health Benefit Exchange: automatic health care coverage enrollment.

SUMMARY: Expands an existing streamlined Covered California enrollment process to include individuals who have submitted health coverage applications through the county Statewide Automated Welfare System (the county eligibility system). Currently, this system enables Covered California to enroll people moving from Medi-Cal to Covered California in the lowest cost silver plan available in Covered California or the individual's previous Medi-Cal managed care (MCMC) plan, if Covered California has that information. Requires, for the existing streamlined process and for the expanded process established by this bill, Covered California to use the available information to be able to opt the person into the plan in which other members of the person's household are enrolled, or the lowest cost plan available to an Indian (as defined in federal law) who is eligible for reduced cost-sharing. These two streamlined enrollment options are in addition to opting the person into the lowest cost silver plan or the individual's prior MCMC plan under existing law.

EXISTING LAW:

1) Establishes Covered California as California's health benefit exchange for individual and small business purchasers as authorized under the Patient Protection and Affordable Care Act (ACA); and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [Government Code (GOV) §§ 100500 - 100522, and Welfare and Institutions Code (WIC) § 14000, *et seq*.]

2) Requires a single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs to be developed by the DHCS and the board governing Covered California, and requires the application to be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs and by their agents. [WIC § 15926]

3) Requires, during the processing of an application, renewal, or a transition due to a change in circumstances, an entity making an eligibility determinations for an insurance affordability program to ensure that an eligible applicant and recipient of insurance affordability programs that meets all program eligibility requirements and complies with all necessary requests for information moves between programs without any breaks in coverage and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. [*Ibid*.]

4) Defines an "insurance affordability program" to mean a program that is one of the following:

    a) The Medi-Cal program;

    b) The state's children's health insurance program (CHIP); or,

c) A program that makes available to qualified individuals coverage in a qualified health plan through the Covered California with advance payment of the premium tax credit established under a specified provision of federal law. [*Ibid*.]

5) Requires Covered California, upon receipt of an individual's electronic application from Medi-Cal, to use the available information to enroll the individual or individuals in the lowest cost silver plan available, unless the Covered California has information from the county, DHCS, managed care plan, or another plan as determined by the Covered California that enables the Covered California to enroll the individual with the individual's previous managed care plan within the timeframe required by 6) below. [Government Code § 100503.4]

6) Requires plan enrollment to occur before the termination date of coverage through the insurance affordability program. [*Ibid*.]

7) Prohibits the plan's premium due date from being sooner than the last day of the first month of enrollment. [*Ibid*.]

8) Requires Covered California to provide an individual who is enrolled in a plan pursuant to the above-described provisions with a notice that includes the following information:

   a) The plan in which the individual is enrolled;

   b) The individual's right to select another available plan and any relevant deadlines for that selection;

   c) How to receive assistance to select a plan;

   d) The individual's right not to enroll in the plan;

   e) Information for an individual appealing their previous coverage through an insurance affordability program; and,

   f) A statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date. [*Ibid*.]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, California has long been a leader in expanding access to quality, affordable health care. However, too many eligible individuals still face unnecessary barriers to coverage due to complexity and gaps in the enrollment process. This bill is the next step toward ensuring that no Californian falls through the cracks when it comes to obtaining and maintaining not just the health care they can afford, but the health care they deserve. The author concludes that, by allowing automatic enrollment upon submission of a complete application through the county Statewide Automated Welfare System (SAWS), the state can reduce delays in coverage while also lowering administrative burden, making the health care system more efficient and seamless.

2) **BACKGROUND.** Medi-Cal provides free or low-cost health coverage to adults with incomes up to 138% of the federal poverty level (FPL), and to children with family incomes up to 266% of the FPL. People with legal immigration status and incomes above those limits can get financial help to buy health insurance through Covered California. Under the ACA, people earning up to 400% of the FPL can receive help paying for their health insurance premiums. Those earning up to 250% of the FPL can also get help with out-of-pocket costs.

   Every month, thousands of Californians are found eligible for either Medi-Cal or subsidized coverage through Covered California, typically through one of two on-line enrollment systems. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the state's centralized, automated system used to determine eligibility for and enroll Californians in insurance affordability programs (Medi-Cal and Covered California). SAWS is the county system for determining and managing eligibility and benefits for various public assistance programs at the county level, including Medi-Cal, CalFresh and CalWORKS.

   People applying for insurance affordability programs must have their eligibility determined upon application and once every year, a process known as "redetermination." When people have a change in income or family size, they may move from Medi-Cal to Covered California (for example, if they had an increase in income above the Medi-Cal income eligibility threshold) or from Covered California to Medi-Cal (if they had a decrease in income to below the Medi-Cal income thresholds).

   California created a streamlined automated system to help people move from one insurance affordability program to another through SB 260 (Hurtado), Chapter 845, Statutes of 2019. SB 260 set up automatic enrollment for people who lose Medi-Cal eligibility and instead qualify for Covered California. These individuals are placed into the lowest-cost silver plan available, or into a Covered California plan that matches their previous Medi-Cal plan.

   As part of this process, consumers receive a notice when they are disenrolled from Medi-Cal and auto-enrolled in a Covered California plan. This eligibility notice is provided before the effective date of their new coverage, and provides information for consumers on why they are receiving the notice, what options they have, and how to get help. Since this program started in 2023, over 200,000 people have been automatically enrolled into Covered California coverage.

   This bill would extend the provisions of SB 260 to include new applicants found eligible through SAWS, the county eligibility system. Currently, people who apply for health coverage through SAWS and are found income eligible for Covered California receive a notice from SAWS and another from Covered California telling them of their eligibility for coverage through Covered California, the amount of their premium tax credit and the date by which the person needs to pick a plan. This can result in consumer confusion because this group of people did not apply to Covered California, and they may be unaware of what Covered California is or does. In addition, these individuals must take an extra step of using CalHEERS to choose a health plan, because SAWS does not have a health plan selection option for plans offered through Covered California. This bill would simplify the Covered California plan selection process, reduce confusion, and help more Californians get insured faster. Covered California estimates that more than 100,000 people each year could benefit

from this change to make it easier for eligible individuals to access affordable, quality health care.

3) **SUPPORT.** Western Center on Law and Poverty and Health Access California write to support this bill, which would extend automatic enrollment to Covered California for consumers who newly apply for coverage through counties, but are also determined ineligible for Medi-Cal. As the cosponsors of SB 260, which extended automatic enrollment to those who lose Medi-Cal coverage, they argue this bill would similarly help people access health coverage.

   Through SB 260, Covered California has been able to ease transitions from Medi-Cal to Covered California for hundreds of thousands of Californians. While SB 260 enabled Covered California to implement the Medi-Cal to Covered California enrollment program for those losing Medi-Cal eligibility, the law does not apply to consumers who newly apply for coverage through counties but are also determined ineligible for Medi-Cal. This bill would streamline the process for consumers who newly apply for coverage through counties but are determined ineligible for Medi-Cal. Supporters state that, rather than going through the existing SB 260 auto-enrollment process, these consumers must navigate a variety of discrete steps to enroll. They receive a notice informing them of their Covered California eligibility along with a deadline to pick a Covered California plan. They must then engage with our enrollment portal to create or log into an account and then enter the plan selection process. Supporters conclude that this bill would minimize the steps a consumer must take to obtain health coverage, by following the existing SB 260 auto-enrollment process that requires consumers to take affirmative action to effectuate health coverage.

4) **AMENDMENT.** To clarify the existing law streamlined enrollment provisions enacted by SB 260 and the extension of those streamlined enrollment provisions in this bill, the proposed amendments agreed to by the author following discussions would make two changes. First, the amendment would clarify that notice is required prior to the individual's effective date of coverage. Second, the amendment would more accurately describe how the existing instructions in the notice sent to the consumer to make their health plan coverage take effect is by either paying the premium, or if the consumer does not owe a premium for their plan, instructions to the consumer on how to opt out of the selected plan.

   100503.4
   (d) The Exchange shall provide an individual who is enrolled in a plan pursuant to this section with a notice **prior to the individual's effective date of coverage** that includes the following information:
   ***
   (6) ~~**A statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date.**~~ **Instructions on how to effectuate coverage in the selected plan such as by paying the premium by the due date, or, if there is no premium due, instructions on how to opt into the selected plan**.

REGISTERED SUPPORT / OPPOSITION:

Support

California Pan - Ethnic Health Network
Health Access California
Western Center on Law & Poverty, Inc.

Opposition

None on file

Analysis Prepared by: Scott Bain / HEALTH / (916) 319-2097

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1460 (Rogers) – As Introduced February 21, 2025

SUBJECT: Prescription drug pricing.

SUMMARY: Prohibits a prescription drug manufacturer from engaging in discriminatory practices that would impose additional conditions, prohibit, restrict, deny, or interfere with a covered entity's (CE), such as a federally qualified health center, a specified entity receiving a federal grant or federal funds, a state operated aids drug assistance program, or a specified hospital meeting certain criteria) purchase or delivery of a drug eligible for discounts under the federal pricing requirements set forth in the federal 340B program, if the CE utilizes a specified pharmacy, including a contract pharmacy, that dispenses the drug to an eligible patient of the CE.

EXISTING LAW:

Federal Law

1) Establishes Section 340B(a)(1) of the Public Health Service Act (commonly referred to as 340B Program), which requires the Secretary of Health and Human Services (HHS) to enter into a pharmaceutical pricing agreement (PPA) with each manufacturer of covered outpatient drugs in which the manufacturer agrees to charge a price for covered outpatient drugs that will not exceed an amount determined under the statute (340B ceiling price). [42 United States Code (USC) § 256b]

2) Requires each agreement entered under 1) above to require drug manufacturers to furnish the Secretary of HHS with reports, on a quarterly basis of the price of each covered outpatient drug, subject to that agreement, that, according to the manufacturer, represents the maximum price that CEs may be required to pay for the drug. [42 USC § 256b]

3) Defines a ''CE'' under the federal 340B statute to mean an entity that meets specified federal requirements and is one of several entities listed in the federal 340B statute, including a federally qualified health center (FQHC), specified entities receiving a federal grant or federal funds (such as for services for HIV, sexually transmitted diseases, family planning, black lung clinic, a hemophilia diagnostic treatment center, a Native Hawaiian Health Center, an urban Indian Organization), a state-operated AIDS drug assistance program, and specified hospitals meeting certain criteria, including disproportionate share hospitals, children's hospitals, free-standing cancer hospitals, critical access hospitals, a rural referral center, and a sole community hospital. [42 USC § 256b]

State Law

1) Prohibits, under Medi-Cal, a CE from billing (in Medi-Cal) an amount exceeding the entity's actual acquisition cost for a 340B drug, as charged by the manufacturer at a price consistent with federal 340B, plus one of two different professional dispensing fee amounts. Requires a CE to identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement. [Welfare and Institutions Code (WIC) § 14105.46]

2) Requires the Department of Health Care Services (DHCS) to establish, implement, and maintain a supplemental payment pool for non-hospital 340B community clinics, subject to an appropriation by the Legislature. [WIC § 14105.467]

3) Requires DHCS, beginning January 1, 2021, and any subsequent fiscal year to the extent funds are appropriated by the Legislature for this purpose, to make available fee-for-service (FFS)-based supplemental payments from a fixed-amount payment pool to qualifying non-hospital 340B community clinics. [*Ibid.]*

FISCAL EFFECT: This bill is keyed non-fiscal.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, the federal 340B discount medications program is a critical component of rural and urban healthcare. Not only does the program make medications more affordable for uninsured patients, it also provides pass-through savings to healthcare centers who serve under-insured and uninsured patients. The author continues that these pass-through savings help fund the essential operations of these clinics. The author notes that during the pandemic, while our country was in a public health crisis, pharmaceutical companies started imposing restrictions on how many contract pharmacies clinic systems could use to supply patients with 340B medications. The author notes that limiting clinic systems, such as those that serve his district, to only one contract pharmacy location has created a major roadblock for access to affordable medications for vulnerable populations. The author continues that clinic systems can be spread across large geographic areas, so limiting a system to one pharmacy location can make it effectively inaccessible to patients seen at clinics located far away from the one pharmacy their provider can contract with. The author notes that beyond contract pharmacy restrictions, drug companies are restricting the 340B programs in other ways, including placing arbitrary distance restrictions on pharmacies, requesting excessive claims data information, and limiting the types of medications that are eligible for discount.

The author notes that all of these restrictions conflict with the program's intent, which is to help CE's stretch scarce resources. The author contends that for community clinics with in-house pharmacies that operate as their sole pharmacy, there is grave concern that patients will not only miss appointments as immigration enforcement efforts continue, but also stop coming in to pick up their vital (and sometimes lifesaving) medications. The author notes that it is critical we ensure immigrant patients can maintain access to their medications, rather than limit access. The author concludes that at a time when we are facing a massive Medi-Cal shortfall of billions of dollars and an increasingly uninsured and underinsured population, it would be negligent to allow pharmaceutical companies to continue restricting access to 340B pricing so that they can enjoy higher profits—especially when the state will be left to foot the bill.

2) BACKGROUND

a) THE 340B PROGRAM. The federal 340B program was established in 1992 to increase access to health care for low-income and vulnerable patients. It is intended to help safety-net providers improve access to affordable medicines and health care services. The 340B program generates cost savings that are to be reinvested in health centers to meet the needs of the communities they serve. The 340B program is administered by the federal

Health Resources and Services Administration (HRSA). The 340B program requires drug manufacturers to provide discounts on the outpatient prescription drugs they sell to certain eligible health care providers, referred to as "CEs" which must recertify their eligibility yearly. HRSA identifies the CEs eligible to participate in the 340B Program to include the following entities:

i) Health Centers: FQHCs; FQHC Look-Alikes; Native Hawaiian Health Centers; Tribal/Urban Indian Health Centers;

ii) Ryan White HIV/AIDS Program Grantees;

iii) Hospitals: Children's Hospitals, Critical Access Hospitals, Disproportionate Share Hospitals, Free Standing Cancer Hospitals, Rural Referral Centers, Sole Community Hospitals; and,

iv) Specialized Clinics: Black Lung Clinics, Comprehensive Hemophilia Diagnostic Treatment Centers, Title X Family Planning Clinics, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics.

b) The 340B program provides significant discounts for CEs. The 340B Program generally requires CEs to receive prescription drug discounts from drug manufacturers that reduce the prices paid by a CE to be at least the lower of: a) the best price offered to most public and private entities; or; b) the average manufacturer sales prices minus a percentage of between 13% and 23.1% (depending on the type of prescription drug).

Under 340B, discounted prescription drugs are available to CEs' patients regardless of payer. Under federal law, CEs may dispense or arrange for the dispensing of 340B prescription drugs to their own patients, regardless of who ultimately pays for the prescription drugs. According to a January 2020 Governmental Accountability Office (GAO) report titled, "*340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement*," from 2010 to 2019, the national number of CEs participating in the 340B Program increased from nearly 9,700 to nearly 13,000.

In addition to the annual recertification of CEs, the 340B program also requires CEs to ensure program integrity and maintain accurate records documenting compliance with all 340B Program requirements. The 340B Program requires audits of CEs and drug manufacturers. HRSA, on its own or pursuant to a request by a pharmaceutical manufacturer, is authorized to audit a CE. Only one audit of a CE is permitted at any one time. When HRSA has received a request from a manufacturer to conduct an audit, HRSA will determine whether an audit should be performed by the government or the manufacturer. A manufacturer is authorized to audit a CE in accordance with procedures established by HRSA relating to the number, duration, and scope of audits. These manufacturer audits must be conducted to ensure CE compliance of the following two requirements:

i) Prohibition on Duplicate Discounts or Rebates. The 340B statute prohibits duplicate discounts, which occur when a CE obtains a 340B discount on a drug and a Medicaid agency obtains a discount in the form of a rebate from the manufacturer for

the same medication. CEs must have mechanisms in place to prevent duplicate discounts.

ii) **Resale or Diversion of Drugs.** The 340B Program prohibits CEs from reselling or otherwise transferring 340B drugs to ineligible patients.

c) CEs and Pharmacy Arrangements. CEs are authorized to dispense 340B drugs through in-house pharmacies they own, or through the use of contract pharmacy arrangements, in which they contract with outside pharmacies, or both.

Historically, according to a 2014 RAND Corporation perspective titled, "*The 340B Prescription Drug Discount Program - Origins, Implementation, and Post-Reform Future,*" at the inception of the 340B program, 340B covered drugs could only be dispensed through an in-house pharmacy. With less than 5% of CEs using an in-house pharmacy at the time of the inception of the 340B program, many CEs could not participate in 340B. Beginning in 1996, the 340B program allowed CEs without an in-house pharmacy to contract with a single outside pharmacy, also known as a contract pharmacy, to distribute 340B drugs to their patients. The use of contract pharmacies was expanded in 2010, when CEs were allowed to contract with an unlimited number of pharmacies to provide 340B-discounted drugs.

According to the aforementioned January 2020 GAO report from 2010 to 2019, since the change in HRSA guidance allowing CEs to have an unlimited number of contract pharmacies, there also has been a large increase in the number of contract pharmacies. Specifically, the national number of contract pharmacies increased from about 1,300 at the beginning of 2010 to around 23,000 in 2019. According to a October 2021 University of Southern California (USC) white paper on the 340B program titled, "*The 340B Drug Pricing Program: Background, Ongoing Challenges, and Recent Developments,*" the growth of contract pharmacies since 2010 has been controversial in part because they are not mentioned in the federal 340B statute, because HRSA guidance allows for an unlimited number of contract pharmacies, and because they were not originally meant to benefit financially from the 340B program.

Contract pharmacies provide a means for CEs without in-house pharmacies to access the 340B program, and for CEs with an in-house pharmacy to reach patients who opt to use external pharmacies.

As of July 2017, approximately one-third of CEs used a contract pharmacy and hospitals were more likely to have a contract pharmacy than other types of CEs. The share of major pharmacy chains such as Walgreens and CVS that serve as contract pharmacies has increased since 2010. Specifically, Walgreens, CVS, and Walmart accounted for 28%, 20% and 10% of contract pharmacy locations in 2020 (nearly 28,000 total).

d) Financial arrangements between CEs, contract pharmacies, and third-party administrators.

i) **In-house pharmacies.** A CE with an in-house pharmacy benefits from dispensing 340B drugs through its in-house pharmacy because it can bill health plans for the drug at the regular pharmacy reimbursement rate for a drug the CE acquired at the lower 340B price.

ii) **Contract pharmacies.** Contract pharmacy arrangements vary but generally involve a contract pharmacy and the CE sharing in the savings resulting from the lower acquisition cost of a 340B prescription drug and the higher reimbursement provided by what a health plan or pharmaceutical benefit manufacturer (PBM) pays the contract pharmacy for a drug dispensed to a patient with commercial health plan coverage. The savings are shared between the contract pharmacy and the CE in order to encourage both entities to participate in the contract pharmacy 340B arrangement. A June 2018 GAO report titled, "*Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement,"* reviewed 30 contracts and found that all but one contract included provisions for the CE to pay the contract pharmacy a flat fee for each eligible prescription. The flat fees generally ranged from $6 to $15 per prescription, but varied by several factors, including the type of drug or patient's insurance status. Some CEs also agreed to pay pharmacies a percentage of revenue generated by each prescription. The report noted that some CEs hire and pay a private company, referred to as a third-party administrator (TPA), to help determine patient eligibility and manage 340B inventory as a means to ensure compliance with 340B Program requirements at contract pharmacies. In these cases, the CE pays both the contract pharmacy and the TPA fees that they have negotiated for their roles in managing and distributing 340B drugs. These fees are typically deducted from the reimbursed amounts received from patients and their health insurers by the pharmacy and TPA, and then the balance is forwarded to the CE.

e) **Pass-through savings to patients.** According to the aforementioned June 2018 GAO report, 30 of the 55 CEs reviewed reported providing low-income, uninsured patients discounts on 340B drugs at some or all of their contract pharmacies. Of the 30 CEs that provided discounts, 23 indicated that they pass on the full 340B discount to patients, resulting in patients paying the 340B price or less for drugs. Additionally, 14 of the 30 CEs said they determined patients' eligibility for discounts based on whether their income was below a specified level, 11 reported providing discounts to all patients, and 5 determined eligibility for discounts on a case-by-case basis.

f) **Other uses of 340B savings.** The sponsors of this bill provided information to the committee regarding examples of how clinics use their 340B savings. According to the sponsors, the Family Health Care Network based in the Central Valley (FHCN) experienced savings due to 340B participation through both in-house and contract pharmacies. The sponsors highlighted that FHCN's activities as a result of 340B savings have included: reducing the price of pharmaceuticals and the nominal fee associated with outpatient office visits for patients through the sliding fee scale program; implementing door-to-door van routes (including new vans) in both Visalia and Porterville; supporting FHCN operations by helping to offset operating expenses of pharmacies, dispensaries, and health centers; expanding its hospitalist program to allow for better patient care and continuity between the hospital and outpatient settings, reducing the total cost of care to the system; and, adding mobile vision screening equipment (in conjunction with a grant).

The sponsors also cite state Open Door Health Centers' activities as a result of 340B savings including: low-cost medications for all patients without coverage or high deductible costs; funding for residency programs; funding for clinical training programs for behavioral health clinicians to achieve licensure as licensed clinical social workers and medical assistants to achieve certification; mobile van services for medical, case

management and behavioral health services; member services coordinators who help connect patients to insurance coverage and supportive services; patient education resources; and, recruitment and retention efforts related to educational expenses not covered by existing loan repayment programs for a variety of clinical positions.

g) Pharmaceutical manufacturers and 340B. The 340B program has been the subject of litigation, Congressional hearings, and federal guidance. According to the October 2021 USC white paper on the issue, in 2020, both Eli Lilly and AstraZeneca announced they would limit distribution of 340B-priced drugs to CEs and their affiliate sites and would no longer distribute 340B-priced drugs to contract pharmacies. The USC white paper states Merck, Sanofi, and Novartis have taken a different approach, notifying CEs that they must provide contract pharmacy claims data to an entity to prevent duplicate discounts. Because these actions would essentially have manufacturers scaling back the 340B program, they were met with complaints from hospital and provider organizations such as the American Hospital Association, 340B Health, and 28 state Attorneys General. In response, the federal Department of Health and Human Services (HHS) issued advisory guidance stating that manufacturers participating in 340B must provide 340B discounts to CEs' contract pharmacies. Eli Lilly, Sanofi, and AstraZeneca have all separately challenged the HHS guidance in court.

In a letter to one manufacturer, HRSA stated the 340B statute requires that manufacturers offer each CE to cover outpatient drugs for purchase at or below the applicable ceiling price, and this requirement is not restricted or qualified by the how the CE chooses to distribute the covered outpatient drugs. HRSA further stated the 340B statute does not permit manufacturers to impose conditions on CEs' access to 340B pricing, including the production of claims data. Further, HRSA stated that manufacturers have signed a PPA to comply with 340B requirements, and the manufacturer is bound by the terms of the PPA and must ensure that the 340B ceiling price is available to all CEs. HRSA indicated to the manufacturer that the 340B statute provides a mechanism by which a manufacturer can address concerns with compliance issues arising from contract pharmacy arrangements by conducting an audit and submitting a claim through the Administrative Dispute Resolution process contained in the 340B statute, and that the 340B statute does not permit a manufacturer to impose industry-wide universal restrictions.

As recently as 2024, at least three prescription drug manufacturers established restrictions limiting a 340B drug to CEs to a single contract pharmacy.

h) 340B and payors. The 340B Program was aimed at enabling certain health care providers that met the federal definition of CEs "to stretch scarce federal resources to reach more eligible patients or provide more comprehensive services." Since its inception, the number of CEs has been expanded legislatively, and administrative actions authorized contract pharmacies, initially on a limited basis and then subsequently expanded without limit. The dollar volume and number of 340B drugs dispensed has grown significantly. As the program has expanded, payors have taken note of the lower prices and attempted to reduce reimbursements based on the availability of 340B prices, including PBMs, the federal Medicare program, and the State of California.

In California, existing law (for purposes of the Medi-Cal program), requires CEs to bill an amount not to exceed the entity's actual acquisition cost for a drug, as charged by the

manufacturer at a price consistent with 340B, plus the Medi-Cal pharmacy professional dispensing fee. CEs must also identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement.

In 2020, the state enacted AB 80 (described below) which authorized DHCS to implement a payment methodology to provide for supplemental payments to qualifying non-hospital 340B community clinics to secure, strengthen, and support the community clinic and health center delivery system for Medi-Cal beneficiaries. The state plan amendment submitted pursuant to AB 80 was approved in 2021 and became effective on January 1, 2022.

i) **Legislation in other states**. Several other states including Maryland, Arkansas, West Virginia, Minnesota, South Dakota, North Dakota, Missouri, Utah, Nebraska, Louisiana and New Mexico have passed legislation prohibiting pharmaceutical manufacturers, distributors, logistics providers, and their affiliates from limiting or restricting the acquisition or delivery of a 340B drug to a pharmacy that is a under contract with a 340B CE.

3) **SUPPORT.** The California Primary Care Association (CPCA) and the California Partnership for Health (CPH) are the co-sponsors of this bill. CPCA and CPH state that the bill seeks to promote health equity and access to care by ensuring community health centers and other safety-net providers that qualify for the 340B drug pricing program can utilize contract pharmacies to dispense medications to their patients in underserved communities. CPCA and CPH note that since 2020, many drug manufacturers have introduced restrictions that diminish the ability of CEs to use 340B contract pharmacies to dispense medications to their patients. CPCA and CPH write that these restrictions often limit CEs to one contract pharmacy location and restrict which drugs qualify for 340B pricing at those pharmacies, making it harder for CEs to leverage contract pharmacies for greater access to affordable medications for their patients. CPCA and CPH notes that community health clinics (CHCs) are required by statute and regulation, as well as by mission – to invest all 340B savings into activities that support their federally-approved goal of expanding access to care for medically-underserved patients. These savings are a critical component of the funding infrastructure of CHCs and play a significant role in the ability of CHCs to serve all who enter through their doors.

   At a time when threats to healthcare access are being made at the federal level, the sponsors state that California should be taking every opportunity available to ensure its most vulnerable patients can maintain access to services and lifesaving medication. CPCA and CPH conclude that this bill would prohibit these restrictions that are harming patients and would enable CEs to utilize more than one contract pharmacy, expanding access during this critical time.

4) **OPPOSITION.** California Life Sciences (CLS) opposes this bill on the grounds that it perpetuates the subversion of the 340B, which was intended to serve vulnerable patient populations. CLS states the exploitation of loopholes in the program has veered a well-intentioned program into one where certain entities are gaming the system to inappropriately exploit revenue-generating opportunities at the expense of patients. CLS argues that this bill requires biopharmaceutical manufacturers to ship 340B drugs to an unlimited number of pharmacies that contract with 340B CEs and prohibits drug manufacturers from requesting

any data from CEs about the patients to whom the 340B drugs are being administered to and verifying whether they are eligible for 340B discounted drugs. Due to the lack of transparency in the 340B program, it has ballooned to the second largest federal prescription drug program behind Medicare Part D. From 2013 to 2021, 340B discounted drug revenue increased 374%, reaching $56.1 billion nationwide and the 340B program is now on pace to surpass Medicare Part D spending by 2027. CLS would like to continue working with the author to identify alternative approaches that provide state funding for rural clinics rather than the inefficient and flawed approach taken in this bill, which exacerbates the misuse of a well-intentioned program that ultimately shortchanges patients who need access to health care.

5) PREVIOUS LEGISLATION.

a) SB 786 (Portantino), Chapter 414, Statutes of 2023 prohibits a pharmacy benefit manager from discriminating against a CE or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a CE from retaining the benefit of discounted pricing for those drugs.

b) SB 939 (Pan) of 2022 would have prohibited a PBM from discriminating against a CE or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a CE from retaining the benefit of discounted pricing for those drugs. Further, SB 939 would have prohibited a drug manufacturer that is subject to federal pricing requirements from imposing preconditions, limitations, delays, or other barriers to the purchase of covered drugs that are not required under federal law or regulations.

c) AB 1050 (Gray) of 2021 would have prohibited the DHCS director from taking any action that materially increases the administrative burden or cost of dispensing 340B drugs by FQHCs and rural health clinics (RHCs), including, but not limited to, changes that adversely impact the use of contract pharmacy arrangements. The bill would have required the DHCS director, before taking an action that materially impacts the 340B drug program, to prepare a detailed report describing the proposed action, including a determination that the action does not violate this provision. AB 1050 was held in Assembly Appropriations Committee.

d) AB 80 (Committee on Budget) Chapter 12, Statutes of 2020 authorizes DHCS to implement a payment methodology to provide for supplemental payments to qualifying non-hospital 340B community clinics to secure, strengthen, and support the community clinic and health center delivery system for Medi-Cal beneficiaries.

6) SUGGESTED AMENDMENTS. This bill prohibits a prescription drug manufacturer from engaging in discriminatory practices that would impose additional conditions, prohibit, restrict, deny, or interfere with a CE's purchase or delivery of a drug eligible for discounts under the federal pricing requirements set forth in the federal 340B program, if the CE utilizes a specified pharmacy, including a contract pharmacy, that dispenses the drug to an eligible patient of the CE. This bill does not define "discriminatory practice." The Committee may wish to amend this bill by specifying the nature of discriminatory practices this bill refers to, such as prohibiting CEs from using more than one contract pharmacy, restricting the number of contract pharmacies a CE may use to dispense drugs to an eligible patient, restricting a CE from being able to use a contract pharmacy if the CE has an in-house pharmacy, restricting a non-hospital 340B clinic from being able to ship to eligible patients

over a certain distance if the CE has an in-house pharmacy, imposing limitations on which drugs can be qualify for 340B pricing at contract pharmacies, and imposing arbitrary distance requirements on contract pharmacies. To address opposition concerns, the Committee may also wish to narrow the bill to only apply to clinics and clarify that this bill does not diminish federal and state laws with regard to 340B program.

Concerns have been raised to the Committee with regard to the financial arrangements between 340B CEs and contract pharmacies, as well as transparency with regard to the uses of 340B savings. It is important to note that the 340B program is a federal program intended to enable covered entities to stretch federal resources, reach more eligible patients, and provide more comprehensive services. As part of their participation in the program, covered entities are required to re-certify eligibility to participate in the program, prevent diversion to ineligible patients, prevent duplicate discounts, and maintain auditable records documenting compliance with 340B program requirements, which manufacturers or the federal government may audit. The Committee may also wish to clarify that federal requirements with regard to program integrity and auditing remain in place under this bill.

7) REGISTERED SUPPORT / OPPOSITION:

Support

Achievable Health
AIDS Healthcare Foundation
AltaMed Health Services
APLA Health
Arroyo Vista Family Health Center
Asian Health Services
California Children's Hospital Assn
California Farmworker Foundation
California Hospital Association
California Retired Teachers Association
CalPACE
Centers for Family Health and Education
Central Neighborhood Christian Health Clinics
Central Valley Health Network
Central Valley Opportunity Center (CVOC)
Chinatown Service Center
Clinica Romero
Coalition of Orange County Community Health Centers
Community Clinic Association of Los Angeles County (CCALAC)
Community Health Centers of the Central Coast
Community Health Partnership
Community Health Systems, INC.
Comprehensive Community Health Centers
County of Humboldt
CPCA Advocates, Subsidiary of The California Primary Care Association
Desert Aids Project
East Valley Community Health Center
Eisner Health

Family Health Centers of San Diego
Family Healthcare Network
Gardner Family Health Network, Inc.
Gardner Health Services
Golden Valley Health Centers
Gracelight Community Health
Health Alliance of Northern California
Health Center Partners of Southern California
Hill Country Community Clinic
Innercare
LA Clinica De LA Raza, INC.
Latino Coalition for a Healthy California
Los Angeles LGBT Center
Marin City Health and Wellness Clinics
Merced County Board of Supervisors
Merced Union High School District
Neighborhood Healthcare
North Coast Clinics Network
North East Medical Services (NEMS)
Northeast Valley Health Corporation
Ochin, Inc.
Petaluma Health Center, Inc.
Planned Parenthood Affiliates of California
Providence St. Joseph Health
Ridgecrest Regional Hospital
Rural County Representatives of California (RCRC)
Saban Community Clinic
Salud Para LA Gente
San Fernando Community Health Center
San Ysidro Health
Santa Rosa Community Health
Share Our Selves
Southside Coalition of Community Health Centers
St. Jude Neighborhood Health Center
St. Vincent De Paul Villages, Inc.
Sutter Health
Tarzana Treatment Centers, Inc.
The Roads Foundation, Inc.
TrueCare
United Health Centers
University of California
Valley Community Healthcare
Venice Family Clinic
Via Care Community Health Center
Watts Healthcare Corporation
WellSpace Health
Wesley Health Centers
Westside Family Health Center
White Memorial Community Health Center

Wilmington Community Clinic

Opposition

ADAP Advocacy
Aiarthritis
AMAAD Institute (Arming Minorities Against Addiction & Disease)
Association of Hidradenitis Suppurativa and Inflammatory Diseases
Axis Advocacy
Biocom California
Biomarker Collaborative
Biotechnology Innovation Organization
Blackdoctor.org
California Life Sciences Association
California Manufacturers and Technology Association
California-Hawaii State Conference of the NAACP
Carrie's Touch
Coalition of Hematology & Oncology Practices
Coalition of State Rheumatology Organizations
Community Access National Network
Community Health Action Network
Community Oncology Alliance (COA)
Connecting to Cure Crohn’s and Colitis
Exon 20 Group
Hispanic Business Alliance
ICAN, International Cancer Advocacy Network
Infusion Access Foundation
Infusion Access Foundation (IAF)
Johnson & Johnson Services, Inc. and Affiliated Entities
Latino Diabetes Association
Let's Kick Ass (AIDS Survivor Syndrome) Palm Springs
Liver Coalition
Liver Health Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of Southern California
Lupus LA
Met Crusaders
Mexican American Opportunity Foundation
National Infusion Center Association
Patient Advocates United in San Diego County
Pd-l1 Amplifieds
Retiresafe
The Wall Las Memorias Project

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

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1487 (Addis) – As Amended March 28, 2025

SUBJECT: Public health: the Two-Spirit, Transgender, Gender Nonconforming, and Intersex Wellness and Equity Fund.

SUMMARY: Renames the Transgender, Gender Nonconforming, and Intersex (TGI) as the Two-Spirit (2TGI) Wellness and Equity Fund, expands the purpose for which grants can be awarded from the 2TGI Fund, and expands the requirements for grant fund availability for 2TGI individuals to include providing workforce development training, resettlement and social integration programs for asylees and immigrants, and for diversion programs for, and outreach to, transitional age 2TGI youth. Specifically, **this bill**:

1) Renames the Transgender, Gender Nonconforming, and Intersex (TGI) as the Two-Spirit (2TGI) Wellness and Equity Fund (2TGI Fund).

2) Expands the purpose for which grants can be awarded from the 2TGI Fund to also include cultural competency training.

3) Expands the requirement for grant fund availability for 2TGI individuals to include:

    a) Requiring grants to be available to 2TGI-serving organizations for the purpose of providing workforce development training for 2TGI individuals;

    b) Requiring grants to be available to 2TGI-serving organizations for the purpose of providing resettlement and social integration programs for 2TGI asylees and immigrants; and,

    c) Requiring grants to be available to 2TGI-serving organizations for the purpose of providing diversion programs for, and outreach to, transitional-age 2TGI youth.

4) Expands the definition of "health care" for purposes of the 2TGI Fund and the grants from the 2TGI fund to also include "mental health services."

5) Defines "Two-Spirit" as a term referring to unique indigenous cultural roles that intersect with diverse sexual orientations and gender embodiments.

EXISTING LAW:

1) Establishes the Transgender, Gender Nonconforming, and Intersex (TGI) Wellness and Equity in the State Treasury. [Health and Safety Code § 150900]

2) Requires the Department of Public Health's (DPH) Office of Health Equity (OHE) to administer the TGI Wellness and Equity Fund for purposes of funding grants to create programs, or funding existing programs, focused on coordinating trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex. [*Ibid.*]

3) Permits, upon appropriation by the Legislature, moneys in the TGI Wellness and Equity Fund to be used to fund grants to various organizations for the following purposes:

    a) TGI-serving organizations for the purpose of increasing the capacity of health care professionals to effectively provide TGI health care and institute TGI-inclusive best practices, including the creation of educational materials or facilitation of capacity-building trainings;

    b) TGI-serving organizations for the purpose of facilitating therapeutic arts programs, such as dancing, painting, or writing;

    c) TGI-serving organizations for purposes of assisting, identifying, and referring TGI people to access supportive housing, including case management opportunities, financial assistance, and assisting TGI people in receiving and utilizing housing vouchers. Authorizes a TGI-serving organization that has already implemented a TGI-specific housing program to utilize funding to maintain or expand existing housing programs; or,

    d) A hospital, health care clinic, or other medical provider that currently provides gender-affirming health care services, such as hormone therapy or gender reassignment surgery, to continue providing those services, or to a hospital, health care clinic, or other medical provider that will establish a program that offers gender-affirming health care services and has an established relationship with a TGI-serving organization that will lead in establishing the program. Requires a hospital, health care clinic, or other medical provider that applies for a grant to apply in partnership with a TGI-serving organization and consult with the TGI-serving organization throughout the process of creating and implementing its trans-inclusive health care program. [*Ibid.*]

4) Defines, for purposes of the above-described provisions:

    a) "Health care" to mean all of the following:

        i) Medical, behavioral, and spiritual care, which includes, but is not limited to, guided meditation and nondenominational therapy;

        ii) Therapeutic arts programs, which includes, but is not limited to, dancing, painting, and writing classes;

        iii) Services related to substance use disorder or substance abuse; and,

        iv) Supportive housing as a mechanism to support TGI-identified individuals in accessing other social services. [*Ibid.*]

    b) "Transgender" as a broad and inclusive of all gender identities different from the gender a person was assigned at birth. [*Ibid.*]

    c) "Gender nonconforming" as an inclusive term used to describe individuals who may experience a gender that is neither exclusively male nor female or is in between or beyond both of those genders, including, but not limited to, nonbinary, gender fluid, a gender or without gender, third gender, genderqueer, gender variant, Two-Spirit, Hijra, Kathoey, Mak nyah, Muxe, Waria, Māhū, and Fa'afafine. [*Ibid.*]

d) "Intersex" as an umbrella term referring to people whose anatomy, hormones, or chromosomes fall outside the strict male and female binary. [*Ibid.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, as federal attacks escalate and attempts to erase people's identity intensify, California cannot be complacent. The author states that, when policies or people waver, real commitment means standing firm, and not shifting with the political winds. This bill strengthens this critical fund to ensure Two-Spirit, Transgender, Gender Nonconforming, and Intersex individuals receive the support they need to thrive, including access to health care, job training, and social integration programs.

2) **BACKGROUND.** AB 2218 (Santiago), Chapter 181, Statutes of 2020, establishes the now-named TGI Fund for the purpose of funding grants to organizations serving people that identify as TGI, to create or fund TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers, and to provide TGI-focused health care, and related education programs for health care providers. In 2022, AB 2521 (Santiago), Chapter 869, Statutes of 2022, renamed the fund the TGI Fund. The 2021-22 State Budget allocated $13 million to the Fund, which was rolled over to the 2022-23 fiscal year. DPH's OHE indicates it has awarded seventeen active grantees for a total of $6.8 million and three totaling $2.8 million which are pending grant execution, for a total of 20 grants. The grants are awarded across the four statutorily defined categories in existing law.

3) **BACKGROUND ON TRANSGENDER HEALTH.** The Williams Institute at the University of California Los Angeles School of Law (which conducts independent research on sexual orientation and gender identity law and public policy) estimates over 150,000 adults and 49,000 youth (ages 13 to 17) identify as transgender in California. Data from the US Transgender Population Health Survey indicates that transgender individuals experience more poor mental and physical health days per month than cisgender individuals. Studies have also shown that the prevalence of suicidal thoughts and attempts among transgender adults is significantly higher than that of the general population.

   Among transgender individuals, 28.2% and 31.2% reported hazardous drinking and problematic drug use, respectively; 44.4% reported recent suicidal ideation, 6.9% reported a recent suicide attempt, and 21.4% reported recent non-suicidal self-injury. In their lifetime, 81.3% of transgender respondents had suicidal ideation, 42% had attempted suicide, and 56% reported non-suicidal self-injury. Most had utilized formal mental health care and 25.5% had sought informal mental health support. In addition, according to the National Center for Transgender Equality, one in three transgender people has experienced homelessness.

   A 2022 report titled *"Early Insights: A Report of the 2022 U.S. Transgender Survey"* (USTS) stated early one-quarter of respondents (24%) did not see a doctor when they needed to in the last 12 months due to fear of mistreatment. Forty-four percent (44%) of respondents experienced serious psychological distress in the last 30 days, 79% of respondents saw a doctor or health care provider within the last 12 months, and 9% saw a provider between one and two years ago. Of those who saw a health care provider within the last 12 months, nearly one-half (48%) reported having at least one negative experience because they were transgender, such as being refused health care, being mis-gendered, having a provider use

harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them.

More than one-third (34%) of respondents were experiencing poverty. The unemployment rate among USTS respondents was 18%. More than one in ten (11%) respondents who had ever held a job said they had been fired, forced to resign, lost the job, or been laid off because of their gender identity or expression. Nearly one-third (30%) of respondents had experienced homelessness in their lifetime.

4) **SUPPORT.** This bill is sponsored by TransLatin@ Coalition and other organizations committed to supporting marginalized communities' rights and well-being. Supporters write the expansion of the grant programs contained in this bill are critical in ensuring that 2TGI people receive the holistic support they need, from health care to housing to workforce training, to successfully reintegrate into society. Supporters argue this legislation represents a meaningful step forward in addressing the systemic inequalities that 2TGI individuals face. Supporters conclude that this bill will help ensure that 2TGI people have access to the resources and services they need to rebuild their lives and thrive in society.

5) **PREVIOUS LEGISLATION.** AB 2521 renamed the Transgender Wellness and Equity Fund the Transgender, Gender Nonconforming, or Intersex Wellness and Equity Fund, defined various terms including transgender, and included in the definition of a TGI-serving organization a nonprofit that serves as the fiscal agent or sponsor for an organization with a mission statement that centers around serving TGI people, and where at least 65% of the clients of the organization are TGI. Also requires a nonprofit serving as fiscal agent or sponsor to pass all funding to the TGI organization, but would authorize a reasonable or industry standard fee for administrative costs of not more than 16%.

REGISTERED SUPPORT / OPPOSITION:

Support

TransLatin@ Coalition (sponsor)
American Civil Liberties Union California Action
API Equality-LA
APLA Health
Asian Americans Advancing Justice-Southern California
California Legislative LGBTQ Caucus
California LGBTQ Health and Human Services Network
Central Coast Coalition for Inclusive Schools
County Welfare Directors Association of California
End the Epidemics: Californians Mobilizing to End HIV, Viral Hepatitis, STIs, and Overdose
Equality California
Gender Alchemy
Gender Justice LA
GLIDE
GUSD Parents for Public Schools
I Understand You
Imperial Valley Equity & Justice Coalition
Interact Advocates for Intersex Youth

Lavender Phoenix
National Health Law Program
Open Door Community Health Centers
Parivar Bay Area
Parivarbayarea
Pride at the Pier
The LGBT Asylum Project
The San Diego LGBT Community Center
Transgender Law Center
Unique Woman's Coalition
Universidad Popular
Four individuals

Opposition

None on file

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