

An act to add Chapter 2.6 (commencing with Section 127500) to Part 2 of Division 107 of the Health and Safety Code, relating to health care costs.

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Chapter 2.6 (commencing with Section 127500) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 2.6. HEALTH CARE AFFORDABILITY

Article 1. General Provisions and Definitions

127500. This chapter shall be known, and may be cited, as the California Health Care Quality and Affordability Act.

127500.2. As used in this chapter, the following definitions apply:

(a) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing.

(b) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans in the individual market, employers purchasing group coverage, and the state, for health coverage and shall include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

(c) "Alternative payment model" means a state or nationally recognized payment approach that rewards high quality and cost-efficient care.

(d) "Board" means the Health Care Affordability Advisory Board established by Section 127501.10.

(e) "Director" means the Director of Statewide Health Planning and Development.

(f) "Exempted provider" means a provider that meets standards established by the office for exemption from the statewide, sector-specific, and geographic region cost targets or submitting data directly to the office. The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, member months, and market share in a given service or geographic region.

(g) "Health care cost target" means the target percentage for the change in total health care expenditures in the state, whether negative or positive.

(h) "Health care entity" means a payer or provider.

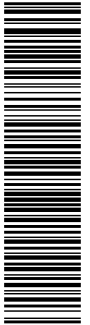
(i) "Insurance market" means the public and private insurance markets.

(j) "Line of business" means the different individual, small, and large group business lines, as defined in Section 1348.95 of this code and Section 10127.19 of the Insurance Code.

(k) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

(l) (1) "Net cost of health coverage" or "administrative costs and profits" means the costs associated with the administration of health coverage, and is defined as the difference between the premiums received by a payer and expenditures for covered benefits.

(2) For health care service plans and health insurers, the net cost of health coverage is derived from all costs not attributable to the numerator of the Medical Loss



Ratio calculation, as defined in subdivision (a) of Section 1367.003 of this code and subdivision (a) of Section 10112.25 of the Insurance Code, respectively.

(m) "Office" means the Office of Health Care Affordability within the Office of Statewide Health Planning and Development.

(n) "Payer" means private and public health care payers, including all of the following:

(1) A health care service plan or a specialized health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(2) A health insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays or reimburses for any part of the cost for the provision of health care.

(o) "Provider" means an individual, organization, or business entity that provides health care services, including, but not limited to, a physician organization or other similar group of providers, health facility, health clinic, including a clinic operated or maintained as an outpatient department of a hospital, or other institutions licensed by the state to deliver or furnish health care services.

(p) "Total health care expenditures" means all health care expenditures in the state by public and private sources, including all of the following:

(1) All payments on providers' claims for reimbursement of the cost of health care provided.

(2) All non-claims based payments to providers.

(3) All cost-sharing paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.

(4) The net cost of health coverage.

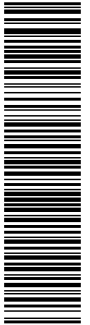
127500.5. (a) The Legislature finds and declares all of the following:

(1) It is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

(2) While California has reduced the uninsured share of its population to a historic low of 7 percent through implementation of the federal Patient Protection and Affordable Care Act (PPACA: Public Law 111-148) and other state efforts, affordability has reached a crisis point as health care costs continue to grow.

(3) As costs rise, employers are increasingly shifting the cost of premiums and deductibles to employees, negatively impacting the potential for wage growth. Between 2010 and 2018, wages in the state kept pace with inflation by increasing by 19 percent. Meanwhile, families with job-based coverage experienced a 45 percent increase in premiums, or more than twice the rate of wage growth. During the same period, families experienced a 70 percent increase in PPO deductibles, or nearly four times the rate of wage growth. While health insurance premium increases for 2021 may be considered moderate due to lower utilization as a result of the novel coronavirus (COVID-19) pandemic, this abatement in health care cost growth is expected to be temporary.

(4) Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly in geographic



areas and sectors where there is a lack of competition due to consolidation, market power, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.

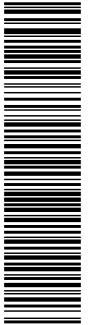
(5) Californians of color experience health disparities, including barriers to accessing care, receiving lower quality of care, and experiencing worse health outcomes. Certain communities, including low-income, Black, Latino, Pacific Islander, and essential workers, have been disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths. These negative health outcomes further highlight a public health imperative to reduce racial and ethnic disparities in health care.

(6) The COVID-19 pandemic has exposed vulnerabilities within the current system with regard to provider payments. Although a significant share of physician organizations receive capitated payments at the organizational level, individual providers and practices are largely reimbursed on a fee-for-service (FFS) basis, an approach that rewards the volume of services delivered, rather than quality and cost efficiency. As Californians stayed home, the loss of FFS payment revenue for providers has downstream impacts on access to care and for health care workers' economic security. Beyond exposing providers to considerable financial instability, FFS payments may not be the most effective way to incentivize providers to deliver high quality and cost-efficient care or offer the flexibility to make practice changes that enable improved access, care coordination, patient engagement, and quality.

(7) Primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. However, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other countries.

(8) Behavioral health needs are common among Californians, with most who need it not receiving treatment. National research finds that persons with mental health or substance use disorders have approximately two to three times higher medical costs than those with no behavioral health diagnosis. This research also shows that total health care spending on mental health and substance use disorder services have remained relatively flat between 2012 and 2017. Models that integrate primary care and behavioral health services have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.

(9) Surveys show that people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill. In California, one in four people report problems paying or being unable to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing to pay those



bills. Concerns about affordability of coverage and care are expected to be exacerbated during the economic recession related to the COVID-19 pandemic.

(10) High drug prices contribute significantly to health care costs. Prescription drugs account for nearly one-fifth of health care spending. The Centers for Medicare and Medicaid Services project that prescription drug spending will grow faster and outpace other categories of health care spending in the years to come. Cost-effectiveness analyses often find that drugs are priced in excess of the value they deliver to patients.

(11) The State of California has a substantial public interest in the price and cost of health care coverage. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. The government also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) It is the intent of the Legislature to have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce health care costs while maintaining quality of care, with the goal of improving affordability and equity of health care for Californians.

(c) It is the intent of the Legislature to encourage policies, payments, and initiatives that improve the affordability, quality, efficiency, and value of health care service delivery, with a particular focus on ensuring health equity and reducing disparities in care and outcomes across California.

(d) It is the intent of the Legislature for the State of California to achieve more affordable health care and better outcomes by consistently measuring and promoting sustained systemwide investment in primary care and behavioral health.

(e) It is the intent of the Legislature to facilitate increased adoption of alternative payment models that reward high quality and cost-efficient care, including strategies for shared savings and downside risk arrangements and population-based payments.

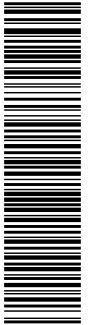
(f) It is the intent of the Legislature to promote the goal of health care affordability while recognizing the need to maintain and increase the supply of trained health care workers, and to monitor the effects of cost containment efforts on health care workforce stability and the training needs of health care workers.

(g) It is the intent of the Legislature to increase transparency on mergers, acquisitions, and corporate affiliations involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities that may impact market competition and affordability for consumers and purchasers.

(h) It is the intent of the Legislature to analyze cost trends in the pharmaceutical sector, study the impact of drug prices and pharmaceutical market failures on affordability, and inform policy interventions to improve competition and lower consumer costs.

(i) It is the intent of the Legislature in enacting this chapter to provide accountability to the State of California for the affordability and cost of health care in California.

(j) It is the intent of the Legislature, therefore, to establish a single entity within state government charged with doing all of the following:



- (1) Developing a comprehensive strategy for cost containment in California, resulting in growth of health care expenditures at or below an established economic indicator, including measuring progress towards lowering per capita health care spending while maintaining quality and equity of care.
- (2) Addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions commensurate with the offense or violation.
- (3) Referring transactions that may reduce market competition or increase costs to the Attorney General for further review.

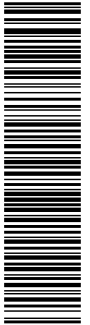
Article 2. Office of Health Care Affordability

127501. (a) There is hereby established, within the Office of Statewide Health Planning and Development, the Office of Health Care Affordability.

(b) The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

(c) The office shall do all of the following:

- (1) Increase cost transparency through public reporting of total health care spending and factors contributing to health care cost growth.
- (2) Establish a statewide health care cost target for per capita spending.
- (3) Set specific targets by health care sector, including by payer, provider, insurance market, or line of business, as well as by geographic region.
- (4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve corrective action plans, monitor impacts on health care workforce stability, and carry out all other functions of the office.
- (5) Analyze cost trends in the pharmaceutical sector.
- (6) Oversee the state's progress towards the health care cost target by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, and assessing administrative penalties, including escalating administrative penalties for noncompliance.
- (7) Promote and measure quality and health equity through the adoption of a priority set of standard quality and equity measures for assessing health care service plans, health insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.
- (8) Advance standards for promoting the adoption of alternative payment models.
- (9) Measure and promote sustained systemwide investment in primary care and behavioral health.
- (10) Advance standards for health care workforce stability and training, as these relate to costs.
- (11) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target.
- (12) Address consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations



involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

(d) For purposes of implementing this chapter, including hiring staff and consultants, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Until January 1, 2026, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

127501.2. (a) Until January 1, 2027, any necessary rules and regulations for the purpose of implementing this chapter may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including subdivisions (e) and (h) of Section 11346.1, an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the office pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation.

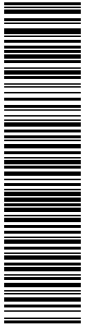
(c) Any rule or regulation adopted pursuant to this section shall be discussed by the office during at least one properly noticed meeting prior to the adoption of the rule or regulation.

(d) Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2030, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.

127501.4. (a) Notwithstanding any other state or local law, the office shall collect data and other information it determines necessary from health care entities to carry out the functions of the office. To the extent consistent with federal law and to the greatest extent possible, the office may leverage existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting. The office may request data and information from the Department of Managed Health Care, the Department of Insurance, and other relevant state agencies that monitor compliance of plans and providers with access standards, including timely access, language access, geographic access, and other access standards as provided by law and regulation.

(b) The office shall establish requirements for payers to submit data and other information necessary to do all of the following:

- (1) Measure health care expenditures.
- (2) Determine whether health care entities met health care cost targets.
- (3) Identify the annual change in health care costs of health care entities.
- (4) Approve and monitor implementation of corrective action plans.
- (5) Assess performance on quality and equity measures.



(c) The office may establish requirements for providers to submit data in support of this section as necessary to carry out the functions of the office.

(d) (1) For the baseline health care spending report published pursuant to Section 127501.6, payers shall submit data on total health care expenditures for the 2021 and 2022 calendar years on or before December 31, 2023. This initial baseline health care spending report shall serve as baseline data for measuring the statewide cost target effective for the 2023 calendar year.

(2) For subsequent annual reports, commencing with the 2025 calendar year, published pursuant to subdivision (b) of Section 127501.6, payers shall submit data on total health care expenditures in the prior calendar year according to the reporting schedule established by the office.

(e) The office shall require health care service plans, health insurers, hospitals, and physician organizations to report data on the priority set of standard quality measures pursuant to Section 127503.

(f) (1) The office shall require payers to submit data and other information to measure the adoption of alternative payment models pursuant to Section 127504.

(2) The office shall establish requirements for payers to report data and other information, including, but not limited to, the types of payment models, the number of members covered by alternative payment models, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to those payment models.

(g) (1) The office shall require payers to submit data and other information to measure the percentage of total health care expenditures allocated to primary care and behavioral health pursuant to Section 127505.

(2) For the calculation of total health care expenditures allocated to primary care and behavioral health, the office shall do all of the following:

(A) Leverage the health care payments data program, established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible to minimize reporting burdens for payers.

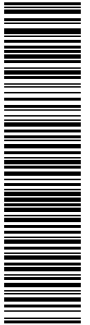
(B) Determine the categories of health care professionals who should be considered primary care and behavioral health providers.

(C) Determine specific procedure codes that should be considered primary care and behavioral health services.

(D) Determine the categories of non-claims-based payments to primary care or behavioral health care providers and practices, including alternative payment models, that should be included when determining the total amount spent on primary care and behavioral health.

(h) (1) The office shall require providers to submit audited financial reports, similar to those required in paragraphs (a) to (e), inclusive, of Section 128735, if not otherwise required to do so under Section 128735.

(2) Notwithstanding any other law, all information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) or any similar local law requiring the disclosure of public records.



(i) (1) Consistent with subdivision (a), the office shall obtain data from existing state data sources and from regulated entities to effectively monitor impacts to health care workforce stability and training needs.

(2) The office may collect all of the following types of data and make it accessible to the public:

(A) Overall trends in the health care workforce, including, but not limited to, statewide and regional workforce supply, unemployment and wage data, trends and projections of wages and compensation, projections of workforce supply by region and specialty, training needs, and other future trends in the health care workforce.

(B) The number and classification of workers in internship, clinical placements, apprenticeships, and other training programs sponsored by an employer.

(C) The percentage of employees employed through a registry or casual employment.

(D) The number of workers at health care entities that were retrained through established public training programs.

(E) Investments by health care entities in private training and retraining programs.

(3) The office may request additional data from health care entities if it finds that the data is needed to effectively monitor impacts to health care workforce stability and training needs.

(4) The office may annually request from health care entities that are in compliance with the cost target, a summary of best practices used for improving health care affordability, if any.

(j) In furtherance of this section, the office shall develop reporting schedules, technical specifications, and other resources that support the submission of timely data in a standardized format. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the office shall engage relevant stakeholders and hold a public meeting.

127501.6. (a) For data submitted to the office for the 2021 and 2022 calendar years, the office shall prepare a report on baseline health care spending consistent with subparagraph (A) of paragraph (2) of subdivision (b) on or before June 1, 2024.

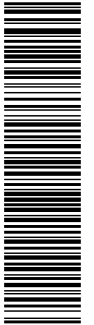
(b) (1) On or before June 1, 2025, the office shall prepare and publish an annual report concerning health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability. The report shall be based on the office's analysis of data collected pursuant to this chapter and information received by the office. The first annual report shall cover the 2023 calendar year.

(2) The annual report shall detail all of the following:

(A) Total per capita health care expenditures, disaggregated by service category, consumer out-of-pocket spending, and health care sector, such as payer, provider, insurance market, or line of business, as well as by geographic region.

(B) Beginning with the annual report for the 2023 calendar year, the state's progress towards achieving the health care cost target and improving affordability for consumers and purchasers of health care, while improving quality, reducing health disparities, and maintaining access to care and high-quality jobs and workforce stability.

(C) Upon implementation of the health care payments data program pursuant to Chapter 8.5 (commencing with Section 127671), or the availability of an alternative



source of medical claims data for payers required to report to the office, cost trends by health care sector, such as type of provider or service type. Any detailed analysis of cost trends in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate, without disclosing any product- or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement.

(D) Factors that contribute to cost growth within the state's health care system.

(E) Access, quality, and equity of care measures and data, as available. Access includes timely access, language access, geographic access, and other measures of access reported through available data.

(F) Corrective action plans required, administrative penalties imposed and assessed, and the amount returned to consumers, if any.

(G) A summary of best practices for improving affordability, as well as any concerns regarding impacts on the health care workforce stability and training needs of health care workers, as feasible.

(c) (1) Following the completion of the report on baseline health care spending, the office shall conduct a public meeting to present the report's findings to the board and the broader public. The report on baseline health care spending shall be finalized at a subsequent public meeting.

(2) On or before June 1, 2025, and each year thereafter, the office shall conduct a public meeting to present the annual report to inform the board, policymakers, including the Governor and the Legislature, and the broader public about implementation of this chapter, including health care cost targets, cost trends, and actionable recommendations for mitigating cost growth. The annual report shall be finalized at a subsequent public meeting.

(3) The director may call for public statements on findings of the annual report from payers, providers, and experts on matters relevant to health care affordability, costs, quality and equity of care, workforce stability, and administrative simplification.

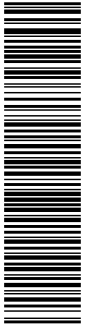
(4) (A) The director may solicit and collect comments from the public, submitted orally, electronically, or in writing, regarding any impacts of health care affordability efforts on health care workforce stability or training needs. A person submitting comments may do so anonymously. All comments shall be posted on the office's internet website.

(B) The office shall notify the relevant regulatory agency if a health care entity is complying with the cost targets by impacting health care workforce stability or quality jobs, lowering quality, or reducing access or equity of care.

(d) The annual report and the report on baseline health care spending shall be submitted to the Governor and the Legislature, shall be made available to the public on the office's internet website. The reports submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

(e) The public meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.



(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and payers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

127501.10. (a) (1) There is hereby established, within the office, the Health Care Affordability Advisory Board. The board shall be composed of nine members, appointed as follows:

(A) Five members shall be appointed by the Governor.

(B) Two members shall be appointed by the Senate Committee on Rules.

(C) Two members shall be appointed by the Speaker of the Assembly.

(2) The Secretary of Health and Human Services or their designee shall serve as an ex officio member of the board.

(3) The Attorney General shall appoint an ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. A member of the board may continue to serve until the appointment and qualification of a successor. Vacancies shall be filled by appointment for the unexpired term. The Governor shall appoint the chair of the board.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least one of the following areas: health care economics; health care delivery; health care management or health care finance and administration, including payment methodologies; health plan administration and finance; health care technology; competition in health care markets; primary care; behavioral health, including mental health and substance use disorder services; purchasing or self-funding group health care coverage for employees; enhancing value and affordability of health care coverage; organized labor; or health care consumer advocacy.

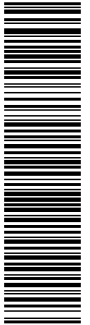
(2) Appointing authorities shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise.

(3) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

(d) A board member shall not receive compensation for service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(e) (1) The board shall meet at least quarterly or at the call of the chair.

(2) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).



(3) The board shall be subject to Article 3 (commencing with Section 87300) of Chapter 7 of Title 9 of the Government Code, and the regulations promulgated thereunder.

127501.11. (a) The board shall provide both of the following to the director:

(1) A recommended statewide cost target, pursuant to Section 127502, approved by a majority vote of the board.

(2) Specific recommended targets by health care sector and geographic region, pursuant to Section 127502, approved by majority vote of the board.

(b) The board shall advise the director on all of the following:

(1) Collection, analysis, and public reporting of data for the purposes of implementing this chapter.

(2) Factors that contribute to cost growth within the state's health care system, including the pharmaceutical sector.

(3) Strategies to improve affordability for both individual consumers and purchasers of health care, including data collection, targets, and other steps.

(4) Recommendations for administrative simplification in the health care delivery system.

(5) Approaches for measuring access, quality, and equity of care.

(6) Setting statewide goals and measuring progress for the adoption of alternative payment models and developing standards that payers and providers can use during contracting.

(7) Recommendations for updates to statutory provisions necessary to promote innovation and to enable the increased adoption of alternative payment models.

(8) Health care workforce stability and training as these relate to health care costs.

(9) Addressing consolidation, market power, and other market failures.

Article 3. Health Care Cost Targets

127502. (a) (1) The director shall establish a statewide health care cost target for total health care expenditures. This target shall be based on the health care cost target recommendation from the advisory board established in Section 127501.10, unless either of the following circumstances apply:

(A) The director issues a public report that provides justification for using an alternate target.

(B) The advisory board fails to reach a majority agreement on a recommended statewide health care cost target pursuant to paragraph (1) of subdivision (a) of Section 127501.11.

(2) When the circumstances in subparagraph (A) or (B) of paragraph (1) apply, the director shall establish a statewide health care cost target for total health care expenditures, considering the recommendation from the advisory board, the data received by the office, and the requirements of this section.

(b) (1) The director shall set specific targets by health care sector and geographic region. These targets shall be based on the health care sector and geographic region target recommendations from the advisory board established in Section 127501.11, unless either of the following circumstances apply:



(A) The director issues a public report that provides justification for using an alternate target.

(B) The advisory board fails to reach a majority agreement on a recommended statewide health care cost target pursuant to paragraph (2) of subdivision (a) of Section 127501.11.

(2) When the circumstances in subparagraph (A) or (B) of paragraph (1) apply, the director shall establish specific targets by health care sector and geographic region, considering the recommendation from the advisory board, the data received by the office, and the requirements of this section.

(3) For purposes of this subdivision, health care sector may include, but is not limited to, payer, provider, insurance market, or line of business.

(4) The office shall promulgate regulations for exempted providers with regard to sector-specific targets.

(5) This subdivision does not exempt claims- and non-claims-based payments for exempted providers, and associated cost-sharing amounts paid by consumers, in the calculation of total health care expenditures submitted by payers.

(6) For purposes of this subdivision, “geographic region” may either be the regions specified in Section 1385.01 or may be otherwise defined by the office.

(7) The director may adjust cost targets by individual health care entity, when warranted, to account for that entity’s baseline costs in comparison to other health care entities in a region or health care sector.

(8) Targets set for payers shall also apply to the net cost of health coverage to deter growth in administrative costs and profits.

(9) The setting of different targets shall be informed by historical cost data and other relevant data, as well as access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127505.

(c) The health care cost targets shall meet all of the following requirements:

(1) Promote a predictable and sustainable rate of change in total health care expenditures.

(2) Be based on established economic indicators reflecting the broader economy and labor market.

(3) Be met by health care entities in the state.

(4) Be annually reviewed and updated.

(5) Be developed, applied, and enforced with consideration of multiple year rolling averages.

(6) Improve affordability for consumers and purchasers of health care.

(d) (1) The director shall establish a methodology to set health care cost targets, including adjustment factors and the economic indicators to be used in establishing the target.

(2) The targets established for a payer’s net cost of health coverage under this section are subject to annual adjustment, but shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.

(e) The director shall direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care costs on an aggregate and per capita basis for any or all of the following:

(1) Statewide.

(2) By geographic region.



(3) By insurance market and line of business.

(4) For payers and providers, both unadjusted and using a standard risk adjustment methodology.

(5) For impact on affordability for consumers and purchasers of health care.

(f) (1) For the 2023 calendar year and each calendar year thereafter, the director shall establish a statewide health care cost target in accordance with this chapter. The 2023 calendar year shall be a reporting year only, and beginning in the 2024 calendar year, applicable cost targets shall be enforced for compliance pursuant to Section 127502.5.

(2) Not later than the 2025 calendar year, the director shall set specific targets by health care sector and geographic region in accordance with this chapter.

(g) Following the board's delivery of recommendations for statewide, sector-specific, or geographic region cost targets, the director shall hold a public meeting to discuss the recommendations. The director shall consider the recommendations of the board and public comment. Cost targets and other decisions of the director consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. Both meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(h) The adoption of cost targets under this section is exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

127502.5. (a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that both ensures compliance with targets and allows each health care entity opportunities for remediation. The director shall consider each entity's contribution to cost growth in excess of the applicable target and the extent to which each entity has control over the applicable components of its cost target. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

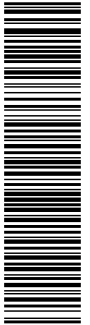
(2) Require public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of corrective action plans.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

(b) (1) If a health care entity exceeds an applicable cost target, the office shall notify the entity of their status and provide technical assistance. The office may require a health care entity to submit and implement a corrective action plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed corrective action plan.

(2) The office shall monitor the health care entity for compliance with the corrective action plan. The office shall publicly post the identity of a health care entity completing a corrective action plan while the plan remains in effect and shall transmit an approved corrective action plan to appropriate state regulators for the entity.



(3) A health care entity shall work to implement the corrective action plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the corrective action plan.

(c) (1) If the office determines a corrective action plan is not appropriate or if the health care entity does not meet the cost target after the implementation of a corrective action plan, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target.

(2) The administrative penalty may be an amount up to the health care entity's spending in excess of the health care cost target and shall be deposited into the Health Care Affordability Fund.

(3) If, after the implementation of one or more corrective action plans, the health care entity repeatedly exceeds the cost target, the director may assess escalating administrative penalties.

(4) In determining the amount of the administrative penalty, the office shall consider the nature and number of offenses.

(d) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

(e) (1) For payers, the director shall enforce cost targets established by Section 127502 against the cost growth for the net cost of health coverage.

(2) If a payer exceeds the target for total health care expenditures, but has met its target for the net cost of health coverage, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth. The office shall review this information to determine the appropriate health care entity that may be subject to enforcement actions under this section.

(f) If data from multiple sources indicate adverse cost impacts from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

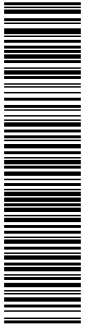
(g) (1) The director may assess administrative penalties when a health care entity has failed to comply with the enforcement process by doing any of the following:

- (A) Willfully failing to report complete and accurate data.
- (B) Neglecting to file a corrective action plan with the office.
- (C) Failing to file an acceptable corrective action plan with the office.
- (D) Failing to implement the corrective action plan.
- (E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) In determining the amount of the administrative penalty, the office shall consider the nature and number of offenses.

(3) The director shall refer a payer who has failed to comply with enforcement procedures, as specified in paragraph (1), to the respective regulator. Failure to comply with enforcement procedures shall constitute a violation of the licensing law applicable to the payer and subject to all civil, administrative, and equitable, but not criminal, remedies.



(4) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

(h) The office may establish requirements for health care entities to file for a waiver of enforcement actions under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

(i) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(j) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(k) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Article 4. Quality and Equity Performance

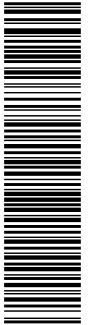
127503. (a) (1) The office shall adopt a priority set of standard measures for assessing health care quality and equity among health care service plans, health insurers, hospitals, and physician organizations. Performance on quality and health equity measures shall be included in the annual report required in Section 127501.6.

(2) The standard quality and equity measures shall use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations.

(3) The standard quality and equity measures shall reflect the diversity of California in terms of race, ethnicity, gender, age, language, sexual orientation, and gender identity. The standard quality and equity measures shall be appropriate for a population under 65 years of age, including children and adults.

(4) The standard quality and equity measures shall consider available means for reliable measurement of disparities in health care, including race, ethnicity, gender, age, language, sexual orientation, and gender identity.

(5) The office shall reduce administrative burden by selecting quality and equity measures that simplify reporting and align performance measurement with other payers and programs.



(b) In implementing this section, the office shall consult with state departments, external quality improvement organizations and forums, payers, physicians, and other providers.

(c) The office shall annually review and update the priority set of standard measures for assessing the quality and equity of care pursuant to subdivision (a).

Article 5. Alternative Payment Models

127504. (a) The office shall promote the shift from payments based on fee-for-service to those rewarding high quality and cost-efficient care. In furtherance of this goal, the office shall set statewide goals for the adoption of alternative payment models and measure the state's progress toward those goals.

(b) (1) On or before July 1, 2023, the office shall adopt standards for alternative payment models that may be used by providers and payers when contracting.

(2) The standards for alternative payment models shall focus on improving affordability, efficiency, equity, and quality by considering the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or population-based payments.

(3) The standards shall include minimum criteria for what is considered an alternative payment model, but be flexible enough to allow for innovation and evolution over time.

(4) The standards shall address appropriate incentives to physicians and other providers and balanced measures, including total cost of care and quality and equity requirements, to protect against perverse incentives and unintended consequences.

(5) The standards shall attempt to reduce administrative burden by incorporating alternative payment models that align with other payers and programs or national models.

(c) The office shall include an analysis of alternative payment model adoption in the annual report required in Section 127501.6.

(d) In implementing this section, the office shall consult with state departments, external organizations promoting alternative payment models, and other entities and individuals with expertise in health care financing and quality and equity measurements.

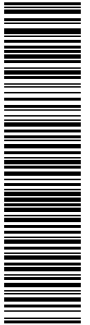
Article 6. Primary Care and Behavioral Health Investments

127505. (a) (1) The office shall measure and promote a sustained systemwide investment in primary care and behavioral health. In furtherance of this goal, the office shall measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks.

(2) The intent of the spending benchmarks is to build and sustain infrastructure and capacity for primary care and behavioral health without increasing costs to consumers or increasing the total costs of health care.

(3) In addition to measuring performance of health care entities with the spending benchmarks, the office shall promote improved outcomes for primary care and behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

(A) Increase access to advanced primary care models.



(B) Integrate primary care and behavioral health services.

(C) Leverage alternative payment models that provide resources at the practice level to enable improved access, care coordination, patient engagement, quality, and population health.

(D) Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.

(b) The office shall include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report required pursuant to Section 127501.6.

(c) In implementing this section, the office shall consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.

Article 7. Health Care Workforce Stability

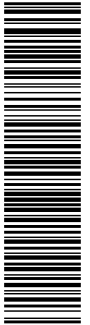
127506. (a) The intent of this section is to monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers. The Legislature intends that the office use a transparent process that allows for public input to monitor how health care entities achieve the cost targets and highlight best practices and discourage practices harmful to workers and patients.

(b) The office shall monitor health care costs while promoting health care workforce stability and the professional judgment of health professionals, acting within their scope of practice. The office shall monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability. The office shall also promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.

(c) To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, the office, on or before July 2023, in consultation with the board, shall develop standards to advance the stability of the health care workforce. The standards may be considered in the approval of corrective action plans imposed pursuant to Section 127502.5.

Article 8. Health Care Market Trends

127507. (a) The office shall monitor cost trends, including conducting research and studies, on the health care market, including, but not limited to, the impact of consolidation, market power, and other market failures on competition, prices, access, quality, and equity. In collaboration with the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall 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, pharmacy benefit managers, and other health care entities.



(b) (1) A health care entity shall provide the office with written notice of agreements or transactions that will occur on or after April 1, 2023, that do either of the following:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.

(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

(2) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. Upon receipt of a written notice under this subdivision, the office shall make the notice of material change publicly available.

(3) The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net patient revenues and market share in a given service or region.

(c) The requirement to provide notice of a material change pursuant to subdivision (b) does not apply to any of the following:

(1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care under Article 10.2 (commencing with Section 1399.65) of Chapter 2.2 of Division 2.

(2) Agreements or transaction involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code.

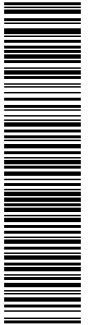
(3) Agreements or transactions involving health care entities under the control of, and operated by, a political subdivision.

(4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code.

(d) Agreements or transactions exempted under subdivision (c) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

(e) This section does not limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system.

127507.2. (a) (1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact review that examines factors relating to a health care entity's business and its relative market position, including, but not limited to, changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or any other factors the office determines to be in the public interest. The office also may conduct cost and market impact reviews on any health care entity based on a determination by the director under subdivision (e) of Section 127502.5, or in association with agreements or transactions referred to the office by a reviewing authority listed in paragraphs (1) to (4), inclusive, of subdivision (c) of Section 127507. An agreement or transaction for which a cost and market impact review proceeds under



this section shall not be implemented without a written waiver from the office or until 30 days after the office issues a final report.

(2) Within 60 days of receipt of a notice of material change, the office shall either advise the noticing health care entity of the office's determination to conduct a cost and market impact review or provide a waiver or conditional waiver. The health care entity shall have 30 days to object to a conditional waiver in writing, and the office shall proceed with a cost and market impact review upon receipt of a written objection.

(3) In furtherance of this article, the office shall conduct investigations, including, but not limited to, compelling, by subpoena, health care entities and other relevant market participants to submit data and documents.

(4) Upon completion of the cost and market impact review, the office shall make factual findings and issue a preliminary report of its findings. After allowing for the affected parties and the public to respond in writing to the findings in the preliminary report, the office shall issue its final report.

(b) The office shall adopt regulations for notification to affected parties for the basis of the review, factors considered in the review, requests for data and information from affected parties, the public, and other relevant market participants, and relevant timelines.

(c) (1) The office shall keep confidential all nonpublic information and documents obtained under this article that were not required with the notice of material change, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in a preliminary report or final report under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations.

(2) Notwithstanding any other law, all nonpublic information and documents obtained under this article shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

(d) (1) The office may refer its findings, including the totality of documents gathered and data analysis performed, to the Attorney General for further review of unfair methods of competition or anticompetitive behavior.

(2) This section does not limit the authority of the Attorney General to protect consumers in the health care market under any other state law.

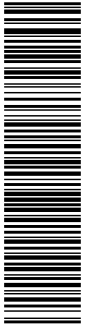
127507.4. In furtherance of this article, the office may do all of the following:

(a) Contract with, consult, and receive advice from any state agency on terms and conditions that the office deems appropriate.

(b) Contract with experts or consultants to assist in reviewing a proposed agreement or transaction.

(1) Contract costs shall not exceed an amount that is reasonable and necessary to conduct the review and complete the report.

(2) The office shall be entitled to reimbursement from the health care entity subject to review for all actual, reasonable and direct costs incurred in reviewing, evaluating, and making the determination referred to in Section 127507.2, including administrative costs. The health care entity subject to review shall promptly pay the office, upon request, for all of those costs.



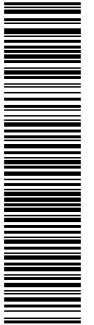
127507.6. In addition to any legal remedies, the office shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of any of the requirements of this article and shall be entitled to recover its attorney's fees and costs incurred in remedying each violation.

SEC. 2. The Legislature finds and declares that Section 2 of this act, which adds Section 127501.4 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

This act balances the need for a government agency to obtain proprietary business information and private health care data with the public interest in monitoring the cost, quality, equity, and accessibility of health care services.

SEC. 3. The provisions of this measure are severable. If any provision of this measure or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: California Health Care Quality and Affordability Act.

Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, including hospitals. Existing law requires health facilities to meet specified cost and disclosure requirements, including maintaining an understandable written policy regarding discount payments and charity.

Existing law establishes the Office of Statewide Health Planning and Development (OSHPD) to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans.

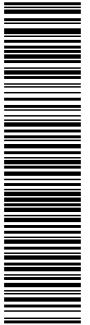
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner.

This bill would establish, within OSHPD, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The bill would also establish the Health Care Affordability Advisory Board, composed of 9 members and 2 ex officio members, appointed as prescribed, to recommend health care cost targets and to advise the Director of Statewide Health Planning and Development and the office.

The bill would require the director to establish a statewide health care cost target for total health care expenditures and specific targets by health care sector and geographic region. The bill would authorize the office to take progressive actions against health care entities for failing to meet the cost targets, including corrective action plans and escalating administrative penalties. The bill would establish the Health Care Affordability Fund for the purpose of receiving and, upon appropriation by the Legislature, expending revenues collected pursuant to the provisions of the bill.

The bill would require the office to set priority standards for various health care metrics, including health care quality and equity, alternative payment methods, primary care and behavioral health investments, and health care workforce stability. The bill would require the office to gather data and present a report on baseline health care spending trends and underlying factors on or before June 1, 2024. On or before June 1, 2025, the bill would require the office to prepare and publish annual reports concerning health care spending trends and underlying factors, along with policy recommendations to control costs and the other stated metrics.

The bill would require the office to monitor cost trends in the health care market and to examine health care mergers, acquisitions, corporate affiliations, or other



transactions that entail material changes to ownership, operations, or governance of health care service plans, insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities. The bill would require the health care entities to provide the office with written notice, as specified, of agreements and transactions that would sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of assets, or that would transfer control, responsibility, or governance of a material amount of the assets or operations to one or more entities. The bill would require the office to conduct a cost and market impact review, as specified, if it finds that the change is likely to have a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers. The bill would prohibit an agreement or transaction for which a cost and market impact review proceeds to be implemented without a written waiver from the office or until 30 days after the office issues its final report. The bill would require the health care entity to pay specified costs associated with that review and completing the report.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

This bill would declare that its provisions are severable.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

