2004 FEDERAL AND STATE LEGISLATIVE REPORT

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
OFFICE OF POLICY AND PLANNING

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I. INTRODUCTION

A. LEGISLATIVE ADVOCACY AND THE STRATEGIC PLAN

Under goal four of the Department of Public Health's revised Strategic Plan, the Department is directed to engage in local, State, and federal advocacy efforts in order to ensure that health policy changes are consistent with Department priorities. The Department's advocacy activities are coordinated in the Office of Policy and Planning, which, through legislative analysis, participation in statewide coalitions, and collaboration with community partners and colleagues from other counties, reviews and analyzes health-related legislation for the Department and the City. The Department works closely with the Mayor's Office of Public Policy and Finance to impact those policies that will affect the health of San Franciscans. As set forth in the Strategic Plan, the Department's advocacy strategies are to:

- Engage in local, State, and federal advocacy efforts through the Mayor's Office;
- Advocate for State and federal legislative changes addressing programmatic issues; and
- Coordinate with the State on licensing and regulatory matters.

B. THE CITY'S FEDERAL LEGISLATIVE PROCESS

The Department works with the Mayor's Office of Public Policy and Finance and also directly with the City's federal lobbyist to impact federal legislation and appropriations. The Department relies heavily on the City's federal lobbyist to communicate the Department's positions in the most timely and effective manner. The Department also works in coalition with organizations such as the National Association of Public Hospitals and Health Systems, the Public Health Pharmacy Coalition, the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition, and others to impact federal policy. By its participation in these coalitions, the Department ensures that the City's interests are well represented at the federal level. Because responsibility for health care lies largely with states rather than with the federal government, the majority of the Department's advocacy activities are focused at the State level.

C. THE CITY'S STATE LEGISLATIVE PROCESS

Pursuant to City policy, the Department of Public Health, like all other City departments, does not take positions on State legislation; that is, the Department does not itself support or oppose State legislation. Rather, the Department makes recommendations to the Mayor's Office of Public Policy and Finance and the Mayor's State Legislative Committee for City positions on health-related legislation. The Mayor's Office approves City positions on legislation in one of two ways: (1) by approving at the beginning of each legislative session the Department's State Legislative Plan, which outlines the Department's recommendations on issues likely to arise in the upcoming year; or (2) through a hearing before the State Legislative Committee for those issues that are not addressed in the State Legislative Plan.

Because the Mayor's Office responds to a large number of such requests coming from all City departments, the Department ensures that the bills it recommends for City positions are those where the impact of the City's position is maximized. In many other instances, worthy bills are supported by statewide coalitions of which the Department is a member. The Department is an active member of the County Health Executives Association of California, the California Conference of Local Health Officers, the Health Officers Association of California, the California Association of Public Hospitals and Health Systems, the California State Association of Counties, and the California Healthcare Association, to name a few. By its participation in these coalitions, the Department ensures that the City is represented in coalition positions. As another example, the Department may not recommend a City position on legislation that is clearly not moving within the Legislature. Though these issues may be important, the City's efforts would not be best spent on inactive legislation.

II. FEDERAL LEGISLATIVE SUMMARY

A. OVERVIEW OF THE LEGISLATIVE SESSION

2004 marked the final year of the two-year Congressional session of the 108th Congress. This year was extraordinary for a number of reasons – most significantly that 2004 was a Presidential election year, but also notable was the significant federal budget deficit of nearly $420 billion. As is typical during any Presidential election year, the focus of the national policy debate centered on the campaign trail for the final months of the Congressional session. Health issues featured prominently in both party platforms, with stump speeches focusing on health care for the uninsured, Medicare prescription drug coverage, medical malpractice reform, and stem cell research.

A highly partisan political environment in Congress is also typical during a Presidential election year and, as a result, most issues of substance were postponed until the new 109th Congress is assembled in January. Nevertheless, during the weeks prior to the August recess, both parties took one last turn at advancing their respective agendas. Republicans pressed forward with legislation to secure a ban on same-sex marriage while Democrats attempted to thwart their efforts using procedural tactics that would allow consideration of a host of their healthcare agenda items, including proposals to enable the government to negotiate for lower prescription drug prices; offer health coverage for legal immigrant children; and automatically enroll low-income beneficiaries into the Medicare drug discount program. Not surprisingly, both parties were unsuccessful in making headway on these issues. However, before returning to their district offices, Congress did adopt two long-pending health bills – patient safety legislation that would establish a voluntary error reporting system and Project Bioshield legislation, a measure that provides funding for the development of vaccines and other countermeasures to bolster the nation's bioterror defenses.

B. MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003

On December 8, 2003, the President signed into law the landmark legislation to add a prescription drug benefit to the Medicare program, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which makes sweeping changes to the

Medicare program. In addition to the bill's most significant provision that establishes a prescription drug benefit in Medicare for the first time, the Medicare legislation also includes provisions on Medicaid Disproportionate Share Hospital (DSH) relief and 340B inpatient drug pricing. The bill included $3 billion in Medicaid DSH funding, drug pricing language that will allow 340B hospitals such as San Francisco General Hospital to negotiate better prices on inpatient drugs, and $250 million annually for providers of emergency health services to undocumented immigrants. More information on these provisions follows.

C. MEDICAID DSH

Medicaid DSH payments, a special type of Medicaid funding for hospitals with large populations of low-income patients, are an essential component of financing for safety net care. As the number of uninsured increases, Medicaid DSH becomes even more critical. Due to legislation passed long before the current economic crises, DSH allotments nationwide decreased by over $1.1 billion (over 11.5 percent of the program) from 2002 to 2003. This decrease is commonly referred to as the DSH "cliff" and, without remedy, would have reduced Medicaid revenues to California's safety net providers by $122 million per year, including a $6.2 million reduction to revenues at San Francisco General Hospital. However, the Medicaid DSH provision that was included in the final version of the MMA gave DSH cliff states a 16 percent increase over FY 2003 allotments in FY 2004. California received more than $1 billion in DSH payments in FY 2004. Allotments for DSH cliff states remain at the 2004 level until 2010, at which time allotments increase by a CPI inflator.

D. 340B, INPATIENT DRUG PRICING

Many public hospitals, including San Francisco General Hospital, receive a significant discount on outpatient pharmaceuticals through the federal 340B Drug Discount Program. Under 340B, certain hospitals and clinics that serve vulnerable populations may purchase outpatient drugs at the Medicaid "best price" from pharmaceutical companies that participate in the Medicaid program. In addition, these eligible providers – or "covered entities" – are free to negotiate discounts even lower than the maximum allowable price. However, for inpatient drugs these same public hospitals are forced to pay 20 to 25 percent more. However, the MMA removed this barrier. The bill included a provision that allows safety net hospitals participating in the 340B pharmaceutical discount program, like San Francisco General Hospital, to negotiate better prices on inpatient drugs. While the provision does not *require* pharmaceutical companies to provide the same 340B discounts that are available on outpatient purchases, it removed a major disincentive that has made it very difficult for drug manufacturers to offer lower prices on inpatient drugs to 340B hospitals.

E. EMERGENCY SERVICES FOR UNDOCUMENTED IMMIGRANTS

Section 1011 of the MMA allocates $250 million a year for the federal fiscal years 2005 through 2008 to directly reimburse providers of emergency health services to undocumented immigrants. In July 2004, the Centers for Medicare and Medicaid Services (CMS) issued a proposed payment methodology for what is called the Section 1011 program, and in early September CMS released the first portion of the finalized methodology, which describes the provider enrollment process to be eligible to receive payments. CMS has not released the remainder of the finalized

methodology including the more controversial aspects of the proposal that focus on how eligible patients will be identified and how providers should bill for services.

The initial draft of the methodology CMS released in July would have required providers to query patients directly about their immigration status and to submit individual claims to receive payments. However, in a dramatic change in policy from the July proposal, CMS subsequently stated that providers will not be required to query patients about citizenship status. This is likely due to the strong advocacy in opposition to tracking undocumented patients. The Department, along with many other providers, wrote to the Director of Health and Human Services in strong opposition to the proposal. CMS's latest correspondence on the subject advises that "providers will not be asked – and should not ask – about a patients citizenship status in order to receive payment under [Section 1011]." The final methodology has yet to be released.

F. FEDERAL BUDGET

Late last November, Congress passed the FY 2005 omnibus appropriations bill. The portion of the bill funding the Departments of Labor, Health and Human Services, and Education (Labor-HHS) included $93.3 billion in mandatory spending and $143.3 billion in discretionary funding, a 2.8 percent increase over fiscal 2004. Included in the federal budget were three earmarks for DPH:

- $1.5 million from the Center for Medicare and Medicaid Services for HIV/AIDS services provided to Medicare and Medicaid eligible populations;
- $1.5 million from the Substance Abuse and Mental Health Services Administration for supportive housing for persons with mental illness or substance abuse disorders; and
- $750,000 from the Department of Justice for supportive housing and services for recently released ex-offenders.

These funding opportunities are the result of the hard work and continued support of House Democratic Leader Nancy Pelosi. The Department is grateful for her assistance, particularly during this time of fiscal uncertainty when the need is most critical.

G. LOOKING AHEAD

Looking ahead to the 109th Congress, which will convene in January 2005, campaign themes including medical malpractice reform and uninsured issues may reemerge on Capitol Hill next year. Of major concern, Medicaid reform also is expected to figure prominently during the 2005 Congress. In addition, the Ryan White CARE Act expires in September 2005. Legislation reauthorizing the CARE Act for another five years is expected to move through Congress in the next year.

In response to criticism over increasing the federal deficit, President Bush has pledged to cut the deficit in half over the next five years. Without significant tax increases, unlikely in the current political environment, it will be difficult to meet this goal without enacting significant cuts in the Medicare and Medicaid programs. It is unclear what, if any, Medicaid changes will be included in the President's FY 2005 budget request, which will be submitted to Congress by February 7, 2005. The House and Senate Budget Committees will then have until April 15 to hold budget

hearings, mark up a Budget Resolution and reconcile differences between the House and Senate Resolutions. It is not unusual, however, for Congress to miss the April 15 target. The levels of Medicaid cuts outlined in the Budget Resolution will likely determine whether the House and Senate authorizing committees propose language such as DSH and IGT reforms or a significant restructuring of the Medicaid program, such as a block grant.

III. STATE LEGISLATIVE SUMMARY

A. OVERVIEW OF THE LEGISLATIVE SESSION

The Legislature ended the second year of its two-year 2003-04 Legislative session in August 2004. The 2003-04 session was unprecedented in many ways. The first year of the session brought the first gubernatorial recall in the history of California. The State has had serious fiscal shortfalls with deficits estimated at more than $45 billion over the two fiscal years of the session. During the 2003-04 session, the Legislature was called into special session five times to address these critical fiscal issues, as well as workers' compensation reforms, and drivers' licenses for undocumented immigrants.

During the two-year session, lawmakers introduced more than 5,000 bills and resolutions in the regular session and sent 2,200 (45%) of those to the Governor's desk. Of those, 1,863 (33%) became law and 370 (6%) were vetoed. In just year two of the session, 1,265 were sent to Governor Schwarzenegger, who set new records for a first-year Governor for the fewest bills signed (75%) and the most bills vetoed (25%). The Department monitored 730 health-related bills in the 2003-04 session. Of those, the Governor signed 260 (36%) and vetoed 57 (8%). Any bill that was not acted upon before the Legislature adjourned in August 2004 is dead and must be reintroduced as a new bill in the 2005-06 session.

B. MEDI-CAL REDESIGN

In January 2004, Governor Schwarzenegger announced his intention to redesign the Medi-Cal program as part of his budget proposal for FY 2004-05. Citing skyrocketing costs and the complex and burdensome nature of the Medi-Cal program structure, the Governor stated that the restructured Medi-Cal program would "provide the State with the flexibility to continue to provide health care coverage to over 6.8 million currently eligible Californians, but do so in a more rational and affordable manner." The redesign is to be accomplished through a Section 1115 Medicaid Demonstration Waiver, which would enable the State to use federal funds in ways that would not otherwise be permitted.

In his FY 2005-06 budget proposal released on January 10, 2005, the Governor began to flesh out his proposal for Medi-Cal redesign. Although it currently lacks specificity, a number of the Governor's proposals could impact the Department including the requirement that new aged, blind, and disabled participants enroll into managed care, changes to the financing of DSH hospitals, an annual cap on adult dental benefits, monthly premiums for individuals above 100 percent of the federal poverty level, and monitoring of county performance standards. The Department will continue to monitor developments.

In August 2004, the Health Commission passed a resolution setting forth principles governing Medi-Cal Redesign to guide the Department in its advocacy on these issues. These will be

critical to the Department's continued advocacy on these issues in 2005 and have been incorporated into the Department's State Legislative Plan, discussed below.

C. HOSPITAL FINANCING

In both of the announcements postponing the release of the Redesign proposal, the Administration referred to the difficulties involved with hospital financing. Many direct and indirect changes proposed in the Medi-Cal reform would impact safety net hospitals. The Administration's current hospital financing proposal attempts to significantly alter the structure of the SB 855 DSH program and the SB 1255 Supplemental Payment program by changing the method by which federal financial participation is brought into California while maintaining each hospital's existing level of funding. Currently, public hospitals provide intergovernmental transfers (IGTs) to the State, which are, in turn, forwarded to the federal government to be matched by Medicaid. Due to the federal government's desire to decrease use of IGTs, the State is proposing to instead fund SB 855 and SB 1255 using certified public expenditures (CPEs). CPEs are based on the costs public hospitals actually incur in providing care to eligible populations. However, whether there are sufficient costs in the system to keep hospitals whole is questionable. The Administration is continuing to work on a proposal that is agreeable to both the federal Centers for Medicare and Medicaid Services and the hospitals and the Department expects that these discussions will continue into 2005. The Department has been and will continue to be actively engaged with its hospitals partners and its delegation on this critical issue.

D. CALIFORNIA PERFORMANCE REVIEW

In August 2004, the California Performance Review (CPR) formally presented their long-awaited report on reforming and revitalizing state government to the Governor, and also released their recommendations to the public. The CPR report is a 2,500-page plan proposes to consolidate 11 agencies and 79 departments into 11 departments and cut growth in state employment by 12,000 positions by 2010 while eliminating 118 boards and commissions to save an estimated $32 billion over the next five years. The report includes everything from general policy recommendations to very specific programmatic or statutory changes. The report includes a number of recommendations in the area of health. The recommendations most likely to impact the Department are summarized below:

- Restructuring of the current Realignment program, wherein counties would return responsibility for indigent health care to the State and, in turn, take responsibility for all mental health programs. (Additional recommendations for significantly realigning social service programs are also included.)
- Replacing the current unique identifier system for reporting HIV cases with a names-based system.
- Discontinuing the provision of DSH funding to hospitals that do not provide core hospital services (including ER, OB and neo-natal intensive care), or hospitals that are not developing credible plans to meet seismic safety requirements.
- Creation of a new Health and Human Services Department that would be composed of the following seven centers:
  - Health Purchasing
  - Public Health

- Quality Assurance
- Behavioral Health
- Services to the Disabled
- Social Services
- Finance and Supportive Services

- Creation of a State Public Health Officer to oversee all core public health functions.

Although the Governor expressed his support for the general themes of the CPR's recommendations, he has not yet indicated which pieces of the recommendations he is likely to pursue. It is likely that some of these recommendations may be included in the Governor's January budget and/or in legislation introduced in the 2005-06 session.

E. STATE BUDGET

The Governor signed the 2004-05 State budget on July 31st, 2004. The budget included total expenditures of $105 billion and bridged a $15 billion gap. According to the Legislative Analyst, the 2004-05 budget included significant ongoing savings and made some progress toward resolving the State's ongoing structural budget shortfall. Nevertheless, like the two prior budgets, the current spending plan contains a significant number of one-time or limited-term solutions and obligates additional spending in future years. The combination of these factors suggests that State will continue to face out-year budget shortfalls, absent corrective action. In fact, the Legislative Analyst estimates a $6.7 billion shortfall for fiscal year 2005-06.

The final 2004-05 State budget contained very few of the reductions in health services that the Governor proposed in January. The most notable January proposals that were rejected in the final budget are Medi-Cal provider rate reductions, reductions in federally qualified health center reimbursement, and enrollment caps for several health programs, including Healthy Families, Medi-Cal for immigrants, the AIDS Drug Assistance Program and the California Children's Services program.

The final budget did, however, eliminate funding to local mental health programs for the Children's System of Care (CSOC) Program. Though the Legislature had restored funding for this program in the budget it submitted to the Governor, the Governor used his line item veto authority to eliminate this funding. This resulted in a reduction in the Department's revenues of approximately $500,000, substantially less than the $5.3 million in estimated losses the Governor's January budget would have produced.

On January 10, 2005, the Governor released his proposed budget for FY 2005-06. Notable health-related proposals include redesign of the Medi-Cal program designed to generate administrative savings of $12.3 million, expansions of health insurance coverage for children, a new California Obesity Initiative, establishment of California Rx – Prescription Drugs for the Uninsured, expansion of the Genetic Disease Testing Fund to test and treat newborns for genetic disease, a revenue decrease for Proposition 99, increases in Realignment revenues to cover unfunded 02-03 and 03-04 caseloads, suspension of SSI COLAs, and changes to the outpatient prescription drug program for dually eligible Medi-Cal/Medicare recipients.

F. SUMMARY OF SELECTED HEALTH-RELATED BILLS ENACTED IN 2004

Following is the health-related legislation enacted in 2004, the second year of the two-year Legislative session. Health-related legislation enacted in 2003 was highlighted in the 2003 Federal and State Legislative Report, presented to the Health Commission in December 2003.

AB 1457 (Budget Committee) Signed CCSF Support

Realignment: Provides a partial fix to Poison Pill problem by allowing the Department of Motor Vehicles (DMV) to transfer vehicle license fee funds to the Realignment Account. Also requires Controller to transfer funds to Local Revenue Fund for 02/03 and 03/04 the amount that would have been transferred absent the VLF "gap".

> ***Impact:*** *AB 1457 restores approximately $160 million in health care funding for counties jeopardized by a "poison pill" measure included in Realignment. Realignment law contains a provision stating that if any county successfully challenged the State in court or filed any appeals, the funding would be revoked for all counties. The poison pill was activated earlier this year after the state Supreme Court awarded $3.4 million to San Diego County for indigent care costs. Without AB 1457, California counties would have lost tens of millions of dollars in funding for health, mental health and social service programs.*

AB 1881 (Berg) Signed CCSF Support

Integrated Health Services Programs: Authorizes any county to implement a program for the funding and delivery of health and human services and benefits through an integrated, consolidated contracting program.

> ***Impact:*** *AB 1881 builds upon successful pilot projects implemented in Humboldt and Placer counties. In these counties, as in other counties, public health and social services were developed and organized around categorical funding streams and target populations, rather than on core public health and social service functions and sound principles. The result has been a maze of contracts and administrative obligations to the State, with each program having its own reporting, training, and staffing, and with limited consistency or coordination among programs. The consolidated contracting system, however, enabled these pilot counties to overcome many of these obstacles by reducing and standardizing program reporting requirements, improving accountability through outcome and performance measures, and improving the utilization of local government staff. AB 1881 extends the opportunity to implement the consolidated contracting program to all 58 counties in California.*

AB 2301 (Maze) Signed CCSF Support

Health Care For Indigents Reports: Eliminates the requirement for counties that receive funding under the California Healthcare for Indigents Program (CHIP) to submit quarterly and estimated annual reports under the Medically Indigent Care Reporting System (MICRS).

> ***Impact:*** *AB 2301 will reduce the number of MICRS reports counties must provide to the State from six to one each year. At DPH, which receives approximately $1.7 million in CHIP funding annually, it is estimated that each report takes several DPH staff a total of 150 to 200 hours to complete. Reducing these time-consuming reports would free these staff to attend to other public health functions.*

SB 678 (Ortiz) Signed CHEAC Support

Bioterrorism: Appropriates $18,145,889 in federal funds to the State Department of Health Services for implementing bioterrorism and smallpox preparedness measures by the state and local jurisdictions.

> ***Impact:*** *SB 678 provided the State with the authority to make allocations of federal funds to counties. DPH's allocation for fiscal year 2004-05 is $1.3 million.*

SB 1159 (Vasconcellos) Signed CCSF Support

Disease Control Demonstration Project: In local jurisdictions that authorize such programs: (1) allows licensed pharmacists to sell up to 10 syringes to an adult without a prescription; (2) requires pharmacists who sell non-prescription syringes to provide information on how to access drug treatment, and programs to prevent or treat hepatitis C and HIV/AIDS; (3) provides for the safe disposal of used syringes; and (4) decriminalizes the possession of 10 or fewer syringes.

> ***Impact:*** *California is one of only six states that requires a prescription in order to purchase a sterile syringe. Lack of access to sterile syringes has resulted in higher rates of HIV and hepatitis C infection in California than in neighboring states that do not prohibit the sale of syringes. In San Francisco, there are approximately 17,100 injection drug users (IDUs). It is estimated that nearly 20% of San Francisco's IDUs are infected with HIV and 90% are infected with Hepatitis C. While several needle exchange programs operate in San Francisco, approximately 15% of new AIDS cases reported in 2002 identified injection drug use as the main exposure category. Limited access to sterile syringes contributes to the transmission of these infections among IDUs, their sex partners and their children. SB 1159 establishes an effective harm reduction strategy that will increase access to new, sterile syringes for each injection to prevent transmission of these blood-borne pathogens.*

SB 1847 (Perata) Signed CCSF Support

Omnibus Tuberculosis Control and Prevention Act: Extends from 2006 to 2011 the sunset provisions of the Omnibus Tuberculosis Control and Prevention Act of 2002 (OTCPA), which allows local health departments to use certified personnel other than licensed staff to place and measure TB skin tests.

> ***Impact:*** *The OTCPA is critical to DPH's TB control efforts. For the past two and a half decades, the San Francisco TB control program has used health workers and disease control investigators to perform TB skin tests without any adverse effects or complaints. These experienced and well-trained personnel have been certified as tuberculin skin test technicians and have performed over 11,000 TB skin tests over the past 3 years. The surveillance data kept on their activities is reviewed biannually and recognized as valid by the Center of Disease Control in Atlanta. SB 1847 ensures that DPH can continue to use certified personnel to place and measure skin tests as a critical component of its TB control efforts.*

SB 1895 (Burton) Signed CCSF Support

Special Education, Mental Health Services: Provides clarification and accountability to funding allocated to provide mental health services to special education pupils through the AB 3632 program.

Impact: *In 1984, the Legislature passed AB 3632, which required the counties to provide mental health services to schoolchildren with special needs. In San Francisco, DPH does this at a cost of approximately $3 million per year. Since the implementation of AB 3632, however, counties have received insufficient – and at times no – reimbursement for these services. Further, because there could be so many entities involved – schools, school districts, county mental health departments, and various State offices and departments –responsibilities for these programs were unclear. SB 1895 clarifies the roles and responsibilities of each entity involved and authorizes funding for these programs.*

G. SUMMARY OF SELECTED HEALTH-RELATED BILLS THAT FAILED IN 2004

AB 1988 (Hancock) Vetoed CCSF Support

Irradiated Food: Would have required that the governing board of a school choosing to serve irradiated food in its federal free and reduced school meals program follow specified notification requirements.

Veto Message: *While we always want to keep parents informed of a variety of issues, imposing the additional administrative duties proscribed in this bill would increase the cost on school districts by an estimated $5.3 million annually. Since information concerning irradiated food is already available from a variety of sources, these funds would be better spent in the classroom.*

AB 2483 (Chan) Died CCSF Support

Adolescent Alcohol And Substance Abuse Care: Would have established a pilot program to develop an annual plan to ensure an evidence-based methodology to providing services to adolescents with alcohol and other drug-related problems.

AB 2766 (Richman) Died CCSF Oppose

Local Human Service Programs: Would have changed the allocation formulas under Realignment by redirecting sales tax growth from "over-equity" counties to "under-equity" counties.

AB 2769 (Richman) Died CCSF Watch

Public Health Administration: Would have established within the California Health and Human Services Agency the State Department of Public Health, under the direction of the State Health Officer, and would have required the department to administer various health-related programs. Would have also established the Public Health Improvement Board to provide advice to the department in the development of policies, regulations, and programs that are administered by the department or that directly affect the health of Californians.

AB 2871 (Berg) Vetoed CCSF Support

Clean Needle And Syringe Exchange: Would have authorized cities, counties or cities and counties to have a clean needle and syringe exchange project without having to declare a local state of emergency every two weeks.

Veto Message: *I am committed to the public health goal of reducing the transmission of HIV and Hepatitis C among injection drug users through syringe exchange programs. Current law requires that local governments renew their declaration of a local emergency due to a critical local public health crisis every two to three weeks. While cumbersome, this reauthorization ensures that local government and local public health officials review the status of the syringe exchange program when deciding to continue the program.*

I am willing to reconsider the concept of this bill in the future if there are appropriate local control measures in place. It is imperative that local communities, public health officials and local law enforcement are provided the opportunity to provide input to local leaders to ensure that the health benefits of a syringe exchange program outweigh any potential adverse impact on the public welfare.

AB 2963 (Pacheco) Died CCSF Watch

Nurse-to-Patient Ratios: Would have required the Department of Health Services (DHS) to evaluate the regulations that became effective on January 1, 2004, relating to nurse-to-patient ratios in medical/surgical care units and would have prohibited DHS from imposing the 1:5 nurse-to-patient ratio requirement unless the department is able to demonstrate that certain conditions are satisfied.

SB 379 (Ortiz) Vetoed CCSF Support

Charity Care and Reduced Payment Policies and Applications: Would have established charity care and reduced payment policies for hospitals, which include minimum eligibility requirements of 400 percent of the federal poverty level ($74,500 for a family of four) and limitations on expected payments to Medicare, Medicaid, or workers' compensation payment amounts.

Veto Message: *I share the authors concern about the cost of health care and the implications of overwhelming and unexpected hospital bills on uninsured Californians. Large hospital bills can lead to devastating financial consequences for those least capable of bearing the costs of unplanned visits to the hospital.*

Recently, the hospital community voluntarily adopted guidelines to assist low-income uninsured Californians who receive services at a hospital but cannot afford to pay the bill in full. At a minimum, these guidelines allow patients who are at or below 300% of the federal poverty level to apply to the hospital for financial assistance. Additionally, the guidelines limit the costs of procedures to reflect the prices paid by government payers, require hospitals to post their financial assistance policies and their eligibility criteria and encourage hospitals to help eligible patients apply for public health programs. By choice, many hospital systems have adopted guidelines that exceed the aforementioned minimum standards adopted by the hospital community, further protecting patients at risk of financial harm.

I recognize the proponents desire to assist self-pay patients with large hospital bills by requiring price discounts but I also recognize that the hospital community took a significant step in adopting these guidelines, especially those hospitals that are struggling financially themselves. Ultimately, I decided that the voluntary guidelines must be given time to be implemented and reviewed.

Nevertheless, it is my expectation that all hospitals in the state uphold their important commitment to the voluntary guidelines and that they are applied evenly, consistently and without hesitation. A strong commitment to the guidelines, in lieu of a statutory mandate, ensures that hospitals retain individual flexibility in recognition that some hospitals face different challenges than others.

Technically, the provisions of this bill could create an unintended impact on federal reimbursements for the Medi-Cal program, which would neither help patients or hospitals. In fact, a reduction in federal reimbursements to hospitals erodes the safety net, which generally cares for those individuals that this bill is intended to help.

SB 494 (Escutia) Vetoed CCSF Support

Third Party Claims: Would have enabled a health care provider who has provided care to a Medi-Cal beneficiary because of an injury caused by a third party to establish lien for the cost of those services against the portion of the beneficiary's recovery relating to medical expenses.

Veto Message: *This bill would authorize health care providers who treat Medi-Cal patients injured by a third party to claim reasonable and necessary charges from the liable third party, rather than the Medi-Cal reimbursement rate. This bill would also extend counties current lien rights against judgments to also include settlements, compromises, arbitration awards, mediation settlements, and any other recovery obtained.*

I understand that health care providers should be reasonably compensated for services they provide, but this bill proposes a solution that provides for inflated medical and settlement costs.

Earlier this year, we struggled to control the growing costs of medical care within the workers compensation system. We fought to limit the litigious nature encouraged by a system that benefited special interests at the expense of California workers. If enacted, SB 494 will encourage the same abuse we worked to correct in the workers compensation system within the auto insurance market.

Finally, and perhaps most troubling is the fact that the inflated cost to the insurance system for these overcharges will be borne by consumers, increasing the likelihood of growing the number of uninsured in this state.

SB 858 (Ortiz) Died CCSF Watch

Public Health Administration: Would have created the California Department of Public Health (CDPH) within the Health and Human Services Agency, transferred specified programs and responsibilities from the Department of Health Services to CDPH, and established a 13-member Public Health Board to provide involvement of the programs administered by DPH.

SB 1149 (Ortiz) Vetoed CCSF Support

Canadian Pharmacies: Would have required the State Board of Pharmacy to (1) develop and disseminate information identifying pharmacies in Canada that meet recognized standards for the safe acquisition, shipment, handling and dispensing of prescription drugs to persons in California, (2) collect and publish information concerning pharmacies located outside the United

States that have violated recognized standards for safe shipment and handling of those drugs, and (3) establish and post the above information on an interactive Internet web site.

> ***Veto Message:*** *A top priority of my Administration is to provide access to affordable prescription drugs. However, importing drugs from Canada or assisting residents in their efforts to do so would violate federal law and could expose the State to civil, criminal and tort liability. We all would like to see low-income uninsured residents have access to more affordable medicines, but measures such as this, over-simplify the complex safety, trade, supply and pricing issues involved in this marketplace. In light of these circumstances, I do not believe SB 1149 will bring the necessary relief to Californians who require assistance in accessing necessary medicines.*
>
> *In an effort to bring significant price reductions to California's most at-risk consumers, my Administration put forward California Rx that seeks to provide real assistance to these Californians. California Rx represents an approach that harnesses the purchasing power of low-income seniors and uninsured Californians up to 300% of the federal poverty level ($47,000 for a family of three) to secure meaningful discounts in prescription drug costs. My Administration has begun negotiations with pharmaceutical companies regarding their participation in California Rx. While I am encouraged by the concrete commitments made by some members of the industry, I am disappointed that many companies have not yet stepped up and offered meaningful discounts for this population. Over the next six weeks, I will continue negotiations to secure significant discounts for California's low-income uninsured, and I hope to move forward with a legislative proposal in January 2005 to implement California Rx. If, however, specific companies and the industry as a whole are not willing to provide a real solution to this problem, I will work closely with the State Legislature to develop an approach that guarantees significant reductions in prescription drug prices for California's low-income uninsured residents.*
>
> *Come January, I will propose legislation that will bring lower-cost prescription drugs to California's most vulnerable residents. I am still hopeful that California Rx will be the vehicle to secure those price reductions, but for a voluntary, negotiated model such as California Rx to work, the drug companies must come forward and negotiate in good faith. I call upon the companies to help solve this problem through California Rx; but if I cannot rely on the good faith negotiations of the industry, I will use all the options at my disposal to secure lower-cost prescription drugs for low-income, uninsured Californians.*

SB 1192 (Chesbro) — Died — CCSF Support

Substance Abuse: Would have required health care service plans (health plans) and health insurers to provide coverage for the medically necessary treatment of substance-related disorders, excluding caffeine and nicotine related disorders, on the same basis as coverage is provided for any other medical condition.

SB 1585 (Speier) — Vetoed — CCSF Support

Food Safety: Would have provided for notification of the State Department of Health Services and local health officers in the event that meat sold in California is recalled by the U.S. Department of Agriculture.

> ***Veto Message:*** *Safety of our food supply for the protection of our citizens is a priority of our State. California is one of 12 states that entered into a Memorandum of*

Understanding (MOU) with the United States Department of Agriculture (USDA) governing the voluntary recall of meat and poultry products.

During recalls, participation and cooperation of the entire food chain is essential. This bill mandates reporting requirements that conflict with the MOU, compromising California's ability to obtain timely information from the federal government, which could weaken our ability to protect public health.

To assist in improving the distribution of accurate timely information during these voluntary recalls, I direct the Department of Health Services to enter into a new MOU with USDA that expressly authorizes them to share recall information with local public health officials. This will increase the cooperation among all entities and provide greater protection of our states consumers.

SB 1703 (Alarcon) Vetoed CCSF Support

California Certified Green Business Program: Would have established a voluntary California certified green business program to certify businesses that engage in environmentally beneficial operations.

Veto Message: *Certified green business programs are a useful tool for consumers, businesses and government entities to promote environmentally responsible practices. These green certification programs have been increasing in numbers since 1996. This bill creates a California certified green business program for businesses that comply with specified criteria and checklists adopted by California State University (CSU) Hayward's Environmental Finance Center.*

This bill creates one-size-fits all approach to green business programs and does not give local governments the flexibility to respond to the needs of businesses in their community. This bill impedes the ability of existing local green business programs that operate independently to acquire grant funding. Several successful green business programs are already in place on a voluntary basis and operate without government involvement or assistance.

H. LOOKING AHEAD

The first year of the Legislature's next two-year session begins in 2005. The new year will be filled with challenges new and old. Once again, the State will be facing a significant budget shortfall currently estimated at $8.1 billion. The State's new Director of Finance, Tom Campbell, said that the spending plan he was crafting for Gov. Arnold Schwarzenegger included no new taxes and instead relied heavily on cuts to healthcare programs for the poor and elderly to bridge the budget gap. In particular, Campbell suggested that the Administration would push for changes is the $13-billion Medi-Cal program. However, because the Medi-Cal reform plan will require approval from the federal Department of Health and Human Services, the Administration does not expect significant savings from the proposal in the upcoming fiscal year. As a result, Campbell has recommended that the Governor reduce funds for other health care programs as part of his budget plan for fiscal year 2005-2006.

In addition to the budget challenges that the State will face, it is likely that many of the legislative issues that were unresolved in 2004 will be reintroduced in the new session. These include Medi-Cal redesign, hospital financing, nonprofit hospital charity care, prescription drug reimportation, and a possible new realignment of State and local programs and funding.

IV. STATE LEGISLATIVE PLAN FOR 2005

As discussed above, the Department relies heavily on its State Legislative Plan to guide the City's positions on health-related legislation at the State level. The State Legislative Plan is submitted to the Mayor's Office for approval at the beginning of each Legislative Session. Appendix A, attached, is a draft State Legislative Plan for the Department for 2005. Appendix B, attached, is a draft resolution approving the Legislative Plan.