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Health Care. Consumer Protection. Initiative Statute.

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Health Care. Consumer Protection. Initiative Statute.

Official Title and Summary Prepared by the Attorney General

HEALTH CARE. CONSUMER PROTECTION. INITIATIVE STATUTE.

- Prohibits health care businesses from: discouraging health care professionals from informing patients or advocating for treatment; offering incentives for withholding care; refusing services recommended by licensed caregiver without examination by business's own professional.
- Requires health care businesses to: make tax returns and other financial information public; disclose certain financial information to consumers including administrative costs; establish criteria for authorizing or denying payment for care; provide for minimum safe and adequate staffing of health care facilities.
- Authorizes public/private enforcement actions. Provides penalties for repeated violations. Defines "health insurer."

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact:

- Increased state and local government costs for existing health care programs and benefits, probably in the range of tens of millions to hundreds of millions of dollars annually, depending on several factors.

BACKGROUND

Health Care Spending

Annual spending on health care in California totals more than $100 billion. About two-thirds of this cost is covered by various forms of health insurance, with the remainder paid by other sources.

Roughly 80 percent of all Californians are covered by health insurance. Specifically:

- About half receive health insurance through their employer or the employer of a family member.
- Roughly 20 percent are covered by two major government-funded health insurance programs: the federal Medicare Program, primarily serving persons age 65 or older, and the Medi-Cal Program, jointly funded by the federal and state governments, serving eligible low-income persons.
- About 10 percent of Californians directly purchase health insurance.

Until recently, spending on health care had been growing much faster than inflation and population changes. During the 1980s, for example, average health care spending in the United States grew by almost 11 percent annually after adjusting for inflation and population. Since 1990, however, this rate of growth has slowed to about 4 percent annually.

Health Maintenance Organizations

In part, this slower growth has been due to efforts by employers and government to control their health insurance costs. One way they have attempted to hold down costs is to contract with health maintenance organizations (HMOs), which provide health services through their own doctors and hospitals or through contracts with physicians and hospitals. About one-third of Californians belong to HMOs. Most of these HMO members are covered under employee health plans, but many persons covered by Medicare or Medi-Cal also receive their health care through HMOs.

Generally, health coverage provided by an HMO is less expensive than comparable health insurance coverage provided on a "fee-for-service" basis. Health Maintenance Organizations use several methods to control costs, such as "capitation" payments, other financial incentives, and utilization review.

Capitation and Other Financial Incentives. Under the traditional fee-for-service approach, doctors and hospitals charge fees based on the specific service provided to a patient. By contrast, HMOs generally use capitation to pay doctors. Under this approach, doctors receive a fixed payment for each HMO member regardless of the amount of service provided to the member. Capitation gives doctors a financial incentive to use cost-effective types of care.

In addition to capitation, HMOs use other financial incentives to control health care costs. The federal government, however, limits the types of financial incentives that may be used by HMOs when serving Medicare or Medi-Cal recipients. Specifically, federal law prohibits any financial incentives to doctors that could act to reduce medically necessary care to *individual* patients, such as a bonus payment for each patient that is not hospitalized during the year. However, federal law does allow "risk pools" and other types of profit-sharing arrangements that enable doctors to benefit from controlling costs for *groups* of patients.

Utilization Review. HMOs—as well as the state's Medi-Cal program and insurers using the fee-for-service approach—also attempt to contain costs by using "utilization review" procedures. Under these procedures, health plans will not pay for certain types of expensive or unusual treatments unless they have approved the treatment in advance.

Controlling Hospital Costs

Health maintenance organizations also control their costs by reducing their use of hospitals and encouraging more treatment in doctors' offices and clinics. This trend has contributed to an excess of hospital beds.

On average, about half of the hospital beds in California were unused in 1994. As a result, some hospitals have downsized, merged, or closed; and many hospitals are seeking ways to reduce costs in order to compete for business more effectively. Since staffing is a major cost, hospital cost control efforts often focus on reducing staff and using less expensive personnel in place of more expensive personnel where possible (using nurses' aides rather than nurses, for example).

Regulation of Health Care Facilities

Licensing of Facilities. The Department of Health Services (DHS) licenses many types of health facilities in California, such as hospitals and nursing homes, and has general authority to set staffing standards for those facilities. Clinics that are owned and operated directly by doctors, however, are not licensed.

Staffing Standards. State regulations generally require hospitals to keep staffing records and to base their staffing levels for nurses on an assessment of patient needs. Hospitals are not required to have a specified number of nurses per patient, except in intensive care units. State law requires nursing homes to have at least one registered nurse per shift and sets minimum staffing standards for nurses and nursing assistants per patient.

The DHS is revising its current hospital staffing regulations to cover all departments within each facility. Additionally, the pending regulations require hospitals to establish their staffing needs using a system that more specifically takes into account the condition of each patient. The DHS also enforces federal requirements that health facilities serving Medicare or Medi-Cal patients must have enough staff to provide adequate care.

Regulation of Health Plans and Health Insurance

The state Department of Corporations regulates the financial and business operations of health plans, including HMOs, in California. The Department of Insurance regulates companies that sell health insurance but do not provide health care themselves, including workers' compensation insurers.

PROPOSAL

This measure establishes additional requirements for the operation of health care businesses. The measure:

- Prohibits health care businesses from denying recommended care without a physical examination.
- Requires the state to set more comprehensive staffing standards for more types of health care facilities.
- Prohibits health care businesses from using financial incentives to withhold medically appropriate care.
- Increases protections for certain health care employees and contractors.
- Requires health care businesses to make various types of information available to the public.

The measure's provisions would affect both public and private health facilities. However, it is not clear whether the state's Medi-Cal Program would be considered a "health care business" subject to the requirements of this measure.

FISCAL EFFECT

The fiscal effect of this measure is subject to a great deal of uncertainty. The health care industry is large, complex, and undergoing rapid change, making it difficult to estimate the effect of new requirements on the overall health care marketplace. Furthermore, several of the measure's provisions could have widely varying fiscal effects, depending on how they are implemented or interpreted by the courts.

Effect of the Measure on Health Care Costs Generally

Changes in health care costs have an impact on the state and local governments because of their role in directly operating health programs as well as purchasing health care services. The following provisions of this measure would increase health care costs generally.

Physical Examination. Currently, HMOs, health insurers, and other health care businesses may refuse to authorize recommended care that they believe to be unnecessary, unproven, or more expensive than an effective alternative treatment, without physically examining the patient. Patients usually have a right to appeal such a denial. This measure requires health insurers, health plans, or other health care businesses to physically examine a patient before refusing to approve care that is a covered benefit and that has been recommended by the patient's doctor or nurse (or other licensed health professional). The person conducting the examination would have to be a licensed health care professional with the expertise to evaluate the patient's need for the recommended care.

Requiring a physical examination prior to denying care would increase general health care costs in two ways. First, health care businesses would have to add staff to provide additional examinations. Second, requiring an examination probably would result in some approvals of care that otherwise would be denied.

Staffing Requirements. The measure requires that all health care facilities provide "minimum safe and adequate" staffing of doctors, nurses, and other licensed or certified caregivers. The DHS would set, and periodically update, staffing standards for health care facilities that it licenses, such as hospitals, nursing facilities, and certain types of clinics. The Department of Corporations would set, and periodically update, staffing standards for medical clinics operated by health plans, which are not licensed by the DHS.

The staffing standards required by this measure would cover more types of facilities and all licensed and certified caregivers. In addition, these standards would have to be based on the specific needs of individual patients. Depending on the specific standards adopted, some health care facilities might have to add more staff, hire more highly skilled staff, or both. The effect on overall health care costs could range from minor to significant.

Financial Incentives. The measure prohibits insurers, health plans, and other health care businesses from offering financial incentives to doctors, nurses, or other licensed or certified caregivers if those incentives would deny, withhold, or delay medically appropriate care to which patients are entitled.

Restricting financial incentives could increase general health care costs by limiting the use of risk pools and profit-sharing arrangements that encourage providers to restrain costs. However, the measure specifically allows the use of capitation payments. Furthermore, it is not clear whether the measure prohibits any financial incentives that are not already prohibited under federal restrictions that apply to providers who serve Medicare or Medi-Cal patients. Consequently, the provision's effect on health care costs is unknown, but could range from minor to significant.

Protection for Certain Health Care Professionals. The measure prohibits health care businesses from attempting to prevent doctors, nurses, and other health care professionals from giving patients any information relevant to their medical care. The measure also broadens existing protections for health care professionals who advocate for patient care.

In addition, the measure protects doctors, nurses, and other licensed or certified caregivers from adverse actions by health care businesses—such as firing, contract termination, or demotion—without "just cause." Examples of just cause include proven malpractice, endangering patients, drug abuse, or economic necessity. Just cause protections currently apply to some health care professionals, such as those who work for public agencies under civil service and those who work under labor agreements with just cause provisions. This provision of the measure would reduce some employers' flexibility and thereby could increase costs to health care businesses by an unknown amount. The additional costs would include the need to keep records to document the basis for actions taken against employees or contractors in order to show just cause for the action.

Liability of Health Care Professionals. The measure specifies that licensed health care professionals who set guidelines for care, or determine what care patients receive, shall be subject to the same professional standards that apply to health care professionals who provide direct care to patients. This provision would increase the risk of malpractice liability for some health care professionals who make decisions affecting patient care, but who do not provide direct care. This could increase health care costs by an unknown amount.

Access to Information. The measure requires private health care businesses with more than 100 employees to make certain types of information available to the public regarding staffing, guidelines for care, financial data, and the status of complaints against the business.

EFFECT OF THE MEASURE ON THE STATE AND LOCAL GOVERNMENTS

Summary. This measure would result in unknown additional costs, probably in the range of tens of millions to hundreds of millions of dollars annually, due to the measure's effects on the state's and local governments' costs of directly operating health programs as well as purchasing health care services.

Increased Costs to Government to Operate Health Programs

Requirement for Physical Examinations. If the Medi-Cal Program is subject to this measure, the requirement for a physical examination prior to denial of care would increase state costs by an unknown amount, potentially exceeding $100 million annually.

Counties operate health care programs for people in need who do not qualify for other health care programs such as Medicare or Medi-Cal. These programs also would experience some increase in costs to provide additional examinations and for additional costs of care. These costs are unknown, but probably less than the potential costs to the Medi-Cal Program.

Staffing Requirements. The staffing requirements in this measure could increase the costs of health facilities operated by the state and local governments, including University of California hospitals, state developmental centers and mental hospitals, prison and Youth Authority health facilities, state veterans' homes, county hospitals and clinics, and hospitals operated by hospital districts. The amount of this potential increase is unknown and could range from minor to significant, depending on the actual staffing standards that are adopted.

Increased Costs to Government to Purchase Health Care Services

State Medi-Cal Program. The state contracts with HMOs and health care networks to serve a portion of the clients in the Medi-Cal Program. Cost increases to these organizations would tend to increase Medi-Cal costs by an unknown amount. The state spends about $6 billion annually (plus a larger amount of federal funds) for the Medi-Cal Program, primarily to purchase health care services. The potential cost increase to the state could range from a few million dollars to more than one hundred million dollars annually, due to the measure's effects on health care costs generally (as described above).

County Health Care Costs. Counties spend over $2 billion annually to provide health care to indigents. In addition to services that they provide directly, counties contract to purchase a significant amount of services. The potential county cost increases could be up to tens of millions of dollars annually, due to the measure's effects on health care costs generally.

State and Local Employee Health Insurance Costs. The state currently spends about $900 million annually for health benefits of employees and retirees, and the amount spent by local governments is greater. By increasing health care costs generally, the measure could increase benefit costs to the state and local governments by an unknown amount, potentially in the tens of millions of dollars annually. However, the disclosure of financial information as a result of this measure could assist in negotiating lower rates with health plans, offsetting some portion of these costs.

State Administration and Enforcement Costs

The measure would result in additional costs to the Departments of Health Services and Corporations and to other state agencies to administer and enforce its provisions (primarily the staffing standards). These costs could be roughly $10 million annually, to various special funds that are supported by fees imposed on health care businesses and professionals.

For text of Proposition 214 see page 102

214 Health Care. Consumer Protection. Initiative Statute.

Argument in Favor of Proposition 214

The health care industry is changing rapidly, and some of those changes could be dangerous to your health. That's why we need Proposition 214, the HMO Patient Rights Initiative. All of us, especially those of us who depend on health care the most—seniors, cancer patients, adults and children with disabilities—must be certain that our health insurance will be there when we need it.

Proposition 214:

- Prohibits written and unwritten gag rules that keep doctors from telling patients about the care they need.
- Protects doctors, nurses, nursing home aides, paramedics and other health care givers from intimidation when they speak out on behalf of patients.
- Prohibits financial incentives for withholding care patients need.
- Requires insurers to disclose guidelines for denying care and to give patients a second opinion—including a physical examination—before denying care recommended by the patient's doctor.
- Forces HMOs and insurers to disclose how much they spend on patient care and how much is spent on executive salaries and corporate overhead.
- Requires that hospitals and nursing homes have safe levels of staffing.
- Prohibits the sale of your medical records without your permission.
- Will be enforced by existing state agencies and without new taxes.

Gag rules on doctors and nurses are wrong. Intimidation of caregivers is wrong. Bonuses for denying care that people need are wrong. Secret guidelines for denying care are wrong. Unsafe staffing in hospitals and nursing homes is wrong.

It is dangerous for everyone if HMOs and health insurers worry more about making money than they do about your health when they make decisions about your care.

If you get sick, you have a right to know what care you need, and you have a right to get the care your insurance premiums have paid for.

You should not have to worry whether your doctor is afraid of retaliation for referring you to a specialist or whether nursing home aides fear being punished for speaking up for their patients. You should not have to worry that your health plan could drop your doctor for no reason.

You should not need to be afraid your doctor is being paid a bonus for denying you the care you need.

You should know how much of your insurance premium is spent on actual patient care and how much on bureaucratic overhead and executive salaries.

Is it important to contain costs to keep health care affordable? Yes.

Should cost controls be used as an excuse to deny patients the treatments they need just because administrators for HMOs and insurers think it will cost them too much money? Never.

214 will be enforced by existing agencies, minimizing enforcement costs. And those costs are necessary in order to make sure the rights of patients are safeguarded.

Proposition 214 is a decision about life and death. Please consider carefully and join us in voting yes on Proposition 214.

MARY TUCKER
Chair, State Legislative Committee
American Association of Retired Persons

LOIS SALISBURY
Executive Director, Children Now

LAURA REMSON MITCHELL
Issues Coordinator, National Multiple Sclerosis Society, California Chapters

Rebuttal to Argument in Favor of Proposition 214

PROPOSITION 214, LIKE 216, IS A COSTLY TROJAN HORSE. We don't need special-interest ballot initiatives to "protect" patients. EXISTING LAW ALREADY: protects patient advocacy; prohibits gag rules; requires coverage criteria be developed by physicians; provides for safe staffing in hospitals; prohibits paying doctors to deny needed care; and prohibits disclosing confidential patient records.

These provisions are part of 214 to hide the measure's real purposes: to add bloated, costly staffing requirements, to give special-interest job protection to some health care workers, and to help trial lawyers file frivolous health care lawsuits.

Proposition 214 DOES NOT provide health coverage to a single Californian. It costs consumers BILLIONS OF DOLLARS in higher health insurance costs while costing taxpayers HUNDREDS OF MILLIONS more for administration and to cover government workers. Not a penny of 214 will provide health insurance for the uninsured.

Real health care reform should make insurance more affordable and reduce the number of uninsured. Props. 214 and 216 dramatically increase health insurance costs and will lead to MORE UNINSURED.

That's why groups like the Seniors Coalition, 60 Plus Association and United Seniors Association oppose 214 and 216. It's why leaders of groups that care for the poor like SISTERS OF MERCY and DAUGHTERS OF CHARITY oppose the initiatives. And it's why small business and taxpayer groups like the CALIFORNIA TAXPAYERS ASSOCIATION and the NATIONAL TAX LIMITATION COMMITTEE say NO on 214 and 216.

Don't be fooled by special-interest, trojan horse ballot initiatives. VOTE NO.

GORDON JONES
Legislative Director, The Seniors Coalition

MARY DEE HACKER, R.N.
Childrens Hospital, Los Angeles

KIRK WEST
President, California Chamber of Commerce

Arguments printed on this page are the opinions of the authors and have not been checked for accuracy by any official agency.

Argument Against Proposition 214

PROPOSITIONS 214 and 216 are two peas in a pod. They contain similar language promising bogus health care reforms that will dramatically raise health insurance and taxpayer costs for consumers and taxpayers in California.

Just ask yourself:

DOES PROPOSITION 214 MAKE HEALTH INSURANCE MORE AFFORDABLE?—No. An independent economic study estimates that under 214 insurance premiums could go up by as much as 15%. That would cost Californians OVER 3 BILLION DOLLARS A YEAR IN HIGHER HEALTH COSTS.

WHAT DOES A 15% INCREASE IN HEALTH INSURANCE DO TO YOUR FAMILY'S BUDGET? For many families, that's ALMOST $1,000 PER YEAR. Seniors and people on fixed incomes will be hardest hit. That's one reason why groups like The SENIORS COALITION and the 60 Plus Association OPPOSE PROP. 214.

Small business employees are also concerned:

"I work for a small company struggling to survive. If health insurance goes up, my employer couldn't afford it, and neither could my family."
— Aletha Hill, Camellia City Landscape Management, Sacramento

DOES PROP. 214 HELP THE UNINSURED?—No. Higher insurance costs will lead to MORE Californians WITHOUT INSURANCE. That's why California nurses and physicians oppose 214.

"For the past 20 years, I've cared for patients who have no health coverage. Proposition 214 means fewer people will have health insurance. That's just what California DOESN'T need."
— Joseph Coulter, M.D., Yuba City

DOES 214 HELP THE POOR AND MEDICALLY INDIGENT?—No. Hospitals that are committed to care for the poor would be SEVERELY HURT under 214.

"Our mission is to provide health care to the poor and underserved. Proposition 214 will make it much more difficult to help people in need."
— Sister Brenda O'Keeffe, R.N. Sisters of Mercy

DOES PROP. 214 HELP TAXPAYERS?—No. The non-partisan Legislative Analyst says 214 could cost state taxpayers HUNDREDS OF MILLIONS of dollars MORE per year. These higher costs will need to be cut from existing programs like law enforcement and education, or TAXES WILL NEED TO BE RAISED.

"According to one expert study, taxpayers in Los Angeles County alone would be forced to pay almost $60 MILLION more to insure government employees. Taxpayers in every jurisdiction will be hurt by 214."
— California Taxpayer's Association.

WHO'S BEHIND 214? The Service Employees International Union—a labor union representing health care workers. They'll have more workers to unionize under 214. And, 214 provides special interest job protection to certain health care workers. Trial lawyers will be able to file lawsuits over virtually every employment decision involving a health care worker because of 214.

WHAT'S IN IT FOR THE REST OF US?

. . . HIGHER INSURANCE COSTS FOR FAMILIES AND SMALL BUSINESSES
. . . MILLIONS IN TAX INCREASES
. . . MORE GOVERNMENT BUREAUCRACY
. . . and up to 60,000 LOST CALIFORNIA JOBS

California needs health care reform but Proposition 214—like Prop. 216—WILL MAKE THINGS WORSE. That's why a diverse coalition opposes them, including Democrats, Republicans and Independents, seniors, physicians, nurses, hospitals, taxpayer groups, small businesses, and local government organizations.

Propositions 214 and 216 are the WRONG SOLUTIONS to California's health care ills.

SISTER CAROL PADILLA, R.N.
Daughter of Charity

RICHARD GORDINIER, M.D.
Arcadia

KIRK WEST
President, California Chamber of Commerce

Rebuttal to the Argument Against Proposition 214

Let's be clear. Who opposes 214? The California Association of HMOs and the Association of California Life and Health Insurance Companies. HMOs and insurers plan to spend millions of your insurance premium dollars to defeat 214.

The opponents call 214's patient protections "bogus". Read Proposition 214. Then ask yourself, are its protections "bogus" or are they genuine protections patients need?

- Is it "bogus" to protect freedom of speech between patients and doctors?
- Is it "bogus" to make sure medical decisions are made by patients and doctors, not by HMO and insurance company bureaucrats?
- Is it "bogus" to prevent HMOs and insurers from using gag rules, intimidation, or financial incentives to discourage doctors from providing needed care?
- Is it "bogus" to require HMOs and insurers to tell consumers if their insurance premiums are being spent on actual patient care or bureaucratic overhead and executive salaries?

Opponents make wildly exaggerated claims about costs, based on an "economic study" paid for by their own campaign. An independent analysis states that 214's patient protections would increase overall costs by less than 1%.

Opponents try to confuse 214 with Proposition 216. But Propositions 214 and 216 are NOT "two peas in a pod:"

- 214 is a simple, effective measure that relies on existing agencies to implement its patient protections, minimizing enforcement costs. 214 CONTAINS NO NEW TAXES.
- 216 lacks some of 214's key patient protections and 216 includes billions of dollars in new taxes.

Please, help protect patient rights. VOTE YES ON PROPOSITION 214.

ROBYN WAGNER HOLTZ
President, Orange County Chapter, THE Susan G. Komen Breast Cancer Foundation

W. E. (GENE) GIBERSON
President, Alzheimers Association, California Council

JONATHAN SHESTACK
Vice President, Cure Autism Now

(2) The parties have determined to compromise and enter into a settlement of some or all of the disputed claims and the court, after hearing, determines that the settlement is in the public interest. Any settlement or compromise approved by the court shall be deemed to be a finding of violation for purposes of subdivision (c) of Section 91002 and Section 91009.

SEC. 26. Section 91012 of the Government Code is amended to read:

91012. The court ~~may~~ *shall* award to a plaintiff ~~or defendant other than an agency,~~ who prevails in any action authorized by this title his *or her* costs of litigation, including reasonable attorney's fees. ~~On motion of any party, a court shall require a private plaintiff to post a bond in a reasonable amount at any stage of the litigation to guarantee payment of costs.~~ *The court may award to a defendant other than an agency who prevails in any action authorized by this title his or her costs of litigation, including reasonable attorney's fees, only if the court finds, on the record, that the matter was frivolous, or brought in bad faith or for some other improper purpose. The provisions of Section 425.16 of the Code of Civil Procedure shall not apply to any action filed pursuant to Section 91004, 91005, or 91005.5.*

SEC. 27. Section 91015 of the Government Code is repealed.

~~91015. The provisions of this chapter shall not apply to violations of Section 83116.5.~~

MISCELLANEOUS PROVISIONS

SEC. 28. There is hereby appropriated annually from the General Fund the sum of three cents ($0.03) per individual of the voting age population in the state, to be adjusted to reflect changes in the Cost of Living Index in January of each even-numbered year after the operative date of this act, for expenditures to support the operations of the Fair Political Practices Commission in administering and enforcing this title. The Franchise Tax Board shall, as soon as possible after the end of the first calendar year in which Sections 17221 and 24335 of the Revenue and Taxation Code have been in effect, calculate the amount of the increased tax revenues to the state as a result of these sections. From the amount so calculated, the Controller shall, for each fiscal year, transfer to the commission, from the General Fund, the amount necessary to meet the appropriation to the commission set forth above. In any event, regardless of whether the increased revenue from Sections 17221 and 24335 of the Revenue and Taxation Code is sufficient, the Legislature shall provide the appropriation to the commission set forth above. To the extent the Legislature provides budgetary support for local agencies for administration and enforcement of this title, the amount of increased tax revenues to the state as a result of Section 86102 of the Government Code shall also be provided for this purpose. If any provision of this title is challenged successfully in court, any attorney's fees and costs awarded shall be paid from the General Fund and shall not be assessed or otherwise offset against the Fair Political Practices Commission budget. Any savings or revenues derived from this title shall be applied to the Anti-Corruption Act of 1996 Enforcement Fund to pay costs related to the administration and enforcement of the title, with the remainder to be placed in the General Fund for general purposes.

SEC. 29. If any provision of this law, or the application of that provision to any person or circumstances, shall be held invalid, the remainder of this law to the extent that it can be given effect, or the application of that provision to persons or circumstances other than those as to which it was held invalid, shall not be affected thereby, and to this extent the provisions of this law are severable. In addition, if the expenditure limitations of Section 85401 of act shall not be in effect, the contribution limits of Sections 85301, 85302, 85303, and 85 shall remain in effect.

SEC. 30. This law shall become effective November 6, 1996. In the event that this measure and another measure or measures relating to campaign finance reform in this state shall appear on the statewide general election ballot on November 5, 1996, the provisions of these other measures shall be deemed to be in conflict with this measure. In the event that this measure shall receive a greater number of affirmative votes, the provisions of this measure shall prevail in their entirety, and the provisions of the other measure or measures shall be null and void in their entirety. In the event that the other measure or measures shall receive a greater number of affirmative votes, the provisions of this measure shall take effect to the extent permitted by law.

SEC. 31. It is the sense of the people of California that candidates for the United States House of Representatives and the United States Senate seeking to represent the people in the Congress of the United States should comply with the contribution limits and expenditure limits, prescribed herein for candidates for the State Senate and Governor, respectively. The people recognize that the limitations prescribed in this law may not be mandated by the people for candidates for federal office. However, it is the sense of the people that these limitations are necessary to prevent corruption and the appearance thereof and to preserve the fairness and integrity of the electoral process in California. The people, therefore, suggest that candidates for federal office seeking to represent the people in the Congress of the United States comply voluntarily with the limitations prescribed herein until such time as comparable limitations are adopted by the Congress of the United States or through a constitutional amendment.

It is also the sense of the people of California that the broadcast licensees, as public trustees, have a special obligation to present voter information broadcasts. For the privilege of using scarce radio and television frequencies, the broadcasters are public trustees with an obligation to provide at no cost and no profit time for candidates to appear and use the station, whether radio or television, for the presentation of candidates' views for some brief period during prime viewing or listening time in the 30-day period prior to an election. The people of California recognize that the federal government has jurisdiction for such a mandate, and strongly urge the Congress of the United States to require the Federal Communications Commission to enforce these requirements upon broadcasters as a condition of holding a public broadcast license and fulfilling the broadcaster's public service obligation.

Proposition 213: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds sections to the Civil Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Title

This measure shall be known and may be cited as "The Personal Responsibility Act of 1996."

SECTION 2. Findings and Declaration of Purpose

(a) Insurance costs have skyrocketed for those Californians who have taken responsibility for their actions. Uninsured motorists, drunk drivers, and criminal felons are law breakers, and should not be rewarded for their irresponsibility and law breaking. However, under current laws, uninsured motorists and drunk drivers are able to recover unreasonable damages from law-abiding citizens as a result of drunk driving and other accidents, and criminals have been able to recover damages from law-abiding citizens for injuries suffered during the commission of their crimes.

(b) Californians must change the system that rewards individuals who fail to take essential personal responsibility to prevent them from seeking unreasonable damages or from suing law-abiding citizens.

(c) Therefore, the People of the State of California do hereby enact this measure to restore balance to our justice system by limiting the right to sue of criminals, drunk drivers, and uninsured motorists.

SECTION 3. Civil Justice Reform

Section 3333.3 is added to the Civil Code, to read:

3333.3. In any action for damages based on negligence, a person may not recover any damages if the plaintiff's injuries were in any way proximately caused by the plaintiff's commission of any felony, or immediate flight therefrom, and the plaintiff has been duly convicted of that felony.

Section 3333.4 is added to the Civil Code, to read:

3333.4. (a) Except as provided in subdivision (c), in any action to recover damages arising out of the operation or use of a motor vehicle, a person shall not recover non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages if any of the following applies:

(1) The injured person was at the time of the accident operating the vehicle in violatio Section 23152 or 23153 of the Vehicle Code, and was convicted of that offense.

(2) The injured person was the owner of a vehicle involved in the accident and the vehicle was not insured as required by the financial responsibility laws of this state.

(3) The injured person was the operator of a vehicle involved in the accident and the operator can not establish his or her financial responsibility as required by the financial responsibility laws of this state.

(b) Except as provided in subdivision (c), an insurer shall not be liable, directly or indirectly, under a policy of liability or uninsured motorist insurance to indemnify for non-economic losses of a person injured as described in subdivision (a).

(c) In the event a person described in paragraph (2) of subdivision (a) was injured by a motorist who at the time of the accident was operating his or her vehicle in violation of Section 23152 or 23153 of the Vehicle Code, and was convicted of that offense, the injured person shall not be barred from recovering non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages.

SECTION 4. Effective Date

This act shall be effective immediately upon its adoption by the voters. Its provisions shall apply to all actions in which the initial trial has not commenced prior to January 1, 1997.

SECTION 5. Severability

If any provision of this measure, or the application to any person or circumstances is held invalid or void, such invalidity or voidness shall not affect other provisions or applications that can be given effect without the invalid or void provision or application, and to this end, all of the provisions of this measure are declared to be severable.

SECTION 6. Conflicting Measures

In the event another measure to be voted on by the voters at the same election as this measure, and which constitutes a comprehensive regulatory scheme, receives more affirmative votes than this measure, the electors intend that any provision or provisions of this measure not in direct and apparent conflict with any provision or provisions of that other measure shall not be deemed to be in conflict therewith, and shall be severed from any other provision or provisions of this measure that are in direct and apparent conflict with the provision or provisions of the other measure. In that event, the provision or provisions not deemed in conflict shall be severed according to Section 5 of this measure upon application to any court of competent jurisdiction.

Proposition 214: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds sections to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Chapter 2.25 (commencing with Section 1399.900) is added to Division 2 of the Health and Safety Code, to read:

CHAPTER 2.25. THE HEALTH CARE PATIENT PROTECTION ACT OF 1996

Article 1. Purpose and Intent

1399.900. (a) This chapter shall be known as the "Health Care Patient Protection Act of 1996." The people of California find and declare all of the following:

(1) No health maintenance organization (HMO) or other health care business should be

able to prevent physicians, nurses, and other health caregivers from informing patients of any information that is relevant to their health care.

(2) Doctors, nurses, and other health caregivers should be able to advocate for patients without fear of retaliation from HMOs and other health care businesses.

(3) Health care businesses should not create conflicts of interest that force doctors and er caregivers to choose between increasing their pay or giving their patients medically appropriate care.

(4) Patients should not be denied the medical care their doctor recommends just because their HMO or health insurer thinks it will cost too much.

(5) HMOs and other health insurers should establish publicly available criteria for authorizing or denying care that are determined by appropriately qualified health professionals.

(6) No HMO or other health insurer should be able to deny a treatment recommended by a patient's physician unless the decision to deny is made by an appropriately qualified health professional who has physically examined the patient.

(7) All doctors and health care professionals who are responsible for determining in any way the medical care that a health plan provides to patients should be subject to the same professional standards and disciplinary procedures as similarly licensed health professionals who provide direct care for patients.

(8) No hospital, nursing home, or other health facility should be allowed to operate unless it maintains minimum levels of safe staffing by doctors, nurses, and other health caregivers.

(9) The quality of health care available to California consumers will suffer if health care becomes a big business that cares more about making money than it cares about taking good care of patients.

(10) It is not fair to consumers when health care executives are paid millions of dollars in salaries and bonuses while consumers are being forced to accept more and more restrictions on their health care coverage.

(11) The premiums paid to health insurers should be spent on the health care services to which patients are entitled, not on big corporate salaries, expensive advertising, and other excessive administrative overhead.

(12) The people of California should not be forced to rely only upon politicians and their political appointees to enforce this chapter. The people themselves should have standing with administrative agencies and the courts to make sure that the provisions, purposes, and intent of this chapter are carried out.

(b) This chapter contains reforms based upon these findings. It is the purpose and intent of each section of this chapter to protect the health, safety, and welfare of the people of California by ensuring the quality of health services provided to consumers and patients and by requiring health care businesses to provide the services to which consumers and patients are entitled in a safe and appropriate manner.

Article 2. Full Disclosure of Medical Information to Patients

1399.901. No health care business shall attempt to prevent in any way a physician, nurse, other licensed or certified caregiver, from disclosing to a patient any information that the egiver determines to be relevant to the patient's health care.

Article 3. Physicians Must Be Able to Advocate for Their Patients

1399.905. (a) No health care business shall discharge, demote, terminate a contract with, deny privileges to, or otherwise sanction, a physician, nurse, or other licensed or certified caregiver, for advocating in private or in public on behalf of patients or for reporting any violation of law to appropriate authorities.

(b) No physician, nurse, or other licensed or certified caregiver, shall be discharged, demoted, have a contract terminated, be denied privileges, or otherwise sanctioned, except for just cause. Examples of just cause include, but are not limited to, proven malpractice, patient endangerment, substance abuse, sexual abuse of patients, or economic necessity.

Article 4. Ban on Financial Conflicts of Interest

1399.910. No health care business shall offer or pay bonuses, incentives, or other financial compensation, directly or indirectly, to any physician, nurse, or other licensed or certified caregiver, for the denial, withholding, or delay, of medically appropriate care to which patients or enrollees are entitled. This section shall not prohibit a health care business from using capitated rates.

Article 5. Written Criteria for the Denial of Care

1399.915. Health insurers shall establish criteria for authorizing or denying payment for care and for assuring quality of care. The criteria shall comply with all of the following:

(a) Be determined by physicians, nurses, or other appropriately licensed health professionals, acting within their existing scope of practice and actively providing direct care to patients.

(b) Use sound clinical principles and processes.

(c) Be updated at least annually.

(d) Be publicly available.

Article 6. Patients Must Be Examined Before Care is Denied

1399.920. In arranging for medical care and in providing direct care to patients, no health care business shall refuse to authorize the health care services to which a patient is entitled and which have been recommended by a patient's physician, or other appropriately licensed health care professional, acting within their existing scope of practice, unless all of the following conditions are met:

(a) The employee or contractor who authorizes the denial on behalf of the health care business has physically examined the patient in a timely manner.

(b) That employee or contractor is an appropriately licensed health care professional with the education, training, and relevant expertise that is appropriate for evaluating the specific nical issues involved in the denial.

(c) Any denial and the reasons for it have been communicated by that employee or contractor in a timely manner in writing to the patient and the physician or other licensed health care professional responsible for the care of the patient.

Article 7. Physicians Determine Medical Care

1399.925. A physician, nurse, or other licensed caregiver, who is an employee or contractor of a health care business and who is responsible for establishing procedures for assuring quality of care, or in any way determining what care will be provided to patients, shall be subject to the same standards and disciplinary procedures as all other physicians, nurses, or other licensed caregivers providing direct patient care in California.

Article 8. Safe Physician and Nursing Levels in Health Facilities

1399.930. (a) All health facilities shall provide minimum safe and adequate staffing of physicians, nurses, and other licensed and certified caregivers.

(b) The Director of Health Services shall periodically update staffing standards designed to assure minimum safe and adequate levels of patient care in facilities licensed by the State Department of Health Services. Those standards shall be based upon all of the following:

(1) The severity of patient illness.

(2) Factors affecting the period and quality of patient recovery.

(3) Any other factor substantially related to the condition and health care needs of patients.

(c) For those health services that are provided by health care service plans licensed by the Department of Corporations and provided in organized medical clinics not licensed by the State Department of Health Services, the Commissioner of Corporations shall periodically update staffing standards designed to assure minimum safe and adequate levels of patient care.

(d) Licensed health facilities shall make available for public inspection reports of the daily staffing patterns utilized by the facility and a written plan for assuring compliance with the staffing standards required by law.

Article 9. Disclosure of Excessive Overhead of Health Insurers

1399.935. (a) Health care insurers shall disclose to all purchasers of health insurance coverage the amount of the total premiums, fees, and other periodic payments received by the insurer spent providing for health care services to its subscribers or enrollees and the amount spent on administrative costs. For the purposes of this chapter, administrative costs are defined to include all of the following:

(1) Marketing and advertising, including sales costs and commissions.

(2) Total compensation, including bonuses, incentives, and stock options for officers and directors of the corporation.

(3) Dividends, shares of profit, or any other compensation received by shareholders, if any, or any other revenue in excess of expenditures for the direct provision of health care.

(4) All other expenses not related to the provision of direct health care services.

(b) If the amount of administrative costs exceeds ten percent (10%) of the total premiums, fees, and other periodic payments received by the insurer, the insurer shall further disclose to all its purchasers of health insurance the specific amounts spent on marketing and advertising, on total compensation, dividends, profits or excess revenues, and on other expenses not related to the provision of direct health care services.

(c) The disclosures required by this section also shall be filed with the appropriate state agency and be made available for public inspection.

Article 10. Protection of Patient Privacy

1399.940. The confidentiality of patients' medical records shall be fully protected as provided by law. No section of this chapter shall be interpreted as changing those protections, except that no health care business shall sell a patient's medical records to any third party without the express written authorization of the patient.

Article 11. Public Disclosure

1399.945. (a) The appropriate agencies shall collect and review any information as is necessary to assure compliance with this chapter.

(b) Each private health care business and its affiliated enterprises with more than 100 employees in the aggregate shall file annually with the responsible agency all of the following:

(1) Data or studies used to determine the quality, scope or staffing of health care services, including modifications in such services.

(2) Financial reports substantially similar to the reports required of nonprofit health care businesses under existing law.

(3) Copies of all state and federal tax and securities reports and filings.

(4) A description of the subject and outcome of all complaints, lawsuits, arbitrations, or other legal proceedings brought against the business or any affiliated enterprise, unless disclosure is prohibited by court order or applicable law.

(c) Any information collected or filed in order to comply with this section shall be available for public inspection.

Article 12. Interpretation

1399.950. (a) This law is written in plain language so that people who are not lawyers can read and understand it. When any question of interpretation arises it is the intent of the people that this chapter shall be interpreted in a manner that is consistent with its findings, purpose, and intent and, to the greatest extent possible, advances and safeguards the rights of patients, enhances the quality of health care services to which consumers are entitled, and furthers the application of the reforms contained in this chapter.

(b) If any provision of this chapter conflicts with any other provision of California statute or legal precedent, this chapter shall prevail.

Article 13. Implementation and Enforcement

1399.955. (a) This chapter shall be administered and enforced by the appropriate state agencies, which shall issue regulations, hold hearings, and take any other administrative actions that are necessary to carry out the purposes and enforce the provisions of this chapter.

(b) Health care consumers shall have standing to intervene in any administrative matter arising from this chapter. Health care consumers also may go directly to court to enforce any provision of this chapter individually or in the public interest, and any successful enforcement of the provisions of this chapter by consumers confers a substantial benefit upon the general public. Conduct in violation of this chapter is wrongful and in violation of public policy.

(c) Any private health care business found by a court in either a private or governmental enforcement action to have engaged in a pattern and practice of deliberate or willful violation of the provisions of this chapter shall for a period of five years be prohibited from

asserting as a defense or otherwise relying on any of the antitrust law exemptions contained in Section 16770 of the Business and Professions Code, Section 1342.6 of the Health and Safety Code, or Section 10133.6 of the Insurance Code, in any civil or criminal action against it for restraint of trade, unfair trading practices, unfair competition or other violations of Part 2 (commencing with Section 16600) of Division 7 of the Business and Professions Code.

(d) The remedies contained in this chapter are in addition and cumulative to any other remedies provided by statute or common law.

Article 14. Severability

1399.960. (a) If any provision, sentence, phrase, word, or group of words in this chapter, or their application to any person or circumstance, is held to be invalid, that invalidity shall not affect other provisions, sentences, phrases, words, groups of words or applications of this chapter. To this end, the provisions, sentences, phrases, words and groups of words in this chapter are severable.

(b) Whenever a provision, sentence, phrase, word, or group of words is held to be in conflict with federal law, that provision, sentence, phrase, word, or group of words shall remain in full force and effect to the maximum extent permitted by federal law.

Article 15. Amendment

1399.965. (a) This chapter may be amended only by the Legislature in ways that further its purposes. Any other change in the provisions of this chapter shall be approved by vote of the people. In any judicial proceeding concerning a legislative amendment to this chapter, the court shall exercise its independent judgment as to whether or not the amendment satisfies the requirements of this chapter.

(b) No amendment shall be deemed to further the purposes of this chapter unless it furthers the purpose of the specific provision of this chapter that is being amended.

Article 16. Definitions

1399.970. The following definitions shall apply to this chapter:

(a) "Affiliated enterprise" means any entity of any form that is wholly owned, controlled, or managed by a health care business, or in which a health care business holds a beneficial interest of at least twenty-five percent (25%) either through ownership of shares or control of memberships.

(b) "Available for public inspection" means available at the facility or agency during regular business hours to any person for inspection or copying, or both, with any charges for the copying limited to the reasonable cost of reproduction and, when applicable, postage.

(c) "Caregiver" or "licensed or certified caregiver" means health personnel licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, including a person licensed under any initiative act referred to therein, health personnel regulated by the State Department of Health Services, and health personnel regulated by the Emergency Medical Services Authority.

(d) "Health care business" means any health facility, organization, or institution of any kind that provides, or arranges for the provision of, health services, regardless of business form and whether or not organized and operating as a profit or nonprofit, tax-exempt enterprise, including all of the following:

(1) Any health facility defined herein.

(2) Any health care service plan as defined in subdivision (f) of Section 1345 of the He and Safety Code.

(3) Any nonprofit hospital service plan as governed by Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(4) Any disability insurer providing hospital, medical, or surgical coverage as governed by Section 11012.5 and following of the Insurance Code.

(5) Any provider of emergency ambulance services, limited advanced life support, or advanced life support services.

(6) Any preferred provider organization, independent practice association, or other organized group of health professionals with 50 or more employees in the aggregate contracting for the provision or arrangement of health services.

(e) "Health care consumer" or "patient" means any person who is an actual or potential recipient of health services.

(f) "Health care services" or "health services" means health services of any kind, including, but not limited to, diagnostic tests or procedures, medical treatments, nursing care, mental health, and other health care services as defined in subdivision (b) of Section 1345 of the Health and Safety Code.

(g) "Health facility" means any licensed facility of any kind at which health services are provided, including, but not limited to, those facilities defined in Sections 1250, 1200, 1200.1, and 1204, and home health agencies, as defined in Section 1374.10, regardless of business form, and whether or not organized and operating as a profit or nonprofit, tax-exempt or non-exempt enterprise, and including facilities owned, operated, or controlled, by governmental entities, hospital districts, or other public entities.

(h) "Private health care business" means any health care business as defined herein except governmental entities, including hospital districts and other public entities. "Private health care business" shall include any joint venture, partnership, or any other arrangement or enterprise involving a private entity or person in combination or alliance with a public entity.

(i) "Health insurer" means any of the following:

(1) Any health care service plan as defined in subdivision (f) of Section 1345 of the Health and Safety Code.

(2) Any nonprofit hospital service plan as governed by Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(3) Any disability insurer providing hospital, medical, or surgical coverage as governed by Section 11012.5 and following of the Insurance Code.

Proposition 215: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds a section to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Section 11362.5 is added to the Health and Safety Code, to read:

11362.5. (a) This section shall be known and may be cited as the Compassionate Use Act of 1996.

(b)(1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:

(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

(C) To encourage the federal and state governments to implement a plan to provide for . safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(2) Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.

(c) Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

(d) Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

(e) For the purposes of this section, "primary caregiver" means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person.

SEC. 2. If any provision of this measure or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or applications of the measure that can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

Proposition 216: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds sections to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

Division 2.4 (commencing with Section 1796.01) is added to the Health and Safety Code to read:

Division 2.4. The Patient Protection Act

Chapter 1. Purpose and Intent

1796.01. This division shall be known as the "Patient Protection Act." The people of California find and declare all of the following:

(a) No health maintenance organization (HMO) or other health care business should be able to prevent doctors, registered nurses, and other health care professionals from informing patients of any information that is relevant to their health care.

(b) Doctors, registered nurses, and other health care professionals should be able to advocate for patients without fear of retaliation from HMOs and other health care businesses.

(c) Health care businesses should not create conflicts of interest that force doctors to choose between increasing their pay or giving their patients medically appropriate care.

(d) Patients should not be denied the medical care their doctor recommends just because their HMO or health insurer thinks it will cost too much.

(e) HMOs and other health insurers should establish publicly available criteria for authorizing or denying care that are determined by appropriately qualified health professionals.

(f) No HMO or other health insurer should be able to deny a treatment recommended by a patient's physician unless the decision to deny is made by an appropriately qualified health professional who has physically examined the patient.

(g) All doctors and health care professionals who are responsible for determining in any way the medical care that a health plan provides to patients should be subject to the same professional standards and disciplinary procedures as similarly licensed health professionals who provide direct care for patients.

(h) No hospital, nursing home, or other health facility should be allowed to operate unless it maintains minimum levels of safe staffing by doctors, registered nurses, and other health professionals.

(i) The quality of health care available to California consumers will suffer if health becomes a big business that cares more about making money than it cares about taking g care of patients.

(j) It is not fair to consumers when health care executives are paid millions of dollars in salaries and bonuses while consumers are being forced to accept more and more restrictions on their health care coverage.

(k) The premiums paid to health insurers should be spent on health care services for