CONCURRENCE IN SENATE AMENDMENTS
AB 988 (Bauer-Kahan, et al.)
As Amended August 18, 2022
2/3 vote. Urgency

SUMMARY

Requires the California Health and Human Services Agency (CHHSA) to appoint and convene a state 988 policy advisory group (AG) to advise CHHSA on the implementation and administration of the five-year implementation plan for the 988 Suicide Prevention System. Requires the Office of Emergency Services (OES) to appoint a 988 system director and convene an advisory board (Board) to guide how 988 is implemented and made interoperable with 911, including the creation of a new surcharge for 988 to fund the crisis services. Requires health plan and insurer coverage of 988 center services when medically necessary and without prior authorization. Establishes a 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month, and for years beginning January 1, 2025 at an amount based on a specified formula, but not greater than $0.30 per access line per month. Appropriates $300,000 from the General Fund to the 988 State Suicide and Behavioral Health Crisis Services Fund ((fund) previously the State Mental Health and Crisis Services Special Fund) to the Department of Tax and Fee Administration (DTFA) for purposes of implementing this bill. States it is the intent of the Legislature that the go live date for the federally established 988 Suicide and Crisis Lifeline using the three-digit telephone number 988 will be established by July 16, 2022; and, the 988 number receives and responds to the anticipated call volume in the first year of operation for 988 in order to provide crisis intervention services and crisis care coordination to individuals accessing 988.

Senate Amendments:

1) Name this bill the Miles Hall Lifeline and Suicide Prevention Act (Act).

2) Require, by July 16, 2022, the OES to ensure that designated 988 centers utilize technology that allow for transfers between 988 centers and 911 public safety answering points (PSAP).

3) Require OES, no later than 90 days after the passage of the Act, to:

    a) Appoint a 988 system director to implement and oversee the policy and regulatory framework for the technology infrastructure coordination and transfer of calls between 988, 911, and behavioral health crisis centers;

    b) Establish and convene a State 988 Technical Advisory Board (Board) to advise OES on:

        i) Recommendations on the feasibility and plan for sustainable interoperability between 988, 911, and behavioral health crisis services, including the identification of any legal or regulatory barriers to the transfer of 911 calls;

        ii) The development of technical and operational standards for the 988 system that allow for coordination with California's 911 system; and,

        iii) The creation of standards and protocols for when 988 centers transfer 988 calls into the "911" PSAPs, and vice versa.

4) Require the Board to meet at least quarterly until December 31, 2028, and authorize the Board to be disbanded after that time at the discretion of OES.

5) Require the Board to consist of a representative from CHHSA and expert representatives, including, but not limited to those from 988 centers, 911, and behavioral health crisis service providers.

6) Requires OES, by July 1, 2024, to verify interoperability between 988 and 911. Require OES to consult with the National Suicide Prevention Lifeline (NSPL) and the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) on any technology requirements for 988 centers.

7) Require CHHSA, by December 31, 2023, to create a set of recommendations to support a five-year implementation plan for a comprehensive 988 system.

8) Require CHHSA to convene a state 988 AG to advise CHHSA on the set of recommendations to support the five-year implementation plan.

9) Require the AG to include but not be limited to, the Department of Health Care Services (DHCS), OES, and the Department of Public Health, representatives of counties, representatives of employees working for county behavioral health agencies and agencies who subcontract with county behavioral health agencies who provide these services, health plans, emergency medical services, law enforcement, consumers, families, peers, and other local and statewide public agencies.

10) Require the AG to meet at least quarterly until December 31, 2023 and allow the AG to be disbanded at the discretion of CHHSA, but not prior to January 1, 2024.

11) Require CHHSA and the AG to make recommendations on all of the following:

    a) Federal SAMHSA requirements and national best practices guidelines for operational and clinical standards, as specified;

    b) Maintenance of an active agreement with the administrator of the NSPL for participation within the network;

    c) Compliance with state technology requirements for the operation of 988;

    d) A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988

    e) 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat 24 hours per day, seven days per week;

    f) Access to crisis receiving and stabilization services and triage and response to warm handoffs from 911 and 988 call centers;

    g) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services;

h) Statewide and regional public communications strategies informed by the NSPL and the SAMHSA to support public awareness and consistent messaging regarding 988 and behavioral health crisis services;

i) Recommendations to achieve statewide provision of mobile crisis team services that meet specified criteria;

j) Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths;

k) A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system;

l) Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. Requires findings to include an inventory of the infrastructure, capacity and needs as specified;

m) Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988 system consistent with federal law; and,

n) Strategies to support the behavioral health crisis service system to ensure it is adequately funded, including mechanisms for reimbursement of behavioral health crisis responses as specified.

12) Require that commencing December 31, 2024, and until December 31, 2029, the CHHSA to report annually on or before December 31 each year, on the status of 988 implementation including any actions take in that calendar year, planned actions for the future calendar year, barriers to implementation, need for additional funding, and any legislative action required to support implementation.

13) Establish the fund, consisting of the revenue generated by the 988 surcharge assessed on users, to be used solely for the operations of the 988 center and mobile crisis teams, as defined. Provides that the fund may also consist of any other appropriations made to it by the Legislature.

14) Require the revenue generated by the 988 surcharge to be prioritized to fund the following:

a) First, the 988 centers, including the efficient and effective routing of telephone calls, personnel, and the provision of acute mental health services through telephone call, text, and chat to the 988 number; and,

b) Second, the operation of mobile crisis teams accessed via telephone calls, texts, or chats made to or routed through 988 as specified.

15) Prohibit money in the fund being subject to transfer to any other fund or to transfer, assignments, or reassignment for any other use or purpose outside of those specified in this bill.

16) Provide that 988 surcharge revenue in the fund be available, upon appropriation by the Legislature, for the purposes specified in this bill.

17) Require the revenue generated by the 988 surcharge to be used to supplement and not supplant federal, state, and local funding for 988 centers and mobile crisis services.

18) Specify that the revenue generated by the 988 surcharge can only be used to fund service and operation expenses that are not reimbursable through Medicaid, federal financial participation, Medicare, health care service plans, or disability insurers.

19) Authorize the OES, in consultation with DHCS, to adopt regulations regarding how funds received are to be disseminated to support the operations of the 988 system and related behavioral health crisis services. Require the OES to require entities seeking funds to file annually an expenditure and outcomes report as specified on a form and manner as determined by OES and DHCS.

20) Authorize OES and DHCS to implement, interpret, or make specific this bill, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, regulations, or other similar instructions.

21) Specify that coverage of mental health (MH) and substance use disorder (SUD) treatment pursuant to existing law includes medically necessary treatment of a MH or SUD, including, but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team regardless of whether the service is provided by an in-network or out-of-network provider.

22) Prohibit a health plan or insurer from requiring prior authorization for medically necessary treatment of a MH or SUD provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to an enrollee or insured.

23) Require a health plan or insurer to reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for medically necessary treatment of a MH or SUD consistent with the requirements of existing law with respect to the authorization of emergency services.

24) Prohibit the enrollee or insured from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from an in-network provider if an enrollee or insured receives medically necessary treatment for a MH or SUD from a 988 center, mobile crisis team, or other provider of behavioral health crisis services outside the plan network. Require this amount to be referred to as the "in-network cost-sharing amount." Prohibit an out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services from billing or collecting an amount from the enrollee or insured for services except for the in-network cost-sharing amount.

25) Define "behavioral health crisis services" to mean the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a MH or SUD crisis that are wellness, resiliency, and recovery oriented. Include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

26) Clarify that 21) to 24) above do not excuse a health plan or insurer from complying with existing law.

27) Exempt Medi-Cal managed care contracts between the DHCS and a health care service plan for enrolled Medi-Cal beneficiaries from provisions of this bill related to coverage.

28) Exempt accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies from this bill.

29) Allow the California Department of Insurance to promulgate regulations subject to the Administrative Procedure Act, as specified.

30) Create, beginning January 1, 2023, a 988 surcharge on each telephone access line for each month or part thereof for which a service user subscribes with a service supplier. Set the 988 surcharge for the 2023 and 2024 calendar year at $0.08 per access line per month and, for years beginning January 1, 2025, at an amount based on a specific formula, but no greater than $0.30 per access line per month.

31) Make various conforming changes throughout the Emergency Telephone Users Surcharge Act to provide authority for OES to implement the surcharge for 988 in addition to 911.

32) Require all amounts of the 988 surcharge collected to be spent for specified purposed. Before funds are dispersed, require the funds to be used to pay authorized refunds and the DTFA's and OES's administrative costs.

33) Appropriate $300,000 from the General Fund to the 988 State Suicide and Behavioral Health Services Fund for the expenditure of DTFA in the 2022-23 fiscal year for purposes of implementing the bill to cover the state's first year of administrative costs and to fund the designated 988 centers to support the first year of their implementation of the 988 system.

34) Include an urgency clause to ensure that the provisions of this bill go into immediate effect upon enactment.

35) Include legislative findings that to enable public agencies to implement the 988 hotline required by the provisions of the Act, it is necessary that a surcharge be imposed upon access lines purchased by every person in the state for access to the 988 crisis hotline.

36) Declare uncodified Legislative intent as follows:

    a) To implement the National Suicide Hotline Designation Act of 2020 (NSHD), in compliance with the Federal Communication Commission's rules designating "988" as a three-digit number for the National Suicide Prevention Hotline now known as the 988 Suicide and Crisis Lifeline, to assure all persons residing in and visiting the State of California have access to the "988" suicide prevention and behavioral health crisis hotline and care 24 hours per day, seven days per week;

    b) The 988 system in California operate as an emergency suicidal, mental health, and substance use disorder crisis system that provides compassionate, appropriate, and easily accessible care to save lives and reduce law enforcement engagement, arrests, hospitalizations, and deaths; and,

c) By July 16, 2022, the federally established go-live date for the 988 number will be prepared to receive and respond to the anticipated call volume in the first year of operation of 988.

37) Require by June 30, 2024, the CHHSA and the OES to develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services. Specify the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030.

COMMENTS

1) *NSHD.* NSHD was authored by Republican Senator Cory Gardner and passed unanimously through both chambers of Congress. It designated 988 as the new three-digit number for the national suicide prevention and mental health crisis hotline. The NSHD provides for the following:

   a) *Phone Number and Services:* Specifically, NSHD requires the Federal Communications Commission (FCC) to designate 988 as the universal telephone number for a national suicide prevention and mental health crisis hotline, which operates through the NSPL. The NSHD legislation declares that "to prevent future suicides, it is critical to transition the cumbersome, existing 10-digit National Suicide Designation Hotline to a universal, easy-to-remember, three-digit phone number and connect people in crisis with lifesaving resources."

   b) *Funding:* To adequately and sustainably fund the 988 system, NSHD authorized states to impose a fee on access lines for providing 988 related services. In the California Emergency Telephone User Surcharge Act, an access line is defined as a wireline communications service (landline), a wireless communication service line (cell phones), and Voice Over Internet Protocol. Revenue from the fee must be held in a designated account to be spent only in support of 988 services, and the FCC must submit an annual report on state administration of these fees. The fees may only be spent on:

      i) Ensuring the efficient and effective routing of calls made to the 988 national suicide prevention and mental health crisis hotline to an appropriate crisis center; personnel; and,

      ii) The provision of acute mental health crisis outreach and stabilization by directly responding to the 988 national suicide prevention and mental health crisis hotline.

   c) *Health Equity:* The United States Department of Health and Human Services (DHHS) and the Department of Veterans Affairs must, within 180 days of the enactment of the NSHD jointly report on how to make the use of 988 operational and effective across the country, and DHHS must develop a strategy to provide access to competent, specialized services for high-risk populations such as lesbian, gay, bisexual, and queer youth, minorities, and rural individuals.

2) *NSPL.* The NSPL is a national network of approximately 180 local crisis centers that provide free and confidential support 24/7/365 for people in suicidal crisis or emotional distress. There are 13 NSPL affiliated centers currently operating in California. Lifeline call centers in

California set the hours and coverage areas for when they will take lifeline calls. They do this based on funding and staffing levels. When an individual calls the national number, (800)-273-TALK, they are routed to the local crisis center that is closest to them. If a crisis center is unable to respond to all callers at any time, calls are diverted to backup centers. When calls are re-routed to centers out-of-state, California callers in crisis often wait two to three times longer, receive fewer linkages to effective local care, and are more likely to abandon their calls. In 2019, the NSPL received nearly 2.3 million crisis calls from across the United States and 290,619 of those calls were from California. Of those calls, 199,192 were connected to crisis centers in the state. Since 2016, California Lifeline call volume has increased 60% and this is expected to rise even higher given the ongoing COVID-19 pandemic and the resultant increase in mental health and substance use disorder crisis needs.

3) *911.* The Warren 911 Act authorizes cities and counties to form contracts regulating the implementation of a 911 system. The basic structure of the 911 system is designed to ensure that when a person dials 911, a law enforcement agency serving as a primary PSAP receives 911 requests from the area where the person is calling. If a 911-caller requests emergency medical assistance, the primary PSAP may retain the caller if it directly provides emergency medical services (EMS) dispatch, or may transfer the caller to a secondary PSAP for emergency medical response. The medical secondary PSAP can be a public agency, public/private partnership, or private EMS provider designated or recognized by the local EMS agency as serving the entire EMS area or portion of the EMS area.

4) *MH AND SUD COVERAGE LAWS.*

   a) *Federal Mental Health Parity Act (MHPA).* In 1996, the U.S. Congress passed the MHPA, which prohibits large group health plans from imposing higher annual or lifetime dollar limits on MH benefits. However, the MHPA did not mandate coverage for MH services and only applied to group health plans that offered MH benefits. The MHPA also did not apply to SUDs, services limits, limitations on the types of facilities covered, or differences in cost sharing, and plans could have stricter prior authorization requirements for MH services than for other medical services. It should be noted that these restrictions were lifted in the federal Act discussed below.

   b) *State Mental Health Parity.* In 1999, California passed AB 88 (Thompson), Chapter 534, Statutes of 1999, which requires a health plan contract or disability insurance policy to provide coverage for the diagnosis and medically necessary services of serious mental illness of a person of any age and of serious emotion distress of a child. Benefits must be applied under the same terms and conditions as applied to other medical conditions. AB 88 also requires copayments, deductibles, and maximum lifetime benefits to be applied equally to all benefits under the plan.

   c) *Federal Act.* In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (federal Act) to cover some of the gaps in the MHPA. Similar to the MHPA, the federal Act only applies to large-group health plans. However, the federal Act also included Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children's Health Insurance Program plans. Unlike the MHPA, the federal Act prohibited differences in services limits, cost-sharing, in-and-out-of-network coverage, and applied to services for SUDs.

The federal Act requires, if health plans include services for MH/SUDs as part of their benefits, to provide those services under the same terms and conditions as other medical services. The federal Act eliminated all differences between MH/SUDs and other medical services as they related to: services and visit limits; deductibles; copayments; coinsurance; and, the use of out-of-network providers when a health plan gave this option. Further, federal regulations in 2010 and then the final rule in 2013, prohibited health plans from imposing a financial requirement or services limit restriction that is more restrictive than what are offered for medical and surgical benefits in the same classification. Both the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) provide regulatory oversight of federal and California parity laws and are monitoring filings for compliance with these laws.

d) *The federal Patient Protection and Affordable Care Act (ACA) and essential health benefits (EHBs) and recent state law.* The ACA applied the federal Act to issuers in the individual market and qualified health plans offered through a health benefit exchange, including small group products. The ACA also specified coverage of the 10 EHBs, including MH/SUD treatment services. California's EHB statute also specifically states that the federal Act applies to health plans that must comply with EHBs, including products offered off the exchange. The ACA states that coverage of MH/SUD services along with any scope and duration limits imposed on the benefits be in compliance with the federal Act and all rules, regulations, and guidance issued pursuant to the federal Act. According to a 2015 *Health Affairs* Health Policy Brief, the ACA went beyond the federal Act by mandating coverage instead of requiring parity only if coverage is provided. SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers to provide full coverage for the treatment of all MH conditions and SUDs. SB 855 also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. SB 855 applies to all state-regulated health care service plans and insurers that provide hospital, medical, or surgical coverage, and to any entity acting on the plan or insurer's behalf. A health plan cannot limit benefits or coverage for MH or SUD treatments or services when medically necessary.

According to the sponsors of this bill, under current law, California plans are already required to cover all medically necessary treatment of MH and SUDs. The sponsors state that further, emergency transport is an EHB and thus included in the benchmark plan under the ACA and the federal Act also prohibits medical necessity reviews under that emergency classification. Plans have to provide equal coverage within that classification of care. Given this standard on the physical health side, the regulators could reasonably prohibit plans from requiring medical necessity reviews for emergency services but they need regulating authority to do so. Regarding in and out of network provisions of this bill, state and federal balance billing protections would apply, according to the sponsors. This language allows both CDI and DMHC to write regulations to ensure this parity between physical and MH and ensure these services are covered pursuant to state and federal parity laws. Without this language, the sponsors understand that the regulators do not feel they have the authority to issue guidance on this bill. This has come up numerous times as the sponsors have gone through the regulations process on SB 855. In short, plans should already be providing medically necessary care and for emergency services and they should be doing so at in network rates. The author and sponsor believe that this bill does not change that but does make it clarify services provided under this bill

are not left out of existing law and gives the departments authority to regulate. Additionally, the Committee reached out to the DMHC with questions regarding the technical assistance provided in this bill and have not received a response. The Governor's Office, however, responded to the author that the language currently in this bill is intended to clarify how reimbursement for services already covered would operate. The language regarding "medical necessity" keeps the coverage requirement for 988 services consistent with the coverage requirements for other services, including MH and SUD services provided pursuant to Health and Safety Code (HSC) Section 1374.12. However, if the 988 service provided falls into the existing definitions of "emergency services and care" (HSC Section 1371.4 (a)), then HSC Section 1371.4 (c) prohibits the health plan from denying payment for services rendered regardless of medical necessity (unless it is determined that emergency services and care were not performed). According to the Governor's Office, the language added to this bill does not supplant HSC Section 1371.4 when that section is applicable, it instead elaborates on how the MH and SUD coverage mandate in HSC Section 1374.72 would apply to 988 services.

It should be noted that due to the timing of these amendments, the Committee was not accorded the opportunity to further research these issues, nor confer with Legislative Counsel on interpretations of existing law and the amendments to this bill.

According to the Author
A previous version of this bill created a new three-digit phone line, 988, for suicide prevention and immediate, localized emergency response by trained mental health professionals for individuals in mental health crisis. The author opines that the current system relies on law enforcement and confinement and puts people suffering from mental illness through an expensive and traumatizing revolving door as they shuttle between jails, emergency rooms, and the street. The author concludes by stating that a comprehensive crisis response system can help prevent avoidable tragedies, save money, and increase access to the right kind of care. The author states, we must make significant changes in how we respond to those suffering from a mental health crisis.

Arguments in Support
The Steinberg Institute and The Kennedy Forum, cosponsors of this bill, state in support of a previous version of the bill, that California is facing a mental health crisis. One in six Californians now live with a mental illness and suicides have been steadily climbing, increasing by 35% nationally over the last two decades. This tragic trend has only been exacerbated by COVID-19. With calls to existing suicide prevention call centers skyrocketing as a result of the COVID-19 pandemic, this bill will ensure the state is prepared to answer calls of all Californians in need by providing a seamless transition from our current suicide prevention system and handling the expected increase in volume demand of calls to suicide prevention lines. The cosponsors conclude, this bill takes a monumental step forward in addressing these systemic inequities in our mental health system by creating a crisis response system that provides support to help individuals and communities thrive.

Arguments in Opposition
The California Association of Health Plans (CAHP) in an oppose position states that this bill as amended on August 18, 2022, creates an overly broad and substantive new mandate on health plans and insurers despite the fact that the language has not been analyzed by any policy committee or reviewed by the California Health Benefits Review Program. CAHP concludes that

this exceptionally flawed process does not provide stakeholders with any opportunity to provide feedback or discuss the merits of this new mandate despite the significant operational and cost impacts this bill will have.

Arguments in Oppose Unless Amended

The County Behavioral Health Directors Association (CBHDA), in oppose unless amended, states that this bill makes clear that private plans are only required to reimburse for "medically necessary" mobile crisis services. The addition of "medically necessary" as a qualifier does not apply to EMS services, and therefore would establish a new high-bar standard for field-based mobile crisis teams addressing emergency behavioral health crisis needs. CBHDA is concerned that applying the medical necessity standard is unfair and it would have such detrimental consequences that it would impact the viability of efforts to stand up statewide 24/7 mobile crisis services under Medi-Cal and 988 (e.g. it gives the perception of help but would set a bad precedent for requiring private insurance reimbursement for mobile crisis services generally – not just within 988; increase documentation burden for providers; require a level of clinician participation in mobile crisis that is untenable in the current workforce crisis environment; and, limit the use of paraprofessionals). According to CBHDA, this language creates such an uneven playing field for field-based crisis response across behavioral health and medical services.

Also in an oppose unless amended position, the Service Employees International Union – California (SEIU) states that this bill threatens the jobs of county behavioral health workers and jeopardizes the health of individuals in crisis by opening the door for lower quality services by providers with little or poor training. They further state the bill establishes an unfair, unsustainable system, blocking access to funding for most behavioral health services. They state the current definitions in the bill are written in a way that the majority of services delivered by county behavioral health services, emergency responders other behavioral health providers would not be able to access this funding – leaving counties responsible for payment of these services.

FISCAL COMMENTS

According to Senate Appropriations on an earlier version of the bill, the OES anticipates approximately $55.6 million in annual revenue from the monthly surcharge of $0.08 per access line, to be deposited into the 988 State Mental Health and Crisis Services Special Fund. Revenue from the surcharge will offset, to some extent, OES's stand-up and administrative costs, which include one-time costs of approximately $35 million for information technology equipment and services and ongoing annual costs of approximately $31.5 million to implement and administer the program.

Unknown, likely significant fiscal impact to the CHHSA to among other things, designate centers and create the 988 system implementation plan, convene the working group, and administer the program.

The DTFA anticipates implementation costs of approximately $50,000 to $250,000. And beginning in fiscal year (FY) 2023-24, ongoing administrative costs of approximately $445,000.

The CDI estimates costs of $377,000 in FY 2021-22, $902,000 in FY 2022-23, and $679,000 ongoing to coordinate with CHHS and the DMHC to develop a guidance and adopt regulations (Insurance Fund). CDI does not anticipate these costs to be absorbable.

This bill appropriates $8,035,700 from the General Fund to the 988 State Suicide and Behavioral Health Services Fund to cover the state's first year of administrative costs and to fund the designated 988 centers to support the first year of their implementation of the 988 system.

VOTES:

ASM HEALTH: 11-2-2
YES: Wood, Aguiar-Curry, Bonta, Burke, Carrillo, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago
NO: Bigelow, Waldron
ABS, ABST OR NV: Mayes, Flora

ASM COMMUNICATIONS AND CONVEYANCE: 10-0-3
YES: Santiago, Boerner Horvath, Cervantes, Eduardo Garcia, Holden, Low, Quirk-Silva, Rodriguez, Bennett, Ting
ABS, ABST OR NV: Patterson, Davies, Valladares

ASM APPROPRIATIONS: 12-4-0
YES: Lorena Gonzalez, Calderon, Carrillo, Chau, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Holden, Luz Rivas
NO: Bigelow, Megan Dahle, Davies, Fong

ASSEMBLY FLOOR: 70-0-9
YES: Aguiar-Curry, Arambula, Bauer-Kahan, Bennett, Berman, Bloom, Boerner Horvath, Bryan, Burke, Calderon, Carrillo, Cervantes, Chau, Chiu, Cooley, Cooper, Cunningham, Daly, Davies, Frazier, Friedman, Gabriel, Gallagher, Cristina Garcia, Eduardo Garcia, Gipson, Lorena Gonzalez, Gray, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Lackey, Lee, Levine, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Mullin, Muratsuchi, Nazarian, Nguyen, O'Donnell, Petrie-Norris, Quirk, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Smith, Stone, Ting, Valladares, Villapudua, Voepel, Waldron, Ward, Akilah Weber, Wicks, Wood, Rendon
ABS, ABST OR NV: Bigelow, Chen, Choi, Megan Dahle, Flora, Fong, Kiley, Patterson, Seyarto

SENATE FLOOR: 38-0-2
YES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Melendez, Min, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Hertzberg, Newman

UPDATED

VERSION: August 18, 2022

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