

Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1244 (Allen) – As Amended June 11, 2026

SENATE VOTE: 30-0

SUBJECT: Public Agency Benefits Intermediary Compensation Disclosure Act.

SUMMARY: Requires a covered service provider, including brokers, agents, and consultants, to disclose to a public agency or its group health plan the direct and indirect compensation it expects to receive for providing brokerage or consulting services before it enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or its plan. Requires a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for the public agency or its group health plan, as specified. Specifically, **this bill:**

- 1) Requires a covered service provider to disclose to the responsible public agency official, and to the governing body of the public agency or the clerk or other designee identified by the governing body, in writing, specified information before the covered service provider enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or covered plan.
- 2) Requires a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for a public agency or covered plan, including compensation paid by carriers, vendors, third-party administrations, pharmacy benefit managers, enrollment firms, joint powers authorities (JPAs), captives, and other sources, whether or not the compensation is solely attributable to the public agency's specific contract or policy. Includes compensation received for recommending, facilitating, or influencing a public agency's decision to join, remain with, or purchase coverage through a JPA, regardless of whether the compensation is paid by the JPA, a vendor contracting with the JPA, or any other source.
- 3) Requires disclosure pursuant to 1) and 2) above if a covered service provider reasonably expects it would receive, during the term of the contract arrangement, \$1,000 or more in compensation, direct or indirect, including compensation received by a related party. Requires noncash compensation to be included in this calculation and disclosed if it exceeds \$250 in the aggregate during the term of the contract or arrangement, or if a reasonable person would consider it material.
- 4) Permits a description of compensation or cost to be expressed as a monetary amount, formula, percentage, or a per capita charge for each participant, beneficiary, enrollee, or insured. Permits, if the compensation or cost cannot reasonably be expressed in those terms, it to be described by any other reasonable method. Allows the description to include a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost, if the covered service provider explains the methodology and

assumptions used to prepare the estimate. Requires the description to contain sufficient information to permit the public agency to understand the nature and potential magnitude of the compensation or cost and identify potential conflicts of interest.

- 5) Requires the disclosure pursuant to 1) and 2) above to include the following information:
- a) A description of the brokerage services or consulting services to be provided;
 - b) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the public agency or covered plan as a fiduciary under applicable law. Does not create or expand fiduciary status under state law;
 - c) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, a subcontractor, or a related party reasonably expects to receive in connection with the services;
 - d) A description of all indirect compensation that the covered service provider, an affiliate, a subcontractor, or a related party reasonably expects to receive in connection with the services, including all of the following:
 - i) A description of the arrangement pursuant to which the indirect compensation is paid;
 - ii) Identification of the services for which the indirect compensation will be received, if applicable;
 - iii) Identification of the payer of the indirect compensation;
 - iv) Indirect compensation includes compensation from a carrier, vendor, or third party based on a structure of incentives not solely related to the public agency's contract or policy, including book-of-business incentives, volume bonuses, retention bonuses, and other market-derived income; and,
 - v) Disclosure that identifies categories, types, or sources of compensation without providing corresponding amounts, good-faith estimates, or formulas for calculating amounts for each identified category, type, or source does not satisfy the requirements of this bill. States that general descriptions of compensation arrangements that may exist or that the covered service provider may from time to time receive are insufficient. Requires the disclosure to state if the covered service provider reasonably expects to receive the compensation in connection with the specific public agency or covered plan during the applicable contract period.
 - e) A description of any compensation that will be paid among the covered service provider, an affiliate, subcontractor, or related party in connection with the services if the compensation is set on a transaction basis, such as commissions, finder's fees, placement fees, or other similar incentive compensation based on business placed or retained, including identification of the services for which the compensation will be paid and identification of the payers and recipients of that compensation;

- f) A description of any compensation that the covered service provider, an affiliate, related party, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon termination;
- g) A description of the manner in which the compensation described in this bill will be received;
- h) A description of noncash compensation, including the nature of the noncash compensation and a reasonable good faith estimate of fair market value;
- i) Identification of an ownership interest, equity stake, or other financial interest, including a pending or proposed interest under negotiation or under consideration, that the covered service provider or any related party holds in a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement;
- j) If any compensation cannot reasonably be expressed as a monetary amount at the time of disclosure, a reasonable and good faith estimate and an explanation of the methodology and assumptions used to prepare the estimate, including any reasonable allocation methodology for compensation that is pooled across multiple clients;
- k) For all compensation disclosed pursuant to c), d), e), and h), a breakdown showing all of the following separately:
 - i) Compensation to the individual broker, agent, consultant, or advisor;
 - ii) Compensation to the firm or company by which the individual is employed or contracted; and,
 - iii) Compensation to an affiliate, subcontractor, or related party, regardless of whether the compensation is paid directly or routed through a third party or other entity.
- l) For covered service providers that recommend, place, or service benefits arrangements for retirees, including Medicare supplement plans, Medicare Advantage plans, retiree health exchanges, or other retiree coverage, a separate statement disclosing all of the following:
 - i) All compensation related to retiree benefits arrangements, broken out separately from compensation related to active employee arrangements;
 - ii) Whether compensation for retiree-related services is considered by the covered service provider in determining or offsetting fees for active employee services; and
 - iii) Any arrangement pursuant to which retiree-related compensation subsidizes, offsets, or is otherwise connected to the pricing of services for active employee benefits.
- m) Identification of a material business relationship between the covered service provider, or any related party, and a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement. States that a business relationship is “material” if the covered service provider or related party

received or expects to receive compensation exceeding \$10,000 in the aggregate from the carrier or vendor during the 12 months preceding the disclosure or the 12 months following the disclosure.

- 6) Requires the covered service provider to disclose information in accordance with both of the following:
 - a) For a prospective contract or arrangement, to provide the disclosure with the first written communication to the responsible public agency representative or governing board that contains a formal offer, proposal, or solicitation to provide brokerage, agent, advisory, or consulting services, and to be updated before execution if there is any material change to the expected compensation;
 - b) For an extension, renewal, or material amendment of an existing contract or arrangement, to provide the disclosure not later than 60 days before the effective date of the extension, renewal, or material amendment;
 - i) Requires, if the covered service provider delivers ongoing services, the covered service provider to give an updated disclosure annually, not later than 60 days before the renewal date of each covered health care benefits arrangement for which the covered service provider provides brokerage services or consulting services;
 - ii) Specifies that a covered service provider is in compliance with i) above if they provide a comprehensive disclosure covering all covered health care benefits arrangements not later than 60 days before the annual renewal date of the contract or arrangement with the responsible public agency official or governing board;
 - iii) Requires, for any compensation disclosed as an estimate, the covered service provider to provide an annual true-up that includes revised disclosure not later than 90 days after the end of the contract year or plan year, as applicable. For purposes of this requirement, the “contract year” or “plan year” means the 12-month period used for coverage under the covered health care benefits arrangement, or, if that period is not specified, the 12-month period following the effective date or renewal date of the contract; and,
 - iv) Requires, if the covered service provider discovers an error or omission in a disclosure, to provide corrected information as soon as practicable, but not later than 30 days after the date the covered service provider knows of the error or omission.
- 7) Requires a covered service provider that provides brokerage services, consulting services, or administrative services to a JPA to do both of the following:
 - a) Provide the disclosures described above to the responsible official of the JPA and governing body; and,
 - b) Make the disclosures available, either directly or through the JPA, to the governing body or responsible official of each public agency that participates in the pooled arrangement, upon request and at least annually.
- 8) Authorizes a JPA that receives disclosures under this bill to do both of the following:

- a) Maintain the disclosures and make them available to its member public agencies upon request; and,
 - b) Include in its annual reporting to member agencies a summary of compensation disclosed by covered service providers or provide a copy of the full disclosure.
- 9) Requires a covered service provider that recommends, facilitates, or materially influences a public agency's decision to join, remain with, or purchase coverage through a JPA to disclose to that public agency all compensation received or reasonably expected to be received, directly or indirectly, in connection with that recommendation, including all of the following:
- a) Referral fees, finder's fees, or placement fees paid by the pooling arrangement or an entity affiliated with the pooling arrangement;
 - b) Commissions, overrides, or other compensation paid by a carrier, vendor, or third party contracting with or through the pooling arrangement;
 - c) Administrative fees, marketing allowances, or other payments received for maintaining or increasing membership in the pooling arrangement; and,
 - d) An ownership interest, board position, governance role, or profit-sharing arrangement the covered service provider or a related party holds with respect to the pooling arrangement.
- 10) Prohibits a covered service provider from doing any of the following:
- a) Requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or covered plan unless the compensation is disclosed;
 - b) Structuring, routing, recharacterizing, allocating, or otherwise arranging compensation, including through an affiliate, subcontractor, or other related party, for the purpose of evading the disclosure requirements;
 - c) Relabeling, renaming, or recharacterizing compensation as fees, consulting payments, administrative charges, service fees, or any other designation for the purpose of circumventing the disclosure requirements; and,
 - d) Avoiding disclosure obligations by entering into a separate consulting agreement or advisory agreement for substantially similar services that would otherwise require disclosure.
- 11) Requires a covered service provider to retain records sufficient to support the required disclosures for not less than three years following the later of the following:
- a) The date the disclosure is provided; or,
 - b) The termination of the contract or arrangement.
- 12) Requires, upon request by the Attorney General, a county counsel, a city attorney, or an authorized local prosecutor, a covered service provider to make these records available for inspection.

- 13) Provides that these provisions apply to contracts or arrangements entered into, extended, or renewed on or after January 1, 2028. States that public agencies and covered service providers are encouraged to voluntarily comply with this article before January 1, 2028.
- 14) Defines “covered service provider” as a broker, agent, consultant, or advisor that enters into a contract or arrangement with a covered plan or public agency and reasonably expects, knew, or should have known it would receive, compensation, direct or indirect, to be received in connection with providing brokerage services or consulting services described in this bill, regardless of if those services will be performed, or the compensation received, by the covered service provider, an affiliate, a subcontractor, or a related party.
- 15) Defines “covered health care benefits arrangement” as a contract, policy, program, or arrangement for health care employee benefits or health care benefits-related services that is recommended, placed, renewed, extended, or materially influenced by a covered service provider for a covered plan or public agency, including all of the following:
 - a) Medical coverage, whether insured, self-funded, or both;
 - b) Stop-loss, captive, or reinsurance arrangements;
 - c) Dental coverage;
 - d) Vision coverage;
 - e) Voluntary or worksite benefits, including life insurance, disability insurance, accident insurance, critical illness insurance, and hospital indemnity insurance;
 - f) Third-party administration services, including trust or JPA administration, health reimbursement arrangements, health savings accounts, flexible spending accounts, continuation coverage, and leave administration;
 - g) Network administration services;
 - h) Network access vendors and rental network arrangements;
 - i) Provider aggregators, including centers of excellence and direct contract aggregators;
 - j) Pharmacy benefit management services and related rebate programs;
 - k) Pharmacy benefit cost containment programs;
 - l) Recordkeeping services;
 - m) Medical management and utilization review vendors;
 - n) Wellness services and programs;
 - o) Transparency tools and data analytics vendors;
 - p) Group purchasing organization preferred vendor panels;
 - q) Disease management vendors and products;
 - r) Care navigation and care management services;

- s) Telehealth services and platforms;
 - t) Compliance services;
 - u) Employee assistance programs;
 - v) Human resource information systems;
 - w) Benefits or coverages purchased through a multiemployer purchasing arrangement, such as a JPA, trust fund, or cooperative;
 - x) Benefits or coverage for retirees, including Medicare supplement plans, Medicare Advantage plans, retiree health exchanges, and other retiree coverage programs;
 - y) Actuarial services, including actuarial valuations, ratesetting analysis, reserve certifications, and other actuarial consulting related to covered health care benefits arrangements;
 - z) Enrollment services and benefit enrollment platforms;
 - aa) Digital health and specialty condition management programs, including mental health, musculoskeletal, fertility and family-building, diabetes management, weight management, and substance use disorder programs;
 - bb) Reference-based pricing and direct contracting programs;
 - cc) Onsite, near-site, or shared-site clinic services;
 - dd) Claims auditing, claims repricing, and subrogation services;
 - ee) Dependent eligibility verification and audit services;
 - ff) Patient advocacy, health care concierge, and medical bill negotiation services;
 - gg) Benefits communication and employee education services;
 - hh) Banking and custodial services for health-related accounts, including health reimbursement arrangement, health savings account, and flexible spending account custodians;
 - ii) Captive insurance management and captive feasibility consulting services; and,
 - jj) Any other product, service, or vendor recommended if compensation is paid, directly or indirectly, because of the covered service provider's recommendation, placement, renewal, or material influence. For purposes of this paragraph, "materially influence" includes providing advice, analysis, recommendations, or other input that was relied upon or adopted by the public agency in making a procurement, renewal, or vendor selection decision.
- 16) Defines "affiliate" to mean an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another entity, or is an officer, director, or employee of, or partner in, that entity. Unless otherwise specified, "affiliate" refers to an affiliate of the covered service provider. "Affiliate" includes a person

or entity created, recruited, or designated with the intent to avoid the disclosure requirements of this article.

- 17) Defines “brokerage services” to include soliciting, recommending, placing, arranging, enrolling, renewing, extending, or otherwise materially influencing the selection of a covered health care benefits arrangement or vendor for a covered plan or public agency, and related assistance with procurement, marketing, negotiation, or implementation of those arrangements.
- 18) Defines “compensation” as anything of monetary value paid in cash or noncash form, including money, fees, commissions, consulting payments, retainers, overrides, contingent or volume-based compensation, bonuses including retention bonuses, referral fees, revenue sharing, marketing allowances, administrative allowances, rebates, technology subsidies, gifts, awards, trips, profit sharing, data access or data monetization payments, and any other remuneration or economic benefit received in connection with services provided to a public agency or covered plan, including credits, allowances, expense reimbursements, and expense offset.
- 19) Defines “direct compensation” as compensation received directly from the covered plan or from the public agency plan sponsor.
- 20) Defines “indirect compensation” as compensation received from any source other than the covered plan, the public agency plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation unless it is received in connection with services performed under the subcontractor’s contract or arrangement.
- 21) Defines “noncash compensation” as compensation that is not paid in cash, including travel, lodging, meals, entertainment, gifts, conference sponsorships, lead lists, technology, preferred access, or other items of value.
- 22) Defines “public agency” as a county, a city, a city and county, a school district, a community college district, a special district, a JPA, a public authority, a public entity, or any other local governmental entity in this state that is authorized to sponsor, purchase, or administer employee health care benefits. “Public agency” also includes a public joint labor-management trust or similar entity that provides or administers health or welfare benefits for public employees or retirees.
- 23) Defines other terms and makes legislative findings and declarations.

EXISTING FEDERAL LAW:

- 1) Requires, under the Employee Retirement Security Act of 1974 (ERISA), certain retirement and health plans to provide participants with certain information. ERISA generally does not cover plans maintained by governmental entities. [29 U.S.C. § 1001, *et seq.*]
- 2) Requires, under the Consolidated Appropriations Act of 2021 (CAA), comprehensive broker, agent, and consultant compensation disclosure for ERISA-covered group health plans. [§ 202, Pub. L. No 116-260 (Dec. 27, 2020).]

EXISTING STATE LAW: Requires a health plan or a health insurer to annually disclose to the governing board of a public agency that is the subscriber of a group contract or the policyholder of a group health insurance policy specified information, including, but not limited to, any fees or commissions paid to any agent, broker, or other individual related to the public agency's group contract or policy. [Health & Safety Code § 1367.08 and Insurance Code § 10604.5.]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, healthcare premiums have more than tripled over the past 20 years. The author states that public agencies have been grappling with these rising prices that are, in some cases, compounded by compensation paid to insurance intermediaries who advise employers on health care options to select for their employees' benefits package. The author notes that private employers receive compensation disclosures from these intermediaries, which can help guide decisions on which benefits to select and which intermediaries to contact with. Public agencies, however, currently receive no such transparency, and thus have to make large financial decisions with less information available to them. The author concludes that this bill will close this gap in the law and help public agencies make more fiscally sound decisions when selecting employee benefits options by requiring insurance intermediaries to proactively disclose the compensation they earn for advising these agencies to select certain health care options.
- 2) **BACKGROUND.** Brokers and agents are licensed professionals who offer insurance products. They can service individuals seeking coverage or employers looking for group insurance. Public agencies, including school districts, cities, counties, community colleges, and special districts, spend billions annually on employee health benefits. Just like private employers, public agencies often rely on brokers and consultants to recommend insurance carriers, negotiate rates, and select vendors for benefits. These brokers generally receive compensation directly from the carriers. The fact that they are being compensated is usually disclosed; however, the exact amount of compensation is not.
 - a) **Federal disclosure requirements.** The No Surprises Act, part of the 2021 CAA, added several provisions regarding health plan cost transparency, including requiring disclosures of covered service provider compensation. Specifically, section 202(a) requires disclosure of direct and indirect compensation before an employer-sponsored health plan enters into a contract or arrangement for services. Section 202(a) became effective December 27, 2021, for contracts entered, renewed, or extended on or after the effective date. These provisions apply to private employer sponsored small and large group health plans and require the employer-sponsored health plans to obtain written disclosure of compensation for broker and consulting services from their broker and/or consultant prior to entering a contract to assess the reasonableness of the compensation to be paid to such broker and/or consultant and any potential conflicts of interest. Under the federal law, disclosures are required for arrangements that are expected to result in \$1,000 or more in compensation, including nonmonetary compensation. The covered service provider is required to make the disclosure regarding direct and indirect compensation to the group health plan or its fiduciary in a timely manner. The employer-

sponsored health plan is required to review broker compensation for reasonableness and any potential conflicts of interest prior to entering the contract.

This bill is intended to ensure that public agencies receive similar transparent disclosures of compensation and potential conflicts of interest on a reasonable timeframe to inform procurement and renewal decisions regarding health care benefits and benefits-related services.

- 3) SUPPORT.** A coalition of labor groups representing public sector workers support this bill, stating that public entities spend billions of dollars annually on employee health benefits and rely on insurance brokers, agents, and consultants to recommend carriers and negotiate rates. However, the supporters note that these intermediaries often receive compensation from insurers and third parties that public agencies never see. The supporters continue that it is common for the service contracts between public agencies and intermediaries to contain a vague disclosure that the broker may receive indirect compensation. The supporters argue that these opaque arrangements create a clear conflict of interest, which potentially steers local agencies toward more expensive vendors simply because the broker's compensation is higher for those options. The supporters state that the stakes for their members are significant. Commissions can be as high as 50% of the premium for some supplemental products, while base commissions for entire health plans often range from 3% - 6% of the total premium. With insurance costs having tripled over the last 20 years, the supporters argue that these hidden costs compound the affordability crisis facing local government employers and their workforce. The supporters conclude that their members deserve to know that their health care dollars are being spent on care, not on undisclosed incentives for intermediaries.
- 4) OPPOSED UNLESS AMENDED.** A coalition of associations representing insurance agents and brokers oppose this bill, stating that the bill would create significant compliance challenges and unintended consequences. To address these concerns, the opposition has suggested targeted amendments to align this bill with federal standards. The opposition notes that despite the characterization that this bill is federal parity, the bill goes well beyond the established federal structure by significantly expanding the scope of covered vendors, services, level of compensation reporting, and doesn't align with existing data reporting systems. The opposition continues that in its current form, this bill risks creating a system in which compliance is impractical, liability is misaligned, and administrative burdens may discourage qualified agents and brokers from serving public agencies. This would not be because agents are uninterested in providing transparency, but because there is no effective way of delivering the transparency that this bill requires – which simply means that agents would be putting themselves in legal jeopardy for participating in the marketplace for governmental plans. The opposition argues this could ultimately limit competition, reduce choice, and negatively impact the public entities the bill seeks to protect. The opposition notes that this bill comes at a time when securing affordable coverage for their clients has never been more critical or more difficult. As drafted, the opposition asserts that their members will be unable to comply with the overreaching complexities of the bill, and the anti-competitive nature of the legislation will discourage competitive participation in the public entity market. The opposition requests for this bill to be amended to true federal parity which would advance transparency while remaining aligned with operational realities.

5) **POLICY QUESTIONS.** While the overarching goal of this legislation is to ensure that public employers have parity in transparency on broker/agent compensation, this bill does exceed the federal standards in ways that raise questions about feasibility. Many of these questions exceed the jurisdiction of this committee, but if this bill is to move forward the Legislature may wish to contemplate the following questions:

- a) **Expanded scope beyond federal framework.** This bill identifies 36 categories of covered vendors and service providers from which compensation needs to be reported, extending well beyond the health plan-focused entities covered under the federal framework. This expansion pulls in a wide range of ancillary vendors including telehealth platforms, actuarial services, human resource information system providers, retiree exchanges, enrollment platforms, digital health vendors, reference-based pricing entities, onsite clinics, claims repricing and subrogation firms, and patient advocacy services. The opposition notes that these additional service providers are not subject to corresponding obligations to furnish necessary compensation or financial data to agents and brokers, leaving them without access to much of the data necessary to comply with the disclosure requirements of this bill. The author argues that since the passage of federal law, more compensation forms have been identified including technology-related compensation routed through enrollment platforms and benefits administration systems, hidden commissions related to voluntary insurance products and payments related to digital point solution vendors. The author believes it is critical to ensure that public agencies receive as much of a full picture as possible when they are considering a contract for services. While maximum transparency is a laudable goal, what is the feasibility of an individual broker or agent truly being able to realistically disclose the information requested under this bill?
- b) **Individual broker responsibility.** In addition to the issues raised in the question above, the opposition has noted that oftentimes brokers and agents are part of larger consulting firms or agencies and aren't privy to the full scope of compensation to those entities. However, this bill would make the brokers and agents responsible for reporting compensation to such affiliated entities. Is it appropriate to place this level of compliance and reporting burden for compensation disclosure directly on individual brokers and agents, given that they are often one participant in a complex, multi-party benefits arrangement involving carriers, larger consulting firms, TPAs, and vendors, many of whom control compensation data the broker may not have direct access to? Should disclosure responsibility instead be assigned to the entity with the most complete visibility into the full compensation structure? If disclosure responsibility is left with the broker, are protections in the bill sufficient to ensure a broker isn't fully liable for disclosing accurate data that they may not have access to?
- c) **Parity for other employers and agents.** Health insurance brokers would face new disclosure and reporting obligations under this bill. Are brokers operating in other lines of business with public or private agencies subject to comparable requirements? Given that this bill goes beyond federal requirements, what is the benefit or policy rationale for creating different standards for health insurance brokers supporting public agencies vs. other employers?

With broad questions about implementation and feasibility lingering, the Legislature should ponder what the policy justification is for going beyond the federal standard that has already

been successfully implemented nationally. If the goal is transparency and parity, should the Legislature begin by aligning this bill with federal law and take time to expand disclosures to meaningfully encompass the expanded entities that the author and supporters are aiming to capture?

REGISTERED SUPPORT / OPPOSITION:

Support

AFSCME California
Association of California School Administrators
Benicia Unified School District
California Federation of Labor Unions, AFL-CIO
California Federation of Teachers
California School Employees Association
California State Association of Counties
California Teachers Association
Faculty Association of California Community Colleges
Health Access California
Orange County Employees Association
Rural County Representatives of California
SEIU California
SMART - Transportation Division
Urban Counties of California

Opposition

None on file

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