Date of Hearing: January 11, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1400 (Kalra) – As Introduced February 19, 2021

SUBJECT: Guaranteed Health Care for All.

SUMMARY: Establishes the California Guaranteed Health Care for All or CalCare as California's single-payer health care coverage program. Specifically, **this bill**:

1) Specifies the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

2) Establishes CalCare, governed by the CalCare Board (board), to administer the single-payer health care coverage program.

3) States that this bill does not preempt a city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this bill.

4) States that bill prevails over any inconsistent law unless explicitly indicated.

Governance/board

1) Requires CalCare to be governed by the board, consisting of nine voting members who are residents of California. Makes the board an independent public entity not affiliated with an agency or department.

2) Specifies the members of the board as follows:
   a) Five members appointed by the Governor and subject to Senate confirmation;
   b) Two members appointed by the Senate Committee on Rules; and,
   c) Two members appointed by the Speaker of the Assembly.

3) States that the Secretary of California Health and Human Services (CHHSA) or the Secretary's designee to serve as a nonvoting, ex officio member of the board.

4) Staggers the appointments of the board members. Permits the reappointment of board members for succeeding four-year terms.

5) Requires each person appointed to the board to have demonstrated and acknowledged expertise in health care policy or delivery; and for the appointing authorities to also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care and the diversity of various regions within the state.

6) Specifies the appointments to the board as follows:
   a) Two health care professionals who practice medicine;

b) One registered nurse;
c) One public health professional;
d) One mental health professional;
e) One member with an institutional provider background;
f) One representative of a not-for-profit organization that advocates for individuals who use health care in California;
g) One representative of a labor organization; and,
h) One member of the CalCare Public Advisory Committee (advisory committee), to serve on a rotating basis to be determined by such committee.

7) Requires each member of the board to have the responsibility and duty to meet the requirements of this bill and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through CalCare, and to ensure the operational well-being and fiscal solvency of CalCare.

8) Requires the appointing authorities in making appointments to take into consideration the racial, ethnic, gender, and geographical diversity of the state so that the board's composition reflects the communities of California.

9) Prohibits a member of the board or of the staff of the board from being employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health care professional, institutional provider, or group practice while serving on the board or on the staff of the board, except board members who are practicing health care professionals may be employed by an institutional provider or group practice. Prohibits a member of the board or the staff of the board from being a board member or an employee of a trade association of health professionals, institutional providers, or group practices while serving on the board or on the staff of the board. Permits a member of the board or the staff of the board to be a health care professional if that member does not have an ownership interest in an institutional provider or a professional health care practice.

10) Requires a board member to receive compensation for service on the board. Permits a board member to receive a per diem and reimbursement for travel and other necessary expenses, as specified, while engaged in the performance of official duties of the board.

11) Prohibits a member of the board from making, participate in making, or attempting to use the member's official position to influence the making of a decision that will have a reasonably foreseeable material financial effect on the member or a person in the member's immediate family, or on either of the following:
    a) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months before the decision is made; or,
    b) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

12) Exempts from liability in a private capacity the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, as specified.

13) Requires the board to hire an executive director to organize, administer, and manage the operations of the board. Exempts the executive director from civil service and to serve at the pleasure of the board.

14) Subjects the board to the Bagley-Keene Open Meeting Act (Bagley Keene), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and provider rates.

15) Permits the board to adopt rules and regulations as necessary to implement and administer this bill in accordance with the Administrative Procedure Act (APA), as specified.

Advisory committee

16) Requires the board to convene an advisory committee to advise the board on all matters of policy for CalCare.

17) Requires the members of the advisory committee to be residents of California; appointed for a term of two years and may be reappointed for succeeding two-year terms.

18) Specifies the members of the committee as follows:
    a) Four health care professionals;
    b) One registered nurse;
    c) One representative of a licensed health facility;
    d) One representative of an essential community provider;
    e) One representative of a physician organization or medical group;
    f) One behavioral health provider;
    g) One dentist or oral care specialist;
    h) One representative of private hospitals;
    i) One representative of public hospitals;
    j) One individual who is enrolled in and uses health care items and services under CalCare;
    k) Two representatives of organizations that advocate for individuals who use health care in California, including at least one representative of an organization that advocates for the disabled community; and,
    l) Two representatives of organized labor, including at least one labor organization representing registered nurses.

19) Requires the board, in convening the advisory committee, to make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

20) Specifies that members of the committee serve without compensation, but to be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and to receive one hundred fifty dollars ($150) for each full day of attending meetings of the advisory committee. Defines “full day of attending a meeting” to mean presence at, and participation in, not less than 75% of the total meeting time of the advisory committee during any particular 24-hour period.

21) Requires the committee to meet at least once every quarter, and to solicit input on agendas and topics set by the board. Requires all meetings to be open to the public, pursuant to the Bagley-Keene.

22) Requires the committee to elect a chairperson who serves for two years and who may be reelected for an additional two years.

23) Prohibits committee members, or their assistants, clerks, or deputies, from using for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

Powers of the board

24) Requires the board do the following:
    a) Provide, under CalCare, comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state;
    b) To the maximum extent possible, organize, administer, and market CalCare and services as a single-payer program under the name "CalCare" or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. Specifies that in implementing this bill, the board to avoid jeopardizing federal financial participation in the programs that are incorporated into CalCare and to take care to promote public understanding and awareness of available benefits and programs;
    c) Consider any matter to effectuate the provisions and purposes of this bill. Prohibits the board from having executive, administrative, or appointive duties except as otherwise provided by law.
    d) Designate the executive director to employ necessary staff and authorize reasonable, necessary expenditures from the CalCare Trust Fund to pay program expenses and to administer CalCare. Requires the executive director to hire or designate another to hire staff, who are not exempt from civil service, to implement fully the purposes and intent of CalCare. Requires the executive director, or the executive director's designee, to give preference in hiring to all individuals displaced or unemployed as a direct result of the implementation of CalCare.

25) Requires the board or delegate to the executive director to do all of the following:
    a) Determine goals, standards, guidelines, and priorities for CalCare;
    b) Annually assess projected revenues and expenditures and assure financial solvency of CalCare;
    c) Develop CalCare's budget, as specified;
    d) Establish standards and criteria for the development and submission of provider operating and capital expenditure requests, as specified;
    e) Establish standards and criteria for the allocation of funds from the CalCare Trust Fund, as specified;
    f) Determine when individuals may begin enrolling in CalCare. Requires an implementation period that begins on the date that individuals may begin enrolling in CalCare and ends on a date determined by the board;
    g) Establish an enrollment system that ensures all eligible California residents, including those who travel out of state, those who have disabilities that limit their mobility, hearing, vision or mental or cognitive capacity, those who cannot read, and those who do not

speak or write English, are aware of their right to health care and are formally enrolled in CalCare;

h) Negotiate payment rates, set payment methodologies, and set prices involving aspects of CalCare and establish procedures, including procedures for negotiating fee-for-service (FFS) payment to certain participating providers, as specified;
i) Oversee the establishment, as part of the administration of CalCare, of the advisory committee;
j) Implement policies to ensure that all Californians receive culturally, linguistically, and structurally competent care, as specified, ensure that all disabled Californians receive care in accordance with the federal Americans with Disabilities Act, as specified, and develop mechanisms and incentives to achieve these purposes and a means to monitor the effectiveness of efforts to achieve these purposes;
k) Establish standards for mandatory reporting by participating providers and penalties for failure to report, including reporting of data, as specified;
l) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services;
m) Ensure the establishment of policies that support the public health;
n) Meet regularly with the advisory committee;
o) Determine an appropriate level of, and provide support during the transition for, training and job placement for persons who are displaced from employment as a result of the initiation of CalCare, as specified;
p) In consultation with the Department of Managed Health Care (DMHC), oversee the establishment of a system for resolution of disputes and a system for independent medical review;
q) Establish and maintain an internet website that provides information to the public about CalCare, as specified;
r) Establish a process that is accessible to all Californians for CalCare to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of CalCare;
s) Annually prepare a written report on the implementation and performance of CalCare functions during the preceding fiscal year, that includes, at a minimum:
    i) The manner in which funds were expended;
    ii) The progress toward and achievement of the requirements of this bill;
    iii) CalCare's fiscal condition;
    iv) Recommendations for statutory changes;
    v) Receipt of payments from the federal government and other sources;
    vi) Whether current year goals and priorities have been met; and,
    vii) Future goals and priorities.

Requires the report to be transmitted to the Legislature and the Governor, on or before October 1 of each year and at other times, as specified, and to be made available to the public on the internet website of CalCare.

26) Permits the board to do or delegate to the executive director all of the following:
    a) Negotiate and enter into any necessary contracts, including contracts with health care providers and health care professionals;
    b) Sue and be sued;

c) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state;
d) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation; and,
e) Share information with relevant state departments, consistent with the confidentiality provisions in this bill, necessary for the administration of CalCare.

27) Specifies that a carrier may not offer benefits or cover health care items or services for which coverage is offered to individuals under CalCare, but may, if otherwise authorized, offer benefits to cover health care items or services that are not offered to individuals under CalCare. Indicates that this bill does not prohibit a carrier from offering either of the following:
a) Benefits to or for individuals, including their families, who are employed or self-employed in the state, but who are not residents of the state; or,
b) Benefits during the implementation period to individuals who enrolled or may enroll as members of CalCare.

28) Prohibits, after the end of the implementation period, a person from being a board member unless the person is a member of CalCare, except the ex officio member.

29) Requires the board, no later than two years after the effective date of the above board provisions, to develop proposals for both of the following:
a) Accommodating employer retiree health benefits for people who have been members of the Public Employees' Retirement System, but live as retirees out of the state; and,
b) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state before the implementation of CalCare and live as retirees out of the state.

30) Requires the board to develop a proposal for CalCare coverage of health care items and services currently covered under the workers' compensation system, as specified.

Contracting with Not-for-Profit Organizations

31) Permits the board to contract with not-for-profit organizations to provide both of the following:
a) Assistance to CalCare members with respect to selection of a participating provider, enrolling, obtaining health care items and services, disenrolling, and other matters relating to CalCare; and,
b) Assistance to a health care provider providing, seeking, or considering whether to provide health care items and services under CalCare.

Advisory Commission on Long Term Services and Supports (LTSS commission)

32) Establishes in state government an LTSS commission to advise the board on matters of policy related to LTSS for CalCare.

33) Requires the eleven members of the LTSS commission to be residents of California; five of whom to be appointed by the Governor, three each to be appointed by the Senate Committee on Rules, and by the Speaker of the Assembly.

34) Specifies the membership to include all of the following:
   a) At least two people with disabilities who use LTSS;
   b) At least two older adults who use LTSS;
   c) At least two providers of LTSS, including one family attendant or family caregiver;
   d) At least one representative of a disability rights organization;
   e) At least one representative or member of a labor organization representing workers who provide LTSS;
   f) At least one representative of a group representing seniors; and,
   g) At least one researcher or academic in LTSS.

35) Requires the appointing authorities, in making the above appointments, to make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the diversity of the population of people who use LTSS, including their race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographic location, and socioeconomic status.

36) Specifies that a member of the board may continue to serve until the appointment and qualification of that member's successor. Requires vacancies to be filled by appointment for the unexpired term.

37) States that appointments to the LTSS commission is for a term of four years, except that the initial appointment by the Senate Committee on Rules to be for a term of five years, and the initial appointment by the Speaker of the Assembly to be for a term of two years. Permits these members to be reappointed for succeeding four-year terms.

38) Requires vacancies to be filled within 30 days after the occurrence of the vacancy. Requires the CHHSA Secretary to notify the appropriate appointing authority of any expected vacancies on the LTSS advisory commission.

39) Indicates that members of the LTSS commission serve without compensation, but to be reimbursed for actual and necessary expenses incurred in the performance of their duties, as specified. Requires members to also receive one hundred fifty dollars ($150) for each full day of attending meetings of the LTSS commission. Defines "full day of attending a meeting" to mean presence at, and participation in, not less than 75% of the total meeting time of the advisory commission during any particular 24-hour period.

40) Requires the LTSS commission to meet at least six times per year pursuant to Bagley-Keene.

41) Requires the LTSS commission to elect a chairperson to serve for two years and who may be reelected for an additional two years.

42) Makes it unlawful for the members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the advisory commission and that is not generally available to the public.

Employment assistance

43) Requires the board to provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for program assistance to individuals employed or previously employed in the fields of health insurance, health care service plans, or other third-party payments for health care, individuals providing services to health care providers to deal with third-party payers for health care, individuals who may be affected by and who may experience economic dislocation as a result of the implementation of this bill, and individuals whose jobs may be or have been ended as a result of the implementation of CalCare, consistent with otherwise applicable law.

44) Specifies that assistance under 43) above to include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits, and education benefits.

Data Collection

45) Requires the board to utilize existing health facility data to assess patient outcomes and to review utilization of health care items and services paid for by CalCare.

46) Requires the board, as applicable to the type of provider, to require and enforce the collection and availability of all of the following data to promote transparency, assess quality of care, compare patient outcomes, and review utilization of health care items and services paid for by CalCare, to be reported to the board and, as applicable, the Office of Statewide Health Planning and Development (OSHPD) or the Medical Board of California (MBC):
    a) Inpatient discharge data, including severity of illness and risk of mortality, with respect to each discharge;
    b) Emergency department, ambulatory surgical center, and other outpatient department data, including cost data, charge data, length of stay, and patients' unit of observation with respect to each individual receiving health care items and services;
    c) For hospitals and other providers receiving global budgets, annual financial data, including all of the following:
        i) Community benefit activities, including charity care, as specified, provided by the provider in dollar value at cost;
        ii) Number of employees by employee classification or job title and by patient care unit or department;
        iii) Number of hours worked by the employees in each patient care unit or department;
        iv) Employee wage information by job title and patient care unit or department;
        v) Number of registered nurses per staffed bed by patient care unit or department;
        vi) A description of all information technology, including health information technology and artificial intelligence, used by the provider and the dollar value of that information technology; and,
        vii) Annual spending on information technology, including health information technology, artificial intelligence, purchases, upgrades, and maintenance.

    d) Risk-adjusted and raw outcome data, including:
        i) Risk-adjusted outcome reports for medical, surgical, and obstetric procedures selected by OSHPD, as specified;
        ii) Any other risk-adjusted outcome reports that the board may require for medical, surgical, and obstetric procedures and conditions as it deems appropriate.

e) A disclosure made by a provider, as specified in provisions of law relating to unearned rebates, refunds, and discount.

47) Requires the MBC to collect data for the outpatient surgery settings it regulates that meets the existing Ambulatory Surgery Data Record requirements and to submit that data to the board. Requires the board to make this data publicly available and searchable through an internet website and through the OSHPD public data sets.

48) Requires the CalCare board, consistent with state and federal privacy laws, to make available data collected through CalCare to OSHPD and the CHHSA, as specified.

49) Requires the board, before full implementation of CalCare, and, for providers seeking to receive global budgets or salaried payments to provide for the collection and availability of the following data:
   a) The number of patients served; and,
   b) The dollar value of the care provided, at cost, for all of the following categories of OSHPD data items:
      i) Patients receiving charity care;
      ii) Contractual adjustments of county and indigent programs, including traditional and managed care; and,
      iii) Bad debts or any other unpaid charges for patient care that the provider sought, but were unable to collect.

50) Requires the board to regularly analyze information reported to it and to establish rules and regulations to allow researchers, scholars, participating providers, and others to access and analyze data for purposes consistent with this bill without compromising patient privacy.

51) Requires the board to establish regulations for the collection and reporting of data to promote transparency, assess patient outcomes, and review utilization of services provided by physicians and other health care professionals, as applicable, and paid for by CalCare. Requires the board to utilize data that is already being collected pursuant to other state or federal laws and regulations whenever possible. Specifies that data reporting required by participating providers to supplement the data collected by OSHPD and not modify or alter other reporting requirements to governmental agencies.

52) Prohibits the board from utilizing quality or other review measures established under the above provisions for the purposes of establishing payment methods to providers.

53) Permits the board to coordinate and cooperate with OSHPD or other health planning agencies of the state to implement the data collection requirements.

Participation Agreements

54) Requires the board to establish and use a process to enter into participation agreements with health care providers and other contracts with contractors. Exempts this contract from the State Contract Act and from the review or approval of the Department of General Services (DGS). Requires the board to adopt a CalCare Contracting Manual incorporating procurement and contracting policies and procedures to be followed by CalCare. Requires the policies and procedures in the manual to be substantially similar to the provisions

contained in the State Contracting Manual. Exempts from the APA the adoption of the manual and any procurement process conducted by CalCare.

55) Prohibits CalCare, a state or local agency, or a public employee from providing or disclosing to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

56) Prohibits law enforcement agencies from using CalCare moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of a requirement that individuals register with the federal government or a federal agency based on religion, national origin, ethnicity, immigration status, or other protected category, as specified.

Eligibility and Enrollment

57) Makes every resident of the state eligible and entitled to enroll as a member of CalCare.

58) Prohibits a member from being required to do the following:
    a) Pay a fee, payment, or other charge for enrolling in or being a member of CalCare;
    b) Pay a premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits under CalCare.

59) Permits a college, university, or other institution of higher education in the state to purchase coverage under CalCare for a student, or a student's dependent, who is not a resident of the state.

60) Permits an individual entitled to benefits through CalCare to obtain health care items and services from any institution, agency, or individual participating provider.

61) Requires the board to establish a process for automatic CalCare enrollment at the time of birth in California.

62) Entitles all residents of this state, no matter their sex, race, color, religion, ancestry, national origin, disability, age, previous or existing medical condition, genetic information, marital status, familial status, military or veteran status, sexual orientation, gender identity or expression, pregnancy, pregnancy-related medical condition, including termination of pregnancy, citizenship, primary language, or immigration status, to full and equal accommodations, advantages, facilities, privileges, or services in all health care providers participating in CalCare.

63) Prohibits under 62) above a participating provider, or an entity conducting, administering, or funding a health program or activity under this bill, from discriminating based upon the categories described in 62) above in the provision, administration, or implementation of health care items and services through CalCare.

64) Specifies that discrimination that is prohibited includes the following:

a) Exclusion of a person from participation in or denial of the benefits of CalCare, except as expressly authorized by this bill for the purposes of enforcing eligibility standards, as specified in the above provisions;
b) Reduction of a person's benefits; and,
c) Any other discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity pursuant to this bill.

65) States that unless specified, a participating provider or entity is in violation of 63) above if the complaining party demonstrates that any of the categories listed in 62) above was a motivating factor for any health care practice, even if other factors also motivated the practice.

Benefits

66) Entitles individuals enrolled for benefits under CalCare to have payment made by CalCare to a participating provider for the health care items and services in 68) below, if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition.

67) Requires the determination of medical necessity or appropriateness to be made by the member's treating physician or by a health care professional who is treating that individual and is authorized to make that determination in accordance with the scope of practice, licensing, the program standards, as specified below, and by the board, and other laws of the state.

68) Includes as covered health care benefits for members all of the following categories of health care items and services:
a) Inpatient and outpatient medical and health facility services, including hospital services and 24-hour-a-day emergency services;
b) Inpatient and outpatient health care professional services and other ambulatory patient services;
c) Primary and preventive services, including chronic disease management;
d) Prescription drugs and biological products;
e) Medical devices, equipment, appliances, and assistive technology;
f) Mental health and substance abuse treatment services, including inpatient and outpatient care;
g) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services;
h) Comprehensive reproductive, maternity, and newborn care;
i) Pediatrics;
j) Oral health, audiology, and vision services;
k) Rehabilitative and habilitative services and devices, including inpatient and outpatient care;
l) Emergency services and transportation;
m) Early and periodic screening, diagnostic, and treatment services as specified;
n) Necessary transportation for health care items and services for persons with disabilities or who may qualify as low income;
o) LTSS, including LTSS covered under Medi-Cal or the federal Children's Health Insurance Program; and,

p) Any additional health care items and services the board authorizes to be added to CalCare benefits.

69) The categories of covered health care items and services in 68) above include all the following:
   a) Prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for their use by an individual;
   b) Child and adult immunizations;
   c) Hospice care;
   d) Care in a skilled nursing facility;
   e) Home health care, including health care provided in an assisted living facility;
   f) Prenatal and postnatal care;
   g) Podiatric care;
   h) Blood and blood products;
   i) Dialysis;
   j) Community-based adult services, as defined, as of January 1, 2021;
   k) Dietary and nutritional therapies determined appropriate by the board;
   l) Therapies that are shown by the National Center for Complementary and Integrative Health in the National Institutes of Health to be safe and effective, including chiropractic care and acupuncture;
   m) Health care items and services previously covered by county integrated health and human services programs, as specified;
   n) Health care items and services previously covered by a regional center for persons with developmental disabilities, as specified; and,
   o) Language interpretation and translation for health care items and services, including sign language and braille or other services needed for individuals with communication barriers

70) Specifies that covered health care items and services under CalCare include all health care items and services required to be covered under the following, without regard to whether the member would be eligible for or covered by the source referred to:
   a) The federal Children's Health Insurance Program;
   b) Medi-Cal;
   c) The federal Medicare program;
   d) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975;
   e) Health insurers; and,
   f) All essential health benefits (EHBs) mandated by the federal Patient Protection and Affordable Care Act (ACA) as of January 1, 2017.

71) Prohibits health care items and services covered under CalCare from being subject to prior authorization or a limitation applied through the use of step therapy protocols.

LTSS

72) Entitles individuals enrolled for benefits under CalCare to have payment made by CalCare to an eligible provider for LTSS, in accordance with the standards established in this bill, for care, services, diagnosis, treatment, rehabilitation, or maintenance of health related to a medically determinable condition, whether physical or mental, of health, injury, or age, that either:

a) Causes a functional limitation in performing one or more activities of daily living or in instrumental activities of daily living; or,
b) Is a disability that substantially limits one or more of the member's major life activities, as defined.

73) Requires the board to adopt regulations that provide for the following:
a) The determination of individual eligibility for LTSS;
b) The assessment of the LTSS needed for an eligible individual; and,
c) The automatic entitlement of an individual who receives or is approved to receive disability benefits from the federal Social Security Administration to the LTSS under this bill.

74) Requires LTSS provided under this bill to do all of the following:
a) Include long-term nursing services for a member, whether provided in an institution or in a home- and community-based setting;
b) Provide coverage for a broad spectrum of LTSS, including home- and community-based services (HCBS), other care provided through noninstitutional settings, and respite care;
c) Provide coverage that meets the physical, mental, and social needs of a member while allowing the member the member's maximum possible autonomy and the member's maximum possible civic, social, and economic participation;
d) Prioritize delivery of LTSS through HCBS over institutionalization;
e) Unless a member chooses otherwise, ensure that the member receives home- and community-based LTSS regardless of the recipient's type or level of disability, service need, or age;
f) Have the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the member's needs;
g) Be provided in a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity;
h) Provide LTSS that are of equal quality and equitably accessible across geographic regions; and,
i) Ensure that LTSS provide recipients the option of self-direction of service, as specified.

75) Requires the board, in developing regulations to the LTSS provisions to consult the LTSS commission.

Evaluation of CalCare Benefits

76) Requires the board, on a regular basis and at least annually, to evaluate whether the benefits under CalCare should be expanded or adjusted to promote the health of members and California residents, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science.

77) Prohibits the board from removing or eliminating covered health care items and services under CalCare that are listed in this bill.

78) Requires the board to establish a process by which health care professionals, other clinicians, and members may petition the board to add or expand benefits to CalCare.

79) Requires the board to establish a process by which individuals may bring a disputed health care item or service or a coverage decision for review to the Independent Medical Review System established in DMHC, as specified.

80) Defines the following:
    a) "Coverage decision" means the approval or denial of health care items or services by a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for items and services furnished under CalCare from a participating provider, substantially based on a finding that the provision of a particular service is included or excluded as a covered item or service under CalCare. A "coverage decision" does not encompass a decision regarding a disputed health care item or service;
    b) "Disputed health care item or service" means a health care item or service eligible for coverage and payment under CalCare that has been denied, modified, or delayed by a decision of a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for health care items and services furnished under CalCare from a participating provider, in whole or in part, due to a finding that the service is not medically necessary or appropriate. A decision regarding a disputed health care item or service relates to the practice of medicine, including early discharge from an institutional provider, and is not a coverage decision.

Delivery of Care – Participating Provider

81) Specifies that a health care provider or entity is qualified to participate as a provider in CalCare if the health care provider furnishes health care items and services while the provider, or, if the provider is an entity, the individual health care professional of the entity furnishing the health care items and services, is physically present within the State of California, and if the provider meets all of the following:
    a) The provider or entity is a health care professional, group practice, or institutional health care provider licensed to practice in California;
    b) The provider or entity agrees to accept CalCare rates as payment in full for all covered health care items and services;
    c) The provider or entity has filed with the board a participation agreement, as described; and,
    d) The provider or entity is in good standing.

82) Requires the board to establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under CalCare for members who require out-of-state health care services while the member is temporarily located out of the state.

83) Specifies that a provider or entity is not qualified to furnish health care items and services under CalCare if the provider or entity does not provide health care items or services directly to individuals, including the following:

    a) Entities or providers that contract with other entities or providers to provide health care items and services shall not be considered a qualified provider for those contracted items and services;

b) Entities that are approved to coordinate care plans under the Medicare Advantage program as of January 1, 2020, but do not directly provide health care items and services;

84) Requires the board to do the following:
   a) Establish and maintain procedures for members and individuals eligible to enroll in CalCare to enroll onsite at a participating provider; and,
   b) Establish and maintain procedures and standards for members to select a primary care physician, which may be an internist, a pediatrician, a physician who practices family medicine, a gynecologist, a physician who practices geriatric medicine, or, at the option of a member who has a chronic condition that requires specialty care, a specialist health care professional who regularly and continually provides treatment to the member for that condition.

85) States that a referral from a primary care provider is not required for a member to see a participating provider.

86) Permits a member to choose to receive health care items and services under CalCare from a participating provider, subject to the willingness or availability of the provider, and consistent with the provisions of this bill relating to discrimination, and the appropriate clinically relevant circumstances and standards.

87) Requires a health care provider to enter into a participation agreement with the board to qualify as a participating provider under CalCare.

88) Requires a participation agreement between the board and a health care provider to include provisions for at least the following, as applicable to each provider:
   a) Health care items and services to members to be furnished by the provider without discrimination. Specifies that this provision does not require the provision of a type or class of health care items or services that are outside the scope of the provider's normal practice;
   b) A charge shall not be made to a member for a covered health care item or service, other than for payment authorized by this bill. Prohibits a contract from being entered into with a patient for a covered health care item or service, except as specified;
   c) The provider to follow the policies and procedures in the CalCare Contracting Manual, as specified;
   d) The provider to furnish information reasonably required by the board and to meet specified reporting requirements for at least the following:
      i) Quality review by designated entities;
      ii) Making payments, including the examination of records as necessary for the verification of information on which those payments are based;
      iii) Statistical or other studies required for the implementation of this bill; and,
      iv) Other purposes specified by the board.
   e) If the provider is not an individual, the provider to not employ or use an individual or other provider that has had a participation agreement terminated for cause to provide covered health care items and services;
   f) If the provider is paid on a FFS basis for covered health care items and services, the provider to submit bills and required supporting documentation relating to the provision of covered health care items or services within 30 days after the date of providing those items or services;

g) The provider to submit information and any other required supporting documentation reasonably required by the board on a quarterly basis that relates to the provision of covered health care items and services and describes health care items and services furnished with respect to specific individuals;
h) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider to disclose the following to the board: i) Any case mix indexes, diagnosis coding software, procedure coding software, or other coding system utilized by the provider for the purposes of meeting payment, global budget, or other disclosure requirements under this bill; and, ii) any case mix indexes, diagnosis coding guidelines, procedure coding guidelines, or coding tip sheets used by the provider for the purposes of meeting payment or disclosure requirements under this bill.

   Prohibits, if the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider from doing the following:
   i) Using proprietary case mix indexes, diagnosis coding software, procedure coding software, or other coding system for the purposes of meeting payment, global budget, or other disclosure requirements under this bill;
   ii) Requiring another health care professional to apply case mix indexes, diagnosis coding software, procedure coding software, or other coding system in a manner that limits the clinical diagnosis, treatment process, or a treating health care professional's judgment in determining a diagnosis or treatment process, including the use of leading queries or prohibitions on using certain codes;
   iii) Providing financial incentives or disincentives to physicians, registered nurses, or other health care professionals for particular coding query results or code selections; or,
   iv) Using case mix indexes, diagnosis coding software, procedure coding software, or other coding system that make suggestions for higher severity diagnoses or higher cost procedure coding.
i) The provider to comply with the duty of patient advocacy and reporting requirements, as specified;
j) If the provider is not an individual, the provider to ensure that a board member, executive, or administrator of the provider to not receive compensation from, own stock or have other financial investments in, or receive services as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider;
k) If the provider is a not-for-profit hospital, the hospital to submit to the board the community benefits plan, as specified;
l) Health care items and services to members to be furnished by a health care professional while the professional is physically present within the State of California; and,
m) The provider to not enter into risk-bearing, risk-sharing, or risk-shifting agreements with other health care providers or entities other than CalCare.

89) Specifies that the provisions in 88) above do not limit the formation of group practices.

90) Permits a participation agreement to be terminated with appropriate notice by the board for failure to meet the requirements of this bill or may be terminated by a provider.

91) Requires a participating provider to be provided with notice and a reasonable opportunity to correct deficiencies before the board terminates an agreement, unless a more immediate termination is required for public safety or similar reasons.

92) Requires the procedures and penalties under the Medi-Cal program for fraud or abuse to apply to an applicant or provider under CalCare.

93) Defines the following for purposes of 90) to 92) above:
    a) "Applicant" means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the board to participate as a provider in CalCare; and,
    b) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to CalCare program members.

94) Prohibits a person from discharging or otherwise discriminating against an employee on account of the employee or a person acting pursuant to a request of the employee for any of the following:
    a) Notifying the board, executive director, or employee's employer of an alleged violation of this bill, including communications related to carrying out the employee's job duties;
    b) Refusing to engage in a practice made unlawful by this bill, if the employee has identified the alleged illegality to the employer;
    c) Providing, causing to be provided, or being about to provide or cause to be provided to the provider, the federal government, or the Attorney General information relating to a violation of, or an act or omission the provider or representative reasonably believes to be a violation of, this bill;
    d) Testifying before or otherwise providing information relevant for a state or federal proceeding regarding this bill or a proposed amendment to this bill;
    e) Commencing, causing to be commenced, or being about to commence or cause to be commenced a proceeding under this bill;
    f) Testifying or being about to testify in a proceeding;
    g) Assisting or participating, or being about to assist or participate, in a proceeding or other action to carry out the purposes of this bill; and,
    h) Objecting to, or refusing to participate in, an activity, policy, practice, or assigned task that the employee or representative reasonably believes to be in violation of this bill or any order, rule, regulation, standard, or ban under this bill.

95) Specifies that an employee covered by 94) above who alleges discrimination by an employer in violation of 94) above may bring an action governed by the rules and procedures, legal burdens of proof, and remedies applicable under the False Claims Act or an action against unfair competition, as specified.

96) Specifies the following about the provisions in 94) above:
    a) It does not diminish the rights, privileges, or remedies of an employee under any other law, regulation, or collective bargaining agreement. The rights and remedies cannot be waived by an agreement, policy, form, or condition of employment; and,

b) It does not preempt or diminish any other law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination.

Provisions relating to billing

97) Specifies that the below provisions are effective on the date the implementation period ends, as determined by the board under 25) f) above.

98) Prohibits an institutional or individual provider with a participation agreement in effect from billing or entering into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is a covered benefit through CalCare.

99) Permits an institutional or individual provider ***with a participation agreement*** in effect to bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is not a covered benefit through CalCare if the following requirements are met:
   a) The contract and provider meet the requirements specified in 100) and 101) below;
   b) The health care item or service is not payable or available through CalCare; and,
   c) The provider does not receive reimbursement, directly or indirectly, from CalCare for the health care item or service, and does not receive an amount for the health care item or service from an organization that receives reimbursement, directly or indirectly, for the health care item or service from CalCare.

100) Requires a contract described in 99) above to do the following:
   a) Be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the health care item or service is furnished pursuant to the contract, and to not be entered into at a time when the individual is facing an emergency health care situation;
   b) Clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:
      i) The individual to not submit a claim or request that the provider submit a claim to CalCare for the health care item or service;
      ii) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service;
      iii) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service; and,
      iv) The individual understands that the provider is providing services outside the scope of CalCare.

101) Requires a participating provider that enters into a contract described in 99) above to have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, to be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. Requires the affidavit to identify the provider who is to furnish the noncovered health care item or service, state that the provider will not submit a claim to CalCare for a noncovered health care item or service provided to a member, and be signed by the provider.

102) Requires, if a provider signing an affidavit described 101) above knowingly and willfully submits a claim to CalCare for a noncovered health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract, all of the following apply:
   a) A contract described in 99) above is void;
   b) A payment will not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. Requires a payment made by CalCare to the provider during that two-year period is to be remitted to CalCare, plus interest; and,
   c) A payment received by the provider from the member, CalCare, or other payer for a health care item or service furnished during the period described in b) above to be remitted to the payer, and damages to be available to the payer consistent with existing law.

103) An institutional or individual provider with a participation agreement in effect may bill or enter into a private contract with an individual ineligible for benefits under CalCare for a health care item or service. Requires an institutional or individual provider to report to the board, on an annual basis, aggregate information regarding services furnished to ineligible individuals, as specified.

104) Permits an institutional or individual provider ***without a participation agreement*** in effect to bill or enter into a private contract with an individual eligible for benefits under CalCare for a health care item or service that is a covered benefit through CalCare only if the contract and provider meet the requirements in 105) and 106) below.

105) Requires a contract described in 104) above to be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the item or service is furnished pursuant to the contract, and to not be entered into at a time when the individual is facing an emergency health care situation.

106) Requires a contract specified in 105) above to clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:
   a) The individual understands that the individual has the right to have the health care item or service provided by another provider for which payment would be made under CalCare;
   b) The individual to not submit a claim or request that the provider submit a claim to CalCare for the health care item or service, even if the health care item or service is otherwise covered under CalCare;
   c) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service;
   d) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service; and,
   e) The individual understands that the provider is providing services outside the scope of CalCare.

107) Requires a provider that enters into a contract described in 104) above to have in effect, during the period a health care item or service is to be provided, an affidavit, to be filed with

the board no later than 10 days after the first contract to which the affidavit applies is entered into. Requires the affidavit to identify the provider who is to furnish the health care item or service, state that the provider will not submit a claim to CalCare for a health care item or service provided to a member during a two-year period beginning on the date the affidavit was signed, and be signed by the provider.

108) Requires, if a provider who signed an affidavit described 107) above knowingly and willfully submits a claim to CalCare for a health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract described in an affidavit signed under 107) above, all of the following apply:
   a) A contract described in 104) above is void;
   b) A payment will not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. Requires a payment made by CalCare to the provider during that two-year period to be remitted to CalCare with interest; and,
   c) A payment received by the provider from the member, CalCare program, or other payer for a health care item or service furnished during the period described b) above to be remitted to the payer, and damages will be available to the payer under existing law.

109) Permits an institutional or individual provider without a participation agreement in effect to bill or enter into a private contract with an individual for a health care item or service that is not a benefit under CalCare.

Payment for Health Care Items and Services

110) Requires the board to adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services provided to members under CalCare by participating providers. Requires all payment rates to be reasonable and reasonably related to all of the following:
   a) The cost of efficiently providing the health care items and services;
   b) Ensuring availability and accessibility of CalCare health care services, including compliance with state requirements regarding network adequacy, timely access, and language access; and,
   c) Maintaining an optimal workforce and the health care facilities necessary to deliver quality, equitable health care.

111) Considers payment for health care items and services to be payment in full.

112) Prohibits a participating provider from charging a rate in excess of the payment established through CalCare for a health care item or service furnished under CalCare and to not solicit or accept payment from any member or third party for a health care item or service furnished under CalCare, except as provided under a federal program.

113) Specifies that the payment provisions do not preclude CalCare from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

114) Requires the board, no later than the beginning of each fiscal quarter during which an institutional provider of care, including a hospital, skilled nursing facility, and chronic dialysis clinic, is to furnish health care items and services under CalCare, to pay to each institutional provider a lump sum to cover all operating expenses under a global budget (provisions below). Requires an institutional provider receiving a GBP to accept that payment as payment in full for all operating expenses for health care items and services furnished under CalCare, whether inpatient or outpatient, by the institutional provider.

115) Permits a group practice, county organized health system (COHS), or local initiative to elect to be paid for health care items and services furnished under CalCare either on a FFS basis or on a salaried basis.

116) Requires a group practice, COHS, or local initiative that elects to be paid on a salaried basis to negotiate salaried payment rates with the board annually, and the board to pay the group practice, COHS, or local initiative at the beginning of each month.

117) Requires health care items and services provided to members under CalCare by individual providers or any other providers not paid under 114) to 116) above to be paid for on a FFS basis.

118) Requires capital-related expenses for specifically identified capital expenditures incurred by participating providers to meet specified requirements (beginning with 146) below)

119) Requires payment methodologies and payment rates to include a distinct component of reimbursement for direct and indirect costs incurred by the institutional provider for graduate medical education (GME), as applicable.

120) Requires the board to adopt, by regulation, payment methodologies and procedures for paying for out-of-state health care services.

121) Specifies that the payment provisions do not regulate, interfere with, diminish, or abrogate a collective bargaining agreement, established employee rights, or the right, obligation, or authority of a collective bargaining representative under state or local law; does not compel, regulate, interfere with, or duplicate the provisions of an established training program that is operated under the terms of a collective bargaining agreement or unilaterally by an employer or bona fide labor union.

122) Requires the board to determine the appropriate use and allocation of the special projects budget for the construction, renovation, or staffing of health care facilities in rural, underserved, or health professional or medical shortage areas, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

Global Budget Payments (GBP)

123) Requires an institutional provider's global budget to be determined before the start of a fiscal year through negotiations between the provider and the board. Requires the global budget to be negotiated annually based on the payment factors specified in 126) below.

124) Requires an institutional provider's global budget to be used only to cover operating expenses associated with direct care for patients for health care items and services covered under CalCare; prohibits using an institutional provider's global budget for capital expenditures, and capital expenditures to not be included in the global budget.

125) Requires the board, on a quarterly basis, to review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and to determine whether adjustment to the institutional provider's payment is warranted.

126) Requires a GBP to take into account, with respect to each provider, all of the following:
   a) The historical volume of services provided for each health care item and service in the previous three-year period;
   b) The actual expenditures of a provider in the provider's most recent Medicare cost report for each health care item and service, or other cost report that may otherwise be adopted by the board, compared to the following:
      i) The expenditures of other comparable institutional providers in the state;
      ii) The normative payment rates established under the comparative payment rate systems (discussed below) including permissible adjustments to the rates for the health care items and services;
      iii) Projected changes in the volume and type of health care items and services to be furnished;
      iv) Employee wages;
      v) The provider's maximum capacity to provide the health care items and services;
      vi) Education and prevention programs;
      vii) Permissible adjustments to the provider's operating budget from the previous fiscal year due to factors including an increase in primary or specialty care access, efforts to decrease health care disparities in rural or medically underserved areas, a response to emergent conditions, and proposed changes to patient care programs at the institutional level; and,
      viii) Any other factor determined appropriate by the board.
   c) In a rural or medically underserved area, the need to mitigate the impact of the availability and accessibility of health care services through increased GBP.

127) Specified that a GBP or payment methodology to not do any of the following:
   a) Take into account capital expenditures of the provider or any other expenditure not directly associated with furnishing health care items and services under CalCare;
   b) Be used by a provider for capital expenditures or other expenditures associated with capital projects;
   c) Exceed the provider's capacity to furnish health care items and services covered under CalCare; or,
   d) Be used to pay or otherwise compensate a board member, executive, or administrator of the institutional provider who has an interest or relationship that is prohibited under this bill.

128) Permits the board to negotiate changes to an institutional provider's global budget based on factors not prohibited under 127) above or any other provision of this bill.

129) Requires, subject to 121) above, compensation costs for an employee, contractor employee, or subcontractor employee of an institutional provider receiving a global budget to meet the

compensation cap established in federal law and its implementing regulations, except that the board may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that those exceptions are needed to ensure CalCare continued access to needed skills and capabilities.

130) Prohibits a payment to an institutional provider from allowing a participating provider to retain revenue generated from outsourcing health care items and services covered under CalCare, unless that revenue was considered part of the global budget negotiation process. States that this provision applies to revenue from outsourcing health care items and services that were previously furnished by employees of the participating provider who were subject to a collective bargaining agreement.

131) Defines "operating expenses" of a provider to include the following:
   a) The costs associated with covered health care items and services under CalCare, including the following;
      i) Compensation for health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider;
      ii) Pharmaceutical products administered by health care professionals at the institutional provider's facility or facilities;
      iii) Purchasing supplies;
      iv) Maintenance of medical devices and health care technologies, including diagnostic testing equipment, except that health information technology and artificial intelligence shall be considered capital expenditures, unless otherwise determined by the board;
      v) Incidental services necessary for safe patient care;
      vi) Patient care, education, and preventive health programs, and necessary staff to implement those programs;
      vii) Occupational health and safety programs and public health programs, and necessary staff to implement those programs for the continued education and health and safety of clinicians and other individuals employed by the institutional provider;
      viii) Infectious disease response preparedness, including the maintenance of a one-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, and contact tracing.
   b) Administrative costs of the institutional provider.

Appeal of Payments and Global Budget

132) Requires the board to consider an appeal of payments and the global budget, filed by an institutional provider that is subject to the payments or global budget, based on the following:
   a) The overall financial condition of the institutional provider, including bankruptcy or financial solvency;
   b) Excessive risks to the ongoing operation of the institutional provider;
   c) Justifiable differences in costs among providers, including providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations; and,
   d) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the provider, including:
      i) Natural disasters;

ii) Outbreaks of epidemics or infectious diseases;
iii) Unanticipated facility or equipment repairs or purchases;
iv) Significant and unanticipated increases in pharmaceutical or medical device prices;
v) Changes in state or federal laws that result in a change in costs; or,
vi) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

133) Requires the payments set and global budget negotiated by the board to be paid to the institutional provider to stay in effect during the appeal process, subject to interim relief provisions. Empowers the board to grant interim relief based on fairness. Requires the board to do the following:
a) Develop regulations governing interim relief;
b) Establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by an institutional provider. Requires a decision on interim relief to be granted within one month of the filing of an interim relief appeal. Requires an institutional provider to certify in its interim relief appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the institutional provider has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those described in 132) d) above.

134) Permits the board to delegate the conduct of a hearing to an administrative law judge (ALJ), who shall issue a proposed decision with findings of fact and conclusions of law, as specified. Permits the ALJ to hold evidentiary hearings and requires the ALJ to issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted payment or global budget, within four months of the filing of the appeal.

135) Permits the board, within 30 days of receipt of the proposed decision by the ALJ, to approve, disapprove, or modify the decision, and issue a final decision for the appealing institutional provider.

136) States that a final determination by the commission shall be subject to judicial review, as specified.

Comparative Payment Rate System

137) Requires the board to use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations described in 126) b) ii) above. Requires the board to update the comparative payment rate system annually.

138) Requires the board, in developing the comparative payment rate system, to use only the operating base payment rates under each Medicare prospective payment system with applicable adjustments.

139) Prohibits the comparative rate system from including value-based purchasing adjustments or capital expenses base payment rates that may be included in Medicare prospective payment systems.

140) Requires the board, in the first year that GBPs are available to institutional providers, and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for an institutional provider, to take into account the appropriate Medicare prospective payment system from the most recent year to determine what operating base payment the institutional provider would have been paid for covered health care items and services furnished the preceding year with applicable adjustments, excluding value-based purchasing adjustments, based on the prospective payment system.

FFS Payment

141) Requires to board to engage in good faith negotiations with health care providers' representatives to determine rates of FFS payment for health care items and services furnished under CalCare.

142) Establishes a rebuttable presumption that the Medicare FFS rates of reimbursement constitute reasonable FFS payment rates. Requires the fee schedule to be updated annually.

143) Specifies that payments to individual providers does not include payments to individual providers in salaried positions at institutional providers receiving global budgets or individual health care professionals who are employed by or otherwise receive compensation or payment for health care items and services furnished under CalCare from group practices, COHS, or local initiatives that receive payment under CalCare on a salaried basis.

144) Requires the board in establishing FFS payment rates to ensure that the fee schedule compensates physicians and other health care professionals at a rate that reflects the value for health care items and services furnished.

145) Permits the board, in a rural or medically underserved area, to mitigate the impact of the availability and accessibility of health care services through increased individual provider payment.

Payment for Capital Projects for Not-for-Profit or Governmental Entities

146) Requires the board to adopt, by regulation, payment methodologies for the payment of capital expenditures for specifically identified capital projects incurred by not-for-profit or governmental entities that are health facilities.

147) Requires the board to prioritize allocation of funding to projects that propose to use the funds to improve service in a rural or medically underserved area, or to address health disparities, as specified. Requires the board to consider the impact of any prior reduction in services or facility closure by a not-for-profit or governmental entity as part of the application review process.

148) Requires health care facilities and governmental entities to apply to the board for the funding of capital expenditures. Requires all capital-related expenses generated by a capital project to received prior approval from the board to be paid under CalCare.

149) Requires the approval of an application for capital expenditures to be based on achievement of the program standards described below.

150) Prohibits the board from granting funding for capital expenditures for capital projects that are financed directly or indirectly through the diversion of private or other non-CalCare program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

151) Prohibits a participating provider from using operating funds or payments from CalCare for the operating expenses associated with a capital asset that was not funded by CalCare without the approval of the board.

152) Prohibits a participating provider from doing either of the following:
   a) Using funds from CalCare designated for operating expenses or payments for capital expenditures; or,
   b) Using funds from CalCare designated for capital expenditures or payments for operating expenses.

Profit Margins

153) Permits a margin generated by a participating provider receiving a global budget to be retained and used to meet the health care needs of CalCare members.

154) Prohibits a participating provider from retaining a margin if that margin was generated through inappropriate limitations on access to health care, compromises in the quality of care, or actions that adversely affected or are likely to adversely affect the health of the persons receiving services from an institutional provider, group practice, or other participating provider under CalCare.

155) Requires the board to evaluate the source of margin generation.

156) Requires a payment under CalCare, including provider payments for operating expenses or capital expenditures, to not take into account, include a process for the funding of, or be used by a provider for any of the following:
   a) Marketing, which does not include education and prevention programs paid under a global budget;
   b) The profit or net revenue, or increasing the profit, net revenue, or financial result of the provider;
   c) An incentive payment, bonus, or compensation based on patient utilization of health care items or services or any financial measure applied with respect to the provider or a group practice or other entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider;
   d) A bonus, incentive payment, or incentive adjustment from CalCare to a participating provider;
   e) A bonus, incentive payment, or compensation based on the financial results of any other health care provider with which the provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship;

f) A bonus, incentive payment, or compensation based on the financial results of an integrated health care delivery system, group practice, or other provider; or,
g) State political contributions.

157) Requires the board to establish and enforce penalties for violations of this section, consistent with the Administrative Procedure Act.

158) Requires penalty payments collected for violations to be remitted to the CalCare Trust Fund for use in CalCare.

Prescription Drugs

159) Requires the board, in consultation with DGS, the Department of Health Care Services (DHCS), and other relevant state agencies, to negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. Specifies that negotiations by the board is on behalf of the entire CalCare program. Requires a state agency to cooperate to provide data and other information to the board.

160) Requires the board, in consultation with the DGS, DHCS, the CalCare Public Advisory Committee, patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals, to establish a prescription drug formulary system. Requires the board, in establishing the prescription drug formulary system, to do all of the following:
a) Promote the use of generic and biosimilar medications;
b) Consider the clinical efficacy of medications;
c) Update the formulary frequently and allow health care professionals, other clinicians, and members to petition the board to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary; and,
d) Consult with patient advocacy organizations, physicians, nurses, pharmacists, and other health care professionals to determine the clinical efficacy and need for the inclusion of specific medications in the formulary.

161) Prohibits the prescription drug formulary system from requiring a prior authorization determination for coverage under CalCare and to not apply treatment limitations through the use of step therapy protocols.

162) Requires the board to promulgate regulations regarding the use of off-formulary medications that allow for patient access.

Program Standards

163) Requires CalCare to establish a single standard of safe, therapeutic, and effective care for all residents of the state by the following means:
a) The board to establish requirements and standards, by regulation, for CalCare and health care providers, consistent with this bill and with the applicable professional practice and licensure standards of health care providers and health care professionals established under existing law, including requirements and standards for, as applicable:
i) The scope, quality, and accessibility of health care items and services.
ii) Relations between participating providers and members;

iii) Relations between institutional providers, group practices, and individual health care organizations, including credentialing for participation in CalCare and clinical and admitting privileges, and terms, methods, and rates of payment.

b) The board to establish requirements and standards, by regulation, that include provisions to promote all of the following:
   i) Simplification, transparency, uniformity, and fairness in the following:

      (1) Health care provider credentialing for participation in CalCare;
      (2) Health care provider clinical and admitting privileges in health care facilities;
      (3) Clinical placement for educational purposes, including clinical placement for prelicensure registered nursing students without regard to degree type, that prioritizes nursing students in public education programs;
      (4) Payment procedures and rates; and,
      (5) Claims processing.

   ii) In-person primary and preventive care, efficient and effective health care items and services, quality assurance, and promotion of public, environmental, and occupational health;
   iii) Elimination of health care disparities;
   iv) Nondiscrimination;
   v) Accessibility of health care items and services, including accessibility for people with disabilities and people with limited ability to speak or understand English; and,
   vi) Providing health care items and services in a culturally, linguistically, and structurally competent manner.

164) Requires the board to establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with CalCare health care items and services and ancillary services currently provided by other programs, including Medicare, the Affordable Care Act, and federally matched public health programs.

165) Requires a participating provider to furnish information as currently required by OSHPD and permit examination of that information by the board as reasonably required for purposes of reviewing accessibility and utilization of health care items and services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of CalCare or for protection and promotion of public, environmental, and occupational health.

166) Requires the board to use the data furnished under this bill to ensure that clinical practices meet the utilization, quality, and access standards of CalCare. Prohibits the board from using a standard developed for the purposes of establishing a payment incentive or adjustment under CalCare.

167) Requires the board, in developing requirements and standards and making other policy determinations under 163) to 166) above, to consult with representatives of members, health care providers, health care organizations, labor organizations representing health care employees, and other interested parties.

Duty of Health Care Practitioners

168) Requires, as part of a health care practitioner's duty to advocate for medically appropriate health care for their patients, a participating provider to act in the exclusive interest of the

patient. Applies this duty to a health care professional who may be employed by a participating provider or otherwise receive compensation or payment for health care items and services furnished under CalCare.

169) Specifies that consistent with existing law provisions requiring healing arts practitioners to advocate for appropriate care and protection of physicians against retaliation:
   a) An individual's treating physician, or other health care professional who is authorized to diagnose the individual in accordance with all applicable scope of practice and other license requirements and is treating the individual, is responsible for the determination of the medically necessary or appropriate care for the individual;
   b) Requires a participating provider or health care professional who may be employed by CalCare or otherwise receive compensation or payment for health care items and services furnished under CalCare from a participating provider or other person participating in CalCare to use reasonable care and diligence in safeguarding an individual under the care of the provider or professional and to not impair an individual's treating physician or other health care provider treating the individual from advocating for medically necessary or appropriate care.

170) Indicates that a health care provider or health care professional described 168) above violates their duty for any of the following:
   a) Having a pecuniary interest or relationship, including an interest or relationship disclosed under 171) below, that impairs the provider's ability to provide medically necessary or appropriate care;
   b) Accepting a bonus, incentive payment, or compensation based on any of the following:
      i) A patient's utilization of services;
      ii) The financial results of another health care provider with which the participating provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship, or of a person that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider; or,
      iii) The financial results of an institutional provider, group practice, or person that contracts with, provides health care items or services under, or otherwise receives payment from CalCare.
   c) Having a board member, executive, or administrator that receives compensation from, owns stock or has other financial investments in, or serves as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

171) Requires a participating provider, to evaluate and review compliance with 168) to 170) above, to report, at least annually, to the OSHPD all of the following:
   a) A beneficial interest required to be disclosed to a patient under existing law;
   b) A membership, proprietary interest, coownership, or profit-sharing arrangement, required to be disclosed to a patient under existing law;
   c) A subcontract that contains incentive plans that involve general payments, including capitation payments or shared risk agreements, that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions;
   d) Bonus or other incentive arrangements used in compensation agreements with another health care provider or an entity that contracts with or provides health care items or

services, including pharmaceutical products and medical devices or equipment, to the provider;

e) An offer, delivery, receipt, or acceptance of rebates, refunds, commission, preference, patronage dividend, discount, or other consideration for a referral made in exception to existing law provisions.

172) Permits the board to adopt regulations as necessary to implement and enforce the above provisions and to adopt regulations to expand reporting requirements.

173) Defines for purposes of the provisions in 168) to 172) above, a "person" to mean an individual, partnership, corporation, limited liability company, or other organization, or any combination thereof, including a medical group practice, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer.

Override of Health Information Technology or Clinical Practice Guideline

174) Permits an individual's treating physician, nurse, or other health care professional, in implementing a patient's medical or nursing care plan and in accordance with their scope of practice and licensure, to override health information technology or clinical practice guidelines, including standards and guidelines implemented by a participating provider through the use of health information technology, including electronic health record technology, clinical decision support technology, and computerized order entry programs.

175) Requires an override under 174) above, in the independent professional judgment of the treating physician, nurse or other health care professional, to meet all of the following requirements:

a) The override is consistent with the treating physician's, nurse's or other health care professional's determination of medical necessity or appropriateness or nursing assessment;
b) The override is in the best interest of the patient; and,
c) The override is consistent with the patient's wishes.

Funding: Federal Health Programs and Funding

176) Authorizes the board and requires it to seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare consistent with this bill.

177) Authorizes the board to apply for a federal waiver or federal approval as necessary to receive funds to operate CalCare, as specified.

178) Requires the board to apply for federal waivers or federal approval under 176) above by January 1, 2023.

179) Requires the board to apply to the United States Secretary of the Department of Health and Human Services (HHS) or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the ACA, and any other federal programs or laws, as appropriate, that are

necessary to enable all CalCare members to receive all benefits under CalCare through CalCare, to enable the state to implement this bill, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the CalCare Trust Fund, and to use those funds for CalCare and other provisions under this bill.

180) Requires the board, to the fullest extent possible, to negotiate arrangements with the federal government to ensure that federal payments are paid to CalCare in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs. Requires, to the extent any federal funding is not paid directly to CalCare, the state to direct the funding and moneys to CalCare.

181) Permits the board to require members or applicants to provide information necessary for CalCare to comply with any waiver or arrangement under this bill. Prohibits information provided by members to the board from being used for any other purpose.

182) Permits the board to take any additional actions necessary to effectively implement CalCare to the maximum extent possible as an independent single-payer program consistent with this bill. Specifies the intent of the Legislature to establish CalCare, to the fullest extent possible, as an independent agency.

183) Permits the board to take actions to enable CalCare to administer Medicare in California. Requires CalCare to be a provider of supplemental insurance coverage and to provide premium assistance for drug coverage under Medicare Part D for eligible members of CalCare.

184) Permits the board to waive or modify the applicability of any provisions of this billrelating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement or to maximize the federal benefits to CalCare.

185) Permits the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause a member to lose a health care item or service provided by CalCare or diminish any right the member would otherwise have.

186) Requires the board, notwithstanding any other law, by regulation, to increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the ACA.

187) Permits the board to act, upon a finding approved by the Director of the Department of Finance and the board that the action does all of the following:
   a) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the ACA;

b) Will not diminish any individual's access to a health care item or service or right the individual would otherwise have;
c) Is in the interest of CalCare; and,
d) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

188) Permits the board, to enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, to require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

189) Requires, as a condition of continued eligibility for health care items and services under CalCare, a member who is eligible for benefits under Medicare to enroll in Medicare, including Parts A, B, and D.

190) Requires the board to provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan, limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services (CMS) and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare Advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to CalCare.

191) Indicates that if the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under the Social Security Administration, the member to provide, and authorize CalCare to obtain, any information or documentation required to establish the member's eligibility for that subsidy. Requires the board to attempt to obtain as much of the information and documentation as possible from records that are available to it.

192) Requires the board to make a reasonable effort to notify members of their obligations under the provisions above. Requires, after a reasonable effort has been made to contact the member, the member to be notified in writing that the member has 60 days to provide the required information. Permits, if the required information is not provided within the 60-day period, the member's coverage under CalCare to be suspended until the issue is resolved.

193) Requires the board to assume responsibility for all benefits and services paid for by the federal government with those funds.

CalCare Trust Fund

194) Establishes the CalCare Trust Fund in the State Treasury for the purposes of this bill to be administered by the CalCare Board. Requires all moneys in the fund to be continuously appropriated without regard to fiscal year for the purposes of this bill and permits any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year to be carried forward to the next succeeding fiscal year.

195) Prohibits moneys deposited in the fund from being loaned to, or borrowed by, any other special fund or the General Fund, a county general fund or any other county fund, or any

other fund.

196) Requires the board to establish and maintain a prudent reserve in the fund to enable it to respond to costs including those of an epidemic, pandemic, natural disaster, or other health emergency, or market-shift adjustments related to patient volume.

197) Prohibits the board or staff of the board from utilizing any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

198) Specifies sources of funding for the fund.

CalCare Budget

199) Require the board to annually prepare a budget for CalCare that specifies a budget for all expenditures to be made for covered health care items and services and to establish allocations for each of the budget components under 200) below that cover a three-year period.

200) Requires the CalCare budget to consist of at least the following components:
   a) An operating budget;
   b) A capital expenditures budget;
   c) A special projects budget;
   d) Program standards activities;
   e) Health professional education expenditures;
   f) Administrative costs; and,
   g) Prevention and public health activities.

201) Requires the board to allocate the funds it receives to ensure the following:
   a) The operating budget allows for participating providers to meet the health care needs of the population;
   b) A fair allocation to the special projects budget to meet the purposes described in 204) below in a reasonable timeframe;
   c) A fair allocation for program standards activities; and,
   d) The health professional education expenditures component is sufficient to meet the need for covered health care items and services.

202) Requires the operating budget to the board to be used for payments to providers for health care items and services furnished by participating providers under CalCare.

203) Requires the capital expenditures budget to be used for the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term services and supports under CalCare, and other capital expenditures.

204) Requires the special projects budget to be used for the payment to not-for-profit or governmental entities that are health facilities for the construction or renovation of health care facilities, major equipment purchases, staffing in a rural or medically underserved area, and to address health disparities, including those based on race, ethnicity, national origin,

primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status. Permits, to mitigate the impact of the payments on the availability and accessibility of health care services, the special projects budget to be used to increase payment to providers in a rural or medically underserved area.

205) Specifies, for up to five years following the date on which benefits first become available under CalCare, at least one% of the budget to be allocated to programs providing transition assistance.

CalCare Financing Intent

206) Specifies the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare and in developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

207) Specifies the intent of the Legislature to enact legislation that would require all state revenues from CalCare to be deposited in an account within the CalCare Trust Fund to be established and known as the CalCare Trust Fund Account.

Authorized Collective Negotiation

208) Permits health care providers to meet and communicate for the purpose of collectively negotiating with CalCare on any matter relating to CalCare FFS rates of payment for health care items and services or procedures related to FFS payment under CalCare.

209) States that the provisions on authorized collective negotiation does not allow a strike of CalCare by health care providers related to the collective negotiations.

Collective Negotiations

210) Requires collective negotiation to meet all of the following requirements:
   a) A health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with CalCare;
   b) A health care provider may communicate with a health care provider's representative;
   c) A health care provider's representative is the only party authorized to negotiate with CalCare on behalf of the health care providers as a group; and,
   d) A health care provider can be bound by the terms and conditions negotiated by the health care provider's representative.

211) Specifies that before engaging in collective negotiations with CalCare on behalf of health care providers, a health care provider's representative to file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with collective negotiations provisions.

212) Requires a person who acts as the representative of negotiating parties to pay a fee to the board to act as a representative. Requires the board, by regulation, to set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.

213) States that the collective negotiation provisions do not authorize competing health care providers to act in concert in response to a health care provider's representative's discussions or negotiations with CalCare, except as authorized by other law.

214) Prohibits a health care provider's representative from negotiating an agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by a health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

Operative Date and Severability

215) Provides that except for 1) to 56) above, this bill does not become operative until the date the Secretary of CHHSA notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that the Secretary has determined that the CalCare Trust Fund has the revenues to fund the costs of implementing this bill. Requires CHHSA to publish a copy of the notice on its internet website.

216) States that the provisions of this bill are severable.

217) Defines various terms.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which low income individuals are eligible for medical coverage. Medi-Cal provides coverage to adults and parents with incomes up to 138% of the federal poverty level (FPL) who are under age 65, and to children with incomes up to 266% of the FPL. Undocumented children receive full scope Medi-Cal coverage, while undocumented adults receive limited scope services under Medi-Cal (primarily emergency only).

2) Provides federal funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children through the Children's Health Insurance Program (CHIP).

3) Requires, under the ACA (Public Law 111-148), as amended by the Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), each state, by January 1, 2014, to establish an American Health Benefit Exchange that makes qualified health plans (QHPs) available to qualified individuals and qualified employers. Requires, if a state does not establish an Exchange, the federal government to administer the Exchange. Establishes requirements for the Exchange and for QHPs participating in the Exchange, and defines who is eligible to purchase coverage in the Exchange. Limits enrollment in the Exchanges to citizens or nationals of the United States, or aliens lawfully present in the United States.

4) Allows, under the ACA and effective January 1, 2014, eligible individual taxpayers, whose household income is between 100% and 400% of the FPL, an advanceable and refundable premium tax credit (APTC) to use for coverage under a QHP offered in the Exchange. Requires a reduction in cost-sharing for individuals with incomes below 250% of the FPL. Legal immigrants with household incomes less than 100% of the FPL who are ineligible for

Medicaid because of their immigration status are also eligible for the APTC and the cost-sharing reductions. Undocumented individuals and incarcerated individuals are ineligible to purchase coverage in Exchanges.

5) Authorizes, under Section 1332 of the ACA, waivers for state innovation under which states can seek federal approval to waive major provisions of the ACA, including the requirement for Exchanges, QHPs, premium tax credits and cost-sharing reductions, the individual mandate and the employer responsibility requirement, provided federal requirements for comprehensive benefits, affordability, and comparable coverage are met and the state proposal does not increase the federal deficit.

6) Establishes, pursuant to federal law, the Medicare program, which provides coverage for seniors and certain persons with disabilities. Medicare is funded by payroll taxes, premiums paid by individuals who enroll in various "parts" of Medicare (Part A is hospital services, Part B is medical services, Part C is Medicare Advantage plans, and Part D is prescription drug coverage) and general revenue. Authorizes the federal Secretary of HHS, to develop and engage in experiments and demonstration projects for specified purposes, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations.

7) Creates within CMS a Center for Medicare and Medicaid Innovation (CMMI), the purpose of which is to test innovative payment and service delivery models to reduce program expenditures under the Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under those programs.

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, today's U.S. health care system is a complex, fragmented multi-payer system that still leaves wide gaps in coverage and poses significant issues of affordability. Despite health care spending in the U.S. far exceeding other high-income, industrialized countries that offer a publicly financed single-payer system, we consistently report worse health outcomes and disparities among vulnerable populations. This bill sets in motion a single-payer health care coverage system in California, called CalCare, for all residents, regardless of citizenship status. By streamlining payments and lowering per-capita health care spending, CalCare guarantees quality health care and long-term care while eliminating barriers to care and out-of-pocket costs. The author concludes that by guaranteeing health care for all Californians and establishing a payment system that eliminates waste and aligns reimbursements with the actual cost of care, we can make tremendous progress on health care as a human right.

2) **BACKGROUND.**

   a) **Sources of Health Coverage**. According to the California Health Care Foundation (CHCF), in 2020, California health insurers covered 33.8 million enrollees — 28.2 million were enrolled in commercial coverage or public managed care, and 5.6 million were enrolled through administrative services only arrangements for self-insured employers. There were 14.4 million Californians enrolled in commercial insurance which

consists of small group (2.3 million), large group (9.9 million), and individual enrollment (2.2 million). Approximately 13.8 million were enrolled in public health programs, including Medicare and Medi-Cal. Current data from the DHCS indicate there are over 13.9 million Californians enrolled in Medi-Cal. The majority of Californians still get employment-based health coverage (46%).

California's implementation of the ACA significantly reduced the number of uninsured. In 2012, there were 6.5 million Californians who were uninsured. Medi-Cal expansion to undocumented young adults, providing state subsidies to improve affordability of insurance through Covered California, and implementing a state mandate to purchase insurance brought down the state's uninsured rate. According to the UC Berkeley Labor Center (UC Labor Center), nearly 3.2 million Californians will remain uninsured in 2022, or about 9.5% of the population age 0-64. The highest uninsured rates will be among undocumented Californians (65%) and those eligible only for insurance through Covered California (28%). These projections, using the California Simulation of Insurance Markets model, take into account the projected economy in 2022 as the state recovers from the pandemic and recession and the associated impacts on coverage eligibility.

b) **Health Care Expenditures.** According to the National Health Expenditures, U.S. health care spending increased 9.7% to reach $4.1 trillion in 2020, a much faster rate than the 4.3% increase experienced in 2019. Gross Domestic Product (GDP) declined 2.2% in 2020, leading to a sharp increase in the share of the overall economy related to health care spending—from 17.6% in 2019 to 19.7% in 2020. The acceleration in national health spending in 2020 was primarily due to a 36.0% increase in federal expenditures for health care that occurred largely in response to the COVID-19 pandemic. In 2020, most of the faster growth was not directly linked to patient care events. Rather, spending growth was driven by federal financial assistance to health care providers through the Provider Relief Fund and Paycheck Protection Program loans, increased federal public health activity, as well as increased federal Medicaid funding. Although the pandemic led to economic and employment disruptions, the number of uninsured people fell slightly (by 0.6 million, or 1.9%). At the same time, fewer people were covered through employer-sponsored insurance, and more people had insurance through the individual market and public programs, in particular for Medicaid. Spending for hospital care services (31% share) increased 6.4% in 2020, a similar growth rate to that of 6.3% in 2019, and reached $1.3 trillion. The growth in 2020 reflected a substantial amount of funding from other federal programs (COVID-19 relief is included in this category) and faster increases in Medicaid spending. Spending on physician and clinical services (20% share) increased 5.4% to $809.5 billion in 2020, up from 4.2% growth in 2019. Like hospital care, this increase was largely due to substantial growth in funding from federal programs that provided COVID-19 relief. While total physician and clinical services spending growth accelerated, both Medicare and Medicaid expenditure growth for physician and clinical services slowed in 2020. Retail prescription drug spending (8% share) increased 3.0% to $348.4 billion in 2020, a slower rate than in 2019 when spending increased 4.3%. The slowdown was a result of a 4.2% decline in out-of-pocket expenditures, which resulted from slower overall utilization and an increased use of coupons, which lower point-of-sale expenditures for consumers. Private health insurance (28% share) spending decreased by 1.2% in 2020 to $1.15 trillion and was driven by a decline in enrollment and lower use of health care services as a result of the COVID-19 pandemic. Influenced by losses in employer-sponsored health insurance coverage, private

health insurance enrollment fell by 1.7 million (-0.8%) and per enrollee spending declined 0.4% following growth of 2.3% in 2019. Spending attributable to the net cost of insurance, which includes administrative costs, taxes, fees, changes in reserves, and profits, increased by $21.6 billion in 2020 to reach $151.1 billion, or a 13.1% share of total private health insurance expenditures compared to a share of 11.1% in 2019. Medicare spending (20%) grew at a rate of 3.5% to $829.5 billion in 2020 compared to a rate of 6.9% in 2019. The growth in 2020 reflected the combination of a 5.3% decline in spending for FFS expenditures (accounting for 55% of total Medicare expenditures) and a 17.1% increase in Medicare private health plan spending. Per enrollee Medicare expenditures increased 1.4% in 2020, slowing from 4.2% in 2019, as enrollment growth slowed from 2.6% in 2019 to 2.1% in 2020. Total Medicaid spending (16% share) experienced faster growth in 2020, increasing 9.2% to $671.2 billion compared to growth of 3.0% in 2019. The faster growth in 2020 was influenced primarily by increased enrollment in the program (from slight declines in both 2018 and 2019 to 5.1% growth in 2020). Per enrollee Medicaid expenditures decelerated slightly to 4.0% in 2020 from 4.6% in 2019. Out-of-pocket spending (9% share) declined by 3.7% in 2020 to $388.6 billion after an increase of 4.4% in 2019. The decrease was driven by lower use of services, a reduction in the number of uninsured, and a changing mix of services in 2020.

According to a report entitled "An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California" submitted by the Healthy California for All Commission to the Legislature in August 2020, in 2018, California's total health expenditures were an estimated $399.2 billion which accounted for 13.2% of the state's GDP which was $3.018 trillion. California's per capita health care spending in 2018 was $10,086. Similar to the federal data, the major payers for health care in California were private insurance (32.2%), Medicare (19.6%), Medi-Cal (18.5%), and other (29.7%).

According to the UC Labor Center, since 2008, premiums for job-based family health coverage in California have grown by 49% on average; but real median wages have remained stagnant. For example, single coverage premiums averaged $8,712 per year in 2018, equivalent to $4 per hour for someone working 40 hours per week and for family coverage, the average annual premium was $20,843 which is equivalent to $10 per hour work for a full-time worker, which is $2 less per hour than the current $12 minimum wage for employers with more than 25 employees. In addition to premium costs, consumers are also facing higher out-of-pocket spending.

A CHCF report entitled, "Getting to Affordability: Spending Trends and Waste in California's Health Care System," points out that from 2000 to 2016, annual out-of-pocket patient spending increased by almost 36% for those with employer-sponsored coverage or an average annual increase of 2% per year while those with private, individual market coverage had an annual average growth rate of around 4%. The UC Labor Center states that these affordability challenges are causing financial difficulties for those struggling to pay premium or medical bills, deter enrollment in and retention of coverage, and decrease access to care.

c) How Critical is Health Care Affordability to Consumers? According to the 2020 "Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey," conducted by CHCF on how California residents view health care policy and their experiences with the health care system, eight out of 10

residents (84%) rate making health care more affordable as an "extremely important" or "very important" priority for the Governor and Legislature to address in 2020. This survey also paints a picture of Californians worried about many types of health care costs, including unexpected medical bills and out-of-pocket expenses. Due to these affordability issues, many residents reported delaying or skipping medical treatment or medications, including cutting pills in half or skipping doses. Additionally, 24% of those surveyed reported that they or someone in their family, had problems paying for or were unable to pay medical bills within the past 12 months, and as a result, they have cut back on basic household needs like food and clothing, used up their savings, increased their credit card debt, taken on extra work, borrowed money from friends or relatives, or taken money out of their savings accounts. Although disturbing, the survey results are not surprising.

3) **MAJOR PROVISIONS OF THIS BILL.** Below are some of the major provisions of this bill:

   a) **Governance**. The board would administer the CalCare program as an independent public entity consisting of nine members. Five board members would be appointed by the Governor and subject to Senate confirmation. The Senate Rules Committee and the Speaker of the Assembly each appoint two members. The nine-member board consists of two health care professionals who practice medicine; one registered nurse; one public health professional; one mental health professional; one member with an institutional provider background; one representative of a non-profit organization that advocates for individuals who use health care in California; one representative of a labor organization; and one member of the advisory committee. The Secretary of CHHSA serves as a nonvoting, ex-officio member of the board.

      In addition to receiving compensation, board members are also permitted to receive reimbursement for per diem and travel expenses. This bill includes strict conflict of interest standards for board members and staff of the board who will be subject to Bagley-Keene, and authorizes the hiring of an executive director to manage board operations.

      Among various functions, the board will develop CalCare's budge and will assess revenues and expenditures and assure financial solvency of CalCare. It is also empowered to negotiate payment rates, set payment methodologies, and set prices and set procedures for negotiating FFS payment to providers. The board will also establish an enrollment system and determine the transition for, training and job placement for persons displaced from employment as part of the implementation of a single-payer health program.

      The board will also collect various data to assess patient outcomes and review utilization of health care items and services. The board is also charged with developing a proposal for CalCare coverage and services currently covered under the worker's compensation system.

   b) **Eligibility**. Every resident of the state is eligible for CalCare, regardless of immigration status. The board will adopt residency requirements. An eligible resident is an individual whose primary place of abode is in this state, without regard to the individual's

immigration status, and who meets residency requirements to be established by the board.

c) Benefits. Any resident of California is entitled to health care services if medically necessary as determined by a treating physician or another treating health care professional. There will be no premium, copayment or any form of cost sharing for any covered benefits nor prior authorization or step therapy. Additionally, all services currently covered by Medi-Cal, Medicare, Knox-Keene, health insurers, CHIP, Medicare, and all EHBs mandated by the ACA are covered health care items and services regardless of eligibility. The CalCare board is required to annually evaluate whether the benefits should be expanded or adjusted.

This bill also covers out-of-state services defined as a health care item or service provided in person to a member while the member is temporarily, for no more than 90 days, and physically located out of the state under either of the following circumstances: i) it is medically necessary or appropriate that the health care item or service is provided while the member physically is out of the state; or, ii) it is medically necessary or appropriate, and cannot be provided in the state, because the health care item or service can only be provided by a particular health care provider physically located out of the state.

d) LTSS. LTSS is a covered benefit under this bill. This bill establishes an LTSS Commission to advise the board of LTSS. LTSS is defined as long-term care, treatment, maintenance, or services related to conditions, injury or age, that are needed to support the activities of daily living for a person with disability, including HCBS.

e) Displaced employees. This bill requires the board to provide funds for program assistance to individuals employed or previously employed in health insurance, health service plan, or other third-party payments for health care who may experience economic dislocation as a result of this bill. This assistance will include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits and education benefits.

f) Data Collection. This bill requires the board to require and enforce the collection of specified data to be reported to the board, OSHPD or the MBC. Data sets to be reported include existing hospital and patient discharge data and for hospitals receiving global budgets, annual financial data.

g) Health care providers and participation agreements. In order for providers to be paid for providing services under CalCare, they must enter into participation agreements with the board. CalCare will determine the rates of payment for services and items furnished by health care providers. A health care provider without a participation agreement cannot bill or enter into a contract with a consumer eligible for benefits under CalCare for health care items or services that is a covered benefit under CalCare.

Health care providers or treating physicians are responsible for the determination of medical necessity or appropriate care for the individual and can override health information technology or clinical practice guidelines, as specified.

h) **Payment for health care services**. Group practice, COHS or local initiatives may elect to be paid for health care items either on a FFs basis or salaries basis. Individual providers will be paid on a FFS payment. There is a rebuttable presumption that the Medicare FFS rates of reimbursement is a reasonable payment rate. This bill allows the board to increase individual provider payment to mitigate the impact of the availability and accessibility of health care services.

i) **Global budget**. This bill requires the board to pay institutional providers a lump sum to cover all operating expenses under a global budget system. Institutional providers include general acute care hospitals, primary care clinics, long-term care facilities, county medical facilities, federally qualified health centers and residential care facilities. The global budget payment cannot be used for capital expenditures.

   Under global budget, providers are paid a prospectively-set, fixed amount for the total number of services they provide during a given period of time. Providers are responsible for expenditures in excess of the set amount in addition to quality outcomes, creating an incentive to reduce unnecessary utilization and invest in prevention. The use of all-payer global hospital budgeting as a public policy tool in the United States began in Maryland.[3] In 2010, Maryland's independent rate-setting agency launched a pilot program for 10 rural hospitals, in which each was guaranteed a set amount of revenue for the coming year, regardless of the number of inpatient admissions, emergency department visits, and other volume measures. In 2014, Maryland and CMS announced a payment model that expanded all-payer global budgets to all 46 acute care hospitals in the state.

j) **Prescription Drugs**. The board is empowered to negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. The board will also establish a prescription drug formulary in consultation with various stakeholders. The prescription drug formulary will not require prior authorization and step therapy.

k) **Waivers**. Among other functions, the board has authority to seek federal waivers or federal approvals to implement CalCare and negotiate arrangements with the federal government to ensure that federal payments are paid to CalCare in place of federal public health programs.

4) **FEDERAL WAIVER AUTHORITY**. Medicaid (known as Medi-Cal in California) is a joint federal-state program to provide health coverage to low-income individuals. Section 1115 of the federal Social Security Act (Act) gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act. This includes certain federal Medicaid requirements in any experimental pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of Medicaid. In addition, Section 1115 also allows states to use federal Medicaid funds to reimburse for costs in ways that are not otherwise allowed under federal Medicaid law. This is referred to as expenditure authority for "costs not otherwise matchable." Section 1115 waivers are approved at the discretion of the Secretary of HHS through negotiations between a state and CMS for projects that the Secretary determines promote Medicaid program objectives. Section 1115 waivers are generally approved for a five-year period and then must be renewed. Although not required by statute or regulation, longstanding federal administrative policy has required waivers to be "budget neutral" for the federal government,

meaning that federal spending under a waiver must not be more than projected federal spending in the state without the waiver.

The ACA also contained waiver provisions related to Medicare and Medicaid through a newly established CMMI and through a waiver of the tax credits for small employers and the premium and cost-sharing subsidies in the individual market under Section 1332. Specifically, under Section 1332, the ACA permits states to apply to the federal government for a waiver of major provisions of the ACA beginning in 2017. The provisions of the ACA that can be waived under Section 1332 include any or all parts of the provisions relating to QHPs (including the EHBs package requirement), the Exchanges, APTC and cost-sharing reductions, the minimum coverage requirement (commonly referred as the "individual mandate"), and the employer responsibility requirements. If a state is granted a Section 1332 waiver, the state can fund its reforms through the aggregate amount of federal funding that otherwise would have been paid out within the state for premium tax credits, cost-sharing reduction payments, and small business tax credits. However, to qualify for an innovation waiver, the state must establish that its reform plan would provide coverage that:

a) Will provide coverage that is at least as comprehensive as ACA coverage;
b) Will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the as ACA coverage;
c) Will provide coverage to at least a comparable number of its residents as the ACA would provide; and,
d) Will not increase the federal deficit.

The CMMI allows the Medicare and Medicaid programs to test models that improve care, lower costs, and better align payment systems to support patient-centered practices. CMMI evaluates innovative reform efforts widely used in the private sector, and is unique in its ability to develop provider-proposed approaches and quickly adjust models in response to feedback from clinicians and patients.

Congress created the CMMI for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or CHIP benefits. Congress provided the Secretary of HHS with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis. In order for the Secretary to exercise this authority, a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits.

5) SELECT COMMITTEE. On August 23, 2017, Speaker Rendon created the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage (Select Committee) to hold hearings to develop plans for achieving universal health care in California. The Committee held six days of hearings on various topics including cost containment efforts, achieving better access and greater value in California's health care system, implementation considerations and options for universal coverage. The Select Committee also published a report, authored by a team of academics from the University of California San Francisco and University of California San Diego. The report included recommendations for achieving universal coverage in California.

6) **HEALTHY CALIFORNIA FOR ALL COMMISSION**. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, established the Council on Health Care Delivery Systems (Council) as an independent body to develop a plan that includes options for advancing progress toward achieving a health care delivery system that provides coverage and access through a unified financing system for all Californians. In 2019, AB 1810 was subsequently amended by SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, and renamed the Council into the Healthy California for All Commission for purposes of developing a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians.

7) **OTHER STATES**. In 2011, under Governor Shumlin, Vermont enacted Green Mountain Care, the first state level single-payer health care system in the country. On December 17, 2014, Vermont abandoned Green Mountain Care, citing the measure's cost. At that time according to the governor's financial models, financing the system would have required an 11.5% payroll tax on all businesses in Vermont and a sliding-scale, income-based premium assessment of up to 9.5%. Then Governor Shumlin indicated: "These are simply not tax rates that I can responsibly support or urge the Legislature to pass. In my judgment, the potential economic disruption and risks would be too great to small businesses, working families and the state's economy."

8) **CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM (CHBRP) ANALYSIS.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics.

   On March 3, 2021, this Committee requested CHBRP to complete a limited analysis of this bill. This limited analysis synthesized various robust studies and research support consideration of fiscal and policy implications of this bill. Subsequently, on December 9, 2021, this Committee requested CHBRP to look at assumptions/estimates for the following services if reimbursement rates were paid at Medicare rates: a) LTSS; b) Inpatient hospital services; c) Physician services; and, d) Dental Services and to trend these estimates to 2022, if at all possible.

   a) **LTSS**. Since Medicare does not cover LTSS or custodial care unless medical care is needed, the Committee requested CHRBP to extrapolate and estimate the difference between Medi-Cal and Medicare expenditures. Using the 2018 $16.2 billion spend by Medi-Ca on LTSS, CHBRP used the 2019 Milliman Consolidated Health Sources Database to provide some insight to build a rough estimate. CHBRP also used CMS expected health trend rates to apply on the $16.2 billion spent on Medi-Cal, from 2018 to 2022. Using an annual trend of 5.5%, the $16.2 billion would trend to $17.1 billion in 2019, $18 billion in 2020, $19 billion in 2021, and **$20.1 billion in 2022**.

i) **Nursing home care.** California spent roughly $3 billion for nursing home care in 2020. Trending to 2022 at a 5.5% annual trend rate produces an estimate spend of $3.3 billion. CHBRP also notes that if one uses the observed relationship that Medi-Cal reimburses approximately 53% of Medicare reimbursement levels for skilled nursing facility services to create a "proxy Medicare LTSS rate," then a very rough estimate of California's spend for nursing home care in 2022 at Medicare reimbursement levels would be approximately **$6.2 billion**.

ii) **Home health services**. Medi-Cal spent $19 billion on home health services in 2020. Trending out to 2022 at 5.5% annual trend produces an estimated spend of $21.2 billion for home health services in 2022. Estimates of Medi-Cal relativities to Medicare are challenging for several reasons, including the bundled payment structure used for Medicare and differences in services covered between Medi-Cal and Medicare. CHBRP cited a study that California's Medi-Cal payments for physician services were 73% of Medicare, and CHBRP believes that this is a reasonable assumption to use for this calculation given the limitations just described. If one uses the observed relationship that Medi-Cal reimburses approximately 73% of Medicare reimbursement levels for professional services to create a proxy Medicare rate for all home health services, then a reasonable estimate of California's spend for home health services for Medi-Cal members in 2022 at Medicare reimbursement levels would be approximately **$29.0 billion**.

In aggregate, trending the $16.2 billion estimates from 2018 in current Medi-Cal spending to 2022 (which would be $20.1 billion), accounting for trend and reimbursement level increases, projections for both home health and nursing home care could be **$35.3 billion in 2022.**

2022 Estimated Projections Medi-Cal LTSS Spending to 2022 at "Proxy Medicare Reimbursement Rates"

Service Type	2022 Medi-Cal	2022 Medicare LTSS Rate	Total
Medi-Cal FFS long-term care expenditures ($16.2 billion trended forward to 2022)	$20.1 billion		
Nursing home care	$3.34 billion	$6.2 billion	
Home health services	$21.2 billion	$29.0 billion	
Projected total home health and nursing care spending using "Medicare Rates"			**$35.3 billion**

Source: California Health Benefits Review Program, 2022.

iii) **Ten percent Growth in LTSS.** Assuming that an additional 10% of the population gets LTSS under this bill, CHBRP estimates an additional **$3.53 billion**. Thus, adding the estimates for nursing home care, home health with a 10% growth, CHBRP estimates **over $38 billion in 2022** would be the cost of LTSS if the reimbursement rates were paid at Medicare rates.

b) **Hospital Rates.** CHBRP was asked to provide an assumption on hospital care payment changes if adjusted at Medicare FFS. CHBRP points out that it is difficult to provide an

estimate but concludes that transitioning to Medicare FFS **would not result in large increases in overall spending in the Medicaid program.** CHBRP points out that Medicaid programs typically exceed Medicare rates for inpatient services once supplemental payments are included in the calculation. States typically have a base Medicaid inpatient FFS rate that is lower than Medicare but is enhanced through additional payments to hospitals over a specific period of time. These types of supplemental payments include Disproportionate Share Hospital, indirect GME, and uncompensated care pool payments. Medicare's Upper Payment Limit acts as a cap for payments to ensure hospitals are not overpaid for inpatient services, such that making Medicaid Diagnostic Related Group payments equivalent to Medicare would potentially shrink the magnitude of supplemental payments and would not result in large increases in overall spending in the Medicaid program. According to another study, aggregate reimbursement for Medicaid inpatient services often exceeds Medicare once supplemental payments are factored in. Furthermore, changing the base Medicaid rate could alter the mix of state share and federal matching funds paying for those services.

Commercial rates. The Committee requested CHBRP to provide an estimate if commercial spend is lowered to Medicare FFS rate, adjusted for inflation to provide a 2022 estimate. CHBRP notes:

Based on recent work, the difference between Medicare and commercial inpatient hospitalization reimbursement is significant. Kaiser Family Foundation analysis suggests that commercial insurers pay rates ranging from 160% to 250% of Medicare. On average, commercial rates are double that of Medicare. Based on $104 billion in spending on private insurance in California in 2014, and 36% of those services being hospital-based, we would anticipate that the $37.44 billion in hospital spending would drop to $18.72 billion in 2014 dollars if payment rates were halved by this bill. **Once inflated for 2022 dollars, the total hospital spending would be reduced by $22.3 billion for a total of $22.3 billion in spending.**

c) Physician and clinical services spend. This Committee requested an estimate on the following: if Medi-Cal spend is raised to Medicare FFS; and, if commercial spend is lowered to Medicare FFS rate, adjusted for inflation.

CHBRP's research points out that California's Medi-Cal payments for physician services were 73% of Medicare. The Medicaid-to-Medicare payment ratio varies by service type, with the ratio being worse for obstetric services (61%) and better for primary care (76%). It is notable that in 2016, the Medicaid-to-Medicare payment ratio was only 0.52. However, recent increases in the Medi-Cal primary care fee schedule due to the passage of Proposition 56, which added supplemental payments for over twenty evaluation and management-focused CPT codes. Implementation of the supplemental payments started in July 2017. If CHBRP assumes that, on average, Medi-Cal Managed Care Plan payments to physicians are equivalent to the Medi-Cal Physician Fee Schedule, CHBRP would need to multiply current physician spending in Medi-Cal by 137% to estimate the total cost of physician fees under the Medicare Outpatient Prospective Payment Fee Schedule. Based on Kaiser Family Foundation's State Health Facts, California's total Medi-Cal spending from all sources was $88.74 billion in fiscal year 2020. Based on 2014 data from CMS, physician services represented 15% of spending in Medi-Cal.

Thus, $88.74 billion × 15% for physician services only × 37% = $18.24 billion total, which is an additional $4.93 billion in new spending in 2020 dollars.

If CHRBP were to inflate 2020 dollars to 2022 dollars using a low 1.74% annual medical Consumer Price Index (CPI) (which was the increase from November 2020 to November 2021), there would be $5.02 billion additional spending due to increasing the Medicaid Fee Schedule to be equivalent to Medicare for physician services only.

CHBRP notes however that this rough calculation would ignore the Medi-Cal physician services delivered through federally qualified health centers (FQHCs) and look-alikes, which obtain cost-related reimbursement for their care, which already equals or exceeds the typical Medicare fee for equivalent services. If CHBRP remove the $4 billion in Medi-Cal–related collections for FQHC-provided patient services from physician services spending in Medi-Cal, total current spending on physician services would be reduced to $9.3 billion; and increasing it by 137%, based on the Medicaid-to-Medicare payment ratio, CHBRP would estimate $3.44 billion additional spending in Medi-Cal for a total of $12.74 billion in non-FQHC physician services spending. In 2022 dollars, that represents $**3.57 billion in additional physician services** spending for a total of $**13.2 billion**.

Commercial health insurance. Commercial health insurance represents the majority of insured individuals in the state. Physician reimbursement rates in commercial insurance products exceed typical Medicare and Medicaid payments. Based on analysis by the Health Care Cost Institute, California's health insurers pay approximately 129% of Medicare for physician services. If reimbursement rates for commercially insured patients were reduced to Medicare levels due to this bill, the reduction in fees paid would result in $9.33 billion fewer dollars spent if the actual use of services were held constant and the reduction in fees did not change physician availability or consumer use of services. However, the actual spending change associated with reducing commercial fees to Medicare levels is unpredictable and would be influenced by physician response (i.e., delivering and providing additional services to recover lost revenue in a FFS environment) and consumer utilization of lower priced services due to lower coinsurance/copayments (i.e., potential induced demand).

According to data from CHCF, private health insurance spending was $104 billion in 2014. Based on the same report, approximately 26% of spending overall was on physician services, resulting in $27 billion spent on physician services in 2014. If we reduced that spending by 29% to reflect a reduction in commercial rates to Medicare rates, the amount would decrease to $19.2 billion for a reduction of $7.83 billion in 2014 dollars. In 2022 dollars (adjusted using the Medical CPI from 2014 to 2021 to trend forward), this would be equivalent to **$9.33 billion in savings due to reduced commercial rates** if we assume no changes in consumer utilization, physician availability, or physician response due to the reduction in physician fees.

d) Dental Services. In 2019-20, dental benefits constituted 1% of the total Medi-Cal budget of $94.7 billion, or approximately $9.5 billion. Trended to 2022 at 4% annual trend, this would be approximately $9.85 billion. Denti-Cal reimburses providers approximately 65% of what commercial plans reimburse providers for child dental services and approximately 87% for adult dental services. Note that California's Denti-Cal reimbursement relative to commercial may look closer than in other states because of the prevalence of dental HMOs in California. In particular, dental HMOs are more widely offered than other states, so this unit-cost relativity is not generalizable to other states. CHBRP does not have a meaningful estimate for how Denti-Cal costs are distributed among adults and children, so it simply averaged the reimbursement rates using a straight average, for an average Denti-Cal reimbursement of 76% of commercial reimbursement rates.

Because Medicare doesn't cover dental services, there's not a well-defined reimbursement level for dental for Medicare beneficiaries. Some Medicare Advantage plans do cover dental benefits. CHBRP's opinion is that it is reasonable to assume that commercial is approximately 120% of "proxy Medicare dental reimbursement levels."

If Denti-Cal were reimbursed at proxy Medicare dental reimbursement levels, the 2022 annual spend of **$9.85 billion would increase to $10.8 billion** ($9.85 billion / 76% Denti-Cal relativity to commercial / 120% commercial relativity to proxy Medicare).

Currently, Denti-Cal has a coverage cap. It will only provide up to $1,800 in covered services per year for adults. Some services are not counted toward the cap, such as dentures, extractions, and emergency services. Many commercial plans have caps of $1,500 per year.

CHBRP is unable to make further projections on Denti-Cal given the limited experience, pent-up demand, and uncertainty over how the market would respond to changes in reimbursement rates.

9) **SUPPORT.** Supporters include numerous California cities and counties, universal healthcare advocates, social justice in healthcare organizations, political organizations, and labor unions. Supporters state this bill would ensure all Californians, regardless of employment, income, immigration status, race, gender, or any other considerations, may get the healthcare they need, free at the point of service. The support writes that our state and economy are still reeling from the impact of the coronavirus pandemic that definitively exposed the failure of health insurance as an employment benefit and the inadequacy of ACA reforms to provide a guarantee of healthcare access to all. CalCare health benefits will be fully comprehensive at a time when nearly three million Californians have no health insurance and millions more have insurance they cannot afford. Meanwhile, for-profit insurance companies are reporting record-breaking profits, even while the COVID-19 pandemic continues to ravage California and medical bankruptcies are at an all-time high.

   Supporters claim the COVID-19 pandemic has also magnified the enormous racial disparities in health care, especially in California where Black, Indigenous, and other people of color are experiencing higher Covid-19 infection and death rates. Indigenous, Black, and Latinx people are being hospitalized from Covid-19 at around 4 times the rate of whites and are dying from Covid-19 at about twice to four times the rate of white people. CalCare health benefits will be fully comprehensive, including all primary and preventive care, hospital and outpatient services, prescription drugs, dental, vision, audiology, reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more. Patients will have freedom to choose doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is "in-network." The CalCare program would be a truly transformative change to California's health care system. In addition to guaranteeing health care to all Californians, it would save families and businesses thousands in annual health care costs by cutting out the bloat, waste, and inefficiencies of our fragmented, for-profit insurance system.

10) **SUPPORT IN CONCEPT.** Health Access California (HAC) writes that they support this bill in concept. HAC states they strongly support universal healthcare that offers coverage to everybody and leaves no one uninsured; a progressively finance system where we pay for

what we can afford; a comprehensive system that improves on the minimum standard for benefits included in the ACA; is a cost-effective system that focuses on greater financial efficiency and effectiveness; a streamlined system that removes some of the bureaucracy and profit-taking of multiple private insurance companies; that fills in the gaps, diminishes the confusion and complications of the current fragmented system; a system focused on patients and not profits; and, that is prevention-oriented rather than simply disease management. HAC has questions about this bill as introduced including: the effectiveness of the current financing mechanism in ACA 11 as introduced on January 5, 2022; the specifics of the federal approvals and how the Governor can negotiate with the federal government; the plan for transition from the current system that includes many types of coverage; the governance of CalCare by appointed and not elected board members with a questionable role of oversight by elected officials; an advisory committee dominated by health professionals and not on consumer, patient, and community representation; unclear consumer protections; CalCare's purchasing power for cost, quality, and equity; cost controls are vague, including what can be considered "reasonable" payments for FFS rates; role of the safety net that currently includes county hospitals, community clinics, and those who serve Medi-Cal recipients and the remaining uninsured; and, the potential exclusion of some forms of care and treatment in the definition of "medical necessity.

11) **OPPOSITION.** The opposition includes health insurers and provider organizations, hospitals, and chambers of commerce. In its opposition, America's Physician Groups (APG) state that this bill fragments patient care, leading to increased clinical practice variation and poorer health outcomes. This bill expressly prohibits the use of information technology and clinical practice guidelines, in favor of individual licensees' professional judgement. Removing all existing managed care mechanisms, it leaves oversight of an individual licensee's performance to their existing licensing boards. APG points out that its physician group members have been uniquely responsible for the care of millions of patients across the country under an accountable model for the several past decades. In the course of their work, they have pioneered the use of best clinical practices guidelines to standardize care approaches, focus on evidence-based medicine, improve patient outcomes, and decrease variation in medical practice. Clinical variation involves the overuse, underuse, different use and waste of healthcare practices and services with varying outcomes. It has been associated with poorer health outcomes, increased costs, disparities in care and increased burden on the public health system. Building accountable systems of patient care that decrease variation in medical practice involves peer-supported oversight, use of clinical practice guidelines and intensive use of information technology. It is also highly dependent upon provider payment mechanisms other than pure FFS. APG further states that this bill enshrines the defunct mechanism of FFS provider payment. This bill prohibits the use of risk-bearing, risk-sharing, and risk-shifting agreements "with other health care providers or entities other than CalCare." It also bars Accountable Care Organizations, Restricted Knox Keene Licensees, and Independent Practice Associations from participating in the health care system. Additionally, this bill restricts payment of physician practices to two models, either FFS or salaried. Individual physicians may only be paid on FFS basis. This bill further prohibits any provider payments to compensate for capital expenditures. Capitated payment models enable physician groups to purchase electronic health records, practice management systems, predictive modeling software for population health management and online patient information portals. Such expenditures are prohibited under this bill's provider reimbursement provisions. APG concludes that in combination, these factors dismantle the best elements of the California healthcare delivery system and replace it with outdated,

obsolete 1950's style, cottage-industry healthcare delivery. This bill ignores decades of evidence that organized, accountable, capitated-delegated physician organizations provide superior access, quality of care at lower total cost of care than does fragmented, FFS-based coverage and delivery systems.

The California Medical Association (CMA) states in its opposition that this bill would completely upend the existing health care delivery system and replace it with a single health plan governed by a board of nine unelected individuals. This would transform the practice of medicine in unknowable ways, without any input from those who practice medicine. CMA states this bill contemplates consolidating Medi-Cal, private insurance and the Covered California exchange into a single health insurance product provided by the state — without the constitutional protections that are essential to ensuring that an adequate, guaranteed amount of resources will be allocated to a single-payer system to ensure its viability. Without these needed protections and given the volatility of California's tax revenue from year to year, a single-payer program could default to a system that it is unable to provide timely access to quality care for the beneficiaries it would cover and would mean higher taxes for heard-working families with no increased access or quality of care for patients. CMA concludes that this bill would throw patients and the entire health care system into chaos at a time when stability is needed to guide California through the COVID-19 pandemic and its aftermath.

The California Hospital Association states in its opposition that while there are different ways to achieve universal coverage, California's current path has proven to be highly successful. To change course now would undo years of progress, requiring every Californian to give up their coverage, including 6.5 million seniors and other vulnerable individuals covered by Medicare. Over the past several decades, California has made great strides with innovating and integrating the delivery of care for patients. These relationships and gains in the coordination of care among providers could be rolled back under a single-payer system. Lastly, as has happened in the recent past, when the state has faced budget deficits, the Legislature and Administration have taken to cutting health services for the Medi-Cal program in order to balance the books. Californians should not have to worry about whether their access to health care services will get slashed the next time the state faces a budget deficit.

Kaiser Permanente states that this bill would fundamentally dismantle Kaiser Permanente, the largest private employer and provider of health care coverage in California, and threaten the employment and financial livelihoods of our 17,000 physicians and 157,000 employees, of which130,000 are represented by more than 30 labor union locals. Kaiser states that this bill would also undermine its unique integrated health care delivery system. Kaiser's model, which is consistently embraced by health care organizations across the country, combines care and coverage and would not be able to operate under the rigid system proposed in the bill. Kaiser also points out that this bill is fiscally irresponsible; and stifles competition and innovation essential to affordable coverage and high-quality care.

Health plans and health insurers state in their opposition that California has done a tremendous amount of work in enacting comprehensive network adequacy requirements that ensure patients get access to timely, quality care. Imposing a single-payer health care system could actually harm these existing consumer protections. The state must focus on filling the gaps in the current health care system, including investing in workforce development and

increasing access to care in rural areas, but this bill does nothing to address those issues. This bill would also mean the loss of thousands of jobs from California's economy. Health plans employ over 160,000 Californians and more than an additional 100,000 Californians are employed in insurance-related jobs. These are very good paying jobs that would no longer exist should this bill pass. In addition, to implement this bill, the state would have to apply for numerous waivers from the federal government relating to Medicaid, CHIP, Medicare, and the commercial market. None of the existing waivers is meant to implement this type of system and it is unknown whether the federal government would approve waivers for such an effort or fund such a broad expansion of state government-run health care coverage. They conclude that instead of overhauling the health care system for an unworkable and unproven proposal, we should focus on improving what's working while fixing what's broken in health care.

12) **RELATED LEGISLATION**. ACA 11 (Kalra) imposes impose an annual tax of 2.3% on businesses that have at least $2 million in annual revenue; a 1.25% tax on payroll for companies with at least 50 employees; a 1% tax for those employers who pay employees at least $49,900. ACA 11 also includes a series of tax hikes on wealthier people, starting with a 0.5% levy on the income of people who make at least $149,509 per year and ending at a 2.5% income tax for people who make more than $2.48 million per year. ACA 11 also permits the Legislature to pass a statute that increases any or all of the tax rates by a majority vote. Authorizes the Legislature, upon an economic analysis determining insufficient amounts to fund these purposes, to increase any or all of these tax rates, as specified. ACA 11 is pending referral in the Assembly Rules Committee.

13) **PREVIOUS LEGISLATION.** Since 2003, there have been five single payer bills and one bill to fund single payer, as follows:

a) SB 562 (Lara) of 2017 died in Assembly Rules Committee. The Senate Appropriations Committee analysis of SB 562 indicated the following on the cost to implement it:

i) Total annual costs of about $400 billion per year, including all covered health care services and administrative costs, at full enrollment;

ii) Existing federal, state, and local funding of about $200 billion could be available to offset a portion of the total program cost; and,

iii) About $200 billion in additional tax revenues would be needed to pay for the remainder of the total program cost. Assuming that this cost was raised through a new payroll tax (with no cap on wages subject to the tax), the additional payroll tax rate would be about 15% of earned income.

It is important to note that the overall cost of those new tax revenues would be offset to a large degree by reduced spending on health care coverage by employers and employees. Although precise estimates of total spending for employer sponsored health insurance are not available, the best available information indicates that existing spending is between $100 and $150 billion per year. Therefore, total new spending required under the bill would be between $50 and $100 billion per year.

b) SB 810 (Leno) of 2011 failed passage on the Senate Floor in 2012.

c) SB 810 (Leno) of 2009 was not taken up on the Assembly Floor.

d) SB 840 (Kuehl) of 2007 was vetoed by Governor Schwarzenegger. In his veto message, the Governor cited a Legislative Analyst's Office analysis that estimated the bill to cost $210 billion in its first full year of implementation and cause annual shortfalls of $42 billion, and he could not support a bill that placed an annual shortfall of over $40 billion on California's economy.

e) SB 1014 (Kuehl) of 2007 would have imposed a payroll tax to fund the single payer system. SB 1014 was heard in the Senate Revenue and Taxation Committee but no vote was taken.

f) SB 921 (Kuehl) of 2003 was never heard in the Assembly Appropriations Committee.

14) POLICY COMMENTS.

a) Federal issues. To implement a single payer system in California, there is a need to address federal law and regulation, including Medicare and Medicaid; address limitations under the Employee Retirement Income Security Act of 1974 (ERISA) on the state's ability to impose requirements on employer benefit programs and navigate existing constraints on how California raises and spends revenue.

i) Waivers. This bill requires the board to seek federal waivers and other federal approvals to receive funds to operate CalCare. As indicated above, the HHS Secretary has broad authority under Section 1115 to waive provisions of major health and welfare programs, including Medicaid requirements. Additionally, Section 1332 of the ACA which established CMMI permits states to apply to waive major provisions of the ACA.

There is disagreement on whether a waiver is sufficient to implement this bill in California. Those who argue that a waiver is sufficient point out that since the state jointly administers Medicaid with the federal government, it may be possible for the state to combine Medicaid funding with other funding streams though on a time-limited basis (usually five years for waivers) and with numerous limitations and constraints imposed by federal law.

Those who argue that a waiver is insufficient point out that since waivers are discretionary, different Administrations may take different approaches, and Administrations are not legally obligated to approve waivers. Thus, even if a waiver is approved by the Biden administration, it is possible that a new administration could take a different approach and revoke a single payer waiver. Additionally, testimony during the Select Committee hearings indicated "broader changes would be needed for implementation of a single-payer system. Waivers or demonstrations typically test new payment and delivery models, not permanent changes to a state's entire health care delivery system, they are time-limited, oriented around improving quality and/or reducing spending in Medicare, and typically federally-guided or controlled efforts, or state-federal partnerships. Using CMMI authority to implement a single payer system is necessary but not sufficient."

Furthermore, Section 1332 has limits and constraints. For example, California enacted SB 10 (Lara), Chapter 22, Statutes of 2016, to allow Covered California to create California-specific QHPs in order to allow undocumented immigrants to buy coverage through Covered California. But it should be noted that California could not waive the provisions of federal law requiring that Covered California determine citizenship or lawful permanent residency as a condition of eligibility determination. California subsequently decided not to request the SB 10 waiver.

Perhaps more importantly, the question is whether the Secretary of HHS can transfer Medicare and Medicaid funds to implement a single payer system. According to a presentation to the Select Committee, "there is no authority granted the HHS Secretary to redirect Medicare's funding streams or trust fund dollars to states to oversee and manage these funds on behalf of a state's entire Medicare population."[1] This is echoed by a presentation made to the Healthy California Commission:

- The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicare funds to a State for a unified financing system;

- The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicaid funds to a State for a unified financing system; and,

- If California wants to use federal Medicare and Medicaid funds as part of a unified financing system, including single payer, it will need to persuade the Congress and the President to change federal law.[2]

Recognizing the limits or constraints of existing waiver authority, on January 7, 2019 when Governor Newsom assumed office, he sent a letter to the Trump Administration requesting an amendment to federal law to enable states to apply for and receive Transformation Cost and Universal Coverage Waivers, empowering California to truly innovate and to begin transformative reforms that provide the path to a single-payer health care system. In part, the Governor's letter states the following:

"The federal government has given States the flexibility to make innovative changes in health care through the use of waivers. However, the existing State Innovation Waiver is too limited to effectively design and implement comprehensive solutions. Congressional leaders have recognized this fact, proposing legislation last year to expand States' waiver authority to promote universal coverage. In this spirit, the federal government should enact new law enabling States to apply for

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[1] Juliette Cubanski, Kaiser Family Foundation, "Implementation Considerations for Universal Coverage: Federal Law Considerations and Medicare," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, (February 5,2018) https://www.assembly.ca.gov/sites/assembly.ca.gov/files/Archives/2_-_final_cubanski.pdf

[2] Andy Schneider, McCourt School of Public Policy at Georgetown University, "Can the Secretary of Health and Human Services transfer federal Medicare and Medicaid funds to a unified financing system in California?" Testimony before the Healthy California for All Commission (September 23, 2021), https://www.chhs.ca.gov/wp-content/uploads/2021/09/Healthy-CA-for-All-9-23-21-Meeting-Slides.pdf

Transformational Cost and Universal Coverage Waivers to re-invest federal funding-combined with State funds-to increase coverage, contain costs, and drive improvements in health care quality. Employing such waivers, States could design and tailor their own solutions, and lay the groundwork for more comprehensive solutions, such as a single-payer system."

On May 25, 2021, Governor Newsom sent a similar letter to the Biden Administration.

ii) ERISA. Another federal issue that California will need to address is the potential conflicts with the federal ERISA as it relates to self-funded funds which are exempt from state regulation or requirements. As discussed below, the federal court will need to address the ERISA issue.

ERISA preempts "any and all State laws insofar as the may now or hereafter relate to any employee benefit plan." Self-funded funds are those in which the employer assumes the financial risk of employees health care costs and pays for their health care expenses directly rather than purchasing insurance and having the risk shifted to a third party. It should be noted that Hawaii is the only state in the nation that has an ERISA exemption. Hawaii's Prepaid Health Care Act was enacted in 1974 and employers of all sizes are required to offer coverage to any employee working 20 or more hours per week.

The ERISA preemption was also raised with the passage of Healthy San Francisco (Healthy SF). In 2006, Healthy SF was enacted which subsidizes medical care for uninsured residents of San Francisco who have no other sources of coverage nor eligible for any public health program. Healthy SF created an employer mandate which required employers to meet minimum standards on spending for employees. It is not an insurance program. Funding for Healthy SF includes quarterly fees from individuals based on their income, county general fund and contributions from employers and providers. Healthy SF applies to employees working 8 hours or more per week. The Golden Gate Restaurant Association sued alleging ERISA preemption but the Ninth Circuit ruled ERISA did not preempt the mandatory employer spending requirement of Healthy SF. The court's holding is grounded in two key observations: first, that Healthy SF does not require employers to establish their own ERISA plans or modify any existing ERISA plans, and second, that Healthy SF is concerned only with the dollar amounts of employer payments, rather than the nature of health care benefits provided to employees.

At least 5.5 million Californian are covered through self-funded ERISA plans. According to "An Environmental Analysis of Health Care Delivery Coverage, and Financing in California" submitted in August 2020 to the Healthy California for All Commission, "How ERISA's complex provisions may apply within the context of a specific state policy construct would be subject to court interpretation. State single payer proposals offer a range of strategies to reach their goals without ERISA preemption. For example, proposals may rely on funding plans that include employer contributions, such as broad-based payroll taxes. Another approach could be to place restrictions on providers, for example prohibiting providers from accepting payment from any source other than the unified system or at any different rates. These

strategies would allow employers to continue to offer a self-funded plan if they chose to do so. Employers' decisions would depend on the perceived value to employees of the self- funded plan when compared to services available under unified financing at little or no additional cost. While strong legal arguments can be made for these approaches, given the high financial stakes, litigation is likely."

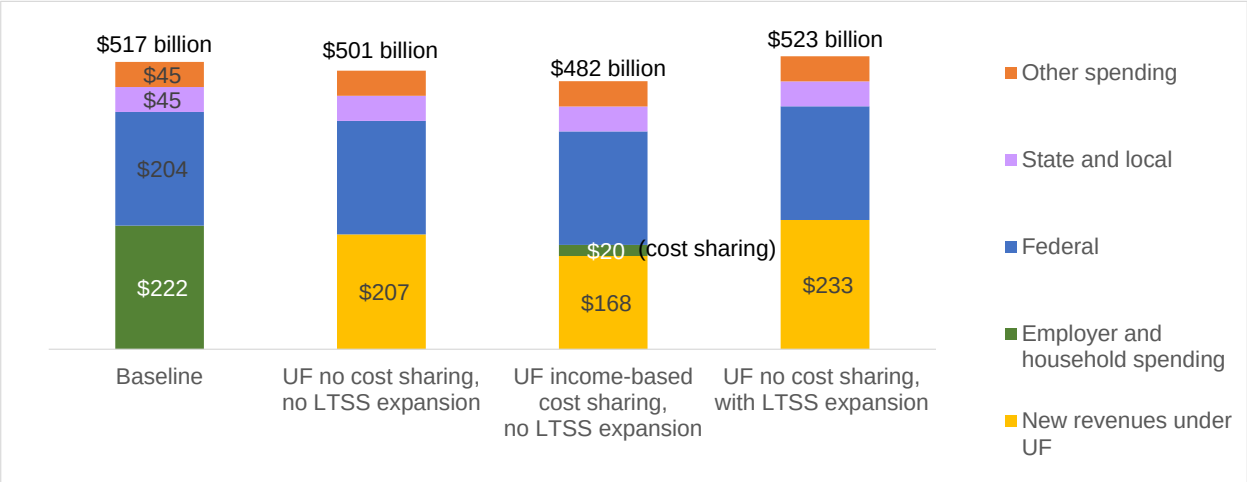
iii) **Regulatory Taking**. The Fifth Amendment of the United States Constitution mandates that if the government takes private property for public use, the government must provide "just compensation." Under this bill, one can argue that approximately 90% to 95% of health plans and health insurers business will be folded into the single-payer system. Although this bill allows health plans or health insurers to sell supplemental insurance to cover services or benefits that is not covered under CalCare, a federal court will also need to decide whether there is regulatory taking that would require the State to reimburse health plans or insurers for lost business.

b) **Funding and Financing.** On January 5, 2022, the author introduced a constitutional amendment, ACA 11 to fund this bill. ACA 11 would impose an annual tax of 2.3% on businesses that have at least $2 million in annual revenue, plus a 1.25% tax on payroll for companies with at least 50 employees and a 1% tax for those employers who pay employees at least $49,900. ACA 11 also includes a series of tax hikes on wealthier people, starting with a 0.5% levy on the income of people who make at least $149,509 per year and ending at a 2.5% income tax for people who make more than $2.48 million per year. The California Taxpayers Association asserts the plan would increase tax collections by $163 billion per year. ACA 11 also permits the Legislature to pass a statute that increases any or all of the tax rates by a majority vote.

A presentation made to the Healthy California for All Commission by the UC Labor Center on November 17, 2021 probably offers the closest estimate on how much it would cost to implement single-payer in California with necessary federal and state approvals. (i.e. maintaining all of the baseline projected federal expenditures in year one). According to the UC Labor Center, by 2031, total health spending in California is projected to grow by $158 billion in current dollars. Under the current system, the 2022 estimate for health care expenditures in California would be $517 billion, broken down as follows: Employer and household spending is projected at $222 billion, federal spending at $204 billion, state and local spending at $45 billion and other spending is projected at $45 billion. According to this presentation, California would need to replace the $222 billion of employers and household spending. However, the presentation also pointed out that there would be substantial savings related to administrative overhead, significant drug cost reductions and reduced provider payments reflecting billing and insurance related savings for providers but otherwise assuming that doctors, hospitals and other providers are paid, in aggregate, what they are paid. Additionally, under unified financing there would be increased use of services associated with the expansion of coverage and reduction in consumer cost-sharing. Reduced health spending growth could be achieved by various means including payment reforms, systems accountability and care coordination. The estimate indicated that the $222 billion in employer and household spending could be replaced by $207 billion in more progressive financing under a single-payer scenario with no cost sharing and no expansion of LTSS. Under a no cost sharing and with LTSS expansion, the estimate indicates the State would need to raise **$233**

billion. The estimates with different decision designs are reflected in the table below:

Total California health expenditures by payer, 2022



Reserves. The UC Labor Center presentation also estimated that the state would need 10% of financial reserves to cover fluctuations in revenue resulting from economic downturns. Additionally, a risk reserve of 5.2% to 11.7% would be necessary depending on the option the state implements, to cover fluctuations in claims. To create the reserves, the UC Labor Center assumes that $20 billion is bonded over a 30 year period to establish the initial reserve fund, with annual payments of $1.33 billion. Annual payment amounts are based on an analysis by the Legislative Analyst's Office of the repayment costs for a 30 year bond at 5%. The UC Labor Center further assumed that the remainder of the reserve is built up out of annual revenues over a ten year period. There is a limit to the amount of bonds the state can issue at any given time but assumes that $20 billion would provide sufficient reserves at inception.

Depending on the design, the UC Labor Center indicated the following: The first year cost to fund reserves in a no-cost sharing, direct payment scenario would be $5.2 billion: $1.33 billion for bond payments and $3.8 billion towards building the reserve fund. The first year cost of reserves in a no-cost sharing, model with intermediaries would be $3.7 billion. If it were possible to issue bonds for a greater share of the reserve at inception, the costs could be lowered slightly. For example, if the entire target reserve amount for the direct payment with no-cost sharing option was bonded at inception and invested to receive a return that matches the GDP, the annual cost for bond repayments and setting aside reserves would be $3.9 billion in 2022. The calculations for the later years assume that the reserve funds are not utilized during this time period. If the fund goes below a certain level, e.g. 80% of the target amount for that year, the payments would need to be increased accordingly. If the reserve fund reaches a certain level above the target (120%), the fund could decide to reduce the annual payments.

CHBRP's abbreviated analysis estimates that 50% of the current estimated health care spending plus additional spending due to the implementation of this bill should be placed in a reserve fund to ensure benefits can be offered to California residents and this amounts to $158.5 billion to $195.5 billion in reserves.

ACA 11 is projected to raise $163 billion. This estimate is significantly less than the actual need, whether using the estimates of projected by the UC Labor Center above or the fiscal analysis of SB 562. Thus, the Committee may wish to ask the author how he plans to fund the remaining balance, including funding for expected year to year increases in expenditures and the reserves needed to cover fluctuations in revenue.

c) State Constitutional Issues. There are two state constitutional issues that must be addressed if California is to implement a single-payer program. Proposition 4 of 1917 established a constitutional state spending limit that is known as the "Gann Limit." The original Gann Limit was later modified by two ballot measures: Proposition 98 of 1988 and Proposition 111 of 1990. Proposition 98 of 1988, as modified by Proposition 111 of 1990, constitutionally guarantees a minimum level of funding for K-12 schools and community colleges. Thus, any taxes/revenues raised to support this bill would be subject to the requirements of the Gann limit and Proposition 98. It should be noted that ACA 11 addresses both these issues by excluding the revenues derived from taxes imposed by ACA 11 from the Gann Limit or Proposition 98. ACA 11 also provides that taxes to fund the system could be increased on a simple majority vote rather than a two-thirds vote as required under the existing California Constitution.

d) Cost Containment. This bill contains certain cost containment provisions, including establishing a GBP for institutional providers, and giving the board the authority to negotiate prices for prescription drugs, medical supplies and other health care items. However, this bill also relies on a FFS payment mechanism and although it uses 100% of Medicare FFS as the reasonable basis for payment, under a FFS payment, providers would each be paid separately for each test, procedure or treatment. Thus, FFS rewards providers for volume and quantity of services provided, regardless of the outcome. As APG indicated "FFS ignores decades of evidence that organized, accountable, capitated-delegated physician organizations provide superior access, quality of care at lower total cost of care than does fragmented, FFS-based coverage and delivery systems." Even using the Medicare payment rate system, the cost of health care will continue to rise thus it is important for the Committee to evaluate whether this bill includes sufficient cost containment mechanisms to identify and address cost drivers in the system, ensure it eliminates waste and fraud, and evaluate the price of health care while improving quality and care.

e) Health Information Technology. A single payer system functions more efficiently with a robust or comprehensive health information technology (Health IT). Health IT makes it possible for health care providers to better manage patient care through the secure use and sharing of health information. By developing secure and private electronic health records and making health information available electronically when and where it is needed, Health IT can improve the quality of care, even as it makes health care more cost effective. With the help of Health IT, health care providers will have: i) accurate and complete information about a patient's health - providers can give the best possible care, whether during a routine visit or a medical emergency; ii) the ability to better coordinate the care given - this is especially important if a patient has a serious medical condition; iii) a way to securely share information with patients and their family caregivers over the Internet, for patients who opt for this convenience – this means patients and their families can more fully take part in decisions about their health care; and, iv) information to help diagnose health problems sooner, reduce medical errors, and provide safer care at lower

costs. The Committee may wish to inquire from the author how he intends to implement Health IT.

f) Governance. This bill will be administered by a nine-member CalCare board, as follows: two health care professionals who practice medicine; one registered nurse; one public health professional; one mental health professional; one member with institutional provider background; one representative of a not-for-profit organization that advocates for individuals who use health care in California; one representative of a labor organization; and one member of the advisory Committee. Six of these appointees are providers and although this bill requires the members to have expertise in health care policy or delivery and comply with conflict of interest standards, a board made up of mostly providers could undermine its integrity, for example, by making it appear that the board's composition have a vested interest in increasing health care payments. The Committee may wish to consider whether the board's governance and structure promotes or hampers efforts to create efficiencies, encourage innovation, and ensure accountability and program sustainability. Alternatively, the Committee may wish to consider whether a quasi-governmental entity similar to the California Public Utilities Commission is an appropriate governance structure.

g) Transition. Although this bill empowers the board to determine an appropriate level and provide support during the transition for, training and job placement for persons who are displaced from employment as a result of the initiation of CalCare, it would displace thousands of workers currently employed by health plans and health insurers. According to the Estimated Effects of Unified Financing in California: Methods and Assumptions that was shared with the Healthy California for All Commission at its July 8, 2021 meeting, researchers at the University of Massachusetts Amherst Political Economy Research Institute (PERI) estimated that there are 746,600 insurance industry workers nationally and 1.06 million administrative support workers in health care setting would face displacement under the federal Medicare for All proposal. If California's share of this workforce is roughly proportional to the state's share of the population, this is equivalent to 219,000 administrative workers in California who may face displacement or more than one percent of the total California workforce in 2017. The Healthy California for All Commission consulting team noted in the July 8, 2021 document that loss of administrative jobs under the bill may be partially or wholly offset by an increase in other health sector employment providing patient care given higher demand for health care services under the bill. Further analysis would be needed to estimate the overall net employment effects of the bill in California.

Even if the net employment changes due to the bill are positive, a transition plan could help to support any displaced workers. The PERI researchers also developed a framework or plan to ease the transition for displaced insurance or administrative workers which includes: pension fund guarantees for all affected workers, a voluntary path to retirement for workers age 60 and older that provides 100% wage replacement until their pension begins, and support for displaced workers via one year of wage replacement and job retraining and relocation support as needed.

According to the Healthy California for All Commission consulting team, to extrapolate the costs for California under the scenario with direct payment to providers, this national estimate was adjusted for California's share of the U.S. population and inflated to 2022

dollars based on personal income growth projections from CMS. The investment is assumed to be spread over 10 years using a bond with an annual interest rate of 2.3%. For the scenario in which health plans or health systems plan an intermediary role, it is assumed that half of the support would be needed because there would be fewer displaced workers in the insurance and health services industries given that not as much administrative simplification would occur in this scenario. Based on these assumptions, the analysis assumes $1.7 billion in just transition costs per year for the first 10 years of policy under the scenario with direct payment to providers and nearly $0.9 billion per year under the scenario with a role for health plans or health systems as intermediaries. The Committee may wish to ask the author for further analysis to estimate the overall net employment effects of the bill in California, a blueprint for a transition plan which includes how much and how to pay for transition.

h) Workforce. A 2020 analysis by the Congressional Budget Office (CBO) indicates that in a single payer system, "The total amount of health care used would rise, and in that sense, overall access to care would expand. CBO estimates that the increase in demand under its single-payer options would exceed the increase in supply, resulting in more unmet demand. That increase in unmet demand would correspond to greater congestion in the health care system, including delays and forgone care. (Overall access to care and unmet demand would grow simultaneously because people would use more care and would have used even more if it were supplied)." The Committee may wish to inquire how potential workforce challenges could be addressed if single payer is implemented.

i) LTSS. Estimating how much an expansion of LTSS will cost under a single payer program is complex and difficult. To estimate how much LTSS would cost in California under a single payer program, the UC Labor Center used the CBO's analysis on an option to make institutional care and HCBS universally available to anyone with one or more limitations to Activities of Daily Living or Instrumental Activities of Daily Living. CBO assumed no explicit limit on the quantity and costs to LTSS, but that a single payer system would employ some cost containment strategies, such as requiring a detailed plan of care for patients and electronic verification of visits.

CBO estimates a 5% increase in total health expenditures due to the expansion of LTSS in the context of single payer, which is used to estimate the increase in expenditures in California under Unified Financing. A 5% increase in total health expenditures is equivalent to $26 billion in increased spending in California in 2022. By comparison, total California LTSS spending (institutional and HCBS) by all payers under current policy is roughly estimated at approximately $40 billion in 2022. One large component of current LTSS spending in California is the $17 billion in projected federal, state and local spending on In-Home Supportive Services in 2021-22.

The UC Labor Center points out that the national CBO estimate and their application of their assumptions to California are subject to significant uncertainty. For example, significant uncertainty exists about how much and how quickly care will continue to shift from institutional settings to HCBS and how the pandemic has changed families' preferences about those settings. Additionally, there is significant uncertainty about how use of LTSS would change under a broad expansion of eligibility and covered services along with a reduction in out-of-pocket costs. Furthermore, changes to the policy assumptions could significantly alter the projected expenditure change.

The UC Labor Center also states that further analysis would be needed to understand California-specific differences and adjust the national expenditure estimates accordingly. For example, factors that may lead to an HCBS expansion being more costly in California than in the U.S. on average include California having the second highest average life expectancy in the country and California's seniors being expected to spend more time with a disability than seniors nationally, in part reflecting our more diverse senior population. On the other hand, factors that may make an HCBS expansion less costly in California include the state already spending a higher share of Medi-Cal and state-funded LTSS expenditures on HCBS than the U.S. average and waiting lists for HCBS being a barrier that is less common in California as in other states.

Additionally, it will be important for the state to ultimately project and plan for LTSS expenditures over a longer time horizon than 10 years. Californians ages 65 and older will make up a growing part of the population over the coming decades. The California Department of Finance projects that the share of the state's population ages 65 and older will grow from 16.8% in 2021 to 22.5% in 2040 and 26.4% in 2060.

Consistent with the UC Labor Center's recommendations, the Committee may wish to ask the author to establish an LTSS plan or analysis that includes the UC Labor Center's recommendations to better understand the impact of LTSS on single-payer financing and funding.

13) **TECHNICAL AMENDMENTS.** As this bill moves forward, the author may wish to amend or clarify this bill as follows:
   - **a)** Delete references to OSHPD and replace with California Department of Health Care Access and Information;
   - **b)** On page 14, line 13, clarify reference to Section 11009;
   - **c)** On page 21, line 26, replace board with "commission;"
   - **d)** One page 24, line 8, capitalize Medical Board;
   - **e)** On page 48, line 19, replace commission with "board;"
   - **f)** On page 49, line 5, clarify reference to Section 100800; and,
   - **g)** On page 57, line 14, the author may wish to adjust the date.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda Labor Council
Bend the Arc: Jewish Action
Berkeley; City of
Bonita Democratic Council
Butte County Health Care Coalition
CA Women for Workplace Justice
California Alliance for Retired Americans
California Dental Association
California Labor Federation, AFL-CIO
California Onecare
California Teachers Association
City of Alameda

City of Long Beach
City of Richmond
City of Sacramento
City of Sacramento - Office of Councilmember Katie Valenzuela
City of Santa Monica
Contra Costa Central Labor Council
Council Member Mateo Bedolla, City of Tracy
County of Santa Clara
Delano; City of
Democratic Party of Contra Costa County
Democratic Party of The San Fernando Valley
East Valley Indivisibles
El Dorado Progressives
Emeryville; City of
Feel the Bern Democratic Club, Los Angeles
Feel the Bern San Fernando Valley Democratic Club
First Wednesdays San Leandro
Green Party of Santa Clara County CA
Hand in Hand: the Domestic Employers Network
Health Care for All - California
Health Care for All - Los Angeles Chapter
Health Care for All California Nevada County Chapter
Health Care for All Contra Costa County
High Desert Progressive Democrats
Humboldt County Democratic Central Committee
Indivisible CA Statestrong
Inland Mendocino Democratic Club
Lamorinda Peace and Justice Group
Long Beach, City of
Los Angeles County Democratic Party
Mendocino County Democratic Central Committee
Monterey; County of
National Association of Social Workers, California Chapter
National Council of Jewish Women Los Angeles
Oakland; City of
Our Revolution
Our Revolution Scv
Palm Springs; City of
Peace & Justice Center of Nevada County
Peace and Freedom Party of California
Physicians for A National Health Program -- California Chapter
Physicians for Progress Ventura County / Ventura Chapter Physicians for National Health Program
Placer Democratic Action Network
Progressive Asian Network for Action (PANA)
San Francisco Board of Supervisors
San Jose-evergreen Community College District
San Jose; City of
Santa Barbara Women's Political Committee

Santa Clara County Democratic Party
Save Our Seniors Network
Silicon Valley Democratic Socialists of America
Simi Valley Democratic Club
South San Francisco; City of
Students for A National Health Program (SNAHP), South Bay Chapter
The Social Justice Ministry of The Live Oak Unitarian Universalist Congregation of Goleta, CA
UPTE-CWA
Western Center on Law and Poverty

Opposition

America's Health Insurance Plans (AHIP)
Association of California Life & Health Insurance Companies
California Agents & Health Insurance Professionals (CAHIP)
California Association of Health Plans
California Chamber of Commerce
California Children's Hospital Association
California Hospital Association
California Landscape Contractor's Association
California Taxpayers Association
Health Net and Its Affiliated Companies
Independent Insurance Agents & Brokers of California, INC.
Kaiser Permanente
Military Officers Association of America, California Council of Chapters
National Association of Insurance and Financial Advisors - California
National Federation of Independent Business- CA
Rady Children's Hospital San Diego
Redondo Beach Chamber of Commerce
United Hospital Association

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