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California lawmakers bring back universal health care proposal, but lack funding plan

By Eric He

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Two years after suffering a stinging defeat in an effort to bring universal health care to California, lawmakers and the California Nurses Association are trying again to make the Golden State the first in the nation to implement a single-payer insurance system.

Assemblymember Ash Kalra (D-San Jose) reintroduced the measure as AB 2200 this year. The bill is largely similar to AB 1400, his 2021 proposal that would have established the California Guaranteed Health Care for All program, or CalCare, and would have enacted a framework for a single-payer, state-run coverage system that controls health care costs for all residents. But ultimately, that proposal never made it to the Assembly floor for a vote.

Kalra's goal is to first pass a policy framework before determining the necessary funding for the measure, which would likely involve a combination of obtaining federal waivers, consolidating existing health care programs and utilizing taxpayer money. The Bay Area lawmaker's prior effort was opposed by numerous medical and business organizations, and ultimately stymied when Kalra said the vote would have failed by double-digits.

"This is not about a short-term policy victory," Kalra told POLITICO ahead of the latest bill's introduction. "This is about long-term health care justice."

But Kalra's strategy could backfire. Assembly Speaker Robert Rivas (D-Hollister) called the bill a "good idea" but added that it would be a "tough sell" due to the cost, raising doubts the bill will pass unless lawmakers find a way to pay for it.

The cost of universal health care in California would be somewhere between $314 billion and $390 billion, according to analysis of previous attempts in 2017 and 2022.

WHAT'S IN THE BILL?

This Pro Bill Analysis is based on the text of the bill as introduced on Feb. 7.

The bill states in its declarations that it is the Legislature's intent to establish a comprehensive universal single-payer health care program called CalCare, which would be free at the point of service and without deductibles, coinsurance, premiums or other cost-sharing (Sec. 1).

The text states that Californians have experienced a rise in health care costs, and individuals often find that they are unable to access affordable care or make choices regarding their care due to their health benefit plans — which it states are typically dictated by economic needs, rather than patients' health care needs. The measure also states that its intent would not be to impact the authority of state agencies that oversee health care or the licensure standards for health care providers (Sec. 1).

Further, the bill states that the Legislature intends to address high prescription drug costs (Sec. 1).

AB 2200 would add new language to the Government Code, titled the California Guaranteed Health Care for All Act (Sec. 2).

General Provisions (Chapter 1)

Chapter 1 would establish the California Guaranteed Health Care for All program, or CalCare, and lists dozens of definitions relevant to the rest of the bill.

The measure would not prevent cities and counties from adopting additional health care coverage that goes beyond the measure, and would supersede existing law that is found inconsistent with the measure.

Governance (Chapter 2)

The health care program would operate under the CalCare Board — an independent entity consisting of nine members who are California residents and have "demonstrated and acknowledged expertise in health care policy or delivery." Five members would be appointed by the Governor and the Senate Committee on Rules and the Speaker of the Assembly would each appoint two.

The board would then separately appoint a 17-member advisory committee to provide input on policy regarding CalCare. Both the board and committee would be required to include representatives of labor organizations and individuals who use health care in California, in addition to various healthcare professionals.

The board would have all powers and duties necessary to establish and implement the program, and the executive director — hired by the board — would be able to hire staff needed to implement CalCare.

The board would be responsible for determining CalCare's priorities, ensuring the program's financial solvency, creating an enrollment system and negotiating payment rates, among other things.

The section also outlines the benefits and coverage that carriers would be able to provide, and would bar private insurers from offering coverage to people under CalCare for benefits or services already provided by the program.

The board would need to accommodate benefits for retirees who live out of state but accrued those benefits as California residents before CalCare was implemented.

Nonprofit organizations would be able to be contracted to provide CalCare services, as well.

The measure would establish an 11-member Advisory Commission on Long-Term Services and Supports for CalCare, which would meet at least six times each year.

The board would be directed to use CalCare funds to help employees who may have lost their jobs as a result of the program' s implementation, such as those working to provide third-party payments for health care.

The legislation would establish another advisory committee focused on public employees' retirement system health benefits, which would help transition health and retirement benefits provided through labor organizations into CalCare.

Data collected under the measure — such as financial information and patient outcomes — would have to be made public and used to assess services and quality of care provided by CalCare.

Contracts that the board enters into with health care providers would be exempt from review by the Department of General Services.

The measure would prohibit CalCare from disclosing personally identifiable information to law enforcement or immigration agencies.

By a certain date, the board would have to present a fiscal analysis to the state Legislature in order to determine whether CalCare can be implemented, and if revenue would cover program costs within eight years of implementation.

Eligibility and Enrollment (Chapter 3)

Under the measure, every California resident would be eligible to enroll in CalCare free of charge, and those born in California would be automatically enrolled upon birth. Colleges would be able to purchase coverage under CalCare for nonresidents.

Additionally, the bill would prohibit discrimination under CalCare.

Benefits (Chapter 4)

CalCare would cover the following benefits:

— Inpatient and outpatient hospital services

— Primary and preventative care

— Prescription drugs and contraceptives

— Medical devices and equipment

— Mental health and substance abuse treatment services

— Diagnostic imaging and laboratory services

— Reproductive care, including abortions, contraception and newborn care

— Pediatric services

— Vision, audiology and oral health

— Rehabilitative services, including both inpatient and outpatient care

— Emergency services and transportation

— Early screening services

— Gender-affirming care

— Transportation to health care services for people with disabilities or low-income patients

— Long-term services and supports

More specifically, CalCare would cover the following services:

— Prosthetics, glasses and hearing aids

— Child and adult immunizations

— Hospice care, skilled nursing facility care and home health care

— Prenatal and postnatal care

— Podiatric care

— Blood and blood products

— Dialysis

— Community-based adult services

— Dietary and nutritional therapies

— Therapies like chiropractic care and acupuncture

— Language interpretation and translation for health care services

Any service covered under existing state or federal health insurance programs would also be covered under CalCare.

CalCare recipients would be eligible for long-term services and support if they have a condition or disability that limits their daily activities.

The board would be required to meet annually to discuss expanding or adjusting the benefits covered under CalCare; however, it would not be able to remove the covered items already listed in the measure. The board would need to establish a process by which individuals can petition to add or expand benefits, as well as a process for recipients to dispute a coverage decision through the Independent Medical Review System.

Delivery of Care (Chapter 5)

Health Care Providers (Article 1): A health care provider who is licensed and in good standing is qualified to participate in CalCare, and the board would need to establish standards for CalCare recipients who receive services from out-of-state providers, while living temporarily outside California. People would be able to enroll onsite at a provider and select a primary care provider without a referral.

Providers would not be allowed to enter into risk-bearing, risk-sharing or risk-shifting agreements with health care providers other than CalCare. Its board members would not be allowed to receive compensation from or invest in from another provider. Providers could be terminated for not abiding by the measure, which would contain whistleblower protections for employees.

A provider would be allowed to bill individuals separately for services not covered through CalCare if the service is not available or payable through the program and certain conditions are met.

Payment for Health Care Items and Services (Article 2): Payment rates to providers would be based on the cost of efficiently providing health care and the availability and accessibility of services, as well as the ability to maintain an optimal workforce and necessary health care facilities.

Providers would not be able to charge more than the established rate, and institutional providers — like hospitals, skilled nursing facilities and dialysis clinics — would receive lump sum payments to cover operating expenses under a global budget. That figure would be determined annually, based on a number of factors such as the volume of services and expenditures. Rural or medically underserved areas could see an increase in the budget based on the need for health care services. The board would be able to provide interim payments to institutional providers, which could also appeal for payments and receive interim relief during the process.

The board would adopt policies to pay for out-of-state services, and determine if group practices, county organized health systems and local initiatives should be paid on a salaried, hourly or fee-for-service basis.

The comparative rate system for global budget negotiations would be based on the existing Medicare payment system. The board would have to engage in good faith negotiations with providers on fee-for-service payments, with the “rebuttable presumption” that the Medicare rates are reasonable.

There would be specific payments for projects to build health facilities, prioritizing services in rural or medically underserved areas or to address health disparities. Remaining funds from the global budget could be used by providers for CalCare health care needs — unless the margin was generated by limiting health care access or compromising quality of care. However, CalCare payments would not be able to be used for marketing, profit, incentive payments or state political contributions.

The board would create a system for prescription drugs that promotes generic and biosimilar medications and that continues to be updated frequently to remove dangerous or ineffective medicine.

Program Standards (Chapter 6)

Standard of Care (Article 1): CalCare would establish professional practicing and licensing standards for health care providers and professionals that span scope, quality and accessibility of health care services, as well as relationships between providers, members and other stakeholders. The standards would also promote certain transparent and equity goals.

The board would create standards for merging CalCare services with federal programs. Moreover, it would need to coordinate with state health agencies to monitor providers for compliance and establish programs to ensure and manage CalCare access.

Next, the measure would prohibit a provider from having a financial interest or accepting incentives and payment that would impair them from providing appropriate care. Providers would have to send an annual report to the state listing potential conflicts, like beneficial or proprietary interests and contracts involving incentive plans.

A patient's physician or nurse would be able to override guidelines in treatment if it is in the best interest of the patient and consistent with the patient's wishes.

Health Equity (Article 2): The bill would establish the Office of Health Equity, which would be tasked with coordinating health equity programs under CalCare and the California Health and Human Services Agency. The office would collect data and make recommendations to address a wide range of health inequity issues, such as barriers to health care, disproportionate burden of disease and discrimination in health care settings. The office would be able to enter into contracts to hire staff and otherwise implement the intentions laid out in the bill.

Funding (Chapter 7)

Federal Health Programs and Funding (Article 1): The board would be authorized to seek federal waivers and approvals to fund CalCare before 2026. The measure states that it is the goal to have CalCare ultimately operate as an independent agency. CalCare would also help administer Medicare in California, providing supplemental insurance coverage and assistance for drug coverage. Anyone concurrently enrolled in Medicare or a federally matched public health program would not lose any coverage under CalCare.

Those enrolled in CalCare could be asked to provide their eligibility for Medicare, and those eligible for the federal program would be required to enroll in Medicare in order to receive services under CalCare. Members would have 60 days after a written notice by the board to provide the required information, or else face suspension of their eligibility for CalCare.

CalCare Trust Fund (Article 2): The measure would create the CalCare Trust Fund to implement the program, with money appropriated continuously and able to be carried forward at the end of each fiscal year. The fund would consist of appropriations from the Legislature, along with federal and state contributions. The board would have to establish a reserve in the fund for health emergencies like a pandemic or natural disaster, or an increase in patient volume.

Each year, the board would be required to prepare a three-year budget for CalCare outlining how health care services would be covered. The budget would need to include:

— An operating budget that allows for providers to meet the health care needs of the population

— A capital expenditures budget for the construction and renovation of health care facilities

— A special projects budget for nonprofit or government entities intended to provide extra funding for providers in a rural or medically underserved area. The board would develop criteria for applications for payment via this budget, in consultation with other state agencies.

— Program standards activities

— Health professional education expenditures

— Workforce recruitment and retention expenditures

— Administrative costs

— Prevention and public health activities

For the first five years of CalCare, at least 1 percent of the budget would be allocated for transition assistance and 1 percent for health care workforce education, recruitment and retention.

CalCare Financing (Article 3): The measure states the Legislature's intent to pass a bill that would develop a revenue plan for CalCare with anticipated federal funding. The future legislation would also require state revenues from CalCare to be deposited into a trust fund for the program.

Transition (Chapter 8)

During the transition period in setting up CalCare, individuals enrolled in an existing health care plan would still have coverage. Those eligible for CalCare during the transition period would be automatically enrolled, and able to select a primary care provider.

The board would use funding to create programs to address health care workforce education, recruitment and retention under the CalCare Health Workforce Working Group. This would include expanding education programs at community colleges, addressing workforce attrition, identifying underserved areas in the state and providing career ladders into health professions for ancillary and allied health workers. The board would appoint members of a working group for this purpose.

Collective Negotiations by Health Care Providers with CalCare (Chapter 9)

The measure would authorize negotiations between CalCare and providers regarding payment for working with CalCare. It would explicitly prohibit a strike of CalCare by providers, and would bar competing providers from responding collectively to negotiations with CalCare. Providers would also not be allowed to negotiate a contract that limits participation in the program, reimbursement or the scope of services it would provide.

Operative Date (Chapter 10)

The measure would not take effect until the Secretary of California Health and Human Services determines that there is enough revenue to fund the program.

Additionally, the bill's provisions would be severable if one or more parts of it are struck down (Sec. 3). Lastly, the measure would provide an exception for public right of access to confidential health information required as part of Section 2 (Sec. 4).

WHO ARE THE POWER PLAYERS?

Assemblymember **Ash Kalra** (D-San Jose) is again teaming up with the **California Nurses Association** to introduce the proposal, and both are emphasizing how the Covid-19 pandemic underscored a need to address inequities in health care. The **California Labor Federation**, **California Teachers Association,** a number of local governments and health advocacy organizations supported Kalra's prior effort.

"CalCare will ensure that public health — not profit — is the priority of our health care system," **Cathy Kennedy**, president of the California Nurses Association, said in a statement.

The bill's principal coauthors in the Assembly are **Isaac Bryan** (D-Los Angeles), **Wendy Carrillo** (D-Boyle Heights), **Damon Connolly** (D-San Rafael) and **Alex Lee** (D-San Jose). They are joined in the Senate by **Dave Cortese** (D-San Jose) and **Lena Gonzalez** (D-Long Beach).

Other coauthors are: Assemblymembers **Laura Friedman** (D-Glendale), **Matt Haney** (D-San Francisco), **Corey Jackson** (D-Moreno Valley), **Kevin McCarty** (D-Sacramento), **Tina McKinnor** (D-Hawthorne), **Liz Ortega** (D-San Leandro), **Eloise Gomez Reyes** (D-Grant Terrace), **Luz Rivas** (D-North Hollywood), **Miguel Santiago** (D-Los Angeles) and **Phil Ting** (D-San Francisco), and Sens. **Josh Becker** (D-Menlo Park) and **John Laird** (D-Santa Cruz).

Various groups opposed the measure in 2021, including the **California Medical Association**, the **California Association of Health Plans**, the **California Hospital Association**, the **California Chamber of Commerce** and other business and medical forces.

The California Chamber of Commerce appears poised to oppose the measure again, noting that a single-payer health care system is expensive, untested and will raise taxes.

"The exorbitant taxes and costs associated with this system will systemically eradicate new jobs while driving out existing industries," CalChamber Senior Policy Advocate **Preston Young** said in a statement. "The consequences associated with adopting a single-payer health care model should discourage the Legislature from pushing forward any such proposal in California."

Assembly Speaker **Robert Rivas** (D-Hollister) — whom the California Nurses Association counts among its allies — may be heeding the warnings about cost.

Despite prior support from Rivas, Senate President pro Tempore **Mike McGuire** (D-Healdsburg) and Gov. **Gavin Newsom** — who campaigned on the promise of single-payer — state leaders appear tepid on AB 2200, given the mounting budget deficit.

Newsom has not weighed in on the legislation this year, and McGuire told POLITICO that “every bill will get a fair shot” but stopped short of agreeing to endorse Kalra’s proposal if it makes it to the Senate.

WHAT’S HAPPENED SO FAR?

The new legislation follows the unsuccessful 2021 effort that failed to get a vote on the Assembly floor, but not without high drama. Kalra ultimately pulled the bill because he said it was clear that it would fail, despite then-Assembly Speaker Anthony Rendon (D-Lakewood) backing the measure and noting that he was “deeply disappointed” in Kalra for holding the measure. Rendon himself previously took heat in 2017 for failing to advance a single-payer effort he described as "woefully inadequate.”

The California Nurses Association accused Kalra of “giving up on patients across the state” and “providing cover for those who would have been forced to go on the record about where they stand on guaranteed health care for all people in California.” The two sides have since appeared to make nice, with the CNA sponsoring Kalra’s current effort.

The California Democratic Party's left wing factions had also vowed to block endorsements for members who didn't vote in favor of the previous effort. But that ultimatum may have cost the bill support among some moderate Democrats.

In response to Rivas’ comments pouring cold water on the bill, CNA Lead Regulatory Policy Specialist Carmen Comsti said passing the policy before securing financing would follow the steps laid out by the federal government.

"CalCare bill language is clear that it would not go into effect until fully funded," Comsti said.

WHAT’S NEXT?

The measure is awaiting its first hearing in the Assembly, although it’s not clear how lawmakers will proceed now that Rivas has questioned whether this bad budget year is the right time for the proposal.

Still, the California Nurses Association has spent the past two years working to get pro-single payer candidates elected, such as Bryan and Assemblymember Pilar Schiavo (D-Chatsworth).

In addition, some lawmakers who have supported the concept in the past are now in positions of power, including McGuire, Assemblymember Mia Bonta (D-Alameda), who chairs the Assembly Health Committee, and Assemblymember Buffy Wicks (D-Oakland), who chairs the Appropriations Committee.

This had led Kalra to believe that both time and politics are on his side, saying before Rivas’ remarks that he believes he has “enough colleagues that are supportive.”

WHAT ARE SOME STORIES ON THE BILL?

Read POLITICO news on AB 2200.

Rachel Bluth and Victoria Colliver contributed to this report.