AB 2200 CalCare

Frequently Asked Questions

1. What would AB 2200, the California Guaranteed Health Care for All Act, accomplish?

The California Guaranteed Health Care for All Act, or AB 2200, would enact a comprehensive framework of governance, benefits, program standards, and health care cost controls for a single-payer health care coverage system in California. This system would be called CalCare, and it would be available to all California residents. By passing this policy framework, California can set in motion consolidation of existing health care programs, obtain necessary federal waivers, and determine public financing.

2. What is the guaranteed benefit coverage under CalCare?

CalCare is designed to cover all medically necessary and appropriate care as determined by a patient's treating physician or health care professional and consistent with the patient's best interest and wishes. Californians will have access to comprehensive health care coverage, including and not limited to all primary and preventive care, hospital and outpatient services, prescription drugs, dental, vision, audiology, reproductive health services, maternity and newborn care, gender-affirming care, long-term services and supports, mental health and substance abuse treatment, laboratory and diagnostic services, and ambulatory services.

3. Will there be any copays, deductibles, or out-of-pocket costs for accessing CalCare benefits?

No, Californians would receive health care services and other defined benefits without having to pay any copays, reach a deductible, or provide other out-of-pocket costs.

4. Who is eligible for CalCare?

Every California resident would be eligible to receive benefits under the CalCare program regardless of their citizenship or immigration status. Residency would be determined by the principles and requirements used by Medi-Cal. Additionally, a college or university would be able to purchase CalCare coverage for a student or student's dependent who is not a California resident. AB 2200 also prohibits health care providers from discriminating based on citizenship or immigration status.

5. Can individual states implement a publicly financed single-payer system in the United States?

Yes, a state single-payer health care program could be granted a Medicare innovation waiver or other federal waivers that would make it possible for a state to capture or administer federal health care dollars and enroll residents that are traditionally covered by Medicare or other federal health care programs. In fact, the ability for states to "pass-through" or use federal funding for implementing innovative health care programs, like single-payer, was envisioned under the Patient Protection and Affordable Care Act (PPACA). Specifically, the U.S. Health and Human Services Secretary could exercise waiver authority under Section 1332 of the PPACA to integrate federal programs with a publicly financed single-payer health care system in California if the state includes a detailed plan.

6. How much will AB 2200 cost or save in the long-term?

Study after study has shown that a single-payer health care system with comprehensive coverage for all would produce massive savings on health care costs, and as a result of single-payer savings, California could provide better health care coverage to all people and do so for less money than our current system. By simplifying our health care system, CalCare would save billions in administrative costs. By directly negotiating prescription drug prices and provider payments on a statewide basis, CalCare would be able to lower prices for drugs and health care services, resulting in substantial savings overall.

Currently, the total health care spending in California is roughly $400 billion annually and funded by a patchwork of pay sources, resulting in administrative waste largely due to the complexity of our fragmented health system. The cost of a single-payer system, however, is envisioned to be lower than the cost of the current multi-payer system. This assumption is supported by numerous studies, including a high-level meta-analysis of single-payer systems (Cai et al., 2020) that estimated lower costs due to simplified administration and projected long-term net savings from a more tightly controlled rate of growth. A cost comparison of California's current system and a proposed single-payer system that provided comprehensive coverage to all California residents by the Political Economy Research Institute (Pollin et al., 2017) found that the single-payer system would have a net savings of 10% relative to our current system.

AB 2200 includes cost-controls and would minimize new spending by consolidating existing funds and redirecting funds spent on administrative waste toward providing more equitable health care to all Californians.

7. How does AB 2200 control health care costs?

CalCare controls health care costs in several different ways. First, a simplified payment system constitutes the largest area of reduced spending, as there is strong evidence that billing and insurance-related administration account for higher system-wide costs. AB 2200 would also establish reasonable payment methodologies for health care providers that align with actual costs of care rather than profit. Additionally, leveraging its negotiating power as the single-payer for health care in California, CalCare would be able to obtain reasonable prices for prescription drugs and other provider payments through direct negotiations with drug manufacturers, hospitals, doctors, and other providers.

In order to ensure that hospitals and larger institutional providers do not have unsustainable rates of growth, CalCare would negotiate adequate global budgets to cover all operating expenses while making strategic investments to promote high quality, equitable health care. Tailored to each hospital or institutional provider, global budgets ensure that providers get the appropriate funding for the services that their patients need and that reimbursements are being used towards care.

To ensure that CalCare funds are used to target health care inequities, special projects funding and adjustments in the global budgeting process would ensure that hospitals and clinics in underserved areas would be able to receive increased payments.

8. How would AB 2200 address the rising cost of prescription drugs?

CalCare will be able to leverage bulk purchasing power to negotiate lower costs of prescription drugs in California. Currently, drug prices are set high by drug manufacturers that expect insurance companies, pharmacy benefit managers, and health providers to use their market share to negotiate a lower price. Having a single large public purchaser of prescription drugs will allow hospitals and other institutional providers to pay less.

9. How will CalCare address long-term care?

AB 2200 will fully cover long-term care for older adults and people living with disabilities.

CalCare provides long-term care with the goal to cause as little disruption to a person's life as possible. One of the hardest aspects of needing long-term care is the fear of losing the ability to live a healthy and independent lifestyle. The CalCare long-term care benefit is geared toward helping people remain in their homes, though it also covers long-term care facilities for those who need them.

The CalCare governance structure would include an Advisory Commission on Long-Term Services and Supports (LTSS), which must include people who use LTSS, to help guide the CalCare board's policymaking on LTSS.

10. Can people opt-out of CalCare?

The benefits outlined by AB 2200 are guaranteed to all California residents, and their health care services will be paid through the CalCare single-payer system. Individuals will not be able use an alternative payment system for a provider reimbursed by CalCare. However, individuals could choose to receive services from providers without participating agreements with CalCare and pay out-of-pocket for services that would have been covered by CalCare if the care was rendered by a CalCare provider.

11. Will I see a difference in the way my health care is delivered under CalCare?

No, in fact Californians can expect greater benefits and access to providers than existing health coverage plans and closed integrated health systems. CalCare is a simplified payment system that will not disrupt the delivery or quality of health care that Californians have grown accustomed to. On the contrary, CalCare will end persistent disruptions to care that arise from

changes in health insurance and provider networks. A visit to the doctor would be adequately reimbursed by CalCare without the need for a prior approval or authorization from an insurer or health plan. Under CalCare, the only thing that would change is how your health care is paid.

12. Would CalCare be making any decisions on the health care I receive?

No, CalCare would put health care decisions in the hands of you and your health care provider. CalCare also ensures that the professional judgment of health care professionals, in consultation with their patients, is the basis for health care decisions.

13. Will I be able to choose my own doctor and health care providers?

Yes, a patient will have the freedom to choose their doctors, hospitals, and other providers without worrying about whether a provider is "in-network."

14. Can I keep my current health insurance or private health plan under CalCare?

No, commercial health insurance would not be allowed to pay for services covered under CalCare's comprehensive benefits package. Additionally, CalCare providers would agree to exclusively accept payment for covered care through CalCare. However, insurance companies could offer commercial coverage for benefits that may not be covered by CalCare (e.g., nonmedically necessary services or coverage for anyone who is not eligible for CalCare).

15. What will happen to integrated health systems, like Kaiser Permanente, under CalCare and can I access health providers in their system?

CalCare envisions a statewide integrated health system that is both prevention-oriented and health care accessible when you need it. In contrast, existing integrated health systems have a closed network for its enrolled members and obtain provider reimbursement using capitation, or payment per person-month. This can lead to limited access to providers and barriers to care.

The health care providers and health care facilities that actually deliver care in integrated health systems, like Kaiser Permanente, will be able to join CalCare either as physician groups or institutional providers without the risk-bearing business model attached that tends to ration care. It is the intent that members in CalCare will be given the opportunity to automatically keep their providers they have grown used to prior to implementation. CalCare members will be able to choose from any participating provider that is accepting new patients.

16. What will happen to pension entitlement for public employee retirees like CalPERS?

It is the intent that CalCare enhance the lives of those with earned retirement benefits with better benefits. Prior to CalCare implementation, AB 2200 would establish an Advisory Committee on Public Employees' Retirement System Health Benefits to recommends actions to ensure public employee retiree are not harmed and seamless transition. This could include a recommended plan to phase-out contributions and duplicative health benefits under public employees' retirement systems and effort to ensure coordination to fully integrate beneficiaries into CalCare.

17. How would CalCare affect the Veterans Health System, TRICARE, and Indian Health Services?

The Veterans Health Administration, military hospitals and clinics, and Indian Health Services would not be affected by CalCare, unless the federal government chooses to contract with CalCare to provide care for TRICARE or IHS enrollees. California residents eligible for care through the Veterans Health Administration, TRICARE, or the Indian Health Services would be fully eligible for CalCare just like every other California resident.

18. How would CalCare ensure patients have timely access to care?

Under CalCare, patients should expect timely access to care. Currently, patients experience wait times due to lack of providers, particularly in rural and or medically underserved areas. Hospital closures have also affected access, particularly in rural areas.

CalCare's program design includes a provider reimbursement structure to incentive care where it is needed. It also allows for a special projects budget that would create reliable funding streams for hospitals and other providers in rural and medically underserved areas that could be used to increase the capacity of providers. For example, special projects funds could be used to expand health care provider facilities, increase staffing, or extend operating hours. Additionally, there would be capital expenditures available to prioritize funding for the construction or renovation of health care facilities in rural or medically underserved areas.

Currently, our existing system causes patients to delay seeking care due to burdensome costs of access and other financial barriers such as cost-sharing or potential surprise medical bills. CalCare would remove cost barriers such as copays and deductibles.

19. How will CalCare address health care disparities and inequities in the health care system?

CalCare will remove barriers to care that prevent underserved populations, like people of color and those with low incomes, from accessing the current health care system. Financial barriers

to care, such as copays and deductibles, will end with CalCare. Other barriers, like limited insurance networks and prior authorization requirements, will also end.

CalCare will also create and support new ways for underserved populations to access health care. For example, it will establish a special projects budget to fund the construction, renovation, or staffing of health care facilities in rural and other underserved communities. CalCare will also prioritize the funding of special projects that address the health inequities that pervade our current health care system.

Additionally, CalCare will fund hospitals with global budgets that align payments with the needs and actual cost of care of patients. This will ensure that rural and safety net hospitals have adequate resources to provide quality care and not be dependent on an area's patient-payer mix. Creating a system that supports our most underserved communities will ensure a more equitable health care system for all.

From a public health perspective, the COVID-19 pandemic has also demonstrated how important it is to address health disparities. Controlling the spread of infectious disease is much more difficult when disparities and inequities are allowed to persist and place the entire health system at risk.

20. How can rural or medically underserved areas of the state with more limited access to care see a benefit under CalCare?

Under our current system, health care services are typically concentrated in areas where there is greater density of payers (privately and publically insured patients). In contrast, CalCare would consider health care needs and disparities when determining how to fund health care services and explicitly addresses rural or medically underserved health care needs in setting provider payments rates. For example, CalCare can give incentives through increased provider payment rates to attract more providers and retain them in those areas of need.

Similarly, for hospitals and other institutional providers, CalCare can increase global operating budgets in these areas to mitigate the impact of availability and accessibility of health care services. Properly funded global budgets can also stabilize rural hospitals at risk of closure by ensuring they have the resources to fully cover their operating expenses. Finally, the global operating budgets for hospitals, clinics, and other institutional providers include funding for graduate medical education.

Lastly, CalCare will make strategic investments throughout the state to improve and maintain quality health care through the use of special projects budgets that could go towards the construction, renovation, or staffing of health care facilities in rural or medically underserved areas. Specifically, AB 2200 would require the CalCare Board to create a transparent application and approval process for special projects budget funding to improve the availability and accessibility of health care services in rural or medically underserved areas.

21. How would CalCare address provider shortages and maintain adequate workforce?

Workforce shortage is a problem with today's system and AB 2200 is designed to remedy those systemic issues by improving efficiency and reallocating resources to areas with the most need. For example, structural issues within our health care payment system exacerbate provider shortages because far too often hospital corporations and large health care employers will try to minimize labor costs which places strain on our health care workforce, leading to "burnout" and high turnover rates. Additionally, by eliminating administrative complexity, CalCare allows doctors and nurses to spend less time on billing and coding and more time on what they do best—caring for patients

A main tenet in CalCare's methodology is maintaining an optimal workforce to deliver quality and equitable health care. AB 2200 has provisions to increase payment rates in areas that have provider shortages. Specifically, the CalCare Board could increase payment rates to improve the availability and accessibility of health care services and CalCare includes a special projects budget to be used to increase payment rates to improve the availability and accessibility of health care services in rural or medically underserved areas.

Health care workforce recruitment and retention expenditures will be specifically budgeted through CalCare and during its implementation. Up to 1 percent of the entire budget will be dedicated to programs providing health care workforce education, recruitment, and retention. There will also be a CalCare Health Workforce Working Group comprised of diverse expertise that will continue to identify and prioritize efforts to improve the workforce and address issues of attrition.

22. Can CalCare achieve health equity?

Full equity in our health care system will only be achieved through a single-payer system of guaranteed health care for all. Additionally, AB 2200 would establish an Office of Health Equity to ensure that all aspects of the CalCare program promote health equity across race, ethnicity, national origin, primary language use, immigration status, age, disability, sex, including gender identity and sexual orientation, geographic location, socioeconomic status, incarceration, housing status, and other population-based characteristics.