A REPORT TO THE 2025-2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California AB 1900 Guaranteed Health Care for All

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California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 1900 Guaranteed Health Care for All

Summary to the 2025-2026 California State Legislature, April 13, 2026

CHBRP

Bill Scope

Assembly Bill (AB) 1900, reintroduced on February 12, 2026, seeks to establish a single-payer system providing no-cost care at the point of service for all residents.

Background and Context

The Assembly Committee on Health requested that CHBRP complete a limited analysis of AB 1900, refreshing previous estimates and initial state reserve estimates needed to implement AB 1900. CHBRP has prepared these updates with additional updated background information.

More than 20 states have considered single-payer bills. No state single-payer models have been implemented.

Key Considerations and Unknowns

The ability to manage a universal health care system is predicated on a unified risk pool and a governmental entity that has the authority to impose cost controls. AB 1900 would rely on California's (CA) ability to collect sufficient revenues (including federal funding) to fund its health system, including social services, under a unified umbrella. AB 1900 aims to eliminate fragmented care delivery and streamline resources across siloed state and federal programs.

Financing Mechanisms

CHBRP assumes federal revenue will be available through various waiver or demonstration agreements with the Centers for Medicare and Medicaid Services (CMS) to redirect and consolidate funds from Medicare, Medicaid federal contributions, and ACA exchange tax credits into CalCare. AB 1900 does not establish a revenue model for financing its provisions. CHBRP is aware of two existing provisions in the State's Constitution (Proposition 4 of 1979 and Proposition 98 of 1988) that affect California's ability to raise and spend revenues necessary to successfully implement AB 1900.

Cost and Reserve Estimates

CHBRP projects CA's current health care spending from all sources to be $717.54 billion in 2027. Adjusted for inflation, reduced cost sharing and deductibles, and new benefits[1], CHBRP projects **$731.4 billion in total health care spending assuming that the bill is fully implemented and reaches a steady state by 2027**[2].

A reserve fund is designed to ensure financial stability and protect against budget deficits. In AB 1900, a dedicated reserve fund is mandated to maintain the program for years with lower revenues and to meet Knox-Keene requirements.[3] **CHBRP projects reserve fund requirements of $109.7 billion**.

Conclusion

CHBRP estimates that single-payer financing could lead to efficiency savings that exceed added costs due to the reduction of administrative overhead and introduction of a uniform fee schedule governing payment to providers. External estimates suggest that increases in utilization due to reduced cost sharing barriers will be offset by efficiencies of a single-payer system. A net cost increase of 2% is likely initially due to AB 1900's inclusion of long-term care benefits. However, savings could occur over time. Without long-term care benefits a net cost reduction of 3-4% is likely. AB 1900 would enhance greater equity and may reduce the financial burden that millions of Californians, even those with insurance, experience. Some individuals, however, could pay more, depending on the revenue model implemented. The scale and challenge of implementing AB 1900 may result in unanticipated transition risks and impacts on the health care sector, state finances, and segments of the health care workforce.

[1] New benefits including long-term care services and supports (LTSS).
[2] In financial and organizational planning, a steady state budget assumption is the projection that an entity (like CalCare) will maintain current level of operations, services, and fiscal position without significant expansion, contraction, or structural changes.
[3] The Knox-Keene Health Care Service Plan Act of 1975 is a comprehensive California law regulating consumer protections through quality assurance, network adequacy, and financial stability standards for health plans.

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Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

APTCA – Advance Premium Tax Credits

CA – California

CalCare – California Guaranteed Health Care for All program

CalHHS – California Health and Human Services Agency

CHBRP – California Health Benefits Review Program

CHIP – Children's Health Insurance Program

CMMI – Center for Medicare and Medicaid Innovation / CMS Innovation Center

CSRs – Cost Sharing Reductions

DMHC – Department of Managed Health Care

ERISA – Employee Retirement Income Security Act

HCFA – Healthy California for All Commission

LTSS – Long-term services and supports

NHE – National Health Expenditure

SB – Senate Bill

TNE – Tangible Net Equity

Terminology

CHBRP uses the following terminology for this analysis:

CalCare: Proposed by AB 1900, a single-payer, publicly funded health care system intended to guarantee universal coverage for all California residents.

Center for Medicare and Medicaid Innovation / CMS Innovation Center (CMMI) develops and tests new, often mandatory, healthcare payment and service delivery models to improve quality and reduce costs in Medicare,

Medicaid, and CHIP. Established by the Affordable Care Act, it aims to shift providers from fee-for-service to value-based care, targeting areas like oncology, primary care, and specialty care.

Clinician: Refers to healthcare professionals (physicians, nurses, therapists) directly involved in patient care, often emphasizing expertise and clinical practice.

Cost Sharing Reductions: Cost-sharing reductions (CSRs) are discounts that lower the out-of-pocket costs for Marketplace health insurance, specifically for deductibles, copayments, coinsurance, and out-of-pocket maximums. Eligibility is limited to enrollees with household incomes between 100% and 250% of the federal poverty level (FPL) and enrollment in a Silver Plan.

Global Budgets: Global budgets are fixed, prospectively-set expenditure limits, typically used in health care to control costs by providing hospitals with a set amount of revenue for a specific period.

Healthy California for All Commission: The Healthy California for All Commission was an advisory body established by the California State Legislature and Governor Gavin Newsom in 2019 to develop a plan for achieving a unified health care financing system in California. This system was intended to provide health care coverage and access for all Californians, with the commission specifically tasked to explore single-payer options.

Institutional Global Budget, as defined by AB 1900 Under the CalCare framework, is a prospectively-determined, fixed amount of funding allocated annually to an institutional provider (like a hospital) to cover its operating expenses for providing covered healthcare items and services for that fiscal year. The CalCare Board would determine the budget in advance.

Knox-Keene: The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), as amended, is the set of laws or statutes passed by the California state legislature providing the DMHC with the authority to regulate health care service plans. The Knox-Keene Act can be found in the California Health & Safety Code, section 1340 et seq. Additionally, regulations are used by the DMHC to implement, interpret, or make specific the laws enforced by the Department. These regulations are codified under Title 28 of the California Code of Regulations.

Medi-Cal: Medi-Cal is California's version of the federal Medicaid program. It provides free or low-cost health, dental, and vision coverage for eligible residents, including families with children, seniors, persons with disabilities, and pregnant individuals.

Single Payer: One entity that collects funds and pays for health care on behalf of an entire population.

Tangible Net Equity (TNE): Tangible Net Equity (TNE) is a regulatory financial standard used to ensure health care service plans have sufficient "buffer" capital to remain solvent and fulfill their obligations to members.

Overview: AB 1900 and Single-Payer Financing

On February 12, 2026, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[4] conduct a limited fiscal analysis of Assembly Bill (AB) 1900 (Kalra), which would establish a single-payer health care system in California. In 2021, CHBRP completed an abbreviated analysis of AB 1400 (Kalra), which was substantially similar to this bill. In that analysis, CHBRP provided estimates on fiscal impact, including fiscal reserves necessary to implement the bill. The Committee has requested that CHBRP update its prior estimates on fiscal impact and projected fiscal reserve needs to reflect current health spending and economic conditions. In this report, CHBRP leverages past work by the Healthy California for All (HCFA) Commission from 2019 to 2022 to estimate the cost of developing unified financing plans, including a single-payer scenario that closely resembles the approach proposed in AB 1900 (no cost sharing, direct payments to providers via single payer, and inclusion of long-term services and supports in the benefit package). The HCFA report[5] estimated the total spending in California from all sources under several scenarios for unified financing and universal insurance coverage, including multipayer and single-payer approaches.

Bill Language of AB 1900

Introduced February 12, 2026, AB 1900 (the California Guaranteed Health Care for All Act) establishes 'CalCare,' a state-run universal single-payer system. The program provides high-quality coverage to all Californians — specifically targeting the uninsured and underinsured — while controlling costs through a unified fee schedule and global hospital budgeting.

AB 1900 mandates comprehensive coverage by integrating the benefits and standards of existing state and federal programs, such as CHIP, Medi-Cal, and Medicare. The bill leverages federal funding from these sources while ensuring a seamless user experience; although CalCare manages eligibility verification on the backend, the process remains invisible to the beneficiary. The bill proposes a shift in California's healthcare landscape through several core mandates. Key provisions include:

- **Universal & Comprehensive Coverage:** Guarantees healthcare to all California residents, including primary care, hospitalization, mental health, dental, vision, and long-term services and supports (LTSS).
- **Out-of-State Care:** Coverage extends beyond state lines for emergency and urgent care. It also covers medically necessary services that cannot be provided within California or must be performed by a specific out-of-state provider.
- **Elimination of Financial Barriers:** Prohibits all premiums, copayments, and deductibles for covered services. Additionally, it bans "balance billing" (charging patients for the difference between a provider's fee and the insurance payment) for emergency services.
- **Unified Single-Payer Funding:** Establishes the **CalCare Trust Fund** within the State Treasury. This continuously appropriated fund consolidates all federal and state health care revenue into a single stream to pay for the system.
- **Prescription Drug & Supply Controls:** Empowers the CalCare Board to negotiate prices for pharmaceuticals and medical supplies. The Board will also establish a "unified, comprehensive" prescription drug formulary to standardize and lower medication costs.
- **Commitment to Health Equity:** Creates the **Office of Health Equity**, which is specifically tasked with prioritizing underserved communities and eliminating disparities in health outcomes across the state.
- **Transition from Private Insurance:** CalCare replaces private insurance for all services covered by the state plan. However, the bill does not explicitly address self-funded **ERISA plans** (large employer-sponsored plans), which are generally exempt from state regulation and may present legal challenges to a universal state system.
- **Contingent Implementation (The "Trigger"):** To ensure fiscal responsibility, the bill includes a "trigger" mechanism. Core provisions will not take effect until the Secretary of California Health and Human Services certifies that the CalCare Trust Fund has sufficient revenue to fully cover the program's costs.

[4] See CHBRP's authorizing statute.
[5] https://www.chhs.ca.gov/wp-content/uploads/2022/05/HCFA-Final-Report-Comments.pdf.

This legislation establishes a cost-control framework to support the implementation of CalCare. Under AB 1900, providers are prohibited from billing patients for any services covered by the plan, though they may charge for non-covered services under specific conditions. The bill also empowers providers to negotiate reimbursement rates collectively through a third-party representative (for non-covered benefits). Furthermore, instead of traditional billing, hospitals and institutions would operate on a fixed annual "global budget" set by the CalCare Board to cover all yearly operating expenses.

Existing state and federal programs in California would be affected if the legislation were fully implemented. AB 1900 would require the board of CalCare "to seek all necessary federal waivers, approvals, and agreements to allow various existing federal health care payments to be paid into CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds." If California were to be successful in obtaining the necessary Medicaid 1115 Demonstration Waiver, legislative waiver for Medicare rules or participation in a Medicare Demonstration through CMMI, and 1332 ACA Innovation waiver, then federal revenues flowing into the state based on historical spending would be available to fund the CalCare program. However, the state would still need to verify eligibility and track people based on the current rules for each program to correctly capture the spending subject to federal matching or direct support.

The bill also states the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act.

Finally, AB 1900 would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services certifies the CalCare Trust Fund has the revenues to fund the costs of implementing AB 1900. See the full text of AB 1900 in Appendix A.

California's Existing Health Insurance Coverage and Financing System

California's health care market in 2026 is currently navigating a period of "federal instability" and rising underlying costs. While the state remains a leader in coverage expansion, the expiration of enhanced federal financial supports from the American Rescue Plan Act/Inflation Reduction Act have created a significant affordability gap for many residents, while impending changes due to new eligibility and work requirements in Medicaid will result in fewer people with health insurance and a reduction in federal funds coming to the state.

Californians primarily access health insurance through employer-based plans. Among those under age 65 (roughly 55%), it is followed by Medi-Cal (29%), California's Medicaid program. Other major sources include the Covered California marketplace and private individual plans (8%), Medicare (1%), and approximately 7% of residents remaining uninsured (KFF, 2025). California's population is aging rapidly, with residents aged 60+ projected to reach 11.4 million by 2040, making up 1-in-4 Californians. By 2030, seniors will outnumber those under 18 (Johnson et al., 2025).

The multipayer nature of the California health system causes fragmentation and does not rely on a single fee schedule or approach to reimbursing physicians. Even Medicare and Medicaid are primarily delivered through Managed Care Organizations, which directly negotiate with providers rather than adopt the same uniform fee schedule used in Medicare Part A/B or Fee-for-Service Medi-Cal. The fragmentation, price negotiations, and differences in benefits and eligibility across programs lead to administrative inefficiencies and differences in managed care plan networks and access across enrollee groups.

The health care safety net for low-income residents of California represents a "patchwork of programs and providers." (Newman and Roh, 2019). The core indigent care programs for those without insurance coverage are provided and financed by the counties under Section 17000 of the Welfare and Institutions Code. When the ACA's Medicaid expansion was implemented in California in 2014, realignment of Section 17000 funds from the county to the state occurred in 2013 to partially offset the cost to the state budget of enacting Medi-Cal expansion (Legislative Analyst's Office, 2026).[6]

[6] https://lao.ca.gov/handouts/health/2026/Realignment-and-County-Indigent-Health-Care-Programs-031926.pdf.

California General Fund spending on Medi-Cal has experienced significant volatility and growth between 2020 and 2025, driven by pandemic-era expansions and subsequent efforts to manage budget deficits. While spending dipped due to Managed Care Organization (MCO) tax offsets in 2024-25, it is projected to reach record highs near $45 billion in 2025-26, reflecting an all-time high for the program and around 20 percent of overall General Fund spending (Petek, 2025).

The affordability of health insurance coverage is a significant concern for families, according to the KFF/California Health Care Foundation (CHCF) 2025 Survey[7]:

- **Premiums:** The average total premium for family coverage in California rose to $28,397 in 2025, a 24% increase since 2022.
- **Worker Contributions:** On average, California workers pay 30% of the premium for family coverage, amounting to roughly $6,850 annually.

What is a Single-Payer System?

Single-payer systems have been proposed as a health care reform alternative in the United States. Most definitions characterize single-payer as one entity that collects funds and pays for health care on behalf of an entire population (Liu et al., 2017). Currently, federal payroll tax dollars, employer-shared responsibility payments to the IRS, and general federal income tax revenues from Californians are redistributed to spending on various health care programs, including those that benefit residents in other states. To draw down sufficient federal revenue to fund CalCare, California would need to leverage those federal funds, given there is no mechanism for redirecting federal income tax payments, Medicare Part B premiums, or ACA Advance Premium Tax Credits (APTCs) to specific needs within the state of California.

Knox-Keene Reserve Requirements

Under current legislative proposals, CalCare would be established as a health care service plan governed by the Knox-Keene Health Care Service Plan Act of 1975.[8] This designation requires the program to maintain specific financial reserves to ensure it can fulfill its medical and financial obligations to all members.

The Department of Managed Health Care (DMHC)[9] enforces these mandates primarily through Tangible Net Equity (TNE) standards.

- **TNE Calculation**: All licensed full-service plans must maintain a TNE level at least equal to the greatest of:
  - $1 million as a flat minimum;
  - 2% to 4% of annualized premium revenues (scaled based on total revenue);
  - 6% to 12% of annualized health care expenditures (scaled based on payment types like capitation or per diem).
- **Ongoing Monitoring**: Plans whose TNE fall below 150% of the requirement must submit monthly financial statements to the DMHC to demonstrate solvency.

Specific CalCare Fiscal Challenges

Because CalCare is a proposed single-payer system, traditional "premium-based" reserve models would likely shift toward state-level fiscal management. The CalCare commission would need to consider the redistribution of federal revenue sources for Medicare and Medicaid, employer and employee contributions to health insurance, state Medicaid spending, and redirected APTCs and Cost Sharing Reductions (CSRs) and the amount of state tax revenue or other state sources that would provide the necessary budget for CalCare to replace health insurance coverage statewide. For example, many people receive health benefits as part of their employment through private health insurance plans. These are often HMO or PPO products with contracted networks of physicians being paid between 139% and 263% of Medicare

[7] https://www.kff.org/health-costs/2025-california-health-benefits-survey/.
[8] https://www.dmhc.ca.gov/Portals/0/Docs/OLS/2026%20Knox-Keene%20Act%20and%20Title%2028%20Book/CA%20Knox-Keene%20Act%202026%20Edition%20_508.pdf.
[9] https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing.aspx.

for the services they deliver to commercial enrollees (Marshall et al., 2024).[10] On average, premiums for single enrollees in 2025 were $10,033 in California, with 14% paid by the enrollee ($1,405) in pre-tax dollars, while employers contribute 86% ($8,628) (Rae et al., 2025).[11] Depending on the employer's contribution model, enrollee contribution percentages may not be income-based. If CalCare decided to vary enrollee contributions based on income, it is likely that a high-income enrollee would lose the tax benefits of having employer-based coverage while also paying a higher proportion of their income in state taxes or other fees to pay into the now state-run single-payer CalCare system. Conversely, lower income Medicare beneficiaries who do not qualify for Medi-Cal currently might benefit from the redistribution because of lower income-based premiums combined with the removal of cost-sharing requirements (which are substantial, uncapped out-of-pocket burden for Medicare beneficiaries). The commission would have to carefully weigh these redistributions and understand how continued federal contributions (via payroll taxes, Part B premiums) might need to be considered when reallocating state resources to subsidize lower income enrollees and leveraging additional taxes for workers with higher incomes.

- **Projected Reserve Needs**: Analysis from the Legislative Analyst's Office (LAO)[12] suggests CalCare would need a substantial reserve of 10% to 15% of annual costs to manage year-to-year revenue and cost fluctuations.
- **Timely Reimbursement from Federal Government**: CalCare would partially rely on revenues from the federal government to fund the program. California would not only need to negotiate waivers and demonstrations to make CalCare possible but would also have to manage the potential long-term barrier of ongoing renewals which could be subject to federal politics and constraints.

Differences Between AB 1900 and Previous Single-Payer Attempts in California:

Four prior California proposals (SB 840 of 2007, SB 810 of 2011, SB 562 of 2017, and AB 1400 of 2021) included comprehensive benefits and attempted to achieve universal coverage for all California residents (including the undocumented), by redirecting revenues from individual and employer premiums, federal and state government programs, and taxes into a fund set aside for each proposed single-payer system. Many single payer bills in California separate the funding side from the policy initiative, due to the supermajority requirement to pass tax and fee increases. For example, the tax revenue might be voted on through a proposition while the policy agreed to in the state legislature is disconnected from the ballot proposition. In this case, the policy language is separate from and contingent upon a separate funding package that partially relies on drawing down federal funds to support the broader program. In all four bills, a health care board would determine benefits and negotiate reimbursement rates for private providers. All four prior bills required the state to negotiate waivers in Medicare and Medicaid to allow for the pass-through of federal funds to the new single-payer system. For more detailed comparisons of the four prior proposals, please see CHBRP's 2021 analysis of AB 1400.

Evidence From California

Healthy California For All Commission

The Healthy California for All Commission (HCFA)[13] was established in 2019 to develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system.

The Commission's first report required by its enabling legislation explored strengths and limitations of California's existing health care system and identified areas for improvement. The Commission's second report[14] provided considerations to inform the design of a unified financing system. Two of the design scenarios included in the Commission's second report discuss a unified financing model aligned with the provisions of AB 1900. Both are based on eliminating health insurers and health service plans, providing direct payments to providers, and eliminating cost sharing for covered benefits. The

[10] https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates.
[11] https://www.chcf.org/resource/california-health-benefits-survey-2025/.
[12] https://lao.ca.gov/letters/2022/Cooley-Cunningham-CalCare-031722.pdf.
[13] Established by Senate Bill 104 (Chapter 67, Statutes of 2019).
[14] https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf.

only difference is that in one scenario, long-term services and related supports would be expanded, while in the other they would not (it would only maintain Medi-Cal's current LTSS benefits and eligibility) . AB 1900 includes long-term services and supports in the covered benefit list, but it is useful to understand what the likely impact would be if long-term services and supports were excluded or subject to specific eligibility or medical necessity criteria. AB 1900 would ban health insurers and health plans and require direct payments to providers negotiated or set by the CalCare program. Over five million covered lives in the state are in Administrative Service Organizations (ASOs) that are subject to federal ERISA law, rather than state insurance regulation. While setting prices for providers does not violate ERISA, state laws governing specific benefits could. The state would need to explore a carve-out of ERISA, Medicare, or the programs that are operated by the federal government and might overlap or conflict with CalCare. In the example of ERISA plans, employers could benefit from the state fee schedule for services created by CalCare but would not have to comply with specific benefit mandates. It is generally accepted that states have the authority to adopt a uniform fee schedule and engage in rate setting activities (e.g., Delaware, Maryland, Colorado) without triggering ERISA preemption. However, requiring employers to provide specific state mandated benefits to their employees would likely trigger an ERISA preemption argument and lawsuit.

Senate Bill 770

Signed by Governor Newsom in October 2023, California Senate Bill 770 (SB 770) authorized the state to "formally study and pursue a unified, publicly-financed health care system," which is widely understood as a step toward a universal single-payer or multipayer health care system with a uniform fee schedule and fixed benefits. It tasked the California Health and Human Services Agency (CalHHS) with developing a federal waiver framework by November 2025 to create a comprehensive, universal health care program.

The law authorized the California Health and Human Services Agency (CalHHS) to:

- Engage in discussions with the federal government to secure waivers needed to redirect federal funds (Medicare, Medicaid) into a state-run, universal, comprehensive healthcare system (CalMatters, 2023);
- Work with a contractor to study the various options coming from the HCFA report, engage stakeholders, and provided an approach and waiver framework to the Legislature.[15] The contractors from UCLA, RAND, and UC Irvine (including a co-author of this report on AB 1900) developed a preliminary presentation, conducted a stakeholder session to obtain feedback and input, completed the Phase 1 report in 2026,[16] and will be completing Phase 2 by the Summer of 2026.

The Commission Report emphasizes that the transition to a unified financing system depends on a complete overhaul of existing health care financing and coverage arrangements. However, the Commission Report did not set forth a fully developed framework for a proposed unified financing system. Instead, it set out that, at a future time, it would be necessary to develop and implement design choices, including those relating to eligibility and enrollment, covered benefits and services, patient cost sharing (if any), provider payment, purchasing arrangements (and the role of intermediaries), care coordination, and greater efficiency and cost containment. These decisions would likely be guided by a commission or advisory board, similarly to AB 1900.

Equity in Current System

Research indicates that health disparities persist largely due to structural flaws in how insurance is tiered. The HCFA Commission report noted that inequities were rooted in factors such as affordability and accessibility of care and structural racism. While a universal single-payer system based on a uniform fee schedule might ensure that all providers accept all patients, there are still underlying social needs and geographic barriers that could exacerbate or at least maintain existing disparities. In addition, the CalCare model appears to include the possibility of global budgeting for hospital settings. While global budgets can incentivize investments in population health and equity in the long-term, the typical "safety net" hospital does not have the capacity or resources to suddenly change course and respond to new incentives. This has been seen over the past decade in states like Massachusetts, where their Health Policy Commission provided additional

[15] The website for the August 2024 Public Meeting and Presentation on the HCFA Draft Report can be accessed at: https://www.chhs.ca.gov/sb770meeting/.
[16] Updated May 11, 2026": https://healthpolicy.ucla.edu/our-work/publications/pathways-unified-health-care-financing-system-california.

funds to support ACO readiness (Massachusetts Health Policy Commission, 2019).[17] There likely needs to be some investment in vulnerable providers, including non-profit community hospitals and public hospitals, to ensure readiness for any major changes in financing and incentives around the provision of care (Bailit Health Purchasing, 2016).

Administrative Costs in Current System

Health plans operate within a regulatory framework that influences costs and the scheduling of care for providers and patients. For providers, billing and insurance-related tasks — including eligibility verification and prior authorization across various plans — contribute to the overall administrative workload. While administrative requirements are present in various healthcare structures, some research suggests that a unified, single-payer model could streamline these specific processes.

For patients, the impact of administrative tasks varies across different demographic groups, including women, people of color, individuals with disabilities, and those with lower incomes. While studies indicate these groups may spend more time on appointment management and billing issues, the specific financial and time-related impacts are still being researched. Another set of administrative requirements relates to Medicare and Medicaid eligibility and enrollment. Due to AB 1900's reliance on federal matching funds from Medicaid and CHIP, and the pass-through of ACA APTC and CSR subsidies, there will be an ongoing need to track eligibility criteria, collect information on work requirements, conduct periodic eligibility checks, and use ACA income guidelines to determine who would have been eligible for federal matching funds in an alternative multipayer counterfactual scenario. These burdens will likely fall partially on lower-income and racially/ethnically minoritized groups to complete, despite the state not actually using the information collected to determine insurance coverage.

The Affordable Care Act set acceptable percentages of collected premiums for health plans and health insurers to meet, or face penalties. Insurers in the individual market must spend 80% of their overall premium on medical services, while in the group market the threshold increases to 85%. The remaining 15-20% is spent on administrative costs, including marketing, advertising, sales commissions, administrative staff salaries, and company profits.

Existing Data on Impact of Single-Payer Proposals in California

As previously mentioned, several bills have been introduced in California to create a single-payer system, including AB 1400 (Kalra) in 2021, SB 562 (Lara) in 2017, SB 810 (Leno) in 2011, SB 840 (Kuehl) in 2007. None of those bills were enacted, but each proposal and cost estimate was reviewed for CHBRP's previous analysis of AB 1400. Please see CHBRP's 2021 report for a detailed comparison of previous California single-payer bills and their estimated fiscal impacts. For this report on AB 1900, CHBRP used the most recent report from the HCFA commission to estimate the total cost of AB 1900's implementation, because of the similarities between AB 1900 and one of the HCFA scenarios, and the more recent nature of the HCFA analysis, which was completed in 2022.

In the HCFA Commission's final report, which provides design considerations for unified financing models, there is one scenario modeled that is similar to the CalCare proposal included in AB 1900. At baseline, the HCFA Commission found that California would spend $517 billion in 2022 on the California health care system. In Scenario 1 (which does not include expansion of LTSS),[18] when trended forward using National Health Expenditure (NHE) data or projections for 2023 through 2027, that amount is $717.5 billion. Under scenario 2, which includes an LTSS expansion, but does require direct provider payments and no cost sharing for covered benefits, they estimated $527 billion would be needed in 2022 to pay for the cost of the system (or $731.4 billion in 2027).

A high-level meta-analysis[19] (Cai et al., 2020) identified 22 modeled predictions (over the past 30 years) of the cost of single-payer financing in the United States but did not consider financing or revenue plans. Cai et al. found that 19 of the 22 studies (86%) predicted net savings during the first year of operation. Net financial impacts during the first year of

[17] https://www.mass.gov/doc/chart-program-impact-brief/download.
[18] In the HCFA Report there is a contrast between scenarios without LTSS expansion (assumes status quo of current LTSS provided through Medi-Cal) and those with a widely available LTSS benefit that goes beyond the status quo.
[19] A meta-analysis is a statistical method combining the results of several scientific studies that focus on the same question.

single-payer implementation ranged from a 7.2% increase in costs to a 15.5% decrease (net savings). The study found the median value was 3.5% in net savings in the first year. The range of costs increases due to insurance coverage improvements resulting in higher use of services ranged between 2% and 19%. Simplification of payment administration, reduced prescription drug costs, and other components resulted in net savings of 3% to 27%. Overall, the authors estimated that net savings averaged 1.4% per year.

Over a longer time horizon of ten years, projected net savings increased for all 22 models, including in the three estimates for proposals that had net costs in the first year (Cai et al., 2020). The included studies systematically suggest that the efficiencies of rate setting and avoiding insurer overhead will create savings or offsets of new use that will be helpful in controlling budgets (Cai et al., 2020).[20] Although the HCFA report (2022) was published after the Cai et al. systematic review, the most recent study included in Cai et al. estimated that implementing a single-payer health program in California would result in an 8% net reduction in spending (Pollin et al., 2017).[21] However, there is an acknowledgement that industry-wide disruption will likely result from major changes to insurance regulation, a fixed uniform fee schedule that blends commercial and government rates, and a standard benefit design that is no longer offered by employers (Nelson, 2022).[22]

Long-Term Care Costs

Previous analyses (see AB 1400 Report) showed that including Long-Term Care costs (also called Long-Term Services and Supports (LTSS) would have a substantial impact on CalCare spending. According to the HCFA Report (Healthy California for All Commission, 2022), including an expansion of LTSS beyond the status quo would cost an additional $26 billion per year in 2022 when compared to a unified financing system with no expansion of LTSS. To calculate the impact of AB 1900, CHBRP relied on the HCFA Report scenario that includes an expansion of LTSS, which would result in $36.1 billion additional spending (in 2027 dollars) when compared to the HCFA scenario without an LTSS expansion. Other analyses suggest that adding a comprehensive long-term care benefit to a single-payer health reform package will result in higher spending when compared to the status quo, but will reduce burdens on disabled, low-income, and older people (Favreault, 2020).[23]

The overall cost of AB 1900 is expected to be higher than average spending on health care each year throughout California from all payers due to the expansion of LTSS benefits. Based on the HCFA Report, a unified financing system with direct provider payment and no cost sharing without LTSS would result in a net reduction in spending of 3%. However, the same unified financing model with LTSS expanded would result in a net increase of 2%.

Other State Single-Payer Proposals

Four states, including California, currently have single-payer proposals under consideration (see Table 1).

Table 1. States with Current Single Payer Legislation

State	Bill Number	Name / Description
California	AB 1900	CalCare (Guaranteed Health Care for All Act): Reintroduced in February 2026, this bill seeks to establish a single-payer system providing no-cost care at the point of service for all residents.
New York	S3425	New York Health Act: This bill would create a universal single-payer plan funded by broad-based revenue based on ability to pay.

[20] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013.
[21] https://peri.umass.edu/wp-content/uploads/joomla/images/publication/Pollin-et-al-ECONOMIC-ANALYSIS-OF-CA-SINGLE-PAYER-PROPOSAL-5-31-17.pdf.
[22] https://www.cbo.gov/system/files/2022-02/57637-Single-Payer-Systems.pdf.
[23] https://www.urban.org/urban-wire/closer-look-single-payer-proposals-cover-long-term-services-and-supports.

Florida	H1489 / S0740	Healthy Florida Act: Introduced in early 2026, this would create a state-managed system providing universal coverage to all residents regardless of immigration status.
New Jersey	S426	Medicare for All (NJ): This bill proposes expanding Medicare to cover all residents and eventually prohibiting private insurers from offering duplicative coverage.

Source: California Health Benefits Review Program, 2026.

Green Mountain Care was a 2011 Vermont initiative aiming to create the first US state-level single-payer, universal health care system. The intent was to eliminate private insurance, provide universal coverage for all Vermont residents, and reduce administrative costs. In December 2014, Governor Peter Shumlin abandoned the plan, citing the massive tax increases required for financing, political challenges, and economic risks, opting instead to utilize the Affordable Care Act exchange (McDonough, 2015). The primary cause for cancellation was the inability to secure a politically acceptable or economically sustainable funding mechanism (McDonough, 2015). Projections required substantial new payroll and income taxes. Following the cancellation, Vermont shifted focus to strengthening its health insurance exchange under the Affordable Care Act.

Single Payer Studies

Some states, like Colorado in 2025 (SB25-045) have focused on passing "Payment System Analysis" or "Universal Health Care Commissions" to model the costs of a single-payer system before formally introducing a mandate. Oregon passed a bill that established a Universal Health Plan Governance Board to design a structure for a universal health care program. New York has long debated the New York Health Act, which aims to create a state-level single-payer system. Other states that have introduced legislation or studies regarding universal health coverage include Illinois, Michigan, and Pennsylvania.

The state of Washington formed a commission on universal health care[24] and recently passed a trigger bill in 2026 to start a single payer health care planning process (SB 5947) called the Washington Health Trust.[25]

[24] The Washington Health Trust is a statewide universal healthcare policy in Washington that has been introduced to the public both as bills and ballot initiatives. It would create a universal public insurance program that all Washington residents paid for through public financing, and it would have a four-year transition plan. See: https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care-commission.
[25] https://wholewashington.org/text/.

Analytic Approach and Assumptions

In this limited analysis, CHBRP synthesized available studies and simulation modeling released by researchers, government entities, and policy analysts to assess the potential fiscal impact of a single-payer health care system on the existing health care system in California, highlighting some of the related implications and considerations. Since CHBRP's analysis of AB 1400 (2021), new information from California's Healthy California for All (HCFA) Commission was released, which provides cost estimates for several scenarios of single payer health care approaches. These scenarios, which include a direct funding option and a multipayer option, also help identify the challenges of potentially implementing AB 1900 at the state level. The second report to the HCFA Commission found that California spent $517 billion at baseline in 2022 and estimated that implementation of single payer in 2022 would result in between $494 billion and $552 billion in spending depending on the design of the proposal (LAO, 2022). In this analysis, CHBRP has provided updates on the impact on California by incorporating new National Health Expenditures (NHE) data and forecasting spending in the two scenarios most aligned with AB 1900.

For this analysis of AB 1900, CHBRP determined it would be more appropriate to estimate the 2027 cost of the two scenarios from the HCFA Commission's report, both of which would require direct payments to providers without cost sharing. Rather than simply inflating the spending estimate from 2022 using the personal health expenditures of the National Health Expenditure data, the HCFA projection includes personal health expenditures, government administration, net cost of private insurance, government public health activities, and investment. The baseline 2022 estimate from the HCFA report (Healthy California for All Commission, 2022) is inflated by 38.779% to represent dollar amounts for 2027. The 38.779% rate applied to 2022 data represents NHE actual and future estimates of spending growth by year (see Tables 2 and 3).[26]

Table 2. Actual and Projected Growth Rates based on NHE, 2022-2027

Year	NHE Total Growth
2022	Baseline
2023	7.528%
2024	8.154%
2025	7.064%
2026	5.413%
2027	5.736%
Total 2022-2027	38.779%

Source: California Health Benefits Review Program, 2026.

[26] The 2022-2024 NHE growth rates use actual expenditures, and the 2025-2027 growth rates are projections.

Table 3. Projected Spending HCFA Commission Report in 2027: Two Scenarios

Scenario	Spending in 2022 (based on HCFA Report)	Forecast to 2027 relying on NHE inflator
Baseline	$517 billion	$717.5 billion
Scenario 1: Direct Payment to Providers without cost sharing or LTSS	$501 billion	$695.3 billion
Scenario 2: Direct Payment to Providers without cost sharing, includes LTSS	$527 billion	$731.4 billion

Source: California Health Benefits Review Program, 2026.

Single-Payer Fiscal Modeling

AB 1900 and Long-Term Care

California's Medicaid program (Medi-Cal) is the primary payer for long-term services and supports (LTSS), with estimated expenditures of more than $30 billion annually (joint federal-state funding), while Medicare generally covers only home health and short-term skilled nursing or rehabilitation, not long-term custodial care. Medicaid increasingly focuses on home and community-based services (HCBS), as Federal Medicaid rules allow states to cover a wide range of institutional and home and community based long-term services and supports (LTSS) (Carpenter et al., 2023). AB 1900 would greatly enhance the coverage for long-term care services throughout the state; it would not only cover the costs from existing payers, but it is likely to also subsidize families providing caregiving on their own who do not benefit from one of the existing coverage programs (Medi-Cal, Medicare, or private long-term care insurance) or social services programs (e.g., In-Home Supportive Services). Because long-term care is not a traditional benefit for employer-based or private individual market plans, the change in service use and spending would be sizable if AB 1900 were implemented.

Fiscal Consolidation

To optimize administrative and service efficiency, AB 1900 proposes the consolidation of over $200 billion in annual Medicare and Medi-Cal expenditures (KFF, 2026). Achieving the bill's objectives would require the integration of diverse funding streams, including those for social services and developmental disability programs — under a unified umbrella. This centralized model aims to eliminate fragmented care delivery and streamline resource allocation across previously siloed state and federal programs.

According to the Kaiser Family Foundation's State Health Facts, federal health care spending in California includes $107.5 billion in health care spending on behalf of Medi-Cal enrollees, $43.2 billion (in 2021) supporting traditional Medicare enrollees (Parts A/B), and $11.76 billion in ACA APTCs (in 2025) helping Californians purchase insurance through Covered California (KFF, 2026).[27] In sum, if one only counted those three programs, $162.5 billion per year was provided by the federal government that would need to be maintained to partially fund the single-payer program proposed by AB 1900. Taken together, those three federal sources represent slightly less than 23% of California's overall health spending.

Addressing Funding Gaps and Unknowns

The success of this transition would depend on securing supplemental funding to bridge existing service gaps, specifically for populations relying on private long-term care insurance or out-of-pocket "self-pay" models. A primary fiscal challenge is the lack of empirical data regarding the total market value of private long-term care premiums and the out-of-pocket costs incurred by individuals who do not currently meet the eligibility criteria for Medi-Cal custodial care or Medicare home health services.

If someone is eligible for Medi-Cal due to the cost of skilled nursing care effectively lowering their income, they are considered to have a share of cost. The share of cost is the amount paid by individuals on Medi-Cal for their skilled nursing services and is not currently borne by the Medi-Cal program itself.

Estimating Changes in Payment for Services Based on Reimbursement Levels and Changes in Utilization

Over recent decades, numerous studies focused on the U.S. have shown that individuals do vary their utilization of health care, at least to some degree, depending on how much they must pay out-of-pocket for their care. The RAND Health

[27] https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Insurance experiment showed that health care use and individual spending tended to fall as the amount of cost sharing increased (Manning et al., 1988). Following from the results of the RAND study and subsequent relevant literature, it is expected that average health spending would increase if cost sharing were reduced, as proposed in AB 1900 (Cai et al., 2020).

To estimate changes in utilization rates under CalCare, as compared to current utilization, especially among the uninsured and underinsured, CHBRP used studies that followed the above RAND study. Some of this subsequent literature that has emerged following from the RAND study is informative here. These modeling findings estimate that, on average, a 10% increase in out-of-pocket costs would be associated with a 2% decrease in health expenditures. Conversely, this result suggests that a 10% decrease in out-of-pocket costs would be associated with a 2% increase in health expenditures.[28] This evidence suggests that eliminating out-of-pocket costs for enrollees, as proposed by AB 1900, would likely lead to a significant increase in health care utilization.

More recent data suggests that the ability to obtain preventive services without cost sharing due to the ACA resulted in large increases in the use of certain services (e.g., blood pressure checks increased by 18%) (Bates et al., 2025). There are some services and procedures that are likely to experience higher use due to the lack of cost sharing requirements (Borgschulte and Martorell, 2015).

Impact of Payment Rates on Clinician Supply and Hospitals

Due to the required standardization of benefits, eligibility, and medical necessity determinations proposed by AB 1900, variations in spending would occur due to differences in provider prices or use of services. AB 1900 allows for direct negotiation with individuals and groups of providers and facilities. Due to this provision, there does not seem to be an intent to link provider fees to the Medicare Fee Schedule directly using a “multiples-of-Medicare” model. However, even if Medicare Relative Value Unit (RVU)[29] and Diagnosis Related Group (DRG)[30] values were used as a basis for payment, the negotiations are likely to lead to prices for services that blend Medi-Cal, Medicare, and Commercial payments to create an equitable rate that is the same across payments (although the CalCare Advisory Board could decide to incentivize provision of care in certain geographies or settings by adjusting prices upward for eligible providers).

Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates and revenue most clinicians receive. If Medicare rates were not sufficient to cover the actual cost of delivering services for a clinician, such a reduction in provider payment rates could result in clinicians leaving the market (closing practices, relocating to other states, or trying to provide care outside of the single-payer program), reducing services, and would reduce the quality of care (Ellis and McGuire, 1986; Rice, 1997). In Maryland, commercial physician payment is often 103% of Medicare, but the fairly low price in Medicare is offset by Medicaid paying the same as Medicare[31]. It could also result in clinicians attempting to bill for a higher volume of services or services with higher intensity to generate additional revenue and offset the reduced fees (Brunt, 2015). Studies have found that increases in provider payment rates lead to a greater supply of medical care, whereas decreases in payment rates lead to a lower supply. However, those studies are based only on changes in Medicare’s payment rates in our existing multipayer system. These results may not be relevant for a single-payer system because of the lack of ability to avoid certain lower-paying patients or payers. Provider responses to payment changes are challenging to predict under a state-based single-payer system because providers might be able to offset losses in one payer by increasing their rates for other payers or seeing more patients from other payers in a multi-payer system. Those opportunities would no longer exist in a single-payer system (CBO, 2020).

Total spending on health care would be lower if clinician payment rates under a single-payer system (as proposed by AB 1900) were set based on a lower cost fee schedule, like those in Medicare Part A and Part B, rather than at a higher level,

[28] At the same time, several studies have raised significant concerns with respect to relying on a single, static estimate of the relationship between out-of-pocket expenditures and overall health care spending. For instance, it has been shown that the extent to which people will alter their health care utilization rates will be responsive to the specific types of cost-sharing arrangement being used.
[29] In the Medicare system, a **Relative Value Unit (RVU)** is a measure of value used to determine how much physicians are paid for their services. Instead of a direct dollar amount, an RVU represents the relative resources—such as time, intensity, and overhead—required to perform a specific medical procedure.
[30] **A Diagnosis Related Group (DRG)** is a classification system used by Medicare to determine a fixed, predetermined payment for an inpatient hospital stay.
[31] https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/documents/presentations/2025/20250515/ag7a_psr_mhcc_rpt.pdf.

such as average commercial health insurance reimbursement rates. It is likely that CalCare's negotiations and attempts at fee setting would result in physician and provider payments that exceed current Medicare and Medi-Cal reimbursement but is lower than the average provider payment for the service. That uniformity could create less incentive for providers to see specific patient groups or enrollees in different insurance products over others but could also create incentives to maximize revenue based on volume (quantity) of services delivered. A reduction in the fee schedule in Australia reduced expenditures for certain groups of physicians, while increases expenditures and fees in others (Jun and Scott, 2023).

Legal and Financial Hurdles for State Single-Payer Health Care

To finance these universal and comprehensive benefits, other state single-payer bills use several strategies similar to AB 1900 to capture health expenditures from the existing multipayer system, while seeking to navigate several financial and legal impediments. These state bills combine federal funds from Medicare, Medicaid, and the ACA marketplace tax credits and cost-sharing reductions into the single-payer plan using waivers in those federal programs (Wiley, 2018). The U.S. Department of Health and Human Services (DHHS) has substantial flexibility over approving or negotiating state waivers in Medicaid, Medicare, and Section 1332 of the ACA. However, proposed legislation usually does not have substitute revenue to rely on, were the agency to deny the waivers. Instead, the waiver's failure would typically undermine the ability to deliver the single-payer program as proposed. State budget rules often harm a state's ability to maintain spending levels during economic recession or downturn (Bagley, 2017). This means that, without a series of federal waivers related to Medicare, Medicaid, and Affordable Care Act requirements and federal funding, the revenues to support AB 1900 would not exist at the state level.

While Medicaid Section 1115 Demonstration waivers and Section 1332 ACA Innovation Waivers are routinely granted by CMS, a Medicare waiver is less frequent and subject to federal legislation. For example, Maryland's All Payer waiver dating back to 1977 (when hospital payments in Medicare were still per diem) was continued via legislation that exempted the state from the implementation of Diagnosis-Related Group (DRG) payments in 1983. In the current climate, federal legislation creating a California-specific waiver is unlikely, instead the most likely path is through a Demonstration Project via the Center for Medicare and Medicaid Innovation (CMMI) that is either part of a larger multi-state demonstration, or an ad hoc demonstration permitted via 1115A waiver (GAO, 1994).

State single-payer proposals also face challenges in redirecting premiums for employer-sponsored health plans due to the Employee Retirement Income Security Act (ERISA) (Chernew et al., 2021). About 5.9 million Californians are enrolled in self-insured plans (Administrative Services Only) as of late 2024. These plans are strictly regulated by federal ERISA law and are exempt from most California state insurance mandates (Gaffney et al., 2021). States do retain broad power to regulate health care providers and health insurers (KFF, 2019b). ERISA challenges states' abilities to capture employer health spending — a source of funding that would be critical to the viability of a single-payer system.

The complexity of ERISA pre-emption has inspired "creative drafting of state single-payer bills to do indirectly what ERISA prohibits them from doing directly" (Fuse Brown and McCuskey, 2019). State single-payer proposals appear to use three strategies for state bills to capture employer health spending and shift employees into the state single-payer system:

- Payroll taxes on employers;
- Income taxes on employees; and
- Restrict clinicians from accepting reimbursement from private insurance companies.

Nearly all states' bills include one of these strategies; most include a combination of them. In California, the Healthy San Francisco program[32] was able to avoid ERISA preemption by focusing on fees paid by employers that directly supported health care services, rather than requiring employers to provide insurance benefits (Jacobs, 2008).

[32] Healthy San Francisco (HSF) is a program by the San Francisco Department of Public Health that provides affordable health access to uninsured residents, regardless of immigration or employment status. It offers a "medical home" model for preventive, specialty, and emergency care within the city but is not insurance.

Key Considerations and Unknowns

CHBRP's analysis is not intended to make recommendations regarding the appropriateness or feasibility of AB 1900. However, in reviewing the analyses and evidence from numerous studies, CHBRP offers a few high-level integration considerations and unknown variables for the Legislature's decision-making process.

Integration Considerations

Plan Design in AB 1900 that eliminates premiums and cost sharing will likely need to secure offsets. This could be accomplished via increased tax revenue, lower payments to clinicians, or some other funding mechanism. Premiums and cost sharing account for a substantial portion of health care expenditures today. Eliminating cost sharing may improve access to care and consumer affordability but could also increase costs due to greater use of services and ultimately compromise long-term sustainability. Findings from the RAND Health Insurance Experiment and more recent work on the impact of cost sharing and coinsurance in reducing the use of health care suggest that removing cost barriers through a single-payer system could trigger new use to be paid for by the system (Cai et al., 2020). Much of that use may be necessary, but it is not currently occurring or is being delayed due to cost barriers for a segment of the population. In addition, reduced premiums are likely to draw new enrollees into the health care system, so that they have increased access to care in contrast to being uninsured (MACPAC, 2015).

Clinician Impact and Hospitals

Although a single-payer system allows private clinicians to continue operating as private entities, the payment sources would be limited to the new CalCare single-payer program. In the short term, a state-based single-payer system likely impacts hospitals through reduced payment rates (e.g., matching Medicare) and significantly lowered administrative expenses. While covering the uninsured increases volume, revenue may decline due to lower reimbursement, potentially reducing operating margins and straining financially vulnerable hospitals (Galvani et al., 2020). Currently, hospitals and health care clinicians negotiate reimbursement rates with private insurance companies (including Medicare Advantage and Medi-Cal managed care plans), receive lower fee-schedule-based payments from fee-for-service Medicare and Medicaid, and also receive cost-sharing payments from insured patients, and partial or full payment for self-pay services from uninsured or out-of-network patients. Consolidating all Californians under one single-payer system would require price setting that takes the previous multi-payer rates into consideration, adjusts them downward to address administrative efficiencies, and pays hospitals and clinicians a new, blended payment rate for services rendered or individuals receiving care.

A single-payer health care system in California could help the state meet several goals — universal health care coverage, comprehensive benefits, increased equity, greater access and quality, improved affordability, lower administrative costs, and slower growth in health care costs (CHCF, 2017).

Fiscal Uncertainties

The ability to manage costs is predicated on a single government entity budgeting for the health care costs of a single risk pool that has the potential to centrally impose cost controls. If that single risk pool is less than universal, market forces will limit its reach, potentially undermining the ability to address consumer affordability, at least for some consumer segments. It may be difficult to achieve system wide access and quality goals if a substantial portion of the population is excluded from the single-payer program. For example, the Medicare population accounts for 14% of the California population and is responsible for about 20% of total state health care spending — it may therefore be difficult to see system-wide improvements if this population is excluded and program goals are not well aligned.

California's ability to collect sufficient dollars to fund a single-payer system and its ability to aggregate and direct funds currently devoted to health care within the state depends on robust revenues. States, unlike the federal government,

cannot operate with a budget deficit. Therefore, the ability to ensure that revenue trends keep pace with health care cost trends is a fundamental concern for a state-based, single-payer program. Any external factor that reduces expected revenues in a given year, or increases unpredictability of revenues or costs, could jeopardize program sustainability.

Health spending (the sum of public and private spending, including personal out-of-pocket spending by consumers) under a single-payer system could increase or decrease, depending on the extent to which:

- Health care benefits improve relative to currently available coverage;
- Utilization of health care services increases due to reduced out-of-pocket costs and additional insured people;
- Clinician reimbursement rates are reduced; and
- Administrative costs of health insurance and health care delivery are reduced.

Administrative and Legal Questions

Revenues

As stated in AB 1900, CHBRP assumes that CalCare would only move forward if federal revenues were redirected to California's single payer model via a combination of waiver agreements and demonstration authority. The series of Medicare, Medicaid, and ACA waivers or demonstration programs required would need federal support from the Secretary of Health and Human Services, and multiple CMS offices, including the Center for Medicaid and CHIP Services State Demonstrations group, the Office of the Actuary, the Center for Medicare and Medicaid Innovation (CMMI), and the Center for Consumer Information and Insurance Oversight (CCIIO). The CalCare Commission and the state of California would need to negotiate appropriate waivers and demonstrations directly with the federal government in a way that aligns with the mission of DHHS and CMS and would satisfy budget neutrality requirements for each waiver type.

A single-payer state plan, in its purest form, would include all state residents, whether publicly or privately insured, in a single government program. Such a plan would require waivers or demonstration authority from ACA, Medicaid, and Medicare. The Section 1332 Waiver of the ACA, which is also known as the State Innovation Waiver, went into effect in January 2017. It allows the U.S. Department of Health and Human Services (HHS) to waive certain ACA structural requirements while continuing federal funding to states, provided the reform is deficit neutral and provides coverage and cost-sharing benefits that remain the same or increase in value (Tolbert et al., 2018). To date, eight states have won approval for 1332 waiver applications (Singer et al., 2024). All but one of these states has used the waiver authority to receive federal pass-through funding to implement reinsurance programs that reimburse insurers for certain high-cost claims in order to lower premiums overall.

Colorado used its 1332 waiver to establish a public option in the individual marketplace to compete with commercial plans, while also establishing fee setting for physician and provider payments. However, other states, namely Iowa and Idaho, had proposed more significant changes to their insurance markets that the administration ultimately did not approve. Generally, the 1332 waiver can only be used to draw down the federal dollars that would have gone into cost sharing reduction subsidies and income-based tax credits to purchase insurance for those without affordable employer-based health care, Medicare, or Medicaid coverage. Although helpful in financing the system proposed by AB 1900, ACA 1332 waiver funds would not be substantial enough to fund a single payer program. However, Medicare and Medicaid funds and the population enrolled in each program are much larger.

While a legislative Medicare waiver is unlikely, a legal memo completed by Brown, Peisch, and Seidenberg in January of 2022[33] for the HCFA Commission found that California could leverage CMS 1115A demonstration authority for a one-off program, like a statewide Accountable Care Organization. Or, alternatively, California could attempt to join an existing CMMI Demonstration model for global hospital payments or primary care reimbursement. There is also demonstration authority created in 1968 and updated in 1972 under Medicare, granted by Section 402 of the Social Security Act (KFF, 2021). However, since the creation of CMMI the Section 402 demonstration authority seems to have been unused, due to

[33] See page 96: https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf.

the relatively easier path created by CMMI's authority via the ACA. These waivers allow for the testing of innovations that might improve access and quality or lower health care costs. Lastly, a Medicaid Demonstration Waiver (1115) would be required to ensure federal matching funds for Medi-Cal enrollees would be available in the CalCare model. California has had several successful 1115 waivers, including the CalAIM model currently in operation.

The bill does not establish the revenue model for financing AB 1900. CHBRP assumes federal revenues would be obtained through subsequent waivers of Medicaid (Section 1115), Medicare, and ACA (Section 1332) requirements and regulations. In addition, California would need to leverage potential savings from the implementation of AB 1900 such that the federal cost of Medicaid, Medicare, and Covered California plan tax credits would decrease, allowing federal savings to be allocated to California for the purposes of financing the single-payer system. The federal government would also receive previously foregone tax revenues from individuals and employers who were receiving tax-exempt or tax-deductible employee health benefits. While California would receive a share of tax revenues on newly taxable payroll or income through state taxes, a substantial amount of revenue would be collected by the federal government. The state would benefit from capturing those funds to ensure they flowed into the CalCare program through one of the federal waivers mentioned above. AB 1900 also requires that all state revenues from CalCare would be placed in an account within the CalCare Trust Fund Account. CHBRP is aware of the following existing provisions in the state's Constitution that affect California's ability to raise and spend revenues.

The following legal considerations raise additional uncertainties:

- The first legal consideration is Proposition 4 of 1979. Proposition 4 established a constitutional limit on spending known as the "Gann Limit." The Gann Limit was later updated by Prop. 98 of 1988 and Prop. 111 of 1990. According to the state Senate Appropriations Committee analysis of SB 562, "the very large tax revenues that this bill would require…would clearly exceed the Gann Limit."
- The second legal consideration is Proposition 98 of 1988 (which was subsequently modified by Prop. 111 of 1990). Proposition 98 amended the constitution to require a minimum level of funding for K-12 schools and community colleges. The state Senate Appropriations Committee analysis of SB 562 (McCarthy, 2017) stated taxes raised to support the single-payer program would be "considered the proceeds of taxes and would be subject to the requirements of Proposition 98." It is likely that California voters would have to vote to change the funding guarantee in Prop. 98 or explicitly exempt the new taxes from Prop. 98-eligible tax revenues.[34]
- Balanced Budget Requirement (Proposition 58, 2004). Unlike the federal government, California is constitutionally prohibited from operating with a budget deficit.
- Supermajority Vote for Taxes (Proposition 13, 1978 & Proposition 26, 2010) creates an additional complexity. Any increase in state taxes "for any purpose" must be approved by a two-thirds vote in both houses of the Legislature (Assembly and Senate). This sets a very high political threshold for passing the financing legislation (e.g., payroll taxes, income surtaxes) that would be required to fund the system established by AB 1900.

[34] State Appropriations Limit (Gann Limit) was added by Proposition 4 (1979). This Proposition restricts the total amount of tax-funded appropriations the state can make annually. Revenues exceeding this limit over two years must be split between taxpayer rebates and Proposition 98 school funding. Because CalCare would require a massive shift of private spending into state tax revenue, it could cause the state to abruptly exceed this limit. Proposition 98 (Minimum School Funding), requires a specific percentage of the state's General Fund and local property tax revenue to be allocated to K-14 education. New taxes raised for CalCare could trigger a massive increase in the mandatory minimum funding for schools, potentially leaving insufficient funds for the healthcare program itself unless specifically exempted. In addition, Proposition 2 (State Reserves) requires a portion of "excess" capital gains tax revenues to be deposited into the Budget Stabilization Account (Rainy Day Fund). This limits the Legislature's discretion to spend all collected tax revenue on program services in high-revenue years. Article XIII A of the California Constitution generally requires a two-thirds vote of both houses of the Legislature to increase any state tax.
AB 1900 currently includes "intent" language to develop a revenue plan, but any resulting tax would face this high legislative hurdle unless passed via a ballot initiative.

Conclusion

Implementation Considerations

As described above, there are legal and financial hurdles for state single-payer legislation such as AB 1900. Successful implementation of CalCare would require the consolidation of federal funds from Medicare, Medicaid, and the ACA exchanges into the state single-payer plan using waiver provisions in those federal programs (Weinberg and Haase, 2018). Proposed state single-payer plans generally lack fallback plans for capturing federal funds should the federal government deny the waivers. In addition, state constitutional prohibitions on deficit spending constrain state plans when tax revenues fall during economic recession.

The scale and risks of managing hundreds of billions of dollars in health care spending provide a live experiment with opportunity but also unanticipated risks and costs. CHBRP is aware of existing provisions in the state's Constitution that affect California's ability to raise and spend revenues. The CBO (2020) itself noted that "a high degree of uncertainty surrounds its own estimates." That uncertainty stems from many factors, including estimates of how clinicians and patients would respond to the single-payer system, administrative costs under the system and under current law, how regulations and other administrative actions following enactment of the legislation creating the system would affect costs, health care spending and economic conditions in the future under current law, spending on certain components of health care today, and aftereffects of the current coronavirus pandemic.

New health care utilization might be induced by lower copays/deductibles/patient cost (and the removal of utilization management). This could create financial and access challenges. The CBO projected that some offsets may be achieved in hospital costs, as the share of revenues that hospitals spend on administration may fall under a single-payer system. Similarly, physicians' and other health care clinicians' administrative overhead may fall, and physicians and nurses could spend less time on administrative activities.

Long-Term Care Conclusions

Although spending information from Medicare and Medicaid on custodial and rehabilitation-related long-term care is available, there is limited information on the informal caregiving, private long-term care insurance premium costs and spending, and out-of-pocket costs for individuals and families. Therefore, it is difficult to predict the monetary impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide. There is no available estimate calculating the level of pent-up demand for publicly funded long-term care services. However, available evidence suggests a significant and growing level of pent-up demand for publicly funded long-term care (LTC) services, driven by an aging population, limited private insurance options, and high out-of-pocket costs. Estimates suggest that approximately 70% of adults turning 65 will develop severe needs for long-term services and supports (LTSS), with a quarter of the older population reporting unmet needs, which rises to over 50% in rural areas (Rahman et al., 2022). Currently, enrollees in insurance that does not provide long-term care benefits might rely on informal caregivers, home health through Medicare, or self-payment to assisted living and skilled nursing facilities. The only mainstream insurance program that covers custodial long-term care is Medicaid, and the program is based upon financial and medical need. Therefore, it is challenging to assess the level of long-term care supply that would be needed to quickly respond to pent-up demand and new demand for long-term care services due to the expansion of benefits proposed by AB 1900.

Upfront Reserve Estimates

Overall health care spending in California under a single payer model with direct payments to clinicians and no cost sharing is estimated to be $731.4 billion in 2027 dollars. Spending is likely to increase due to comprehensive benefits and reduced cost sharing, which means utilization will also increase. Some estimates suggest another $26 billion (Healthy

California for All Commission, 2022) in spending due to the removal of cost sharing and demand for services increasing.[35] Given the need to spend state dollars to leverage federal matching funds, and the new spending projected, CHBRP estimates that 15% of the current estimated health care spending plus the additional spending due to the implementation of AB 1900 should be placed in a reserve fund to ensure benefits can be offered to California residents. That amounts to $109.75 billion in reserves. It is notable that the $731.4 billion estimate is $13.9 billion higher than the expected amount of money spent on health care in California by 2027 without any policy intervention. The HCFA Report (Healthy California for All Commission, 2022) found that savings would accrue due to reduced administrative burdens and a uniform fee schedule. However, the $717.5 billion spent on health care via the existing multipayer system cannot easily be redirected into California as revenue to directly support the single payer proposal in AB 1900. Instead, the state would need to leverage ways to steer Medicare, Medicaid, ACA tax credits and cost sharing reductions, employer shared responsibility payments, payroll taxes, and other revenues into the Trust Fund to support a new system. That will require agreement from the federal government to pass through federal funds that would have been allocated to other programs, such as Medicare and Covered California.

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[35] The $26 billion in spending due to the removal of cost sharing is from comparing the scenarios with and without cost sharing in the HCFA report and adjusting the 2022 estimates to represent spending in 2027 based on National Health Expenditures (NHE) data and projections.

Appendix A. Legislative Text Analyzed

CHBRP analyzed AB 1900, as introduced/amended on February 12, 2026, per the request of the California Assembly Committee on Health. The text analyzed is copied below.

SECTION 1.

(a) The Legislature finds and declares all of the following:

(1) Although the federal Patient Protection and Affordable Care Act (PPACA) brought many improvements in health care and health care coverage, PPACA still leaves many Californians without coverage or with inadequate coverage.

(2) Californians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles, and copayments, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than patients' health care needs.

(5) Out-of-pocket health care costs for Californians are projected to nearly double in 2026 and 3,400,000 million Californians are expected to lose health care coverage as a result of federal health care cuts.

(6) To address the fiscal crisis facing the health care system and the state, and to ensure Californians get the health care they need, comprehensive health care coverage needs to be provided.

(7) Billions of dollars that could be spent on providing equal access to health care are wasted on administrative costs necessary in a multipayer health care system. Resources and costs spent on administration would be dramatically reduced in a single-payer system, allowing health care professionals and hospitals to focus on patient care instead.

(8) It is 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.

(b) (1) It is further the intent of the Legislature to establish the California Guaranteed Health Care for All program to provide universal health care coverage for every Californian, funded by broad-based revenue.

(2) It is the intent of the Legislature to first pass policy legislation to initiate a transition to the California Guaranteed Health Care for All program and that the California Guaranteed Health Care for All program shall not become operative until the Secretary of California Health and Human Services notifies the Legislature that the CalCare Trust Fund has the revenues to fund the costs of implementing the program.

(3) It is the intent of the Legislature to establish the CalCare Board that governs the California Guaranteed Health Care for All program and to convene the CalCare Public Advisory Commission before the program becomes operative in order to develop a transition plan and to ensure a seamless transition to CalCare.

(4) It is the intent of the Legislature to work to obtain waivers and other approvals relating to Medi-Cal, the federal Children's Health Insurance Program, Medicare, PPACA, and any other federal programs pertaining to the provision of health care so that any federal funds and other subsidies that would otherwise be paid to the State of California,

Californians, and health care providers would be paid by the federal government to the State of California and deposited in the CalCare Trust Fund.

(5) Under those waivers and approvals, those funds would be used for health care coverage that provides health care benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(6) Those programs would be replaced and merged into CalCare, which will operate as a true single-payer program.

(7) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of funding from federally matched public health programs and other federal health programs in CalCare.

(8) Even if other programs, including Medi-Cal or Medicare, may contribute to paying for care, it is the goal of this act that the coverage be delivered by CalCare, and, as much as possible, that the multiple sources of funding be pooled with other CalCare program funds.

(9) It is the intent of the Legislature to provide universal health care coverage with greater benefits and access to providers than existing health coverage plans, including for Californians who primarily receive care through an integrated health care delivery system, that is free at the point of service and does not have deductibles, coinsurance, premiums, or other cost-sharing.

(c) This act does not create an employment benefit, nor does the act require, prohibit, or limit providing a health care employment benefit.

(d) (1) It is not the intent of the Legislature to change or impact in any way the role or authority of a licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law, including the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code.

(2) This act would in no way authorize the CalCare Board, the California Guaranteed Health Care for All program, or the Secretary of California Health and Human Services to establish or revise licensure standards for health care professionals or providers.

(e) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians, registered nurses, and other licensed health care professionals. Physicians, registered nurses, and other licensed health care professionals shall be free to override health information technology and clinical practice guidelines if, in their professional judgment and in accordance with their scope of practice and licensure, it is in the best interest of the patient and consistent with the patient's wishes.

(f) (1) It is the intent of the Legislature to prohibit CalCare, a state agency, a local agency, or a public employee acting under color of law 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.

(2) This act would also prohibit law enforcement agencies from using CalCare's funds, 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 any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act (Part 2 (commencing with Section 51) of Division 1 of the Civil Code).

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 23 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 23. The California Guaranteed Health Care for All Act

CHAPTER 1. General Provisions

100600. This title shall be known, and may be cited, as the California Guaranteed Health Care for All Act.

100601. There is hereby established in state government the California Guaranteed Health Care for All program, or CalCare, to be governed by the CalCare Board pursuant to Chapter 2 (commencing with Section 100610).

100602. For the purposes of this title, the following definitions apply:

(a) “Activities of daily living” means basic personal everyday activities including eating, toileting, grooming, dressing, bathing, and transferring.

(b) “Advisory committee on LTSS” means the Advisory Committee on Long-Term Services and Supports established pursuant to Section 100614.

(c) “Advisory committee on PERS” means the Advisory Committee on Public Employees’ Retirement System Health Benefits established pursuant to Section 100616.

(d) “Affordable Care Act” or “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(e) “Allied health practitioner” means a group of health professionals who apply their expertise to prevent disease transmission and diagnose, treat, and rehabilitate people of all ages and in all specialties, together with a range of technical and support staff, by delivering direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include audiologists, occupational therapists, social workers, and radiographers.

(f) “Board” means the CalCare Board described in Section 100610.

(g) “CalCare” or “California Guaranteed Health Care for All” means the California Guaranteed Health Care for All program established in Section 100601.

(h) “Capital expenditures” means expenses for the purchase, lease, construction, or renovation of capital facilities, health information technology, artificial intelligence, and major equipment, including costs associated with state grants, loans, lines of credit, and lease-purchase arrangements.

(i) “Carrier” means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(j) “Commission” means the CalCare Public Advisory Commission established pursuant to Section 100611.

(k) “Essential community provider” means a provider, as defined in Section 156.235(c) of Title 45 of the Code of Federal Regulations, as published February 27, 2015, in the Federal Register (80 FR 10749), that serves predominantly low-income, medically underserved individuals and that is one of the following:

(1) A community clinic, as defined in subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(2) A free clinic, as defined in subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(3) A federally qualified health center, as defined in Section 1395x(aa)(4) or Section 1396d(l)(2)(B) of Title 42 of the United States Code.

(4) A rural health clinic, as defined in Section 1395x(aa)(2) or 1396d(l)(1) of Title 42 of the United States Code.

(5) An Indian Health Service Facility, as defined in subdivision (v) of Section 2699.6500 of Title 10 of the California Code of Regulations.

(l) “Federally matched public health program” means the state’s Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the federal Children’s Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(m) “Fund” means the CalCare Trust Fund established pursuant to Article 2 (commencing with Section 100675) of Chapter 7.

(n) “Global budget” means the payment negotiated between an institutional provider and the board pursuant to Section 100651.

(o) “Group practice” means a professional corporation under the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code) that is a single corporation or partnership composed of licensed doctors of medicine, doctors of osteopathy, or other licensed health care professionals, and that provides health care items and services primarily directly through physicians or other health care professionals who are either employees or partners of the organization.

(p) “Health care professional” means a health care professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act, who, in accordance with the professional’s scope of practice, may provide health care items and services under this title.

(q) “Health care item or service” means a health care item or service that is included as a benefit under CalCare.

(r) “Health professional education expenditures” means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

(s) “Home- and community-based services” means an integrated continuum of service options available locally for older individuals and functionally impaired persons who seek to maximize self-care and independent living in the home or a home-like environment, which includes the home- and community-based services that are available through Medi-Cal pursuant to the home- and community-based waiver program under Section 1915 of the federal Social Security Act (42 U.S.C. Sec. 1396n) as of January 1, 2019.

(t) “Implementation period” means the period under paragraph (6) of subdivision (e) of Section 100612 during which CalCare is subject to special eligibility and financing provisions until it is fully implemented under that section.

(u) “Institutional provider” means an entity that provides health care items and services and is licensed pursuant to any of the following:

(1) A health facility, as defined in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(3) A long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612.

(4) A county medical facility licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(5) A residential care facility for persons with chronic, life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.

(6) An Alzheimer’s daycare resource center licensed pursuant to Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.

(7) A residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(8) A hospice licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(9) A pediatric day health and respite care facility licensed pursuant to Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(10) A mental health care provider licensed pursuant to Division 4 (commencing with Section 4000) of the Welfare and Institutions Code.

(11) A federally qualified health center, as defined in Section 1395x(aa)(4) or 1396d(l)(2)(B) of Title 42 of the United States Code.

(v) “Instrumental activities of daily living” means activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(w) “Integrated health care delivery system” has the same meaning as defined in paragraph (13) of subdivision (b) of Section 1182.14 of the Labor Code.

(x) “Long-term services and supports” means long-term care, treatment, maintenance, or services related to health conditions, injury, or age, that are needed to support the activities of daily living and the instrumental activities of daily living for a person with a disability, including all long-term services and supports as defined in Section 14186.1 of the Welfare and Institutions Code, home- and community-based services, additional services and supports identified by the board to support people with disabilities to live, work, and participate in their communities, and those as defined by the board.

(y) “Medicaid” or “medical assistance” means a program that is one of the following:

(1) The state’s Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The federal Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(z) "Medically necessary or appropriate" means the health care items, services, or supplies needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, or disease, or its symptoms, and that meet accepted standards of medicine as determined by a patient's treating physician or other individual health care professional who is treating the patient, and, according to that health care professional's scope of practice and licensure, is authorized to establish a medical diagnosis and has made an assessment of the patient's condition.

(aa) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(ab) "Member" means an individual who is enrolled in CalCare.

(ac) "Out-of-state health care service" means 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:

(1) It is medically necessary or appropriate that the health care item or service be provided while the member physically is out of the state.

(2) 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.

(ad) "Participating provider" means an individual or entity that is a health care provider qualified under Section 100640 that has a participation agreement pursuant to Section 100641 in effect with the board to furnish health care items or services under CalCare.

(ae) "Prescription drugs" means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(af) "Resident" means an individual whose primary place of abode is in this state, without regard to the individual's immigration status, who meets the California residence requirements adopted by the board pursuant to subdivision (m) of Section 100610. The board shall be guided by the principles and requirements set forth in the Medi-Cal program under Article 7 (commencing with Section 50320) of Chapter 2 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations.

(ag) "Rural or medically underserved area" has the same meaning as a "health professional shortage area" in Section 254e of Title 42 of the United States Code.

100603. This title 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 title.

100604. To the extent any law is inconsistent with this title or the legislative intent of the California Guaranteed Health Care for All Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

CHAPTER 2. Governance

100610. (a) CalCare shall be governed by an executive board, known as the CalCare Board, consisting of nine voting members who are residents of California. The CalCare Board shall be an independent public entity not affiliated with an agency or department. Of the members of the board, four shall be appointed by the Governor, two shall be appointed by

the Senate Committee on Rules, two shall be appointed by the Speaker of the Assembly, and one shall be determined by the commission established pursuant to Section 100611. The Secretary of California Health and Human Services or the secretary's designee shall serve as a nonvoting, ex officio member of the board.

(b) (1) A member of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. These members may be reappointed for succeeding four-year terms.

(2) Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of the member's successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care policy or delivery.

(2) Appointing authorities shall 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.

(3) Appointments to the board shall be made as follows:

(A) Two health care professionals who practice medicine. At least one is a practicing physician or medical doctor.

(B) One registered nurse.

(C) One public health or mental health professional.

(D) One member with an institutional provider background.

(E) Two representatives of a not-for-profit organization that advocates for individuals who use health care in California.

(F) One representative of a labor organization.

(G) One member of the commission established pursuant to Section 100611, who shall serve on a rotating basis to be determined by the committee.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title 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.

(e) (1) An appointee to the board designated in subparagraph (D), (E), (F), or (G) of paragraph (3) of subdivision (c) shall not receive financial compensation from, or be employed by, a participating provider under CalCare and shall not otherwise receive funding from CalCare.

(2) An appointee to the board designated in subparagraph (A), (B), or (C) of paragraph (3) of subdivision (c) shall not receive financial compensation from a participating provider under CalCare and shall not otherwise receive funding from CalCare, except for the purposes of employment by a participating provider to provide direct patient care and in a position that is not as an officer or a managerial, supervisory, or confidential position.

(3) For purposes of this subdivision, an appointee's prohibited financial compensation and employment does not include employment by a participating provider as a tenured academic instructor with duties and compensation unrelated to the health care operations of the entity.

(4) For purposes of this subdivision, financial compensation does not include compensation received pursuant to a retirement plan.

(5) For purposes of this subdivision, financial compensation does not include clinical volunteer services if all of the following conditions are met:

(A) The board member is a health care professional who was actively participating in that profession before appointment to the board.

(B) The board member does not receive compensation for performing volunteer services and does not have an ownership interest or other financial interest in the entity, facility, clinic, or provider group.

(C) The clinical volunteer services are performed at the University of California or a nonprofit educational institution, a facility, clinic, or provider group operated by, or affiliated with, an academic medical center of either the University of California or a nonprofit educational institution, or a facility, clinic, or provider group operated by a state agency or county health system.

(6) For purposes of paragraph (5), compensation and financial interest for a health care professional who performs clinical volunteer services does not include either of the following:

(A) A contribution to a professional liability insurance program made by the entity, facility, clinic, or provider group for the member or staff.

(B) The provision of physical space, equipment, support staff, or other supports made by the entity, facility, clinic, or provider group for the member or staff necessary for the performance of clinical volunteer services described in paragraph (5).

(f) The representation of varied interest groups on the board shall be deemed essential to obtaining information for the development of policy and decisions of the board. It shall not be a conflict of interest for appointees to the board designated in subparagraph (A), (B), (C), or (D) of paragraph (3) of subdivision (c) to serve as members of the board. If any board member has a financial interest, as described in Section 87103, the interest shall be disclosed as a matter of official public record and shall be described with particularity, as determined by the other members of the board. A board member shall not make, participate in making, or in any way attempt to use their position to influence a decision of the board in which the member knows or has reason to know that they have a financial interest.

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

(h) (1) A member of the board or of the staff of the board shall not be 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. A member of the board or of the staff of the board shall not be 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. A member of the board or of the staff of the board may be a health care professional if that member does not have an ownership interest in an institutional provider or a professional health care practice.

(2) Notwithstanding Section 11009, a board member shall receive compensation for service on the board. A board member may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(i) A member of the board shall not make, participate in making, or in any way attempt to use the member's official position to influence the making of a decision that the member knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the member or a person in the member's immediate family, or on either of the following:

(1) 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.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(j) There shall not be liability in a private capacity on the part of 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, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(k) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(l) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and provider rates.

(m) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

(n) A violation of this section by a board member shall constitute grounds for disqualification as a board member.

100611. (a) (1) The board shall convene a CalCare Public Advisory Commission to advise the board on all matters of policy for CalCare. The commission shall consist of members who are residents of California.

(2) The commission may provide input, including recommendations, to the board on all matters of policy for CalCare, which includes all of the following:

(A) Governance.

(B) Eligibility and enrollment.

(C) Covered benefits and services.

(D) Delivery of care, including provider participation and payments.

(E) Program standards, including standards of care, health equity, and consumer protections.

(F) Funding, including federal funding, special projects budgeting, and broad-based financing.

(G) Transition plan to CalCare, including any matters related to the implementation period.

(H) Collective negotiations with providers.

(I) Other areas requested by the board or the executive director.

(b) Members of the commission shall be appointed by the board for a term of two years. These members may be reappointed for succeeding two-year terms.

(c) The members of the commission shall be as follows:

(1) Four health care professionals.

(2) One registered nurse.

(3) One representative of a licensed health facility.

(4) One representative of an essential community provider.

(5) One representative of a physician organization or medical group.

(6) One behavioral health provider.

(7) One dentist or oral care specialist.

(8) One representative of private hospitals.

(9) One representative of public hospitals.

(10) One individual who is enrolled in and uses health care items and services under CalCare.

(11) 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.

(12) Two representatives of organized labor, including at least one labor organization representing registered nurses.

(d) In convening the commission pursuant to this section, the board shall 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.

(e) Members of the commission shall serve without compensation, but shall 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 shall receive one hundred fifty dollars ($150) for each full day of attending meetings of the commission. For purposes of this section, “full day of attending a meeting” means presence at, and participation in, not less than 75 percent of the total meeting time of the commission during any particular 24-hour period.

(f) The commission shall meet at least once every quarter, and shall solicit input on agendas and topics set by the board. All meetings of the commission shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(g) The commission shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(h) Commission members, or their assistants, clerks, or deputies, shall not use for personal benefit any information that is filed with, or obtained by, the commission and that is not generally available to the public.

100612. (a) The board shall have all powers and duties necessary to establish and implement CalCare. The board shall 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) The board shall, 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. In implementing this title, the board shall avoid jeopardizing federal financial participation in the programs that are incorporated into CalCare and shall take care to promote public understanding and awareness of available benefits and programs.

(c) The board shall consider any matter to effectuate the provisions and purposes of this title. The board shall not have executive, administrative, or appointive duties except as otherwise provided by law.

(d) The board shall 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. The executive director shall hire or designate another to hire staff, who shall not be exempt from civil service, to implement fully the purposes and intent of CalCare. The executive director, or the executive director's designee, shall give preference in hiring to all individuals displaced or unemployed as a direct result of the implementation of CalCare, including as set forth in Section 100615.

(e) The board shall do or delegate to the executive director all of the following:

(1) Determine goals, standards, guidelines, and priorities for CalCare.

(2) Develop a plan to transition to CalCare and a plan for the implementation period before the program becomes operative.

(3) Develop a plan to seek all federal waivers, other federal approvals and arrangements, and state plan amendments as necessary to operate CalCare pursuant to Section 100670.

(4) Annually assess projected revenues and expenditures and ensure the financial solvency of CalCare.

(5) Develop CalCare's budget pursuant to Section 100676 to ensure adequate funding to meet the health care needs of the population, and review all budgets annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices to address disparities.

(6) Establish standards and criteria for the development and submission of provider operating and capital expenditure requests pursuant to Article 2 (commencing with Section 100650) of Chapter 5.

(7) Establish standards and criteria for the allocation of funds from the CalCare Trust Fund pursuant to Section 100676.

(8) Determine when individuals may begin enrolling in CalCare. There shall be an implementation period that begins on the date that individuals may begin enrolling in CalCare and ends on a date determined by the board.

(9) 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.

(10) Negotiate payment rates, set payment methodologies, and set prices involving aspects of CalCare and establish procedures thereto, including procedures for negotiating fee-for-service payment to certain participating providers pursuant to Chapter 8 (commencing with Section 100685).

(11) Oversee the establishment, as part of the administration of CalCare, of the commission pursuant to Section 100611.

(12) Implement policies to ensure that all Californians receive culturally, linguistically, and structurally competent care, pursuant to Chapter 6 (commencing with Section 100660), ensure that all disabled Californians receive care in accordance with the federal Americans with Disabilities Act (42 U.S.C. Sec. 12101 et seq.) and Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794), and develop mechanisms and incentives to achieve these purposes and a means to monitor the effectiveness of efforts to achieve these purposes.

(13) Establish standards for mandatory reporting by participating providers and penalties for failure to report, including reporting of data pursuant to Section 100617 and to Section 100641.

(14) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services.

(15) Ensure the establishment of policies that support the public health.

(16) Meet regularly with the commission.

(17) 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 pursuant to Section 100615.

(18) In consultation with the Department of Managed Health Care, oversee the establishment of a system for resolution of disputes pursuant to Section 100637 and a system for independent medical review pursuant to Section 100637.

(19) Establish and maintain an internet website that provides information to the public about CalCare that includes information that supports choice of providers and facilities and informs the public about meetings of the board and the commission.

(20) 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.

(21) (A) 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 title.

(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.

(vii) Future goals and priorities.

(B) The report shall be transmitted to the Legislature and the Governor, on or before October 1 of each year and at other times pursuant to this division, and shall be made available to the public on the internet website of CalCare.

(C) A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

(f) The board may do or delegate to the executive director all of the following:

(1) Negotiate and enter into any necessary contracts, including contracts with health care providers and health care professionals.

(2) Sue and be sued.

(3) 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.

(4) 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.

(5) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of CalCare.

(g) (1) On and after the date the implementation period ends, a carrier shall not offer benefits or cover health care items or services for which coverage is offered to individuals under CalCare.

(2) Notwithstanding paragraph (1), if otherwise authorized under state law, a carrier may offer benefits to cover health care items or services that are not offered to individuals under CalCare.

(3) This title 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.

(B) Benefits during the implementation period to individuals who enrolled or may enroll as members of CalCare.

(4) Paragraph (1) applies to a carrier except as otherwise prohibited by federal law.

(h) After the end of the implementation period, a person shall not be a board member unless the person is a member of CalCare, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop proposals for the following:

(1) In consultation with the Advisory Committee on Public Employees' Retirement System Health Benefits established under Section 100616, 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.

(2) 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.

(j) The board shall develop a proposal for CalCare coverage of health care items and services currently covered under the workers' compensation system, including whether and how to continue funding for those item and services under that system and how to incorporate experience rating.

100613. The board may 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.

(b) Assistance to a health care provider providing, seeking, or considering whether to provide health care items and services under CalCare.

100614. (a) There is hereby established in state government an Advisory Committee on Long-Term Services and Supports, to advise the board on matters of policy related to long-term services and supports for CalCare.

(b) The advisory committee on LTSS shall consist of 11 members who are residents of California. Of the members of the advisory committee on LTSS, five shall be appointed by the Governor, three shall be appointed by the Senate Committee on Rules, and three shall be appointed by the Speaker of the Assembly. The members of the advisory committee on LTSS shall include all of the following:

(1) At least two people with disabilities who use long-term services and supports.

(2) At least two older adults who use long-term services and supports.

(3) At least two providers of long-term services and supports, including one family attendant or family caregiver.

(4) At least one representative of a disability rights organization.

(5) At least one representative or member of a labor organization representing workers who provide long-term services and supports.

(6) At least one representative of a group representing seniors.

(7) At least one researcher or academic in long-term services and supports.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall 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 long-term services and supports, including their race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographic location, and socioeconomic status.

(d) (1) A member of the advisory committee on LTSS may continue to serve until the appointment and qualification of that member's successor. Vacancies shall be filled by appointment for the unexpired term.

(2) Members of the advisory committee on LTSS shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. These members may be reappointed for succeeding four-year terms.

(3) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was initially selected or appointed. The Secretary of California Health and Human Services shall notify the appropriate appointing authority of any expected vacancies on the long-term services and supports advisory committee on LTSS.

(e) Members of the advisory committee on LTSS shall serve without compensation, but shall 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. Members shall also receive one hundred fifty dollars ($150) for each full day of attending meetings of the advisory committee on LTSS. For purposes of this section, “full day of attending a meeting” means presence at, and participation in, not less than 75 percent of the total meeting time of the advisory committee on LTSS during any particular 24-hour period.

(f) The advisory committee on LTSS shall meet at least six times per year in a place convenient to the public. All meetings of the advisory committee on LTSS shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(g) The advisory committee on LTSS shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(h) It is unlawful for the advisory committee on LTSS 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 committee on LTSS and that is not generally available to the public.

100615. (a) The board shall 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 title, and individuals whose jobs may be or have been ended as a result of the implementation of CalCare, consistent with otherwise applicable law.

(b) Assistance described in subdivision (a) shall include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits, and education benefits.

100616. (a) The board shall establish an Advisory Committee on Public Employees’ Retirement System Health Benefits to provide input, including recommendations, to the board on matters of policy related to public employee retiree health benefits and CalCare, including all of the following:

(1) Processes to obtain approval of CalCare as a health benefits plan under public pension or retirement systems.

(2) Recommendations to the Legislature and Governor to provide tax or other accommodations for people who have accrued retiree health benefit contributions under public employees’ retirement systems.

(3) Recommendations to, and coordination with, public employee retirement system boards to fully integrate beneficiaries into CalCare.

(4) Processes to change or phase out health benefits under public employees’ retirement systems to fully integrate beneficiaries into CalCare.

(5) Federal approvals that may support transition of Medicare plans under public employees’ retirement systems to CalCare.

(b) (1) The board shall appoint the members of the advisory committee on PERS during the implementation period. Appointments shall be made by a majority vote of the voting members of the board. When appointing members to the advisory committee on PERS , the board shall aim for broad representation, including, at a minimum, the following representatives of public sector labor organizations: the Public Employees’ Retirement System, the State Teachers’ Retirement System, the University of California Retirement System, and locally administered public pension or retirement

systems. At a minimum, one-half of the advisory committee on PERS members shall be representatives of public sector labor organizations.

(2) Each appointed member shall serve at the discretion of the board and may be removed at any time by a majority vote of the voting members of the board.

(3) Advisory committee on PERS members shall not have access to confidential, nonpublic information that is accessible to the board and office. Instead, the advisory committee on PERS shall only have access to information that is publicly available. Neither the board nor the office shall disclose any confidential, nonpublic information to the advisory committee on PERS members.

(4) Advisory committee on PERS members shall receive reimbursement for travel and other actual costs.

(c) The advisory committee on PERS shall meet at least four times per year in a place convenient to the public. All meetings of the advisory committee on PERS shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(d) The board shall consider input, including recommendations, from the advisory committee on PERS, along with public comments, in the board's deliberation and decisionmaking.

100617. (a) The board shall utilize the data collected pursuant to Chapter 1 (commencing with Section 128675) of Part 5 of Division 107 of the Health and Safety Code to assess patient outcomes and to review utilization of health care items and services paid for by CalCare.

(b) As applicable to the type of provider, the board shall 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, which shall be reported to the board and, as applicable, the Department of Health Care Access and Information or the Medical Board of California:

(1) Inpatient discharge data, including severity of illness and risk of mortality, with respect to each discharge.

(2) 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.

(3) For hospitals and other providers receiving global budgets, annual financial data, including all of the following:

(A) Community benefit activities, including charity care, to which Section 501(r) of Title 26 of the United States Code applies, provided by the provider in dollar value at cost.

(B) Number of employees by employee classification or job title and by patient care unit or department.

(C) Number of hours worked by the employees in each patient care unit or department.

(D) Employee wage information by job title and patient care unit or department.

(E) Number of registered nurses per staffed bed by patient care unit or department.

(F) 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.

(G) Annual spending on information technology, including health information technology, artificial intelligence, purchases, upgrades, and maintenance.

(4) Risk-adjusted and raw outcome data, including:

(A) Risk-adjusted outcome reports for medical, surgical, and obstetric procedures selected by the Department of Health Care Access and Information pursuant to Sections 128745 to 128750, inclusive, of the Health and Safety Code.

(B) Any other risk-adjusted outcome reports that the board may require for medical, surgical, and obstetric procedures and conditions as it deems appropriate.

(5) A disclosure made by a provider as set forth in Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code.

(c) (1) The Medical Board of California shall collect data for the outpatient surgery settings that the Medical Board of California regulates that meets the Ambulatory Surgery Data Record requirements of Section 128737 of the Health and Safety Code, and shall submit that data to the CalCare board.

(2) The CalCare board shall make that data available as required pursuant to subdivision (d).

(d) The board shall make all disclosed data collected under this section publicly available and searchable through an internet website and through the Department of Health Care Access and Information public data sets.

(e) Consistent with state and federal privacy laws, the board shall make available data collected through CalCare to the Department of Health Care Access and Information and the California Health and Human Services Agency, consistent with this title and otherwise applicable law, to promote and protect public, environmental, and occupational health.

(f) Before full implementation of CalCare, and, for providers seeking to receive global budgets or salaried payments under Article 2 (commencing with Section 100650) of Chapter 5, as applicable, before the negotiation of initial payments, the board shall provide for the collection and availability of the following data:

(1) The number of patients served.

(2) The dollar value of the care provided, at cost, for all of the following categories of Department of Health Care Access and Information data items:

(A) Patients receiving charity care.

(B) Contractual adjustments of county and indigent programs, including traditional and managed care.

(C) Bad debts or any other unpaid charges for patient care that the provider sought, but was unable to collect.

(g) The board shall regularly analyze information reported under this section and shall establish rules and regulations to allow researchers, scholars, participating providers, and others to access and analyze data for purposes consistent with this title, without compromising patient privacy.

(h) (1) The board shall 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.

(2) In implementing this section, the board shall utilize data that is already being collected pursuant to other state or federal laws and regulations whenever possible.

(3) Data reporting required by participating providers under this section shall supplement the data collected by the Department of Health Care Access and Information and shall not modify or alter other reporting requirements to governmental agencies.

(i) The board shall not utilize quality or other review measures established under this section for the purposes of establishing payment methods to providers.

(j) The board may coordinate and cooperate with the Department of Health Care Access and Information or other health planning agencies of the state to implement the requirements of this section.

100618. (a) The board shall establish and use a process to enter into participation agreements with health care providers and other contracts with contractors. A contract entered into pursuant to this title shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of the Department of General Services. The board shall adopt a CalCare Contracting Manual incorporating procurement and contracting policies and procedures that shall be followed by CalCare. The policies and procedures in the manual shall be substantially similar to the provisions contained in the State Contracting Manual.

(b) The adoption, amendment, or repeal of a regulation by the board to implement this section, including the adoption of a manual pursuant to subdivision (a) and any procurement process conducted by CalCare in accordance with the manual, is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100619. (a) Notwithstanding any other law, CalCare, a state or local agency, or a public employee acting under color of law shall not provide or disclose 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.

(b) Notwithstanding any other law, law enforcement agencies shall not use 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 recognized in the Unruh Civil Rights Act (Section 51 of the Civil Code).

100620. (a) On or before July 1, ____, the board shall conduct and deliver a fiscal analysis to determine both of the following:

(1) Whether or not CalCare may be implemented.

(2) If revenue is more likely than not to be sufficient to pay for program costs within eight years of CalCare's implementation.

(b) The board may contract with one or more independent entities with the appropriate expertise or coordinate with other state agencies to conduct the fiscal analysis.

(c) The board shall deliver, and upon request present, the fiscal analysis to the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, the Chair of the Senate Committee on Appropriations, and the Chair of the Assembly Committee on Appropriations.

CHAPTER 3. Eligibility and Enrollment

100630. (a) Every resident of the state shall be eligible and entitled to enroll as a member of CalCare.

(b) (1) A member shall not be required to pay a fee, payment, or other charge for enrolling in or being a member of CalCare.

(2) A member shall not be required to pay a premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits under CalCare.

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

(d) An individual entitled to benefits through CalCare may obtain health care items and services from any institution, agency, or individual participating provider.

(e) The board shall establish a process for automatic CalCare enrollment at the time of birth in California.

100631. (a) All residents of this state, no matter what 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, are entitled to full and equal accommodations, advantages, facilities, privileges, or services in all health care providers participating in CalCare.

(b) Subdivision (a) prohibits a participating provider, or an entity conducting, administering, or funding a health program or activity pursuant to this title, from discriminating based upon the categories described in subdivision (a) in the provision, administration, or implementation of health care items and services through CalCare.

(c) Discrimination prohibited under this section includes the following:

(1) Exclusion of a person from participation in or denial of the benefits of CalCare, except as expressly authorized by this title for the purposes of enforcing eligibility standards in Section 100630.

(2) Reduction of a person's benefits.

(3) Any other discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity pursuant to this title.

(d) Section 52 of the Civil Code shall apply to discrimination under this section.

(e) Except as otherwise provided in this section, a participating provider or entity is in violation of subdivision (b) if the complaining party demonstrates that any of the categories listed in subdivision (a) was a motivating factor for any health care practice, even if other factors also motivated the practice.

CHAPTER 4. Benefits

100635. (a) Individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to a participating provider for the health care items and services in subdivision (c), if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition.

(b) The determination of medical necessity or appropriateness shall 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 established in Chapter 6 (commencing with Section 100660), and by the board, and other laws of the state.

(c) Covered health care benefits for members include all of the following categories of health care items and services:

(1) Inpatient and outpatient medical and health facility services, including hospital services and 24-hour-a-day emergency services.

(2) Inpatient and outpatient health care professional services and other ambulatory patient services.

(3) Primary and preventive services, including chronic disease management.

(4) Prescription drugs, biological products, and all contraceptive items approved by the United States Food and Drug Administration.

(5) Medical devices, equipment, appliances, and assistive technology.

(6) Mental health and substance abuse treatment services, including inpatient and outpatient care.

(7) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(8) Comprehensive reproductive care, including abortion, contraception, and assisted reproductive technology, maternity care, and newborn care.

(9) Pediatrics.

(10) Oral health, audiology, and vision services.

(11) Rehabilitative and habilitative services and devices, including inpatient and outpatient care.

(12) Emergency services and transportation.

(13) Early and periodic screening, diagnostic, and treatment services as defined in Section 1396d(r) of Title 42 of the United States Code.

(14) Comprehensive gender-affirming health care.

(15) Necessary transportation for health care items and services for persons with disabilities or who may qualify as low income.

(16) Long-term services and supports described in Section 100636, including long-term services and supports covered under Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) or the federal Children's Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.))

(17) Care coordination.

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

(d) The categories of covered health care items and services under subdivision (c) include all the following:

(1) Prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for their use by an individual.

(2) Child and adult immunizations.

(3) Hospice care.

(4) Care in a skilled nursing facility.

(5) Home health care, including health care provided in an assisted living facility.

(6) Prenatal and postnatal care.

(7) Podiatric care.

(8) Blood and blood products.

(9) Dialysis.

(10) Community-based adult services as defined under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code as of January 1, 2021.

(11) Dietary and nutritional therapies determined appropriate by the board.

(12) 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.

(13) Health care items and services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18990) and Chapter 12.991 (commencing with Section 18991) of Part 6 of Division 9 of the Welfare and Institutions Code.

(14) Health care items and services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(15) Language interpretation and translation for health care items and services, including sign language and braille or other services needed for individuals with communication barriers.

(e) Covered health care items and services under CalCare include all health care items and services required to be covered under the following provisions, without regard to whether the member would be eligible for or covered by the source referred to:

(1) The federal Children's Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

(2) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) The federal Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(5) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.

(6) All essential health benefits mandated by the federal Patient Protection and Affordable Care Act as of January 1, 2017.

(f) Health care items and services covered under CalCare shall not be subject to prior authorization or a limitation applied through the use of step therapy protocols.

100636. (a) Subject to the other provisions of this title, individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to an eligible provider for long-term services and supports, in accordance with the standards established in this title, 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:

(1) Causes a functional limitation in performing one or more activities of daily living or in instrumental activities of daily living.

(2) Is a disability, as defined in Section 12102(1)(A) of Title 42 of the United States Code, that substantially limits one or more of the member's major life activities.

(b) The board shall adopt regulations that provide for the following:

(1) The determination of individual eligibility for long-term services and supports under this section.

(2) The assessment of the long-term services and supports needed for an eligible individual.

(3) The automatic entitlement of an individual who receives or is approved to receive disability benefits from the federal Social Security Administration under the federal Social Security Disability Insurance program established in Title II or Title XVI of the federal Social Security Act to the long-term services and supports under this section.

(c) Long-term services and supports provided pursuant to this section shall do all of the following:

(1) Include long-term nursing services for a member, whether provided in an institution or in a home- and community-based setting.

(2) Provide coverage for a broad spectrum of long-term services and supports, including home- and community-based services, other care provided through noninstitutional settings, and respite care.

(3) 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.

(4) Prioritize delivery of long-term services and supports through home- and community-based services over institutionalization.

(5) Unless a member chooses otherwise, ensure that the member receives home- and community-based long-term services and supports regardless of the recipient's type or level of disability, service need, or age.

(6) 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.

(7) Be provided in a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity.

(8) Provide long-term services and supports that are of equal quality and equitably accessible across geographic regions.

(9) Ensure that long-term services and supports provide recipients the option of self-direction of service, including under the Self-Directed Services Program described in Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, from either the recipient or care coordinators of the recipient's choosing.

(d) In developing regulations to implement this section, the board shall consult the advisory committee on LTSS established pursuant to Section 100614.

100637. (a) (1) The board shall, on a regular basis and at least annually, 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.

(2) In implementing this section, the board shall not remove or eliminate covered health care items and services under CalCare that are listed in this chapter.

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

(c) The board shall 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 the Department of Managed Health Care pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(d) For the purposes of this chapter:

(1) “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.

(2) “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.

CHAPTER 5. Delivery of Care

Article 1. Health Care Providers

100640. (a) (1) 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 described in Section 100641.

(D) The provider or entity is otherwise in good standing.

(2) The board shall 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.

(b) A provider or entity shall not be 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:

(1) 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.

(2) Entities that are approved to coordinate care plans under the Medicare Advantage program established in Part C of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1851 et seq.) as of January 1, 2020, but do not directly provide health care items and services.

(c) A health care provider qualified to participate under this section may provide covered health care items or services under CalCare, as long as the health care provider is legally authorized to provide the health care item or service for the individual and under the circumstances involved.

(d) (1) The board shall establish and maintain procedures for members and individuals eligible to enroll in CalCare to enroll onsite at a participating provider.

(2) A participating provider shall accept onsite enrollment of members and eligible individuals under the procedures established pursuant to paragraph (1).

(e) The board shall establish and maintain procedures and standards for members to select a primary care provider, 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, and other participating providers.

(f) A referral from a primary care provider is not required for a member to see a participating provider.

(g) A member may 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 title relating to discrimination, and the appropriate clinically relevant circumstances and standards.

100641. (a) A health care provider shall enter into a participation agreement with the board to qualify as a participating provider under CalCare.

(b) A participation agreement between the board and a health care provider shall include provisions for at least the following, as applicable to each provider:

(1) Health care items and services to members shall be furnished by the provider without discrimination, as required by Section 100631. This paragraph 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.

(2) A charge shall not be made to a member for a covered health care item or service, other than for payment authorized by this title. Except as described in Section 100644, a contract shall not be entered into with a patient for a covered health care item or service.

(3) The provider shall follow the policies and procedures in the CalCare Contracting Manual established pursuant to Section 100618.

(4) The provider shall furnish information reasonably required by the board and shall meet the reporting requirements of Sections 100617 and 100661 for at least the following:

(A) Quality review by designated entities.

(B) Making payments, including the examination of records as necessary for the verification of information on which those payments are based.

(C) Statistical or other studies required for the implementation of this title.

(D) Other purposes specified by the board.

(5) If the provider is not an individual, the provider shall 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.

(6) If the provider is paid on a fee-for-service basis for covered health care items and services, the provider shall 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.

(7) The provider shall 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.

(8) (A) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall 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 title.

(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 title.

(B) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall not do the following:

(i) Use 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 title.

(ii) Require 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) Provide financial incentives or disincentives to physicians, registered nurses, or other health care professionals for particular coding query results or code selections.

(iv) Use 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.

(9) The provider shall comply with the duty of patient advocacy and reporting requirements described in Section 100661.

(10) If the provider is not an individual, the provider shall ensure that a board member, executive, or administrator of the provider shall 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.

(11) If the provider is a not-for-profit hospital subject to Article 2 (commencing with Section 127340) of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code, the hospital shall submit to the board the community benefits plan developed pursuant to Article 2 (commencing with Section 127340) of the Health and Safety Code.

(12) Health care items and services to members shall be furnished by a health care professional while the professional is physically present within the State of California.

(13) The provider shall not enter into risk-bearing, risk-sharing, or risk-shifting agreements with other health care providers or entities other than CalCare.

(c) This section does not limit the formation of group practices.

100642. (a) A participation agreement may be terminated with appropriate notice by the board for failure to meet the requirements of this title or may be terminated by a provider.

(b) A participating provider shall be provided 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.

(c) The procedures and penalties under the Medi-Cal program for fraud or abuse pursuant to Sections 14107, 14107.11, 14107.12, 14107.13, 14107.2, 14107.3, 14107.4, 14107.5, and 14108 of the Welfare and Institutions Code shall apply to an applicant or provider under CalCare.

(d) For purposes of this section:

(1) “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.

(2) “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.

100643. (a) A person shall not discharge or otherwise discriminate against an employee on account of the employee or a person acting pursuant to a request of the employee for any of the following:

(1) Notifying the board, executive director, or employee’s employer of an alleged violation of this title, including communications related to carrying out the employee’s job duties.

(2) Refusing to engage in a practice made unlawful by this title, if the employee has identified the alleged illegality to the employer.

(3) 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 title.

(4) Testifying before or otherwise providing information relevant for a state or federal proceeding regarding this title or a proposed amendment to this title.

(5) Commencing, causing to be commenced, or being about to commence or cause to be commenced a proceeding under this title.

(6) Testifying or being about to testify in a proceeding.

(7) Assisting or participating, or being about to assist or participate, in a proceeding or other action to carry out the purposes of this title.

(8) 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 title or any order, rule, regulation, standard, or ban under this title.

(b) An employee covered by this section who alleges discrimination by an employer in violation of subdivision (a) may bring an action governed by the rules and procedures, legal burdens of proof, and remedies applicable under the False Claims Act (Article 9 (commencing with Section 12650) of Chapter 6 of Part 2 of Division 3 of Title 2) or Section 12990, or an action against unfair competition pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code.

(c) (1) This section does not diminish the rights, privileges, or remedies of an employee under any other law, regulation, or collective bargaining agreement. The rights and remedies in this section shall not be waived by an agreement, policy, form, or condition of employment.

(2) This section 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.

(d) For purposes of this section:

(1) “Employer” means a person engaged in profit or not-for-profit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and who is subject to liability for violating this title.

(2) “Employee” means an individual performing activities under this title on behalf of an employer.

100644. (a) This section shall be effective on the date the implementation period ends pursuant to paragraph (6) of subdivision (e) of Section 100612.

(b) (1) An institutional or other health care provider with a participation agreement in effect shall not bill or enter 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.

(2) An institutional or other health care provider with a participation agreement in effect may 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 paragraphs (3) and (4).

(B) The health care item or service is not payable or available through CalCare.

(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.

(3) (A) A contract described in paragraph (2) shall 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 shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (2) shall 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 shall 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.

(iv) The individual understands that the provider is providing services outside the scope of CalCare.

(4) A participating provider that enters into a contract described in paragraph (2) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall 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.

(5) If a provider signing an affidavit described in paragraph (4) 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 paragraph (2) shall be void.

(B) A payment shall 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. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(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 subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(6) An institutional or other health care 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. Consistent with Section 100619, the institutional or other health care provider shall report to the board, on an annual basis, aggregate information regarding services furnished to ineligible individuals.

(c) (1) An institutional or other health care provider without a participation agreement in effect may 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 specified in paragraphs (2) and (3).

(2) (A) A contract described in paragraph (1) shall 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 shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (1) shall 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 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.

(ii) The individual shall 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.

(iii) 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.

(iv) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service.

(v) The individual understands that the provider is providing services outside the scope of CalCare.

(3) A provider that enters into a contract described in paragraph (1) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall 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.

(4) If a provider who signed an affidavit described in paragraph (3) 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 pursuant to paragraph (3), all of the following apply:

(A) A contract described in paragraph (1) shall be void.

(B) A payment shall 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. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(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 in subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(5) An institutional or other health care provider without a participation agreement in effect may bill or enter into a private contract with an individual for a health care item or service that is not a benefit under CalCare.

Article 2. Payment for Health Care Items and Services

100650. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services provided to members under CalCare by participating providers. All payment rates under CalCare shall be reasonable and reasonably related to all of the following:

(1) The cost of efficiently providing health care items and services.

(2) Ensuring availability and accessibility of CalCare health care services, including compliance with state requirements regarding network adequacy, timely access, and language access.

(3) Maintaining an optimal workforce and the health care facilities necessary to deliver quality, equitable health care.

(b) (1) Payment for health care items and services shall be considered payment in full.

(2) A participating provider shall not charge a rate in excess of the payment established through CalCare for a health care item or service furnished under CalCare and shall 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.

(3) This section does not preclude CalCare from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(c) Not 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, the board shall pay to each institutional provider a lump sum to cover all operating expenses under a global budget as set forth in Section 100651. An institutional provider receiving a global budget payment shall 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.

(d) (1) A group practice, county organized health system, or local initiative practice may elect to be paid for health care items and services furnished under CalCare either on a fee-for-service basis under Section 100655 or on a salaried basis.

(2) A group practice, county organized health system, or local initiative practice that elects to be paid on a salaried basis shall negotiate salaried payment rates with the board annually, and the board shall pay the group practice, county organized health system, or local initiative at the beginning of each month.

(3) The board may determine whether a group practice, county organized health system, or local initiative practice may elect to be paid on an hourly or other time-based rate for certain health care items and services furnished under CalCare, including primary and preventive care and care coordination.

(e) Health care items and services provided to members under CalCare by individual providers or any other providers not paid under subdivision (c) or (d) shall be paid for on a fee-for-service basis under Section 100655.

(f) Capital-related expenses for specifically identified capital expenditures incurred by participating providers shall meet the requirements under Section 100656.

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

(h) The board shall adopt, by regulation, payment methodologies and procedures for paying for out-of-state health care services.

(i) (1) This article does 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.

(2) This article 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.

(j) The board shall 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.

100651. (a) An institutional provider's global budget shall be determined before the start of a fiscal year through negotiations between the provider and the board. The global budget shall be negotiated annually based on the payment factors described in subdivision (d).

(b) An institutional provider's global budget shall be used only to cover operating expenses associated with direct care for patients for health care items and services covered under CalCare. An institutional provider's global budget shall not be used for capital expenditures, and capital expenditures shall not be included in the global budget.

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

(d) A payment negotiated pursuant to subdivision (a) shall take into account, with respect to each provider, all of the following:

(1) The historical volume of services provided for each health care item and service in the previous three-year period.

(2) 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:

(A) The expenditures of other comparable institutional providers in the state.

(B) The normative payment rates established under the comparative payment rate systems pursuant to Section 100654, including permissible adjustments to the rates for the health care items and services.

(C) Projected changes in the volume and type of health care items and services to be furnished.

(D) Employee wages and compensation.

(E) The provider's maximum capacity to provide health care items and services.

(F) Education and prevention programs.

(G) Health care workforce recruitment and retention programs, including programs to maintain optimal staffing levels of health care workers as established by the board and to maintain mandatory minimum safe registered nurse-to-patient ratio regulations adopted pursuant to Section 1276.4 of the Health and Safety Code.

(H) 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.

(I) Any other factor determined appropriate by the board.

(3) In a rural or medically underserved area, the need to mitigate the impact of the availability and accessibility of health care services through increased global budget payment.

(e) A payment negotiated pursuant to subdivision (a) or payment methodology shall not do any of the following:

(1) Take into account capital expenditures of the provider or any other expenditure not directly associated with furnishing health care items and services under CalCare.

(2) Be used by a provider for capital expenditures or other expenditures associated with capital projects.

(3) Exceed the provider's capacity to furnish health care items and services covered under CalCare.

(4) Be used to pay or otherwise compensate a board member, executive, or administrator of the institutional provider who has an interest or relationship prohibited under paragraph (10) of subdivision (b) of Section 100641 or paragraph (3) of subdivision (c) of Section 100661.

(5) Take into account relief pending appeal granted to a provider under Section 100653.

(f) The board may negotiate changes to an institutional provider's global budget based on factors not prohibited under subdivision (e) or any other provision of this title.

(g) Subject to subdivision (i) of Section 100650, compensation costs for an employee, contractor employee, or subcontractor employee of an institutional provider receiving a global budget shall meet the compensation cap established in Section 4304(a)(16) of Title 41 of the United States Code 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.

(h) A payment to an institutional provider pursuant to this section shall not allow 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. This subdivision shall apply 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.

(i) For the purposes of this section, "operating expenses" of a provider include the following:

(1) The costs associated with covered health care items and services under CalCare, including the following:

(A) Compensation for health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider.

(B) Pharmaceutical products administered by health care professionals at the institutional provider's facility or facilities.

(C) Purchasing supplies.

(D) Maintenance of medical devices and health care technologies, including diagnostic testing equipment, except that health information technology that is not necessary to comply with data collection and reporting requirements under this title or otherwise required by law and artificial intelligence shall be considered capital expenditures, unless otherwise determined by the board.

(E) Incidental services necessary for safe patient care.

(F) Patient care, education, and preventive health programs, and necessary staff to implement those programs.

(G) 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.

(H) 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.

(I) Recruitment, retention, and training of health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider, including programs to maintain optimal staffing levels of health care workers as

established by the board and to maintain mandatory minimum safe registered nurse-to-patient ratio regulations adopted pursuant to Section 1276.4 of the Health and Safety Code.

(2) Administrative costs of the institutional provider.

100652. (a) The board shall consider a request for interim payment, filed by an institutional provider that is subject to the payments or global budget, or filed by health care workers of an institutional provider that is subject to the payment or global budget or their representatives, based on the following:

(1) The overall financial condition of the institutional provider, including bankruptcy or financial solvency.

(2) Excessive risks to the ongoing operation of the institutional provider.

(3) 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.

(4) 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. Those factors may include:

(A) Natural disasters.

(B) Outbreaks of epidemics or infectious diseases.

(C) Unanticipated facility or equipment repairs or purchases.

(D) Significant and unanticipated increases in pharmaceutical or medical device prices.

(E) Public health emergencies.

(5) Changes in state or federal laws that result in a change in costs.

(6) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

(b) The board shall establish uniform written procedures under which it reviews requests for interim payment pursuant to subdivision (a), including procedures to provide immediate payment in the event of a public health emergency.

(c) On a quarterly basis, the board shall review the global budget and payments to institutional providers that are not-for-profit or governmental entities and may initiate an interim payment review under subdivision (b) based on the factors set forth in this section.

100653. (a) The board shall consider an appeal of payments, the global budget, or a determination of a request for interim payment, filed by an institutional provider that is subject to the payment or global budget or filed by health care workers of an institutional provider that is subject to the payment or global budget or their representatives.

(b) (1) The payments set and global budget negotiated by the board to be paid to the institutional provider shall stay in effect during the appeal process, subject to relief pending appeal under this subdivision.

(2) The board shall have the power to grant interim relief based on fairness. The board shall develop regulations governing interim relief. The board shall establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by an institutional provider. A decision on interim relief shall be granted within one

month of the filing of an interim relief appeal. An institutional provider shall 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 paragraph (4) of subdivision (a) of Section 100652.

(c) (1) In accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2), the board may delegate the conduct of a hearing to an administrative law judge, who shall issue a proposed decision with findings of fact and conclusions of law.

(2) The administrative law judge may hold evidentiary hearings and shall 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.

(3) Within 30 days of receipt of the proposed decision by the administrative law judge, the board may approve, disapprove, or modify the decision, and shall issue a final decision for the appealing institutional provider.

(d) A final determination by the board shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure.

100654. (a) The board shall use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations described in subparagraph (B) of paragraph (2) of subdivision (d) of Section 100651. The board shall update the comparative payment rate system annually.

(b) To develop the comparative payment rate system, the board shall use only the operating base payment rates under each Medicare prospective payment system with applicable adjustments.

(c) The comparative rate system shall not include value-based purchasing adjustments or capital expenses base payment rates that may be included in Medicare prospective payment systems.

(d) In the first year that global budget payments 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, the board shall 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.

100655. (a) The board shall engage in good faith negotiations with health care providers' representatives under Chapter 8 (commencing with Section 100685) to determine rates of fee-for-service payments for health care items and services furnished under CalCare.

(b) There shall be a rebuttable presumption that the Medicare fee-for-service rates of reimbursement constitute reasonable fee-for-service payment rates. The fee schedule shall be updated annually.

(c) Payments to individual providers under this article shall not include payments to individual providers in salaried positions at institutional providers receiving global budgets under Section 100651 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 that receive payment under CalCare on a salaried basis.

(d) To establish the fee-for-service payment rates, the board shall 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.

(e) In a rural or medically underserved area, the board may mitigate the impact of the availability and accessibility of health care services through increased individual provider payment.

(f) The board shall consider a request for interim payment, filed by a health care provider that is subject to the payments under this section, or by health care workers of a health care provider that is subject to the payments under this section or their representatives, based on the factors and procedures developed pursuant to Section 100652.

100656. (a) (1) The board shall 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 pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) The board shall prioritize allocation of funding under this subdivision to projects that propose to use the funds to improve service in a rural or medically underserved area, or 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. The board shall 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.

(3) For the purposes of funding capital expenditures under this section, health care facilities and governmental entities shall apply to the board in a time and manner specified by the board. All capital-related expenses generated by a capital project shall have received prior approval from the board to be paid under CalCare.

(b) Approval of an application for capital expenditures shall be based on achievement of the program standards described in Chapter 6 (commencing with Section 100660).

(c) The board shall not grant 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.

(d) A participating provider shall not use 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.

(e) A participating provider shall not do either of the following:

(1) Use funds from CalCare designated for operating expenses or payments for capital expenditures.

(2) Use funds from CalCare designated for capital expenditures or payments for operating expenses.

100657. (a) (1) A margin generated by a participating provider receiving a global budget under CalCare may be retained and used to meet the health care needs of CalCare members.

(2) A participating provider shall not retain 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.

(3) The board shall evaluate the source of margin generation.

(b) A payment under CalCare, including provider payments for operating expenses or capital expenditures, shall not take into account, include a process for the funding of, or be used by a provider for any of the following:

(1) Marketing, which does not include education and prevention programs paid under a global budget.

(2) The profit or net revenue, or increasing the profit, net revenue, or financial result of the provider.

(3) 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.

(4) A bonus, incentive payment, or incentive adjustment from CalCare to a participating provider.

(5) 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.

(6) A bonus, incentive payment, or compensation based on the financial results of an integrated health care delivery system, group practice, or other provider.

(7) State political contributions.

(c) (1) The board shall establish and enforce penalties for violations of this section, consistent with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

(2) Penalty payments collected for violations of this section shall be remitted to the CalCare Trust Fund for use in CalCare.

100658. (a) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, and other relevant state agencies, negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. Negotiations by the board shall be on behalf of the entire CalCare program. A state agency shall cooperate to provide data and other information to the board.

(b) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, the CalCare Public Advisory Commission, patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals, establish a prescription drug formulary system. To establish the prescription drug formulary system, the board shall do all of the following:

(1) Promote the use of generic and biosimilar medications.

(2) Consider the clinical efficacy of medications.

(3) 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.

(4) 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.

(c) The prescription drug formulary system shall not require a prior authorization determination for coverage under CalCare and shall not apply treatment limitations through the use of step therapy protocols.

(d) (1) The prescription drug formulary system shall include coverage for prescription drugs in a manner in which there is no cost sharing for CalCare enrollees.

(2) The board may consider cost sharing for providers that prescribe drugs with a lower cost medically equivalent generic or lower cost drug substitution.

(3) The prescription drug formulary system shall include antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis as defined in former Section 4052.02 of the Business and Professions Code and postexposure prophylaxis as defined in former Section 4052.03 of the Business and Professions Code, in a manner in which there is no cost sharing for CalCare enrollees.

(e) The board shall promulgate regulations regarding the use of off-formulary medications that allow for patient access.

CHAPTER 6. Program Standards

Article 1. Standard of Care

100660. CalCare shall establish a single standard of safe, therapeutic, and effective care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for CalCare and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care items and services.

(2) Relations between participating providers and members.

(3) 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 shall establish requirements and standards, by regulation, under CalCare that include provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in the following:

(A) Health care provider credentialing for participation in CalCare.

(B) Health care provider clinical and admitting privileges in health care facilities.

(C) 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.

(D) Payment procedures and rates.

(E) Claims processing.

(2) In-person primary and preventive care, efficient and effective health care items and services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Nondiscrimination pursuant to Section 100631.

(5) Accessibility of health care items and services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing health care items and services in a culturally, linguistically, and structurally competent manner.

(7) Prevention-oriented care.

(c) The board shall 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.

(d) A participating provider shall furnish information as required by the Department of Health Care Access and Information pursuant to Sections 100617 and 100641, and to Division 107 (commencing with Section 127000) of the Health and Safety Code, 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.

(e) The board shall use the data furnished under this title to ensure that clinical practices meet the utilization, quality, and access standards of CalCare. The board shall not use a standard developed under this chapter for the purposes of establishing a payment incentive or adjustment under CalCare.

(f) To develop requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, health care organizations, labor organizations representing health care employees, and other interested parties.

(g) The board shall coordinate with the Office of Health Equity, the Department of Health Care Access and Information, and the Department of Managed Health Care to do both of the following:

(1) Monitor participating providers for, and establish procedures related to, compliance with the requirements and standards established under this section.

(2) Establish programs, including special projects under Section 100677, to ensure or manage CalCare member access to in-person primary and preventive care, efficient and effective health care items and services, and quality care.

100661. (a) (1) As part of a health care practitioner's duty to advocate for medically appropriate health care for their patients pursuant to Sections 510 and 2056 of the Business and Professions Code, a participating provider has a duty to act in the exclusive interest of the patient.

(2) The duty described in paragraph (1) applies 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.

(b) Consistent with subdivision (a) and with Sections 510 and 2056 of the Business and Professions Code:

(1) 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.

(2) A participating provider or 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 from a participating provider or other person participating in CalCare shall use reasonable care and diligence in safeguarding an individual under the care of the provider or professional and shall not impair an individual's treating physician or other health care provider treating the individual from advocating for medically necessary or appropriate care under this section.

(c) A health care provider or health care professional described in subdivision (a) violates the duty established under this section for any of the following:

(1) Having a pecuniary interest or relationship, including an interest or relationship disclosed under subdivision (d), that impairs the provider's ability to provide medically necessary or appropriate care.

(2) Accepting a bonus, incentive payment, or compensation based on any of the following:

(A) A patient's utilization of services.

(B) 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.

(C) 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.

(3) 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.

(d) To evaluate and review compliance with this section, a participating provider shall report, at least annually, to the Department of Health Care Access and Information all of the following:

(1) A beneficial interest required to be disclosed to a patient pursuant to Section 654.2 of the Business and Professions Code.

(2) A membership, proprietary interest, coownership, or profit-sharing arrangement, required to be disclosed to a patient pursuant to Section 654.1 of the Business and Professions Code.

(3) A subcontract entered into 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.

(4) 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.

(5) An offer, delivery, receipt, or acceptance of rebates, refunds, commission, preference, patronage dividend, discount, or other consideration for a referral made in exception to Section 650 of the Business and Professions Code.

(e) The board may adopt regulations as necessary to implement and enforce this section and may adopt regulations to expand reporting requirements under this section.

(f) For purposes of this section, "person" means 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.

100662. (a) 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, may 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.

(b) An override described in subdivision (a) shall, in the independent professional judgment of the treating physician, nurse, or other health care professional, meet all of the following requirements:

(1) 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.

(2) The override is in the best interest of the patient.

(3) The override is consistent with the patient's wishes.

Article 2. Health Equity

100665. (a) There is hereby established, within CalCare, the Office of Health Equity. The Director of the Department of Health Care Access and Information shall be the director of the office and shall carry out all functions of that position, including enforcement.

(b) The office shall be responsible for coordination and collaboration across the programs and activities of CalCare and the California Health and Human Services Agency with respect to ensuring health equity under CalCare and other health programs of the California Health and Human Services Agency.

(c) The office shall do all of the following:

(1) Support the board through data collection and analysis of, and recommendations to address, all of the following:

(A) The disproportionate burden of disease and death by 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.

(B) Barriers to health, including barriers relating to income, education, housing, food insecurity, employment status, working conditions, and conditions related to the physical environment.

(C) Barriers to health care access, including lack of trust and awareness, lack of transportation, geography, hospital and service closures, lack of health care infrastructure and facilities, lack of health care professional staffing and recruitment, disparities in quality of care received, and disparities in utilization of care.

(D) Inequitable distribution of health care services, including health care professional shortage areas, medically underserved areas, medically underserved populations, and trends in hospital closures and service reductions.

(E) Discrimination in health care settings and the use of racially biased or other discriminatory practice guidelines, health care technologies, and algorithms.

(F) Increasing access to high-quality primary health care, particularly in medically underserved areas and for medically underserved populations

(G) Prevention-oriented care through the identification of social determinants of health and gaps in human services programs that address social determinants of health.

(2) Ensure that analysis and data collected under this section are made publicly available and allow for the analysis of cross-sectional information on people's identities.

(3) Support the board through the development and coordination of programs and recommendations to enhance health equity in California, including programs and recommendations on all of the following:

(A) Improving the provision of culturally, linguistically, and structurally competent care.

(B) Increasing diversity in the health care workforce.

(C) Ensuring sufficient health care professionals and facilities to meet the health care needs across the state.

(D) Ensuring equitable access and distribution of health care professionals and facilities to meet the health care needs across the state.

(E) Recruitment and retention of a health care workforce that meets the cultural, linguistic, and other needs of Californians.

(F) Recruitment and retention of a health care workforce in rural and medically underserved areas.

(4) Develop, coordinate, and provide recommendations on programs that expand the number of primary health care providers and practitioners, including primary care physicians, registered nurses, and dentists, in the state.

(5) Develop, coordinate, and provide recommendations on targeted programs and resources for federally qualified health centers, rural health centers, community health centers, and other community-based organizations that provide primary care in the state.

(6) Conduct ongoing research and evaluation on health equity and access to primary care in California.

(7) Support the board and the CalCare Public Advisory Commission through data collection and analysis and recommendations to develop, propose, and review special projects under Section 100677.

(8) Adopt and promulgate regulations for the purpose of carrying out this chapter.

(9) Establish advisory or technical committees, as necessary.

(d) For purposes of implementing this section, including hiring staff and consultants, through the procurement authority and processes of the department, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Until January 1, 2029, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

Article 3. Consumer Protections

100667. (a) It is the intent of the Legislature that all existing consumer protections related to health care service plans, including network adequacy, timely access, and language access, apply to CalCare.

(b) It is the intent of the Legislature that all existing patient rights and protections in the delivery and provision of health care items and services apply to CalCare and participating providers in CalCare.

(c) This title does not diminish or eliminate any protections consumers have under existing state and federal law, including health care spending targets and data collection required by the Office of Health Care Affordability.

(d) For purposes of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), the CalCare program is a health care service plan, including for purposes of the Independent Medical Review System established in Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e) This title does not diminish or eliminate any of the rights and protections afforded to Californians by the Medicare and Medicaid programs under state and federal law or the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

CHAPTER 7. Funding

Article 1. Federal Health Programs and Funding

100670. (a) (1) The board is authorized to and shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare consistent with this title.

(2) The board is authorized to apply for a federal waiver or federal approval as necessary to receive funds to operate CalCare pursuant to paragraph (1), including a waiver under Section 18052 of Title 42 of the United States Code.

(3) The board shall apply for federal waivers or federal approval pursuant to paragraph (1) by July 1, 2029.

(b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, 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 title, 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, created pursuant to Section 100675, and to use those funds for CalCare and other provisions under this title.

(2) To the fullest extent possible, the board shall 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. To the extent any federal funding is not paid directly to CalCare, the state shall direct the funding and moneys to CalCare.

(3) The board may require members or applicants to provide information necessary for CalCare to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement CalCare to the maximum extent possible as an independent single-payer program consistent with this title. It is the intent of the Legislature to establish CalCare, to the fullest extent possible, as an independent agency.

(c) The board may take actions consistent with this article to enable CalCare to administer Medicare in California. CalCare shall be a provider of supplemental insurance coverage and shall provide premium assistance for drug coverage under Medicare Part D for eligible members of CalCare.

(d) The board may waive or modify the applicability of any provisions of this title relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to CalCare under this section.

(e) The board may 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.

(f) (1) Notwithstanding any other law, the board, by regulation, shall 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 Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director 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 Affordable Care Act.

(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.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may 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.

(h) As a condition of continued eligibility for health care items and services under CalCare, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The board shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services 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.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize CalCare to obtain, any information or documentation required to establish the member's eligibility for that subsidy. The board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The board shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that the member has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under CalCare may be suspended until the issue is resolved. Information provided by a member to the board for the purposes of this section shall not be used for any other purpose.

(l) The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. CalCare Trust Fund

100675. (a) The CalCare Trust Fund is hereby created in the State Treasury for the purposes of this title to be administered by the CalCare Board. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other law, moneys deposited in the fund shall not be 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.

(c) The board shall 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.

(d) The board or staff of the board shall not utilize 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.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under Section 100680.

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under CalCare.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under CalCare.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care items or services for services and benefits covered under CalCare. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the CalCare Federal Funds Account, which is hereby created within the CalCare Trust Fund.

(h) Moneys in the CalCare Trust Fund shall only be used for the purposes established in this title.

(i) (1) Before the delivery of the fiscal analysis required pursuant to Section 100620:

(A) Moneys in the CalCare Trust fund shall not be used for startup and administrative costs to implement Section 100612.

(B) Moneys in the CalCare Trust Fund may be used to design and commission the fiscal analysis required pursuant to Section 100620.

(2) After delivery of the fiscal analysis required pursuant to Section 100620, moneys in the CalCare Trust Fund may be used for startup and administrative costs to implement Section 100612.

100676.

(a) The board annually shall prepare a budget for CalCare that specifies a budget for all expenditures to be made for covered health care items and services and shall establish allocations for each of the budget components under subdivision (b) that shall cover a three-year period.

(b) The CalCare budget shall consist of at least the following components:

(1) An operating budget.

(2) A capital expenditures budget.

(3) A special projects budget.

(4) Program standards activities.

(5) Health professional education expenditures.

(6) Health care workforce recruitment and retention expenditures.

(7) Administrative costs.

(8) Prevention and public health activities.

(c) The board shall allocate the funds received among the components described in subdivision (b) to ensure the following:

(1) The operating budget allows for participating providers to meet the health care needs of the population.

(2) A fair allocation to the special projects budget to meet the purposes described in subdivision (f) in a reasonable timeframe.

(3) A fair allocation for program standards activities.

(4) The health professional education expenditures component is sufficient to meet the need for covered health care items and services.

(d) The operating budget described in paragraph (1) of subdivision (b) shall be used for payments to providers for health care items and services furnished by participating providers under CalCare.

(e) The capital expenditures budget described in paragraph (2) of subdivision (b) shall 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.

(f) The special projects budget described in paragraph (3) of subdivision (b) shall be used for the payment to not-for-profit or governmental entities pursuant to Section 100677.

(g) For up to five years following the date on which benefits first become available under CalCare, at least 1 percent of the budget shall be allocated to programs providing transition assistance pursuant to Section 100615.

(h) During the implementation period and for at least five years following the date on which benefits first become available under CalCare, up to 1 percent of the budget shall be allocated to programs providing health care workforce education, recruitment, and retention pursuant to Section 100686.

100677. (a) (1) The special projects budget described in paragraph (3) of subdivision (b) of Section 100676 shall be used for the payment to not-for-profit entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code or governmental entities 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.

(2) To mitigate the impact of the payments on the availability and accessibility of health care services, the special projects budget may be used to increase payment to providers in a rural or medically underserved area.

(b) (1) An agency of the state, a city, a county, a city and county, or another political subdivision of the state or a not-for-profit entity that is a health facility pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code may submit an application to the board for payment from the special projects budget for a special project under this section.

(2) The board shall develop criteria to evaluate applications for payment from the special projects budget for special projects in consultation with the CalCare Public Advisory Commission, the Office of Health Equity, the California Health Facilities Financing Authority, the Department of Health Care Access and Information, the State Department of Health Care Services, the Department of Managed Health Care, the State Department of Public Health, and other relevant state agencies.

(3) The criteria to evaluate applications shall consider factors, including if the special project will support a health facility in a rural or medically underserved area, and if the special project will 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.

(4) The criteria to evaluate applications shall also be used for identification and monitoring of health facilities at risk of understaffing in rural or medically underserved areas and of populations experiencing health disparities.

(c) (1) The board may issue a request for applications for a special project paid under subdivision (b) in consultation with the Office of Health Equity.

(2) The CalCare Public Advisory Commission may develop and recommend the board issue a request for applications for a special project paid under subdivision (b).

(d) (1) An applicant for payment from the special projects budget shall provide the board with financial, demographic, and other information regarding the proposed health care service area as determined by the board, in a format determined by the board, to review an application to receive payment from the special projects budget for a special project.

(2) An applicant for payment from the special projects budget shall submit a plan to the board detailing the projected uses of the proposed payment and strategies proposed to address a health disparity or other qualifying need identified by the board.

(e) (1) The board shall determine the application process and methodology for approval and distribution of payments from the special projects budget.

(2) In reviewing a plan submitted by an applicant for payment from the special projects budget under this section, the board shall evaluate if there is a reasonable likelihood that it will address a health disparity or other qualifying need identified by the board.

(3) The board shall provide public notice of an application submitted under this section and post a copy of the applicant's plan submitted under this section on its internet website.

(4) The board shall make its application process and methodology publicly accessible on its internet website.

(f) (1) Within 90 days of receipt of a complete application for a payment from the special projects budget for a special project, the board shall provide a preliminary report to the applicant of the board's initial review of the application and provide public notice of the preliminary report.

(2) The board shall provide the public the opportunity to provide written comment on a preliminary report of an application for payment from the special projects budget for a special project.

(3) Before the board approves an application for payment from the special projects budgets for a special project, the CalCare Public Advisory Commission shall conduct at least one public hearing to receive public input and comment on the application.

(4) The CalCare Public Advisory Commission shall provide a recommendation to the board on the approval of an application submitted to the board under this section.

(g) The board shall have the authority to determine service provision requirements or other conditions in approving, and for the duration of, special projects payments to health facilities or that support health facilities. In making its determination, the board shall consider the impact of any changes to the health facilities service delivery on access to medical care.

Article 3. CalCare Financing

100680. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is 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.

CHAPTER 8. Transition

100685. (a) An individual who meets all of the following requirements shall be eligible to enroll as a member of CalCare during the implementation period:

(1) The individual meets the eligibility standards established by the board under Section 100630.

(2) The individual is 55 years of age or older, 18 years of age or younger, or is currently enrolled in Medicare or Medicaid during the implementation period.

(b) The board shall ensure that all persons enrolled, or who seek to enroll, in a health plan during the implementation period are protected from disruptions in their care during the implementation period, including continuity of care with current health care teams.

(c) (1) During the implementation period, a carrier shall not end coverage for a CalCare member until the end of the implementation period except as expressly agreed upon under the terms of the plan.

(2) During the implementation period, a carrier shall not impose any exclusion or limitation of coverage on the basis of a person's disability, complex medical need, or chronic condition.

(3) This subdivision applies to a carrier except as otherwise prohibited by federal law.

(d) The board shall consult with the Advisory Committee on Long-Term Services and Supports, communities and advocacy organizations of persons living with disabilities, and other patient advocacy organizations to ensure that CalCare coverage during the implementation period takes into account the continuity of care for persons with disabilities, complex medical needs, or chronic conditions.

(e) In the case of inpatient hospital services and extended care services during a continuous period of stay that began before the end of the implementation period, and that had not ended as of the end of the implementation date, the board shall provide for continuation of benefits under CalCare until the end of the period of stay.

(f) During the implementation period, the board shall establish and maintain procedures that, to the greatest extent possible, provide for the following:

(1) Automatic enrollment in CalCare of individuals who are eligible to enroll in CalCare during the implementation period.

(2) Automatic enrollment in CalCare of individuals who will become eligible to enroll in CalCare after the end of the implementation period.

(g) (1) During the implementation period, the board shall establish and maintain procedures for individuals who will become eligible to enroll in CalCare after the end of the implementation period to select a primary care provider under subdivision (e) of Section 100630.

(2) During the implementation period, the board, to the greatest extent possible, shall establish and maintain procedures for individuals who are currently members of an integrated health care delivery system to automatically select participating providers in the individual's integrated health care delivery system care team as their primary care provider upon enrollment in CalCare.

(h) A person who is eligible to receive CalCare benefits during the implementation period may opt to maintain coverage outside of CalCare, including private health care coverage or coverage offered through the California Health Benefit Exchange, until the end of the implementation period.

100686. (a) (1) The board shall provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for programs to address health care workforce education, recruitment, and retention to meet health workforce demands under CalCare, including programs implemented during the implementation period.

(2) The board shall coordinate with the CalCare Public Advisory Commission, the Office of Health Equity, the Department of Health Care Access and Information, the Labor and Workforce Development Agency, the California Health and Human Services Agency, and health care professional licensing boards, including the Board of Registered Nursing, Medical Board of California, and Dental Board of California, to implement programs and policies related to health care workforce education, recruitment, and retention.

(b) The board shall establish a CalCare Health Workforce Working Group to provide input, including recommendations, to the board and Secretary of Labor and Workforce Development on issues related to health care workforce education, recruitment, and retention, including all of the following:

(1) Programs and measures to expand clinical education capacity at California community colleges providing associate degree programs in health professions, including through programs to ensure the fair and equitable distribution of clinical placement at clinical education sites among approved health professions education programs and through programs to recruit and retain clinical faculty.

(2) Data collection and analysis and recommendations on health workforce attrition from direct care positions, including on moral distress and moral injury, safe staffing, and gaps in active California health professions licensees and those working in direct care.

(3) Identification and prioritization of geographical areas or populations in the state with unmet primary care or other health care needs, including access and availability of family physicians, primary care clinics, and registered nurses.

(4) Programs and measures to retain health care workforces, including public loan repayment assistance programs, minimum safe staffing requirements, investments in personal protective equipment, and occupational safety and health programs.

(5) Programs and measures to support expansion of graduate medical education programs and assistance for medical residents.

(6) Career ladders into health professions for ancillary and allied health workers, including licensed vocational nurses, certified nursing assistants, medical technicians, behavioral health technicians, health navigators, and community health workers.

(7) Career technical education pathways toward an associate degree at a California community college in a health professions education program.

(8) Programs to address barriers to health professions, including student debt levels, tuition assistance, childcare or other support, and debt-free residency or mentorship programs.

(c) The board shall appoint the members of the CalCare Health Workforce Working Group. Appointments shall be made by a majority vote of the voting members of the board. When appointing members to the working group, the board shall aim for broad representation, including, at a minimum, all of the following:

(1) Representatives of health professions and other health care workers, including specialties for primary care and behavioral health, physicians, registered nurses, and ancillary services.

(2) Representatives of labor organizations representing health care workers.

(3) Representatives of California community colleges, graduate medical education and training programs, and nursing education programs.

(4) Representatives of consumer and patient groups.

(5) Representatives of health care providers, including hospitals, nonacute care providers, and medical groups.

(d) (1) Each appointed member of the CalCare Health Workforce Working Group shall serve at the discretion of the board and may be removed at any time by a majority vote of the voting members of the board.

(2) Working group members shall not have access to confidential, nonpublic information that is accessible to the board and office. Instead, the working group shall only have access to information that is publicly available. Neither the board nor the office shall disclose any confidential, nonpublic information to the working group members.

(3) Working group members shall receive reimbursement for travel and other actual costs.

(e) The working group shall meet at least four times per year in a place convenient to the public. All meetings of the working group shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(f) The board shall consider input, including recommendations, from the working group, along with public comments, in the board's deliberation and decisionmaking.

CHAPTER 9. Collective Negotiation by Health Care Providers with CalCare

Article 1. Definitions

100690. For purposes of this chapter, the following definitions apply:

(a) (1) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is either of the following:

(A) An individual who practices that profession as a health care professional or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care group practice that has elected to receive fee-for-service payments from CalCare pursuant to subdivision (d) of Section 100650.

(2) A health care provider licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) "Health care provider's representative" means a third party that is authorized by a health care provider to negotiate on their behalf with CalCare over terms and conditions affecting those health care providers.

Article 2. Authorized Collective Negotiation

100691.

(a) Health care providers may meet and communicate for the purpose of collectively negotiating with CalCare on any matter relating to CalCare fee-for-service rates of payment for health care items and services or procedures related to fee-for-service payment under CalCare.

(b) This chapter does not allow a strike of CalCare by health care providers related to the collective negotiations.

(c) This chapter does not allow or authorize terms or conditions that would impede the ability of CalCare to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100692. (a) Collective negotiation under this chapter shall meet all of the following requirements:

(1) A health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with CalCare.

(2) A health care provider may communicate with a health care provider's representative.

(3) 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.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care provider's representative.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with the health care provider's employer or any other lawful collective action or collective bargaining.

100693. (a) Before engaging in collective negotiations with CalCare on behalf of health care providers, a health care provider's representative shall 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 this chapter.

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

Article 4. Prohibited Collective Action

100694. (a) This chapter does 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.

(b) A health care provider's representative shall not negotiate 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.

CHAPTER 10. Operative Date

100695. (a) Notwithstanding any other law, this title, except for Chapter 1 (commencing with Section 100600), Chapter 2 (commencing with Section 100610), and Article 1 (commencing with Section 100670) of Chapter 7, shall not become operative until the date the Secretary of California Health and Human Services 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 title.

(b) The California Health and Human Services Agency shall publish a copy of the notice on its internet website.

(c) The Secretary of California Health and Human Services shall make a notification pursuant to subdivision (a).

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610, 100617, and 100619 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

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CHBRP developed its Cost and Coverage model in collaboration with Milliman, an independent actuarial firm, to estimate fiscal values. The model projects premium and other financial impacts of proposed health insurance benefits. Milliman verified that model inputs, calculations, and outputs comply with generally accepted actuarial standards and are consistent, reasonable, and appropriate. Public health impacts are estimated using literature review data and fiscal projections.

For more information about CHBRP's methods and approach, please visit our website.

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