MARINA COAST WATER DISTRICT

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Board of Directors
Executive Committee Meeting
Marina Coast Water District
920 2nd Avenue, Suite A, Marina, CA
and via Zoom Teleconference

May 14, 2024 at 6:30 p.m.

MCWD Committee members and staff will be attending the meeting in person. While the meeting is open to the public, the public may also attend via Zoom at the link provided below.

Committee Members
Gail Morton
Jan Shriner

Agenda

This meeting has been noticed according to the Brown Act rules. The Committee will receive information on, discuss and consider making recommendations to the MCWD Board on the items contained in this agenda. Disruptive behavior may result in removal of the individual responsible.

1. Call to Order/Roll Call
2. Public Comment on Any Item Not on the Agenda *Anyone wishing to address the Committee on matters not appearing on the Agenda may do so at this time. Please limit your comment to four minutes. The public may comment on any other item(s) listed on the Agenda at the time the item(s) is considered by the Committee. Disruptive behavior may result in removal of the individual responsible.*
3. Approve the Draft Minutes of the April 2, 2024 Meeting
4. Discuss the Draft Agenda for the May 20th Board Meeting
5. Review and Discuss AB 2200 - Guaranteed Health Care for All Act
6. General Manager Update
7. Identify Agenda Items for Future Committee Meetings
8. Committee Member Comments
9. Adjournment

Zoom access information:
https://us02web.zoom.us/j/83213140494?pwd=dE9sR3RQRWlSbEduMkhxR2VJeDVKZz09
To join via phone: 1-669-900-9128
Webinar ID: 832 1314 0494
Passcode: 301021

Marina Coast Water District

Draft Minutes
Executive Committee Meeting

April 2, 2024

1. Call to Order:

The April 2, 2024 Executive Committee meeting was called to order at 6:30 p.m. by President Morton. In attendance were:

- Committee members: President Morton and Vice President Shriner
- Staff: Remleh Scherzinger, Roger Masuda, Teo Espero, and Paula Riso
- Public members: None

2. Public Comments on Any Item Not on the Agenda:

There were no comments made.

3. Approve the Draft Minutes of the February 6, 2024 Meeting:

Vice President Shriner made a motion to approve the minutes of February 6, 2024. President Morton seconded the motion. The minutes were approved by a vote of 2-Ayes (Shriner, Morton), 0-Noes, and 0-Absent.

4. Discuss the Draft Agendas for the April 6th Strategic Planning Workshop; April 17th Public Rate Workshop; and April 22nd Board Meeting:

Mr. Scherzinger reviewed the draft agendas for the April 6th Strategic Planning Workshop; April 17th Public Rate Workshop; and April 22nd Board Meeting with the Committee members. The Committee members asked clarifying questions and proposed adding Director Comments on the April 6th agenda.

5. Review the Proposed Privacy Policy:

Mr. Espero introduced this item and reviewed a draft Privacy Policy with the Committee. Discussion followed regarding language changes: deletions and additions. Staff will revise the document and bring it back to a later meeting.

6. General Manager Update:

Mr. Scherzinger stated that he had nothing to update.

7. Identify Agenda Items for Future Committee Meeting:

Vice President Shriner asked if the District could take a position on an Assembly Bill, referring to AB 2200 – Guaranteed Health Care for All Act. Mr. Scherzinger answered that it could as long as it was connected with the Districts core function. Vice President Shriner asked that it be brought back to the Executive Committee for discussion. President Morton stated she would like LAFCO to give a presentation to the Board sometime in the next several months.

8. Committee Member Comments:

Vice President Shriner commented that they covered a lot of ground thanked staff for their hard work. President Morton stated that she had received a notice in the mail from Monterey One Water about their upcoming billing change and noted the notice was done very well.

9. Adjournment:

The meeting was adjourned at 7:36 p.m.

Assembly Bill 2200

California Guaranteed Health Care for All Act (CalCare)

Assembly Member Ash Kalra

Prin. Coauthors: Assembly Members Bryan, Wendy Carrillo, Connolly, Lee and Senators Cortese and Gonzalez
Coauthors: Assembly Members Addis, Bonta, Friedman, Haney, Holden, Jackson, McCarty, McKinnor, Ortega, Reyes, Luz Rivas, Santiago, Ting, and Senators Becker and Laird

SUMMARY

Today's U.S. health care system is a complex, fragmented, multi-payer system that leaves wide gaps of coverage and poses major issues of affordability. Despite health care spending in the U.S. far exceeding other high-income, industrialized countries that offer a publicly financed single-payer system, we consistently report worse health outcomes and disparities among vulnerable populations.

AB 2200 sets in motion a single-payer health care coverage system in California, called CalCare, for all residents, regardless of citizenship status. By streamlining payments and lowering per-capita health care spending, CalCare guarantees quality health care and long-term care and eliminates barriers to care and out-of-pocket costs.

By affirming health care as a right to all Californians and focusing on a single-payer policy that eliminates waste and aligns reimbursements with the actual cost of care, we can make significant progress on acquiring state and federal approvals.

HEALTH SYSTEM STATUS QUO

According to a recent 2023 Health Policy Survey, nearly **two-thirds** of Californians report being worried about unexpected medical bills and out-of-pocket health care costs[1]. The average cost of family premiums for job-based health insurance climbed **7%** to nearly $24,000/year in 2024[2], creating an unsustainable burden on workers and employers. Even health plans offered through Covered California will increase an average of nearly **10%**, the highest since 2018.

Even with the planned Medi-Cal expansion, an estimated 2.6 million Californians will remain uninsured[3] and millions more with coverage will be forced to delay or forgo necessary medications or health care services due to cost.

Health care spending in the United States far outpaces other industrialized countries.[4] While Americans use significantly fewer health care services[5] – including physician visits and hospital admissions – spending is greater due to higher prices. Despite higher spending, Americans have worse health outcomes, including shorter life expectancy and greater prevalence of chronic conditions.[6]

Another challenge with our health care system is the pervasiveness of health disparities. California is a diverse state – racially, ethnically, economically, and geographically – and vulnerable populations face greater health risks and less access to safety net programs.

California's growing population aged 60 years and over is expected to grow more than three times as fast as the total population[7], which will place additional strain on health care services. As more aging adults enter Medicare, CalCare can improve access and lower costs by pooling state and federal funds.

[1] California Health Care Foundation and NORC, *California Health Policy Survey* (Sept 30-Nov 1, 2022).
[2] KFF, *2023 Employer Health Benefits Survey*.
[3] UC Berkeley Labor Center. *California's Uninsured in 2024*. March 2023.
[4] OECD, *Health at a Glance 2023: OECD Indicators*, November 2023– health expenditure in relation to GDP and per capita.
[5] *Health at a Glance 2023: OECD Indicators* – number of doctor consultations per person, hospital discharges, and average length of stay in hospital.
[6] The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, January 2023.
[7] California Department of Aging, *Facts About California's Elderly*.

California Guaranteed Health Care for All (CalCare)

The COVID-19 pandemic has exposed how grossly flawed and inequitable our multi-payer health system is and how critical it is for all Californians to be guaranteed access to health care. AB 2200 is the policy framework that will bring California closer to achieving a single-payer system by setting in place a comprehensive framework of governance, eligiblity and enrollment, delivery of care, health care cost controls, and a just transition towards greater benefits and access to care.

By passing the California Guaranteed Health Care for All Act, the state positions itself to seek consolidated federal waivers. These waivers would make it easier for California to consolidate health care dollars, provide flexiblity, expand benefits, and eliminate cost-sharing.

Upon being authorized and financed, CalCare will establish a comprehensive universal single-payer health care coverage program and a health care cost control system. CalCare will be an independent public entity governed by a nine-member executive board with expertise in health care policy and delivery.

AB 2200 provides a seamless transition for people with existing treatment or who want to keep their preferred care team. CalCare also includes health care workforce recruitment and retention provisions that are linked to global budgets, special projects, and other programs.

The CalCare Mission and Duties

CalCare will be charged with overseeing the state's single-payer system, and will ensure the following:

Comprehensive Benefits and Freedom of Choice
Californians will have access to comprehensive health care coverage, including all primary and preventive care, hospital and outpatient services, prescription drugs, dental, vision, audiology, reproductive health services, maternity and newborn care, gender-affirming care, long-term services and supports, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more. Patients will have freedom to choose doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is "in-network."

No Premiums, Copays, or Deductibles
Californians would receive health care services and other defined benefits without paying any premiums or deductibles. Upon receiving care, patients would not be charged any copays or other out-of-pocket costs.

Addressing Health Care Disparities
CalCare would establish an Office of Health Equity to coordinate efforts to remove barriers to care and create a special projects budget to fund the construction, renovation, and staffing of health care facilities in rural or underserved communities.

Long-Term Services and Supports for People with Disabilities and Seniors
Long-term services and supports for daily living will be fully covered for medically determinable conditions, whether physical, mental, or due to age.

Reducing Health Care Costs and Improving Care
CalCare would move the state to a simplified health care payment system that will free health care providers from devoting time to billing and instead focus on patient care. The new system would establish reasonable payment methodologies for providers that are aligned with the actual costs of care rather than driven by profits. Health care professionals and institutional providers would be prohibited from over utilizing services. CalCare would negotiate bulk drug prices for all Californians and take other measures to lower the costs of prescription drugs.

Global Budgets for Institutional Providers
CalCare would negotiate fair, adequate global budgets to hospitals and other institutional providers to help contain exorbitant costs by aligning health care payments with the actual cost of care and eliminating the waste present in the system today. Institutional providers may submit appeals to the global budget to address justifiable or unforeseen circumstances.

AB 2200 CalCare

Frequently Asked Questions

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

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

2. What is the guaranteed benefit coverage under CalCare?

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

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

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

4. Who is eligible for CalCare?

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

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

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

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

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

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

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

7. How does AB 2200 control health care costs?

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

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

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

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

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

9. How will CalCare address long-term care?

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

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

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

10. Can people opt-out of CalCare?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22. Can CalCare achieve health equity?

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