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ASSEMBLY COMMITTEE ON HEALTH
MIA BONTA, CHAIR
ASSEMBLYMEMBER, EIGHTEENTH DISTRICT

Informational Hearing

Tuesday, January 27, 2026

BACKGROUND PAPER

The Devastating Impact of Federal Disinvestment on California's Health Care System: What We Know and How the State, Health Care Providers, and Communities Are Responding

Executive Summary

Health care coverage in California is at an inflection point. The state expanded access to affordable health care coverage between 2010 and 2024, culminating in a historically low uninsured rate of 5.9%. However, recent federal policy choices and state budget challenges are poised to significantly erode progress toward the goal of universal health care coverage. Projections suggest millions may lose health care coverage. California's health care system stands to lose tens of billions of dollars annually due to the federal H.R.1 of 2025 and the recent expiration of enhanced federal subsidies that allowed people to purchase affordable coverage through Covered California. H.R.1 represents the largest-ever federal cut to Medicaid funding. Remaining health care safety net programs and providers have little capacity to absorb a significant influx of demand for health care from millions of Californians who are newly uninsured. Although the state does not have, and is not likely to create, the capacity to fully backfill federal cuts, the Legislature can explore options to mitigate the impact of coverage losses. Engagement with health care stakeholders throughout the state have suggested important actions the state can take to support communities, including maximizing enrollment of individuals eligible for Medi-Cal, increasing support for workforce programs, partnering with counties and the health care safety net, and considering revenue options as needed to maintain Californians' access to health care. In addition, increased fiscal pressure on the state makes it more important than ever that the Legislature continue to monitor and support ongoing efforts to improve the performance of the health care system and reduce cost growth.

Contents

1. A Brief History of Health Care Coverage Expansion in California

From the 2010 passage of the federal Patient Protection and Affordable Care Act (ACA) until 2025, the state made substantial progress in expanding access to affordable health coverage.

The Bad Old Days

Seasoned health care advocates sometimes refer to the era prior to the ACA as the "bad old days": health care coverage was often unaffordable, sometimes inaccessible, and far from universal. Prior to the ACA, individuals purchasing their own health insurance could be denied outright based on their health status; Medicaid coverage was limited to children, parents, and the elderly and disabled; and low-income individuals and small businesses purchasing health insurance directly often couldn't afford the cost. Insurers had limited financial incentives to promote preventive care and about a third of young adults aged 19-25 were uninsured. Counties, who are obligated under Section 17000 of the Welfare and Institutions Code (WIC) to provide "indigent care," offered a limited backstop to help the uninsured receive health care.

ACA

The passage of the ACA was a turning point for access to health care, creating multiple new opportunities to access affordable coverage. Key provisions of the ACA:

- Prohibited discrimination based on health status;
- Limited how insurers calculate premiums to better spread risk among the population;
- Expanded Medicaid (Medi-Cal in California) to include all adults under 138% of the Federal Poverty Level (FPL) at state option, with a generous federal matching rate;
- Allowed health insurance marketplaces, including what is now Covered California, to offer affordable plans to lower-income individuals and to small businesses through the application of federal tax credits;
- Mandated free preventive care like vaccines and checkups; and,
- Allowed young adults to remain as dependents on their parents' coverage until age 26.

Medi-Cal "ACA Expansion" to Low-Income Adults

California expanded Medi-Cal as authorized under the ACA, beginning in 2014. To prepare for this expansion, California administered a federal waiver called "Bridge to Reform," which allowed counties to receive federal matching funds to operate Low-Income Health Programs (LIHPs) at county option, with counties funding the non-federal share of costs. LIHP programs standardized a prior county-based waiver program called the Health Care Coverage Initiative (HCCI); they provided basic health care coverage to adults ages 19-64 without dependent children who had incomes below 138% of FPL. The LIHP program served as a "bridge" to Medi-Cal eligibility; in 2014, these LIHP-eligible low-income adults without dependent children transitioned to Medi-Cal.[1]

Medi-Cal "Health4All" Expansion

Beginning in 2016, in a stepwise fashion, California expanded full-scope Medi-Cal to individuals regardless of immigration status: first to children, then to young adults, then to older adults, and finally to adults aged 26-50. As of 2024, these changes had made Medi-Cal available to all income-eligible Californians, regardless of immigration status.[i]

Asset Test Elimination

In recent years, California also increased the amount of assets someone could own and still be eligible for Medi-Cal. Generally, seniors and persons with disabilities are only eligible for Medi-Cal if their assets are under a specific limit. Between July 1, 2022, and December 31, 2023, the asset limits were increased to $130,000 for individuals and $195,000 for couples; these limits were fully eliminated effective January 1, 2024.[ii]

Pandemic Pause on Medi-Cal Redeterminations and Subsequent Flexibilities

Actions during and after the COVID-19 pandemic also increased Medi-Cal enrollment. Pursuant to federal rules, during the COVID-19 Public Health Emergency (PHE), the state maintained Medi-Cal coverage for enrolled populations without redetermining eligibility annually, as is normally required. During the PHE "Unwinding" period when counties resumed eligibility redeterminations, the state implemented certain flexibilities to streamline the process. Some of these flexibilities helped seniors stay enrolled in Medi-Cal. For example, one flexibility allowed counties to more easily renew eligibility for individuals who rely on Social Security income and similar fixed income sources.

Progress Toward Universal Coverage Is Now Threatened

Because of the policy changes described above and the corresponding infusion of additional federal and state resources into health care coverage, California's uninsured rate dropped from over 18% prior to the ACA to 5.9% in 2024.[2,3] In 2024, even though California's health care system still faced challenges including high costs, workforce constraints, growing unaffordability of employer-based coverage, and some financially struggling hospitals, this historically low rate of uninsured Californians represented significant progress towards universal health care coverage. This progress was driven by a political culture in which access to affordable, high-quality health care was increasingly seen as a right for all Californians. In turn, the tangible progress towards universal coverage increased enthusiasm for, and the credibility of, such a vision.

Based on changes over the last year, California's progress toward universal health care coverage is poised to recede. Federal cuts will drive the uninsured rate higher and state budget woes have already posed challenges to California's continued progress toward this goal. Current projections suggest that millions of Californians will lose coverage by 2030, due to the combination of eligibility changes in Medi-Cal, lower subsidy levels available through Covered

[i] This policy was partially reversed as of January 1, 2026 (discussed further in Section 3).
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California, and state actions to restrict Medi-Cal coverage for populations with unsatisfactory immigration status (UIS, a term to describe the population on behalf of which the state cannot seek federal matching funds in Medi-Cal due to immigration status. The UIS population includes some immigrants with valid legal status.). These changes are discussed further below.

2. Federal Disinvestment Restricts Access to Health Care Coverage

Although the federal government has taken many and varied actions on health-related issues over the past year,[iii] this paper and hearing will focus largely on the impacts to health care coverage and access. The largest impacts to health care coverage and access are from Medicaid-related changes in federal H.R. 1 (titled the "One Big Beautiful Bill Act") and the recent expiration of enhanced federal subsidies for individuals receiving subsidized coverage through health benefit exchanges. H.R. 1 represents the largest-ever cut to the Medicaid program.

Medi-Cal (California's Medicaid Program)

The Department of Health Care Services (DHCS), which administers the Medi-Cal program, projects H.R. 1 impacts include up to two million Medi-Cal members losing coverage, tens of billions in federal funding at risk annually, and major disruption in the Medi-Cal financing structure for safety net providers. Several key provisions of H.R.1, discussed below, will have an outsized impact on Medi-Cal enrollment. (For a more comprehensive summary of H.R.1 provisions, see, for instance, those published by KFF or Families USA.)

Work Requirements

With certain exceptions, H.R.1 requires the ACA expansion population—generally, adults ages 19 through 64 without dependent children— to engage in a minimum of work requirements (called "community engagement requirements" in H.R.1) beginning in 2027. This means an individual needs to document at least 80 hours per month of work, community service, or job training to keep Medi-Cal coverage. This requirement is the most administratively burdensome and the most consequential; it is likely to lead to large coverage losses for individuals who work but encounter administrative difficulties demonstrating compliance, as well as for individuals who face barriers to work but aren't designated as disabled or otherwise exempt from work requirements. A Congressional Budget Office analysis found that a Medicaid work requirement would not have any meaningful impact on the number of Medicaid enrollees working, and cited research from the implementation of work requirements in Arkansas indicating that "many participants were unaware of the work requirement or found it too onerous to demonstrate compliance," resulting in coverage loss.[4]

[iii] Other concerning areas of federal disinvestment not discussed here include Medicare, public health, medical research, limits on federal student loans for health professionals, and behavioral health. H.R.1 included one bright spot: a fund called the Rural Health Transformation Program (RHTP), from which California is slated to receive $233 million this year. The RHTP will not backfill cuts to services but is available to make infrastructure improvements such as information technology systems for rural health providers.

Mandatory Six-month Eligibility Checks

H.R.1 requires states to redetermine eligibility for the ACA expansion population twice a year instead of once a year. Many eligible Medi-Cal members are projected to lose coverage because of the increased frequency of eligibility paperwork. In recent analysis of those disenrolled at their eligibility redetermination, DHCS has found so-called "procedural disenrollments" to be common (procedural disenrollment is when an individual is disenrolled without having been deemed ineligible, often due to missing or late paperwork). When DHCS partnered with the California Health Care Foundation to survey those procedurally disenrolled in 2024, about one-third (31%) reported they did not know they would lose Medi-Cal if they failed to complete their renewal, nearly four in ten (37%) said they would like to restart Medi-Cal but did not know how, and nearly half (45%) of all survey respondents said they did not receive a renewal form.[5]

Restrictions On Lawful Immigrant Eligibility

H.R.1 redefines many categories of lawfully immigrants as UIS, making the costs for their care newly ineligible for federal matching funds. These categories include most refugees and asylees as well as victims of human trafficking.[6] In response, the 2026-27 Governor's Budget proposes to move these categories of immigrants to restricted-scope coverage (emergency and pregnancy care only), leaving this population essentially uninsured.

Retroactive Coverage Restrictions

H.R.1 reduces retroactive Medi-Cal coverage from three months to one month for ACA expansion adults and to two months for all others. This reduces financial coverage for costs individuals incurred prior to enrollment and is likely to result in more people incurring medical debt.

Financing Restrictions and Cost Shifts

California has long used allowable and federally approved financing options, such as the Managed Care Organization (MCO) tax on health plans and the Hospital Quality Assurance Fee (HQAF) to fund a portion of the nonfederal share of Medi-Cal costs. H.R.1 limits the state's ability to use these options, which is expected to result in billions of dollars in lost revenue. H.R.1 also shifts costs from the federal government to the state. For instance, H.R.1 reduces the federal matching percentage (FMAP) for emergency care provided to certain UIS populations from 90% to 50%, effective October 1, 2026. This single change results in additional state General Fund costs of $658 million in fiscal year 2026-27. Restrictions on "State-Directed Payments" (supplemental payment for specific purposes) limit what the state and managed care plans can pay providers, which will disproportionately impact and limit funding for public hospitals and health care systems.

Even beyond the mandatory federal changes to eligibility and redetermination processes, increased state costs as a result of these financing restrictions and costs shifts will make it difficult for California to maintain eligibility levels, benefits, and provider rates—the three main drivers of Medi-Cal costs.

Restrictions on Medicaid Participation for Abortion Providers

Federal funding has long been prohibited from being used for abortion services, but abortion providers like Planned Parenthood also provide a wide array of sexual and reproductive health services, like cancer screening, sexually transmitted infection testing and treatment, and birth control. A final key provision of H.R.1 bans federal Medicaid funding for "prohibited entities" that provide abortion services, for one year (ending July 3, 2026). The federal ban is designed in a way that specifically defines Planned Parenthood clinics as "prohibited entities." The sudden and dramatic decline in federal funding for non-abortion services at these clinics poses an existential threat to their continued operation. Closures would severely compromise access to these services for Medi-Cal enrollees and others who rely on Planned Parenthood.

Covered California (California's Health Benefit Exchange)

Expiration of Enhanced Premium Tax Credits (ePTCs)

As noted above, the ACA created a system whereby individuals could shop for health care coverage and receive federal tax credits, depending on their income, to subsidize the costs. The 2021 application of Enhanced Premium Tax Credits (ePTCs) dramatically improved the affordability of commercial coverage through Covered California, the state's health benefit exchange for ACA plans. The ePTCs removed all income caps and limited ACA premiums to 8.5% of income for all enrollees. Since the introduction of ePTCs through the American Rescue Plan Act of 2021 and their extension through the Inflation Reduction Act of 2022, Covered California reached a record enrollment number of 1.98 million individuals. However, ePTCs were not renewed at the end of 2025. This loss of an estimated $2.5 billion in enhanced subsidies led to a staggering 97% premium increase for nearly 1.7 million Californians enrolled in subsidized coverage. Covered California estimates that this rise in premiums will lead to 400,000 Californians being priced out and foregoing their health coverage altogether.

The state has taken some action to protect the lowest-income Covered California enrollees from premium spikes by offering state-funded premium subsidies. California collects revenue from a tax penalty imposed on individuals without health coverage (individual mandate), which is deposited into the Health Care Affordability Reserve Fund (HCARF). In the 2025-2026 budget, the Legislature and Governor allocated HCARF dollars to establish state-funded premium subsides for enrollees earning up to 165% of the FPL. These subsidies will ensure the lowest-income Covered California enrollees can keep their premium costs in range similar to what they were paying in 2025.

Restrictions On Lawful Immigrant Eligibility

H.R. 1 also revokes access to financial support from immigrants enrolled in Covered California coverage. Lawfully present immigrants with incomes under the FPL are now ineligible for federal subsidies. Beginning in 2027, only certain immigrant groups will be eligible for federal subsidies to help pay for their insurance: lawful permanent residents (green card holders), Cuban and Haitian entrants, and Compact of Free Association (COFA) migrants. As a result, refugees, asylees, TPS holders, and other lawfully present immigrants will lose access to financial support to obtain or maintain coverage.

Through rules finalized in August of 2025, the federal government also also revoked Covered California eligibility for Deferred Action for Childhood Arrival (DACA) recipients, leaving this population without affordable commercial coverage options.

Federal Threats on the Horizon

With stated goals of delivering health care freedom and improving affordability of health care, the federal Republican House Study Committee announced the intention to pursue hundreds of billions of dollars more in additional health care and welfare cuts through an effort dubbed "Reconciliation 2.0." Some of these proposed cuts would disproportionately harm California. Proposed nationwide cuts include the following:

- Eliminate the Prevention and Public Health Fund. ($11 billion)
- Make all non-citizen foreign nationals ineligible for Medicaid and other forms of government benefits. ($231 billion)
- Implement a 20% penalty on the federal Medicaid matching rate for states that refuse to prohibit UIS populations from participating in state Medicaid programs, even if services are provided at state expense (unquantified)
- Extend and make permanent the one-year freeze on federal funding for non-abortion Medicaid services provided by abortion providers (Listed as $31 million; this appears to be a significant underestimate.)

3. State Fiscal Trouble, High Costs for Coverage Expansions Also Threaten Coverage

As discussed above, California has run headlong into a federal administration with wildly different health policy priorities than its own. State budget realities have also forced the state to reassess what coverage policies it can afford, particularly against a backdrop of federal disinvestment.

In the 2025-26 Budget, California addressed a nearly $15 billion budget problem, grappling with a deficit that was driven in part by higher-than-projected costs of major expansions in Medi-Cal.[7] Expanding Medi-Cal to the UIS population and eliminating the asset test both resulted in more individuals enrolled than projected. Per-enrollee costs for the UIS expansion were also higher than expected.[8] Medi-Cal services to UIS population are relatively costly to the state because any year-over-year increase in health care costs for this population, instead of being shared by the state and the federal government, are almost exclusively borne by the state.

Key state Medi-Cal policy changes that are projected to erode health care coverage include an enrollment freeze for individuals over age 18 with UIS (projected to save over $3 billion General Fund per year by 2028-29), as well as the reinstatement of the asset limit (projected to save over $500 million General Fund per year by 2028-29). Additional changes include a monthly premium for UIS adults who remain in coverage, scheduled to begin in July 2027, which was projected to save over $670 million per year by 2028-29 and result in additional disenrollments from Medi-Cal by individuals who do not pay the monthly premium.

Although it does not directly affect coverage, the state is also implementing a payment reduction to the normal "prospective payment system" (PPS) Medi-Cal rate for Federally Qualified Health Centers and Rural Health Clinics for services provided to the UIS population, which was projected to save over $1 billion annually beginning in 2026-27. This cut has the effect of reducing capacity in the health care safety net and poses severe implementation challenges for clinics.

Deficits were projected in the 2025-26 Budget and budget solutions were adopted prior to passage of H.R.1, but with knowledge that large federal cuts to Medicaid and other health programs were likely because of that bill.

4. California's "Semi-Retired" Health Care Safety Net

For those who fall out of coverage based on federal or state policy changes, what alternatives are available? Largely due to California's coverage expansions and reduced demand for care, programs for the uninsured are much smaller and less robust than they were prior to the ACA. According to a 2025 publication, "*Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses,"* state policymakers and leaders from the health care delivery system may need to rethink and possibly redesign what safety-net health care services look like for people who are uninsured.[9,10] Expecting California's existing health care safety net for the uninsured to be ready for a new, large influx of uninsured Californians is unrealistic.

County Indigent Care Programs

WIC Section 17000 was codified in 1965. It requires counties to "*relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions*." However, this language by no means guarantees a meaningful health care safety net for millions of Californians who may lose coverage.

County indigent care programs generally do not offer "coverage"—they instead directly provide or pay for a limited set of health care services. Case law establishes some basic responsibilities of counties for indigent care, but eligibility and service levels largely depend on county resources and priorities. Few counties provide care for Californians without legal immigration status, and Section 17000 does not require it.[11] Programs are funded largely with state realignment funds provided to counties. Because demand for indigent care services had declined over the last decade, commensurate with expanded Medi-Cal and Covered California eligibility, counties explain these programs now lack both the resources and the infrastructure to handle significantly increased demand. [12]

State Programs

Some state programs, largely limited to certain "body parts" or medical conditions, remain options for individuals with qualifying incomes who are otherwise uninsured and have a specific medical need met by one of the programs. These include restricted-scope Medi-Cal, which pays

for emergency and pregnancy care; Family Planning, Access, Care, and Treatment (Family PACT), which provides family planning and some reproductive health services; Every Woman Counts, which pays for breast and cervical cancer screening; the Breast and Cervical Cancer Treatment Program; and the Prostate Cancer Treatment Program. The AIDS Drug Assistance Program (ADAP) provides medications used in the treatment and suppression of HIV/AIDS and related opportunistic infections.

Health Care Providers

Certain health care providers directly provide some free or discounted care:

- Nonprofit hospitals must offer charity care and other community services as a condition of their exemption from income, property, and sales taxes. The facilities provide charity care to eligible uninsured and insured patients, with no expectation of payment. AB 2297 (Friedman), Chapter 511, Statutes of 2024, standardized some aspects of hospital charity care and discount programs and added other consumer protections. Starting January 1, 2025, those without insurance who have incomes below 400% of the FPL are eligible for some level of assistance.
- County-administered hospitals and public health systems, located in some urban centers in California, generally have a mission to provide access to health care services for all Californians, regardless of insurance status, immigration status, ability to pay, or other circumstances. However, financial assistance programs in these systems generally function similarly to those in nonprofit hospitals, and the level of generosity of the program varies by system.
- Federally Qualified Health Clinics, as part of federal requirements, must offer comprehensive primary care services on a sliding fee scale based on ability to pay.

Even providers who do offer free or discounted care have become inured to far less demand for such care in recent years and would have difficulty providing such care to millions more uninsured individuals.

Pursuant to the federal Emergency Medical Treatment & Labor Act (EMTALA), all hospitals that participate in the Medicare program and operate emergency departments must provide screening and emergency stabilization services. However, EMTALA only requires services to be provided; the cost of services is not covered by the federal government, and EMTALA does not require hospitals to provide free or discounted emergency care. This requirement is often characterized as an unfunded mandate.

5. State Implementation of New Federal Medicaid Requirements

As the administering agency for Medi-Cal, DHCS is charged with complying with new federal laws and policies, including the new Medicaid financing and eligibility rules imposed by H.R.1. DHCS has released "Implementation Guiding Principles" to explain the department's implementation approach to complying with federal requirements. These include the following:

Automate to Protect Coverage.

Maximize the use of data sources to confirm eligibility without burdening members. Reduce paperwork, streamline verifications, and safeguard coverage stability.

Communicate with Clarity and Connection.

Implement an outreach and education campaign that is culturally relevant, linguistically accurate, and written in plain language to build trust and help members understand the changes.

Simplify the Renewal Experience.

Modernize and streamline the Medi-Cal renewal process with a clearer, member-friendly form and six-month renewal steps that are easier to navigate.

Educate and Train Those Who Serve Medi-Cal Members.

Deliver comprehensive training on all H.R. 1 provisions for county eligibility workers. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties and DHCS Coverage Ambassadors (community volunteers who help people find, understand, or keep their health coverage) can confidently support members.

Provide Timely and Transparent Communication to Members.

Share information on H.R. 1 changes early on so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

DHCS has begun releasing updates to their implementation approach through stakeholder forums, workgroups, and other communication channels, and has solicited and accepted stakeholder feedback. DHCS also plans to release an H.R. 1 Implementation Plan in late January 2026 that will discuss the state's implementation of eligibility-related changes. According to DHCS, ongoing workgroups with counties, managed care plans, advocates, and community partners are shaping policy and streamlining operations to support implementation readiness. DHCS has released preliminary guidance to counties on implementation of work requirements.

6. Feedback from Chair Mia Bonta's "Health of Health Care" Roundtables

To further assess how various health care stakeholders understand the impacts of the major changes discussed above and to hear how they are responding, Assemblymember and Chair of the Assembly Health Committee Mia Bonta, in coordination with other legislators, hosted a series of roundtable conversations throughout November and December 2025 titled "The Health of Health Care." The intent of these sessions was to provide a regional perspective on health care challenges and an opportunity for legislators to hear directly from their local health stakeholders. Roundtables were organized in Santa Rosa, Oakland, San Jose, Fresno, Los Angeles, and San Diego, with events engaging local and regional stakeholders.

Each conversation emphasized some concerns and ideas unique to the region. For instance, stakeholders in Fresno emphasized concerns related to capacity constraints, including health care

provider shortages and overcrowded emergency rooms, while the Santa Clara County Public Health System discussed the disproportionate impact to that county of federal cuts because the county directly administers four hospitals and 15 clinics. In Santa Rosa, a representative from the County Medical Services Program (a 35-county indigent care program) emphasized the program is projected to be out of cash in six months unless changes are made quickly, given the projected growth in the number of uninsured. Every roundtable had concerns about coverage losses, and expected such losses to create more emergency room delays and increase uncompensated care.

Stakeholder Concerns and Impacts

The following is a brief, high-level summary of some of the most common concerns and impacts expressed by various categories of health care stakeholders in the roundtable discussions, supplemented by some information provided by statewide health care organizations. Not all stakeholders and concerns are represented here, and certain entities have unique characteristics that may make them vulnerable to the impacts of H.R.1 and state budget cuts.

Designated Public Hospitals

Designated public hospitals (DPHs) note they are disproportionately impacted because they serve a higher volume of Medi-Cal and uninsured patients while training 50% of the state's doctors. They rely heavily on federal funding streams and supplemental payments like State Directed Payments (SDPs), which are now under threat. DPHs face an estimated $2.3 billion net loss annually by 2032 due to the mandatory phase-down of SDPs. They also anticipate a direct loss of hundreds of millions annually due to the reduction of the federal match for emergency services for individuals with UIS. These facilities are already operating with a $1.5 billion structural deficit. DPHs note cuts begin in 2025, but full impact is gradual, creating cascading financial pressures.

Other Hospitals

Private hospitals are concerned about regulatory pressures, such as requirements for seismic compliance and the Office of Health Care Affordability, as well as massive revenue losses. The phase-out of Medicaid financing tools jeopardizes their ability to raise funds to sustain adequate Medi-Cal rates. District hospitals similarly reported concerns about thin margins and financial solvency, state mandates and regulatory burdens, and the shifting of the indigent care burden.

Counties

Counties play a number of critical roles in the health care safety net and in the Medi-Cal program.[13] Counties process Medi-Cal eligibility and enrollment but lack the staff and IT infrastructure to handle the doubling of the frequency of redeterminations for millions of Medi-Cal enrollees and new work requirements. Counties expect the cost of the increased workload to be in the hundreds of millions of dollars annually. Counties are also concerned about cost pressure to indigent care programs and other cost shifts that will put severe cost pressure on other parts of county budgets.

FQHCs and Safety Net Clinics

FQHCs face a "double whammy" of federal cuts and state budget decisions, such as the elimination of PPS rates for services to individuals with UIS. Some clinics are seeing patients too scared to seek care due to immigration enforcement.

Physicians

Physicians are concerned about a severe workforce shortage and a "danger of moral injury" as providers may be unable to meet the needs of increasingly sick, uninsured patients. Recruitment is stalled by a new $100,000 fee on cost of foreign worker visas, and potential medical students are concerned about caps on professional student loans. Surgeons in some regions are retiring faster than they can be hired.

Health Care Workers

Health care workers are concerned that financial instability will lead to mass layoffs and facility closures. An analysis by UC Berkeley Labor Center found H.R.1 could cost California up to 217,000 jobs, about two-thirds of them in health care.[14]

Rural Health Care Providers

Rural health care providers, often the largest employers in their town, are operating on thin margins and express concern about state mandates that result in increased costs. Some rural areas have experienced an exodus of clinicians following natural disasters.

Reproductive Health Providers (Planned Parenthood)

Planned Parenthood clinics, which serve 25,000 patients per week in California, are no longer being paid for most Medi-Cal services they provide. Planned Parenthood has already closed five health centers and closed prenatal and behavioral health programs in response to an estimated $305 million annual federal loss. Other community safety net clinics report they do not have the capacity to absorb this sudden surge in patients.

Community-Based Organizations (CBOs)

CBOs that provide social supports like medically tailored meals are hampered by the impermanent, non-mandatory nature of Medi-Cal waiver programs like CalAIM Community Supports (CalAIM is California's Medi-Cal transformation effort that began in 2021). Although programs are authorized for now, Community Supports are only provided at the discretion of DHCS and managed care plans. CBOs are hesitant to invest in infrastructure for a program with an uncertain future. Many CBOs rely on health care funding for 25% of their total budget; if this funding disappears, private charity will be unable to fill the gap and services to the community will evaporate.

Stakeholder Solutions and Recommendations

Each stakeholder and each region offered a unique perspective. However, despite regional differences, there were common themes among stakeholders on some potential solutions and

suggested areas of focus for the state. The following list includes the state-level solutions most frequently recommended by regional stakeholders:

- Keep eligible individuals enrolled in Medi-Cal:
    - Use automation to ease the Medi-Cal redetermination process.
    - Create more flexibilities for data-sharing to allow outreach.
    - Support counties in staffing to address the workload of new eligibility requirements (work requirements and six-month redeterminations).
    - Create a unified public message for Medi-Cal enrollment.
- Delay state budget cuts to allow stakeholders to understand and plan for H.R.1.
- Provide more resources for health care workforce development and retention.
- Reexamine the legal and fiscal framework of the county indigent care mandate and further define the state's role in supporting counties.
- Examine CalAIM and continue the CalAIM programs that work.
- Consider revenue measures as part of the long-term solution to bolster health programs.
- Invest in prevention and primary care to move care out of the emergency rooms.
- Streamline regulatory approvals/regulatory processes for health facilities.
- Carefully examine and avoid passing state mandates that increase costs.

7. Conclusion

The state is unlikely to be able to backfill the staggering level of losses projected due to federal disinvestment—currently estimated in the tens of billions of dollars annually. Federal cuts are occurring at a time of state budget constraints, workforce challenges, withered county-based indigent care programs, and ever-higher costs, even for those commercially insured. The situation is dire. The unarticulated yet clear vision that is emerging is of a California where access to affordable health care coverage is increasingly uncertain.

However, the Legislature can and should think creatively and deeply about available options and how to mitigate the harm caused by federal disinvestment and state budget cuts that occurred before the extent of the federal cuts were understood. The Legislature faces decisions, beginning this year, that will require difficult choices and long-term thinking about the state's role in ensuring access to needed health care in an increasingly constrained environment, and how it can best work with counties, health care providers, and other partners to accomplish its goals.[15] Engagement with these partners has helped focus attention on the most critical issues for the Legislature to pursue right now, including maximizing retention of eligible Medi-Cal members, ensuring access to prevention and primary care, and prioritizing the health care workforce development pipeline.

There is no "quick fix" for the challenges that face California's health care system; therefore, other ongoing health care reforms that can reduce costs and improve care should also be monitored and supported. For instance:

- Continuing Medi-Cal transformation efforts through CalAIM is likely to bear fruit through better health outcomes and lower costs.

- Continued improvements to more traditional functions of the Medi-Cal program like children's health care, maternal care, and home and community-based services can ensure appropriate interventions and better management of health conditions, which will reduce costs, improve care, and create a healthier population over the long term.
- Ensuring robust health data exchange can reduce redundancy and costs and improve care.
- Analysis of data from the state's newly functional statewide health care claims database can offer strategic and actionable insights for improvement.
- Efforts to promote healthy food, environments, and behaviors can also reduce costs as well as reduce disease burden, demand for health care, and human suffering caused by health conditions.

Finally, given that sky-high health care costs and prices continue to exacerbate all the challenges discussed throughout this paper, doubling down on the important work of the Office of Health Care Affordability is also critical. Lower price tags will allow the state, counties, employers and individuals to maintain greater health care access and coverage with limited funds.

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