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California Legislature

Joint Informational Hearing
Senate and Assembly Committees on Health
The Cost of Uncertainty: Health Coverage Access & Affordability Amid Federal Instability
March 10, 2026, 1:30pm - 1021 O Street, Room 1100

BACKGROUND

Over the last two decades, significant federal policy changes have reshaped the health insurance landscape in California, expanding coverage, increasing affordability, and strengthening consumer protections for millions of residents. These policies drove historic reductions in the uninsured rate and provided greater stability for families, providers, and health systems across the state. These gains, however, are now under threat. The expiration or rollback of key federal supports, combined with broader economic uncertainty and rising health care costs, risk reversing hard-won progress and increasing the number of Californians who are struggling to obtain or maintain affordable coverage. The purpose of this joint informational hearing is to provide an overview on health insurance in California with a focus on affordability and access to coverage, the scope of prior progress, and the potential consequences of ongoing federal policy shifts. The hearing will allow policymakers to hear from California purchasers, providers, counties, and others from different regions of the state, and will include a discussion about actions the state has taken to address health coverage affordability. Legislators will also hear recommendations for additional policies the state may pursue to support Californians during this unstable time.

Affordable Care Act.
The federal Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and is the most significant legislative reform of the U.S. health care system since the establishment of Medicare and Medicaid in 1965. The passage of the ACA brought sweeping changes to health care coverage in California, including establishing more generous eligibility rules and federal funding for Medi-Cal (California's Medicaid program), providing federally funded premium and cost-sharing subsidies offered through Covered California (the state's health benefit exchange), and imposing new requirements on health insurance that make it easier for individuals with pre-existing conditions to obtain coverage.

The ACA and subsequent federal changes to the law bolstered access to coverage, insuring over 44 million previously-uninsured (16.4% of the nonelderly U.S. population in 2024), including 21.4 million in marketplace coverage (health benefit exchanges) and 21.3 million in Medicaid.[1] Under the ACA, Medicaid eligibility was expanded to adults under age 65 without minor children with incomes up to 138% of the federal poverty level (FPL) ($22,025 for an individual and $29,863 for a couple in 2026), parents with income up to 138% FPL who were not previously eligible, and former foster youth up to age 26. The ACA allowed "No Wrong Door"

enrollment, eliminated the asset test for certain groups, and established a new method for counting income (known as modified gross income). The ACA also required states to establish hospital presumptive eligibility, whereby hospitals can determine temporary eligibility and immediate access to no-cost Medicaid coverage while patients apply for longer-term coverage.

The ACA requires states to establish health benefit exchanges or participate in a federal exchange where individuals and small businesses (with up to 100 employees) can shop for comprehensive health coverage. Additionally, federal subsidies or tax credits reduce the cost of insurance coverage for individuals with incomes below 400% FPL ($63,840 for an individual and $128,600 for a family of four in 2026) who purchase individual/family insurance coverage through an exchange. Premium tax credits were temporarily increased and expanded to those earning more than 400% FPL under the American Rescue Plan of 2021 (and subsequently the Inflation Reduction Act of 2022), with the guarantee that no one would pay more than 8.5% of their household income on health insurance premiums. This enhancement of the tax credits significantly reduced premiums and allowed for no premium plans for enrollees earning less than 150% FPL. Cost-sharing reductions are required in exchanges for individuals with income below 250% FPL ($39,125 for an individual in 2026). Limited tax credits for small employers were also made available, which are more generous for smaller businesses with lower annual wages.

The ACA individual coverage mandate requires most individuals to purchase minimum essential coverage or pay a penalty (although the financial penalty was eliminated by Congress in 2017). Exceptions to the federal mandate were made for individuals without access to an affordable plan, individuals not lawfully present, religious objectors, incarcerated individuals, individuals with income below tax filing thresholds, members of Indian tribes, and people granted a hardship waiver or those going without coverage for less than three months. In California, SB 78 (Senate Committee on Budget and Fiscal Review), Chapter 38, Statutes of 2019 created the Minimum Essential Coverage Individual Mandate modeled after the federal requirement. Beginning on January 1, 2020, California residents and their dependents were required to obtain and maintain minimum essential coverage or claim an exemption. Exemptions in California include the federal exemptions but are based on the state income tax filing threshold (which is higher than the federal filing threshold). Exemptions for short coverage gaps, low income, and lack of affordable coverage (if the cost of the lowest-cost plan is more than 8.05% percent of income in 2026) can be claimed when filing state income taxes. Exemptions for general hardship, religious conscience, and affordability can be requested through Covered California. The penalty for noncompliance in 2025 for California residents who did not have coverage, and who do not qualify for an exemption, will be $950 per adult, $475 per child, or 2.5% of their gross income over the tax filing threshold, whichever is higher. To illustrate, a family of four with qualified income of $60,000 who had no coverage for 12 months would not be subject to the penalty because their income is below the filing threshold. A family of four with qualified income of $100,000 would pay $2,850, and if the family had qualified income of $200,000 would pay $3,127. California's penalty formula is identical to the penalty formula included in the ACA prior to it being zeroed out beginning in 2018. Under the ACA, employers with over 200 employees are required to offer full-time employees coverage, and those with over 50 fulltime employees are required to pay a penalty if qualifying coverage was not offered and an employee qualifies for federal tax credits in an exchange.

Under the ACA, insurance companies are required to comply with a number of reforms depending on the markets their products are sold in, with most applicable to the individual and small group markets. Some of those reforms include:

1) Annual and lifetime limits: Prohibits insurers from imposing lifetime or annual limits on the dollar value of essential health benefits.

2) Essential health benefits: Requires coverage for ten essential benefits including prescription drugs, mental health, substance use disorder treatment and behavioral health, rehabilitation and habilitative services and devices.

3) Guaranteed issue and renewability: Requires acceptance of every employer and individual that applies/renews and pays premiums. Individual purchasers are subject to open enrollment and special enrollment periods.

4) Preexisting conditions: Prohibits health insurance companies from imposing preexisting condition exclusions.

5) Health status factors: Prohibits health insurers from establishing rules based on certain health status-related factors.

6) Premium rates: Limits variations in premiums to only family structure, geographic area, age (older people cannot be charged more than three times a younger person), and tobacco use. In other words, premiums cannot be based on health status anymore.

7) Rate review: Requires rate monitoring for unreasonable rate increases.

8) Dependent coverage to age 26: Allows children to remain on parents' coverage until age 26.

9) Waiting periods: Prohibits excessive health insurance imposed waiting periods before coverage is effective.

10) High deductible plans: Allows high deductible catastrophic coverage for certain individuals under the age of 30.

11) Preventive services without cost-sharing: Requires coverage of specified categories of preventive services as recommended by the U.S. Preventive Services Task Force.

12) Medical loss ratios: Requires annual rebates to businesses and individuals that purchase health insurance when less than 85% or 80% of premiums are spent on medical care.

13) Grandfathered plans: Allows people to maintain coverage that does not meet ACA standards.

Sources of health care coverage in California.
Publicly funded health insurance options include Medicare (for older adults, covering 14% of Californians), Medi-Cal (California's Medicaid program for low-income earners, 24% of Californians), CalPERS (for certain public employees, 2% of Californians), and TriCare (for military personnel, veterans, and dependents, about 1% of Californians).

Privately funded insurance is often employer-sponsored, consisting of small-group plans (for ≤100 employees, covering 6% of Californians) or large-group plans (for >100 employees, covering 22% of Californians). Rather than purchasing one of these small- or large-group plans from a state-licensed health insurer, some employers and employee labor management boards choose to self-insure their employees, meaning they pay for employee health care costs directly. Approximately 14% of Californians have coverage through self-insured plans. These private-sector plans are referred to as "ERISA" plans after the federal Employee Retirement Income Security Act, which governs them. States are preempted from enforcing laws on ERISA self-insured plans, but states are not barred from regulating state-licensed, fully insured health plans that may contract with ERISA plans. Some self-insured public plans (operated by state and local governments) and church plans may be subject to state regulation. Individuals can also buy their own plans for themselves, and family members offered through the Covered California marketplace, or insurance carriers operating outside of Covered California. About 6% of Californians purchase individual market coverage.

The regulatory landscape for health insurance is a patchwork, depending on the program, its funding, and historical departmental jurisdictions. The federal government regulates Medicare, TriCare, and ERISA self-funded employer plans. In contrast, Medi-Cal, CalPERS, individual plans (including those available through Covered California), and small- or large-group employer plans are regulated by the state. In California, the Department of Managed Health Care (DMHC) regulates health care service plans, including preferred provider organizations (PPOs). These plans are offered in the individual and group markets, covering approximately 13 million Californians and another 16 million in public coverage (mostly Medi-Cal). The California Department of Insurance also regulates health insurance (other PPOs) in the individual and group markets for approximately 800,000 Californians, mostly in large-group coverage.

Coverage statistics.
Nearly 60% of non-elderly Californians receive health insurance from their jobs.[2,3] California has one of the largest Medicaid programs in the nation, enrolling nearly 30% of Californians under the age of 65. Medi-Cal has expanded over the past decade, first through the bridge to reform waiver program, which transitioned low-income adults to Medi-Cal during the federal ACA expansions, and then through the "Health4All" program, which expanded Medi-Cal access to any eligible person regardless of immigration status. These expansions started with children in 2016, young adults in 2020, older adults in 2022, and finally, adults aged 26-49 in 2024. These expansions have helped create historically low uninsured rates—as low as 5.9% in 2024, down from over 17% in 2013.[4] The proportion of Californians on Medi-Cal is likely to shrink in the coming years due to federal eligibility restrictions and state budget cuts. In response to a loss of federal funds for certain immigrant groups included in H.R. 1 and state budget deficits, California has instituted an enrollment freeze for full-scope Medi-Cal for undocumented adults 19 and older. Additionally, beginning in 2027, adults with "unsatisfactory immigration status" (UIS, a group that includes undocumented adults, those with Deferred Action for Childhood Arrivals (DACA) status, and Green Card holders who have not yet met the federally required five-year waiting period) enrolled in Medi-Cal will be required to pay a $30 monthly premium.[5]

Coverage losses.
Importantly, although most Californians are required to have health insurance due to the individual mandate, the California Health Benefits Review Program (CHBRP) estimates that

6.8% of Californians will be uninsured in 2026. This population is disproportionately American Indian or Alaskan Native and Latinx.[3] Given recent state and federal policy changes, a UC report estimates that nearly three million Medi-Cal enrollees could lose coverage by 2028, along with up to 400,000 Covered California enrollees.[6]

Medi-Cal enrollee costs.
Because Medi-Cal is designed to cover low-income Californians, most enrollees do not pay any premiums, deductibles, or co-pays. Children under 19 can also qualify for Medi-Cal if their family income is below 266% FPL ($87,780 for a family of four in 2026). For those with monthly incomes above the 138% FPL cutoff, some still qualify for Medi-Cal if they pay a share of cost, similar to a monthly deductible. As mentioned above, Medi-Cal costs will increase for UIS adults in July 2027, when the state will begin imposing a $30 monthly premium. Adults making over 100% FPL will also encounter increased Medi-Cal costs in October 2028 when H.R. 1 imposes mandatory co-pays up to $35 per service, excluding primary care and behavioral health services.[7]

Covered California costs.
Covered California is the state's ACA marketplace, often used by small businesses or those who are self-employed. Plans in Covered California are standardized by the percent of average medical care costs covered by the premium (see Table 1).

Table 1: 2026 Covered California Coverage Options

Plan Design	Average Annual Cost of Health Care Paid by Premium	Patient Cost-Sharing Responsibility	Deductible (Individual/Family)	Out-of-Pocket Maximium Cost-Sharing (Individual/Family)	Average Gross Premium**
Bronze	60%	40%	$5,800/$11,600	$9,800/$19,600	$682
Silver	70%	30%	$5,200/$10,400	$9,800/$19,600	$741
Silver 73	73%	27%	$5,200/$10,400	$8,100/$16,200	$831
Silver 87	87%	13%	$1,400/$2,800	$3,350/$6,700	$765
Silver 94	94%	6%	Zero	$1,400/$2,800	$761
Gold	80%	20%	Zero	$9,200/$18,400	$912
Platinum	90%	10%	Zero	$5,000/$10,000	$968
Catastrophic or minimum coverage*	0% until out-of-pocket max is reached	N/A	N/A	$10,600/$21,200	N/A

* Must be under 30 years old
** Premiums listed are the average gross premium per member per month for those who qualified for advance premium tax credits in July 2025. Premiums will vary based on the family size, geographic region and issuer.

California has 19 premium rating regions. Most larger counties have their own rating region, except for Los Angeles County, which is split into two regions. Table 2 illustrates the impact of federal premium tax credits (and enhanced premium tax credits, if they would have been extended) on average premium prices on a per-member-per-month basis in the top three most expensive premium rating regions (Regions 9, 8, and 1), and the least expensive premium rating region (Region 15).

Table 2: 2026 Tax Credit Adjustments in Select California Premium Rating Regions

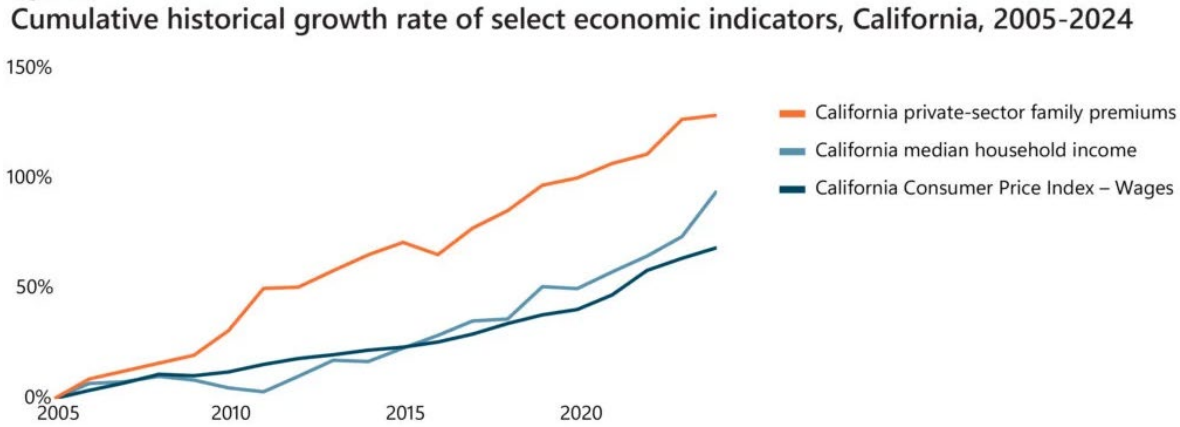
Region	Premium Expense Relative to Other Regions	Average Gross Premium per Member per Month	Premium with Federal Premium Tax Credits	Premium with Enhanced Premium Tax Credits, if continued after 2025
Region 9 – Santa Cruz, Monterey, and San Benito Counties	$$$	$1,098	$307	$104
Region 8 – San Mateo County	$$$	$1,074	$380	$180
Region 1 – 18 Northern Counties and Amador, Alpine, Calaveras, Tuolumne	$$$	$1,073	$273	$94
Region 15 – 10 zip codes in Los Angeles County	$	$623	$177	$92

Subsidies and tax credits.
Over 90% of Covered California enrollees receive some combination of state and federal subsidies. Those making under 400% FPL are eligible for state and federal subsidies for Covered California plans, and those making less than 250% FPL can enroll in cost-sharing reduction plans within Silver-level coverage. However, the expiration of federal enhanced premium tax credits at the end of 2025 is creating stark affordability concerns. The state is attempting to backfill some of this $2.5 billion loss in federal aid; California has allocated $190 million to provide state-funded tax credits for individuals earning up to 165% FPL ($25,823 in 2026) to help keep monthly premiums consistent with 2025 levels.[15] Even so, Covered California estimates that about 1.7 million Californians will be at risk of significant increases to their premium costs in 2026; on average, enrollees will notice 97% increases to their monthly health insurance premiums.[16] California Health Care Foundation (CHCF) demonstrates the impact of these premium increases in its analyses of five family scenarios, highlighting that those hit the hardest will be those just over the 400% FPL cutoff who will no longer be eligible for federal subsidies. For example, an older (but not Medicare-eligible) couple making $107,000 a year in a rural area will be spending a third of their monthly income on their health insurance premium in 2026.[17] The effect of more costly premiums is reflected in the 2026 Covered California enrollment data. As of February, Covered California estimates a 3% decrease in enrollment overall, with a 32% decrease in new enrollments compared to 2025. One-third of enrollees are opting for lower-cost Bronze plans, compared to 25% in 2025, and 75% of renewals who switched plans downgraded to Bronze-level coverage. About 14% of previous enrollees cancelled their plans, and for those making over 400%, policy termination rates are double what they were in 2025 (22% up from 11%).

Employer coverage.
For those on employer-based individual and family plans, the California Health Benefits Survey found that the average total premium for family coverage in California has increased by 24% since 2022 - rapidly outpacing the national rates of inflation (12%) and wages (14%). This continues a 20-year trend: according to the UC Labor Center, family health care premiums for private-sector workers have grown by 129% since 2005, faster than the state's median household

income (94%) and the inflation rate (69%) (see Figure 1).[18] Because health insurance is part of an employee's total compensation plan, higher premiums cut into employee wage increases and other benefits. Furthermore, workers are increasingly being asked to cover deductibles. In 2025, 75% of covered workers in California were enrolled in a plan with an annual deductible, up from 68% in 2022. Since 2022, average deductible amounts have increased about 10% annually.[2]

Figure 1



Note: Medical Expenditure Panel Survey data was not collected in 2007.
Sources: UC Berkeley Labor Center analysis of data from Medical Expenditure Panel Survey Insurance Component, Federal Reserve Bank of St. Louis' analysis of U.S. Census Bureau Current Population Survey, and California Department of Finance

Health care spending in California.
According to the 2023 California Health Care Cost 101 Almanac, between 2010 and 2020, annual average health care spending in California grew faster than national health spending in all payer categories and outpaced economic growth in the state. In 2020, baseline health care expenditures were $405.5 billion in the state, comprised of $125 billion spent by private insurance, $87 billion for Medicare, and $87 billion for Medi-Cal.[8] More recent 2022–2023 data, collected by the California Office of Health Care Affordability (OHCA) from 17 California commercial or Medicare Advantage payers, estimate statewide baseline health care expenditures (claims and nonclaims payments, patient cost sharing, and health insurance costs and profits) at $408.6 billion. Commercial spending was $127.8 billion, Medicare spending was $112 billion, and Medi-Cal spending was $134.1 billion. Other categories of spending, such as correctional and veterans' health, comprised another $26.2 billion. Total health care expenditures increased 8.4% from 2022 to 2023.[9]

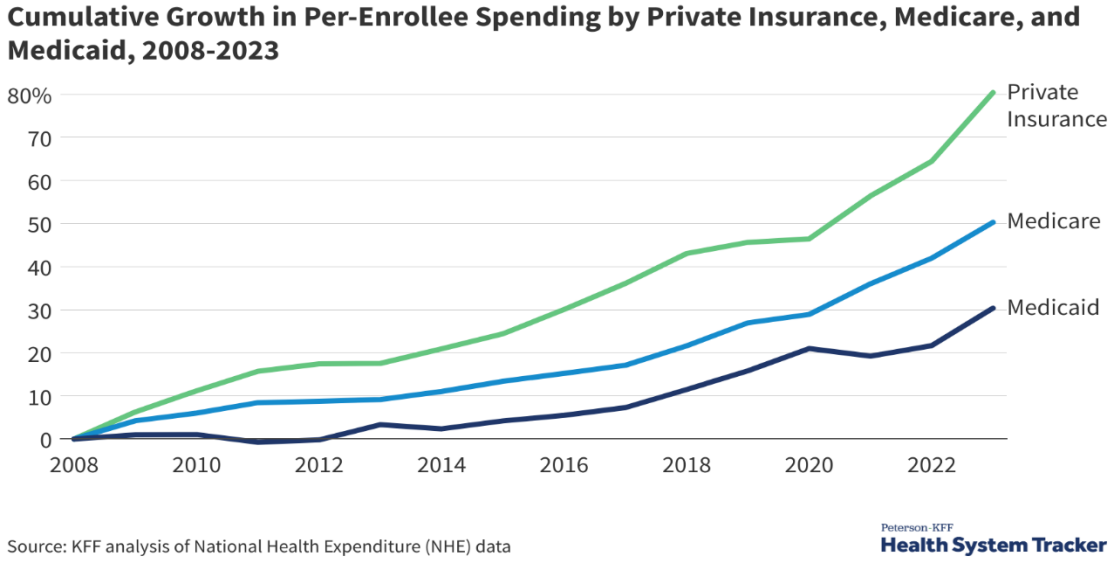
U.S. comparisons.
A KFF publication on cost and affordability indicates that the U.S. spends more on inpatient and outpatient care than peer countries, independent of utilization rates.[10] This includes payments to hospitals, clinics, and physicians for services and fees such as primary care or specialist visits, surgical care, provider-administered medications, and facility fees. Nationally, payments to hospitals, physicians, and clinics together comprised half of all health care expenditures in 2023.[11] Between 2013 and 2020, inpatient and outpatient care costs grew by $2,216 per capita, contributing to 60.3% of the total growth in health spending over this period. In comparable

countries, inpatient and outpatient care costs grew by only $710 per capita and contributed to 39% of health care spending growth.[10]

The significantly higher cost of health care and overall outlay on health care in the U.S, as compared to peer countries, does not translate to better health outcomes overall. In 2023, Americans had a life expectancy of 78.4 years, compared to an average of 82.5 among peer countries. The U.S. also lags behind peer countries on other health standards.[12] Although California performs slightly better on some health behaviors and outcome measures than the national average, this is likely due to targeted public health and clinical quality interventions, such as the state's groundbreaking tobacco control program and the California Maternal Quality Care Collaborative initiative, rather than what Californians spend on health care.[13,14]

Cost drivers.
Many factors contribute to the growth of health care expenditures, including new technologies and treatment innovations, delays in care, administrative activities, and market conditions. In 2024, U.S. health spending reached $5.3 trillion, 18% of gross domestic product.[11] Nationally, per-enrollee spending has risen significantly, and private insurance spending is consistently much higher than public coverage spending (see Figure 2).

Figure 2



Market consolidation: One driver of the high cost of care is pervasive consolidation across health care markets, including hospitals, physicians, insurance, and pharmaceutical markets. While consolidation can theoretically reduce fragmentation and improve efficiency, it also makes smaller entities subject to sophisticated business strategies of a larger organization that may seek to use disproportionate market power to charge prices beyond what would be viable in a competitive marketplace. An environmental scan of consolidation trends (mergers, purchases, acquisitions, ownership, and contractual agreements for joint price negotiations) published in Rand Health Quarterly in 2023 reported findings that health care consolidation—particularly horizontal consolidation of providers (hospitals acquiring other hospitals)—was associated with higher prices, with little or no impact on health care quality. Furthermore, although horizontal

consolidation of commercial insurers is associated with lower provider costs, these savings are not passed on to consumers, who face higher premium costs after consolidation.[19] A September 2025 report published by the General Accounting Office indicates that vertical integration of physicians into hospital systems increased Medicare spending and the prices paid by commercial insurers.

Private Equity: Private equity arrangements with physician practices and other players of the health system are growing and vary by specialty and geographic market.[20] Private equity is a form of corporate ownership that often entails relying on loans to acquire a business, taking it private if not already, and attempting to increase its value to sell it at a profit in three to seven years. In California, private equity acquisitions in health care providers, health care technology, and pharmaceutical and biotech industries totaled $20 billion. Private equity acquisitions of health care providers, including clinics, hospitals, and nursing homes, made up a significant portion of deals in the state. Private equity firms now own approximately 8% of all private hospitals in the U.S. and approximately 6% of private hospitals in California. These acquisitions lead to higher costs for patients and insurers, lower patient satisfaction, and worse financial outcomes for the entities being acquired.[21]

Prescription Drugs: In 2021, the U.S. spent an average of $691 more per person on retail pharmaceuticals, over-the-counter drugs, and medical equipment than comparable countries.[10] From 2020 to 2023, national retail prescription drug spending rates increased by 8.6%, following a 3.3% increase in average annual growth the decade before, outpacing spending growth on hospitals or physicians and clinics.[11] When drug prices increase, these costs get passed to employers and health plan enrollees via increased premiums. The 2025 California Health Benefits Survey reports that 36% of large California companies (over 200 employees) report that prescription drug prices contributed "a great deal" to higher premiums, including 63% of companies with 5,000 or more workers. An example of prescription drug cost drivers is GLP-1 agonist drugs. Although typically covered for diabetes, these drugs are offered by 28% of large employers for weight loss purposes. The high cost of these drugs and prolonged utilization have led to 44% reporting "significant" impacts on prescription drug spending. Despite the expense, given that over 70% of large employers offering GLP-1 drug coverage—and nearly half of those that don't—believe this benefit is "very" or "somewhat" important to employee satisfaction, employers may feel pressured to keep or add GLP-1 agonist coverage in their health plan offerings.[2] A recent Milliman study found that while GLP-1 medications may reduce medical costs for many chronic conditions, the savings currently do not outweigh the cost of the drugs. More research is needed to understand their overall impact on total health care costs.[22] An analysis commissioned by the California Hospital Association indicates drug costs have increased 19% from 2019 to 2023.[23] DMHC reports that prescription drug costs paid by California health plans have increased by 72%, or $6.2 billion, since 2017.[24]

Administration and other cost drivers: CHCF has estimated that as much as 25% of health care spending in California does not contribute to helping people get healthier or get better care, resulting in $73 billion lost every year. They estimate that about 29% of this is due to administrative complexities throughout our health care systems, such as incompatible technology systems and high paperwork and processing workloads. Another 26% is due to unfair pricing, stemming from a lack of competition and increased consolidation as discussed above. An estimated 18% is due to a lack of investment in preventive care – in the U.S., only five cents of

every health care dollar is spent on primary care compared to other countries spending three times that amount. Research shows that investments in primary care reduce costs while improving outcomes.[25] Overtreatment and failure of care coordination comprise the remaining 28%.[26] California hospitals reported vendor services, such as software, marketing, recruitment, management and maintenance have increased 22% from 2019 to 2023, and labor costs have increased 111% in this time frame. The analysis also suggests longer hospital stays translate to more severe health needs and that labor shortages in post-acute settings and prior authorization policies prevent timely discharge of patients from hospitals and lead to increased expenses.[23] According to a recent article from the Center on Health Insurance Reforms, in the last decade administrative spending outpaced the growth in private health insurance spending on physician and clinic services, retail drugs, and other expenses collectively, except for hospitals. This can be attributed in part to various "middlemen" in the market that profit by increasing revenues for insurers or providers, and sometimes both through. For example, revenue cycle management companies were valued at $172 billion in 2024 and are expected to grow by another 10% by 2030.[27]

Health impacts of rising health care costs.
A vast majority (71%) of Californians are experiencing financial strain of health care costs. Four in ten Californians have some form of medical debt, and over the past year, 51% of Californians report that their health care expenses have increased faster than their income. Nearly two-thirds of Californians say they are "somewhat" or "very" worried about being able to afford unexpected medical bills, and over half of Californians are "somewhat" or "very" worried about being able to afford out-of-pocket medical costs (58%), long-term care facilities for themselves or family members (54%), and monthly health insurance premiums (52%), surpassing concerns about housing, transportation, groceries, or utility costs. Latinx Californians report that it has been "very" or "somewhat" difficult for them or their family to afford health care in the past year.[28] According to a January 2026 NORC report, women are particularly affected by the financial stress of rising costs and benefit changes, as they often shoulder the burden of navigating coverage and care for their families. Compared to men, women are more likely to report being "extremely" or "very" worried about affording out-of-pocket health care costs, unexpected medical bills, health insurance premiums, and prescription drugs.[29]

When Californians are concerned about their ability to afford health care, they may modify, avoid, or postpone care. Nationally, about one in five adults report that they have not filled a prescription due to cost, one in four have used over-the-counter alternatives instead, and one in seven have cut pills in half or skipped doses of medicine because of the cost.[30] The 2026 CHCF Health Policy Survey reveals that 59% of Californians skipped or postponed care in the past year due to cost, and 42% of those respondents report that avoiding or postponing care made the condition worse.[28] NORC emphasizes that because women use more health care services than men, policy changes that affect the affordability of health care will disproportionately impact women.[31]

OHCA.
California created OHCA in 2022 to rein in health care spending growth in the state. Housed in the Department of Health Care Access and Information (HCAI), OHCA is charged with collecting, analyzing, and reporting health care spending data. OHCA's goals include identifying sources and drivers of health care expenditures, establishing cost growth caps, promoting

alternative payment models to increase investment in primary and preventive care providers, and evaluating proposed mergers and acquisitions to promote healthy competition. In 2024, OHCA's eight-member Health Care Affordability Board set statewide spending targets, ramping down from 3.5% in 2025 to 3% by 2029. The Board also established hospital cost growth targets in 2025 that match the statewide targets, except in high-cost hospitals, which have a 1.6% growth target by 2029. These targets are intended to check spending growth so that it does not outpace median household incomes and cut into families' food and housing budgets.

H.R. 1 and other federal policy changes impacting California.

Medi-Cal: The passage of H.R. 1 creates Medicaid eligibility requirements that will result in many people losing Medi-Cal coverage due to either immigration status, work requirements, or administrative burden.[32] H.R. 1 restricts access to Medicaid programs for undocumented Californians, refugees, and asylees. Furthermore, beginning in 2027, individuals with satisfactory immigration status must prove that they are engaged in work, community service, or job training for 80 hours per month, unless they meet certain exemptions (i.e., high unemployment rates in their area, caretaking responsibilities, pregnancy, or medical frailty).[33] Studies of Medicaid enrollment in states with work requirements show that work requirements are unlikely to increase the number of Medi-Cal enrollees working.[34–36] Lastly, H.R. 1 requires states to verify these eligibility requirements every six months, increasing the risk of an applicant losing coverage due to seasonal work that doesn't meet the work requirements or increased administrative burden. The UC Berkeley Labor Center estimates that 1.9 million people will lose Medi-Cal coverage due to work requirements, 270,000 will lose coverage due to increased eligibility verification, and 200,000 will lose full-scope coverage due to immigration status.[6] Other provisions of H.R. 1 have significant impacts on Medi-Cal financing through restrictions on provider taxes and payment caps to hospitals and providers. While these topics are being discussed in other hearings, this hearing will focus more on the impacts of H.R. 1 and other federal policy changes on access to health insurance.

Covered California: H.R. 1 and other federal policy changes also restrict eligibility for, access to, and affordability of state health insurance marketplaces. In 2025, the federal Center for Medicare and Medicaid Services (CMS) Marketplace Integrity Rule barred DACA recipients from the Covered California marketplace and ended special enrollment opportunities for people with incomes under 150% FPL. Covered California's generous open enrollment period of three months (Nov 1 to Jan 31) will be shortened for plan year 2027 to two months (Nov 1 to Dec 31). Beginning in 2027, H.R. 1 prohibits specified lawfully present immigrants from accessing federal premium assistance in ACA plans, including asylees, refugees, and immigrants granted temporary protected status, and those with work or student visas. Covered California estimates that this change will cause 112,000 enrollees to lose the financial assistance they rely on to afford coverage. Additional administrative requirements will also make it more difficult for Californians to enroll in or maintain federal subsidies for Covered California coverage. Beginning in 2028, those applying for federal subsidies will need pre-enrollment verification of subsidy qualifications, and automatic re-enrollment for those who have not updated their information will end. Furthermore, those who lose Medi-Cal due to work requirements will not be eligible for premium tax credits in the Covered California marketplace. Some CMS Marketplace Integrity Rule provisions around verification and reconciliation of income requirements, as well as premium and plan design requirements, are currently stayed by a federal court.[37]

County safety net programs: Under California law (Welfare & Institutions Code §17000, et seq.), counties are required to provide medically necessary basic health services and last-resort emergency care to uninsured adults through indigent care programs. However, the eligibility requirements and scope of these programs vary throughout the state. Medi-Cal expansions over the past decade have transferred many people who would have been served by safety net programs to Medi-Cal, reducing the burden on counties and cities to provide this care. Many county safety net programs now operate at a diminished capacity as counties have shifted their focus to supporting Medi-Cal administration instead.[38,39] Given changes in Medi-Cal eligibility and health care affordability, counties may need to revive safety net programs in response to a growing uninsured population.

Conclusion.

The rollback of federal policies will stifle much of California's progress and efforts to make health care coverage more accessible and affordable. While it is unlikely that the state can fully prevent the impacts of federal changes, the Legislature must understand the consequences and explore what can be done to improve affordability and protect coverage for the millions at risk of losing it.

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