California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, March 3, 2025

2:30 P.M. – State Capitol, Room 126

Items To Be Heard

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4140 Department of Health Care Access and Information
6440 University of California

Issue 1: Physician Workforce Development

Note: Segments of this background are adapted from materials provided courtesy of the University of California and the Legislative Analyst's Office.

About Graduate Medical Education

Graduate medical education (GME) is the period of clinical training in a medical specialty or subspecialty that follows completion of medical school and prepares physicians for independent practice in that specialty or subspecialty, as well as eligibility to be board certified in that specialty or subspecialty. This is also referred to as residency or fellowship education. Following a four-year medical school education, resident physicians spend three to seven years in residency training and additional years if they complete a fellowship. Following high school, it takes a minimum of 11 years of education before a student becomes eligible to be an independently practicing, board-certified physician.

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the accreditation of medical residency and fellowship programs throughout the U.S. The ACGME accredits over 180 specialties and subspecialties. There are around 1,178 ACGME-accredited residency programs in California which train over 15,000 medical residents and fellows. These programs are run by 115 different sponsoring institutions, which are the organizations responsible for compliance with the rigorous ACGME requirements and the financial sustainability of medical residency programs. Around 5,600 residents are enrolled in UC-sponsored residency and affiliated family medicine programs – about 35 percent of California's total.

Federal Funding for GME

Medicare, the federal program that provides health care coverage for adults ages 65 and older, is the primary source of public funding for residency programs. In acknowledgement of the medical staff needed to serve this population, Medicare provides payments to hospitals to cover a portion of their resident training costs. Hospitals' residency payments are largely determined by two key factors. First, hospitals generally qualify for payments by providing inpatient services to Medicare patients, with a hospital's payment increasing as the share of its inpatient hours devoted to Medicare patient increases. This factor is intended to recognize Medicare's share of

the cost to train residents, with private payers expected to cover the remaining portion of training costs. Second, hospitals' Medicare's payments generally increases with the number of residents they train until they reach a certain cap.

Proposition 56 Funding for GME Programs

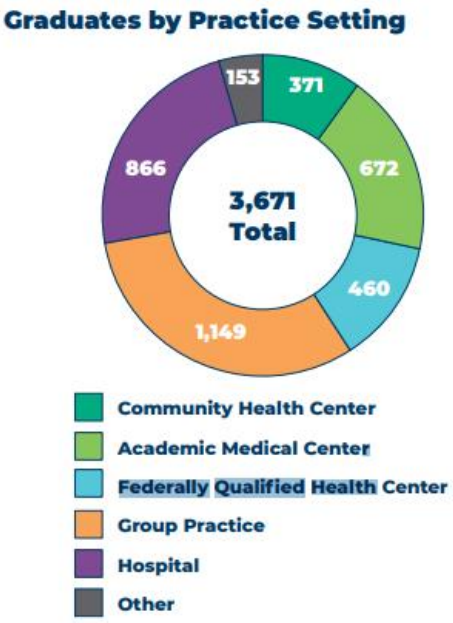
Proposition 56, which was approved by voters in 2016, increased California's state tobacco tax and allocated a portion of revenue **($40 million)** annually to the University of California (UC) to "sustain, retain, and expand" California's residency training programs. UC contracted with Physicians for a Healthy California to administer a statewide GME grant program, known as CalMedForce, that provides grants to residency programs in five specialties (emergency medicine, family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology) and combined programs in these specialties (e.g., internal medicine/pediatrics). CalMedForce is also authorized to fund residency programs in other specialties in which shortages exist but has not done so due to high demand for funding from specialties that are specifically referenced in Proposition 56.

Proposition 56 funds support GME programs across the state, not just those sponsored by the University of California. On average, UC residency programs make up almost 16% of award recipients of the CalMedForce program.

CalMedForce Impact and Outcomes Thus Far

After seven award cycles, CalMedForce has granted over **$255 million (total of 780 awards)** to residency programs across 32 counties in CA (added Butte County in 24-25). To date, approximately 57% of graduates of residency programs funded by CalMedForce have remained in CA and spend the majority of their time in primary care and Emergency Medicine settings. The majority of these graduates are from Family Medicine residency programs.

CalMedForce grant award funds may be used exclusively to support costs directly associated with GME. Examples of such costs include salary and benefits of medical residents, training resources, and education activities. Funding is awarded for the entire duration of training for the supported resident position.



These award funds have helped residency programs expand and fund additional residents, provide resources (including training equipment) to meet educational needs, expand efforts to recruit more residents, improve resident wellness and reduce burnout, and focus more on resident experiences with patients with greater needs. The CalMedForce funds has supported expansion of residency rotations and provided resources for improved clinical experiences. Curriculum enhancements such as language electives have been created with CalMedForce support. These funds have also helped sustain accreditation of residency programs with the Accreditation Council of Graduate Medical Education (ACGME). Administrative costs or any indirect costs that do not solely benefit the resident or residency program are not allowed.

General Fund Backfill Previously Offset Declines in Prop 56 Revenue for GME Programs

Over the past several years, the state has provided a General Fund (GF) support to offset declines in Proposition 56 tobacco-tax revenue for GME. The state ended the GF backfill during the 2024-25 budget cycle, so the **total amount of program support dropped to $24.6 million.**

During the 2023-24 cycle, 155 applications were submitted requesting 693 positions for a total funding request of $121,680,000 and resulted in 217 resident positions being funded by Proposition 56 revenues. This grant cycle awarded 27 new programs, 14 expanding programs, and 99 existing programs, for a total of $38.7 million.

The University of California notes that even without the backfill, the 2024-2025 CalMedForce award cycle marks the largest applicant pool to date. CalMedForce awarded 184 positions in 2024-25 (reduction of 33 resident positions from the prior cycle), with 173 applications submitted requesting 773 positions for a total of $135,560,000 in total funding requested. Of the 142 residency programs awarded, 30 are new programs, 14 are expanding programs, and 98 are existing programs. Because there was a significant cut to the Prop 56 funding in 2024-2025, only 82% of programs that applied and 24% of positions were funded (compared to 89% and 31% in 2023-2024).

2024-2025 Award Cycle (reduction of funding because no backfill)	Applications Received	Applications Awarded	Programs Awarded	Requested Positions	Positions Funded	Positions Awarded
	173	142	82%	773	184	24%

2023-2024 Award Cycle (backfill = $11,164,000)	Applications Received	Applications Awarded	Programs Awarded	Requested Positions	Positions Funded	Positions Awarded
	155	138	89%	693	217	31%

Future Outlook with Declining Prop 56 Funds

While both Proposition 56 and the recently enacted Proposition 35 provide funding for GME, only new or expanding residency programs are eligible to receive Proposition 35 funds. The majority of Prop 56 funds goes to sustain existing residency programs facing financial challenges, which may be due to inadequate Medicare reimbursement, expanding ACGME requirements, higher expenditures required in collective bargaining agreements, and/or clinical site fiscal problems. The University of California notes that without additional support, existing residency programs must either absorb the additional cost of administering GME programs, or risk downsizing or even closure. With declining support for already existing residency programs and an increasing amount of financial challenges faced by health care organizations, there is a risk of reversing some of the work to expand the state's physician workforce.

Song-Brown and GME Programs

Note: At time of writing, the Administration did not provide the subcommittee with requested information and updates on the Song-Brown program in time for publication. The information presented below may not be complete.

Originally established by Chapter 1175 of 1973 (SB 1224, Song), the Song-Brown program was created to address shortages of family physicians by increasing support for residency programs. Since this initial legislation, Song-Brown has expanded to support residency programs in all four primary care areas (family medicine, internal medicine, pediatrics, and obstetrics and gynecology) as well as certain advanced nursing practice and physician assistant postgraduate training programs.

The Song-Brown program is administered by HCAI and receives **$33 million in ongoing funding from the General Fund,** of which $2 million is for state operations and $31 million is for local assistance.

Specifically for the primary care residencies, Song-Brown provides grant funding to educate and train primary care residents to work in underserved communities. All residency programs are required to incorporate the following strategies into their programs:

- Providing training sites in medically underserved multi-cultural communities, lower socioeconomic neighborhoods, or rural communities, and preparing primary care physicians for service in such neighborhoods and communities.

- Establishing procedures to identify, recruit, and match primary care residents who possess characteristics which would suggest a predisposition to practice in areas of unmet need, and who express a commitment to serve in areas of unmet need.

- Implementing counseling and placement programs to encourage training program graduates to enter practice in areas of unmet need.

- Providing a preceptorship experience in an area of unmet need to enhance the potential of training program graduates to practice in such an area.

Out of the $33 million of Song-Brown funding allocated each year:

- $18,667,000 is used to fund grant awards for existing primary care residency slots

- $5,667,000 is used to fund primary care residency slots for existing teaching health centers

- $3,333,000 is used to fund new primary care residency slots at existing residency programs; and

- $3,333,000 is used to fund newly accredited primary care residency programs

For the period 2017-2024, the table below summarizes the total numbers of slots supported (1603) and created (436). For the period 1998- 2017 HCAI supported 50 existing slots per year.

	2017	2018	2019	2020	2021	2022	2023	2024	Total
SB PCR Existing Slots	134	134	153	163	155	166	206	150	1261
SB PCR Existing Slots at THCs	30	30	30	48	50	55	55	44	342
SB PCR Slots at New Programs	59	31	28	54	28	32	73	10	315
SB PCR New Slots at Existing (Expansion)	13	13	7	25	13	22	15	13	121
Total	236	208	218	290	246	275	349	217	2039

*SB PCR = Song Brown Primary Care Residency
THCs: Teaching Health Centers

Panel

- Dr. Deena Shin McRae, Associate Vice President, Academic Health Sciences for the University of California
- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Libby Abbott, Deputy Director, Office of Health Workforce Development, Department of Health Care Access and Information
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

In response to growing healthcare workforce shortages, California has over the years made significant one-time investments to strengthen workforce development initiatives across both physician and allied health professions training. However, past budgets have also implemented cuts to these initiatives due to the state's ongoing fiscal challenges.

While the Song-Brown program has maintained modest ongoing General Fund appropriations for graduate medical education, overall state funding to expand the physician pool is likely to decline further, particularly as Proposition 56 and tobacco-related revenues continue to shrink. With limited backfill options, the subcommittee may wish to assess whether the current allocation of resources represents the most effective strategy for sustaining graduate medical education, expanding the physician workforce, and improving access in shortage areas.

The Subcommittee may wish to ask the following questions:

1. Has the University of California / HCAI conducted any analysis comparing the effectiveness of funding existing residency slots versus funding new residency programs in terms of producing physicians who remain in California?

2. What percentage of physicians work in shortage areas? How is the state ensuring that GME programs align with California's healthcare workforce needs, particularly in underserved areas?

3. What are the factors that influence whether a physician remains in California or leaves the state following completion of graduate medical education?

4. Has the University of California and its partners developed a long-term funding strategy to address the declining Proposition 56 revenues? Are other sources of funding being considered? Without additional financial support, what is the projected impact on the number of available residency slots in California?

5. Given the increasing number of funding requests, what changes, if any, have been made to the CalMedForce grant evaluation and award process?

6. How does CalMedForce verify that award recipients use funds appropriately, particularly for resident salaries and training-related expenses?

7. Does the Legislative Analyst’s Office has any recommendations on reporting metrics that could be used to assess the effectiveness of state-funded GME programs in producing physicians and expanding access to care in shortage areas?

Staff Recommendation:

This item is informational only.

4140 Department of Health Care Access and Information
0950 California Health Facilities Financing Authority

Issue 2: Health Facilities Financing & Distressed Hospitals

This background will cover the Distressed Hospital Loan Program, the Small and Rural Hospital Relief Program, as well as the bond financing and loan programs available under the California Health Facilities Financing Authority Program operated by the State Treasurer's Office.

Distressed Hospital Loan Program

The Distressed Hospital Loan Program (DHLP), jointly developed and administered by the Department of Health Care Access and Information (HCAI) and the California Health Facilities Financing Authority (CHFFA) offers interest-free, working capital loans to non-profit and publicly-operated financially distressed hospitals, including hospitals that belong to integrated health care systems with no more than two separately licensed hospitals in California that are facing a risk of closure. Generally, the DHLP focuses on hospitals at significant risk of financial failure that have a viable turnaround plan.

Eligibility for Distressed Hospital Loan Program

HCAI and CHFFA have developed an evaluation methodology when evaluating loan applications that focus on four components:

1- **Liquidity:** this includes cash on hand, ability to pay short-term obligations and access to working capital like lines of credit.

2- **Profit-loss analysis:** this includes a facility's operating margin and the impact of operating loss to liquidity.

3- **Turnaround plan:** this includes cash-flow projections, potential actions taken by facility leadership, plan on how the loan will be used, and how such actions will affect revenues and expenses.

4- **Community need:** this includes distance to nearest alternative hospitals, service offerings, service area designation and payor mix (the ratio of Medi-Cal, Medicare, commercial, an uninsured patients)

Funding & Awards

The program has $300 million in total available resources ($150 million from the General Fund and $100M from one-time funding from the Managed Care Organization tax).

Accounting for administrative costs, **$292.5 million was awarded to 16 borrowers**, as listed below:

	Borrower Name	Final Loan Award Amount
1	Chinese Hospital *San Francisco, CA (San Francisco County)*	$10,350,000
2	Dameron Hospital *Stockton, CA (San Joaquin County)*	$29,000,000
3	El Centro Regional Medical Center *El Centro, CA (Imperial County)*	$28,000,000
4	Hayward Sisters/St. Rose Hospital *Hayward, CA (Alameda County)*	$17,650,000
5	John C. Fremont Healthcare District *Mariposa, CA (Mariposa County)*	$9,350,000
6	Kaweah Delta Health Care District *Visalia, CA (Tulare County)*	$20,750,000
7	Madera Community Hospital *Madera, CA (Madera County)*	$57,000,000
8	MLK Jr. Community Hospital *Los Angeles, CA (Los Angeles County)*	$14,000,000
9	Palo Verde Hospital *Blythe, CA (Riverside County)*	$8,500,000
10	Pioneers Memorial Healthcare District *Brawley, CA (Imperial County)*	$28,000,000
11	Ridgecrest Regional Hospital *Ridgecrest, CA (Kern County)*	$5,500,000
12	San Benito Healthcare District / Hazel Hawkins Memorial Hospital *Hollister, CA (San Benito County)*	$10,000,000
13	San Gorgonio Memorial Healthcare District *Banning, CA (Riverside County)*	$9,800,000
14	Sonoma Valley Hospital *Sonoma, CA (Sonoma County)*	$3,100,000
15	Tri-City Medical Center *Oceanside, CA (San Diego County)*	$33,200,000
16	Watsonville Community Hospital *Watsonville, CA (Santa Cruz County)*	$8,300,000
	TOTAL	**$292,500,000**

Small and Rural Hospital Relief Program

The Small and Rural Hospital Relief Program (SRHRP) provides grants to qualified small, rural and Critical Access hospitals for the purpose of funding seismic safety compliance projects. The Alfred E. Alquist Hospital Facilities Seismic Safety Act requires that hospitals be constructed to remain open and safely provide services to the public after an earthquake.

The SRHRP supports qualified small, rural and Critical Access hospitals (a designation issued by the federal government) by providing state grant funding and technical assistance to help meet safety standards and preserve access to general acute care.

Eligibility for Grants

Hospitals that meet any of the following criteria are eligible for the SRHRP:

- Small hospitals defined as having fewer than 50 licensed general acute care beds.
- Rural hospitals defined as having a Rural or Frontier designation status in the Medical Service Study Area.
- Critical Access Hospitals are those possessing this designation from the Centers for Medicare and Medicaid Services.

Grant funding is awarded to eligible facilities based on cost-efficient project readiness, community need and financial status. SRHRP focuses on applicants who operate in Medically Underserved Areas and/or Medically Underserved Populations and/or Health Professional Shortage Areas as defined by Medical Service Study Areas. Grant applicants are expected to remain financially viable during and after the foreseeable future of the proposed seismic safety compliance related project. Priority is given to applicants who are able to demonstrate their ability to complete the proposed project with the SRHRP Grants and other available funds, loans, and grants.

Funding and Awards

SB 395 (Caballero, Chapter 489, Statutes of 2021) increased taxes on electronic cigarette products, with approximately ten percent of the funds allocated HCAI to operate the SRHRP. In addition, $50 million in one-time Managed Care Organization tax was allocated for the program. Of note, because the MCO tax was conditioned on receiving federal approval, the funds were not available at the start of the 2023-24 fiscal year.

To date, HCAI has issued 5 grant awards totaling $1.1 million. Nine applications totaling more than $10 million are currently under review.

	Awardee	Amount
1	George L Mee Memorial Hospital	$280,000
2	Kern Valley Healthcare District	$180,000
3	Mad River Community Hospital	$625,000
4	Oak Valley Hospital District	$65,000
5	Plumas District Hospital	$25,000
	TOTAL	**$1,175,000**

California Health Facilities Financing Authority Programs

CHFFA was established in 1979 under the State Treasurer's Office for the purpose of providing financial assistance to public and private, non-profit health care providers in California. This background will provide an update on CHFFA Bond Financing Program and the Healthcare Expansion Loan Program II (HELP II)

CHFFA Bond Financing Program

The Bond Financing Program provides eligible health facilities with access to low interest rate capital markets through the issuance of tax-exempt and taxable revenue bonds. Bond proceeds may be used to fund construction/renovation projects, land acquisition for future projects, acquisition of existing health facilities, refinancing of existing debt, working capital, and to pay costs of issuance.

Since program inception through 2023, CHFFA has issued 619 bonds for approximately $48 billion.

Bond Financing Program 2023 Update

In 2023, CHFFA authorized five bond financings for four California health facilities, with three of the bonds closing in 2023, resulting in a total issuance of $432,640,000. The following provides a summary of CHFFA's bond issues that closed in 2023.

Borrower	Amount	Type of Issue
Stanford Health Care	$260,545,000	New Money
Adventist Health System/West	$95,000,000	New Money
Adventist Health System/West	$77,095,000	Refunding
Total	**$432,640,000**	

As of December 31, 2023, CHFFA had 102 outstanding bond issuances totaling approximately $16.5 billion.

CHFFA Healthcare Expansion Loan Program II (HELP II)

HELP II is designed to provide eligible small and rural health facilities with financing for capital project needs through low-cost loans. As of December 31, 2023, CHFFA had 69 outstanding loans in the approximate amount of $40.1 million.

Since program inception through 2023, CHFFA has issued 303 HELP II Loans for approximately $145 million.

HELP II 2023 Update

In 2023, CHFFA closed 11 HELP II loans, which resulted in a total issuance of $13,138,039.

Borrower	**Amount**	**Use of Proceeds**
Chinatown Service Center	$2,000,000	Purchase Real Property
Southern Humboldt Community Health Care District	$2,000,000	Renovation
Sonoma Valley Health Care District	$2,000,000	Purchase Equipment
Transitions – Mental Health Association	$1,840,000	Purchase Real Property
Asian Pacific Health Care Venture, Inc.	$1,500,000	Renovation
Northern California P.E.T. Imaging Center	$1,091,039	Purchase Equipment
Castle Family Health Centers	$878,750	Purchase Real Property
Fleming & Barnes, Inc. dba Dimondale Adolescent Care Facility	$817,250	Purchase Real Property
Guiding Light Home for Boys	$598,500	Purchase Real Property
Northeastern Rural Health Clinics	$412,500	Renovation & Purchase Equipment
TOTAL	**$13,138,039**	

Emergency Loan Program for Health Facilities Affected by the Los Angeles Area Fires

In response to the Greater Los Angeles fires, CHFFA has established the Emergency Wildfire Help Loan Program, an initiative to support health facilities affected by the wildfires. The program draws its funding from HELP II, offering low-cost loans to impacted facilities to ensure the continued delivery of essential health care services to their communities.

Loan Terms:

- 0% fixed interest rate.
- Maximum loan amount: $500,000 per borrower.
- Loan maturities of up to 20 years for property acquisition, construction, remodeling, or renovation; up to 5 years for equipment and furnishings.

Eligible Uses of Funds:

- Property acquisition in the same service area.
- Construction, remodeling, renovation, and improvements.
- Equipment and furnishings.

Eligibility Requirements:

- Health facilities must be located in Los Angeles, Ventura, or San Bernardino counties and impacted by the 2025 Los Angeles area fires.
- Facilities must be non-profit 501(c)(3) organizations or public health facilities, with gross annual revenues under $40 million (no revenue limit for rural health facilities or district hospitals).
- Borrowers must demonstrate fiscal soundness, provide sufficient collateral, and submit documentation of wildfire impact and intended use of funds

Panel

- Fiona Ma, California State Treasurer
- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Scott Christman, Chief Deputy Director, Department of Health Care Access and Information
- Dean O’Brien, Acting Deputy Director Office of Health Facility Loan Insurance, Department of Health Care Access and Information
- Albert Pineda, Finance Budget Analyst, Department of Finance

- Victoria Rappleye, Staff Services Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

A concerning number of hospitals in California have either closed in recent years, or are experiencing extreme financial distress and therefore are at high risk of closure. In 2024, this subcommittee convened an oversight hearing on hospital financing and closures.

This panel will provides an update on key programs aimed at easing the fiscal challenges faced by California's hospitals.

The Subcommittee may wish to ask the following questions:

On the Distressed Hospital Loan Program:

1- What is HCAI's overall assessment of the turnaround plan provided by hospitals who have been provided a loan?

2- Has HCAI identified any common factors among distressed hospitals that make financial recovery more or less likely?

3- Are there any hospitals that received loans that are still at risk of closure? If so, what support can HCAI provide?

4- Have any hospitals applied for a loan modification? If so, what is the process to assess, determine necessity, and effectuate a loan modification?

5- What oversight mechanisms are in place to track whether hospitals are adhering to their turnaround plans?

On the Small and Rural Hospital Relief Program:

1- What percentage of small and rural hospitals in California remain noncompliant with seismic safety requirements, and what is the estimated cost to bring all facilities into compliance?

2- How does HCAI ensure that hospitals receiving grants will complete their seismic retrofitting projects on time and within budget?

On CHFFA programs:

1- How does CHFFA measure the impact of bond investments on health care accessibility and affordability?

2- Similarly, metrics are used to determine the HELP II's success in supporting small and rural health facilities?

Staff Recommendation:

This item is informational only.

4140 Department of Health Care Access and Information

Issue 3: Office of Health Care Affordability

Note: segments of this background is adapted from materials developed by the California Health Care Foundation and the UC Berkeley Labor Center

Consumer health care affordability has deteriorated over the past two decades in California due to rising premiums along with increasingly common and increasingly large deductibles for job-based coverage. Taken together, these trends in premium and deductible growth result in health care taking up a larger and larger share of household income. The UC Berkeley Labor Center notes that a significant portion of California adults reported that in 2024 they or a family member had delayed or postponed care due to cost (52%), had problems paying or couldn't pay any medical bills (27%), or had some type of medical debt (36%).

About the Office of Health Care Affordability

In response to widespread cost-related access challenges among California residents, the Office of Health Care Affordability (OHCA) was established within HCAI through SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022). At a high-level, OHCA has three primary responsibilities:

1. **Slow underlying spending growth.** OHCA will collect, analyze, and publicly report data on sources and drivers of spending across the health care system. To reduce excess spending, OHCA will establish a cost growth target for the system as a whole, and accountable entities within that system.

2. **Promote high-value system performance**. OHCA will promote adoption of alternative payment models (APMs), which compensate health care providers based on the quality (not quantity) of care they provide. OHCA will measure quality, equity, investment in primary care and behavioral health, and workforce stability to ensure the state's health care system is delivering value commensurate to the resources it receives.

3. **Assess market consolidation.** California's health care marketplace is heavily consolidated. Through cost and market impact reviews (CMIRs), OHCA will analyze transactions that are likely to significantly impact health care market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on the review, OHCA will coordinate with other state agencies to address consolidation as appropriate.

Driving OHCA's policy-making is the Health Care Affordability Board, a body established in statute and charged with setting the statewide and sector-specific spending targets. The Board has eight members: California's Health and Human Services Secretary, the CalPERS Chief Health Director (non-voting), four appointees from the Governor's Office, and one each from the Assembly and the Senate. Members may not receive compensation from health care entities.

Other responsibilities of the Board include appointing a Health Care Affordability Advisory Committee; approving key benchmarks, such as statewide goals for alternative payment model adoption and share of spending dedicated to primary care and behavioral health; and approving the scope and range of administrative penalties and penalty justification factors to apply in enforcing the spending targets.

Statewide Health Care Spending Target

In April of 2024, the Office of Health Care Affordability's Board approved a statewide health care spending target of 3 percent. The spending target will be phased in over-time, initially starting at 3.5 percent for 2025 and 2026, the target will be lowered to 3.2 percent for 2027 and 2028 before ultimately reaching 3 percent for 2029 and beyond. According to HCAI, the spending target is based on the average growth rate of median household income from 2002-2022, with the central tenet that health care spending should not grow faster than the incomes of California families.

The spending target will apply to health care entities, including health plans, provider organizations (with at least 25 physicians) and hospitals. Beginning with the Calendar Year 2026 target, OHCA can begin taking progressive enforcement action against health care entities that exceed the spending growth target. Progressive enforcement approaches include technical assistance, requiring an explanation at public meetings, imposing performance improvement plans, and ultimately, if warranted, assessing financial penalties.

All health care entities – payers, providers, and fully integrated delivery systems – will be subject to the spending targets, except for exempted providers. The Board will set the standards for exemption from statewide and sector-specific spending targets, considering factors such as annual revenue, patient volume, and high-cost outlier status in a geographic region or service line. Physician organizations with fewer than 25 physicians are exempt unless the practice is a high-cost outlier.

Sector Targets

In addition to statewide spending target, OHCA is tasked to establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. Such sector targets must be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to

state agencies and the Health Care Payments Data Program (discussed in Issue #5), as well as consideration of access, quality, equity, and health care workforce stability.

In 2024, OHCA focused on hospitals as a sector target as they are a significant source of health care spending. In January 2025, OHCA's board approved of defining a health care sector consisting of all hospitals and established stricter spending targets on a specific set of high-cost hospitals. At time of writing, OHCA has begun the work of promulgating regulations to codify the definition of this initial sector and its associated targets. Those regulations are undergoing the public comment period, with formal approval expected in April or May of 2025.

Panel

- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Vishaal Pegany, Deputy Director, Office of Health Care Affordability, Department of Health Care Access and Information
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

While California has made significant gains in expanding access to health coverage through Medi-Cal expansion and Covered California, the underlying cost of health care continues to be a significant barrier to consumers, with health care costs outpacing income growth for Californians.

By establishing OHCA, California joins eight other states that have established an independent commission or authority tasked with limiting growth in health spending. If implemented correctly, OHCA represents an opportunity for California to slow spending growth, promote alternative payment models focused on outcomes, and thoughtfully assess the impacts of market consolidation.

As OHCA implements these policies, the subcommittee may wish to assess whether the spending targets effectively balance cost containment with maintaining health care access, quality, and workforce stability.

The Subcommittee may wish to ask the following questions:

1- Can OHCA provide an overview of the methodology used to develop both the statewide and sector-specific spending targets? How did it engage stakeholders, and how was their feedback incorporated into the final targets?

2- What are the anticipated effects of implementing and enforcing the spending targets on health care affordability for consumers? How will OHCA measure success in reducing costs while maintaining quality of care?

3- Can OHCA outline the progressive enforcement process for implementing spending targets? What criteria will be used to determine when and how enforcement actions escalate?

4- What guardrails will OHCA put in place to ensure the enforcement of spending targets does not disrupt access to care?

5- Beyond the current focus areas, what additional sector-specific spending targets is OHCA considering for the future, and what factors will guide its decision-making process?

Staff Recommendation:

This item is informational only.

Issue 4: CalRx

Note: Content for this background has been adapted from materials developed by the Legislative Analyst's Office

Over the years, California has taken a number of steps to help reduce the cost of prescription drugs in state programs and to consumers. One key step was the creation of the CalRx program under HCAI. Established by statute, the program aims to reduce the cost of drugs by expanding the availability of low-cost generics in the market. The program accomplishes this objective by entering into partnerships with private entities to distribute or manufacture generic drugs. Before entering into these partnerships, HCAI must ensure they result in savings, address market failures, improve patient access, and are viable.

There are two key initiatives under CalRx: Insulin, and Naloxone.

CalRx: Insulin Update

The 2022-23 budget provided **$100 million one-time General Fund** for a partnership to manufacture a biosimilar insulin product. Of note, insulin, which helps regulate blood sugar, is among the costliest drugs for health insurance plans and consumers. Of this amount, one-half was for the contract with the partner and the other half was to help support the construction of a new manufacturing facility in California. The 2024-25 budget later deferred the facility construction funds to 2025-26.

In February 2023, HCAI executed a contract with a nonprofit drug maker (Civica Rx) to produce a biosimilar insulin product. Adopting a public-private partnership, HCAI is committed to paying up to $50 million for meeting specified project milestones. The contract also grants other specific oversight mechanisms, such as giving HCAI representation on the partner's governing board. The agreement extends for a ten-year period after the first commercial sale of the new product. According to HCAI, the partnership will produce three generic insulin products, with insulin glargine (also known by the brand name Lantus) most likely to be launched first.

As part of the agreement, the partner has set a target price for the new product of $30 for each vial or $55 for a pack of five prefilled insulin pens. According to HCAI, these prices are close to the cost of production. As a result, HCAI anticipates these products could result in significant savings when they reach the market. For example, in a 2023 report to the legislature, HCAI projected commercial health plans could save 43 percent on per-enrollee spending on insulin glargine as a result of the new product, even after factoring rebates. (Estimated savings were even higher for other insulin products.) For uninsured or underinsured patients that pay the full price out of pocket, HCAI estimated potential savings to be over 90 percent.

Because key aspects of the partnership are confidential, **it is unknown when the new product will enter the market.** HCAI recently reported to the Legislative Analyst's Office that manufacturing has started, though the partner has not received final federal approval of the new product. HCAI also indicates that it has reviewed data from the partner on initial tests and studies. Moreover, the partner and HCAI are engaging with wholesalers and patients to determine distribution.

CalRx: Naloxone Update

The 2023-24 budget provided **$30 million one-time Opioid Settlements Fund** for a partnership to produce a generic, over the counter naloxone nasal spray product. Naloxone is used to alleviate the effects of an opioid overdose. The 2024-25 budget later reduced this amount to $25 million, reflecting updated available Opioid Settlements Fund resources. The Opioid Settlement Fund was established to manage and allocate the state's share of settlement monies received from opioid-related lawsuits against manufacturers, distributors, and pharmacies that allege that such companies fueled the opioid crisis. Resources from the Opioid Settlement Fund are generally used to support opioid remediation activities across California.

In February 2024, HCAI entered into a contract with a private company (Amneal Pharmaceuticals) for the naloxone initiative. Under the contract, which extends through the end of 2026, the contractor is to sell the new over-the-counter naloxone nasal spray product at $24 for each twin pack. The product entered the market in May 2024. One key reason why this initiative was able to move relatively quickly is that it used an existing program to distribute the product. The Naloxone Distribution Project, which is administered by DHCS, provides free naloxone products by request to hospitals, schools, law enforcement, and other public and community-based organizations. In May 2024, the new CalRx naloxone product became the primary supplier to this state program, reflecting a 40 percent lower rate than the previous supplier. As a result, HCAI estimates the new product has saved the state millions of dollars annually. HCAI indicates it plans to launch a direct-to-consumer approach with the contractor in spring 2025.

Panel

- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Vishaal Pegany, Deputy Director, Office of Health Care Affordability, Department of Health Care Access and Information
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

LAO Comments

With Some Initial Successes Under Its Belt, Three Key Questions Remain on CalRx. To date, the state has successfully entered into two partnerships to reduce the cost of two key drugs. One of these drugs has received federal approval and resulted in savings to the state, while the other has the potential to reduce costs in the private market. Despite these initial successes, three key questions remain about CalRx:

- **When Will the Products Become Available to Consumers?** As of this analysis, neither CalRx product is available directly to consumers. Far less is known around the timing of the insulin initiative, as key components remain confidential. Selling to consumers is not a simple task, and key risks remain. For example, generic drugs can struggle to compete with brand drugs, despite being substantially lower cost. This is because brand drugs can come with large rebates that, on net, benefit health plans and their contracted pharmacy benefit managers. As CalRx initiatives move further along, the Legislature likely will want to keep apprised of their availability and utilization among consumers.

- **Will the New Products Lower Costs to Consumers?** In concept, CalRx aims to offer lower-cost drugs to the market, offering less costly alternatives to consumers and creating more competition. According to HCAI, several months after the Naloxone Distribution Project began using CalRx as the primary supplier, the program's previous supplier notably reduced its prices. HCAI attributes this reduction to the competition created by the new CalRx naloxone product. Whether or not CalRx has broader impacts to consumers, however, will depend on how available these new drugs are to consumers, as well as utilization.

- **How Will the Products Compare to Other Competitors?** Since the start of the insulin and naloxone initiatives, a handful of other generic competitors have received federal approval and entered the market. Moreover, as part of recent federal legislation, Medicare out-of-pocket costs for insulin are capped at $35, just slightly higher than the $30 cost per vial intended for the CalRx product. These developments could limit the potential savings effect of CalRx. However, these issues remain very uncertain. According to HCAI, many generic competitors have pursued more traditional high price, high rebate models, limiting their affordability to consumers. Also, HCAI states that it has heard of patients experiencing difficulty accessing price-capped insulin products. The Legislature likely will want to track these market and policy developments over time as it assesses the impact of CalRx.

Need for Manufacturing Funds Are Uncertain. As adopted in last year's budget, the Governor's budget includes $50 million one-time General Fund to HCAI to help support construction of a new manufacturing facility. The funds originally were appropriated in 2022-23, but were later deferred to 2025-26 as a budget solution. At the time, HCAI indicated that it could defer these funds because construction of the new insulin product will instead occur at an existing site in Virginia. According to HCAI, a forthcoming report to the Legislature will further examine the feasibility of the state engaging more directly in drug manufacturing. With key implementation details of the insulin initiative still uncertain, the legislature likely will want to work with HCAI to better understand the continued need for these funds. If stronger justification is not forthcoming, the Legislature could redirect these funds for other one-time budget priorities or further defer them as needed.

Staff Comments

The Subcommittee may wish to ask the following questions:

General oversight of CalRx:

1- What is CalRx's timeline for making both insulin and naloxone widely available to consumers in California? What are the key challenges affecting full implementation of the initiative?

2- What findings does HCAI anticipate in its upcoming report to the Legislature on the feasibility of direct state involvement in drug manufacturing?

3- Does HCAI have preliminary data available regarding CalRx impact on the market, and whether the initiative will yield long-term cost savings for consumers?

4- Does HCAI require additional resources to continue implementing CalRx?

On the Insulin initiative:

1- What federal approvals remain outstanding for the insulin product? What steps is HCAI taking to expedite the process?

2- Does HCAI have an update on establishing a new manufacturing facility in California?

On Naloxone:

1- What were the key factors that allowed the naloxone initiative to move more quickly than the insulin initiative?

2- Is HCAI on track on offer direct-to-consumer Naloxone in 2025?

Staff Recommendation: This item is informational only.

Issue 5: Healthcare Payments Data Program, Related Budget Change Proposal, and Trailer Bill

About the Healthcare Payments Data Program

The Healthcare Payments Data (HPD) program, also referred to as the All-Payer Claims Database, enables HCAI to collect detailed healthcare claims, utilization, enrollment, and provider data on insured Californians. This enables HPD to serve as both a reporting tool and a research database, which is central to HCAI and OHCA's ability to develop data-informed policies lowering health care costs and enforcing cost targets.

The HPD program currently collects a wide range of administrative data, including claims and encounters generated by transactions among payers and providers on behalf of insured individuals. This includes the following data on member eligibility, medical claims, pharmacy claims, dental claims, and provider data.

The data is sourced from the Department of Health Care Services for Medi-Cal members; the Centers for Medicare & Medicaid Services for Medicare fee-for-service members; and health plans and insurers for those with employer-based, individual, or Medicare Advantage coverage.

Some of HPD's core activities include:

- Collect core data from public and commercial health plans and insurers, including monthly medical and pharmacy claim payments, enrollment, and provider information.
- Support the addition of other data sources, such as non-claims payment data (including capitation and payments under other alternative payment models).
- Develop and maintain policies and practices to ensure the privacy, security, and confidentiality of consumers' individually identifiable health information.
- Integrate, and make ready for analysis, data from California's disparate submitters
- Use data analysis and visualization capabilities to produce reports and data sets on healthcare payments and utilization.
- Develop and maintain processes and a technical environment to support secure access to non-public data by researchers and other approved users.
- Respond to the demand for additional data, uses, and users over time.

In November of 2024, HPD completed its Program Data Use, Access, and Release regulations, which will allow researchers, state agencies, and other entities to apply for access to non-public HPD data – enabling qualified applicants to conduct their own research using HPD data.

Budget Change Proposal

The Budget Act of 2018 allocated **$60 million in General Fund** to fund the startup implementation and operation of the HPD program, with funding expiring June 2025. The budget intended that no General Fund resources beyond that original allocation could fund the program, and statutes required HCAI to provide a report to the Legislature on recommendations for long-term funding options.

HCAI submitted the required report in March of 2023, **recommending an annual total funds budget of $22 million** for the HPD Program starting with Fiscal Year 2025-26. The proposed budget change proposal and trailer bill, described below, implement this recommendation.

The budget change proposal has three main components. First, HCAI requests $22 million in ongoing annual funding to support the operation of the HPD program. Second, HCAI requests making 47 temporary positions permanent. Third, HCAI requests that any remaining General Fund moneys originally appropriated in the Budget Act of 2018 be reappropriated.

The $22 million in funding for 2025-26 to support HPD would come from 3 sources:

- $9 million of reappropriated, leftover General Fund from the original 2018 allocation

- $5.5 million of Medicaid matching funds (a portion of HPD is eligible for Medicaid funding, related to the data on Medi-Cal enrollees).

- $7.5 million in special funds. The special funds supplementing the HPD program are the Managed Care Administrative Fines and Penalties Fund and the California Health Data and Planning Fund.

In 2026-27 and beyond, HPD will solely rely on non-General Fund sources to continue operations.

Trailer Bill

The Governor’s budget proposes statutory changes implementing the stream of special-funds that will support HPD. Specifically, the trailer bill would transfer specified dollar amounts from the Managed Care Administrative Fines and Penalties Fund to the Health Care Payments Data Fund.

Panel

- Scott Christman, Chief Deputy Director, Department of Health Care Access and Information
- Michael Valle, CIO / Deputy Director of Information Services, Department of Health Care Access and Information
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance

Staff Comments

The Subcommittee may wish to ask the following questions:

1- In addition to supporting the work of OHCA, how has HPD data been used so far to inform HCAI and stakeholders on potential initiatives to lower health care costs?

2- Does HCAI consider the data it receives accurate, complete, and submitted timely? Are there any gaps in reporting that need to be addressed?

3- When will researchers, state agencies, and other entities be able to apply for and access non-public HPD data? What will the application and approval process look like?

4- What policies and technical safeguards are in place to ensure the privacy and security of the information collected by the HPD?

Staff Recommendation:

HOLD OPEN

Issue 6: Budget Overview, General Budget Change Proposals, and Trailer Bill

Budget Overview

The Department of Health Care Access and Information is tasked with expanding access to quality, affordable health care for Californians with a focus on facilities, data, and workforce.

The Department has four key program areas:

1- **Facilities:** monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities and provide loan insurance for nonprofit healthcare facilities to develop or expand services.

2- **Workforce:** promote a culturally competent and linguistically diverse health workforce.

3- **Affordability:** improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

4- **Data:** collect, manage, analyze and report information about California's healthcare landscape.

The Governor's 2025-26 budget provides **$580.9 million and 824 staff positions** for HCAI. Of this total, $206.8 million in General Fund, and the remaining funding derived from special funds and reimbursements.

Budget Change Proposals

The Governor's budget proposes 6 general budget change proposals for HCAI:

1- **Diaper Access Initiative:** Allocates $19.9 million from the General Fund over two years from the General Fund to support the procurement of diapers, direct program operation costs, and warehousing and program management of a diaper initiative. There are two proposed phases: Phase 1 is to procure 168 million diapers per year to offer at no cost for every baby born in California; Phase 2 tasks HCAI with exploring a commercial distribution model where California can order low-cost diapers.

2- **AB 112 Implementation – Data Reporting.** Proposes 3 permanent staff position to implement portions of AB 112 (Committee on Budget, Chapter 6, Statutes of 2023) related

to hospitals reporting balance sheet data and authorizing HCAI to make additions or deletions of data on the quarterly financial and utilization report on an emergency basis.

3- **AB 1577 Implementation – Health Facilities and Clinics Clinical Placements Nursing.** Appropriates $170,000 in ongoing funding from the Health Data and Planning Fund to implement AB 1577 (Low, Chapter 680, Statutes of 2024) to develop and support a program that will track, receive and post written justifications from health facilities and clinics regarding nursing clinical placement opportunities, and other compliance activities.

4- **HCAI Chaptered Legislation Related to Facilities (AB 869, SB 1382, SB 1447).** Provides $2,565,000 in 2025-26, $2,420,000 in 2026-27, $2,420,000 in 2027-28, and $2,170,000 in 2028-29 and ongoing from the Hospital Building Fund and 10 staff positions to implement legislation related to building standards and seismic safety for health care facilities. The bills implemented are AB 869 (Wood, Chapter 801, Statutes of 2024), SB 1382 (Glazer, Chapter 796, Statutes of 2024), and SB 1447 (Durazo, Chapter 896, Statutes of 2024).

5- **Enterprise Risk Management Cybersecurity, Patient Privacy, and Governance Staffing for Workload.** Provides $209,000 in ongoing funding from the Health Data and Planning Fund and 1 staff position to respond to increased workload from new state and federal cybersecurity, patient privacy, data laws and policies affecting HCAI.

6- **May Lee State Office Complex Relocation Support.** This is a multi-agency budget request involving five departments to cover rent at the May Lee State Office Complex (MLSOC) and incremental increases thereafter. For HCAI specifically, the budget provides $2,447,000 ($839,000 General Fund) in 2025-26 for rent and moving costs, and $1,164,000 ($399,000 General Fund) in 2026-27, for rent. HCAI currently leases space at 2020 West El Camino Avenue in Sacramento, CA which is a privately leased office space. HCAI will relocate its Sacramento headquarters office to the MLSOC in July 2025.

Budget Trailer Bill

The Children and Youth Behavioral Health Initiative (CYBHI) is a multi-year investment taking a “whole child” approach to address the factors that contribute to the mental health and well-being of our children and youth. As part of the CYBHI, HCAI is tasked with designing and building the Certified Wellness Coach (CWC) profession. The CWC role is a nonclinical role that provides wellness education, screening support, care coordination, individual and group support, and crisis referral support in a school setting. The position was originally established in 2021 as a “behavioral health coach.”

The Administration proposes a trailer bill to:

1- Change “behavioral health coach” to “Certified Wellness Coach.”

2- Specify that persons with Pupil Personnel Services Credentials or school nurse services credential can supervise Certified Wellness Coaches.

3- Remove crisis de-escalation and safety planning, and add crisis referral as part of a CWC training and certification.

4- Provide for other minor technical changes.

According to the Administration, the statutory change will clarify the supervision of this new entry-level profession. Specifically, many school settings are staffed by Pupil Personnel Services-Credentialed employees (PPS) with the skills necessary to do so. Additionally, this proposal removes crisis de-escalation and safety planning activities and adds crisis referral activities reflecting input from the stakeholder engagement process. There are no costs associated with these changes.

Panel

- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Scott Christman, Chief Deputy Director, Department of Health Care Access and Information
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst’s Office

LAO Comments

The Legislative Analyst’s Office offers the following recommendations related to the Diaper Access Initiative:

Weigh Expanding Diaper Access Against Priorities in Light of Fiscal Constraints. As the LAO has noted in recent publications, the General Fund has little capacity to pursue new initiatives, particularly ongoing ones. This is because the state faces future deficits down the road that will require actions to address, such as increasing taxes or reducing spending. As such, the Legislature likely will want to be cautious in adopting new proposals, funding those that are at the top of its policy agenda. We therefore recommend the Legislature carefully weigh expanding access to diapers against its many other fiscal priorities.

If a Priority, Pursue Alternatives to Administration's Proposal. To the extent the Legislature wishes to expand access to diapers in this year's budget, the LAO recommends it pursue approaches that build upon the state's existing programs. Taking such actions would better target limited resources to low-income households and provide more certainty around implementation and cost. Below, the LAO offers two key options that could be taken separately or in tandem:

- ***Increase CalWORKs Subsidy.*** The Legislature could increase the CalWORKs diaper subsidy, which already is targeted to low-income families. We estimate every $1 increase in the monthly subsidy would cost around $600,000 annually.

- ***Provide More One-Time Support to Diaper Banks.*** The Legislature could allocate more funding for diaper banks to acquire and distribute diapers. Much like the first option, this approach likely better targets diaper access to low-income households. This option also would leverage an existing distribution model, providing greater likelihood that the initiative would be successful. Moreover, diaper banks also engage in bulk purchasing, potentially providing much of the same price-reducing effects envisioned by the administration.

Consider Pursuing Other Long-Term Options. To the extent the Legislature would like to pursue longer-term ways to improve diaper access and affordability, the LAO recommends it take actions in this year's budget. For example, the Legislature could adopt supplemental reporting language directing HCAI to report back on potential market interventions, following HCAI's exploratory work in fall 2025. The Legislature could then make better informed decisions, to the extent HCAI's exploratory work yields promising options. In addition, the Legislature could resume its work with DHCS to pursue federal waiver authority for Medi-Cal coverage of diapers for infants. In pursuing Medi-Cal coverage, the Legislature would want to ensure it understands the potential benefit, cost, and likelihood of obtaining federal approval.

Staff Comments

The Subcommittee may wish to ask the following question related to budget change proposals:

1- What is the Administration's response to the LAO's recommendation?

On the budget trailer bill related to Certified Wellness Coaches, staff notes that there is significant ongoing implementation efforts related to the CYBHI that spans multiple state departments and jurisdictions. Given the size and scope of the initiative, the subcommittee may wish to ask the following oversight questions related to CWC:

1- Has the Department received feedback from school districts about the introduction of Certified Wellness Coaches?

2- Has HCAI engaged with PPS credentialed professionals to gauge their interest in supervising wellness coaches?

3- What specific non-clinical services are CWCs trained to provide, and how will they complement existing behavioral health roles?

4- How many Wellness Coaches have been certified by the Department to date?

5- How many individuals are enrolled in wellness coach preparation programs and how many have been certified through their experience?

6- Does the Department have an estimate of the actual labor market demand for this workforce and how that compares to state's goals in certifying wellness coaches? How many schools have hired wellness coaches or expressed interest in doing so?

7- How are wellness coach services intended to be financially sustained long-term? Are wellness coaches currently able to bill for service? Has this been approved as eligible for federal reimbursements?

Staff Recommendation:

HOLD OPEN

4800 Covered California

Issue 7: Budget Overview, HCARF and 2025-2026 Subsidies Update

Budget Overview

Covered California, also known as the Health Benefit Exchange, is California's state-based health insurance marketplace established under the federal Patient Protection and Affordable Care Act. Covered California allows individuals and small businesses to compare, select, and enroll in participating qualified health plans. Covered California also helps Californians determine eligibility and receive financial assistance to lower health-care costs.

The Governor's 2025-26 budget proposes **$629 million and 1,419 positions** for Covered California. While Covered California receives some General Fund, it is largely a special-funded entity. There are two special funds funding Covered California: the **California Health Trust Fund** which derives revenues from charges assessed on health plans participating in Covered California; and the **Health Care Affordability Reserve Fund**, which derives revenues from personal health care mandate penalties.

2025-26 Fund Source	Amount
General Fund	$20,350
California Health Trust Fund	$442,009
Health Care Affordability Reserve Fund	$167,000
TOTAL	**$629,359**

*dollars in thousands

Background on the Health Care Affordability Reserve Fund

In general, Covered California offers two forms of financial assistance: premium subsidies, which lower the cost of a household monthly health care premium; and cost-sharing reductions, which reduce out-of-pocket costs (e.g. deductibles and copayments).

Broadly, federally-funded premium subsidies are provided for qualified individuals with income between 138% and 400% of the Federal Poverty Level (FPL). Recognizing the need to provide further assistance for middle-income households, California launched a state-funded California Premium Subsidy program in 2019 to lower premiums for consumers with income above 400% and at or under 600% FPL. The Budget Act of 2019 provided $428.6 million General Fund for the California Premium Subsidy program.

The California Premium Subsidy program however changed course with the passage of the federal American Rescue Plan (ARP) in 2021. Among its many provisions, the ARP expanded premium subsidies to individuals earning more than 400% of the FPL, so that no subsidy-eligible marketplace enrollee has to spend more than 8.5% of their income on a health care plan. Because the federal subsidies provided by the ARP were more generous, the California Premium Subsidy Program was discontinued.

As part of the 2021-22 budget package, $333.4 million General Fund originally earmarked for the California Premium Subsidy Program was moved to the Health Care Affordability Reserve Fund (HCARF) to support future affordability efforts in Covered California.

In 2024, Covered California launched a State-Enhanced Cost-Sharing Reduction program, which uses HCARF funds to reduce out-of-pocket costs, eliminate deductibles in select plans, and expands eligibility for such plans to all subsidy-eligible consumers. $82.5 million was appropriated for HCARF and the State-Enhanced Cost-Sharing Reduction program in 2023-24, $167 million for 2024-25, and $167 million is proposed for appropriation in the 2025-26 budget.

Of note, the federal Inflation Reduction Act (IRA) passed in 2022 extended the availability of ARP enhanced premium subsidies through the end of 2025.

HCARF Loans to the General Fund

In addition to receiving $333.4 million from the General Fund in 2021, HCARF also receives revenues from the personal health care mandate penalty. In 2023, after the HCARF fund accrued significant resources, the following loans were made to the General Fund to assist with the state's budget deficit:

- $600 million 2023-24,
- $62 million in 2024-25,
- $109 million proposed for 2025-26.

In total, $771 million has been loaned from HCARF to the General Fund.

HCARF Loan Repayment

As part of the 2024 Budget Act (Chapter 40, Statutes of 2024) the $600 million loan repayment was split into three repayments of $200 million over 2026-27, 2027-28, and 2028-29.

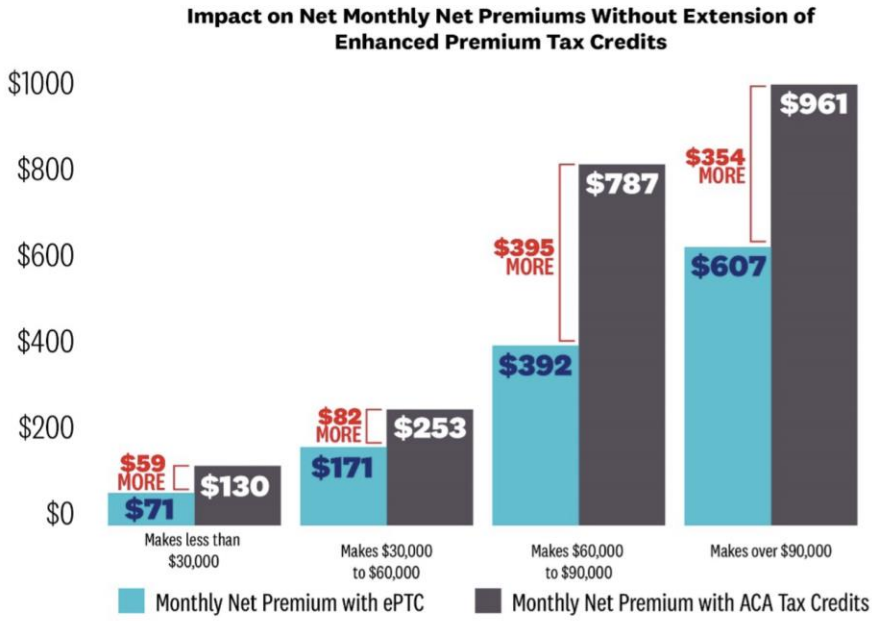
The $62 million loan has a projected repayment of 2027-28.

As part of the 2024 Budget Act a $109 million loan in 2025-26 was included and the Governor's Budget assumes it will be repaid in 2028-29.

Open Enrollment Update, and 2025-2026 Premium Subsidies

For 2025, Covered California reports that 345,711 Californians newly selected a health plan during open enrollment and more than 1.6 million Californians renewed their health insurance, bringing Covered California's overall enrollment to 1,979,504 consumers. For plan year 2025, eligible consumers can receive financial assistance both in the form of federal premium subsidies enhanced by the ARP/ IRA, as well as California-only Cost-Sharing Reduction funded by HCARF.

However, enhanced federal premium subsidies provided through the ARP and IRA are set to expire at the end of 2025. Without renewal or extension from the federal government, California consumers will see higher premiums in 2026. According to Covered California, data shows that on average, consumers save an additional $101 on premium costs each month and that includes over 170,000 middle-income enrollees that are now receiving tax credits when they weren't previously eligible. For some consumers, this could mean as much as $395 a month in financial assistance.



Panel

- Katie Ravel, Director, Policy Eligibility and Research Division, Covered California
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Ryan Miller, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff notes the significant uncertainty regarding the availability of enhanced federal subsidies for plan year 2026. At the time of writing, it remains unclear whether the federal government will renew these subsidies or allow them to expire. If they are not extended, most marketplace enrollees will face substantial increases in monthly premium costs. While HCARF was established to support state-funded affordability programs, it does not have the capacity to fully replace the subsidies provided under the American Rescue Plan and the Inflation Reduction Act.

The Subcommittee may wish to ask the following questions:

1- Has Covered California conducted a preliminary analysis of the anticipated premium increases across the 19 Covered California regions should enhanced federal subsidies expire? How will this affect enrollment and affordability? What groups are most at risk of losing coverage?

2- Has Covered California conducted any assessments or analyses to determine the most effective use of HCARF resources for future affordability programs? How should California prioritize funding between premium subsidies, cost-sharing reductions, and other potential affordability initiatives?

3- Is the Administration on track to fully repay the HCARF loans to the General Fund? Are any delays being considered?

Staff Recommendation:

HOLD OPEN

4150 Department of Managed Health Care

Issue 8: Budget Overview & Budget Change Proposal

Budget Overview

The Department of Managed Health care is tasked with consumer protection of health care rights and safeguarding the stability of the health care delivery system. Key responsibilities of the Department include:

- Licensing and regulating the full scope of managed care models, including all Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Point-of-Service (POS) products and Medi-Cal managed care plans.

- Enforcing the Knox-Keene Health Care Service Plan Act of 1975

- Conducting medical surveys and financial examinations to verify that health plans are complying with the law and are financially stable to serve their enrollees

- Operating a 24-hour-a-day Help Center to resolve health care consumer complaints and administer the Independent Medical Review program.

- Reviewing proposed health plan rate changes for sufficient justification and reasonableness.

- Monitoring the financial solvency of the medical groups with whom health plans contract to provide health benefits to their enrollees.

- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial and health plan industries, to advise the Director on strategies to keep the managed care industry financially stable.

The 2025-26 Governor's budget proposes **$186.6 million and 807 staff positions** for the Department. DMHC is entirely funded through a special fund called the Managed Care Fund, which derives revenues from fees, assessments, and reimbursements collected by the Department as part of its regulatory and oversight duties.

Budget Change Proposal

The Governor's budget proposes 12 budget change proposals for the DMHC, outlined below:

1- **Customer Relationship Management (CRM) Modernization – Project Planning.** Appropriates $1,157,000 in one-time funding from the Managed Care Fund to initiate the planning phase to modernize the consumer and provider complaint Customer Relationship Management (CRM) system in the DMHC's Help Center to meet mandated timeframes for reviewing consumer and provider complaints.

2- **AB 3275 Implementation – Claim Reimbursement.** Provides $4,568,000 in 2025-26, $5,385,000 in 2026-27, $5,381,000 in 2027-28, $5,425,000 in 2028-29, $5,477,000 in 2029-30 and from the Managed Care Fund to implement AB 3275 (Soria, Chapter 763, Statutes of 2024) to initiate the planning phase to implement an Electronic Filing and Analysis of Claims Settlement (eFACS) data solution. The bill requires health plans to reimburse a claim within 30 calendar days after receipt of the claim, or if a claim is contested or denied, notifying the claimant in writing within 30 calendar days.

3- **AB 2072 and AB 2434 Implementation – Biomedical Industry & Multiple Employer Welfare Arrangements.** Issues $508,000 in one-time funding from the Managed Care Fund to implement AB 2072 (Weber, Chapter 374, Statutes of 2024) and AB 2434 (Grayson, Chapter 398, Statutes of 2024) requiring an analysis of the impact of health plans and health insurers offering large group contracts and policies to small employers through multiple employer welfare arrangements. Funding will be used for consulting funding to conduct the analysis.

4- **AB 1842 Implementation – Medication Assisted Treatment.** Provides $64,000 in 2025-26 and $133,000 in 2026-27 and ongoing from the Managed Care Fund to implement AB 1842 (Reyes, Chapter 633, Statutes of 2024) which requires group or individual health plans to cover at least one drug in specified opioid use disorder treatment categories without prior authorization, step therapy, or utilization review. Funding will be used by the Department for specialized consulting for clinical and statistical consultants to develop survey methodology and provide clinical review during health plan surveys.

5- **SB 729 Implementation – Treatment for Infertility Services.** Provides $691,000 in 2025-26, $2,030,000 in 2026-27, $2,125,000 in 2027-28 and ongoing and 7 staff positions to implement SB 729 (Menjivar, Chapter 930, Statutes of 2024) requiring a large group health plan contract to provide coverage for the diagnosis and treatment of infertility and fertility services and removed the exclusion of IVF from coverage. Funding will be used to develop compliance assessment tools, conduct file reviews, provide statistical consultation for surveys, provide clinical review, and conduct enforcement investigations.

6- **SB 1120 Implementation – Utilization Review.** Allocates $761,000 in 2025-26, $740,000 in 2026-27 and ongoing from the Managed Care Fund to implement SB 1120 (Becker, Chapter 879, Statutes of 2024) requiring plans that use artificial intelligence to comply with specific requirements as well as prohibiting AI, algorithms, or other software tools from making a decision to deny, delay or modify health care services based, in whole or in part, on medical necessity. Funding will be used to revise survey methodology to assess compliance, review health plan processes, review health plan filings, and review health plan documents to ensure only licensed physicians are making adverse utilization management decisions.

7- **AB 2063 Implementation - Risk-Based or Global Risk Provider Arrangement Pilot Extension.** Appropriates $178,000 yearly for two years from the Managed Care Fund to implement AB 2063 (Maienschein Chapter 818, Statutes of 2024) which granted a two-year extension for the pilot programs related to Voluntary Employees' Beneficiary Association. Funding will be used to provide review of clinical patient outcomes and report pilot program findings to the Legislature by 2029.

8- **SB 1180 Implementation – Emergency Medical Services.** Provides $357,000 in 2025-26, $421,000 in 2026-27, $423,000 in 2027-28, $425,000 in 2028-29, $427,000 in 2029-30 an ongoing and 1 staff positions to implement SB 1180 (Ashby, Chapter 884, Statutes of 2024) which requires health plans to establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.

9- **AB 3059 Implementation (Human Milk).** Provides $64,000 in 2025-26 and $133,000 in 2026-27 and ongoing from the Managed Care Fund to implement AB 3059 (Weber, Chapter 975, Statutes of 2024) related to the provision of medically necessary pasteurized donor human milk obtained from a licensed tissue bank.

10- **Program Workload Resources.** Provides $2,569,000 in 2025-26, $2,339,000 in 2026-27, $2,451,000 in 2027-28, $2,475,000 in 2028-29, and $2,501,000 in 2029-30 and ongoing from the Managed Care Fund to modernize information technology (updating equipment, implement security measures, improving online access, procure new software) and cover ongoing consultant costs related to increased volume of consumer complaints and mandated caseload.

11- **Identity and Access Management (IDAM) Project Planning.** Allocates $187,000 in one-time funding from the Managed Care Fund to implement the planning stage of a project to provide IDAM solution. Currently, DMHC is maintaining 11,000 external users accounts across six different datasets for public-facing web portals. An individual can have multiple accounts within one portal or across multiple portals depending on the

number of organizations the person represents – creating a problem for DMHC who must process about 200 password-related support requests per year in a high-risk cybersecurity environment. Funding will be used to begin implementing single-sign-on capability, application user role, and user account management for application security, user access and management of digital identities.

12-**Web Accessible Service Portal (WASP) Replacement.** Appropriates $618,000 in 2025-26 and $348,000 in 2026-27 only from the Managed Care Fund to replace the existing WASP enterprise service management system. This system, which is used to manage IT incidents, change requests and asset management as requested by DMHC users and employees, is reaching its end of life and, according to the Department, requires replacement.

Panel

- Mary Watanabe, Director, Department of Managed Health Care
- Dan Southard, Chief Deputy Director, Department of Managed Health Care
- Albert Pineda, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff notes that nearly all budget change proposals submitted by the Department request funding for contracted consultants, even as the Department continues to expand its total number of authorized full-time positions year-to-year. The Department explains that consultant support is particularly necessary for the Office of Plan Monitoring (OPM), which conducts both routine and issue-specific, non-routine surveys to assess health plan operations. Because OPM's survey work is cyclical rather than year-round, the Department explains that relying on specialized consultants as needed is a more efficient use of resources than hiring full-time permanent staff for seasonal review activities.

Staff Recommendation:

HOLD OPEN.

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