MAY 19, 2025

The 2025-26 Budget: Medi-Cal in the May Revision

LEGISLATIVE ANALYST'S OFFICE

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Background

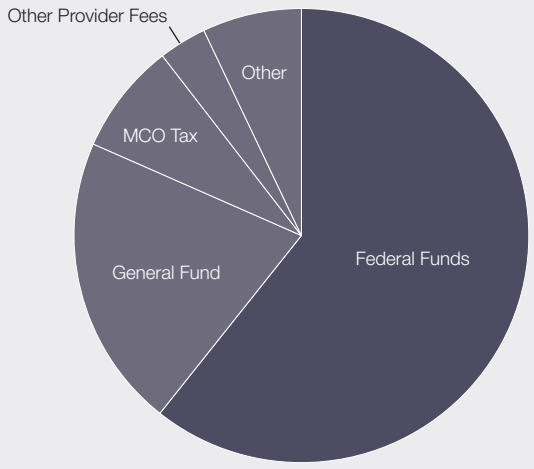
Medi-Cal Budget

Medi-Cal Covers Health Care for Low-Income People. Medi-Cal is a joint federal-state health coverage program. Low-income Californians (below specified income thresholds) qualify for Medi-Cal coverage. More than one-third of Californians are enrolled in the program.

Medi-Cal Is Supported by Federal, State, and Local Funds. Under federal law, the federal government covers a share of Medi-Cal costs. The state is responsible for covering the remaining cost. As the figure below shows, more than half of Medi-Cal's budget is federal funding. The General Fund covers a sizable portion of the state's share of cost, as do special taxes and fees on health care providers (such as the state's managed care organization [MCO] tax).

Federal Funds Comprise More Than Half of Medi-Cal Funding

$179 Billion Total Funds, Revised 2024-25



MCO = managed care organization.

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Background

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Federal Share of Cost Differs for Some Populations and Services. Generally, the federal share of cost is 50 percent. However, it can be higher or lower depending on the service or population served. For example, it is higher (as much as 90 percent) in some areas, such as for family planning services or services to adults who became eligible for Medi-Cal under the federal Patient Protection and Affordable Care Act (ACA). On the other hand, there is no federal cost sharing in other areas, such as most services to individuals with unsatisfactory immigration status (undocumented immigrants, as well as certain other immigrant groups).

Medi-Cal Is Growing Share of State's Overall Budget… On a total funds basis, Medi-Cal is the largest program in the state budget, currently comprising more than one-third of total spending. This share generally has grown over the last two decades. The main driver was the ACA, the implementation of which made many more Californians eligible for Medi-Cal.

…But a Fairly Consistent Share of General Fund Spending. Medi-Cal is the second largest program in the state budget on a General Fund basis (after K-14 education). Medi-Cal has comprised a somewhat consistent share (around 15 percent) of the state's total General Fund spending over the last few decades. (Although California's implementation of the ACA increased Medi-Cal enrollment considerably, the federal government covered most of the cost of the eligibility expansion.) That said, Medi-Cal's share of the state's total General Fund spending has been growing in more recent years (for reasons described further in the next section).

Background

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Recent Spending Developments

California Has Enacted Number of Key Policy Changes in Medi-Cal. In recent years, the Legislature has expanded eligibility and services in Medi-Cal. For example, over several years, the Legislature has made low-income undocumented immigrants eligible for comprehensive coverage (sometimes referred to as the "undocumented expansion population"). Other recent actions include eliminating asset limit eligibility rules for seniors, reducing enrollee cost-sharing requirements (such as premiums and copays), and restoring certain services cut during the Great Recession (such as certain adult dental benefits).

Some Policies Are Costing More Than Expected. Very recently, costs for some of the state's recent policy actions have come in much higher than originally expected. For example, costs for the undocumented expansion population are considerably higher than initial estimates. This is both because there are more individuals enrolled and per-enrollee costs are higher than expected. The state's recent elimination of asset limit requirements also has resulted in many more seniors enrolling in Medi-Cal than originally expected. These upward revisions reflect the inherent uncertainty in estimating the costs of major expansions in Medi-Cal.

Pharmacy Spending Also Has Grown Over Time. Some areas of Medi-Cal also have been growing faster than expected even without policy changes. For example, current spending on pharmacy services is higher than budgeted last year. Newer specialty drugs, such as specialty diabetes and anti-obesity drugs, likely are a key contributor.

State Recently Provided Sizable Loan to Cover Higher Medi-Cal Costs. In March, the administration signaled that Medi-Cal's costs would significantly exceed the program's costs assumed at budget enactment last year. As a result, the administration executed a $3.4 billion loan (the maximum allowed under state law) to the program from the General Fund. (Such loans are not uncommon, though the size of loan was much larger than in past years.) In addition, the Legislature directly increased the program's appropriation authority in 2024-25 by $2.8 billion.

Background

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Proposition 56 (2016) and Proposition 35 (2024)

Proposition 56 Has Supported Various Supplemental Payments. Proposition 56 increased tobacco taxes and allocated most of the revenue to Medi-Cal. Since the measure was enacted in 2016, the Legislature has largely used the funds to support supplemental rate increases for certain services in Medi-Cal. (Early on, some of the money was initially used to cover baseline cost growth in the Medi-Cal program.)

General Fund Has Backfilled Declining Proposition 56 Revenues. Proposition 56 revenue has declined steadily over time due to a decline in statewide tobacco consumption. Accordingly, available funding has fallen below the cost of the provider rate increases originally established as part of the state's multiyear Proposition 56 spending plan. Though not required under law, the Legislature has chosen to backfill the declining revenues with General Fund support. As a result, Proposition 56 funds and the General Fund now jointly support base rate increases for physicians, as well as supplemental payment increases for women's health, family planning, and dental providers.

Proposition 35 Provides Funding for Provider Rate Increases From Tax on Health Plans. More recently approved by voters, Proposition 35 involved a special tax on health plans called the MCO tax. The tax existed before Proposition 35; the measure makes the tax ongoing and creates new rules on how to spend the funds. In particular, a portion of tax funds are set aside each year to support provider rate increases. The remaining funds help cover baseline costs in the Medi-Cal program. The state has not yet implemented most of the provider rate increases.

Overview of May Revision

Overall Medi-Cal Budget

Increases Medi-Cal Spending Over Level in Governor's January Budget. As the figure below shows, Medi-Cal's budget is up by $4.4 billion in 2024-25 and $6.4 billion in 2025-26 at May Revision. General Fund spending is only a portion of this upward revision. It is almost unchanged in 2024-25, and $2.5 billion higher in 2025-26. (As we note later, the revision in spending would be even higher without expected savings from proposed budget solutions.)

Medi-Cal Spending Is up at May Revision

(Dollars in Billions)

			Change	
	2024-25	2025-26	Amount	Percent
Governor's Budget				
Total Funds	$174.6	$188.1	$13.5	7.7%
Federal Funds	107.5	118.1	10.6	9.9
General Fund	37.6	42.1	4.5	11.8
Other Funds	29.5	28.0	-1.5	-5.1
May Revision				
Total Funds	$179.0	$194.5	$15.5	8.7%
Federal Funds	108.6	118.8	10.1	9.3
General Fund	37.4	44.6	7.2	19.2
Other Funds	32.9	31.1	-1.8	-5.5
Change				
Total Funds	$4.4	$6.4	—	—
Federal Funds	1.2	0.7	—	—
General Fund	-0.2	2.5	—	—
Other Funds	3.4	3.1	—	—

Overview of May Revision

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Per-Enrollee Spending Appears to Be Key Driver of Growth. Much of Medi-Cal's budget is driven by caseload and per-enrollee costs. As the figure on the next page shows, both are higher in the May Revision. Of the two, however, per-enrollee spending appears to be a much larger driver in the upward revision in spending. Relative to the Governor's budget, the May Revision estimates average monthly caseload to be nearly equal to the level in 2024-25 (15 million people) and up 2 percent in 2025-26 (14.8 million people). By contrast, we estimate that per-enrollee General Fund spending is around 10 percent greater at May Revision in both the current year and budget year. Several factors likely driving the growth in per-enrollee spending, including rising utilization of services, higher medical care prices, and greater use of certain high-cost specialty drugs.

Undocumented Beneficiaries Drive Sizable Portion of Spending Increase. Growth in spending for the undocumented expansion population appears to be a key (but not the only) reason for the higher per-enrollee spending. This population results in more General Fund spending, because federal funds only help cover a small portion of services (emergency and pregnancy-related care). The May Revision estimates General Fund spending for this population to be $10.8 billion in 2025-26, up nearly 50 percent from the Governor's budget level. (This estimate includes costs in the In-Home Supportive Services program for this population.) Most of this upward revision appears to result from an around 30 percent increase in revised caseload (about 1.7 million enrollees total). Per-enrollee spending for this population also is up around 10 percent to 15 percent in each year.

Overview of May Revision

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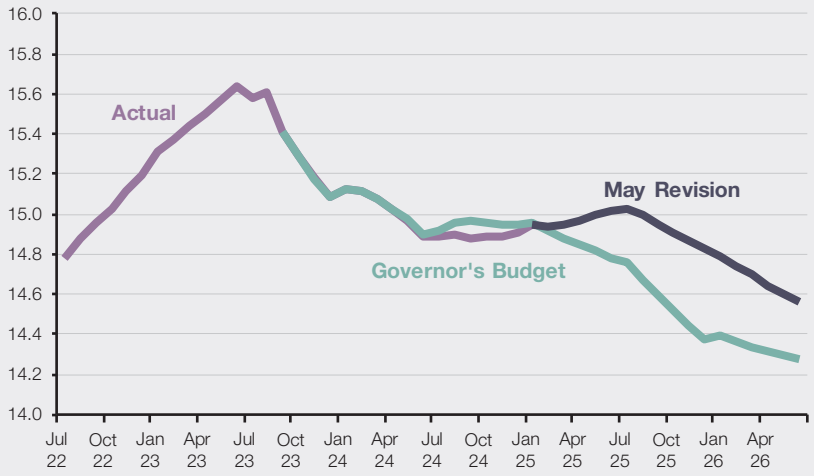
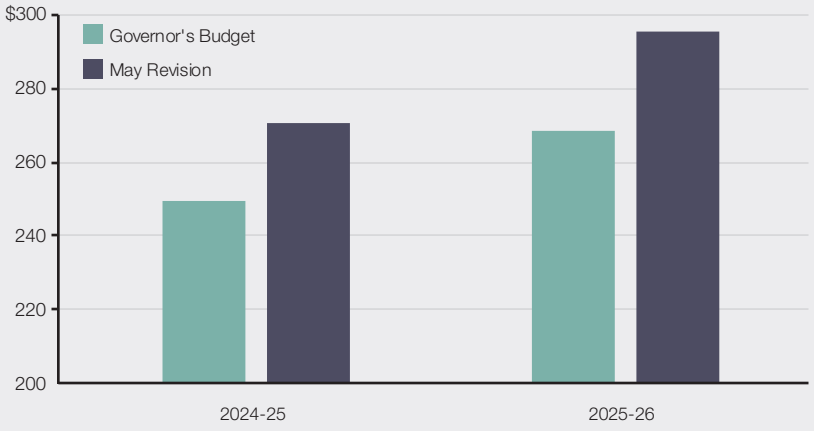
Under May Revision, Both Caseload and Per-Member Spending Is Up

Monthly Medi-Cal Members (In Millions)



Ongoing Monthly General Fund Spending Per Enrollee, LAO Estimates



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Overview of May Revision

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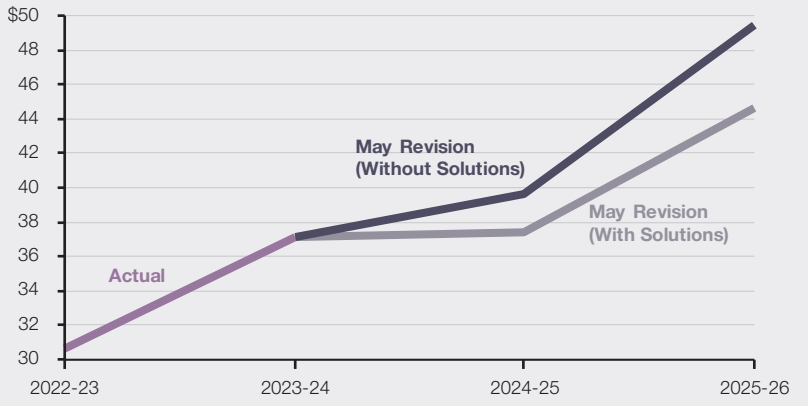
Budget Solutions

Proposed Solutions Help Limit General Fund Spending. Though General Fund spending in Medi-Cal is only somewhat higher at May Revision compared to the Governor's January budget proposal, this level is net of numerous proposed budget solutions. As the figure below shows, without these solutions, General Fund spending in Medi-Cal would be significantly higher under the May Revision. The effect is particularly striking in 2025-26, where spending would be more than $7 billion higher without budget solutions relative to the Governor's budget.

Medi-Cal Spending Would Be Notably Higher Without Proposed Budget Solutions

General Fund (In Billions)



Overview of May Revision

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Most Solutions Fall in Four Key Areas. The Governor proposes numerous solutions to help control General Fund spending in Medi-Cal. These solutions fall into four key areas:

- ***Medi-Cal Financing.*** The Governor proposes delaying repayment on the recent $3.4 billion Medi-Cal loan (spread over two years), which helps reduce General Fund spending in the short run. (We are not aware of another time the state used these kinds of loans to Medi-Cal as a budget solution.) In addition, the Governor proposes using a portion of Proposition 35 funds to help cover growth in program costs.
- ***Adults With Unsatisfactory Immigration Status.*** The Governor proposes a number of solutions to reduce spending on adults with unsatisfactory immigration status (adults in the undocumented expansion population, as well as certain other noncitizen groups that had been receiving comprehensive Medi-Cal coverage even prior to the recent expansions). Most notably, the Governor proposes freezing enrollment for this population, prohibiting new applicants from enrolling in comprehensive coverage while maintaining eligibility for existing enrollees. (New enrollees would still be eligible for certain limited services, such as emergency and pregnancy-related care, that are partially funded by the federal government.) Existing enrollees also would have pay a monthly premium ($100) to maintain eligibility for comprehensive coverage.
- ***Pharmacy Spending.*** A number of solutions also aim to control pharmacy spending. The largest solution would end coverage of specialty anti-obesity drugs. A number of initiatives also aim to increase savings from drug rebates paid by drug makers and control utilization.
- ***Other.*** Of the remaining solutions, the largest savings would result from reinstating the asset limit for Medi-Cal eligibility of senior enrollees, which the Legislature fully eliminated as of last year.

Overview of May Revision

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Solutions Ramp Up in Out-Years. As the figure below shows, these solutions ramp up over time, with the estimated savings reaching nearly $11 billion by 2028-29.

The Largest Medi-Cal Solutions Focus on a Few Key Areas

(In Millions)

Solution	2024-25	2025-26	2026-27	2027-28	2028-29
Medi-Cal Financing					
Medi-Cal loan repayment delay	$2,150	$1,291	—	-$500	-$500
Proposition 35 support of program growth	—	1,289	$264	—	—
Adults With Unsatisfactory Immigration Status					
Enrollment freeze	—	$86	$858	$2,036	$3,295
New premiums ($100 per month)	—	-30	1,138	2,435	2,122
Clinic finance change	—	453	1,131	1,131	1,131
End of long-term care coverage[a]	—	333	800	800	800
End of dental coverage	—	—	308	336	336
Prescription Drugs					
End of anti-obesity drug coverage	—	$85	$200	$450	$680
New aggregator to increase rebates	—	300	514	409	362
New utilization management practices	—	175	350	350	350
Higher rebates on HIV and cancer-related drugs	—	75	150	150	150
End of over-the-counter pharmacy coverage	—	3	6	6	6
Other					
Asset limit reinstatement	—	$69	$514	$765	$765
Operational improvements	—	—	—	737	503
End of Proposition 56 supplemental payments	—	530	550	550	550
Lower medical loss ratio	—	—	—	—	200
Long-term care directed payment elimination	—	70	140	140	140
Prior authorization for hospice	—	25	50	50	50
PACE capitation rate limit	—	13	30	30	30
End of acupuncture coverage	—	5	13	13	13
BHSF cost shift	$40	100	—	—	—
Totals	**$2,190**	**$4,873**	**$7,016**	**$9,888**	**$10,983**

[a] Applies to both children and adults. The May Revision also would end in-home supportive services for adults with unsatisfactory immigration status, reflected in the Department of Social Services' budget.

PACE = Programs of All-Inclusive Care for the Elderly and BHSF = Behavioral Health Services Fund.

Overview of May Revision

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May Revision Plan for Proposition 56 and Proposition 35 Funding

Uses Initiatives to Help Cover Program Spending Growth. The Governor proposes using both measures to help cover cost growth in the Medi-Cal program. This works somewhat differently in each measure:

- ***Proposition 56: End Supplemental Payments.*** The Governor proposes ending the remaining Proposition 56 supplemental payment programs, which include family planning, women's health, and dental services. Any Proposition 56 funds would support recent physician rate increases.
- ***Proposition 35: Count Some Program Growth as Provider Rate Increases.*** The Governor proposes using a portion of Proposition 35 funds designated for rate increases to cover program growth in Medi-Cal. Specifically, the funds would cover the cost of baseline rate increases that would have otherwise been covered by the General Fund.

Releases Plan for Proposition 35 Augmentations. In addition, the administration has released its initial plan for the Proposition 35-funded provider rate increases. As the figure below shows, after covering baseline program growth, the administration proposes to fund a mix of ongoing and one-time provider rate increases. This plan extends through 2026. In 2027, new Proposition 35 rules would become effective, requiring a new plan from the administration.

Proposed Proposition 35 Spending Plan Focuses on a Few Key Areas

Planned Augmentations (In Millions)

	2025	2026
Base managed care rate growth	$1,101	$452
Hospital and clinic directed payments	455	455
Base physician rate increases (to 87.5 percent of Medicare)	356	374
Supplemental rates (physicians and ground emergency transport)	116	835
Workforce initiatives	240	240
Behavioral health coordination	200	200
Housing subsidies	100	100
Totals	**$2,568**	**$2,656**

Assessment

Key Questions About Medi-Cal Estimates Remain

Heightened Uncertainty Exists Around Caseload Trends. Projecting caseload in the Medi-Cal program has become significantly more uncertain in recent years. This is because of several simultaneous policy changes affecting eligibility. Most importantly, the state is still unwinding federal policies and flexibilities that kept Medi-Cal enrollment at historically high levels during the COVID-19 pandemic. The end of these policies likely will help drive down overall enrollment over time, but the exact trend is uncertain. Also, senior caseload has notably increased recently, primarily driven by the end of the asset test in January 2024. Given how recently this policy change occurred, however, its effects through the end of 2025 on the senior caseload are difficult to predict.

Recognizing Uncertainty, May Revision Caseload Estimates Appear Reasonable. Factoring in this heightened uncertainty, we conclude that the administration's caseload projections fall within the reasonable range of possibilities. That said, we think there is a chance caseload could be lower than is estimated in the May Revision. This could happen if the unwinding of federal policies results in higher disenrollment than assumed.

Growth in Per-Enrollee Costs More Difficult to Gauge. Compared to caseload, there is limited data on per-enrollee costs in Medi-Cal. Much of this limitation is a function of how Medi-Cal delivers services. Medi-Cal delivers most services to members by enrolling them in health plans. The health plans in turn pay providers for services, and in exchange receive monthly per-enrollee payments from Medi-Cal. This system significantly limits insights into cost drivers in Medi-Cal, because health plan payments to providers are trade secrets and not publicly available. Also, Medi-Cal's budget documents provide only very limited data on actual spending, making it challenging to fully assess the administration's estimates and projections for the budget window.

Assessment

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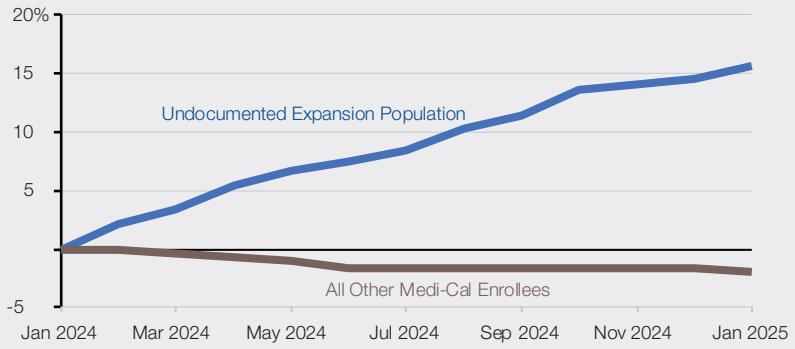
Estimate Provides Insufficient Data on Undocumented Expansion Costs. It is plausible that, absent budget solutions, undocumented enrollees will continue to increase General Fund costs in Medi-Cal. This is because, as the figure below shows, caseload for the population has been growing much faster than for other Medi-Cal enrollees. That said, there is not enough information to fully assess the administration's estimates, particularly around per-enrollee costs. This is because Medi-Cal's budget back up does not fully breakout spending for these enrollees. Instead, it embeds these data into more aggregate-level program information.

Undocumented Expansion Population Is Growing, While Other Caseload Is Declining

Cumulative Change Since January 2024



Assessment

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Solutions Try to Curtail Key Areas of Spending Growth

Focus on Ongoing Solutions Is Warranted. As our office has noted elsewhere, the General Fund has a structural deficit, with projected shortfalls in the out-years. The deficit largely is the result of growth in program spending outpacing growth in revenues. In light of this structural deficit, focusing on ongoing solutions is warranted. Medi-Cal is a reasonable area to look for solutions, given its large share of state spending and recent program growth.

Largest Proposed Solutions Target Key Areas of Spending Growth in Medi-Cal… Many of the largest budget solutions target areas of key General Fund spending growth, such as the undocumented expansion and pharmacy benefits. Such an approach provides a greater chance of yielding sufficient savings to help limit General Fund spending overall.

…And Focus on Areas With Fewer Federal Constraints. Because of the federal government's role in helping to cover costs, the Medi-Cal program is subject to many federal policies protecting access to health care. Violating these policies can jeopardize some or all of California's federal Medicaid funds. Accordingly, the administration reasonably focuses on areas in Medi-Cal with fewer federal constraints. Most notably, the state has considerable flexibility regarding people with unsatisfactory immigration status, because the state General Fund covers most of the cost for this population without federal financial contributions.

Assessment

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Some Solutions Raise Key Trade-Offs

Proposition 35 Solution Does Not Expand Services. The Governor proposes using a portion of Proposition 35 funds to cover growth in the cost of existing service levels. In taking this approach, the administration does not use these funds to expand services or rates beyond Medi-Cal's baseline services. This proposed solution helps manage General Fund spending growth in the short run, but also potentially undercuts the original intent of the measure to expand provider rates above base levels. The Legislature likely will want to weigh this trade-off. Also, the Legislature will want to keep in mind that Proposition 35's rules change in 2027, potentially limiting the ability of the state to identify longer-term budget solutions in the future.

Proposition 56 Solution Leaves Significant Federal Funding on the Table. Proposition 56 does not require the state to backfill declining tobacco tax revenues with General Fund to maintain provider supplemental payments at historical levels. That said, the proposal to eliminate the General Fund backfill for family planning services would cause the state to forego a significant amount of federal funds. Family planning services receive a 90 percent match in federal funding (with the exception of abortion services, which do not receive any federal match).

Proposed Enrollment Freeze and Monthly Premiums Raise Three Key Issues. The administration's proposed enrollment freeze and monthly premiums on adults with unsatisfactory immigration status raises three key issues:

- ***Enrollment Freeze Not Well Targeted.*** Freezing enrollment means that no new applicants will be eligible to enroll in comprehensive coverage in the Medi-Cal program. Such an approach could keep out very low-income people, while preserving eligibility for others who have relatively higher incomes.
- ***Enrollment Freeze and Premiums Have Potentially Conflicting Goals.*** In concept, freezing enrollment protects eligibility for people already in Medi-Cal. However, the proposed premiums primarily save the state money because they result in disenrollment among existing enrollees. This is because many enrollees—who are at or near the poverty level—may not be able to pay the higher cost of the premium.

Assessment

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- ***Premiums Impose New Costs on Enrollees, Without Regard for Income or Service Level Provided.*** The administration proposes charging the same premium on all adult undocumented enrollees. This means that some enrollees with lower incomes or lower service costs would pay same amount as enrollees with higher incomes or service costs.

Reintroducing Asset Limit Would Complicate Eligibility Rules. The Governor's proposal would return Medi-Cal eligibility for seniors to the criteria that existed prior to July 2022. At that time, seniors' eligibility was based on a set of rules that limited the amount of assets held by an individual or couple. (Separate from assets, seniors still needed to meet income eligibility criteria.) The asset rules limited the amount of countable assets an applicant could have to $2,000 per individual and $3,000 per couple. While some of the asset rules were straightforward, others were complex to understand and demonstrate compliance. It is possible that these complex rules deterred seniors from applying for Medi-Cal even if they were eligible. Reinstating the asset test could reintroduce these challenges.

Assessment

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Effects of Some Solutions Are Uncertain

Some Undocumented Enrollee-Related Solutions Have Difficult-to-Predict Effects. Some of the largest proposed solutions around adults with unsatisfactory immigration status have uncertain fiscal impacts. For example, it is difficult to gauge if, and by how much, premiums will result in accelerated disenrollment of this population. According to the Department of Finance, the administration's estimates assume the premiums result in a 20 percent reduction in enrollment among this population. Some state Medicaid programs, however, have experienced even greater disenrollment rates from enacting or increasing premiums on Medicaid enrollees, as much as 50 percent in some cases. On the other hand, more people might enroll in Medi-Cal ahead of the start of the enrollment freeze in January 2026 to ensure they are eligible for coverage, potentially driving up costs in the short run.

Savings From Many Pharmacy-Related Solutions Are Uncertain. Many of the proposed pharmacy-related solutions aim to generate ongoing savings by increasing rebates and limiting utilization of higher-cost drugs. The assumed fiscal impact of these actions, however, is uncertain in many ways. For example, the actual increase in rebates will depend on negotiations with drug makers.

Solutions Could Be Administratively Challenging to Implement. Several of the proposed solutions would require the Department of Health Care Services (DHCS), counties, health care plans, and providers to apply different eligibility and payment criteria to Medi-Cal enrollees with unsatisfactory immigration status compared to enrollees with satisfactory immigration status. For example, the administration proposed reducing payments to safety net clinics for services to this population. This proposal could require a new level of coordination among DHCS, health plans, and clinics to collect, track, and share patients' immigration status to implement the new payment system. Past attempts to restructure Medi-Cal provider payments have proven to be challenging, and implementation is often delayed due to the heightened workload demands from plans and providers to adjust to the new system. As a result, some of the expected savings from these proposals could be delayed or hindered by implementation hurdles.

Assessment

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Multiyear Includes Unclear Proposed Budget Solution. The administration's multiyear assumes substantial out-year savings in Medi-Cal ($737 million in 2027-28 and $503 million in 2028-29) related to "operational improvements." (The administration also assumes some related savings in the Department of Social Services.) At the time of this handout, key details of this proposal remain unclear. As such, it is unclear whether these assumed savings are realistic.

Assessment

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Potential Federal Medicaid Policy Changes Could Increase State Costs

Federal Administrators Propose New Rules Around Provider Taxes. On May 12, federal administrators proposed new rules around taxing health care providers to support Medicaid programs. Specifically, the new rule would further constrain states' ability to charge higher tax rates on Medicaid services than non-Medicaid services. The federal government is concerned about this because higher taxes on Medicaid services tend to increase federal costs.

Congress Also Is Considering Various Medicaid Changes. At the time this handout was developed, Congress was considering potentially significant changes to federal Medicaid funding as part of its budget development process. The potential changes under consideration were varied, and included reducing federal funding for states that provide full-scope coverage to undocumented individuals, as well as prohibiting states from establishing new provider taxes.

Policy Changes Could Increase Costs in Several Ways. The biggest potential risk to the state is around its use of provider taxes to help cover Medi-Cal costs. In particular, the federal government's proposed new rules appear targeted at the state's MCO tax, which currently raises more than $7.5 billion net revenue each year. Broader constraints considered by Congress could affect other state provider taxes as well, such as the state's hospital fee program. Changes in the federal share of cost for childless adults also could create billions of dollars in state costs. In total, these risks could reduce federal funding to California by the billions or even tens of billions of dollars annually, depending on the scope of what is enacted.

Final Package of Changes Remains Uncertain. To date, the federal government has not finalized these potential new policies and rules. The final package could change considerably. In fact, many of the financing issues at hand have been long-standing areas of discussion at the federal level. For this reason, the potential fiscal impact remains highly uncertain.

Recommendations

Consider Administration's Caseload Estimates as Starting Point… Because the administration's caseload estimates appear to fall within the reasonable range of uncertainty, we recommend treating them as the starting point to determine Medi-Cal's base budget.

…But Pursue More Information on Per-Enrollee Cost Growth. Before determining Medi-Cal's base budget, we recommend the Legislature work with the administration to get better information on the drivers of higher per-enrollee spending.

Treat Proposed Level of Budget Solutions as a Starting Point. Given the state's structural budget deficit, we recommend the Legislature treat the proposed level of budget solutions as a starting point in developing its budget. To the extent the Legislature chooses to reject a specific Medi-Cal budget solution, we recommend it take actions (either in Medi-Cal or in another area of the budget) to create a like-amount of savings.

Weigh Alternatives to Improve Some Solutions. Though we recommend pursuing substantial savings in this year's budget, in some cases the Legislature could improve upon the administration's proposed solutions. Below are some key examples:

- ***Adjusted Income Thresholds.*** Rather than freezing enrollment for individuals with unsatisfactory immigration status, the Legislature could lower the income eligibility thresholds for some or all of these populations. While such an approach would disenroll existing enrollees above the new thresholds, it would better prioritize access for the lowest-income individuals.
- ***Sliding Scale Cost Sharing.*** Rather than charging the same monthly premium on all affected enrollees, the Legislature could create a sliding scale cost sharing approach. For example, the Legislature could vary the size of the premium by income level or by age group. Such an approach could be somewhat more complex to administer, but also better align cost sharing with ability to pay and/or service costs.

Recommendations

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- ***Simplified Asset Test.*** If it is a legislative priority to maintain Medi-Cal eligibility for seniors, the Legislature could consider working with DHCS to simplify the asset test rules. While there are broad definitions of assets at the federal level, the state could have some leeway to simplify the rules that were in place prior to July 2022. Nonetheless, if the Legislature were to take this approach, it would want to ensure that seniors have access to less-costly home- and community-based services as an alternative to costlier institutional care.

Consider Broader Uncertainties When Developing Budget. Given the significant uncertainties around the administration's proposed budget solutions, growth in per-enrollee spending, and federal Medicaid policy changes, the Legislature faces significant challenges in adopting a budget for Medi-Cal this year. Generally, we recommend the Legislature keep these uncertainties in mind when adopting its budget for Medi-Cal. This could entail revisiting some of these issues in next year's budget process as more details emerge over time.