California State Assembly

Agenda

Assembly Budget Subcommittee No. 7 on Accountability and Oversight

Assemblymember Gregg Hart, Chair

Wednesday, August 5, 2026

9:00 A.M., – State Capitol, Room 126

PART 1: INDIGENT HEALTH

Issue 1: Indigent Health

Hearing Background & Objectives

The 2025 federal reconciliation law H.R. 1, once referred to as the "One Big Beautiful Bill," enacts sweeping changes to Medicaid eligibility for adults beginning January 1, 2027. Combined with new federal health care rules, an estimated 1.9 million Californians are projected to lose health coverage in the coming years, including 1.3 million from Medi-Cal by 2029 and 500,000 from Covered California by 2030.

Federal changes and their impact on California have been examined in detail in the following Assembly Subcommittee 1 on Health hearings:

1- *Physician Workforce Development in the Wake of H.R.1: Education, Training & Retention* (February 23, 2026)

2- *Federal Impacts on Coverage: Medi-Cal, Covered California, and Immigrant Access to Care* (March 9, 2026)

3- *Financing California's Health Care Safety Net Under HR 1* (April 6, 2026)

It is widely anticipated that for Californians who will no longer be eligible to receive health care insurance through Medi-Cal or Covered California, their only source of care will be community clinics, county indigent care programs, or hospital charity care provided in an emergency room setting.

Historically, counties have provided indigent care to low-income Californians who lacked any other source of health coverage. These indigent health programs are required to furnish only basic, subsistence-level medical services only, and are not required to provide comprehensive health benefits. County indigent care programs have largely been dormant in the last decade since the Affordable Care Act dramatically expanded eligibility for health insurance in 2014.

Although the enacted Budget Act of 2026 included resources to mitigate the impacts of HR1 and other federal rules -- including financial support for county administration, public hospitals, and community clinics -- the final budget did not include resources to address the projected increased demand for county indigent health services.

This oversight hearing aims to:

1- Articulate the current and projected landscape for indigent health in the coming years.

2- Understand projected health care coverage losses for Medi-Cal and Covered California in the short and long-term.

3- Receive perspectives from county stakeholders.

4- Examine potential proposals for consideration in advance of the 2027-28 budget cycle, including any interim implementation options.

Projected Health Insurance Coverage Losses

Medi-Cal:

California's Medicaid program, known as Medi-Cal, is the state's public health insurance program providing no-cost and low-cost health care coverage to eligible individuals and families. Currently, more than 14.5 million Californians, or nearly 37 percent of the state's population, are enrolled in Medi-Cal.

Eligibility for Medi-Cal expanded significantly following the implementation of the Affordable Care Act (ACA) Medicaid expansion in 2014, which extended coverage to adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level (about $22,025 per year for a single adult in 2026). This group, called the "New Adult Group," currently represents approximately 4.9 million of Medi-Cal's 14.5 million enrollees and is the population most directly affected by HR1.

The most significant HR1 change is the work requirements, which mandates adults ages 19 to 64 in the New Adult Group to demonstrate at least 80 hours per month of qualifying work, volunteer, or educational activity in order to maintain Medi-Cal coverage. This is the first time in California's history that Medi-Cal has imposed a work-related activity requirement as a condition of eligibility. HR 1 also requires New Adult Group members to renew their Medi-Cal eligibility every six months instead of annually. Under current law, all Medi-Cal members renew once per year.

DHCS estimates that taken together, the new work requirements and the six-month renewals will result in up to 1.3 million Medi-Cal members losing coverage over the next few years. Disenrollment will not happen all at once: DHCS expects coverage losses to occur over the long-term.

Estimated Medi-Cal Coverage Losses

Provision	Near-Term Estimate Losses	Long-Term Estimate Losses
Work & Community Engagement Requirements	728,000 by 2027-28	1.06 million by 2029-30
Six-Month Renewals	87,000 by 2027-28	279,000 by 2029-30
Combined (both provisions)	815,000 by 2027-28	1.3 million by 2029-30

Covered California

Covered California is the state's health benefit exchange, established under the federal Affordable Care Act (ACA) and created by California statute in 2010. It is a health care marketplace through which eligible Californians can shop, compare, and enroll in private health insurance plans and access federal and state financial assistance to help pay for coverage. Covered California plays a key role in the state's health insurance infrastructure, alongside Medi-Cal. While Medi-Cal covers lower-income Californians Covered California is primarily designed to serve low-to-middle-income individuals and families who do not have access to affordable employer-sponsored health insurance.

The combination of HR1, new federal rules, and the expiration of federal enhanced subsidies are anticipated to significantly impact how consumers enroll in and maintain Covered California coverage.

Covered California projected that enrollment will decline from its August 2025 peak of approximately 1.96 million to roughly 1.45 million by 2030 – a loss of more than 500,000 enrollees.

Background on Indigent Health

The County Mandate

Counties have been legally required to provide basic health care services to low-income residents who have no other means of receiving care since the 1930s, under Welfare and Institutions Code Section 17000. This mandate applies to individuals based on lawful residence and economic need, and operates as a program of last resort, meaning other programs such as Medi-Cal must be pursued first as a condition of eligibility. Court decisions over the years have clarified that counties are required to provide only the basic care necessary to prevent serious harm, pain, or infection. This is a significantly lower standard than what Medi-Cal covers. Counties have broad discretion in setting income eligibility thresholds and the scope of benefits offered, and practices vary considerably across the state's 58 counties.

Pre-Affordable Care Act History

Prior to the implementation of the Affordable Care Act in 2014, county indigent care programs served a large population: an estimated 850,000 Californians were enrolled in county indigent health programs statewide. The state provided some funding support for these programs in the 1980s. For larger counties, direct General Fund support was provided through the budget process. For smaller counties, the County Medical Services Program (CMSP), which still exists today, provided General Fund support to contract with the state to administer their indigent care programs.

Realignment

In 1991, the Legislature enacted a major realignment package that shifted significant fiscal and programmatic responsibility for health and human services programs from the state to counties. As part of this realignment, the state eliminated most of its direct General Fund support for county indigent health care. In exchange, counties were given a new dedicated ongoing revenue stream, coming from a portion of state sales tax and vehicle license fee revenues. Those revenue streams are deposited into special funds to support their “realigned” responsibilities. These revenues are allocated to various subaccounts, and counties may only use funds in the

Health Subaccount (referred to as "health realignment revenues") for public health and indigent care responsibilities. The key feature of realignment revenues is that they grow with the economy over time but do not automatically adjust to meet increased program costs or demand.

AB 85 and the Affordable Care Act Redirection

In 2013, anticipating the dramatic expansion of Medi-Cal eligibility under the ACA beginning in 2014, the Legislature enacted AB 85. The ACA expansion was expected to dramatically reduce demand for county indigent care, as most adults who had previously relied on county programs would become eligible for Medi-Cal. Based on that assumption, AB 85 redirected a portion of the health realignment revenues that counties had historically used for indigent care to offset state General Fund costs for CalWORKs grants.

Indigent Health Today

Following expansion of health care eligibility under the Affordable Care Act, county indigent care enrollment fell dramatically, from an estimated 850,000 before the ACA to approximately 10,000 currently enrolled statewide. As demand declined, many counties broadened their eligibility requirements or expanded the scope of benefits offered, using available realignment resources for populations not covered by Medi-Cal. Some counties chose to serve individuals with unsatisfactory immigration status or provide specialty care beyond the minimum statutory requirement. However, the administrative infrastructure for operating large-scale indigent care programs was largely dismantled or left unused as it was no longer needed.

Of note, counties rely primarily on health realignment funding (around $1.2 billion in 2026-27) to fund public health services as well health care services for any individuals still participating in the indigent health care program.

With the combined impacts of HR1 and new federal rules, up to 1.9 million Californians may lose coverage in the coming years, which is expected to significantly increase demand for safety-net programs of last resort, such as county indigent health programs -- most of which have little remaining administrative infrastructure to absorb that demand.

2026 Budget Actions and Proposals

Although the enacted 2026 state budget did not include resources directly for county indigent health, it included the following items to mitigate the impacts and coverage losses related to HR1 and federal actions:

- $196.9 million for county eligibility workload related to HR1 implementation, including work requirements and twice-a-year eligibility redetermination.

- $250 million to support California's public hospital system.

- $1 billion to support community clinics, including Federally Qualified Health Centers and Rural Health Clinics.

- $364.1 million to provide full-scope Medi-Cal coverage until July 1, 2027 for specified lawfully present immigration categories who are losing Medicaid eligibility under HR1. These include Qualified Non-Citizen populations, such as refugees, asylees, and victims of trafficking.

- $300 million ongoing for free and subsidized coverage of premiums for eligible Covered California enrollees up to 200 percent of the Federal Poverty Level.

- $90 million for grants to distressed hospitals, with authority to augment the program with an additional $50 million.

The following proposals were submitted for consideration during the 2026-27 state budget process but were not included in the final enacted budget:

- $761 million in 2026-27 and $2.4 billion in 2027-28 for direct support of county indigent care programs. This proposal would have been inclusive of infrastructure building and set up, as well as direct medical services and administration in all 58 counties. Smaller versions of this proposal were also considered.

- $50 million in 2026-27 and $461 million in 2027-28 to create a state-administered and state-funded emergency services program for individuals who lose eligibility for Medi-Cal benefits as a result of HR1. Smaller versions of this proposal were also considered.

Panel

Indigent Health Background

- Will Owens, Senior Fiscal and Policy Analyst
- Mark Newton, Deputy Legislative Analyst

Projected Health Care Coverage Losses

- Sonal Panel, Department of Finance
- Angel Coronel, Department of Finance
- Laura Ayala, Department of Finance
- Andrew Huitt, Department of Finance
- Albert Pineda, Department of Finance

- Andrew Duffy, Department of Finance
- Shelina Noorali, Department of Finance

County Perspectives

- Tanja Heitman, Assistant County Executive Officer, Santa Barbara County
- Elizabeth Hernandez, Interim Health and Human Services Director, San Diego County
- Jason Britt, County Administrative Officer, Tulare County

Recommendations & Looking Ahead to 2027-28

- Katie Heidorn, Director of State Health Policy, California Health Care Foundation
- All previous panelists

Staff Comment

With nearly 1.9 million Californians expected to lose health coverage in the coming years, the safety net of last resort will play an increasingly important role in the state's health care infrastructure. While the 2026 Budget included resources to mitigate some of these impacts -- including funding for county eligibility workload, public hospitals, community clinics, and temporary coverage for specified immigration categories -- it remains unclear what the net demand for county indigent care will actually be once these mitigation measures are factored in against the scale of projected coverage losses.

The subcommittee may wish to explore two areas: first, what policy, budget, or fiscal options are available to respond to a potential spike in county indigent care demand; and second, what data infrastructure the state can leverage to track coverage losses over the coming year in order to design an appropriate response for the 2027-28 budget cycle.

The Subcommittee may wish to ask the following questions:

1- Given that county indigent care infrastructure was largely dormant and unused post-Affordable Care Act, what are the counties' realistic timeline and cost to rebuild capacity if demand spikes, and does that timeline align with when coverage losses are projected to hit?

2- Accounting for the budget measures included in the 2026 budget, can the counties provide additional details on their projected resource needs to recreate larger-scale county indigent care programs, such as infrastructure building and set up?

3- How are counties currently using health realignment revenues?

4- Are there early indicators that counties, county hospitals, or the Administration are already seeing, such as emergency room utilization, charity care claims, county hotline volume, etc. that could serve as a leading indicator of indigent care demand?

5- Do county indigent care programs serve Californians with unsatisfactory immigration status?

6- What kind of data infrastructure currently exists that the Administration can leverage to determine in real time potential demand for county indigent care?

7- Does the Administration have updated coverage loss projections in Medi-Cal and Covered California? How frequently would the Administration plan to update these estimates to inform future potential legislative actions?

8- What is the Administration's current visibility California's uninsured rate? For example, does the Data Exchange Framework (California's, real-time exchange of data among health and social services entities throughout California) or the Department of Health Care Access and Information have real-time data on emergency room utilization trends to track whether uncompensated care is rising ahead of formal Medi-Cal / Covered California enrollment data?

PART 2: STATE LEADERSHIP ACCOUNTABILITY ACT AND AUDIT REPORTING TRAILER BILL

Issue 2: State Leadership Accountability Act and Audit Reporting Language

The Governor's Budget included a proposal to change statutory language related to the responsibility of risk management and internal control policy for departments.

Panel

- Jennifer Arbis, Department of Finance
- Zach Stacy, Department of Finance

Trailer Bill Proposal

The Governor's Budget included a proposal to change statutory provisions in the Government Code related to risk management and audits.

Audit Provision

The Governor's budget proposal deletes a current requirement that requires the Director of Finance to supply a certified copy of each periodical audit of the accounts of any state agency to the Controller, and to the Legislature and the affected state agency if the audit includes a review of federal funds.

Risk Management

Risk management is a systematic process including risk assessment, risk response designed to mitigate or reduce risks, and risk monitoring to achieve agency objectives, which is ongoing and iterative to manage the ever-changing likelihood and impact of adverse events that may occur across an agency's operations. This process helps address risks proactively and may be preventative or encourage opportunity-taking when successful.

Risk management's desired outcomes include increased likelihood of successfully delivering on agency goals and objectives; fewer unanticipated outcomes encountered; and better assessment of risks associated with changes in the environment.

Risk management is an integral part of internal control. Through successful risk management tools like risk assessments and continuous monitoring, necessary controls may be identified to

mitigate risks. Risk assessments and continuous risk management can help ensure effective internal control and identify necessary controls. Management is responsible for implementing practices that identify, assess, respond to, and report on risk.

Agency heads are currently responsible for the system of internal control within state agencies. Risk management is inherent within the system of internal control and has been a component of the State Leadership Accountability Act (SLAA) process since its inception. To ensure an adequate system of internal control, the entity must have an awareness of the risks to achieving its objectives. This SLAA process is intended to have departmental and agency staff discuss potential organizational risks and actions that can be taken to mitigate these risks. The Department of Finance provides guidance to state entities on the implementation, reporting, and monitoring of SLAA. The current framework includes a risk-based approach to identify entity risks and related internal controls.

Under current law, agencies must submit an SLAA report biennially to the California State Library, and the Department of Finance must report any agency that has not submitted a report as noncompliant. Additionally, under current law, agencies are required to submit a plan for correcting inadequacies or weaknesses every six months until all corrections are implemented.

The implementation of SLAA in the early 1980's was derived from the Federal Managers' Financial Integrity Act of 1982 (FMFIA). Historically, Finance generally follows the federal guidance for SLAA but does not directly adopt the Federal guidance to provide flexibility with implementing concepts as they apply to California state operations.

As an example, the Department of Finance provided a copy of their risk assessment process that highlighted three risk areas for that department:

1. Workforce Development and Retention
2. Information Security
3. Statewide Budget and Fiscal Integrity

According to the Department of Finance, the January Budget proposes Government Code revisions are intended to align and acknowledge the process state entities already perform by updating terminology and wording, including a definition section. Within this section, "risk management system" is defined to capture the importance of risks and controls. According to the Department of Finance, the only significant change to the Government Code other than terminology/wording is revising the reporting timing from a biennial basis to an annual basis with submittal in July. The proposed changes also remove the every six month requirement to report the plan and schedule for correcting identified inadequacies or weaknesses

Staff Comment

The January budget proposal was not accompanied by background describing the need for the proposal, but subsequent communication with the Finance staff provided the context for this proposal. Given the critical role that risk assessment plays in governance, this item is agendized to allow for discussion prior to consideration of adopting the administration's proposal in August budget clean up actions.

The Subcommittee may wish to consider the following questions:

1. How does the Department of Finance use SLAA plans?
2. Can you provide an example of how the SLAA process or report has resulted in a change in governance or decision making by the administration?
3. Why is the proposed language increasing the frequency of the reporting?
4. How often are agencies noncompliant with the SLAA requirements and what are the consequences of not reporting?
5. What is the rationale for the change in the audit reporting?

Staff Recommendation

Staff believe these proposals should be adopted as part of August Budget Clean Up.