California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, April 20, 2026

2:30 P.M. – State Capitol, Room 127

Items To Be Heard

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4140 Department of Health Care Access and Information
0977 California Health Facilities Financing Authority

Issue 1: Distressed Hospital & Health Facilities Financing

Background on the Distressed Hospital Loan Program

The Distressed Hospital Loan Program (DHLP) was established in 2023 and is jointly developed and administered by the Department of Health Care Access and Information (HCAI) and the California Health Facilities Financing Authority (CHFFA). The program 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.

The program had $300 million in total available resources ($150 million from the General Fund and $150M one-time funding from the Managed Care Organization tax). Accounting for administrative costs, **$292.5 million was awarded to 16 hospital borrowers**.

2026 Update on the Distressed Hospital Loan Program

The DHLP allows for modifications to loan terms, including the possibility of extending the loan repayment start date, or loan forgiveness.

HCAI explains that DHLP loan modifications follow a structured two-step process designed to balance flexibility and accountability. The steps are:

- **Step 1:** Twelve-month extension of the repayment start date and loan maturity date, with amortization recast over 60 months.

- **Step 2:** Potential forgiveness of up to 12 months of principal debt service. Step 2 is available only after Step 1 approval and only upon a finding of continued financial distress and satisfaction of program criteria.

At the time of this agenda's publication, HCAI reports:

- 15 of 16 hospitals received Step 1 modifications
- 8 of those hospitals have applied for Step 2, which are currently under review
- No restructuring of loan principal amounts has occurred

DHLP Hospital Status

Facility Name	Approved Loan Amount	Initial Monthly Payment Due on	Step 1 Loan Mod. Approval	First Monthly Payment Due after Step 1
Chinese Hospital	$10,350,000	6/1/2025	5/14/2025	6/1/2026
Dameron Hospital Association	$29,000,000	8/1/2025	7/24/2025	8/1/2026
El Centro	$28,000,000	5/1/2025	4/30/2025	5/1/2026
St. Rose Hospital	$17,650,000	7/1/2025	6/3/2025	7/1/2026
Hazel Hawkins Memorial	$10,000,000	2/1/2026	Did not qualify	2/1/2026
John C. Fremont	$9,350,000	8/1/2025	7/24/2025	8/1/2026
Kaweah Delta	$20,750,000	9/1/2025	7/31/2025	9/1/2026
Madera Community Hospital	$57,000,000	1/1/2026	12/24/2025	1/1/2027
Martin Luther King, Jr.	$14,000,000	6/1/2025	5/28/2025	6/1/2026
Palo Verde Hospital	$8,500,000	6/1/2025	5/30/2025	6/1/2026
Pioneers Memorial Hospital	$28,000,000	5/1/2025	4/23/2025	5/1/2026
Ridgecrest Regional Hospital	$5,500,000	6/1/2025	5/27/2025	6/1/2026
San Gorgonio Memorial	$9,800,000	8/1/2025	7/16/2025	8/1/2026
Sonoma Valley Hospital	$3,100,000	3/1/2026	2/26/2026	3/1/2027
TriCity Medical Center	$33,200,000	6/1/2025	5/20/2025	6/1/2026
Watsonville Hospital	$8,300,000	5/1/2025	4/16/2025	5/1/2026

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. CHFFA provides such assistance through bonds, loans and grants.

Inclusive of the Distressed Hospital Loan Program administered above, CHFFA has approximately 7 active programs to about 21 different types of health facilities ranging from hospitals, clinics, mental health facilities, developmentally disabled facilities, adult day, elderly residential, and dental clinics.

2025 Bond Financing Program Update

The CHFFA 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 2025, CHFFA has issued 643 bonds for **approximately $52.8 billion**. In 2025, CHFFA closed six bond financings for six California health facilities, resulting in a total issuance of $1,653,295,000.

The following provides a summary of CHFFA's bond issues that closed in 2025:

Borrower	Amount Issued	Type of Issue
Stanford Health Care	$416,120,000	New Money & Refunding
Providence St. Joseph Health	$345,795,000	Refunding
Adventist Health System/West	$302,115,000	New Money
El Camino Health	$264,295,000	New Money & Refunding
City of Hope	$189,140,000	Refunding
Children's Hospital Los Angeles	$135,830,000	Refunding
Total 2025	**$1,653,295,000**	

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, 2025, CHFFA had 67 outstanding loans in the approximate amount of $42.7 million. Since program inception through 2025, CHFFA has issued 314 HELP II loans for approximately $155.3 million.

In 2025, CHFFA closed 3 HELP II loans, which resulted in a total issuance of $2,451,894, as provided below:

Borrower	Loan Amount	Use of Proceeds
Marin Ventures	$1,000,000	Refinance
The Carolyn E. Wylie Center for Children, Youth & Families	$951,894	Refinance
The Carolyn E. Wylie Center for Children, Youth & Families	$500,000	Renovation
Total	**$2,451,894**	

Panel

- Fiona Ma, California State Treasurer
- Carolyn Aboubechara, Executive Director, California Health Facilities Financing Authority
- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Dean O'Brien, Deputy Director for Health Facility Financing, Department of Health Care Access and Information
- Victoria Rappleye, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Sara Swan, Principal Program Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

The DHLP update reflects the depth of financial distress among California's hospitals. Of the 16 hospitals in the program, only one, Hazel Hawkins Memorial, is making payments under original loan terms. Fifteen hospitals have received Step 1 modifications extending their repayment timelines, and eight of those have already applied for Step 2 modifications that could result in partial principal forgiveness. While the program was designed with flexibility to modify provisions, the pattern raises important questions about the program's long-term strategy in supporting distressed hospitals via interest-free loans. The subcommittee may wish to ask:

1- How is HCAI / CHFFA evaluating whether hospitals receiving Step 2 forgiveness have viable long-term turnaround prospects?

2- Is HCAI / CHFFA considering additional modifications or forgiveness beyond Step 2? At what point does the program's flexibility options are considered exhausted?

Staff Recommendation:
Hold Open

4140 Department of Health Care Access and Information

Issue 2: Budget Overview, Budget Change Proposals, and Department Updates

Background on the Department of Health Care Access and Information (HCAI)

HCAI was established to expand equitable access to health care by supporting the state's health workforce needs, ensuring the safety and reliability of health care facilities, and analyzing health care data and information. The Department administers a wide variety of programs across four areas:

- **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.
- **Workforce**: expand and diversify California's health workforce for underserved areas and populations.
- **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.
- **Data:** collect, manage, analyze and report information about California's healthcare landscape.

2026-27 HCAI Budget Overview, Budget Change Proposals, and Provisional Language

The 2026-27 Governor's budget proposes a **$841.2 million budget and 844 staff positions** for HCAI. Of this total, $175 million is from the General Fund, and the remaining comes from federal funds, reimbursements, and a wide range of special funds.

The HCAI budget includes seven budget change proposals, as summarized below:

1. **Healthcare Payments Data Program.** HCAI requests funding of $22.5 million in 2026-27 and $23.6 million starting in 2027-28 and ongoing from various special fund sources, to support the operation of the Healthcare Payments Data (HPD) Program. HCAI also requests 4 existing positions be transferred to the Department of Health Care Services (DHCS), and DHCS requests funding of $829,000 ($207,000 California Health Data and Planning Fund, $622,000 Federal Fund) in 2026-27 and $793,000 ($198,000 California Health Data and Planning Fund, $595,000 Federal Fund) in 2027-28 and ongoing, for the

purposes of managing and transmitting Medi-Cal data to HCAI and utilizing HPD to support management of the Medi-Cal program, which is a requirement for HPD's federal funding.

2. **Data Exchange Framework and Office of the Patient Advocate Shift.** HCAI requests $8,800,000 General Fund, and $2,360,000 Health Plan Improvement Trust Fund in 2026-27 and ongoing, for 16 positions and costs for consulting, to facilitate the transfer of two Center for Data Insights and Innovation (CDII) programs to HCAI. The transfer includes the Data Exchange Framework (DxF) and Office of the Patient Advocate (OPA). According to the Administration, this shift is budget neutral, as it is part of a reorganization that is transferring DxF and OPA over to HCAI. This BCP would effectuate the transition.

3. **Data Exchange Framework (SB 660 Implementation).** HCAI requests $1.5 million in 2026-27 and 2027-28 from the California Health Data and Planning Fund to implement and administer the provisions of SB 660 (Menjivar, Chapter 325, Statutes of 2025). expands the authority of the state and the requirements for the DxF in several ways, including making HCAI the new administrator of the DxF Program;

4. **Healthcare Workforce Programs.** HCAI requests an increase in expenditure authority for a total of $931,000 in the Mental Health Practitioner Education Fund, $1,816,000 in the Registered Nurse Education Fund, and $142,000 in the Vocational Nursing Education Fund in FY 2026-27 and ongoing to continue supporting various workforce programs. HCAI also requests an increase in spending authority of $353,000 in FY 2026-27 and ongoing from the Federal Trust Fund to continue support for the Primary Care Office (PCO) and Medicare Rural Hospital Flexibility Program (FLEX) federal grants awarded through the Health Resources and Services Administration.

5. **Hospital Pricing (AB 1312).** HCAI requests 8 positions and $1,611,000 for 2026-2027, 2027-28, and 2028-29 from the California Health Planning and Data Fund to support program services associated with the implementation of AB 1312 (Schiavo, Chapter 450, Statutes of 2025). The bill expanded existing hospital fair pricing statutes by connecting eligible patients with hospital financial assistance before they receive a bill.

6. **Employee Healthcare Coverage Reporting (AB 1418).** HCAI requests $178,000 to fund one position in 2026-27 and annually thereafter from the California Health Data and Planning Fund to implement new reporting requirements related to health care workers' health coverage waiting periods, pursuant to AB 1418 (Schiavo, Chapter 398, Statutes of 2025). The bill mandates annual reporting and public disclosures of employer-sponsored health coverage waiting periods.

7. **Long-Term Care Payment Transparency Final Rule Extension.** HCAI requests 3 permanent positions and expenditure authority of $597,000 in FY 2026-27 and ongoing

from the California Health Data and Planning Fund to implement healthcare data reporting requirements established by new federal rules. This proposal also has a funding component requested by DHCS, which was heard by this subcommittee at its April 6, 2026 hearing.

The HCAI budget also includes two requests for provisional language to be added to the budget bill. These amendments are technical in nature, and include:

1- An amendment to delay the date by which unspent funds allocated for newly accredited primary care residency programs may be redirected to existing programs to June 30, 2028.

2- An amendment to authorize encumbrance or expenditure of the amounts allocated for workforce training contracts and the County Medical Services Loan Repayment Program until June 30, 2029

Rural Health Transformation Program Update

Background on the Rural Health Transformation Program

H.R.1 established the Rural Health Transformation Program, a $50 billion national program administered by the Centers for Medicare & Medicaid Services. These federal funds are distributed to all 50 states based on a semi-competitive application process over a five-year period, with the goal to strengthen access, quality, and sustainability of health care delivery for rural communities.

California was awarded $233.6 million for the first budget period (January–October 2026). The California program developed by HCAI revolves around three integrated initiatives, each approved by the federal government: the Transformative Care Model (TCM), Rural Workforce Development, and Technology and Tools, as described below:

- **Transformative Care Model:** Includes investments in regional hub-and-spoke care networks; expands telehealth services, eConsult, and evidence-based care models; and strengthens local capacity to reduce avoidable out-of-area travel for care.

- **Rural Workforce Development:** Supports workforce mapping, pipeline programs, clinical training capacity, targeted retention, and relocation incentives tied to service commitments in rural communities.

- **Health Technology & Digital Tools:** Investments in foundational infrastructure including Electronic Health Records, Data Exchange, and interoperability, telehealth expansion, cybersecurity. The program includes a Rural Health Technical Assistance Center to support implementation direct to participating grantees, across all components.

The program is designed to complement, not duplicate, existing state and federal programs by targeting gaps specific to rural health delivery systems, workforce shortages, and infrastructure limitations that are not otherwise addressed through existing funding streams.

On March 31, 2026, after approving a program modification submitted by HCAI, all $233.6M in federal funds are now “unrestricted” from CMS and available for distribution.

Implementation Timeline and Parameters

Grant opportunities under the California Rural Health Transformation Program will be offered on a rolling and phased basis, with multiple Request for Applications (RFAs) anticipated over the life of the program rather than as a single, one-time opportunity.

HCAI anticipates the following rollout:

- **Late Spring - Summer 2026**: RFAs anticipated for Accelerator Partnerships, Transformative Care Model, Workforce Development, and Technology & Tools initiatives.

- **Summer - Fall 2026**: Application reviews and award announcements, subject to CMS approval.

- Grantees must be approved by CMS before receiving funds; CMS may approve, request modifications, or deny awards

- All funds must be obligated by October 30, 2026, consistent with federal requirements under this cooperative agreement.

To be eligible, applicants must serve rural California communities and may include:

- Rural hospitals and critical access hospitals

- Clinics, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics, and Tribal clinics

- Tribal governments and Tribal organizations

- Local governments and nonprofit organizations

- Educational institutions and training partners
- Urban-based providers that deliver services into rural communities

According to HCAI, funding is intended for system transformation activities such as care model redesign, workforce development, regional coordination, and technology modernization. Funds may not be used for routine operating subsidies, direct patient care reimbursement, or to supplant any existing funding streams. All grant awards are subject to CMS review and approval prior to funding.

Panel

- Scott Christman, Chief Deputy Director, Department of Health Care Access and Information
- Michael Valle, Assistant Director, Department of Health Care Access and Information
- Victoria Rappleye, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Sara Swan, Principal Program Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff Recommendation:
Hold Open

4120 Emergency Medical Services Authority

Issue 3: EMSA Budget Overview and Budget Change Proposals

Background on the Emergency Management Services Authority (EMSA)

EMSA is the state entity providing statewide coordination for the planning, development, and implementation of local Emergency Management Services (EMS) systems. California has 34 local EMS systems that are providing emergency medical services for California's 58 counties.

Broadly, EMSA has three core functions:

- **Quality and Planning:** EMSA regulates local EMS systems through review of local EMS plans; provides oversight of state specialty care systems (e.g. trauma centers); and manages the California Poison Control system.

- **Professional Standards:** EMA sets standards for training, certification, licensing, and scope of practice for emergency medical services professionals including Emergency Medical Technicians (EMTs), paramedics, and public safety personnel (firefighters, peace officers, lifeguards); oversees the licensure and disciplinary management of paramedics statewide; and approves first aid and CPR training programs required for childcare providers and bus drivers

- **Disaster Medical Services:** EMSA coordinates California's medical response to disasters, is required and provides medical response resources to local governments in support of their disaster response when the disaster exceeds local capability.

2026-27 EMSA Budget Overview & Budget Change Proposals

The 2026-27 Governor's budget proposes a **$61.1 million budget and 119 staff positions** for EMSA. Of this total, $32.8 million is from the General Fund, and $28.2 million is from federal funding, reimbursements, and special funds.

The EMSA budget includes three budget change proposals, summarized below:

1- **Disaster Response Vehicle Replacement:** EMSA requests $2,550,000 in 2026-27 from the General Fund to replace critical disaster response vehicles essential for statewide medical operations. The requested funding would support the replacement of EMSA fleet vehicles identified as aging and at risk of mechanical failure.

2- **Security Architecture Compliance Assessment:** EMSA requests $250,000 one-time in 2026-27 from the General Fund to conduct initial activities to meet information technology cybersecurity requirements. This includes the implementation of Multifactor Authentication (the process to require more than one form of identify verification) and Zero Trust Architecture (a cybersecurity framework that authenticates every access request and anticipates cyberattacks)

3- **Human Resources, Enforcement and Legal Workload:** EMSA requests four positions and $1,368,000 in 2026-27 and $1,319,000 in 2027-28 and ongoing from the General Fund to support workload in the Human Resources Branch of the Administration Division, the Enforcement Branch of the Professional Standards Division, and the Legal Division.

Panel

- Gabrielle Santoro, Chief Deputy Director, Emergency Medical Services Authority
- Riley Thompson, Finance Budget Analyst, Department of Finance
- Nina Hoang, Principal Program Budget Analyst, Department of Finance
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff does not have any concerns about the three budget change proposals.

Staff Recommendation:
Hold Open

4800 Covered California (Health Benefit Exchange)

Issue 4: Covered California Budget and Operations in an Era of Federal Uncertainty

Background on Covered California

Covered California is the state's health benefit exchange, established under the federal Affordable Care Act and created by California statute in 2010. It is a 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 is primarily designed to serve low-to-middle income individuals and families who do not have access to affordable employer-sponsored insurance.

Covered California does not provide health care directly: it contracts with private health insurance plans, negotiates prices on behalf of consumers, and ensures that participating plans meet quality standards. All plans offered through Covered California must cover the ten essential health benefits required under the ACA, including preventive care, hospitalization, prescription drugs, and mental health services.

Covered California was established as an independent public entity, not affiliated with any state agency or department. It is governed by a five-member board: two members appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly, with the Secretary of California Health and Human Services serving as a voting ex officio member. Board members serve four-year terms and are required to have demonstrated expertise in areas such as health care finance, health plan administration, information technology, or enrollment assistance. The board hires an executive director who serves at the board's pleasure and is exempt from civil service.

Despite its independent status, Covered California remains subject to a number of statutes that govern its operations. For example, Government Code Section 100520 establishes Covered California’s budget, and explicitly prohibits the use of exchange funds for "staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications." The board is also subject to the Bagley-Keene Open Meeting Act, though it may hold closed sessions for matters related to litigation, personnel, contracting, and rates. Government Code Section 100503(q) further requires the board to be responsive to legislative requests for information, including providing testimony, commenting on proposed legislation, and preparing reports on Covered California -- activities the Legislature has explicitly declared to be "necessary state requirements."

Covered California's Budget Process

Covered California is entirely self-funded. Its primary revenue source is the participation fee: a charge assessed on insurance carriers based on the gross premiums they collect from enrollees. This fee is set by the board and is intended to be reasonable and necessary to support the development and operations of the exchange. Beyond its core marketplace operations, Covered California administers two state-funded programs on behalf of the State of California: the Health Care Affordability Program funded through the Health Care Affordability Trust Fund which provides state-funded financial assistance to enrollees, and the California Premium Tax Credit program funded through the state's General Fund. As an independent public entity, Covered California is largely not subject to the annual state budget process in the same way as other traditional state departments. The Covered California budget is developed by executive leadership and approved by its board, typically in May and June of each year, on a timeline that does not align with the Legislature's budget process.

Covered California's 2025-26 Budget

Key definitions:
Operating and capital expenditures *refer to Covered California's total annual spending on staffing, contracts, technology, marketing, facilities, and capital investments such as equipment and tenant improvements.*

Individual market participation fee *is the percentage of gross premiums that insurance carriers pay to Covered California in exchange for access to the Covered California marketplace. This fee is the exchange's primary revenue source and is ultimately reflected in premium costs paid by consumers.*

Working capital balance *is the accumulated reserve held by Covered California, the difference between total assets and total liabilities. Working capital enables the exchange to absorb operating losses in lean years without raising the participation fee abruptly.*

At the time of this agenda's publication, Covered California is still developing its FY 2026-27 budget, with a planned draft presentation to its board in May 2026 and board approval anticipated in June 2026. This section discusses Covered California's approved FY 2025-26 budget as context and framing for legislative oversight. It is important to note that this budget was built on assumptions that may have shifted materially since its approval.

The approved FY 2025-26 budget totals $496.1 million in operating and capital expenditures, authorizes 1,506 positions, sets the individual market participation fee at 2.25 percent, and begins the fiscal year with a working capital balance of approximately $578 million.

In developing its budget, Covered California acknowledged "significant uncertainty on multiple fronts," arising from proposed federal policy changes, an uncertain macroeconomic environment, and the potential expiration of enhanced federal premium tax credits. Those factors

have since fully materialized, as examined in depth at this subcommittee's March 9, 2026 hearing on the impacts of HR 1 and federal actions on the Covered California marketplace.

Covered California's FY 2025-26 budget approved in June 2025 projected the following outcomes for FY 2026-27 under its base enrollment scenario:

- Working capital declining to approximately $413 million as the exchange draws down excess reserves.
- Total operating expenditures growing to approximately $514 million, an increase of roughly 3.6 percent.
- The individual market participation fee rising from 2.25 percent to 2.75 percent.
- Average monthly enrollment declining to approximately 1.6 million members, reflecting projected losses following the expiration of enhanced federal premium tax credits.
- An operating loss of approximately $78 million, funded by working capital drawdown.

In discussions with the subcommittee, Covered California has indicated that enrollment is declining, working capital is decreasing as planned, and the exchange expects to lower the participation fee (however, it is understood that this is temporary, and that participation fees are expected to be raised in the coming years). In response to the changing fiscal environment. Covered California will present its board in May with a proposed budget that is less than current year's budget.

Of note, this trajectory represents a planned and structured fiscal adjustment. It is not considered a fiscal emergency. However, the scale of the change (declining enrollment, growing expenditures, and rising carrier fees) warrants careful legislative review, particularly as federal policy uncertainty continues to evolve.

Panel

- Kathleen Webb, Chief Deputy Executive Director of Operations, Covered California
- Jim Watkins, Chief Financial Officer and Director, Financial Management Division, Covered California
- Angel Coronel, Staff Services Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Min Lee, Economist, Legislative Analyst's Office

Staff Comments

Health care marketplace disruption will impact the exchange and warrants legislative review of Covered California's sustainability strategies. Covered California is entering a period of planned but consequential fiscal stress. The risks the exchange anticipated when developing its FY 2025-26 budget (declining enrollment, growing expenditures, and rising participation fees) have largely materialized. Federal policy changes, including HR 1, new federal marketplace rules, and the elimination of enhanced premium tax credits, have further pressured the exchange's revenue base. The result is a structural tension between lower consumer enrollment, lower revenues, and a budget that is projected to grow, which Covered California plans to manage through a combination of working capital drawdown and participation fee increases through 2028-29.

The Subcommittee may wish to ask:

1. With a clearer picture of the federal impact on the state exchange, how is Covered California adjusting its fiscal strategy as it develops its FY 2026-27 budget to ensure long-term sustainability?

2. Does Covered California anticipate any major changes in budget allocations or operational priorities for the upcoming and subsequent budget cycles?

3. What cost-containment strategies is Covered California deploying to protect long-term financial sustainability?

Staff Recommendation:
Hold Open

4150 Department of Managed Health Care

Issue 5: DMHC Budget Overview and Budget Change Proposals & Trailer Bill

Background on the Department of Managed Health Care (DMHC)

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 which regulates health care service plans.

- **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.

2026-27 DMHC Budget Overview

The 2026-27 Governor's budget proposes **$186 million and 798 staff positions** for the Department. DMHC is entirely funded through special funds, with the Managed Care Fund as the primary fund, which derives revenues from fees, assessments, and reimbursements collected by the Department as part of its regulatory and oversight duties.

Menopause Coverage: Trailer Bill & Budget Change Proposal

Menopause Budget Trailer Bill

The Governor's budget proposes the inclusion of a trailer bill that would expand coverage for menopause treatment, by (1) specifying that health plans, including Medi-Cal managed care plans, and health insurers must include coverage for evaluation and federal Food and Drug Administration (FDA)-approved, medically necessary treatments for menopause, (2) require health plans and health insurers to base their utilization review criteria on guidelines developed by relevant nonprofit professional associations; (3) improve enrollee access to and awareness of menopause treatment and symptoms; and, (4) increase provider education in menopause care. In the context of the proposed trailer bill, menopause is defined to include perimenopause, menopause, and postmenopause.

Specifically, the proposed trailer bill language would make the following changes:

1- **Rx Drug Coverage.** Specifies that health plans and health insurers that provide an outpatient prescription drug benefit include coverage for perimenopause and menopause evaluation and FDA-approved treatments including, but not limited to, hormone replacement therapy, low-dose antidepressants, mood stabilization medication, medications to prevent or treat osteoporosis, nonhormonal medications for hot flashes and night sweats, and bioidentical hormones, as medically necessary.

2- **Standards of Menopause Care**. When a health plan or health insurer makes a determination about whether menopause care is medically necessary for an individual or performs utilization review, the plan or insurer must base their criteria on generally accepted standards of menopause care from nonprofit professional associations for the relevant clinical specialties. The plan or insurer cannot use different or more restrictive decision criteria.

3- **Medi-Cal Program Menopause Coverage**. Codifies the Medi-Cal Program's menopause coverage policy, which includes FDA-approved treatments (both services integrated with primary care and OB/GYN services as well as prescription drugs), subject to medical necessity.

4- **Consumer and Provider Awareness**. Requires health plans and health insurers to increase provider and patient awareness regarding menopause health services. Health plans would be required to annually screen enrollees age 40 and older for menopause during primary care and OB/GYN appointments and provide these enrollees with a notice of the services available to them. Health plans would also be required to notify providers biannually of best practices for care.

5- **Menopause Care Reimbursements.** Requires health plans and health insurers to ensure that primary care providers and specialists are reimbursed for care, including reimbursement for menopause care integrated with primary care and OB/GYN services.

6- **Menopause-Certified Providers.** Allows qualifying physicians who complete continuing education courses in menopause care to receive two hours of credit for each hour completed. Requires health plans and health insurers to maintain policies to include menopause-certified providers in plan networks, and to incentivize in-network providers to become menopause-certified.

Menopause Budget Change Proposal

To implement the proposal described above, the DMHC requests two positions and $407,000 in 2026-27, $391,000 in 2027-28 and annually thereafter from the Managed Care Fund to support implementation of the proposed menopause coverage statutes.

In addition, California Health and Human Services Agency requests budget bill language authorizing the Department of Finance to provide up to $3 million General Fund in 2026-27 for a statewide public awareness campaign that would support greater understanding of perimenopause and menopause, the challenges facing women during the menopause transition, and how to access evaluation and treatments. The language specifies that the funds may be used for necessary personnel services expenditures, contracts, and interagency agreements.

Other Budget Change Proposals

The Governor's budget includes four additional budget change proposals:

1- **Pharmacy Benefit Manager Licensure and Data Requirements.** DMHC requests 8 positions and $5,641,000 in 2026-27, 9 positions and $4,333,000 in 2027-28, 10 positions and $4,426,000 in 2028-29, and 10 positions and $4,418,000 in 2029-30 and annually thereafter from the Pharmacy Benefit Manager Fund to replace the existing registration requirement for Pharmacy Benefit Managers (PBMs) with a licensure requirement for all PBMs operating in California that contract with either a DMHC licensed health plan or California Department of Insurance (CDI) licensed insurer. This proposal will also require the PBMs to report specified data to support a better understanding of their impact on prescription drug costs.

2- **Pharmacy Benefit Managers (SB 41 Implementation).** The DMHC requests seven positions and $1,721,000 in 2026-27, increasing to nine positions and $2,169,000 in 2027-28, and $2,160,000 in 2028-29 and annually thereafter from the Pharmacy Benefit Manager Fund to implement the requirements of Senate Bill 41 (Wiener, Chapter 605,

Statutes of 2025). The bill added additional legal requirements related to PBM revenue practices and pharmacy network reforms.

3- **Health Care Provider Credentials (AB 1041 Implementation).** The DMHC requests four positions and $1,196,000 in 2026-27, $1,166,000 in 2027-28, increasing to five ongoing positions and $1,434,000 in 2028-29, and $1,426,000 in 2029-30 and annually thereafter from the Managed Care Fund to implement the requirements of AB 1041 (Bennett, Chapter 630, Statutes of 2025). The bill expanded credentialing requirements for health plans and their delegates. Beginning January 1, 2028, every full-service health plan, or its delegate must subscribe to and use the Council for Affordable Quality Healthcare credentialing form except as otherwise specified.

4- **Prior Authorization Reporting (SB 306 Implementation).** The DMHC requests four positions and $1,449,000 in 2026-27, increasing to eight positions and $1,562,000 in 2027-28, and $1,809,000 in 2028-29 and annually thereafter from the Managed Care Fund to implement the requirements of SB 306 (Becker, Chapter 408, Statutes of 2025). The bill made changes to the prior authorization requirements and exemptions processes.

Panel

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

Staff Comments

Menopause Coverage Technical Amendments. The menopause coverage trailer bill has received technical assistance suggestions related to the continuing education provisions, including clarifying the definition of qualifying medical specialties and clarifying credit eligibility standards. The subcommittee will be collaborating with the Assembly Committee on Business and Professions and the Administration to address these technical clarifications.

Staff Recommendation:
Hold Open

This agenda and other publications are available on the Assembly Budget Committee's website at Sub 1 Hearing Agendas | California State Assembly:. You may contact the Committee at (916) 319-2099. This agenda was prepared by Patrick Le.