CMSP GOVERNING BOARD
MEETING AGENDA ITEM
SUMMARY REPORT

AGENDA ITEM

IV – State and Federal Health Program Changes and Implications for CMSP Counties

The federal Affordable Care Act (ACA) took effect January 1, 2014, and expanded Medi-Cal coverage to low-income adults with incomes up to 138% of the federal poverty level (FPL) and expanded marketplace coverage through Covered California to populations with incomes above 138% FPL. Prior to the ACA, CMSP monthly enrollment was over 80,000 members, most of which were enrolled in the CMSP Low Income Health Program (LIHP). The CMSP-LIHP provided a vehicle for early implementation of the Medi-Cal expansion in the 35 CMSP counties. Federal matching funds of 50% were provided for all health care services provided to CMSP-LIHP enrollees. Since 2014, enrollment in CMSP benefit programs (CMSP, Connect to Care and Path to Health) has not exceeded 20,000 total members.

Since 2014, the CMSP Governing Board has enacted many program changes designed to reach more of the remaining uninsured. These included the creation of new primary care benefit programs – Path to Health and Connect to Care – and a wide range of changes to CMSP eligibility, benefits, and financing that expanded eligibility and reduced or eliminated county financial contributions to CMSP. In addition, the Governing Board has enacted a variety of grant and healthcare workforce programs designed to support and expand the health care infrastructure in CMSP counties and provide funding to these counties to support local strategies to address local indigent health care needs.

Changes at the state-level enacted in the FY 2025-26 Budget Act and changes at the federal-level contained in HR-1 will reduce eligibility for certain current populations enrolled in Medi-Cal and are likely to make enrollment more difficult for many more. These combined changes will likely result in significant losses of Medi-Cal enrollment, and many that lose Medi-Cal coverage are expected to seek health care services from counties. The timing of these state and federal changes varies.

In addition, changes under HR-1 will reduce enrollment in Covered California, and if the enhanced premium subsidies that expire at the end of 2025 are not extended by Congress before the end of the year, these enrollment reductions will be substantially increased, resulting in an expansion of the uninsured, some of whom are expected to seek health care services from counties.

Governing Board staff, in collaboration with other county and state representatives, have worked to develop high-level estimates of the potential impacts of the state and federal changes on CMSP counties. These estimates are based on the most current state data available, including data on Medi-Cal enrollment, Covered California enrollment and

current populations in each CMSP county. The Executive Director will walk through the CMSP program pre- and post-ACA, CMSP program changes since the ACA, state and federal health program changes and their potential population impacts on CMSP counties (see attached).

Additionally, attached is an Issue Brief published by the California Healthcare Foundation titled, “Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses.” Key takeaways from the author include the following:

- California achieved its lowest uninsured rate ever in 2024 through Medi-Cal expansions and Covered California, which were made possible by the Affordable Care Act (ACA). However, millions of Californians, especially those with low incomes and many immigrants, face losing coverage in 2026 and beyond due to changing state and federal policies.
- California’s pre-ACA safety net for uninsured residents offers valuable lessons as policymakers consider how to address new coverage gaps, with some programs like the County Medical Services Program and Healthy San Francisco still operational and potentially adaptable.
- Key considerations for addressing the needs of newly uninsured Californians include whether to provide comprehensive or limited benefits, how to share responsibilities between state and counties, whether to standardize services statewide, and how to ensure continuity of care for those transitioning out of Medi-Cal.

RECOMMENDATION

Item is informational only.

ITEMS TO COVER

- CMSP Programs
- CMSP Revenues
- CMSP Expenditures
- CMSP Programmatic Changes
- State & Federal Changes

CMSP BENEFIT PROGRAMS (PRE-ACA)

Programs for Residents of CMSP Counties	CMSP COUNTY MEDICAL SERVICES PROGRAM	LIHP
Age Limit	21 - 64	19 - 64
Income Limit	200% FPL or less	100% FPL or less
Citizenship Requirement	Yes, for full-scope No, for limited scope (undocumented immigrants)	Yes
How to Enroll	County Social Services Dept	County Social Services Dept
Enrollment Term	6-months for full-scope 2-months for limited scope (undocumented immigrants)	6-months
Share of Cost (SOC)	Yes, for incomes above 100% FPL	No
Coverage for No-Cost Primary Health Care	Yes, with SOC & certain limits	Yes, with certain limits
Coverage for Basic Prescription Medications	Yes, with SOC & certain limits	Yes, with certain limits
Coverage for Dental, Emergency Room, Urgent Care, & Inpatient Hospital Services	Yes, with SOC & certain limits	Yes, with certain limits

CURRENT CMSP BENEFIT PROGRAMS

Programs for Residents of CMSP Counties	CMSP COUNTY MEDICAL SERVICES PROGRAM	CONNECT TO CARE BY CMSP
Age Limit	21 - 64	21 - 64
Income Limit	138% - 300% FPL <138% FPL with certain deductions	138% - 300% FPL
Citizenship Requirement	No	No
How to Enroll	County Social Services Dept & Participating Health Centers	Participating Health Centers
Enrollment Term	Up to 6 months	Up to 6 months
Share of Cost (SOC)	Yes, for incomes above 138% - 300% FPL	No
Coverage for No-Cost Primary Health Care	Yes, with certain limits	Yes, with certain limits
Coverage for Basic Prescription Medications	Yes, with $5 copay & certain limits	Yes, with $5 copay & certain limits
Coverage for Dental, Emergency Room, Urgent Care, & Inpatient Hospital Services	Yes, with SOC & certain limits	No, application needed for CMSP

CMSP REVENUES PRE-ACA & RECENT

Revenue Sources	FY 2012-13 Program Budget*	FY 2023-24 Program Budget
County Realignment	$89,068,961	$0
CMSP Realignment	$127,061,881	$0
County Participation Fees	$5,459,395	$0
Federal Match	$164,528,229	$0
Other	$9,013,567	$10,029,954
Total Revenue	**$395,132,033**	**$10,029,954**

** Final FY of federal matching funds for Low Income Health Program (LIHP) due to early ACA implementation*

CMSP EXPENDITURES PRE-ACA & RECENT

Expenditures	FY 2012-13 Program Budget*	FY 2023-24 Program Budget
Medical & Pharmacy	$365,138,204	$5,438,992
Grant Programs	$900,012	$12,579,730
County Eligibility Administration	$20,084,748	$120,215
Other	$2,841,142	$3,440,538
Total Expenditures	**$388,964,106**	**$21,579,475**

	FY 2012-13	FY 2023-24
Total Enrollment	72,211	7,870

** Final Full FY of LIHP*

CMSP PROGRAMMATIC CHANGES SINCE ACA (CURRENT)

BUDGET

Date	Summary
7/2014	Board approved waiving CMSP county participation fees of $5.9 Million per year
7/2014	Board approved provider and hospital rate increases
7/2018	Board allocated annual funds for marketing and media expenses
12/2020	Board launched the Connect to Care benefit program
7/2025	Board launched CMSP in mCase

ELIGIBILITY

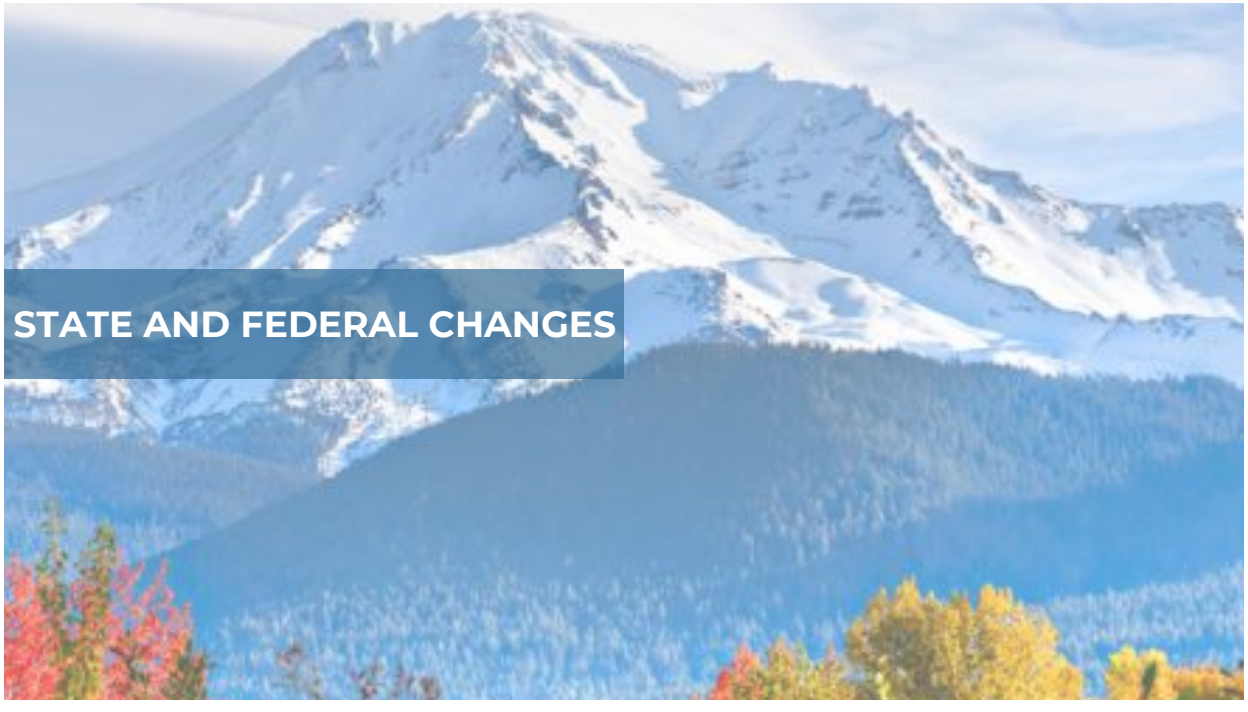
Date	Summary
5/2016	Board approved increasing the upper income limit for CMSP from 200% FPL to 300% FPL
5/2016	Board approved increasing the asset limit for CMSP applicants with incomes above 138% FPL to 300% FPL from $2,000 individual / $3,000 couple to $20,000 individual / $30,000 couple
5/2016	Board approved removing asset limit for CMSP applicants with incomes up to 138% FPL
5/2016	Board approved 75% reduction to the monthly SOC amount for CMSP members with incomes above 138% FPL to 300% FPL
5/2016	Board approved removing monthly Share of Cost (SOC) amount for CMSP applicants with incomes up to 138% FPL
5/2016	Board approved increasing the retroactive coverage period from 10-days to 1 month
5/2016	Board approved increasing CMSP enrollment terms from a minimum of 2-months to 6-months
10/2023	Board approved removing the requirement for CMSP applicants to apply for Covered California

BENEFITS

Date	Summary
9/2018	Board approved coverage for selected primary care and pharmacy services without CMSP members having to meet monthly SOC amount
7/2021	Board approved coverage under CMSP for chiropractic services
7/2023	Board approved coverage under CMSP for additional benefits including vision, audiology, and dental services
7/2023	Board increased coverage for undocumented immigrants from emergency services only to full-scope coverage
7/2023	Board approved coverage under CMSP for additional benefits including outpatient substance use disorder treatment services and mental health services

GRANTS

Date	Summary
10/2019	Board approved $50 Million for Local Indigent Care Needs Grants and Technical Assistance ($46.9 Million committed)
12/2022	Board approved $10 Million for Healthcare Infrastructure Development Matching Grants ($2.2 Million committed)
12/2024	Board approved $14 Million for Building the Healthcare Workforce Grants ($2.9 Million committed)
12/2024	Board approved $7.1 Million for continuation of the Loan Repayment Program ($1 Million committed)
1/2025	Board approved $2.98 Million for Scholarships ($1.1 Million committed)



STATE AND FEDERAL CHANGES

MEDI-CAL & COVERED CA CHANGES FOR FY 2025-26

Date	Level	Action	Potential Impact to CMSP
8/31/2025	State	DACA eligibility eliminated from Covered CA	Not likely (estimate in CMSP counties is up to 240 persons)
Fall 2025	Federal	Enhanced exchange (Covered CA) subsidies cease	TBD, pending federal action (if no action, estimate in CMSP counties is up to 38,000 persons)
1/1/2026	State	Reinstatement of the Medi-Cal asset limit	Not likely
1/1/2026	State	Enrollment freeze of full-scope Medi-Cal coverage for undocumented ages 19 and older	Not likely

MEDI-CAL & COVERAGE CA CHANGES FOR FY 2026-27

Date	Level	Action	Potential Impact to CMSP
10/1/2026	Federal	Restrictions on lawfully present immigrants for Medi-Cal eligibility	Likely (estimate in CMSP counties is up to 19,000 persons)
1/1/2027	Federal	Restrictions on lawfully present immigrants for Covered CA eligibility	Likely (estimate in CMSP counties is up to 10,000 persons)
1/1/2027	Federal	Redetermine eligibility for Medi-Cal expansion adults once every six months	Unknown
1/1/2027	Federal	Retroactive coverage reduction to 1 month for Medi-Cal expansion adults and 2 months for other Medi-Cal enrollees	Not likely
1/1/2027*	Federal	Implement mandatory work requirements for Medi-Cal expansion adults	Likely (estimate in CMSP counties is up to 73,000 persons)

***** *With federal approval, State has option to delay the implementation of work requirement until 12/31/28*

MEDI-CAL & COVERAGE CA CHANGES FOR FY 2027-28

Date	Level	Action	Potential Impact to CMSP
7/1/2027	State	Medi-Cal imposes monthly premiums for undocumented ages 19-59	Unknown
1/1/2028	Federal	New Covered California applicants needing specified verifications	Unknown
10/1/2028	Federal	Cost sharing of up to $35 per service for Medi-Cal expansion adults	Not likely

CHCF Issue Brief

SEPTEMBER 2025

by Len Finocchio, DrPH

Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses

After over a decade of expanding coverage and achieving the lowest uninsured rate ever in the state, California now faces the possibility of millions of people losing health care coverage due to state and federal policy changes, especially those with low incomes and those with unsatisfactory immigration status (UIS). State policymakers and leaders from the health care delivery system, including health plans, providers, and counties, may need to rethink and possibly redesign what safety-net health care services look like for people who are uninsured. These will be challenging conversations involving eligibility, benefits, systems of care, and financing.

To inform that dialogue, this paper:

- Provides a concise overview of how California achieved its lowest-ever uninsured rate over the last decade through policy changes like the Affordable Care Act and Medi-Cal expansions to Californians regardless of immigration status.
- Describes pre–Affordable Care Act approaches to providing coverage and health care services to people who were uninsured.
- Raises high-level considerations for policymakers and delivery system leaders and experts that should be part of discussions when planning for if and how the state can provide health care services to newly uninsured Californians, particularly those with lower incomes.

Background: How California Achieved Its Lowest-Ever Uninsured Rate

Since Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010, the percentage of Californians without health insurance has dropped from 15% in 2013 to 8% in 2024.[1] This rise in insurance coverage is due primarily to the implementation of key ACA components in California: adopting the optional Medicaid expansion for adults without dependents, establishing a state-based health benefit exchange (Covered California) for individuals and small businesses, and enforcing health insurance consumer protections. These major changes led to dramatic growth in health care coverage for Californians with lower incomes: Medi-Cal enrollment has grown from 8.4 million people in 2013 to 15 million today, and a decade after its launch, Covered California now insures 2 million people.[2] Table 1 below shows the number of enrollees in each of the Medi-Cal expansion groups described in the section above. See Appendix A for expansion enrollment population by county.

California's commitment to achieving universal coverage also extends to people with UIS. According to a study by the Bay Area Council, 1.5 million of California's 2.3 million immigrants with UIS make up 8% of the state's workforce and contribute $23 billion annually in state, federal, and local taxes.[3] Yet immigrants with UIS have the highest rate of uninsurance.[4]

Research shows that people without insurance face serious barriers to care:[5]

- They are less likely to have a regular doctor or health clinic.
- They delay getting care because of cost concerns.
- They experience more preventable hospitalizations.
- They have poorer health overall.

Studies show that Medicaid expansions save lives. Research found that expanding Medicaid reduced deaths among adults with low incomes by 21%. This life-saving impact was seen across all age groups, including younger adults.[6]

Figure 1. Timeline of Insurance Coverage Expansions in California, 2010–24

- **2010:** Bridge to Reform Section 1115 demonstration waiver and Low-Income Health Program
- **2013:** Healthy Families Program transitions into Medi-Cal
- **January 2014:** ACA Optional Medicaid Adult Expansion
- **January 2014:** California Health Benefit Exchange
- **May 2016:** Medi-Cal expansion to all income-eligible children and youth under 19
- **January 2020:** Medi-Cal expansion to all income-eligible people age 19–26
- **May 2022:** Medi-Cal expansion to all income-eligible people over 50
- **January 2024:** Medi-Cal expansion to all income-eligible people age 26–49
- **January 2024:** Elimination of the asset test as Medi-Cal eligibility requirement
- **January 2026:** Enrollment moratorium for UIS adults 19 and older in full-scope Medi-Cal
- **January 2026:** Reinstate asset test as a Medi-Cal eligibility requirement

Note: *UIS* is unsatisfactory immigration status.

Sources: "Medi-Cal Facts and Figures Almanac, 2024 Edition, CHCF, June 2024; California Section 1115 Comprehensive Demonstration Project Waiver. A Bridge to Reform: A Section 1115 Waiver Proposal (PDF), DHCS, June 3, 2010; Healthy Families Program Transition to Medi-Cal: Final Comprehensive Report (PDF), DHCS, February 4, 2014; S.B. 1, 2013–14 Leg., Reg. Sess. (Cal. 2014); "California's Health Benefit Exchange," Covered California, accessed July 2, 2025; S.B. 75, 2015–16 Leg., Reg Sess. (Cal. 2016); A.B. 133, 2021–22 Leg., Reg. Sess. (Cal. 2021); and A.B. 116, 2025–26 Leg., Reg. Sess. (Cal. 2025)."

Table 1. Medi-Cal Expansion Populations, May 2025

POPULATION	ENROLLMENT
ACA Medicaid Expansion	
Expansion adults	5,065,200
Children under 19 with UIS	
Children under 19	217,550
Adults with UIS	
Adults 19–25	152,912
Adults 26–49	849,349
Adults 50+	445,707
Total adults with UIS	**1,447,968**

Note: *UIS* is unsatisfactory immigration status.

Sources: *2025–26 May Revision: Department of Health Care Services Highlights* (PDF), California Department of Health Care Services, May 14, 2025, 8; "SB 75 - Full Scope Medi-Cal for All Children," California Health and Human Services Agency (CalHHS), last updated August 13, 2025; "Young AE (19–25) Population (by County)," CalHHS, last updated August 13, 2025; "Age 26–49 AE Population (by County)," CalHHS, last updated August 13, 2025; and "Older AE (50 and Over) Population (by County)," CalHHS, last updated August 13, 2025.

Learning from Programs Past: Health Care Services Programs for the Uninsured Before the ACA

Before the ACA and other expansions of Medi-Cal, California and its 58 counties had a confusing patchwork of programs to provide a range of services to the uninsured. Each program was unique in its design, benefits covered, eligibility requirements, financing, and other features, and few counties provided care for Californians with UIS. These pre-ACA programs can be sorted into three groups: state programs, hospital charity care and discount programs, and county programs. Many of these programs remain operational today. The descriptions below are complemented by an overview in Appendix B.

State Programs

Over time, the state implemented several programs targeting narrow groups of people who were uninsured. Examples include:

- Major Risk Medical Insurance Program
  - The Major Risk Medical Insurance Program (MRMIP) was narrowly focused and provided health insurance for California residents unable to obtain insurance in the individual health insurance market due to preexisting conditions (before the ACA, individual market plans could deny coverage because an applicant had a preexisting condition).
  - Eligible adults could not have had Medicare or been eligible for Medi-Cal but denied coverage due to a preexisting condition in the preceding 12 months.
  - Eligible people were subject to a three-month waiting period before receiving minimum essential coverage (excluding dental and vision services) and had monthly premiums, an annual deductible, cost sharing, and a lifetime cap.
  - Services were provided through contracted health plans. Funding came largely from the state General Fund, with some portion temporarily provided through the Pre-Existing Condition Insurance Plan created by the Affordable Care Act.[7]
  - As of January 1, 2025, per Senate Bill 159, coverage through MRMIP was terminated and enrollees were transitioned to Covered California.[8]
- Restricted Scope Medi-Cal
  - Provides a limited set of benefits (e.g., emergency and pregnancy-related services) to those not meeting eligibility requirements. Restricted scope Medi-Cal remains available today.
  - Funding comes from both the state General Fund and federal financial participation.[9]
- Medi-Cal Presumptive Eligibility
  - Provides full-scope benefits through fee-for-service providers for up to 60 days for those self-attesting to selected eligibility requirements with no documentation required. Enrollment is done electronically through selected providers. The program limits the number of times presumptive eligibility benefits can be received: twice in 12 months for children, once in 12 months for adults, once per pregnancy for pregnant people.
  - Medi-Cal presumptive eligibility has evolved over the years and remains available today.
  - Funding for Medi-Cal presumptive eligibility benefits come from the state General Fund and federal financial participation.[10]
- Breast and Cervical Cancer Treatment Program
  - Provides coverage for cancer treatments to eligible low-income California residents diagnosed with breast or cervical cancer. The program remains available to the eligible today.
  - Funding comes from the state General Fund and federal financial participation.[11]
- Family Planning, Access, Care, and Treatment
  - Provides comprehensive family planning and reproductive health services at no cost to eligible low-income Californians through a network of enrolled providers. The program remains available today.
  - Funding comes from the state General Fund and federal financial participation.[12]

- Low-Income Health Program
  - As part of the 2010 Bridge to Reform 1115 demonstration waiver of the California Department of Health Care Services (DHCS) leading up to the ACA Medicaid expansion, 54 counties participated in the Low-Income Health Program (LIHP) managed by DHCS.[13]
  - County participation in LIHP was voluntary for counties and included two programs for which eligibility had to follow Medicaid eligibility rules: the Medicaid Coverage Expansion (MCE) for those with incomes below 133% of the federal poverty level (FPL) and the Health Care Coverage Initiative (HCCI) for those with income above 133% FPL but below 200% FPL.
  - LIHP programs offered a core set of benefits (e.g., outpatient and acute inpatient hospital services, prescription medications, physical therapy) through MCE and HCCI and several additional benefits through MCE (e.g., minimum mental health services, nonemergency medical transportation). Counties used local funds to claim federal matching to finance services and administration. LIHP did not cover residents with UIS. At its peak, county LIHP programs provided services to some 650,000 California residents.
  - The LIHP program ended after the launch of Medi-Cal expansion in January 2014 and LIHP enrollees were transitioned into Medi-Cal.

Hospital Charity Care and Discount Payment Programs

While not an organized program, state laws providing guidelines for hospital "charity care" programs have been in place for decades. Since 2007, acute care, psychiatric, and specialty hospitals must provide information to the uninsured about available charity care, discounted payment programs, and government-sponsored health insurance. Recent laws, generally called Hospital Fair Pricing policies, have clarified eligibility requirements for hospital charity care and discount programs, increased standardization of billing and collections, and added other consumer protections. Starting January 1, 2025, hospitals must offer financial assistance to those without insurance with incomes up to 400% FPL.[14]

County Programs for the Uninsured

Before the ACA, counties had wide discretion to provide services to medically indigent adults (MIA) as required by their Welfare and Institutions Code Section 17000 obligation as the "provider of last resort."[15] Some counties had more than one program for uninsured adults. A 2019 paper from Insure the Uninsured Project offers a detailed resource of these programs by county, many of which remain operational but have adapted programmatic features since the various Medi-Cal expansions described above.[16] As described in that brief, there were four models of MIA programs:

- Provider counties that use county-operated hospitals and clinics to provide services.
- Payer counties that contract with or pay private hospitals, clinics, and providers to deliver care.
- Hybrid counties that provide some services through county clinics but contract other services to private hospitals.
  - County Medical Services Program for 35 counties with populations under 300,000 that contracts with a provider network (see the longer description below). The program is still operational.

Eligibility for these programs varied by age group, family income, and immigration status, and many had specific periods for eligibility to receive services (e.g., from several months to a full year). Benefits varied by county and program, and they ranged from primary care and preventive services only to extensive benefits, including inpatient hospital care, pharmacy, behavioral health, and dental services. Financing these

MIA programs were a combination of county General Funds and state realignment funds provided to counties for this and other related purposes.

One example of these programs is My Health LA. It was an outgrowth of the Los Angeles County LIHP program Healthy Way LA and provided primary and specialty care for residents of Los Angeles County age 26–49 with incomes at or below 138% FPL and who were not eligible for other coverage. Participants were required to have a medical home to coordinate and manage their care. Enrollees received services from a network of contracted clinics as well as Los Angeles Department of Health Services clinics and hospitals. My Health LA was operational from October 2014 to January 31, 2024, when the program ended due to the Medi-Cal expansion, and its 87,000 enrollees were transitioned to Medi-Cal.[17]

Continuing County Programs Post-ACA Implementation

Many counties continue to operate their MIA programs, though several have closed completely. These programs are not standardized and have varying program eligibility requirements, services provided, and other features. Some do not cover the immigrants with UIS who are ineligible for Medi-Cal. Most have evolved their eligibility and other program features since the Medi-Cal expansions to offer services to those not income-eligible for Medi-Cal. Most remaining programs make it clear that they are not offering insurance coverage. With the ACA optional expansion of Medi-Cal, the state and counties passed AB 85 in 2013 redirecting realignment funds away from county indigent programs to CalWORKs grant increases.[18] See Appendix C for a description of counties with operational programs.

Two examples of these county-based programs are the County Medical Services Program and Healthy San Francisco.

The County Medical Services Program

The County Medical Services Program (CMSP) continues to operate in 35 mostly small and rural counties, providing health coverage for uninsured low-income, indigent adults age 21–64 with incomes under 300% FPL who are not otherwise eligible for other publicly funded health care programs, notably Medi-Cal. A governing board sets policy for the program, and each county contracts with CMSP to provide services in that county.[19]

The CMSP does cover residents with UIS. The covered benefits, while broad, are not comprehensive (e.g., pregnancy-related services and long-term care are not included).[20]

Services are subject to prior authorization and medical necessity requirements, a share of cost, and some benefit limits. Interested people enroll through county health and human services departments.

Starting in 2020, the CMSP added the Connect to Care program offering preventive health services and prescription drugs, with enrollment directly through participating community providers such as clinics and pharmacies.

Healthy San Francisco

- Healthy San Francisco was established in 2007 and covers San Francisco residents age 18 and older with income up to 500% of the FPL who are uninsured and ineligible for Medi-Cal or Medicare.
- The program offers a wide range of services, including primary and preventive care, prescription drugs, inpatient services, and mental health services from the network of providers.
- Healthy San Francisco is funded through fees imposed on local businesses and patient copayments.
- Participants have a medical home and receive services from a network composed of San Francisco Department of Public Health clinics, San Francisco

Community Clinic Consortium clinics, and other providers within the City and County of San Francisco.

Issues, Considerations, and Questions for Providing Health Care Services to the Uninsured

After over a decade of expanding coverage and achieving the lowest uninsured rate ever in the state, California now faces the possibility, due to state and federal policy changes, of nearly four million people losing health care coverage, especially those with low incomes or UIS.[21] State policymakers and leaders from the health care delivery system, including health plans, providers, and counties, may need to rethink and possibly redesign what safety-net health care services look like for people who are uninsured. These will be challenging conversations, involving discussions around eligibility, health care services, systems of care, and financing. This will require discussions among state and county policymakers, Medi-Cal leadership, managed care plans, hospitals, clinics and other providers, advocates, and Medi-Cal enrollees who may face a transition. Table 2 lists a few high-level issues, considerations, and questions that could be addressed during those discussions.

Table 2. Issues, Considerations, and Questions for Providing Health Care Services to the Uninsured

ISSUE	CONSIDERATIONS AND QUESTIONS
Values	▸ What values and goals would frame these discussions and decisionmakings? ▸ How will the state protect the health of uninsured Californians, regardless of immigration status? ▸ How could this be an innovative opportunity to build upon the universal coverage system that the state has built up over the past decade? ▸ Is it the goal of this effort to provide every income-eligible uninsured Californian, regardless of immigration status, the same coverage as full-scope Medi-Cal, including physical care, behavioral health care, prescription drugs, long-term care, In-Home Supportive Services, and dental services? ▸ Or is it the goal to provide a limited set of services designed to keep people as healthy as possible? ▸ Is it a goal to provide these same services statewide? Or to allow counties to choose different programs, eligibility requirements, and services?
Leadership and governance	▸ How should these health care services be governed? ▸ The statewide Medi-Cal program has systematically taken most of the responsibility for the health care coverage of low-income uninsured people back from counties since 2014. Should the state maintain this responsibility? ▸ How will or could these responsibilities be shared by the state and counties, safety-net hospitals and clinics, private hospitals and providers, employers and individuals?
Adapting or building upon previous or existing coverage programs	▸ How should a program for this population be structured? ▸ What past or existing state and county programs could be adapted or used as models to provide meaningful health and other services to uninsured Californians (e.g., LIHP, CMSP, Healthy Way LA, Healthy San Francisco, MRMIP)? ▸ What new and innovative approaches to programs might offer coverage or services to California's uninsured? ▸ Would health care services require premiums, copayments, or a share of cost? If so, would these vary based on family size, age, income? Who would collect these? ▸ Would eligibility and enrollment processes be uniform across the state and counties?

Health care services	➤ Which health care and other services should be provided? ➤ Would services be extensive or limited? ➤ Primary care and prevention only? Prescription drugs? Long-term care? Dental care? ➤ Should behavioral health services be included? Hospital inpatient services? ➤ Should covered services mirror the "minimum essential coverage" provided in Covered California and Medi-Cal? ➤ To what degree would new or expanded programs be required to keep existing Medi-Cal providers?
Financing and realignment	➤ How should these health care services be financed? ➤ Should the state dedicate General Fund and other resources specifically to providing services to the uninsured? ➤ Should the state decide to once again "realign" responsibility for the uninsured back to counties, and how would costs be determined (e.g., number of uninsured served, health care services covered, age)? ➤ Would such a realignment to counties create a state mandate? How would the state and counties share costs? ➤ Would existing realignment statutes and formulas need to be renegotiated or amended? If so, how? ➤ Should employers participate financially in supporting coverage for employees? If so, how? Would it vary based on the size of the business?
Minimizing harmful impact on people	➤ How will establishing or adapting programs for the uninsured minimize negative impacts on those who transition out of Medi-Cal? ➤ For current Medi-Cal enrollees who drop from coverage, how would continuity of care be addressed as they move to a different program or change providers? Would existing Medi-Cal continuity of care policies apply? ➤ Would the state, counties, and providers engage in a planning process to facilitate such transitions? ➤ How would the recent Medi-Cal unwinding and managed care plan transition inform such planning and implementation?

"Notes: *LIHP* is Low Income Health Program; *CMSP* is County Medical Services Program; *MRMIP* is Major Risk Medical Insurance Program."

Conclusion

As California grapples with an evolving coverage landscape, this paper offers a foundation for informed, forward-looking policy and delivery-system planning. By reflecting on past successes and anticipating future challenges, it aims to support efforts to protect and reimagine care for the state's most vulnerable residents.

Appendix A. Medi-Cal Expansion Populations, May 2025 and August 2024

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Alameda	10,884	8,100	34,751	14,536	181,032	249,303
Alpine	†	†	‡	†	96	96
Amador	16	11	94	38	2,862	3,021
Butte	389	228	1,199	535	28,167	30,518
Calaveras	33	19	121	74	4,503	4,750
Colusa	135	75	303	166	2,538	3,217
Contra Costa	7,271	4,781	17,912	7,485	109,706	147,155
Del Norte	25	‡	95	78	3,578	3,776
El Dorado	274	151	1,010	411	14,104	15,950
Fresno	6,475	4,270	19,464	7,871	156,436	194,516
Glenn	184	116	587	272	3,440	4,599
Humboldt	193	156	978	322	21,913	23,562
Imperial	338	102	699	336	26,478	27,953
Inyo	48	27	148	95	1,716	2,034
Kern	6,647	4,401	22,895	9,964	131,818	175,725
Kings	764	522	2,112	986	18,749	23,133
Lake	586	273	1,274	381	10,095	12,609
Lassen	12	‡	58	29	2,533	2,632
Los Angeles	66,641	49,553	311,750	200,863	1,480,597	2,109,404
Madera	1,314	963	5,640	1,907	22,484	32,308
Marin	1,952	2,152	7,038	1,978	20,497	33,617
Mariposa	11	‡	55	22	2,069	2,157
Mendocino	642	342	2,087	780	14,039	17,890
Merced	2,125	1,318	7,019	2,704	40,027	53,193
Modoc	35	16	72	23	1,034	1,180

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Mono	63	41	233	87	1,317	1,741
Monterey	3,965	3,830	20,351	5,968	51,329	85,443
Napa	816	573	2,436	1,168	11,017	16,010
Nevada	128	78	525	187	10,707	11,625
Orange	14,734	9,955	61,444	35,888	373,166	495,187
Placer	738	376	2,102	744	25,339	29,299
Plumas	19	15	44	20	1,842	1,940
Riverside	9,931	6,001	38,114	20,345	314,980	389,371
Sacramento	6,214	3,818	20,717	7,823	197,282	235,854
San Benito	307	206	1,145	455	6,219	8,332
San Bernardino	8,712	5,122	34,641	19,495	299,244	367,214
San Diego	10,391	6,001	37,292	22,228	370,813	446,725
San Francisco	4,568	4,295	16,782	6,589	97,612	129,846
San Joaquin	4,210	2,336	14,125	5,429	85,817	111,917
San Luis Obispo	1,116	835	3,252	1,034	23,000	29,237
San Mateo	7,190	5,559	23,669	9,456	60,207	106,081
Santa Barbara	4,106	4,278	17,852	4,900	52,823	83,959
Santa Clara	12,876	8,356	43,625	21,384	156,282	242,523
Santa Cruz	916	907	5,035	2,030	28,683	37,571
Shasta	138	73	417	145	19,391	20,164
Sierra	‡	‡	‡	‡	225	225
Siskiyou	104	28	249	109	5,562	6,052
Solano	2,277	1,436	6,732	2,815	47,887	61,147
Sonoma	2,615	1,725	9,177	3,937	47,960	65,414
Stanislaus	4,168	2,182	12,204	5,001	73,675	97,230
Sutter	556	367	1,986	659	12,033	15,601

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Tehama	433	243	1,228	513	8,018	10,435
Trinity	‡	‡	48	‡	1,863	1,911
Tulare	4,127	2,652	15,290	6,825	86,914	115,808
Tuolumne	‡	17	71	25	4,857	4,970
Ventura	4,046	3,448	17,844	7,051	86,748	119,137
Yolo	676	393	2,268	1,078	19,913	24,328
Yuba	416	190	1,090	463	10,197	12,356
Statewide	**217,550**	**152,912**	**849,349**	**445,707**	**4,893,433**	**6,188,489**

* The ACA Expansion Adult enrollment figure here differs from that in Table 1, as this source with county data has August 2024 figures.

† County not included in the dataset.

‡ Cell suppressed due to small numbers.

Sources: "Medi-Cal Adult Full Scope Expansion Programs," California Health and Human Services Agency (CalHHS), August 13, 2025; "SB 75 - Full Scope Medi-Cal for All Children," CalHHS, last updated August 13, 2025; "Certified Eligible Individuals, by Aid Code, 2010 to the Most Recent Reportable Month," CalHHS, last updated August 13, 2025; and "Medi-Cal Certified Eligibles Data by Month with Demographics, by Aid Category," CalHHS, last updated July 3, 2025

Appendix B. County and State Programs for the Uninsured

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
County Programs					
County medically indigent adult programs (see Appendix C) have wide discretion to provide services to uninsured adults. Large counties typically have their own programs. Smaller counties participate in CMSP. **Financing.** County General Fund and some state realignment funds. **Status.** Many medically indigent adult programs have closed. Those still operational have adapted eligibility and other features to adapt to Medi-Cal expansions (see Appendix A).	Varies by county but typically not eligible for Medi-Cal or other insurance coverage. **Income eligibility.** Ranges from <100% of the federal poverty limit (FPL) to <500% FPL. Some counties include an asset test. **Age eligibility.** Varies by county: no age restriction, over 19, 19–64, and under 64. **Immigration status restriction.** Varies by county.	Varies by county. A few counties provide extensive benefits but most provide limited or moderate coverage, such as prevention and primary care services; some offer specialty care, mental health, and dental. Some counties offer discount programs to support payment for services.	Varies by county and could include premiums, copays, and deductibles.	Models of medically indigent adult programs: ▸ Provider counties that use county-operated hospitals and clinics ▸ Payer counties that contract with or pay private hospitals, clinics, and providers ▸ Hybrid counties that provide services through county clinics but contract other services to private hospitals.	California Welfare and Institutions Code Section 17000[22]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Low-Income Health Program (LIHP) was a voluntary county-funded program administered by the county health department or social services agency. LIHP included two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). **Financing.** County funds with federal reimbursement. CMS-approved claims process for counties to receive federal reimbursement for LIHP costs. **Status.** Programs transferred enrollees into Medi-Cal in January 2014 and subsequently closed.	Ineligible for Medicaid and Children's Health Insurance Program, not pregnant. For MCE, a person may have other health insurance as long as they meet the other program requirements for enrollment. For HCCI, a person must not have other health coverage and must meet all other program requirements for enrollment. **Income eligibility.** For MCE, family income at or below 133% FPL. For HCCI, family income above 133% and up to 200% FPL. **Age eligibility:** 19–64. **Immigration status restriction.** Required proof of US citizenship or satisfactory immigration status.	LIHP programs offered a core set of benefits (e.g., outpatient and acute inpatient hospital services, prescription medications, lab services, physical therapy) through MCE and HCCI and several additional benefits through MCE (e.g., minimum mental health services, nonemergency medical transportation). Both MCE and HCCI program also provided care coordination.	No	Varied by county but largely existing safety-net providers. Enrollees were assigned to a medical home.	Bridge to Reform Section 1115 Medicaid Demonstration waiver (PDF)[23]
County Medical Services Program (CMSP) provides health coverage for uninsured low-income, indigent adults not eligible for other publicly funded health care programs. CMSP serves 35 small and rural counties with populations under 300,000. **Status.** CMSP has been operational since 1983 and still offers services to eligible people.	Residents not eligible for publicly funded health care programs, notably Medi-Cal. **Income eligibility.** Under 300% FPL. **Age eligibility.** Adults 21–64. **Immigration status restriction.** None.	**Connect to Coverage program.** Routine preventive care, some mental health services, and prescription drugs. Maximum prescription drug benefit of $1,500. **CMSP benefit.** Broad but not comprehensive (e.g., pregnancy-related and long-term care services are excluded). Services are subject to prior authorization, medical necessity requirements, and some benefit limits.	Copays for prescriptions in the Connect to Coverage program and share of cost for some services (depending on income).	Contracted community health clinics and hospitals.	Welfare & Institutions Code Sections 16809 et seq.[23] CMSP Governing Board Regulations (PDF) [24]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Statewide Programs					
California Major Risk Medical Insurance Program (MRMIP) provided health insurance for residents unable to obtain insurance in the individual health insurance market due to preexisting conditions. **Financing.** State funds with temporary ACA funding through Pre-Existing Condition Insurance Plan program. **Status.** Terminated January 1, 2025.	Unable to obtain other coverage. Enrollment subject to a maximum enrollment cap and waiting list. **Income eligibility.** No. **Age eligibility.** No. **Immigration status restriction.** Must be California resident.	Comprehensive but no dental or vision coverage. **Other features.** Covered enrollee dependents.	Yes. Premium, $500 deductible (not applied to certain preventive services), out-of-pocket maximum, $75,000 annual cap, $750,000 lifetime cap.	Contracted health plans.	Welfare and Institutions Code Section 15870[25] Terminated in SB 159[26]
Restricted Scope Medi-Cal provides a limited set of benefits. It may also be referred to as "Emergency Medi-Cal." **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligible people.	**Income eligibility.** Same income and other requirements as Medi-Cal eligibility. **Immigration status restriction.** Must be California resident.	Provides emergency and pregnancy-related services to those not meeting eligibility requirements.	No	All enrolled Medi-Cal providers.	
Medi-Cal Presumptive Eligibility ▶ Children's ▶ Hospital ▶ Pregnant People **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligible people.	Self-attestation to: ▶ California residency ▶ Not enrolled in Medi-Cal ▶ Within household income limits ▶ Not exceeded Presumptive Eligibility enrollment period limitations **Age eligibility.** Under 19 for children. **Immigration status restriction.** Must be California resident. Enrollment is digital, through selected providers.	Provides full-scope benefits for children and adults through fee-for-service providers for up to 60 days. Provides limited scope coverage for selected outpatient prenatal services. The program limits number of times presumptive eligibility benefits can be received: ▶ Twice in 12 months for children ▶ Once in 12 months for adults ▶ Once per pregnancy for pregnant people	No	Enrolled providers for presumptive eligibility enrollment and services and fee-for-service providers.	Children's Presumptive Eligibility[27] Hospital Presumptive Eligibility[28] Presumptive Eligibility for Pregnancy[29]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Breast and Cervical Cancer Treatment Program (BCCTP) **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligibles.	Diagnosis of breast or cervical cancer requiring treatment. **Income eligibility.** Monthly income less than $5,360 for a family of four. **Immigration status restriction.** Must be California resident.	Cancer treatments for eligible low-income California residents diagnosed with breast or cervical cancer who do not have insurance.	No	All enrolled Every Woman Counts providers for screening and diagnosis.[30] Other enrolled Medi-Cal providers for treatment.	BCCTP home page[31]
Family Planning, Access, Care, and Treatment (FPACT) **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligibles.	Medical need for family planning. **Age eligibility.** No. Must be able to get pregnant or cause a pregnancy. **Income eligibility.** At or below 200% FPL. **Immigration status restriction.** Must be California resident.	Provides comprehensive family planning and related services to people who qualify.	No	All enrolled FPACT providers.	FPACT home page[32]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Hospital Charity Care and Discount Payment Programs					
Hospital Charity Care and Discount Payment Programs. Acute care, psychiatric, and specialty hospitals must provide information about charity care, discounted payment programs, and government health insurance. Recent Hospital Fair Pricing policies have clarified eligibility requirements, increased standardization of billing and collections, and added consumer protections. **Status.** Numerous current laws with oversight by the California Department of Health Care Access and Information.	Hospitals must offer financial assistance to those without insurance with incomes up to 400% FPL. Assets may not be considered for eligibility determination.	Not coverage but instead episodic hospital-based services.	Patients may still incur costs if eligible for discounted payments. Hospitals must limit discount payments to the amount the hospital would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater.	All acute care, psychiatric, and specialty hospitals.	A.B. 2297 (Chapter 511, Statutes of 2024)[33] S.B. 1061 (Chapter 520, Statutes of 2024)[34] A.B. 1020 (Chapter 473, Statutes of 2021)[35]

Appendix C. Counties with Operational Medically Indigent Adult Programs

This appendix presents information about medically indigent adult programs in 23 large counties that are not part of the County Medical Services Program (CMSP). All the programs listed in this appendix are operational unless otherwise noted. Although some programs remain operational with policies, applications, and provider contracts in place, they have been "dormant" in that there have been few, in any, enrollees and claims submitted in recent years (e.g., Merced, Placer). Where available, links to the program landing page and other resources are provided.

- **Methodology.** The authors reviewed county program websites and validated operational status via phone call or email inquiries. For some counties, the authors reached out to county administrators for additional validation, program information, or both. For most programs, deep validation of each element was not undertaken beyond what is posted online or shared in communications, and how these programs are financed was not assessed. Some program features may be different.
- **Benefits/services.** Services provided vary widely but generally group into three coverage categories: (1) limited — selected outpatient services, but no or limited inpatient hospital services; (2) moderate — numerous outpatient services and inpatient hospital services, but no dental or mental health services; and (3) extensive — wide array of outpatient services, inpatient hospital services, and dental and/or mental health services. Most programs make clear that the coverage is not health insurance.
- **Eligibility requirements.** All programs require county residency for eligibility and that applicants are ineligible for Medi-Cal, Medicare, Covered California, and other health insurance coverage. Some programs require an eligible medical condition or diagnosis. Some programs offer coverage or service eligibility for a specified time of several months to a full year. Counties also vary in whether their programs cover residents with unsatisfactory immigration status.
- **Costs.** Counties vary widely in terms of copayments or cost sharing that may be charged to enrollees for services. Costs may also vary depending on family income.

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Alameda Health Program of Alameda County (HPAC)[36]	Extensive ▸ Preventive and routine care ▸ Urgent care ▸ Specialty care ▸ Prescription drugs ▸ Radiology ▸ Laboratory services ▸ Hospital inpatient services ▸ Emergency services ▸ Mental health services ▸ Dental services ▸ Medical equipment and supplies ▸ Ambulance and nonemergency transportation	Age ▸ 19 and over Income ▸ ≤200% FPL	Copayments <138% FPL: ▸ None >138%–150% FPL: ▸ Emergency: $35 ▸ Outpatient: $10 ▸ Inpatient: $100 ▸ Pharmacy: $5 per prescription, $50 max per visit ▸ Special procedures: $100 >150%–200% FPL: ▸ Emergency: $50 ▸ Outpatient: $15 ▸ Inpatient: $100 ▸ Pharmacy: $5 per prescription, $50 max per visit ▸ Special procedures: $100	Yes	Brochure (PDF)[37] Participant Handbook (PDF)[38]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Contra Costa Contra Costa Basic Health Care Program[39]	Extensive ▸ Advice nurse ▸ Physical exams ▸ Allergy injections and testing ▸ Bloodwork ▸ Emergency dental ▸ Basic dental (age 5–14) ▸ Diabetic testing and supplies ▸ Durable medical equipment ▸ Emergency and urgent care ▸ Family planning services ▸ Hearing test ▸ Hemodialysis (acute) ▸ Hospitalization ▸ Immunizations ▸ Outpatient care ▸ Over-the-counter and prescription medications on preferred drug list ▸ Sterilization ▸ Supplies, disposable	Age ▸ All ages Income ▸ ≤300% FPL	Cost sharing Annual cost sharing based on income for a family of four: ▸ 100%–200% FPL: $0 ▸ 201%–250% FPL: $120 per adult, $60 per child ▸ 251%–300% FPL: $240 per adult, $180 per child	Yes	FAQ (PDF)[40] List of services[41] Cost sharing table (PDF)[42]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Fresno Fresno County Medically Indigent Services Program (MISP)[43]	Moderate ▸ Emergency services ▸ Adult primary care ▸ Specialty care (e.g., cardiology, ob/gyn, neurology) ▸ Inpatient hospitalization ▸ Outpatient surgery ▸ X-rays, CT scans, MRIs ▸ Laboratory services ▸ Home health ▸ Pharmacy services ▸ Physical and occupational therapy	Age ▸ 19–64 Income ▸ ≤224% FPL Asset limit ▸ $3,300 (family of four)	Cost sharing Based on income (example for a household of four): ▸ $0–$2,743: no share of cost ▸ $2,744–$4,453: share of cost	No	Share of cost fact sheet (PDF)[44]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Kern Kern Medical Wellness Program[45]	Limited ▸ Physician services (including specialty care and outpatient clinics) ▸ Cardiology ▸ Pulmonology ▸ Urology ▸ Women's health ▸ Neurology ▸ Endocrinology ▸ Generic prescription drugs ▸ Emergency care services ▸ Radiology/imaging services ▸ Orthopedics ▸ Physical therapy ▸ Wellness/health education ▸ Laboratory services ▸ Physical therapy	Age ▸ 19–64 Income ▸ ≤138% FPL	Cost sharing ▸ Percentage of the cost depends on the specific service and the member's program plan.	Yes	
Los Angeles My Health LA (PDF)[46]	Program closed January 31, 2024				

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Merced Medical Access Program	Moderate ▸ Primary care ▸ Outpatient specialty care ▸ Basic emergency care ▸ General acute care ▸ Ob/gyn services ▸ Intensive care ▸ Coronary care ▸ Clinical laboratory ▸ Radiology ▸ Pharmacy	Age ▸ 21–64 years old Income ▸ ≤100% FPL Other criteria ▸ Medical need must be established	Cost sharing ▸ No	No	
Monterey Esperanza Program	Program closed in 2024				
Orange Medical Safety Net Program[47]	Limited ▸ Immediate treatment of life- or limb-threatening urgent and emergent conditions ▸ Hospital care (inpatient and outpatient) ▸ Emergency ambulance transportation ▸ Nonemergency ambulance ▸ Physical therapy ▸ General x-rays, ultrasounds, MRIs, CT scans, diagnostic mammo-grams, and other diagnostics ▸ Laboratory services	Age ▸ 19–64 Income ▸ >138%–200% FPL ▸ $3,300 (family of four)	Copayments* ▸ Minute clinic: $20 ▸ Urgent care: $75 ▸ Lab test: $45 ▸ Specialist visit: $70 ▸ Emergency room visit: $300 ▸ Inpatient admission: $300 * See patient handbook for complete list of copayments.	No	Patient handbook (PDF)[48]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Placer Medical Care Services Program (MCSP)[49]	Extensive ▸ Preventive and primary care services ▸ Pharmacy ▸ Chronic illness treatment ▸ Specialty care ▸ Inpatient hospitalization ▸ Mental health ▸ Dental services	Age ▸ 21–64 Income ▸ <100% FPL	Cost sharing ▸ Depends on income	No	
Riverside Riverside County MISP[50]	Limited ▸ For people who suffer trauma or have other emergency needs ▸ Financial assistance program	Age ▸ 21–64 Income ▸ ≤200% FPL	Copayments If income >100% FPL: ▸ $2 per prescription ▸ $5 per outpatient visit, such as doctors or special visits ▸ $10 per emergency room visit ▸ Eligibles with income that's 100%–200% FPL may qualify with a share of cost	Yes	Run through Riverside University Health System[51]
Sacramento Sacramento County MISP[52]	Moderate ▸ Primary care ▸ Specialty care ▸ Pharmacy ▸ Emergency ▸ Hospital ▸ Ancillary services ▸ Some services require prior authorization	Age ▸ 21–64 Income ▸ 138%–400% FPL	Cost sharing ▸ Share of cost if income >138% FPL ▸ Some share of cost for pharmacy	No	

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
San Bernardino Arrowhead Regional Medical Center[53]	Limited ▸ Financial assistance through charity care and discounted payment plan at Arrowhead Regional Medical Center	▸ Uninsured (self-pay) OR ▸ High medical costs AND income ≤400% FPL	Cost sharing ▸ Depends on income	Yes	Fact sheet (PDF)[54]
San Diego San Diego County Medical Services[55]	Moderate ▸ Outpatient ▸ Inpatient ▸ Pharmacy ▸ Dental ▸ Emergency room ▸ Specialty physician referrals	Age ▸ 21–64 Income ▸ ≤165% FPL ▸ <165% can apply for hardship and may have share of cost	Copayments ▸ None	No	Patient handbook (PDF)[56]
San Francisco Healthy San Francisco[57]	Extensive ▸ Preventive, routine, and specialty care ▸ Prescription medicines ▸ Laboratory services and tests ▸ Hospital care ▸ Mental health care ▸ Alcohol and substance use treatment ▸ Ambulance services ▸ Family planning services	Age ▸ 18+ Income ▸ ≤500% FPL	Participant fees ▸ Quarterly fees based on income range from $0 to $450 Point of service copayment ▸ Based on income	Yes	
San Joaquin Medical Financial Assistance program[58]	Limited ▸ Charity care and discount payment program for hospital outpatient and inpatient services	Age ▸ 19 and older Income ▸ ≤400% FPL	Cost sharing ▸ Depends on income	Yes	Application (PDF)[59] Financial Assistance Policy (PDF)[60]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
San Luis Obispo MISP program[61]	Limited ▸ Services provided through community health centers ▸ Primary care ▸ Pharmacy ▸ Some diagnostic laboratory tests, x-rays, and ultrasounds ▸ Emergency hospital services	Age ▸ 19–64 Income ▸ 138%–250% FPL Asset limit ▸ Must meet asset limit	Cost sharing ▸ Monthly share of cost varies based on household income and Maintenance Need Level	No	Share of cost fact sheet[62]
San Mateo Access and Care for Everyone (ACE)[63]	Moderate ▸ Preventive care ▸ Prescription medicines ▸ Hospital visits ▸ Mental health ▸ Eye care ▸ Hospice ▸ Short-term skilled nursing ▸ Emergency dental ▸ Medical transportation	Age ▸ 19–64 Income ▸ ≤200% FPL	Copayments ▸ $360 application fee ▸ $360 annual participant fee ▸ $15 copays for most ▸ Copayments may be waived depending on income ▸ $1,000 annual out-of-pocket maximum	Yes	Participant handbook (PDF)[64]
Santa Barbara Indigent Care Program (ICP)[65]	Limited ▸ Primary care and specialty outpatient services provided through Santa Barbara County Health Care Centers ▸ Hospital inpatient services after application for charity care ▸ Limited pharmaceutical benefits	Age ▸ 18–64 Income ▸ <100% FPL	Cost sharing ▸ Varies based on income and household size	No	Board of Supervisors actions to change ICP program[66] Potential funding sources for uninsured patients[67]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Santa Clara Primary Care Access Program (PCAP)[68] and Healthcare Access Program (HAP)[69]	Limited ▸ Primary and preventive care ▸ Laboratory ▸ Mammography and radiology ▸ Pharmacy ▸ Some specialty services ▸ Financial assistance for inpatient and emergency care in HAP program	Age *PCAP* ▸ 19 and older *HAP* ▸ 18 and older Income *PCAP* ▸ ≤650% FPL *HAP* ▸ ≤650% FPL: sliding scale financial assistance	Copayments *PCAP* May apply for some services *HAP* Sliding scale financial assistance: ▸ <400% FPL: 100% charity care ▸ 401%–650% FPL: discounted payment between 70% and 25%	Yes	PCAP services (PDF)[70] HAP notice[71]
Santa Cruz Medi-Cruz[72]	Limited ▸ By referral from primary care physician only ▸ Specialty services covered: ▸ Dermatology ▸ Enterology ▸ Gastroenterology ▸ Ob/gyn ▸ Nephrology ▸ Neurology ▸ Orthopedics ▸ Urology	Age ▸ 19+ Income ▸ 139%–160% FPL Residency ▸ Resident for at least 6 months Other criteria ▸ Must have a medical need covered by the program	Copayments ▸ None	Yes	Services not covered[73]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Stanislaus Stanislaus County Indigent Health Care Program[74]	Moderate ▸ Primary care ▸ Specialty care ▸ Urgent care ▸ Inpatient services ▸ Emergency room ▸ Laboratory and diagnostic services ▸ Pharmacy ▸ Dental care	Age ▸ 21–65 Income ▸ ≤171% FPL (21–29 yrs) ▸ ≤198% FPL (30–39 yrs) ▸ ≤226% FPL (40–49 yrs) ▸ ≤251% FPL (50–59 yrs) ▸ ≤279% FPL (60–64 yrs) Asset limits ▸ $2,000 for individuals ▸ $3,000 for households Other criteria ▸ Prior authorization for some services	Cost sharing ▸ Yes	No	
Tulare Tulare County Medical Services	Limited ▸ Outpatient services ▸ Physician services ▸ Nonemergency hospital outpatient and inpatient ▸ Emergency medical services ▸ Laboratory and radiology ▸ Pharmacy and supplies dispensed by hospital ▸ Physical and speech therapy ▸ Podiatry	Age ▸ 21–65 Income ▸ ≤275% FPL Asset limits ▸ Net value ▸ Personal property ▸ Vehicle Other criteria ▸ Medical need and prior authorization for services	Cost sharing ▸ $0 if income ≤135% FPL Copayments ▸ $5 copayment minimum	No	

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Ventura County Health Care Agency programs[75]	Limited ▸ Outpatient and inpatient services provided by Ventura County Health Care Agency clinics and hospitals ▸ Programs: ▸ Self-pay discount ▸ Charity care ▸ Sliding fee discount payments	Age ▸ No age restriction Income ▸ ≤400% FPL Other criteria ▸ Self-pay patient ▸ High medical costs ▸ Medically necessary services	Cost sharing ▸ Yes ▸ Amount varies depending on program eligibility	Yes	Discount Payment Program Policy (PDF)[76] Charity Care Program Policy (PDF)[77] Sliding Fee Scale Program Policy(PDF)[78]

Note: *UIS* is unsatisfactory immigration status; *FPL* is federal poverty level.

Endnotes

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About the Author

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The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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