ASSEMBLY THIRD READING
AB 1923 (Soria)
As Amended May 20, 2026
2/3 vote. Urgency.

SUMMARY

Makes a hospital, regardless of ownership type or system affiliation eligible for state assistance under the Distressed Hospital Loan Program (DHLP). Requires the evaluation for loan forgiveness in the DHLP to incorporate projections of future financial performance, and, in place of the current criteria, requires the Department of Health Care Access and Information (HCAI) to provide loan forgiveness to any participant in DHLP who received a loan award before the effective date of this bill, if HCAI and the California Health Facilities Financing Authority (CHFFA) determine the participant has demonstrated a good faith effort to comply with program requirements through January 1, 2026, and the financial projections demonstrate that the participant will become financially distressed as a result of loan repayments or other outside factors, including, but not limited to, the impacts of the federal One Big Beautiful Bill Act. Makes enactment of this bill contingent upon appropriation. Contains an urgency clause to ensure that the provisions of this bill go into immediate effect upon enactment.

COMMENTS

DHLP. AB 112 (Committee on Budget), Chapter 6, Statutes of 2023, establishes the DHLP, until January 1, 2032, which will provide interest free cashflow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals. The DHLP is jointly administered by HCAI and CHFFA. The following hospitals received a total of $300 million in financial support:

1) Beverly Hospital - $5 million;

2) Dameron Hospital Association - $29 million;

3) El Centro Regional Medical Center (El Centro) - $28 million;

4) Hayward Sisters Hospital, dba St. Rose Hospital - $17.65 million;

5) Hazel Hawkins Memorial - $10 million;

6) John C. Fremont Healthcare District - $9.35 million;

7) Kaweah Delta Health Care District - $20.75 million;

8) Madera Community Hospital - $2 million;

9) Martin Luther King, Jr. Community Hospital- $14 million;

10) Palo Verde Hospital - $8.5 million;

11) Pioneers Memorial Healthcare District - $28 million;

12) Ridgecrest Regional Hospital - $5.5 million;

13) San Gorgonio Memorial Healthcare District - $9.8 million;

14) Sonoma Valley Hospital - $3.1 million;

15) TriCity Medical Center - $33.2 million; and,

16) Watsonville Community Hospital - $8.3 million.

The loans are at zero-interest and are repayable over 72 months, with an initial 18-month grace period at the beginning of the loan term. The program will sunset on January 1, 2032. HCAI and CHFFA received 30 applicants for the program, however, not all hospitals were awarded funds. During the extensive loan application review process, HCAI considered a diverse set of criteria. Hospitals that demonstrated the greatest levels of financial distress, at-risk of closing in the near term, and had a well-founded plan to remain open and provide services and care, were prioritized and issued loans through the program. Hospitals that did not receive funds from the program demonstrated less financial distress when compared to other hospitals that applied.

DHLP Loan Modifications. Current law states DHLP loans are to be structured as zero-interest working capital loans with a 72-month term and an initial 18-month payment deferment period. When those deferment periods began to expire, HCAI and CHFFA established a formal loan modification process rather than granting blanket extensions. Existing borrowers seeking a loan modification must complete a two-step process. Step 1 is a 12-month extension of the payment deferral period and maturity date with a recast of the amortization over 60 months. Step 2 is forgiveness of the next succeeding 12 months of principal debt service, and Step 2 may only be considered after Step 1 has first been approved. An applicant must apply no earlier than 120 days and no later than 90 days, before a loan modification or forgiveness is needed. Submitting within this period ensures that the applicant's most current financial information is used in the analysis and determination.

To be considered, a DHLP borrower must submit a complete application and justify that, despite its best efforts to implement the Turnaround Plan initiatives, the borrower remains in financial distress. The evaluation uses minimum financial thresholds referred to as the "Stable Financial Ratios," which are: greater than 60 days cash on hand, greater than 1.5x debt service coverage, and greater than 2.0x current ratio.

Continuing Distressed Hospitals. HCAI utilizes quarterly financial data to track each hospital's performance as well as consolidated program performance. The hospital also submits a turnaround plan narrative that is evaluated in conjunction with the financial data to build a comprehensive view of the hospital's performance. This information is used to calculate Stable Financial Ratios and determine how a hospital is performing over time. Turnaround plans are evaluated to determine if the initiatives are being implemented and if these efforts are effective. This allows HCAI to determine which hospitals are continuing to face distress and which ones are improving.

Expansion of the DHLP as proposed by this bill. Under existing law, hospitals belonging to integrated health care systems with more than two separately licensed hospital facilities are ineligible for assistance under DHLP. This bill would change that prospectively for future awards provided after its effective date. For existing borrowers, the public loan modification materials do require applicants to disclose changes in ownership, management, or other extraordinary events and to update turnaround plans. That means affiliation activity is relevant to

the modification review. HCAI and CHFFA review those requests based on the governing agreements, the modification criteria, the borrower's current and projected financial condition, and the facts of the affiliation.

HCAI has the authority to determine service provision requirements in approving and for the duration of loans to eligible hospitals and can consider service provision requirements in the context of loan modification requests. Hospitals also must adhere to conditions provided in their respective approved turnaround plans, including any applicable provisions requiring continuation of specific service lines, such as emergency services or labor and delivery services.

However, HCAI may experience limitations in the currently available hospital-level data, should the DHLP be broadened to larger systems that become financially distressed. HCAI's data documentation notes that hospitals operating under a consolidated license may report financial data under the parent facility because they often use an integrated accounting system, which means that public and reported financial data may not always isolate the acquired or affiliated hospital on a standalone basis. As a result, for a system-affiliated applicant, HCAI may need more entity-specific and projection-based information to determine whether the individual hospital, as opposed to the larger system, is financially distressed.

Peterson-Milbank Program for Sustainable Health Care Costs. The Peterson-Milbank Program published a study in September of 2025 titled "Separating the Haves from the Have-Nots: State Options for Targeted Application of Hospital Affordability Policies," which notes that states pursuing health care affordability strategies face major pushback from hospitals and their lobbying groups. The report acknowledges that certain increase in uncompensated care in the coming years (resulting from people losing their insurance due to the terms of federal HR 1 of 2025, recently passed and signed into law) will increase financial pressures. Hospitals argue that these policies will have disastrous financial impacts for them and that this legislation could force them to make service cuts or even close facilities, endangering patient access to care. However, these arguments mask a critical truth: Not all hospitals and health systems are in the same financial position. Rather, the hospital industry is characterized by a mix of what the study coauthors have referred to as haves and have-nots. Some hospitals and health systems (the haves) retain large reserves and strong market power, and others (the have-nots) are financially precarious. The haves are often large and/or located in high-income communities, whereas the have-nots are often small and/or located in low-income communities. Historical information suggests that high-asset hospitals grow their assets particularly through nonpatient care activities, using their wealth to generate more funds, while low-asset hospitals are likely to stay asset-poor.

According to the Author
In January of 2023, Madera Community Hospital (MCH) shut its doors and filed for bankruptcy, leaving thousands of people in the Central Valley without timely access to emergency care. In response to the closure of MCH and the significant financial challenges facing hospitals around the state, particularly those serving rural or large Medi-Cal populations, the Legislature created the DHLP to prevent other hospital closures and help reopen MCH. The $300 million program has been a success, saving 15 hospitals from closing or severely curtailing services, and helping MCH reopen its doors. The author states that since the conclusion of the program, financial strain on California's hospitals has continued to grow with four California hospitals closing or being saved from closure by last-minute bailouts. In addition to existing financial difficulties, healthcare cuts passed by Congress in H.R. 1 are set to create a health care financing crisis in the state. Without direct intervention, these cuts threaten to upend California's entire hospital system.

The author concludes that this bill would provide relief to California's most distressed hospitals by investing a new round of funding into the program to give loans to newly financially distressed hospitals and granting loan forgiveness for current recipients of distressed hospital loans to the extent that repayment would cause financial distress.

Arguments in Support
The California Hospital Association (CHA) supports this bill and states that, created in 2023 in the aftermath of the COVID-19 pandemic, the DHLP has proven incredibly effective. It successfully prevented closures and cuts for 15 participating hospitals and — against significant odds — helped one closed hospital, Madera Community Hospital, reopen its doors. CHA notes that at the time the program was created, this assistance was limited to only certain hospital types, making this lifeline unavailable to dozens of hospitals throughout the state. Now, funding for this successful program is depleted. CHA contends that federal funding cuts have made it challenging for existing recipients to repay the loans that are now coming due; they may be forced to once again consider layoffs, service reductions, or closure. CHA asserts that rejuvenating the DHLP would give hospitals a fighting chance to continue serving their communities.

Arguments in Opposition
The Private Equity Stakeholder Project is opposed to this bill and states that private equity investment in healthcare is often accompanied by financial practices such as high levels of debt, dividend payments, and real estate transactions that can place additional strain on provider operations. In hospital settings, these dynamics can affect staffing, service availability, and long-term financial stability, particularly for facilities serving vulnerable communities. Expanding eligibility for the DHLP to include for-profit hospitals may increase the risk that public funds are used to support entities operating under these financial models. As policymakers consider this bill, it is important to evaluate whether the program's resources are best directed toward stabilizing community-based providers without introducing additional financial risks.

FISCAL COMMENTS

HCAI estimates approximately $1 million in fiscal year 2026-27 and ongoing for five positions, as well as approximately $6 million in consulting costs over the life of the program.

VOTES

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Aguiar-Curry, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

VERSION: May 20, 2026

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