Date of Hearing: April 14, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2368 (Bonta) – As Introduced February 19, 2026

SUBJECT: Indigent health care: information and planning.

SUMMARY: Requires the State Department of Health Care Services (DHCS), by July 1, 2027, to establish an internet website where the public can access specified information on safety-net health care services in the state. Requires each county, no later than January 1, 2028, to prepare and submit to DHCS a plan to operate programs to provide health care to medically indigent individuals, as necessary to meet additional need due to reduced access to health care coverage. Specifically, **this bill**:

1) Requires DHCS, by July 1, 2027, to establish an internet website where the public can access information on safety-net health care services in the state.

2) Requires the website include, at a minimum, all of the following:

   a) A person's legally protected right to emergency medical care under state and federal law;

   b) Payment support resources, including coverage options, state programs, hospital charity care, and other assistance that is available to help people access health care services;

   c) Information about each county medically indigent health care program for uninsured individuals, including, but not limited to, all of the following:

      i) All eligibility requirements, including age, residency requirements, and income limits;

      ii) The cost of services;

      iii) The telephone number to reach the appropriate county program administrator; and,

      iv) A hyperlink or Uniform Resource Locator (URL) for each county internet website related to safety-net services or medically indigent programs.

   d) Any other information or resources that will assist an individual seeking comprehensive and accurate information about accessing medically indigent health care services in the state.

3) Requires DHCS, in consultation with California State Association of Counties, local health officers, organizations advocating for consumers' access to health care, and other entities with expertise in health care for medically indigent individuals, to review the information and resources on the website and update annually, at a minimum.

4) Requires each county, no later than January 1, 2028, to prepare and submit to DHCS a plan to operate programs to provide health care to medically indigent individuals, as necessary to meet additional need due to reduced access to health care coverage.

5) Requires the plan to include information on projected caseload and expenditure increases, projected investment, and assessment of funding sources.

6) Requires DHCS to provide technical assistance upon the request of any county in developing its plan.

EXISTING LAW:

1) Requires every county and every city and county to relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions. [Welfare and Institutions Code (WIC) § 17000]

2) Requires the board of supervisors of every county as a board, or by committee or by any person or society as it may authorize to investigate every application for relief from the funds of the county, to supervise by periodic visitation every person receiving that relief, to devise ways and means for bringing persons unable to maintain themselves to self-support, and to keep full and complete records of the investigation, supervision, relief, and rehabilitation, as specified. [WIC § 17006]

3) Requires emergency departments (EDs), under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and also under similar provisions of state law (state EMTALA), to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay. Federal EMTALA imposes this requirement on any hospital that participates in Medicare. State EMTALA imposes this requirement on any hospital that operates an ED. [Title 42, United States Code § 1395dd and Health and Safety Code (HSC) § 1317]

4) Requires a hospital to provide a person without health coverage with a written estimate of the amount the hospital will require the person to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to the person by the hospital, based upon an average length of stay and services provided for the person's diagnosis. Allows the hospital to provide this estimate during normal business office hours. Requires the hospital to provide information about its financial assistance and charity care policies and contact information for a hospital employee or office from which the person may obtain further information about these policies. Requires the hospital to also provide the person with an application form for financial assistance or charity care. Excludes emergency services from these requirements. [HSC § 1339.585]

5) Requires each hospital to maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Makes uninsured patients or patients with high medical costs who are at or below 400% of the federal poverty level (FPL) level eligible to apply for participation under a hospital's charity care policy or discount payment policy. Requires the written policy regarding discount payments to include a statement that an emergency physician who provides emergency medical services in a hospital that provides emergency care is also required to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of FPL. [HSC § 127405]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, under HR 1 California is bracing for a surge in uninsured residents, with counties estimating that indigent programs will experience new enrollment of between 417,000 and 1.3 million. When federal policies restrict eligibility, introduce intentional barriers to enrollment, or roll back coverage, people don't simply stop getting sick. Instead, they fall into our county safety nets to be the provider of last resort. The author argues that without a coordinated, statewide strategy to collect safety net program eligibility and contacts in a single platform to connect people to care, and understand the strain on local resources, our county health systems risk being overwhelmed, leaving our most marginalized communities without life-saving care. The author concludes this bill establishes a vital framework for transparency, access, and proactive planning to bridge the gap left by federal attack. We cannot wait for federal cuts to dismantle our health care safety net before we decide to act.

2) **BACKGROUND.**

   a) **County indigent care programs.** WIC Section 17000 was codified in 1965. It requires counties to "relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions." However, this language by no means guarantees a meaningful health care safety net for millions of Californians who may lose coverage.

      County indigent care programs generally do not offer "coverage," they instead directly provide or pay for a limited set of health care services. Case law establishes some basic responsibilities of counties for indigent care, but eligibility and service levels largely depend on county resources and priorities. Few counties provide care for Californians without legal immigration status, and Section 17000 does not require it. Programs are funded largely with state realignment funds provided to counties. Because demand for indigent care services had declined over the last decade, commensurate with expanded Medi-Cal and Covered California eligibility, counties explain these programs now lack both the resources and the infrastructure to handle significantly increased demand.

      According to the Legislative Analyst's Office (LAO), court decisions have clarified that indigent health care programs are required to provide only the basic care necessary to prevent serious harm, pain, or infection. Programs are not required to provide specific benefits, so the minimum level of service required is significantly less than what is provided by other public programs (such as Medi-Cal). Counties are also able to set income-eligibility requirements based on subsistence living costs and an individual's ability to pay. These requirements may take the form of cost-sharing arrangements with a sliding scale depending on an individual's income.

      Prior to the passage of the Patient Protection and Affordable Care Act (ACA), there were an estimated 850,000 enrolled in county indigent health care programs across the state. As the state has expanded Medi-Cal eligibility (to mostly childless adults and undocumented individuals), county indigent health care caseload has decreased, with

counties estimating around 10,000 individuals currently enrolled. However, the number of enrollees per county can vary widely due to the broad county discretion over their programs. As enrollment in county indigent health programs declined as access to other health coverage for low-income individuals increased significantly, many counties have broadened their eligibility requirements to include additional participants and/or the scope of the benefits offered by their indigent care programs, as available resources allow. For example, some counties have chosen to accept individuals with unsatisfactory immigration status (UIS) or provide certain specialty care beyond the basic level of care required in statute.

b) **County Medical Services Program (CMSP).** According to the California Health Care Foundation's (CHCF) recent issue brief, "Covering the Uninsured," the 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. 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). 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.

c) **AB 85.** In 2014, after implementation of the ACA, particularly the expansion of Medi-Cal to childless adults up to 138% of the FPL, the state made adjustments to realignment revenues supporting county indigent programs to account for the newly expanded Medi-Cal population that would no longer need to be covered at the county level. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, redirected realignment funds according to various formulas in different counties. For the thirty-four largely rural counties participating in CMSP, AB 85 required 60% of health realignment funding that would have been received to be redirected to the state. The 12 public hospital counties and the remaining 12 counties were able to choose whether to have 60% of realignment redirected, or to use a formula-based approach that takes into account a county's cost and revenue experience. All but four of those counties chose a formula-based approach.

d) **HR 1 impacts.** The LAO estimates that by 2030, nearly 2 million individuals could be disenrolled from Medi-Cal due to new eligibility requirements (effectively doubling the number of uninsured individuals). Many of these individuals may have difficulty finding other sources of health coverage and may therefore seek care through county indigent care programs. The LAO estimates anywhere between 20% and 50% (400,000 to 1 million) of these individuals may enroll in county indigent health care programs, though these estimates are highly uncertain.

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

a significant increase in costs to grow their indigent health care programs, the structure of the AB 85 redirection of realignment funding affecting most counties does not consider to any extent an increase in costs. Therefore, given that available health realignment funding also supports counties' public health responsibilities, counties are unlikely to have the resources required to meet the increased indigent health care demand without new, additional means of support. The counties estimate that county indigent programs will experience new enrollment of between 417,000 and 1.3 million with anticipated costs of $2 billion to $5.5 billion per year.

e) **State programs.** Some state programs, largely limited to certain "body parts" or medical conditions, remain options for individuals with qualifying incomes who are otherwise uninsured and have a specific medical need met by one of the programs. These include restricted-scope Medi-Cal, which pays for emergency and pregnancy care; Family Planning, Access, Care, and Treatment (Family PACT), which provides family planning and some reproductive health services; Every Woman Counts, which pays for breast and cervical cancer screening; the Breast and Cervical Cancer Treatment Program; and the Prostate Cancer Treatment Program. The AIDS Drug Assistance Program provides medications used in the treatment and suppression of HIV/AIDS and related opportunistic infections.

f) **Health care provider programs.** Certain health care providers directly provide some free or discounted care. Nonprofit hospitals must offer charity care and other community services as a condition of their exemption from income, property, and sales taxes. The facilities provide charity care to eligible uninsured and insured patients, with no expectation of payment. AB 2297 (Friedman), Chapter 511, Statutes of 2024, standardized some aspects of hospital charity care and discount programs and added other consumer protections. Starting January 1, 2025, those without insurance who have incomes below 400% of the FPL are eligible for some level of assistance. County-administered hospitals and public health systems, located in some urban centers in California, generally have a mission to provide access to health care services for all Californians, regardless of insurance status, immigration status, ability to pay, or other circumstances. However, financial assistance programs in these systems generally function similarly to those in nonprofit hospitals, and the level of generosity of the program varies by system. Federally Qualified Health Clinics, as part of federal requirements, must offer comprehensive primary care services on a sliding fee scale based on ability to pay.

   Even providers who do offer free or discounted care have become inured to far less demand for such care in recent years and would have difficulty providing such care to millions more uninsured individuals. Pursuant to the federal EMTALA, all hospitals that participate in the Medicare program and operate emergency departments must provide screening and emergency stabilization services. However, EMTALA only requires services to be provided; the cost of services is not covered by the federal government, and EMTALA does not require hospitals to provide free or discounted emergency care. This requirement is often characterized as an unfunded mandate.

g) **EMTALA.** EMTALA was passed to address the problem of hospitals refusing to treat indigent, uninsured, or Medicaid patients, or "dumping" these patients by transferring them to county hospitals or other charity hospitals. Federal EMTALA obligates

Medicare-participating hospitals that offer emergency services to provide a medical screening and treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. State EMTALA imposes its obligation on any hospital that operates an ED, and has similar requirements to federal EMTALA. Hospitals are required to provide stabilizing treatment for patients with an emergency medical condition. A patient is "stabilized" when the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the release or transfer of the patient. If a hospital is unable to stabilize a patient within its capability, then a patient is required to be transferred to an appropriate facility with the necessary specialized treatment services. Once a patient is stabilized, if the patient needs post-stabilization care, the hospital will typically seek more information about the medical history of the patient, including whether the patient has insurance.

3) **SUPPORT.** California Academy of Family Physicians (CAFP) supports this bill stating that stable, continuous health insurance coverage is critical to ensuring patients can receive timely preventive care, manage chronic conditions, and avoid unnecessary complications. However, when individuals lose coverage, they often face significant barriers to accessing care and may delay or forgo needed services. Safety-net programs play a vital role in filling these gaps, but information about available services can be difficult to find and varies widely by county. CAFP argues that this bill would improve transparency and help patients, providers, and community organizations better understand and navigate available resources.

   Health Access California also supports this bill noting that recent changes to state and federal law will result in hundreds of thousands or even millions of Californians losing their health care coverage. Health Access contends that there is currently no state entity that compiles and displays for Californians relevant information about how to access county-provided health services. In fact, this is a role that many nonprofits end up playing, including Health Access on several occasions. This has involved direct outreach to each individual county to get updates on their programs, who they are serving and where individuals can find information; in many cases this information was not readily available online. Given the difficulty for advocates of tracking down this information, it is certainly not accessible to the consumers who most need resources. Health Access concludes that, though the patchwork of county indigent care programs should be a last resort safety net, it is imperative that consumers in need of care be able to readily access information on these local programs.

   The Western Center on Law and Poverty supports this bill arguing that by requiring DHCS to establish a website to collect and display information about payment support resources available to help people access health care services, uninsured individuals will have access to critical information. They recommend that, in addition to the website, consideration should be given to providing information to individuals about resources available by phone or other means for those without access to the internet.

4) **PREVIOUS LEGISLATION.**

   a) SB 1142 (Caballero), Chapter 556, Statutes of 2022, requires the California Health and Human Services Agency, or a designated entity, to establish a website where the public can access specified information about abortion services.

b) AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, revised realignment formulas, redirecting a portion of the health realignment revenues that counties had historically spent on indigent care to offset state General Fund costs for CalWORKs grants.

5) COMMITTEE AMENDMENTS. The committee may wish to strike Paragraph (4) of subdivision (b) in Section 2.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Family Physicians
Health Access California
Western Center on Law & Poverty

Opposition

None on file

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