2025 Health Care Affordability State Policy Snapshot

CALIFORNIA

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HEALTHCARE VALUE HUB

State Has Active Legislation

State Does Not Have Active Legislation

The Health Care Value Hub ("the Hub") is proud to launch the 2025 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of June 1, 2025. Sources for this information can be found in the downloadable **Data and Source Document available on the Dashboard page. Definitions and descriptions for each policy category can be found in the Glossary.**

The Hub offers online and hands-on support with staff dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Address Consolidation and Promote Competition

Consolidation Oversight

Policy	Status as of June 2025	Summary
Transaction Notification Required	Requires health systems or providers to notify the state of consolidation transactions	California requires health care entities provide notice of health care mergers, acquisitions, affiliations and other changes of ownership at least 90 days prior to entering into an agreement or transaction. Transactions may be referred to the Attorney General for review of unfair methods of competition, anticompetitive behavior, or anticompetitive effects.
Authority to Modify or Reject Consolidation Transactions	Has authority to approve, set conditions, or disapprove consolidation transactions	California law grants the Attorney General approval authority over any sale or transfer of nonprofit health care facilities. The Office of Health Care Affordability reviews and conducts Cost and Market Impact Review and reports to the AG, but does not itself have approval authority.
Affordability Criteria included in Transaction Review	Includes consumer affordability or price growth in review criteria, approval conditions, or both	When reviewing proposed transactions, the California Office of Health Care Affordability and Attorney General examine whether a transaction will have a negative impact on availability, accessibility of services, or quality of services in affected communities, as well as negative impact on costs for payers, purchasers, or consumers.

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Address Consolidation and Promote Competition

Facility Fees

Policy	Status as of June 2025	Summary
Prohibits Facility Fees	⊗ State does not prohibit providers from charging any facility fees	
Facility Fee Transparency Laws	⊗ State does not require providers to disclose facility fees to consumers, requires off-campus outpatient departments to identify the physical location where care was provided on claims forms, or both	
Limits Cost-Sharing for Facility Fees	⊗ The state has no laws that limit the amount a patient may be billed out-of-pocket for facility fees	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program * No Source, or Limited Information Found

Address Consolidation and Promote Competition

Anti-Competitive Contract Provisions

Policy	Status as of June 2025	Summary
Restricts All-or-Nothing Contract Provisions	⊗ No law restricting All-or-Nothing contract provisions	
Restricts Anti-Tiering and Anti-Steering Contract Provisions	⊗ No law restricting Anti-Tiering or Anti-Steering contract provisions	
Restricts Physician Noncompete Clauses	● Non-competes generally unenforceable or prohibited	California prohibits noncompete agreements in all employment contracts and will not enforce agreements made in other states.
Restricts Most-Favored Nation Contract Provisions	⊗ No law restricting Most Favored Nation contract provisions	California does not ban Most Favored Nation clauses, but under Ca. Health & Saf. Code § 1371.22 if a contract between an insurer and provider includes a Most Favored Nation clause it may not apply to any to cash payments made to a provider from uninsured patients.

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Medical Debt Prevention

Balance Billing and Short-Term Insurance

Policy	Status as of June 2025	Summary
Prohibits Balance Billing for Ground Ambulance Services	● Prohibits balance billing for out-of-network ground ambulance services	California has established balance bill protections that extend to both public and private ground ambulance services and cover both emergency and non-emergency transport.
Prohibits Short-Term, Limited Duration Health Plans	● State law has eliminated short-term, limited duration health plans	California law prohibits the sale of short-term, limited duration health plans.

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Medical Debt Prevention

Charity Care and Community Benefit

Policy	Status as of June 2025	Summary
Mandated Hospital Charity Care	State law requires hospitals to provide free or discounted care to low-income patients and sets standards for eligibility (see notes)	California hospitals are required to offer discounted or charity care to uninsured patients or patients with high medical costs that earn at or below 400% FPL. Hospitals may voluntarily extend eligibility to patients above 400% FPL. Rural hospitals may set lower thresholds if needed to remain financially viable.
Hospital Charity Care Screening Requirements	State does not require health care providers to screen patients for Medicaid, Marketplace, or charity care eligibility before collecting payment	California does not require hospitals to screen patients for charity care before discharge. However, state law prohibits hospitals from requiring patients to apply for Medicare or Medi-Cal before being screened for or provided with charity care or discounted payment. Additionally, hospitals must determine whether a patient is ineligible or unresponsive before selling debt, and must send a charity care application before doing so—indicating some expectation of prior screening efforts.
Hospital Charity Care Notification Requirement	State law requires health care providers to notify patients of charity care options before collecting payment	Hospitals must provide patients with written notice about the availability of charity care and discount payment policies, including eligibility information and contact details. Notices must be provided at the time of service, during discharge, or mailed within 72 hours if not delivered in person. Notices must also be publicly posted in multiple hospital locations and on the hospital's website.
Hospital Community Benefit Reporting Requirement	State law requires hospitals to annually report the amount of charity care provided	Hospitals must submit an annual community benefits plan to the Department of Health Care Access and Information detailing the value of benefits provided and any unmet needs. They must also post this plan on their website each year.

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Medical Debt Prevention

Reducing Financial Consequences

Policy	Status as of June 2025	Summary
Mandates Waiting Prior to Collections	State law prohibits sending medical debts to collections for a prescribed period (see note)	Before assigning a bill to collections or selling the debt, California hospitals must notify the patient in writing and include detailed billing and financial assistance information. Unless certain criteria is met, the debt cannot be sent to collections while the patient is applying for financial assistance or making good-faith efforts to pay.
Limits on Liens or Foreclosures due to Medical Debt	State law prohibits initiating a lien or foreclosure to collect medical debt	Hospitals, collection agencies, and debt buyers cannot place liens on a patient's real property or conduct property sales to collect medical debt if the patient is eligible for charity care or a discount payment policy.
Limits Wage Garnishment due to Medical Debt	State law exceeds federal wage garnishment protections for residents with medical debt	California prohibits hospitals from garnishing a patient's wages if they are eligible for charity care or discount policies. A collection agency may pursue wage garnishment if ordered by a court; however, the court must consider the patient's ability to pay, current and future medical expenses, and other financial obligations before approving garnishment.
Limits on the Amount of Interest Charged to Medical Debt	State law limits interest rates on medical debt	California prohibits debt buyers from charging interest or fees on purchased medical debt. Additionally, hospitals are not allowed to charge interest on extended payment plans offered to patients who qualify for charity care, discount payment policies, or other hospital programs for low-income, uninsured, or high-cost patients.

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Curb Excess Costs in the System

Premium Rate Review

Policy	Status as of June 2025	Summary
Effective Rate Review per Centers for Medicare and Medicaid Services (CMS)	● Has an effective rate review process	
Authority to Modify or Reject Premium Rate Increases	⊗ Does not have the authority to modify or reject premium rate increases	The California Department of Insurance (CDI) does not have the authority to approve or deny proposed rate changes, although it may request that the insurer amend the rate change or make an official determination that the rate change is unreasonable. Carriers operating in the large group market are required to submit aggregate rate information, but the state does not have authority to review large group rates.
Affordability Criteria Included in Premium Rate Review	● Incorporates affordability criteria into premium rate review	The state requests information from carriers regarding cost containment and quality efforts in rate filing materials.

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Curb Excess Costs in the System

Hospital Price Regulation

Policy	Status as of June 2025	Summary
Medicare Reference-Based Pricing	State uses reference-based pricing tied to Medicare rates to regulate hospital pricing	Since 2011, California's Public Employee's Retirement System (CalPERS) HAS applied reference-based pricing to high-cost, elective procedures such as knee and hip replacements, cataract surgeries, and colonoscopies. Enrollees pay standard coverage at or below the reference price but must cover any amount above it, reducing plan costs while shifting some financial risk to patients. Although this approach limits costs, it may expose patients to surprise medical bills.
Hospital Global Budgets	State has not implemented hospital global budgets	

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Curb Excess Costs in the System

Affordable Coverage

Policy	Status as of June 2025	Summary
Public Option	⊗ State does not offer an active public option insurance plan	California has not implemented a statewide Public Option. However, eligible Los Angeles County residents can purchase insurance through L.A. Care, a county-based public option available on the Covered California Marketplace.
Public Option Includes Provider Participation Mandate	⊗ State does not does not offer a public option, with or without a participation mandate	
Basic Health Plan	⊗ State does not operate a Basic Health Plan	
State-Based Premium Subsidies	● Supplementary state-funded premium subsidies are available to eligible residents	California provides state-funded cost-sharing reductions for Silver plan enrollees earning up to 250% FPL, eliminating deductibles and reducing out-of-pocket costs. In 2025, additional funding ensures all Covered California enrollees qualify for at least an Enhanced Silver 73 plan. In 2026, if federal subsidy enhancements expire, the state will shift to supplemental premium assistance for households up to 165% FPL

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Biologic Substitution Laws: Prescriber Permission Requirements	State does not require express authorization for biologic substitution	
Biologic Substitution Laws: Prescriber Notification Requirements	Pharmacists are required to notify prescribers of biologic substitution	Pharmacists in California are required to notify the prescribing physician of a substitution within five business days.
Drug Purchasing Consortium	State does not participate in a drug purchasing consortium*	
Drug Coupon Prohibitions	State prohibits the use of drug manufacturer coupons	California prohibits manufacturers from offering coupons, discounts, repayments, or other co-pay assistance for brand-name medications with a generic equivalent covered by insurance or if the active ingredient for the drug is available at a lower cost without a prescription. Exceptions exist if the patient has competed step therapy or prior authorizations, single-tablet drug regimens for treatment of HIV/AIDS, and discounts for self-pay patients. The law does not apply if the product is free of cost to both the patient and the patient's insurer.
Medicaid Managed Care Organization (MCO) Carve Out	State Medicaid carves out any drug classes from their MCO benefits (see note)*	As of July 1, 2023, California carves out the following drugs/classes from MCO benefits: Hemophilia factor, HIV/AIDS anti-retrovirals, mental health drugs, opioid use disorder drugs.
Mandatory Generics in Medicaid Fee-for-Service (FFS)	Medicaid Fee-for-Service (FFS) programs and pharmacists are required to substitute a generic version of a drug	California has policies or tools to promote mandatory generics.

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Supplemental Rebate Programs	Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place	
Drug Rebate Transparency and Reporting Requirements	Pharmacy benefit managers are required to report rebate data to the state	
Spread Pricing Restrictions	State does not prohibit pharmacy benefit managers from engaging in spread pricing	Beginning January 1, 2026, new contracts between a pharmacy benefit manager and a payer, health care service plan, or a health insurer may not include language authorizing spread pricing. By January 1, 2029, not contracts between a pharmacy benefit manager may prohibit spread pricing.
Pharmacy Benefit Manager Reimbursement and Clawbacks	State does not prohibit PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”)	
Cost-Disclosure and Gag Clause Restrictions	State law prohibits gag clauses in pharmacy contracts	
Prohibits Copay Accumulator Programs	State does not prohibit copay accumulator programs	

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Curb Excess Costs in the System

Medicaid Costs

Policy	Status as of June 2025	Summary
Medical Loss Ratio (MLR) Remittances for Medicaid Managed Care Population	State requires MLR remittances for its Medicaid managed care population	
Medicaid Site Neutral Payments	State has not enacted Medicaid site neutral payment legislation*	

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Medicaid Services and Immigrant Coverage

Medicaid Administration

Policy	Status as of June 2025	Summary
Medicaid Managed Care (MCO)	State partners with MCOs to operate their Medicaid program	In California, it is mandatory for the following populations to be enrolled in managed care plans: Children, pregnant people, parents/caretaker relatives, adults without dependents, seniors and people with disabilities, enrollees in long-term care, HCBS waiver enrollees, dually eligible individuals, those with any other health insurance, and American Indians / Alaska Natives in County Organized Health System counties.
Medicaid Vendor — Eligibility and Enrollment	State contracts with a vendor for Medicaid enrollment or eligibility	
Integrated Medicaid-Medicare	State integrates Medicare-Medicaid to coordinate care for the dually eligible population	California has either or a combination of both highly integrated or fully integrated dual eligible special needs programs (HIDE/FIDE), as well as program of all-inclusive care for the elderly (PACE).

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Medicaid Services and Immigrant Coverage

Medicaid Covered Services

Policy	Status as of June 2025	Summary
Medicaid Coverage for Fertility Services	⊗ State Medicaid program does not cover infertility treatments or fertility preservation services	
Medicaid Coverage for Doula Services	● State Medicaid program actively reimburses for doula services	
Medicaid Coverage for Abortion Care	● State Medicaid program utilizes state-based funds to cover abortion care	
Medicaid Coverage for Transition-Related Care	● State Medicaid program explicitly covers any transition-related care for adults	
Medicaid Coverage for Hearing Aids	● State Medicaid program covers hearing aids for all adults	Medicaid covers up to $1,510 of hearing services per person each fiscal year. Pregnant women are not subject to the hearing aid benefit cap if services are part of their pregnancy-related care or if services are used to treat a condition that may cause problems in pregnancy.
Medicaid Coverage for Eye Exams and Glasses	◉ State Medicaid program covers only eye exams or eyeglasses but not both, or biannually or less frequently, or restricts coverage based on age or health condition (see notes)	Exams and glasses covered biannually.
Medicaid Coverage for Dental Services	● State Medicaid program covers preventive and diagnostic dental services, extractions, dentures, root canals, fillings, and crowns for adults	

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Medicaid Services and Immigrant Coverage

Medicaid Eligibility

Policy	Status as of June 2025	Summary
Medicaid Expansion	State has expanded Medicaid eligibility to 138% of the federal poverty level (FPL)	
Retroactive Medicaid	State retroactively extends Medicaid benefits 90 days prior to application date for all adult enrollees	
Adult Medicaid Continuous Eligibility	State has not authorized 12-month continuous eligibility for non-pregnant adult Medicaid enrollees*	
12-Month Postpartum Coverage	State has authorized 12-month postpartum Medicaid coverage	
Medicaid Available to People who are Incarcerated	State has not authorized Medicaid coverage for justice-involved individuals while they are in a correctional setting*	Under the CalAIM Section 1115 waiver, incarcerated residents in California who meet certain criteria may receive select Medicaid benefits 90 days before release, including case management, counseling, medications and medical equipment.
Medicaid Aged, Blind and Disabled (ABD) Asset Limits	State has expanded the asset limit for Medicaid for the Elderly and Disabled eligibility beyond $2,000 for an individual applicant and $3,000 for joint applicants	California Medicaid has no asset limit for applicants.
Medicaid Aged, Blind and Disabled (ABD) Life Insurance Exemption	Life insurance exemption limits exceed $1,500	California eliminated its asset limit, therefore life insurance has no impact on Medicaid eligibility.
Medicaid Aged, Blind and Disabled (ABD) Retirement Account Exemptions	State exempts both applicants' and spouses' retirement savings from Medicaid eligibility determinations	California eliminated its asset limit, therefore applicant / non-applicant spouse's IRA has no impact on Medicaid eligibility.

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Medicaid Services and Immigrant Coverage

Immigrant Coverage

Policy	Status as of June 2025	Summary
From Conception to End of Pregnancy (FCEP)	Covers pregnancy-related services through the CHIP From-Conception-to-End-of-Pregnancy (FCEP) Option and post-partum coverage	California extends postpartum coverage to 12 months for parents covered under the From Conception to End of Pregnancy option.
Immigrant Children without a Five-Year Bar	State offers coverage for lawfully residing immigrant children without a five-year bar	
Pregnant Immigrants without a Five-Year Bar	Offers coverage for lawfully residing pregnant immigrants without a five-year bar	
State-Funded Coverage for Children Regardless of Citizenship Status	Offers coverage for children regardless of immigration status	
State-Funded Coverage for Adults Regardless of Citizenship Status	Offers coverage for adults regardless of immigration status	California extended state-funded health coverage to income-eligible young adults ages 19-25 in January 2020, adults ages 50 and older in May 2022 and adults ages 26 to 49 regardless of immigration status in January 2024, making all low-income immigrants in the state eligible for state-funded health coverage regardless of immigration status. California plans to pause enrollment for undocumented adults 19 and older who are not pregnant starting January 2026, end dental benefits for all undocumented adults who are not pregnant or up to one year post-partum starting July 2026, and charge $30 monthly premiums for adults ages 19-59 who are not pregnant starting July 2027.

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Improve Oversight, Accountability, and Transparency

All-Payer Claims Database

Policy	Status as of June 2025	Summary
Established an All-Payer Claims Database (APCD)	State has a(n) all-payer or multi-payer claims database	
All-Payer Claims Database (APCD) Operated by the State	APCD is operated by the state	

Prescription Drug Affordability Board

Policy	Status as of June 2025	Summary
Established Prescription Drug Affordability Board (PDAB)	The state has not established or passed legislation to establish a prescription drug affordability board	
Prescription Drug Upper Payment Limits	The state has not established Upper Payment Limits for prescription drugs	

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Improve Oversight, Accountability, and Transparency

Price Transparency

Policy	Status as of June 2025	Summary
Service Cost Price Transparency Tool	⊗ State does not have a public-facing price transparency tool	
Prescription Drug Price Reporting Requirement	● Organizations are required to report prescription drug price information to a state entity	California requires drug manufacturers to report price increases for drugs currently on the market and when introducing new drugs that exceed a specific cost threshold.

Health Care Spending Oversight

Policy	Status as of June 2025	Summary
Health Care Spending Benchmark	● State has established a health care spending benchmark for providers, insurance carriers, or both	California's Office of Health Care Affordability has approved a statewide healthcare spending target of 3.5% from 2025-2026, 3.2% from 2027-2028, and 3% for 2029 and beyond. The target will apply to health care entities including health plans, provider organizations with at least 25 physicians, and hospitals. The Office has also announced its proposed Primary Care Investment Benchmark recommendation with a relative improvement benchmark for each payer of 0.5 to 1 percentage points per year increase in primary care spending as a percent of total medical expense through 2034, as well as a statewide benchmark of 15% of total medical expense allocated to primary care by 2034.
Authority to Enforce Health Care Spending Benchmark	⊗ State does not have an enforcement mechanism for their health care spending benchmark(s)	Starting 2026, OHCA can take enforcement action against entities that exceed the target, including technical assistance, explanation at public meetings, performance improvement plans, and financial penalties. The office will not enforce penalties until 2028-2029.
Hospital or Primary Care Spending Oversight Entity	● State monitors and reports hospital spending, primary care spending, or both	California's Office of Health Care Affordability, established in 2022, monitors primary care spending. It sets statewide and sector-specific health care spending targets, appoints a Health Care Affordability Advisory Committee, approves adoption of alternative payment models, and other strategies to increase primary care and behavioral health spending.

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Reduce Cost-Sharing for Patients

Reduce Cost-Sharing: Prescription Drugs

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Diabetes Medications	⊗ State has not enacted legislation limiting cost-sharing for insulin, diabetes related equipment, or both	California SB40, introduced in 2025, would prohibit individual and small group health insurance carriers from imposing a copayment exceeding $35 for a 30-day supply of insulin. At the time of writing, the bill has passed both houses of the Legislature and is waiting for the governors signature.
Waives or Reduces Cost-Sharing for Asthma Inhalers	⊗ State has not enacted legislation limiting cost-sharing for asthma inhalers	
Waives or Reduces Cost-Sharing for Epinephrine Auto-Injectors	⊗ State has not enacted legislation to limit cost-sharing for prescription epinephrine autoinjector(s)	
Waives or Reduces Cost-Sharing for Specialty Drugs	● State has enacted legislation to limit cost-sharing for specialty drugs	California caps cost-sharing for outpatient prescription drugs at $250.00 and $500.00, depending on the enrollee's coverage tier. Oral anticancer medications have a separate cap of $250.00.

Reduced Cost-Sharing: Behavioral Health

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for an Annual Behavioral Health Office Visit	⊗ State does not require private insurers to cover at least one annual mental health wellness exam without cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Preventive Care

Policy	Status as of June 2025	Summary
Waives Cost-Sharing for Preventive Services Recommended by the U.S. Preventive Services Task Force (USPSTF)	State mandates private insurers cover USPSTF recommended preventive services without cost-sharing	

Reduced Cost-Sharing: Maternal and Reproductive Health Care

Policy	Status as of June 2025	Summary
Individual and Small Group Health Plans Required to Cover Fertility Treatment	The state requires individual and small group health plans to offer coverage for fertility preservation services, but not for in-vitro fertilization	California requires health insurance policies (except Medi-Cal MCO plans) to cover fertility preservation services when medically necessary treatments may cause iatrogenic infertility. In vitro fertilization (IVF) is not required to be covered.
Individual and Small Group Health Plans Required to Cover Doula Services	State law requires private health insurers to cover doula services for enrollees	California's Public Employees' Retirement System provides coverage for doula services in some 2025 health plans.
Individual and Small Group Health Plans Required to Cover Abortion Services	The state requires individual and small group health plans to cover abortion services	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Colorectal Cancer Screenings	State law requires insurers to cover colorectal cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Follow-Up Colorectal Cancer Screening Exams	State law requires insurers to cover follow-up colorectal cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Lung Cancer Screenings	State law does not require coverage or waive cost-sharing for lung cancer screening exams	California law does not explicitly require insurance carriers to provide coverage for lung cancer screening, but the state does require carriers to cover USPSTF recommended services without cost-sharing, which includes health services rated "A" or "B" by the U.S. Preventive Services Task Force such as lung cancer screening.

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Cervical Cancer Screenings	State law requires insurers to cover cervical cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Breast Cancer Screenings	State law requires insurers to cover breast cancer screening with no cost-sharing	
Waives or Reduces Cost-Sharing for Supplementary Breast Cancer Screenings	State law requires insurers to cover supplementary breast cancer screening but allows cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Prostate Cancer Screenings	State law requires insurers to cover prostate cancer screening but allows cost-sharing	California law requires insurers to cover prostate cancer screenings, although cost-sharing may be allowed. Legislation to require coverage for prostate cancer screening without cost-sharing passed both the California House and Senate in 2023, but was vetoed.
Waives or Reduces Cost-Sharing for Ovarian Cancer Screening	State law does not require coverage or waive cost-sharing for ovarian cancer screening exams	
Waives or Reduces Cost-Sharing for Biomarker Testing for Cancer	State requires coverage of biomarker testing for cancer screening but allows cost-sharing	California requires health insurance carriers and Medi-Cal to cover medically necessary biomarker testing, including whole genome sequencing, for diagnosis, treatment, management, and monitoring. However, certain insurance carriers may still impose cost-sharing.

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