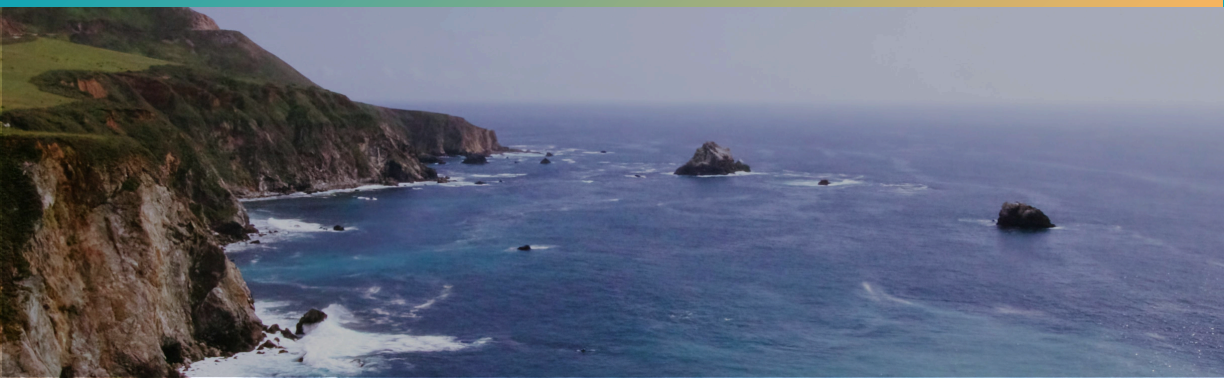
Paying the Price: **Californians Struggle with the High Cost of Health Care**

The financial burden of health care is shaped by income, race, and county of residence. Without relief, new policies mean Californians will pay more for less.

California Pan-Ethnic
HEALTH NETWORK



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California's Health Care Affordability Crisis

Today, in California and nationwide, we are in the midst of a health care affordability crisis. Every year, families struggle to pay their medical bills, take on medical debt, and forego basic necessities to afford health care.

Most Californians are worried about health care costs, and concerns about affordability are heightened across different communities.

In a recent survey from the California Health Care Foundation, about two in three Californians said they were worried about being able to afford unexpected medical bills (67%) compared to more than three in four Californians with low incomes (81%). Most Californians also worry about out-of-pocket costs (65%), but not as much those with low incomes (78%), or Black Californians (70%) when compared to White Californians (58%). When it comes to caring for aging or disabled family members, Multiracial (74%), Asian (61%), and Latine Californians[i] (60%) are more worried about affording care than White Californians (52%) [1].

Californians have good reason to worry, as the costs of health care in the state are high and have grown substantially over time.

From 2002 to 2021, while median hourly wages in California grew only by 69%, personal health care spending per capita grew by 163% [2]. These rising expenditures are reflected in California's hospital prices. California has the sixth highest hospital prices in the United States, with relative prices over 300% of Medicare prices, meaning private insurers pay triple what Medicare pays [3].

"The health care system is a tale of two Californias. One in which health care corporations continue to enrich themselves through irrationally high prices and opaque business practices, and another in which everyday Californians struggle to pay for the basic care needed to live a healthy, fulfilling life. No Californian should be choosing between putting food on their table or seeing a doctor. And yet, this is the reality for millions of workers and families. The existence of individual medical debt is a systemic failure of epic proportions.

At the same time, there is hope. More Americans than ever want to see bold health system reform to bring down costs and hold corporate health care accountable for overcharging and taking advantage of people. We know that by taking on greed and profit in the system, we can provide quality health care for every person who calls California home. Together, change is possible."

Kiran Savage-Sangwan, Executive Director, California Pan-Ethnic Health Network

[i] CPEHN uses the term "Latine" to replace "Hispanic" or "Latino/x" when describing those of Latin American descent

Over the last two decades, Californian families who have employer-sponsored coverage have seen their premium and potential deductible costs grow from 4% to 12% of their household income [4]. The growth in health insurance premiums was a large driver of this increase.

From 2013 to 2024, employee contributions more than doubled from $4,518 to $9,148 for family plans and nearly doubled from $1,091 to $1,947 for individual plans **(Figure 1)**. Employer contributions to premiums also increased over this period but not as dramatically as employee contributions [5].

For many Californians, the rising cost of care has impacted their health negatively.

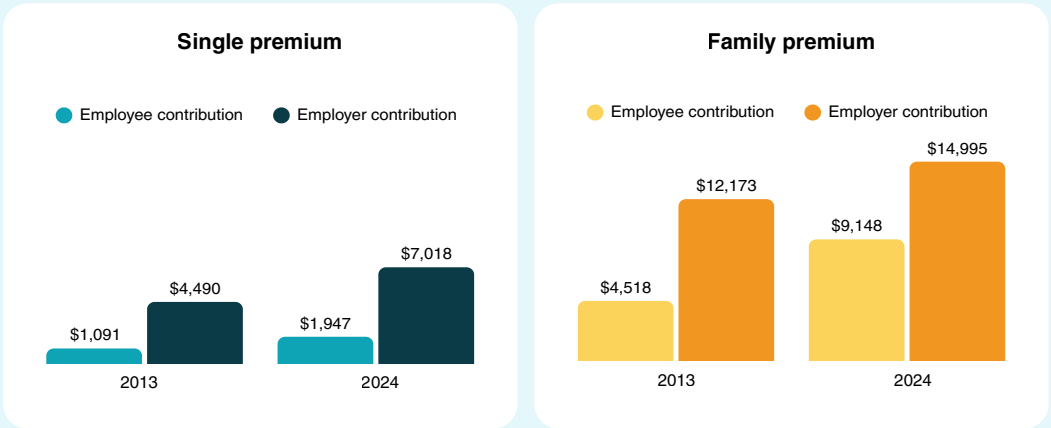
In 2024, more than half of Californians (53%) said they skipped or postponed care due to cost in the last year — a number that rises to a startling three of four when it comes to Californians with low incomes (74%) [1].

This is leading to greater health challenges, as more than half of those with low incomes who skipped care (54%) say their condition got worse as a result [1].

Unfortunately, health care affordability is expected to get worse under recently enacted state and federal policy.

The 2025-2026 California state budget and the federal Republican megabill, H.R. 1, will make health care even less affordable at a time when California families are already struggling with high costs. Together they are projected to significantly reduce enrollment in both Medi-Cal, California's Medicaid program, and Covered California, California's health insurance marketplace, reversing years of progress toward universal coverage and increasing costs for all Californians. Without action, these changes will further strain the state's health care system and leave California families to pay the price.

Figure 1. Average annual premium cost per enrolled employee for employer-based health insurance, California, 2013-2024



Source: KFF State Health Facts [5]

Data analyzed by CPEHN for this report show that everyday Californians have been left to pay the price of the health care affordability crisis.

This burden is influenced by income, race, ethnicity, and county of residence. Those who are already struggling will be hit hardest by state and federal policy rollbacks. Rising costs are not only making health care increasingly out of reach, they are threatening the livelihood of millions across the state.

Key Takeaways:

- **Three million Californians struggled to pay medical bills in 2024.** Californians with low to moderate incomes and Californians of color were more likely to report problems paying medical bills.
- **Californians currently owe more than $10.5 billion in medical debt.** Californians with the lowest incomes are struggling to pay the highest amount, and of the 3 million Californians struggling to pay their own or their household medical bills, nearly 1 in 3 owe $4,000 or more.
- **More than one million Californians couldn't afford basic necessities because of medical bills.** Paying for food, rent, and heat is a challenge for all Californians struggling to pay medical bills, but the burden falls disproportionately on low income households, communities of color, and certain counties.
- **Millions of Californians face large premium increases or loss of health care coverage altogether due to recent federal and state policies.** Devastating cuts and restrictions are poised to make the challenges even greater for Californians to access and afford healthcare.

Californians want action on health care affordability. Families need relief, not higher medical bills. With H.R. 1 threatening to strip billions from California's safety net and state budget cuts compounding the crisis, policymakers must act to protect coverage for millions at risk of losing Medi-Cal and Covered California, and take bold steps to lower the costs driving higher premiums and out-of-pocket expenses.

Reverse Harmful State Cuts
Reverse state Medi-Cal cuts, maintain full coverage for immigrants losing federal Medicaid funding, and reject proposals that would strip essential benefits from vulnerable communities.

Control Costs and Consolidation
Empower the Attorney General to block anti-competitive mergers, strengthen oversight of private equity acquisitions, and enforce cost growth targets to hold hospitals and insurers accountable.

Strengthen the Safety Net
Invest in Medi-Cal systems and culturally responsive navigation services to prevent coverage losses from administrative barriers, and pursue alternative revenue solutions to backfill lost federal funding.

Rein in Out-of-Pocket Spending
Ban surprise hospital facility fees for routine and preventive care, cap excessive hospital payments, and strengthen oversight of health plan practices that limit access to care and push patients out of network.

Understanding the Impact through Data

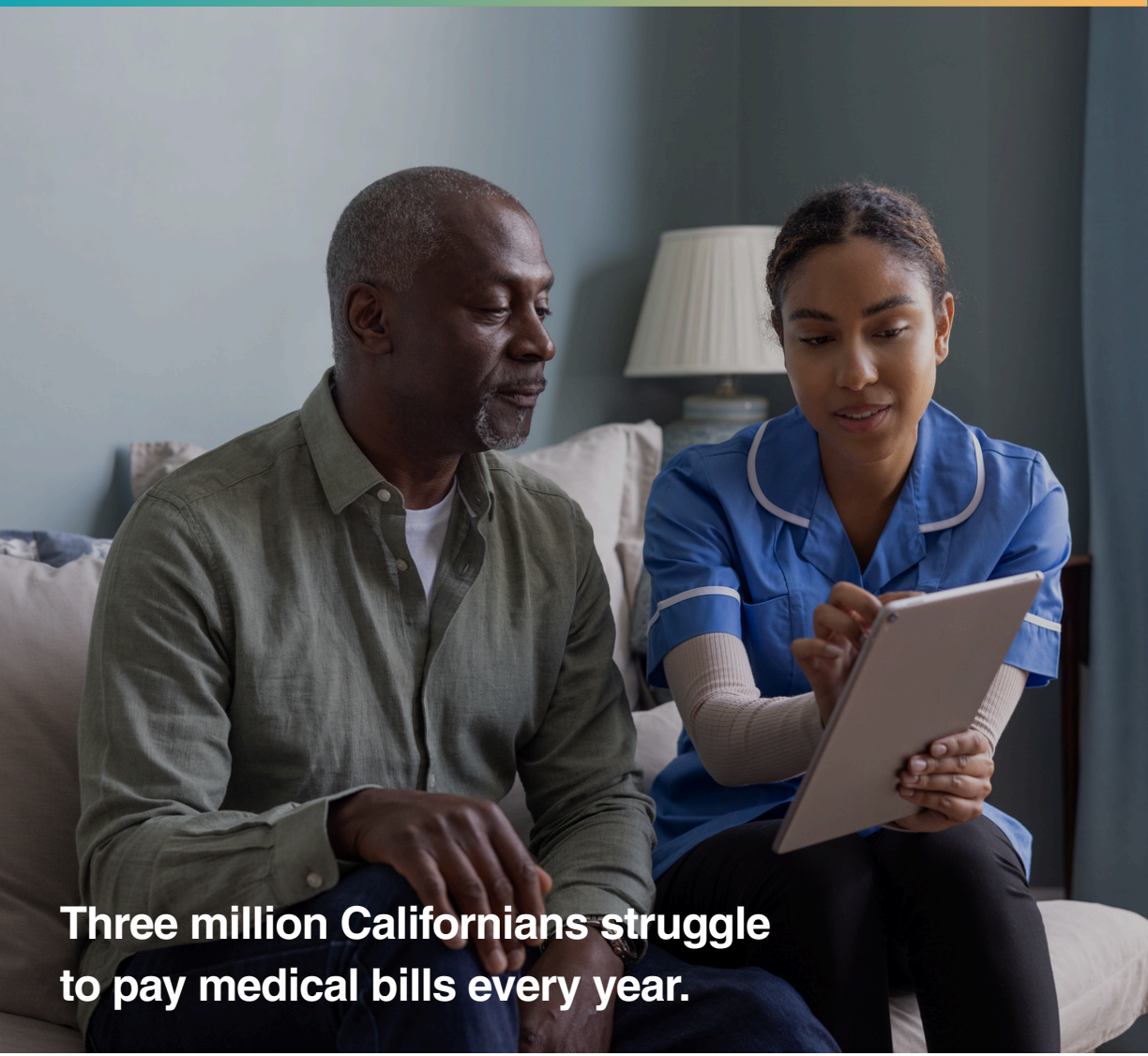
About the Data

The following sections of this report use recently released data from the 2024 California Health Interview Survey (CHIS) to examine health care affordability and medical debt [6]. This report focuses on three questions asking about problems paying medical bills in the past year, the inability to pay for basic necessities because of medical bills, and total amount of medical debt owed (the latter two questions were only asked of those who answered "yes" to problems paying medical bills). Data was pooled across 2022, 2023, and 2024 for county and racial and ethnic subgroups to improve statistical confidence. For the purposes of this report, low income refers to Californians with incomes below 200% of the federal poverty level (FPL); moderate income to Californians with incomes between 200% and 400% of the FPL; and higher income to Californians with incomes of 400% of the FPL or higher. The 2024 guidelines for the FPL have been provided in **Table 1** as a reference that aligns with the years of data used. *See more details on analysis methods (Appendix A) and data tables (Appendix B) at the end of this report.*

Table 1. Reference for 2024 Federal Poverty Level (FPL) Guidelines

	Annual Income 2024 FPL	
Income Range Used in Report	**One Person**	**Family of Four**
Low Income (<200% FPL)	$0-$30,119	$0-$62,399
Moderate Income (200-399% FPL)	$30,120-$60,239	$62,400-$124,799
Higher income (≥400% FPL)	$60,240 and higher	$124,800 and higher

Source: U.S. Department of Health and Human Services 2024 Poverty Guidelines [7]



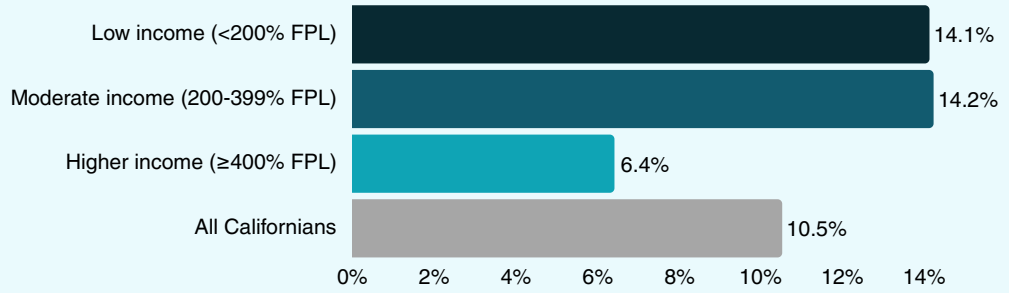
Three million Californians struggle to pay medical bills every year.

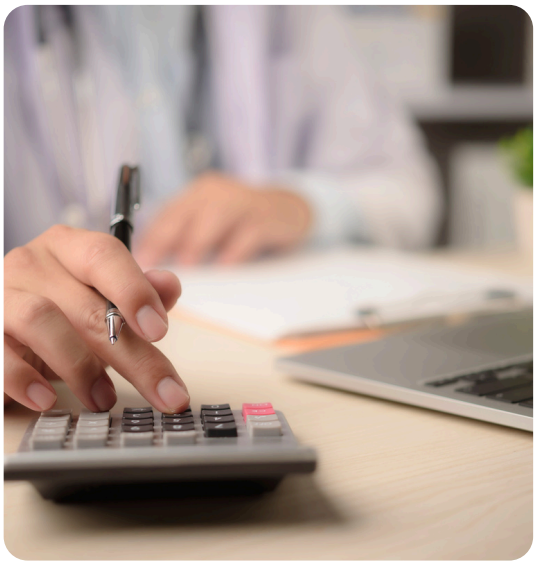
Across the state, Californians are struggling to pay their medical bills, but disparities persist in who experiences the most difficulty. Californians with low-incomes, no insurance, and communities of color are most impacted. People living in Northern California and Central Coast counties also face high rates of having problems paying medical bills while already living in regions with some of the most expensive hospitals in the nation.

Californians with low incomes have more difficulty paying medical bills.

About 1 in 10 Californians (10.5%) reported having problems paying or being unable to pay for their own or their family's medical bills in the past 12 months. One in seven Californians (14%) with low to moderate incomes reported difficulty paying medical bills, compared to about 1 in 16 Californians (6%) with higher incomes **(Figure 2)**. In total, more than 2.2 million Californians with low to moderate incomes are struggling to pay medical bills.

Figure 2: Percent of Californians having problems paying their own or their household medical bills, by poverty level, 2024





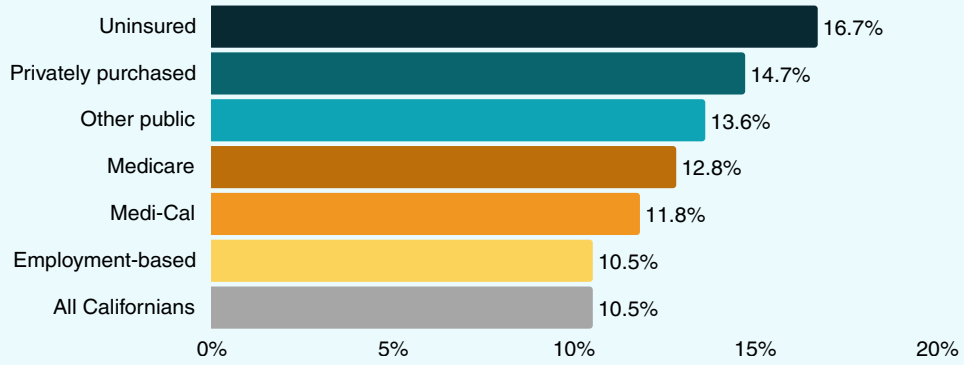
Financial help is available.

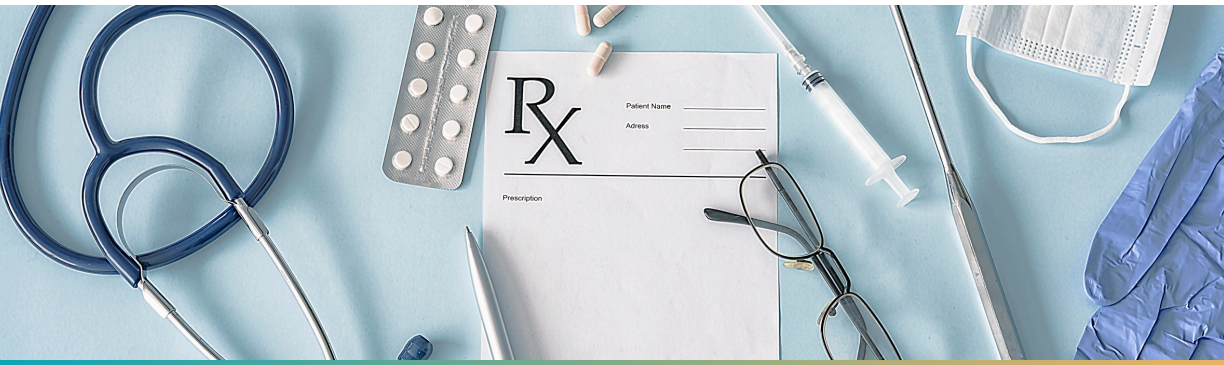
Californians with incomes up to 138% of the federal poverty level (FPL) may qualify for Medi-Cal which provides low or no-cost services. Those with low to moderate incomes above that level may receive premium tax credits through Covered California. State law also requires hospitals to offer financial assistance to both uninsured and insured patients facing high medical costs, with eligibility extending to households up to 400% FPL. *Read more and check your eligibility for assistance at Dollar For* [8].

Uninsured Californians and those with privately purchased insurance were more likely to report problems paying medical bills.

In 2024, 17% of uninsured Californians and 15% of those with privately purchased insurance reported problems paying medical bills. Californians with Medi-Cal (12%) were also more likely to report experiencing problems than Californians with employment-based coverage (10.5%), despite the program typically covering most costs **(Figure 3)**. Medi-Cal enrollees can still incur medical debt by receiving services not covered by the program, clerical errors, or being erroneously charged when their insurance status is unknown [9].

Figure 3. Percent of Californians having problems paying their own or their household medical bills, by insurance type, 2024





Californians of color report more difficulty paying medical bills.

Looking at problems paying medical bills across racial and ethnic groups reveals clear racial inequities. In 2022-2024, American Indian or Alaska Native (17%) and Native Hawaiian/Pacific Islander Californians (15%) reported the highest level of problems paying for their own or their family's medical bills in the past 12 months. Latine (13%), Multiracial (12%) and Black Californians (12%) also experienced more problems paying medical bills than White (9%) and Asian Californians (7%) **(Figure 4)**.

Further disaggregation unveils disparities among subgroups that are often masked in broader race and ethnicity categories. Among Asian Californians, rates varied across groups. One in 10 Filipino (10%) and nearly 1 in 10 Korean Californians (9%) had problems paying medical bills **(Figure 5)**.

Figure 4. Percent of Californians having problems paying their own or their household medical bills, by race and ethnicity, 2022-2024

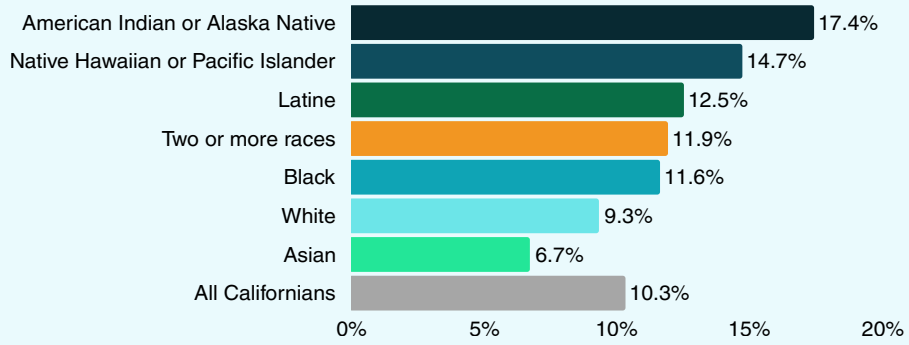
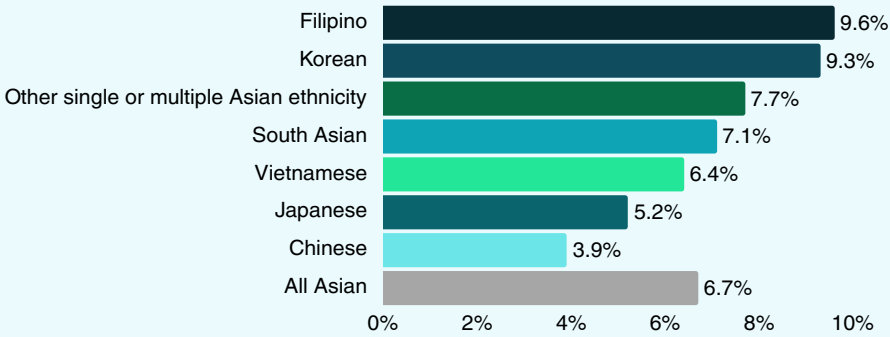


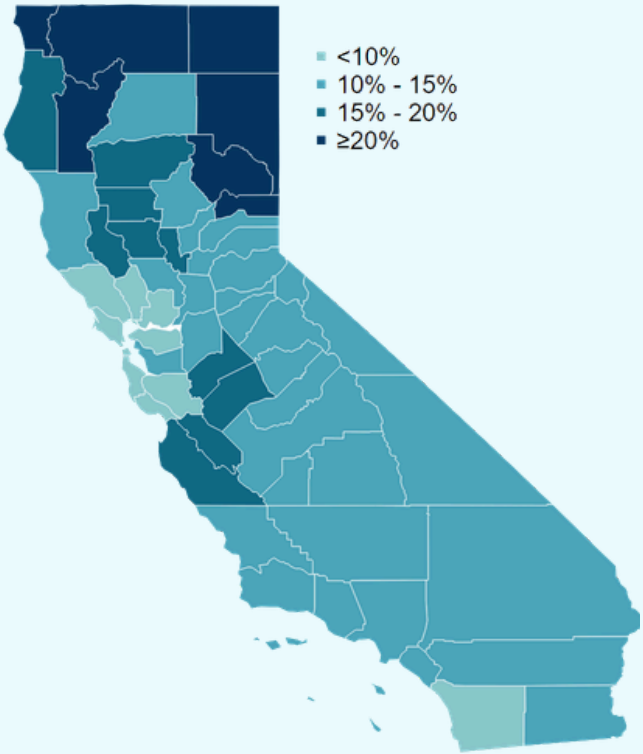
Figure 5. Percent of Californians having problems paying their own or their household medical bills, by Asian ethnicity, 2022-2024



Residents of rural Northern California and Central Coast counties experienced the highest rates of problems paying their household medical bills.

Challenges paying medical bills varied across the state. More than 1 in 5 adults (21%) in Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, and Sierra Counties reported problems paying medical bills. Other counties with high percentages of residents reporting difficulty paying medical bills include: San Benito (19.6%); Sutter (16.9%); Humboldt (16.9%); and Monterey (15.8%) **(Figure 6)**.

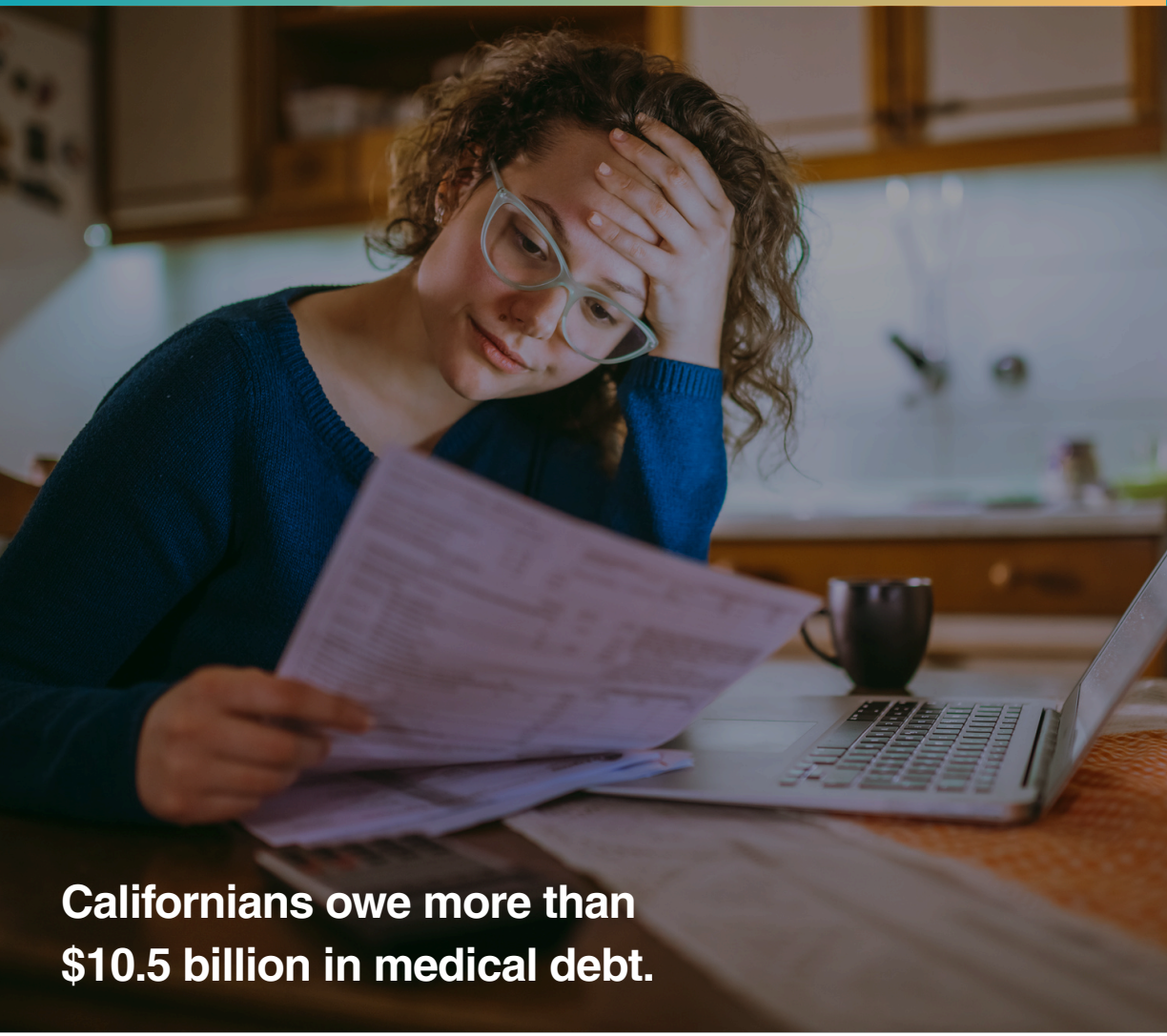
Figure 6. Percent of Californians struggling to pay their medical bills, by county, 2022-2024



Hospital Prices are Higher Here

California is home to some of the highest-priced hospitals in the country. A national study found that 11 of the 19 regions with the largest increases in hospital commercial-to-Medicare price ratios were in California, including 8 in Northern California [10]. Four of the seven high-cost hospitals identified by the Office of Health Care Affordability in 2025 are in counties where 15% or more of residents reported problems paying medical bills [11]. A recent state study found that Monterey County hospitals charge much higher prices without delivering better quality care [12].

Note: The UCLA Center for Health Policy Research groups the 17 smallest counties by population size into 3 group county strata as follows: group 1 - Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte; group 2 – Tehama, Glenn, Colusa; group 3 - Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine. See Appendix Table B1 for a complete list of counties.



Californians owe more than $10.5 billion in medical debt.

Medical debt places a significant financial burden on Californians who struggle to afford care. Californians who reported problems paying medical bills collectively owed more than $10.5 billion in medical debt in 2024.[ii] Over half of Californians struggling to pay medical bills owe $2,000 or more, with those at the lowest incomes struggling to pay the highest amount.

[ii] The amount owed by Californians reporting they had problems paying their own or household medical bills is a conservative estimate, as those who said yes to: "During the past 12 months, did you have medical bills that you had problems paying or were unable to pay, either for yourself or any family member in your household?" were asked: "What is the total amount of medical debt?".

1 in 3 Californians struggling to pay their medical bills owe $4,000 or more.

One in three Californians (33%) struggling to pay their medical bills owe $4,000 or more; 17% owe $8,000 or more **(Figure 7)**. Unexpected health emergencies, high out-of-pocket costs, and errors in billing are common causes of medical debt [13].

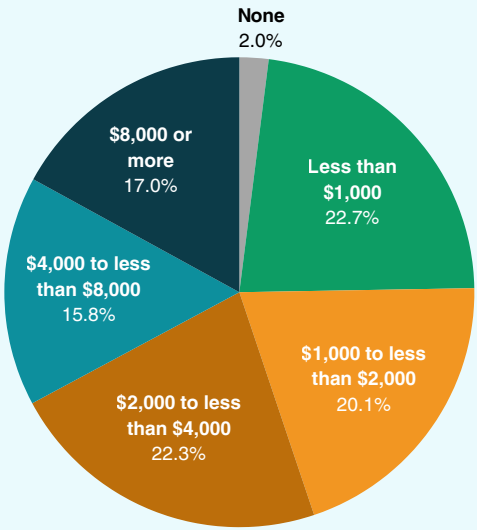
Preventing Medical Debt Before It Starts: AB 1312

Hospital financial assistance programs exist to help patients, but too often patients don't know about them until it's too late. Recognizing this gap, CPEHN sponsored AB 1312, the Patient Debt Prevention Act, alongside Health Access California, Blood Cancer United, and Rising Communities. Authored by Assemblymember Pilar Schiavo, AB 1312 was signed into law by Governor Newsom in 2025 [14].

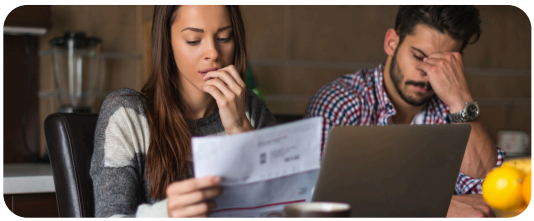
AB 1312 requires hospitals to proactively screen patients likely eligible for financial assistance and automatically apply discounts before sending them a bill. This includes patients who are uninsured, enrolled in means-tested programs, enrolled in Covered California, or experiencing homelessness.

AB 1312 standardizes a proven best practice already required in states like Oregon and Illinois, ensuring all eligible patients receive the financial assistance they are entitled to so they can focus on getting the care they need [14].

Figure 7. Medical debt owed by Californians who reported problems paying medical bills, by dollar amount, 2024



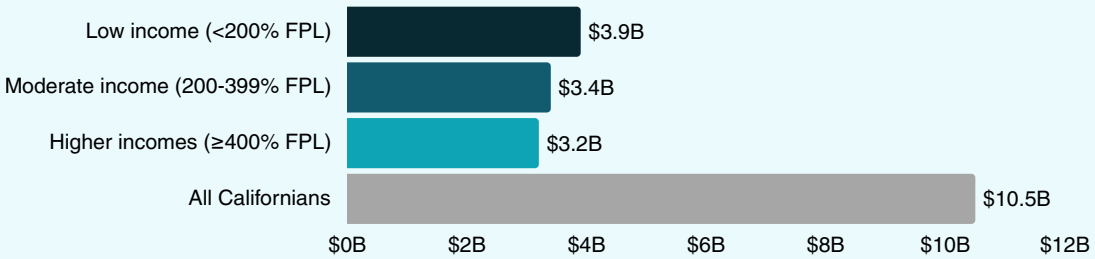
Note: Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months



Californians with the lowest incomes have the highest amount of medical debt.

Disaggregating the data also reveals disparities in how much Californians owe in medical bills. Low income (<200% FPL) Californians reporting having problems paying medicals bills were struggling to pay the most amount at $3.9 billion collectively. Californians living with a moderate income (200-399% FPL) owed $3.4 billion, and those living with higher incomes (≥ 400% FPL) owed $3.2 billion **(Figure 8)**.

Figure 8. Amount of medical debt owed (in billions) by Californians reporting problems paying medical bills, by poverty level, 2024



Note: The amount of medical debt owed is a conservative estimate. This question is only asked of those who said yes to: "During the past 12 months, did you have medical bills that you had problems paying or were unable to pay, either for yourself or any family member in your household?".

Medical debt impacts many Californians—38% of Californians report having any medical debt—and has serious consequences. In 2024, more than three in four (78%) Californians who said they had any kind of medical debt reported skipping care due to cost [1].

Medical debt is not limited to the uninsured: a national survey found that 30% of adults with employer-based coverage had medical debt they were paying off over time [15].

Medical Debt Hurts More Than Just Your Finances

UC Berkeley Labor Center's report *Medical Debt in California: Causes, Consequences, and Solutions* describes how medical debt drains savings, makes it harder to afford essentials like food, housing, and utilities, and delays major life decisions such as buying a home or going back to school. Medical debt also creates significant stress and anxiety, and can cause people to delay or avoid care out of fear of cost, allowing health problems to worsen. Addressing medical debt not only protects families financially, but also safeguards their health, well-being, and long-term stability [13].

Case Study: Medical Debt in Los Angeles County

In 2024, similar to Californians statewide, 1 in 10 of Los Angeles residents (10%) reported problems paying their medical bills. Among these LA residents with medical debt, over half (51%) with medical debt reported insurance denied coverage or payment as a cause of their medical debt.[iii] Other leading drivers of medical debt for LA residents were high co-pays (45%) and high deductibles (40%). Among LA residents with medical debt, hospitals (34%) were the location that led to the greatest amount of medical debt, followed by a doctor's office or clinic (27%), and dentist (26%) [6].

Los Angeles County has taken a coordinated, system-wide approach to addressing medical debt, led by LA County Department of Public Health in partnership with a coalition of consumer advocates, nonprofits, public agencies, and health care leaders. In 2024, the County adopted an ordinance requiring hospitals to report on financial assistance and debt collection practices. The County also invested $5 million, with additional funding from LA Care Health Plan and the LA County Medical Association, to relieve medical debt [16]. As of December 2025, the program has erased over $363 million in medical debt for more than 171,000 residents [17].

[iii] LA County respondents who reported problems paying medical bills even though at least one person receiving care was insured were asked: "Did any of the following lead to your problems paying for these medical bills?

One million Californians cannot afford basic necessities because of medical bills.

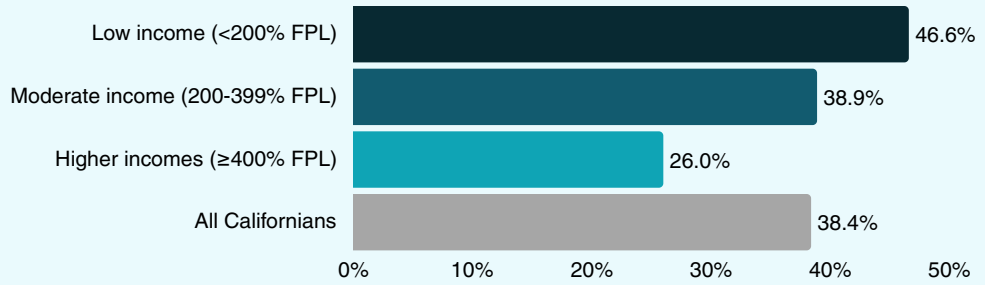
For many Californians, challenges paying medical bills significantly impacts their lives beyond access to health care. In 2024, nearly 4 in 10 (38%) Californians who struggle with medical bills report being unable to pay for basic necessities like food, rent, or heat due to medical bills.[iv]

[iv] Californians who said yes to: "During the past 12 months, did you have medical bills that you had problems paying or were unable to pay, either for yourself or any family member in your household?" were asked: "Because of these medical bills, were you unable to pay for basic necessities like food, heat, or rent?"

Nearly half of Californians with low incomes report being unable to pay for basic necessities.

Among Californians who report problems paying medical bills, 47% of those with low incomes and 39% of those with moderate incomes said they could not afford basic necessities because of medical bills. Both of these groups report much more difficulty than Californians with higher incomes, 26% of whom said they could not afford basic necessities because of medical bills **(Figure 9)**.

Figure 9. Percent of Californians that can't afford basic necessities because of medical bills, by poverty level, 2024

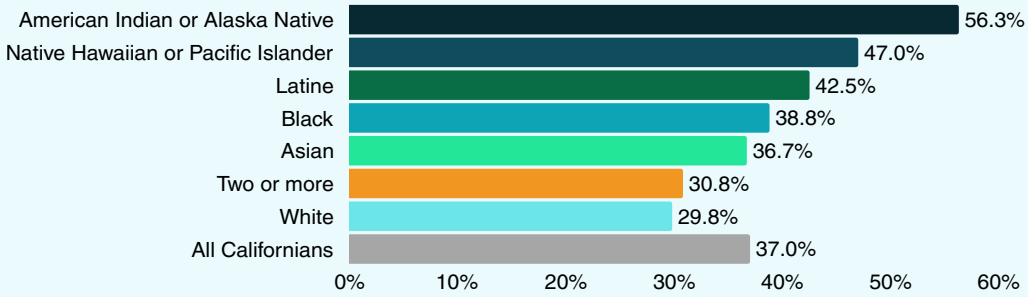


Note: Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months

Californians of color who struggle with medical bills have more challenges affording basic necessities.

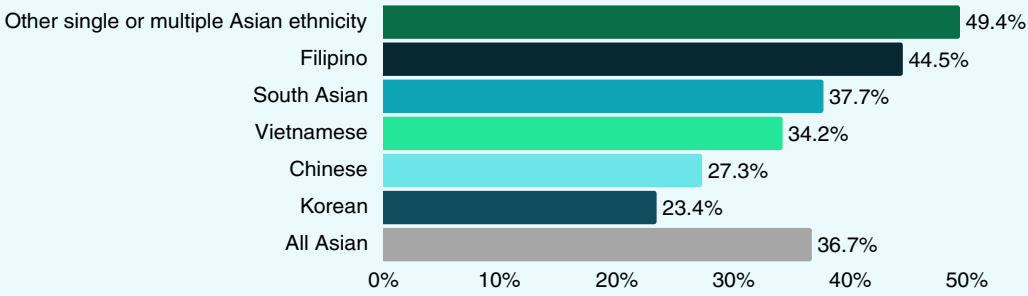
Many Californians of color who reported having problems paying medical bills said they could not afford basic necessities (e.g. food, rent, or heat) because of medical bills. In 2022-2024, more than half of American Indian or Alaska Native (56%) and nearly half of Native Hawaiian/Pacific Islander Californians (47%) said they could not afford necessities because of medical bills. Latine (43%), Black (39%), and Asian Californians (37%) were more likely to say they could not afford basic necessities than White Californians (30%) **(Figure 10)**. Among Asian Californians, rates varied across groups from a high of 50% for other single or multiple Asian ethnicity to a low of 23% of Korean Californians **(Figure 11)**.

Figure 10. Percent of Californians that can't afford basic necessities because of medical bills, by race and ethnicity, 2022-2024



Note: Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months

Figure 11. Percent of Californians that can't afford basic necessities because of medical bills, by Asian ethnicity, 2022-2024

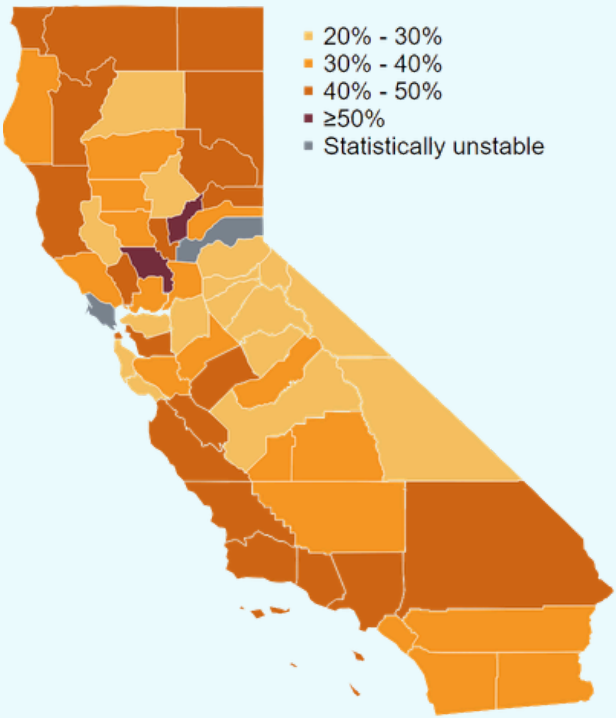


Note: Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months. The estimate for percent of Japanese Californians that can't afford basic necessities because of medical bills is excluded from this chart due to being statistically unstable for the years included in this report.

Across California counties, people are struggling to afford basic necessities because of medical bills.

Challenges affording basic necessities such as food, rent, and heat because of medical bills varied across California counties. Medical bills have a considerable impact on Californians' ability to afford basic necessities, even in counties where the percent of people reporting having problems paying medical bills was relatively low. California counties with high percentages of residents reporting being unable to afford basic necessities due to medical bills include Yolo (59%), Yuba (50%), San Luis Obispo (48%), San Benito (48%), Alameda (47%), and Merced (47%) **(Figure 12)**.

Figure 12. Percent of Californians that couldn't afford basic necessities because of medical debt, by county, 2022-2024



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Understanding the Impact of State and Federal Policy

About the Budget and Legislation

The following section of this report examines the way that recently passed state and federal policy is poised make it even harder for Californians to afford the care they need. Taken together, the 2025-2026 California state budget enacted in June 2025 and the H.R. 1 megabill enacted in July 2025 will undo many of the gains in health insurance coverage made over the last two decades [18]. Devastating federal cuts and restrictions contained in H.R. 1 are designed to push struggling workers out of Medi-Cal coverage. On top of this, state leaders made deep cuts to care for immigrant communities. While Californians with Medi-Cal and Covered California coverage will be hardest hit, all Californians are likely to face higher health care costs as increases in uncompensated care will put upward pressure on provider prices, insurance premiums, and out-of-pocket costs. The passage of these policies means Californians and families will be more likely to take on medical debt, face impossible choices between going to the doctor and paying for food or rent, or get sicker or even die from delaying care.

Table 2. Major Policy Changes to Medi-Cal and Covered California

2025-2026 California State Budget

- Freezes new Medi-Cal enrollment for undocumented adults ages 19+ (January 2026)
- Eliminates non-emergency Medi-Cal dental benefits for undocumented adults and certain other immigrant groups (July 2026)
- Imposes $30 monthly Medi-Cal premium for undocumented adults and certain other immigrant groups (July 2027)

Federal H.R. 1

- Fails to extend enhanced premium tax credits, significantly increasing premiums for 1.8 million Covered California enrollees (expired end of 2025)
- Eliminates federal Medicaid funding for certain immigrants under humanitarian protections including refugees and trafficking survivors (October 2026)
- Reduces federal funding for emergency Medicaid for certain immigrants (October 2026)
- Imposes Medicaid work reporting requirements for ACA expansion adults (January 2027)
- Requires Medicaid ACA expansion adults to renew coverage every six months (January 2027)
- Shortens retroactive Medicaid coverage to one month for ACA expansion adults and two months for all other enrollees (January 2027)
- Imposes copayments for some Medicaid services for certain ACA expansion adults (October 2028)

Source: California Budget and Policy Center [19]

Millions of Californians will lose coverage and pay more for care because of recent policy changes.

With nearly 1 in 10 Californians already experiencing problems paying their own or their household medical bills, recent policy changes are expected to worsen the state of health care affordability. Changes to Medi-Cal eligibility and spikes in Covered California premiums will leave millions of Californians uninsured. Tens of billions of dollars in federal Medi-Cal funding are at risk annually, threatening the financial stability of California's health care system. Patients and their families will see higher bills, longer wait times, and fewer options for care.

Up to 2 million Californians may lose Medi-Cal coverage.

According to state leaders, up to 2 million Californians with Medi-Cal may lose coverage and become uninsured due to H.R. 1 [20]. Coverage losses stem from new work requirements, more frequent eligibility renewals, and other administrative and eligibility changes to Medicaid expansion adults that will make it harder for people to stay enrolled, even when they remain eligible. Individuals who lose Medi-Cal because they do not meet the new work requirements will also be barred from receiving Covered California marketplace subsidies, leaving them with no affordable coverage options [21]. In 2028, H.R. 1 requires states to impose cost sharing for some services provided to Medicaid expansion adults, increasing affordability challenges for Medi-Cal enrollees and likely leading to delayed or foregone care [19].

California's recent state budget decisions will also result in significant coverage losses for immigrant communities. In the 2025-2026 budget, the Governor and Legislature eliminated or restricted key Medi-Cal benefits for immigrants who receive state-funded Medi-Cal, including undocumented immigrants [19]. Beginning in 2026, California froze new Medi-Cal enrollment for undocumented adults ages 19 and older. On July 1, 2026, Medi-Cal will also end non-emergency dental coverage for undocumented adults and those with specific immigration statuses. Starting July 1, 2027, undocumented adults and certain immigrants ages 19-59 will be required to pay a $30 monthly premium to keep their Medi-Cal coverage, putting many at risk of losing care they cannot afford to replace.

Covered California premiums will nearly double on average, with 660,000 enrollees at risk of losing coverage.

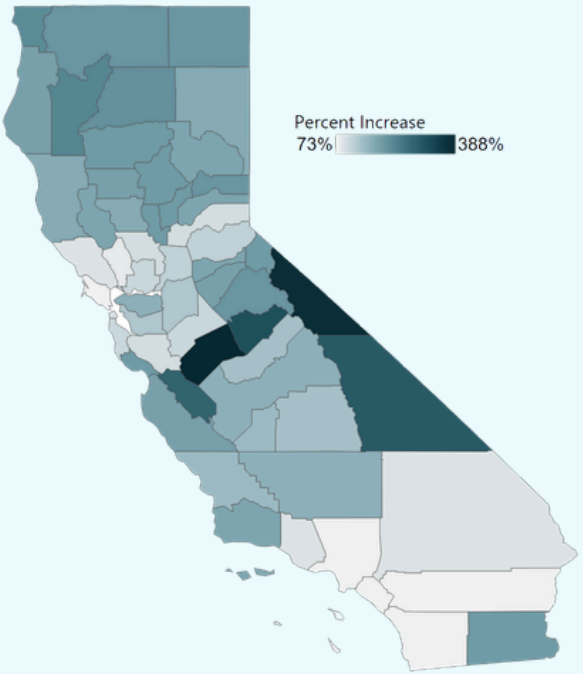
Federal enhanced premium tax credits (ePTCs) enacted during the COVID-19 pandemic vastly improved the affordability of health care coverage through ACA exchanges, driving record enrollment of nearly 2 million Californians in Covered California in 2025 [22]. H.R. 1 failed to extend these tax credits and as of January 2026 Congress has not restored them, allowing the credits to lapse and significantly reducing Californians' ability to afford Covered California plans. As a result of these projected premium increases and additional administrative burdens, it is estimated that as many as 660,000 Covered California enrollees could go uninsured due to H.R. 1 [23].

Covered California estimates that enrollees face an average **97% increase** in monthly premiums if the enhanced premium tax credits that expired at the end of 2025 are not renewed. Nearly 1.7 million Californians are facing increases in their monthly premiums; increases range from 73% higher to 388% higher across the state's counties [22]. Merced, Mono, Mariposa, and Inyo County residents face premium increases of more than 300% **(Table 3 and Figure 13)**.

Table 3 and Figure 13. Top 15 California counties with the highest percent increase in monthly net premium if enhanced premium tax credits expire

County	Percent Increase in Monthly Net Premium if ePTCs Expire
Merced	388%
Mono	379%
Mariposa	311%
Inyo	301%
San Benito	285%
Trinity	224%
Del Norte	220%
Shasta	214%
Sierra	205%
Modoc	202%
Siskiyou	202%
Tuolumne	201%
Alpine	197%
Butte	196%
Imperial	196%

Source: Covered California [24]



Across all income levels, Californians are being hit hard by these increases. For communities of color, premiums are more than doubling on average, deepening existing structural barriers to affordable coverage.

- Over 1.5 million individuals making **less than $62,600** will see premium increases ranging between $45 to $104 more per month, or an additional $1,020 per year on average [22].
- Californians **making more than $62,600** will see even greater premium increases ranging between $485 to $513 more per month, or an additional $6,052 per year on average [22].
- For Californians who identify as American Indian, premiums are projected to rise by 117%. For Latine Californians by 122%, for Native Hawaiian Californians by 116%, for Asian Californians by 112%, and for Black Californians by 106% [24].

Half a million additional Californians are likely to take on medical debt.

Medicaid expansion and health insurance premium caps implemented with the Affordable Care Act reduced both the percentage of people with medical debt and the average amount of medical debt individuals carried [13]. H.R. 1 is likely to have significant impacts on medical debt nationally and in California. National think tank Third Way estimates that an additional 571,782 Californians will take on medical debt as a result of H.R. 1 [25]. The amount of medical debt held by Californians is projected to increase by an additional $5.35 billion. These impacts are likely to be even more severe when coupled with California's recent Medi-Cal budget cuts for undocumented adults and certain immigrant populations, which will increase the number of uninsured and underinsured Californians and further exacerbate the state's medical debt crisis.

Californians will lose essential services as safety net providers face financial crisis.

Taken together, H.R. 1 and the 2025-2026 state budget threaten patients' access to safety net providers their communities depend upon. H.R. 1 caps enhanced payments and federal funding that California has historically used to increase reimbursement rates for Medi-Cal providers [26]. Safety net hospitals and clinics that serve large numbers of Medi-Cal patients will face mounting financial pressure just as millions of Californians are projected to lose coverage. The resulting surge in uncompensated care costs will have devastating impacts on areas that have already struggled to keep essential services open. Both urban and rural hospitals may eliminate vital services and programs deemed too expensive to continue like emergency departments, trauma services, obstetrics, and behavioral health, leaving all patients in those communities with fewer options for care [27].

Rural areas in California are expected to see a $4.09 billion decline in federal Medicaid spending, which is likely to accelerate rural hospital closures that have already affected many California communities [28]. Together, these shifts in the landscape decrease patient access to care, and also inflict significant job losses in these communities.

POLICY RECOMMENDATIONS

Californians want policymakers to take action on health care affordability.

Californians are sounding the alarm on health care affordability. In 2023, 82% of Californians said it was extremely or very important for state lawmakers to reduce health care costs [1] and in 2025, a California Wellness Foundation poll found that 90% of people polled want the next governor to prioritize capping out-of-pocket costs [29].

California must act now. The following recommendations are key actions the state can take to mitigate the harmful impacts of H.R. 1 while taking bold steps to lower health care costs for all Californians.

Protect California's Health Care Safety Net

Protecting California's safety net prevents the cascading costs that come when people lose coverage. When Medi-Cal or Covered California coverage is lost, families are more likely to skip care, incur medical debt, and experience worse health outcomes. This drives up costs and destabilizes the entire health system. The following recommendations are critical to protecting coverage for millions of Californians.

Delay and Reverse Harmful State Medi-Cal Cuts That Threaten Access to Care
At a time when immigrant communities face heightened threats to their safety and well-being, recent state budget actions have already frozen new Medi-Cal enrollment for undocumented adults and put even deeper cuts on the horizon. These cuts will force families into impossible choices: skipping care, accumulating debt, or losing coverage when they need it most. Lawmakers must delay or rescind planned cuts to dental care and the imposition of new monthly premiums, and reverse the enrollment freeze.

Maintain Full Medi-Cal Coverage for Immigrants Losing Federal Funding
California risks reversing decades-long commitments by stripping full-scope Medi-Cal from about 200,000 immigrants losing federal Medicaid funding under H.R. 1, including refugees, survivors of domestic violence, human trafficking, and other traumas [30]. Choosing not to replace federal funding will eliminate access to essential care. California lawmakers must reject the Governor's FY 2026-2027 budget proposal and preserve full coverage to protect continuity of care for vulnerable communities.

Bolster Culturally and Linguistically Responsive Navigation Services
As Medi-Cal rules and benefits change, trusted community health workers, promotoras/es, and health representatives (CHW/P/Rs) provide culturally and linguistically competent support that helps families maintain coverage and stay connected to care. Without this support, recent policy changes will lead to confusion, paperwork barriers, and preventable coverage losses. California lawmakers should make robust investments to expand CHW/P/R and community-based organization capacity for culturally responsive health navigation, renewal assistance, and outreach, ensuring eligible Californians do not lose coverage during this time.

Invest in Systems to Mitigate H.R. 1 and Prevent Unnecessary Coverage Loss
H.R. 1 introduces new eligibility and work requirements that significantly increase the risk of coverage losses due to paperwork and administrative barriers rather than ineligibility. To mitigate these harms, California must invest in Medi-Cal systems that automate eligibility verification, integrate data across state programs, and increase ex parte renewal rates. At the same time, state lawmakers should reject proposals applying federal work and biannual renewal requirements on immigrants enrolled in state-only programs, including those without work authorization [30]. Doing so would create unnecessary complexity, strain limited county resources, and lead to unjust coverage losses.

Backfill Lost Federal Funding
H.R. 1 strips billions of dollars in federal funding from California's health care safety net to finance federal tax cuts for corporations and wealthy individuals. A recent report found that the 2017 Trump tax law, expanded through H.R. 1's nearly $1 trillion in health care cuts, allowed eight major health care corporations to avoid $34 billion in taxes, even as they raised prices, denied care, and cut staff [31]. Patients and families will pay for these tax cuts through higher costs, reduced coverage, and weakened public programs. To protect Medi-Cal and maintain health care affordability, California must pursue alternative revenue solutions that allow the state to backfill lost federal funding and prevent federal actions from undermining access to care.

Take Bold Action to Lower Health Care Costs

Californians' concerns are part of a broader national alarm about rising health care costs. A 2025 national poll showed 91% of voters believe lawmakers must do more to bring down health care costs [32]. A separate 2025 survey found that 76% of voters want their state to pass laws protecting people from medical debt, and two-thirds are dissatisfied with the current health insurance system [33]. California policymakers can respond with the following recommendations.

Monitor and Enforce Cost Growth Targets
California must continue to ensure the Office of Health Care Affordability (OHCA) has the authority, resources, and data necessary to effectively enforce cost growth targets and spending goals. Under OHCA's targets, hospitals, medical groups, and health insurers cannot increase spending by more than 3% annually [34], and OHCA has set a goal for health plans to allocate 15% of spending to primary care by 2034 [35]. As these and other benchmarks take effect, lawmakers must monitor compliance and hold health system actors accountability for meeting these goals.

Curb Health Care Consolidation
Research shows that health care consolidation reduces competition, leading to increased prices without delivering better quality of care [36]. While OHCA can review and refer anti-competitive hospital, physician, and health plan mergers to the California Attorney General, the Attorney General must rely on litigation to block them. California should grant the Attorney General direct authority to block or conditionally approve mergers, streamlining the process to prevent harmful consolidation before it occurs [37].

Enhanced oversight is especially urgent as H.R. 1 threatens to destabilize safety net providers, making them targets for private equity acquisitions that research shows is associated with worse patient outcomes and financial distress as facilities are sold and resold [38]. Lawmakers should also cap debt-financed acquisitions, prohibit rapid resales of health care facilities, and require new owners to demonstrate financial solvency to protect patients and preserve continuity care [39].

Rein in Excessive Health Care Prices.
Policymakers should advance bold reforms to limit excessive hospital prices for commercially insured patients by prohibiting facility fees and implementing price caps. Patients are increasingly hit with unexpected hospital "facility fees" which are administrative charges that make routine office visits more expensive simply because their doctor's practice was acquired by a hospital or health system. To protect consumers from these surprise charges, California should follow the lead of states like Connecticut and New York and prohibit facility fees for office-based, telehealth, and preventive care [40]. California should also explore price caps to address market failures driving unsustainable hospital prices, as Oregon has done by capping what state employee health plans pay hospitals, saving the state hundreds of millions of dollars [41]. Researchers from Brown University estimate California could save roughly $993 million annually by capping state employee health plan payments to 200% of Medicare [42].

Strengthen Health Plan Accountability
Policymakers should build on insurance regulators' existing oversight by expanding authority to assess provider reimbursement rates, rate disparities, and other non-quantitative treatment limits that contribute to inadequate networks and reduced access to care. This oversight is especially needed in behavioral health, where low reimbursement and uneven contracting push patients out of network, increasing out-of-pocket costs [43]. Health plan reporting on network adequacy metrics should be expanded to include data on how often enrollees must seek care out of network due to inadequate provider networks. Additionally, health plans must be held accountable for providing care that meets and exceeds minimum quality performance standards and a demonstrated ability to meet the needs of diverse enrollees such as through network adequacy, timely access, after-hours availability of services, language access and physical accessibility standards, and explicit reduction of disparities.

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This report was researched and written by:

Marlyn Pulido
Senior Research Manager, CPEHN

Stephany Strahle
Data Scientist, CPEHN

Selene Betancourt
Senior Policy Manager, CPEHN

Feedback and technical contributions provided by:

Kiran Savage-Sangwan
Executive Director, CPEHN

Cary Sanders
Senior Policy Director, CPEHN

Jen Joynt
Health Care Consultant

Edinam Ablordeppy
Research & Data Intern, CPEHN

Design by:

Emily Lintner
Digital Engagement Manager, CPEHN

Sami Sanchez
X97 Labs

California Pan-Ethnic HEALTH NETWORK

The California Pan-Ethnic Health Network (CPEHN) is a BIPOC-led, multicultural, state policy organization, which seeks to advance health equity by dismantling structural racism and ensuring opportunity and health for all Californians. For 30 years, CPEHN has worked with a diverse network of community-based organizations across the state to identify and elevate community priorities to state policymakers. CPEHN is dedicated to building power with communities of color through policy advocacy, research, network and leadership building, and storytelling.

Appendix A

Methods

Data presented in this report was analyzed from the recently released results of the 2024 California Health Interview Survey (CHIS). CHIS asks California adults if they have had problems paying their own or their household's medical bills in the past 12 months. Adults responding yes to this question are then asked if they've been unable to afford basic necessities because of medical bills in the past 12 months. In addition, adults responding yes to problems paying medical bills are asked how much medical debt they have in the following categories: less than $1,000; $1,000 to less than $2,000; $2,000 to less than $4,000; $4,000 to less than $8,000; $8,000 or more; or none. To estimate the total amount of medical debt Californians have, the midpoints of these ranges are multiplied by the number of people in each range. These midpoint dollar amounts are then summed to create an estimated total.

Statewide estimates and estimates by federal poverty level (FPL) are shown for 2024 to provide the most recent data available. For estimates by county and by race and ethnicity, this report uses data pooled across 2022-2024 for improved statistical confidence, resulting in an of N=3,029,000 for adults having problems paying their own or their household medical bills in the past 12 months. In some subgroups and smaller counties, however, 3-year estimates were still statistically unstable, and caution is urged in making claims from these unstable estimates.

CHIS also asks demographic questions, such as race and ethnicity. This report uses racial and ethnic groups as defined by the U.S. Office of Management and Budget (OMB) and the California Department of Finance. CPEHN uses the term "Latine" to replace "Hispanic" or "Latino/x" when describing those of Latin American descent. For the purposes of this analysis, respondents were grouped into three income levels by federal poverty level (FPL): lower incomes (0-199% FPL); moderate incomes (200-399% FPL); and higher incomes (400% FPL and higher).

Appendix B

Table B1: Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by county, 2022-2024
Counties are ordered from highest to lowest percent of adults that had problems paying medical bills.

County	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
Statewide	3,029,000	10.3%	10.0 - 10.6	1,122,000	37.0%	35.3 - 38.8
Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte**	22,000	21.2%	16.9 - 25.4	11,000	45.3%	33.7 - 56.9
San Benito	10,000	19.6%	13.7 - 25.5	5,000	47.8%	33.8 - 61.9
Sutter	12,000	16.9%	13.2 - 20.6	5,000	39.7%	28.5 - 51.0
Humboldt	17,000	16.9%	13.8 - 20.1	6,000	35.4%	24.6 - 46.3
Merced	33,000	16.4%	12.8 - 20.0	15,000	47.0%	35.3 - 58.8
Monterey	48,000	15.8%	11.9 - 19.7	19,000	40.3%	28.1 - 52.5
Lake	8,000	15.6%	11.6 - 19.5	2,000	24.1%	13.5 - 34.8
Tehama, Glenn, Colusa**	13,000	15.3%	11.2 - 19.5	5,000	37.4%	24.4 - 50.3
Stanislaus	60,000	15.1%	11.7 - 18.6	23,000	37.8%	25.6 - 49.9
Santa Barbara	48,000	14.9%	10.2 - 19.6	23,000	45.6%	27.0 - 64.2
Kings	14,000	14.4%	10.3 - 18.5	6,000	38.9%	25.9 - 51.8

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.
**The UCLA Center for Health Policy Research groups the 17 smallest counties by population size into 3 group county strata as follows: group 1 - Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte; group 2 – Tehama, Glenn, Colusa; group 3 - Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine.

Appendix B (continued)

Table B1 (cont.): Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by county, 2022-2024
Counties are ordered from highest to lowest percent of adults that had problems paying medical bills.

County	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
Yuba	8,000	14.2%	11.0 - 17.3	4,000	49.7%	37.5 - 61.9
Shasta	18,000	13.3%	10.3 - 16.4	5,000	25.3%	14.1 - 36.5
Fresno	92,000	12.8%	9.8 - 15.8	24,000	26.4%	15.7 - 37.2
San Joaquin	73,000	12.7%	9.7 - 15.7	19,000	26.9%	20.0 - 33.8
Placer	41,000	12.6%	9.8 - 15.4	8,000	20.1%***	8.2 - 32.0
Mendocino	9,000	12.4%	9.1 - 15.6	4,000	45.2%	28.8 - 61.6
Kern	77,000	12.3%	9.4 - 15.2	27,000	34.9%	23.2 - 46.7
Tulare	41,000	12.2%	9.0 - 15.3	15,000	37.9%	25.6 - 50.3
Butte	20,000	12.2%	9.2 - 15.2	4,000	26.4%	16.6 - 36.2
Yolo	20,000	11.8%	6.2 - 17.4	13,000	59.1%	36.5 - 81.8
Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine**	17,000	11.8%	8.9 - 14.7	4,000	25.6%	14.5 - 36.6

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.
**The UCLA Center for Health Policy Research groups the 17 smallest counties by population size into 3 group county strata as follows: group 1 - Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte; group 2 – Tehama, Glenn, Colusa; group 3 - Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine.
***Estimates are statistically unstable. Interpret with caution.

Appendix B (continued)

Table B1 (cont.): Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by county, 2022-2024
Counties are ordered from highest to lowest percent of adults that had problems paying medical bills.

County	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
Nevada	10,000	11.8%	8.7 - 14.9	3,000	29.7%	17.9 - 41.5
Imperial	14,000	11.2%	6.9 - 15.5	5,000	35.3%	19.2 - 51.4
San Luis Obispo	24,000	11.0%	8.2 - 13.8	11,000	47.9%	34.8 - 61.0
Madera	12,000	10.8%	7.1 - 14.4	4,000	31.7%	20.2 - 43.1
Riverside	194,000	10.6%	9.2 - 12.0	73,000	38.3%	30.9 - 45.6
El Dorado	16,000	10.5%	7.1 - 13.9	4,000	28.1%	13.1 - 43.1
Ventura	66,000	10.4%	7.9 - 12.9	28,000	43.4%	31.3 - 55.5
Los Angeles	786,000	10.4%	9.8 - 11.1	313,000	39.9%	36.4 - 43.3
San Bernardino	162,000	10.3%	8.7 - 11.8	72,000	45.2%	38.1 - 52.3
Sacramento	119,000	10.1%	8.6 - 11.5	35,000	30.5%	22.2 - 38.9
Orange	245,000	10.1%	8.8 - 11.4	88,000	36.2%	29.2 - 43.1
Alameda	126,000	10.1%	8.4 - 11.7	60,000	47.4%	39.0 - 55.8

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.
**The UCLA Center for Health Policy Research groups the 17 smallest counties by population size into 3 group county strata as follows: group 1 - Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte; group 2 – Tehama, Glenn, Colusa; group 3 - Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine.

Appendix B (continued)

Table B1 (cont.): Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by county, 2022-2024
Counties are ordered from highest to lowest percent of adults that had problems paying medical bills.

County	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
Sonoma	35,000	9.2%	6.3 - 12.1	10,000	29.5%	16.6 - 42.4
Napa	9,000	8.8%	5.4 - 12.2	4,000	40.8%	27.7 - 53.9
Solano	30,000	8.7%	6.0 - 11.5	11,000	36.0%	20.7 - 51.3
Contra Costa	78,000	8.7%	6.9 - 10.5	22,000	28.7%	18.7 - 38.6
San Diego	202,000	8.4%	7.4 - 9.4	69,000	34.3%	28.0 - 40.7
Marin	16,000	8.0%	4.8 - 11.1	3,000	20.4%***	5.1 - 35.7
Santa Cruz	16,000	7.8%	5.2 - 10.5	4,000	26.6%	13.4 - 39.8
Santa Clara	99,000	6.8%	5.5 - 8.1	27,000	31.4%	22.7 - 40.2
San Francisco	39,000	5.7%	3.9 - 7.6	19,000	46.2%	25.9 - 66.5
San Mateo	31,000	5.3%	3.5 - 7.2	9,000	27.1%	13.1 - 41.1

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.
**The UCLA Center for Health Policy Research groups the 17 smallest counties by population size into 3 group county strata as follows: group 1 - Trinity, Siskiyou, Sierra, Plumas, Modoc, Lassen, Del Norte; group 2 – Tehama, Glenn, Colusa; group 3 - Tuolumne, Mono, Mariposa, Inyo, Calaveras, Amador, Alpine.
***Estimates are statistically unstable. Interpret with caution.

Appendix B (Continued)

Table B2: Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by race and ethnicity, 2022-2024

Race and Ethnicity	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
All Californians	3,029,000	10.3%	10.0 - 10.6	1,122,000	37.0%	35.3 - 38.8
American Indian or Alaska Native	23,000	17.4%	10.9 - 23.8	12,000	56.3%	32.0 - 80.6
Asian	315,000	6.7%	6.0 - 7.5	115,000	36.7%	31.5 - 41.8
Black or African American	188,000	11.6%	10.0 - 13.3	74,000	38.8%	30.8 - 46.8
Latino	1,351,000	12.5%	11.8 - 13.1	574,000	42.5%	39.6 - 45.4
Native Hawaiian or Pacific Islander	16,000	14.7%	7.5 - 21.8	8,000	47.0%	36.5 - 57.6
Two or More Races	88,000	11.9%	9.9 - 13.8	28,000	30.8%	23.5 - 38.2
White	1,047,000	9.3%	8.8 - 9.7	311,000	29.8%	27.5 - 32.0

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.

Appendix B (Continued)

Table B3: Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by Asian race and ethnicity, 2022-2024

Race and Ethnicity	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
All Asian	314,000	6.7%	6.0 - 7.5	114,000	36.7%	31.6 - 41.9
Chinese	55,000	3.9%	3.0 - 4.8	15,000	27.3%	18.0 - 36.7
Japanese	11,000	5.2%	3.0 - 7.4	2,000	20.2**	3.1 - 37.3
Korean	35,000	9.3%	7.2 - 11.3	8,000	23.4%	13.5 - 33.2
Filipino	100,000	9.6%	7.6 - 11.5	44,000	44.5%	32.7 - 56.2
South Asian	54,000	7.1%	5.6 - 8.7	20,000	37.7%	26.5 - 48.9
Vietnamese	36,000	6.4%	3.9 - 9.0	13,000	34.2%	22.6 - 45.8
Other single or multiple Asian ethnicities	23,000	7.7%	5.5 - 10.0	12,000	49.4%	34.4 - 64.3

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.
**Estimate is statistically unstable. Interpret with caution.

Appendix B (Continued)

Table B4: Californian adults reporting they had problems paying their own or their household medical bills and were unable to afford basic necessities due to medical debt, by poverty level, 2024

Income Level	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval	Number of adults that were unable to afford basic necessities due to medical debt *	Percent of adults that were unable to afford basic necessities due to medical debt *	95% Confidence Interval
Low income (<200% FPL)	1,259,000	14.1%	12.9 - 15.3	586,000	46.6%	41.4 - 51.7
Moderate income (200-399% FPL)	983,000	14.2%	12.9 - 15.6	383,000	38.9%	33.9 - 43.9
Higher income (≥400% FPL)	873,000	6.4%	5.7 - 7.0	227,000	26.0%	21.8 - 30.2
All Californians	3,116,000	10.5%	10.0 - 11.0	1,196,000	38.4%	35.7 - 41.1

*Out of Californians that ever had problems paying their own or their household medical bills within the past 12 months.

Table B5: Californian adults reporting they had problems paying their own or their household medical bills, by health insurance type, 2024

Health Insurance Type	Number of adults that had problems paying their own or their household medical bills	Percent of adults that had problems paying their own or their household medical bills	95% Confidence Interval
Uninsured	312,000	16.7%	13.6 - 19.8
Privately purchased	212,000	14.7%	11.9 - 17.5
Other public	35,000	13.6%	5.8 - 21.3
Medicare only	66,000	12.8%	8.9 - 16.7
Medi-Cal	689,000	11.8%	10.4 - 13.1
Employment-based	1,449,000	10.5%	9.7 - 11.2
All Californians	3,116,000	10.5%	10.0 - 11.0

References

1. Joynt, J., Catterson, R., Alverez, E., Bye, L., Pineau, V., & Liu, L. (2024). *The 2024 CHCF California Health Policy Survey*. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf

2. Lucia, L., Dietz, M., & Challenor, T. (2023). *What Can We Afford? Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases*. https://laborcenter.berkeley.edu/wp-content/uploads/2023/09/What-can-we-afford.pdf

3. Whaley, C., Kerber, R., Wang, D., Kofner, A., & Briscombe, B. (2024). *Prices Paid to Hospitals by Private Health Plans*. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

4. Dietz, M., & Lucia, L. (2024). *Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability Executive summary*. https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

5. KFF. (2024). *Employer-Based Health Insurance Premiums and Deductibles*. https://www.kff.org/state-category/health-costs-budgets/employer-based-health-insurance-premiums/

6. UCLA Center For Health Policy Research. (2025). *California Health Interview Survey*. UCLA Center for Health Policy Research. Exported on October 9,2025. http://ask.chis.ucla.edu

7. U.S. Department of Health and Human Services. (2024). 2024 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii) Dollars Per Year. https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailed-guidelines-2024.pdf

8. Dollar For. (2025). Charity Care Law in California. https://dollarfor.org/state_sheet/california/

9. Walker, B., Wallace, J., Callison, K., Anderson, A., Siebert, A., & Ndumele, C. D. (2024). *How Medicaid Protects Beneficiaries from Financial Stress — and How It Could Do More*. Commonwealth Fund. https://www.commonwealthfund.org/blog/2024/how-medicaid-protects-beneficiaries-financial-stress-and-how-it-could-do-more

10. Levinson, Z., Qureshi, N., Liu, J. L., & Whaley, C. M. (2022). *Trends in Hospital Prices Paid by Private Health Plans Varied Substantially Across the US*. https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01476

11. HCAI. (2025). *Update to Draft Motions Presented*. https://hcai.ca.gov/wp-content/uploads/2025/04/Update-to-Draft-Motions-Presented-April-2025.pdf

12. OHCA. (2025). *An Investigative Study of Hospital Market Competition in Monterey County*. https://hcai.ca.gov/wp-content/uploads/2025/11/OHCA-Investigative-Study-of-Hospital-Market-Competition-in-Monterey-County.pdf

13. Manzanilla, A. (2025). *Medical Debt in California: Causes, Consequences and Solutions*. https://laborcenter.berkeley.edu/wp-content/uploads/2025/05/Medical-Debt-in-California.pdf

14. CPEHN. (2025). *Landmark Medical Debt Prevention Law Signed by Gov. Newsom*. https://cpehn.org/about-us/blog/ab1312-signed/

15. Collins, S., Roy, S., & Masitha, R. (2023). *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer*. https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey

16. LA County Department of Public Health. (2025). *Preventing and Reducing Medical Debt in LA County*. http://publichealth.lacounty.gov/hccp/medicaldebt/prevent.html

References

17. LA County Department of Public Health. (2025). *Over $363 Million in Medical Debt Relieved for Low-Income Los Angeles County Residents.* http://publichealth.lacounty.gov/phcommon/public/media/mediapubhpdetail.cfm?prid=5196

18. Health Access. (2025). *The State of Health Care Coverage: H.R.1 and State Budget Impacts.* https://health-access.org/wp-content/uploads/2025/07/20250902_federal-state-impacts-implementation_.pdf

19. California Budget & Policy Center (2025). *H.R. 1 and the Federal Budget: How California Leaders Can Respond to Trump's Cuts.* https://calbudgetcenter.org/resources/hr1-and-the-federal-budget-how-california-leaders-can-respond-to-trumps-cuts/

20. California HHS. (2026). *How Federal Policy Changes are Impacting a Healthy California for All.* https://www.chhs.ca.gov/wp-content/uploads/2026/01/CalHHS-Connect-Webinar_JAN26.pdf

21. KFF. (2025). Health Provisions in the 2025 Federal Budget Reconciliation Law. KFF. https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/#2ca666ac-5d15-4454-8973-241566e22bb5

22. Covered California. (2025). *Impacts of the Enhanced Premium Tax Credits in California.* https://hbex.coveredca.com/data-research/library/Fact%20Sheet%20Enhanced%20Premium%20Tax%20Credit%20Expiration%20Impacts.pdf

23. California HHS. (2025). *President Trump's "Big Beautiful" Bill.* https://www.chhs.ca.gov/wp-content/uploads/2025/07/CalHHS-Merged-HR1-Slides-7.19.25.pdf

24. Covered California. (2025). Impact of Enhanced Premium Tax Credits for Covered California Enrollees - 2026. https://hbex.coveredca.com/data-research/library/Impact%20of%20Enhanced%20Premium%20Tax%20Credits%20for%20Covered%20California%20Enrollees%20-%202026.xlsx

25. Kendall, D., Elliott, B., & Kusuma, T. (2025). *GOP Health Care Cuts: A Recipe for Medical Debt Disaster.* https://www.thirdway.org/memo/gop-health-care-cuts-a-recipe-for-medical-debt-disaster

26. Joyce, D. (2025). *How Massive Federal Cuts Will Create Unprecedented Challenges for Medi-Cal Patients and Providers.* https://www.chcf.org/resource/how-massive-federal-cuts-will-create-unprecedented-challenges-medi-cal-patients-providers/

27. Badger, E., Parlapiano, A., & Sanger-Katz, M. (2025). *When the G.O.P Medicaid Cuts Arrive, These Hospitals Will Be Hit Hardest.* https://www.nytimes.com/2025/11/18/upshot/urban-hospitals-medicaid-cuts.html

28. Saunders, H., Burns, A., & Levinson, Z. (2025). How Might Federal Medicaid Cuts in the Enacted Reconciliation Package Affect Rural Areas? https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/

29. Ibarra, Ana (2025). *Health care costs and mental health access weigh on Californians, poll shows.* https://calmatters.org/health/2025/10/wellness-foundation-gubernatorial-poll/

30. CPEHN. (2026). *Newsom's Cruel Cuts to Immigrant Health Care are Trumpian.* https://www.cpehn.org/about-us/blog/fy26-27-budget-statement/

31. Straus, M., & Rice, W. (2025). *Sick Profits.* *https://communitycatalyst.org/resource/sick-profits-how-health-care-corporations-profit-from-tax-breaks-while-patients-pay-the-price/*

32. Families USA (2025). *NEW POLL: Crushing Health Care Costs Top Priority for Voters.* https://www.familiesusa.org/press-releases/new-poll-crushing-health-care-costs-top-priority-for-voters/

33. Undue Medical Debt. (2025). *Voters Show Strong Bipartisan Support for Policies that Protect People from Medical Debt.* https://unduemedicaldebt.org/bipartisan-support-for-policies-that-protect-people-from-medical-debt/

References

34. HCAI. (2024). *Statewide Health Care Spending Target Approval is Key Step Towards Improving Health Care Affordability for Californians.* https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians/

35. HCAI. (2024). *California Sets Benchmarks for Primary Care Investment to Promote High-Quality, Equitable Health Care.* https://hcai.ca.gov/california-sets-benchmarks-for-primary-care-investment-to-promote-high-quality-equitable-health-care/

36. Brown E., Singh, Y., Whaley, C., & Perkins, J. (2024). *The Rise Of Health Care Consolidation And What To Do About It.* https://www.healthaffairs.org/content/forefront/rise-health-care-consolidation-and-do

37. Stremikis, K., & Teare, C. (2025). *Unfair Pricing and Too Few Choices.* https://www.chcf.org/resource/why-health-care-is-so-expensive/unfair-pricing-and-too-few-choices/

38. Healthcare Quality and Outcomes Lab. (2025). *Medicaid Cuts Likely to Affect Urban Safety-Net Hospitals.* https://hsph.harvard.edu/health-quality/news/medicaid-cuts-likely-to-affect-urban-safety-net-hospitals/

39. Leuchter, R., & Walsh, T. (2026). *Balancing Investment And Oversight: A Legislative Framework For Health Care Acquisitions.* https://www.healthaffairs.org/content/forefront/balancing-investment-and-oversight-legislative-framework-health-care-acquisitions

40. Georgetown CHIR. (2025). *From Check-Ups to Cha-Ching: Consumers' Exposure to Facility Fees.* https://chir.georgetown.edu/from-check-ups-to-cha-ching-consumers-exposure-to-facility-fees/

41. Vangeli, A., & Angeles, J. (2025). *How States Can Lower Hospital Prices and Make Health Care More Affordable.* https://www.commonwealthfund.org/blog/2025/how-states-can-lower-hospital-prices-and-make-health-care-more-affordable

42. Murray, R., Whaley, C., Brown, E., & Ryan, A. (2024). *Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy.* https://cahpr.sph.brown.edu/tools/simulator

43. Mark, T., & Parish, W. (2024). *Behavioral health parity – Pervasive disparities in access to in-network care continue.* https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue

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