California Pan-Ethnic
HEALTH NETWORK

SACRAMENTO REGION

Health Care Access, Affordability, and Equity: Sacramento Region Landscape



Overview of Sacramento Health Care Market

This report presents an analysis of the Sacramento region's health care access, affordability, and equity landscape. It draws upon state and federal data to assess key elements of the health care delivery system and presents recommended actions for consumer and community advocates.

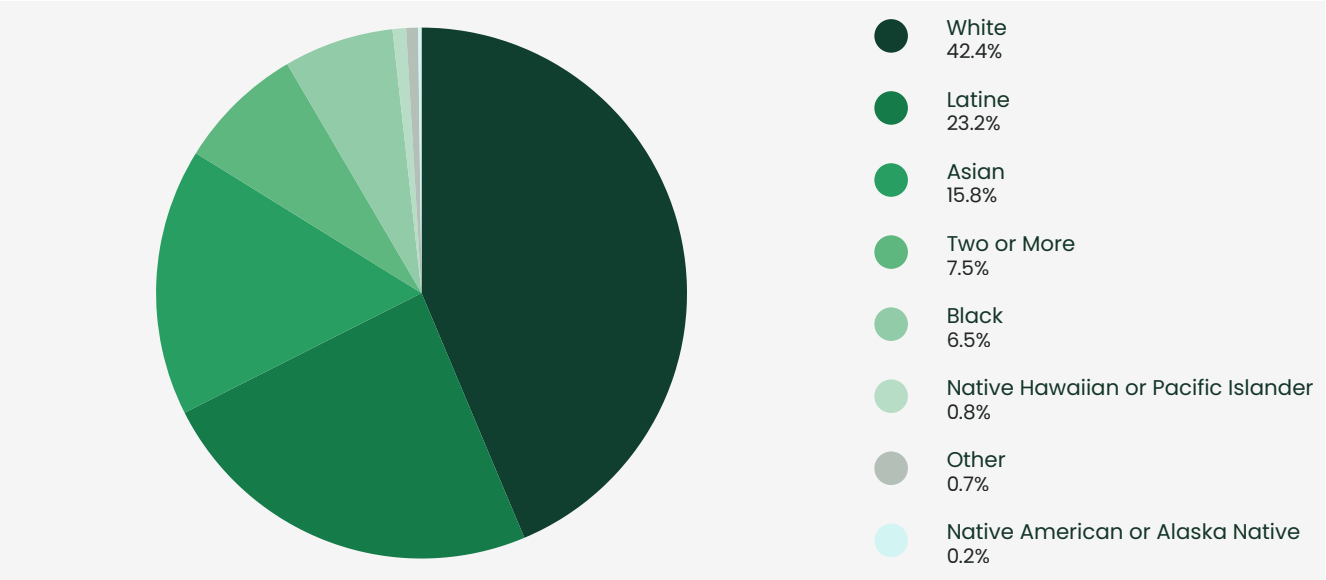
The Sacramento region, comprised of Sacramento, Yolo, Placer, and El Dorado counties, has a diverse population of nearly 2.5 million. Its residents are 42% White, 23% Latine, and 16% Asian. The cost of health care is high compared to California as a whole, as indicated by Covered California premium rates and the cost of inpatient hospital stays.

The highly consolidated hospital market, with three systems and one academic medical center owning 94% of beds, is a key driver of high costs.

The safety net infrastructure is relatively weak, with no county hospital and only three dozen federally qualified health centers, who are operating with a negative average margin. The safety net is fractured because of the use of geographic managed care as the Medi-Cal model in Sacramento County.

While most Sacramento region residents (56%) have commercial health insurance, nearly one in three residents (32%) have Medi-Cal coverage. Fifteen percent have Medicare coverage, and 4.6% are uninsured.

Figure 1: Sacramento Region by race and ethnicity, 2024



Source: *2024 American Community Survey (ACS) 1-year estimates.*

Note: This report uses the term "Latine" when referring to Hispanic or Latino individuals.

More than 1 in 10 Sacramento area residents (11.8%) say they have no usual source of care, and more than one in five residents with Medi-Cal coverage (22.8%) say they have no usual source of care [1]. Fifteen percent of Sacramento region residents say their health is fair or poor compared to 18% of residents statewide.

Table 1: Health indicators among adults ages 18 and older, California Health Interview Survey, 2024

Health Indicator	Sacramento Region	Statewide
Percent of adults reporting fair or poor health, 2023–2024	14.9%	17.8%
Percent of adults reporting ever being diagnosed with asthma	18.4%	16.6%
Percent of adults reporting ever being diagnosed with diabetes	11.1%	12.4%
Percent of adults reporting ever being diagnosed with high blood pressure	25.2%	26.2%

Source: *2024 California Health Interview Survey*

Note: Data for health status was pooled over 2023-2024 for statistical stability. All other table measures are for 2024 only.

About 1 in 10 Sacramento region residents (10.4%) said they had problems paying their own or their household medical bills in the past year, similar to California residents overall (10.2%) [2]. In 2025, 31% of Sacramento region residents report having medical debt, lower than California residents overall (40%) [3].

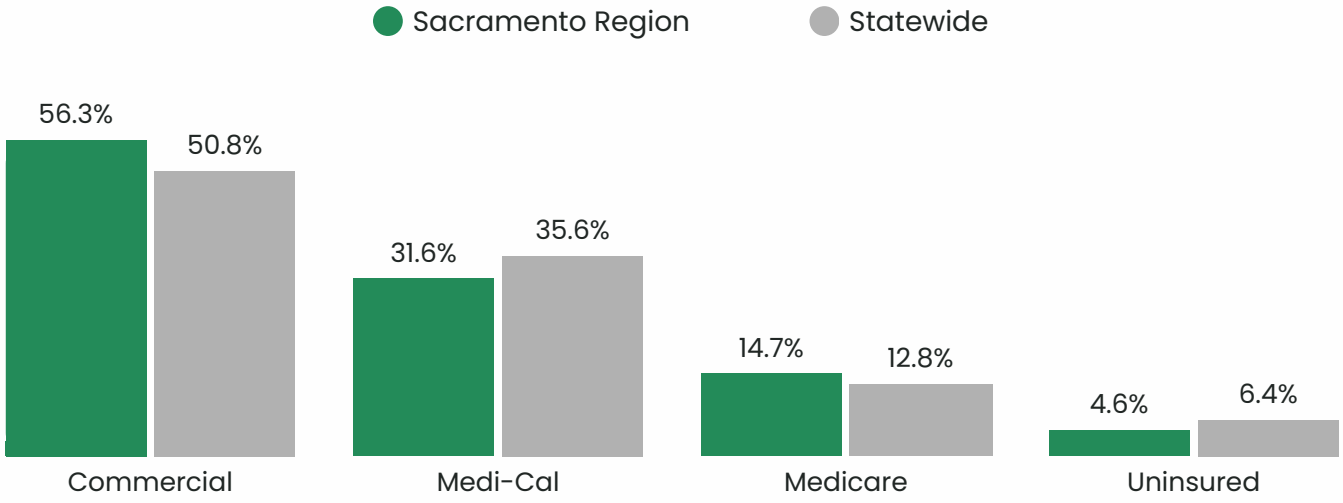
Despite these challenges, there are several key opportunities for advocates and community leaders to strengthen access to affordable health care and advance health equity.



Health Insurance Coverage in Sacramento Region

Compared to California overall, more Sacramento residents have commercial insurance and fewer have Medi-Cal coverage or are uninsured.

Figure 2: Source of Health Insurance Coverage in the Sacramento Region, 2023



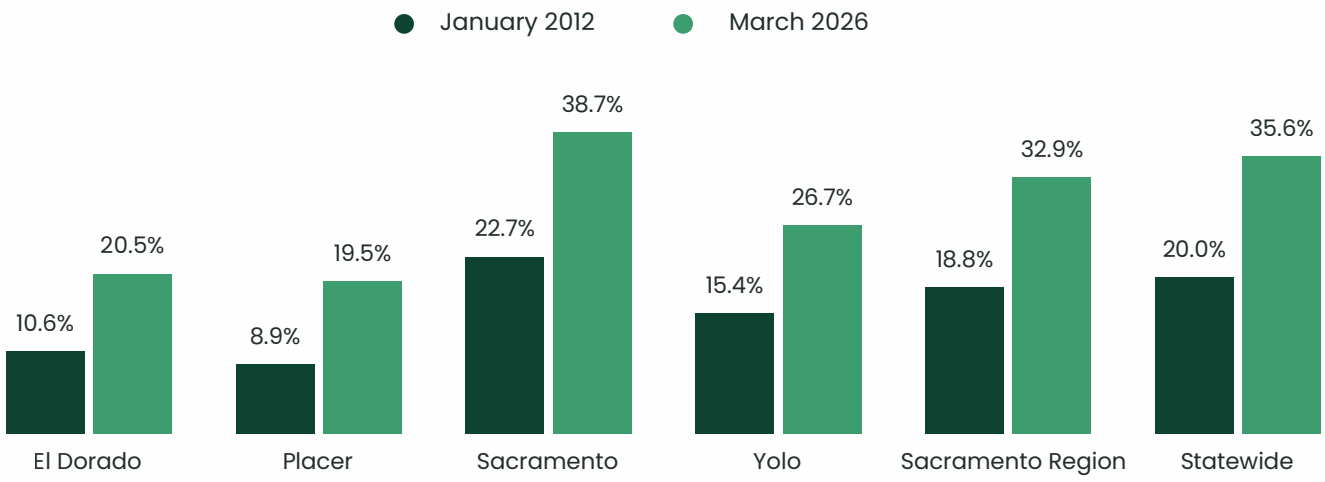
Source: *California Health Care Foundation Regional Market Report 2026 (in preparation).*



Medi-Cal in the Sacramento Region

From 2012 to 2026, Medi-Cal enrollment in the Sacramento region increased from 19% to 33%. Sacramento County had the highest Medi-Cal enrollment in the region in both years and had a higher enrollment rate than the state in 2026.

Figure 3: Source of Health Insurance Coverage in the Sacramento Region, 2023



Source: *CHCF Medi-Cal Enrollment Tracking Tool*

Note: Sacramento region totals were calculated using ACS 5-Year population estimates for 2008-2012 and 2020-2024.



Nearly all the region's Medi-Cal enrollees (94%) are enrolled in a managed care plan (MCP), the same as California overall. Currently six Medi-Cal MCPs operate in the Sacramento region; Anthem Blue Cross (36%), Kaiser Permanente (21%), and Health Net (19%) have the largest share of Medi-Cal enrollees in the region. All of the MCPs operating in the Sacramento region posted positive income in the past year, with the exception of Mountain Valley Health Plan, which only has 1% of the region's enrollees, and Anthem Blue Cross, which had a slightly negative margin in 2025 but was profitable for each of the prior four years.

Table 2: Medi-Cal Managed Care Plans, Sacramento Region, 2025

Managed Care Plan	Counties Served in the Sacramento Region	Number of Medi-Cal Enrollees	Share of Region's Medi-Cal Enrollment	Net Profit (Loss) in Dollars	Net Profit Margin (%)
Blue Cross of California Partnership Plan	El Dorado, Sacramento	279,776	35.8%	-$3,436,000	-0.1%
Mountain Valley Health Plan (Health Plan of San Joaquin)	El Dorado	8,408	1.1%	-$156,172,108	-9.5%
Kaiser Foundation Health Plan, Inc.	El Dorado, Placer, Sacramento, Yolo	161,256	20.6%	$9,325,472,000	6.9%
Partnership HealthPlan of California	Placer, Yolo	108,591	13.9%	$209,947,504	3.1%
Health Net Community Solutions, Inc.	Sacramento	147,667	18.9%	$208,897,478	1.6%
Molina Healthcare of California	Sacramento	75,280	9.6%	$210,532,231	4.1%

Sources: *California Department of Health Care Services (DHCS) Medi-Cal Certified Eligibles Data by Month; DMHC Health Plan Dashboard*

Note: Medi-Cal Managed Care Plan enrollment figures are based on January 2025 eligibility data. Net profit margin and net profit (loss) are based on revenues and costs for commercial, government (e.g., Medi-Cal, Medicare), and other types of business. The majority of Kaiser's enrollment comes from their commercial plans.

The California Department of Health Care Services (DHCS) requires all Medi-Cal managed care plans to contribute a minimum percentage of their annual net revenue to qualifying community reinvestment activities each year [4]. MCPs that fail to meet certain quality standards are required to make additional investments. Community reinvestment activities should meet identified community needs and must be non-clinical activities such as programs that address the social determinants of health.

Table 3: 2026 Medi-Cal Managed Care Plan Community Reinvestment Obligations, Sacramento County

Sacramento County			
Plan Name	**Base Obligation**	**Quality Obligation**	**Total Obligation**
Anthem Blue Cross	$173,811	$434,166	$607,976
Health Net	$2,076,422	$1,737,580	$3,814,001
Molina	$1,198,947	$1,215,256	$2,414,203
County Total	**$3,449,179**	**$3,387,001**	**$6,836,180**
Yolo County			
Plan Name	**Base Obligation**	**Quality Obligation**	**Total Obligation**
Partnership Health Plan	$439,425	$678,513	$1,117,938
County Total	**$439,425**	**$678,513**	**$1,117,938**
Placer County			
Plan Name	**Base Obligation**	**Quality Obligation**	**Total Obligation**
N/A	N/A	N/A	N/A
El Dorado County			
Plan Name	**Base Obligation**	**Quality Obligation**	**Total Obligation**
Anthem Blue Cross	$56,678	$46,168	$102,846
County Total	**$56,678**	**$46,168**	**$102,846**

Source: *Community Reinvestment Obligations: Managed Care Plan & Qualifying Subcontractor Preliminary Obligations, DHCS*
Note: There are no community reinvestment obligations for Placer County in 2026.

Sacramento County is one of only two "geographic managed care" (GMC) counties in Medi-Cal, which means that it allows multiple commercial health plans to operate in the county. GMC has repeatedly been shown to cause confusion, weaken networks, and worsen health outcomes [5]. The Sacramento County Health Authority Commission has meaningful authority over Medi-Cal in the county and requires representative membership including Medi-Cal members, providers, and advocates. The Commission may become a county-operated/local initiative health plan or select at least two health plans to provide services in the county. For the plan contract period beginning in 2024, the Commission selected three health plans: Anthem Blue Cross Partnership, Health Net Community Solutions, and Molina Health Care of California. Kaiser Permanente was added through its direct contract with the state, and its membership is limited primarily to Medi-Cal members who were previously enrolled or have a family member who is enrolled in a Kaiser commercial plan [6].

Yolo and Placer counties have a local initiative model for Medi-Cal and are served by Partnership Health Plan. El Dorado County has a managed care two-plan model with Anthem Blue Cross Partnership and Mountain Valley Health Plan (Health Plan of San Joaquin).

Sacramento County also has Dental Managed Care and is the only county that requires Medi-Cal members to be enrolled in a dental plan - Health Net Dental, Liberty Dental, or the California Dental Network - and receive dental services through that plan. In the rest of California, Medi-Cal members participate in "fee-for-service" dental, which means that individuals find and use a Medi-Cal dental provider, who is then paid directly by the state for the care provided. Dental managed care has generally been shown to result in less access to care compared to fee-for-service dental, while costing the state more to administer.

Table 4: Preventive Dental Services for Medi-Cal Enrollees, California, 2025

Dental Plan	Preventative Services for Children (Age 0–20)	Preventative Services for Adults (Age 20+)
FFS Dental Statewide	47.5%	15.4%
Health Net Dental	41.4%	11.0%
Liberty Dental	45.1%	16.3%
California Dental Network	30.7%	9.1%

Source: *DHCS Dental Fee-for-Service (FFS) and Dental Managed Care (DMC) Performance Fact Sheet: January - December 2025 data.*

Medicare in the Sacramento Region

In 2024, 463,705 area residents had Medicare coverage. Among these, 57% used Medicare Advantage plans, which bundle hospital services, physician services, and often prescription drugs into one health plan sold by private insurance companies, slightly more than California overall (51%). The remainder use Original Medicare [7].



Commercial Insurance in the Sacramento Region

While regional data is not available, California's largest health plans are Kaiser Permanente, Blue Shield, and Anthem Blue Cross, which together account for 77% of commercial health enrollees in the state. In 2025, the latest year for which data is available, six of the seven largest health plans had positive profit margins, while Health Net had a negative margin. Kaiser Permanente posted a net profit of $9.3 billion in 2025.

In addition to all seven of the largest health plans, Sutter Health Alliance and Western Health Advantage serve enrollees in the Sacramento Region.

Table 5: Top 7 Commercial Insurers in California, 2025

Health Plan	Number of Commercial Enrollees	Share of California's Commercial Enrollees (%)	Net Profit (Loss) in Dollars	Net Profit Margin (%)
Kaiser Permanente	6,653,930	48.50%	$9,325,472,000	6.90%
Blue Shield of California	1,964,613	14.30%	$234,973,000	0.90%
Elevance (Anthem Blue Cross)	1,924,050	14.00%	$426,274,000	2.20%
UnitedHealthcare of California	829,462	6.00%	$106,488,000	1.50%
Centene (Health Net of California, Inc.)	530,883	3.90%	-$100,688,270	-1.80%
CVS (Aetna Health of California, Inc.)	426,484	3.10%	$41,041,917	2.40%
Cigna HealthCare of California, Inc.	295,781	2.20%	$46,019,893	5.40%

Source: *DMHC Health Plan Dashboard; CDI Health Insurance Covered Lives Report*

Note: Number of commercial enrollees and share of California's commercial enrollees calculated based on combined data from the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). Net profit margin and net profit (loss) are based on revenues and costs for commercial, government (e.g., Medi-Cal, Medicare), and other types of business, and only pertain to DMHC-regulated plans, which represent 95% of commercial enrollment in California.

Table 6: Commercial Insurers Serving the Sacramento Region, 2026

Health Plan	
Aetna Health of California Inc.	Kaiser Permanente
Blue Cross of California (Anthem Blue Cross)	Sutter Health Alliance
Blue Shield of California (California Physicians' Service)	UnitedHealthcare of California
Cigna HealthCare of California, Inc.	UnitedHealthcare Benefits Plan of California
Centene (Health Net of California, Inc.)	Western Health Advantage

Source: *DMHC Health Plan Dashboard*

Note: Only plans regulated by DMHC are represented in this table. All plans listed in this table serve all four counties in the Sacramento Region: El Dorado, Placer, Sacramento, and Yolo.



Covered California

In 2026, 99,350 Sacramento residents were enrolled in Covered California health plans. Most enrollees in the region were covered by Kaiser (65%), followed by Western Health Advantage (18%) and Blue Shield of California (10%). More than 9 in 10 Covered California enrollees in the Sacramento region (93%) receive a premium subsidy, compared to 89% of enrollees statewide [8]. The average monthly premium for Sacramento area enrollees who receive a subsidy is $156, similar to California overall ($153). Residents who do not receive subsidies pay on average $810 monthly across the region, 15% higher than the statewide average of $704.

Table 7: Covered California Enrollment and Average Monthly Premiums, Sacramento Region, 2026

Geography	Number of Enrollees	Members Receiving Subsidies: Average Monthly Premium per Member	Unsubsidized Members: Average Monthly Premium per Member
El Dorado County	9,380	$162	$900
Placer County	19,900	$167	$811
Sacramento County	62,940	$138	$742
Yolo County	7,130	$156	$786
Regional Total	99,350	$156	$810
Statewide	1,785,900	$153	$704

Source: *Covered California Active Member Profile, March 2026*

Table 8: Covered California plans operating in Sacramento Region counties, 2026

Plan	Number of Enrollees, El Dorado	Number of Enrollees, Placer	Number of Enrollees, Sacramento	Number of Enrollees, Yolo	Region Total	
					Number of Enrollees	Percent of Enrollees
Anthem Blue Cross of California	2,110	1,990	1,210	290	5,600	5.6%
Blue Shield of California	1,510	2,390	5,090	940	9,930	10.0%
Health Net	0	650	1,220	230	2,100	2.1%
Kaiser Permanente	4,000	11,930	44,420	3,800	64,150	64.6%
Western Health Advantage	1,760	2,930	10,970	1,860	17,520	17.6%
Total	**9,380**	**19,900**	**62,940**	**7,130**	**99,350**	**100.0%**

Source: *Covered California Active Member Profile, March 2026*

Note: Only plans with more than 10 enrollees in a county are shown.

Statewide quality data for the Covered California plans offered in the Sacramento region reveals that only a minority of children and adolescents are receiving annual well-care visits in most plans (ranging from 28% to 53%). In addition, more than 1 in 10 Covered California enrollees in all plans have received no care (ranging from 11% to 23%). See Appendix A for data.

Medically Indigent Adult Program

California's Medically Indigent Adult (MIA) programs are not considered health insurance but can help low-income uninsured adults pay for health services. 23 counties operate independent programs with county level discretion determining eligibility, benefits, enrollment period, and cost. 35 counties are centrally administered under the County Medical Services Program (CMSP) with uniform offerings in all participating counties. MIA programs generally do not provide care outside of their specified county, with some exceptions for emergency care.

- El Dorado and Yolo County operate under California's centrally administered **County Medical Services Program (CMSP)**. The CMSP Governing Board recently approved changes that reduce covered benefits, eligibility, and costs that will take effect January 1, 2027; current program details will remain in place through December 31, 2026.
- Placer County currently operates an independent program called **Medical Care Services Program (MCSP)**. Effective April 1st, 2027 Placer County will switch to operating under the centrally administered CMSP program, with the same offerings as other participating counties.
- Sacramento County operates an independent program called **County Medically Indigent Services Program (CMISP)**. Sacramento also operates another program important to the counties safety net landscape called **Healthy Partners** which serves eligible county residents regardless of immigration status.



Table 9: Medically Indigent Adult Programs, Sacramento Region Counties

Program Name	Program Type	Covered Benefits	Eligibility	Cost
El Dorado County & Yolo County — *Through December 31st, 2026**				
El Dorado CMSP	CMSP**	Primary & preventative care, emergency services, hospitalization, dental, vision, mental health & substance use disorder, outpatient care, and prescription coverage.	**Duration:** 6 Months; **Age:** 21–64; **Income:** ≤300% FPL; **Citizenship Status:** Regardless of Immigration Status	No cost or share of cost
Yolo CMSP	CMSP**	Primary & preventative care, emergency services, hospitalization, dental, vision, mental health & substance use disorder, outpatient care, and prescription coverage.	**Duration:** 6 Months; **Age:** 21–64; **Income:** ≤300% FPL; **Citizenship Status:** Regardless of Immigration Status	No cost or share of cost
Placer County — *Starting April 1, 2027 will join CMSP*				
Medical Care Services Program (MCSP)	County Specific	Current information on covered benefits is limited.	**Duration:** 60 days; **Age:** 21–64; **Income:** <100% FPL; **Citizenship Status:** US Citizen or Lawful Permanent Resident	No cost or share of cost >100% FPL
Sacramento County				
County Medically Indigent Services Program (CMISP)	County Specific	Medically necessary primary care, pharmacy, specialty, emergency, hospital, and ancillary services.	**Duration:** Unclear; **Age:** 19–64; **Income:** ≤138% FPL; Above this may qualify for exception; **Citizenship Status:** US Citizen or meets federal immigration status requirements	Possible share of cost
Healthy Partners (HP)***	Not a MIA program	Primary & preventative care, behavioral health, women's health, treatment of chronic conditions, lab and radiology, and low cost prescription medications.	**Duration:** Unclear; **Age:** 19+; **Income:** ≤138% FPL; **Citizenship Status:** Regardless of immigration status	No cost, low cost prescriptions

**Effective January 1, 2027 the CMSP income limit will decrease to 200% FPL, cost-sharing and asset limit requirements will change, and coverage for undocumented immigrants will be reduced to emergency only coverage. [Continued]*

Other discontinued services include outpatient substance use disorder treatments, certain mental health services, chiropractic care, and some vision, audiology, and dental services.

***CMSP enrollment is through corresponding County Social Services Departments and participating Community Health Centers. Through December 31, 2026 participating community health centers in CMSP counties may also offer the "Connect to Care" program, which offers less comprehensive health benefits for those with annual incomes between 138% and 300% FPL.*

****While not a Medically Indigent Adult (MIA) program, Sacramento's Healthy Partners program is an important safety net program for undocumented county residents.*

MIA programs are one way counties comply with their legal obligation under California Welfare and Institutions Code 17000, which names them the "providers of last resort" for county residents with no other sources of care. Recent health policy changes have renewed interest in these programs as a possible resource for people who are no longer eligible for Medi-Cal, and some counties are exploring ways to reform them. For example, the centrally administered CMSP recently made program changes that will reduce eligibility and benefits for El Dorado and Yolo Counties. Placer County residents may receive more comprehensive care when the county joins CMSP in April 2027 because their currently county-operated program is limited.



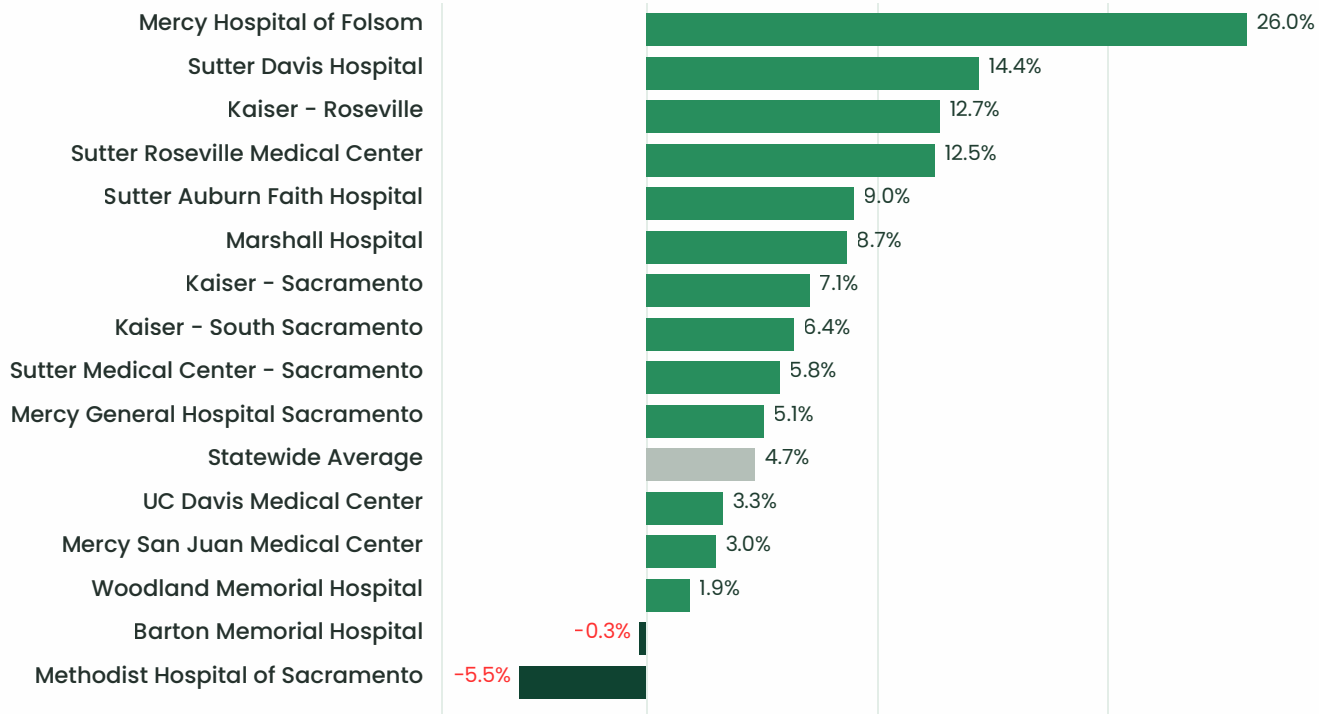
Hospitals

The Sacramento region has 15 nonprofit general acute care hospitals, one public academic medical center, and no county hospitals. **The hospital market is highly consolidated—12 hospitals are operated by three large nonprofit health systems – Sutter Health, CommonSpirit (Dignity), and Kaiser.** Together with UC Davis Health, these hospitals account for 94% of the region's hospital beds.

Although the level of consolidation in the county is long-standing and appears relatively stable, it has significant impacts on access, price, and patient choice. The region has fewer hospital beds per capita than California overall, with 168 beds per 100,000 population compared to 198 for the state. In addition, hospital consolidation may be a reason that the Sacramento region has higher health plan premiums than the statewide average (as indicated by Covered California premiums).

Sacramento area hospitals are profitable, more so than hospitals statewide. The 3-year average net income margin for Sacramento area hospitals is 6.7% versus 4.7% statewide across 2021-2023. The only hospital operating significantly in the red is Methodist Hospital in South Sacramento (-5.45% total margin), but it is owned by the larger and profitable CommonSpirit (Dignity) system.

Figure 4: Net income margin by hospital, Sacramento Region, 2021-2023 (Average)



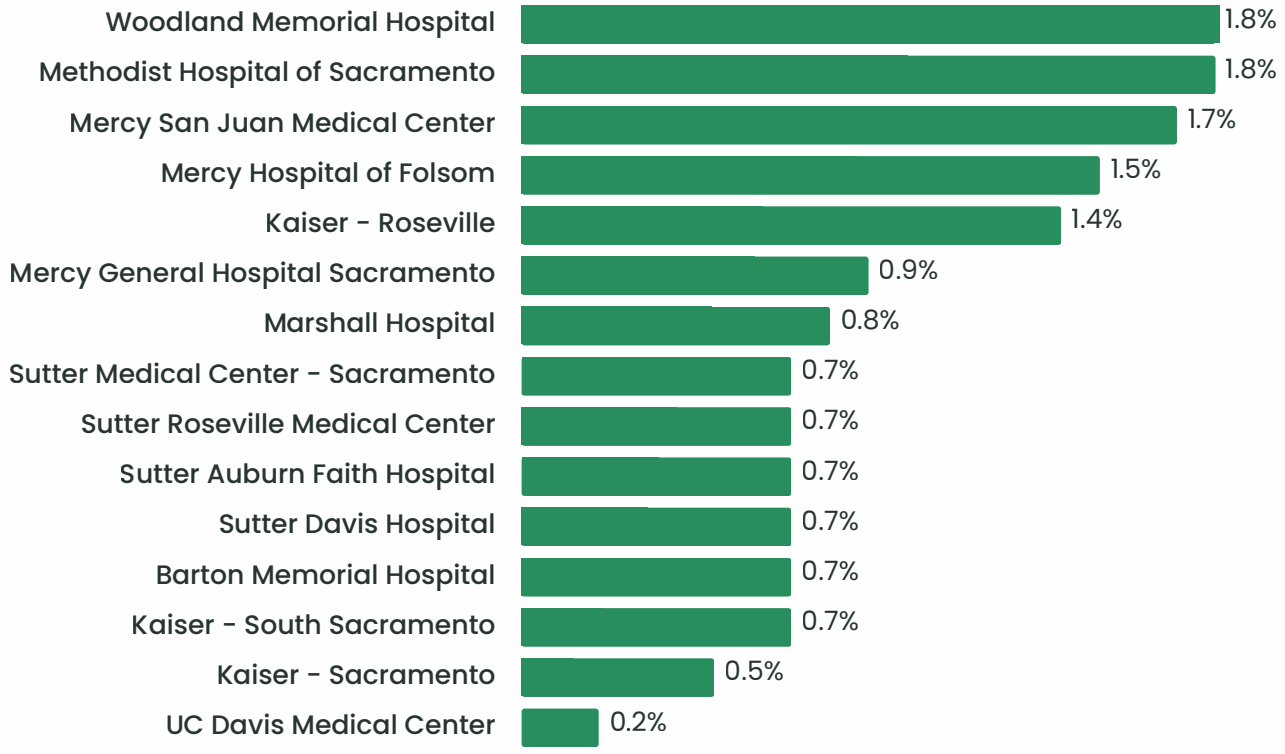
Source: *HCAI Hospital Annual Financial Data: Selected Data, 2021-2023 CY*
Note: The data includes hospitals HCAI classifies as general acute care facilities; excludes specialty, psychiatric, children, long-term care, and rehabilitation hospitals. Net income margin is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue.

Sacramento's 14 nonprofit hospitals avoid a total of $40.9 million in property taxes annually and receive $250 million in total tax exemptions (including federal income, state income, federal unemployment, property, value of tax-exempt donations and bonds) annually [9].[i] **Eleven of Sacramento's 14 nonprofit hospitals spend less on financial assistance, community health programs, subsidized health services, and community group grants combined than they gain in total tax exemptions.**

Financial assistance and debt collection practices vary across the region's hospitals and health care systems.

- The amount of financial assistance provided to patients as a share of total expenses ranged from a low of 0.22% at UC Davis Medical Center to a high of 1.77% at Methodist Hospital of Sacramento. The median financial assistance provided was 0.74%.
- CommonSpirit hospitals take the extraordinary collection steps of selling patient debt and reporting unpaid medical bills to collection agencies.
- Kaiser Permanente hospitals report debt to credit agencies and allow legal actions, including lawsuits and wage garnishments.

Figure 5: Financial assistance provided to patients as a share of total expenses by hospital, Sacramento Region, 2021-2023 (Average)



Source: *Data provided by The Lown Institute Hospitals Index for Social Responsibility sourced from IRS Form 990 or CMS hospital cost reports.*

[i] Data provided by the Lown Institute Hospitals Index for Social Responsibility. Real estate assessed value sourced from Parcel Quest, includes all tax-exempt real estate owned by hospital or system in the county. Only available for private nonprofits. Property taxes avoided includes real property and equipment. Only available for private nonprofits.

Medical Groups and FQHCs

The region has 35 FQHCs that serve 0.15 patients per capita, slightly less than FQHCs statewide that serve 0.21 patients per capita. The region's FQHCs are less financially stable than FQHCs statewide with an operating margin of -3.0% compared to 1.2% statewide [10]. The largest FQHC system is WellSpace, but Elica and One Community Health are also large. The Sacramento Native American Health Center is also important to the region, and Communicare serves communities in Yolo County specifically.

Most physician groups are owned by the major hospital systems, except for Hill Physicians. CommonSpirit, Sutter, and UC Davis each own physician groups sharing their name (CommonSpirit's physician group is Mercy). Kaiser is the only fully integrated system (owns hospitals, the physician group, and the health plan). Hill Physicians is an Independent Practice Association (IPA), which means that it contracts independent physicians and organizes networks, which it contracts to health plans. It can take on some functions of a health plan, for example by managing prior authorization. In this way, it acts as an intermediary between independent physicians and health plans to increase the bargaining power and decrease the administrative overhead for doctors.



Workforce

Sacramento-area health care worker wages are generally at or above the California statewide median across most occupations. Registered nurses earn 20.6% above the statewide median, the largest positive gap in the region, and medical assistants, dental assistants, and behavioral health counselors also show notable above-median wages. Marriage and family therapists earn 14.2% above the California statewide median. Two occupations fall below the statewide median: maids and housekeeping cleaners (-5.3%) and nursing assistants (-0.4%), both low-wage support roles [11]. The overall pattern suggests a relatively strong wage environment for clinical and administrative occupations in the Sacramento labor market.[ii]

Despite the relatively higher wages, the Sacramento region still struggles with some provider shortages, especially for behavioral health care.

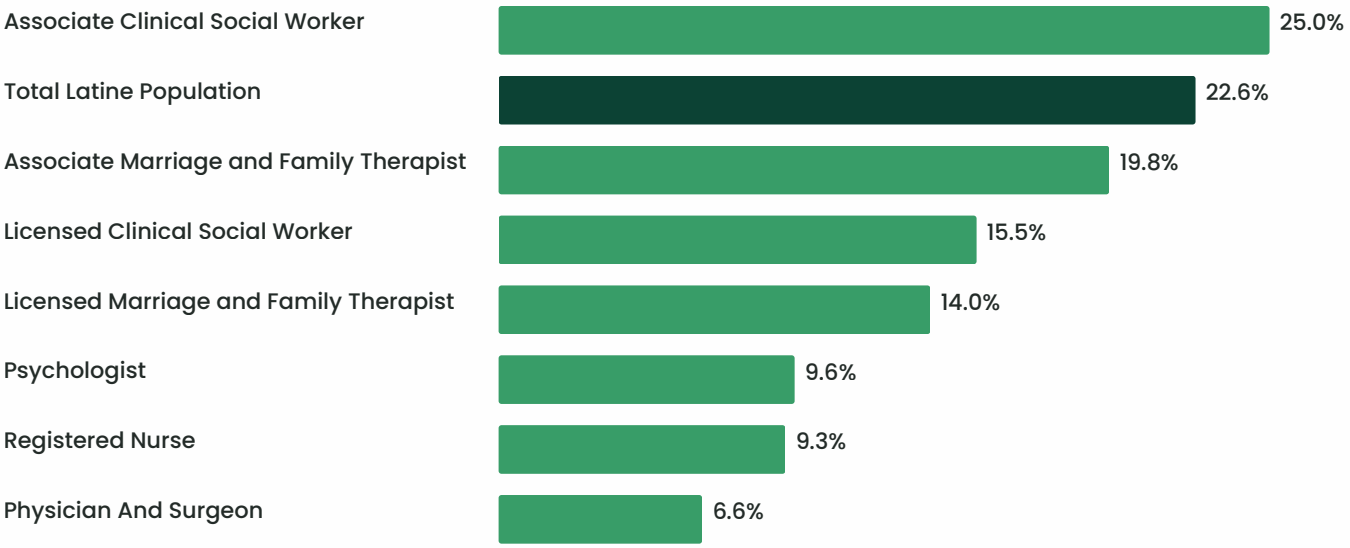
- Behavioral health provider shortage is universal across the region and projected to worsen for many types of providers. In 2024, the region has a shortage of 201 psychiatrists, 1,068 associate-level clinicians, and 3,402 non-prescribing license clinicians [12].
- Registered nurse supply is mixed, with surpluses in urban regions and shortages in rural areas [13].
- 18 primary care shortage areas exist across the region: 9 in Sacramento County concentrated in South and North Sacramento (3 of which are majority Latino and Black communities); 4 in Yolo including two areas with zero providers [14].

The diversity of the Sacramento area's health care workforce does not align well with the region's population. Latine workers are especially underrepresented in the region's physicians, registered nurses, and psychologists. Asian physicians and registered nurses are overrepresented relative to their population in the Sacramento region, while Asian workers are underrepresented in key behavioral health positions.

[ii] Uses metro statistical area: Sacramento-Roseville-Folsom.

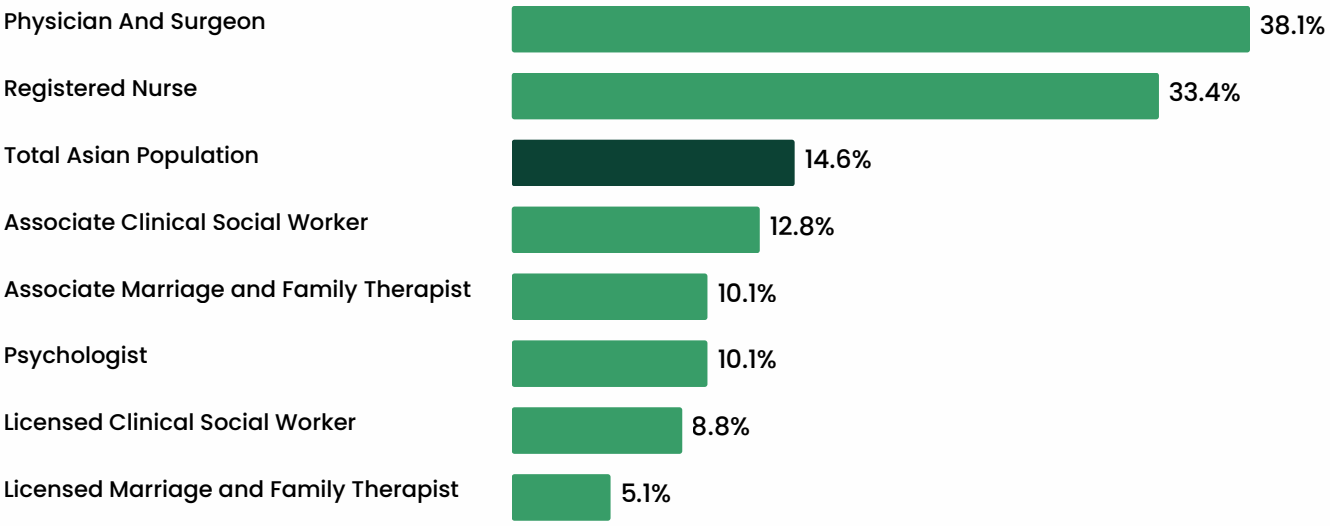


Figure 5: Latine licensed health care workforce by license level, Sacramento Region, 2024



Source: *HCAI Health Workforce Race & Ethnicity Data*

Figure 6: Asian licensed health care workforce by license level, Sacramento Region, 2024



Source: *HCAI Health Workforce Race & Ethnicity Data*

Opportunities for Advocacy/Policy Recommendations

1 **Address the fractured Medi-Cal infrastructure in Sacramento County**

A **Establish a local health plan:** Advocates could urge the Sacramento County Board of Supervisors to choose a different Medi-Cal model with a smaller number of health plans, like most of the state. This could help consumers and providers navigate the system and improve quality outcomes. Sacramento could propose either a smaller number of commercial plans to serve the region or establish a local initiative plan. Importantly, even if the county does not feel equipped to act as the health plan at this time, the county could still establish the health plan and have jurisdiction over it, but contract with an existing plan to provide the administration and infrastructure.

B **End Dental Managed Care:** Ending dental managed care and transitioning to a fee-for-service dental system would require state action. However, since most of the state is under a fee-for-service model currently, it is likely possible. The state has considered this in previous years and determined there would be cost savings, so advocates could also consider asking for transition funding from the state to strengthen the local dental provider infrastructure.



2 **Hold hospital systems accountable for high prices, scant community investment, and aggressive debt collection practices**

A **Target egregious actors:** While hospital prices are not regulated locally, advocates could focus on a few of the most egregious components of this problem including but not limited to UC Davis' disproportionately low financial assistance spending and Dignity/CommonSpirit Health's aggressive debt collection practices. Publicly urging these hospital systems to improve their practices could be effective.

B **Demand greater community investment, particularly as hospitals seek to expand:** Sacramento's three major hospital systems – Kaiser, Sutter, and CommonSpirit (Dignity) – have positive margins and, systemwide, contribute less to the community than they receive in tax exemptions. Advocates could demand greater community investment, particularly during the Community Health Assessment process every three years and when hospitals seek to expand their facilities and require city and county approvals to do so. Furthermore, advocates could urge hospital systems to contribute to some of the acute community needs at this time, including care for people who are or become uninsured or shoring up the safety net including financially distressed community clinics.

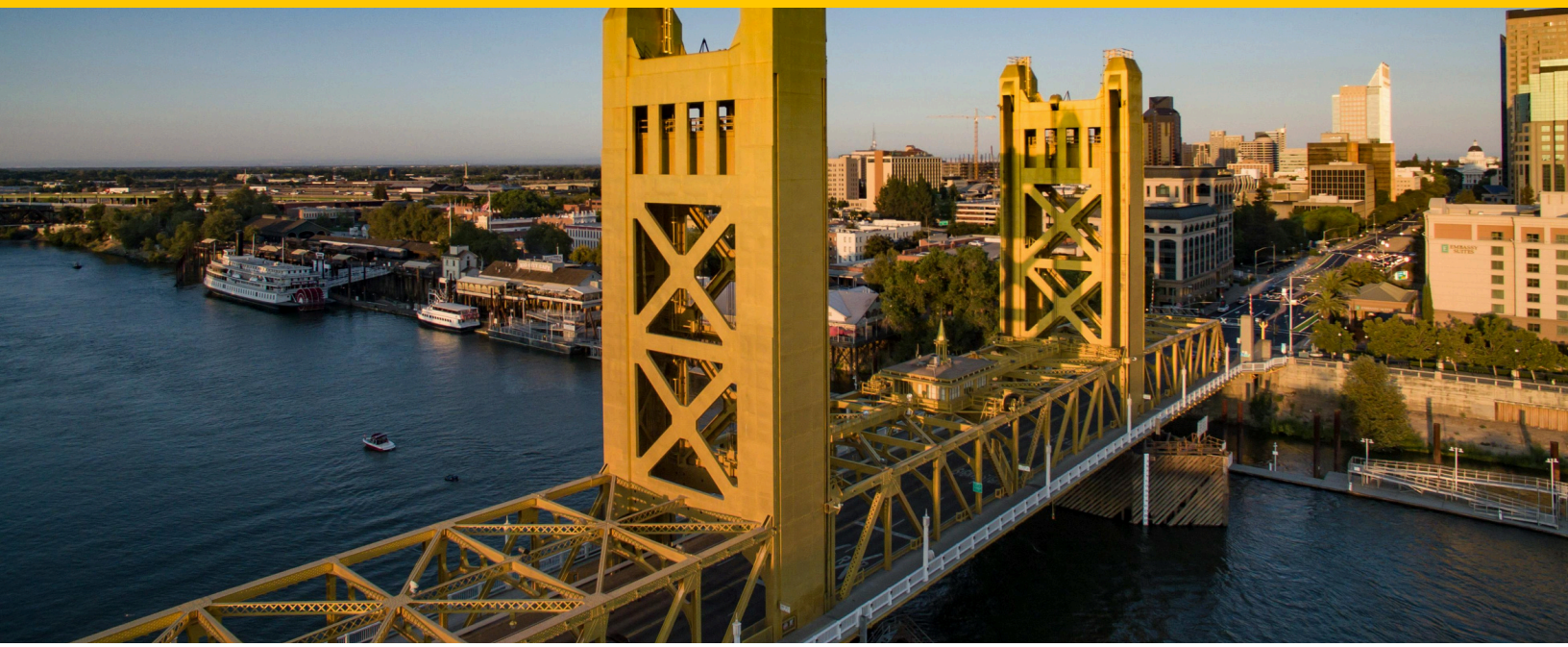
C **Engage in the Office of Health Care Affordability:** The state's Office of Health Care Affordability will publish the cost growth rates of individual hospitals in 2027 and begin to enforce a statewide target [15]. If hospitals fail to meet the target, they will undergo a performance improvement plan process. Advocates could engage in this process and encourage the adoption of long-term cost control efforts that benefit patients, including investment in primary care, prevention, and home and community-based services for older adults.

3 Strengthen County Health Programs

A Advocates could ensure that Sacramento County protects the Healthy Partners Program or opens eligibility for the County Medically Indigent Services Program to all otherwise eligible people regardless of immigration status. Advocates should also urge the County Medical Services Program in Yolo and El Dorado counties to restore access for undocumented residents and urge Placer County to remove its immigration status eligibility requirement.

B Advocates could examine the budget of each county, in particular the general fund spending, and advocate for each county to shift dollars from public safety/law enforcement to health care services. CPEHN's previous analysis showed that Sacramento County, for example, spent 14% of its general fund on the Sheriff's Department compared to only 2.5% on health services in the 2021-22 budget [16]. Shifting dollars to health services could enable the county to maintain a more comprehensive safety net for the uninsured.





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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.

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Appendix

Covered California Qualified Health Plan Performance by Plans, Statewide, 2024

Qualified Health Plan	Percent of adults ages 18+ with no utilization	Number of ER visits per 1,000 enrolled members ages 18+	Percent of children and adolescents ages 3–21 with at least one well-care visit
Aetna HMO	28%	181	28%
Anthem EPO	19%	204	34%
Anthem HMO	23%	143	28%
Blue Shield HMO	15%	190	32%
Blue Shield PPO	11%	196	53%
Chinese Community HMO	27%	81	58%
Health Net HMO	17%	161	35%
Health Net PPO	23%	149	38%
Kaiser HMO	16%	168	39%
L.A. Care HMO	25%	121	36%
Molina HMO	24%	138	30%
Sharp HMO	14%	160	52%
Valley Health Plan HMO	34%	172	17%
Western Health Advantage HMO	16%	182	42%

Source: *Covered California Plan Performance Report 2025 Healthcare Evidence Initiative (HEI): Utilization Dashboard*

Notes: 1) The percent of adults age 18+ with no utilization is the percent of members with 12 months of continuous enrollment who had no medical or drug services during the year. A lower value indicates better performance. 2) With annual number of emergency room visits per 1,000 enrolled adult members, higher rates may signal difficulty accessing care through appropriate channels. 3) The well-care visit measure refers to the percent of children and adolescents ages 3-21 who had at least one well-care visit during the year.



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