

PROP 44: THE CLINIC FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT

Quick Facts

- **Official ballot title:** “Requires Community Health Clinics Spend 90% of Revenue on Program Services. Initiative Statute” (circulating title and summary issued by the attorney general, October 7, 2025). The measure’s own name is the “Clinic Funding Accountability and Transparency Act.”
- **Type:** Initiated state statute (AG No. 25-0008A1). It adds new sections to the Government Code and the Health and Safety Code. It is not a constitutional amendment.
- **A vote YES means:** Nonprofit federally qualified health centers must spend at least 90 percent of their total annual revenue on mission-related “program services” or pay a penalty equal to the shortfall. Clinics must report the underlying figures to the attorney general, who publishes a “mission spend ratio” for each clinic.
- **A vote NO means:** No revenue-spending floor is imposed on these clinics. Their spending stays governed by existing nonprofit and federal-grant rules and by their own boards.
- **Sponsor/proponent:** Californians for Responsible Healthcare, sponsored by SEIU-UHW West (Service Employees International Union-United Healthcare Workers West). Proponents of record are Shawna Brown and Sean Fleming.¹
- **On the ballot because:** Proponents submitted about 1.03 million signatures on April 1, 2026, against a 546,651 valid signature requirement, and the secretary of state projected enough valid signatures to qualify for the November 3, 2026, ballot.²
- **Full legal text:** [Initiative 25-0008A1, “Clinic Funding Accountability and Transparency Act,” California Office of the Attorney General \(PDF\)](#)
- **LAO analysis:** [Ballot analysis of Initiative 2025-008](#)

CALIFORNIA DECIDES

1. WHAT WOULD IT DO?

Proposition 44 would set a spending floor on California's nonprofit community health clinics. Each covered clinic would have to spend at least 90 percent of its total annual revenue on "program services" that advance its charitable mission, meaning patient care and related services rather than management, overhead, or accumulated surplus [1, Sec. 3].³

The measure works through a ratio it calls the mission spend ratio. That ratio is the amount a clinic spends on activities accomplishing its exempt purpose divided by its total revenue [1, Sec. 3]. The building blocks come from the clinic's IRS Form 990. The numerator starts from "total program service expenses" on line 4e of Part III, and the denominator starts from total revenue on line 12 of Part I, for tax year 2024 or later [1, Sec. 3(b)(1)]. The attorney general may issue binding guidance adjusting how both figures are counted, so the final definition of qualifying spending is not fixed in the text—it is delegated [1, Sec. 3(b)(2)].⁴

A clinic whose mission spend ratio falls below 90 percent would owe an administrative penalty equal to the gap between what it actually spent on mission-directed expenses and 90 percent of its total revenue [1, Sec. 4(b)(1)]. Penalty money is held in escrow in a state fund for five years. A clinic can get the money back if it comes into compliance and agrees with the Department of Public Health on a plan to spend the returned funds on mission-directed expenses. Money not returned within five years is appropriated for clinic-worker training, recruitment, and retention [1, Sec. 4(a)]. The Department of Public Health can grant one-year waivers for unexpected or exceptional circumstances or where compliance would raise going-concern doubts under generally accepted accounting principles [1, Sec. 4(c)]. Separate reporting fines of \$5,000 for a first violation and \$10,000 per month thereafter apply to clinics that do not file on time [1, Sec. 3(d)].

2. THE LEGAL LANGUAGE

- **Full text:** [Initiative 25-0008A1, "Clinic Funding Accountability and Transparency Act" \(as amended September 2025\), California Office of the Attorney General](#)

- Key language:

"Mission Spend Ratio" is the total amount spent on activities that accomplish each clinic's exempt purpose divided by that clinic's total revenue." [1, Sec. 3(a)(2)]

"The Department of Public Health shall annually assess on each clinic subject to Section 12586.3 of the Government Code that has a Mission Spend Ratio below ninety percent (90%) an administrative penalty equal to the difference between the amount the clinic spent on mission-directed expenses and 90 percent of the clinic's total revenue." [1, Sec. 4(b)(1)]

- **What it amends:** Adds Section 12586.3 to the Government Code (reporting and the mission spend ratio) and Section 1234.1 to the Health and Safety Code (penalties and the escrow fund) [1, Secs. 3-4]. As an initiative statute rather than a constitutional amendment, the legislature could later amend it only in ways consistent with the measure's terms.

3. WHO, WHAT, WHERE, WHEN, WHY?

- **Who?** The covered universe is narrow. A "clinic" under the measure means a nonprofit clinic corporation that is a federally qualified health center (FQHC) under federal law, and it expressly includes "FQHC Look-Alikes," which meet FQHC program requirements without receiving the federal grant [1, Sec. 3(a)(1)]. The measure excludes federally recognized tribes, tribal organizations, and urban Indian organizations [1, Sec. 3(a)(1)]. It does not reach hospitals, for-profit clinics, or medical groups. The sponsor is SEIU-UHW West, a union representing roughly 120,000 healthcare workers, through the committee Californians for Responsible Healthcare.⁵ The opposition is led by the California Primary Care Association and allied clinics, operating as Protect Patients California.⁶

CALIFORNIA DECIDES

- **What?** A hard floor requiring at least 90 percent of total revenue to go to program services, enforced by a penalty equal to the shortfall, plus annual reporting and a state-published mission spend ratio for every covered clinic [1, Secs. 3-4].
- **Where?** Statewide, applied to every nonprofit FQHC and FQHC Look-Alike operating in California.
- **When?** On the November 3, 2026, ballot. The mission spend ratio calculation is built on Form 990 data for tax year 2024 or later, and the attorney general must make each clinic's data public within ninety days of receipt [1, Sec. 3(b)(4)].
- **Why?** The proponents' findings say many clinics spend excessive shares of revenue on executive compensation and administration, that some report surpluses as high as 20 percent of revenue, and that clinic workers face chronic understaffing and turnover. The stated intent is to create "a reasonable minimum standard of mission-directed spending" so that patient care and workforce stability are prioritized over management and overhead [1, Sec. 2].

4. TRADE-OFFS

Proposition 44 is one front in a long-running fight between SEIU-UHW and the California healthcare industry. The union placed three measures in this cycle: this clinic-spending floor, an executive-pay cap on hospitals and medical groups, and a billionaire wealth tax. The hospital industry answered with its own initiative requiring unions to get member approval before large political spending.⁷ Union-backed healthcare measures in California have a track record of functioning as leverage in labor-management disputes, most visibly the dialysis fights of 2018 through 2020, where roughly \$340 million was spent and every measure failed.⁸ Reading Proposition 44 only as a patient-care reform, and not also as a bargaining instrument, misses half of what it is.

That does not make the underlying concern fake. FQHCs are nonprofit, tax-exempt, and heavily taxpayer funded. There is no serious dispute that some accumulate large surpluses or pay executives generously while frontline staffing lags. Requiring that a defined, high share of revenue flows to program services, while publishing each clinic's ratio, is a coherent accountability idea with real appeal. The patient-care-first framing is not a pretext for nothing.

The hard question is whether a rigid revenue ratio is the right tool. Three features cut against it. First, the denominator is total revenue, not expenses. A clinic that runs a prudent operating surplus or builds reserves for a lean year is mechanically pushed below 90 percent and penalized, even if every dollar it spends is spent well. The measure effectively caps nonprogram spending plus surplus plus reserves at a combined 10 percent of revenue. Second, "program services" is anchored to a single Form 990 line, and the opposition argues that essential functions such as interpretation, transportation, and case management may not count, so clinics could be penalized for spending that patients experience as care.⁹ Third, the definition is not actually fixed. The attorney general may issue binding guidance moving the line in either direction, which concentrates significant discretion over clinic finances in one elected office [1, Sec. 3(b)(2)].¹⁰

The measure tries to soften the edges with waivers for going-concern risk and for rural or distressed clinics, with a five-year window to earn penalties back [1, Sec. 4]. Whether those valves are wide enough is the crux. An opposition analysis commissioned by the clinics estimated that more than 90 percent of clinic organizations would face penalties totaling about \$1.7 billion in the first year.¹¹ That figure comes from an interested party and should be treated as a claim, not a finding, but even a fraction of it would fall on the safety-net providers that serve California's lowest-income patients at the same moment federal Medicaid reductions are tightening their budgets.¹²

5. POTENTIAL RISKS AND BENEFITS

Potential benefits

- Proposition 44 creates a clear, published accountability metric for nonprofit clinics that receive large amounts of public money, letting the state and the public see how much of each clinic's revenue reaches program services [1, Sec. 3(b)(4)].
- It targets a real pattern the proponents document, in which some clinics report administrative costs of 30 to 40 percent of revenue or surpluses near 20 percent while frontline staffing suffers [1, Sec. 2].
- Recovered penalties are steered toward clinic-worker training, recruitment, and retention, which addresses the understaffing the findings describe [1, Sec. 4(a)].
- The escrow-and-refund design means a clinic that corrects course can recover its penalty rather than simply losing the money [1, Sec. 4(a)].
- Waiver provisions for going-concern risk and for small, rural, or frontier clinics give the Department of Public Health room to protect the most vulnerable providers [1, Sec. 4©].

Potential risks

- The floor is measured against total revenue, so a clinic can be penalized for running a prudent surplus or building reserves even when its actual spending is sound [1, Sec. 4(b)(1)].
- Anchoring "program services" to one Form 990 line may exclude services patients rely on, such as interpretation, transportation, and case management, penalizing spending that functions as care.¹³
- The measure hands the attorney general broad discretion to redefine the numerator and denominator through binding guidance, concentrating power over clinic finances in an elected partisan office [1, Sec. 3(b)(2)].
- It applies only to nonprofit FQHCs and Look-Alikes, the core of the safety net, and not to hospitals or for-profit providers, so the burden lands on the clinics serving the lowest-income patients [1, Sec. 3(a)(1)].¹⁴
- Penalties could reach from the hundreds of millions to more than a billion dollars in the first year on the opposition's estimate, arriving alongside federal Medicaid cuts that are already straining clinic budgets.¹⁵
- The California Primary Care Association has a pending federal lawsuit arguing the measure conflicts with federal law governing FQHCs, so passage may not settle whether it can take effect.¹⁶
- The Legislative Analyst estimates state enforcement costs in the low tens of millions of dollars annually, partly offset by fees and penalties on the clinics themselves.¹⁷

6. OPEN QUESTIONS

- How will the attorney general define “program services,” and will functions such as interpretation, transportation, and case management count toward the 90 percent?
- Because the floor is measured against revenue, how will clinics that need operating surpluses or reserves avoid penalties without cutting into their financial cushion?
- How many of California’s roughly 1,300-plus FQHC sites would actually fall below 90 percent under the final definition, and what is the realistic total penalty exposure once waivers are applied?
- Will the Department of Public Health’s waiver process move fast enough to keep a distressed or rural clinic open before a penalty forces service cuts?
- Does the measure conflict with federal FQHC funding and reimbursement rules, and how will the pending federal lawsuit resolve that before it can take effect?
- Is a ballot-locked revenue ratio the right instrument for a problem that varies clinic by clinic, or would board-level and grant-level oversight fit better?

7. THE QUESTIONS TO ASK BEFORE YOU VOTE

“Spend 90 percent on patient care” sounds like a floor no one could oppose. But the measure counts spending against total revenue, ties “care” to one tax-form line the attorney general can redefine, and applies only to the nonprofit clinics that serve California’s poorest patients. Before you vote, ask whether this rewards clinics that spend well or mainly penalizes clinics that keep a surplus.

This measure sits inside a labor-industry fight, sponsored and fully funded by one union that has three measures on this ballot. Ask whether Proposition 44 would mostly change how safety-net clinics deliver care, or how much leverage one side carries into its next dispute with the healthcare industry.

CALIFORNIA DECIDES

ENDNOTES

¹ Full text, Initiative 25-0008A1, "Clinic Funding Accountability and Transparency Act" (as amended September 2025), California Office of the Attorney General: <https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf>; Bernard J. Wolfson, "Looming Medicaid Cuts Supercharge California's Latest Labor-Industry Fight," *KFF Health News*, June 10, 2026: <https://kffhealthnews.org/medicaid/seiu-uhw-union-healthcare-industry-california-ballot-initiatives-clinic-executive-pay/>.

² Victoria Antrim, "SEIU-UHW Sponsored Initiative That Would Set Spending Requirement on Patient Care for Health Clinics Qualifies for Ballot in California," *Ballotpedia News*, May 19, 2026: <https://news.ballotpedia.org/2026/05/19/seiu-uhw-sponsored-initiative-that-would-set-spending-requirement-on-patient-care-for-health-clinics-qualifies-for-ballot-in-california/>.

³ Legislative Analyst's Office, ballot analysis of Initiative 2025-008 (nonprofit safety-net health clinic expenses): <https://www.lao.ca.gov/BallotAnalysis/Initiative/2025-008>.

⁴ LAO, ballot analysis of Initiative 2025-008.

⁵ Wolfson, "Looming Medicaid Cuts."

⁶ Mandy Asgeirsson, Bill Hamm, Julian Brock, and Ethan Hesse, "Study of Potential Impacts from the Attorney General Initiative 25-0008A1," Berkeley Research Group, November 2025: https://protectpatientsca.com/wp-content/uploads/2025/11/BRG-Report-on-Clinic-Funding-Accountability-Transparency-Act-2025_1117.pdf.

⁷ Wolfson, "Looming Medicaid Cuts."

⁸ Wolfson, "Looming Medicaid Cuts."

⁹ Asgeirsson et al., "Study of Potential Impacts."

¹⁰ LAO, ballot analysis of Initiative 2025-008.

¹¹ Asgeirsson et al., "Study of Potential Impacts."

¹² Wolfson, "Looming Medicaid Cuts."

¹³ Asgeirsson et al., "Study of Potential Impacts."

¹⁴ Asgeirsson et al., "Study of Potential Impacts."

¹⁵ Wolfson, "Looming Medicaid Cuts"; Asgeirsson et al., "Study of Potential Impacts."

¹⁶ Antrim, "SEIU-UHW Sponsored Initiative"; Asgeirsson et al., "Study of Potential Impacts."

¹⁷ LAO, ballot analysis of Initiative 2025-008.