

Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2161 (Bonta) – As Amended March 23, 2026

SUBJECT: Medi-Cal: redeterminations and work or community engagement.

SUMMARY: Establishes requirements for implementation of federally required changes to Medi-Cal eligibility rules in a manner that prioritizes maintaining Medi-Cal coverage. Limits implementation to what is federally required and codifies mandatory and state-optional exemptions to the rules. Prohibits Department of Health Care Services (DHCS) from applying these more stringent eligibility processes to Medi-Cal members for which these processes are not federally required. Requires data sources to be leveraged to automate eligibility determinations. Specifies notices and noncompliance procedures. Specifically, **this bill:**

WORK OR COMMUNITY ENGAGEMENT REQUIREMENTS

Intent and Definitions

- 1) Establishes the intent of the Legislature that DHCS implement work or community engagement requirements set forth in Section 71119 of federal House Resolution 1 (H.R. 1; Public Law 119-21) to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome to applicants and beneficiaries.
- 2) Defines “applicable individual,” for the purposes of work or community engagement requirements, as an individual, other than a specified excluded individual, who is an individual aged 19-64 without dependent children for whom eligibility was added pursuant to a state option under the 2010 Patient Protection and Affordable Care Act (ACA) (sometimes referred to as the “ACA expansion” population)).

Populations Excluded or Deemed Compliant

- 3) Specifies numerous populations to whom work or community engagement requirements do not apply, including:
 - a) An individual who is a foster youth or former foster youth under 26 years of age;
 - b) A Native American, as specified;
 - c) The parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age or younger;
 - d) The parent, guardian, caretaker relative, or family caregiver of an individual with a chronic or other health condition, disability, or functional limitation;
 - e) A veteran with a disability rated as total under federal law;

- f) An individual who is medically frail or otherwise has special medical needs, as defined by the United States Secretary of Health and Human Services (federal HHS Secretary), including, but not limited to, any of the following individuals:
 - i) An individual who is blind or disabled, as defined in Section 1382c of Title 42 of the United States Code;
 - ii) An individual with a substance use disorder;
 - iii) An individual with a disabling mental disorder;
 - iv) An individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or,
 - v) An individual with a serious or complex medical condition.
 - g) An individual in compliance with the work requirements under the federal Temporary Assistance for Needy Families (TANF) (CalWORKS in California);
 - h) A member of a household that receives food assistance through the Supplemental Nutrition Assistance Program (SNAP) and is not exempt from a work requirement under that act;
 - i) An individual participating in a drug addiction or alcoholic treatment and rehabilitation program, as specified;
 - j) An inmate of a public institution; and,
 - k) An individual who is pregnant or entitled to postpartum medical assistance under specified Medicaid programs.
- 4) Excludes the following additional population groups from a requirement to comply with work or community engagement rules:
- a) An individual under 19 years of age;
 - b) An individual entitled to, or enrolled for, benefits under Medicare;
 - c) An individual enrolled in eligibility categories established prior to the ACA, including children, foster youth, and pregnant women, among others;
 - d) An inmate of a public institution at any point during the three-month period ending on the first day of that month;
 - e) An individual excluded based on any other federally required or approved exemptions outlined in the state plan or waivers; and,
 - f) Any other individual not specifically required by federal law to comply with work or community engagement requirements.

- 5) Deems an applicable individual to have demonstrated work or community engagement for a particular month if they experience a short-term hardship, defined as any of the following:
 - a) The individual receives institutional services, including inpatient hospital services, nursing facility services, or other services of similar acuity, and the individual requests a short-term hardship exemption;
 - b) The individual or their dependent must travel outside of their community for an extended period of time to receive medical services, as specified, and the individual requests a short-term hardship exemption;
 - c) The individual resides in a county in which a federal emergency or disaster was declared; or,
 - d) The individual resides in a county with an unemployment rate that is at or above the lesser of 8% or 1.5 times the national unemployment rate, subject to a request from DHCS to the federal HHS Secretary.

Requirements, Compliance Details, and Verifications

- 6) Requires DHCS, before verifying an individual's compliance with work or community engagement requirements, to ensure and confirm that systems are programmed to maintain coverage with minimal data request to an applicant or beneficiary by doing both of the following:
 - a) Limiting compliance to applicants or beneficiaries who are required under federal law to meet work or community engagement requirements; and,
 - b) Measuring compliance through interfaces with data sources that include, but are not limited to, wage data, gig economy, Medi-Cal eligibility aid codes, Medi-Cal claims and encounter data, and data from the Department of Social Services (DSS).
- 7) Requires an applicable individual to demonstrate work or community engagement pursuant to federal law, as a condition of Medi-Cal eligibility and following DHCS's confirmation that systems are programmed to maintain coverage with minimal data request to an applicable individual.
- 8) Requires an applicable individual who applies for Medi-Cal to demonstrate work or community engagement for one month immediately preceding the month during which the individual applies for the Medi-Cal program.
- 9) Requires an applicable individual enrolled and receiving Medi-Cal services to demonstrate work or community engagement for any one month during the period between the individual's most recent determination or redetermination, as applicable, of eligibility and their next regularly scheduled redetermination of eligibility.
- 10) Deems an applicable individual compliant for a month if they meet one or more of the following conditions with respect to that month, as determined in accordance with criteria established by federal regulation:
 - a) The individual works no less than 80 hours;

- b) The individual completes no less than 80 hours of community service;
- c) The individual participates in a work program for no less than 80 hours;
- d) The individual is enrolled in an educational program, as specified, at least half-time;
- e) The individual engages in any combination of the activities described in paragraphs a) to d), inclusive, for a total of no less than 80 hours;
- f) The individual has a total monthly income, as specified, that is no less than the federal minimum wage, multiplied by 80 hours (\$580 per month in 2026); and,
- g) The individual had an average monthly income, as specified, over the preceding six months that is no less than the federal minimum wage, multiplied by 80 hours and is a seasonal worker, as described in specified federal law.

Requirements on DHCS and Counties When Verifying Compliance

- 11) Requires, for beneficiaries who cannot be deemed compliant following ex parte (automated) review, a county to request a Medi-Cal managed care plan to provide any data that will verify that a beneficiary is exempted or meets work or community engagement requirements before requesting information directly from the beneficiary.
- 12) Requires a county, when there is a conflict in reliable data sources that adversely impacts an applicant's or beneficiary's eligibility, to use data that are most beneficial to the applicant or beneficiary or to maintain eligibility following verification from an applicant or beneficiary.
- 13) Requires DHCS, when establishing compliance and verification processes, to establish processes and use available and reliable information without requiring, where possible and only when sufficient verification has been submitted, the applicable individual to submit additional information.
- 14) Establishes processes a county must follow when a county is unable to verify that an applicable individual either has met the requirement to demonstrate work or community engagement, including providing sufficient notice and an opportunity to provide verification of compliance and continuation of Medi-Cal services for 30 days for enrolled beneficiaries. Requires a county to approve applicants pending verification of work or community engagement and maintain active Medi-Cal eligibility until at least the last day of the 30-calendar-day period.
- 15) Requires a county, when an applicable individual attests to not receiving the notice of noncompliance or has good cause, to maintain or reactivate Medi-Cal eligibility, without a gap in coverage, for a specified time period.
- 16) Requires a county, before denying the applicable individual's application or disenrolling the individual, to first do both of the following:
 - a) Determine whether there is any other basis for Medi-Cal eligibility or for another insurance affordability program for the individual; and,
 - b) Provide written notice and grant the individual an opportunity for a fair hearing.

- 17) Establishes detailed requirements for explanatory notices and notices of noncompliance related to work or community engagement requirements, including an explanation of the requirement and how to comply, as well as their right to a state hearing to appeal a decision that results in disenrollment.

Bulletin Authority and Implementation Conditions

- 18) Authorizes DHCS to implement its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted. Requires DHCS to adopt regulations by July 1, 2028 and to provide a semiannual status report on implementation to the Legislature until regulations have been adopted.
- 19) Makes provisions implementing work and community engagement requirements operative only as long as the corresponding federal law establishing these requirements remains operative.
- 20) Conditions implementation of work and community engagement requirements on a finding by the DHCS director that systems have been programmed for implementation.

SIX-MONTH REDETERMINATIONS

- 21) Requires a county, effective no sooner than January 1, 2027, to perform redeterminations once every six months for the ACA Expansion population, consistent with federal requirements.
- 22) Prohibits the application of 6-month redeterminations to certain Indian/tribal members, as defined, and any other individual whose Medicaid eligibility is not specifically required by federal law to be redetermined every six months.
- 23) Adds flexibility for a beneficiary returning an eligibility form by allowing the beneficiary to return forms by person, by telephone, online, via mail, or through commonly available electronic means, and requires a county to accept electronic signatures, including telephonically recorded signatures, signatures obtained through an online application, and handwritten signatures transmitted via any other electronic means.

EXISTING FEDERAL LAW:

- 1) Authorizes states, beginning January 1, 2014, to expand Medicaid to individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare, and whose income does not exceed 133% of the poverty line plus applicable income disregards. [Title 42, United States Code (42 U.S.C.), §1396a (a)(10)(A)(i)(VIII), as interpreted by *National Federation of Independent Business v. Sebelius* (2012), 567 U.S. 519]
- 2) Requires, beginning January 1, 2027, the ACA Expansion population enrolled in Medicaid to comply with “community engagement requirements.” Creates mandatory and state-optional exemptions from compliance. Allows states to conduct compliance checks more frequently than as part of eligibility reverification. Requires states to establish processes and use reliable information available to the state, without requiring, where possible, the applicable individual to submit additional information. Establishes hours and income thresholds that constitute

compliance, and procedures for noncompliance. Requires notice and outreach to affected individuals. Allows the federal HHS Secretary to exempt a state from complying with the law for a defined period if the state requests exemption and the state is demonstrating a good faith effort to comply. [42 U.S.C. § 1396a(xx)]

- 3) Prohibits a state from using a Medicaid managed care entity or other specified entity, or other contractor to determine beneficiary compliance with the provisions described in 2) above, unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity or other specified entity that is responsible for providing or arranging for Medicaid services pursuant to a contract with the state. [Uncodified; Public Law 119–21 § 71119 (c)]
- 4) Requires, not later than June 1, 2026, the federal HHS Secretary to promulgate an interim final rule for purposes of implementing the provisions described in 2) above. [Uncodified; Public Law 119–21 § 71119 (d)]
- 5) Requires states, on or after the first day of the first quarter that begins after December 31, 2026, to redetermine once every 6 months for the ACA Expansion population, excluding specified Indian/tribal groups, as defined. [42 U.S.C. § 1396a(e)(14)(L)]

EXISTING STATE LAW:

- 1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]
- 2) Makes Medi-Cal eligibility and enrollment functions a county function and responsibility, subject to the direction, authority, and regulations of DHCS. [WIC § 14001.11]
- 3) Establishes a process for the determination and redetermination of an individual’s eligibility for Medi-Cal, as specified in 4) through 11), below. [WIC § 14005, *et seq.*]
- 4) Requires a county to perform redeterminations of eligibility for beneficiaries every 12 months and promptly redetermine eligibility whenever the county receives information about changes in a beneficiary’s circumstance that may affect eligibility. [WIC § 14005.37]
- 5) Requires eligibility to continue during the redetermination process and prohibits eligibility from being terminated until the county makes a specific determination based on facts clearly demonstrating the beneficiary is no longer eligible, and due process rights have been met. [*Ibid.*]
- 6) Requires, for purposes of acquiring information necessary to conduct eligibility redeterminations, a county to gather information available to the county that is relevant to the beneficiary’s eligibility, prior to contacting the beneficiary. Specifies state and federal data sources for this information. [*Ibid.*]
- 7) Requires, if a county is able to make an eligibility determination based on accessible data, the county to notify the beneficiary of the determination and the information on which it is based, and requires the county to notify the beneficiary that they must inform the county if

any of the information is inaccurate, but that the beneficiary is not required to sign and return the notice if all information is accurate. [*Ibid.*]

- 8) Requires a beneficiary to sign a renewal form if the beneficiary chooses to return the form in person or via mail. [*Ibid.*]
- 9) Requires, in the case of a redetermination due to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, a county to send the beneficiary a form that states the information needed to redetermine eligibility, and limits the additional data a county can request from the beneficiary. [*Ibid.*]
- 10) Requires a county to terminate eligibility if the purpose for a redetermination is loss of contact with the beneficiary, and the renewal form is also returned as undeliverable. [*Ibid.*]
- 11) Requires, during the 30-day period after the date of mailing a form to the beneficiary requesting additional information for redetermination of eligibility, the county to attempt to contact the beneficiary to request necessary information. Requires, if the beneficiary does not supply the necessary information to the county within the 30-day limit, a 10-day notice of termination of eligibility to be sent. [*Ibid.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, in 2025, the Trump administration championed H.R. 1, which enacted new, stringent Medicaid eligibility rules with the intent to remove low-income people from the Medicaid rolls and offset the cost of tax cuts for the wealthiest Americans. The author explains these new eligibility rules include work or community engagement requirements for individuals ages 19-64 in Medicaid who are not raising young children, requiring beneficiaries to jump through hoops to prove they are working or are otherwise exempt to maintain their coverage. It also subjected these individuals to eligibility re-checks every six months. The author argues these rules are designed not to help people find jobs or stay covered, but to bury them in paperwork until they lose coverage. Through the Governor's Budget, the author laments that DHCS has proposed doubling down on these failed and burdensome policies by applying the rules to state-funded populations, which is not required by H.R. 1. The author states that this is cruel, it will result in more people losing coverage, and it wastes time and money on unnecessary paperwork. The author concludes that this bill is intended to protect Californians' Medi-Cal coverage to the maximum extent possible by limiting the application of these new, onerous Medicaid eligibility rules to what is federally required under H.R. 1, codifying state-optional exemptions to these rules, requiring available data sources be leveraged to keep people covered, and requiring robust notification and cure processes to help people keep covered when verifying compliance.

2) BACKGROUND.

a) **Basic Medi-Cal Eligibility Redetermination Requirements and Processes.** As with most components of Medicaid, the federal government has rules establishing minimum requirements for eligibility groups that must be covered and eligibility rules that must be

followed. States also have a variety of options in how they design their programs, provided they seek federal approval for program changes.

Currently, individuals who have been found eligible and are enrolled in Medi-Cal must have their eligibility redetermined every 12 months to retain coverage for the next year. If, during the 12-month period, new information that affects eligibility becomes available to the county, either reported by the individual or accessed through other electronic data sources, a beneficiary or enrollee will automatically have their eligibility redetermined based on the new information. Beneficiaries must report to the county any change in their circumstances that may affect their Medi-Cal eligibility within ten calendar days of the change.

To renew beneficiaries' Medicaid coverage, states must first attempt to confirm ongoing eligibility using data available to the agency without requiring information from the individual. This requirement, also known as "ex parte" renewals, can reduce the administrative burden for states and simplify the process for beneficiaries. An ex parte renewal is a redetermination of eligibility that states can make based on reliable information available to the agency without requiring information from the individual.

The ACA required states to implement data-sharing strategies to simplify eligibility and redetermination processes for beneficiaries. Medicaid and Children's Health Insurance Program (CHIP) agencies now rely primarily on information available through data sources (e.g., the federal Social Security Administration and the Departments of Homeland Security and Labor) rather than paper documentation from families for purposes of verifying eligibility.

State law establishes specific process requirements and due process safeguards for redeterminations of eligibility. Generally, a beneficiary has 30 days to respond to a request for information, if additional information is needed to establish eligibility. If the beneficiary does not provide the necessary information to the county within the 30-day period, the county may send the beneficiary a ten-day Notice of Action of terminating their eligibility. If terminated, the beneficiary still has 90 days from termination to "cure" or provide the information requested. Beneficiaries also have the right to appeal an adverse determination.

- b) "ACA Expansion" Population.** California expanded Medi-Cal as authorized under the ACA, beginning in 2014 to adults ages 19-64 without dependent children who had incomes below 138% of the federal poverty level (ACA Expansion population). Some large states, including Florida and Texas, did not adopt this optional expansion, and eliminating the ACA expansion of Medicaid had been a key goal of "repeal" efforts over the last 15 years by opponents of the ACA. The ACA was structured to mitigate states costs related to the Medicaid expansion; the federal government generally pays for 90% of the cost of coverage for this population, with the state responsible for the remaining 10%.

Research consistently demonstrates significant benefits to adopting the ACA expansion. A KFF review of 404 studies conducted in 2020 found the ACA expansion has been linked to gains in coverage; improvements in access, financial security, and some measures of health status/outcomes; and economic benefits for states and

providers. Other studies show Medicaid expansion is linked to reductions in poverty rates, food insecurity, and evictions.

The ACA also simplified income calculation for most eligibility groups, including the ACA Expansion population, by implementing a “Modified Adjusted Gross Income” (MAGI) methodology. California’s procedures for determining eligibility for the populations groups subject to the MAGI methodology, including data sources that are consulted, are documented in a federally required MAGI-Based Eligibility Verification Plan.

- c) **H.R. 1 Eligibility Rules.** H.R. 1 of 2025, officially titled the “One Big Beautiful Bill Act,” includes significant Medicaid-related changes that reduce federal investment in Medicaid, including new eligibility rules for the ACA Expansion population. More stringent eligibility rules result in cost savings from individuals losing Medicaid coverage. H.R. 1 represents the largest-ever cut to the Medicaid program, with savings from Medicaid eligibility-related and financing changes projected to partially offset the loss of federal revenue associated with tax cuts that disproportionately benefit the wealthy and corporations.

There is substantial evidence that imposing additional paperwork requirements on Medicaid enrollees leads to coverage losses due to procedural issues, including not receiving or understanding notices or forms or not returning forms within required timeframes, even when the beneficiary still qualifies for coverage. According to a KFF report, there are several recent examples of state Medicaid programs experiencing declining enrollment due to changes in eligibility processes.

- i) **Work or Community Engagement Requirements.** Section 71119 of federal H.R.1 with certain exceptions, requires the ACA expansion population—generally, adults ages 19 through 64 without dependent children—to engage in a minimum of work or community engagement requirements (called “community engagement requirements” in H.R. 1) beginning in 2027. This means an individual needs to document at least 80 hours per month of work, community service, or job training to keep Medi-Cal coverage. The law outlines mandatory and short-term hardship exemptions, which must be verified every 6 months. The full list of exemptions is detailed in Summary, 3) through 5), above.

- (1) Data Shows Lost Coverage, Not More Work, When These Rules are Implemented.** Although rhetoric related to work requirements indicates these policies are designed to support employment, evidence from other states and programs consistently shows that significant coverage losses under policies similar to H.R. 1’s occur because individuals face administrative barriers, paperwork burdens, and documentation challenges even when they remain eligible.

According to a 2020 study, Arkansas’ experience with Medicaid work requirements led to a decrease in the number of Arkansans with health coverage and no significant changes in employment outcomes compared to similar states without work requirements. Furthermore, data analyzed by KFF and reported by the UC Berkeley Labor Center demonstrates that most Medi-Cal members who can work are already working. Data from 2023 show that 63% of non-disabled,

non-elderly adults reported working full-time or part-time, 14% were not working due to being a caretaker for a family member, 8% were students, and 7% reported a disability or other illness that was not eligible for a federal disability designation. Missed notices, unstable housing, limited internet access, language barriers, or confusion about reporting requirements can result in termination of coverage even when individuals meet eligibility requirements.

A federal Congressional Budget Office (CBO) report found that work requirements in safety net programs not only fail to meaningfully increase employment rates or average earnings, but also delay access to care and decrease program participation by creating an additional administrative barrier. The CBO cited research from the implementation of work requirements in Arkansas indicating that “many participants were unaware of the work requirement or found it too onerous to demonstrate compliance.”

(2) Projected Impact on Medi-Cal Coverage in California. The new work and community requirement is estimated to lead to large coverage losses. The ACA Expansion population, to which the rule applies, includes about 4.6 million Medi-Cal members. Of these, about 1.8 million are projected to be determined either exempt from the rule or income compliant via an automated source. This leaves an estimated 2.8 million Medi-Cal members whose compliance with work or community engagement requirements will need to be verified.

Ultimately, DHCS estimates that 233,000 Medi-Cal members will lose coverage by June 2027, 1 million by January 2028, and 1.4 million by June 2028 as a result of the imposition of work requirements. DHCS projects this coverage loss will significantly drive up California’s uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

ii) Six-Month Eligibility Checks. Section 71107 of federal H.R. 1 requires states to redetermine eligibility for the ACA expansion population twice a year instead of once a year. Many eligible Medi-Cal members are projected to lose coverage because of the increased frequency of eligibility paperwork. In recent analysis of those disenrolled at their eligibility redetermination, DHCS has found so-called “procedural disenrollments” to be common (procedural disenrollment is when an individual is disenrolled without having been deemed ineligible, often due to missing or late paperwork). When DHCS partnered with the California Health Care Foundation to survey those procedurally disenrolled in 2024, about one-third (31%) reported they did not know they would lose Medi-Cal if they failed to complete their renewal, nearly four in ten (37%) said they would like to restart Medi-Cal but did not know how, and nearly half (45%) of all survey respondents said they did not receive a renewal form. Many of the same concerns noted in the section above about missed notices, unstable housing, limited internet access, and other practical barriers also apply to the six-month eligibility checks.

d) Projected Administrative Impacts. New work or community engagement rules impose significant administrative work on counties to verify compliance and on beneficiaries and applicants to prove they comply. The California Welfare Directors Association (CWDA), representing county health and human services agencies that conduct eligibility

determination on behalf of the state, estimates 3.5 additional hours would be needed per client, per year for robust exemption and compliance review for individuals who cannot be verified via automated data matches, as well as approximately 50 additional minutes of follow-up for clients initially deemed noncompliant and to resolve documentation issues. CWDA estimates an additional 1.2 hours per client, per year to support the shift from annual to six-month redeterminations. CWDA has requested a budget allocation for increased administrative costs related to these new requirements for \$270 million General Fund in fiscal year 2026-27; \$343 million General Fund in 2027-28; \$215 million General Fund in 2028-29, and \$153 million General Fund ongoing annually thereafter.

When individuals disenrolled for procedural reasons later re-enroll in the program, usually when they try to seek care, this phenomenon is referred to as caseload “churn.” A 2021 HHS report found that reducing churn can reduce administrative costs from counties sending out far fewer renewal packets and streamlining county staff time since they receive and process fewer renewal packets and new applications. A 2015 study estimated that the administrative cost of a single person disenrolling and reenrolling in Medicaid costs \$560-840 when adjusted for inflation.

- e) **DHCS Implementation of H.R. 1.** As the administering agency for Medi-Cal, DHCS is charged with complying with new federal laws and policies, including the new Medicaid financing and eligibility rules imposed by H.R. 1. DHCS has released “Implementation Guiding Principles” to explain the department’s implementation approach to complying with federal requirements. These include the following:
- i) **Automate to Protect Coverage.** Maximize the use of data sources to confirm eligibility without burdening members. Reduce paperwork, streamline verifications, and safeguard coverage stability;
 - ii) **Communicate with Clarity and Connection.** Implement an outreach and education campaign that is culturally relevant, linguistically accurate, and written in plain language to build trust and help members understand the changes;
 - iii) **Simplify the Renewal Experience.** Modernize and streamline the Medi-Cal renewal process with a clearer, member-friendly form and six-month renewal steps that are easier to navigate;
 - iv) **Educate and Train Those Who Serve Medi-Cal Members.** Deliver comprehensive training on all H.R. 1 provisions for county eligibility workers. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties and DHCS Coverage Ambassadors (community volunteers who help people find, understand, or keep their health coverage) can confidently support members; and,
 - v) **Provide Timely and Transparent Communication to Members.** Share information on H.R. 1 changes early on so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

DHCS has begun releasing updates to their implementation approach through stakeholder forums, workgroups, and other communication channels, and has solicited and accepted stakeholder feedback. DHCS also released the first iteration of an H.R. 1 Implementation Plan. According to DHCS, ongoing workgroups with counties, managed care plans,

advocates, and community partners are shaping policy to support implementation readiness. DHCS has released preliminary guidance to counties on implementation of work requirements, including two all-county welfare director's letters (ACWDLs): ACWDL 25-30 with guidance on work reporting requirements and ACWDL 25-31 with guidance on more frequent renewals.

- f) **Data Sources to Improve Ex Parte Renewal Rate.** Consistent with DHCS's guiding principle to automate coverage, this bill requires DHCS to use data sources that include, but are not limited to, wage data, gig economy, Medi-Cal eligibility aid codes, Medi-Cal claims and encounter data, and data from DSS. As described in California's MAGI-Based Eligibility Verification Plan discussed above, DHCS already receives data from numerous state and federal sources to facilitate ex parte reviews, including State Quarterly Wage Data from the Employment Development Department and data from the Internal Revenue Service and Social Security Administration, among others. Medi-Cal uses the same eligibility system as CalFresh, the state's SNAP program, and CalWORKS, the state's TANF program, making CalFresh and CalWORKS data accessible for Medi-Cal eligibility purposes. DHCS is exploring the potential for data matching with higher education systems, the Department of Rehabilitation, and other sources to verify exemptions based on, for instance, participation in work programs or enrollment in college coursework. DHCS is also considering contracts with private sources of timely wage data, including companies Equifax and Truv. Finally, DHCS states it plans to use Medi-Cal claims and encounter data to automate exemptions to work or community engagement requirements based on "medical frailty" and certain diagnoses (such as substance use disorder) that can exempt an individual from compliance.
- g) **2026-27 Governor's Budget Proposal.** As part of the Governor's 2026-27 Proposed Budget released in January, the Newsom Administration proposes to apply work or community engagement rules and six-month eligibility verification to individuals whose citizenship status disqualifies them from federal eligibility and whose full-scope Medi-Cal coverage is funded at 100% state cost. Individuals who meet other Medi-Cal eligibility criteria, but for whom federal matching funds are unavailable for full-scope Medi-Cal, are referred to as having unsatisfactory immigration status (UIS) for purposes of federal matching funds. Because coverage for individuals who have UIS is state-funded, the state has discretion to establish eligibility rules for this category of individuals.

The imposition of H.R. 1 eligibility rules on state-funded UIS populations ages 19-64, as the Administration proposes, is, therefore, a discretionary eligibility proposal. This bill would reject that proposal, limiting the state's ability to impose work or community engagement requirements and six-month redeterminations on the state-funded UIS population and any other population that is not explicitly required by federal law to comply with these new rules.

UIS status is different than legal immigration status; some legal immigrants are also considered UIS. In fact, H.R. 1 redefines many categories of lawfully residing immigrants as UIS, making the costs for their coverage newly ineligible for federal matching funds. These categories include most refugees and asylees, as well as victims of human trafficking. The Governor's 2026-27 Proposed Budget, in response, proposes to move these categories of immigrants to restricted-scope coverage (emergency and

pregnancy care only), leaving this population essentially uninsured. Other UIS populations with legal status that are currently enrolled in Medi-Cal would be subject to new H.R. 1 eligibility rules under the Governor's 2026-27 Proposed Budget. The Medi-Cal program is currently closed to new applicants with UIS, pursuant to an enrollment freeze for these populations adopted in the 2025-26 Budget Act.

The Administration has proposed Trailer Bill Legislation (TBL) to implement H.R. 1, much of which is similar to this bill. However, in addition to not applying H.R. 1 eligibility rules to state-funded populations, this bill contains other provisions that are not part of the Administration's proposed eligibility-related TBL, including:

- i) Legislative intent to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome to applicants and beneficiaries;
 - ii) An explicit requirement to measure compliance using specified data sources;
 - iii) Additional specificity about the type of income that counts for compliance;
 - iv) A requirement for counties to request data from managed care plans to demonstrate compliance;
 - v) The right for a beneficiary or applicant to use the most beneficial data source to demonstrate compliance;
 - vi) Additional specificity about the notice of noncompliance and requirements that the county maintain active eligibility for a specified time period or reactivate eligibility without a gap in coverage, as specified;
 - vii) A requirement for DHCS to eventually adopt implementing regulations and to report on the status of regulations; and,
 - viii) A contingency provision requiring DHCS implement the new eligibility rules only to the extent the federal law implementing these eligibility rules is in place.
- 3) SUPPORT.** A wide range of consumer and health advocates, labor organizations, legal services organizations, and safety net providers support this bill, arguing it protects Medi-Cal coverage for low-income Californians from H.R. 1's administrative red tape. Co-sponsors Western Center on Law & Poverty, Health Access California, Justice in Aging, and National Health Law Program argue that the application of H.R. 1 eligibility rules to state-funded Medi-Cal expansion adults is more severe than H.R. 1 demands, legally problematic, and punitive to immigrant communities. Co-sponsors argue that for immigrant communities who face the threat of daily immigration enforcement actions, the state's proposal to impose work requirements on individuals who may not have authorization to work in the U.S. could put these individuals at risk and exclude more people from Medi-Cal, even if they are engaging in work activities. Co-sponsors note these requirements fail to meaningfully increase employment rates or average earnings but delay access to care and decrease program participation. In addition, co-sponsors argue that the bill minimizes administrative burden for some Medi-Cal members to prove compliance by automating data sources, exemptions, and exceptions; applies work requirements in least harmful way for members to obtain and

maintain coverage; and codifies and clarifies notification rights so that people know how to demonstrate compliance before their Medi-Cal coverage is terminated.

4) RELATED LEGISLATION. A package of bills, sponsored by the coalition co-sponsoring this bill, are all related to implementing various aspects of H.R. 1:

- a)** AB 2201 (Boerner), also being heard on April 7, 2025, by the Assembly Health Committee, would extend eligibility-related flexibilities to streamline asset and income verifications where federally allowable.
- b)** AB 2208 (Stefani), also being heard on April 7, 2025, by the Assembly Health Committee, would maintain three months of retroactive coverage despite H.R.1's restriction to one or two months, depending upon the population; would implement one-cent copayments to minimize barriers to accessing health care, and would allow individuals to update eligibility information using mobile devices.
- c)** SB 1202 (Weber Pierson), pending in the Senate Health Committee, would require the state to collect data to document the impact of H.R. 1 and would require robust outreach to assist Medi-Cal members to preserve coverage.

5) PREVIOUS LEGISLATION. AB 2956 (Boerner) of 2024 would have extended numerous temporary federally allowable processes (federal flexibilities) related to the redetermination of Medi-Cal eligibility and establish 12-month continuous Medi-Cal eligibility for adults. AB 2956 was held on suspense in the Assembly Appropriations Committee.

6) POLICY COMMENT. Federal regulations implementing work or community engagement requirements is forthcoming; H.R. 1 requires the federal HHS Secretary to issue regulations by June 1, 2026. The author should review the details of these regulations when they are released and consider whether future amendments are needed to ensure the provisions in the bill remain consistent with the forthcoming regulations.

REGISTERED SUPPORT / OPPOSITION:

Support

Western Center on Law & Poverty (co-sponsor)
 Health Access California (co-sponsor)
 Justice in Aging (co-sponsor)
 National Health Law Program (co-sponsor)
 Access Reproductive Justice
 Alliance for a Better Community
 Alzheimer's Greater Los Angeles
 Alzheimer's Orange County
 Alzheimer's San Diego
 American College of Obstetricians & Gynecologists - District IX
 American Diabetes Association
 American Federation of State, County and Municipal Employees, AFL-CIO
 Asian Americans for Community Involvement
 Asian Resources, Inc.
 Association of Regional Center Agencies

California Academy of Family Physicians
California Advocates for Nursing Home Reform
California Alliance for Retired Americans
California Alliance of Child and Family Services
California Community Foundation
California Faculty Association
California Family Resource Association
California Immigrant Policy Center
California Kidney Care Alliance
California LGBTQ Health and Human Services Network
California Opioid Maintenance Providers (COMP)
California Pan - Ethnic Health Network
California Physicians Alliance
California Retired Teachers Association
Cardea Health
Caring Across Generations
Center for Employment Opportunities
Child Abuse Prevention Center and its Affiliates Safe Kids California, Prevent Child Abuse
California and the California Family Resource Association; the
Children Now
Choice in Aging
Coalition of California Welfare Rights Organizations
Coalition of Orange County Community Health Centers
Community Clinic Association of Los Angeles County (CCALAC)
Community Health Partnership
Community Legal Aid SoCal
Community Legal Services in East Palo Alto
Courage California
CPCA Advocates, Subsidiary of the California Primary Care Association
Disability Rights California
East Bay Community Law Center
Family Voices of California
Friends Committee on Legislation of California
Gender Affirming Professionals
Grace Institute - End Child Poverty in CA
Health4Kern
Indivisible CA: StateStrong
Inland Empire Immigrant Youth Collective
Jewish Family Service of Los Angeles
LA Best Babies Network
Latino Coalition for a Healthy California
LeadingAge California
Maternal and Child Health Access
Multi-faith Action Coalition
National Multiple Sclerosis Society
Neighborhood Legal Services of Los Angeles County
Northeast Valley Health Corporation
Orale: Organizing Rooted in Abolition Liberation and Empowerment
Planned Parenthood Affiliates of California

Public Counsel
San Francisco Aids Foundation
San Francisco Senior and Disability Action
Senior Services Coalition of Alameda County
Serving Seniors
South Asian Network
Southeast Asia Resource Action Center
The Children's Partnership
Unidosus
One individual

Opposition

None on file

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097