

ASSEMBLY THIRD READING

AB 2161 (Bonta)

As Amended May 18, 2026

Majority vote

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. Makes implementation contingent on an appropriation for these purposes.

COMMENTS

Basic Medi-Cal Eligibility Redetermination Requirements and Processes. Medi-Cal is California's Medicaid program. 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.

The Patient Protection and Affordable Care Act (ACA) required states to implement data-sharing strategies to simplify eligibility and redetermination processes for beneficiaries. Medicaid agencies now verify eligibility largely through available data sources rather than paper documentation. State law establishes specific process requirements and due process safeguards for redeterminations of eligibility.

"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.

H.R. 1 Eligibility Rules. Federal 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. Substantial evidence has shown imposing additional paperwork requirements on Medicaid enrollees leads to coverage losses due to procedural issues even when the beneficiary still qualifies for coverage.

- 1) *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 new work or 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.
- 2) *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).

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, 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.

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.

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, among other things:

- 1) Legislative intent to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome, including an explicit requirement to measure compliance using specified data sources;
- 2) A requirement for DHCS to eventually adopt implementing regulations and to report on the status of regulations; and,
- 3) A contingency provision requiring DHCS implement the new eligibility rules only to the extent the federal law implementing these eligibility rules is in place.

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. 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. 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, 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. This is cruel, it will result in more people losing coverage, and it wastes time and money on unnecessary paperwork. 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.

Arguments in 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.

Arguments in Opposition

None on file.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

Cost pressures in the tens of millions to low hundreds of millions of dollars per year (General Fund (GF), federal funds), as this bill is subject to an appropriation. The County Welfare Directors Association of California (CWDA), representing county health and human services agencies, which perform Medi-Cal eligibility determinations on behalf of the state, estimates agencies will be able to maintain enrollment for about 30% of Medi-Cal beneficiaries through ex parte review and exemptions. CWDA estimates 70% of beneficiaries will go through the redetermination process, with costs estimated as follows:

- 1) Fiscal year (FY) 2026-27: \$45 million (\$11 million General Fund (GF)) to \$105 million (\$26 million GF).
- 2) FY 2027-28: \$202 million (\$51 million GF) to \$524 million (\$131 million GF).
- 3) FY 2028-29: \$177 million (\$44 million GF) to \$413 million (\$103 million GF).
- 4) FY 2029-30: \$127 million (\$32 million GF) to \$297 million (\$74 million GF).

CWDA notes redetermination costs would decrease over time due to declining Medi-Cal enrollment. These local costs are potentially reimbursable by the state, subject to a determination by the Commission on State Mandates (GF).

VOTES

ASM HEALTH: 12-2-2

YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Patel, Rogers, Schiavo, Sharp-Collins, Stefani

NO: Johnson, Sanchez

ABS, ABST OR NV: Chen, Patterson

ASM APPROPRIATIONS: 11-2-2

YES: Wicks, Aguiar-Curry, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache

NO: Dixon, Tangipa
ABS, ABST OR NV: Hoover, Ta

UPDATED

VERSION: May 18, 2026

CONSULTANT: Lisa Murawski / HEALTH / (916) 319-2097

FN: 0003009