Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2201 (Boerner) – As Introduced February 19, 2026

SUBJECT: Medi-Cal: eligibility redetermination.

SUMMARY: Implements processes to facilitate redetermining an individual's Medi-Cal eligibility by streamlining required income and asset verification. Specifically, **this bill**:

1) Aligns state law with a new federal requirement to redetermine eligibility every six months instead of every 12 months for certain populations, and makes conforming changes.

2) Requires a county to verify countable income and assets at renewal without requesting additional verification information or documentation if any of the following sets of conditions are met:

   a) All of the following are true ("100% FPL" Flexibility):

      i) An individual's most recent income documentation was based on previously verified attestation of income at or below 100% of the federal poverty level (FPL) during initial application or at their most recent renewal within the last 12 months;

      ii) The county has checked financial data sources and no information was received, but all other eligibility criteria has been verified; and,

      iii) There is no contradictory information on file;

      or,

   b) All of the following are true ("Stable Income" Flexibility):

      i) The most recent income determination, at either initial application or most recent renewal, was within the last 12 months;

      ii) The beneficiary receives Social Security benefits or other sources of stable income at the most recent determination; and,

      iii) There is no contradictory information on file;

      or,

   c) All of the following are true (Streamlining of Asset Verification):

      i) The most recent asset verification was based on a previously verified attestation of assets, at either initial application or most recent renewal, within the last 12 months;

      ii) The county has checked financial data sources and no information is received or no response has been received within a reasonable timeframe, but all other eligibility criteria are verified; and,

iii) No contradictory information is on file.

EXISTING FEDERAL LAW:

1) Requires states, on or after January 1, 2027, to redetermine once every 6 months for most adults ages 19-64 without dependent children. States the six-month verifications do not apply to other populations, as specified. [42 U.S.C. § 1396a(e)(14)(L)]

EXISTING STATE LAW:

1) Establishes the Medi-Cal Program, administered by the Department of Health Care Services (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 processes for the determination and redetermination of an individual's eligibility for Medi-Cal, as specified in 4) through 14), 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 a loss of contact, as evidenced by the return of mail marked in such a way as to indicate it could not be delivered or that there was no forwarding address, to prompt a redetermination of eligibility. [*Ibid*.]

6) 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*.]

7) 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*.]

8) 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*.]

9) Requires a beneficiary to sign a renewal form if the beneficiary chooses to return the form in person or via mail. [*Ibid*.]

10) 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*.]

11) 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*.]

12) 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*.]

13) Specifies procedures whereby an individual can request to receive retroactive eligibility for the three months preceding an eligibility determination. [*Ibid*.]

14) Requires a beneficiary to report any change in circumstance that may affect their eligibility within 10 calendar days following the date the change occurred. [*Ibid*.]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill will help minimize the negative impacts of the Trump Administration's attack on Medi-Cal. Specifically, the author explains, this bill will help to streamline the Medi-Cal verification process, removing administrative barriers that threaten Medi-Cal health coverage. The author argues that work requirements for Medi-Cal participation and increased frequency of renewals from annual to every six months mean county offices will be stretched thin by the sheer volume of additional paperwork, which ultimately puts Californians at risk of losing access to Medi-Cal. The author concludes that we cannot stand idly by and let the Trump Administration destroy lifeline programs for our most vulnerable populations.

2) **BACKGROUND.** During the federal COVID-19 public health emergency (PHE), regular Medicaid redetermination processes were suspended as a condition of receiving a temporary increase in federal Medicaid matching funds. During that time, Medi-Cal beneficiaries were not subject to annual eligibility redetermination, and those who were enrolled stayed on the program unless they voluntarily disenrolled or moved out of state. States began redetermining eligibility as of April 1, 2023 in a process known as the "PHE Unwinding." Resuming eligibility determinations after three years of continuous enrollment was a major workload for states, and was projected to result in significant coverage losses as a result of "procedural disenrollment." Procedural disenrollment is when an individual is disenrolled without having been deemed ineligible, often due to missing or late paperwork. To ease implementation and assist Medicaid enrollees to retain coverage during the PHE Unwinding, the federal government offered states a number of strategies (sometimes called "federal flexibilities") that allowed states to streamline aspects of the redetermination process, including verification of income, and assets. States applied for and were granted waivers to implement these strategies, which generally sunset by June 30, 2025. Based on positive feedback from states and their review of the risks and benefits of these strategies, the Centers for Medicare and Medicaid Services (CMS) codified states' abilities to use many of these strategies long-term beyond the end of the PHE Unwinding. These are documented in the Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin, "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes." This bulletin explains which strategies may be

implemented permanently at state option and the process needed to effectuate the change (i.e., an amendment to the Medicaid State Plan or documentation in the state's "Eligibility Verification Plan").

According to "California's Journey with Medi-Cal Redeterminations," an issue brief published by the California Health and Human Services Agency (CHHSA issue brief), California implemented 17 strategies approved by CMS through waiver authority or under existing federal Medicaid law to streamline enrollment and keep individuals in coverage as the Medi-Cal redetermination process restarted. This bill extends some of the strategies that the state implemented on a temporary basis during the PHE Unwinding with respect to redetermination of eligibility.

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, and states have a variety of options in how they design their programs, as long as they seek federal approval for program changes.

   Individuals who have been found eligible and are enrolled in Medi-Cal must have their eligibility redetermined every 12 months in order 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 federal Patient Protection and Affordable Care Act (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 Social Security Administration, 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 10-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) H.R. 1. H.R. 1 (Public Law 119-21), 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. These changes create significant concern about Medi-Cal coverage loss and county administrative effort and costs to address increased eligibility workload.

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.

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.

iii) **Impact**. DHCS expects approximately 1.4 million people to lose Medi-Cal coverage because of implementation of work or community engagement requirements. In addition, many eligible Medi-Cal beneficiaries are projected to lose coverage because of the increased frequency of eligibility paperwork.

New work or community engagement rules also imposes significant administrative work on counties to verify compliance and on beneficiaries and applications 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.

c) Federally Allowable Strategies Improve Ex Parte Rates and Reduce Procedural Disenrollments. According to DHCS, nationwide data on Medicaid unwinding of the COVID-19 emergency continuous coverage provision show that a majority of disenrollments occurred due to procedural reasons (e.g., late submission of paperwork, failure to respond to a state's request for information, lost forms), rather than legitimate losses of eligibility (i.e., changes in income or circumstances that would make individuals ineligible for Medicaid). One key metric related to state's Medi-Cal eligibility processing is how many individuals are able to be renewed through the "ex parte" process, that is, in an automated manner without an individual being contacted to provide supplemental documentation. A higher ex parte rate reflects a more efficient renewal process and helps

more eligible people maintain coverage, and is shown to dramatically reduce procedural disenrollments.

The ex parte rate when redeterminations began in 2023 was low: an average of 34% from the period from June 2023 to November 2023. This rate increased to 66% by December 2023, and it stayed high throughout the period in which strategies were operational. Starting in July 2025, when the strategies were discontinued, the ex parte rate began to decline dramatically. Specifically, the rate declined from an average of 77% in the period from March through June of 2025, to an average of 40% in the period from July 2025 through January 2026.

d) Effect of This Bill. This bill implements strategies as noted below. Restarting eligibility streamlining strategies would be expected to improve the state's ex parte rate, thereby reducing county administrative workload and keep more people on Medi-Cal. To implement these strategies, states must document their use in the appropriate state verification policies and procedures. CMS states in the 2024 guidance that approval of state verification plans is not required, but states must submit their plans to CMS upon request and CMS may require specific policies be included in verification plans in the future.

i) "100% FPL" and "Stable Income" Strategies. One of these income-related strategies allows for automatic verification of income for households whose attestation of income under 100% FPL was verified within the last 12 months (at application or renewal) when no income information is returned through data sources and there is no contradictory information on file. This will allow more beneficiaries to have the annual renewal completed through ex parte and without the need to complete an annual renewal packet. The other flexibility extends automatic determination of income to individuals who receive payments under the Social Security disability insurance program or other stable sources of income, and have no other conflicting income information on file. According to the aforementioned CHHSA brief, during the PHE Unwinding, these changes have had the largest impact on improving the ex parte renewal rate.

ii) Streamlined Use of Asset Verification System (AVS). For individuals subject to an asset test whose eligibility is being determined on the basis of being age 65 or older or having blindness or a disability, federal law requires states to use an AVS to verify assets held in a financial institution. An AVS collects information directly from financial institutions to determine whether certain seniors and people with disabilities who are applying for or receiving Medicaid have assets below eligibility caps. According to CMS, as long as the state builds into its ex parte renewal process a reasonable period of time for financial institutions to respond to an AVS query, CMS has determined that the state may assume no change in the value of a previously verified asset if the state submits a request through its AVS and no information is returned or there is no response from the AVS within the reasonable timeframe the state has established. This would enable the state to complete an ex parte renewal without requesting additional documentation of asset types that can be verified with AVS. Information returned by AVS that might impact eligibility after an individual's eligibility has been renewed must be treated as a change in circumstances, which triggers a reverification of assets.

3) **SUPPORT.** This bill is supported by a large number of consumer and health advocates and health care providers. Supporters note that with the looming implementation of H.R. 1 work reporting requirements for Medi-Cal participation, increased frequency of renewals from annual to every 6 months, and reinstatement of Medi-Cal asset limits, county eligibility offices will be stretched thin by the sheer volume and complexity of cases. Supporters point out various estimates project that between 1.4 million and 3 million Californians could lose Medi-Cal coverage and become uninsured as a result of H.R. 1-imposed rule changes, largely due to increased paperwork barriers. Supporters note that when the strategies were turned off on June 30, 2025, the rate of successful automatic renewals was cut in half, meaning county workers now have to manually process hundreds of thousands of applications that could have been processed automatically had the strategies remained in place. Supporters argue this bill will save counties administrative effort and cost, reduce procedural disenrollments, and keep more people covered.

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 2161 (Bonta), also being heard on April 7, 2026, by the Assembly Health Committee, would implement federally required changes to Medi-Cal eligibility rules in a manner that prioritizes maintaining Medi-Cal coverage; would limit implementation to what is federally required and codifies mandatory and state-optional exemptions to the rules; would prohibit DHCS from applying these more stringent eligibility processes to Medi-Cal members for which these processes are not federally required.; would require data sources to be leveraged to automate eligibility determinations; and would specify notices and noncompliance procedures.

   b) AB 2208 (Stefani), also being heard on April 7, 2026, 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.**

   a) AB 2956 (Boerner) sought to allow people to keep their Medi-Cal coverage for a full 12 months, regardless of changes in income, and directed California to seek federal approval, when necessary, to make permanent all federal Medi-Cal enrollment streamlining strategies. AB 2956 was held on suspense in the Assembly Appropriations Committee.

   b) SB 1289 (Roth) requires, commencing on January 1, 2026, and each month thereafter, a county with a call center for Medi-Cal applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage to collect and submit to DHCS call-center data metrics, including, but not limited to, total call volume, average call wait times by language, and the average call abandonment rate.

c) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, implemented continuous eligibility for children younger than age five, but made the bill contingent on appropriation, the availability of funds, and systems readiness.

6) **AMENDMENTS.** This bill would benefit from technical amendments to clarify that meeting conditions related to assets would satisfy the asset verification, and, similarly, that meeting either condition related to income would satisfy the income verification. Essentially, amendments will split those two issues apart and address them separately, consistent with the author's intent, without making substantive changes.

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 Children's Rights
American Federation of State, County and Municipal Employees, AFL-CIO
Association of Regional Center Agencies
Bay Area Legal Aid
California Academy of Family Physicians
California Alliance for Retired Americans
California Immigrant Policy Center
California LGBTQ Health and Human Services Network
California Pan - Ethnic Health Network
Cardea Health
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 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
Gender Affirming Professionals
Grace Institute - End Child Poverty in CA
Indivisible CA: StateStrong
Jewish Family Service of Los Angeles
LA Best Babies Network
Latino Coalition for a Healthy California
Maternal and Child Health Access
Multi-faith Action Coalition

Planned Parenthood Affiliates of California
San Francisco Aids Foundation
San Francisco Senior and Disability Action
Serving Seniors
Sharp Healthcare
South Asian Network
United Domestic Workers/AFSCME Local 3930
Vision Y Compromiso

Opposition

None on file

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