

ASSEMBLY THIRD READING
AB 2201 (Boerner and Bonta)
As Amended May 18, 2026
Majority vote

SUMMARY

Implements processes to facilitate redetermining an individual's Medi-Cal eligibility by streamlining required income and asset verification, contingent on an appropriation of funds for such purposes.

COMMENTS

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.

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 key strategies that the state implemented on a temporary basis during the PHE Unwinding with respect to redetermination of eligibility.

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.

House of Representatives (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. 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. H.R. 1 also requires states to redetermine eligibility for the ACA expansion population twice a year instead of once a year.

The Department of Health Care Services (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.

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. Starting in July 2025, when the streamlining strategies were discontinued, the ex parte rate began to decline 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.

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.

- 1) *"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% of the federal poverty rate (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.
- 2) *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.

According to the Author

This bill will help minimize the negative impacts of the Trump Administration's attack on Medi-Cal. Specifically, this bill will help to streamline the Medi-Cal verification process, removing administrative barriers that threaten Medi-Cal health coverage. New H.R. 1 paperwork requirements mean county offices will be stretched thin by the sheer volume of work, which puts Californians at risk of losing access to Medi-Cal. The author concludes that we cannot stand by and let the Trump Administration destroy lifeline programs for our most vulnerable populations.

Arguments in Support

This bill is co-sponsored by Western Center on Law and Poverty, Health Access, Justice in Aging, Latino Coalition for a Healthy California, National Health Law Program, and The Children's Partnership. It is also supported by a large number of consumer and health advocates and health care providers. 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.

Arguments in Opposition

None on file.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

Cost pressures of an unknown amount to county health and human services agencies, which perform Medi-Cal eligibility determinations on behalf of the state. Based on an estimate provided by the County Welfare Directors Association of California for AB 2161 (Bonta), which also addresses implementation of related H.R. 1 requirements on Medi-Cal redeterminations, costs could be in the hundreds of millions of dollars annually (General Fund, federal funds).

The author submitted a letter to the Assembly Budget Committee requesting language in the June 2026 trailer bill directing DHCS to reinstate strategies that streamline the renewal process and minimize coverage losses.

VOTES**ASM HEALTH: 16-0-0**

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

ASM APPROPRIATIONS: 11-0-4

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

ABS, ABST OR NV: Hoover, Dixon, Ta, Tangipa

UPDATED

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