
SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2201
AUTHOR: Boerner and Bonta
VERSION: May 18, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Jen Flory

SUBJECT: Medi-Cal: eligibility redetermination

SUMMARY: Implements the federal requirement to renew specified Medi-Cal recipients' eligibility every six months instead of twelve and specifies additional conditions that require counties to verify a Medi-Cal recipient's eligibility based on information the county has in the recipient's file.

Existing federal law:

- 1) Establishes the Medicaid program to enable each state to furnish medical assistance on behalf of individuals whose income and resources are insufficient to meet the costs of necessary medical services. [42 USC §1396, et seq.]
- 2) Requires the eligibility of all Medicaid recipients to be renewed when the recipient reports a change in circumstances or once every 12 months. [42 C.F.R. §435.916 and §435.919]
- 3) Starting January 1, 2027, as enacted by H.R. 1 (Public Law No. 119-21), requires individuals with incomes below 138% of the federal poverty level (FPL) who are under age 65, not pregnant, and have no Medicaid-eligible dependents (known as "the Affordable Care Act (ACA) expansion adults") have their eligibility for Medicaid additionally redetermined every six months. Exempts individuals who are Indian, Urban Indian, California Indian, or otherwise eligible for Indian Health Services. [42 USC §1396a]

Existing state law:

- 1) Establishes the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [WIC §14000, et seq.]
- 2) Delegates, to the county of residence, the responsibility for Medi-Cal eligibility determinations and ongoing case management. [WIC §14015.5]
- 3) Requires a county to perform redeterminations of eligibility for Medi-Cal recipients every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a recipient's circumstances that may affect eligibility for Medi-Cal benefits. [WIC §14005.37]
- 4) Requires a county to make a determination of continued eligibility when redetermining eligibility, if based on information available to the county, including the Medi-Cal, CalWORKs, and CalFresh case files of the recipient or their immediate family members or information accessed through electronic databases, the county is able to verify eligibility *ex parte* (without seeking information from the recipient). When eligibility is verified based on such information, requires the county to notify the recipient of their continued eligibility and the information it is based on. Requires the recipient to contact the county by internet, phone,

mail, in person, or other commonly available electronic means where such communication is available with the county, if any information in the notice is inaccurate. Requires nothing of the recipient to maintain eligibility if the information is correct. [WIC §14005.37]

This bill:

- 1) Implements the new federal requirement that ACA expansion adults have their eligibility redetermined every six months instead of 12.
- 2) Requires counties to use three additional methods for renewing eligibility *ex parte* for Medi-Cal recipients at their annual or semiannual redetermination:
 - a) If the most recent income determination within the past 12 months was based on a previously verified attestation of income at or below 100 percent of the FPL there is no contradictory information on file, and the county checks financial data sources, and no information is received, then countable income shall be considered verified;
 - b) If the most recent income determination within the past 12 months was based on a previously verified attestation of only federal retirement, survivors, or disability insurance, or other income that does not fluctuate except for cost-of-living adjustments, there is no contradictory information on file, then countable income shall be considered verified; and,
 - c) If the most recent asset verification within the past 12 months was based on a previously verified attestation of assets, and the county has checked financial data sources and no information is received or the recipient has only stable assets that are unlikely to increase in value, and no contradictory information is on file, then countable assets shall be considered verified.
- 3) Makes other technical changes in reference to the new six month renewal requirement.
- 4) Conditions implementation of this bill upon and appropriation made by the Legislature and provides for reimbursement to local agencies should the Commission of State Mandates determine that this bill contains costs mandated by the state.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

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 committee also noted that 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.

PRIOR VOTES:

Assembly Floor:	78 - 0
Assembly Appropriations Committee:	11 - 0
Assembly Health Committee:	16 - 0

COMMENTS:

- 1) *Author's statement.* According to the author, this bill will help minimize the negative impacts of the Trump Administration's attack on Medi-Cal. This bill will help to streamline the Medi-Cal verification process, removing administrative barriers that threaten Medi-Cal health coverage. Currently, 14 million Californians rely on Medi-Cal coverage, of which 5 million are children. Work requirements for Medi-Cal participation and increased frequency of renewals from annual to every 6 months mean county offices will be stretched thin by the sheer volume of additional paperwork and ultimately put Californians at risk of losing access to Medi-Cal. California needs to protect healthcare services, especially for children. We cannot stand idly by and let the Trump Administration destroy lifeline programs for our most vulnerable population.
- 2) *H.R. 1.* H.R. 1, the federal budget reconciliation bill passed in July 2025, makes a number of changes primarily to lower taxes, increase funding for immigration control and national defense, and restrict access to and funding for SNAP and Medicaid. Medicaid payments were reduced by defunding family planning providers that provide abortions, prohibiting new or increased provider taxes to fund Medicaid and requiring a gradual reduction of existing provider taxes, capping the rate the state may set for certain services, reducing the federal share of payment for emergency services to adults with unqualified immigration status, and making changes in allowable payments under federal waiver programs. More relevant to this bill are a number of changes to the Medicaid eligibility rules, which were enacted to reduce the number of people receiving assistance through the Medicaid program.

Under current federal regulation and state law, Medi-Cal eligibility must be redetermined once every 12 months or whenever an individual reports a change in circumstances. H.R. 1 requires an additional eligibility renewal process every six months for the same group of ACA expansion adults that the work requirements apply to, starting January 1, 2027. This is intended to reduce Medicaid enrollment because eligible individuals often fail to respond to requests for information. In fact, prior to the ACA's requirement that redeterminations be done only annually, California would use additional redeterminations, at times quarterly redeterminations when the state budget was tight, to reduce Medi-Cal enrollment.

- 3) *Medi-Cal redeterminations and the COVID-19 unwinding flexibilities.* Since the passage of SB 87 (Escutia, Chapter 1088, Statutes of 2000) over 25 years ago, the Medi-Cal program has required counties to first look to the information the county has in a recipient's case file when processing a Medi-Cal redetermination to attempt to renew eligibility with only the minimum amount of information required from the recipient. This model was incorporated and expanded by the ACA. The ACA exempted many populations from assets tests, simplified how their income is counted, and allowed for self-attestation of many elements of eligibility such as income that is accepted unless the county has information to the contrary in the file or via electronic verification databases. The ACA also required sending recipients prepopulated renewal forms showing the information already on file, only requiring recipients to correct incorrect information or supply missing information. Nonetheless, redeterminations are still a considerable burden for county eligibility workers both for the time on the back end to find the information necessary to redetermine eligibility and the time required to obtain any missing information from the recipient. This was most evident after the COVID-19 public health emergency. After three years of keeping people on Medi-Cal without redeterminations due to the public health emergency, counties had to resume redeterminations, only information in the case files was in many cases three years out of date. At that time, according to DHCS's September 2023, "Medi-Cal COVID-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan," DHCS obtained

approval from the federal government to utilize the three sets of conditions in this bill (among 14 others) that would allow for faster redeterminations: 1) verifying the income of those below 100% of the FPL with just a check in the case file and with electronic resources; 2) verifying the income of those with income sources deemed stable (such as social security benefits) with just a check of the case file; and, 3) expanded use of an electronic asset verification report to verify assets. According to a March 2024 issue brief by DHCS, the first two of these flexibilities had the greatest impact on counties' ability to renew Medi-Cal *ex parte*, though it should be noted that Medi-Cal only had an assets test for part of the time the unwinding occurred. After the unwinding, DHCS revoked these flexibilities via All-County Letter 25-09, effective June 30, 2025.

However, in November 2024, the federal Centers for Medicare and Medicaid Services issued a guidance, "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes," that authorized states to implement these flexibilities (now called "strategies") indefinitely without requiring the need of a federal waiver. The guidance outlines where state plan amendments are needed, where updated verification plans are needed, and where the state may just implement pursuant to the guidance. According to a tracker by the Kaiser Family Foundation, as of January 2026, across the political spectrum, 15 states are utilizing the below 100% of the FPL strategy and 6 are utilizing the stable source of income strategy. The asset verification strategy is not tracked there. Another 11 states used a modified version of the below 100% FPL strategy for just for those individuals reporting no income.

- 4) *Related legislation.* SB 987 (Weber Pierson) would have created the California Health Access Fund to redirect any savings to the state resulting from decreased enrollment in the Medi-Cal program caused by the implementation of H.R. 1 to ensure that California residents losing health coverage can continue to receive health care services and that health care providers are reimbursed for these services. *SB 987 was held on the Senate Appropriations suspense file.*

SB 1202 (Weber Pierson) would require DHCS to track and publish data including the number of individuals who lose coverage due to eligibility barriers imposed by H.R. 1 and requires DHCS, counties, and plans to conduct outreach to Medi-Cal recipients about the H.R. 1 program changes. *SB 1202 is pending in the Assembly Appropriations Committee.*

AB 2161 (Bonta) would codify H.R. 1's work requirements; requires DHCS to implement the work requirements in the least administratively burdensome way to Medi-Cal applicants and recipients as possible; and, prohibits DHCS from applying H.R. 1's work requirements to state-only Medi-Cal populations. *AB 2161 is set for hearing in this on July 1, 2026 in this Committee.*

AB 2208 (Stefani) would codify H.R. 1's Medicaid cost-sharing requirements and limits the cost sharing to one cent; require Medi-Cal systems implementing H.R. 1 changes to be user-tested; and require the state to provide three months of retroactive eligibility for Medi-Cal even after H.R. 1 limits federal payments for retroactive eligibility. *AB 2208 2161 is set for hearing on July 1, 2026 in this Committee.*

- 5) *Prior legislation.* AB 2956 (Boerner of 2024) would have allowed individuals 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 the Assembly Appropriations Committee suspense file.*

SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022) implements continuous eligibility for children under age five (no redetermination required), contingent upon an appropriation, the availability of funds, and systems readiness.

AB X1 1 (Perez, Chapter 3, Statutes of 2013) implements the Affordable Care Act, which incorporated various changes to the renewal process such as the inclusion of simplified eligibility determined based on Modified Adjusted Gross Income and the requirement for prepopulated renewal forms that sought from the recipient only the information the county was missing in order to renew Medi-Cal eligibility.

SB 87 (Escutia, Chapter 1088, Statutes of 2000) makes various changes to the Medi-Cal eligibility, renewal, and termination procedures, including requiring the *ex parte* process for renewals.

- 6) *Support.* A number of county organizations including the County Welfare Directors Association and other related associations write that counties have experience navigating large-scale eligibility transitions. During the Medi-Cal unwinding process in 2023, California implemented federal renewal streamlining strategies that reduced procedural terminations and doubled the automatic renewal rate. When the strategies ended on June 30, 2025, automatic renewal success was cut in half, resulting in hundreds of thousands of renewals that county workers must manually process each month. This workload is expected to grow further starting January 1, 2027, when counties must conduct renewals twice a year. This bill would reinstate proven Medi-Cal renewal streamlining strategies which would reduce county workloads, minimize wrongful terminations, and preserve staff capacity for complex cases, protecting thousands of Californians from losing their coverage. Sponsors 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 write that this bill would also deliver meaningful administrative and downstream healthcare cost savings to the state and counties. Improving the rate of automatic renewals and decreasing procedural terminations will minimize gaps in coverage, thus reducing ‘churn’. Churning causes gaps in healthcare coverage, which can lead to postponing visits to the doctor or delaying a prescription refill leading to major financial consequences for everyone involved. Beyond administrative costs associated with churning, people who get back on coverage often have higher monthly health care costs due to pent-up demand for services, contributing to less predictable expenditures for the state. Further, keeping people on Medi-Cal will generate downstream cost savings by reducing uncompensated emergency care and reducing the pressures on county indigent care programs.
- 7) *Amendment.* The committee and author have agreed to a technical amendment to incorporate these additional processes into the existing *ex parte* process that requires notifying the recipient of the eligibility determination and only requiring a response if the information is not correct:
- 14005.37(e)(3): In the case of an annual *or* semiannual redetermination, if, based upon information obtained pursuant to paragraph (1) *or* (2), the county is able to make a determination of continued eligibility, the county shall notify the beneficiary of both of the following . . .

SUPPORT AND OPPOSITION:

Support: Health Access California (co-sponsor)
Justice in Aging (co-sponsor)
Latino Coalition for a Healthy California (co-sponsor)
National Health Law Program (co-sponsor)
The Children's Partnership (co-sponsor)
Western Center on Law & Poverty (co-sponsor)
Access Reproductive Justice
All for Kids
Alliance for Children's Rights
AltaMed Health Services
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
American Federation of State, County and Municipal Employees
Asian Americans Advancing Justice Southern California
Asian Resources, Inc.
Association of Regional Center Agencies
Bay Area Legal Aid
Bleeding Disorders Council of California
Buen Vecino
California Academy of Family Physicians
California Alliance for Retired Americans
California Association of Public Hospitals & Health Systems
California Behavioral Health Association
California Collaborative for Long-term Services and Supports
California Community Foundation
California Dental Association
California Immigrant Policy Center
California Kidney Care Alliance
California LGBTQ Health and Human Services Network
California Pan - Ethnic Health Network
California Physicians Alliance
California Primary Care Association Advocates
California Rural Legal Assistance, Inc.
California School-Based Health Alliance
California State Association of Counties
California State Council of Service Employees International Union
Cardea Health
Celestria Health
Child Care Resource Center
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
County Health Executives Association of California
County of Contra Costa
County of Los Angeles

County of San Diego
County Welfare Directors Association of California
Courage California
Desert Healthcare District and Foundation
Disability Rights California
East Bay Community Law Center
Families in Schools
Family Voices of California
Friends Committee on Legislation of California
Gender Affirming Professionals
GLIDE
Health4Kern
Healthy Contra Costa
Hispanas Organized for Political Equality
Indivisible CA: Statestrong
LA Best Babies Network
Legal Aid Foundation of Los Angeles
Los Angeles LGBT Center
Maternal and Child Health Access
Multi-Faith Action Coalition
Neighborhood Legal Services of Los Angeles County
Orange County United Way
Planned Parenthood Affiliates of California
Private Essential Access Community Hospitals
Rural County Representatives of California
San Francisco AIDS Foundation
San Francisco Senior and Disability Action
Santa Cruz Community Ventures
Senior Services Coalition of Alameda County
Sharp Healthcare
South Asian Network
The Los Angeles Trust for Children's Health
Transitions Clinic Network
United Domestic Workers/AFSCME Local 3930
Urban Counties of California
Venice Family Clinic
Vision Y Compromiso
Western Center on Law & Poverty, Inc.
Youth Take Lead

Oppose: None received.

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