

Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2208 (Stefani) – As Introduced February 19, 2026

SUBJECT: Medi-Cal: cost sharing, retroactivity, and accessibility.

SUMMARY: Preserves the ability of Medi-Cal enrollees to apply for up to three months of retroactive Medi-Cal coverage despite reductions in the number of months of coverage eligible for federal Medicaid matching funds; implements nominal cost-sharing for specified Medi-Cal populations as allowed by federal law; and makes a number of changes to improve the usability of the state’s Medi-Cal application and to conform the application process to new eligibility requirements under federal law. Specifically, **this bill:**

Retroactive Coverage

- 1) Maintains up to three months of retroactive Medi-Cal coverage, regardless of the availability of federal matching funds, and requires the Department of Health Care Services (DHCS) to seek federal reimbursement for these services to the maximum extent federally allowable.

Copayments

- 2) Applies copayments to specified populations (generally, adults without dependent children with income exceeding 100% of, and up to 138%, of the federal poverty level (FPL)), not to exceed the maximum permitted under federal regulations or federal waivers, as follows:
 - a) Requires a copayment of one cent (\$0.01) to be made for nonemergency services received in an emergency department or emergency room when the services do not result in the treatment of an emergency medical condition or inpatient admission and defines “nonemergency services.”
 - b) Allows the copayment amounts to be collected and retained, or waived by the provider.
 - c) Prohibits DHCS from reducing the reimbursement otherwise due to providers as a result of the copayment and provides the copayment amounts are in addition to any reimbursement otherwise due to the provider for services rendered under the Medi-Cal program.
 - d) Exempts the following services and populations from the imposition of copayments:
 - i) Emergency services;
 - ii) Family planning services;
 - iii) Services received by any of the following: an individual who is pregnant; an individual under 21 years of age; an individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution; and an individual who is receiving hospice care;
 - iv) COVID-19 testing-related services;

- v) Vaccines, as specified;
 - vi) Items or services furnished to Indians through the federal Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral;
 - vii) Primary care services;
 - viii) Mental health care and substance use disorder services; and,
 - ix) Services provided by a federally qualified health center, certified community behavioral health clinic, or rural health clinic.
- e) Prohibits a provider of services from denying care or services to an individual solely because of nonpayment of the specified copayment.
 - f) Prohibits the total aggregate amount of deductions, cost-sharing, or similar charges imposed for all individuals for a family from exceeding 5% of the family income of the family involved, as applied on a monthly basis.
 - g) Implements copayments only to the extent that any necessary federal approvals are obtained and federal financial participation is available, and no sooner than October 1, 2028.

User-Friendly Applications for Health Care Affordability Programs

- 3) Requires that an individual have the option to apply for insurance affordability programs (generally, Medi-Cal and Covered California) through a mobile-friendly website.
- 4) Adds smart phones or other smart devices to the list of available methods for reporting renewal information.
- 5) Requires an application or changes to an application to comply with federal Public Law 119-21 (H.R. 1 of 2025; officially titled the “One Big Beautiful Bill Act”), to be user-tested for accuracy and readability and requires them to be operational by the date as required by the federal Secretary of Health and Human Services, including prior to the effective date of any applicable changes required pursuant to H.R. 1.
- 6) Applies existing criteria (that apply to applications) to supplements to an application, such as those that will be used to collect information on compliance with new eligibility requirements under H.R. 1.
- 7) Allows the existing form used to apply for health care affordability programs to be used, to the extent possible, to determine compliance with work or community engagement requirements set federal law, as specified, including any exemptions to those requirements, without seeking additional information.
- 8) Requires insurance affordability programs to accept self-attestation, instead of requiring an individual to produce a document, for various applicable criteria, including compliance status with work or community engagement requirements, needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law.

- 9) Adds H.R. 1 to the list of laws, regulations, and guidance that must be complied with in the design and use of the health care affordability program application and adds work or community engagement requirements as a factor that is considered in multiple aspects of application design and process.
- 10) Requires an applicant who is not eligible for an insurance affordability program because of work or community engagement requirements to be referred to the county health coverage program in their county of residence.
- 11) Adds more specificity to an existing stakeholder process related to the functionality of eligibility systems. Broadens the issues considered to functionality, accuracy, and legally appropriate determination of the other public benefit electronic eligibility systems.

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 FPL plus applicable income disregards (referred to as the ACA Expansion population). [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) Limits retroactive Medicaid coverage for ACA Expansion enrollees to one month prior to month of application, and limits retroactive coverage for other populations to two months prior to month of application. [42 U.S.C. § 1396a(a)(34), effective December 31, 2026.]
- 3) Beginning October 1, 2028:
 - a) Prohibits enrollment fees, premiums, and similar charges for ACA Expansion enrollees,
 - b) Requires states to impose cost-sharing on certain care, items, or services furnished to ACA Expansion enrollees who are over the FPL (essentially, between 100% FPL and 138% FPL), as determined by the State and as follows:
 - i) Requires a state to impose “such deductions, cost-sharing, or similar charges determined appropriate by the state (in an amount greater than \$0)”;
 - ii) Imposes a limit of \$35 for a service;
 - iii) Limits cost-sharing for drugs;
 - iv) Prohibits the aggregate amount of deductions, cost-sharing, or similar charges imposed under the Medicaid State Plan for all individuals in the family from exceeding 5% of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the state);
 - v) Allows states to permit providers to condition the provision of care on payment of applicable cost-sharing; and,
 - vi) Allows providers to reduce or waive such cost-sharing on a case-by-case basis. [42 U.S.C. § 1396o(k)]

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 processes for the determination and redetermination of an individual's eligibility for Medi-Cal. [WIC § 14005, *et seq.*]
- 4) Allows for retroactive eligibility determination and Medi-Cal payment for services prior to an individual's Medi-Cal application if, during any of the three months immediately prior to the month in which application was made, under conditions prescribed by DHCS and to the extent required by federal law, a person would have otherwise been eligible. [WIC § 14019]
- 5) 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. Establishes numerous related processes. [WIC § 14005.37]
- 6) Allows a beneficiary to request a Medi-Cal eligibility determination for any of the three months immediately prior to the month in which the beneficiary provided needed information to the county, in accordance with 4) above, if, within 90 days of a Medi-Cal beneficiary's eligibility termination date or a change in eligibility status due to the beneficiary's failure to provide needed information, the discontinued beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county. [*Ibid.*]
- 7) Allows, if someone is incapable of acting on their own behalf and who would otherwise be eligible for Medi-Cal, and that individual loses Medi-Cal because their guardian failed to provide required information, then anyone with knowledge of the person's need for Medi-Cal coverage may apply for retroactive eligibility for any of the three preceding months on behalf of the person. [WIC § 14016.2]
- 8) Requires DHCS, in consultation with Covered California to develop a single, accessible, standardized paper, electronic, and telephone application for insurance affordability programs (known as the "Single Streamlined Application"). [WIC § 15926]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, as Washington, D.C. threatens to rip health care away from over three million Californians, our state must act. The author introduced this legislation that ensures that no one must choose between lifesaving care and crushing medical debt by capping costs for low-income Medi-Cal patients at a penny, protecting retroactive Medi-Cal coverage, and requiring clear communication about benefits. The author concludes that when the federal government turns its back on patients, California will step in to protect them.

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

The federal ACA required states to implement data-sharing strategies to simplify eligibility and redetermination processes for beneficiaries. Medicaid 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. Finally, applicants who are successfully enrolled can request retroactive eligibility for up to three months, provided they can demonstrate eligibility in those months.

- b) **The Joint Medi-Cal/Covered California “Health Care Affordability Program” Application.** The federal Patient Protection and Affordable Care Act (ACA) improves access to health coverage through expanded Medicaid eligibility and the creation of health insurance exchanges where individuals and small businesses purchase federally subsidized health plans. To support implementation, the ACA also streamlines Medicaid eligibility rules for most populations and requires states to coordinate eligibility and enrollment processes between Medicaid and subsidized coverage on health insurance exchanges (collectively referred to as health care affordability programs in California law). The goal of these federal policies is to reduce gaps in coverage when a beneficiary experiences changes in income or other circumstances.

The state’s main information technology system that supports these functions is called California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). CalHEERS supports account creation, consumer application, eligibility rules, and health plan selection for health care affordability programs (Covered California and Medi-Cal). CalHEERS also interfaces with the Statewide Automated Welfare Systems (SAWS) for certain Medi-Cal eligibility categories, enrollment and reporting, and provides data for potential eligibility to other health and human services programs. It supports the “Single Streamlined Application” (SSApp) that is used for Covered California and Medi-Cal.

The state has made significant efforts to improve the usability of the application process through user testing, engagement with stakeholders, and improvements to the SSApp. DHCS introduced the SSApp in 2013 and has made numerous updates. The latest release was September 22, 2025. The changes this bill makes to improve the user-friendliness of

the process and align state law with federal work and community engagement requirements would be implemented in the SSApp through CalHEERS.

- c) **Retroactive Coverage.** Prior to H.R. 1, under federal Medicaid law, states were required to provide coverage for care and services received up to three months prior to the date an individual applied for Medicaid. The individual must demonstrate they met appropriate Medicaid eligibility criteria in each month they receive retroactive coverage. Once determined retroactively eligible, Medicaid will pay bills for services incurred prior to the application.

According to Justice in Aging, retroactive Medicaid coverage is a key financial protection for low-income, uninsured, and underinsured older adults, especially those who experience a health emergency, need long-term services and supports following an illness, or have other unexpected high-cost health care needs. Justice in Aging notes retroactive eligibility protects people from financial ruin and helps ensure prompt access to care when individuals experience an emergency or sudden illness, need long-term services in a nursing facility or at home, or when a family is facing mounting routine medical bills. Families USA also calls retroactive coverage a critical safeguard for new enrollees, noting retroactive coverage can be extremely helpful for people experiencing new life events such as pregnancy or childbirth. For example, delays in submitting an application following the birth of a child or medically difficult miscarriage (when eligibility levels change) could result in no coverage for families for the care provided and large hospital bills.

- d) **Cost-Sharing.** Cost-sharing in health care includes copayments, coinsurance, and deductibles. A copayment is a flat dollar amount paid by the enrollee for services subject to a copayment, while coinsurance is the percentage of the total cost of a service that will be paid by the enrollee. A deductible is an amount that must be paid prior to a health plan paying for services. Peer-reviewed literature indicates higher cost-sharing at the point of service reduces the use of health care services, including necessary and appropriate care. This is a particularly acute problem for lower-income people, as research shows even a nominal amount can discourage the use of care. Although cost-sharing is common in commercial plans, Medi-Cal currently does not impose cost-sharing at the point of service.
- e) **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 rules that apply to the ACA Expansion population. H.R. 1 represents the largest-ever cut to the Medicaid program, with savings from Medicaid eligibility, coverage, and financing changes projected to partially offset the loss of federal revenue associated with tax cuts that disproportionately benefit the wealthy and corporations.
- 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) **Changes to Retroactive Coverage.** Section 71112 of federal H.R. 1 restricts retroactive Medicaid coverage to one month for the ACA Expansion population and two months for other populations.
 - iv) **Cost-Sharing.** Section 71120 of federal H.R. 1 requires states to impose cost-sharing on ACA Expansion enrollees who are over 100% of the FPL, but grants significant flexibility to states on implementation (see Existing Federal Law above).
- f) **2026-27 Governor’s Budget Proposal.** As part of the Governor’s 2026-27 Proposed Budget released in January, the Newsom Administration proposes budget changes and Trailer Bill Legislation (TBL) to implement H.R. 1, including the implementation of work or community engagement requirements and six-month eligibility determinations. The proposed budget does not address H.R. 1-required copayments, nor does it address improving the user-friendliness of the application process. However, the proposed budget does include TBL and a related budget proposal to implement a reduction in retroactive eligibility. The Administration’s approach is to align California’s policy with the time period of retroactive coverage that is eligible for federal matching funds, i.e., one month for the ACA Expansion population and two months for other populations. In contrast, this bill would maintain three months of retroactive coverage, at state cost for those additional months where federal matching funds are unavailable. The Administration assumes implementation no sooner than January 1, 2027, and projects estimated savings from reducing retroactive eligibility in 2026-27 is \$23 million total funds (\$9.6 million General Fund). An estimated 86,000 Medi-Cal members per year would be affected by this reduction in eligibility.
- 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 Californians from H.R. 1 policies. Co-sponsors Western Center on Law & Poverty, Health Access California, Justice in Aging, and National Health Law Program note the cuts included in H.R. 1 threaten to unravel years of progress on health care coverage and affordability in a matter of months. Co-sponsors argue that H.R. 1’s cost-sharing requirements could result in Medi-Cal enrollees likely to forgo care altogether because of the high cost. Co-sponsors note the retroactivity provision protects individuals who do not know they’re eligible for Medi-Cal or are not able to apply until after an emergency happens. Finally, co-sponsors note the importance of continuing to make progress on improving the application and renewal processes, arguing it is critical to make these processes as easy and seamless as possible so individuals can preserve their coverage.
- 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 2201 (Boerner), also being heard on April 7, 2026, by the Assembly Health Committee, would extend eligibility-related strategies to streamline asset and income verifications where federally allowable.
- 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 116 (Committee on Budget), Chapter 21, Statutes of 2025, beginning July 1, 2027, imposes cost-sharing through the imposition of premiums of \$30 per beneficiary on individuals in full-scope Medi-Cal coverage with unsatisfactory immigration status, ages 19 to 59, with a three-month “cure” period to remit unpaid premiums before being disenrolled.
- b) AB 1296 (Bonilla), Chapter 641, Statutes of 2011, enacted the Health Care Reform Eligibility, Enrollment, and Retention Planning Act, which requires the California Health and Human Services Agency, in consultation with the DHCS, the California Health Benefit Exchange, the California Office of Systems Integration, counties, health care service plans, consumer advocates, and other stakeholders, to plan and develop standardized single, accessible application forms and related renewal procedures for state health subsidy programs.

REGISTERED SUPPORT / OPPOSITION:

Support

Health Access California (co-sponsor)
 Western Center on Law & Poverty (co-sponsor)
 Justice in Aging (co-sponsor)
 National Health Law Program (co-sponsor)
 Access Reproductive Justice
 Alliance for Children's Rights
 Alzheimer's Greater Los Angeles
 Alzheimer's Orange County
 Alzheimer's San Diego
 American Federation of State, County and Municipal Employees, AFL-CIO
 Asian Resources, INC.
 Bay Area Legal Aid
 California Academy of Family Physicians
 California Alliance for Retired Americans
 California Alliance of Child and Family Services

California Dental Association
California Immigrant Policy Center
California LGBTQ Health and Human Services Network
California Pan - Ethnic Health Network
California Physicians Alliance
California School Employees Association
CANHR
Cardea Health
Caring Across Generations
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
CPAC 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
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
National Multiple Sclerosis Society
Northeast Valley Health Corporation
Public Counsel
San Francisco Aids Foundation
San Francisco Senior and Disability Action
Senior Services Coalition of Alameda County
Serving Seniors
South Asian Network
The Children's Partnership
Unidosus
Vision Y Compromiso
One individual

Opposition

None on file

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