SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2208
AUTHOR: Stefani
VERSION: June 22, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Jen Flory

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

SUMMARY: Requires the state to continue to provide three months of retroactive coverage for the Medi-Cal despite loss of federal funding for one or two of these months, depending on the population; specifies that federally-mandated cost sharing required in the Medi-Cal program starting October 1, 2028 is limited to one cent; and, makes technical changes to the Medi-Cal application and renewal processes.

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) Authorizes payment for health care services rendered during any of the three months immediately prior to the month in which application was made if a person would have otherwise been eligible. [42 USC §1396a]

3) Starting January 1, 2027, as enacted by H.R. 1 (Public Law No. 119-21), reduces the retroactive eligibility period for Medicaid from three months prior to the month of application to one month prior to the month of application for individuals with incomes below 138% of the federal poverty level (FPL) who are under age 65, not pregnant, and have no Medicaid-eligible dependents (Affordable Care Act (ACA) expansion adults) and two months prior to the month of application for all other individuals. [42 USC §1396a]

4) Prohibits states from imposing enrollment fees and premiums on the ACA expansion adults, but starting October 1, 2028, requires states to impose cost sharing in an amount greater than $0 and less than $35, as determined by the state, and not to exceed 5% of the family income as applied on a monthly or quarterly basis. Exempts services to pregnant women, services to individuals with household incomes below the federal poverty line, inpatient services, emergency services, hospice care, covid tests, vaccines, primary care, mental health care services, substance use disorder services, or services provided by a federally qualified health center, rural health clinic, or a certified community behavioral clinic, and specifies additional limitations on cost sharing for prescription drugs. [42 USC §1396o]

5) Starting January 1, 2027, as enacted by H.R. 1, requires ACA expansion adults to demonstrate community engagement through at least 80 hours of work, community service, or participation in a work program, or at least half-time participation in an educational program, or have a monthly income not less than 80 times the federal minimum wage in a specified month. Provides for some exceptions to this requirement. This is referred to as "work or community engagement" requirements. [42 USC §1396a]

Existing state law:

1) Establishes the Medi-Cal program, which is administered by the California 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) Allows a recipient to request a Medi-Cal eligibility determination for any of the three months immediately prior to the month in which the recipient provided needed information to the county, if, within 90 days of a Medi-Cal recipient's termination date or a change in eligibility status due to the recipient's failure to provide needed information, the discontinued recipient submits to the county a signed and completed form or otherwise provides the needed information to the county, known as the 90-day cure period. [WIC §14005.37]

5) Authorizes payment for health care services rendered during any of the three months immediately prior to the month in which application was made if a person would have otherwise been eligible, as required by federal law. [WIC §14019]

6) Allows anyone with knowledge of the person's need for Medi-Cal coverage to apply for retroactive eligibility for any of the three preceding months on behalf of the individual if that individual is incapable of acting on their own behalf and would otherwise be eligible for Medi-Cal, and that individual loses Medi-Cal because their guardian failed to provide required information. [WIC §14016.2]

7) Allows people to apply for any of the state insurance affordability programs (defined as Medi-Cal, the Medi-Cal Access Program, and Covered California) in person, by mail, online, by telephone, or other commonly available electronic means. Requires the single application for all programs to comply with a number of requirements including the requirement to be tested, be consistent with federal statutes and regulations, include simple language and instructions, require only the information necessary to support program eligibility and enrollment processes, but allows for the inclusion of demographic questions. [WIC §15926]

8) Allows the state insurance affordability programs to accept self-attestation to the extent permitted by state and federal law. [WIC §15926]

9) Requires renewal procedures to include all available methods for reporting renewal information, including face-to-face, telephone, mail, and online renewal or renewal through other commonly available electronic means. [WIC §15926]

10) Requires an applicant who is not eligible for an insurance affordability program for a reason other than income eligibility, or for any reason in the case of applicants and recipients residing in a county that offers a health coverage program for individuals with income above the maximum allowed for the Covered California premium tax credits, to be referred to the county health coverage program in their county of residence. [WIC §15926]

11) Requires DHCS, the California Health and Human Services Agency, and the Covered California board to establish a process for receiving and acting on stakeholder suggestions regarding the functionality of the eligibility systems supporting Covered California, including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. [WIC §15926]

This bill:

1) Maintains the existing three-month retroactive eligibility period for all Medi-Cal applicants and recently terminated recipients, and requires the state to seek federal reimbursement for the services to the maximum extent federally allowable, but specifies that some of these services may be state funded.

2) Implements the federal law requiring the state to impose cost-sharing on ACA expansion adults no sooner than October 1, 2028, but limits the copayment to one cent, unless the visit, service, or device has a Medi-Cal program payment of $10 or less, in which case no copayment is required.

3) Prohibits a provider from denying care or services to an individual solely for nonpayment of the copayment, and conditions implementation upon the receipt of federal approvals and federal financial participation.

4) Makes a number of technical or conforming changes to the existing insurance affordability application and processes, including:
   a) Requires the application to have a mobile-friendly website and allow renewals to be done via smart phones or other smart devices;
   b) Requires the application to be user-tested for accuracy and readability in all Medi-Cal threshold languages, including prior to the effective date of changes required by H.R. 1;
   c) Requires supplements to the application to follow the same rules as for the application itself;
   d) Authorizes the application to be used to determine compliance with the H.R. 1 work or community engagement requirements;
   e) Requires the acceptance of self-attestation with regards to work or community engagement requirements to the extent permitted by state or federal law;
   f) Authorizes allowing applicants additional time to demonstrate compliance with work or community engagement requirements;
   g) Requires referrals to county health coverage programs to persons ineligible for an insurance affordability program due to work or community engagement requirements; and,
   h) Specifies which eligibility systems require stakeholder input and user-testing on functionality and accuracy.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

Based on DHCS′s estimated savings from reducing retroactive eligibility in fiscal year (FY) 2026-27, maintaining three months of retroactive eligibility would cost approximately $23 million ($9.6 million General Fund (GF)) in FY 2026-27. In FY 2027-28 and beyond, with full-year implementation, GF costs could be in the low tens of millions of dollars per year. Costs to the Medi-Cal program would likely decrease over time as the state implements the various

provisions of H.R. 1 and more people lose Medi-Cal coverage. The author has requested $23 million in the state budget to fund the provisions of this bill.

The Legislative Analyst's Office recently warned of GF structural deficits of around $35 billion per year in FY 2027-28 and ongoing

PRIOR VOTES:

Assembly Floor:	58 - 19
Assembly Appropriations Committee:	11 - 3
Assembly Health Committee:	12 - 3

COMMENTS:

1) *Author's statement.* According to the author, as Washington threatens to rip health care away from over three million Californians, our state must act. This bill ensures that no one has to 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. When the federal government turns its back on patients, California must step in to protect them.

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 the Supplemental Nutrition Access Program 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.
   a) *Retroactive eligibility.* Under existing state and federal law, individuals applying for Medi-Cal can also have medical bills paid for the three months prior to application, known as the "retroactive eligibility period." H.R. 1 reduces this period to one month prior to the month of application for the ACA expansion adults and two months prior to the month of application for everyone else, starting January 1, 2027. This retroactive period affects not just applications, but renewals as well, due to policy allowing recipients to "cure" their termination from the program if they are able to provide any missing documentation within 90 days that was needed to redetermine their eligibility. A reduction in the retroactive eligibility period means that although someone can still cure their termination and be reinstated into the program, they may not get all medical expenses covered during the period they were not enrolled.
   b) *Cost-sharing requirements.* H.R. 1 also requires states to impose new cost-sharing requirements on ACA expansion adults. Although it maintained the prohibition on premiums, exempted households below the FPL and a number of services, imposing cost-sharing on the rest of this group is no longer optional for the state. However, states have considerable leeway in determining the amounts of copayments, so long as those co-payments do not exceed $35 or the aggregate amount of copayments do not exceed 5% of the household's income in any given month or quarter.

c) *Work requirements.* The new work or community engagement requirements require ACA expansion adults to demonstrate 80 hours of work, education, or volunteer activities a month to be eligible for Medicaid coverage, unless they qualify for a limited exemption (pregnant or postpartum; incarcerated; parents with dependent children under age 14; disabled veterans; individuals with serious or complex medical conditions, including substance use or disabling mental disorders; and former foster youth; or live in either an area with a federally declared disaster or with a recognized high unemployment rate). Because the work requirement is calculated based on federal minimum wage, many may be exempt if they earn at least $580 in monthly income. States are required to verify that an individual meets the community engagement requirements twice a year, starting January 1, 2027. This bill contains a number of technical changes to account for the additional information that will be needed at application due to the imposition of work requirements and to ensure that individuals no longer eligible for Medi-Cal due to the work requirements are referred to a county health program.

3) *Cost-sharing in Medi-Cal.* The Medi-Cal program had low co-payments in the past ranging from $1 for most services, to $5 for non-emergency care delivered in the emergency department. In 2022, these copayments were eliminated from the Medi-Cal program based on a proposal from the administration. DHCS explained its proposal stating that it was an effort to remove any potential barriers in access to care and to avoid costly system changes otherwise needed to come into compliance with federal regulations. DHCS explained that providers may not deny care if the beneficiary is unable to pay copayments at the time of the appointment, meaning there is little rationale for maintaining the nominal, non-enforceable requirement for copayments. Further, the state does not receive any revenue based on collection of copayments. Finally, changes to various systems to effectuate the tracking of copayments would present a significant cost. Federal law requires states to track copayments to ensure Medicaid-enrolled individuals do not pay more than 5% of their family income on Medicaid premiums and cost-sharing on a monthly or quarterly basis. Medicaid programs are required to have processes in place to track each family's incurred premiums and cost-sharing through a mechanism that does not rely on an enrollee's documentation. Not imposing copayments would obviate the need for a tracking system.

   Given the federal poverty level of income for an individual is currently $1,330, and this requirement only applies to those with incomes above the poverty level, the one cent cost sharing in this bill means that an individual would need to receive at least 6,651 items or services in a month subject to the co-payment to exceed the 5% threshold, thus tracking co-payments could still likely be irrelevant. In addition, a number of services such as inpatient, emergency, and primary care are exempt.

   A September 2021 Kaiser Family Foundation Research issue brief reviewing and summarizing recent literature on the impact of premiums and cost-sharing on low-income populations found that in regards to cost sharing, higher out-of-pocket costs are associated with decreased access to and utilization of care, including for individuals with significant health needs. In particular, studies indicate that higher cost-sharing contributes to decreased prescription refills. Several studies find higher out-of-pocket costs are associated with worse health outcomes including increased mortality and unintended pregnancies. Finally, cost-sharing results in higher costs, decreased affordability, and greater financial burden for low-income adults.

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 passed the Assembly Health Committee by a vote of 15-0 on June 9, 2026.*

   AB 2161 (Bonta) would codify H.R. 1's work requirements; require 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 Committee on July 1, 2026.*

   AB 2201 (Boerner) would codify H.R. 1's semiannual redetermination requirements and allow more instances where a Medi-Cal recipient may be renewed *ex parte*, or without requiring a recipient to produce income information such as for individuals with minimal, stable income sources, such as Supplemental Security Income. *AB 2201 is set for hearing in this Committee on July 1, 2026.*

5) *Prior legislation.* AB 116 (Committee on Budget, Chapter 21, Statutes of 2025) a health trailer bill that among other things imposes cost-sharing through the imposition of premiums of $30 per month for specified individuals in full-scope Medi-Cal coverage with unsatisfactory immigration status beginning July 1, 2027.

   AB 204 (Committee on Budget, Chapter 738, Statutes of 204) a health trailer bill that among other things eliminates co-payments from the Medi-Cal program.

   AB 1296 (Bonilla, Chapter 641, Statutes of 2011) requires the California Health and Human Services Agency, in consultation with the DHCS, Covered California, the California Office of Systems Integration, counties, health plans, consumer advocates, and other stakeholders, to plan and develop standardized single, accessible application forms and related renewal procedures for state insurance affordability programs.

6) *Support.* Co-sponsors Health Access California, Justice in Aging, National Health Law Program, and Western Center on Law & Poverty write that retroactive coverage is a key financial protection for low-income, uninsured, and underinsured people, 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. 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. With regards to the cost-sharing imposed by H.R. 1, they state that this could result in Medi-Cal enrollees having to pay more than they can afford and going into debt just to access health care, with some likely to forgo care altogether because of the high cost. California eliminated cost-sharing in Medi-Cal just a few years ago after DHCS

found that the cost of administering them far outweighed the amount collected. This proposal will impose the minimum level of cost-sharing now required by federal law, and aims to impose the new requirement narrowly in order to lessen the administrative burden and cost of the change.

7) *Amendments.* The author and committee have agreed to the following amendments:
   1) Strike sections 1-3 requiring the state to continue months of retroactive eligibility absent federal funding.
   2) A technical amendment at the end of Section 5, 15926(l) replacing the term "Medi-Cal" with "insurance affordability program" to account for other programs such as Covered California that are governed by this subsection:
   . . . "The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements to the eligibility systems, and to monitor screening and evaluation for ~~**Medi-Cal**~~ ***insurance affordability program*** eligibility.

SUPPORT AND OPPOSITION:

Support: Health Access California (co-sponsor)
Justice in Aging (co-sponsor)
National Health Law Program (co-sponsor)
Western Center on Law & Poverty (co-sponsor)
Access Reproductive Justice
AIDS Healthcare Foundation
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
Asian Resources, Inc.
Bay Area Legal Aid
Bleeding Disorders Council of California
California Academy of Family Physicians
California Advocates for Nursing Home Reform
California Alliance for Retired Americans
California Alliance of Child and Family Services
California Association of Medical Product Suppliers
California Behavioral Health Association
California Collaborative for Long-term Services and Supports
California Community Foundation
California Coverage & Health Initiatives
California Dental Association
California Immigrant Policy Center
California Kidney Care Alliance
California LGBTQ Health and Human Services Network
California Long Term Care Ombudsman Association
California Pan - Ethnic Health Network
California Physicians Alliance
California Podiatric Medical Association
California Primary Care Association Advocates

California Religious Action Center of Reform Judaism
California School Employees Association
California State Council of Service Employees International Union
Caring Across Generations
Celestria 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
Community Legal Aid SoCal
Community Legal Services in East Palo Alto
County of Contra Costa
County of Los Angeles
County of San Diego
Courage California
Cystic Fibrosis Foundation
Desert Healthcare District and Foundation
Disability Rights California
East Bay Community Law Center
Family Voices of California
Friends Committee on Legislation of California
Gender Affirming Professionals
GLIDE
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
Los Angeles LGBT Center
Maternal and Child Health Access
Multi-Faith Action Coalition
National Multiple Sclerosis Society
Northeast Valley Health Corporation
Orange County United Way
PICO California
Planned Parenthood Affiliates of California
Public Counsel
San Francisco AIDS Foundation
San Francisco Marin Medical Society
San Francisco Senior and Disability Action
Senior Services Coalition of Alameda County
South Asian Network
The Children's Partnership
The Los Angeles Trust for Children’s Health
UnidosUS
Vision Y Compromiso

Oppose: None received.

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