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## SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

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**BILL NO:** AB 2368  
**AUTHOR:** Bonta  
**VERSION:** June 11, 2026  
**HEARING DATE:** July 1, 2026  
**CONSULTANT:** Jen Flory

**SUBJECT:** Indigent health care: internet website and information

**SUMMARY:** Requires the Department of Health Care Services to establish a website with public information about safety-net health care services in the state, including specified information about each county health care program for uninsured individuals.

**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) 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 to:
  - a) Have their eligibility for Medicaid additionally redetermined every six months; and,
  - b) 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 the “work and community engagement” requirements. [42 USC §1396a]
- 3) Starting October 1, 2026, as enacted by H.R. 1, limits Medicaid payments to states for individuals who are not citizens or nationals of the U.S., lawful permanent residents, Cuban or Haitian entrants, or individuals lawfully residing in the U.S. in accordance with a Compact of Free Association. [42 USC §1396b]

**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) Establishes a number of condition-specific screening or treatment health programs administered by DHCS for uninsured and underinsured individuals with incomes below 200% of FPL including the State-Only Family Planning Program (known as Family PACT) to provide family planning services; the Every Women Counts program to provide breast and cervical cancer screening; the Breast and Cervical Cancer Treatment Program to provide breast and cervical cancer treatment; and the California Prostate Cancer Treatment Program to provide prostate cancer treatment. Establishes the Genetically Handicapped Persons Program, administered by DHCS, which provides coordinated care to adults with specific diseases of any income level. [WIC §24007, et seq.; HSC §104160, et seq.; HSC §104160, et seq.; HSC §104322, et seq; and HSC §125175]

- 4) Requires counties to support residents who are low-income or incapacitated who are not otherwise supported by relatives, friends, their own means, or state or private institutions. This obligation has been interpreted by courts to require counties to provide subsistence medical care to those who cannot afford it. [WIC §17000]
- 5) Requires hospital emergency departments, under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and also under similar provisions of state law (state EMTALA), to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay. Federal EMTALA imposes this requirement on any hospital that participates in Medicare. State EMTALA imposes this requirement on any hospital that operates an emergency department. [42 USC §1395dd and HSC §1317]
- 6) Requires hospitals to have charity care or discount payment policies for uninsured or under insured patients with incomes below 400% of FPL. [HSC §127400]
- 7) Defines a "free clinic" as a nonprofit clinic that does not charge patients and a "community clinic" as a nonprofit clinic that only charges patients based on the patient's ability to pay, utilizing a sliding scale. [HSC §1204]

**This bill:**

- 1) Requires DCHS to establish a website where the public can access information on safety-net health care services in the state that includes information on the right to emergency medical care under state and federal law, payment support resources such as coverage options, state programs, hospital charity care, and information, resources, or other assistance available to help people access health care services, and all of the following information about each county medically indigent health care program:
  - a) All eligibility requirements, including age, residency requirements, and income limits;
  - b) The cost structure for applicants;
  - c) The telephone number to reach the appropriate county program administrator; and,
  - d) A hyperlink or Uniform Resource Locator (URL) for each county internet website related to safety-net services or medically indigent programs.
- 2) Requires DHCS to consult with the California State Association of Counties, organizations advocating for consumers' access to health care, and other entities with expertise in health care for medically indigent individuals, as determined by DHCS.
- 3) Requires the website to have mobile capabilities and comply with existing federal law and regulation on disability access, existing state law on language access, and requires the information and resources be made available in a manner that is accessible to all state residents. Requires DHCS, in consultation with the stakeholders, to review the information and resources on the website to ensure it is current and updated at least annually.
- 4) Requires each county to submit any changes regarding its medically indigent health care program to DHCS within 120 days of the approval by the board or other administrative change.
- 5) Requires reimbursement from the state to counties if the Commission on State Mandates determines that this bill contains costs mandated by the state.

**FISCAL EFFECT:** According to the Assembly Appropriations Committee, the County Health Executives Association of California notes costs in the tens of thousands to hundreds of thousands of dollars per county, overwhelmingly related to staff time. Total cost for all counties could be in the low millions of dollars. If the Commission on State Mandates determines the provisions of this bill creates a new program or imposes a higher level of service for which the state must reimburse local costs, counties could claim reimbursement from the state (General Fund). Costs to DHCS of an unknown mount, potentially in the low hundreds of thousands of dollars to establish and maintain the website (General Fund).

**PRIOR VOTES:**

Assembly Floor:	77 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0

**COMMENTS:**

- 1) *Author’s statement.* According to the author, under H.R. 1, California is bracing for a surge in uninsured residents, with counties estimating that indigent programs will experience new enrollment of between 417,000 and 1.3 million. When federal policies restrict eligibility, introduce intentional barriers to enrollment, or roll back coverage, people don’t simply stop getting sick. Instead, they fall into our county safety nets to be the provider of last resort. Without a coordinated, statewide strategy to collect safety net program eligibility and contacts into a single platform to connect people to care, we risk leaving our most marginalized communities without life-saving care. This bill establishes a vital framework for transparency, access, and proactive planning to bridge the gap left by federal attack. We cannot wait for federal cuts to dismantle our health care safety net before we decide to act.
  
- 2) *H.R. 1.* H.R. 1, a vast budget reconciliation bill, 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.
  - a) *Work requirements.* The new “community engagement requirements” (or “work requirements”) require nondisabled adults between the ages of 19 and 65 who gained coverage through the Affordable Care Act (“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. States are required to verify that an individual meets the community engagement requirements twice a year, starting January 1, 2027.
  - b) *Semiannual eligibility redeterminations.* 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.

- c) *Reduced federal funding for previously qualified immigrants.* H.R. 1 also ends the availability of full-scope federal Medicaid funding for additional groups of immigrants who are lawfully present, including refugees, asylees, victims of trafficking and others under humanitarian immigration statuses, starting October 1, 2026. The state can only continue to provide for full-scope Medi-Cal for these populations by paying for the entirety of their care, with the exception of emergency and pregnancy services.
- 3) *Impacts of H.R. 1 eligibility barriers.* The UC Berkeley Labor Center estimates that 1.87 million adults will lose coverage due to the work requirements, and 270,000 will lose coverage due to the semiannual eligibility redeterminations. The most recent estimate from DHCS in the “Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1,” released on January 29, 2026, estimates up to 1.8 million will lose coverage due to work requirements, increased renewals, and the normal churn of individuals transitioning from Medi-Cal to Covered California. DHCS has also shared that approximately 200,000 immigrants will no longer have satisfactory immigration status due to the H.R. 1 change regarding immigrant eligibility and, according to the current Governor’s budget proposal, will lose full-scope Medi-Cal. These numbers are somewhat in flux now that the Centers for Medicare and Medicaid Services have released an interim final rule interpreting the work or community engagement requirements that indicate that certain exemptions will be interpreted more narrowly than expected, so the numbers could be even higher. This bill requires DHCS to create a website to ensure individuals seeking safety-net health care services outside of Medi-Cal have comprehensive information.
- 4) *Health care for the remaining uninsured.* Individuals who lose Medi-Cal will have limited options to otherwise obtain health care. Very few of these individuals will be eligible for subsidies through Covered California, as it has similar restrictions on immigration status, a lower income cap, and H.R. 1 also specified that individuals losing Medicaid due to work requirements are not eligible for subsidies to purchase coverage through a state Exchange like Covered California. As a result, the remaining options in California are the handful of condition-specific coverage programs that generally offer coverage for very limited health services, the safety net programs run by each county as part of their statutory obligations to support low-income residents who cannot afford health care, or to self-pay. Free clinics or community clinics offer free care or sliding scales to people who cannot afford care and general acute care hospitals in California are required to offer charity care or discount payment programs to patients earning less than 400% of FPL. However, while hospitals must offer discounts for the care they provide, in general, they are not obligated to provide services to individuals without coverage, unless they are in a medical emergency. It should be noted that both clinics and hospitals are also facing funding cuts due to various provisions of H.R. 1 affecting health care financing and Medi-Cal eligibility.

Prior to the implementation of the ACA in 2014, which expanded Medi-Cal to previously ineligible adults and established Covered California as a more affordable option for purchasing health coverage, county safety net programs played a much larger role in health care for the uninsured. According to a March 2026 report by the Legislative Analyst’s Office, over the years, court decisions have clarified that these health care programs are required to provide only the basic care necessary to prevent serious harm, pain, or infection. Programs are not required to provide specific benefits, so the minimum level of service required is significantly less than what is provided by other public programs such as Medi-Cal. Counties are also able to set income-eligibility requirements based on subsistence living costs and an individual’s ability to pay. These requirements may take the form of cost-sharing

arrangements with a sliding scale depending on an individual's income. While counties previously had specific funding through revenues derived from state sales tax and a vehicle license fee (known as the realignment formula), in 2013, the state revised realignment formulas due to the expansion of health care under the ACA to redirect a significant portion of these revenues to offset state General Fund costs for CalWORK's cash aid grants to very low-income families as well as account for the new state costs of the Medi-Cal expansion through AB 85 (Committee on Budget, Chapter 24, Statutes of 2013). According to a September 2025 issue brief by the California Health Care Foundation, as a result of the expansion of Medi-Cal, while many counties continue to operate these programs, now often covering people with higher incomes, some counties have closed their programs completely. Many do not cover immigrants who do not have qualified immigration status for other programs. Given the change in funding and the expected large numbers of newly uninsured individuals, it is far from certain that counties will be able to pay for the health services these individuals need. Nonetheless, counties are still obligated to cover subsistence medical care.

- 5) *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 recently enacted federal enrollment barriers and required moneys in the fund to be used 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 suspense in the Senate Appropriations Committee.*
- 6) *Prior legislation.* AB 85 (Committee on Budget, Chapter 24, Statutes of 2013), redirected county realignment funds to the state according to various formulas in different counties due to declining enrollment in county health programs as a result of the expansion of Medi-Cal under the ACA.
- 7) *Support.* Health Access California writes that there is currently no state entity that compiles and displays for Californians relevant information about how to access county-provided health services. In fact, this is a role that many nonprofits end up playing, including Health Access on several occasions. This has involved direct outreach to each individual county to get updates on their programs, who they are serving and where individuals can find information; in many cases this information was not readily available online. Given the difficulty for advocates in tracking down this information, it is certainly not accessible to the consumers who most need resources.
- 8) *Amendments.* The author and committee have agreed to a number of technical amendments that modernize program description and refine the required elements about county health care programs:

Section 1, 17031(a)(3)

(3) Information about each county ~~medically indigent health care~~ program ~~for uninsured individuals~~ that provides health care to low-income county residents who are uninsured or underinsured, including, but not limited to, all of the following:

(A) All eligibility requirements, including age, citizenship or immigration status requirements, residency requirements, and income and other resource limits.

(B) The cost structure for applicants.

(C) The telephone number to ~~reach the appropriate county program administrator~~ obtain information about the program.

(D) A hyperlink or Uniform Resource Locator (URL) for each county internet website related to safety-net services or medically indigent programs.

(E) Whether use of the program is subject to repayment and by what means the county may collect.

(4) Any other information or resources that will assist an individual seeking comprehensive and accurate information about accessing ~~medically indigent~~ affordable health care services in the state.

(c) The department shall consult with the California State Association of Counties, organizations advocating for consumers’ access to health care, and other entities with expertise in health care for ~~medically indigent individuals~~ low-income Californians, as determined by the department.

**SUPPORT AND OPPOSITION:**

**Support:** California Academy of Family Physicians  
California Association of Medical Product Suppliers  
California Chapter of the American College of Emergency Physicians  
Desert Healthcare District and Foundation  
Disability Rights California  
Drug Policy Alliance  
Health Access California  
Western Center on Law & Poverty, Inc.

**Oppose:** None received.

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