Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2729 (Bonta) – As Amended March 19, 2026

**SUBJECT**: Medi-Cal: Employer Responsibility for Medi-Cal Trust Fund.

**SUMMARY**: Creates a fund that consists of new taxes and deposits, including employer penalties, as specified in the Budget Act of 2026, and directs the fund's moneys to restore health care services under Medi-Cal as a result of federal and state budget cuts to the program. Specifically, **this bill**:

1) Creates the Employer Responsibility for Medi-Cal Trust Fund in the State Treasury.

2) Constitutes the fund with new taxes and deposits, including, but not limited to, employer penalties, as specified in the Budget Act of 2026. Requires the Director of Finance, in consultation with the State Treasurer, to determine the total amount of moneys that may be deposited in the fund from all sources.

3) Continuously appropriates dollars from the fund to Department of Health Care Services (DHCS) to fund direct and indirect costs of administering the Medi-Cal program in a manner necessary to prevent loss of or to restore health care coverage, benefits, or access to care following the passage of federal House Resolution 1 (H.R. 1; Public Law 119-21) and subsequent state budget actions.

4) Specifies it is operative only if the Medicaid provisions of federal H.R. 1 are not repealed prior to January 1, 2027.

**EXISTING FEDERAL LAW**:

1) Authorizes states, under the Patient Protection and Affordable Care Act (ACA) 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 poverty line plus applicable income disregards. This is called 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) Requires, pursuant to H.R. 1, beginning January 1, 2027, the ACA Expansion population enrolled in Medicaid to comply with "community engagement requirements." Establishes hours and income thresholds that constitute compliance, and procedures for noncompliance. [42 U.S.C. § 1396a(xx)]

3) Requires, pursuant to H.R. 1, beginning January 1, 2027, states to redetermine eligibility once every 6 months for the ACA Expansion population, excluding specified Indian/tribal groups, as defined. [42 U.S.C. § 1396a(e)(14)(L)]

**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 Medi-Cal eligibility policy, including, effective January 1, 2014, expanding Medi-Cal to adults who are under age 65, not pregnant, and not otherwise currently eligible for Medi-Cal coverage, with incomes up to 133% of the federal poverty level (FPL) plus a 5% income disregard and provides full-scope Medi-Cal benefits, as supplemented with mental health and substance abuse disorder benefits, to these populations. [WIC § 14005, *et seq.*]

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

**COMMENTS**:

1) **PURPOSE OF THIS BILL.** According to the author, California has made historic progress in expanding access to health care, yet millions of residents still face barriers to coverage and affordability. Today, approximately 14.5 million Californians rely on Medi-Cal as their primary source of care, making it a cornerstone of our state's health care system and a lifeline for working families, children, seniors, and people with disabilities. Despite this progress, the author explains, an estimated 2.5 million Californians remain uninsured, and many more are underinsured or struggle to access the care they need, while corporations receive billions in tax breaks. Recent federal actions under H.R. 1 threaten to reverse these gains by increasing barriers to coverage and shifting costs onto states. The author notes with concern that these changes are expected to result in significant coverage losses, disproportionately impacting working families, immigrants with humanitarian protections, and communities already facing systemic inequities in access to care. The author states this bill establishes the Employer Responsibility for Medi-Cal Trust Fund to ensure California is prepared to respond. The fund is designed to provide a dedicated, flexible funding stream to help the state prevent the loss of health coverage, restore benefits, and maintain access to care in the face of federal retrenchment. The author notes this measure reflects a core principle: health coverage should not be destabilized by policies that create unnecessary administrative burdens or shift costs onto states without regard for the real impacts on families. Instead, the author concludes, California must take a proactive approach to protect coverage and ensure that our health care system continues to serve those who depend on it.

2) **BACKGROUND.**

   a) **Affordable Care Act.** The ACA was signed into federal law on March 23, 2010, and is the most significant legislative reform of the U.S. health care system since the establishment of Medicare and Medicaid in 1965. The passage of the ACA brought sweeping changes to health care coverage in California, including establishing more generous eligibility rules and federal funding for Medi-Cal (California's Medicaid program), providing federally funded premium and cost-sharing subsidies offered through Covered California (the state's health benefit exchange), and imposing new

requirements on health insurance that make it easier for individuals with pre-existing conditions to obtain coverage. Changes under the ACA have reduced the percentage of Californians who lack health insurance from 15% in 2013, just before Medi-Cal was expanded, to 5.9% in 2024.

b) **H.R. 1.** In contrast to the ACA, the most recent large-scale federal change to H.R. 1 is expected to significantly reduce federal investment in health care, increasing state costs for the Medi-Cal program while reducing health care coverage for millions in California. DHCS, which administers the Medi-Cal program, projects H.R. 1 impacts include up to two million Medi-Cal members losing coverage, tens of billions in federal funding at risk annually, and major disruption in the Medi-Cal financing structure for safety net providers. With certain exceptions, H.R.1 requires the ACA expansion population—generally, adults ages 19 through 64 without dependent children— to engage in a minimum of work 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. This requirement is administratively burdensome and consequential; it is likely to lead to large coverage losses for individuals who work but encounter administrative difficulties demonstrating compliance, as well as for individuals who face barriers to work but aren't designated as disabled or otherwise exempt from work requirements. H.R.1 also requires states to redetermine eligibility for the ACA expansion population twice a year instead of once a year. Many eligible Medi-Cal members are projected to lose coverage because of the increased frequency of eligibility paperwork. H.R.1 also redefines many categories of lawfully immigrants as "unsatisfactory immigration status," or UIS (i.e., ineligible for federal matching funds for full-scope Medicaid). These categories include most refugees and asylees as well as victims of human trafficking. Even beyond the mandatory federal changes to eligibility and redetermination processes, increased state costs as a result of a number of financing restrictions and other costs shifts will make it difficult for California to maintain eligibility levels, benefits, and provider rates—the three main drivers of Medi-Cal costs.

c) **Recent State Budget Cuts to Health Care.** State budget realities have recently forced the state to reassess what coverage policies it can afford, particularly against a backdrop of federal disinvestment. Key state Medi-Cal policy changes that are projected to erode health care coverage include an enrollment freeze for individuals over age 18 with UIS. This change is projected to save over $3 billion General Fund per year by 2028-29. The reinstatement of the asset limit for certain populations is projected to save over $500 million General Fund per year by 2028-29. Additional changes include a monthly premium for UIS adults who remain in coverage, scheduled to begin in July 2027, which is projected to save over $670 million per year by 2028-29 and result in additional disenrollments from Medi-Cal by individuals who do not pay the monthly premium.

d) **Employer Sponsored Insurance (ESI).** Unlike many other nations, the U.S. relies on voluntary, private health insurance as the primary source of coverage for most residents who are not elderly, poor or disabled. According to KFF, ESI is by far the most common source of private health insurance. There are two primary reasons for this. The first is that providing health insurance through the workplace is efficient, with advantages relating both to risk management and to the costs of administration. The second is that contributions towards premiums by employers and (in most cases) by employees are not

subject to income or payroll taxes, providing a substantial federal and state subsidy towards the costs of ESI.

Overall, 60% of people under age 65, or about 165.6 million people nationwide, had employment-sponsored health insurance in 2025. The level of coverage varies significantly with income and other factors, even among working families.

According to research by the U.C. Berkeley Labor Center (Labor Center), workers paid low wages are less likely to have coverage through their job. They may have no offer of coverage, with small firms under 50 employees less likely to offer coverage. They may be ineligible because of part-time work or because they were recently hired and are subject to a waiting period. Finally, coverage may be unaffordable. The average annual worker premium contribution in 2025 was $1,303, which is 8% of income for a person at the federal poverty level. For family coverage, the average annual worker premium contribution is $7,312, making this 23% of income just for premiums. These plans often have high deductibles when health care is actually needed, meaning people have to pay thousands of dollars for their health care out of pocket, in addition to their premium payments, before getting any help from their insurance plan.

e) **Low-Wage Workers Enrolled in Medi-Cal**. 3.6 million California workers ages 19-64 are enrolled in Medi-Cal, excluding 900,000 self-employed workers. The Labor Center estimates $36 billion will be spent to provide Medi-Cal to these workers, including state and federal spending, in Fiscal Year 2026-27. Certain industries are more likely to employ individuals who are also enrolled in Medi-Cal, including agriculture, forestry, fishing, and mining (35% of workers in this industry are on Medi-Cal); restaurants, bars, and food service (35%); administrative and building services, and retail (26%). Medi-Cal enrollees work across a range of firm sizes, with 27% of Medi-Cal enrolled workers working in companies with over 1,000 employees, 17% working in companies with 101-999 employees, and 7% working in companies with 51-100 employees. Nearly half of working Medi-Cal enrollees work in businesses with under 50 employees.

f) **Employer Contributions and Penalties Generally.** Given employers benefit from publicly subsidized insurance for their employees, the concept of "shared responsibility" of employers who do not provide comprehensive and affordable health coverage to their employees has informed national, state, and local policy and budgetary approaches.

   i) **ACA Employer Responsibility Payments.** Under the Affordable Care Act, applicable large employers may face penalties if they don't make affordable coverage available. Employers with over 200 employees are required to offer full-time employees coverage, and those with over 50 fulltime employees are required to pay a penalty if qualifying coverage was not offered and an employee qualifies for federal tax credits in an exchange.

   ii) **Other States**. In 2014, Massachusetts introduced an Employer Medical Assistance Contribution (EMAC) to fund health benefits for uninsured state residents. Employers with more than five employees in Massachusetts are automatically subject to an EMAC assessment of 0.34% of the Massachusetts wage base for unemployment taxation purposes (approximately $50 per employee per year). This contribution applies whether or not the employer offers health insurance to employees. It is assessed and paid with other unemployment insurance contributions to the

Massachusetts' Department of Unemployment Assistance (DUA). The DUA determines employer liability for the EMAC Supplemental payment and assesses the liability by adding it to the DUA statement showing the employer's unemployment insurance liability.

Massachusetts also implemented a temporary supplemental EMAC payment in 2017 to address rising MassHealth (Medicaid) enrollment and costs. The contribution was 5% of annual wages for each non-disabled employee, up to an annual wage cap of $15,000, for a maximum of $750 per affected employee per year. Employers with six or more employees in Massachusetts were subject to the EMAC Supplement. The calculation is based on wages (up to $15,000), not hours worked, regardless of whether the employee is part-time, full-time, or seasonal.

iii) **Healthy San Francisco**. The San Francisco Health Care Security Ordinance, passed in 2006 and still active today, is a local ordinance designed to promote universal health care. It provides access to health services for the uninsured while requiring employers to contribute financially toward employees' health care costs. Employers with 20 or more workers must spend a minimum amount on health care for employees who work 8 or more hours per week: $4.11 per hour payable for businesses over 100 workers, and $2.74 per hour for businesses with 20-99 workers. The majority of employers meet the spending requirement by providing health, dental, or vision insurance directly. Other options for fulfilling the requirement include paying into a health savings or reimbursement account; directly paying health claims; and making payments to the SF City Option program, which is administered by the San Francisco Health Plan on behalf of the San Francisco Department of Public Health.

iv) **California State Senate's "Foundation for the Future" Budget Plan**. On April 16, 2026, leadership in the California State Senate released a proposed budget plan that includes an estimated $5-$8 billion in revenues from a "Fair Share Contribution." The plan notes the following:

**(1)** Medi-Cal costs are a driving factor in the state's long-term structural deficit;

**(2)** Medi-Cal costs have grown during stable economic times and not due to traditional reasons of a recession and growing unemployment that in the past have spiked Medi-Cal enrollment;

**(3)** When corporations pay too low, hold back on adequate hours, and fail to enroll their workforce in company health insurance plans, their workers remain in Medi-Cal at the cost to taxpayers; and,

**(4)** 42% of working-age Medi-Cal enrollees have full time jobs, resulting in a multi-billion taxpayer funded corporate subsidy for profitable corporations in the state.

The budget plan calls for establishing the Fair Share Contribution for the state's largest employers. The plan notes details will be worked out through deliberations with the Assembly and the Administration, with the goal of applying only to the state's top one to two percent of the largest corporations – those with at least several hundreds of employees – and therefore would not include small and medium size

employers. The plan notes corporations would be required to contribute to the state to offset a portion of taxpayer costs for paying their workers' healthcare costs. The plan states that ideally, employers will choose to enroll their workforce in company insurance plans, which will directly reduce state Medi-Cal costs even more than if employers simply pay the contribution, but notes that if employers do choose to make the contribution, the Fair Share Contribution is expected to generate $5 – $8 billion in total annual revenues.

3) **SUPPORT.** Labor, consumer advocacy, and other organizations support this bill. SEIU California writes in support that Medi-Cal is intended as a public safety net program, yet many employers evade their responsibilities and shift the cost of job-based health coverage onto taxpayers and the public. SEIU California writes that employers that don't provide affordable or any health care and that pay low wages have workers that rely on Medi-Cal not as a safety net, but as their only source of coverage, despite being employed. SEIU California notes the federal H.R. 1, signed into law in 2025, threatens to shred the Medi-Cal safety net for millions of Californians and leave states on the hook to provide care and forcing families to forgo needed care or risk medical bankruptcy. SEIU California argues that only with new revenue can we prevent further loss of or restore health care coverage, benefits, or access to care following the passage of federal H.R. 1 and subsequent state budget actions. Health Access California argues in support that California taxpayers are subsidizing large employers and profitable companies who refuse to provide health care coverage to their employees. Health Access California states that this bill will ensure that if the Legislature takes action in this year's budget act to hold large employers accountable, a fund is in place to ensure that those contributions can safeguard the sustainability of California's vital safety net program.

4) **OPPOSITION.** Business interests oppose this bill. CalChamber notes that without being given the opportunity to review the underlying "fair share" proposal, it's unclear how much of an impact this measure, and other related measures, will have on California's economy. However, CalChamber notes, they are opposed to the approach of penalizing employers for their employees enrolled in the Medi-Cal program. CalChamber contends this bill seeks to punish California's businesses without addressing the underlying drivers of health coverage inequities, such as increasing costs of healthcare services across all markets, healthcare workforce shortages, etc. They argue individuals like students, second-chancers, and seasonal workers, who may only be able to work part-time, or are looking to build their resumes and gain professional experience, will have a more difficult time securing certain positions. Lastly, CalChamber asserts this bill attempts to implement new taxes and penalties on employers without providing meaningful input from affected stakeholders.

5) **PREVIOUS LEGISLATION.**

   **a)** AB 880 (Gomez) of 2013 would have created the Employer Responsibility for Medi-Cal Cost of Employees Act, requiring large employers employing 500 or more employees to pay an employer responsibility penalty, if their employees who worked more than 12 hours per week and more than 45 days in a calendar year were enrolled in Medi-Cal, as specified. AB 880 died on the Assembly Floor.

   **b)** SB 78 (Committee on Budget and Fiscal Review), Chapter 38, Statutes of 2019, implements an individual mandate penalty for individuals that fail to purchase minimum essential coverage during a calendar year.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Alliance for Retired Americans
California LGBTQ Health and Human Services Network
California Physicians Alliance
California State Council of Service Employees International Union (SEIU California)
Community Health Partnership
Courage California
CPCA Advocates, Subsidiary of the California Primary Care Association
Health Access California
National Health Law Program
United Domestic Workers/AFSCME Local 3930
Western Center on Law & Poverty

**Opposition**

California Attractions and Parks Association
California Chamber of Commerce
California Farm Bureau
California Fuels and Convenience Alliance
California Grocers Association
California Restaurant Association
California Trucking Association
International Franchise Association
TechNet

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