

Date of Hearing: June 9, 2026

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
SB 1202 (Weber Pierson) – As Amended May 14, 2026

**SENATE VOTE:** 39-0

**SUBJECT:** Medi-Cal: dashboard and outreach.

**SUMMARY:** Requires Medi-Cal managed care plans and counties to do outreach to retain eligible members in Medi-Cal, and requires the Department of Health Care Services (DHCS) to produce a dashboard to track eligibility data and the impacts of H.R. 1, a recently passed federal law that restricts eligibility for Medi-Cal. Specifically, **this bill:**

- 1) Requires DHCS to conduct outreach about work or community engagement requirements, more frequent redeterminations, and changes to retroactive eligibility (new policies that were codified through H.R. 1). Specifies the content and manner of outreach, requires outreach to be coordinated across public programs and requires DHCS to conduct listening sessions to inform strategies and communications.
- 2) Requires counties to make a good faith effort to collaborate with community-based organizations to conduct outreach efforts, as specified, and requires county outreach efforts to meet cultural and linguistic appropriateness standards, as specified.
- 3) Requires DHCS to require the sharing of beneficiary redetermination data, including the date of redetermination, with managed care plans.
- 4) Removes the requirement for beneficiary consent for managed care plans to share updated contact information with the appropriate county.
- 5) Requires a Medi-Cal managed care plan to establish and conduct an outreach and education plan for its enrollees about work or community engagement guidelines. Requires such a plan to address specified issues, including beneficiary rights, local resources, and information on maintaining Medi-Cal eligibility. Requires such a plan to be informed by stakeholder input, best practices issued by DHCS, and the Medi-Cal managed care plan's Population Needs Assessment, and to meet cultural and linguistic appropriateness standards.
- 6) Requires DHCS, no later than January 1, 2028, in collaboration with the California Health and Human Services Agency and in consultation with Covered California, to establish a public-facing dashboard that provides data on Medi-Cal applications, enrollment, redeterminations, disenrollments, and terminations, stratified by geography and demographic data, and to meet other specified requirements.
- 7) Establishes objectives for the dashboard described in 6) above as:
  - a) To learn and document the impact of H.R. 1;
  - b) To allow DHCS and stakeholders to identify trends or problems with Medi-Cal eligibility and enrollment and to address technology issues with the eligibility system; and,

- c) To obtain reliable data that are collected and analyzed in a timely fashion.

**EXISTING FEDERAL LAW:**

- 1) Authorizes states, through the Patient Protection and Affordable Care Act (ACA), beginning January 1, 2014, to expand Medicaid (Medi-Cal in California) 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. [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, beginning January 1, 2027, the Medicaid ACA Expansion population described in 1) above to comply with “community engagement requirements.” Creates mandatory and state-optional exemptions from compliance. Allows states to conduct compliance checks more frequently than as part of eligibility redetermination. Requires states to establish processes and use reliable information available to the state, without requiring, where possible, the applicable individual to submit additional information. Establishes hours and income thresholds that constitute compliance, and procedures for noncompliance. Requires notice and outreach to affected individuals. Allows the federal Health and Human Services (HHS) Secretary to exempt a state from complying with the law for a defined period if the state requests exemption and the state is demonstrating a good faith effort to comply. [42 U.S.C. § 1396a(xx)]
- 3) Requires, not later than June 1, 2026, the federal HHS Secretary to promulgate an interim final rule for purposes of implementing the provisions described in 2) above. [Uncodified; Public Law 119–21 § 71119 (d)]
- 4) Requires states, on or after the first day of the first quarter that begins after December 31, 2026, 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 a process for the determination and redetermination of an individual’s eligibility for Medi-Cal, as specified. [WIC § 14005, *et seq.*]
- 4) 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. [WIC § 14005.37]
- 5) Authorizes the DHCS Director to contract, on a bid or non-bid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care

of Medi-Cal beneficiaries and establishes managed care models that DHCS contracts within each county. [WIC §§ 14087.3, 14089, 14087.98, 14087.967, and 14087.5]

- 6) Defines a Medi-Cal plan as any individual, organization, or entity that enters into a comprehensive risk contract with DHCS to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries. [WIC § 14184.101]

**FISCAL EFFECT:** According to the Senate Committee on Appropriations:

- 1) Unknown ongoing General Fund costs, potentially low millions, for DHCS to establish and maintain the dashboard.
- 2) Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

**COMMENTS:**

- 1) **PURPOSE OF THIS BILL.** According to the author, last July, President Trump and Congress enacted H.R. 1, a federal reconciliation bill that gutted our Medicaid program to give tax cuts to the wealthy. In addition to drastically impacting how our state can raise money for Medi-Cal, H.R. 1 also created new eligibility barriers that could cut nearly two million people off the Medi-Cal program. These barriers include new work requirements, more frequent eligibility checks, and the loss of federal funding for several groups of immigrants who have not previously been denied federal assistance. The author introduced this bill to require DHCS to create a public data dashboard tracking how H.R. 1 affects Medi-Cal eligibility and enrollment. It also strengthens and expands outreach requirements for DHCS, counties, and Medi-Cal managed care plans to help prevent eligible residents from losing coverage because of the new federal rules. The author argues Medi-Cal enrollees need clear, culturally and linguistically appropriate information so they understand what requirements are changing, what documentation may be required to keep coverage if they remain eligible, and when coverage could end if they do not. The author concludes collecting and publicly reporting this data will also allow California to document the harm of these federal policy changes and direct specific outreach strategies to communities disproportionately impacted as shown by the data dashboard.

## 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. States also have a variety of options in how they design their programs, provided they seek federal approval for program changes.

Currently, individuals who have been found eligible and are enrolled in Medi-Cal must have their eligibility redetermined every 12 months to retain coverage for the next year. If, during the 12-month period, new information that affects eligibility becomes available to the county, either reported by the individual or accessed through other electronic data sources, a beneficiary or enrollee will automatically have their eligibility redetermined based on the new information. Beneficiaries must report to the county any change in their

circumstances that may affect their Medi-Cal eligibility within ten calendar days of the change.

To renew beneficiaries' Medicaid coverage, states must first attempt to confirm ongoing eligibility using data available to the agency without requiring information from the individual. This requirement, also known as "ex parte" renewals, can reduce the administrative burden for states and simplify the process for beneficiaries. An ex parte renewal is a redetermination of eligibility that states can make based on reliable information available to the agency without requiring information from the individual.

The ACA required states to implement data-sharing strategies to simplify eligibility and redetermination processes for beneficiaries. Medicaid and Children's Health Insurance Program (CHIP) agencies now rely primarily on information available through data sources (e.g., the federal Social Security Administration and the Departments of Homeland Security and Labor) rather than paper documentation from families for purposes of verifying eligibility.

- b) **“ACA Expansion” Population.** California expanded Medi-Cal as authorized under the ACA, beginning in 2014 to adults ages 19-64 without dependent children who had incomes below 138% of the federal poverty level (ACA Expansion population). Some large states, including Florida and Texas, did not adopt this optional expansion, and eliminating the ACA expansion of Medicaid had been a key goal of “repeal” efforts over the last 15 years by opponents of the ACA. The ACA was structured to mitigate states costs related to the Medicaid expansion; the federal government generally pays for 90% of the cost of coverage for this population, with the state responsible for the remaining 10%. Research consistently demonstrates adopting the ACA expansion has led to significant benefits for the health and wellbeing of those who gained coverage.
- c) **H.R. 1 Eligibility Rules.** H.R. 1 of 2025, officially titled the “One Big Beautiful Bill Act,” includes significant Medicaid-related changes that reduce federal investment in Medicaid, including new eligibility rules for the ACA Expansion population. More stringent eligibility rules result in cost savings from individuals losing Medicaid coverage. H.R. 1 represents the largest-ever cut to the Medicaid program, with savings from Medicaid eligibility-related and financing changes projected to partially offset the loss of federal revenue associated with tax cuts that disproportionately benefit the wealthy and corporations.

There is substantial evidence that imposing additional paperwork requirements on Medicaid enrollees leads to coverage losses due to procedural issues, including not receiving or understanding notices or forms or not returning forms within required timeframes, even when the beneficiary still qualifies for coverage. According to a KFF report, there are several recent examples of state Medicaid programs experiencing declining enrollment due to changes in eligibility processes.

- d) **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”) 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. The new work and community requirement is estimated to lead to large coverage losses. The ACA Expansion population, to which the rule applies, includes about 4.6 million Medi-Cal members. Of these, about 1.8 million are projected to be determined either exempt from the rule or income compliant via an automated source. This leaves an estimated 2.8 million Medi-Cal members whose compliance with work or community engagement requirements will need to be verified. Ultimately, DHCS estimates that 233,000 Medi-Cal members will lose coverage by June 2027, 1 million by January 2028, and 1.4 million by June 2028 as a result of the imposition of work requirements. DHCS projects this coverage loss will significantly drive up California's uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

- e) **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. Many eligible Medi-Cal members are projected to lose coverage because of the increased frequency of eligibility paperwork. In recent analysis of those disenrolled at their eligibility redetermination, DHCS has found so-called “procedural disenrollments” to be common (procedural disenrollment is when an individual is disenrolled without having been deemed ineligible, often due to missing or late paperwork). When DHCS partnered with the California Health Care Foundation to survey those procedurally disenrolled in 2024, about one-third (31%) reported they did not know they would lose Medi-Cal if they failed to complete their renewal, nearly four in ten (37%) said they would like to restart Medi-Cal but did not know how, and nearly half (45%) of all survey respondents said they did not receive a renewal form. Many of the same concerns noted in the section above about missed notices, unstable housing, limited internet access, and other practical barriers also apply to the six-month eligibility checks.
- f) **Outreach for Medi-Cal Member Retention.** According to “*Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R.1*,” DHCS will lead a coordinated communication and outreach strategy to ensure stakeholders, including counties, plans, community partners, and Medi-Cal members, have the information they need as the H.R. 1 provisions discussed above take effect. DHCS notes it will also leverage existing channels to reach diverse communities, including mailed notices, social media, targeted texting and earned media. DHCS will also produce plain-language materials and toolkits to help ensure members receive accurate and consistent information. The plan also describes the role and readiness of counties, as well as the role of providers, managed care plans, and community health workers and navigators. According to DHCS, the department developed a memorandum of understanding (MOU) for counties to share eligibility and retention-related data with managed care plans, such as a plan member's eligibility redetermination date. The MOU is encouraged but it is not mandatory. This bill would mandate counties to share such information with plans.
- g) **Data Dashboards.** In recent years, DHCS has developed several data dashboards that allow the public to track various aspects of the program. Dashboards have been created to report on initiatives under a multipronged Medi-Cal improvement effort called “California Innovating and Advancing Medi-Cal” (CalAIM). These dashboards include utilization and other data on Community Supports and Enhanced Care Management services. DHCS has also created dashboards to display information on quality metrics and telehealth utilization. Most relevant to this bill, DHCS created a dashboard to track a

variety of eligibility and enrollment statistics throughout the “Unwinding” period of the COVID-19 Public Health Emergency, where eligibility redeterminations resumed after a three-year hiatus. This bill would require DHCS to create a data dashboard to track specified eligibility and enrollment statistics to document the impact of H.R. 1.

- 3) **SUPPORT.** Co-sponsors Justice in Aging, Health Access, National Health Law Program, and Western Center on Law and Poverty, and other supporters write that many Medi-Cal recipients are already working or are excused from the requirements because they are a caregiver, student, or have a disability, but may need support to apply for an exemption or prove their employment or schooling. These new requirements add extra layers of red tape that will result in coverage losses because of the additional paperwork. Furthermore, comprehensive data tracking of the impacts is imperative to understanding if specific groups are disproportionately harmed and mitigating coverage loss. The American Federation of State, County, and Municipal Employees writes that transparency and communication are the most effective tools in preventing administrative disenrollments, and an all-hands-on-deck approach that is coordinated, and culturally and linguistically appropriate outreach will ensure all Californians who rely on Medi-Cal understand the steps necessary to maintain eligibility. The California Hospital Association points out that if estimates are correct about the number of Californians that lose access to Medi-Cal, this translates to more than \$2 billion annually in uncompensated care costs that will threaten hospitals’ financial stability.
- 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 2201 (Boerner) would extend eligibility-related flexibilities to streamline asset and income verifications for Medi-Cal eligibility where federally allowable. AB 2201 is pending in the Senate Health Committee.
  - b) AB 2208 (Stefani) would maintain three months of retroactive coverage despite H.R.1’s restriction to one or two months, depending upon the population; would implement one-cent copayments to minimize barriers to accessing health care, and would allow individuals to update eligibility information using mobile devices. AB 2208 is pending in the Senate Health Committee.
  - c) AB 2161 (Bonta) would establish requirements for implementation of federally required work requirements and 6-month eligibility determinations in a manner that would prioritize maintaining Medi-Cal coverage, would limit implementation to what is federally required and would codify 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 specifies notices and noncompliance procedures. AB 2161 is pending in the Senate Health Committee.
- 5) **AMENDMENTS.** To strengthen and clarify this bill’s intent, the author and Committee have agreed to amendments as follows:
  - a) Clarify the sharing of redetermination data with health plans by amending as follows:
    - (d) *The department shall share, or require each county to share, the sharing of beneficiary redetermination data, including the date of redetermination, with applicable*

*managed care plans to aid in managed care plans' efforts to assist beneficiaries with retaining Medi-Cal coverage, including incorporation into the managed care plans' outreach and education efforts described in Section 14197.81.*

- b) Allow a Medi-Cal managed care plan to share beneficiary redetermination data, including the date of redetermination, with applicable contracted providers to assist those providers to help beneficiaries retain Medi-Cal coverage.

## **REGISTERED SUPPORT / OPPOSITION:**

### **Support**

Western Center on Law & Poverty (co-sponsor)  
 Health Access California (co-sponsor)  
 Justice in Aging (co-sponsor)  
 National Health Law Program (co-sponsor)  
 Alzheimer's Greater Los Angeles  
 Alzheimer's Orange County  
 Alzheimer's San Diego  
 American Cancer Society Cancer Action Network Inc.  
 American College of Obstetricians & Gynecologists - District IX  
 American Federation of State, County and Municipal Employees, AFL-CIO  
 APLA Health  
 Asian Resources, Inc.  
 Bay Area Legal Aid  
 California Academy of Child and Adolescent Psychiatry  
 California Alliance for Retired Americans  
 California Alliance of Child and Family Services  
 California Association of Food Banks  
 California Collaborative for Long-term Services and Supports (CCLTSS)  
 California Community Foundation  
 California Dental Association  
 California Elder Justice Coalition (CEJC)  
 California Hospital Association  
 California Immigrant Policy Center  
 California In-home Supportive Services Consumer Alliance  
 California Kidney Care Alliance  
 California LGBTQ Health and Human Services Network  
 California Pan - Ethnic Health Network  
 California Physicians Alliance  
 California State Association of Psychiatrists (CSAP)  
 CalPACE  
 CANHR  
 Cardea Health  
 Caring Across Generations  
 Children Now  
 Children's Specialty Care Coalition  
 Choice in Aging  
 Coalition of California Welfare Rights Organizations

Community Clinic Association of Los Angeles County (CCALAC)  
Community Legal Aid SoCal  
Community Legal Services in East Palo Alto  
Courage California  
CPCA Advocates, Subsidiary of the California Primary Care Association  
Disability Rights California  
Disability Rights Education & Defense Fund (DREDF)  
Disability Voices United (DVU)  
East Bay Community Law Center  
Economic Security Project Action  
Family Voices of California  
Gender Affirming Professionals  
Grace Institute - End Child Poverty in CA  
Indivisible Ca: StateStrong  
Inland Empire Health Plan Foundation  
Jewish Family Service of Los Angeles  
LA Best Babies Network  
Latino Coalition for a Healthy California  
Legal Aid Society of San Diego  
Legal Aid Society of San Mateo County  
Legal Assistance for Seniors  
Los Angeles LGBT Center  
Maternal and Child Health Access  
Multi-faith Action Coalition  
Northeast Valley Health Corporation  
Placer Independent Resource Services  
Planned Parenthood Affiliates of California  
PRC  
Public Counsel  
Retired Public Employees Association  
San Francisco Senior and Disability Action  
Senior Coastsiders  
Senior Services Coalition of Alameda County  
South Asian Network  
Southeast Asia Resource Action Center  
The Arc and United Cerebral Palsy California Collaboration  
The Children's Partnership  
The Law Foundation of Silicon Valley  
The Los Angeles Trust for Children's Health  
Vision Y Compromiso  
One individual

**Opposition**

None on file

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