SENATE COMMITTEE ON HEALTH
Senator Dr. Akilah Weber Pierson, Chair

BILL NO: SB 1252
AUTHOR: Durazo
VERSION: March 25, 2026
HEARING DATE: April 22, 2026
CONSULTANT: Jen Flory

SUBJECT: California resident taxpayer health care coverage

SUMMARY: Creates an entitlement to health care for every taxpaying resident whose income is below 138% of the federal poverty level and requires the Department of Health Care Services to ensure these individuals have access to public health coverage through the programs it administers, including Medi-Cal.

Existing law:

1) Establishes the Medicaid program under federal law 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) Requires states to use the modified gross income methodology for determining income eligibility for specified Medicaid populations based primarily on gross income as it is reported for income tax purposes with certain exceptions. [42 USC §1396a; 26 USC §36B; and WIC §14005.64]

3) Establishes the Medi-Cal program, administered by the California Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. [WIC §14000, et seq.]

4) Establishes eligibility for full-scope Medi-Cal benefits to individuals over age 19 without satisfactory immigration status who are lawful permanent residents for less than five years or are permanently residing under color or law. [WIC §14007.5]

5) Establishes Medi-Cal eligibility for individuals without satisfactory immigration status or those individuals included in 2) above (collectively, "undocumented immigrants") using state funds, and directs DHCS to maximize federal financial participation to the extent allowable under federal law. Starting January 1, 2026, freezes program enrollment for individuals over age 19, except for nonminor dependents and former foster youth until their 26th birthday. [WIC §14007.8]

6) 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 who are under age 65, not pregnant, and have no Medicaid-eligible dependents who do not meet a specified exception to demonstrate community engagement through not less than 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. [42 USC §1396a]

7) Establishes a number of taxes in the state of California including state and local sales and use taxes, occupancy taxes, motor vehicle and fuel taxes, other taxes on specified products or services, corporate tax, and income tax. [RTC §6001-§65004]

8) Defines "resident," for the purposes of individuals subject to income tax, as every individual in or domiciled in the state for other than a temporary or transitory purpose, with exceptions for individuals domiciled in the state but outside of the state for extended periods of time, unless the primary purpose is to avoid state income tax. [RTC §17014]

This bill:

1) Entitles every person to the public health care coverage their tax dollars support so long as they are a resident as is defined for income tax purposes in 8) above, and are subject to any of the taxes listed in 7) above and whose income is below 138% of the federal poverty level using the MAGI methodology in existing state and federal law.

2) Requires DHCS to implement this bill by ensuring all individuals described in 1) have access to programs administered by DHCS, including, but not limited to, Medi-Cal, and in a manner that reduces cost shifts to county indigent care systems to protect the financial stability of public hospitals and safety-net providers.

3) Authorizes DHCS to implement this bill via guidance until any necessary regulations are adopted and allows for the provisions of this bill to be severed should a provision be held invalid.

4) Includes legislative findings stating that California's large gross domestic product is fueled simultaneously by invention and exploitation of America's largest low-wage workforce; that California has made historic progress toward inclusive access to health care coverage and achieving the lowest uninsured rate in the state's history; that during the COVID-19 pandemic, undocumented workers were called essential workers; that recent state and federal policy changes threaten to reverse progress and shift significant health care costs onto counties and safety-net providers while excluding Californians from the public programs they fund with their state and local tax contributions; that workers who lose access to preventive and primary care do not lose their health care needs; that undocumented Californians and other resident taxpayers contribute billions of dollars annually in state and local taxes and play a critical role in California's economy; that ensuring access to health care coverage for California resident taxpayers promotes public health, economic stability, workforce participation, family wellness, and the financial sustainability of the state's safety-net health program.

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

COMMENTS:

1) *Author's statement.* According to the author, until last year, California was the gold standard in coverage for all. At a time when essential workers, the backbone of our economy, are continuously under attack from the federal government, California must have their back and provide real leadership to protect the state's health care system. I take pride in calling California the 4th largest economy in the world. Yet this is an economy fueled simultaneously by both invention and exploitation of America's largest low-wage workforce. The pandemic made clear that our health is deeply interconnected with that of every Californian. Denying coverage to low-paid essential workers, counties, and safety-net

providers, does nothing to address underlying health care costs. Workers who lose Medi-Cal do not lose their health needs. Instead, they are forced into emergency rooms, shifting costs to county hospital and clinic systems and driving up uncompensated care. Counties face billions of dollars in new costs, while public hospitals are projected to lose billions more in funding. County indigent care programs are fragmented, under-resourced, and not comprehensive. Emergency rooms become the only guaranteed source of care. Our health care system works better when all California residents have access to comprehensive health care including preventive treatment and well-patient checkups.

2) *Expansions of Medi-Cal through #Health4All.* After the expansion of Medicaid to previously ineligible adults aged 19 to 64 without dependents under the Affordable Care Act, a coalition of immigrant and health care rights organizations began sponsoring a campaign to expand full-scope Medi-Cal to undocumented immigrants. A number of bills in both the Senate and Assembly were run from 2014 through 2021. Ultimately, the program was expanded incrementally through health budget trailer bills each time the Senate, Assembly, and Governor agreed that funding was sufficient, starting with children, then young adults, then adults over age 50, and finally all adults. The last budget trailer bill was passed in 2022 and the expansion was fully implemented on January 1, 2024, making California the first state in the nation to cover all income-eligible individuals, regardless of immigration status, in its Medicaid program.

3) *Recent reductions in immigrant eligibility.* After years of program expansion in relatively good budget years, in early 2025, despite a decline in Medi-Cal caseload, an overall increase in Medi-Cal spending was projected. According to DHCS's published highlights from the Governor's 2025-26 proposed budget, the major drivers in these increased costs were an approximately $2.7 billion increase in costs for individuals with unsatisfactory immigration status due to higher than anticipated enrollment and increased pharmacy costs for this population. The other drivers are increased pharmacy costs for the rest of the Medi-Cal population, higher caseload retention rates than predicted, and a reduction in a provider tax due to the passage of ballot Proposition 35 (which redirected how proceeds from the tax could be spent). By May 2025, DHCS's published highlights stated that the increase in costs for individuals with unsatisfactory immigration status had grown to $5 billion over the previous year's projection because enrollment had not declined as predicted, and the average costs of care were still higher than predicted. The Governor's May budget revision thus proposed a number of cuts to this population including an enrollment freeze, monthly premiums, service cuts, and reducing provider payments to clinics serving this population. The Legislature agreed to and enacted a modified version of these proposals, including an enrollment freeze for otherwise eligible undocumented immigrants, $30 monthly premiums for most nonpregnant adults between the ages of 19 and 59 with unsatisfactory immigration status, the elimination of dental benefits for nonpregnant adults over age 19, and the proposed provider rate cuts to clinics.

4) *H.R. 1 and work requirements*. The federal budget reconciliation bill, H.R. 1 (passed in July 2025), has a new "community engagement requirement" (or "work requirement") that requires nondisabled adults between the ages of 19 and 65 who gained coverage through the Affordable Care Act 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. 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 provision was included to reduce state Medicaid rolls. The UC Berkeley Labor Center estimates that 1.87 million adults will lose coverage due to the work requirements. According to an estimate from DHCS given in a presentation *Implementation Plan for New Eligibility and Enrollment Changes Under H.R. 1* on February 5, 2026, by June 2028, 1.4 million recipients will have lost Medi-Cal coverage due to this requirement. While H.R. 1 does not strictly apply to immigrants without satisfactory immigration status as they are not eligible for federally-matched benefits, according to DHCS's implementation plan, in order to maintain parity across all groups receiving full-scope Medi-Cal benefits, DHCS plans to implement work reporting requirements equally to those in federally-funded Medi-Cal and those immigrants in state-only Medi-Cal. This bill would require coverage for all individuals losing Medi-Cal whether due to immigration status, work requirements, or other administrative barriers, as long as those individuals are taxpaying residents with incomes below 138% of the federal poverty level.

5) *Related legislation.* SB 987 (Weber Pierson) would create 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. SB 987 requires 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 is pending on the Senate Appropriations Committee suspense file.*

   SB 1422 (Durazo) would delete provisions of existing state law that freezes program enrollment in full-scope Medi-Cal for undocumented immigrants. *SB 1422 is set for hearing on April 20, 2026 in the Senate Appropriations Committee.*

   AB 1900 (Kalra, Bryan, Lee, Ortega, and Rogers) would create the California Guaranteed Health Care for All Program (CalCare) to provide comprehensive universal single-payer health care coverage for all residents of the state. *AB 1900 is pending in the Assembly Health Committee.*

6) *Prior legislation.* AB 116 (Committee on Budget, Chapter 21, Statutes of 2025) froze the enrollment into full-scope Medi-Cal of nonpregnant undocumented individuals 19 years of age or older starting January 1, 2026, implemented $30 monthly premiums for nonpregnant individuals 19 to 59 years of age starting July 1, 2026, eliminated dental benefits from full-scope Medi-Cal for nonpregnant individuals 19 years of age or older starting January 1, 2027.

7) *Support.* Western Center on Law & Poverty writes in support stating that California achieved the lowest uninsured rate in state history. That progress is now under threat. The 2025–26 State Budget froze Medi-Cal enrollment for income-eligible adults, cutting off access to routine care, prescription drugs, and preventive services. At the same time, H.R. 1 imposes new federal eligibility restrictions projected to push hundreds of thousands, and potentially millions, of Californians out of comprehensive Medi-Cal coverage meaning millions will be excluded from health care that they fund.

8) *Policy comments.*
   a) *Adding program complexity does not solve the coverage problem.* This is not the only bill the author has introduced to respond to undocumented immigrants being excluded from Medi-Cal in last year's budget. SB 1422 would simply delete the exclusion from existing

law so those individuals could again enroll in Medi-Cal. While that requires a significant budget investment, it is implementable. This bill affects a broader population, so would also need a significant budget investment, but also has significant implementation challenges. Although this bill's findings focus on the contributions of immigrant workers, persons losing Medi-Cal next year due to the new federal work requirements would also be eligible, so long as they pay some form of state or local tax, including sales tax. Although covering all persons losing Medi-Cal is laudable, the policy rationale is contradictory, and at worst aligns with the rationale of H.R. 1 work requirements – only those who contribute through work or community engagement are deserving of health care.

More importantly, Medi-Cal coverage expansion works best when the new population is treated the same as the existing Medi-Cal population. Here, someone found ineligible for Medi-Cal would need to then be found eligible for Medi-Cal based on taxpayer residency status, which would need to be programmed and implemented at the county level where eligibility is verified. It is not clear whether this would be the same Medi-Cal benefits or different, depending on how the program would be designed. Although the bill language requires DHCS to ensure access to the public health coverage it administers, including Medi-Cal, the other programs administered by DHCS are generally for specific populations, such as the Indian Health Program, or for specific conditions, such as the Breast and Cervical Cancer Treatment Program, some of which may already be open to these populations.

b) *Tying coverage to taxpayer status.* This bill also seeks to change the nature of the Medi-Cal program from a social welfare program that extends eligibility based on need to a social insurance program like Medicare where workers pay into the program on the expectation that they will receive benefit from the program. However, such a shift begs the question: why are only some resident taxpayers included? Many resident taxpayers with incomes over 138% of the federal poverty level also cannot afford the cost of their health care, particularly as federal subsidies for Covered California plans were reduced this year. While California has drastically lowered its uninsurance rate due primarily to several expansions of the Medi-Cal program and Covered California subsidies, we still have many people who cannot afford coverage at all or cannot afford to use the coverage they have.

SUPPORT AND OPPOSITION:

Support: Health Access California
Western Center on Law & Poverty, Inc.

Oppose: None received.

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