California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, March 9, 2026

2:30 P.M. – State Capitol, Room 447

California's Response to HR 1: Defending Health Care Affordability & Access – Part 2

Federal Impacts on Coverage: Medi-Cal, Covered California, and Immigrant Access to Care

Items To Be Heard

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4800 Covered California
4260 Department of Health Care Services

Issue 1: Impacts of HR 1 and Federal Actions on the Covered California Marketplace

This issue will examine the **three major federal policy changes** that are anticipated to impact enrollment and affordability on the Covered California marketplace:

1- HR1 Policy Changes

2- New federal regulations established by the Centers for Medicare and Medicaid Services (CMS)

3- The expiration of enhanced premium subsidies established under the federal American Rescue Plan Act and the Inflation Reduction Act, which Congress did not renew for 2026.

Background on Covered California

Covered California is the state's health benefit exchange, established under the federal Affordable Care Act (ACA) and created by California statute in 2010. It is a health care marketplace through which eligible Californians can shop, compare, and enroll in private health insurance plans and access federal and state financial assistance to help pay for coverage.

Covered California plays a key role in the state's health insurance infrastructure, alongside Medi-Cal. While Medi-Cal covers lower-income Californians (generally those at or below 138 percent of the federal poverty level) Covered California is primarily designed to serve low-to-middle-income individuals and families who do not have access to affordable employer-sponsored health insurance. Covered California enrollees receive financial assistance in the form of federal subsidies, called Advance Premium Tax Credits (APTCs) which lowers monthly premiums, and Cost-Sharing Reductions (CSRs) which lowers out-of-pocket costs. In some instances, Covered California consumers can receive state-funded subsidies to make coverage more affordable (state-funded subsidies are discussed in a later section of this agenda).

Covered California does not provide health care directly. As the state exchange, it contracts with private health insurance plans, negotiates prices on behalf of consumers, and ensures that plans selected to participate in the exchange meet certain quality standards. All plans offered through Covered California must cover the ten essential health benefits required under the ACA, including preventive care, hospitalization, prescription drugs, and mental health services.

Covered California Enrollment Trends (2020-2025)

Between January 2020 and August 2025, enrollment in Covered California grew significantly, rising by approximately 625,000 enrollees (a 46.7 percent increase), reaching a peak of 1,964,031 individuals. This growth was driven by several factors, including California's individual mandate and penalty, simplified enrollment procedures, the availability of state-funded cost-sharing reduction assistance, and most significantly, the availability of enhanced federal premium tax credits introduced by the American Rescue Plan Act (ARPA) in 2021 and extended through the Inflation Reduction Act (IRA) through the end of 2025.

At its peak, Covered California enrollment represented approximately 5 percent of California's total population.

HR1 Policy Changes Impacting Covered California

HR 1 makes several direct changes to the structure of the ACA marketplace that will affect how consumers enroll in and maintain coverage through Covered California. These provisions primarily restrict eligibility, tighten enrollment verification, and limit access to premium subsidies.

The major HR 1 marketplace provisions are summarized below:

- **Pre-Enrollment Verification and End of Automatic Re-Enrollment.** Under current practice, consumers who are already enrolled in Covered California coverage are generally automatically renewed into a similar plan at the end of each year unless they take action to make changes. HR 1 requires consumers to actively verify their eligibility before enrolling, effectively ending passive automatic re-enrollment. Consumers who do not complete the verification process will not retain coverage.

- **Elimination of the Income-Based Special Enrollment Period.** Prior to HR 1, low-income consumers with household incomes below 150 percent of the federal poverty level (FPL) were eligible for a Special Enrollment Period (SEP) that allowed them to enroll in Covered California coverage at any point during the year, not just during the annual Open Enrollment Period.

- **Removal of Caps on Repayment of Excess Advance Premium Tax Credits.** When consumers enroll in coverage through Covered California, they receive Advance Premium Tax Credits (APTCs) based on their estimated annual income. At tax time, their final credit amount is reconciled against their actual year-end income. Under prior law, consumers who received more in subsidies than they were entitled to were only required to repay up to a specified capped amount. HR 1 removes those repayment caps, meaning consumers may owe the full value of any excess subsidies received.

- **Denial of Premium Tax Credits for Individuals Losing Medi-Cal Due to Work Requirements.** HR 1 includes a provision directly linking Medi-Cal work requirement outcomes to Covered California eligibility. Individuals who lose Medi-Cal coverage specifically because they failed to meet the new work and community engagement requirements will not be permitted to immediately access premium subsidies through Covered California.

New Federal Marketplace Rules Impacting Covered California

In addition to HR 1, the federal Centers for Medicare & Medicaid Services (CMS) finalized several marketplace regulatory changes in 2025 that further affect how consumers enroll in and maintain Covered California coverage. These rules were issued in the 2025 "Marketplace Integrity and Affordability Final Rule," and their major components are summarized below.

Of note, several of these provisions have been temporarily blocked by a federal court injunction in *City of Columbus v. Kennedy* and may be reimplemented through new rulemaking for plan year 2027.

- **Shortened Open Enrollment Period.** Narrows the annual window in which Californians can sign-up for a Covered California plan by two weeks. Special enrollment because of a life change, like moving or getting married, remains unchanged.

- **Tightened Income Verification Requirements.** Requires consumers to submit documentation in two new circumstances: when their tax data shows income below 100 percent of the federal poverty level (FPL), and when no prior tax data is available. Previously, consumers could enroll based on self-attested income in both situations without submitting additional proof.

- **Elimination of Automatic 60-Day Extension for Income Inconsistencies.** When a consumer's income information does not match federal data sources, they are given 95 days to provide documentation to resolve the inconsistency. Prior rules automatically granted an additional 60 days beyond that window. This rule eliminates the automatic extension, leaving consumers with only the standard 95-day period.

- **Reduced Failure-to-Reconcile Period for APTCs.** Consumers who receive Advance Premium Tax Credits must file taxes each year and reconcile the amount they received against their actual income. Under prior rules, consumers who failed to file and reconcile were ineligible for APTCs only if they had not reconciled for two consecutive years. This rule shortens that period to one year.

- **Allowing Issuers to Require Payment of Past-Due Premiums.** Permits health plan issuers to require consumers to pay any outstanding premiums owed before enrolling in

new coverage. Prior federal rules prohibited issuers from conditioning new enrollment on payment of past-due amounts.

- **Higher Out-of-Pocket Limits and Broader Actuarial Value Ranges.** Increases the maximum out-of-pocket costs consumers can be charged, broadens the allowable actuarial value ranges for plan metal tiers, and updates the methodology used to calculate annual premium growth. In practical terms, these changes result in higher premiums and increased cost-sharing for some enrollees.

- **Prohibiting coverage of gender-affirming care.** Prohibits qualified health plans offered through ACA marketplaces from covering gender-affirming care as an essential health benefit. Of note, the 2025 Budget Act provided $15 million from the Health Care Affordability Reserve Fund to defray the costs and continue providing these benefits in the California marketplace.

Expiration of Enhanced Premium Subsidies

While HR 1's marketplace provisions and the new federal rules will have meaningful impacts on enrollment, another major driver of projected enrollment decline in Covered California is the expiration of the enhanced federal premium tax credits, a program that Congress declined to renew for 2026.

What Are Enhanced Premium Subsidies

The enhanced federal premium subsidies were first introduced in 2021 under the federal American Rescue Plan Act (ARPA) and subsequently extended through the end of 2025 under the Inflation Reduction Act (IRA). These credits significantly expanded financial assistance provided for marketplace enrollees in two key ways:

- **For individuals with incomes between 100 and 400 percent FPL**, subsidies were increased, reducing the share of income consumers were required to pay toward their benchmark plan premium.

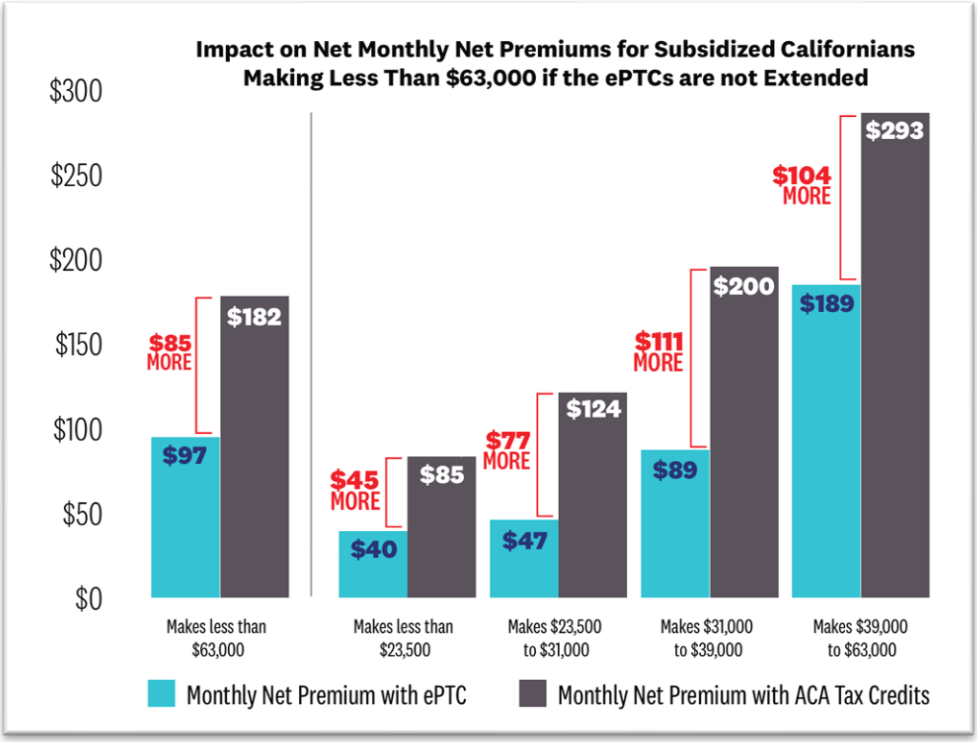
- **For individuals with incomes above 400 percent FPL,** the enhanced credits made them newly eligible for subsidies. That population was previously excluded from any premium assistance under the standard ACA rules.

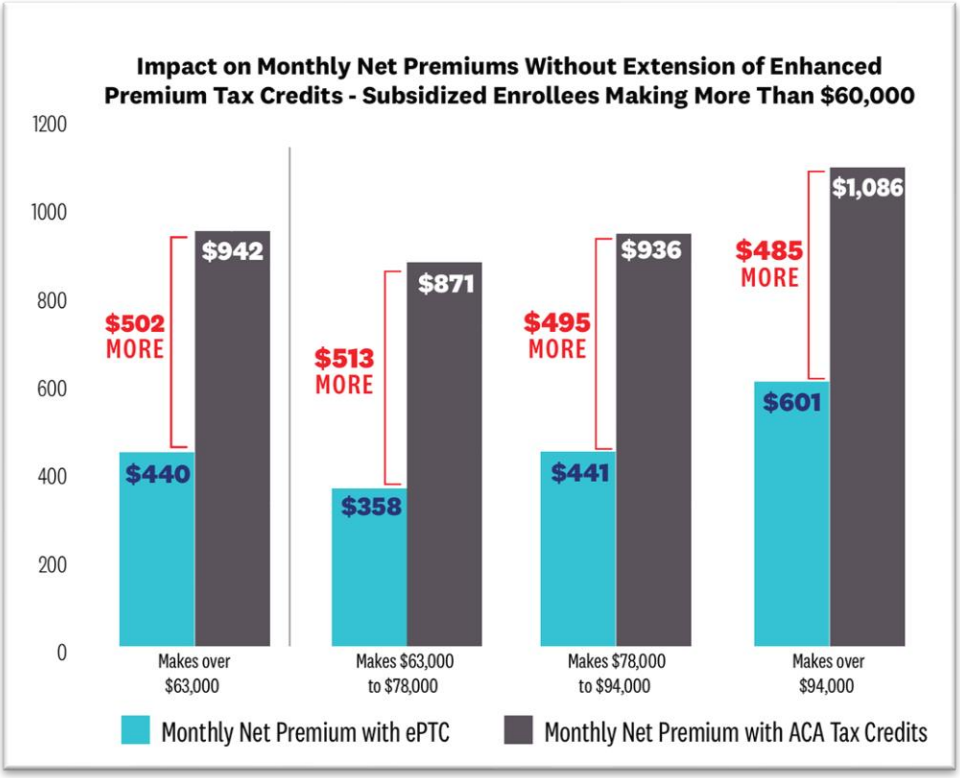
The enhanced credits expired on December 31, 2025, and was not renewed at the federal level. **California received approximately $8.3 billion** in total enhanced premium tax credits over the course of the program.

Impact of Subsidy Expiration on Premiums

The expiration of the enhanced subsidies is expected to result in significant premium increases for many Covered California enrollees. Covered California's analysis estimated an approximately 97 percent average increase in net premiums for enrollees who will no longer receive the enhanced credits.

The following charts, developed by Covered California in September 2025, illustrate the net monthly premium increases without the extension of the enhanced federal premium subsidies.





Note: these charts do not reflect subsequent state actions taken in the 2025 Budget Act (discussed later in this agenda) that aimed to lower premiums for specific enrollee categories.

The scale of the premium increase varies significantly by income level and is particularly acute for consumers above 400 percent FPL who were newly eligible for subsidies under the enhanced program.

Projected Impacts on Covered California Enrollment

Following the peak in Covered California's enrollment in August 2025, coverage through the exchange is expected to decline over the next 4-5 years. Covered California projects that enrollment will decline from its August 2025 peak of approximately 1.96 million to roughly 1.45 million by 2030 – a loss of more than 500,000 enrollees. Those figures would bring enrollment close to pre-pandemic levels.

Expected enrollment losses are anticipated to occur in two waves:

- The first wave will be triggered by the expiration of the enhanced federal premium tax credits. The response to the loss of enhanced federal subsidies is expected to unfold over the next few months from the publication of this agenda, as more consumers find the premiums unaffordable and decide to drop coverage.

- The second wave will result from various provisions of HR1 and the new federal rules. Implementation of those provisions will be phased in from mid-2025 through 2028, with the largest impacts expected in later years.

Timeline	Estimated Enrollment	Key Factors
January 2020 (Pre-pandemic)	1,339,107	Before enhanced federal subsidies
August 2025 (Peak enrollment)	1,964,031	Enhanced subsidies available
Projected: Mid-2026	1,806,188	Subsidy expiration begins to take effect
Projected: July 2030	**1,452,765**	**HR 1 & CMS rule provisions fully in effect**

2026 Open Enrollment Results

The 2026 open enrollment period concluded on January 31, 2026. The results provide a preliminary view of how Californians are responding to the expiration of the enhanced federal premium tax credits.

Over 1.9 million Californians signed up for coverage during the enrollment period, but the composition of that enrollment appears to have shifted significantly. New enrollment fell sharply while renewal enrollment held relatively steady in the near term, though Covered California expects renewal cancellations to continue accumulating through at least April as the full impact of higher premiums continues to unfold.

New Enrollment

More than 235,000 consumers newly enrolled in coverage for 2026, a 32 percent decrease compared to the prior year. The decline was felt across all demographic groups, with particularly sharp drops among specific communities:

- **Latino communities** saw new enrollment fall 39 percent.
- **Black or African American** consumers saw new enrollment fall 34 percent.
- **Middle-income consumers** above 400 percent FPL (approximately $62,000 annually for an individual) experienced a 59 percent drop in new enrollment. This steep decline may reflect the complete loss of premium subsidy eligibility for this population.

Plan selection also shifted meaningfully. More than 1 in 3 new enrollees selected Bronze-tier plans for 2026, compared to fewer than 1 in 4 the prior year. Bronze plans carry lower monthly premiums but substantially higher deductibles and out-of-pocket costs, which can deter consumers from seeking care even when covered.

Renewal Enrollment

Nearly 1.7 million consumers renewed their coverage for 2026, a 4 percent increase compared to the prior year. However, Covered California cautions that this figure reflects early enrollment counts and is likely to decline in the coming months as more consumers respond to higher premiums by dropping coverage.

Key renewal trends include:

- More than 130,000 renewing Californians switched to Bronze-tier plans for 2026, another sign that consumers are trading down to help afford monthly premium costs.

- Middle-income consumers are canceling at double the normal rate: the cancellation rate among this group reached 22 percent, compared to 11 percent last year. As noted above, this group is no longer eligible for any premium tax credits, making the full cost of coverage unaffordable for a significant share.

- Preliminary data indicates that health care plan cancellations are running 32 percent higher than the same period last year and are expected to continue rising through at least April 2026 as the full effects of premium increases are felt.

State-Level Action: California's Premium Subsidy Program

Anticipating the expiration of federal enhanced subsidies, California took proactive action to partially offset the impact on lower-income enrollees. **The 2025 Budget Act appropriated $190 million** from the Health Care Affordability Reserve Fund (HCARF) to fund a state premium assistance program for Covered California enrollees in plan year 2026. The 2026-27 Governor's Budget maintains this $190 million appropriation.

What is the Health Care Affordability Reserve Fund

The Health Care Affordability Reserve Fund (HCARF) was established to support health care affordability programs. It is funded primarily through revenues collected from California's individual shared responsibility penalty, the state's own health coverage mandate, which requires most Californians to have health insurance or pay a penalty.

The penalty generated approximately $270 million in 2025-26, with revenues deposited directly into HCARF.

In prior budget years, excess HCARF revenues were loaned to the state's General Fund to address budget deficits. A total of $771 million in loans were issued across three fiscal years:

- A $600 million loan in 2023-24, to be repaid equally across 2026-27, 2027-28, and 2028-29. This means $200 million is scheduled to return to the fund in 2026-27 alone.
- A $62 million loan in 2024-25, projected to be repaid in 2027-28.
- A $109 million loan in 2025-26, projected to be repaid in 2028-29.

As of the Governor's January Budget, the current-year ending fund balance for HCARF is $85.7 million, a relatively modest balance that reflects the large outstanding loan obligations.

However, the fund's near-term trajectory improves significantly: the 2026-27 budget projects $490.7 million in total new resources flowing into HCARF, combining $290.7 million in new penalty revenues with the $200 million first-tranche loan repayment. Against projected expenditures of $207 million (which include $190 million for the current Covered California premium assistance program, $15 million for gender-affirming care benefits, and $2 million for health care striking worker coverage) **the fund balance is projected to reach $369.4 million by the end of 2026-27.** As currently proposed in the Governor's Budget, that ending balance is unobligated. The May Revision will reflect updated revenue and expenditure projections.

The 2026 California Premium Subsidy Program

Using the $190M appropriated by the Legislature, Covered California designed and adopted a 2026 California Premium Subsidy Program, available for eligible consumers for plan year 2026.

The program provides premium assistance to Covered California enrollees with household incomes at or below 165 percent FPL. To receive the California Premium Subsidy, consumers must be eligible for the federal version of the subsidy.

Broadly, the program is designed to preserve premium generosity that was available through the enhanced federal subsidies for the lowest-income enrollees. Specifically:

- **Enrollees at or below 150 percent FPL** continue to have access to two Silver-tier plans for $0 net premium.
- **Enrollees between 150 and 165 percent FPL** receive state assistance that reduces their required premium contribution.

- **Enrollees above 165 percent FPL** receive no additional state premium assistance.

Approximately 389,620 Covered California enrollees are currently receiving the state premium subsidy, representing the lowest-income segment of the exchange population. The concentration of enrollees is highest in Southern California, as shown below

State Subsidy Program: Enrollment by County (Top 10 Counties)

County	Enrollee	Percentage
Los Angeles	125,500	32.20%
Orange	40,740	10.50%
San Diego	29,660	7.60%
San Bernardino	28,110	7.20%
Riverside	25,220	6.50%
Sacramento	16,220	4.20%
Santa Clara	15,810	4.10%
Fresno	15,630	4.00%
San Joaquin	10,600	2.70%
Alameda	8,610	2.20%
Statewide Total	**389,620**	**100%**

Panel

- Jessica Altman, Executive Director, Covered California
- Katie Ravel, Director, Policy Eligibility and Research Division, Covered California
- Angel Coronel, Staff Services Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Min Lee, Economist, Legislative Analyst's Office
- Mark Newton, Deputy Legislative Analyst, Legislative Analyst's Office

Staff Comments

- **Looking Ahead and the Role of the California Subsidy Program.** As the Subcommittee considers the state's response to the loss of enhanced federal premium assistance, a central question is the extent to which additional HCARF resources could be deployed to expand the state subsidy program in future years. The state could decide to broaden the income eligibility threshold, focus on lowering monthly premiums, lowering out-of-pocket costs, or a combination of those options. However, HCARF is limited in resources, and the state will need to be deliberate about how to use available dollars.

- **The current state subsidy program provides a critical but partial buffer.** The $190 million state subsidy program protects the lowest-income enrollees (approximately 389,620 individuals at or below 165 percent FPL) from premium increases. However, it does not

address the larger population of Covered California enrollees above 165 percent FPL, nor does it address the significant premium increases impacting middle-income Californians at 400 percent FPL and above. The Subcommittee should consider whether California should expand this program, and for whom.

- **Preliminary 2026 open enrollment results indicate coverage losses are already happening.** The 32 percent drop in new enrollment, the 59 percent decline among middle-income consumers, the doubling of the cancellation rate among renewing middle-income enrollees, and plan cancellations running 32 percent above prior year levels point out that enrollment decline due to affordability barriers is actively unfolding.

- **The racial and ethnic enrollment disparities warrant close attention**. Covered California notes a 39 percent drop in new enrollment among Latino communities and a 34 percent drop among Black or African American consumers. Federal actions appear to deepen health care access disparities for underrepresented groups.

- **Administrative churn is a foreseeable risk for Covered California.** New federal policies such as pre-enrollment verification requirements, or linking eligibility to Medicaid work requirements, create new potential points of friction that could cause administrative churn (the temporary loss of coverage in which enrollees disenroll and then re-enroll within a short period of time due to administrative complexities). The Subcommittee may wish to understand what steps Covered California is taking to minimize procedural disenrollment.

The Subcommittee may wish to ask the following questions:

Regarding the California Premium Subsidy Program and HCARF:

1- The Governor's January Budget projects a $369.4 million unobligated HCARF ending balance for 2026-27. Given that this balance is sufficient to fund another round of state premium assistance at or above the current program level, does the Administration intend to propose a plan year 2027 subsidy program?

2- Has Covered California developed other potential models on how to use HCARF resources? For example, has it considered models that support specific income levels, geographic regions, or immigration statuses no longer eligible for federal subsidies?

3- What would it cost to expand the state subsidy program to cover additional enrollees, for example up to 200 percent FPL, or up to 400 percent FPL?

Regarding HR1 and CMS Rule Implementation:

4- How is Covered California preparing for the implementation of new federal policies projected to impact enrollment, and what steps is it taking to minimize procedural coverage loss among eligible consumers?

5- What additional outreach and education efforts are planned ahead of the phased in implementation of new federal policies?

Regarding 2026 Open Enrollment

6- Based on 2026 open enrollment results, what is the current trajectory for terminations among renewing enrollees? Are the results tracking within, above, or below projected enrollment loss scenarios?

7- New enrollment declined 39 percent among Latino consumers and 34 percent among Black or African American consumers. What strategies should Covered California consider to address the potential widening of health disparities, and what resources would be needed to expand such efforts?

Staff Recommendation:

This item is informational only.

Issue 2: Impacts of HR 1 on Medi-Cal Enrollment and the State's Implementation Framework

This issue will examine two key components of HR1 impacting Medi-Cal eligibility & enrollment, and the state's plan to implement those provisions:

1- Work and community engagement requirements
2- Increased eligibility verification

Of note, future subcommittee hearings will cover other aspects of HR1, such as Medi-Cal financing.

Background on Medicaid & Medi-Cal

California's Medicaid program, known as Medi-Cal, is the state's public health insurance program providing no-cost and low-cost health care coverage to eligible individuals and families. Medi-Cal is jointly financed by the state and federal government and covers a broad array of services, including primary care, hospital services, prescription drugs, dental care, and behavioral health. As of October 2025, more than 14.5 million Californians – nearly 37 percent of the state's population – are enrolled in Medi-Cal.

Medi-Cal is administered by the California Department of Health Care Services (DHCS) in partnership with California's 58 counties, which are responsible for determining eligibility, managing active cases, and renewing coverage. The program is delivered primarily through Managed Care Plans, which are contracted health plans that provide comprehensive benefits to enrollees.

Eligibility for Medi-Cal expanded significantly following the implementation of the Affordable Care Act (ACA) Medicaid expansion in 2014, which extended coverage to adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level (FPL). This group, called the **"New Adult Group,"** currently represents approximately 4.9 million of Medi-Cal's 14.5 million enrollees and is the population most directly affected by the HR 1 provisions examined in this issue.

Work and Community Engagement Requirements

Effective January 1, 2027, HR 1 requires adults ages 19 to 64 in the New Adult Group to demonstrate at least 80 hours per month of qualifying work, volunteer, or educational activity in order to maintain Medi-Cal coverage. This is the first time in California's history that Medi-Cal has imposed a work-related activity requirement as a condition of eligibility.

Qualifying Activities

To remain eligible, New Adult Group members must demonstrate one or more of the following each month:

- **Employment** of at least 80 hours per month.
- **Monthly income** of at least $580 (equal to 80 times the federal minimum wage of $7.25/hour).
- **Seasonal employment** averaging at least $580 per month over the preceding six months.
- **Community service** of at least 80 hours per month.
- **At least half-time enrollment** in an educational or vocational program.
- **Participation in a work program** of at least 80 hours per month.
- **A combination** of employment, community service, work program, and/or education totaling at least 80 hours per month.

Exemptions from Work Requirements

HR exempts certain individuals from the work and community engagement requirements, including:

- **Certain eligibility groups:** pregnant or postpartum individuals (up to 12 months), foster youth, former foster care youth under 26, aged/blind/disabled individuals (including SSI recipients), children under 19, and American Indian / Alaska Natives
- **Caregivers:** parents, guardians, or caretakers of a dependent child age 13 or younger, or of a disabled individual.
- **Veterans** with a total disability rating.
- **Individuals recently incarcerated** or released from a correctional facility within the past 90 days.
- **Individuals enrolled in Medicare** Part A or Part B.

- **Individuals already meeting** TANF (CalWORKs) or SNAP (CalFresh) work requirements.

- **Individuals in drug or alcohol treatment programs.**

- **Medically frail individuals,** defined as those with a substance use disorder, a disabling mental disorder, a physical/intellectual/developmental disability that significantly impairs daily living, a serious or complex medical condition, or who are blind or disabled under Social Security definitions.

Outstanding Federal Guidance

A central challenge facing DHCS's implementation planning is the absence of federal guidance on many critical operational questions. HR1 requires that the Secretary of the United States Health and Human Services agency provide implementation guidance to states by June 1, 2026, including definitions and clarifications of standards mentioned in the federal law.

Until such guidance is released, DHCS faces major roadblocks in its ability to finalize its implementation design. Some examples include:

- **Medical frailty definition:** There is currently no guidance on qualifying diagnoses, codes, or documentation standards that would allow a person to qualify for an exemption under this category.

- **Community service definitions:** It remains unclear what types of volunteer activity qualify, or whether organizations offering community service must have a specific designation.

- **Educational enrollment standards:** CMS has not defined what constitutes "half-time" enrollment, or how credits and non-traditional programs are counted.

- **Post-implementation data reporting requirements:** Federal requirements for tracking and reporting on compliance have not been finalized.

Six-Month Eligibility Renewals

HR 1 also requires New Adult Group members to renew their Medi-Cal eligibility every six months instead of annually. Under current law, all Medi-Cal members renew once per year. The new requirement effectively doubles the frequency of renewal for approximately 4.6 million enrollees.

All other Medi-Cal populations, which includes children, pregnant and postpartum individuals, older adults, people with disabilities, foster youth, and American Indian and Alaska Native members, continue on the existing annual renewal schedule.

Estimated Coverage Loss in Medi-Cal

DHCS estimates that taken together, the new work requirements and the six-month renewals will result in up to **1.8 million Medi-Cal members losing coverage** over the next few years. Disenrollment will not happen all at once: DHCS expects coverage losses to occur over the long-term.

Estimated Coverage Losses

Provision	Near-Term Estimate	Long-Term Estimate
Work & Community Engagement Requirements	233,000 by June 2027	1.4 million by June 2028
Six-Month Renewals	289,000 by June 2026	400,000 by 2029-30
Combined (both provisions)	522,000 by June 2027	1.8 million by June 2028

How DHCS Estimated the Work Requirement Impact

DHCS's caseload modeling for work requirements is based on a "verification steps," a tiered process for determining, through automated data matching, which members are already exempt or compliant before requiring manual verification. According to DHCS:

- **Approximately 4,633,636** New Adult Group members are subject to work requirements.
- **Of those, approximately 1,842,155** (about 40 percent) can be determined exempt or compliant through automated data sources, meaning no action is required of the member.
- **The remaining approximately 2,791,481** (about 60 percent) cannot be cleared automatically and will need to manually verify compliance or demonstrate an exemption.
- **DHCS assumes that approximately 50 percent of those required to verify manually will disenroll,** either because they do not respond to notices or because they do not meet the requirements. This yields the estimate of up to 1.4 million will lose coverage due to requirements by June 2028.

DHCS HR1 Implementation Plan

DHCS has released a detailed HR 1 Implementation Plan outlining the Department's approach to managing the transition. The plan acknowledges that coverage losses are unavoidable but commits to minimizing procedural disenrollments through automation, outreach, improved user experience, and coordination with counties, managed care plans, and stakeholder partners.

Outreach & Member Communication Strategy

DHCS has designed a two-phase communication strategy:

- **Phase 1: Awareness and Preparation (currently underway):** DHCS will raise awareness of upcoming changes and prepare members for specific actions they must take to maintain their Medi-Cal coverage ahead of programmatic changes. DHCS notes that it has begun this work, including texting campaigns directed at New Adult Group members regarding the January 2027 changes.

- **Phase 2: Support and Action (October through end of 2027):** As the implementation dates get closer, DHCS will shift its communication to focus on the specific actions members must take, such as responding to notices or completing renewal packets. Messaging will reinforce this through direct outreach, reminders, and targeted assistance to help members retain coverage.

Information Technology and Implementation Readiness

California's IT health eligibility infrastructure is primarily made up of two systems: the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and the California Statewide Automated Welfare System (CalSAWS). DHCS notes that these systems have been substantially upgraded in recent years. DHCS will leverage these systems to manage the automated verification process for work requirements and six-month renewals.

However, DHCS has identified two additional platforms that will require integration to access key data sources for verifying work requirement compliance:

- A platform to provide timely income data and hours-of-work verification.

- A platform to for verifying gig economy workers, a population for whom standard wage data is often unavailable.

The cost for those new IT platforms are currently unknown, however the Administration anticipates that federal match funding will be available for their implementation.

County Readiness

California's 58 county welfare offices are on the front line of HR 1 implementation: they process applications, conduct eligibility determinations, distribute notices, and manage renewal cases. The combination of work requirements and six-month renewals will substantially increase county workloads through more frequent manual case reviews, increased phone and counter traffic, and higher rates of coverage churn.

DHCS is working with the County Welfare Directors' Association (CWDA) to assess the workload impact and identify resource needs. The extent of any additional county administrative funding, which is typically matched at the federal level, is still being determined as part of the state budget process.

Proposed Budget investments for HR1 Implementation:

As part of the 2026-27 Governor's Proposed Budget, DHCS requests the following resources:

1- **H.R.1 Planning and Implementation Budget Change Proposal:** DHCS requests $33,049,000 in 2026-27, $11,325,000 in 2027-28, and $3,277,000 in 2028-29 and in 2029-30 (amounts split between General Fund and federal funds) which will fund staff positions dedicated to the implementation of HR1 as well as fund Medi-Cal member outreach and media.

   Specifically on outreach and media, DHCS plans to use $17.5M of the requested funding to cover the following:

   - Development of a multilingual outreach campaign that includes educational materials, training, and plain-language member communications, which will be translated into threshold languages and alternative formats.
   - Creating county toolkits and statewide training to support uniform implementation.
   - Coordination with CDSS on outreach efforts related to work requirements such as welfare-to-work and able-bodied adults without dependents CalFresh requirements.
   - Update the DHCS public facing Medi-Cal Eligibility Procedures Manual that counties and other enrollment entities utilize to support the policies associated with the determination of Medi-Cal and Medicare Savings Program eligibility.

2- **Health Enrollment Navigators:** The DHCS Medi-Cal local assistance estimate also proposes $4 million of funding to Community Health Centers and Regional Clinic Associations to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care.

Proposed HR1 Trailer Bill

The Governor's budget also includes a budget trailer bill that aims to conform California statute to the new federal requirements. The trailer bill would change state statutes to enable DHCS to:

- Modify existing Medi-Cal eligibility rules to regularly check and update member addresses using trusted sources;
- Conduct six-month eligibility redeterminations for certain adults;
- Reflect eligibility updates for federally funded full-scope Medi-Cal based on immigration status;
- Reduce retroactive coverage periods; and
- Establish work/community engagement requirements.

Panel

- Michelle Baass, Director, Department of Health Care Services
- Tyler Sadwith, Chief Deputy Director & State Medicaid Director, Health Care Programs, Department of Health Care Services
- Yingjia Huang, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- Dr. Hakeem Adeniyi, Chief Clinical Officer, Sacramento Native American Health Center.
- Angel Coronel, Staff Services Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Min Lee, Economist, Legislative Analyst's Office
- Mark Newton, Deputy Legislative Analyst, Legislative Analyst's Office

Staff Comments

- **Lack of federal guidance creates implementation risks.** As noted in the agenda, key federal guidance related to H.R. 1 is not anticipated to be released until June 1, 2026. This guidance is critical to finalizing implementation of federal provisions. If such guidance

is released by this timeline, this would provide DHCS with only seven months to finalize implementation design, update systems, train county staff, and notify affected members before the HR1 January 1, 2027 compliance deadline -- a compressed window for changes of this scale and complexity. If guidance is delayed beyond June 1, 2026, or released in piecemeal fashion, the state may be in the position of having to make consequential design decisions without complete federal direction, increasing the risk of non-compliance, costly system rework, confusing member communications, or unintended coverage disruptions for Medi-Cal members.

- **The Administration's 50 percent disenrollment estimate for the work requirement warrants additional discussion.** Approximately 1.4 million of the projected 1.8 million total coverage losses in Medi-Cal stems from the work requirement alone, driven largely by the assumption that half of those requiring manual verification will disenroll. However, the drivers and sensitivity of this assumption are not fully explained. The Subcommittee may wish to better understand to what extent do projected disenrollments reflect administrative barriers and paperwork burdens versus substantive ineligibility.

- **County capacity is a critical component of implementation, but resource needs remain unaddressed in the proposed budget.** The Department's automation strategy can reduce but not eliminate the need for manual county case review. The roughly 2.8 million New Adult Group members who cannot be auto-verified will require county contact, and a six-month renewal cycle doubles the frequency of that workload. The adequacy of county administrative funding, which DHCS is still assessing, will be a critical determinant of implementation success.

The Subcommittee may wish to ask the following questions:

Regarding Coverage Loss Estimates

1- The 50 percent disenrollment assumption for those requiring manual verification is central to the work requirement estimate. What range of assumptions did DHCS consider, what factors affect those assumptions, and what would the coverage loss estimate be under more optimistic and more pessimistic scenarios?

2- What is DHCS's estimate of the share of projected coverage losses that will be "procedural," meaning the member is still eligible but fails to complete required paperwork, versus "substantive", meaning the member does not meet the work requirement?

Regarding State-Level Implementation:

3- What is DHCS's current assessment of county administrative readiness? Does the Administration have an update on its discussions with county partners?

4- DHCS has described a two-phase outreach strategy and is requesting $17.5 million in resources to bolster these efforts. What metrics will DHCS use to evaluate the effectiveness of outreach, and at what point would DHCS determine that additional investments may be needed?

5- What is the current status of the HR 1 budget trailer bill? Has the Administration captured all of the implementation elements needed for state-level implementation? Does the timeline of the federal guidance impact the components of the trailer bill?

On-the-Ground Perspectives:

The Subcommittee has also invited community-based organizations and health care providers to offer testimony on how these policy changes are affecting the populations they serve. The Subcommittee may wish to ask the following:

6- Safety net providers are often required to provide care regardless of a patient's ability to pay. As Medi-Cal coverage losses materialize, how are providers planning for the anticipated increase in uncompensated care, and what does that mean for the long-term financial sustainability of safety net institutions?

7- Community health centers and community-based organizations have historically played a critical role in outreach and enrollment, serving as trusted messengers in communities that may be skeptical of government agencies. What resources would be needed to meaningfully support Medi-Cal members through the work requirement verification and six-month renewal processes?

8- Are there specific patient populations (for example, individuals with behavioral health conditions, those experiencing homelessness, or patients with limited English proficiency) who are at particularly high risk of losing coverage procedurally, even though they would likely qualify for an exemption if they were able to navigate the verification process?

Staff Recommendation:

This item is informational only.

Issue 3: Impacts of HR 1 and Federal Actions on Immigrant Access to Care

Immigrants represent a significant share of California's health coverage landscape. California has historically taken a more expansive approach to immigrant eligibility than federal law requires, for example by using state funds to extend Medi-Cal coverage to populations excluded from federal programs.

HR 1, combined with new federal marketplace rules and state-level decisions enacted in the 2025 state budget, reverses some of this health coverage expansion by restricting immigrant eligibility across both Medi-Cal and Covered California, and shifting significant costs over to the state.

Background on 2025 Budget Act:

The 2025-26 state budget made significant policy decisions affecting immigrant coverage. These state actions include:

- **Enrollment freeze for undocumented adults.** Beginning January 1, 2026, DHCS froze any new enrollment in Medi-Cal for individuals with Unsatisfactory Immigration Status who are age 19 or older. Current enrollees are not disenrolled, but no new adults may enroll.

- **$30 monthly premium for individuals with Unsatisfactory Immigration Status.** Effective July 1, 2027, Medi-Cal enrollees with Unsatisfactory Immigration Status who are ages 19 to 59 will be required to pay a $30 per month premium to maintain coverage.

- **Elimination of state-funded dental coverage for enrollees with Unsatisfactory Immigration Status.** Effective July 1, 2026, full-scope state-funded dental coverage is eliminated for Medi-Cal enrollees with Unsatisfactory Immigration Status.

These state budget decisions were driven by the significant cost pressures in the Medi-Cal program.

Covered California & Immigrant Access to Care

Currently, U.S. citizens and lawfully present immigrants are eligible to enroll in Covered California and receive federal premium subsidies and cost-sharing reductions. HR 1 significantly narrows that eligibility, as summarized below.

Restricting Subsidized Coverage for "Lawfully Present" Immigration Statuses: Effective January 1, 2027, HR 1 strips federal premium subsidies and cost-sharing reductions from the vast majority of lawfully present immigrants currently enrolled in Covered California. The following groups will lose eligibility for federal financial assistance:

- Refugees and asylees
- Victims of trafficking (T visa holders),
- Victims of domestic violence and other serious crimes (U visa holders)
- Individuals with Temporary Protected Status (TPS)
- Holders of work visas (H-1B, J-1, O, R, P, and others) and student visas (F and M visas)
- Individuals with pending asylum applications
- Individuals granted Deferred Enforced Departure, humanitarian parole, or withholding of removal
- Many other lawfully present categories

These individuals may still enroll in a Covered California plan, but only at full, unsubsidized cost, which for many could be unaffordable.

Ending Subsidies for Low-Income Immigrants Below 100% FPL. Effective January 1, 2026, HR 1 also eliminates APTC eligibility for lawfully present immigrants with incomes below 100 percent of the federal poverty level who are ineligible for Medicaid due to their immigration status.

Excluding DACA Recipients from Marketplace Eligibility Entirely. Federal rules exclude Deferred Action for Childhood Arrivals (DACA) recipients from marketplace eligibility entirely. DACA recipients may not purchase a Covered California plan at any price, subsidized or unsubsidized.

Immigration Statuses Retaining Eligibility

Only three categories of lawfully present immigrants will remain eligible for federal premium subsidies and cost-sharing reductions under HR 1:

- Lawful Permanent Residents (LPRs, or "green card" holders)

- Cuban and Haitian Entrants, as defined under federal law

- Compact of Free Association (COFA) migrants (citizens of Micronesia, the Marshall Islands, or Palau residing in the U.S.)

Impact on Covered California Enrollment.

Covered California estimates that approximately 123,000 lawfully present enrollees will lose eligibility for federal financial assistance in 2027 as a result of HR 1. The projected loss of federal premium subsidies for this population is approximately $600 million for plan year 2027 alone. The affected population is concentrated in Southern California, with approximately 60 percent of impacted enrollees residing in that region.

The immigration categories with the largest enrollment include individuals with asylum or pending asylum status and those with work or student visas. Refugees, victims of trafficking, victims of domestic violence, and individuals with other serious crime victim statuses are also anticipated to be impacted.

Medi-Cal & Immigrant Access to Care

Note: Prior to this hearing, the subcommittee requested information from the Administration regarding immigration categories most impacted by the loss of federally-funded full-scope Medi-Cal, along with the methodology underlying the estimated cost of continuing full-scope coverage for this population. That information had not been provided at the time this agenda was published. The Subcommittee may wish to request that DHCS provide this information at the hearing.

Narrowing Qualified Non-Citizen Eligibility: Effective October 1, 2026, HR 1 ends federal full-scope Medicaid funding for the majority of lawfully present immigrants who currently qualify as "qualified non-citizens" for Medi-Cal. The following groups will lose access to federally-funded full-scope Medi-Cal:

- Refugees and asylees

- Victims of human trafficking

- Individuals granted withholding of deportation or removal

- Individuals who received conditional entry

- Individuals paroled into the United States on humanitarian grounds, including Afghans who aided U.S. military operations or people fleeing violence in the Ukrainian war.

DHCS estimates that approximately 200,000 current Medi-Cal members fall into these categories. Under the proposed Governor's Budget 2026-27, these individuals will be transitioned to restricted-scope Medi-Cal, covering emergency services and pregnancy-related care only.

According to the Department, if the state chose to continue providing full-scope Medi-Cal to the 200,000 losing federal eligibility using state-only General Fund dollars, DHCS estimates the cost would be $786 million in 2026-27, growing to approximately $1.1 billion General Fund ongoing.

Immigration Statuses Retaining Eligibility

Only the following immigration statuses will continue to qualify for federally-funded full-scope Medi-Cal:

- Lawful Permanent Residents who have met the five-year bar
- Cuban and Haitian Entrants
- COFA migrants (citizens of Micronesia, the Marshall Islands, or Palau)

Federal Cost-Shifting on Emergency Care: FMAP Reduction. In addition to narrowing eligibility, HR 1 reduces the federal government's share of emergency care costs for adults with Unsatisfactory Immigration Status. Effective October 1, 2026, the federal financial participation for emergency services provided to this population drops from 90 percent to approximately 50 percent.

In practical terms, this means the federal government is shifting a significantly larger share of emergency care costs for this population onto California. DHCS estimates this reduction will result in approximately $658 million in additional General Fund costs in 2026-27 alone.

Applying Work Requirements to UIS Medi-Cal Enrollees. The Administration has indicated it plans to apply work and community engagement requirements to UIS Medi-Cal enrollees in the New Adult Group, in addition to the federally required population. This is a voluntary state policy proposal: because UIS coverage is funded entirely with state dollars, California is not required by federal law to impose work requirements on this population.

DHCS notes in its implementation plan that the Department “expects that verifying such compliance with existing income data sources may be challenging.” Standard automated income data sources, such as state wage records and IRS data, may not reliably capture the work activity of UIS individuals, many of whom work in informal or gig economy jobs. Still, DHCS plans to develop a verification process for UIS individuals that takes into account expected data

verification limitations. If DHCS is unable to verify compliance or exemption from available data sources, DHCS will rely on other available information provided by the individual, similar to existing processes used today to verify income-based eligibility for UIS members.

The state cost of administering work requirements for the UIS population is not yet available.

Panel

- Jessica Altman, Executive Director, Covered California
- Katie Ravel, Director, Policy Eligibility and Research Division, Covered California
- Michelle Baass, Director, Department of Health Care Services
- Tyler Sadwith, Chief Deputy Director & State Medicaid Director, Health Care Programs, Department of Health Care Services
- Yingjia Huang, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- Vanessa Terán, Director of Policy, Mixteco/Indigena Community Organizing Project
- Ana Arenas, Health Program Coordinator, Centro Binacional para el Desarollo Indígena Oaxaqueño
- Angel Coronel, Staff Services Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Min Lee, Economist, Legislative Analyst's Office
- Mark Newton, Deputy Legislative Analyst, Legislative Analyst's Office

Staff Comments

Several of the immigration categories losing Covered California subsidies and federally-funded Medi-Cal represent some of the most vulnerable individuals in California's health coverage system. And in most cases, their immigration status was conferred by the federal government itself. For example, refugees and asylees are granted protection by the United States after meeting a legal threshold of persecution or serious harm; Afghan parolees are granted Special Immigrant Visas for assisting the U.S. military abroad; Victims of human trafficking are granted T-visas for assisting law enforcement with investigation and prosecution of sex and labor trafficking.

The 123,000 Covered California enrollees losing federal financial assistance due to their immigration status represent a potential HCARF question. As discussed in Issue 1, the state has an unobligated HCARF ending balance of $369.4 million projected for 2026-27. One policy option the Subcommittee may wish to explore is whether a portion of those resources could be used to extend state premium assistance to immigrant populations losing federal subsidy eligibility.

Applying work requirements to UIS enrollees will be a voluntary state choice with real costs and unknown benefits. The Administration's proposal to extend work requirements to the state-funded UIS population is not mandated by HR 1. Given that UIS individuals already face significant barriers to data verification, the administrative cost of implementing work requirements for this population, which DHCS has not yet estimated, may be substantial relative to any coverage savings. The Subcommittee may wish to ask DHCS more details about the policy and fiscal consideration of this proposal.

The Subcommittee may wish to ask the following questions:

Regarding Medi-Cal Immigrant Eligibility Changes

1- The Administration estimates that providing full-scope Medi-Cal to the 200,000 Qualified Non-Citizens would cost $786 million General Fund in 2026-27 and $1.1 billion GF ongoing. Can DHCS provide additional details on the cost modeling and how it arrived at this figure?

2- Applying work requirements to Medi-Cal enrollees with Unsatisfactory Immigration Status is a voluntary state policy decision, as California is not required to do enact this change under HR 1. What is the Administration's policy or fiscal rationale for extending work requirements to this population?

3- What is the estimated administrative cost of implementing work requirements for the UIS population, including systems changes and county workload? Has that cost been separately estimated?

4- DHCS notes the technical challenges that will come with implementing income verification for individuals with Unsatisfactory Immigration Status. What verification process is being designed for this population, and how will DHCS ensure that UIS individuals who are compliant are not erroneously disenrolled due to data limitations?

Regarding Covered California Immigrant Eligibility

5- Covered California estimates $600 million in lost APTC for approximately 123,000 impacted enrollees in plan year 2027. What share of those enrollees are expected to remain enrolled at full, unsubsidized cost, and what share are expected to drop coverage entirely?

6- Has the Administration evaluated whether HCARF resources could be used to extend state premium assistance to immigrants losing federal APTC eligibility under HR 1? If so, what is the estimated cost, and are there statutory barriers to doing so?

7- DACA recipients are now excluded from marketplace eligibility entirely. How many current Covered California enrollees are DACA recipients, and what coverage options, if any, remain available to them?

On-the-Ground Perspectives:

The Subcommittee has also invited community-based organizations and health care providers to offer testimony on how these policy changes are affecting the populations they serve. The Subcommittee may wish to ask the following:

8- Many individuals in immigrant communities may qualify for exemptions from work requirements but may face significant barriers, administrative or otherwise, to documenting these exemptions. What are the anticipated barriers, and what would make the verification process more accessible for immigrant communities?

9- Indigenous and migrant farmworker communities often face compounding barriers when interfacing with government entities: for example, seasonal migration across counties, limited English proficiency, indigenous language needs, and limited access to internet or technology for online reporting. How should the state design its outreach and verification systems to account for these realities?

Staff Recommendation:

This item is informational only.

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