H.R. 1 (OBBBA) and Its Impacts in the San Joaquin Valley

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For More Information

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Policy Brief

H.R. 1 (OBBBA) and Its Impacts in the San Joaquin Valley

Introduction

The San Joaquin Valley is one of the nation's leading agricultural regions and is home to numerous industrial sites. Although the region has promising economic prospects in health care and agriculture, it also has a long history of high and persistent poverty, inequitable climate and economic investment, and disinvestment in neighborhoods affected by historical redlining. The region is home to many mixed-status families, people with disabilities, older adults who rely on long-term care facilities, undocumented residents who gained health coverage through Medi-Cal, and families who depend on social services. Fresno and Tulare Counties have experienced persistent poverty from the 1990s through 2019.[1] Most Fresno County residents (51%) rely on public health insurance coverage.[2] Among Fresno County households that receive benefits from the Supplemental Nutrition Assistance Program (SNAP), an estimated 57.3% include at least one child under 18, and 33.6% include at least one adult aged 60 or older.[3] These figures illustrate baseline conditions in Fresno County and neighboring counties across the San Joaquin Valley.

With the passage of H.R. 1, the One Big Beautiful Bill Act (OBBBA), the law's burdens are expected to deepen economic disinvestment for low- and middle-income households. Tulare County, which already has a relatively low median household income of $51,000, is especially vulnerable to reduced access to health care.[4] In addition, the expiration of enhanced federal premium tax credits at the end of 2025, combined with rising use of health care services, is likely to increase medical debt.[5] In the San Joaquin Valley, 41% of residents have some type of medical debt. [6–8]

With a widening income gap and limited access to health care, many residents are expected to rely on emergency departments for primary care. Stricter eligibility requirements will further limit access and are likely to increase preventable hospital stays in counties such as Merced, which already has 3,367 preventable hospital stays per 100,000 Medicare enrollees.[9] Reduced access to care may also increase deaths from treatable conditions. In 2023, Fresno County recorded 1,631 deaths from heart disease, the most of any San Joaquin Valley county.[10,11] As disenrollment increases, mortality may rise further among people who lose comprehensive coverage. Fresno County also recorded the most deaths from malignant neoplasms (cancer) in the region, with 1,416 deaths in 2023.[10,11] Infant mortality may also rise; Madera County has

the highest infant mortality rate in the San Joaquin Valley, at 6.5 deaths per 1,000 live births.[12]

Since H.R. 1 was signed into law in July 2025, federal and state health and social service programs have begun to feel the effects of reduced federal funding. Many of the law's major health provisions do not take effect until late 2026 or later, yet coverage has already declined. Nationally, enrollment in Affordable Care Act (ACA) Marketplace plans fell by about 2.9 million between February 2025 and February 2026, and enrollment in Medicaid and the Children's Health Insurance Program (CHIP) fell by about 5 million between February 2025 and March 2026.[5] Experts attribute most of these early declines to factors other than H.R. 1, chiefly the expiration of enhanced premium tax credits, because most of the law's coverage provisions had not yet taken effect.[5] Those provisions are still expected to have large effects: the Congressional Budget Office projects that the law's Medicaid provisions alone will increase the number of uninsured people nationally by 7.5 million by 2034.[5] As federal funding declines and General Fund obligations grow, families, individuals, and program administrators are learning new, stringent eligibility criteria while administrative capacity shrinks because of funding cuts. Rebuilding safety-net programs for the families and vulnerable populations most affected by these policy changes will take years of sustained investment. The populations described below are expected to experience the greatest impacts for decades to come.

The populations discussed in this brief are working parents, youth, older adults, and mixed-status families. Across these populations, the brief examines H.R. 1's effects on health and full-scope Medi-Cal coverage, CalFresh benefits (California's version of SNAP), housing, and indigent care.

Working Parents

Housing

Many residents throughout the San Joaquin Valley live in inadequate or unaffordable housing. In Fresno County, for example, 28% of renter households already spend more than 50% of their income on housing costs.[13,14] H.R. 1 itself contains few provisions that directly govern federal rental assistance; its principal housing provisions expand the Low-Income Housing Tax Credit. However, separate federal actions and proposals, including Section 8 voucher reforms, time limits on voucher assistance, and freezes on federal grants, are adding new pressures. These changes come amid rising homelessness and housing shortages, which further impact healthcare access. They include additional eligibility requirements, new voucher timelines, and stricter

compliance obligations for renters and landlords, such as proof of employment and expanded documentation, which disproportionately burden low-income households. Reduced federal support has also changed cost-sharing arrangements between federal and local governments, straining local agencies and state budgets without new funding for implementation infrastructure.

Low-income households that cannot meet new eligibility and compliance requirements face a higher risk of eviction, which is likely to increase the number of unhoused residents. Federal grant freezes have created administrative and financial burdens for local agencies, complicating efforts to scale services as federal funding declines. These pressures shift costs to emergency housing, shelters, and health care systems, while local governments face growing service demands with fewer federal resources. The effects could significantly reduce housing stability in places such as Merced County, where nearly 4% of all housing units are subsidized by the US Department of Housing and Urban Development.[14,15]

Policy Recommendations

To ease financial strain on working parents, policymakers should expand federal housing assistance and restore funding for permanent supportive housing. New income-related eligibility restrictions should include hardship waivers. Restoring federal grants to local agencies will be essential, because shared costs help agencies absorb the effects of stricter requirements. Aligning federal timelines with state budget cycles would reduce financial burdens on local governments. Investment in case management, compliance support, and digital literacy programs will help residents understand and meet housing requirements. Implementation funding will also be needed to build local administrative capacity.

Health

In Fresno County, 49.8% of residents rely on public health insurance,as do 50.3% of residents in Kern County and 52.8% in Madera County.[2] These figures include the many working parents who qualify for public coverage. Under H.R. 1, an estimated 1 million to 2 million Californians could be disenrolled from Medi-Cal.[11] Beginning in January 2027, most able-bodied adults aged 19 to 64 who are enrolled through the ACA Medicaid expansion must complete at least 80 hours per month of work, education, or community service to keep their coverage, with some limited exceptions for parents and caregivers.[16] Medi-Cal has never had such a requirement; since the 2014 ACA expansion, eligible adults have been able to enroll without meeting work requirements. A requirement of this kind can create new barriers and hardships.[16] Beginning in March 2027, H.R. 1 also requires Medi-Cal to renew eligibility every six months, rather than

annually, for adults in the expansion population, which can disqualify people who previously qualified and increases the risk that eligible people lose coverage for procedural reasons.[16,17]

Beyond coverage, California faces a significant shortage of health care providers. In the San Joaquin Valley, there is about one primary care physician for every 2,203 residents across the 12 counties.[9] Continued shortages and low reimbursement rates in the Central Valley are expected to widen this gap relative to the rest of California: by 2030, the Central Valley and Central Coast region is projected to face an 18% shortage of primary care clinicians, compared with 10% statewide.[18,19] Provider shortages and low reimbursement rates in the San Joaquin Valley will also widen existing gaps in rural coverage and could destabilize the finances of facilities essential to rural health care. Rural hospital closures would worsen health outcomes overall.[20] The financial strain will fall hardest on the most vulnerable populations, and the San Joaquin Valley is among the most vulnerable regions in California. Kern County, for example, has an HIV prevalence of 331 per 100,000 residents, among the highest in the region.[21] Leading causes of death, such as malignant neoplasms, accounted for 1,416 deaths in Fresno County alone in 2023.[8]

Working parents in these vulnerable areas may lose coverage as a result of federal funding cuts, which directly affect the state General Fund. These cuts may also reduce mental health and substance use services, further straining the health care system. Under the Governor's 2026-27 budget, Medi-Cal General Fund spending is estimated to exceed $47 billion, a decrease of $1.01 billion (-3.4%) over 2025-26.[22,23] Higher prescription drug costs are also expected to increase General Fund spending. Medicare-related payments are growing as well, with Part B premium costs rising 4.8% and Part D "clawback" costs rising 5.2%, and fee-for-service costs have grown each year since 2017-18 (5.4%).[23] For CalFresh, the proposed budget includes increases of $359 million from the General Fund and $143 million in county funds.[24]

Changes in utilization patterns and pressures on rural hospitals are expected to increase emergency department visits and contribute to poorer health outcomes. Many working parents will lose coverage because of stricter eligibility requirements and, for some immigrant adults, California's enrollment freeze. For Marketplace coverage, H.R. 1 narrows eligibility for premium tax credits and requires pre-enrollment verification that effectively ends automatic re-enrollment with subsidies; a separate federal rule shortens the annual open enrollment period.[20] H.R. 1's cost shifts will add to the state's existing structural budget deficits.[23] California uses taxes on health care providers to help pay for Medi-Cal; H.R. 1 restricts these taxes, which will reduce the revenue they generate.[16] H.R. 1 also requires states to impose cost sharing, making care more expensive for

some adults: beginning in October 2028, certain adults with incomes above the federal poverty level may be charged up to $35 per service.[16,25] The new federal rules, together with limits on the tax on commercial health plan enrollment established by Proposition 35, will reduce the size of the Managed Care Organization (MCO) tax.[24,26] Most of the remaining revenue will be directed to Medi-Cal initiatives such as transitional rent supports and community-based mobile crisis services.[24] These investments should help offset harm to people affected by these policies and by medical debt, which is already a burden in the San Joaquin Valley.[6–8]

Policy Recommendations

Given reduced federal spending and its fiscal effects, Central Valley policy objectives should focus on stabilizing access to care in low-capacity areas, which will require strengthening Medi-Cal provider networks and coverage. Local funding could support the expansion of community clinics, pharmacies, and mobile clinics to reduce reliance on emergency departments as a primary source of care. For rural areas, California received $233.6 million for federal fiscal year 2026, its first-year award under the federal Rural Health Transformation Program, a $50 billion, five-year national fund created by H.R. 1.[27] This funding can help relieve pressure on rural hospitals and support the transformation of rural health care. Additional financing models, such as regional pooled social care funds that draw on philanthropic support, could help ensure that care needs are met and reduce the burden on the health care system. Efforts to reduce avoidable utilization should also address upstream cost drivers, including housing instability, nutrition, and transportation. Counties can coordinate oversight with the Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) and strengthen beneficiary education and compliance support.

Bolder policy proposals would include design features addressing financing and governance, delivery and coordination, community access, data and innovation, and evidence-based models of care. Although ambitious, such proposals could reduce systemic burdens on the health care system. For example, a budget trailer bill would help stabilize Medi-Cal by complying with Federal Guidelines, protect the General Fund, and improve health outcomes by addressing cost drivers upstream. By aligning federal and state budgets, funding legal services under the Community Assistance, Recovery, and Empowerment (CARE) Act, and integrating medical and social services, the state could reduce reliance on institutional care, improve equity, and strengthen long-term fiscal sustainability. Legislative oversight is one essential tool to contain costs.[28]

SNAP

Reductions and new restrictions in SNAP will contribute to hunger and food insecurity and are likely to reduce the number of households receiving benefits, which currently include 21.8% of households in Fresno County and 20.2% in Kern County[3,29]. Food banks are likely to see a surge in demand for produce and pantry items. As SNAP eligibility tightens, rising demand will harm working families who rely on social services. Increased food insecurity will also strain local agencies, which are receiving no new funding to respond. Merced County is likely to be among the most affected, as 8% of its residents have limited access to healthy foods, meaning they have low incomes and do not live close to a grocery store.[9] In addition, new work requirements for "able-bodied adults" now apply to people who previously qualified for SNAP without such conditions.[16] About 525,000 CalFresh enrollees can no longer use the Standard Utility Allowance (SUA) in calculating their benefits, which has reduced their monthly benefits by an average of $39.[24] This shift in costs will require the state to set aside emergency funds to reduce hunger in the region. The Governor's budget proposes increases of $359 million from the General Fund and $143 million in county funds for CalFresh.[24]

Policy Recommendations

A collaborative public awareness campaign about evidence-based interventions (EBIs) would help families access EBIs and build lasting trust between families and social service systems. Policymakers should also strengthen SNAP benefits, using evidence-based tools such as the Thrifty Food Plan, and increase incentives for purchasing local produce through programs such as the Gus Schumacher Nutrition Incentive Program (GusNIP). Farmer–food bank partnerships and US Department of Agriculture (USDA) surplus food purchasing should be protected. Greater engagement of agricultural stakeholders would help prevent destabilization of the agricultural system as a whole. To contain costs, it would be beneficial to fund administrative staff who can help individuals understand the requirements for maintaining SNAP benefits and who can provide accessibility and literacy support for documentation. The Governor's budget includes $78.4 million for counties to train county workers on new eligibility criteria, assist with automation, and to help avoid federal penalties tied to payment error rates.[24] With these funds, trained county workers can help prevent disenrollment, which is essential to protecting the most vulnerable residents. Ultimately, working parents will need to worry about more about food access at a time when the cost of food is already high. Approaches to ensure food security in the region will help not only the parents but the entire family thrive.

Youth

SNAP

Poverty remains high and persistent in Fresno County, where an estimated 57.3% of households receiving SNAP include children under 18.[3] An estimated 55.1% of SNAP households in Merced include children under 18.[30] Further reductions and restrictions in SNAP under H.R. 1 would likely worsen food environments in the region. Merced County has one of the lowest scores in the region on the County Health Rankings Food Environment Index (7.1, on a scale from 0 [worst] to 10 [best]).[20] Youth in Merced County would be especially affected, because many students there are eligible for, and use, free or reduced-price school meals.[31]

Policy Recommendations

A collaborative public awareness campaign about evidence-based interventions (EBIs) would help families access EBIs and build lasting trust between families and social service systems. Policymakers should also strengthen SNAP benefits, using evidence-based tools such as the Thrifty Food Plan, and increase incentives for purchasing local produce through programs such as GusNIP. Farmer–food bank partnerships and USDA surplus food purchasing should be protected. Greater engagement of agricultural stakeholders would help prevent destabilization of the agricultural system as a whole. Policymakers should also expand medically tailored meals and nutrition incentive programs and strengthen SNAP Education (SNAP-Ed) and other community-based nutrition education, which would also lessen the burden on food banks. To contain costs, it would be beneficial to fund administrative staff who can help individuals understand the requirements for maintaining SNAP benefits and who can provide accessibility and literacy support for documentation.

Health

H.R. 1 is expected to reduce behavioral health services for youth. Although the law created a $50 billion Rural Health Transformation Program, those funds are spread across all 50 states over five years and may not offset statewide reductions.[27] In Madera County, 29% of youth report behavioral risk factors related to alcohol or drug use.[32]

Young adults aged 19 and older will also have to meet the community engagement requirement to keep Medi-Cal coverage, yet young people face some of the greatest barriers to employment.[33] According to the Employment Policies Institute, California has the highest unemployment rate in the nation for teens aged 16 to 19.[33] Even among young adults aged 20 to 24, the unemployment rate was 9% as of June 2026.[34] Although

many young adults can meet the requirement through school enrollment, those who lose coverage for procedural reasons will face hurdles in navigating re-enrollment and restarting care. Young workers will also feel increases in Covered California premiums more acutely, because the median wage for workers aged 16 to 19 is $19.00 per hour, compared with $30.00 per hour for workers aged 30 and older.[35]

Undocumented Youth

Over half of California workers are immigrants or children of immigrants.[25] Undocumented Californians paid an estimated $8.5 billion in state and local taxes in 2022.[36] According to Kitson, these contributions include "sales and excise taxes paid on purchases, the property taxes paid on homes or indirectly through rents, individual and business income taxes, unemployment taxes, and other types of taxes."[36] These contributions help support public services and infrastructure that benefit all Californians, including roads, transit, emergency preparedness and response, and safety-net programs such as social services and Medi-Cal.[36]

Since January 1, 2026, California has frozen new enrollment in full-scope Medi-Cal for adults aged 19 and older with unsatisfactory immigration status (UIS); children under 19 remain eligible regardless of immigration status; those youth with UIS will be moved to a fee-for-service plan starting January 1, 2027. Beginning July 1, 2027, adults aged 19 and older with UIS who remain enrolled lost coverage for nonemergency dental care, although emergency dental services remain covered for everyone.[37] Separately, H.R. 1 restricts eligibility for Medicare, Medicaid, and CHIP for certain lawfully present immigrants, including refugees, asylees, and some survivors of domestic violence and human trafficking.[25] The law also bars certain lawfully present immigrants from receiving the premium subsidies that help people afford coverage through Covered California.[25]

Foster Youth

Children under 19, pregnant individuals through one year after the end of pregnancy, and current and former foster youth under age 26 who were in foster care on their 18th birthday are exempt from California's enrollment freeze and dental changes and keep full-scope Medi-Cal regardless of immigration status.[37]

Policy Recommendations

Community health worker (CHW) infrastructure offers a model for strengthening the local workforce, creating career opportunities for youth, and building financial stability. Philanthropic investment can help sustain the community health workforce. Household-based community health models have benefited communities in other

countries; Partners In Health's household model, for example, assigns CHWs to households rather than to individual patients in Liberia, Malawi, and Mexico.[38] A similar approach could work in the San Joaquin Valley. Alongside CHWs, mobile clinics are essential for youth, including undocumented youth, who lack coverage or immigration protections, because mobile clinics do not require patients to report immigration status or show proof of coverage. These models can ease the burden on emergency departments, reduce wait times, and lower overall costs. To ensure sustainability, the state should increase General Fund support and align local funds with state budgets to provide care for undocumented youth who cannot afford higher premiums. Advocates should also ensure that personal data are protected and are not shared with US Immigration and Customs Enforcement (ICE).

Additional funding is needed for dental coverage, because adults aged 19 and older with UIS no longer receive full-scope Medi-Cal dental benefits. Although emergency dental care remains covered for everyone, routine preventive visits are no longer covered for this group.[37] Continued advocacy is needed to remove barriers, exclusionary practices, and causes of disenrollment, which will otherwise worsen health outcomes.

Evidence-based interventions such as SafeCare can improve child welfare outcomes, but they require sustained investment.[39] Multiyear funding cycles promote success by ensuring stability and minimizing funding disruptions; these factors have enabled agencies to sustain SafeCare.[39] To reduce financial strain on community-based organizations (CBOs), funders should revise fee-for-service and performance-based payment models that impose undue costs on CBOs and should introduce stabilization or contingency funds for CBOs that implement EBIs. Market-driven contracts can undermine the maintenance of EBIs and shift financial burdens to CBOs.[39] Successful implementation also requires cross-agency teams, including funders, administrators, CBO leaders, CHWs, executives, supervisors, and frontline staff, to work together. Such teams support accessible care and clear communication across agencies and organizational levels. CBO leaders work at the forefront of their communities, and their staff will need training and support. Hiring multicultural staff with diverse lived experiences strengthens these efforts, and equitable leadership will hire and train staff to communicate effectively and connect residents to safety-net services. CHWs are a key link in health care: they are certified in alignment with DHCS standards and can communicate across cultures to support prevention and help people navigate care. Sustaining this workforce will require reimbursement rates that cover indirect costs, including annual training, to prevent staff turnover. Investment in CBO capacity building will help ensure that funding supports ongoing training and strengthens CBOs' financial management.[39]

Older Adults

Long-Term Care and Long-Term Care Facilities

Given H.R. 1's effects and the number of people who could lose coverage, long-term care benefits under California Advancing and Innovating Medi-Cal (CalAIM) can help support people with disabilities. However, many remain at risk of disenrollment. CalAIM expanded in 2026 to cover more long-term services and supports, including enhanced care management for older adults with complex conditions; expanded community-based services that prevent nursing home placement; housing supports for chronically unhoused older adults; sobering centers and respite care for family caregivers; and more extensive in-home medical equipment and home modifications.[40] These supports are needed. In San Joaquin County, Black/African American residents have the highest disability rate (12%) of any racial or ethnic group.[41] In Tulare and Merced Counties, 24% of residents report fair or poor health.[9] These counties will benefit from the continuous, streamlined enrollment initiated through CalAIM, which will help mitigate poor health outcomes.

However, California reinstated a Medi-Cal asset limit for older adults and people with disabilities on January 1, 2026, at $130,000 for an individual plus $65,000 for each additional household member, the same limit in effect from July 2022 through December 2023.[42] Asset limits are likely to reduce caseloads and increase disenrollment among people living with chronic conditions or disabilities and among older adults whose assets are near the threshold. In addition, H.R. 1 delays until 2034 the minimum staffing standards in a 2024 federal nursing home rule, which was intended to address unsafe staffing ratios in nursing and long-term care facilities.[25] Delaying these standards may perpetuate unsafe conditions that put older adults and people with disabilities at risk. In addition, undocumented adults age 60 and older will only have access to restricted Medi-Cal, with no preventative dental care coverage.[37]

Policy Recommendations

As 2027 approaches, strengthening General Fund support will be essential to protect coverage for older adults, people with disabilities, undocumented older adults, and residents of long-term care facilities. Although CalAIM provides waiver-based long-term care services, these services depend on federal waiver renewals and federal funds. Policy advocates across health sectors therefore have a key role in supporting people at risk of disenrollment. Local funds could also support prevention and care, such as mobile clinics and transportation access, and help ensure that In-Home Supportive Services (IHSS) remain accessible to people who need help to live safely at home. These investments will help close coverage gaps. Local funding for administrative staff

could help people with low literacy or low digital literacy maintain enrollment. As asset limits tighten, appeals may become more common, and some older adults may lose access to care; administrative staff could help older adults and facility residents through the appeals process and keep them enrolled in Medi-Cal, preventing gaps in coverage.[40]

SNAP

CalFresh provides federally funded food assistance to about 5.4 million low-income Californians, including older adults.[16] By 2050, the older adult population is projected to increase in San Joaquin Counties, while already making up as much as 20% in counties like Madera,[43] and many of these residents are likely to need SNAP. An estimated 72,000 CalFresh enrollees are expected to lose benefits because H.R. 1 narrows eligibility for certain lawfully present noncitizens, including refugees, asylees, and trafficking victims.[16] The federal government currently covers 50% of CalFresh administrative costs, with the state and counties covering the remaining 50%. Beginning in October 2026, H.R. 1 reduces the federal share to 25%, increasing ongoing annual costs by approximately $480 million for the state General Fund and $190 million for counties.[16,24] Beginning in October 2027, H.R. 1 also requires states with SNAP payment error rates of 6% or higher to pay part of the cost of benefits. California's most recent error rate was nearly 11%; if that rate continues, the state would pay the maximum share (15%), approximately $2 billion in new annual General Fund costs.[16] These cost shifts will increase state spending even as many residents lose SNAP benefits. The full impacts of the H.R.1 SNAP changes, and how they will impact older adults in the region, have yet to be fully understood. However, we do know that the limits in resources coming into the San Joaquin Valley region will be diminished, and the limits of cost of food adjustments in benefits to only account for inflation will ultimately impact older adults.

Policy Recommendations

As many as 72,000 Californians may lose CalFresh benefits under these new rules.[16] Although General Fund support is important to maintain, these funds are likely to be strained for years to come. Increasing funding for food banks will help prevent further food insecurity in San Joaquin Valley counties. Counties play a key administrative role for Medi-Cal, CalFresh, and other health and human services programs.[23] County administration of programs such as the California Work Opportunity and Responsibility to Kids (CalWORKs) program, which provides cash assistance to families with children, and IHSS is a key part of the safety net; well-supported county administration helps ensure that older adults, people with disabilities, and other dependents continue to receive SNAP benefits. County administrators will need to review eligibility and ensure that people enrolled before the new rules took effect continue to receive the benefits for

which they remain eligible. Continued state funding is necessary for this county work. Counties currently pay 15% of CalFresh administrative costs, a share that will rise to 22.5% in October 2026.[16] These expenditures may exceed county budgets, but counties will ultimately be responsible for ensuring that these populations are not overlooked.

Health

Because of a shifting fiscal and policy landscape, approximately 1 million people could disenroll or exit from Medi-Cal.[42] According to the Legislative Analyst's Office, "coverage for seniors is around three times the cost of families and children."[24] Beginning in January 2027, adults aged 19 to 64 in the expansion population, including older adults aged 50 to 64, must complete 80 hours per month of work, education, or community service to keep their coverage; adults aged 65 and older are exempt, but are subject to the asset limits. This requirement is estimated to apply to about 3.5 million people and could result in the disenrollment of 1 million to 2 million.[16] These policies are likely to worsen health outcomes, particularly in Madera and Tulare Counties, where 24% of residents report fair or poor health.[9] Although many adults younger and older than 65 continue to work or have retired, gaps in community safety-net funding and mobile clinics leave many uninsured. Madera County has the highest uninsured rate in the San Joaquin Valley, at 11%.[9] An estimated 200,000 lawfully present noncitizens enrolled in Medi-Cal, such as refugees and asylees, are expected to lose federally funded coverage because of narrowed eligibility.[16] Under the reinstated asset limit of $130,000 for an individual and $65,000 for each additional household member, some older adults with assets near the threshold, including undocumented older adults, may also lose coverage. Disenrollment in 2027 will add to the growing uninsured population in the San Joaquin Valley.

Undocumented older adults who were enrolled in full-scope Medi-Cal before January 1, 2026, may keep that coverage but must renew it each year to avoid disenrollment. Undocumented adults who apply on or after that date cannot enroll in full-scope Medi-Cal.[37] H.R. 1 also eliminated premium tax credits, beginning in January 2026, for lawfully present immigrants with incomes below the poverty line who are ineligible for Medicaid because of their immigration status.[25] Eligibility restrictions are especially harmful to undocumented residents, who pay taxes at the federal, state, and local levels.[44] Nationwide, undocumented immigrants paid an estimated $97 billion in taxes in 2022.[44] For uninsured undocumented residents, the remaining options are emergency services and safety-net providers such as mobile clinics.

Policy Recommendations

Several policy actions would help older adults and people with disabilities. Now that asset limits have returned, state and local agencies must coordinate to ensure that uninsured residents receive care. Cross-agency coordination would help remove barriers for people who lose coverage. Counties are responsible for providing indigent health care services to individuals with no other coverage; although such coverage is generally less comprehensive than Medi-Cal, it can cover some health care costs.[16] Additional General Fund support will be needed to sustain state and county infrastructure.[16] Legislative oversight will be crucial during implementation, and local legislation can strengthen oversight and increase funding for county indigent care programs. Hospital community benefits programs can be instrumental in filling in the gaps, as some have already identified through their community health needs assessment (CHNA) processes.[45] These mechanisms could also help preserve dental coverage. Because undocumented adults have lost full-scope dental coverage, only restricted-scope emergency dental coverage is available to them. These coverage changes are expected to reduce General Fund spending by $336 million.[25] Legislative oversight will also be needed to ensure that local efforts remain consistent with federal Medicaid law, which may narrow as federal policy changes.

Mixed-Status Families

Indigent Care

Federal funding cuts, rising costs in Medicaid and Medicare, the loss of enhanced premium tax credits, and structural barriers all affect mixed-status families. State budget deficits will place additional strain on counties. As people are disenrolled and lose Medi-Cal benefits, demand will grow for indigent health care, which counties are responsible for providing.[24] Ensuring equitable care for people who lose full-scope coverage remains a central concern. The Health Subaccount of county realignment funding currently provides about $1 billion that supports county health services; however, after the ACA expansion reduced counties' indigent care costs, the state redirected much of this funding to offset General Fund costs in other programs.[46]

Policy Recommendations

Policymakers should ensure that ACA consumer protections are fully preserved so that the most vulnerable populations, including those who will rely on indigent care, continue to receive Medicaid benefits. Safeguarding the stability of Medicaid funding would help prevent coverage loss. The Legislature will need to weigh the benefits of any additional funding; such funding could support trusted community health workers who help with

prevention and assist families in navigating a complex and fragile health care system. The state could also allocate more funding to counties. Counties can design indigent care programs that prioritize prevention, primary care, continuity of care, and administrative policies that help residents receive adequate care regardless of insurance status.[28] Before the 2022 Medi-Cal expansion, many undocumented adults received care through safety-net hospital emergency rooms and community-based clinics that provided primary and pregnancy care.[47] Income thresholds for indigent care should be set county by county and designed so that income does not become a barrier to receiving care. Counties have the flexibility to set program eligibility and benefits so that residents can continue to receive health care.[46] Although many Californians are concerned about tax increases, and state law limits the local taxes counties may impose,[46] a modest local tax increase could expand funding for indigent care.

Health

For mixed-status families, county and community health workers can play an important role in helping California residents who were enrolled in full-scope Medi-Cal before 2026 avoid disenrollment. The State's enacted 2026-2027 budget will shift individuals with UIS to a fee-for-service model, reducing General Fund spending by $60 million in 2026-27, and ramping up to an estimated $3 billion in 2029-30[24] Restrictions on the MCO tax and the Hospital Quality Assurance Fee will cost the General Fund an estimated $650 million in 2026-27, with costs projected to grow in future years.[16] Beginning October 1, 2026, H.R. 1 eliminates federal funding for full-scope Medicaid coverage for refugees, asylees, and battered noncitizens, among others.[23] The Governor's budget also estimated General Fund savings of about $102 million in 2026-27 and coverage losses of up to 1.4 million people by June 2028.[23] The new six-month renewal requirement was projected to result in 289,000 fewer enrollees by June 2027 and 400,000 fewer by June 2028, reducing General Fund spending by $74 million in 2026-27, exact impacts with the transition to fee-for-service are still unclear.[17,23]

Policy Recommendations

One key recommendation concerns the income threshold for state-funded full-scope coverage: adjusting it would help families as the cost of living and inflation rise.[23] Although indigent care will supplement coverage for mixed-status families, the state budget could expand indigent care benefits to more closely match comprehensive coverage, including primary care, outpatient services, and generic prescription drugs for people with serious health needs.[23,28] For families who may rely on indigent care after losing full-scope coverage, CHWs and automated eligibility verification that allows people to enroll automatically would be beneficial.[28] Making health care affordable for

all Californians is essential; an estimated 25 cents of every health care dollar is lost to administrative complexity and incompatible data systems.[48] State funding is essential to sustain eligibility for undocumented residents, whom federal rules exclude.[47] As noted in the indigent care recommendations, income thresholds should not become a barrier to care. Undocumented older adults will feel particular strain because, although many have paid Social Security taxes, they are ineligible for Social Security benefits and therefore rely on state and local health care options.[44] More mobile clinics are needed to provide prevention and primary care. Training for county eligibility workers and CHWs is necessary to help undocumented residents enroll and stay enrolled in the coverage for which they remain eligible.

Conclusion

Ensuring that the San Joaquin Valley has a sustainable system of care that is comprehensive and responsive to geographic and demographic needs is critical for the vitality of the region. H.R.1 will make it more difficult to finance and access care, which will lead to costlier care that might not be covered, further increasing the burden on our already strained system. Sustaining full-scope Medi-Cal coverage and CalFresh benefits should be a regional priority, but it will require substantial public investment. The strategies outlined in this brief can help reduce the impact on vulnerable populations. State policy will require additional General Fund support to compensate for federal restrictions, and local action will be needed to direct funding to community-based organizations, mobile clinics, community health workers, and educational pathways that use evidence-based approaches and to give administrative agencies the capacity to help residents navigate health care, housing, and food access. Counties can model indigent care programs on ACA coverage to help ensure that all residents, regardless of immigration status, can receive care. County policies can also expand indigent care so that existing health disparities in the San Joaquin Valley do not worsen. County funding models should allow eligibility to be reviewed case by case, and work alongside other structures outside of county direct funds to ensure healthcare is being delivered to those left out of federally eligible compensated care. County eligibility workers and CHWs can review applications, explain stringent eligibility requirements, and help residents with low literacy complete automated verification and renewal processes for full-scope Medi-Cal. Local tax revenue can help offset financial strain and the effects of federal and state deficits. Together, these recommendations can protect the most vulnerable residents. Strengthening local governance will be essential to ensure that funds are allocated across key sectors, including benefits, behavioral health, coverage through evidence-based clinics, managed care plans, and housing, so that health inequities across the San Joaquin Valley do not grow. Achieving these goals will require

collaboration across all sectors so that youth, including undocumented and foster youth; older adults; working families; undocumented residents; and mixed-status families can live with dignity.

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