Federal Changes: H.R. 1

How the One Big Beautiful Bill Act (Public Law 119-21) changes who qualifies for coverage and who pays for it



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Health Policy Is Always in Flux. Why Is Now Different?

Federal health policy has shifted from coverage expansion to federal cost reduction through budget reconciliation (H.R. 1 / P.L. 119-21).

The savings don’t disappear. The costs shift:



Two tracks moving at once

Eligibility rules

New rules for who qualifies for coverage

Financing rules

New rules for who pays for coverage

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

H.R. 1 Changes Two Things at Once

Who qualifies for coverage, and who pays for it. Every provision below follows from one of those two mechanisms.

≈$1 trillion

projected federal Medicaid reduction over the ten-year budget window

01 ELIGIBILITY

80 hours a month

Expansion-group adults must document work, community service, a work program, half-time school, or $580 in monthly income. Exemptions are broad on paper; verification is where coverage is actually lost.

By Dec. 31, 2026 · Sec. 71119

02 FINANCING

Fewer tools to pay

Provider tax limits narrow how states raise the non-federal share, the enhanced match for emergency Medicaid ends, and cost sharing of up to $35 per service begins for certain adults.

Starts Oct. 2026 · $35 by Oct. 2028

03 COVERAGE PATHWAYS

Narrower doors

Shorter marketplace open enrollment, no automatic re-enrollment, and narrower premium tax credit eligibility, including restrictions that reach lawfully present immigrants.

Phased 2026–2027

04 FOOD ASSISTANCE

A parallel track

SNAP time limits extend to adults 18–64 and to caretakers, veterans, former foster youth, and people experiencing homelessness. States absorb 75% of administrative costs.

Oct. 1, 2026 → Oct. 1, 2027

05 REINVESTMENT

$50B, time-limited

The Rural Health Transformation Program funds access, workforce, telehealth, efficiency, and payment reform in all 50 states: a five-year overlay, not a permanent stream.

FY 2026–2030 · CA = $233M

WHERE IT LANDS IN CALIFORNIA

1.4M
Medi-Cal members projected to lose coverage statewide by June 2028

2.79M
enrollees who cannot be auto-verified and must file documentation themselves

$685M
annual CalFresh administrative cost shifting onto state and county budgets

22
counties eligible for the high-unemployment exemption, Fresno and Kern among them

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

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How H.R. 1 Reduces Federal Exposure

Medicare (Title XVIII) and Medicaid (Title XIX) are mandatory entitlements, and mandatory health spending now exceeds all discretionary spending.

H.R. 1 reduces federal exposure three ways



Tightening eligibility



Limiting provider taxes



Changing match formulas



Structures intact, funding reduced

Critical access hospital (CAH) and disproportionate share hospital (DSH) payments for rural and high-poverty hospitals, along with rural add-ons, remain in statute. The funding behind them is reduced, so the impact is still unknown.

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

Eligibility: The 80-Hour Requirement

80 hours

per month for the New Adult Group (Affordable Care Act expansion enrollees not in a protected category)

Dec. 31, 2026

effective no later than this date (Sec. 71119)

30 days

to correct noncompliance after a notice is received

What qualifies

- 80+ hours of work, community service, or a work program
- Half-time school enrollment
- Income of at least $580 per month
- Any combination of these

Mandatory exemptions: broad on paper

Aged, blind, or disabled (including SSI recipients); medically frail; pregnant or postpartum; foster youth; children under 19; caregivers of children 13 and under; American Indians and Alaska Natives (AI/AN); veterans with a total disability rating; people recently incarcerated; and TANF or SNAP work program participants.

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

Financing: Fewer Tools to Pay

Provider tax limits

Provider taxes generate the revenue states use to draw down federal matching dollars. New limits constrain how states raise the non-federal share; new taxes and rate increases are banned.

Emergency Medicaid match

Effective Oct. 1, 2026, the federal match for emergency Medicaid for people who would be expansion-eligible except for immigration status drops from 90% to the state's regular rate (often 50%). California's General Fund covers the rest.

Cost sharing

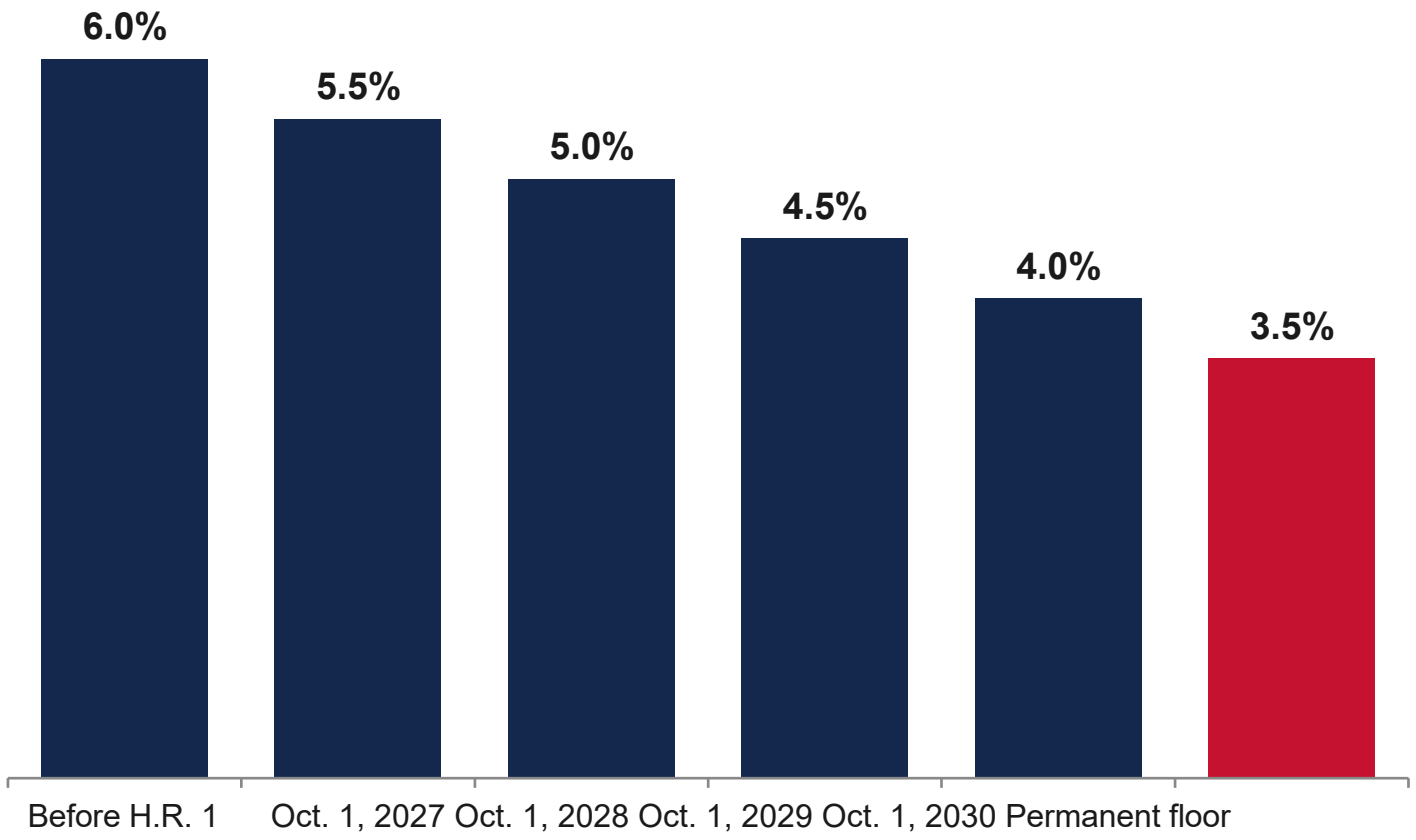
New mandatory cost sharing of up to $35 per service for certain adults, beginning October 2028.

California's exposure: H.R. 1 strips an estimated $30 billion in annual federal funding from the $216.7 billion Medi-Cal program, placing severe pressure on the state's General Fund.

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

The Provider Tax Phase-Down

For Medicaid expansion states like California, the maximum allowable provider tax rate (the “safe harbor,” as a share of net patient revenue) steps down each year.



Freeze on new taxes

New provider taxes and increases to existing rates are prohibited. Rates in place as of July 4, 2025, are grandfathered.

What’s at risk

California’s Managed Care Organization (MCO) tax must be restructured, and the cap threatens funding mechanisms like the Hospital Quality Assurance Fee.

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

How SNAP Benefits Are Also Changing

Jul. 4, 2025

Internet costs no longer deductible

Lowers benefit amounts

Oct. 1, 2025

Thrifty Food Plan restricted

Benefits adjust to inflation only; SNAP nutrition education (SNAP-Ed) eliminated

Nov. 1, 2025

Utility allowance limited

18,000 lose full benefits; 444,000 reduced

Feb. 1, 2026

Waivers need 10%+ unemployment

~359,000 adults at risk; $814M a year

Apr. 1, 2026

Immigrant eligibility narrowed

~74,000 lawfully present Californians lose access

Jun. 1, 2026

Time limits reach new groups

Ages 18–64, veterans, foster youth, unhoused; ~303,000 adults

Oct. 1, 2026

States pay 75% of admin costs

$685M a year: $474M General Fund, $211M county

Oct. 1, 2027

Further federal pullback

Error tolerance drops to $0; benefit costs partly shift to states

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

State Changes Due to H.R. 1

Medi-Cal

Federal funds are over half of total financing; an estimated $30 billion a year in federal funding is lost.

MCO tax revenue

Falls from $7.9B (FY 2024–25) to $3.3B (FY 2026–27), partly from Prop 35 commercial enrollment limits.

Counties

Absorb eligibility administration and indigent care.

Rural hospitals

~$123M in state relief (Small and Rural Hospital Relief and the Distressed Hospital Loan Program); counties must apply.

Providers and households

Uncompensated care rises, emergency departments become primary care, and low-margin service lines close first in places like San Joaquin Valley counties.

Rural Health Transformation

California receives $233M from a $50B, five-year federal program (FY 2026–2030).

Sources: P.L. 119-21 · CMS-2454-IFC · California LAO · DHCS · California Budget & Policy Center

Sources

1. Public Law 119-21 (H.R. 1, the One Big Beautiful Bill Act).
2. Centers for Medicare & Medicaid Services. CMS-2454-IFC: Medicaid community engagement interim final rule.
3. California Legislative Analyst's Office (LAO).
4. California Department of Health Care Services (DHCS).
5. California Budget & Policy Center.