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H.R. 1 State Budget Impacts – Updates for Aging and Disability Advocates

Webinar Transcript

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Yasmin Peled: Hello everyone, and welcome to today's webinar presentation, Medicaid Cuts in H.R. 1, Updates for Aging Advocates in California.

I'm Yasmin Peled, director of California Government Affairs here at Justice in Aging, and today I'm joined by my colleagues Tiffany Huyenh-Cho, director of California Medicare and Medicaid Integration, and Hagar Dickman, director of California LTSS Advocacy.

Before we begin, I would like to go over a few webinar logistics. You are all on mute, but we welcome your participation in today's presentation through the Q&A function in the Zoom control panel. Also available in the Zoom control panel is the closed captioning button, which enables closed captioning.

I'll be watching the participant questions as they come in throughout the webinar and I'll uplift high-level themes during the Q&A segment at the end of today's presentation. Any questions unanswered in today's webinar will be addressed in email following the conclusion of this presentation. You can also use the Q&A function to request technical assistance with Zoom and our staff will do our best to assist you.

This webinar is being recorded, and after the conclusion of this webinar, the slides and recording of today's presentation will be available on our website and will be emailed to all registrants. We would also appreciate your participation in our post-webinar survey that will pop up on your screen following the close of the webinar. Thank you again for joining today.

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources.

Justice in Aging is committed to advancing justice in aging. We must ensure that everyone has access to what they need as they age without discrimination and regardless of race, gender, gender identity, sexual orientation, ability, language, or country of origin. We push for policies that will ensure that those experiencing the greatest barriers to economic security, healthcare, and housing can exercise their rights and fully access the services and programs that they need.

Justice in Aging provides a wealth of information, like the webinar you are viewing today, along with fact sheets, issue briefs, alerts, and other materials to keep you up-to-date with important developments. If you're not already a member of our network, we encourage you to join by going to our website and signing up, or you can also send an email to info@justiceinaging.org.

Thank you for sticking with us through that background information. For today's webinar, here's our agenda. In a moment, I will turn it over to my colleagues to provide an overview of the changes to Medicaid and Medicare in H.R. 1 and the potential impact here in California. We'll then discuss advocacy tips for mitigating harm. We'll provide a brief overview of policy changes in the California state budget. We'll share some of Justice in Aging's resources and then we will have time for questions. And again, please use the Q&A function in Zoom to ask any questions.

Before we dive into the H.R. 1 overview, I'm just going to take a minute to review how critical Medi-Cal is here in California. There are more than 2.4 million older adults and people with disabilities who rely on Medi-Cal here in California, and we receive $112 billion in federal Medicaid funding for the Medi-Cal program.

There are also millions more older adults and people with disabilities who are insured through the ACA's Medicaid expansion. So these are people between the ages of 19 and 64 that gained access to Medicaid through the ACA expansion, and there are over 5 million adults in this population.

And finally, Medicaid is a very broad program. It covers more than just traditional Medicaid's medical services. Notably, home and community-based services are almost entirely funded through Medicaid. Also, nursing facility care is funded through Medicaid, as well as non-emergency medical transportation and the financial assistance that Medicare beneficiaries need who are duly enrolled in Medicaid.

So now I'm going to turn it over to my colleague Hagar Dickman to walk us through an overview of H.R. 1.

Hagar Dickman: Thanks, Yasmin. Good morning. My name is Hagar Dickman. I'm director of California LTSS Advocacy at Justice in Aging, and I use she/her pronouns. I'm going to start us off talking about some background on H.R. 1 and its impact on California's Medi-Cal program.

H.R. 1 is a budget reconciliation bill that passed Congress on July 3rd with only Republican votes, and it was signed by the president into law on July 4th. The bill was previously named the One Big Beautiful Bill Act, but the name was actually removed just before it was passed. And so we will be referring to it as the Budget Reconciliation Act of 2025 or H.R. 1 for short.

H.R. 1 makes the largest cuts to Medicaid in the program's 60-year history, about $990 billion. So that's almost a trillion dollars in cuts according to the official score from the Congressional Budget Office. It's nearly four times as large as any previous Medicaid cut in the program's history. And when you add to it the Medicare cuts and cuts to Affordable Care Act and H.R. 1, the total is well over a trillion dollars in cuts to healthcare.

The impact of H.R. 1 can also be measured based on how many people will lose access to health care. H.R. 1 is expected to terminate coverage for at least 10 million people nationwide, and most of those are people who are Medicaid enrollees. And in California, the Department of Healthcare Services estimated that H.R. 1 will cause approximately 4 million people to lose their health insurance in the state. 3.4 million of those individuals are from Medi-Cal alone.

Congress also made additional changes to the Affordable Care Act including failing to extend enhanced premium tax credits in this bill, which means that in 2026, at the beginning of the year and actually even this fall, as people are looking to enroll in the Affordable Care Act marketplace plans, those premiums are going to really be spiking if Congress does not extend the enhanced premium tax credits and makes those plans too expensive and unaffordable for many Californians. Cuts and changes to the Affordable Care Act are estimated to result in an additional 660,000 people losing their healthcare. Next slide.

In terms of the big picture of how these cuts will result in coverage termination, H.R. 1 cuts federal Medicaid funding and shifts costs to states. Because Medi-Cal is a cost sharing program between the federal and the state government, any loss of funding from the federal government will force California to cut spending, which the state can do through cutting Medi-Cal services, reducing eligibility to the program, or cutting provider reimbursement rates. And most likely the state will need to resort to a combination of these cuts.

H.R. 1 also increases barriers to accessing Medi-Cal, for example, through imposing work requirements and more frequent redeterminations, which we'll talk more about in greater detail later on. And it also directly terminates eligibility for Medi-Cal, Medi-Care, and the Affordable Care Act tax credits for many lawfully present immigrants. In October of 2026, many immigrants will

have Medi-Cal terminated and they will no longer be eligible for the Affordable Care Act premium tax credit at that point.

Now that I've given a general overview of H.R. 1 impacts, we're going to go into some specific changes in the law and how they impact older Medi-Cal members. As I just mentioned, Medicaid is a cost sharing program. So California pays for Medi-Cal services it delivers, and then it requests reimbursement from the federal government for the federal share.

H.R. 1 restricts California's ability to fund its share of Medi-Cal costs by freezing and reducing provider and insurer taxes. These taxes are something that every state, except for Alaska, uses to help fund their share of Medicaid. And they're really important because states need to spend their own money first before they can receive reimbursement from the federal government.

So the federal match, known as the FMAP, kicks in after states spends its own money. If California has less of our own money to spend, we'll also be getting less in federal reimbursement. And finally, H.R. 1 also reduces the federal match for emergency Medi-Cal services provided to adults who are ineligible for Medicaid due to immigration status.

I want to just provide a little bit more detail on these restrictions on provider and insurer taxes which impact state revenues in a couple of ways. First, the law is prohibiting all states from establishing new provider taxes or increasing existing taxes. For Medicaid expansion states like California, the law lowers the limits for these taxes from 6% to %3.5 of provider revenues by 2032, which effectively acts as a cap on how much revenue the state can raise through these taxes.

In a state like California that's an expansion state, using the 6% tax, this cuts the revenue in nearly one-half. To make things more marquee, California's managed care tax is also out of compliance and the state will need to work on coming into compliance, which will be difficult to do while maintaining the same revenue level. In addition, taxes on nursing facilities are subject to a freeze, so states cannot implement new taxes on nursing facilities. But for states that have taxes up to the 6% threshold, they can keep those taxes.

There's another section of the law that also restricts state-directed payments. Directed payments are tools that states use to increase Medi-Cal providers in certain specialties as an incentive and especially to address shortages of those providers. Restricting California's ability to use directed payments will also restrict the ability of the state to address provider shortages in areas of the state. Next slide please.

H.R. 1 undermines the Medicaid program in several ways, especially by putting significant financial pressures on the state. For example, forcing the state to put in place work requirements will add significant cost to California throughout the

implementation and also in actually enforcement of work requirements. Cal-Fresh costs will also increase for the state, and at the same time, American Rescue Plan Act funds are wrapping up.

So the reduction in federal matching together with increased costs imposed by H.R. 1 administrative requirements and with reduced revenue streams that are also imposed by H.R. 1 will all force California to make some very difficult decisions about how to fill the resulting enormous holes in the budget. States have to balance their budgets and Medicaid is one of the biggest line items in most state budgets. So that means they're really forced to cut benefits enrollment or provider payments, and we'll likely cut a combination of those. And California may look to save Medi-Cal costs generally through cutting either enrollment or cutting services.

The easiest thing for the state to do is actually to cut optional services and optional eligibility categories to reduce the number of people receiving services and by reducing provider rates. A lot of programs that older adults and people with disabilities rely on every day are actually optional under federal law. They're not mandatory for states to provide. And these optional services include home and community-based services, things like dental, vision, and hearing that Medicare doesn't cover. And it also includes optional eligibility pathways that benefit older adults, such as the Working Disabled Program or Share of Cost to Medi-Cal eligibility.

Covering immigrants with state only funding is also optional. California has already frozen new enrollment for undocumented immigrants because of last year's tight budget year, and we'll discuss that in a bit. And then in terms of other cuts to enrollment, states that have expanded their age and disabled eligibility or eligibility for their Medicare savings program might choose to also roll that eligibility to the federal minimum.

For example, California expanded eligibility to people with income up to 138% of the federal poverty rate, but may choose to reduce that income level in order to serve less people and save on money. With less money coming in, California may also look to cutting Medi-Cal provider rates. This will certainly worsen what's already in existing direct care workforce shortage and make it harder for older adults to access long-term care. Next slide.

During tough budget years, home and community-based services are particularly at risk because they account for over half of all optional spending and almost a third of all Medicaid spending. And we know from history that HCBS or home and community-based services are cut when Medicaid funding is cut or when state budgets are tight. We have some examples here of times when California older adults and people with disabilities have faced threats to HCBS cuts, including in the most recent governor's proposed budget in May, which suggested putting caps on overtime pay for IHSS providers, which is a

type of a provider rate cut on 2024, when the proposed budget included cutting IHSS access for undocumented Medi-Cal members.

And I do want to take a small pause here, and we'll talk more about opportunities for advocacy and mitigation later on, but I do want to encourage us all to not let history repeat itself. We really need to be making noise and encouraging policymakers at every level to do everything they can to stop HCBS from being scaled back. The law does not prescribe these cuts, but it is going to be a very hard fight to keep HCBS from cuts. For two years now, advocates, many of whom are on this webinar today, showed up and fought against these cuts to California's HCBS programs, especially the IHSS program, and that advocacy has been largely successful.

So I want to just remind us all here that while the threats are grave, we can learn from our previous successes how impactful advocacy can be in saving these essential programs. We're going to talk more about mitigation strategies later on, but for now I'm going to turn it over to Tiffany to talk about additional harmful changes in H.R. 1 including work requirements.

Tiffany Huyenh-Cho: Great. Thanks, Hagar. So I will be covering some of the other provisions that impact eligibility for Medi-Cal in California. One of the biggest pieces of H.R. 1 will be work requirements for adults age 19 through 64 as a condition of Medi-Cal eligibility. So a person will need to demonstrate they have 80 hours of certain qualifying activities, and these activities can be paid employment or volunteer community service, job training or schooling to qualify for Medi-Cal coverage, or a combination of these activities.

You can also be deemed to have met work requirements if your income is more than $580 a month. These qualifying activities or work requirements only apply to the adult expansion group age 19 to 64 that were created under the Affordable Care Act. So people in this adult expansion group qualify based on their income only, not their age or other status like disability or pregnancy. And the work requirements for this group will start January 1st, 2027.

This also means that work requirements do not apply to all Medi-Cal enrollees. So there are groups that are excluded completely. For example, older adults age 65 and older are excluded. Dual eligible who have Medicare and Medi-Cal or people in pregnancy-based Medi-Cal are also not subject to these work requirements. The work requirements would need to be satisfied at initial Medi-Cal applications, so before you apply, and also at renewal. California must verify compliance with these work requirements for at least one month before application and after enrollment, and at least one month every six months after you're enrolled in Medi-Cal.

So this will be a big change for California and for many other states. States do not have the option to opt out and must implement these work requirements. We've never had work requirements in California, so it will be a significant

undertaking. California is estimating that up to 3 million people are estimated to lose Medi-Cal coverage because of work requirements, and these numbers make up the bulk of the coverage loss that's estimated under H.R. 1. Next slide, please.

There are some mandatory exemptions to work requirements that I'll highlight. So people who are considered medically frail or otherwise have special medical needs will be exempt. The law lists out several examples of people who meet this exemption, such as people with disabilities and a list of medical conditions. However, disability is not well-defined in the text. And another group of exempt individuals are parents of children under age 14, or people who are caregivers for a family member with a disability as it's defined in another statute, the Raise Family Caregiver Act.

And while there are limited exemptions, we do not yet know how people can apply for these exemptions and what information is needed to prove they meet the exemption. So the federal government will be releasing more guidance as time goes on and is required to release final guidance by June 2026, detailing how states must implement work requirements. And while work requirements will not directly impact people age 65 and older, there are older adults age 50 to 64 in the Affordable Care Act expansion group, and these older adults will be impacted.

People with disabilities are also in this group too, as it can be easier to qualify for Medi-Cal under the Affordable Care Act expansion categories than the disability-based programs which are more strict and based on federal standards. And even though dual eligible or other groups are not specifically targeted, they will still feel the impact. Counties will be facing an increased workload and will have less capacity to answer routine and other standard procedures like processing applications or answering telephone calls. The counties will be facing a really increased workload.

And then people who are not in compliance with work requirements or otherwise prove they meet an exemption will lose their Medi-Cal coverage. And on top of it all, H.R. 1 also prohibits people who do not meet these work requirements or who can't prove they meet one of these exemptions from receiving the marketplace subsidies on the Covered California exchange. These are the subsidies that help reduce the cost of the monthly premiums and make healthcare more affordable. So this is terribly limiting and will overall increase our uninsured rate in California. Next slide, please.

So while H.R. 1 does exempt people who are medically frail, quote, "medically frail" as it's used in the text of H.R. 1 from work requirements, there is an inherent contradiction between work requirements and proving you meet this medically frail exemption. If you are in the aged 19 to 64 expansion group subject to these work requirements, you will need to prove you have a disability or otherwise meet this medically frail term to qualify for the exemption. But it's

a catch-22 because often you need medical records, you need doctor's notes, supporting medical documentation to prove a disability or medical condition in the first place.

But in order to get that documentation, you need health coverage to see a doctor who can substantiate your disability or medical condition. And if you don't have Medi-Cal because you aren't working and can't prove your disability, you are being put in a terrible position. We already know it's challenging for people to prove they meet disability standards for the disability-based Medi-Cal programs like the Aged and Disabled or through supplemental security income. So we are fearful of the impact that work requirements will have on people who qualify for an exemption but can't prove it. Next slide, please.

So before we move on, I just want to acknowledge that H.R. 1 significantly overhauls Medi-Cal as we know it. And it's going to take time to absorb all of the pieces and timelines. So we will be putting out more materials as time goes on. And there is also just quite a bit that we don't know because the text of H.R. 1 is the only guidance that's been put out by CMS so far that's available to the public.

So state agencies and us as advocates are awaiting further guidance on how this text is interpreted, more clarity on definitions, and what states can and can't do when implementing these provisions. But states can take some steps now, like deciding whether to take up some of the more permissible pieces, like adding in short-term hardship exemptions, or analyzing what systems we currently have in place for folks to use to prove they meet work requirements, or analyzing what other system changes might be needed. So with that, let's get back to some of the other changes.

H.R. 1 also narrows the length of the Medi-Cal retroactive period, which today is three months. So retroactive Medi-Cal allows people, if they meet all other eligibility requirements, to get Medi-Cal coverage for the three months prior to the initial application. And retroactive coverage is really valuable because it provides health insurance for services received prior to applying for Medi-Cal. And it's useful for people who experience sudden health crises or need long-term care.

These are people not on Medi-Cal initially, but after their health crisis need to apply for Medi-Cal coverage. So they need Medi-Cal to begin earlier than their date of application. And retroactive Medi-Cal gives you that cushion to help pay for unexpected medical care. But under H.R. 1, retroactive coverage will be narrowed to two months for people that are over 65. For younger adults, retroactive coverage is limited to one month only. So by limiting that retroactive period, it's making it much harder for people to receive care and use the extra time to gather the documentation they need for their Medi-Cal application.

Another provision takes place in January 2028 and there will be a limit on how much a person can have in home equity and qualify for Medi-Cal funded long-term care services. People with home equity worth more than 1 million will not qualify for Medi-Cal covered nursing facility care or other long-term services and supports. And this particularly impacts California since the typical home costs two times more here than in other parts of the country, especially in our high cost areas like Los Angeles or the Bay Area. And so someone might have bought their home decades ago, when house prices were cheaper, but now the value of their home is worth more than a million. And generally, home equity is the difference between the property value and any outstanding debt or mortgage.

There are some exceptions to the home equity limits, such as having a dependent spouse or child that lives in the home, and land that is zoned for agriculture is also exempt. But by and large, we will see that the home equity limit will make many people ineligible for Medi-Cal long-term care services or they may be forced to sell their home to qualify. So this provision is especially harmful for older adults since Medi-Cal is the primary payer of long-term care in California and for many house is your most significant asset.

Today, California does not have a home equity limit today in 2025, and that's because we do not consider assets for purposes of qualifying for Medi-Cal. However, the asset limit is returning, and in 2028, the home equity limit will apply in California. And later, in today's webinar, we'll be going over some of the state budget changes like the return of the asset limit. Next slide, please.

There are two other provisions I'm going to cover quickly. So first, in December 2026, California must conduct more frequent Me-Ca renewals for the adult expansion group age 19 through 64. Today, renewals are set at once every year or every 12 months for all enrollees, but that will change in December 2026 to every six months for the 19 to 64 new expansion or new adult group. So that means that older adults age 50, 64 that are in this group will also be impacted.

Another provision starts in October 2028, and it will require states to impose cost-sharing for this 19 to 64 new adult expansion group who have incomes over a hundred percent of the federal poverty level. So states will have the option to choose the cost-sharing amount between $1 to $35. Cost-sharing will apply to select medical services only. It does not apply to every thing in the every medical service. And people that are over age 65 or who are a dual eligible will not be subject to this cost-sharing.

As we know, people on Medi-Cal have limited incomes, so requiring people that have limited incomes to pay cost-sharing will simply lead to reduced healthcare usage. People will go without care, and that will lead to a sicker, more vulnerable California. So in the lead-up to the implementation of this provision, one thing that advocates can do is to push their state to set the cost-sharing amount to the lowest amount possible to mitigate the harm that this will cause. Next slide, please.

So the past few slides we covered, restrictions are going to make it harder to qualify. But H.R. 1 also stops regulations that were created to improve access and quality of care. So one such impact is pausing implementation of some provisions of the streamlining Medicaid eligibility and enrollment rule. This streamlining rule removed barriers that people often encounter when they apply for Medi-Cal or doing during the renewal process.

It also had specific provisions for people that were duly eligible in Medicare and Medi-Cal. And because dual-eligibles receive healthcare from two different sources of coverage, the streamlining role tried to make enrolling in the Medicare savings programs less difficult. And again, the Medicaid programs that make Medicare more affordable by helping pay Medicare cost sharing. So by pausing provisions of the streamlining rule, states do not have to implement them as originally required.

In California, however, I'll say that the state already implemented one of the big provisions of the streamlining rule, which was the requirement to automatically enroll people on supplemental security income. People on SSI automatically get Medi-Cal by virtue of getting SSI. So SSI-linked individuals were automatically enrolled in the qualified Medicare Beneficiary program, which is just one of the Medicare savings programs. The qualified Medicare Beneficiary program is really valuable. It provides cost sharing assistance for the lowest of Medi-Cal enrollees because the income limits are set at a hundred percent of the federal poverty level.

California already implemented the provision to automatically enroll SSI-linked individuals into the qualified Medicare Beneficiary program and it will not be rolled back. Part A buy-in will also continue as is as well. There was a provision to change the household size definition in the Medicare savings Program to match the low income subsidy, but that provision is paused because of H.R. 1 and California does not have to comply as originally required.

H.R. 1 also blocks implementation of a nursing home minimum staffing rule, which ensured that a minimum number of nurse aides and registered nurses were on staff at nursing facilities across the country. And this rule was estimated to save 13,000 lives per year. So this is particularly harmful for older adults resigning in nursing homes because as we know, health outcomes and quality of long-term care is based heavily on the number of nurse aides and nurse staff that facilities have. Next slide, please.

And then there are also cuts to Medicare. So we discussed changes to Medicaid, but Medicare is also impacted. There are millions of people duly enrolled in Medicaid and Medicare and almost one-third of all national Medicaid funding is spent on people who are also enrolled in Medicare. So any of these cuts to Medicaid will have an impact on Medicare enrollees as thousands of people rely on Medicaid for long-term care because Medicare's coverage of nursing facility and home-based care is just very limited.

And then additionally, H.R. 1 makes direct cuts to Medicare eligibility for immigrants. So prior to H.R. 1, lawfully present immigrants qualified for Medicare if they otherwise met other program requirements, like age and work history in the US, just like any other US citizen. But now with the passage of H.R. 1, immigrant eligibility for Medicare is limited to three specific groups that are listed on the slide. And these are lawful permanent residents, also known as green card holders, Cubans and Haitians who entered under a family reunification program, and people residing under the Compacts of Free Association or COFA. COFA are people who are from select countries in the Pacific Ocean like Palau or Micronesia.

So that means that outside of these three categories, all other lawfully present immigrants will lose Medicare eligibility. Current enrollees who are immigrants but not one of these three categories will see their Medicare terminated in January 2027. And then more immediately, new enrollment into Medicare is prohibited for all other lawfully present immigrants other than these three groups listed. So new immigrants outside of these three groups can no longer newly enroll into Medicare and then we will also see current Medicare enrollees lose their coverage in January 2027 because of these immigration changes.

Immigrants who are losing eligibility include people who are granted refugee status and people with temporary protected status. These are people who have paid Medicare taxes for years, who have worked and paid into the system under the promise of future coverage. And then by statute, there's also a sequestration issue that could take effect unless congress acts. So by law, any legislation that significantly increases the deficit also triggers $500 billion in cuts and reduce Medicare provider rates. These cuts may lead to fewer Medicare providers if providers decide to leave the Medicare program because of these cuts and Congress would need to pass legislation to exempt Medicare from these cuts. Next slide, please.

The impact of cutting Medicare eligibility for immigrants is that H.R. 1 essentially decoupled social security eligibility and Medicare. Before, lawfully present immigrants that qualified for social security also met the requirements for Medicare, but now limiting Medicare for immigrants breaks Medicare's promise. These are people who have paid into Medicare through payroll taxes expecting to become eligible, and now they're losing a benefit they paid into which is deliberately unfair and punishing. And on top of that, H.R. 1 also excludes the same newly ineligible immigrants from Medicaid and the marketplace subsidies through Covered California.

The culmination of all these changes means that many older immigrants will be left uninsured once Medicare is stripped away. There will be few options for coverage if you cannot afford the full cost of private health insurance or do not have coverage through an employer. So this policy will also harm US citizens as well. Immigrants play a vital role in healthcare and long-term care as one in four direct care workers are immigrants and they provide daily caregiving help in

home-based settings. Immigrant caregivers either paid or unpaid who lose health coverage may need to leave their jobs and find other employment that will provide health insurance, which will impact and jeopardize our already large workforce shortage. Next slide, please.

And as mentioned in the last slide, Medicaid eligibility is also being limited for many lawfully present immigrants. Just like with Medicare, only these three immigrant categories that are listed on this slide remain eligible for federally funded Medicaid after October 2026. And then eligibility for premium tax credits through the Covered California health exchange will also be limited to the same groups on the slide. Other lawfully present immigrants may sign up for coverage on Covered California, but they must pay the full monthly premium which can run several hundred dollars.

And thankfully, in California, there may be other options for people who are low-income. First, our Medi-Cal program has expanded to include all immigrants regardless of immigration status. And California does this using state funds only. So immigrants losing eligibility under H.R. 1 can continue on Medi-Cal once those changes go into effect. And several counties also offer discounted healthcare for low-income people who do not qualify for Medi-Cal or Medicare. And although it may not be comprehensive insurance, these programs are alternative sources of care. Advocates should investigate whether their counties offer these type of health programs. Next slide, please.

And this slide just provides a timeline for each of the provisions that we covered stretching from now to 2028. And with that I will pass it back to Hagar.

Hagar Dickman: Thanks, Tiffany. So I'm going to talk a little bit about some mitigation strategies and advocacy opportunities in response to H.R. 1. Go to the next slide.

Our first mitigation strategy, and at this time I think it's the most important, especially because we haven't really started on implementation. We're sort of all waiting to see what the implementation efforts are going to look like. The most important mitigation strategy right now is education, both about what is and is not in the law. For example, the law doesn't make a lot of direct changes to Medi-Cal. There are no direct changes, for example, to income eligibility rules at this point.

The biggest impact of H.R. 1 is on California's future budget. Because many cuts are not yet in effect, people should continue enrolling and receiving Medi-Cal services. So advocates should really be encouraging continued enrollment in the program. We also don't have a lot of detail at this point about how these cuts and what specific are going to look like, and what specific measures like work requirements will look like or what documentation is going to be needed, if at all, what sort of verification people will need if at all. And so we'll know more about those in months to come and we'll educate our network as well. But at

this point, the most important thing is to remain educated and engaged about what we do know.

And finally, consumers still have their due process rights. There have not been any changes about notices of termination or appeal rights from adverse decisions. So people should really be getting help advocating for themselves and enforcing their rights. If a Medi-Cal member, for example, experiences some negative action on Medi-Cal eligibility or service, they should not assume it's from H.R. 1 impacts and should pursue their appeal rights and fight to keep their access to services. Next slide, please.

As the federal government starts issuing guidance to states, California is going to start also working on implementing H.R. 1, and most of that task will fall to the Department of Healthcare Services. We urge advocates to work with the state to minimize harm wherever there is state discretion. Whether it's asking consumers to pay the most minimal Medi-Cal copay allowable, requiring the least frequent eligibility checks, or using as many automated exemptions allowable for work requirements, these are all things that we as advocates should be encouraging the state to take up.

We don't want California to rush to implementation before guidance is provided. Advocates should be communicating with DHCS instead about concerns and the impact of any proposed policy before implementation. So stakeholder engagement is going to be key in making sure that implementation efforts minimize harm. And much like we've been doing in California, advocates should continue advocating for strengthening home and community-based services, strengthening Medi-Cal eligibility limits, and implementing streamlined provisions that help older adults and people with disabilities get them to keep their Medi-Cal coverage.

So even as we are engaged on potential harmful policies, we should really keep those three principles in mind and really push for expanded services, strengthened Medi-Cal, and streamlined provisions that key people covered. Next slide, please.

Advocates should also continue to connect with community advocates to monitor implementation. So direct service advocates and provider groups as well as aging and disability advocates are all uniquely positioned and can provide different lenses and how implementation is impacting members. And so talking amongst each other and really educating yourselves and the community about what you're seeing and experiencing is going to be very important to inform our advocacy.

And finally, I really urge you to continue sharing and collecting stories about how implementation is impacting Medi-Cal access, and sharing those stories with the media, with policymakers, social media and other platforms because people should really know and are also more responsive to the real-life impact

of these harmful policies. We're going to, if you don't mind, go to the next slide. We're going to now turn to the California budget. Do you mind going to the next slide please?

We're going to turn now to the California budget. You can go to the next slide as well. Governor Newsom signed a state budget on June 27th that responded to a $12 billion budget deficit in the state, and this is unrelated to H.R. 1 or any federal action. This is before any of those harmful federal actions have been implemented or taken place. This is just the nature of the California budget at this point.

The final budget impacted Medi-Cal in two distinct ways, the reinstatement of the Medi-Cal asset test and changes to immigrant eligibility and coverage of certain groups. So I'm going to turn it Tiffany now to go through those changes and impacts.

Tiffany Huyenh-Cho: So like Hagar said, the state budget imposes significant changes to Medi-Cal. These changes were passed in California before H.R. 1 was signed. As you all know today, asset limits were completely eliminated from Medi-Cal in 2024, but these asset limits will be reinstated starting this January 2026. And older adults and people with disabilities are impacted because they are the main group to which asset limits apply. Younger adults and children on Medi-Cal through our Affordable Care Act based programs do not have asset limits.

The common eligibility pathways for older adults and people with disabilities are the Aged and Disabled program. The 250% Working Disabled program, Share of Cost, Long-Term Care, and the Medicare Savings Programs. These programs will see asset limits return. So beginning in January 2026, older adults and people with disabilities must meet both income and asset limits to qualify for Medi-Cal.

The asset limit will be going back to what we had prior to elimination. So it will be set at 130,000 per person with an additional 65,000 per household member. Assets include things like bank accounts, cars, or houses. With assets coming back, the old asset counting rules are also restored. So things that were exempt prior to elimination will also be exempt. The home a person lives in and the first vehicle are not counted, all other countable assets must be below 130,000 for a single person.

And then after January 2026, people who newly apply must certify that they meet the Medi-Cal asset limit, and then current enrollees on Medi-Cal now will not have to certify their assets until their first renewal in 2026. DHCS will also be collecting data on those who lose eligibility during the first year after assets return. So we want to know if people are losing Medi-Cal because they're ineligible and over-asset, or if the process approving assets at renewal is causing people to lose coverage. Next slide, please. Next slide, please. Thanks.

So just as some background before we get into the next slides, Medi-Cal is a jointly funded state and federal insurance program. And then federal government provides funding to help run each state's Medicaid. But the federal government can also set rules on Medicaid eligibility, including which immigrants qualify for federally funded Medicaid. In California, people who have what is called satisfactory immigration status, the federal government provides federal funding to help cover their care. These include refugees, asylees, and green card holders who have been here for five years.

For all other immigrants that are considered to have unsatisfactory immigration status, California's Medi-Cal program does cover these immigrants in our full Medi-Cal, but California uses state funds only to cover the cost of this care. So these include people who are undocumented as well as green card holders under the five-year bar, or people granted temporary protected status in the US. And by expanding our Medi-Cal program over the past few years, California has greatly reduced our state uninsured rate and increased our overall public health and wellbeing. Next slide, please.

So today, like we just covered, full scope Medi-Cal has no immigration exclusions. If you otherwise meet Medi-Cal's income and state residency requirements, you can qualify for Medi-Cal. Older adults over age 50 regardless of their immigration status, were eligible to enroll in Medi-Cal as of May 2022. But starting this January 2026, California is stopping new enrollment into Medi-Cal for undocumented adults age 19 and older. Undocumented adults age 19 and older who are not pregnant and who apply after January 2026 will be limited to restricted or also called Emergency Scope Medi-Cal. These new applicants that apply after January 2026 will not have access to full Medi-Cal benefits, like primary, specialty care, or in-home supportive services. Restricted Scope Medi-Cal is limited to emergency care only.

For current enrollees, they will remain on Medi-Cal. It will be important for this group to retain their Medi-Cal eligibility and complete annual renewals. And that's because losing Medi-Cal for a period of time may mean they have to reapply for Medi-Cal, and then they will be limited to this emergency Medi-Cal because of this new cap on enrollment. And DHCS is referring to this cap on enrollment as the expansion freeze.

Advocates with undocumented clients should provide education on the importance of Medi-Cal renewals, which is now even more important because of the enrollment cap. And I do know that there is understandable fear about enrolling in or using Medi-Cal because immigrants are being targeted by immigration authorities and immigrant data has been shared with immigration officials. It is a deeply personal decision whether to enroll in Medi-Cal or not, but the window is open to enroll right now and it is closing after December 31st for immigrants that will be subject to this cap on enrollment. So next slide, please.

And on top of all of that, California is introducing two other changes that impact immigrants. Dental coverage will be eliminated for immigrants on Medi-Cal who are age 19 and older. This will apply to all immigrants on Medi-Cal who are considered to have unsatisfactory immigration status for Medi-Cal purposes. So that includes green card holders under the five-year bar, as well as undocumented adults or people on humanitarian visas.

These immigrants will still have access to all other full-scope Medi-Cal coverage, your primary specialty care prescriptions, everything minus dental. And this elimination of dental coverage begins July 2026. And then starting July 2027, these same groups of immigrants will be subject to a monthly $30 premium. So to remain in Medi-Cal, you will have to pay this monthly premium for these group of immigrants. The premiums apply to those age 19 to 59 only, people that are age 60 and older will not have to pay the premiums, but the failure to pay could lead to Medi-Cal termination.

And as mentioned before, the federal H.R. 1 does limit the lawfully present immigrants that are eligible for federally funded Medicaid in October 2026. But these immigrants should still qualify under state-funded Medi-Cal rules, but they will be subject to the premiums and loss of dental. So apart from H.R. 1, California is in a tough spot and they're having to cut services due to budget constraints, which only exasperates the challenges that advocates and enrollees are facing today.

So with that, I know we covered a lot today. We will be putting out more resources on the changes. So please sign up for our listserv if you haven't already. On this slide, there's a list of resources that cover the federal changes under H.R. 1 that we discussed. Next slide. And then this slide has additional resources as well. I'll highlight the last two links. This slide are specifically from California's Department of Healthcare Services and it covers both changes from the federal H.R. 1 as well as the California state budget. And with that, I'll turn it back to Yasmin.

Yasmin Peled: Okay, so we are now going to move into questions. Again, if you have additional questions, please use the Q&A function. I think let's start with some clarification around work requirements and who falls into having to meet those work requirements and who does not? There were a number of questions about if you're on SSI or in a regional center or in the aged and disabled pathway. So Tiffany, could you clarify which Medicaid group has to follow work requirements?

Tiffany Huyenh-Cho: Yeah. Work requirements only apply to people that are enrolled in our new adult expansion Medi-Cal category, which is set at 138% of the federal poverty level today. This is the category that was created under the Affordable Care Act over 10 years ago. So only adults in this group will be subject to the work requirements. Aged and disabled is a completely different Medi-Cal pathway.

That group will not be subject to work requirements. People that are duly eligible and have Medicare are not in the Affordable Care Act 19 to 64 group.

SSI individuals will not be impacted by work requirements. SSI folks only get Medi-Cal because of the receipt of SSI. So they have to meet SSI rules, and as long as they meet and receive SSI rules, they get SSI linked Medi-Cal. They don't do Medi-Cal renewals and they will not be subject to work requirements. It's really only the people on the Affordable Care Act 138% adult expansion category. So someone in a regional center that is in that category may be subject to work requirements, but only if they're in that pathway. If you have a disability and are on the aged and disabled program, you will not be subject to the work requirements. I don't know if you want to add anything.

Yasmin Peled: There are also a number of questions clarifying about the immigration restrictions. Can you clarify the groups of immigrants that are not impacted by H.R. 1 that won't have their eligibility changed to the immigration status? Can you just repeat that?

Tiffany Huyenh-Cho: Yeah. So immigrants who have not been impacted by these H.R. 1 changes are lawful permanent residents or also known as green card holders. Sorry, legal, permanent residents, also known as green card holders or LPRs, certain Cuban and Haitian entrants who entered the US through a family reunification program. And then people that are residing in the US under the Compact of Free Association. So these are people from certain countries in the Pacific Ocean who have been granted residency and authorization to work in the US. Only those three groups will retain eligibility for Medicare and federally funded Medicaid.

Other immigrants, such as people granted refugee status or asylum status, although they are considered lawfully present, they are losing eligibility for Medicare and will lose eligibility for Medicaid once those immigrant changes in H.R. 1 take effect. And there are other lawfully present immigrants that are also impacted. There's quite a few. I don't know them all off the top of my head so I don't want to get it wrong, but refugees and asylees are one example. People granted temporary protected status are another group of immigrants that are going to be negatively impacted.

Yasmin Peled: And then on the changes to undocumented individual's access to Medi-Cal here in California, can you again just reiterate when the freeze goes into effect and when the premiums go into effect?

Tiffany Huyenh-Cho: Yes. The freeze goes into effect this January 2026, so we're almost three months away, where California is capping the number of new undocumented immigrants that can get onto our full scope Medi-Cal program. So enrollment is open right now, but in January 2026, the undocumented immigrants can apply for Medi-Cal but will only be eligible for our emergency or restricted scope Medi-Cal.

People that are currently on Medi-Cal now and are undocumented can remain after January 2026. It's the new enrollment that is being capped or frozen as the department is using. And then premiums will start in July 2027. Premiums will apply to all immigrants that are on our state-funded program. So anyone that is considered to have unsatisfactory immigration status. It's more broad than people that are undocumented. It includes people on temporary protected status. It includes green card holders who are under the five-year bar are considered to be unsatisfactory immigration status. So they will also be subject to those premiums in July 2027.

Yasmin Peled: There's one follow-up here on the premium. Is this only for full-scope Medi-Cal recipients or also emergency scope Med-Cal?

Tiffany Huyenh-Cho: It's only for what we know as full-scope now. I don't want to complicate it, but there's another term that is being added because dental is being taken from the Medi-Cal coverage for our state-funded immigrant program. It's going to be full-scope minus dental. So people in this situation who are losing their dental, these are the ones that will be subject to the $30 premiums. If you're on emergency or restricted scope Medi-Cal, that premium does not apply.

Yasmin Peled: On the asset limit and the return of the asset limit, there's a question about retirement accounts and if those are counted towards assets.

Tiffany Huyenh-Cho: If you are on the aged and disabled program or non-Affordable Care Act categories where assets are counted, your retirement account like a 401(k) is not counted as long as you're getting regular distribution. So if you're getting monthly or regular distributions from your retirement account, that money is counted as an income. So it does count towards an income limit, but the remaining balance in your account is not counted towards the asset limit, but only if you're getting regular distributions from your retirement account. And that was what the old rules were. Again, the old asset counting rules are coming back. We're essentially going back to how we were in January 2022 when our asset limits were increased to 130,000.

Yasmin Peled: And then I think maybe a final question is if there are specific issues for dual eligibles that are unique to the dual eligible population in the changes to H.R. 1 that you want to highlight and uplift for our participants today?

Tiffany Huyenh-Cho: Great question. So there are different ways that dual-eligibles will be impacted. I think one of the more immediate ones are if you are dual-eligible who is an immigrant and you're not a legal permanent resident, you're not here under COFA, and you didn't enter as a Cuban or Haitian entrant, you could lose Medicare and you could lose Medi-Cal as well. So there are immigrants who are dual-eligible who may be losing Medicare in January 2027.

I think some of the changes to our Medicare savings program enrollment, like we mentioned, California could have aligned the household size for the

Medicare savings program with the low-income subsidy definition. And the low-income subsidy uses a more generous definition of a household, whereas Medicare savings program looks at your spouse or registered domestic partner or if you have a minor child. But the low-income subsidy program has a more expansive view and it would've included grandparents who take care of their grandchildren.

So that would've made applying for a Medicare savings program easier because your household size would be bigger and you might've been able to qualify under a bigger household size because of your income. So that is a change that California is no longer required to implement. It was going to be a requirement in April 2026, but with the pause, California does not have to do this anymore. It's optional, but it's not a requirement.

So that's another impact that would've helped dual-eligibles more easily qualify for the Medicare savings program. And then again, I think just with the impact of the increased workload that counties will be facing, not with just with work requirements, but also with the more frequent renewals for the ACA category, there just going to be less bandwidth on county staff. So dual-eligibles may also just face longer processing times trying to get in touch with a caseworker or submit documents. All of that could be impacted because of the sheer amount of change that is being wrought through H.R. 1.

Yasmin Peled: And then this will be the final question, one more on the immigration changes. I'm going to read this verbatim. To clarify, all immigrants who are not meeting the H.R. 1 satisfactory immigration status, if they apply now for Medi-Cal and are enrolled prior to Jan. 1 of 26, will not lose their Medi-Cal in 2027? Question.

Tiffany Huyenh-Cho: The January 1, number 2026 is significant for immigrants that are undocumented. They are the ones that are subject to this cap. There are other immigrants who maybe don't meet the satisfactory immigrant status, that's under federal definition, they can still enroll after January 2026. It's the people that are undocumented who do not have a documented status are the ones that will be subject to this cap.

So if you're an immigrant that is considered lawfully present, maybe you have that refugee status, but you're losing your federally funded Medicaid because of H.R. 1, you should be able to apply after those changes take effect and get covered under our state funded Medi-Cal program because we are still covering people with, quote, unquote, "unsatisfactory immigration status on state-funded Medi-Cal subject to premiums and dentals". It's the group of immigrants that are undocumented that are subject to the freeze or cap on enrollment that starts in January 2026. So I hope I answered that question.

Yasmin Peled: Well, I'd like to thank you all again for joining us today and thank you to my colleagues, Hagar and Tiffany. As a reminder, any questions that went unanswered today will be followed up on via email. And please feel free to

reach out to our speakers with additional questions if you come up with them later on. Please don't forget to complete the webinar survey. Your feedback on these programs is very important to us. Thank you and have a great rest of your day.