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Fellowship Capstone | Policy Brief

How Will the Presence of H.R.1 Affect Public Access to Healthcare in California

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I. Executive summary

For a whole century, healthcare in the United States has existed as a polarizing issue, dividing citizens from all over the country, with states like California at the crossroads between maintaining state funding for programs and federal austerity. This brief will focus on the projected budget changes that will impact healthcare within California, and how they can be changed by policy enforcement.

II. Overview

Healthcare within California is intertwined with the ever-changing landscape of the federal government but also within the politics of the state as a whole. Accessibility to healthcare has been directly influenced by institutional and systemic barriers that have plagued Americans throughout the country for decades, but Californians specifically within the past couple of years. With issues varying from coverage to accessibility in rural areas in California, it exacerbates problems throughout the entire state for all its citizens. As a result of H.R.1 (Public Law No: 119-21), most commonly referred to as the One Big Beautiful Bill Act (OBBBA), which was signed into legislation by President Donald Trump in the summer of 2025, it is projected to reduce federal healthcare funding in California by approximately $30 billion annually (Goldstein, 2025). This leaves lawmakers to find a way to cover an annual $20 billion deficit to ensure basic health programs are functional (Alexei, 2025). More importantly, it's estimated to gradually cut about 3.5 million Californians access to the state's Medicaid program, Medi-Cal, after the new regulations presented by OBBBA go into place.

However, the loss of healthcare benefits is not merely financial but has structural and geographical impacts across the state. The deprivation of resources and depletion of the healthcare workforce can leave millions without local access to substantial medical services. Thus, this paper analyzes projected changes to California healthcare programs and resident's access, to argue for state-level policy interventions that will serve to protect programs that benefit the public.

A. Relevance

Healthcare access for all citizens in the United States has been a policy concern that has continuously shaped political and social discourse, especially serving as a topic of interest for individuals who come from disadvantaged socioeconomic backgrounds. This can be seen in California where a large portion of the population utilize public health insurance

programs such as Medi-Cal for coverage which can make them vulnerable to federal funding changes. The cutback in support from federal funding can have detrimental consequences for vulnerable populations particularly low-income and marginalized groups who do not have alternative means for coverage within the state. According to the California Department of Health Care services website (DHCS, n.d.), about one-third of California's population is covered by Medi-Cal. Federal mandated changes can have system-wide implications for accessibility to healthcare.

III. History

A. Current Stances

Medicaid and Medicare have long existed as public opportunities to connect citizens with healthcare. President Lyndon B. Johnson signed the Social Security Amendment in 1965, which expanded Social Security within the United States. This formally introduced Medicaid and Medicare in the country, where it bridged the gap between healthcare access for Americans regardless of social class, disability, and age. Medicare specifically would function for older Americans, while Medicaid would tend to low-income Americans. Medicare is a federally operated program that is funded by payroll taxes (FICA), monthly premiums and federal revenues. Whereas Medicaid is jointly influenced by both the federal and state government.

It was formally introduced to California's legislature several months after being signed into office, where it opted to implement its own state-run program. In March 1966, Medi-Cal became effective. In the beginning, Medi-Cal was directly tied to state-funded welfare programs; it could cover only specific individuals, including people with disabilities, families with dependent children, and those who relied on cash assistance. In 1990, only about one in eight Californians was enrolled in Medi-Cal (Cha & McConville, 2024). This served as a problem for many Americans. Those who could not qualify for Medi-Cal nor could afford private insurance remained uninsured.

The systemic gap remained prominent in political discourse for over a decade. It would culminate into a central issue addressed in the 2008 presidential election. Following his victory, then President Obama, cracked down on policy reforms related to these discrepancies. During his second year as president he would sign into law the Patient Protection and Affordable Care Act, better known as the ACA. The ACA would historically expand Medicaid, bridging public access to healthcare for millions of Americans across the United States. For instance, the ACA would (1) increase how long young adults can be on their parents' insurance to the age of 26 years old. (2) prohibited insurers from denying coverage for preexisting conditions. Lastly, (3) expanded Medicaid to cover low-income adults up to 138% of the federal poverty level. This expansion was influential for California's Medicaid program, Medi-Cal. Before the ACA, approximately 15% of California's population was uninsured but afterwards about 6% were left uninsured. By 2016, the enrollment for Medi-Cal increased by 60%, including low-income adults who did not have children and were disabled (Cha & McConville, 2024).

However, complications persisted despite these

advancements. While the ACA improved insurance benefits for citizens across the country there was still a group that was left out of reaping those same benefits – undocumented residents. Originally, only undocumented residents eligible for emergency and pregnancy-related Medi-Cal were qualified, however experienced limitations as they were not given full-coverage for specific medical treatments (Dietz et al., 2022). In 2016, policymakers in California would expand access to low-income children, regardless of their immigration status. Four years later in 2020, undocumented low-income adults ages 19-25 would qualify for Medi-Cal. This scope would broaden once again in 2022 for undocumented adults ages 50 and older. Finally, all undocumented adults ages 26-49 qualified for full scope Medi-Cal coverage in 2024. This has dramatically increased the number of residents who qualify for Medi-Cal, thus leading to an increase in the population having insurance (roughly 93%). There was an increase in health performances from about 20% to 30%, showcasing that accessibility influences health quality and lifestyle (Saucedo & Ramos-Yamamoto, 2024). However, federal changes to state budgeting can result in the depletion of residents on Medi-Cal, therefore undoing all the progress the state has made in ensuring people have access to health insurance.

IV. Policy Problem

A. Stakeholders

The primary stakeholders are the 38% of California residents who rely on Medi-Cal, especially those who come from marginalized backgrounds, including residents with disabilities, undocumented residents, and low-income households. The changes to Medi-Cal as a result of H.R.1 can have consequential effects on the progress that has accumulated over the sixty years of its existence and since the passing of the ACA. The lack of a substantial budget to adequately support individuals will leave millions uninsured, thus widening pre-existing healthcare disparities for residents across the state.

This issue does not only affect the state of California, but will have nationwide implications for citizens who rely on Medicaid across the country. At the start of 2027, H.R.1 will establish new mandated work requirements, thus making it harder for individuals to qualify for Medicaid within their state if they do not have the proper documentation. Currently in 2026, undocumented residents, outside of children and those facing medical emergencies, have begun losing coverage. Individuals will face delays in how long their applications will be approved and verified for eligibility which will impact the full scope of care that people are receiving in a certain amount of time (Erzouki, 2026). These federal changes extend to the state as well, as they will have to make certain decisions that can sustain Medicaid and residents'access to it. This includes figuring out how to administer their Medicaid budget to make up for the deficit that the federal government won't be fulfilling. Overall, socioeconomically disadvantaged individuals should have a stake in Medicaid funding, as it affects their long-term access to healthcare insurance and medical treatment.

B. Risks of Indifference

The risk of indifference begins with a failure to respond to the implications that the loss or potential loss of Medi-Cal can have for residents in California. If state policymakers lack to address

the loss of substantial funding to services like Medi-Cal that support a large portion of California residents, it can have consequential effects, especially on marginalized communities that do not have the resources to rely on other insurance programs. The level of indifference limits coverage for a multitude of individuals across the state, thereby decreasing the number of residents represented in public health. It can exacerbate public trust in the state legislature and federal government, which weakens solidarity between the government and its citizens.

C. Nonpartisan Reasoning

It's been established that the loss of funding will impact residents in California first and foremost; it does not end in California. This is a nationwide concern about the protection of public health access in the United States at the hands of the federal government as a result of H.R.1 and other future bills to be passed that can affect their existence. It is with urgency that nonpartisan intervention occurs across state lines. Implementing these interventions provides a multitude of advantages, but is not restricted to:

1) Ensuring Long-Term Economic Stability for Public Health Access: California, like other states, relies on funding from the federal government and state revenues to maintain public health programs that support the public. However, strategizing to create a way where the state can utilize more of its budget to maintain Medicaid infrastructure services like Medi-Cal can prevent further instability that is caused by rollbacks in funding. This gives California an advantage in allocating parts of the budget dedicated to healthcare to be used optimally in cross-subsectors, including, preventative care, Medicaid protection, and healthcare workforce retention.

2) Improving conditions for Medical Treatments and Essential Services: An issue that would still need to be addressed due to cutbacks in funding is ensuring that people are receiving medical services despite not being insured. Within the United States, medical accessibility is already a constraint for multiple reasons, including: cost of services, emergency wait times, fee-for-services, etc. Despite this, medicare-participating hospitals are still required to provide medical treatments to individual patients experiencing a medical crisis. The law known as The Emergency Medical Treatment and Labor Act (EMTALA) was signed into office over 40 years ago on August 1st 1986 as an act of prevention against patient dumping. As well as to ensure that patients are receiving medical services despite being uninsured or simply not being able to pay for services (CMS, 2026). However, without efficient funding it can impact medical services as a whole. This penalizes the patients who are seeking medical care while placing unsustainable financial burdens on the clinics and hospitals that have to provide the services. With a proper policy that acknowledges federal cutbacks in state directly tackles patient's needs head-on. This would establish a state that adheres to the needs of its residents to ensure long-term stability.

3) Preserving Healthcare Equity for Undocumented Adults: Within the past decade, there have been trailblazing efforts in California to broaden the scope of healthcare accessibility amongst undocumented residents in the state. However, with the presence of H.R.1 there are rollbacks scheduled to occur in the next two years and have already begun in the fiscal year. The state has implemented a strict enrollment freeze, denying undocumented residents from being eligible to apply to Medi-Cal and transitioning existing enrollees from managed care plans to restrictive, fee-for-service care. Moreover, the state will be imposing a $30 monthly premium by July 2027 for undocumented adults (DHCS, 2026). It is with utmost importance that policymakers create a strategic plan to protect undocumented adults across the state, in order address the systemic repercussions that this will have for healthcare equity.

V. Tried Policy

Although H.R.1 does not fully go into effect over the span of one year but across multiple fiscal years, state policymakers are still seeking feasible solutions that can not only address the deficits caused by the cutbacks but also create long term stability for Medicaid in the state of California. As covered in earlier sections, Medi-Cal has undergone multiple expansions throughout its history in California, most notably in the past couple of years, with undocumented residents receiving coverage regardless of age or immigration status, thereby increasing the number of eligible residents in the state. However, because H.R.1 poses a threat to the amount of federal funding received while simultaneously limiting how the state can raise revenue, California's ability to protect its healthcare budget creates a new obstacle.

In the past, California has protected Medi-Cal's budget from being destabilized without completely depleting state funds by utilizing targeted, state-level corporate provider taxes. An example of this is the state's Managed Care Organization (MCO) Tax, which was implemented into long-term law in California by Proposition 35 in 2024. This proposition applies a specialized tax on commercial health insurance plans (DHCS, 2025). This has generated billions of dollars in independent state revenue with the purpose of sustaining Medi-Cal operations and support provider reimbursement rates (Legislative Analyst's Office, 2026). The state utilizing the corporate insurance sector to self fund public health access showcases how the state has been able to adapt and strategize to implement effective mechanisms that benefit its own safety net.

VI. Policy Options

Increasing State-Level Funding

The state of California can expand its independent budget to ensure the safety of public health in the state for all of its residents. This looks like increasing the state's budget, allocating more money for public health programs like Medi-Cal. By increasing the local financial commitments, the state is able to have more direct input into its Medicaid and public health services. Although this may come at the risk of a

decrease in federal funding, the state will have a direct and meaningful input into protecting residents who rely on Medi-Cal and keeping it sustained overall.

California Billionaire Tax 2026 Proposal

Currently there have been discussions regarding a proposal which would impose a one-time 5% wealth tax on the residents within the state who have a net worth of more than $1 billion. This mechanism is projected to generate billions in independent state funding specifically for maintaining the state's public health safety net. Utilizing the revenue from the state's highest earners, this would allow for California to cover the deficit caused by H.R.1 without having to pull from the state's general funds. Furthermore, the proposal faces many criticisms from corporations and top-earners in the state; it will provide an important, self-sustaining emergency fund to preserve the full scope of Medi-Cal's eligibility and protect marginalized communities from coverage rollbacks.

Medicaid Per Capita Cap Financing Restructure

California could fundamentally restructure its financial relationship with the federal government by transitioning to a per capita cap financing model. This model would transition away from an open-ended federal matching system to a system where the federal government provides a fixed, guaranteed investment per enrolled individual (Waldman & Dyer, 2026). This would require California to utilize any costs of care that may exceed the federal cap, and provides the state with investments that can impact preventative care and public health by maximizing this system efficiency. Moreover, establishing a fixed federal contribution allows California to negotiate for relief without rigid federal mandates, allowing the state to ensure that residents are receiving the full scope of care that they need diligently.

VII. Conclusions

The impending reductions mandated by H.R.1 pose a detrimental threat to the equity and accessibility of California's Medicaid infrastructure. Out of all the policies examined throughout this brief, the policy that can have the most meaningful impact across the state within a short period of time would be the billionaire tax proposal. This progressive proposal would quickly generate the emergency revenue needed to address the deficits without the state sacrificing its own general funds. Despite this, it would be within California's best interest and the long-term sustainability of Medi-Cal to reconsider increasing the state's budget for healthcare and Medicaid's infrastructure to ensure that residents across the state, whether it be urban or rural communities, have access to these important safety nets.

Addressing these critical issues can ensure that the Medicaid infrastructure in California remains steady, remaining a platform that demonstrates equity for people of all backgrounds while systematically closing disparities and overcoming federal policy changes.

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