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California Legislature

Joint Informational Hearing: Senate and Assembly Committees on Health
Federal Action Impacts on Community Health
August 19, 2025 – 1:30 p.m.
1021 O Street, Room 1100

This hearing of the Senate and Assembly Health Committees will provide an overview into how a series of federal actions are negatively impacting the health of California's communities, in particular vulnerable immigrant communities and those that rely on Medi-Cal. Given the interconnectedness of immigrants in California, and the large number of Californians who use the Medi-Cal program (approximately one-third of the state's population, and over half of all children), these impacts are not limited to those two populations. Damage to our health care system and communities could potentially affect all Californians. For example, a significant loss of Medicaid revenue or drop in the number of people with health care coverage could cause hospitals or family planning providers that serve all Californians to close. Similarly, when community members fear leaving their homes, families become vulnerable due to loss of income and loss of access to education and health care which leaves communities as a whole worse off. This hearing will cover the impacts on Medi-Cal of the federal 2025 reconciliation law (H.R. 1), impacts on community health of recent immigration enforcement actions in Los Angeles and elsewhere, and some of the recent federal administrative changes that have made health care less accessible for immigrant communities.

H.R. 1

On July 4, 2025, President Trump signed H.R.1, a vast budget reconciliation bill, into law. This bill makes a multitude of changes in tax laws, increases funding for immigration control and national defense, and cuts spending in multiple areas that affect Medicaid and many other federal programs. According Governor Newsom, in California alone, the bill will take away $28 billion in Medicaid funding, which could result in up to 3.4 million Californians losing their

health care.[1] While H.R. 1 goes far beyond Medicaid and the Children's Health Insurance Program (CHIP), which collectively are operated as Medi-Cal in California, key provisions affecting Medi-Cal follow.

Reductions in financing:

- Prohibits family planning essential community providers that provide abortions from receiving federal Medicaid or CHIP funding. These providers have never received federal funding for abortions, but this eliminates their federal funding entirely. (§ 71113)
- Prohibits new or increased provider taxes to fund the state's share of their Medicaid program; freezes and provides for a gradual reduction of existing taxes until they are at a maximum hold harmless threshold of 3.5%.[2] Prohibits such taxes from being applied in a non-uniform way based on the level of Medicaid services provided. California relies on several of these taxes to fund Medi-Cal, including the Managed Care Organization (MCO) tax and the Hospital Quality Assurance Fee, which generate billions of dollars. (§71115, 71117)
- Caps the rate the state may set (known as State Directed Payments) for specified services to 100% of the Medicare rate.[3] (§ 71116)
- Reduces the federal share of payment from 90% to 50% for emergency services provided to "expansion adults" (those adults between ages 18-65 who were newly covered under the Affordable Care Act[4]) with unqualified immigration status for full-scope federally-funded Medicaid and CHIP. (§71110)
- Changes how Section 1115 waivers are to be evaluated in order to meet the existing "budget neutrality" requirement. Section 1115 waivers allow the state to waive specified federal requirements to test out experimental programs. Parts of the current CalAIM initiative, such as certain transitional housing community supports for Medi-Cal members and the Global Payment Program for public hospitals, are authorized under an 1115 waiver and may be difficult to reauthorize under the new criteria. (§71118)

  Note: there is one provision that establishes a Rural Health Transformation Fund of $50 billion over five years. (§71401) However, these funds are to be distributed to states with applications approved by the Secretary of the U.S. Department of Health and Human

[1] https://www.gov.ca.gov/2025/06/27/governor-newsom-slams-trump-over-bill-that-would-cut-millions-in-health-coverage-food-assistance-for-california/

[2] States that did not expand their Medicaid programs under the Affordable Care Act may continue to tax at the existing 6% rate.

[3] This limitation is 110% of the Medicare rate in states that did not expand their Medicaid programs under the Affordable Care Act.

[4] Note the category "expansion adults" is sometimes referred to as "childless adults" but it includes some parents due to the higher income cut-off for this Medicaid category than for the preexisting parent category.

Services (HHS) with minimal criteria for distribution. Thus, there is no guarantee how much funding, if any, California would receive from this fund.

Reductions in access to care:

- Requires expansion adults to demonstrate 80 hours of work, education, or volunteer activities to be eligible for Medicaid coverage, unless they qualify for a limited exemption (pregnant or postpartum; incarcerated; parents with dependent children under age 14; disabled veterans; individuals with serious or complex medical conditions, including substance use or disabling mental disorders; and former foster youth). Because the work requirement is based on federal minimum wage, many may be exempt if they earn at least $580 in monthly income. Requires states to verify this requirement twice a year. (§71119)
- Limits which lawfully residing immigrants are eligible for federal payment for full-scope Medi-Cal. Newly excludes refugees, asylees, humanitarian parolees, survivors of trafficking or domestic violence, and individuals granted withholding of removal. This change would also limit the federal share of payment to 50% for emergency services for these immigrants, as described under §71110 above, as they now have "unqualified immigration status." (§71109)
- Requires expansion adults to redetermine their eligibility for Medi-Cal twice a year rather than once a year. Expansion adults are currently one-third of the Medi-Cal population, so this will add considerable administrative burden. (§71107)
- Reduces the time period that Medi-Cal recipients can get retroactive coverage prior to the date of application from the current three months to one month for expansion adults and two months for everyone else. This generally occurs when an individual seeks emergency services and is enrolled in Medi-Cal at the hospital. (§71112)
- Limits the value of an exempt home for those subject to the assets test in determining eligibility (seniors and persons with disabilities) to $1 million. (§71108)
- Requires states to impose cost-sharing on expansion adults for Medi-Cal services, excluding primary care, prenatal care, mental health, and substance use disorder services and care provided at federally qualified health centers, rural health centers and behavioral health centers. In many cases this will either limit access to health care or limit the amount providers are paid if services are provided without collecting the co-payment. (§71120)

One bright note is that the bill broadens eligibility for home and community-based services; states are no longer limited to providing home and community-based services only to individuals who are assessed as eligible for institutional level care, as was previously required. (§71121) However, California may not be to expand these services under this option, given the other cuts and administrative requirements are expected to severely constrain resources available for Medi-Cal overall. In addition, there are measures to address fraud, waste, and abuse that align with California's current efforts to ensure that Medi-Cal beneficiaries and providers are not deceased or that the providers are not also enrolled in another state, but the savings from these efforts are not expected to be large (§71103, 71104, 71105). Finally, any

reductions in eligibility for the Medi-Cal program will increase the number of uninsured, which is an indirect cut to providers who still serve these individuals, particularly hospitals and community clinics.

Health impacts of immigration enforcement actions

In January, the Department of Homeland Security reversed guidance requiring Immigration and Custom Enforcement (ICE) to refrain from immigration enforcement actions in certain sensitive locations, with specified exceptions.[5] The policy dates back to at least 2011 and included hospitals as sensitive locations.[6] In 2021, the policy was expanded to also include other health care facilities, such as doctor's offices, health clinics, vaccination or testing sites, urgent care centers, and sites serving pregnant individuals, in addition to the other types of facilities such as schools, institutions of worship, places where children gather, social services establishments, places where disaster or emergency response are being provided, cites of religious or civil ceremonies and observances occur, and during public demonstration.[7]

In June, ICE dramatically increased immigration enforcement, particularly in Los Angeles. According to a June 20, 2025 article in the LA Times, these operations have resulted in the disruption of health care services in Los Angeles. The LA Times reported that "once-busy parks, shops, and businesses have emptied as undocumented residents and their families hole up at home in fear." Health advocates and providers contend that these actions scare people away from seeking basic medical care. The LA Times reported that many patients are opting to skip chronic-care management visits, routine childhood checkups, and childhood vaccinations, and are not picking up their medications at the pharmacy. In response, federally qualified health centers (FQHCs) have been scrambling to organize virtual appointments, house calls, and pharmacy deliveries to patients who no longer feel safe going out in public. A survey of 66 members of the Community Clinic Association of Los Angeles County about patient no-shows found no universal trends. Some clinics have seen a jump in missed appointments, while others have observed no change. One health care system, St. John's Community Health, has seen a significant drop in patient visits. Prior to the raids, the system's network of clinics logged about a 9% no-show rate. In recent weeks, more than 30% of patients have canceled or failed to show. A medical director at St. John's said, "A patient with hypertension who skips blood pressure monitoring appointments now may be more likely to be brought into an emergency room (ER) with a heart attack in the future. If [people] can't get their medications, they can't do follow-ups. That means a chronic condition that has been managed and well-controlled is just going to deteriorate. We will see patients going to the ER more than they should be, rather than coming to primary care." For non-emergency care, the Los Angeles County Department of Health Services published remote care option resources for their patients. Included are phone

[5] https://www.dhs.gov/sites/default/files/2025-03/25_0120_S1_enforcement-actions-in-near-protected-areas.pdf
[6] https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf
[7] https://www.ice.gov/doclib/news/guidelines-civilimmigrationlaw10272021.pdf

numbers and portals where county clinic patients can call a nurse advice line and request medication drop-offs. The department encourages people who would rather stay home to call their clinic and change their appointments to virtual or phone visits.

Health care providers are also experiencing the effects of ICE operations first-hand. A June 14, 2025 article in CalMatters reported that the Hospital Association of Southern California said that it was not aware of any immigration enforcement activity inside or directly outside any Southern California hospital campus, but that the chilling effect was noticeable in some emergency waiting rooms, with some hospitals reporting declines in ER volume. However, according to a CBS News Healthwatch posting from July, one emergency medicine doctor in Los Angeles told the news agency that "…agents are arriving with ski masks and looking intimidating to the general patient, affecting the overall health of the community because it's creating an atmosphere of fear instead of wellness." The doctor also alleged that agents have committed ethics violations, including failing to disclose their identification, disregarding patient privacy during interviews and examinations, preventing doctors from contacting family for necessary medical information, and preventing family from visiting.

Federal administrative actions impacting access to health care

In addition to H.R. 1 and immigration raids, a number of federal administrative actions have had a chilling effect on access to health care, particularly targeting immigrant populations. In June, the California Department of Health Care Services (DHCS) learned that HHS transferred *en masse* the Medicaid data files of millions of individuals to the Department of Homeland Security. According to reporting by the Associated Press, senior HHS political appointees ordered that data be shared immediately, over the objections of career staff who advised that such a transfer would violate federal law.[8] According to DHCS, as required by federal law, DHCS submits monthly reports to the Centers for Medicare and Medicaid Services (CMS) through the Transformed Medicaid Statistical Information System (T-MSIS).[9] These reports include demographic and eligibility information, such as name, address, date of birth, Medicaid ID, Social Security number (if provided), and broad immigration status, for every Medi-Cal member. Data submitted to CMS, including through T-MSIS, is considered sensitive and confidential. Neither HHS nor the Department of Homeland Security acknowledge the transfer; however, the Associated Press later reported obtaining an agreement between the CMS and the Department of Homeland Security to give ICE officials the personal data of the nation's 79 million Medicaid enrollees to identify people for purposes of deportation.[10]

[8] https://apnews.com/article/medicaid-deportation-immigrants-trump-4e0f979e4290a4d10a067da0acca8e22
[9] https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2025/25-20-Statement-Federal-Use-Medi-Cal-Data-6-13-25.aspx
[10] https://apnews.com/article/immigration-medicaid-trump-ice-ab9c2267ce596089410387bfcb40eeb7

California led a group of 20 states in suing the Trump administration seeking to prevent the Department of Homeland Security from using the data for immigration purposes and to end the data-sharing agreement. On August 12, the states obtained a preliminary injunction to stop the use of data obtained from those states for immigration enforcement purposes to stop HHS from continuing to share their Medicaid data.[11] The preliminary injunction stated that while the sharing of data did not appear categorically unlawful, given the previous policy to not use such data for immigration purposes and the publication of that policy, there was a strong reliance interest that should have only been changed by engaging in a reasoned decision-making process before adopting and implementing the change. The preliminary injunction is to remain in place until 14 days after that process occurs or the termination of the case.

Finally, in July HHS announced that it had rescinded a 1998 rule interpreting the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 defining which federal public benefits could exclude individuals for reasons of immigration status.[12] The new policy clarified that no HHS program benefit could be provided to individuals without a qualified immigration status, including several health programs that were previously available to people regardless of immigration status such as certified community behavioral health clinics, health center programs, programs funded through community mental health services block grants, mental health and substance use programs administered by the Substance Abuse and Mental Health Services Administration, and Title X family planning programs.

Conclusion

Recent federal actions will affect the health of many California communities for years to come. While the projected impacts of H.R. 1 are still being analyzed, California will be challenged to maintain current levels of health care access and coverage, based on the magnitude of federal disinvestment contained in the bill. In addition, federal action restricting eligibility for and use of health care services by immigrant communities has the potential to undermine community health by reducing access to, and discouraging use of, medically necessary health care. As the state grapples with a challenging fiscal environment and reduced federal support, in the wake of a pandemic that demonstrated the importance of a strong health care delivery system and how profoundly our neighbors' health can impact our own, it will be important for the Legislature to understand any negative impacts on the health care delivery system and individual Californians, and explore options to mitigate such impacts.

[11] https://oag.ca.gov/system/files/attachments/press-docs/98%20Order%20Granting%20in%20Part%20and%20Denying%20in%20Part%20PI.pdf
[12] https://www.hhs.gov/sites/default/files/prwora-notice.pdf