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CALIFORNIA

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NEVADA COUNTY BOARD OF SUPERVISORS
Board Agenda Memo

MEETING DATE: January 28, 2026

TO: Board of Supervisors

FROM: Ryan Gruver, Health and Human Services Agency Director

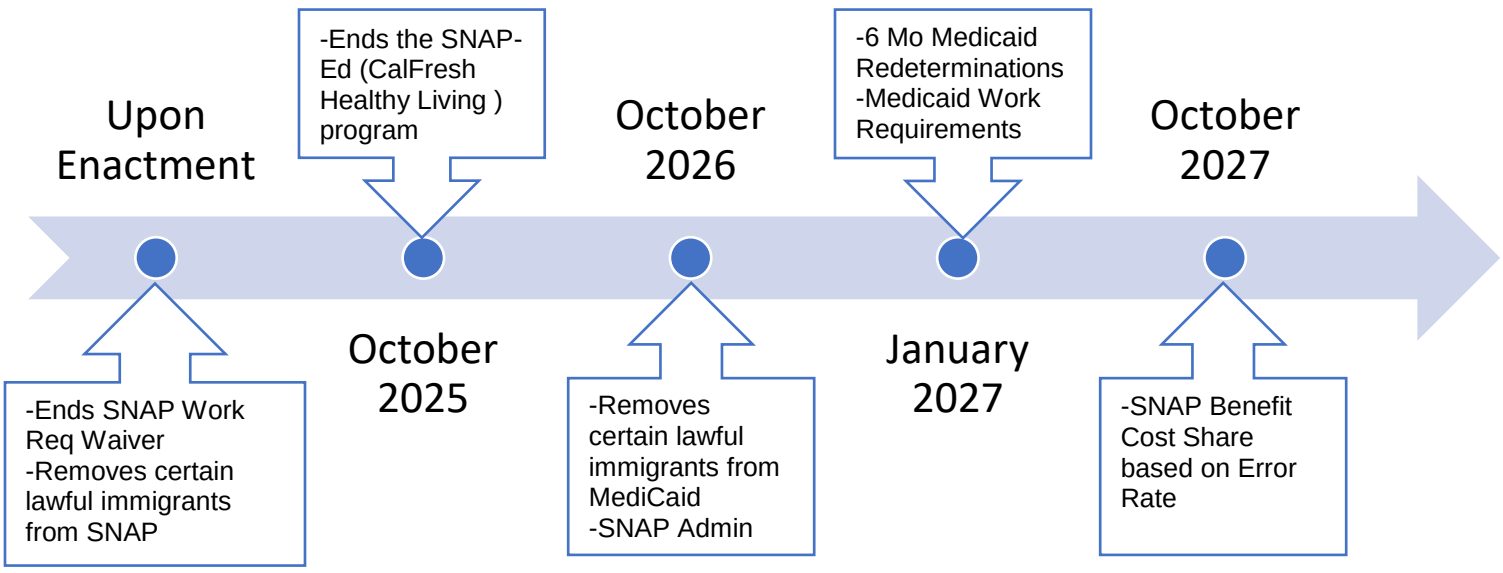
SUBJECT: H.R. 1 Implementation Update

RECOMMENDATION: Information only.

FUNDING: N/A

BACKGROUND:
The Board of Supervisors will receive an update and participate in a panel discussion regarding House of Representatives Resolution 1, the federal reconciliation package of 2025 (H.R.1). This will include a summary of the major provisions of H.R.1 as they relate to county services and finances. Additionally, California counties operate many federal programs on a pass-through basis from the state, meaning that many programs include a blend of State and Federal funding, and that updates to federal guidance, state guidance, and sometimes state law are needed to implement H.R.1. The panel will discuss current status of implementation, and highlight areas needing legislative advocacy.

Timeline of Major H.R. 1 Provisions Affecting Counties



Impacts by Program

While H.R.1 impacts many federal and state programs, impacts that directly relate to County Services include impacts to MediCaid (Medi-Cal in California), and SNAP (CalFresh in California). Additionally and relatedly, the Provider Tax provisions of H.R.1 impact the MediCal and broader Healthcare system and state budget, and thus impact county services and funding indirectly. H.R.1 also makes changes to the Low Income Housing Tax Credit Program.

Many of the changes are effective "upon enactment" and others have specific effective dates, and sometimes waivers that allow for longer implementation. Even where there are enactment dates, often Federal guidance is needed to define how the law must be implemented. For passthrough programs, State guidance, and sometimes updates to State Law are needed before changes can be implemented.

<u>Medi-Cal</u>

Taken together, the changes to the Medi-Cal program are likely to increase workload for county staff, and reduce enrollment in the program, thus increasing the number of uninsured individuals in the County. The increase in workload is highly dependent on forthcoming Federal and State guidance. The number of residents who will lose coverage is unknown, but estimates are in the range from 2,000 to 6,000.

The major provisions impacting county workload and enrollment in MediCal include the following:

- **Work/Volunteer Requirements** – Effective January 1, 2027 H.R.1 imposes an 80/hour a month work, education or "community engagement" requirement for individuals aged 19 to 64. Limits exemptions for households with children to those 13 and under (instead of all households with children). This is a new workload for county eligibility staff. Some citizens will lose coverage because they do not meet the requirement, and others will lose coverage due to this new bureaucratic hurdle.
- **6 Month Redeterminations** – Effective January 1, 2027 MediCal Redeterminations will be required every 6 months for adults 18-64. Currently redeterminations are annual, so this is a doubling of workload for this population.

In both of the above cases, Counties require state guidance before implementation can occur. Additionally, the State funds counties for administering Medi-Cal, and it remains to be seen whether the State will allocate more resources.

Secondary Impacts:

- Impact of increased uninsured on the healthcare sector
- County Indigent Care Requirements (Discussed further below)

County Indigent Care Requirements:

- Counties have had a role in indigent healthcare as long as there have been counties
- Welfare and Institutions Code (WIC) 17000 was created in 1937, codifying county obligations as the provider of last resort.
    - *Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by*

their relatives or friends, by their own means, or by state hospitals or other state or private institutions.

- The State funded counties to meet this obligation through General Fund appropriation
- In 1983, the County Medical Services Program was created, allowing small counties to pool resources to meet WIC 17000 obligations
- In 1991, the California Legislature included WIC 17000 obligations in Realignment, and for CMSP counties realignment was sent to CMSP for operation of the program.
- With the implementation of the Affordable Care Act in 2013, the number of uninsured California residents plummeted, and in Nevada County CMSP enrollment dropped from 1874 in December of 2013, to 34 in January of 2014. The caseload has hovered between zero and 10 ever since.
- Due to the dwindling caseloads and savings in indigent healthcare due to the Affordable Care Act, the California Legislature passed Assembly Bill 85 in 2013, which redirected county indigent healthcare realignment dollars, and repurposed these funds to enhance CalWorks benefits for families.
    - WIC 17000 was not touched as part of this legislation, meaning counties retained this responsibility, even though the funding was redirected.
- With the passage of H.R.1, the number of uninsured is expected to increase. CMSP estimates that the Covered California subsidy losses and work requirements will result in close to 3000 new uninsured Nevada County residents, and 96K across all CMSP counties. If this estimate is correct, CMSP's annual operating cost is anticipated to be $800 to $850 Million, which means they would exhaust their reserves in a matter of months.
    - AB 85 includes trigger language that the State must restore realignment funding if CMSP drops below a certain operating reserve. The State has thus far been silent on this provision.
- Absent CMSP being fully funded, Counties will be obliged to meet WIC 17000 obligations with local resources.
    - This is a key area of legislative advocacy for the county's fiscal health.

<u>SNAP</u>

The Supplemental Nutrition Assistance Program (SNAP) is known as CalFresh in California. As with MediCal, H.R.1 includes numerous changes to eligibility and county workload. Additionally, H.R.1 increases the share of cost for the State and Counties for administering the program, and for the benefits themselves.

The major provisions of H.R.1 as they impact counties and county services are as follows:

- Upon Enactment of the Legislation: H.R.1 removed eligibility for certain legal immigrants, and terminated a work requirement waiver covering veterans, people experiencing homelessness, and former foster youth (This waiver would have expired in 2026). These provisions will result in some people losing benefits, and in more work for County Social Services. While technically effective upon enactment, counties require State and Federal guidance to implement these changes.
- October 2025: H.R.1 terminated the SNAP-Ed program, known as CalFresh Healthy Living. This program was implemented through Public Health, and paid for contracted staff to provide nutritional education in schools and at community events. The program will end when funds are exhausted.
- October 2026: Effective with the 26/27 Federal Fiscal Year, states' share of cost for administering SNAP will increase by 50%. In California, state law gives counties a

percentage share of the State administrative costs, meaning the County's share will also increase by 50%, from an estimated $800,000 up to $1,200,000 (A $400,000 increase).

- October 2027: Effective with the 27/28 Federal Fiscal Year, States will receive a share of cost based on SNAP error rates. Currently the federal government pays for 100% of SNAP benefits. Effective with this change, state share of cost will be as high as 15% based on error rate. California is currently in the highest error tier, meaning the share of cost would be 15%. It's important to note that the error rate can be things like small income reporting errors outside a county's control, as well as small administrative errors. In a small county, a few errors can result in a high percentage error rate.
- A key area of legislative advocacy is to oppose efforts of the State to pass benefit cost share on to counties, as well as to fully fund their share of Administrative Costs.

Provider Tax Limitations

Provider taxes are utilized by 48 states, and are heavily relied on by California to help fund the Medi-Cal program. There are multiple varieties of provider taxes, and in California, the Managed Care Organization (MCO) tax, recently codified and restricted by Proposition 35, is a key tool for funding Medi-Cal. The MCO tax is paid by insurance companies contracted by the state to manage healthcare for Medi-Cal recipients. These taxes allow the state to pay enhanced rates to providers like hospitals and Federal Qualified Health Centers who serve Medi-Cal patients. These revenues are crucial to rural jurisdictions where hospitals often operate on slim margins and where the proportion of public payors (Medi-Cal and Medicare) are typically higher.

The major changes to Provider Taxes as impact healthcare services in Nevada County are as follows:

- Upon Enactment: Ban on non-uniform provider taxes. This means a ban on taxes that impose a higher tax on managed care organizations that support Medi-Cal. California's tax is highly disproportional and not allowed under this new rule. There is a grace period associated with implementation of this change.
- October 2026: H.R. 1 bans new provider taxes
- October 2027: Phase down of the maximum percentage of provider taxes in states that expanded Medicaid under the Affordable Care Act (known as Expansion States).

Collectively these measures are fatal to California's current Provider Tax structure. The precise fiscal impacts to the State budget, to the Medi-Cal program, and to hospital and clinic funding is yet unknown but likely significant. A key area for legislative advocacy is ensuring adequate funding for rural healthcare providers, and resisting efforts by the state to pass new costs on to counties.

The panel will answer questions of the Board of Supervisors.

Item Initiated and Approved by: Ryan Gruver, Health and Human Services Agency Director

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