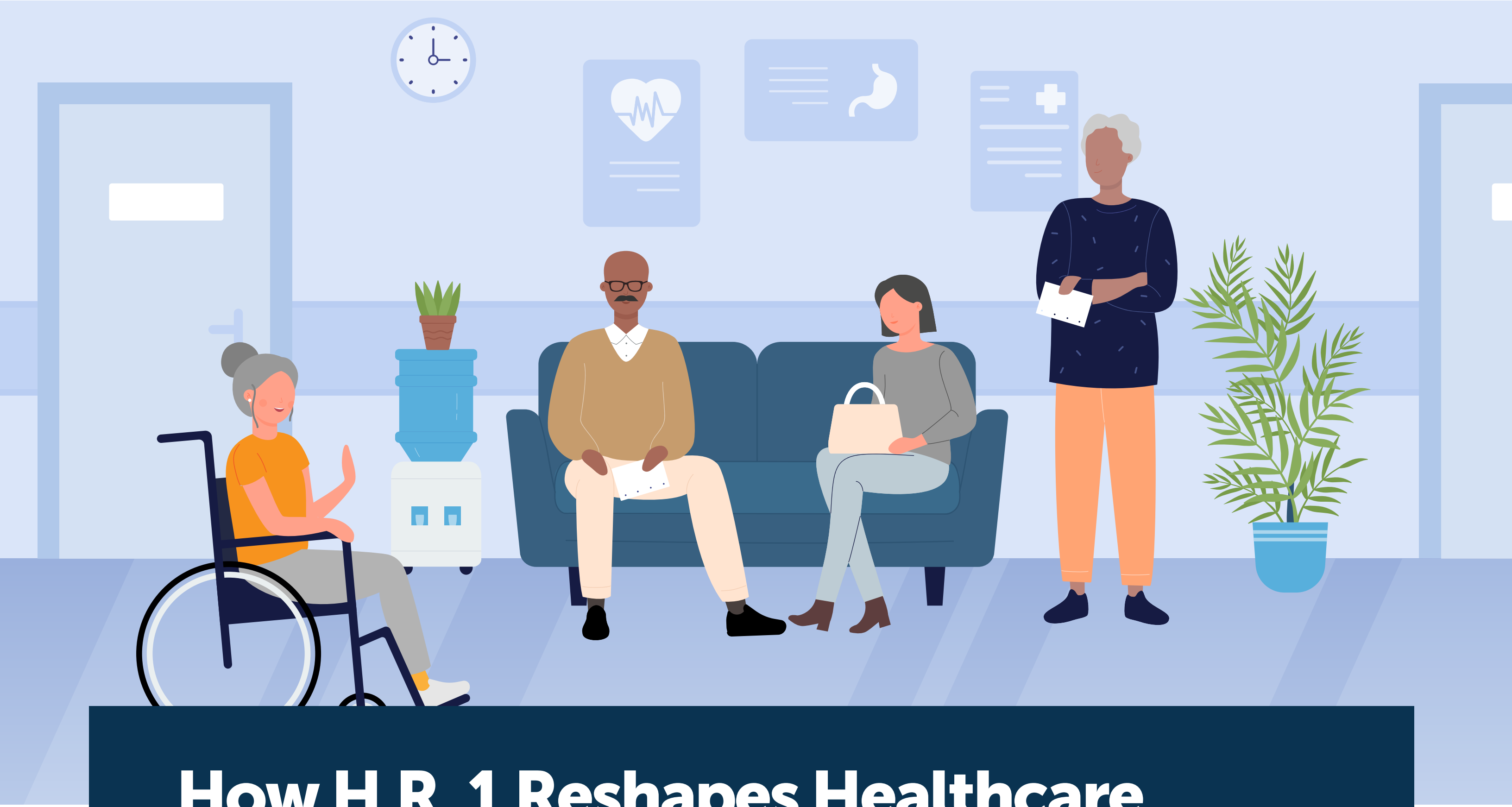
ISSUE BRIEF



How H.R. 1 Reshapes Healthcare for Older Adults

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Introduction

H.R. 1, or the One Big Beautiful Bill Act (OBBBA) was signed into law on July 4, 2025. The legislation introduced wide-ranging reforms across Medicaid and Medicare, with significant implications for how states finance and deliver care to older adults. In addition, OBBBA includes changes to social services, such as the Supplemental Nutrition Assistance Program (SNAP), and provides funding for transforming rural healthcare systems.

This issue brief highlights OBBBA's key Medicaid and Medicare provisions, and other significant changes to the continuum of services for older adults that affect healthcare access and affordability for older adults. While OBBBA's changes will present challenges to states, understanding these provisions can help policymakers and stakeholders find innovative opportunities and solutions to mitigate potential risks for older adults.

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Medicaid Provisions

Medicaid enrollment and eligibility changes

OBBBA includes multiple changes to Medicaid enrollment and eligibility policy, several of which will have implications for older adults' access to care including long-term services and supports (LTSS) including:

Community engagement requirements: The new law mandates that Medicaid enrollees aged 19 to 64 enrolled through Medicaid expansion complete and report 80 hours per month of qualifying activities, such as paid employment, school, or volunteering. States must verify compliance with work requirements during eligibility redeterminations at least every six months and are required to exempt certain groups, such as family caregivers and individuals with disabilities or chronic conditions who meet the definition of 'medically frail'.[1] The new work requirements mean that older adults and their caregivers will have additional administrative barriers to acquiring or maintaining Medicaid coverage.

With most older adults exempt from these requirements, eligible adults ages 50 to 64 will have to comply with the new reporting rules. Many in this age group experience higher rates of chronic illness, disability, and unstable employment patterns and could lose coverage because of administrative or reporting barriers.[2] States have discretion to determine qualifying conditions and required documentation for the medically frail criteria. Without federal guidance, some states may rely on health evaluations or provider attestations, but this variation may put many at risk from losing coverage because of burdensome verification processes to determine medical frailty.[3] Some states may limit this criterion to a narrow set of physical disabilities, making it especially difficult for individuals with mental health conditions, cognitive impairments, or other fluctuations to demonstrate frailty to qualify for an exemption.

Although caregivers may technically qualify for exemptions, they must document and regularly verify their caregiving responsibilities. This may be an administrative burden that can be difficult for caregivers to meet as many often have limited time and caregiving may not always be formally recognized or easily verifiable. Additionally, details on how caregiving is defined are also open to interpretation by states and unpaid caregiving may not always be recognized in policy.[4] This puts caregivers at risk of losing coverage and may affect whether some older adults who depend on caregiving can remain at home.

Delayed implementation of the 2024 Eligibility and Enrollment Final Rule: The rule aimed to reduce administrative burden, decrease barriers to enrollment, and streamline eligibility and enrollment processes. OBBBA delays implementation of this rule until 2034, including maximum timeframes for eligibility redetermination and a renewal process which aligns steps between the Modified Adjusted Gross Income (MAGI) populations and non-MAGI (older adults and adults with disabilities) populations.[5,6]

Enhanced member data validation: States are required to validate member addresses at least monthly using approved data sources to ensure they are not enrolled in multiple states.[7]

Retroactive Medicaid eligibility coverage reduction: Previously, all Medicaid enrollees were entitled to three-month retroactive eligibility during their application period. OBBBA reduces this to two months of retroactive coverage for older adults.[8]

Long-term services and supports home equity limit: Prior to OBBBA, eligibility for Medicaid-covered LTSS was subject to a home equity limit set by each state, with a national ceiling which was annually adjusted for inflation. OBBBA institutes a ceiling of $1,000,000 without an annual inflation adjustment.[9]

The administrative changes may increase the likelihood of older adults being disenrolled in error due to procedural reasons (e.g., misreported addresses) rather than real changes in eligibility status. Retroactive coverage helps older adults manage unexpected medical costs incurred before applying for Medicaid, and a reduction could increase financial risk and delay access to care. Along with home equity limits, these changes may reduce access to LTSS over time. In addition, providers, and particularly hospitals, that serve large Medicaid populations may see reductions in revenue, resulting in less financial stability.

Medicare Savings Program

OBBBA delays the implementation date of a CMS final rule meant to reduce barriers in enrollment in Medicare Savings Programs (MSPs), which provides Medicaid coverage of Medicare premiums and cost sharing for low-income Medicare members.[10] The rule streamlined the Medicaid application process for accessing the Medicare Savings Program in two ways: (1) by automating the MSP application for people who receive Medicare Part D's low-income subsidy, and (2) through automatic enrollment of Medicare members who are already enrolled in the government's Supplemental Security Income program.[11] CMS estimated that it would lead to nearly 1 million additional individuals being enrolled in MSPs.[12]

The suspension of the proposed rule is estimated to reduce federal expenditures by an estimated $66 billion over the next decade.[13] However, it will also reduce access to assistance with Medicare premiums and cost sharing for eligible low-income older adults, making it harder for them to afford the healthcare services they need.

Long-term services and supports[i]

New HCBS waiver option: Medicaid home and community-based services (HCBS) waivers allow older adults and people with disabilities requiring an institutional level of care to live in their home or a setting in their community.

i In addition to provisions below, OBBBA delayed the implementation of an April 2024 rule establishing minimum staffing standards for long-term care facilities like nursing homes until 2034. However, CMS later repealed the rule in December 2025, thus it will not go into effect in 2034.

OBBBA adds a new provision that permits states to expand eligibility of HCBS waivers for individuals who do not require an institutional level of care. Under this provision, states can use a 1915(c) waiver to serve people with lower acuity needs, provided they establish needs-based eligibility criteria, maintain per capita cost neutrality, and ensure that expansion does not lengthen waiting lists for individuals requiring institutional-level HCBS.[14] The provision also makes available to the CMS Administrator $50 million for fiscal year 2026 and $100 million for fiscal year 2027 for implementation purposes.[15]

This option would help more individuals, particularly older adults, remain at home, and possibly reduce future institutional costs. However, it is unclear which states might pursue this option given the requirement that new non-institutional waivers do not extend waiting times or exceed per capita costs. Average time on a waitlist to receive HCBS waiver services was 40 months in 2024, based on a survey in which 32 states responded.[16] As the waiver expansion is optional, states will need to determine whether they can pursue the new non-institutional waiver amidst other fiscal and administrative constraints in OBBBA.

Downstream effects on HCBS:
While OBBBA did not directly reduce HCBS funding, the law is likely to have downstream effects on HCBS access as states face growing budgetary pressures. Over 21 million people rely on HCBS nationwide, of whom 3 million may need to use institutional services if states are unable to sustain current levels of service.[17,18]

Figure 1. Timeline of OBBBA's key provisions

Key:

- Medicaid Provision
- Medicare Provision
- SNAP Provision
- Rural Health Transformation Program Provision

Acronyms:

HCBS: Home and community-based services

SNAP: Supplemental Nutrition Assistance Program

7/24/25

- Delays implementation of the 2024 Eligibility and Enrollment Final Rule
- Introduces restriction preventing states from introducing new provider taxes
- Introduces restriction on state directed payments

12/31/25

- Announcement of Rural Health Transformation Program awardees

1/1/26

- Temporary 2.5% increase in the Medicare physician payments

1/22/26

- Potential sequestration of $45b in Medicare funding

10/1/26

- Increases state share of SNAP administrative costs to 75%

The provisions affecting states' ability to fund their Medicaid programs, including the restrictions on provider taxes and limits on state-directed payments, mean that states may make changes to their HCBS programs to absorb funding losses. States may have to decide whether to cut services, either by reducing benefits or restricting eligibility. However, this must be balanced against maintaining HCBS access for a rapidly growing aging population.

When faced with budgetary pressures in the past, states reduced HCBS, which are optional services, by limiting per-enrollee spending or tightening eligibility. Following the Great Recession in 2009, nearly every state cut HCBS spending or access, leading to increases in waitlists for HCBS waivers.[19] In addition, reduced funding threatens the stability of the direct care workforce and family caregiver programs, both critical to sustaining HCBS access.

12/31/26

- Implementation of Medicaid work requirements by states

1/1/27

- Introduces regular monthly member data validation
- Reduces Medicaid retroactive eligibility coverage
- Increases frequency for Medicaid redeterminations

10/1/27

- Introduces requirement that states pay up to 15% of SNAP expenditures based on the payment error rates in the state

1/1/28

- Reduces the long-term services and supports home equity limit
- Introduces new Medicare drug price negotiation limitations

7/1/28

- Introduces a new HCBS waiver expansion option for states

Medicare Provisions

OBBBA includes several Medicare provisions that will affect healthcare providers and enrollees. While there may be short-term financial relief for physicians, other changes could lead to financial strain for providers, leading to longer waiting times and potential service reductions for Medicare enrollees. Barring additional legislative or regulatory action, this could result in significant changes in Medicare spending over the next decade.

Medicare physician fee schedule increase: Starting in 2026, physicians providing care to Medicare members will receive a temporary 2.5% increase in reimbursement, intended to offset a 3% cut implemented in November 2024.[20] However, the relief is a temporary measure as stakeholders advocate for more permanent updates to the conversion factors that account for inflation and growth in physician practice costs. Currently, Medicare physician payment rates tend to be lower than those paid by private insurers, as private sector rates for physician services range from 110% to more than 300% of Medicare's physician fee schedules.[21]

Medicare funding sequestration: Under the rules of reconciliation, the final bill must comply with the Statutory Pay-As-You-Go Act of 2010 (PAYGO). Under PAYGO, the Office of Management and Budget must cancel budgetary resources, or sequester funds, should the bill show a net increase in the deficit. Per Congressional Budget Office estimates, OBBBA increases the deficit by more than $200 billion per year over the next decade. If Congress does not pass offsetting legislation, the Office of Management and Budget must implement mandatory cuts. Under PAYGO, Medicare spending cuts are limited to 4% of current Medicare expenditures. For FY 2026, this would result in a cut of $45 billion to Medicare. By 2034, total reductions in Medicare spending would total nearly $500 billion.[22]

Medicare drug price negotiation limitations: Under the Medicare Drug Price Negotiation Program, established by the Inflation Reduction Act, Medicare can negotiate prices for drugs without generic competition. Certain orphan drugs, or medications developed to treat rare diseases, were originally exempt from these negotiations. OBBBA expands these exclusions beginning in 2028 by broadening the definition of orphan drugs to include those designated for one or more rare diseases and extending their exemption period from price negotiation.[23] These changes are intended to encourage continued investment and research in treatments for rare conditions and to incentivize manufacturers to develop additional uses for existing orphan drugs, but also reduces Medicare's ability to negotiate lower prices, keeping certain medications costly for enrollees.

Without sustained updates to the physician fee schedule and actions to prevent PAYGO-triggered reductions in Medicare spending, healthcare providers are likely to face financial pressures, which could reduce the number of Medicare enrollees they treat or increase costs for the Medicare program, both of which could negatively affect access to care for Medicare enrollees.

Rural Health Transformation Program

While the U.S. population is rapidly aging, the proportion of older adults in rural areas is higher, with more than 20% of rural residents over 65.[24] Older adults are more likely to use healthcare services, particularly for multiple chronic conditions, and experience poorer health outcomes in rural communities due to provider shortages and limited access to specialty care. This demographic shift is creating increased pressure on rural health systems.

The Rural Health Transformation Program (RHTP) intends to alleviate many of the challenges faced by rural healthcare systems, such as workforce shortages and hospital financial uncertainty.[25] The program distributes $10 billion per year between 2026 and 2030 to all states, each of which applied through a competitive process by the November 5, 2025 deadline. The program's goal is to generate grand-scale changes in the delivery of rural health through technology implementation, innovative financing strategies, and workforce recruitment and development. States were required to detail in their applications how funding will improve rural health outcomes, drive health technology uptake, enhance rural healthcare provider coordination, and strengthen rural hospital financial stability, amongst other factors. Funding amounts reflect each state's respective rural populations and the number of rural health facilities. The RHTP has the potential to strengthen rural health infrastructure in ways that increase access to healthcare services for older adults in rural communities.

Food assistance

OBBBA made other cuts and programmatic changes, which, while not directly related to health services, may impact the continuum of social services which older adults may receive. In particular, the legislation cuts federal funding for SNAP by $187 billion through 2034, or about 20% of the program's budget.[26] These cuts could make it harder for individuals to afford groceries and other food.

The law applies work requirements to older adults aged 55 to 64, who must now document at least 20 hours of work per week or prove they qualify for an exemption.[27] Additional paperwork requirements include eliminating automatic qualifications for a standard utility allowance for those who are enrolled in the Low-Income Home Energy Assistance Program and restricting the ability to deduct internet costs under the standard utility allowance. Collectively, these changes add barriers to SNAP enrollment and could discourage or disqualify older adults from maintaining SNAP benefits.

Historically, SNAP has been federally funded with states covering 50% of administrative expenses. However, OBBBA includes significant cost-shifting to states, who will now be responsible for paying 75% of administrative costs, and up to 15% of SNAP benefits depending on payment error rates in their state.[28] Cuts to state administrative funding could also lead to more frequent procedural terminations and barriers to recertifying benefits. Coupled with Medicaid funding cuts, states will face significant financial strain and may likely make cuts to their SNAP programs, increasing food insecurity for low-income populations, including older adults.

Looking Ahead

The healthcare service reforms outlined in OBBBA will significantly change how care is financed and delivered for older adults going forward. These provisions will continue to take effect through 2029, meaning there will be a long road of changes for policymakers, providers, and individuals. Maintaining access and quality of care for older adults will depend on close coordination between the federal government, state agencies, and local stakeholders.

Federal guidance to monitor

- Stakeholders can expect that CMS will provide rulemaking and guidance on how states should interpret and implement policy, particularly related to state-directed payments, provider tax and payment limits, and compliance with the new work requirements. In addition, CMS may provide guidance if there is a potential sequestration of Medicare funds, unless Congress takes action to suspend or repeal spending cuts.
- As CMS awarded states with RHTP funding, stakeholders should watch how CMS plans to manage oversight of the program to ensure investments effectively strengthen rural health systems. States will depend on local and regional partners to implement approved initiatives and to translate funding into measurable improvements in infrastructure and service delivery.
- The U.S. Department of Agriculture could issue further guidance to help states implement SNAP changes, including details on new cost-sharing requirements and how states can plan for related administrative and programmatic costs.[29]

States' role and partnerships

- The next several years will be characterized by growing budgetary pressures and administrative changes as policymakers work to efficiently implement the provisions of OBBBA.[30] States are preparing for significant changes to Medicaid and SNAP funding structures, which will likely require adjustments to budgets, resources, or service delivery. Stakeholders, including providers, health systems, and managed care organizations, will need to adapt to potential shifts in coverage eligibility, reporting expectations, and other operational changes.
- Policymakers should work with aging partners and stakeholders to consider how to best preserve access to HCBS services amid budgetary uncertainty and an aging population, because while HCBS are optional, they are also cost-effective. This could include conducting internal analyses to identify which services are most impactful, especially for high-need populations, like many older adults.
- Maintaining regular engagement and partnerships between policymakers and key stakeholders, including providers, managed care organizations, community-based organizations, and advocacy groups, can help ensure policy changes align with community needs, protect access to care, and minimize negative impacts on vulnerable populations.

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