May 30, 2025

On May 22, the House of Representatives passed HR 1, the "One Big Beautiful Bill (OBBB)." The Congressional Budget Office (CBO) estimates as of 5/30/2025 (a new score is expected the week of June 2) 10 million people will lose their health care coverage – about 8 million from Medicaid changes and about 2 million from changes to the Marketplaces. This estimate is before the changes that were made in the House Rules Committee on May 21 prior to passage so it will probably be higher in the new score. The bill cuts over $800 billion dollars out of Medicaid and hundreds of billions of dollars via Marketplace changes in order to pay for tax cuts that overwhelmingly benefit the wealthiest Americans. This article provides a non-exhaustive summary of key health provisions in the bill that LeadingAge members should be aware of, and that LeadingAge staff is monitoring closely. We are continuing our advocacy in the Senate and encourage you to take action here.

LeadingAge continues to oppose this bill. This article outlines our concerns with specific policies in the bill as well as the overall negative impact we believe this bill will have. However, we will be working in the Senate to mitigate the impacts on LeadingAge members and those they serve if this bill becomes law.

Medicare Cuts

While the bill does not directly make cuts to Medicare (outside of the changes to coverage for legal immigrants outlined above), the bill as written would result in Medicare payment cuts to providers. A May 21 letter from the Congressional Budget Office (CBO) to House Budget Committee Ranking Member Brendan Boyle (D-PA) indicates that under the statutory Pay As You Go Act of 2010 (PAYGO), the "One Big Beautiful Bill" would trigger an increase in the deficit that would in turn trigger Medicare sequestration cuts (along with other cuts). Medicare sequestration cuts under PAYGO are capped at 4%; CBO anticipates that Medicare cuts between 2027-2034 would be $490 billion (and estimates a $45 billion sequestration for 2026). PAYGO can be waived, but this would require an act of Congress and cannot be done with a majority threshold in the reconciliation process. If waiving PAYGO comes up during a debate during reconciliation, someone will raise a budgetary point of order, and a 60-vote threshold is required to overcome the point of order. In 2017 with the Tax Cuts and Jobs Act (TCJA), a separate bill to waive PAYGO had to be passed after the reconciliation process.

Rule Moratoriums

Section 44101: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs. This section requires the Department of Health and Human Services (HHS) to delay implementation, administration, or enforcement of the final rule "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" until January 1, 2035 (nine years). If implemented, this rule would have increased the number of low-income seniors who were able to access Medicare Savings Programs (MSPs). MSPs use Medicaid dollars to cover Medicare costs like premiums and co-pays. This provision is effective upon the enactment of the legislation.

- CBO Score as of 5/30/2025: Saves $81.8 billion over ten years (2025-2034)

Section 44121: Moratorium on Implementation of Rule Relating to Staffing Standards under the Medicare and Medicaid Programs. This section delays implementation of the Biden-Harris Administration's final nursing home staffing rule, in its entirety, by nine years. These staffing standards would not take effect until January 1, 2035. LeadingAge supports this policy.

- CBO Score as of 5/30/2025: Saves $23.1 billion over ten years (2025-2034)

Changes to eligibility determinations

Section 44108: Increase frequency of eligibility determinations for certain individuals. This section requires that states do eligibility redeterminations every six months for individuals in the expansion population (current law only requires them every 12 months). LeadingAge is concerned that increased eligibility checks will be a major burden on states and, in conjunction with other policies proposed in this bill, will take time, money, and personnel that states will be lacking. Similar to the bill's community engagement requirements detailed below, we worry about the older adult population such as those in HUD-assisted housing who might be utilizing Medicaid expansion for health coverage and therefore, would be subject to increased eligibility checks and may lose coverage due to the administrative burden. The sum of these policies will result in reduced access, rates, services, benefits, or all of the above. This provision is effective for renewals scheduled on or after December 31, 2026.

- CBO Score as of 5/30/2025: Saves $195 million over ten years (2025-2034) but the score does not reflect the updated implementation date of December 31, 2026

Section 44141: Community engagement requirements

The bill requires that states implement community engagement requirements on individuals aged 19-64 who are applying for coverage or enrolled through the expansion eligibility pathway. In order to meet the requirement, individuals must engage in 80 hours/month of work or community service or be enrolled at least part time in an educational program.

States must implement the requirements by December 31, 2026, but they can implement them earlier. These requirements will need to be satisfied at least one month before application (in order to enroll in Medicaid) and during enrollment for at least one month (in between eligibility determinations that will be occurring every six months per section 44108). States can require individuals to demonstrate compliance more frequently, such as every month. States can also require individuals to demonstrate compliance for multiple months preceding their enrollment or redetermination, such as showing they have been working for six months prior to their enrollment and redetermination. It also allows states to impose verification requirements more often than just at initial enrollment or redetermination. People could be asked to verify their community engagement or exemption as frequently as a state decides. These policies will lead to people losing coverage – termination can occur as soon as 30 days after noncompliance.

While there are categorical exemptions outlined in the legislative text, there is no requirement that the exemptions be automated. The mandatory exemptions in the bill are for people who are or have:

- Under age 19
- Pregnant or entitled to postpartum Medicaid coverage
- Enrolled in Medicare Part A or B
- Within three months of release from jail
- Native Americans
- Parent or caretaker relatives of disabled individuals or dependent children
- A veteran with a total disability rating
- Medically frail or otherwise as special medical needs as defined by the Secretary including those who are blind or disabled
- A substance abuse disorder
- Enrolled in an addiction program
- A disabling mental disorder

- A physical, intellectual, or developmental disability that significantly impairs at least one activity of daily living
- Serious and complex medical condition
- In compliance with similar requirements for the Supplemental Nutrition Assistance Program (SNAP) or the Temporary Assistance for Needy Families (TANF).

It is not clear how these exemptions will be further defined by states or what will be approved by CMS so there is likely to be large variability in how these exemptions are operationalized.

- CBO Score as of 5/30/2025: Saves $279.9 billion over ten years (2025-2034) but the score does not reflect the updated implementation date of December 31, 2026

Section 44109: Revising home equity limit for determining eligibility for long-term care services under the Medicaid program. This section establishes a fixed ceiling of $1,000,000 for permissible home equity values for individuals when determining allowable assets for Medicaid beneficiaries that are eligible for long-term care services. Currently, the home equity cap increases with inflation. This provision also eliminates the ability of states to make exceptions to the limit except for in the case of a home that is "zoned for agricultural use." This section also prohibits the use of asset disregards from being applied to waive home equity limits.

LeadingAge is concerned that this would effectively force individuals to choose between forfeiting essential services or borrowing against their home's value and thus jeopardizing their homeownership. Lowering the equity threshold would disproportionately impact low-income individuals, many of whom purchased their homes decades ago when property values were far lower. This issue is particularly acute for older Medicaid enrollees, who may be reliant on fixed incomes but have accumulated equity in their homes, which is their only remaining asset. This asset should not render them ineligible for the services and supports they need and potentially force them (and their dependents) to leave their home and communities.

- CBO Score as of 5/30/2025:Saves $195 million over ten years (2025-2034)

Section 44122: Modifying retroactive coverage under the Medicaid and CHIP programs. This section restricts retroactive coverage for both children and adults in Medicaid to one month prior to an individual's application date; current law provides this coverage for up to three months before an individual's application date. For decades, Congress has guaranteed up to three months retroactive Medicaid coverage for eligible individuals in recognition that individuals may be unaware they are eligible or that the sudden onset of illness often prevents individuals from applying in advance.[1] This time is particularly critical for older adults who typically face high burdens to gather documents to verify their assets and undergo functional needs assessments to access long term care. Limiting retroactive eligibility also puts providers of long-term care in the position of deciding whether to accept beneficiaries in advance of their Medicaid approval – putting themselves at financial risk – or limit admissions to those who have already been approved for care which would cause a major access issue. This provision goes into effect on December 31, 2026.

- CBO Score as of 5/30/2025: Saves $6.4 billion over ten years (2025-2034) but the score does not reflect the updated implementation date of December 31, 2026

[1]Senate Report No. 92-1230, at 209 (Sept. 26,1972) (discussing section 255 of H.R. 1).

Health Care Taxes

Section 44132: Moratorium on new or increased provider taxes. This section freezes, at current rates, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes moving forward. It is unclear if amending or expanding an existing provider tax would be prohibited. Ending states' ability to tax health care providers would severely limit states' ability to raise new revenues to provide health care to millions of Americans who depend upon Medicaid for their care. LeadingAge is working to understand whether the intent here is to establish that the freeze is on the rate of the tax and not on generated revenues which would effectively function as a cap. It is not clear whether the Congressional Budget Office (CBO) scored this provision as a cap on the amount of current taxes as opposed to a freeze on the rate of the tax.

- CBO Score as of 5/30/2025: Saves $89.3 billion over ten years (2025-2034)

Section 44133: Revising the payment limit for certain state directed payments. This provision directs HHS to revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate for states that have adopted the Medicaid expansion and at 110% of the total published Medicare payment rate for states that have not adopted the expansion. It grandfathers state directed payments submitted for approval and approved prior to the legislation's enactment; for states that newly adopt the expansion after enactment, the cap at 100% of the Medicare payment rate applies at the time coverage is implemented even for payments that had prior approval. This section would also likely lock state-directed payments at current levels, preventing payments from growing with inflation and adequately covering the costs of health care down the road. Additionally, it is unclear if grandfathered state directed payments above the caps included in the legislation would have ongoing CMS blessing as they require annual resubmission for approval

- CBO Score as of 5/30/2025: Saves $72.5 billion over ten years (2025-2034) but this score does not reflect the policy changes added at the House Rules Committee regarding the disparate allowable rates between expansion and non-expansion states.

Section 44134: Requirements regarding waiver of uniform tax requirement for Medicaid provider tax. This section modifies the criteria HHS must consider when determining whether certain health care-related taxes are generally redistributive. Currently, states can impose taxes on providers or insurers up to 6% of net revenues as long as the taxes meet certain statutory and regulatory standards. These standards include that the tax must be "uniform"—that is, applied equally to all providers within the specified class (such that the tax rate is not higher for, for example, Medicaid revenue than non-Medicaid revenue). This provision effectively eliminates the ability of some states to continue their existing and already-approved taxes. This section is effective upon the date of enactment. The HHS Secretary may (but is not required to) provide an applicable transition period of up to three fiscal years, seemingly to allow states with non-compliant health care-related taxes to come into compliance. HHS released a proposed rule on May 12, 2025 that mirrors this section, which LeadingAge will be commenting on.

- CBO Score as of 5/30/2025: Saves $34.6 billion over ten years (2025-2034)

Payment Changes

Section 44107: Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid. This provision requires HHS to penalize states by reducing federal financial participation (FFP) for errors that result from states' inaccurate eligibility determinations. Currently, the Centers for Medicare & Medicaid Services (CMS) may waive certain payment restrictions or

disallowances of FFP if a state demonstrates a good faith effort to meet the required error rate thresholds. This means that states can avoid penalties if they are actively working to improve their eligibility processes and reduce errors. This provision essentially eliminates HHS' ability to provide these waivers and updates the formula for identifying a state's erroneous excess payments for medical assistance by updating the definition of ineligible individuals and ineligible services. Many of the other proposed changes in this bill would contribute to the likelihood states could be paying for "ineligible individuals," such as the immigration verification provision and community engagement requirement. This provision will take money away from states and further tighten what will already be strained budgets. This provision is effective in FY2030 (October 1, 2029).

- CBO Score as of 5/30/2025: Saves $7.4 billion over ten years (2025-2034)

Section 44142: Modifying cost sharing requirements for certain expansion individuals under the Medicaid program

This provision requires states to impose cost sharing requirements of up to $35 per service for adults with incomes over 100% of the federal poverty level (FPL) for those in the expansion population. This section also explicitly allows providers to refuse to deliver care to a Medicaid enrollee for non-payment of a cost sharing requirement. Pregnancy related services, inpatient hospital, nursing facility, intermediate care facility, emergency services (unless they are non emergent services received in an emergency room), family planning services, hospice services, primary care services, mental health services, or substance abuse disorder services.

- CBO Score as of 5/30/2025: Saves $13 billion over ten years (2025-2034)

Section 1115 waivers

Section 44135: Requiring budget neutrality for Medicaid demonstration projects under Section 1115.

Adds a new section to Section 1115 waiver demonstrations to require budget neutrality and requires the Secretary to "specify the methodology" to be used when there are savings achieved as a result of an 1115 demonstration. The Secretary is instructed to specify how states can use any 1115 savings with respect to subsequent demonstration waiver renewals. There is no current law or regulation that requires budget neutrality, but this has been the general practice since the 1970s. This new proposal codifies current practice. Under current law, if state spending results in savings, the state can use any accumulated savings to finance spending on populations or services that are not covered by Medicaid. States have recently used savings from demonstrations to fund social determinant of health initiatives that LeadingAge supports. Now, this provision leaves open the door for the Secretary to set more restrictions on this use of savings (and, perhaps, shift away from these types of initiatives).

- CBO does not estimate any savings connected to this provision which may mean it is not compliant with the Byrd Rule in the Senate.

Artificial Intelligence

Section 112204: Implementing Artificial Intelligence Tools for Purposes of Reducing and Recouping Improper Payments Under Medicare.

This section allows the Secretary of HHS to implement artificial intelligence they deem appropriate to identify and reduce improper payments made under Medicare Parts A and B. $12,500,000 will be transferred from the Federal Hospital Insurance Trust Fund and $12,500,000 will be transferred from the Federal Supplementary Medical Insurance Trust Fund to CMS to enter contracts with artificial intelligence tool vendors

- CBO Score as of 5/30/2025: Costs $25 billion dollars over ten years (2025-2034)

Immigrant coverage

Section 112103: Medicare eligibility change
Currently, lawfully present immigrants are eligible for Medicare if they have the required work quarters and meet the disability or age requirements – meaning they have paid taxes to qualify for Medicare. This proposal makes the following groups of immigrants newly ineligible even if they would otherwise qualify:

- Persons granted Temporary Protected Status or Deferred Enforced Departure
- Refugees, asylees, persons granted withholding of removal
- Trafficking survivors
- Survivors of domestic violence who have filed a self-petition under the Violence Against Women Act (or who have an approved I-130 visa petition filed by a spouse/parent)
- Cuban/Haitian entrants under the Refugee Education Assistance Act of 1980 (with the exception of a subset of Cuban nationals)
- Persons granted humanitarian parole into the U.S.
- Non-immigrants, including survivors of serious crimes, and persons on work visas
- Persons granted deferred action
- Spouses and children of U.S. citizens with an approved visa petition and pending application to adjust to lawful permanent residence
- Applicants for asylum, withholding of removal or relief under the Convention Against Torture who have been granted work authorization or if under 14 years old have had an application pending for at least 180 days.

This change would mean that the only categories of immigrants eligible for Medicare would be:

- Lawful permanent residents (green card holders)
- Cubans who entered under a family reunification program
- People residing under the Compacts of Free Association (citizens of Micronesia, the Marshall Islands, and Palau).

This provision may have impacts on those working in LeadingAge communities, residents, clients, or families.

- CBO Score as of 5/30/2025: Saves $49.5 billion over ten years (2025-2034)

Section 44111: Cuts Medicaid matching funds for states that cover immigrants who are not qualified for Medicaid and incentivizes those that don't with increased payments
This provision mandates a 10% cut to a state's expansion Federal Medical Assistance Percentage (FMAP) in the 14 states that offer health insurance or any form of comprehensive health benefits to state residents regardless of their immigration status. The penalty also applies to states that offer health coverage to adults granted humanitarian parole into the U.S. or to other lawfully residing adults who are not "qualified" immigrants - with exceptions for pregnant people. States currently receive a 90% federal FMAP for people who are covered by the Medicaid expansion. That FMAP would be lowered to 80% for the affected states, costing them billions of dollars. This would begin on October 1, 2027.

- CBO Score as of 5/30/2025: Saves $11 billion over ten years (2025-2034) but this score does not reflect the policy changes added at the House Rules Committee regarding a clarification that states can continue to offer coverage to lawfully residing children and pregnant people without the five year waiting period as long as they meet the other requirements.

Section 44110: Ends requirement for Medicaid coverage while citizenship or immigration status is being verified.

This provision ends the requirement that Medicaid be provided during a 90-day reasonable opportunity period for applicants to submit documents establishing their citizenship or immigration status, and while their citizenship or immigration status is being verified. Instead, states would be allowed to opt to provide Medicaid during a reasonable opportunity period and pending verification of an applicant's citizenship and immigration status. The "reasonable opportunity" requirement was intended to ensure that eligible consumers who don't have immediate access to their documents can receive critical medical coverage, and to ensure that they are not penalized for errors and delays in the verification system. This helps prevent costly and harmful medical delays due to the challenges involved in producing paperwork. The provision also potentially ends federal matching funds for states that opt to provide Medicaid during this period if the applicant's citizenship or immigration status is not verified within this period – so states are taking a financial risk if they choose to continue to cover the reasonable opportunity period.

- CBO Score as of 5/30/2025: Saves $844 million over ten years (2025-2034)

Interaction with other coverage

One thing we want to underscore for LeadingAge members is that this legislation does huge harm to the ability of the commercial Marketplaces to function. The bill codifies policies proposed by the Trump Administration that make it harder to enroll in coverage. It does not extend the enhanced premium tax credits, which expire at the end of this year (2025). The bill would enact policy that lowers the value of the premium tax credits that help people purchase more robust plans. Without reinvestment in financial assistance**,** costs will skyrocket for most marketplace enrollees, and some will shift to skimpier plans while others—especially healthy adults that help lower premiums for everyone—forgo coverage altogether because it is too expensive. Additionally, the bill prohibits beneficiaries between 100-138% FPL who do not meet the community engagement requirements or an exemption from buying subsidized Marketplace coverage, effectively locking them out of insurance. Even for employer-based insurance, if these policies go through as proposed by H.R. 1, it is likely that hospitals and physicians will negotiate higher prices with commercial coverage leading to higher prices for employers.