New Fixed Home Equity Caps and Retroactive Coverage Limitations Will Limit Access to Long Term Care

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The "One Big Beautiful Bill Act" (OBBBA), which was signed into law on July 4, 2025, includes massive cuts to Medicaid that will harm people with disabilities. This fact sheet outlines two changes that will impact people with disabilities' ability to access Long Term Services and Supports (LTSS), as well as advocacy strategies for states to lessen the harm of these changes.

1. Fixed Home Equity Caps for Long-Term Services and Supports

Effective January 1, 2028, individuals seeking long-term care will be prohibited from having more than $1 million in home equity for non-agricultural homes.[1] This cap is permanent, and will not rise with inflation. Currently, the home equity limit varies by state and ranges between $730,000 and $1,097,000 and is adjusted each year for inflation. Long-term care includes both nursing facility care and other long term care services, like Home and Community-Based Services (HCBS) waivers and applies to both the Non-MAGI and MAGI Medicaid populations.[2] Individuals with agricultural homes are exempt from this cap, and states are allowed to set different requirements for those types of properties.[3]

The permanent home equity cap for long term services and supports (LTSS) eligibility does not allow states to account for inflation, variability of regional housing markets, or rising property values. OBBBA prohibits exceptions, meaning states will lose flexibility to account for regional housing markets or rising property values. The lower, fixed $1 million cap is especially problematic in places with higher costs of living. These caps will force some people seeking

[1] 42 U.S.C. § 1396p(f)(2)(C); 42 U.S.C. § 1396a(e)(14)(D)(2); 42 U.S.C. § 1396a (r)(2)(A).
[2] 42 U.S.C. § 1396a(e)(14)(D)(2); 42 U.S.C. § 1396p(c)(1)(C); *see also*, CMS, Dear State Medicaid Director Letter (Feb. 21, 2014) (SMD*# 14-001, ACA #29* (February 21, 2014), https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-001.pdf at 5.
[3] 42 U.S.C. § 1396p(f)(1)(C).

Medicaid LTSS, who by definition have significant support needs, to make difficult choices between keeping their home and getting needed care.

According to KFF, twelve states currently have limits that are higher than this cap, so eligibility for nursing facility and other LTSS will effectively be limited in those states.[4] These states include: Alabama, California, Colorado, Connecticut, the District of Columbia, Hawaii, Maine, Massachusetts, New Jersey, New York, Tennessee and Washington State.

The cap increases the risk of costly and unnecessary institutionalization for people with disabilities, by conditioning their access to LTSS on the amount of equity they have in their home. For example, someone with more than $1 million in home equity who is receiving personal care through an HCBS waiver will need to reduce their equity in their home to below the cap or lose access to those services.

Despite the cap imposed by OBBBA, existing protections remain available. These include exemptions from the equity limit if the individual's spouse or child under 21, or child of any age who is blind or disabled, is living in the home.[5] Individuals can also request a waiver of the limit being applied based on "demonstrated hardship."[6] While the law does not prohibit using a reverse mortgage or home equity loan to reduce the equity interest in the home, enrollees should be aware of the serious risks and potential high costs of reverse mortgages.[7] To reduce the impact on people with disabilities, advocates can urge their state to implement "demonstrated hardship" policies that are as transparent and equitable as possible, with clear

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[4] Alice Burns, Maiss Mohamed, and Molly O'Malley Watts, Kaiser Family Foundation, *Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025* (April 7, 2025), **https://www.kff.org/medicaid/medicaid-eligibility-levels-for-older-adults-and-people-with-disabilities-non-magi-in-2025/**.

[5] 42 U.S.C. § 1396p(f)(2).

[6] 42 U.S.C. § 1396p(f)(4). The statute states that the "Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship." Guidance from Secretary on "demonstrated hardship" permits states to use the same procedures they use for undue hardship used in the context of transfers of assets for less than fair market value: "pending publication of a process specific to the home equity limit, States may use their existing procedures for determining the existence of undue hardship as currently required under section 1917(c)(2)(D) (transfers of assets for less than fair market value), or newer procedures developed for transfer of assets undue hardship waivers under section 6011 of the DRA." See the **enclosure** to CMS, Dear State Medicaid Director (July 27, 2006) (guidance on the implementation of the Deficit Reduction Act of 2005) (**SMDL #06-18**) at 7, 24. We are not aware of any more recent guidance.

[7] *Id.* Sarah Bolling Mancini, National Consumer Law Center, *Unmet Promise: Reverse Mortgage Servicing Challenges and How to Preserve Housing Stability for Older Adults* (Feb. 6, 2023), **https://www.nclc.org/wp-content/uploads/2023/02/RevMortgage-Rpt.pdf** (last visited Feb. 12, 2026).

pathways for requesting a waiver based on demonstrated hardship. In addition, advocates and states should engage in consumer education so that current and future Medicaid recipients understand the coming limit and can plan accordingly. This should include prioritizing access to low cost or free estate planning targeted at lower income individuals.

2. Reducing Scope of Retroactive Coverage

Effective January 1, 2027, retroactive coverage for Medicaid applications will be limited to two months for individuals in the non-MAGI Medicaid group and one month for individuals in the Medicaid expansion population.[8] This will particularly impact people with disabilities, for whom retroactive eligibility for three months before a Medicaid application is critical.[9] Disability can happen at any time, and applying for Medicaid can be a lengthy process. Retroactive eligibility helps people avoid medical debt and feel confident seeking medical care while they apply and their application is processed, which takes time.

In addition, reducing the period of retroactive eligibility will mean people with disabilities will have a harder time accessing nursing facility care.[10] In many situations, a sudden health crisis triggers Medicaid eligibility, making it impossible for someone to apply in advance of becoming eligible. Navigating the Medicaid application process after hospitalization can also take considerable time, during which people with disabilities still need access to critical care. Ninety days of retroactive coverage often helps people with disabilities cover the period between admission to a nursing facility, which is often covered by Medicare for short-term rehabilitation, and the approval of Medicaid benefits for long-term care. Without it, individuals and families may feel that they need to leave rehabilitation early, before they are ready to be discharged, and potentially before needed HCBS is in place in the community. In addition, they may be responsible for unaffordable costs during a difficult time of need.

To reduce the impact of shorter retroactive Medicaid periods on people with disabilities, advocates can encourage states to follow lessons from the Covid-era Medicaid unwinding process to streamline the Medicaid application process by simplifying application forms, ensuring better communication with applicants and enrollees, and increasing reliance on

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[8] Amending 42 U.S.C. §1396a(a)(34), 1396d(a)).
[9] Catherine McKee and Jane Perkins, Nat'l Health Law Prog., *OBBBA Slashes Retroactive Coverage for Medicaid* Beneficiaries (July 25, 2025), **https://healthlaw.org/resource/obbba-slashes-retroactive-coverage-for-medicaid-beneficiaries/**.
[10] Natalie Kean, Justice in Aging, *Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection?*(2019), **https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf**.

credible data sources to verify eligibility.[11] In addition, improving the application process in hospitals and facilities by ensuring screening for eligibility-- including having skilled nursing facilities start Medicaid applications immediately upon an individual's admission--will be critical.[12] Advocates should also encourage states to improve and expand outreach and education about Medicaid so that individuals who anticipate needing coverage understand the application timelines.[13]

[11]Farah Erzouki, Center on Budget and Policy Priorities, *Lessons From Unwinding Offer Opportunities to Streamline Medicaid, Improve Efficiency* (April 3, 2025), **https://www.cbpp.org/research/health/lessons-from-unwinding-offer-opportunities-to-streamline-medicaid-improve**.

[12] While all states must ensure Hospital Presumptive Eligibility (HPE) in qualifying hospitals, advocates can encourage their states to expand this practice to all hospitals and skilled nursing facilities. See, Centers for Medicare & Medicaid Services, *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility* (January 2014) **https://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Hospital-PE-01-23-14.pdf**.

[13] Advocates should also encourage states to improve and expand outreach and education about Medicaid so that individuals who anticipate needing coverage understand the application timelines.