Health Care in Motion

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H.R. 1's Impact on Medicare and Opportunities for State-level Advocacy

H.R. 1, the federal budget reconciliation law passed in July, made sweeping cuts to health care and will result in millions of people losing their health insurance. In addition to the largest Medicaid cut in the program's history, H.R. 1 has significant impacts on Medicare, including reductions in eligibility for immigrants who have paid into the system and long-term programmatic changes that will contribute to higher out-of-pocket costs for lower income Medicare members and individuals who rely on certain high-cost drugs. With Medicare open enrollment—the annual period during which members can make changes to their coverage—currently underway, this issue of Health Care in Motion highlights some of H.R. 1's anticipated impacts on health care costs and access for Medicare members and policy opportunities for states to help mitigate harm.

Open Enrollment for the 2026 Plan Year

Medicare open enrollment runs from October 15, 2025, to December 7, 2025. During this time, Medicare members can change their Medicare drug plan (Medicare Part D), change their Medicare Advantage plan (Medicare Part C), or switch between Original Medicare and Medicare Advantage. Any plan changes will become effective January 1, 2026.

Eliminating Medicare eligibility for certain legally present immigrants

Before H.R.1, immigrants who met the age or disability requirements for Medicare and who were legally present in the U.S. qualified for premium-free Medicare Part A if they or their spouse had paid Medicare payroll taxes for at least 40 quarters (10 years). Lawfully present immigrants without sufficient work history could purchase Part A after living in the U.S. continuously for five years. H.R. 1 eliminates Medicare eligibility for all legally present immigrants other than: (1) lawful permanent residents ("LPRs," also known as green card holders), (2) Cuban-Haitian entrants, and (3) people residing in the U.S. under a Compact of Free Association ("COFA" migrants), which applies to migrants from the Marshall Islands, Micronesia, and Palau.

H.R. 1 strips Medicare coverage from all other immigrants lawfully present in the U.S., even if they contributed to the program through paying taxes or by meeting the residency requirement and paying for premiums. This includes many individuals who are present in the U.S. for humanitarian reasons, including those with:

- Temporary protected status: immigrants from a country designated as temporarily unsafe due to ongoing conflict, environmental disaster, epidemic, or other extraordinary conditions.
- Refugee or Asylee status: immigrants subjected to or in fear of persecution based on a protected characteristic (race, religion, nationality, political opinion, membership in a particular social group) in their country of origin.

- Humanitarian parole: immigrants granted entrance into the U.S. based on emergent humanitarian reasons (e.g., critical medical treatment).
- Victims of human trafficking: immigrants granted T visas based on having been victims of sex or labor trafficking and certain eligible family members.
- Victims of criminal activity: immigrants granted U visas based on having been victims of certain crimes and having assisted in law enforcement investigations.
- Domestic violence survivors: Violence Against Women Act (VAWA) self-petitioners who have been abused by a close relative who is a citizen or LPR.

This eligibility restriction for Medicare took effect immediately upon H.R. 1's passage, so immigrants not already on Medicare will not be able to enroll in Part D or Medicare Advantage plans during this year's open enrollment period. Moreover, H.R. 1 specifies that current enrollees who no longer qualify under this new restriction will lose their coverage within 18 months of the July 2025 enactment, meaning Medicare coverage for formerly eligibly immigrants will be terminated by January 4, 2027.

Over the next ten years, these new coverage restrictions are estimated to result in 100,000 legally present immigrants losing their Medicare coverage. The loss of Medicare coverage for previously eligible immigrants is particularly devastating in light of the broader attacks on access to health care levied by H.R. 1, which also bars many legally present immigrants, including those with humanitarian statuses, from other health coverage programs. A recent Health Care in Motion issue detailed H.R. 1's similar eligibility restrictions on Medicaid, ACA marketplace subsidies, and SNAP.

Blocking implementation of Medicare Savings Programs improvements

Medicare Savings Programs ("MSPs") cover premiums and cost sharing for members who meet certain income and resource limits. The Qualified Medicare Beneficiary ("QMB") Program, the most comprehensive of the four MSPs, helps pay for Part A premiums, Part B premiums, deductibles, coinsurance, and copayments. QMB also entitles recipients to help with their Medicare Part D out-of-pocket costs (Extra Help). Other MSPs offer lower levels of financial support for those with slightly higher incomes. These programs are extremely important because of the financial challenges that many older individuals and people with disabilities face. For example, 36% of Medicare members reported going without or delaying health care visits in 2023 because of the cost burden. However, applying and verifying eligibility for MSPs is complicated and can lead to decreased enrollment in MSPs, varying participation rates across states, and loss of coverage among Medicare members with dual enrollment.

Financial Assistance for Lower Income Medicare Members

- Medicare Savings Programs: premium and cost-sharing assistance programs to help make Medicare Part A and Part B more affordable
- Extra Help/Low Income Subsidy (LIS): Medicare Part D assistance, including $0 premiums and deductibles and caps on out-of-pocket prescription drug costs
- Medicare Prescription Payment Plan: allows members to spread out high out-of-pocket drug costs throughout the year

In 2023, CMS issued a final rule intended to ease enrollment in MSPs. The "Streamlining Medicaid, Medicare Savings Program Eligibility Determination and Enrollment" final rule

would have required states to change their enrollment procedures for MSPs to make it easier for individuals who qualify to receive assistance with their health care costs by automatically enrolling certain people and reducing the administrative burden of the application process. CMS estimated that this rule would result in over half a million new MSP beneficiaries. H.R. 1 blocks implementation of this rule until September 2034. However, some of the rule's improvements still apply despite H.R. 1's moratorium, and others, although no longer required federally, may still be optionally implemented by states. Key provisions of this rule include:

Automatic enrollment of SSI recipients in QMB (Effective October 1, 2024): Although most people who receive SSI are also eligible for Medicaid and QMB, many recipients are not automatically enrolled in QMB (which would pay the Part A premium for enrollees who don't have enough work credits to independently qualify for premium-free Part A). The rule requires all states to automatically enroll individuals in QMB if they receive (1) SSI-based Medicaid; and (2) premium-free Part A. Additionally 37 states and D.C. ("Part A Buy-in states") are also required to auto-enroll individuals in QMB if they are (1) enrolled in SSI-based Medicaid; (2) eligible for but not enrolled in premium Part A; and (3) enrolled in Part B. This part of the rule had an earlier effective date than other provisions and was not impacted by H.R. 1's moratorium.

Enforcing automatic enrollment of Extra Help recipients in MSPs (Already required by federal law): States must use data from the Extra Help program to initiate MSP applications and inform members if they are also eligible for full Medicaid benefits. Despite being blocked by H.R. 1, this provision was already required under the Medicare Improvements for Patients and Providers Act (MIPPA). The final rule's provision reiterated this longstanding requirement because many states had failed to comply.

Streamlining MSP and Extra Help definitions (Blocked by H.R. 1 but states maintain option to implement): The final rule would have aligned the MSP definition of family size with the definition used for Extra Help. States would be required to include the applicant, their spouse (if living together), and anyone else in the household that is related to and financially dependent on the applicant for at least half of their financial support. This is important because MSP eligibility depends on income level *in relation to* family size—a broader definition, which accounts for intergenerational families, means more applicants would be eligible for MSPs. Additionally, aligning definitions will likely increase the rate of MSP application processing using Extra Help data.

Reducing income/asset documentation requirements (Blocked by H.R. 1 but states maintain option to implement): States would have been required to accept an applicant's attestation (without additional documentation) at the time of enrollment about their interest and dividend income, non-liquid resources, and certain burial fund information, unless the state had contrary information.

Narrowing the Medicare Drug Price Negotiation Program

H.R. 1 makes changes to key provisions of the Inflation Reduction Act (IRA) that were designed to lower drug costs, including the Medicare Drug Price Negotiation Program. This program aimed to lower drug spending and out-of-pocket costs for Medicare members by allowing the government to negotiate prices with drug companies. Under the program, orphan drugs—drugs approved to treat only a single rare disease or condition—were excluded from the

> Read more about the IRA's impact on drug affordability in Medicare in this previous issue of Health Care in Motion.

negotiation program. H.R. 1 expands the "orphan drug exclusion," making drugs that are designated for multiple rare diseases also ineligible for negotiation. In the long-run, this change could delay or prohibit high-cost drugs from being negotiated, resulting in lost savings for Medicare and higher out-of-pocket drug costs for members reliant on these medications. The Congressional Budget Office has estimated that the expanded exclusion and additional delays in drug eligibility for negotiation are estimated to increase Medicare spending by $8.8 billion from 2025 to 2034.

Protecting access to care for older adults and people with disabilities

As we navigate open enrollment this year, beneficiaries and advocates should be aware of H.R. 1's impact on Medicare, particularly regarding the loss of coverage for certain lawfully present immigrants and the ongoing need to support lower income Medicare members to access all of the subsidies to which they are entitled. Especially for members with high prescription drug costs, education on MSP enrollment and other financial assistance and management tools, such as Extra Help and the Medicare Prescription Payment Plan, is crucial.

State-level policies may help mitigate some of the harms caused by H.R. 1. States can establish or expand programs to help seniors and people with disabilities losing Medicare coverage due to immigrant status restrictions. Currently seven states and D.C. provide state-funded coverage to adults regardless of immigration status, but the programs are restricted by income, and some states are already scaling these programs back due to budget constraints.

Additionally, even under H.R. 1's moratorium on the MSP rule, states still have the option to implement some of the MSP streamlining provisions that would make it easier for lower-income members to receive assistance with premiums, deductibles, and cost-sharing. Specifically, states may choose to streamline Extra Help and MSP family size definitions and to reduce the documentation required for eligibility determinations. Under Section 1902(r)(2) of the Social Security Act, states have significant flexibility to increase MSP enrollment by changing the way they determine eligibility. For example, 11 states don't take assets into account at all in determing MSP eligibility. Policy advocacy at the state level, particularly in relation to how states operate MSPs, could meaningfully lighten the cost-burden of Medicare for many lower-income members, increasing access to health care for some of the most vulnerable populations.

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