Emerging Federal Policy and Potential Implications for Subsidized Health Insurance Programs in Massachusetts

WEBINAR – March 20, 2025

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Today's Presenters

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Objectives

Provide an overview of potential federal changes related to Medicaid and subsidized Affordable Care Act (ACA) Marketplace coverage programs in a new Trump Administration and Congress.

Share potential impacts of changes for MassHealth and Massachusetts ConnectorCare programs and discuss potential strategies to respond to federal changes.

Identify, to the extent possible, the timing, political hurdles, and implementation vehicles for these potential changes.

Agenda

- **Level Setting**
- **Implications of Potential Federal Policy Changes for Massachusetts**
  - MassHealth
  - ConnectorCare
- **Looking Ahead: Responding to Federal Policy Changes**
- **Q&A**
- **Wrap Up**

Level Setting

What's At Stake?

The new Administration and Congress are considering a number of changes that could have broad implications for MassHealth and Massachusetts' ConnectorCare programs.

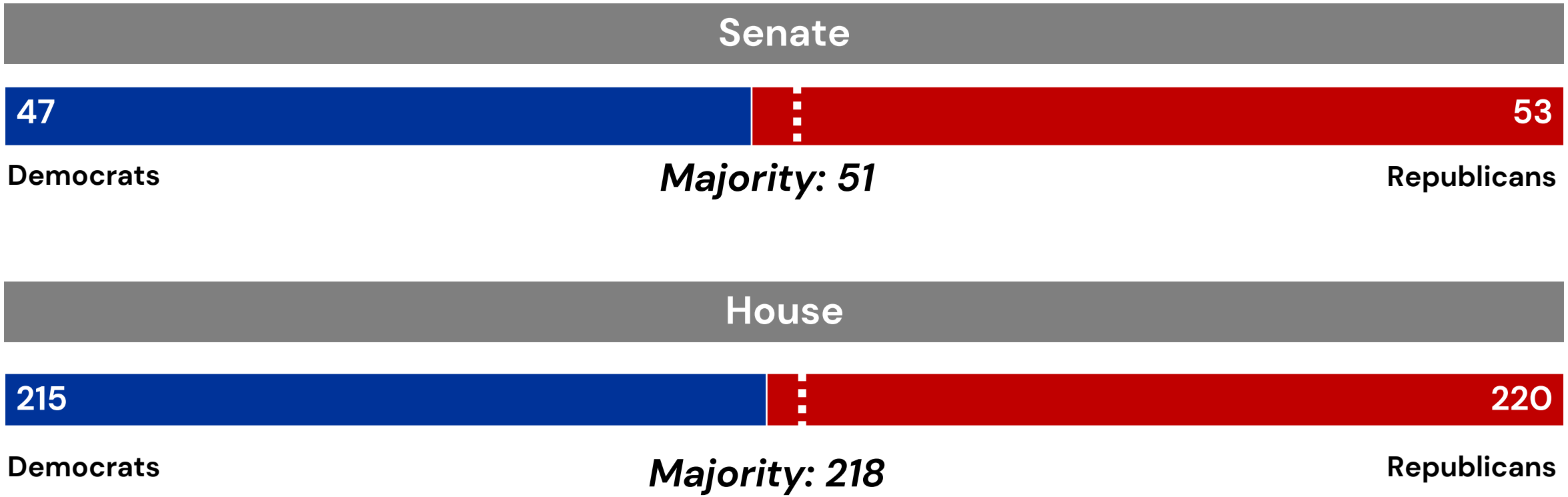
Changes to federal Medicaid funding, if enacted, would intensify financial pressures on the Commonwealth, and could lead to downstream impacts for providers, health plans (e.g., higher uncompensated care costs and reduced reimbursement rates), and enrollees (e.g., potential changes to eligibility and benefits).

Medicaid work reporting requirements, if enacted, would jeopardize enrollees' ability to access needed health care services.

The availability of Marketplace enhanced premium tax credits (PTCs) will sunset at the end of 2025 without Congressional action, with implications for coverage affordability.

Partisan Composition of the 119th Congress

A very narrow Republican majority—especially in the House—may be an obstacle to some partisan policy proposals, including changes to federal Medicaid funding.



Source: Associated Press 2024 Election Results.

Initial Health-Related Priorities of the New Administration

Extension of the **2017 tax cuts** (and potential new tax cuts) is an Administration priority, and **Medicaid is in the crosshairs as a "pay for."**

The president and Congressional Republicans have stated reductions in Medicaid expenditures will come from reining in "waste, fraud, and abuse."

President Trump has issued a flurry of executive orders signaling the Administration's priorities, including:

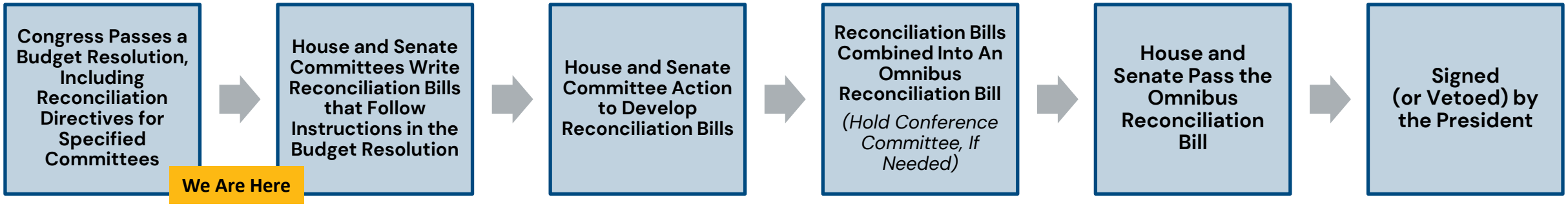
- Restrictions on federal funding for gender-affirming care for youth;
- Enhancing immigration enforcement initiatives and restricting benefits for undocumented individuals;
- Hospital and health plan price transparency regulations; and
- Deregulatory initiatives.

There have been broad **workforce reductions across federal agencies** designed to shrink the size of the federal government.

On February 26, the Administration issued an order for federal agencies to prepare plans by mid-March for **large scale layoffs**.

Deep Dive: Budget Reconciliation Process

Budget Reconciliation is used to fast-track certain legislation related to budgetary changes by bypassing the Senate filibuster, requiring only a simple majority for passage. Timing for each step in this process is variable.



- **On February 21, the Senate passed its budget resolution,** S.Con.Res.7, which includes reconciliation instructions for congressional committees aimed at increasing spending on homeland security and defense. The Senate is planning for a second reconciliation focusing on the expiring tax cuts.
- **On February 25, the House narrowly passed its budget resolution**, which includes reconciliation instructions that direct the House Energy and Commerce (E&C) Committee to reduce the deficit by no less than $880 billion. Per the Congressional Budget Office (CBO), more than 85% of these cuts would have to come from Medicaid to achieve deficit reductions of this magnitude. House Speaker Johnson pledged that the House will look for "**efficiencies**" in Medicaid and would "**not [cut] benefits for people who rightly deserve them**."
- **The two chambers must now reconcile significant differences between the respective budget resolutions.** This would require both the House and Senate passing identical versions of a budget resolution and subsequently drafting aligned reconciliation legislation.

Source: National Women's Law Center, Basics of Budget Reconciliation; CBPP, Introduction to Budget Reconciliation.

Implications of Potential Federal Policy Changes for MassHealth

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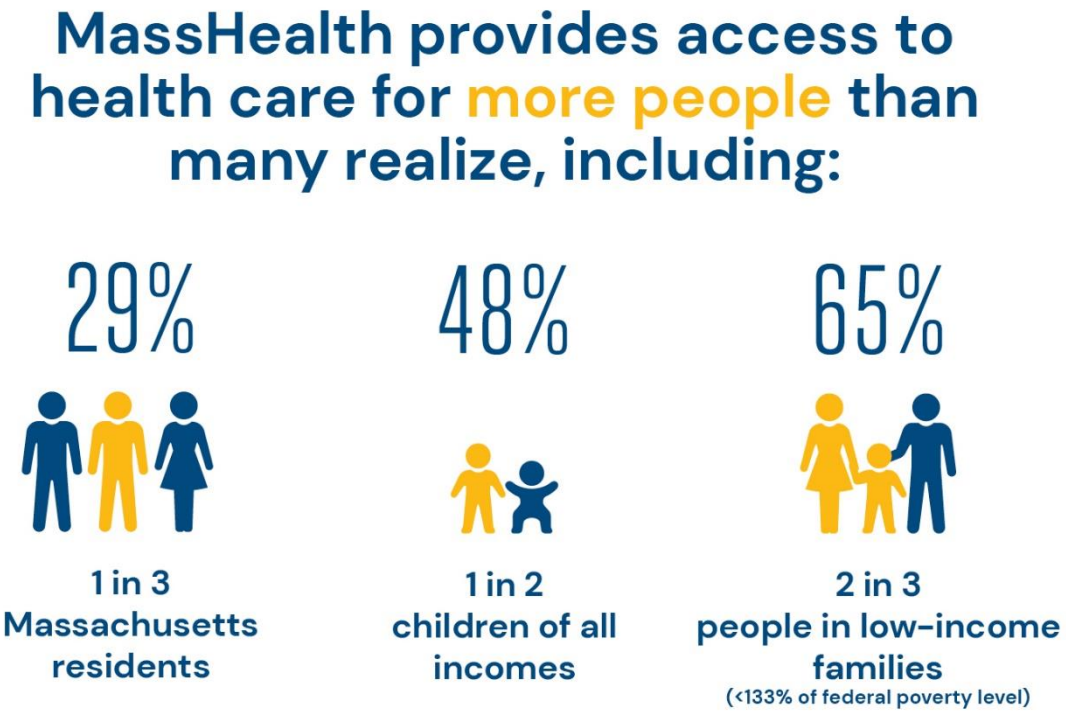
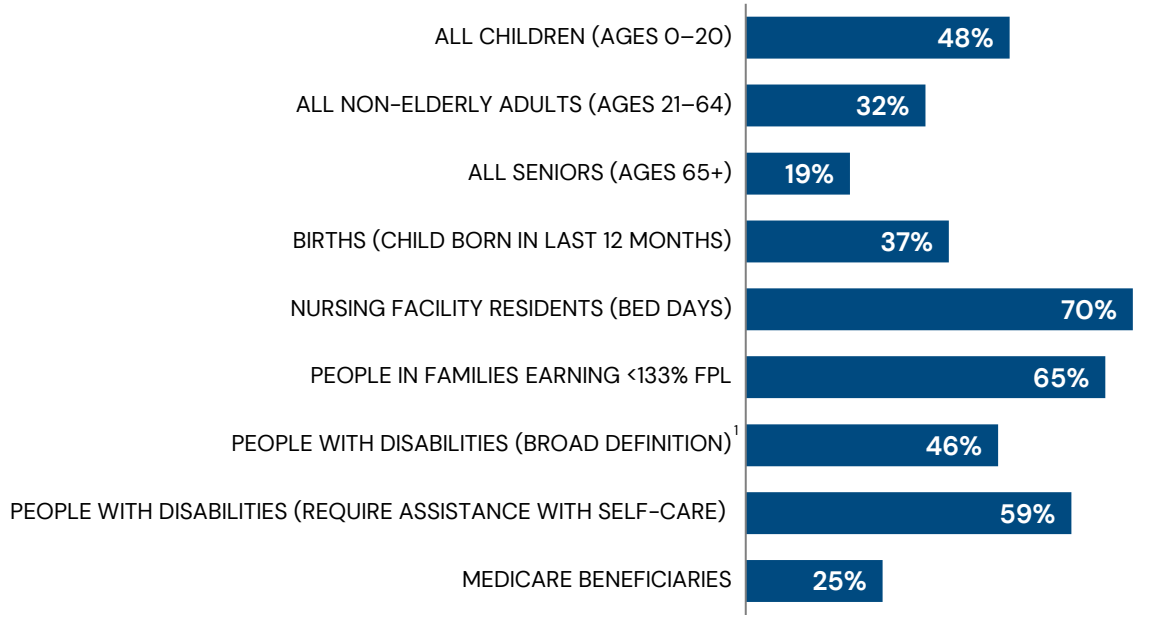
MassHealth 101: Coverage

MassHealth is important to many population groups, covering nearly one in three state residents — over 2 million people — including low-income children, seniors, pregnant people, and people with disabilities.



Source: MassHealth Basics Report, October 2024; MassHealth Matters to Massachusetts.
Note: These data are based on enrollment in state fiscal year (SFY) 2023.

PERCENT OF SELECT MASSACHUSETTS POPULATIONS COVERED BY MASSHEALTH



[1] Deaf or serious difficulty hearing; blind or serious difficulty seeing; cognitive, ambulatory, self-care, or independent living difficulty.

Chart Data: Authors' calculations using the 2018-2022 American Community Survey (ACS) 5-Year Estimates, CHIA 2020 Nursing Facility Cost Reports, and MassHealth Budget Office Data Request, March 2024.

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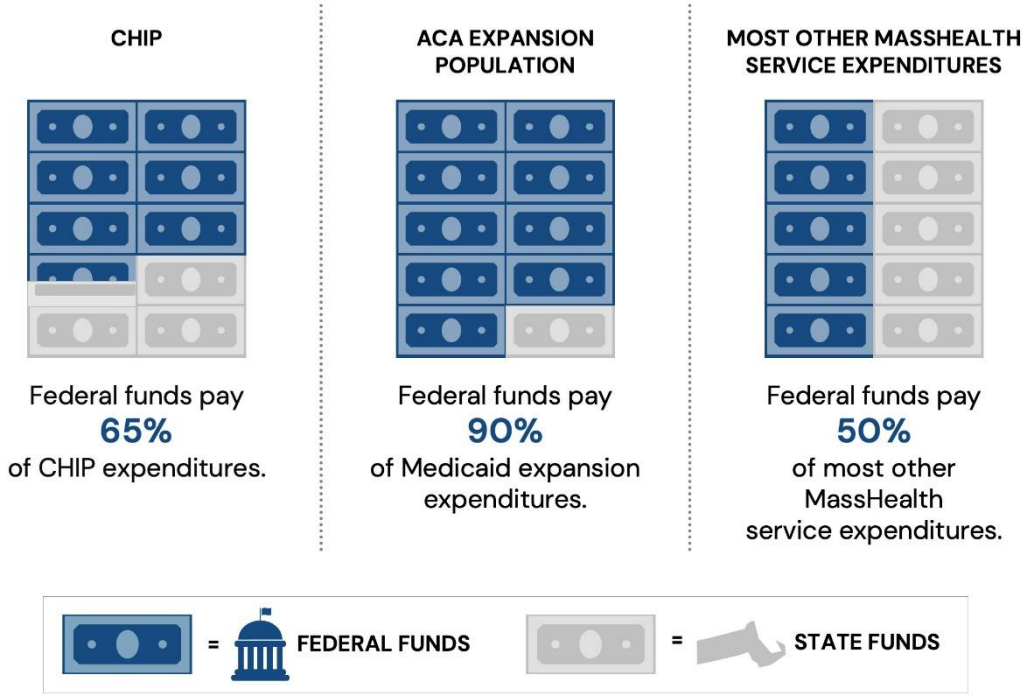
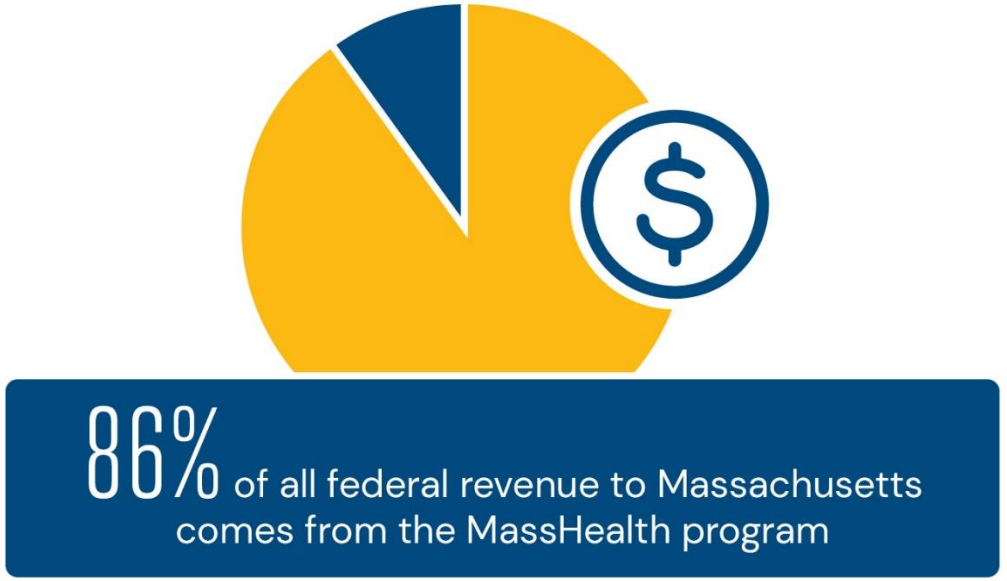
MassHealth 101: Program Spending and Federal Revenues

Medicaid financing is shared by states and the federal government, with the federal share of costs set by a pre-set match rate formula. Nearly every dollar in MassHealth spending is reimbursed by at least 50 cents in federal revenue to the state.

FEDERAL AND STATE SHARES OF MASSHEALTH EXPENDITURES, TYPICAL LEVELS



MassHealth brings in $12.3 BILLION in federal revenues to support the state economy.



Source: MassHealth Basics Report, October 2024; What is the Actual State Cost of MassHealth in FY 2025. MassHealth Matters to Massachusetts.
Note: The federal revenue data are based on MassHealth program revenue for state fiscal year 2025.

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Changes to Medicaid Federal Medical Assistance Percentage (FMAP)

Congress is considering changing the amount of federal funding available to all states, including Massachusetts, through the federal match rate, or FMAP*, potentially forcing programmatic cuts to make up for lost federal revenue.

Potential Policy Change

Reduce the 90% federal match for the Medicaid expansion population to the standard Medicaid match rate.

Change the FMAP rate formula:

- Remove the FMAP floor (i.e., minimum FMAP for medical services the state can receive).
- Implement a 50% administrative match rate for all activities (currently the federal administrative match is 50% for most activities, but some activities have enhanced rates of up to 100%).

Implications

- If in response to removing the 90% federal match Massachusetts ends its Medicaid expansion, **one analysis predicts Medicaid enrollment would decline by 19% (as a share of total enrollment) over the next ten years;** alternatively, if Massachusetts picks up federal Medicaid expansion costs, state spending could increase by up to $15.1 billion over the next ten years.
- **If the FMAP floor is removed, substantial MassHealth funding will be at risk** as Massachusetts is one of ten states that receives the federal match rate at the FMAP floor. CBO estimates federal spending would decrease $530 billion **for these states** over ten years.
- **Elimination of enhanced rates could severely impact MassHealth's investments in information technology**, and ultimately undermine program efficiency, integrity, and innovation. If this proposal is adopted, CBO estimates a reduction in federal spending for **all** states, including Massachusetts, by $69 billion over the next ten years.

***Implementation Vehicles*:** Congress could use the Budget Reconciliation process to enact statutory policy changes to reduce the FMAP.

*FMAP is the percentage of Medicaid costs that the federal government reimburses to each state, which varies based on the state's per capita income.

Medicaid Capped Funding

The current federal financing structure allows states to guarantee Medicaid coverage for all medically necessary health care expenses to all eligible individuals; per capita caps and block grants would change that structure, shifting financial risk for Medicaid cost growth to the Commonwealth.

Potential Policy Change

- **Mandate or allow per capita caps** to limit the amount of federal funding to a fixed amount per enrollee (allows spending growth over time by a pre-set amount and adjusts for enrollment growth).
- **Mandate or allow block grants** to limit the amount of federal funding to a fixed amount over time (allows spending growth over time by a pre-set amount, typically tied to inflation plus an enrollment factor, but does not adjust for enrollment growth).

Implications

- Capping federal Medicaid funding (per capita or block grants) is **estimated to reduce federal spending by hundreds of billions of dollars for all states, including Massachusetts, over the next ten years** (depending on the specifics of the cap).
- One analysis estimates that if Massachusetts responds to a per capita cap by maintaining per enrollee spending and eligibility at current levels (picking up lost federal revenue), **state spending would increase 9% over the next ten years.** Alternatively, if Massachusetts reduces its share of per enrollee spending and eligibility (e.g., reducing payment rates to health care providers), **MassHealth enrollment could decrease up to 17% over the next ten years, depending on the specifics of these reductions.**

***Implementation Vehicles*:** Congress could use the Budget Reconciliation process to enact statutory changes that mandate capped funding models. The Executive Branch could also require states to agree to capped funding as a condition of Medicaid waiver approval.

Medicaid Provider Taxes and State Directed Payments (SDPs)

Limiting states' use of provider taxes or eliminating/restricting SDPs would impact the state budget, overall MassHealth spending, and Massachusetts' delivery system.

Potential Policy Change

- **Change provider tax policy,** the revenues of which are used by states to fund a portion of the state share of Medicaid expenditures.
- **Changes to SDP policy**, through which states may direct Medicaid managed care plan expenditures to advance delivery system and provider payment initiatives.

Implications

- As of 2024, the Commonwealth has three provider taxes for hospitals, nursing homes, and ambulances, **generating millions of dollars for the state**. Massachusetts is also planning to add a new managed care plan tax in 2025.
- Massachusetts provides SDPs to safety net hospital systems **totaling hundreds of millions of dollars**. These payments also support a variety of other initiatives and provider types, including nursing homes.

***Implementation Vehicles*:** Congress could use the Budget Reconciliation process to enact statutory policy changes that reduce the ability of states to use provider taxes and/or eliminate or reduce SDPs. The Centers for Medicare & Medicaid Services (CMS) could also initiate rulemaking and develop guidance to restrict use of provider taxes and/or SDPs.

Medicaid Work Reporting Requirements

Under the first Trump administration, CMS approved thirteen states' Medicaid waivers that conditioned Medicaid coverage for working-age adults (under 65) on meeting work reporting requirements; work reporting requirements are again gaining traction.

Potential Policy Change

- **Mandate work reporting requirements**, whereby Medicaid eligibility for low-income adults is conditioned on compliance.

House and Senate Republicans have introduced legislative proposals to impose work reporting requirements in Medicaid. Bills such as H.R. 1059, H.R.1452, and S. 447 have been referred to their respective committees for review.

Implications

- Implementation of work reporting requirements is estimated by the CBO to lead to **significant coverage loss in all states, including Massachusetts**.
- One analysis estimates that **nearly half of MassHealth enrollees would be required to comply and a meaningful share would be at risk of losing coverage** (however, the impact would depend on the specific proposal, including exclusion criteria, and how it is implemented).
- Evidence shows **substantial administrative costs** associated with implementing work reporting requirements.

***Implementation Vehicles*:** Congress could use the Budget Reconciliation process to enact statutory policy changes to mandate work reporting requirements or make them a state option. The Executive Branch could also require take-up of work requirements as a condition of Medicaid waiver approval.

Federal Medicaid Rulemaking

Recent rulemaking may be rescinded or replaced by new regulations.

Potential Policy Change

- **Rescind rules approved under the Biden administration** (e.g., the Eligibility and Enrollment (E&E) final rule, the Skilled Nursing Facility (SNF) final rule, Medicaid Access final rules); or **initiate new rulemaking.**

Implications

- Estimated by House Republicans to reduce **federal spending by billions of dollars** if these rules are rescinded, rolling back federal requirements that aimed to streamline states' Medicaid eligibility and enrollment processes, improve the quality of nursing home care, and address provider rate transparency.

On March 3, the Department of Health and Human Services (HHS) reversed a long-standing policy that would make it easier to pursue rulemaking without public notice and comment.

***Implementation Vehicles*:** Congress could use the Budget Reconciliation or the legislative process to rescind existing Medicaid rules. Federal agencies could also initiate new rulemaking to rescind/replace regulations or delay implementation of provisions.

Spotlight: MassHealth 1115 Demonstration

Since 1997, Massachusetts has used its MassHealth 1115 Demonstration waiver to improve and reform how it delivers care to Medicaid members. The waiver was recently extended by CMS through December 31, 2027.

There are concerns that the Trump Administration/HHS may seek to modify states' Medicaid waiver demonstrations, either before or at demonstration renewal.

MassHealth waiver initiatives that may be at risk include:

- **Health-related social needs (HRSN) coverage** for evidenced-based clinically-tailored housing and nutrition supports, and other HRSN interventions for certain enrollees where there is a clinical need.

  The administration released an informational bulletin rescinding Biden-era HRSN guidance on March 4. While the bulletin itself does not directly address prior state 1115 Demonstration approvals under this guidance, the Medicaid.gov issued "bulletin" about the release states: "Rescinding this guidance does not negate existing approvals."

- **Continuous enrollment (CE)** for up to 12 months for adults and youth upon release from correctional settings and 24-months of CE for enrollees with a confirmed status of chronic homelessness under 65. MassHealth also has been approved to provide 12 months of CE to adults over age 19 and 24 months of CE for enrollees with a confirmed status of chronic homelessness who are aged 65 or over.
- **Federal funding for ConnectorCare subsidies** for eligible individuals up to 500% of the federal poverty line (FPL).
- **Quality and equity incentive payments** for hospitals to improve the quality of care and advance health equity.

Source: Mass.Gov, MassHealth 1115 Waiver. BCBS Foundation of MA, The MassHealth Demonstration Extension 2022–2027.

Implications of Potential Federal Policy Changes for ConnectorCare

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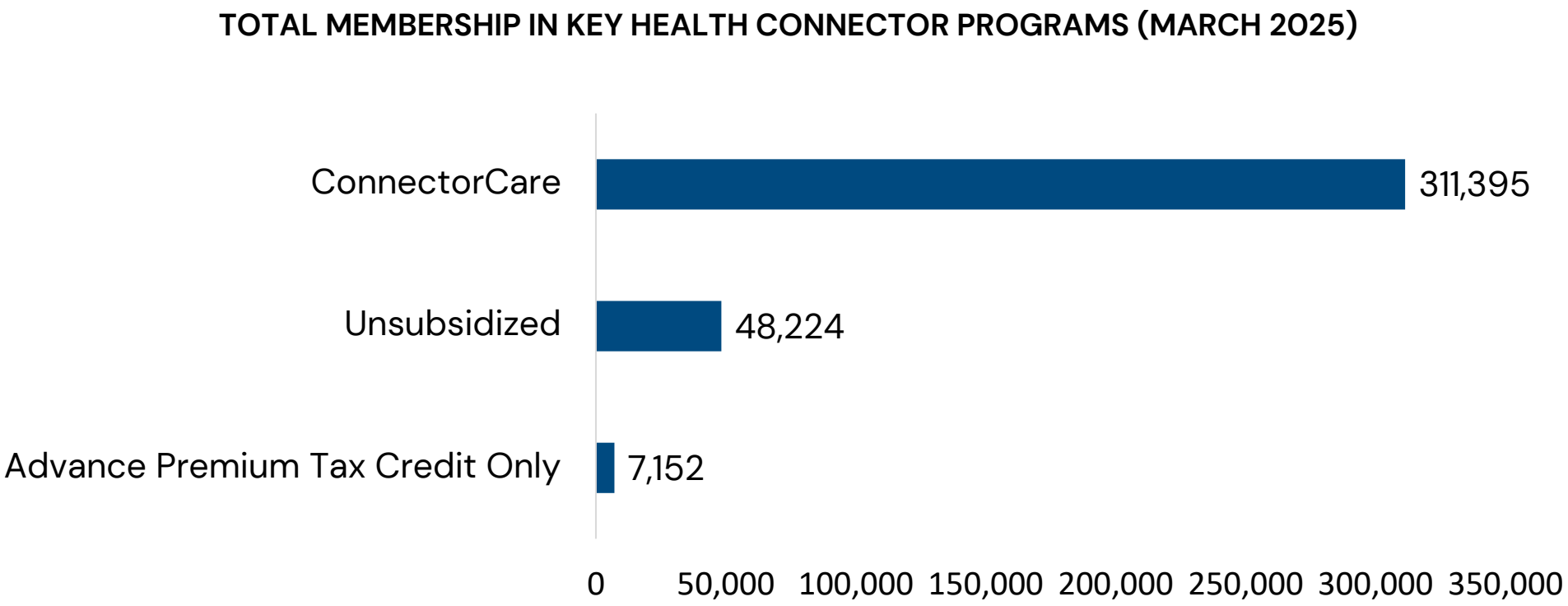
Massachusetts Health Connector Overview



Beyond the Health Connector, over 3.5 million individuals are enrolled in private commercial insurance plans (40% of enrollees are in fully-insured plans).

Source: Health Connector Board Report Metrics, March 2025. CHIA, March 2024. Totals do not include small group and dental enrollees.

Marketplace Affordability

Congress extended enhanced PTCs under the Inflation Reduction Act of 2022; however, these subsidies (which help eligible individuals buy Marketplace insurance) are set to expire at the end of 2025.

Potential Policy Change

- **Make changes to enhanced PTCs** (e.g., eliminate "zero-dollar" plans) or allow them to **expire entirely**.

Under current enhanced PTCs, a zero premium benchmark plan is available for people with income up to 150% FPL and make subsidies available to people with incomes above 400% FPL for the first time.

Implications

- Full or partial elimination of enhanced PTCs is estimated to lead to an **increase in Massachusetts' uninsured population** by up to 3% (to a new uninsured rate of 3.1%).
  - On average, for individuals with income up to 300% FPL, they could expect to **lose about $835 per person per year in PTCs**.
  - On average, for individuals with income above 300% FPL, they could expect to lose about **$990 per person per year in PTCs**.
  - These impacts could be **blunted by the ConnectorCare program, which provides additional state dollars to reduce premiums and out-of-pocket costs, though this would increase state costs.**

***Implementation Vehicles*:** Without Congressional action, enhanced PTCs will expire. Congress could allow the PTCs to sunset or alter eligibility for and/or value of the enhanced PTCs through statutory changes.

Federal Legislative and Rulemaking Changes to the Marketplace

Federal legislative and rulemaking changes to the Marketplace could entail the following:

Potential Policy Change

- **Rescind Marketplace rules approved under the Biden administration** (e.g., Family Glitch final rule).
- **Initiate new rulemaking.** (The administration released the Individual Health Insurance Market and Exchange Program Integrity proposed rule on March 10).

Implications

- **The GOP-issued House Ways and Means Committee budget menu estimates** that over the next ten years, the federal government could reduce federal funding for coverage affordability programs by repealing the Family Glitch final rule, which would reduce access to PTCs for family members of workers with "affordable" employer-sponsored insurance ($35 billion).
- New rulemaking is expected to have a **significant impact on Marketplace premium tax credits, administrative and paperwork requirements for applicants and enrollees, and eligibility (see next slide).**

***Implementation Vehicles*:** Through the Budget Reconciliation or the legislative process, Congress could rescind existing Marketplace rules, reduce funding, or enact new statutory requirements. Federal agencies may also initiate new rulemaking to rescind/replace regulations.

Individual Health Insurance Market and Exchange Program Integrity Proposed Rule

CMS released the first major health care proposed rule of the Trump Administration, including proposals to wipe away some of the most significant changes to the health insurance Marketplace rules made in President Biden's four years. Comments are due to CMS on April 11.

- The proposed rule leans heavily on policies it says will reduce enrollments committed fraudulently by agents and brokers, Navigators, and individual enrollees; improve program integrity; and reduce gross premiums. While the proposed rule includes one proposal directly intended to hold agents, brokers, and web brokers accountable, HHS largely addresses its concerns about improper enrollment by proposing to reinstate Trump-era restrictions.
- Based on CMS' assessment, the proposed rule is estimated to produce federal savings of $13.7 billion in 2026 and nearly $16 billion in 2029, with a projected reduction in annual enrollment of up to two million people.

Among the most significant proposals*:

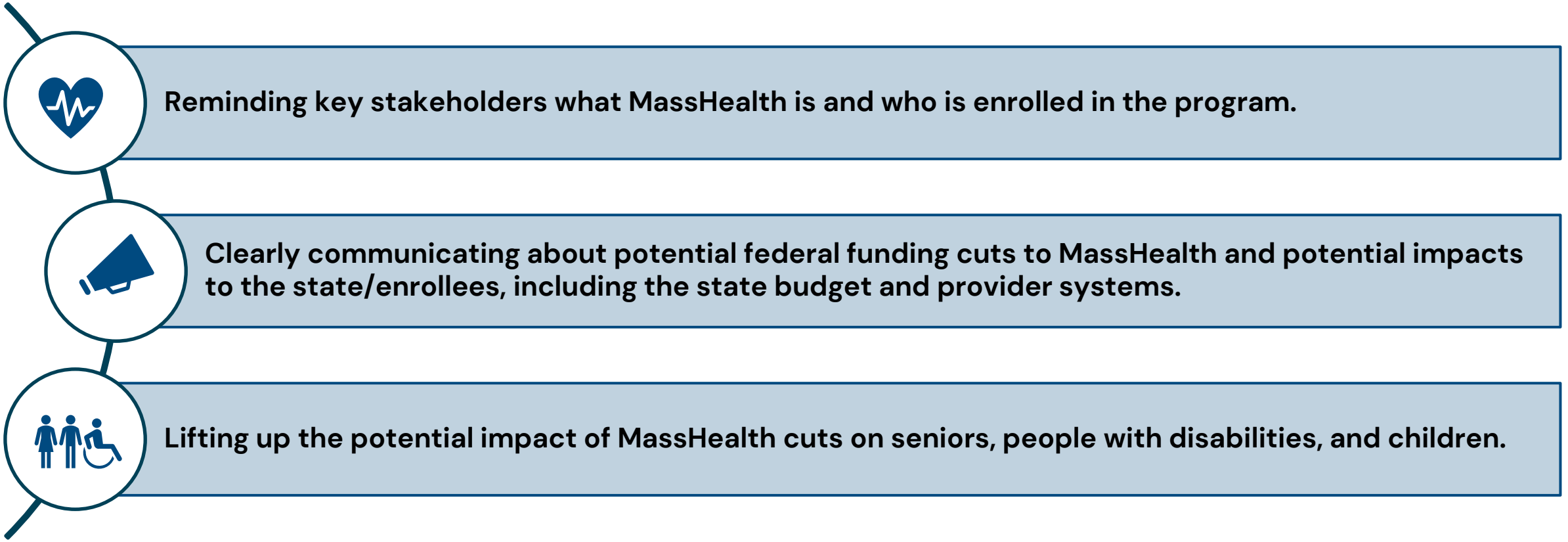
- **Shortening the open enrollment period** by one month in both the federally facilitated Marketplace and the state-based Marketplaces.
- **Eliminating the special enrollment period (SEP)** for people with income up to 150% FPL and increasing pre-enrollment verification for other SEPs.
- **Ending eligibility for people with Deferred Action for Childhood Arrivals (DACA) status.**
- **Increasing income verification procedures**.
- **For consumers who receive enhanced PTCs that fully cover their premiums and are automatically re-enrolled into Marketplace coverage,** the Marketplace would be required to reduce the enhanced PTC amount so that the enrollee must pay $5 towards their monthly premium until they update their eligibility application.
- **Prohibiting coverage of gender-affirming care (GAC) as an essential health benefit (EHB).****
- **Modifying the methodology for calculating the annual limit on cost sharing**, which raises the maximum annual limit on cost sharing by more than 15% in 2026. If finalized, this would apply to all commercial health plans (group health plans and individual health insurance coverage).

*The effective date for each of the proposals varies. Some are effective upon finalization of the rule, others beginning with the 2026 plan year, and others beginning in the 2027 plan year.
**Insurers could, if they choose, continue to cover GAC in addition to EHB, and states could mandate such coverage. However, CMS notes that states that do so would be required to defray the costs associated with GAC coverage.

Looking Ahead: Responding to Federal Policy Changes

Messaging Considerations

In light of potential federal program or policy changes, it will be important to put potential impacts in context for key stakeholders, including by:



Source: Cost and Coverage Collaborative, Defending Medicaid Against Federal Cuts, February 2025.

Key Takeaways

- **Proposed federal changes are expected to have significant impact on MassHealth and ConnectorCare programs, with downstream impacts on health plans, providers, and enrollees. The timing of these potential changes is uncertain.**
- **Massachusetts state law may temper some of the impact though this may increase the state's costs.**
- **It is important to communicate transparently and directly about the impact of potential federal changes on the Commonwealth's subsidized heath care programs.**

Q&A

Thank You!