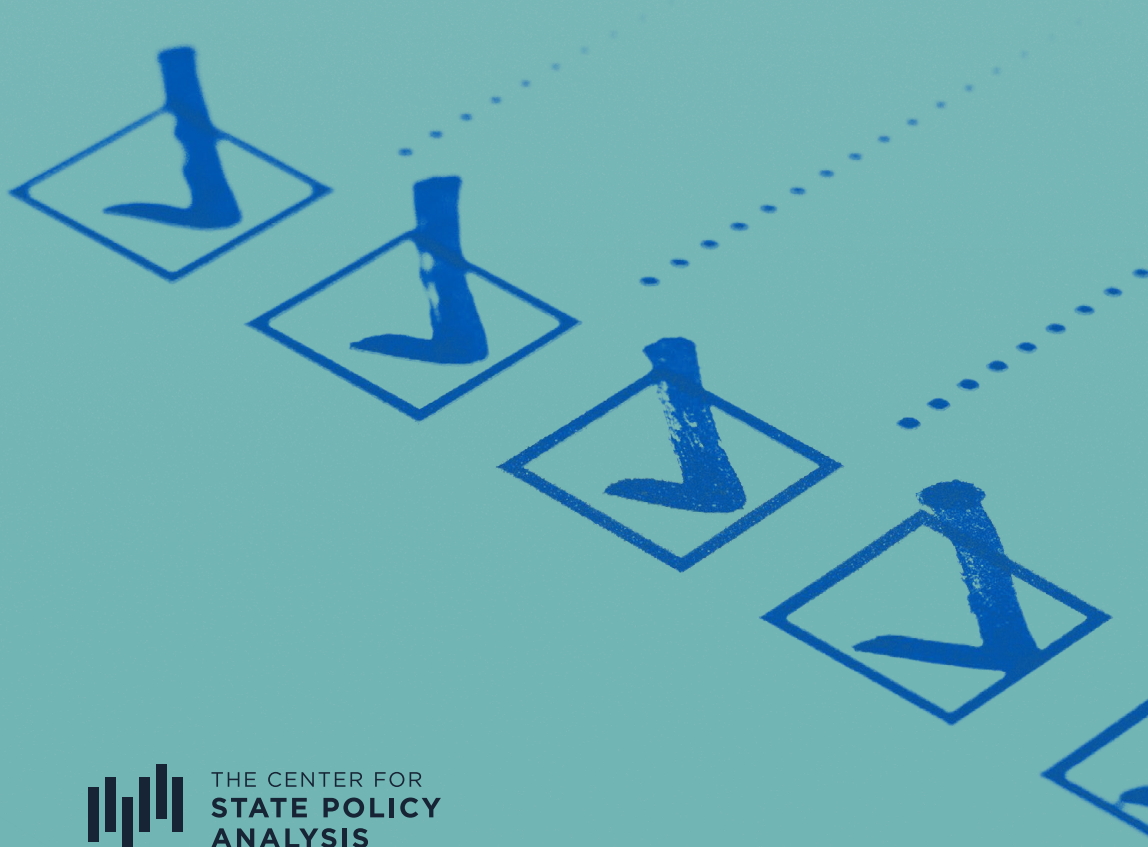
A MASSACHUSETTS MODEL FOR MEDICAID WORK REQUIREMENTS

NOVEMBER 2025



BOSTON INDICATORS

THE CENTER FOR STATE POLICY ANALYSIS

ABOUT BOSTON INDICATORS

Boston Indicators is the research center at the Boston Foundation, which works to advance a thriving Greater Boston for *all* residents across *all* neighborhoods. We do this by analyzing key indicators of well-being and by researching promising ideas for making our city more prosperous, equitable and just. To ensure that our work informs active efforts to improve our city, we work in deep partnership with community groups, civic leaders and Boston's civic data community to produce special reports and host public convenings.

ABOUT THE CENTER FOR STATE POLICY ANALYSIS, TISCH COLLEGE, TUFTS UNIVERSITY

The Center for State Policy Analysis pursues detailed analysis of live legislative issues and ballot questions in Massachusetts in order to:

- Give lawmakers the information they need to improve their legislation
- Help citizens understand — and productively debate — the stakes of new laws and ballot initiatives
- Allow advocates to gauge the trade-offs in proposed regulations

Bridging the divide between lawmakers and universities, cSPA aims to provide academic-quality information on a policy-relevant timeline.

ACKNOWLEDGMENTS

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INTRODUCTION

The federal government is cutting support for Medicaid. But with careful administrative choices, creative data sharing, and deliberate outreach, Massachusetts can protect tens of thousands of vulnerable residents and hold on to more of our federal dollars.

The key thing to understand is that the federal cuts are unusually indirect. The "One Big Beautiful Bill Act" (OBBBA) does not specify new, lower funding levels for our state's Medicaid program, known as MassHealth. Instead, OBBBA requires all U.S. states to introduce new eligibility checks and work requirements—and it assumes those new rules will reduce spending by making people ineligible.

Trial programs in other states have shown that the overwhelming majority of folks who lose coverage already have jobs or attend school. Yet they get tripped up by new bureaucratic hurdles.

Turn this problem around, however, and you can see that the best counter-action Massachusetts can take is to ensure that eligible residents have an easy time meeting the new work requirements. That way we can not only minimize coverage losses but also stanch the loss of federal money.

These changes to Medicaid are part of a broader federal effort to reshape American life, creating uncertainty across many policy areas. To help the Commonwealth meet this challenge, Boston Indicators has partnered with the Center for State Policy Analysis at Tufts University on this report, which we're releasing as part of our broader Meeting the Moment series.

Reviewing the latest research, and talking to leading experts about how Massachusetts can best safeguard MassHealth, we found that:

- Every state that has previously attempted to introduce Medicaid work requirements has seen massive disenrollment (or backed away when massive disenrollment loomed).
- Success hinges on our ability to automatically check incomes, confirm compliance, and identify allowable exemptions by linking disparate data systems from across state agencies and relevant private sources.
- Only a COVID-like command team, centered in the Governor or Lieutenant Governor's office, can mobilize the necessary cross-agency cooperation.
- Developing an effective Massachusetts model for work requirements would help tens of thousands of residents maintain coverage through MassHealth and safeguard hundreds of millions of federal dollars.
- Massachusetts has struggled in the past with these kinds of technology- and systems-oriented projects, most notoriously during the rollout of the Health Connector.

What follows is a fuller exploration of these findings, including background on the new MassHealth work and eligibility requirements, lessons from other states, and a proposed "Massachusetts Model" for adapting in a way that protects our residents and coffers while making state data systems more integrated and efficient.

NEW RULES FOR MASSHEALTH

MassHealth—like all state Medicaid systems—is a partnership with the federal government, where Massachusetts pays part of the cost to insure vulnerable residents and Washington pays the rest. This multiplies our local impact, but it also makes MassHealth a target whenever federal lawmakers seek to reduce spending.

Over the years, Washington has floated various cost-cutting proposals, among them a push to make states pay a higher share and another capping the total federal contribution.

But for OBBBA, Congress chose a different approach. Rather than direct cuts, they tightened the rules for Medicaid eligibility, reducing costs by limiting the number of people in the program.

Some of the restrictions are categorical. For instance, tens of thousands of formerly eligible legal immigrants in Massachusetts will now be barred from state Medicaid programs (and also from purchasing subsidized insurance through the Affordable Care Act).[1] On this front, there's little Massachusetts can do, apart from potentially creating new state-funded programs for these populations.

But the work requirements are different, allowing much more room for creative maneuvering from the states.

Broadly, the new rules require able-bodied 19- to 64-year-old adults in Medicaid expansion programs to work or volunteer for 80 hours each month.[2] This means the rules don't apply to children, seniors, and those with disabilities.

There are also explicit, if not fully defined exemptions for pregnant women, parents of young children, the medically frail, family caregivers, young adults who've aged out of the foster system, those in substance abuse programs, and anyone already meeting work requirements for the supplemental nutrition assistance program (SNAP), among others.

If you don't qualify for any of these exemptions, then you need to meet actual work rules, which you can do by holding down a job, volunteering, being a half-time student, or just earning an amount of income consistent with working 80 hours a month (which, as we'll see, creates a potential workaround here in Massachusetts.)

Broadly, the new rules require able-bodied 19- to 64-year-old adults in Medicaid expansion programs to work or volunteer for 80 hours each month. This means the rules don't apply to children, seniors, and those with disabilities.

In many cases, states will set the precise boundaries for these rules and exemptions, building on guidance we'll eventually get from the federal government. This makes decision-making on Beacon Hill vital to the process of OBBBA implementation, directly shaping outcomes for families and individuals who rely on MassHealth.

Some forms of state discretion are straightforward. For instance, federal rules require states to confirm eligibility at least twice a year—but they allow states to check even more frequently.

More impactful, and more challenging, is the power states will have to ease compliance by updating their enrollment systems, seamlessly identifying those eligible for exemptions and automatically confirming work status whenever feasible.

SCALE OF POTENTIAL DISRUPTION

More than two-thirds of people subject to the new work requirements already work or attend school.[3] Almost everyone else is willing to start. Looking across the country, the Urban Institute found that just 2 percent of Medicaid enrollees said they're not interested in getting a job.[4]

But even if every MassHealth enrollee commits to getting a job, that won't prevent coverage losses under the new rules. Some workers will struggle to pick up enough hours; others may find themselves in cratering job markets with few opportunities.

Perhaps the biggest challenge, though, is simply proving that you're meeting the new work requirements—especially if you're self-employed, volunteering, or doing a mix of gigs and schooling. We just don't have established systems that track the number of hours people spend on these activities.

Uncertainty around how people can prove compliance is one reason that even the most high-quality studies of OBBBA's impact come with large ranges.

A recent Massachusetts-focused analysis from the Urban Institute found that between 141,000 and 203,000 MassHealth enrollees would lose coverage in just the first year.[5] Another recent analysis, from the Massachusetts Taxpayers Foundation, considers coverage losses of 100,000 to 200,000.[6] And when the Center on Budget and Policy Priorities looked at a slightly different metric—those "at risk of losing coverage"—it found a range that spread from 225,000 to 350,000.[7]

Wide ranges like these reflect something more than the normal uncertainty of forecasting. They speak to a profound question about our state's ability to accurately determine compliance and keep eligible residents covered.

Multiple studies project **major potential losses in coverage** to MassHealth, with estimates spanning from 100,000 to 200,000 people.

Or, flipping that around, another thing these wide ranges suggest is that building a successful Massachusetts Model for Medicaid-related work requirements would protect tens of thousands of people from losing insurance. With the right mix of approaches, we might fully defy these estimates and protect even more enrollees than the best-case scenarios currently predict.

And in a serendipitous twist you rarely see in public policy, effective action from the state would not only expand insurance coverage, but it would also save money. Again, that's because OBBBA relies on coverage losses as the main engine for savings. The more we do to help residents maintain coverage, the more federal support we can continue to collect. What's more, because the work requirements apply to people who get especially large federal matches (generally 90 percent), the net benefits for the state's health-care system are sizeable, protecting hundreds of millions of dollars in federal support while also avoiding the need to spend tens of millions of state budget dollars on emergency care for the newly uninsured.

LESSONS LEARNED

The evidence around Medicaid work requirements is very clear and very consistent. Laudable as it may be to encourage people to find jobs, Medicaid work requirements don't seem to actually increase employment.[8] Yet, they do have a significant, negative effect on Medicaid enrollment. Requiring workers to gather and upload multiple documents—while mandating that those materials be validated by state officials—creates administrative backlogs, prolonged processes, and inevitable gaps in coverage.

As part of a recent federal pilot program, two states have fully implemented Medicaid work requirements: Arkansas[9] and Georgia.[10] And the results offer important lessons for lawmakers in Massachusetts to consider.

Independent evaluations of the programs found a host of similar failings, including slow approvals, administrative delays, and unreliable technology. Meanwhile, applicants in both states complained of blanket denials based on administrative issues like missing documents.

There was also a lack of clarity regarding acceptable documentation and never-ending customer service loops when attempting to resolve these issues.

Coverage losses were massive. Of the 110,000 Georgians who initially sought to be considered for the program, only 40,000 ended up submitting applications—and less than half of those were approved for coverage in a state Medicaid program.[11] In Arkansas, the uninsured rate for all 30- to 49-year-olds rose from 23 percent to 30 percent between 2016 and 2019, the bulk of which is attributed to state work requirements.[12] While Georgia's program is still up and running, Arkansas' program was deemed unlawful by a federal court.

Here in Massachusetts, perhaps the most important story for us to understand involves New Hampshire, a fellow New England state that tried to introduce a more effective approach to Medicaid work requirements, including an expansive communications campaign to alert potential applicants.

The outreach plan didn't work. As the deadline for implementation approached, lawmakers discovered that two-thirds of affected applicants had failed to submit any documentation.[13] So, New Hampshire gave up on the program altogether. All that to say: It's hard to find inspiring examples of Medicaid work requirements being soundly and effectively implemented.

Still, across the U.S. and around the world, there are many other social programs that require recipients to work.[14] And they seem to work best—with the highest uptake and biggest impact—when existing administrative data is used to lessen the reporting burden for recipients, including by automatically verifying eligibility and sending out pre-filled forms.

NEW HAMPSHIRE CASE STUDY

New Hampshire offers a cautionary tale that's particularly apt for Massachusetts. Our neighbors to the north sought to add strict work requirements to their state Medicaid program in 2018, requiring adults without an exemption to work at least 100 hours each month,[15] 20 hours more than the 80-hour threshold set in Arkansas.

However, as they were hoping to avoid the massive enrollment fall-off in Arkansas, New Hampshire officials implemented a more flexible, "no wrong door" approach.

For example, applicants would be able to upload their documentation via multiple channels (e.g., online, by phone, in-person). The state also introduced a "curing" process, where applicants who fell short of the 100 hours in one month would have the ability to make up for any missing hours in the following month. And lastly, individuals whose coverage was suspended for insufficient work could be reinstated at any time once they met the requirements.[16]

At the same time, New Hampshire rolled out a communications plan that included phone calls, mass mailings, and multiple in-person information sessions.

However, problems surfaced quickly:

- Few people answer calls from unknown numbers these days, and fewer share sensitive information. Out of 50,000 calls, the state reached just 500 individuals.[17]
- It's hard for people to carve out time between work, errands, and child care to attend info sessions—even if representatives are willing to come to you. A mere 150 home visits out of the planned 1,200 were completed.[18]
- Government mailings seem to have regularly gotten lumped in with junk mail, though the state could not determine the number of opened letters.

Applicants interviewed about their experience complained of technology glitches, long customer service wait times, and confusing applications.[19] By July 2019, after just one month of implementation, officials realized that an estimated 17,000 enrollees were on the path to disenrollment, and the program was repealed.[20]

TIMELINE FOR ACTION

In a saner world, the Medicaid work requirements introduced in OBBBA would be deliberately phased in, starting with clear explication and paired with robust technical assistance from the federal government—not to mention ample opportunity for collaboration between states.

As it stands, however, Massachusetts will have to act fast and find guidance on its own. Regulatory details aren't expected from the federal government until June 2026—just a few short months before states have to notify residents of the new requirements and only half a year before full implementation on January 1, 2027.

Waiting for near-final rules to arrive next summer would make it impossible for Massachusetts to adapt its enrollment procedures, which means we'll need to start developing a Massachusetts Model for successful implementation before the final rules are even available.

OBBBA does have a provision allowing states to delay implementation if they show a good faith effort to comply, but any such delay would require a federal dispensation, which is far from assured.

Because federal regulations won't arrive until June 2026, just months before enrollment, **Massachusetts will need to develop its own processes** and build a model of implementation in advance.

A MASSACHUSETTS MODEL FOR SUCCESS

Given the struggles of other states, our path to success seems very narrow. But the only choice for Massachusetts is to walk it. There are a few clear steps we need to take:

1. Use our discretion wisely.
2. Automate everything we can—exemptions, work requirements, income checks.
3. Make verifications and attestations as easy as possible.
4. Build a statewide ground game to reach the most vulnerable.

1. USE OUR DISCRETION WISELY

OBBBA gives states some latitude to make their verification systems more or less demanding.

For example, under the new rules Massachusetts has to confirm enrollee eligibility at least twice a year, which is double the current pace. This alone can be a significant bureaucratic hurdle for recipients, and it's expected to meaningfully disrupt enrollment. But this twice-a-year requirement is just a floor. States can check even more frequently if they wish.

Similarly, states will have considerable flexibility in how they verify work requirements, including how many months to review and whether those months must be consecutive.

In cases like these, Massachusetts can minimize coverage losses by opting for the least restrictive allowable option.

2. AUTOMATE EVERYTHING WE CAN

Requiring MassHealth members to repeatedly and regularly prove their eligibility is onerous, failure-prone, and often unnecessary. In many cases, the state already has the relevant information.

Trouble is, this vital data is spread across different systems in different state agencies and private entities. Making it available for MassHealth will require a massive but essential effort of technology reconfiguration and cross-agency coordination.

Start with the task of identifying exemptions.

The easiest way to comply with work requirements is to avoid them entirely. And OBBBA includes a range of explicit exemptions that the state can aggressively and automatically apply to waive work requirements.

Potentially useful data sources abound.

- Parents of young children should already be visible in existing MassHealth household data.
- Current and recent inmates can be identified in data from the Department of Corrections.
- Young adults previously in foster care will likely have records in child welfare databases.
- SNAP participants who face (separate) work requirements in that program are exempt from MassHealth work rules.
- Insurance claims data could be searched in a privacy-preserving way to flag people with disabilities, those dealing with complex health problems, and participants in substance abuse rehab programs.

Strong matches across any of these sources can lead to auto-exemptions; uncertain matches can be used to prefill forms for enrollees, who can later correct or confirm.

Those ineligible for an exemption will need to meet the new work requirements. But here again, the state already has data that could help make compliance seamless.

- One promising source involves individual earnings data collected by the Department of Revenue as part of the state's Paid Family Leave program. Income data may not sound particularly useful for proving that someone has worked 80 hours, but OBBBA explicitly allows us to use income as a proxy. Earning $580 per month ensures eligibility, since that's the equivalent of 80 hours at the federal minimum wage (see page 14 sidebar for details on how this gives a special boost to Massachusetts).
- Robust information on hours and earnings is also gathered by the Office of Labor and Workforce Development, thanks to regular reporting from employers large and small. However, this data is quarterly—and comes with a lag—which could limit its value for MassHealth purposes (though Massachusetts can work with the federal government on flexible rules allowing us to leverage this data).
- When state data won't suffice, Massachusetts may be able to automatically verify compliance using other sources, including payroll processing organizations or Equifax's "Work Number" workforce system.

ABOUT THAT MINIMUM WAGE…

Residents don't actually have to work 80 hours per month to meet the new MassHealth work requirements. They just need to earn the equivalent of 80 hours at the federal minimum wage. And since the federal minimum wage is less than half the state wage floor, Massachusetts workers will qualify with just 39 hours of earnings, or fewer than 10 hours per week (sometimes less, if they have higher hourly earnings). Being a state with a high minimum wage, in other words, should dramatically ease eligibility for MassHealth.

3. STREAMLINE SIGN-UPS

Automatic verification won't always be possible, even with the most robust and successful data integration. For instance, we don't have usable information about folks who are self-employed or doing community service. In such cases, applicants and enrollees will need to provide proof of eligibility.

Still, there's a lot we can do to ease this process, including with streamlined forms that require only the most necessary information, mobile-friendly portals paired with text messaging notifications, multilingual materials, and clear communications. And to the extent allowed by final rules, we can also allow people to affirm compliance up front and provide confirmation later, keeping people covered when eligibility is uncertain.

Otherwise, if we fail to make submissions simple, every quirk and frustration with the sign-up system will increase the number of people who lose coverage and find themselves exposed to higher health risks.

4. BUILD A GROUND GAME FOR OUTREACH

All MassHealth members and current applicants need to understand the changes coming to this vital public program, or risk losing access. And that means reaching people all around the state with clear and actionable messages.

To be effective, our outreach plan needs to involve both virtual and in-person approaches, including phone, video conference, and workshops at trusted regional locations.

This is something we have done successfully in the past, including during the redetermination process in 2023 and 2024. And the same approach makes sense this time, where the state contracts with nonprofit and other independent partners ready to mobilize their local networks.

CONSIDER LEGISLATIVE CHANGES AS NEEDED

As we adapt our MassHealth enrollment system, we may encounter obstacles that require legislative intervention. Consider two possible examples:

- Getting timely data is essential but also challenging. Were businesses to switch from quarterly to monthly payroll reporting, it would vastly increase our ability to assess compliance with work requirements. However, it would also create a new burden for local businesses and therefore might require some kind of broader bargain with the business community.
- Even if we do everything right, some people are still going to lose insurance, either because of their immigration status or because they fall through lingering cracks. Fortunately, the state already provides emergency coverage for uninsured individuals through our Health Safety Net program. Now might be an occasion to turn this program into a slightly more robust, "mini-caid" insurance option. Instead of ad-hoc reimbursements for care delivered at hospitals and community health centers, we could create a universal state-funded program for all Massachusetts residents who lack other coverage. This wouldn't replicate the full scope of MassHealth benefits, but it could ensure access to primary care, preventive services, chronic disease management, and emergency care—the essentials that keep people out of crisis and reduce the cost burden on safety net providers.

FROM HERE TO SUCCESS

The challenge is daunting, and the window for action is short. Building a Massachusetts Model to accommodate the new realities of OBBBA—and safeguard federal dollars in the process—requires substantial technical upgrades to our enrollment system, improved coordination across agencies, and a statewide public outreach campaign, among other things.

Management from the top will be essential, with either the Governor or the Lieutenant Governor assembling and leading a dedicated team with a remit for aggressive implementation and a focus akin to the COVID-era command center.

Ideally, members of this MassHealth command team would include high-level and technically-savvy representatives from various agencies, in numbers sufficiently small to maintain a bias toward action.

Quickly, the command team could pursue an audit of the possible, focusing especially on the viability of automatically identifying exemptions and compliance with work requirements. Ground truth needs to be reached in the next few months: Do current government systems allow for the necessary data-sharing? Or what investments are required to create such connections?

Executive leadership will be essential in assembling a dedicated team with a remit for aggressive implementation and a focus akin to the COVID-era command center.

After that, the short window for implementation means that the focus has to remain narrow. The fact that we're rebuilding enrollment systems can't become a reason to make other technical and organizational changes that—while valuable—add complications and extend timelines in ways that could undermine the core project.

Even after the new regulations take effect, this MassHealth command team could remain in place, publishing monthly data on enrollment and insurance rates so we can evolve our strategies over time.

To be sure, this is not the only possible approach; our goal is simply to highlight one promising path. But it does seem like some kind of extraordinary action is needed, given the dismal record of Medicaid work requirements in other states—not to mention our own mixed experience with complex bureaucratic challenges like the troubled rollout of the Health Connector a decade ago.

CONCLUSION

Work requirements and other eligibility changes dictated from Washington are going to rattle MassHealth, leading to lost dollars for the state and lost coverage for families. But there's a lot we can do to minimize the impact.

Massachusetts has one huge advantage in this effort: We care. From the Governor's office to the executive agencies and the halls of the statehouse, everyone is aligned on the need to help residents find and keep insurance coverage.

But our collective good intentions can only get us so far, when the real challenge is coordinated bureaucratic action and public sector technical acumen.

Tens of thousands of at-risk residents need us to develop a Massachusetts Model for successful implementation of OBBBA—before the starting bell in January 2027. Otherwise, we'll be just another place where people lose insurance thanks to overly complicated forms or because vital information about their work history can't be shared across state agencies.

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