Anticipated effects of OBBBA (HR1) on Medicaid Eligibility

Informational Briefing
Senate Committee on Health and Human Services
Senate Committee on Commerce and Consumer Protection

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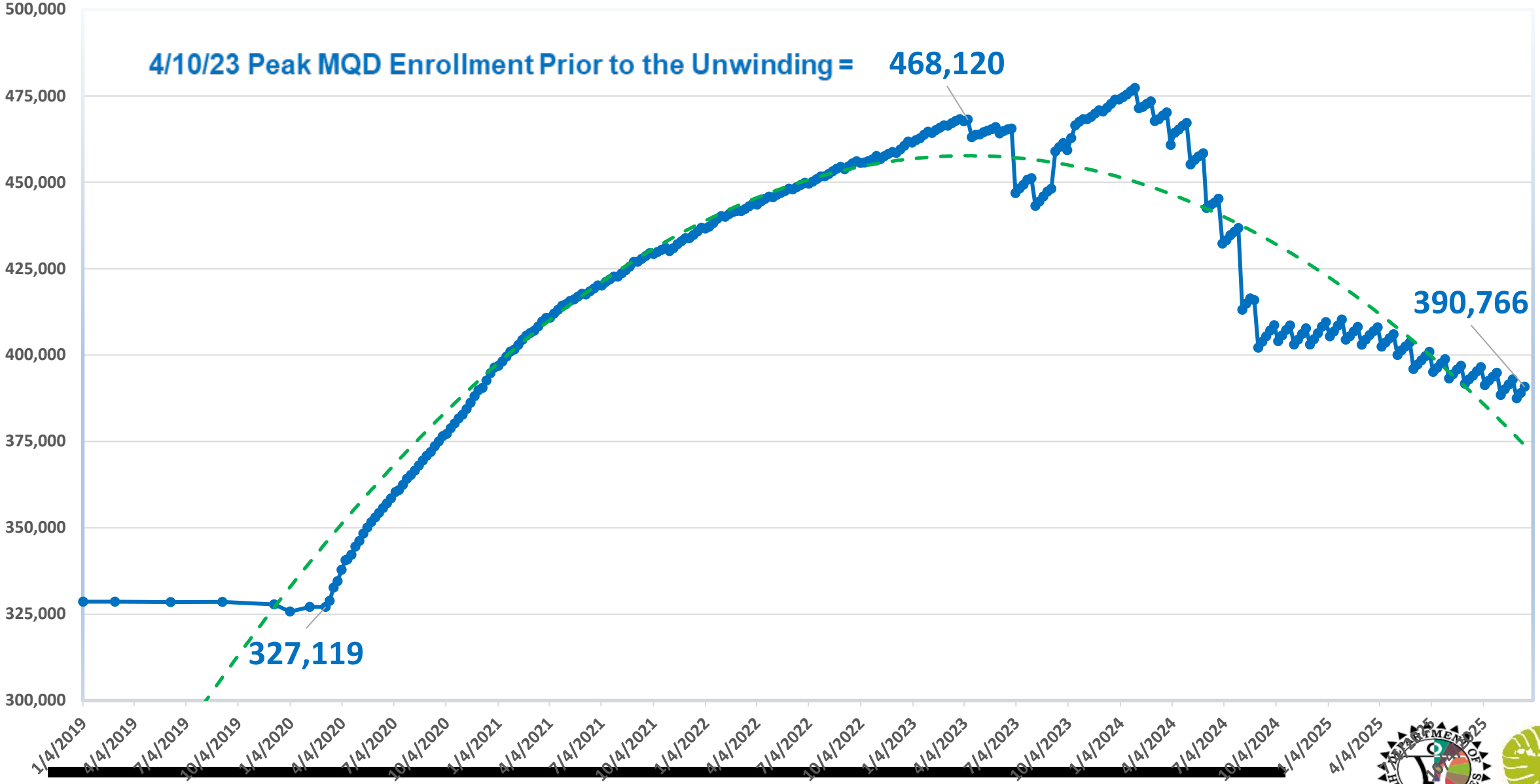
Med-QUEST Division

MED-QUEST CURRENT ENROLLMENT AND TRENDS

Hawai'i Medicaid Monthly Enrollment and Trend: January 2019 to December 15, 2025

141,001 New Enrollments from 3/6/2020 – 4/10/2023 (43% Increase)

77,354 fewer enrollments from 4/10/23 to 12/15/25 (16.5% decrease from peak enrollment prior to unwinding)



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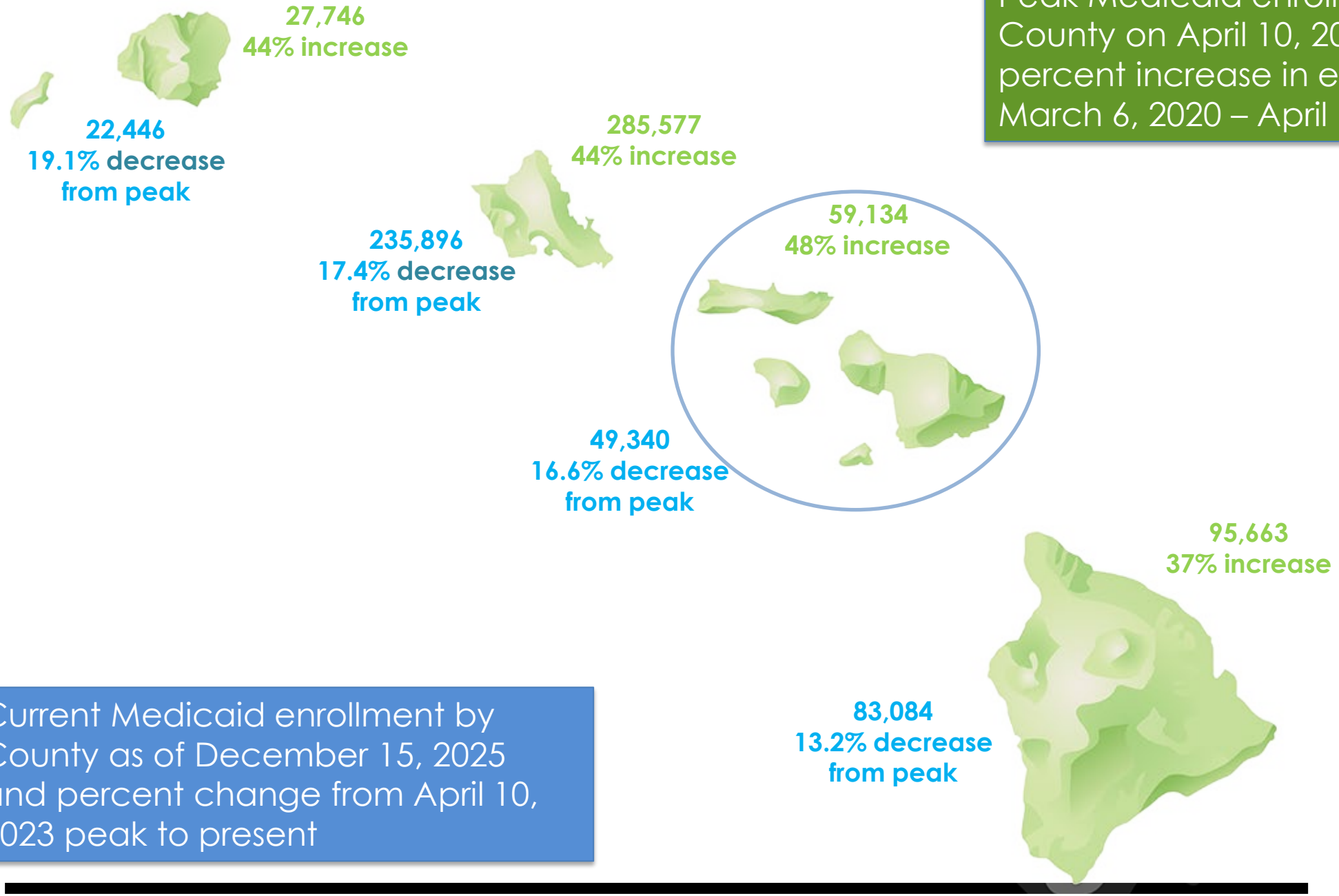
Peak Medicaid enrollment by County on April 10, 2023 and percent increase in enrollments from March 6, 2020 – April 10, 2023



Current Medicaid enrollment by County as of December 15, 2025 and percent change from April 10, 2023 peak to present

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Hawaii Medicaid QUEST: by the numbers (December, 2025)

Hawaii residents on QUEST	390,000; 27% of Hawaii population
Non-disabled adults	180,000 46% of the QUEST population
Affordable Care Act (ACA) Expansion Adults	*128,000*
Parents/Caretaker relatives	*52,000*
Children	151,000 Nearly 1 in 2 HI pop 39% of the QUEST pop.
Aged, Blind, or Disabled (ABD)	58,000 – 15% of the QUEST pop.
Base Federal Matching rate FFY 25	59.08%
Delivery System	99.9% enrolled in QUEST Integration Health Plans

ALOHACARE hmsa KAISER PERMANENTE 'ohana health plan UnitedHealthcare Community Plan

H.R. 1 BUDGET RECONCILIATION (ONE BIG BEAUTIFUL BILL ACT (OBBBA) MEDICAID IMPACTS

Timeline for effective dates of H.R.1's Medicaid policies

Jul. 4, 2025[1]:

- Limit on increases of existing provider taxes begins
- Cap on any new state-directed payments (110% of Medicare rates for non-expansion states, 100% of Medicare rates for expansion states)
- Prohibition on federal match for Prohibited entities (Planned Parenthood)

Dec. 31, 2026[1]:

- A1 Compliance with community engagement requirements for Medicaid begins (some states may qualify for 2-year exemption until 2028)
- A2 Increased eligibility checks for expansion population begin
- A4 Limits on retroactive coverage begins

Jan. 1, 2028[1]:

- C2 Reduction of current safe harbor in expansion states begins (by 0.5% each year until reaching 3.5% in 2032)
- C3 Reduction of existing state-directed payments (SDPs) begins to step down (10% each year until meeting new requirements SDPs)

Oct. 1, 2026[1]:

- A5 Restrictions on definition of "qualified immigrants" for Medicaid take effect
- B2 Restriction on expansion FMAP for the emergency Medicaid begins (No impact Hawaii)

Jan. 1, 2027[1]:

- C1 Strict budget neutrality for new Medicaid 1115 waivers begins
- A3 Verification of enrollee address and other information / concurrent enrollment begins

Oct. 1, 2028[1]:

- B1 Requirement for states to implement cost sharing for ACA expansion adults begins

Jan. 1, 2030[1]:

- B3 Required reduction of federal financial participation to states with eligibility "error rate" above 3% begins

Immigrant eligibility – Limitations on who can qualify

- **Current/Prior to HR1:** A broad range of non-citizens could be eligible for Medicaid, including
  individuals lawfully present, certain Cuban and Haitian immigrants and Compact of Free Association (COFA) migrants.
- **Change: Starting October 1, 2026, cuts** Medicaid eligibility for certain non-citizens by changing the definitions of which non-citizens can qualify for Medicaid eligibility:
  - Refugees
  - humanitarian parolees
  - asylum grantees
  - certain spouses and children fleeing violence/abuse
  - certain trafficking victims
- **Impact:** We estimate that 1,200 to 2,400 current members will lose coverage under the new definitions.
  - Most who lose coverage would be eligible for emergency services only.
  - Approximately 200 of the individuals may qualify for our state-funded Aged, Blind or Disabled category.

Immigrant eligibility-ACA – Limitations on who can qualify

- **ACA Marketplace Tax Credit Eligibility for Low-Income Immigrants Without Medicaid Coverage:**

  The legislation eliminates Marketplace eligibility for all lawfully present immigrants with incomes under 100% of the federal poverty level beginning January 1, 2026, leaving some ineligible for either Medicaid or Marketplace coverage.

  A provision in the final version of the bill signed into law would limit eligibility for subsidized ACA Marketplace coverage to lawfully present immigrants who are lawful permanent residents (LPRs or "green card" holders), Compact of Free Association (COFA) migrants residing in the U.S., and certain immigrants from Cuba and Haiti, thereby eliminating eligibility for many lawfully present immigrants, including asylees, refugees, and people with Temporary Protected Status, beginning January 1, 2027.

BUDGET RECONCILIATION ACT – ACA EXPANSION ADULTS

HR1 : ACA Expansion Adult population

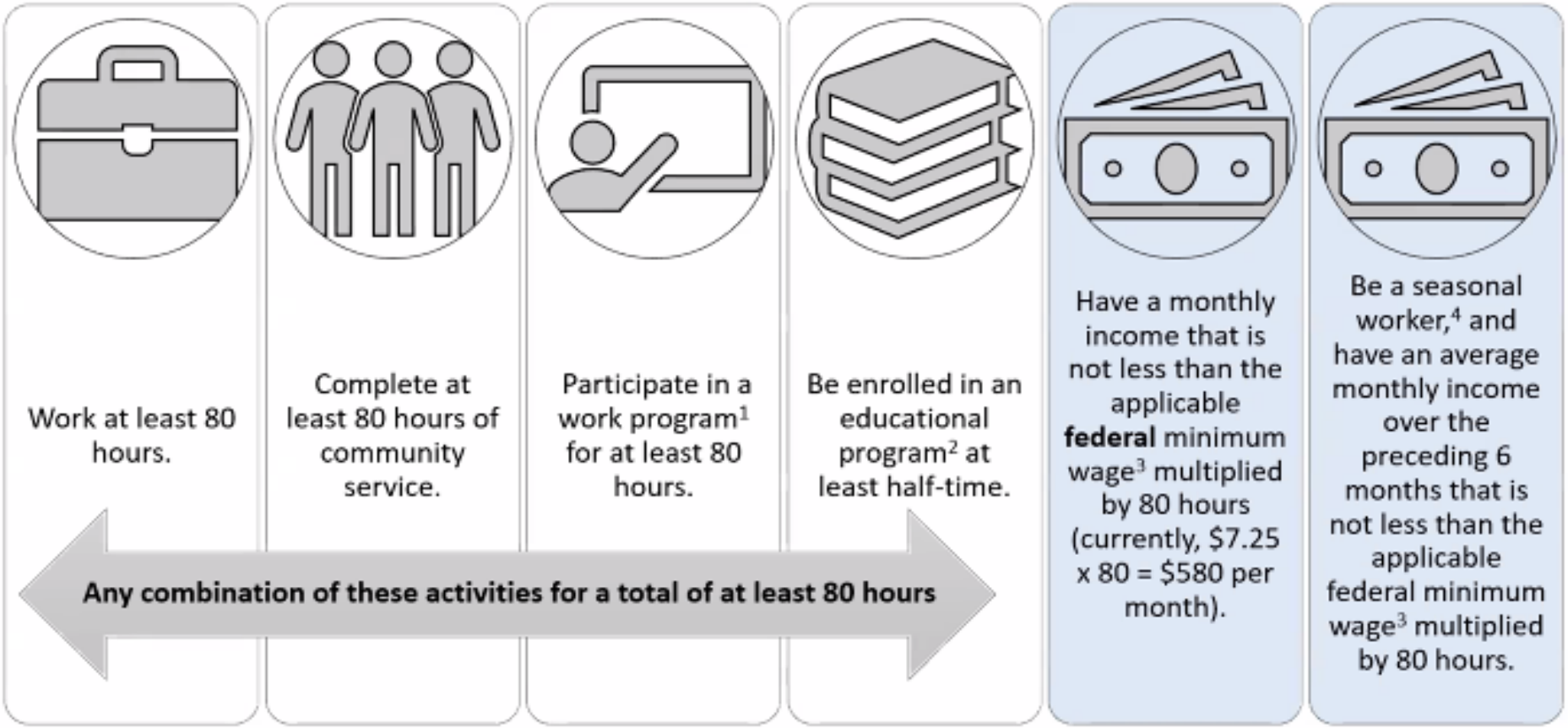
Expansion adult changes: Increased requirements/mandates for Low Income (ACA Expansion) adults to enroll and maintain coverage:

1. Increasing eligibility renewals to every 6 months from the current annual renewal

2. States are required to establish work/community engagement requirements for ACA Expansion adults **aged 19-64** as a condition of Medicaid eligibility effective December 31, 2026.

Definition of Community Engagement

To meet community engagement requirements in a given month, applicable individuals must do one or more of the following:



Section 1902(xx)(2) of the Act.

1. A work program is defined by section 6(o)(1) of the Food and Nutrition Act of 2008.
2. Including an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) and a program of career and technical education (as defined in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006).
3. Federal minimum wage is defined by section 6 of the Fair Labor Standards Act of 1938, 29 U.S.C. § 206(a)(1)(C).
4. A seasonal worker is described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986.

Exclusions from and Exceptions to Community Engagement Requirements (1/2)

Individuals meeting the definition of a "specified excluded individual" for part or all of a relevant month are not subject to demonstrating community engagement for that month:

- former foster care children defined in §1902(a)(10)(A)(i)(IX);
- certain American Indians and Alaska Natives;[1]
- parents, caretaker relatives, guardians, or family caregivers[2] of a dependent child under the age of 14 or a disabled individual;
- veterans with a total disability rating as defined under 38 U.S.C. §1155;
- individuals who are medically frail or otherwise have special medical needs (as defined by the Secretary);[3]
- individuals who are compliant with Temporary Assistance for Needy Families (TANF) work requirements;[4]
- members of households that receive Supplemental Nutrition Assistance Program (SNAP) benefits and are not exempt from SNAP work requirements;[5]
- participants in certain substance use disorder treatment and rehabilitation programs;[5]
- inmates of a public institution; or
- pregnant women or individuals entitled to postpartum medical assistance.[6]

1. Includes individuals who meet one of the following criteria: (A) is an Indian or an Urban Indian (as defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act), (B) is a California Indian (as described in section 809(a) of such Act), or (C) has otherwise been determined eligible as an Indian for the Indian Health Service under HHS regulations.
2. "Family caregivers" are defined in section 2 of the RAISE Family Caregivers Act, P.L. 115-119.
3. Includes individuals who are blind or disabled (as defined in §1614 in the Act), have a substance use disorder, disabling mental disorder, or physical, intellectua developmental disability that impairs the ability of the individuals to perform one or more activities of daily living; or has a serious or complex medical condition.
4. Under section 407 of the Act.
5. As defined in the Food and Nutrition Act of 2008.
6. As defined in section 1902(e)(5) or (16) of the Act.

Exclusions from and Exceptions to Community Engagement Requirements (2/2)

- Applicable individuals are excepted from demonstrating community engagement for a month if, for part or all of that month, they are:
  - under the age of 19;
  - entitled to or enrolled in Medicare Part A or enrolled for benefits under Medicare Part B;
  - described in a mandatory categorically needy eligibility group.[1]
- An additional exception applies to an individual who was an inmate of a public institution at any point during the three-month period ending on the first day of a month in which the individual is otherwise subject to the community engagement requirement.

1. In any of subclauses (I) through (VII) of section 1902(a)(10)(A)(i) of the Act.

Provider impact due to HR1 changes

Provider impacts

With more uninsured people:

- Hardest hit will be safety net providers such as Federally Qualified Health Centers, and hospitals, particularly smaller hospitals located in more rural isolated areas
    - People forego care until it is an emergency, so **overall acuity increases** with decreased ability to pay for the services
    - Hospitals **must screen and stabilize individuals regardless of their ability to pay** (1986 Emergency Medical Treatment & Labor Act (EMTALA))
    - Community Health Centers see everyone, have a sliding scale for payment for self-paying individuals.
- Increase in uninsured = increases in uncompensated care = **rising costs (cost shift) private/commercial** to offset losses elsewhere
- Providers cutting or limiting services, or possibly closing their doors, exacerbating challenges with access to health care services.

Recent CBO estimates on disenrollment and cost are largely consistent with internal analysis for Hawaii

PRELIMINARY

Lever	Hawaii analysis	CBO analysis[1]	Comparison
Increased in uninsured from community engagement rqmts	19K to 38K	33K	✓ Hawaii expansion adults' makeup 0.6% of total expansion population suggesting **33,920 will become uninsured in HI,** which is falls within range of internal HI analysis
6-month redeterminations	6K	4K-10K	✓ Internal HI analysis is **within range of CBO estimate** based on percent that could be disenrolled within the first year and future years
Provider Tax	3.5% Hospital Provider Tax	Provider taxes must go from maximum 6% in 2028 to being reduced by 0.5 percentage points annually until 3.5%	✓ Hawaii's hospital provider tax (hospital sustainability program) is already at the goal 3.5% therefore **there is likely minimal to no impact of HR1 changes to Provider tax**[3]

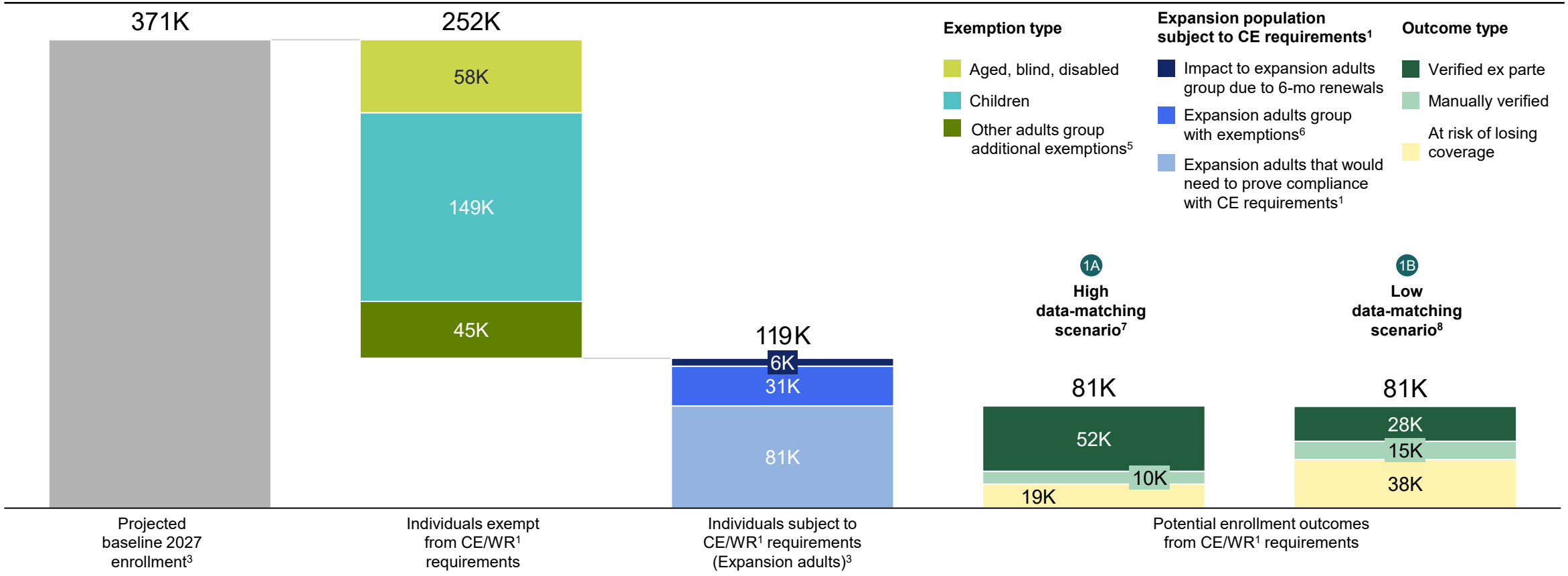
Source: 1. CBO report on national enrollment and cost effects published on October 28, 2025; 2. CBO reported 5.3 million will become uninsured from C.E. requirements in HR1 nationally. 3. HI does not have MCO tax per KFF, HI provider tax amounts per KFF

An estimated 19K to 38K members are potentially at risk of losing Medicaid coverage in 2027 due to CE / WR[1] requirements

Assumes Med-QUEST would invest to automatically verify full-time and part-time working adults on Medicaid[2]

DRAFT FOR DISCUSSION

Preliminary view of potential enrollment change over one year due to community engagement requirements, # in thousands (K)



1. Source: 1. Community engagement / work requirements; 2. Based on Hawai'i's full-time and part-time employment rate within Medicaid adult population as of May 2025 (KFF); 3. Projected 2027 enrollment absent of any H.R.1 policy changes, derived Hawai'i year-to-date enrollment, annualizing rate of change in enrollment following Unwinding (Med-QUEST enrollment reports from June-August 2025); 4. Reflects excluded eligibility and demographic groups as defined in H.R.1 legislation (H.R.1); 5. Includes pregnant women, caretaking, and former foster care beneficiaries in other adult group; 6. Includes caretaking, SUD-diagnosed members, and American Indian or Alaskan native beneficiaries in expansion adult group; 7. Assumes improved data integration and IT systems—64% of individuals subject to work requirements are assumed ex parte verified given either full time or part-time employment, with a 10-point increase in manual verification success relative to the low-data scenario, based on Arkansas outcomes (KFF , Urban Institute); 8. Assumes low ex parte and manual verification rates due to limited data integration and system capacity—only Medicaid adults working full time are assumed ex parte verified (~34%), and 72% of individuals required to manually verify are assumed disenrolled, based on Arkansas outcomes (Urban Institute)

MEDICAID & ACA MARKETPLACE IMPACTS

Affordable Care Act (ACA) Marketplace Changes

- **Expiration of the Enhanced Premium Tax Credits:**

  The enhanced premium tax credits were first made available as part of the American Rescue Plan Act in 2021 and later extended through the end of 2025. These enhanced tax credits, combined with increased funding for outreach and marketing have led to record-high enrollment in the ACA Marketplaces. Unless the enhanced tax credits are extended, enrollees receiving premium tax credits will experience an over 75% increase in their out-of-pocket premium payments, on average.

I'm an older single dad with a teenage son. My wife passed away from cancer. We went without health insurance for over 3 years, but last year, I started to have heart problems, so I needed to get insurance. We were able to get insurance on the marketplace since I received $1,200 in premium tax credits which helped lower my monthly premium to $571.

This year, my tax credits went down to $895 and the cost of my insurance doubled. Now I have to pay $1,108 each month. I don't know what to do. I can't afford that!

Last year my insurance was $254.98 a month. I just found out that starting in January, I have to pay $497.10 each month. That's twice as much! I can't really afford it, but I have surgery coming up, so I don't have any option.


Mahalo!