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MTF Bulletin

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Health Safety Net

Chapter 58 of the Acts of 2006 established the Health Safety Net (HSN) as a critical mechanism to reimburse uninsured care. After 20 years of essentially level financial support, the HSN is under significant strain from a growing funding shortfall and changes at the federal level that have presented a new challenge to ensuring access to medically necessary care for residents. As Medicaid changes made by the One Big Beautiful Bill Act (OB3) are phased in through 2028, MTF estimates more than 255,000 Massachusetts residents could lose health insurance, presenting new financial challenges for policymakers to support uninsured and underinsured care.

This brief provides a review of the Health Safety Net, examining the role of the Health Safety Net Trust Fund in the health care system, program and funding trends, and the new challenges that lie ahead.

Background

Since 1985, Massachusetts has relied on contributions from health plans, providers, and the state to deliver care to low-income residents without sufficient insurance. The Health Safety Net has evolved over the years through a series of health care reforms to ensure residents of the Commonwealth have access to necessary medical care despite their income level.

Uncompensated Care Pool

In 1985, Massachusetts established an uncompensated care pool to mitigate the financial loss experienced by hospitals providing care to low-income, uninsured patients who did not qualify for Medicaid or other public programs and established a financing mechanism to reimburse hospitals for a portion of the costs. The uncompensated care pool made each hospital financially responsible for a share of statewide uncompensated care – hospitals that provided proportionately more uncompensated care than the statewide average received payments from the pool, while those that provided proportionately less uncompensated care made payments into the pool – with no cap on the amount hospitals were required to pay and no state contribution to defray costs to hospitals.¹

While the pool provided a lifeline to hospitals with larger shares of uncompensated care, hospitals would often pass the financial burden of this tax onto private insurance plans and the plans would recoup their costs through increased premiums.² In 1988, the legislature imposed a cap of \$325

¹ *Gen. Hosp. Corp. v. Rate Setting Comm'n*, 407 Mass. 227, 229 (1990).

² Mass. Off. of the Inspector Gen., *Ongoing Review of the Uncompensated Care Pool Pursuant to Chapter 240 of the Acts of 2004: Second Report to the House and Senate Committees on Ways and Means*, 27 (2005).

million on the amount hospitals would pay to cover uncompensated care. The cap was phased down over time to \$315 million and in 1998 payer contributions were introduced, reducing the amounts owed by hospitals by an additional \$100 million.

Uncompensated Care Pool Funding³

Hospital Fiscal Year (October 1 – September 30)	Hospital Contribution	Payer Contribution	State Funding	Allowable Uncompensated Care	Shortfall
1990	\$312	\$0	\$0	\$412	\$100
1991	\$312	\$0	\$0	\$443	\$132
1992 ⁴	\$300	\$0	\$35	\$340	\$13
1993	\$315	\$0	\$15	\$392	\$70
1994	\$315	\$0	\$15	\$423	\$109
1995	\$315	\$0	\$15	\$444	\$130
1996	\$315	\$0	\$15	\$468	\$157
1997	\$315	\$0	\$45 ⁵	\$428	\$106
1998	\$215	\$103	\$100 ⁶	\$367	\$60

\$ in millions

New Mandate from Chapter 58

The enactment of Chapter 58 marked a significant shift in Massachusetts health care reform. Rather than relying primarily on the uncompensated care pool financing to provide access to health services for uninsured residents, the Commonwealth adopted a framework centered on expanding health insurance coverage while preserving a health safety net for individuals who remained uninsured or underinsured.

Chapter 58 included several provisions intended to increase insurance coverage for Massachusetts residents, including:

- Expanding MassHealth coverage for children and certain adults;
- Establishing an individual mandate for all adults to have health insurance;
- Establishing the first in the nation state-based health insurance marketplace;
- Launching a publicly subsidized private coverage option, now known as ConnectorCare, for low income residents; and
- Requiring employer contributions to health insurance costs to support coverage subsidies.

³ Mass. Off. of the State Auditor, *Independent State Auditor's Report on the Uncompensated Care Pool Administered by the Division of Health Care Finance and Policy*, No. 99-5069-3, 30 (1999).

⁴ Chapter 495 of the Acts of 1991 made freestanding community health centers eligible for payments from the pool and began receiving payments in 1992.

⁵ In FY 1997, the state provided hospitals an additional \$12.5 million in outstanding liabilities after hospital rates were deregulated and \$17.5 million through an intergovernmental transfer.

⁶ In FY 1998, the state provided hospitals an additional \$70 million through an intergovernmental transfer.

Through these efforts over the last 20 years, Massachusetts' insured population has increased to nearly 98 percent – the highest rate of health insurance coverage in the nation, with only 2.1 percent of residents reporting being uninsured compared to the national average of 8.2 percent in 2025.⁷

Chapter 58 also redefined the role of the Commonwealth's uncompensated care financing system. By dramatically reducing the uninsured population, the need for uncompensated care would be significantly reduced. The care that remained uninsured would be covered through a new Health Safety Net, which would receive a contribution from the state and revenue from equal assessments on providers and insurers.

Health Safety Net Funding

Funding Sources

The Health Safety Net is currently financed through a multi-source structure comprised of assessments on acute care hospitals and managed care organizations (MCOs) and designated state appropriations, all of which are deposited into the Health Safety Net Trust Fund. While the fund does function to reimburse hospitals and community health centers for health care services provided to eligible uninsured and underinsured residents, the Health Safety Net Trust Fund also includes several statutorily required transfers to support other health care financing programs related to health care access, including MassHealth, behavioral health, and child psychiatry initiatives. For the purposes of this analysis, the discussion focuses on the Health Safety Net's core uncompensated care function.

The resources available to support payments for care provided to uninsured and underinsured residents are:

- **Hospital Assessment** – The state imposes a tax on acute care hospitals depending on the size, services, and payer mix of the hospital. That tax and its structure is subject to approval by the Centers for Medicare and Medicaid Services (CMS). The total amount that must be collected through the hospital assessment is established in statute and is currently set at \$1.5 billion – the Health Safety Net receives \$165 million of the total hospital assessment annually.⁸ Assessments collected from acute care hospitals are deposited into the Health Safety Net Trust Fund.
- **MCO Assessment** – The MCO assessment imposes a tax on MCO services based on the health care services delivered or coordinated in a given month. The total amount collected through the MCO assessment is formulaic and can vary year to year – in 2026, the Executive Office of Health and Human Services (EOHHS) has set the total MCO assessment amount at \$676 million – the Health Safety Net receives \$165 million of the total MCO assessment annually. As with the hospital assessment, amounts collected from MCOs are deposited into the Health Safety Net Trust Fund.
- **State Appropriations** – A portion of the Health Safety Net is funded through state appropriations, including a \$30 million statutorily required transfer from the Commonwealth Care Trust Fund. The legislature has routinely overridden this statutory transfer through the annual budget appropriation process and allocated \$15 million for the Health Safety Net for the past decade along with occasional supplemental appropriations. Similar to the hospital and MCO assessments, these funds are deposited into the Health Safety Net Trust Fund.

⁷ *Health Care Reform in Massachusetts: 20 Years of Impact*, Massachusetts Health Connector (2026).

⁸ Include Note on how the assessment will change beginning in October 2027.

*Annual Health Safety Net
Funding for Uninsured/Underinsured Care*

Funding Source	Amount
Hospital Assessment	\$165
MCO Assessment	\$165
Commonwealth Care Trust Fund (Required Statutory Transfer)	\$30
Total	\$360

\$ in millions

Chapter 58 preserved the shared financing model for uncompensated care, which dates back to 1997, in the creation of the Health Safety Net but established an even split between hospital and payer obligations to support uninsured and underinsured care. Two decades later, the dedicated funding levels from the hospital assessment and MCO assessment, the successor to the surcharge payer contribution, remain essentially unchanged, providing approximately \$330 million in annual funding.⁹

In the last year, the legislature has made additional appropriations to the Health Safety Net from the Commonwealth Care Trust Fund, including \$77 million in FY 2025 in a supplemental budget specifically targeted at ensuring critical funding for hospitals and community health centers, \$50 million in FY 2026 and FY 2027, respectively, as part of the FY 2025 closeout supplemental budget, and an additional \$37.5 million in FY 2027 through the annual budget.¹⁰ Apart from recent supplemental funding, state appropriations for the Health Safety Net have remained relatively unchanged since the enactment of Chapter 58. The House has recently explored another avenue of funding uninsured and underinsured care in the 2026 economic development bill by authorizing wagers on historical horse races and dedicating a portion of each wager specifically for the Health Safety Net, however, this proposal remains in conference. These additional funding allocations have been critical to reducing funding shortfalls, and proposals to increase funding would aid in those efforts, but unlike required statutory funding, they are subject to budget negotiation.

Payment Prioritization

Payments from the Health Safety Net to address the cost of care for uninsured and underinsured patients are prioritized through regulation in the following order for eligible services:

- **Community Health Centers (CHCs);**
 - CHCs are paid using Prospective Payment System (PPS) rates based on the Medicare Federally Qualified Health Center base rate for most medical and behavioral health visits, and at MassHealth rates for ancillary services including vaccines and labs. Community health centers are reimbursed on a claim-by-claim basis for eligible services unlike hospitals that are subject to end of year reconciliation and pro-rata reductions based on the remaining available funding.
- **Acute Care Hospitals**

⁹ The total funding deposited into the Health Safety Net Trust Fund in FY 2026 was approximately \$2.2 billion – approximately \$1.7 billion of these funds are dedicated for other uses not related to uninsured care.

¹⁰ This supplemental funding for the Health Safety Net does not include the Federal Financial Participation (FFP) received by the Commonwealth.

- The order of payments to acute care hospitals depends on whether the Health Safety Net office projects a funding shortfall. Historically, funding shortfalls for the Health Safety Net are common, though the level of those shortfalls has risen dramatically in recent years. During a funding shortfall, funds to acute care hospitals are prioritized in the following manner:
 - **Disproportionate Share Hospitals (DSH)** – Hospitals with a public payer mix of at least 63 percent as of FY 2022. Eligible to receive up to an initial reimbursement cap of 85 percent of allowable health safety net payments for eligible services, before funding is distributed to non-Disproportionate Share Hospitals. Eligible services for reimbursement include reimbursable services to low income patients, services provided to patients with a medical hardship, and services that are determined to be bad debt such as services that are not reimbursable, regarded as uncollectible, or charged as a credit loss.
 - **Non-Disproportionate Share Hospitals (non-DSH)** – Eligible to receive up to an initial reimbursement cap of 75 percent of allowable health safety net payments for eligible services, if funding is available after each DSH receives 85% of its allowable HSN payments.
 - If funding is available after each DSH receives 85% of its allowable HSN payments and each non-DSH receives 75% of its allowable HSN payments, remaining funding is distributed across all hospitals in proportion to their remaining allowable HSN payments.

The Health Safety Net’s pricing also includes a variety of payment adjustments and rate enhancements that differ across health care settings and provider types. These additional reimbursements are primarily based on Medicare rates for covered services. For example, hospitals that qualify as DSH or non-teaching receive a 25 percent rate add-on for outpatient hospital services – a hospital whose HSN outpatient payment rate would otherwise be calculated at \$100 would end up receiving an HSN outpatient payment rate of \$125 for the same service if the hospital qualifies as DSH or non-teaching.

Health Safety Net Funding Shortfall

Over the two decades since its enactment, the Health Safety Net has by and large been a success serving as the Commonwealth’s payer of last resort. Between FY 2010 and FY 2020 the HSN reimbursed 86 percent of claimed costs and through FY 2022 the average shortfall had been below \$60 million for 15 years. However, Health Safety Net spending data illustrates a substantial increase in total demand and funding shortfalls in recent years:

Health Safety Net Spending

HSN Fiscal Years (October 1 – September 30)	Avg. Annual Hospital Spend	Avg. Annual CHC Spend	Avg. Annual Shortfall	Average Total Demand
FY 2008 to FY 2022	\$319	\$66	\$55	\$442
FY 2023 to FY 2026	\$264	\$102	\$178	\$542

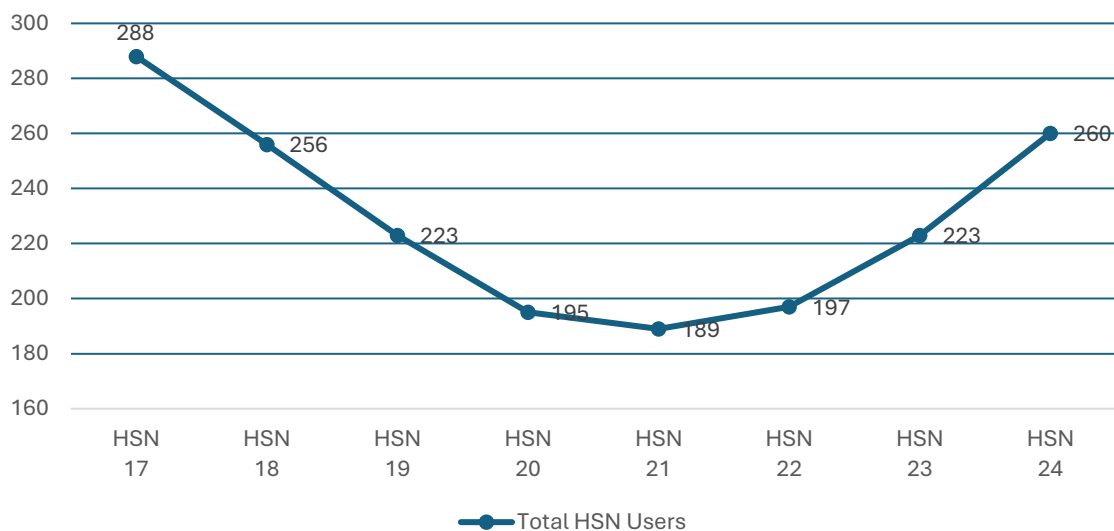
\$ in millions

Key Drivers

The increase in shortfall and total demand of the Health Safety Net in recent years is the product of a combination of factors:

- ***Increased Number of Users*** – Since FY 2021, the Health Safety Net has experienced a nearly 38 percent increase in utilization, however, it is worth noting the context of these increases to fully understand the impact on the funding.¹¹ In FY 2018, the Health Safety Net had 256,000 total users – the number of Massachusetts residents to whom Health Safety Net providers delivered services and billed HSN for those services – with a funding shortfall of \$14 million. In FY 2024, the Health Safety Net experienced 260,000 total users with a funding shortfall of \$197 million. Despite only a 1.5 percent increase in users, the total demand on the Health Safety Net increased by 41 percent when comparing FY 2018 and FY 2024 but due to financial constraints the funding shortfall increased by more than 1,300 percent. As utilization has rebounded above pre-pandemic levels, increased health care costs and other factors discussed below illustrate a vastly different health care landscape. With an estimated 135,000 new users by 2028 as a result of OB3 reforms, the total demand, and in turn the funding shortfall, on the Health Safety Net is expected to grow at a higher rate than previous years.

HSN Total User Trends
(# in thousands)



- ***Increased Pharmacy Use and Cost*** – According to CHIA, Pharmacy spending continues to be a driver of overall health care costs in the Commonwealth – making up over 23 percent of total health care expenditure growth between 2023 and 2024 – and the Health Safety Net is not insulated from the impact.¹² From FY 2021 through FY 2023, pharmacy demand as a percentage of total HSN eligible claims increased 35 percent for Health Safety Net hospitals

¹¹ HSN fiscal year runs from October 1 through September 30 of the following year.

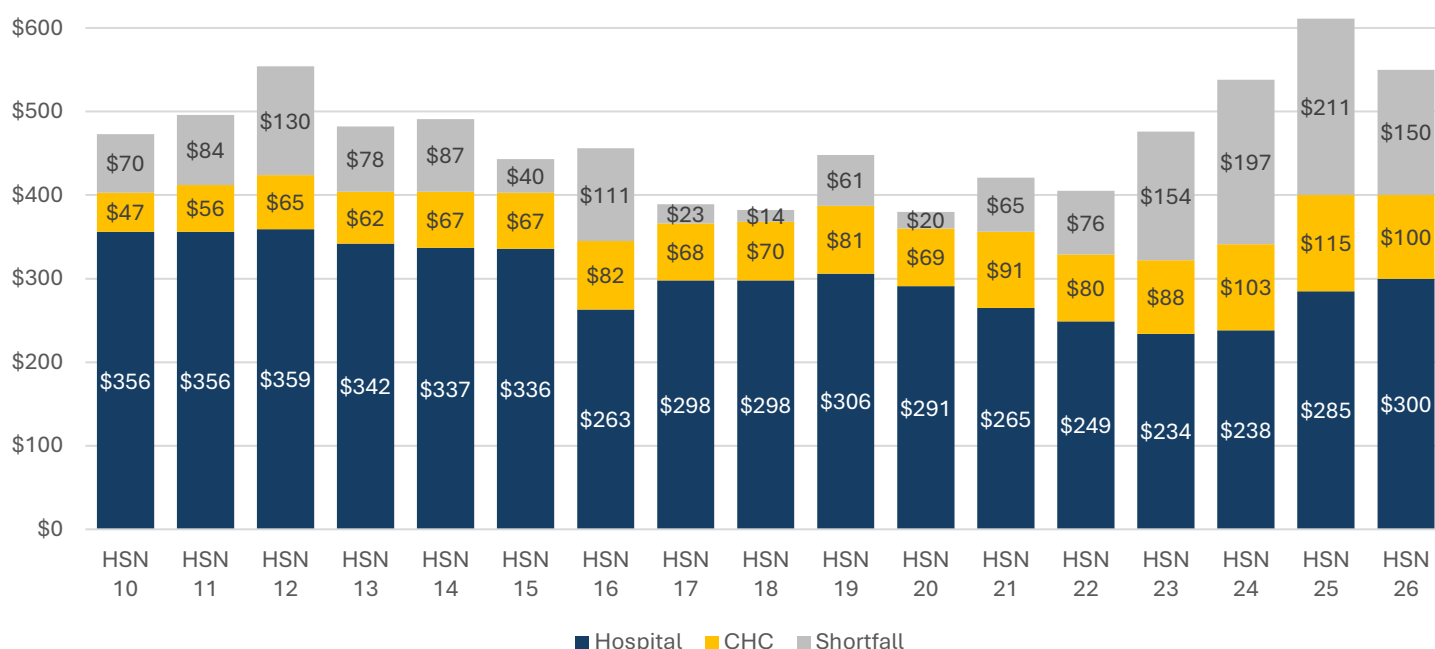
¹² Ctr. for Health Info. & Analysis, *THCE, TME, and APM*, <https://www.chiamass.gov/insights-analysis/cost/spending-expenses/thce-tme-apm>

and 6 percent for CHCs.¹³ The administration has utilized administrative solves related to prescription drugs, including changing from brand name to a largely generic prescription drug formulary, to mitigate pharmacy costs but it is not yet possible to assess the full impact of these adjustments.

- Increased Number of Hospitals Qualifying as DSH – Currently, 42 out of 57 (74 percent) of Health Safety Net hospitals qualify as DSH. As discussed above, hospitals qualifying as DSH are eligible for an initial reimbursement cap of 85 percent for eligible services during a funding shortfall, compared to 75 percent reimbursement for their non-DSH counterparts, and receive a 25 percent rate add on for outpatient hospital services.
- Increased Community Health Center Demand – From 2008 through 2022, payments to CHCs remained relatively flat with slight variation, averaging \$66 million annually, while average payments to acute care hospitals decreased over the same period by 21 percent, from \$319 million to \$252 million. Since 2023, payments to CHCs have increased on average by 55 percent, to approximately \$102 million annually.

As these cost escalators have occurred, absent some periodic supplemental appropriations, funding for uninsured and underinsured care provided by acute care hospitals and CHCs has remained stagnant for the last 20 years. Without additional resources, there are limited avenues for addressing total demand and funding shortfalls facing the Health Safety Net.¹⁴

HSN Demand and Payment Trends
(\$ in millions)



¹³ Mass. Exec. Off. of Health & Hum. Servs., *Health Safety Net FY2021 Annual Report*; Mass. Exec. Off. of Health & Hum. Servs., *Health Safety Net FY2022 Annual Report*; Mass. Exec. Off. of Health & Hum. Servs., *Health Safety Net FY2023 Annual Report*

¹⁴ Please note, official data for HSN FY25 and HSN FY26 in the chart below has not yet been published by EOHHS. Figures displayed for HSN FY26 are preliminary as the fiscal year officially ends September 30, 2026.

New Challenges from OB3

On July 4, 2025, the One Big Beautiful Bill Act (OB3) was signed into law containing a host of reforms to the Medicaid system, including eligibility and work requirement changes as well as limits on state directed payments and provider taxes which states like Massachusetts rely on heavily. The provisions included in OB3 will be fully phased in over the next two years and are estimated to result in up to 300,000 Massachusetts residents losing health insurance coverage which will have a major impact on HSN demand.

Effective October 1, 2026

Immigrant Coverage Restrictions – Beginning October 1, 2026, Medicaid and Children’s Health Insurance Program (CHIP) eligibility, which is integrated into MassHealth, will exclude certain lawfully present immigrants, including:

- Refugees;
- Individuals granted parole for at least one year;
- Individuals granted asylum;
- Individuals from Iraq and Afghanistan admitted on special immigrant visas;
- Certain spouses and children experiencing abuse;
- Certain victims of trafficking; and
- Native American tribal members who were born in Canada.

Effective January 1, 2027

Increased MassHealth Churn

- Work Requirements – Beginning January 1, 2027, Affordable Care Act (ACA) expansion states, like Massachusetts, will be required to implement work reporting and community engagement requirements as a condition of MassHealth eligibility for nondisabled, MassHealth enrollees that do not have children or meet other exemption criteria. Non-exempt adults will be required to complete 80 hours of work or community service activities per month.¹⁵
- Six-Month Redeterminations – Beginning January 1, 2027, redetermination timelines for MassHealth eligibility will be required to occur every 6 months for certain adults. All other members will continue to have their eligibility redetermined every 12 months.

While some individuals will be able to obtain coverage elsewhere, the Health Safety Net is expected to see an additional 135,000 users upon full implementation of OB3. Using conservative basic cost of care estimates, each additional 50,000 users of Health Safety Net services increases total demand by \$100 million. The cascading effect of funding impacts will not only create new challenges for health care providers, but policymakers crafting the state budget as well.

¹⁵ If a state is demonstrating a “good faith” effort to comply with requirements, U.S. Health and Human Services Secretary can issue an exemption through December 31, 2028. States also have the option to start their program sooner than January 1, 2027. Ctrs. for Medicare & Medicaid Servs., Ctr. for Medicaid & CHIP Servs., *Section 71119 of the “Working Families Tax Cut” Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals*, CMCS Informational Bulletin (Dec. 8, 2025), at 10-11.

Key Questions for Policymakers

How do OB3 policy changes impact the Health Safety Net?

As discussed above and in a prior MTF brief, more than 255,000 residents are expected to lose coverage through MassHealth and ConnectorCare by 2028 when Medicaid changes are fully implemented. The overall demand on MassHealth and ConnectorCare will change substantially and create some financial flexibility for those programs. At the same time, state support for the Health Safety Net has remained flat over the last two decades and an anticipated 135,000 residents are expected to be eligible for reimbursement of their healthcare services through the Health Safety Net. Policymakers may consider whether to temporarily divert Medicaid savings from reduced enrollment and increase the state subsidy to the Health Safety Net to absorb the impact of increased utilization. Adjusting dedicated funding could reduce pressure on the Health Safety Net without making changes to the existing financing structure.

What are the policy levers available to address the increased demand and the Health Safety Net funding shortfall?

In recent years, the legislature has used supplemental appropriations from the Commonwealth Care Trust Fund to buoy the Health Safety Net, however, these resources are not inexhaustible. There are different options available to policymakers to address increased demand and funding shortfalls related to the Health Safety Net. As federal changes are implemented, policymakers may look to reforms related to dedicated state funding, reviewing how existing health care system participants contribute to the Health Safety Net, and whether the existing array of reimbursable services appropriately balances access, affordability, and fiscal sustainability.

Is it time to reassess the funding structure and mechanics of the Health Safety Net?

When the Commonwealth first established the Uncompensated Care Pool to reimburse uninsured claims, the state relied entirely on the financial support of providers to support hospitals with higher percentages of uncompensated care. As the health care system evolved, the financing structure was adapted to balance the responsibility between providers and insurers. Almost thirty years later, the financing system remains primarily unchanged despite a vastly different health care landscape. The already growing demand, coupled with Medicaid changes that are expected to increase utilization of the Health Safety Net, presents policymakers with an opportunity to reassess how various players in the health care system support uninsured and underinsured care.