CENTER FOR HEALTH INNOVATION & POLICY SCIENCE
UNIVERSITY of WASHINGTON

CHIPS Policy Brief

October 2019

Medicaid Work Requirements

A Whammy for the WWAMI Region

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Key Points

- Implementation and administration of Medicaid work requirements are costly and may not save money
- Most beneficiaries targeted by Medicaid work requirements are already working but may lose coverage
- Employment is not likely to increase once Medicaid work requirements are put in place
- People living in rural areas are more likely to be harmed by Medicaid work requirements

What is WWAMI?

The WWAMI region includes Washington, Wyoming, Alaska, Montana, and Idaho. These states participate in a regional University of Washington medical training program.

Background

The federal Centers for Medicare and Medicaid Services (CMS) released a guidance letter in January 2018 encouraging states to apply for Section 1115 waivers to test Medicaid work requirements, which they call "community engagement requirements."[1] Most states seeking these waivers are proposing nonexempt adults to report 80 hours of work or qualifying activities per month to receive Medicaid benefits.[2] Adults exempted from the policy may include people with disabilities, caretakers, parents with children, and students. Qualifying activities may include searching for jobs, workforce training, and volunteering. Thirteen states have implemented, been approved, or await approval to test Medicaid work requirements, and federal courts have blocked three state demonstrations.[2] CMS claims work requirements promote health and well-being by increasing community engagement, employment, and financial independence.[3] Some experts, however, say they do not,[4,5] and studies have not shown employment increases.[6]

Several states in the WWAMI region have signaled interest in implementing Medicaid work requirements. Montana[7] and Idaho[8] have passed state legislation to implement Medicaid work requirements: both require reporting 80 hours of qualifying activities per month, but they differ in their nonexempt age group (19–55 and 19–59, respectively), how long the noncompliant lose coverage (six months and two months, respectively), and Montana would audit and reevaluate its program if over five percent of enrollees lose coverage. Alaska[9,10] and Wyoming[11,12] considered but did not pass Medicaid work requirement legislation, with similar reporting requirements to Montana and Idaho but differences in their exemptions for parents, which were more restrictive in Alaska and Wyoming. Washington has not signaled interest. Estimated annual cost savings in interested states ranged from $726,000 in Wyoming to $14,560,000 in Alaska. These cost savings estimates, however, do not account for implementation costs, administrative costs, increased uncompensated care, and other associated costs.

Table 1: Estimated cost savings of a Medicaid work requirement program

State	Total # of non-SSI, nonelderly adult Medicaid enrollees	Total # of Nonexempt Medicare enrollees◊	Estimated # of noncompliant beneficiaries*	Annual cost savings to state (in millions)
Washington	705,000	42,300	37,224	$81.32
Wyoming	20,000	416*	367	$0.726
Alaska	69,000	7,949*	6,996	$14.56
Montana	86,000	1,961	1,726	$1.70
Idaho	87,000	6,090*	5,360	$6.71

Author's calculations based on data from The Kaiser Family Foundation

◊ These estimations include exemptions for those not working due to common exemptions (the disabled, caretakers, those attending school), but do not account for other possible exemptions (e.g., enrolled tribal members)

* Attending school data not provided, nonexempt total may be overestimated

Work requirements do not save money

The cost of implementing and administering a work requirement program tends to be grossly underestimated and savings overestimated. Administrative costs are substantial, with funding needed for additional staffing, IT infrastructure, work verification processes, and job support services. Virginia estimated the second year of its program would require an additional $100 million in administrative and uncompensated care costs.[13] Uncompensated care costs increase as newly uninsured individuals seek care, and they increase even more because the newly uninsured beneficiaries are more likely to have serious chronic conditions.[14] Additionally, states cannot use federal Medicaid funds to cover additional work support services such as job training, transportation, and child care; these costs are substantial. Missouri spent $82 million on work support services for fewer than 12,000 people to meet TANF work requirements.[14] Medicaid work requirement proposals may not anticipate these costs, exaggerating potential savings. For example, Kentucky projected $486 million in savings over two years, but later reported no savings would accrue.[15] The high costs and limited savings of Medicaid work requirements can result in states paying more to cover fewer people.

Work requirements do not increase employment

The purported aims of Medicaid work requirements are to incentivize employment and financial independence to promote health and well-being.[16] However, Medicaid work requirements do not increase employment. Studies show that nearly all individuals

CASE STUDY

HELP-Link program increased employment in Montana

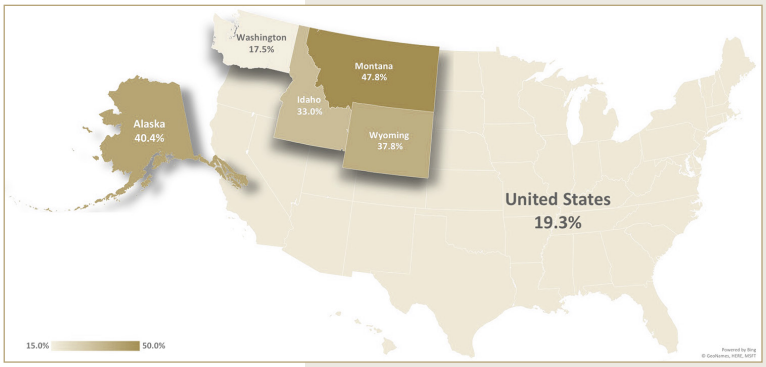
Montana's Health and Economic Livelihood Partnership Link (HELP-Link) is a voluntary workforce program that recruits new Medicaid enrollees looking for work or better paying jobs.[23] New enrollees voluntarily complete an assessment of employment and barriers to work and are contacted to develop a personal employment plan.[4] Montana provides job search services, credit assistance, and on-the-job training through this program.[23] This personalized and targeted approach was very successful: 91 percent of those who received training through the program found work; employment in the non-disabled Medicaid population increased 9 percent and by 6 percent in the disabled population; and nearly 60 percent reported wage increases a year after participation, with a median increase in annual wages of more than $8,000.[4,24] This program has served more than 25,000 clients since its start in 2016,[25] and HELP-Link allocations were just under $890,000 for each fiscal year in 2018 and 2019.[24]

who would be subject to work requirements already meet the proposed work requirements or would qualify for exemption prior to implementation.[6,17] Another goal is for beneficiaries to obtain coverage through their employer or to purchase private insurance, but lower income workers are less likely to be offered or able to afford employer-sponsored coverage.[18] Additionally, Medicaid coverage itself promotes work by empowering individuals with chronic disease to manage their health, allowing them to work.[19] Medicaid work requirements fail to increase employment and can lead to job loss, which may cause harm instead of promoting health and well-being.

Work requirements would hurt rural residents

Medicaid work requirements would disproportionately harm rural residents in the WWAMI region. Unemployment is higher, incomes are lower, and employers are less likely to offer health insurance benefits in rural areas.[20,21] Additionally, work in rural areas is more likely to be part-time and have variable hours or involuntary irregular schedules, resulting in rural beneficiaries losing coverage due to inconsistent scheduling out of their control.[20] Medicaid covered almost 1 in 4 non-elderly adults living in rural areas in 2015.[20] In Medicaid expansion states, rural areas have seen increased insurance coverage, lowered uncompensated care costs, and fewer hospital closings than in non-expansion states.[20,22] Reducing coverage by implementing work requirements may increase uninsured rates, increase uncompensated care costs, and result in more hospital closures and reduced access to care.

Percent of state population living rural



Source: U.S. Census Bureau, 2010 Census & American Community Survey, 2011-2015.

CASE STUDY

Arkansas Works did not work

In June 2018 Arkansas became the first state to implement a Medicaid work requirement, called Arkansas Works, phasing in nonexempt individuals aged 30 to 49 in June 2018 and individuals aged 19 to 29 in January 2019. Beneficiaries were to report 80 hours of work or work-related activities each month and were disenrolled after three nonconsecutive months of noncompliance.[26] By the end of the first year, over 18,000 beneficiaries had been disenrolled due to noncompliance.[26] An increase in uninsured adults suggests that those disenrolled did not obtain other coverage.[6] Most notably, the work requirement was associated with no significant change in employment; more than 95% of the target population in Arkansas appeared to meet the requirements or qualify for an exemption.[6] Noncompliance due to bureaucratic hurdles played a big role in coverage losses, as many were unaware or confused by reporting requirements.[6,27] Internet access was a barrier,[27] as many Arkansans subject to work requirements lack reliable cell phone and internet access.

Recommendations

WWAMI states should not pursue Section 1115 waivers to implement Medicaid work requirements, because the evidence shows:

- Implementation, administrative, and uncompensated care costs would likely exceed Medicaid savings
- Employment will not increase
- Rural populations, which make up a large portion of the WWAMI region, would be disproportionately hurt

To increase employment and promote health:

- Consider Montana's voluntary program as a model
- Expand Medicaid coverage to empower people with chronic conditions to work

In a state with a Medicaid work requirement compared to states without...[6]

- **Medicaid or marketplace coverage decreased by 13.2 percentage points**
- **The number of uninsured increased by 7.1 percentage points**
- **There were no significant changes in employer-sponsored insurance**
- **There were no significant changes in hours worked or in community engagement**

Conclusion

Many states, including the majority of states in the WWAMI region, are considering implementing Medicaid work requirement programs. The future for Medicaid work requirements is uncertain, as federal courts have halted implementation in three states and federal waivers for them may not outlast the current administration. Experimenting with a precarious and expensive program that is not likely to increase employment is fiscally irresponsible and not advised.

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