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Report Rips Arkansas Medicaid Work Requirement

— Thousands lost healthcare coverage, but is the work requirement really to blame?

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WASHINGTON -- Nearly 17,000 people in Arkansas lost healthcare coverage in the 6 months following implementation of the state's Medicaid work requirement, and other states should take note, according to experts at the Center on Budget and Policy Priorities (CBPP).

"What happened in Arkansas serves as a warning to other states about the consequences of implementing Medicaid work requirements," said Jennifer Wagner, JD, on a press call last week, in conjunction with a new CBPP report that details the perceived dangers of Medicaid work requirements, also known as community engagement activities, to Medicaid beneficiaries.

Arkansas is the third state to receive waiver approval from HHS Secretary Alex Azar for a work requirement, and the first state to implement the change. Enrollees in the state are required to report 80 hours of "work or work-like activities" per month to be eligible for Medicaid, and are disenrolled for the remainder of the year if they fail to comply, and if they fail to obtain an exemption, Wagner explained.

The CBPP report states that approximately 0.5% of the group subject to work requirements showed "newly reported work hours." In addition to seeing "no meaningful gains in employment," Wagner said, the primary reason so many people lost coverage was not due to the work requirement itself, but to enrollees' failure to understand the rules and to fulfill the reporting piece of the requirement.

Moreover, she noted that the 20% coverage loss outpaces the 5% subset of Arkansas Medicaid beneficiaries in the expansion population who were projected to be neither working nor exempt -- "the supposed target population of the requirement." In other words, the work requirement in Arkansas is locking out enrollees who are already working, or who should be exempt from the requirement.

"The fact is, 'work requirement' can't be fixed," said CBPP senior fellow Judith Solomon, JD, author of the report. "The extent and speed of coverage loss may vary depending on how a state designs its policy, but every state work requirement will have the unintended consequence of taking coverage away from people who are already working, or who should be exempt based on disability or other reason."

Solomon also noted that low-wage workers hours are often unpredictable.

"Taking coverage away from people who don't work a set number of hours because they are between jobs, can't make a rigid monthly hours target, or have temporary barriers such as illness or a lack of childcare does nothing to encourage work; it just deprives working people of coverage and access to care," Solomon wrote in the report.

The magnitude of work requirements' impact in other states could be even greater than in Arkansas, she said.

Arkansas made some efforts to mitigate potential harms; for example, by excluding people age >50 and parents of children <18 years from meeting the requirements. But most states with approved or pending waivers would include at least some older adults in their work requirement, and several states plan to apply the requirements to parents, according to the report.

A Legal Non-Starter?

Six other states have approved work requirements -- Indiana, Kentucky, Maine, Michigan, New Hampshire, and Wisconsin -- with nine more state waivers pending, according to the Kaiser Family Foundation. But some scholars questioned whether work requirements are tenable anywhere.

"The reason you can't have Medicaid work experiment is because Medicaid work experiments fall outside of the furthest reaches of what the [HHS] secretary could do under 1115 [waivers] ... the whole purpose of 1115 is to improve Medicaid assistance for people," said Sara Rosenbaum, JD, professor of health law and policy at the Milken Institute School of Public Health at George Washington University in Washington, in a phone call with *MedPage Today.*

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Rosenbaum called the work requirement a "harmful and counter-productive choice for any state," as outlined in the CBPP report. "But states, God bless them, make harmful and counterproductive choices in Medicaid all the time."

"The legal purpose of Medicaid ... is not to promote self sufficiency and to create a pathway to commercial insurance coverage program," as the Trump administration claims, Rosenbaum said. "Medicaid is all about giving people insurance if they need it.... So, legally it's a non-starter."

The Medicaid work requirement in Kentucky is currently on hold because of a court challenge.

"What the court has found in Kentucky -- and I don't expect a different result in the re-approval -- is that the experiment simply is not the kind of activity that 1115 [waiver] was designed to foster," said Rosenbaum.

There's also a "sizeable body of evidence" to show that Medicaid makes it possible for beneficiaries to work, she noted, citing a *PBS News Hour* report of a man with chronic obstructive pulmonary disease (COPD) who lost his access to medications, and then his job because the resulting COPD flares forced him to miss work, after failing to report his work hours properly.

"You don't have to threaten people's insurance coverage to get them to work," Rosenbaum noted.

'A Bridge, Not a Destination'

Conservative scholars disagreed that work requirements are bad policy, and found fault with the CBPP report.

"Medicaid should be a bridge, not a destination," wrote Doug Badger, a visiting fellow in domestic policy studies at the Heritage Foundation, a conservative think tank, in an email to *MedPage Today*. "Work requirements offer recipients a way out of poverty; an opportunity to acquire skills and develop habits that increase their earnings and improve their material well-being."

Badger also noted that "everyone who was removed from the rolls could rejoin Medicaid as of January 1 ... If they fail to re-enroll or to work, that is hardly an indication that the work requirements are 'ineffective.'"

Aaron Yelowitz, PhD, an economist at the University of Kentucky in Lexington and director of the Institute for the Study of Free Enterprise, told *MedPage Today* in an email that the report draws some unfounded conclusions.

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He said Medicaid participation could have dwindled for a number of reasons, including "voluntary non-compliance," "red tape," "misreporting," and a "low valuation" of the Medicaid program.

Yelowitz said that no "reasonable person would think that in the current labor market -- with the low unemployment rates -- that finding work is a serious impediment to implementing work requirements."

He also questioned the CBPP report's conclusion that 80% of the lost coverage was due to noncompliance with the reporting requirements.

"They kind of state that, Yelowitz said, "but they don't really show us how hard the application is ... If you would need a lawyer to basically fill out an application ... then that does sound like an impediment to getting on the program," he said. But that wouldn't diminish the argument for work requirements, he added.

Other reasons for decline in Medicaid enrollment could be "new hiccups with new implementation," Yelowitz said, citing the 2013 rollout of Healthcare.gov as an example.

Arkansas is the first state to roll out work requirements and is only in the beginning stages, and "if one looks 1 month out or 2 months out versus 1 year out, you're likely to see very different effects," he said.

The current estimates of how many people were eligible for Medicaid in Arkansas may have been inaccurate, he added, noting that in his own research in Kentucky, "a heck of a lot of people" (approximately 70,000) were reporting incomes that made them "too rich" for Medicaid, and yet they were still enrolled.

Another possibility is that some enrollees that don't find it worthwhile enough to fulfill the reporting requirements, Yelowitz said. "Medicaid is notorious for having bad access to care. It's not terribly popular compared to private insurance ... You can imagine that there are people who basically let their eligibility lapse and when they get sick again ... they'll apply," he said.

Yelowitz also pointed to the growth in the economy as still another possible reason for the lower enrollment in Medicaid. It is "utterly irresponsible" for the report's author not to mention that a decline in enrollment could result from improved economic conditions, Yelowitz said.