

Medicaid Works: No Work Requirement Necessary

Frequently Asked Questions about Medicaid and Work Requirements

Because of expansions in Medicaid eligibility and improved enrollment of people previously eligible, more Americans than ever—nearly 70 million—have health insurance through Medicaid.¹ One threat to this progress is the adoption of additional paperwork due to “work requirements” for adults receiving Medicaid. Such requirements have a record of suppressing enrollment in other programs and are guaranteed to do the same in Medicaid. These new requirements will act as a barrier to health coverage to significant numbers of Medicaid recipients—including those who have major health conditions and those who work in jobs that do not provide consistent hours of work—and will drive up administrative costs.

Several states have submitted proposals for Medicaid waivers to the Centers for Medicare and Medicaid Services (CMS) that include work requirements, and five states have been approved so far (KY, IN, AR, NH, and WI). In some cases, requirements apply to childless adults; in other cases, parents are included. While such waivers have been requested in the past, previous administrations have rightfully denied states the option of implementing work requirements as a condition of eligibility for Medicaid because they are inconsistent with the Medicaid goal of improving health. Arkansas began implementing their work requirement in June 2018. It’s the only state currently tying Medicaid eligibility to work. New Hampshire will implement its work requirement for Medicaid on January 1, 2019. And Kentucky will follow on April 1, 2019. Litigation is pending to stop waivers in both Arkansas and Kentucky.

On January 11, 2018, CMS released a letter to State Medicaid Directors outlining guidance for waiver proposals that include work requirements.² The letter purports to justify imposing punitive work requirements to produce better health outcomes and suggests that work requirements promote the objectives of the Medicaid Act.

While work requirements are new to health programs, we have decades of experience with such requirements in other safety net programs, specifically cash assistance under Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). Ideas and language put forth by states in their Medicaid waivers are clearly drawn from these programs. We know from these programs that the main effect of work requirements is to discourage enrollment, with little effect on employment outcomes. Initial implementation data from Arkansas confirms this

lesson for Medicaid.

Since Medicaid work requirements have been approved by CMS, health advocates and other stakeholders need to be prepared to influence policy decisions that their state administrations will be making. They also need to be prepared to monitor the implementation and document the problems and barriers faced by enrollees. In this FAQ, CLASP seeks to introduce health advocates to the main concepts of work requirements. We are happy to provide additional information to those who want assistance combating work requirements in their state.

Frequently Asked Questions

1. What is a work requirement?

A work requirement is a condition of eligibility that some states are requesting to impose on Medicaid enrollees.

When a work requirement is applied to a program, certain enrollees must work or participate in other “qualifying activities,” such as volunteering or attending school, for a minimum number of hours per week or month to stay enrolled in Medicaid.

2. What is the history of work requirements for Medicaid?

There is no statutory authority under Medicaid to impose work requirements on applicants or enrollees as a condition of eligibility. Before January 2018 CMS had never approved a waiver requesting a Medicaid work requirement and had denied such requests from four states (AZ, AR, IN, and NH) under previous administrations.³ CMS has historically recognized that work requirements do not promote Medicaid’s objective, which is to provide medical assistance to individuals whose incomes and resources are insufficient to meet the costs of necessary medical care and to furnish such assistance and services to help people attain or retain the capacity for independence and self-care.⁴

Section 1115 allows CMS to grant waivers, providing they meet four specific criteria: they must be limited to specific provisions of Medicaid statute; likely to promote Medicaid’s objectives; limited to the extent and period needed to carry out the experiment; and, structured as an experimental, pilot, or demonstration project.⁵ Waivers must also be cost-neutral to the federal government, meaning that policy changes in the waiver must not cost the federal government more than if the changes were not made. However, the cost neutrality component of waivers only applies to the cost of coverage and does not include administrative costs associated with program administration.

Several states have submitted waiver requests currently under consideration by CMS that include work requirements and five states have been approved thus far (KY, IN, AR, NH, and WI)).⁶ Often, language in the waivers is clearly drawn from work-related language in TANF and SNAP, both of

which have statutory provisions that set conditions on when states may impose work requirements. And, the guidance from CMS affirmed its support for states' efforts to align SNAP or TANF work requirements with Medicaid. The Trump Administration's reversal of the long-held position that work requirements do not promote Medicaid's objectives has consequences for millions of enrollees who receive their health insurance through Medicaid.⁷

3. What is happening where work requirements have been implemented for Medicaid?

Arkansas is the only state that has implemented Medicaid work requirements. In June 2018, it began requiring certain Medicaid enrollees to provide proof of their work hours on a monthly basis in order to retain Medicaid health insurance. In August 2018, Arkansas began disenrolling Medicaid beneficiaries. It's disenrolled about 4,000 Arkansans every month since.⁸ Only 2 percent of people subject the work requirement fulfilled the reporting requirements.⁹ In January 2019, Arkansas will expand the requirement to 19-29 year-olds. That's expected to increase monthly disenrollments.

Early research indicates that people disenrolled from Medicaid are often not aware of the requirement to report work hours, do not understand the complex rules about how to report work hours, and/or do not have internet access. (Arkansas requires reporting online.)¹⁰ Furthermore, in October 2018, fewer than 1 percent of people subject to the work requirement reported new work or community engagement activities.¹¹

Many groups, including the Medicaid and CHIP Payment and Access Commission (MACPAC)¹² and multiple national health care provider and patient advocacy groups¹³, have called on HHS to halt the Arkansas program due to the drastic enrollment losses. In Arkansas, people who lose Medicaid coverage for failing to report work hours are barred from re-enrolling for the remainder of the calendar year (regardless of whether they're working the required number of hours).

New Hampshire plans to implement their work requirements in January 2019. Kentucky will follow on April 1, 2019. As a result of litigation against CMS, the Kentucky waiver was vacated in 2018 and implementation paused. With CMS' re-approval of their waiver in November 2018, it's unclear whether implementation will move forward or whether the litigation will once again prevent it.

4. Why are work requirements unnecessary?

Work requirements are trying to solve a problem that does not exist. The truth is that most working-age adults on Medicaid are employed. Sixty percent of working age adults on Medicaid are working and 79 percent are in families with at least one worker.¹⁴ Other adults on Medicaid are likely unable to work due to illness or disability or have another valid reason for not working (such as caring for a

disabled child or spouse).¹⁵

Work requirements in Medicaid will result in many people losing coverage, in most cases simply because of the red tape and bureaucratic reporting requirements, and relatively few for not meeting the requirement to work. In fact, the Congressional Budget Office acknowledged in its score of the “Graham-Cassidy” bill that some states would use work requirements to reduce enrollment and the associated costs.¹⁶

5. Do work requirements help participants get jobs?

No.

The evidence from TANF and SNAP shows that work requirements do little to improve work outcomes.¹⁷ Lessons learned from other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits such as paid leave.¹⁸ A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder, and foster an economy that creates more jobs. In Arkansas, October 2018 data show fewer than 1 percent of people subject to the work requirement are reporting new work or community engagement activities.¹⁹

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.²⁰ Medicaid expansion enrollees from Ohio²¹ and Michigan²² reported that having Medicaid made it easier to look for employment and stay employed. Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Additionally, CMS notes that states will be required to describe how they will assist enrollees in meeting the work requirements and link individuals to other work supports. However, the guidance goes on to say that states will not be able to use Medicaid funding to finance any of these services for individuals.

6. What counts as work?

Each state is proposing in its waiver request what counts as work, including how many hours per week or month someone must work to stay enrolled in Medicaid.

In addition to traditional employment (i.e. working for an hourly wage), other “qualifying activities” are identified by the states as meeting the work requirement. These activities typically include attending school, volunteering, or being a primary caregiver to a young child or a household

member who is disabled. However, there is no requirement that states count such activities.

7. What happens to people who don't meet the work requirement?

In the approved and pending waivers, the sanctions—or consequences—for not meeting the work requirement all lead to being disenrolled from Medicaid. The proposals vary in the sequence of steps that lead to disenrollment, but the bottom line is that people will be disenrolled from Medicaid for not meeting the work requirements (or not completing the paperwork to prove they met the requirements).

The waivers specify various periods for being disenrolled, with some states allowing re-enrollment after one month of meeting the work requirement and other states proposing a “lock-out” period for a specific number of months or until the beginning of the next coverage year (this proposal assumes an open enrollment period for Medicaid rather than the current policy of year-round enrollment). It is important to note that once in a lock-out period, people will remain in the lock-out period for its duration, even if they become employed and are meeting the work requirement.

8. Who will be subject to work requirements in Medicaid?

States propose which enrollees must meet work requirements to receive Medicaid coverage.

In general, states are applying work requirements to “able bodied” adults in Medicaid, meaning those adults who do not qualify for Medicaid based on age or disability. Some states are limiting their proposal to childless adults, while others are including parents.

Both expansion and non-expansion states have submitted waivers for work requirements. In non-expansion states, the only “able bodied” adults eligible for Medicaid are parents with very low incomes. In these states, a work requirement is a catch-22; if people work enough hours to meet the requirement, they will often earn too much to remain Medicaid-eligible. If they do not work enough hours, they will lose eligibility for non-compliance with the work requirement.

States are also able to define who is exempt from the work requirement—and waivers vary greatly. Exempt populations are not required to work to keep Medicaid. States are typically exempting such populations as pregnant women, people who are homeless, and those undergoing substance use treatment.

9. How will people be identified as exempt from the work requirement?

States will decide how to screen Medicaid enrollees for exemptions. Waivers submitted to CMS, and those approved by CMS, make little mention of how someone will be identified as exempt from the work requirement. This will be a critical operational decision by the states.

In SNAP and TANF, the most common way people are determined exempt from a work requirement is through an interview. Because interviews have not been a part of Medicaid application for over two decades, this will add a cumbersome new step to the application process—both for the applicant and the state.

In other situations, internal data matches may be able to identify someone as exempt. For example, if a state exempts adults with young children, the state may be able to identify parents as exempt from the work requirement if their children are also enrolled in Medicaid. However, to accurately use such internal data matches, the state may need to make costly and time-consuming technology updates to their systems.

10. If the work requirements are only for able-bodied adults, why will this hurt people with disabilities?

So far, all state waivers propose to exempt people who are not considered “able bodied” by the state. However, states are proposing different ways to define this population. Several states are using the term “medically frail” but not providing information about how someone will be deemed “medically frail.” We know from experiences with SNAP and TANF that many people with disabilities who should be exempt do not receive an exemption, often due to a complicated process of validating their disability to the state.^{23 24}

Under a stringent definition of “disability” for exemptions, many adults with disabilities or chronic illnesses that do not meet the threshold will lose their Medicaid. For example, states may determine that someone must receive Disability/Supplemental Security Income (SSI) to be considered exempt from a work requirement. This would leave many people with disabilities unable to get an exemption because the state does not consider them sufficiently disabled, yet they are still unable to work due to their illness or disability. Persons with disabilities may also face additional struggles navigating the paperwork processes and bureaucracy to prove they are disabled.

A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.²⁵ And, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,²⁶ and nearly 20 percent had filed for Disability/SSI within the previous 2 years.

The CMS guidance says that states must make reasonable accommodations for persons who have a disability as defined by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the ACA. The guidance instructs states to provide information about how people who have a disability, as defined by these statutes, will receive accommodations and/or supports to meet the work requirement. Importantly, the guidance also states that supports

provided to this population may not receive federal Medicaid funding.

Even with such language in the guidance, persons with disabilities remain at great risk of losing their health insurance through Medicaid. Identifying whether someone has a disability that meets the criteria in the guidance, coordinating supportive services, and tracking any modifications or exemptions to work requirements is a large and complex undertaking that will require much documentation and paperwork. It is highly doubtful that everyone who is disabled and should receive an exemption, reasonable accommodation, or supportive services will. Rather, it is very likely this population will lose their health insurance for not meeting the work requirement.

As implementation unfolds in Arkansas, it appears persons with disabilities are included in the thousands of Arkansans who are losing health insurance or are at risk of losing their insurance in future months.²⁷

11. Do Medicaid enrollees who are working or going to school need to worry about the work requirement?

Yes.

All adult Medicaid enrollees, including those with jobs, will be burdened by the reporting requirements of a work requirement. Stories emerging in Arkansas demonstrate the difficulty of complying with reporting requirements for people who are working. A story highlighted on *PBS Newshour* explains how people are hurt when they lose health insurance. This includes loss of employment and medical debt.²⁸

Additionally, those who are working but have fluctuations in their hours may face unexpected lapses in Medicaid coverage.

Students will also be affected by the work requirement. States are differing in how they are approaching exemptions for students or counting their coursework toward the work requirement. If states do not count class hours toward the work requirement, students will have to work more hours to keep their health insurance through Medicaid.

12. What effect will the extra red tape and reporting requirements have on Medicaid enrollees?

The systems put in place to enforce the work requirement are so cumbersome and bureaucratic that people are likely to lose coverage due to the complexity of the system, not because they are ineligible.

We know that for every additional piece of paperwork that is required, fewer people are able to secure or retain coverage.²⁹ A work requirement compels people to submit documentation of their hours worked (sometimes from multiple jobs) on a regular basis. Failing to submit paperwork—even when they are working and meeting the work requirements—will cause people to lose their Medicaid coverage.

Work requirements do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and, as a result, will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.³⁰ This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job. This will lead to greater “churn” in Medicaid as people who become disenrolled reapply and enroll when they meet the work requirements.

13. If Medicaid enrollees work, won't they get health insurance through their jobs?

Many Medicaid enrollees already work in jobs that do not provide health insurance benefits, and those who will enter the workforce are likely to be employed in industries that typically do not offer health insurance.³¹

Only 49 percent of people in this country receive health insurance through their jobs.³² The reality is that many people in America work in industries, like retail and food service, which typically do not offer employer-sponsored insurance.³³ In 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under their employer-offered insurance.³⁴

Low-wage work in America does not fit into the “9-to-5” conception that many politicians and state administrators have of work. About half of low-wage hourly workers have schedules outside the traditional Monday-Friday, 9-5 routine and are patching together two or more part-time jobs to support their families.³⁵ Frequently, they are not getting traditional employment benefits (such as health insurance) that middle- and upper-income Americans receive with their jobs. Recent data show that 4.6million workers reported working part-time, despite wanting full-time jobs. Involuntary

part-time work is a symptom of the low-wage labor market that makes it difficult for people to gain economic security.³⁶

14. Will states have to provide unemployed Medicaid enrollees with opportunities to meet the work requirements?

No.

Nothing requires states to provide job search or training programs to Medicaid enrollees who are subject to a work requirement. In fact, CMS guidance explicitly prohibits using Medicaid dollars to provide employment services.

Employment services offered to enrollees of TANF and SNAP vary greatly from state to state, and sometimes even within states. Common employment assistance consists of resume development and online job searches but not in-depth career counseling or vocational training that may help someone secure gainful employment with health insurance.

Some states suggest that people could participate in existing workforce or employment programs. However, state employment programs do not have the capacity to absorb the number of people enrolled in Medicaid that would be subject to work requirements.³⁷ Because federal funding for workforce services is capped, states are only able to serve a tiny share of those who might benefit from training services.³⁸³⁹ Employment programs in states are relatively small compared to the number of people enrolled in Medicaid.

15. Will states have to provide Medicaid recipients required to work with child care assistance if they need it to work?

Under CMS guidance, states are required to describe strategies to link enrollees to work supports, including child care assistance in their waiver proposal. However, states are **not** actually required to provide child care to those subject to the work requirement. Under TANF and SNAP, states cannot sanction someone (deny them benefits) for not participating if they cannot obtain appropriate or affordable child care. This rule does not exist for Medicaid. Additionally, states are prohibited from using Medicaid funding to finance work supports.

16. What happens during local or national recessions?

None of the waiver proposals submitted by states envision or make plans for what would happen during a local or national recession. Unless they modified their waivers, work requirements would still be in place during recessions, causing many people to lose their health care if they lose their job. The CMS guidance encourages states to take this factor into consideration, but at this time it's

unclear exactly how states would respond during local or national recessions.

Medicaid has traditionally provided a medical safety-net during recessions. This safety-net would not exist if work requirements were in place.

17. Is there a legal effort to stop work requirements?

In January 2018 three organizations filed a lawsuit on behalf of 15 Kentuckians against HHS challenging the approval of Kentucky's waiver. The lawsuit was filed by the National Health Law Program (NHELP), Kentucky Equal Justice Center, and the Southern Poverty Law Center (SPLC). The lawsuit charges that HHS exceeded its authority under the Social Security Act because the waiver is not an experimental project consistent with the objectives of Medicaid.⁴⁰ In June 2018, the judge vacated the waiver and sent it back to HHS. Following the judge's ruling, HHS opened a new comment period (ending August 2018), before re-approving Kentucky's waiver in November 2018. Very few changes were made to the newly approved waiver. Court challenges are expected to continue.

Kentucky's waiver includes work requirements *and* many other barriers to coverage, such as lock-out periods and eliminating transportation assistance.

In August 2018, NHELP, SPLC, and Legal Aid of Arkansas filed a second lawsuit was in response to Arkansas' waiver approval. Unlike Kentucky, implementation of the work requirement began prior to the lawsuit and continues, as of November 2018, during the pending litigation. The lawsuit challenging HHS's approval of Arkansas' Medicaid waiver states that HHS is changing Medicaid in ways that only Congress may approve.⁴¹ The plaintiffs have requested the judge halt Arkansas' implementation. A ruling is expected in January 2018.

18. Do states use language other than "work requirement" but mean the same thing?

Yes.

Some states have used other terms like "community engagement" and "employment and training" in place of "work requirement." If these provisions require applicants or enrollees to participate and threaten them with loss of health insurance if they fail to do so, they should be treated as synonyms for work requirements.

Some states may also describe these requirements as "time limits" under which people who are working or participating in another qualified activity are exempt.

Endnotes

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