ISSUE REVIEW
Fiscal Services Division
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Medicaid Work Requirements

ISSUE

Beginning January 2018, the federal government began allowing states the option to implement Medicaid work requirements or community engagement activities. This ***Issue Review*** will review the national landscape of states implementing work requirements, review Arkansas's experience, analyze potential costs and savings associated with implementing a program, and present an alternative to work requirements.

AFFECTED AGENCIES

Department of Human Services

CODE AUTHORITY

Iowa Code chapters 249A and 249N

BACKGROUND

On January 11, 2018, the Centers for Medicare and Medicaid Services (CMS) announced[1] a policy change to allow states the option to require work or community engagement activities among nonelderly, nonpregnant adult Medicaid beneficiaries who are eligible for Medicaid or Medicaid Expansion on a basis other than disability. In Iowa, Medicaid Expansion is known as the Iowa Health and Wellness Program, or IHAWP. In allowing this new option, the CMS noted the goal of the policy was to improve enrollee health and well-being and cited various research and polling results showing the positive benefits of work and community engagement and the detriment of unemployment to an individual's health.

The memo announcing the policy change noted that states would be given the flexibility to design their own programs, putting them in the best position to succeed, while the CMS would provide guidance on groups that are exempted from the requirements and set out certain expectations that must be met for a waiver to be approved. The new program is also required to be budget-neutral to the federal government, and the CMS will monitor and evaluate any new program implemented.

Critics dispute the positive impact, arguing that Medicaid was created to provide health care to low-income individuals, the disabled, and children, and was not created as an employment program. There are also concerns about the adverse effects that work requirements might have on individuals with mental health conditions, substance-related disorders, or other chronic health conditions if those individuals are unable to receive treatment or have their health care

[1] Centers for Medicare and Medicaid Services, Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, January 11, 2018.

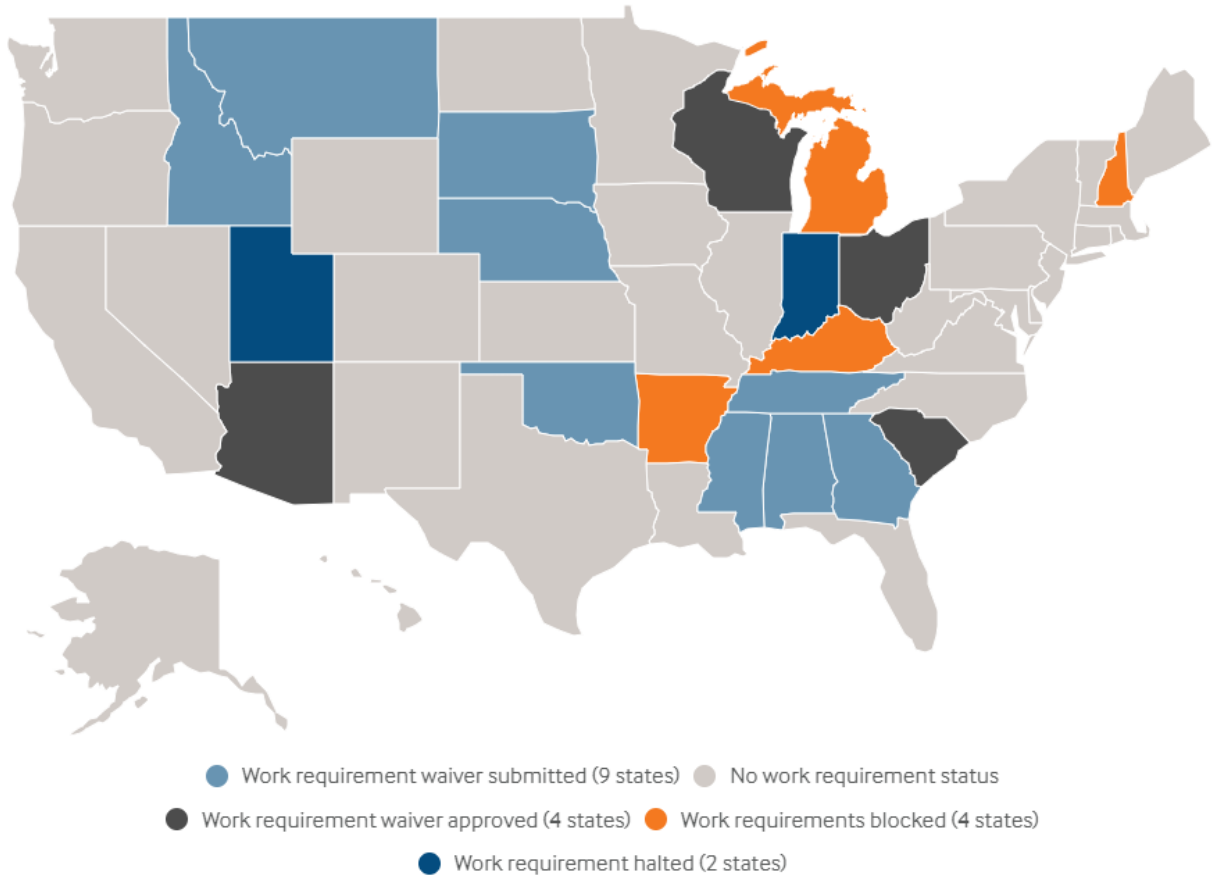
needs met so they are able to reenter the workforce. These concerns have led to numerous lawsuits in states that have attempted to implement a new program. Only one state, Arkansas, has successfully implemented work requirements for any length of time before a federal court vacated the program's federal approval. Arkansas's experience will be examined later in this ***Issue Review*** on page 3.

NATIONAL OVERVIEW

Figure 1 shows the current status of states that have chosen to move forward with work requirements. For the most up-to-date map, please visit the Commonwealth Fund's website dedicated to tracking Medicaid Expansion and work requirement waivers.[2] There are currently no states that have an active work requirement program. Of the states that have pursued the option:

- Four states have had the programs blocked by federal courts.
- Four states have had programs approved, but not implemented.
- Two states have halted programs due to the COVID-19 pandemic.
- Nine states have submitted work requirement waivers to the CMS.

Figure 1
Medicaid Work Requirement Program Implementation Status



Source: Map from the Commonwealth Fund

[2] The Commonwealth Fund, Status of Medicaid Expansion and Work Requirement Waivers, September 8, 2020.

In addition to the states that have requested a waiver from the CMS to implement work requirements, there has been legislation introduced in more than half of all states to request the waiver.[3] Most states have requested waivers to implement programs with similar requirements, including 20 hours per week in work or community engagement activities such as volunteering, and exempting certain groups of individuals such as custodial caretakers, individuals with mental illness, or pregnant women.

States that have received approval vary on the populations subject to work requirements. In some states, such as Arkansas, work requirements only apply to the Medicaid Expansion population, which covers any individuals up to 133.0% of the federal poverty level, but in other states, like Kentucky, work requirements apply to both the Expansion population and the traditional Medicaid population, where enrollment is based on both categorical eligibility and income.

ARKANSAS'S EXPERIENCE

Arkansas became the first state to implement work requirements, beginning in June 2018. The program was suspended in March 2019 when the approval for the waiver was vacated by federal district court order.[4] The work requirement program initially required individuals on Medicaid Expansion between the ages of 30 and 49 with incomes up to 138.0% of the federal poverty level to report 80 hours of work or community engagement activities per month. This requirement was expanded to individuals aged 19 to 29 beginning January 2019. Data from the Arkansas Department of Human Services showed that there were 116,229 individuals subject to Medicaid work requirements in February 2019, and 18,164 individuals were disenrolled from Medicaid for failure to comply with the new reporting requirements while the program was operational.[5]

The New England Journal of Medicine published a special report[6] completed by the Harvard T. H. Chan School of Public Health on the experience in Arkansas. Its findings concluded that work requirements resulted in a significant loss in Medicaid coverage and a rise in the percentage of uninsured. The researchers found there was no significant change in employment, and more than 95.0% of the individuals targeted by the policy appeared to already meet the requirements and should have been exempted. In addition, the report found there was widespread confusion among individuals subject to the requirements, with many unsure if the requirements applied to them or how to report their status to the state.

One of the most significant hurdles to the work requirement program in Arkansas was the lack of Internet access. Approximately 20.0% of individuals on the program had no Internet access,[7] yet individuals were initially required to report their work activities through an online portal with no phone option available. This led to significant confusion and barriers for individuals who were meeting the requirements but could not report to the state.

[3] Kansas Health Institute, States That Are Implementing or Considering Work or Community Engagement Requirements for Some Adult Medicaid Enrollees as a Condition for Continued Medicaid Eligibility or Coverage, 2018.
[4] Gresham v. Azar, No. 19-5094 (DC Cir. 2020)
[5] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall. February State Data for Medicaid Work Requirements in Arkansas. Henry J. Kaiser Family Foundation. March 25, 2019.
[6] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein. Medicaid Work Requirements—Results from the First Year in Arkansas. New England Journal of Medicine 381:1073–82. September 12, 2019.
[7] Anuj Gangopadhyaya et al., Under Medicaid Work Requirements, Limited Internet Access in Arkansas May Put Coverage at Risk, Urban Institute, October 29, 2018.

COST CONSIDERATIONS

There are significant administrative costs associated with implementing Medicaid work requirements. The U.S. Government Accountability Office (GAO) surveyed five states as part of a report to Congress and found that those states had spent or were projected to spend between $6.1 and $271.6 million in administrative costs for the program.[8] The majority of these costs were one-time costs related to Information Technology (IT), for which the federal government reimburses the states between 75.0% and 90.0%. While most states did not report ongoing costs to the GAO survey, Indiana estimated an additional $20.7 million in payments to managed care organizations (MCOs) in 2019 to administer the program, while Kentucky budgeted $50.7 million over two years to administer the program. Both one-time and ongoing administrative costs tend to vary greatly based on the scope of the IT work, including the type of the reporting system, the size of the population impacted, the outreach to members, and the ongoing full-time equivalent (FTE) positions needed to administer the program.

States may experience some cost savings if they disenroll individuals from health care coverage for not meeting work requirements. These savings will vary greatly based on the population and number of individuals who are being disenrolled. For example, in Iowa, the average cost of a Medicaid or IHAWP enrollee who could potentially be subject to work requirements is $5,129 per year. Of this amount, the federal government would pay 90.00% of the cost for an IHAWP member and 61.61% for a Medicaid member. Therefore, disenrollment would result in an annual State General Fund cost savings of $512 for each IHAWP member or $1,969 per Medicaid member. While this may lead to State General Fund savings, there could be increased costs in uncompensated care, which would impact State hospital systems including county critical access hospitals and university hospital systems, or other safety net providers that rely partially on State and federal funding.

ALTERNATIVE TO WORK REQUIREMENTS

In Iowa, one alternative to creating a Medicaid work requirement program is to expand an existing Department of Human Services (DHS) employment and training program, such as PROMISE JOBS, targeting individuals who are receiving health care benefits from the State but are not working. The PROMISE JOBS Program was created in 1998 and provides work and training services to participants in the Family Investment Program (FIP). All participants in FIP who are eligible to work must have a Family Investment Agreement (FIA). The FIA is an individualized agreement between the FIP client and the State that outlines the family's needs, the services to be provided by PROMISE JOBS, the actions the family will take, and the time frames to be met by the family so that the family can become economically self-supporting.[9] Some of the services provided by PROMISE JOBS include:

- Assesses job readiness.
- Provides employment-related services, including job club and job search activities, paid and unpaid work, and postemployment services.
- Provides basic education, including high school completion, English as a second language education, and adult education.

[8] Government Accountability Office, MEDICAID DEMONSTRATIONS — Actions Needed to Address Weaknesses in Oversight of Cost to Administer Work Requirements, October 2019.
[9] Iowa Department of Human Services, PROMISE JOBS, November 2020.

- Provides postsecondary education, including targeted employment-related education and short-term training.
- Provides supportive services, including referrals to family planning counseling, parenting classes, life skills training, mentoring, and family development.

In contrast to a work requirement program that requires an assistance recipient to work or volunteer and simply tracks the recipient's work or volunteer activity, PROMISE JOBS would actively assist in assessing, training, and helping to eliminate barriers to individuals joining and staying in the workforce. While the average annual cost per person in FY 2020 was $2,706, PROMISE JOBS could have greater success in helping individuals gain and keep employment rather than mandating employment. In addition, by expanding PROMISE JOBS, the State could forgo the cost of building a system for the tracking and reporting of work requirements.

CONCLUSION

While Medicaid work requirements are not without controversy, before the global pandemic there was momentum in states across the country to implement them. If the General Assembly chooses to move forward with implementing work requirements, legislators may want to review other states' policies, procedures, and infrastructure to ensure best practices are implemented and to avoid significant losses in coverage. They may also wish to consider alternatives to work requirements, such as making job training programs either mandatory or voluntary for unemployed or underemployed individuals receiving health care throughout the State.

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