Article from

In The Public Interest

January 2018
Issue 16

Medicaid Work Requirements: Overview of Policy and Fiscal Considerations

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Since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the number of uninsured Americans has dropped to historic lows.[1] The ACA's expansion of Medicaid to low-income adults with incomes up to 138 percent of the federal poverty level (FPL) has also significantly increased Medicaid enrollment in states that have elected to expand Medicaid. These expansion states are estimated to have experienced a 45 percent decrease in uninsured rates between 2010 and 2015, compared to a 30 percent decrease for states that did not expand Medicaid.[2]

While most states have experienced significant decreases in uninsured rates, Medicaid expansion has left some states with financial challenges. 2017 has marked the first year these states have been required to share in the cost of the expansion, as federal financial participation has dropped to 95 percent, and it will decrease to its long-term rate of 90 percent in 2020. Now that states are required to share in financing coverage for the expansion population, some states are seeking innovative ways to control costs, while attempting to maintain provider access and improve population health for newly eligible Medicaid beneficiaries. To assist in alleviating these financial challenges, states are considering Section 1115 Demonstration Waivers (Section 1115) to introduce new policies, including work requirements, aimed at helping newly enrolled adults transition off Medicaid. While Section 1115 and Medicaid work requirements have the potential to decrease a state's Medicaid expenditures and improve workforce participation rates, they can also be controversial. This article summarizes the current status of proposed employment initiatives and outlines important considerations for states.

As of the date this article was drafted, the Centers for Medicare and Medicaid Services (CMS) had never approved a work requirement for Medicaid; however, such Medicaid employment initiatives may be favorably viewed under the Trump administration. In March 2017, the Department of Health and Human Services (HHS), together with CMS, jointly issued a letter to governors affirming the agencies' commitment to supporting state innovation, including support for innovations aimed at increasing employment and community engagement among Medicaid beneficiaries.[3] Specifically, the letter stated:

> The best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.

Several states have introduced employment initiatives as part of their respective Medicaid programs; the states include Arkansas, Indiana, Kentucky, Maine, Utah and Wisconsin. Unlike SNAP and TANF program work requirements, which are established at the federal level, states have flexibility through a Section 1115 waiver to design Medicaid-focused employment programs in ways that meet their individual unique challenges and needs. The various employment initiatives proposed to date illustrate the flexibility of Section 1115.

States are looking at related existing programs to help inform and implement their employment programs. For example, a few states are seeking to design employment programs that align with existing SNAP and/or TANF employment and training programs.[4,5] Programs intended to help SNAP, TANF, or Medicaid expansion populations soon become familiar with the additional barriers most beneficiaries face in their quest to find long-term gainful employment. These may include finding stable housing, quality child care, education, and treatment for mental illness or substance abuse. To be successful, programs should make a long-term commitment to helping beneficiaries overcome these challenges. Given the complexity of designing effective employment initiatives, states with managed care may leverage the expertise of the managed care organizations to design and operate their employment programs. To provide additional motivation, states are requesting new eligibility limitations linked to work. For example, Wisconsin's unique proposal[5] seeks to add a finite Medicaid enrollment limit (four years); however, months in which

SECTION 1115 DEMONSTRATION WAIVERS

States can utilize Section 1115 Demonstration Waivers to receive approval from CMS to implement new innovative policy initiatives, including eligibility changes, service coverage changes, and service delivery reforms. For additional information, please visit https://www.medicaid.gov/medicaid/section-1115-demo/index.html

beneficiaries are employed or participating in employment and training programs do not count toward the enrollment limit.

Despite its general support for work initiatives, to date, CMS has not approved or denied any of the proposed work programs, temporarily leaving states wide latitude to develop unique programs to support employment initiatives within their specific Medicaid programs.

POLICY AND FISCAL CONSIDERATIONS

The Section 1115 waiver provisions appear to give states considerable flexibility in designing programs to develop employment initiatives for Medicaid enrollees. States pursuing these policy initiatives must address several fundamental program design elements.

Mandatory VS. Voluntary Participation

While CMS is currently considering several mandatory work requirement proposals, several states that have chosen to expand Medicaid are already operating voluntary employment and training programs for newly eligible adults. Medicaid enrollees who are unemployed or under-employed are connected to existing employment and training resources. As CMS gives states more flexibility, it is likely that more states will seek to strengthen these programs. For example, in summer 2017, Indiana amended[6] its pending Section 1115 application to make participation in its voluntary Gateway to Work program mandatory for certain beneficiaries.

While a simple choice between voluntary and mandatory participation is one option, more complex policy options are also possible. For example, an employment program could be voluntary but require participation as a condition for recipients to access certain enhanced benefits. The design structure could vary for different Medicaid eligibility categories or by federal poverty level. Some common design structure options include:

- Require participation as a condition of eligibility.
- Require participation a condition of receiving incentives (such as enhanced benefits, monetary incentives, reduced cost sharing).
- Require participation as a condition of avoiding penalties (such as increased premiums for non-participation).
- Make participation entirely voluntary.

Participating Populations

State policy makers must define what segment of their Medicaid population will be included in the work and employment training initiative. Although most states have targeted primarily the population newly enrolled under Medicaid expansion, several states have also sought to include other "able-bodied" Medicaid eligibility groups, namely those individuals who obtain Medicaid eligibility because of low income rather than disability.

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When evaluating the populations proposed to participate in Medicaid work and employment training initiatives, it is important to consider employment rates within each participating population. For states that have not expanded Medicaid under the ACA, Medicaid programs serve primarily children, caretakers, and the medically frail, groups for whom having a job is generally not practical. As a result, aggregate Medicaid employment rates are materially lower in non-expansion states than in states that have expanded Medicaid.

Table 1 contains a summary of the employment status of Medicaid populations in expansion and non-expansion states. In developing these estimates, we limited the population to adults eligible for Medicaid but not for Medicare (i.e., non-dual). This equates to approximately 40 percent of the total Medicaid population.

Table 1
Employment Status of Medicaid–only Population
Expansion and Non-expansion States

	Percent of Adult Population by Hours Worked		
Hours Per Week	Expansion State	Non-Expansion State	Composite
1–5 Hours	1%	1%	1%
5-9 Hours	1%	1%	1%
10-19 Hours	5%	3%	4%
20-29 Hours	11%	8%	10%
30-34 Hours	7%	6%	7%
35-39 Hours	5%	4%	5%
40+ Hours	27%	24%	26%
Not Employed	43%	52%	46%
Total	**100%**	**100%**	**100%**

Notes:

- Values developed using the 2015 American Community Survey (ACS).

- Values are rounded to the nearest percentage and may not sum 100.
- Population is limited to those adults eligible for Medicaid but not Medicare.
- Indiana introduced Medicaid Expansion under the Healthy Indiana Plan (HIP) 2.0 on Feb. 1, 2015.
- Alaska, Montana and Louisiana are included in the Non-Expansion states, as they had not expanded by July 1, 2015.[7]

States with high unemployment rates are likely to have a larger portion of the Medicaid population impacted by the implementation of a Medicaid work requirement relative to states with lower unemployment rates, as working individuals are generally more likely to already meet the requirements. As illustrated in Table 1, somewhat less than half of the adult, non-dual Medicaid population is estimated to be unemployed. Employment rates for Medicaid-covered adults are nearly 10 percentage points higher in expansion states compared to non-expansion states (57 percent vs. 48 percent). On a national level, nearly 90 percent of the employed Medicaid population reports working over 20 hours per week on average.

Population Exemptions

In addition to identifying the broad Medicaid eligibility categories that will be subject to the work requirement, state policy makers should thoughtfully consider whether specific exemptions should be allowed within each of the participating Medicaid eligibility categories.

- **Pregnant Women and Caregivers.** Most of the state proposals submitted to CMS to date have included exemptions for pregnant women and/or caregivers. Several states have sought alignment with other programs by allowing exemptions only for individuals caring for children under six years of age. By contrast, a legislative proposal out of Florida limited the caregiving exemption to single parents of an infant less than three months of age, while Kentucky's Section 1115 proposal seeks to allow one exemption per household that includes a dependent child under 18 years of age. Also, recognizing that older adults younger than age 65 may be primary caregivers for aging parents, some states have also proposed caregiving exemptions for beneficiaries caring for individuals other than dependent children.
  - o Exemption Examples:
    i. Pregnant women.
    ii. Adults who are the primary caregiver of a dependent child (with limits depending on age of child).
    iii. Adults who provide care for a disabled or aging family member.

- **Exemptions Based on Medical Considerations.** While most individuals in Modified Adjusted Gross Income (MAGI) eligibility groups do not have a formal disability determination[8], there is a subset of the population that may be unable to meet work requirements due to medical conditions or difficulties with activities of daily living. In order to more narrowly tailor work requirement policies to healthy and able-bodied Medicaid enrollees, state policy makers have sought to create medical exemptions in a variety of ways. Where possible, most states have sought to align the medical exemption with those of existing programs to avoid having to allocate new resources to administer a new unique medical exemption. For example, several states are seeking to exempt individuals already determined eligible for and receiving long-term disability benefits, while other states are seeking to use existing processes to identify "medically frail" individuals exempt from the alternative benefit plan.[9] By contrast, states may create a process to certify individuals with medical conditions that prevent them from participating in the employment program as physically or mentally unable to work.
  - o Exemption Examples:
    i. Exempt individuals receiving long-term disability benefits.
    ii. Align with state's "medically frail" determination.
    iii. Leverage medical review team disability review process.

iv. Allow process for temporary illness or incapacity as certified by a licensed medical professional.

- **Exemptions Based on Administrative Considerations.** Given the historic growth of Medicaid following implementation of the ACA, the scalability of new Medicaid employment and training programs is a significant consideration for policy makers as they design program exemptions. One strategy to reduce the administrative burdens of tracking member compliance is to create broad categories of exemptions. For example, states could exempt individuals who are already working more than 30 hours per week or those who are full-time students. Although these activities may likely also be considered qualifying activities, by creating an exemption the state may reduce the administrative burden by eliminating regular reporting and tracking requirements for a substantial portion of the otherwise-included population.
  - o Exemption Examples:
    i. Full-time or part-time students.
    ii. Unemployment insurance recipients.
    iii. Individuals meeting SNAP and/or TANF work requirements.
    iv. Age limitations (e.g., individuals under age 21 or individuals over age 60).
    v. Individuals on Medicaid for less than a certain amount of time.

- **Vulnerable Populations.** There are several subsets of vulnerable populations, in addition to those with chronic health conditions that may fall within a broader Medicaid eligibility group otherwise subject to new work requirements. State policy makers may also consider giving special consideration to any of the following vulnerable populations.
  - o Exemption Examples:
    i. Homeless individuals.
    ii. Refugees.
    iii. Former foster care youth.
    iv. Temporary exemptions for people transitioning from criminal justice.
    v. Individuals participating in substance use treatment and rehabilitation.
    vi. Other extreme hardship situations.

The exemption criteria utilized to identify individuals not subject to a work requirement may materially influence projections of savings realized by imposing a work requirement. Table 2 contains a summary of the population we estimated to be exempt from a work requirement as the result of common exemption criteria, including age limitations, pregnant women, primary caregivers, the medically frail and students. (In developing these estimates, we utilized data from states that expanded Medicaid as of June 30, 2015, and the population eligible for Medicaid but not Medicare.)

Table 2
Percent of Medicaid-only Population
Exempted Using Various Exemption Criteria

Exemption Status	Percent
Age Limitations	45%
Pregnant Women	5%
Primary Caregivers	15%
Medically Frail	8%
Students	2%
Total Exempt Population	**75%**

Notes:

- Values have been rounded.
- Values developed using the 2015 American Community Survey (ACS) and 2015 Current Population Survey (CPS), based on data from states that expanded Medicaid by July 1, 2015.
- Population is limited to those eligible for Medicaid, but not Medicare.
- The child Medicaid population is included under the "Age Limitations" exemption.

On average, approximately 75 percent of the assessed Medicaid population would be exempt from a Medicaid work requirement based on common exemption criteria. The majority of the non-exempt population are Medicaid expansion adults, as the non-expansion population often meets these exemption criteria. It should be noted that actual values are certain to vary by state depending on Medicaid eligibility requirements.

Participation Requirements & Qualifying Activities

The participation requirements include the number of work, or work equivalent, hours required and the types of activities that meet the requirement. For ease of administration and member communication, states could simply extend the existing employment and training program requirements from SNAP, TANF, or unemployment insurance to the Medicaid population. However, since Section 1115 gives states the flexibility to design unique programs, policies can be designed to improve upon these existing programs, rather than just extending their scope. For example, Indiana and Kentucky[10,11] have proposed a graduated hour requirement structure to assist members transitioning into full compliance with an eventual 20 hour per week work requirement.

Further, although these programs are often described as "work requirement," they are typically much broader and seek to connect individuals to a variety of qualifying activities beyond employment. Some common qualifying activities include:

- Subsidized or unsubsidized employment,
- employment/vocational training,
- job search activities,
- general education participation,
- English as second language,
- community work experience,
- community service/public service,
- caregiving services,
- participation in refugee resettlement programs, and
- participation in substance use disorder treatment.

The structure of participation requirements and qualifying activities can greatly influence the population impacted by a Medicaid work requirement. Table 3 illustrates the estimated portion of the non-dual Medicaid population that is not exempt or actively employed. This information was developed based on common exemption criteria and the estimated portion of the population actively employed.

Table 3
Percent of Medicaid-Only Population Not Exempt from Work Requirement for States Expanding Medicaid

Item	Percent
Non-Dual Medicaid Population	100%
Exempt Population	75%
Actively Employed	15%
Not Exempt	*10%*

Notes:

- Values have been rounded.
- Population is limited to those eligible for Medicaid, but not Medicare.
- Actual values are certain to vary by state based on Medicaid eligibility requirements.
- Assumes that Work Requirement is implemented along with Medicaid Expansion.
- Estimates developed through the use of public data sources and internal research.

Table 3 illustrates that within a Medicaid-only population in states that expanded Medicaid, an estimated 10 percent of Medicaid beneficiaries would need to **begin** engaging in a qualifying activity. We estimate that approximately 50 percent to 75 percent of these individuals are likely to comply by engaging in qualifying activities. It should be noted that the compliance rates are certain to vary by state depending on programmatic structure and policy decisions. Careful consideration should be made in evaluating proposed policies to assess the impact on a state's Medicaid program.

DATA SOURCES AND METHODOLOGY

Results shown in Tables 1 through 3 are for illustrative purposes; however, these estimates are a reasonable approximation for work requirement policies currently being evaluated. Actual results are certain to vary from the values illustrated. Consideration should be given to state-specific information related to items such as Medicaid eligibility, policy decisions, and employment rates.

In developing this information, we used 2015 American Community Survey (ACS) and Current Population Survey (CPS) data compiled by the United States Census Bureau[12] along with internal data and actuarial judgement. We limited data to those who were enrolled in Medicaid but not Medicare and developed expansion/non-expansion categorization based on each state's 2015 expansion status provided by the Kaiser Family Foundation.[13] We provided additional consideration for Indiana, Alaska, Montana, and Louisiana, as noted in this report.

States must analyze each policy element in terms of its operational and fiscal impacts on the state Medicaid program, including scalability, reporting requirements and IT support.

SUMMARY

When developing a Medicaid work requirement and employment initiative, states must analyze each policy element in terms of its operational and fiscal impacts on the state Medicaid program, including scalability, reporting requirements and IT support. The fiscal impact associated with a Medicaid work requirement is highly dependent on the structure and policy decisions of the initiative. In many states, a large portion of the adult population is already actively employed. If some of the Medicaid population does not comply with the work requirement, the state will realize fiscal savings because the state will not pay for services that these people would otherwise use or will not pay capitation rates to managed care plans.

These savings may be partially or fully offset by the cost of operating employment support programs for those who choose to comply with the requirement. Effective programs should be comprehensive and may be considered a long-term investment for the state. When evaluating fiscal savings, states should also consider the impact to the population losing coverage. In addition, the implementation of a Medicaid work requirement has the potential to increase the amount of uncompensated care in a state.

The actual fiscal savings will vary by state depending on the cost of services provided to the population served and the portion of the population that is unenrolled. The analysis we completed suggests that the cost of services provided to the population affected by a Medicaid work requirement is likely to be below that of the average adult Medicaid recipient. By removing lower cost individuals from the Medicaid population, the introduction of a work requirement has the potential to increase per capita spending, while at the same time decreasing aggregate expenditures. States and their actuaries should carefully evaluate the impact of proposed initiatives when evaluating these policy changes and their impact on Section 1115 submissions. ■

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ENDNOTES

1 *https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf*

2 *https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf*

3 *https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf*

4 *http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf*

5 *https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-finalapp.pdf*

6 *https://www.in.gov/fssa/hip/files/HIP_Amendment_-_FINAL_Publication_Version.pdf*

7 *http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-28§435.603(j)(3)*

9 For additional information related to alternative benefit plans (ABPs), please see *https://www.medicaid.gov/medicaid/benefits/abp/index.html*

10 Kentucky later requested eliminating the graduated requirement, citing administrative and technological challenges.

11 *http://chfs.ky.gov/NR/rdonlyres/8803E89E-7197-46AE-AA32-037E9964711D/0/ProposedOperationalModificationstoWaiverApplication.pdf*

12 Further information about the sample size, survey conduction methods, and other items related to the dataset can be found at *https://www.census.gov/programs-surveys/acs/methodology/sample-size-and-data-quality/sample-size-definitions.html.*

13 For additional information, please see *http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act*