Medicaid Work Requirements Shift to New Terrain

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State policies requiring low-income adults to work to maintain Medicaid coverage have been gaining traction and sparking debate. With encouragement from the Centers for Medicare & Medicaid Services (CMS), 20 states have proposed some form of “community engagement” requirements. These proposals typically involve mandating Medicaid beneficiaries to work a certain number of hours (usually 20 hours per week), engage in job training or community service, or obtain an exemption (such as having children with disabilities or being family caregivers).

Ten states have now approved work requirements, though many face legal challenges. Only Arkansas fully implemented the policy before a federal judge issued an injunction that halted the practice there and also barred implementation in Kentucky and New Hampshire, a decision that was upheld this month by a federal appeals court. Michigan's policy is also being challenged in federal court.

Work Requirements in Nonexpansion States

Until recently, the CMS gave a green light for work requirements only to states that had expanded Medicaid under the Affordable Care Act (ACA), as well as to Wisconsin, which had already made all poor adults eligible for Medicaid despite technically not participating in the ACA expansion. This means all adults in these states with incomes at or below the poverty level were eligible for Medicaid. In December 2019, South Carolina received approval to apply work requirements to low-income parents, becoming the first traditional nonexpansion state that has been allowed to proceed. This context elevates questions about the nation’s continuing experimentation with work requirements and warrants additional scrutiny about how it might play out based on each state’s expansion status and enrollee characteristics.

Despite its general support for work requirements, the CMS had rejected a proposal from Mississippi in 2018, arguing that the lack of Medicaid expansion in the state rendered work requirements problematic due to a phenomenon called a “subsidy cliff.” If a beneficiary obtains a new job to meet the requirements in most nonexpansion states, the additional income may leave the person ineligible for Medicaid but still too poor to qualify for the ACA’s subsidized private coverage. The CMS concluded that this makes little sense because the policy would require people to work to keep their insurance coverage but would then take away that coverage once they got a job.

South Carolina and the CMS navigated this complexity by coupling the new work requirements with a limited expansion of Medicaid eligibility, raising the effective income threshold for low-income parents from 67% of the poverty level to 100%. Meanwhile, childless adults (the core constituents who would benefit from the ACA’s Medicaid expansion) remain ineligible for Medicaid in the state. Before South Carolina, discussion over work requirements was often framed as a necessary compromise to gain support for Medicaid expansion from conservative policy makers as in Virginia and Utah (though Virginia subsequently paused implementation of its work requirements). In South Carolina, the compromise was a more modest expansion of coverage to a narrower subset of the population, which many critics have argued is inadequate to justify a policy that may cause large Medicaid enrollment losses.
Insights from Arkansas

Politics aside, what do we know about how the policy will actually play out in South Carolina? Two sources of information offer insights: South Carolina’s proposal to the CMS and studies of Arkansas’s first-in-the-nation Medicaid work requirements. In their application, South Carolina officials predicted that 7100 low-income parents will lose Medicaid coverage because they “will elect not to comply” with the new requirements, which is less than 4% of the estimated 188 000 Medicaid beneficiaries subject to the policy. By comparison, in Arkansas, approximately 18 000 adults (roughly 30%) lost Medicaid coverage out of the nearly 61 000 subjected to the requirements before the courts intervened.

Is South Carolina’s projection plausible? One of the key insights from Arkansas is how many people were confused about work requirements, with 1 of 3 adult Medicaid beneficiaries reporting they had never even heard of the policy. It turns out the key to understanding coverage losses is not whether people are meeting the requirements already—more than 95% of those in Arkansas were indeed already doing so. Rather, the key factor is reporting “community engagement” itself. In Arkansas, most of those who kept their coverage had never been asked by the state for information because the state already knew they were complying based on state data sources like income taxes. Of the nearly 20 000 required to report information to the state, only around 20% did so, with the rest losing coverage. In other words, red tape is the primary hurdle to maintaining coverage. Perhaps in recognition of this result, South Carolina officials aim to exempt 168 000 of the 188 000 Medicaid beneficiaries from having to report data to the state, which is a critical step toward reducing potential loss of coverage.

However, this still leaves 20 000 South Carolinians subject to a new requirement and in danger of losing coverage if they cannot navigate the state’s reporting system. An added concern is that South Carolina’s policy targets low-income parents, which prior research indicates could also reduce Medicaid enrollment among children. The question that remains is: What can South Carolina reasonably expect to accomplish with this policy in terms of financial security and health coverage?

The CMS argues work requirements will lead to more employment and an escape from poverty. Evidence from Arkansas does not support this contention. In a 2019 study, our team compared Arkansas with 3 other southern states and found no significant increase in employment, hours worked, or other community engagement activities. Most individuals targeted by the policy were already working or disabled. Medicaid coverage losses were more than 10%, with no significant increases in employer-sponsored insurance to fill the gap. By the end of the first year, the policy had produced more uninsured adults, substantial administrative cost to the state, and no change in the economic outcomes that were the policy’s goals.

As South Carolina embarks on its experiment with work requirements, with other nonexpansion states likely to follow suit, we offer 2 key lessons. The first is that the behind-the-scenes administrative details matter a lot. To its credit, South Carolina appears to be prioritizing steps to reduce the reporting burden for many beneficiaries, which will likely decrease the scope of potential coverage losses. The second is that—even with these steps—there is good reason to doubt that work requirements will succeed in their stated rationale of improving financial circumstances for low-income adults in the state.
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