



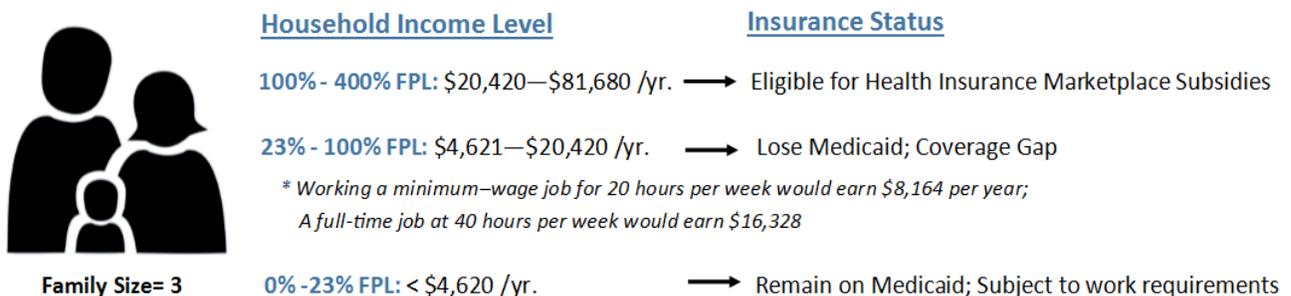
Introduction

On January 11, 2018, the Centers for Medicare and Medicaid Services (CMS) issued new guidance for state Section 1115 waiver proposals that make Medicaid coverage dependent on meeting a work requirement. To date, requests to waive standard Medicaid regulations in order to implement requirements that certain beneficiaries participate in work activities have been approved in four states (Kentucky, Indiana, Arkansas, and New Hampshire) and are pending in six other states. Additionally, several other states have expressed interest in the idea including in Missouri where in the 2018 Legislative session Senate Bill 948 (SB 948) proposes a similar work requirement for non-exempt (able-bodied) Medicaid recipients.

As states consider requiring certain Medicaid recipients to work or participate in other work-related activities in order to maintain eligibility, it is important that they evaluate possible outcomes and weigh the costs of implementation. In Missouri, where only a limited number of Medicaid enrollees would be subject to work requirements, implementation costs may outweigh any potential savings. This brief describes the administrative costs of enforcing Medicaid work requirements and estimates possible gains and losses to Missouri’s state revenue in the short and long term.

Key Takeaway: Because Missouri is a Medicaid non-expansion state, work requirements would apply to a limited number of people compared to the impact in states that have expanded their Medicaid programs to cover non-disabled childless adults and parents with incomes up to 138% of the Federal Poverty Level (FPL). Furthermore, recipients in Medicaid non-expansion states are at greater risk of losing health coverage and becoming uninsured; working even a minimum wage job in order to fulfill proposed requirements in Missouri would raise enrollees’ incomes above the Medicaid eligibility limit of 23% FPL for low-income parents and caretakers, likely causing them to fall into the coverage gap (Figure 1). Thus in addition to the administrative costs of implementing Medicaid work requirements, the state must also consider the potential increase in uncompensated care costs. Ultimately, the greatest cost savings to the state in the long term would come from policies and programs that can help enrollees obtain better jobs that offer them health insurance or pay incomes that render it affordable.

Figure 1. Likely Insurance Status by Income Level in Missouri



Administrative Costs

In considering requiring Medicaid beneficiaries work as a condition for coverage, the cost of implementation should be assessed. Administrative costs for implementing Medicaid work requirements include:

- Tracking compliance (building an IT platform and hiring additional staff)
- Providing job training programs
- Providing other work support services (transportation, child care assistance, etc.)

Tracking & Verification

Medicaid work requirements would require beneficiaries to participate in approved work activities such as employment, job search, job training, or volunteering for 20 hours per week, or 80 hours per month. Tracking and verifying each enrollee's compliance or exemption status would require states to build compatible IT infrastructure and hire additional support staff. Regardless of the size of the population served, additional programming will be needed to integrate a new eligibility factor, exemptions, and compliance information. In Kentucky, \$187 million was budgeted for the first year of implementing Medicaid work requirements in order to create a tracking system and mobile-friendly website for enrollees to log their hours.¹ According to the state's revised budget for fiscal 2018, the federal government will be covering more than \$167 million of this cost, where states can receive a federal match up to 90% for initial Medicaid eligibility-related IT investments. This IT cost would vary depending upon the degree of technology desired and would likely depend somewhat on the size of the population involved.

Work Support

Though states can receive federal matches for new Medicaid administrative costs, they cannot use federal Medicaid funds to cover the cost of work support services such as job training, transportation, or child care. As these services are critical for helping move low-income individuals into the workforce, they are required to be provided by states mandating work in Medicaid; however, they are beyond the scope of the medical and long-term care services that Medicaid can cover under federal law. Based on experience from the Temporary Assistance for Needy Families (TANF) program, the cost to provide employment assistance, such as services listed in Table 1, to recipients required to participate in work can be substantial. In 2016, states spent \$8.8 billion of their federal and state TANF funds on work-related activities and supportive services including child care.² In Missouri, \$82 million was spent to support work for fewer than 12,000 people required to participate in TANF work activities each month; an average of \$2,357 per work slot per year was spent on providing work activities such as education and training alone.³ This does not include the cost of screening and assessing recipients or providing case management.

Table 1. TANF Work Support Categories and Services

Category	Services
Work-Related Activities	Subsidized Employment Education and Training
Work Supports and Supportive Services	Transportation Mental health or domestic violence services Child Care
Program Management	Screening/ Assessment Case Management

To support Medicaid enrollees in fulfilling their work requirement, Indiana estimates a cost of \$90 per enrollee per month (or \$1,080 per year) for assessment, job skills training, job search assistance, and tracking enrollee progress.⁴ Providing work assistance (excluding support services such as transportation or child care) to the estimated 130,000 Medicaid enrollees in Indiana subject to a work requirement would cost to \$140 million. Their request to use federal Medicaid funds to cover the cost was denied by CMS.⁵ Minnesota estimates that enforcing a work requirement would require hiring up to 300 additional case workers to manage the estimated 125,000 enrollees who would be subject to comply.⁶ In Arkansas, where Medicaid coverage was previously expanded to over 300,000 low-income adults, no additional investments to fund work support services will be made for recipients who will be required to work.⁷ Without any additional resources to provide services to more people, the state plans to rely on existing state workforce services to provide employment services for Medicaid enrollees.

In some cases, Medicaid enrollees required to work may also be enrolled in another federal assistance program that has federally funded work support services available. For example, Medicaid enrollees who are eligible for TANF can receive education and training, along with child care and other work support services through the TANF program. Additionally, work support services for Medicaid enrollees who are also receiving Supplemental Nutritional Assistance Program (SNAP) can be covered through the federally funded SNAP Employment and Training program. Though training activities for SNAP can be covered through capped “100 percent funds” grants allocated to state programs each year, the state is responsible for half of the cost in providing supportive services such as transportation and child care.⁸

Outcomes

Cost saving outcomes from implementing Medicaid work requirements include:

- **Short term:** Savings from a reduction in Medicaid enrollment
- **Long term:** Cost of the uninsured (the state’s share of the uncompensated care burden) and those who remain on Medicaid; Savings due to reduced obligation for those who gain employer coverage

Reduced Enrollment

Most cost savings from Medicaid work requirements come from the assumption that a number of people will not comply and therefore lose coverage. Indiana has estimated that 33,000 enrollees will be unable to fulfill the requirement, and Kentucky estimates that nearly 100,000 will drop out of Medicaid by the end of the five-year project. Savings from covering fewer individuals are projected to be \$300 million in Kentucky state funds.¹

Kentucky, Indiana, Arkansas, and New Hampshire, however, have all expanded their Medicaid program to cover non-disabled childless adults and low income parents up to 138% of the Federal Poverty Level (FPL). Since Missouri has not adopted Medicaid expansion, its program does not cover childless adults unless they are elderly, disabled, or pregnant. Furthermore, current eligibility levels for low-income parents and caretakers are near the lowest in the country at less than 23% FPL, which corresponds to an annual income of only \$4,620 per family of three in 2017. Work requirements in Missouri are thus estimated by the state’s Family Support Division to apply to only 44,000 individuals, of whom 17,000 are already currently meeting the work requirement.⁹ The exact number of recipients that would be required to work in Missouri, however, is uncertain; our own prior analysis using the Current Population Survey estimated that up to 102,000 individuals could be required to comply, though this may be an overestimate due to data limitations.¹⁰ Depending on the compliance rate for the 27,000 individuals estimated by the state to be currently failing to meet the proposed work requirement, the fiscal note for SB 948 estimates a net effect on general revenue in Missouri ranging from a loss of \$8 million (75% compliance) to a savings of \$18 million (25% compliance) in state funds.⁹

Uncompensated Care

Though state savings may be generated from a reduction in the number of Medicaid enrollees, estimated savings do not account for the cost of an increasing uninsured population. As recipients lose their health care coverage, uncompensated care costs will increase as more uninsured individuals become reliant on other forms of public care. Given that the recipients most at risk of losing their coverage are also more likely to have serious chronic conditions, uncompensated care costs may be significant; the majority of non-working Medicaid enrollees report illness or disability as their main reason for not working.¹¹ Before Medicaid expansion took effect in 2014, uncompensated care in 2013 cost \$19.8 billion *in state and local funds alone*.¹² From 2013 to 2015, total nationwide hospital uncompensated care costs fell by roughly half, a \$10.4 billion drop.¹³ The majority of this decrease occurred in Medicaid expansion states, where uncompensated care costs in 2014 were 35% less than the previous year (dropping to \$5.8 billion from \$11 billion).¹⁴ Comparatively, uncompensated care costs dropped only 1% from \$18.1 billion in Medicaid non-expansion states.¹⁴ Any savings from Medicaid work requirements must consider the cost of a greater number of uninsured persons.

Coverage Gap

Low-income adults in states that have not expanded Medicaid face the greatest risk of becoming uninsured as a result of Medicaid work requirements. Those who find employment in order to meet the work requirement risk falling into the “coverage gap”, a situation in which their income is above Medicaid eligibility limits but below the lower limit for Health Insurance Marketplace premium tax credits that help low-income people cover the cost of purchasing health insurance through the Marketplace.¹⁵ For example, even working a minimum wage job at \$7.25 per hour, the federal minimum, for the required 20 hours per week would result in earnings of \$7,540 per year, well over the Medicaid eligibility income limit in Missouri; and working a full-time job would earn \$15,080 per year, still below the 100% FPL for a family of 2+ at which eligibility for federal subsidies to reduce monthly premiums and out-of-pocket costs begins. As low-wage job holders and part-time workers are unlikely to receive health benefits from employers, many of these working individuals will be left without health coverage; a Kaiser Family Foundation analysis found that in 2017, fewer than a third of workers who worked at or below their state’s minimum wage had an offer of health coverage through their employers.¹⁶ In contrast, it is possible to work a minimum wage job even full-time and still be eligible for Medicaid in states that have expanded the program to individuals with incomes under 138% FPL. In Medicaid expansion states, individuals would also be eligible to receive federal assistance in purchasing health insurance from the Marketplace if their incomes rose above the limit for Medicaid eligibility (see Figure 1).

Long Term Cost-Savings

Rather than helping move low-income adults into jobs that would provide health coverage, Medicaid work requirements in a non-expansion state are more likely to leave individuals uninsured. To maintain health coverage, low-income adults may thus be incentivized to meet work requirements by volunteering instead of seeking employment. In such cases, recipients will remain dependent on public assistance and states will not benefit from any savings in the long run. The only pathway available to current Medicaid beneficiaries that may save states money in the long term is that which moves Medicaid enrollees into better jobs that offer health insurance or enough wages for them to afford insurance through the Marketplace (Figure 2). Thus policymakers may want to focus on strategies that accomplish this, in particular by emphasizing education and training, even though this likely has higher administrative and programmatic costs in the short term. Such costs could perhaps be minimized by creating a voluntary program targeting individuals enrolled in multiple public programs, and providing assistance in navigating existing education/training funding programs.

Figure 2. Potential Insurance Status and Associated Costs to the State

Work Activity	Insurance Status	Cost to State
1. Does not meet work requirement (Non-compliant)	Lose Medicaid (Uninsured)	Uncompensated Care
2. Work  Earnings < Medicaid limit	Remain on Medicaid	Cost of work req. program
 Earnings > Medicaid limit	Lose Medicaid	Uncompensated Care
	<ul style="list-style-type: none"> No Insurance through job (Uninsured) Insurance through job or Marketplace 	No cost: Savings
3. Volunteer	Remain on Medicaid	Cost of work req. program
4. Education & Training	Remain on Medicaid (short-term); Insurance through job (long-term)	Cost of work req. program (short-term); Potential savings (long-term)

Conclusion

Administrative costs to implement Medicaid work requirements include those for tracking compliance and providing required work supports. Though states can receive a 90% federal match for creating necessary IT upgrades, no federal Medicaid funds can be used to cover the cost of work support services such as job training, transportation, or child care. Based on evidence from previous experiences supporting TANF recipients required to work, these costs can be substantial.

According to the state of Missouri, fewer than 45,000 (4.5%) of Missouri’s 980,000+ Medicaid enrollees would be required to work under the proposed Medicaid work requirement, of whom 17,000 are already currently meeting the 80 hours per month requirement.⁹ Though the exact number of enrollees affected may be higher, administrative costs for implementation could still outweigh any potential savings to the state; fiscal analysis for SB 948 estimates a gain to state revenue only if non-compliance rates are high. Furthermore, estimated cost savings do not include the cost of a rise in the uninsured population, and corresponding increases in uncompensated care, resulting from a loss of Medicaid coverage. Recipients in Medicaid non-expansion states are most at risk for becoming uninsured. Analysis from our previous brief, *The Demographics of Missouri Medicaid: Implications for Work Requirements* finds that the majority (65%) of non-exempt recipients in Missouri who are not meeting a proposed work requirement may be unable to work due to illness or disability.¹⁰ More likely to be older, in worse health, and have less education, they will likely face challenges in entering and remaining in the workforce.

¹ Roll Call, *Medicaid Changes Require Tens of Millions in Upfront Costs* (February, 2018). <https://www.rollcall.com/news/politics/medicaid-kentucky>

² Center on Budget and Policy Priorities, *How States Use Funds Under the TANF Block Grant* (Updated April 2, 2018). <https://www.cbpp.org/research/family-income-support/how-states-use-funds-under-the-tanf-block-grant>

³ Calculated based on \$28 million total annual TANF spending on work activities in Missouri in 2016. https://www.cbpp.org/sites/default/files/atoms/files/tanf_spending_mo.pdf, for 12,000 people required to participate in TANF work activities each month in MO in 2016, <https://www.acf.hhs.gov/ofa/resource/tanf-acf-im-2017-02-state-work-participation-rates-for-fy-2016> (Table 4A).

- ⁴ Indiana Family and Social Services Administration, *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* (July 20, 2017). <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-07202017.pdf>
- ⁵ The Washington Post, *Indiana Wins Federal Permission to Adopt Medicaid Work Requirements* (February 2, 2018). https://www.washingtonpost.com/national/health-science/indiana-wins-federal-permission-to-adopt-medicaid-work-requirements/2018/02/02/f681ccae-02cf-11e8-8acf-ad2991367d9d_story.html?noredirect=on&utm_term=.82d9fd250155
- ⁶ Star Tribune, *Proposed Medicaid Work Requirements Could End Up Costing Minnesota* (March 18, 2018). <http://www.startribune.com/proposed-medicaid-work-requirements-could-end-up-costing-minnesota/477217293/>
- ⁷ Arkansas Advocates for Children and Families, *Arkansas Works 2.0: How Proposed Changes to Expanded Coverage Will Affect Progress* (January, 2018). <http://www.aradvocates.org/wp-content/uploads/ArkansasWorks.webfinal.1.4.18.pdf>
- ⁸ United States Department of Agriculture, food and Nutrition Services, Supplemental Nutrition Assistance Program, *SNAP Employment and Training Toolkit* (2013). https://fns-prod.azureedge.net/sites/default/files/ET_Toolkit_2013.pdf
- ⁹ Missouri Committee on Legislative Research, Oversight Division, *Fiscal Note for SB 948* (February 20, 2018). <http://www.moga.mo.gov/OverSight/Over20181/fispdf/6087-01N.ORG.pdf>
- ¹⁰ Center for Health Economics and Policy, *The Demographics of Missouri Medicaid: Implications for Work Requirements* (March, 2018). <https://publichealth.wustl.edu/wp-content/uploads/2018/03/MO-Medicaid-Demographics-and-Work-Requirement.pdf>
- ¹¹ Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* (Updated January 5, 2018). <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>
- ¹² Kaiser Family Foundation, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (May 20, 2014). <https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>
- ¹³ Council of Economic Advisors, *The Economic Record of the Obama Administration: Reforming the Health Care System* (December, 2016). https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform.pdf
- ¹⁴ Kaiser Family Foundation, *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes* (June 9, 2016). <https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-issue-brief/>
- ¹⁵ Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* (November 1, 2017). <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>
- ¹⁶ Kaiser Family Foundation, *ACA Coverage Expansions and Low-Income Workers* (June 20, 2016). <https://www.kff.org/report-section/aca-coverage-expansions-and-low-income-workers-issue-brief/>