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Updated Estimates of the Effects of Medicaid Work Requirements in Kentucky

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In *Stewart v Azar*, a federal court vacated the federal government's initial approval of Kentucky's Medicaid Section 1115 demonstration project that included work requirements (also called "community engagement"). The court noted that the Centers for Medicare and Medicaid Services (CMS) failed to consider the experiment's effects in reducing Medicaid beneficiaries' coverage. The court observed that Section 1115 projects are supposed to promote program purposes and a central purpose of Medicaid is the provision of medical assistance to eligible people. The court remanded the matter back to CMS; in turn, the agency reopened the public record as part of a reconsideration of its earlier decision.

Following the new public comment period, which once again heavily opposed the demonstration, in December CMS again approved the Kentucky demonstration. As before, the agency failed to independently review the state's estimates. In fact, CMS suggested that the state's estimates were if anything too high. First, CMS confusingly argued that the 95,000 beneficiary reduction figure used by the court was too high since actual way to estimate the loss is in terms of enrollment "member months" and that the projected loss of member months only represents about 5% of the caseload. However, Kentucky actually estimated that 1,160,242 member months would be lost in the fifth year of the demonstration, which roughly translates to a 95,000 person-year reduction or a 15% loss of Medicaid coverage among adults.

Second, CMS asserted that some of those losing Medicaid would gain private health insurance. However, the agency offered no evidence to support its claim, nor did it provide an estimate of how many might gain private coverage. Finally, CMS attempted to portray the loss of coverage not as a reduction in Medicaid but as a modified expansion, similar to other states that adopted the ACA Medicaid expansion via Section 1115. To support this argument CMS ignored the fact that the demonstration applies to both traditional and newly eligible people and relied solely on the Governor's assertions that he would terminate the eligibility expansion if the demonstration is not approved, not on any state law that mandates such an action.

In April 2018, we authored a report contesting Kentucky's estimates of how much work requirements would reduce Medicaid enrollment. The state did not discuss the basis for its estimates of enrollment losses, which appear to have been made up without any effort to examine information about how work requirements trigger caseload reductions. Our report noted that there was already evidence that work requirements lead to substantial and rapid reductions in participation, based on anecdotal experiences of several areas that had recently implemented similar work requirements in the Supplemental Nutrition Assistance Program (SNAP). Those reports suggested that caseloads could quickly fall by as much as 50% and 85%. This evidence was also presented to the court in the Deans, Chairs, and Scholars amicus brief on behalf of plaintiffs in *Stewart.*

Since that time, more evidence has accumulated about the effects of work requirements in Medicaid, making it appropriate to update estimates of the potential effects of a work experiment in Kentucky. The most germane data come from a similar, but not identical, project initiated in Arkansas in June 2018, also approved by CMS under a Section 1115 demonstration project. As of December 2018, data from the Arkansas Department of Human Services indicated that in the first 6 months of implementation of the work experiment in that state, almost 17,000 adults had lost Medicaid coverage. These estimates were widely reported.

In late October, we developed a simple survival analysis model, based on the first four months of data and estimated that within 12 months, between 19% and 30% of Arkansas beneficiaries subject to work requirements could be expected to lose Medicaid coverage. The lower range of losses assumed that after five months, everyone complied with the work rules. Based on the new data suggesting that coverage losses have continued – enough so that the state and federal government have announced as-yet untested modifications to the experiment's work requirement reporting system – we would now revise the lower level of loss to 26%.

We use this information to update our estimates of the potential effects of Kentucky's Medicaid work requirements. We now estimate that, as approved, the Kentucky demonstration could lead to Medicaid coverage losses ranging between 26% and 41% of those required to comply or between 86,000 and 136,000 – in the first year alone – of the roughly 331,000 Medicaid adults that, according to the state's demonstration design, could be affected by the new work requirements. We again expect that the caseload reductions will be rapid, not gradually deepening over five years, as asserted by Kentucky and CMS.

The table below compares key elements of the approved projects in Arkansas and Kentucky. In many respects, Kentucky's policies are harsher and should cause greater losses.

Demonstration Element	**Arkansas**	**Kentucky**
Population Required to Meet Medicaid Work Requirements	19 to 49 year olds in Medicaid eligibility expansion. Those without children in the household, pregnant women and the medically frail exempted.	19 to 64 year olds whether newly or traditionally eligible. Primary caregivers of minor children, pregnant women and medically frail exempted.
Minimum Number of Work Hours Required	80 hours per month	80 hours per month
Number of Months Permitted without Work Compliance	Terminated after three months without work. After that, beneficiaries are locked out for remainder of calendar year.	Terminated after two months without work. Locked out until they meet work requirement for one or more months.
Updated Estimates of Medicaid Loss Among Target Population	26% to 30%	26% to 41%

First, in contrast to Arkansas, Kentucky's work rules extend into the 50-64 age group, despite the fact that this group faces higher unemployment prospects because of age and is also the group in poorest health. Second, the Kentucky demonstration exempts caregivers of children only if they are the primary caregivers, even though secondary caregivers may face similar problems maintaining year-round part-time jobs. Third, the Kentucky experiment provides less leeway for gaps in work hours so caseload reductions will occur more rapidly and affect a greater number of people. Kentucky will end coverage for those who miss the requirement for just two months, while Arkansas ends coverage for those who miss the requirement for three months. (Kentucky lets people "make up" low hours in the next month. For example, if a person works 40 hours one month, but 120 hours the next month, they meet the requirement for both months.) Both Arkansas and Kentucky make it difficult for those terminated to reenroll in Medicaid; both states have lockout policies, although they differ in how they are implemented. Arkansas locks them out for the rest of the calendar year, while Arkansas permits them to reenroll if they worked for at least one month or took a financial or health literacy course. For these reasons, we estimate a higher upper bound of enrollment loss in Kentucky.

Enrollment losses between 26 percent and 41 percent indicate that between 86,000 to 136,000 individuals will lose Medicaid coverage within one year of implementation, not gradually over five years as assumed by the state. (In January 2018, Kentucky estimated that 350,000 beneficiaries would be subject to the new rules, but caseloads have fallen by 5.5% as of September, thereby leading us to assume that 331,000 people may be subject to the new work requirements.) Work requirements are not the only reason that Medicaid beneficiaries might lose coverage; we also estimate that about 23 percent of Medicaid cases would close for other administrative reasons, such as changes in ages or income, moving or failing to reapply on time.

As noted, in reapproving Kentucky's proposal, CMS commented that some of those losing Medicaid may instead find private insurance coverage, so that the number losing health insurance coverage would be somewhat smaller than 95,000. However, CMS failed to provide evidence of this or any estimate of the change in private insurance coverage. While we acknowledge that some people may gain access to private insurance, we believe those gains will not be sufficient to significantly reduce the estimated impact. Using data from the United States Census Bureau's American Community Survey, (Tables HI05, 2013 and 2017), we can compare changes in Kentucky's health insurance coverage between 2013, before its Medicaid expansions and 2017 (the most recent year available). Between 2013 and 2017, the percent of Kentuckians under 65 with Medicaid coverage rose from 19.0% to 29.4%. By contrast, there was virtually no change in private health insurance coverage: 64.1% in 2013 vs. 65.1% in 2017. In other words, even though unemployment fell substantially in Kentucky, there was almost no improvement in private insurance coverage in Kentucky which might serve to offset the loss of Medicaid coverage. Furthermore, as the Urban Institute has noted, employer coverage is virtually non-existent for the state's part-time workers; in 2016 only 13.3 percent of all private part-time workers were eligible for employer-sponsored coverage, a figure that falls to 4.0 percent in low-wage firms.

There is little reason to believe that work requirements will substantially improve long-term employment or incomes among low-income Kentuckians. There is scant evidence that work requirements are successful in attaining these goals, particularly given the fact that CMS does not allow Medicaid funds to be used for job training or related employment opportunities that might actually help beneficiaries gain the skills needed for regular jobs.

For these reasons, the Kentucky experiment will result in a major loss of Medicaid coverage and a consequent loss of access to health care services among those subject to its provisions. At the same time, few of those subject to the demonstration's community engagement requirements (which can include volunteer work for which neither income nor health benefits will be available), will experience either an increase in income sufficient to purchase subsidized Marketplace coverage or access to employer-benefits sufficient to offset coverage losses attributable to the demonstration design.

Kentucky's successful Medicaid expansion led to major increases in insurance coverage and access to care for low-income Kentuckians. The new policies planned by the state and approved by the federal government threaten to reverse progress in the Bluegrass State.