

Challenging Assumptions about Medicaid Waivers

MICHAEL K. GUSMANO, PhD

In light of the failure of the 115th Congress to repeal the Patient Protection and Affordable Care Act, the Trump administration has used executive actions in an effort to reduce the reach of the ACA.¹ As part of that strategy, the administration has encouraged states to submit Medicaid waivers that include work requirements and greater out-of-pocket payments on some adult Medicaid beneficiaries. Although these efforts have been challenged in federal court, such requirements have been implemented in Arkansas, and there are plans to implement similar programs in a number of additional states.

This article reviews efforts to impose work requirements and larger out-of-pocket payments on Medicaid beneficiaries and place these in historical context. Both supporters and opponents of these policies present arguments about fairness to justify their positions. Proponents of work requirements tend to hold negative assumptions about social programs and the beneficiaries of such programs. As with previous attempts to reduce social welfare programs, work requirements for Medicaid beneficiaries assume that social welfare policies undermine personal responsibility and economic performance. Opponents argue that such policies are unfair because, rather than improving the health of poor people, these policies will reduce health insurance coverage, harm vulnerable populations and undermine public health.

MEDICAID WAIVERS UNDER PRESIDENTS OBAMA AND TRUMP

For decades, Medicaid demonstration waivers authorized under Section 1115 of the Social Security Act have been used to promote health policy objectives.² The Obama administration used these waivers to encourage states, in many cases those governed by Republicans, to make Medic-

aid expansion more palatable.³ Some of the efforts in those states included the so-called “neoliberal” model of health care, which stresses private insurance, markets, competition, individual choice, consumer empowerment and personal responsibility.⁴ The Obama administration resisted state requests to impose work requirements or specific cost-sharing requirements on Medicaid recipients.

The Trump administration’s Medicaid waiver policies differ from those of the Obama administration in important ways. Seema Verma, the current administrator of the Centers for Medicare and Medicaid Services, previously had been the head of a health policy consulting firm, where she had assisted Indiana, Kentucky and Ohio in developing waivers that emphasized individual choice and personal responsibility. In March 2017, Verma and then-Secretary of Health and Human Services Tom Price sent a letter to all U.S. governors that encouraged waivers that imposed training or employment requirements on Medicaid beneficiaries.⁵ It also endorsed premiums and other enrollee cost-sharing as well as fees that would penalize enrollees who used hospital emergency rooms for non-urgent care.

Reflecting long-standing philosophical differ-

ences between conservatives and liberals in health policy, a key theme of neoliberal waivers is personal responsibility. Conservatives often emphasize the degree to which health status, and the use of health care, reflect individual choices. In contrast, liberals usually emphasize the role of social factors.⁶ Following the conservative emphasis on individual choice, the Medicaid waivers encouraged by the Trump administration stress a “consumer-driven model” that “incentivizes patients to take greater ownership over their health care decisions” through health savings accounts, cost sharing and other means.⁷

This approach is not new. The George W. Bush administration also encouraged states to adopt Medicaid policies that included “personal responsibility” provisions.⁸ The idea that poor people should work in order to receive government support has its historical roots in English poor laws first established in the 16th century. As with English poor laws, Republican efforts to incorporate work requirements into Medicaid policy assume that, unless the government compels them to do so, adults who receive government assistance will not make an effort to be productive members of society.⁹ The Trump administration takes this argument even further by arguing that, not only will work requirements encourage responsibility, they will improve health. According to the Verma and Price letter to the nation’s governors, “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.”¹⁰ In other words, they argued that the intent of work requirements was not to limit access to Medicaid benefits, but to improve public health by encouraging Medicaid clients to seek work.

Critics have argued that this rationale is a perversion of the literature on the social determinants of health because it withholds health insurance from those who are at greater health risk due to unemployment.¹¹ Nevertheless, Michigan’s Medicaid expansion rests heavily on this kind of waiver,¹² as do the Indiana and Montana waivers. Indeed, Michigan adopted legislation

that requires Medicaid clients to work at least 80 hours per month and would terminate Medicaid expansion coverage unless the federal government approves the state’s work requirement.¹³

Proponents of this theme also believe that Medicaid enrollees will behave more responsibly if they have some “skin in the game” when making health care decisions (e.g., by paying premiums or copayments). They seek to discourage “inappropriate” care by imposing greater cost sharing when enrollees rely on hospital emergency rooms for non-emergent care. They also seek to use economic incentives as carrots, rewarding enrollees if they engage in certain desired health care behaviors (e.g., by waiving premiums if they get an annual wellness exam) or search for employment.

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As with work requirements, calls for increasing cost-sharing and minimizing the problem of “moral hazard” have a long history in U.S. health policy debates. Moral hazard is the claim that health insurance encourages people to consume more health care because it insulates them against the price of care.¹⁴ Many economists argue that health insurance leads to an inefficient consumption of health care because people continue to consume health care beyond the point that its marginal cost equals its marginal benefit. The hope is “if people have to pay hard money every time they use medical care, they will be forced to consider how much they value each item of care — and they will act more responsibly, buying only what they truly need and can afford.”¹⁵ Although researchers have found that higher out-of-pocket costs lead to lower health care spending,¹⁶ these

studies also find that cost sharing is equally likely to reduce the use of useful, as well as wasteful, health care spending.¹⁷ Equally important, increased out-of-pocket spending places greater burden on people with lower incomes.

As of October 2018, 13 states have submitted Medicaid waivers proposing work or community engagement requirements (Alabama, Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, Michigan, Mississippi, New Hampshire, South Dakota, Utah, Wisconsin). These waiver proposals contain other provisions likely to depress Medicaid enrollments, including reporting requirements that increase the administrative burden on enrollees, longer lockout periods and greater cost sharing for enrollees. A few also include drug testing, time limits and income-based reductions in eligibility for Medicaid from 138 percent of the federal poverty level to 100 percent. To date, CMS has approved four work requirement waivers, all from Medicaid expansion states —Arkansas, Indiana, Kentucky and New Hampshire (but not so far in Arizona and Michigan).

CONCERNS ABOUT WORK REQUIREMENTS

Critics have raised several concerns about the imposition of work requirements on Medicaid beneficiaries. First, although there is a correlation between employment and health, the causal direction is unclear. It is likely that good health leads to employment, rather than the other way around.¹⁸ Second, there is also evidence that people who work in jobs with high levels of insecurity or who perform shift work may suffer from poorer health.¹⁹ Third, eliminating health insurance from people who are currently unemployed could further undermine their health status, and providing people with health insurance is actually likely to encourage work. Rather than attempting to improve public health, the motivation may be a “selective culling of current and future beneficiaries.”²⁰

The Kentucky waiver would apply to Medicaid beneficiaries ages 19-64 who are not primary caregiver of a child or adult with a disability, pregnant, medically frail, a recipient of Supplemental Security Income or institutionalized. All of these individuals would be required to spend 20 hours per week working, volunteering, searching for a job or going to school. In June 2018, a federal district court blocked Kentucky from implementing

its work requirements.²¹ The court argued that the state had not adequately considered whether the work requirements of the waiver actually furthered the goals of the Medicaid program.²² The court’s decision to block the Kentucky waiver was based, in part, on the failure of CMS to allow appropriate public comments.²³

Arkansas, which was the third state to receive approval for a waiver that included a work requirement, became the first state to implement

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this requirement on June 1, 2018. The evidence to date reinforces the concerns of work requirement critics. In the initial phase, the requirement applies to people eligible under the state’s Medicaid expansion who are ages 30-49, with no children under 18 living at home, do not have a disability and do not meet other exemption criteria. These individuals are required to use at least 80 hours a month to work, volunteer, go to school, search for work and/or attend health education classes. During the first three months of implementation, more than 4,000 people lost health coverage²⁴ “because those individuals did not report activities under the new work and community engagement requirement for three months.”²⁵ Although there is not yet enough information about why so many people lost Medicaid coverage, the initial research suggests that a lack of public awareness about the requirement was a contributing factor.²⁶

CONCLUSION

The work requirements that states are pursuing in the context of Medicaid reform reflect attitudes about the poor that have been reflected in policy since the establishment of the modern U.S. welfare state in the 1930s under President Franklin Roosevelt’s administration. The upper tier is marked by “social insurance” programs, such as old-age insurance and Medicare, which was established during President Lyndon B. Johnson’s Great Society domestic programs. They enjoy uniform national benefit levels, and the “beneficiaries” of

these programs usually are viewed as deserving because the programs are funded, at least theoretically, through the contributions that the beneficiaries have made throughout their working lives.

By contrast, the welfare programs established by Roosevelt's New Deal and expanded by Johnson's Great Society, such as Aid to Dependent Children (later Aid to Families with Dependent Children and, since 1996, Temporary Assistance for Needy Families) and Medicaid, are sometimes perceived as government handouts to the poor.²⁷ States are permitted wide latitude in setting benefit levels and eligibility requirements. As Margaret Weir and other have argued, this bifurcation was created in part by powerful interests in the South, motivated by racial bias as well as the prospect for economic gain by depriving black people of adequate welfare benefits.²⁸ The division of social insurance versus welfare policies continues to drive social policy interventions by the federal government.

Using Section 1115 waivers to introduce work requirements for adult Medicaid beneficiaries is a continuation of the effort to limit welfare benefits for some of the poor. As George Washington University Professor Sara Rosenbaum explains, these efforts are part of a larger strategy to attack the welfare state and "deprive millions of the nation's poorest children and adults of basic assistance while slashing hundreds of billions of dollars in federal aid to state and local governments."²⁹ In doing so, the Trump administration and Repub-

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licans at the federal and state level are continuing a campaign to undermine the legitimacy of welfare state policies.³⁰ In an effort to reduce federal and state obligations to financing health care services, they are designing policies based on the

inaccurate presumptions that poor beneficiaries of Medicaid are irresponsibly attempting to avoid work. Rather than promoting public health, these policies are likely to undermine the public health of our communities by eroding health insurance protections that had been expanded to poor adults under the ACA.

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