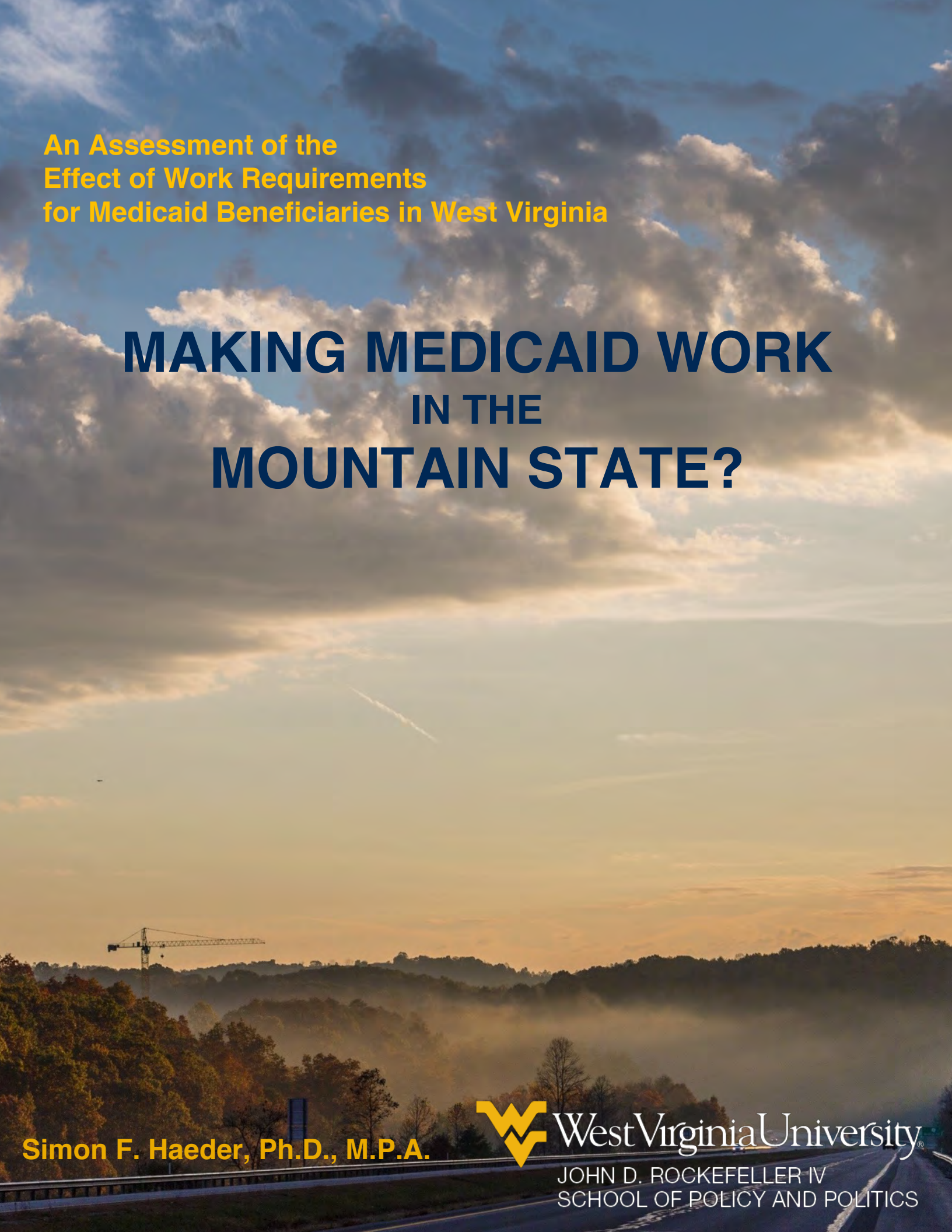

An Assessment of the
Effect of Work Requirements
for Medicaid Beneficiaries in West Virginia

MAKING MEDICAID WORK IN THE MOUNTAIN STATE?

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EXECUTIVE SUMMARY

West Virginia is one of the poorest states in the nation, and West Virginians face some of the highest rates of illness and disability. One of the few bright spots for the health of West Virginians have been government-funded programs like Medicaid and the Children's Health Insurance Program (CHIP). The Affordable Care Act (ACA), including the expansion of Medicaid under Governor Tomblin in 2014, has brought health coverage and access to care to hundreds of thousands of West Virginians. Today, about a third of West Virginians rely on Medicaid, and the program has become the backbone of the state's health infrastructure.

Yet various efforts to transform the Medicaid program, including rolling back the expansion under the ACA or transforming the program into a block grant, pose major challenges to beneficiaries and the state. The most recent proposal, the implementation of work requirements for beneficiaries promoted by the Trump Administration, also falls into this category. Based on this analysis, work requirements would pose a significant challenge for beneficiaries, state government, and the broader health care system in West Virginia.

Work requirements have been touted by proponents for a variety of reasons including as encouraging a "culture of work," prioritizing scarce government resources, providing a way out of poverty for beneficiaries, and undoing the disincentives inherent in public assistance programs. Based on these rationales, work requirements have been implemented in a variety of public assistance programs such as Temporary Assistance for Needy Families (TANF) program, the Supplemental Nutrition Assistance Program (SNAP), and some Section 8 Housing Choice Vouchers or rent subsidies programs. While proponents of work requirements have hailed these developments as vindication, more deliberate analyses raise questions about the overall effects of the reforms. Particularly, assessments of the long-term effects on beneficiaries and their families raise cause for concern.

A number of challenges are inherent to establishing work requirements in the Medicaid program. These challenges make their implementation in an effective, efficient, and equitable manner a dauting task. These include:

- defining covered populations and exemptions
- defining work and community engagement
- developing infrastructure and bureaucratic capacity
- establishing reporting requirements
- defining sanctions and loss of coverage
- developing work supports and work incentives
- protecting beneficiaries and populations with vulnerabilities
- addressing cumulative challenges of out-of-pocket costs and health behavior incentives
- reducing effects on the larger health care system and other support systems

- accounting for other efforts to curtail public assistance

Not surprisingly, most states seeking work requirements for their Medicaid program have only paid limited attention to these tasks. Great care must be taken by policymakers to avoid unintended consequences and inequities.

Applying other states' work requirements to the West Virginia context illustrate the potentially wide-reaching consequences for the state. Based on the U.S. Census Bureau's 2016 American Community Survey (ACS) this analyses finds that a Kentucky-style work requirement, i.e. a work requirement applicable to the entire Medicaid population from ages 19 to 65, with certain exemptions for the disabled, students, caregivers of children or people with disabilities, would affect more than 200,000 West Virginians. Of these, 70,000 would be exempt, 36,000 are working and in compliance with the requirements, 17,000 are working but not in compliance with the requirements, and 78,000 are neither working nor in compliance with the requirements. Based on experience in other public assistance programs and the implementation of work requirements in Arkansas, coverage losses for non-exempt individuals alone could range from 66,000 to 112,000 West Virginians under a Kentucky-style approach. Alternative scenarios developed based on different childcare exemptions and work efforts required estimate coverage losses as high as 144,000 for non-exempt individuals.

A number of barriers would make it particularly challenging for West Virginia's beneficiaries to comply with work requirements. These includes limited educational attainment, health limitations, and limited access to transportation, phone, and internet. Moreover, most jobs obtainable by beneficiaries generally do not offer health benefits. High level of unemployment, labor surpluses, and high rates of persistent poverty point to the often limited demand for labor across the state. State government would also face significant financial exposure including costly IT upgrades, as well as the need to significantly augmented its administrative capacity to establish and implement the program. Finally, a reduction in the influx of federal Medicaid funding and ensuing coverage losses would pose tremendous challenges for health care providers, particularly those in the state's most rural areas. Payment reductions would leave a deep mark on the state's economy.

Taking away medical coverage runs contrary to the goal of alleviating poverty and transitioning Medicaid beneficiaries into stable work environments. An expert consensus has emerged that universally emphasizes the strong positive effects that sustained health coverage has in supporting the work efforts of beneficiaries. Perhaps most concerning, a work requirement may cause significant harm to populations with vulnerabilities, even if they are technically exempted from them.

Several other options exist, however. Strengthening the state insurance market by implementing a state-based individual mandate, establishing a reinsurance program, and restricting short-term, limited duration health plans would reduce premiums and increase

coverage, as would an expansion of the Children's Health Insurance Program and a dedicated outreach and enrollment campaign during open enrollment for the Affordable Care Act's marketplace. Efforts to create healthier environments and lifestyles including higher tobacco and soda taxes and access to clean air and water are equally crucial, as are efforts to combat the rampant opioid epidemic.

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High Levels of Poverty, Poor Health

West Virginia has long been one of the poorest states in the nation. Inherently related to the poverty experienced by West Virginians are poor levels of overall health. Indeed, the state scores worse than the national average on virtually every health-related measure, and usually falls into the bottom decile. Countless statistics, including those on disabilities, pre-existing conditions, and addiction are illustrative of West Virginians poor health. They are perhaps best summarize in the overall health index created by the Social Science Research Council in which West Virginia scores second lowest in the nation.[1]

One of the few bright spots for the health of West Virginians have been government-funded programs like Medicaid and the Children's Health Insurance Program (CHIP). Not surprisingly, poor health and poverty have combined to make West Virginia into a state with some of the highest public coverage rates in the nation. Before the Affordable Care Act,[2, 3] access to Medicaid was decidedly limited by largely excluding non-parents and even some children living in or near poverty. Governor Tomblin moved to expand the West Virginia Medicaid program, once the Affordable Care Act allowed such expansion on January 1, 2014, up to 138 of the Federal Poverty Line (FPL). Initial expectations were that only an additional 91,500 West Virginia would obtain coverage through the Medicaid expansion.[4] Yet, estimates have proven to dramatically miscalculate potential enrollment. Indeed, newly eligible individuals accounted for more than 160,000 beneficiaries alone.[5] Moreover, the so-called woodwork effect, the enrollment of previously eligible individuals who were not enrolled, increase enrollment by tens of thousands of West Virginians more.[5] Expanding Medicaid has thus led a tremendous increase in the number of West Virginians benefiting from the program. Overall, the number of beneficiaries increased from 354,444 in the July-September average in 2013 to 557,580 by July 2017.[5]

While enrollment in Medicaid accounts for about 30 percent of the population statewide, several counties in the state fall significantly above this line. Indeed, four counties, McDowell, Marion, Mingo, and Morgan, have Medicaid coverage rates above 50 percent, while in another 10 counties, coverage rates exceed one third of the population.

As of September 2018, more than 30 states and the District of Columbia have followed the path of West Virginia to expand their Medicaid programs under the Affordable Care Act. In return for their expansion of the program, the Obama Administration proved quite flexible in working with Republican-governed states,[6, 7] offering generous concession such as requiring certain beneficiaries to pay premiums or fulfill certain wellness requirements.[7-9] Yet in line with previous administrations and Medicaid's historical focus on providing health services to its

beneficiaries, the Obama Administration categorically rejected any effort to impose work requirements on Medicaid beneficiaries under so-called 1115 demonstration waivers. These waivers allow states to make changes to their Medicaid programs that temporarily omit certain requirements of the Medicaid statute, and test new approaches to providing coverage to their populations. Historically, these waivers have been used to expand coverage and benefits. As stated in the rejection letter to Arizona's 1115 waiver request, work requirements "could undermine access to care and do not support the objectives of the program."[10]

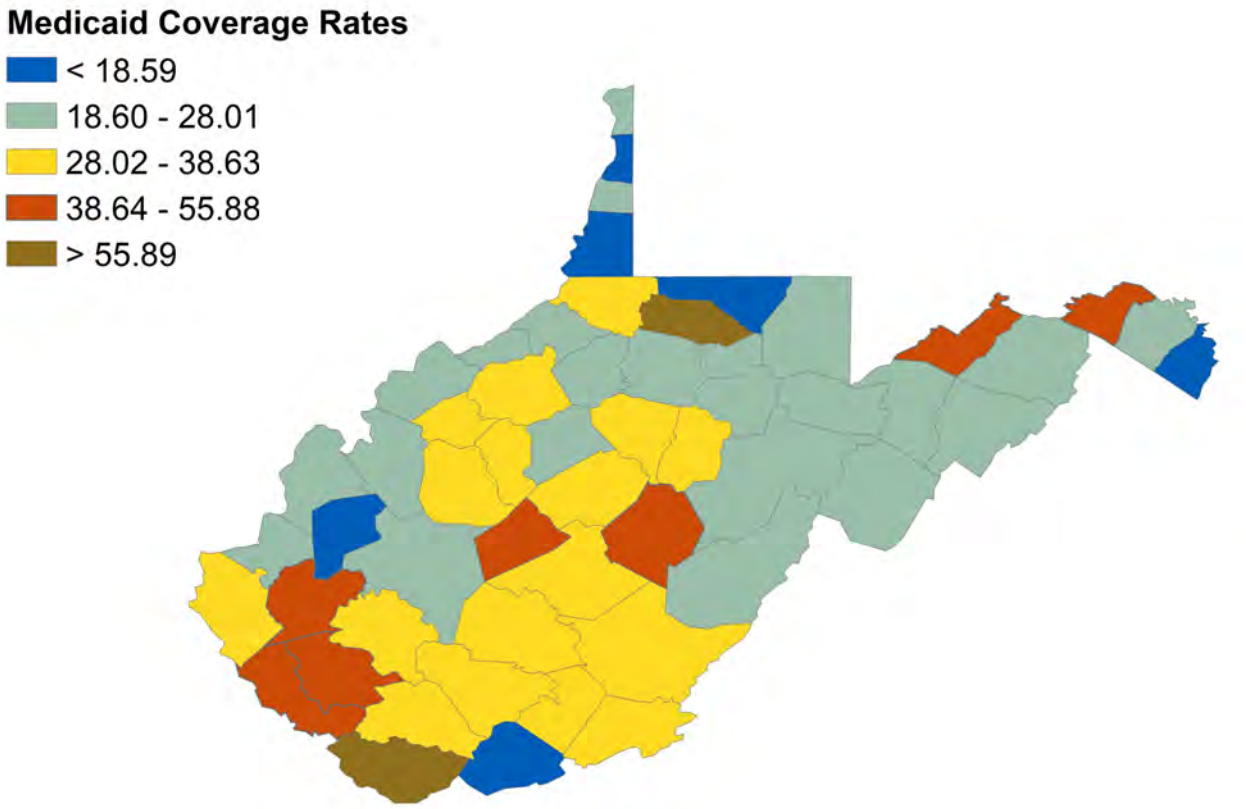

Figure 1: West Virginia Medicaid Coverage Rates by County

Trump Administration and Work Requirements in Medicaid

Under the Trump Administration, CMS has moved away from the decades-long bipartisan consensus on using 1115 waivers to expand coverage and benefits. Indeed, CMS has argued that work requirements are "likely to assist in improving health outcomes;...address behavioral and social factors that influence health outcomes;...incentivize beneficiaries to engage in their own health care and achieve better health outcomes; and...familiarize beneficiaries with a benefit design that is typical of what they may encounter in the commercial market and thereby facilitate smoother beneficiary transition to

commercial coverage."[11] However, a broad scholarly consensus raises concerns about CMS' interpretation of empirical findings.[12]

Nonetheless, CMS is committed to moving forward with the implementation of work requirements in the Medicaid program. As CMS Administrator Verma put it "Let me be clear to everyone in this room, we will approve proposals that promote community engagement activities," i.e. participation in work, training, educational, or volunteer opportunities.[13] As a results, CMS has received more than a dozen 1115 waiver requests seeking to implement some sort of work or community engagement requirement from states likes Kentucky, Wisconsin, Arkansas, Arizona, Indiana, Kansas, Maine, New Hampshire, Utah, and Michigan. Several other states including South Dakota are preparing waiver requests. By now, some of these request, including those from Kentucky, Arkansas, Indiana, and New Hampshire, have been approved by CMS. However, the only one currently in place is in Arkansas, as Kentucky's request has been invalidated by court order, and those from Indiana and New Hampshire have yet to be implemented.

In the wake of the Kentucky ruling, CMS has acknowledged that statutory changes may be necessary to implement work requirements in Medicaid.[14] However, CMS leadership has voiced strong and continued support for the concept,[15] and Health and Human Services Secretary Alex Azar has indicated that CMS will continue to approved 1115 waiver requests.[16] Recently, CMS also reopened the regulatory comment period for the Kentucky waiver.[17, 18]

Rationale Behind Work Requirements

The efforts to impose work requirements for Medicaid beneficiaries comes on the heels of similar efforts across a broad range of other public assistance programs. Four major arguments have traditionally been brought forward to support work requirements.[19, 20]

First, proponents have argued that public programs should encourage a "culture of work" instead of a "culture of dependency."[21] This argument carries particular weight in the United States and its historically underdeveloped welfare state.[9] Yet, the argument is complicated by the apparent racial undertones and connotations in many of the arguments.[22] Nonetheless, it broadly resonates with the American public, as standard surveys of Americans strongly support this undifferentiated line of argument.[23]

Second, many proponents of work requirements emphasize the limited available resources governments have at their disposals.[24] As a result, they argue that public programs should focus on those most in need. This reasoning has been further strengthened in the climate of austerity that has emerged in the aftermath of the Great Recession. Rising government deficits and cuts to other programs like education have further contributed to this notion.

Third, proponents argue that public programs should help beneficiaries escape poverty, i.e. they should serve as a "hand up" and not as a "hand out."[25] As American social programs have traditionally been funded at very low

level, beneficiaries of these programs, by definition, are virtually unable to lift themselves out of poverty if they have to exclusively rely on government support. Work programs then are meant to temporarily support beneficiaries in their transition out of public social programs.

Finally, and perhaps the theoretically strongest argument, critics of social programs have pointed out that many American social programs create strong disincentives for beneficiaries to seek work and transition out of the program.[20] With strict and inflexible eligibility criteria, often even small increases in income may lead to an immediate loss or significant reduction of benefits. In many cases, beneficiaries are thus worse off financially when they work. Hence work requirements are meant to serve as offsetting the disincentives inherent in many public assistance programs.

WORK REQUIREMENTS IN PUBLIC ASSISTANCE PROGRAMS

As aforementioned, various public assistance programs have seen the implementation of work requirements in the past, and efforts are underway to further strengthen these requirements at the federal level.[20, 26]

For example, in the Supplemental Nutrition Assistance Program (SNAP) states may choose to make employment or training mandatory.[19, 20] While there are no general work requirements currently imposed on those receiving Section 8 Housing Choice Vouchers or rent subsidies, some local housing authorities administering these programs have imposed time limits and work requirements locally.[19, 20]

Yet work requirements have featured most prominently in the Aid to Families with Dependent Children (AFDC) program and its post-reform transformation, the Temporary Assistance for Needy Families (TANF) program. Signed by President Clinton in 1996, the Personal Responsibility and Work Opportunity Act (PRWOA) dramatically transformed the nation's premier public assistance program by imposing strict work requirements and time limits for beneficiaries. The resulting changes can only be described as transformational. On the heels of PRWOA, the nation has seen a dramatic decline in the welfare case load.[27-29]

While proponents of work requirements have hailed these developments as vindication for their support, more deliberate assessments have raised questions about the overall effects of the reforms. For one, there is strong evidence that a significant reduction in caseload was a direct result of the strong economy in the late 1990s,[19] as well as the expansion of the Earned Income Tax Credit.[27] Additionally, there is also evidence that a major portion of the reduction of the welfare load has been the results of eligible individuals being diverted and not enrolling in the program in the first place.[28, 30-32] Indeed, the percentage of eligible individuals enrolled in the program was cut in half, from just above 80 percent to just above 40 percent, from 1994 to 2009.[19] Some states have further encouraged this behavior by establishing short-term support programs that divert eligible participants. Beneficiaries have also been shown to stay on the program for shorter periods.[19] At the same time, the most recent studies have indicated only modest work participation for TANF beneficiaries despite large case load reductions.[19, 20, 33]

When it comes to experience of individual beneficiaries, more causes for concern emerge. While initial studies appear to show positive effects for participants and governments alike, long-term studies question the effectiveness of the program, and thus the effect it has had on America's poor. Indeed, most employment and income gains have proven ephemeral.[29, 34] Individuals who were subject to work requirements generally only found entry-level, low paying job.[20, 28, 33-36] Beneficiaries have also not transitioned into better paying jobs over time,[34] and continue to struggle with housing and food security.[35] Importantly, these individuals are often stuck in jobs that do not provide crucial

benefits like employer-provided health insurance.[33, 34] Moreover, employment is often impermanent and highly unstable.[19, 20, 27, 28] Notably, studies have found no hard evidence for sustained reductions in poverty levels for beneficiaries.[19, 20, 28, 29, 34, 35] Critically, studies also indicate a commensurate decline in participation in other assistance programs.[28, 35] Enrollment into TANF may thus have previously served as a connector to other crucial support programs like SNAP and housing.

Findings are particularly concerning for those confronted with significant employment barriers such as chronic health conditions, low job skills, and low education status.[28, 34] Minorities appear to also be disproportionately affected.[20] Similar findings have emerged for those suffering from addiction or domestic violence, or those in need of childcare.[20, 33] Perhaps of greatest concern is evidence that for a significant portion of those beneficiaries forced off public assistance the result has been a slide into deep and persistent poverty.[34, 37] These individuals have also shown to be the disproportionate subjects of sanctions for failure to comply with program requirements.[28]

However, a consensus has emerged that universally emphasizes the strong positive effects that sustained health coverage has in supporting the work efforts of beneficiaries.[28] Recent studies assessing the effect of the Medicaid expansions have strongly affirmed these findings.[33]

Important lessons can be drawn from previous experiences with other public assistance programs. However, establishing and implementing work requirements in health programs entails a set of additional challenges. Even beyond the complex and unclear legal environment, states are confronted with arguably far greater challenges in implementing work requirements in an effective, efficient, and equitable manner.

CHALLENGES IN CREATING WORK REQUIREMENTS

Defining Covered Populations and Exemptions

Deciding Which Populations to Cover

If a state decides to move down the path towards work requirements, the first crucial question to answer is which parts of its Medicaid population should be subject to them. States that have expanded their Medicaid program under the Affordable Care Act, have to decide whether to seek work requirements for only the expansion population or whether requirements should affect their entire population. However, while only certain beneficiaries may technically be subject to work requirements per se, it is crucial to understand that the effects of work requirements inevitably ripple through the state's entire Medicaid program. Ultimately, both beneficiaries and implementing agencies will be confronted with new and challenging issues, with the potential to negatively affect beneficiaries exempted from any requirements, as well.

Particular Concerns for Non-Expansion States

There are additional concerns for those states which have failed to expand their Medicaid programs.[38] With eligibility limits often well below the Federal Poverty Line, virtually any increase in income may directly force beneficiaries off the program and thus off health insurance. Some states have included a transitional component in their 1115 waiver requests that would allow them to provide either financial assistance to purchase coverage on the insurance marketplace (South Dakota[38, 39]) or remain on the Medicaid program for a period of time (Mississippi[40]). However, these approaches are inadequate and likely to provide only symbolic help to beneficiaries. Notably, given the limited access to employer-sponsored insurance in many low-paying jobs, transitional programs may also be necessary for individuals above the poverty level.

Deciding Whom to Exempt

Next, states are confronted with the challenge of deciding which individuals within their target populations should be exempted from work requirements. Relatedly, states must decide how frequent exemption certification needs to be sought. States with waiver requests have generally agreed that only "able-bodied" individuals should be the subject of work requirements. However, many states have failed to offer a clear definition in their waiver requests, while states like Wisconsin and Maine have chosen to exempt only beneficiaries too frail to work at all.[41] One of the strictest definitions would extend exemptions only to beneficiaries with Social Security Income (SSI). However, SSI eligibility criteria are rather limited, and this definition may inadvertently push many ill or disabled individuals off the program.

There is also no general agreement whether certain age groups, for example the young or the old, should be exempted. Similar questions emerge for students, caregivers, pregnant women, mothers and fathers, those suffering from catastrophic events, those on unemployment compensation, those suffering from mental illness, and victims of domestic and sexual abuse, just to

name a few. A particular challenging issue emerges for individuals with substance abuse problems. One state, Wisconsin, is even seeking to allow substance abuse screenings as part of its pending waiver application. States must then decide how to proceed upon a positive test result, i.e. whether to provide treatment or deny coverage. Overall, the issuing and handling of temporary exemptions will thus be particularly challenging, with large potential for inadvertent coverage losses.

Finally, states must consider whether to grant exemptions to certain regions or localities based on local economic conditions or events such as natural catastrophes.[42]

Deciding on Presumptive Eligibility

Even once decisions on exemptions have been settled upon, states must still decide whether beneficiaries should be temporarily presumed exempt until a full certification process can be completed by the responsible state agency. Conversely, states could require potential beneficiaries to comply with work requirements even before enrollment can occur.

Defining Work and Community Engagement

Once the issue of covered populations and exemptions is addressed, states need to decide on definitions for work and community engagement. Again, states with waiver requests vary widely on the issue. Compliance can be achieved, for example, through employment, job search, job training, volunteering, and educational activities.

Next, states must decide how many hours beneficiaries are responsible for completing per week, month, quarter, or even year. This task is particularly crucial because many beneficiaries subject to work requirements are in industries that are highly unstable and dynamic.[43, 44] This means that they could overcomply in a given period, but fall short in another, calling for large amounts of flexibility in determining compliance.

States have found it challenging and inherently costly to develop the administrative support systems to account for work activity. Kentucky, for example, had to move away from a graduated flexible approach because of severe administrative problems.[33, 45, 46] Nonetheless, it has been estimated that the state needs to track more than 140 million hours annually.[47] Arkansas, on the other hand, has put the entire burden on beneficiaries by only allowing for online certification of compliance.[45] Thousands of beneficiaries, many of whom appear to have struggled with the online submission system, have already lost coverage and are unable to requalify until January 1, 2019.[48] This comes on the heels of more than 60,000 beneficiaries losing coverage over the past 18 months due to administrative scrubbing in the state.[49]

Related to this decision, a state must decide whether to put restrictions on any one compliance activity on a monthly or global basis. For example, a state may allow job search and training activities to make up the entire requirements for any three months in a given year or for 50 percent of the work requirement in a given month.

Developing Infrastructure and Bureaucratic Capacity

Work requirements are generally challenging to administer because they require a significant investment into information technology and bureaucratic manpower. The challenges are stark and resemble and exceed those of the implementation of state and federal insurance marketplaces under the Affordable Care Act.[8]

Policy decisions must be reached about what counts as compliance and who is subject to these requirements. Moreover, states must decide about reporting intervals, i.e. the frequency that beneficiaries must report their compliance. Implementation then requires the adjustment of often outdated eligibility systems, finding ways to certify compliance and exemptions, and reaching out to current and potential beneficiaries to disseminate information and requirements.[50] In many cases, states will see the need to contract with IT vendors to make necessary upgrades. States must also be mindful to comply with requirements under the Americans with Disabilities Act[50] and train caseworks in the new processes and guidelines.[50] Perhaps most challenging will be the need to alter agency missions and culture to come in line with newly defined agency goals and objectives.

Not surprisingly, only a limited number of states have provided cost estimates for these efforts. Most prominently, Kentucky estimates to spend hundreds of millions of dollars to implement its work requirements.[45, 46, 50] Costs are expected to be $121 million by 2020 and $163 million by 2021.[45, 46] Estimates for Pennsylvania were as high as $600 million,[50] while those for Alaska were as high as $80 million over 6 years with an additional $14 million in ongoing expenses.[50] Tennessee expects close to $40 million in costs.[51, 52]

Minnesota provided some of the most detailed analyses of expected costs. The state estimated that it would take on average 53 minutes to process an exemption, 22 minutes to refer a client to employment and training, and 84 minutes to verify non-compliance and suspend the client from the program.[45, 50]

Particularly problematic is the fact that most of these efforts and expenses will be ongoing and are unlikely to diminish over the course of implementation.

Recently, Fitch Ratings offered the first glimpse of the excessive implementation costs of work requirements in Kentucky. As assessed by Fitch, the state's Medicaid administrative costs escalated by a striking 40 percent.[53]

Many states have wholly omitted estimates for administrative costs from their requests. Others have deliberately pushed the burden onto the beneficiaries, further exacerbating potential disenrollments for compliance and reporting failure. As mentioned above, Arkansas serves as a particularly concerning example by solely allowing verification via the internet and during limited hours of the day, with state officials estimating costs at a mere $7 million per year for close to 300,000 beneficiaries.[45, 54] Given that the state has some of nation's lowest rates of internet access, it is not surprising that

early indications from the state point to severe problems with this approach.[48, 55]

Reporting & Defining Sanctions and Loss of Coverage

States must also decide what happens to beneficiaries who fail to come into compliance. This includes decisions about the severity and length of sanctions. Moreover, states must decide whether sanctions escalate for repeat offenders, including whether these beneficiaries receive warnings before punitive sanctions are applied. States must further determine what happens to other members of the beneficiary's household, including spouses and children, and what efforts to undertake to assure their wellbeing. Finally, states need to resolve how many non-compliance events will result in a complete loss of coverage, i.e. when beneficiaries are completely locked out from Medicaid. In Arkansas, for instance, beneficiaries will lose coverage for three events in a given year.[45]

In order to preserve beneficiary due process rights, states must also establish an effective and efficient appeals process. Failure to do so will expose states to significant and protracted legal risks from disenrolled beneficiaries.

Finally, some states like Kansas even proposed to strictly limit lifetime access to the Medicaid program, similar to the lifetime restrictions under TANF. These requests have been rejected by CMS so far, and are unlikely to withstand legal review.

Developing Work Supports and Work Incentives

A large number of studies point to the importance of work supports, i.e. programs that support beneficiaries in gaining and maintaining work. One of the main stated rationales behind work requirements is the supposed goal to reduce dependency, and to help beneficiaries become and remain self-sustaining. This is, of course, ironic because of the importance of having health coverage as a crucial work support.[12, 56] Moreover, many other work supports such as SNAP, housing vouchers, and general assistance are by themselves already subject to work requirements.

Importantly, CMS has plainly stated that no Medicaid funding can be used to provide any work supports.[57, 58] This is problematic, as there is now ample evidence that in order to lift many beneficiaries of public programs out of poverty in a sustained fashion, significant investments in the range of $7,500 to $14,000 per individual are often necessary.[34, 59] Programs, like the *Building Nebraska Families Program*,[60] the *Per Scholas* job training program,[61] the *VIDA* training program,[62] and the *QUEST* program,[63] have been evaluated using randomized controlled trials, the gold standard in evaluation research. These programs have led to persistent and substantive income and employment effects, albeit at high rates of initial investment.

States must also decide whether to further encourage employment uptake by allowing beneficiaries to be shielded from benefit losses due to increased

income.[19, 28] Proven approaches include allowing beneficiaries to deduct job-related expenses like travel and childcare from their eligibility determination. The state could also allow newly-employed beneficiaries whose income would lead to disenrollment guaranteed access to Medicaid and CHIP for a predetermined length of time without regard to income.

Alternatively, the state could also invest into a robust navigator program that supports individuals in enrolling into the Affordable Care Act's insurance marketplaces, similar to the successful efforts of Covered California, California's state-based insurance marketplace.[64, 65] This program could be paired with a sustained, community-based outreach and enrollment campaign to encourage eligible individuals to enroll through healthcare.gov. Transitioning to a state-based platform, as currently underway in Nevada, may also help to facilitate administrative streamlining and eligibility determination across programs.

Finally, establishing a state-based Earned Income Tax Credit (EITC) could complement these approaches as the EITC has been proven incredibly effective in lifting families out of poverty by encouraging employment.[66]

Protecting Beneficiaries and Populations with Vulnerabilities

In addition to the generally detrimental effects of work requirements on beneficiaries described above, studies have also found that there are persistent administrative and bureaucratic obstacles in implementing and maintaining these programs. [29, 33] A particular challenge appears to be the effective and efficient administration of exemptions and compliance verification, with often detrimental and lasting effects on beneficiaries.[33] Previous evidence from studies of administrative burdens provide strong evidence that even individuals who fulfill the underlying program requirements often find themselves losing benefits, at least on a temporary basis. Beneficiaries often do not fully understand program rules and what exactly is expected of them.[67] Due to the complex nature and vagueness of exemptions, beneficiaries often need help navigating the process.[68] Moreover, beneficiaries often face a slew of personal barriers and impediments including lack of transportation or internet access.[69]

Work requirements, as well as premiums and frequent recertification demands, often trigger a process referred to as "churning," the disenrollment from a program followed by eventual re-enrollment.[70-72] Churning creates significant costs to both administrator and beneficiary, while endangering program goals. For beneficiaries, various studies have indicated a strong negative effect on their financial and physical health. Findings show that particularly individuals living in poverty and those with lower education attainment are negatively affected.[71, 73] Studies of health-specific public assistance programs also point to large and sustained reductions in enrollment in the wake of adding further administrative requirements.[70-75]

One of the most concerning issues revolves around how to protect the children of parents subject to work requirements, particularly those facing

sanction or even loss of coverage. Strikingly, there have been significant negative effects for the children of individuals subject to work requirements in other public assistance programs. By now, there is solid evidence that children suffer when parents lose coverage because parents without coverage of their own are less likely to maintain enrollment for their children, and because parents are less likely to seek care for them.[38, 76] Studies also indicate that work requirements in TANF led to a reduction in breastfeeding,[77] modest reductions in prenatal care and increased risk of low birth weight,[78] and to increases in children entering foster care.[79]

Particular concerns also emerge for individuals suffering from mental illness or substance abuse problems, both in cases when technically in compliance but failing to complete administrative requirements, and when out of compliance and in sanction.[56] The same holds for the homeless, the disabled and the severely ill. More generally, protecting those of ill-health and disability proves a formidable challenge, as a remarkable 70 percent of people below 200 percent of the federal poverty level report fair to poor health or having one or more chronic conditions; this percentage climbs to 83 percent by age 55.[41, 80]

Out-of-Pocket Costs and Healthy Behavior Incentives

In addition to work requirements, many states have decided to include other components like premiums, co-payments, deductibles, and healthy behavior incentives in their 1115 waivers. As mentioned above, these elements are likely to pose further administrative burdens to beneficiaries, resulting in large coverage losses.[70-75] Some of these predate the requests for Medicaid work requirements. As described above, several of these were approved under the Obama Administration in an effort to encourage the expansion of Medicaid by Republican states. However, several states are moving to further strengthen these components. For example, Kentucky recently sought to establish premiums up to 4 percent of income for certain beneficiaries,[81] while Michigan is currently seeking premiums up to 7 percent of income.[82] Unfortunately, studies have illustrated the negative effects of these components for beneficiaries without any commensurate positive outcomes.[12] States seeking to establish work requirements in these contexts need to be mindful of the cumulative effect on their Medicaid populations and health systems.

Reducing Effects on the Larger Health Care System and Other Support Systems

Due to the large number of individuals affected, work requirements are likely to have significant effects on a state's entire Medicaid program, and even its entire health care system. In Kentucky, state officials estimated that close to 100,000 Kentuckians would be disenrolled from Medicaid over the first 5 years.[45, 46] In Michigan, coverage losses above 50,000 are expected.[83] However, outside expert estimates put coverage losses significant higher, at times in the range of 50 to 85 percent of affected beneficiaries.[12] In Kentucky, this would result in about 175,000 to 300,000 beneficiaries losing coverage in the first year alone. Naturally, the medical needs of these individuals are unlikely to diminish, and they thus will still require medical care.

However, without health coverage via Medicaid, medical providers are at risk for large increases in bad debt, and charity and uncompensated care.[84, 85] A major burden will fall onto public and essential hospitals as well as federally qualified health centers. A number of these may not able to cope with the financial strains, leading to closures, particularly in rural areas.[86]

Decisions made in a neighboring state may also put pressure on health care systems and Medicaid programs. It seems likely that severely sick individuals losing coverage in one state may see themselves forced to migrate to neighboring states with more lenient or no Medicaid requirements. This may create political pressure on neighboring states to follow suit, cascading into a "race to the bottom," i.e. states seeking to subsequently reduce benefits to avoid becoming "welfare magnets."[86]

Moreover, reduced coverage rates entail significant reductions in overall provider payments, and thus create significant effects on state economies. In Kentucky, federal funding for the state was expected to be reduced by $700 million annually by 2021.[87] These large reductions in financial resources will likely hit the state's entire health care system and spread into local economies. Again, damages might be most severe at hospitals with high Medicaid rates or in rural areas. At the same time, medical providers will be tasked with providing, in many cases repeatedly, certifications for exemptions from work requirements. It is unclear who will bear the financial burden of these exams and whether beneficiaries will be required to participate financially.

Finally, repercussions will be felt outside the health care system. With large numbers of beneficiaries losing coverage, pressure may be put on ancillary support systems like food banks and homeless shelters, many of which may be unprepared for the influx of needy.[88]

Other Efforts to Curtail Public Assistance

Developments surrounding work requirements in Medicaid should be viewed in conjunction with the larger policy and political environment confronting public assistance and support programs.[89] Republicans at the national level have moved decisively towards curtailing social safety net programs ranging from Medicare to SNAP.[90] The Medicaid program itself continues to be confronted with severe financial threats in the form of the undoing of the Medicaid expansion,[91] as well as the elimination of its entitlement status with the commensurate shift towards per capita limits or block grants.[92] Litigation[93] and potential statutory changes[89] further threaten crucial components of the Affordable Care Act. Even popular programs like the Children's Health Insurance Program have faced threats.[94] Should any of these efforts be successful, states would be confronted with overwhelming changes to their health care system.[95] Adding work requirements into this mix would further complicate an already complex the situation.

ANALYSIS OF POTENTIAL WORK REQUIREMENTS IN WEST VIRGINIA

Currently, the State of West Virginia has not moved to include work requirements in a potential 1115 waiver. However, West Virginia's Department of Health and Human Resources, the state agency administering the state's Medicaid program, has previously expressed interest in doing so. Going forward, two developments are plausible. One, the legislature or the Justice Administration could move towards the implementation of work requirements in West Virginia's Medicaid program at any time. This holds particularly true if current lawsuits are settled in favor of CMS. Moreover, Congress, similar to the changes made to the Temporary Assistance for Needy Families program in the 1990s, may move to require work participation and community engagement as part of the Medicaid program, leaving states no choice but to implement them.

While details of a potential work requirement in West Virginia are thus unclear, the 1115 waiver from bordering Kentucky serves as a reasonable example of what a West Virginia waiver could look like. For one, Kentucky's economy and demographics are broadly similar to West Virginia. Moreover, both states have expanded their Medicaid program and rely on the federal government for their ACA insurance marketplace platform. Finally, both neighboring states share many commonalities in terms of ideology, politics, and culture.

Kentucky's waiver has several broad outlines. Most importantly, Kentucky requires Medicaid beneficiaries to work or fulfill certain "community engagement" requirements for at least 80 hours per month. Job searches of educational training may bring beneficiaries into compliance. Certain groups will be exempt from these requirements including children under age 19 and adults over age 65. Similarly, those receiving disability benefits, pregnant women, the medically frail, and primary care givers will also be exempt (For further details see Gangopadhyaya and Kenney[96]). Currently, the Kentucky waiver implementation has been halted by federal courts. However, CMS has reopened the public comment period and is actively seeking to alleviate the concerns raised by the courts. Further litigation is likely and the eventual legal outcome remains unclear. Alternatively, as mentioned above, Congress could also make certain statutory changes to circumvent the restrictions raised by the courts.

Data and Methods

Data for this analysis was obtained from the from the U.S. Census Bureau's 2016 American Community Survey (ACS). Specifically, I used the harmonized version provided by the University of Minnesota's Integrated Public Use Microdata Series (IPUMS-USA). I generally follow the approach taken by Gangopadhyaya and Kenney[96] to analyze the Kentucky 1115 waiver. The analysis is restricted to non-elderly adults

who are recipients of Medicaid in West Virginia. Excluded are those Medicaid beneficiaries who also receive Supplemental Security Income (SSI) or Medicare (so-called dual eligibles).

Relying on ACS survey data, I utilized three main criteria to establish whether individuals would be subject to work requirements. First, attending school exempts an individual from the requirement. Second, individuals are also exempt if they serve as primary care givers of a minor, or third, as primary caregivers for an individual on SSI. Notably, only one caregiver per household is allowable under the Kentucky waiver. Information about previous employment in the ACS is further used to determine whether beneficiaries would currently be in compliance with the work requirements. This leads to the categorization of individuals into three main groups:

1) Medicaid Beneficiaries Likely Exempt from Work Requirements
2) Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Working
3) Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Not Working

I further divide Group 2 into two subcategories:

2a) Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Working More than 20 Hours per Week and 50 Weeks per Year

2b) Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Working, But Less Than 20 Hours per Week and 50 Weeks per Year

Both subgroups for Group 2 are obtained as follows. First, I determine whether an individual is currently working. Next, I assess how much the individual worked in the past year. If the individual generally worked 20 hours or more per week and worked for more than 50 weeks, the individual is assigned to Group 2a; otherwise the individual is assigned to Group 2b.

While the ACS serves as an appropriate source of data for this analysis, there are several limitations. Relying on survey data from the ACS does not allow to assess whether individuals conduct enough community service requirements to come into compliance. The ACS also provides only information on school attendance but does not provide enough information on whether attendance is full-time. Moreover, the ACS does not provide information on pregnancy status. There is also no information on an individual's compliance with Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) requirements, which may serve as compliance indicators. The ACS employment information is further limited to whether individuals worked more than 20 hours per week for at least 50 hours in the previous year. Finally, all surveys come with a certain degree of misreporting. This naturally also applies to the ACS. These limitations, in line with those in Gangopadhyaya and Kenney,[96] are nonetheless reasonable, and allow

for an empirically sound picture of the potential effects of work requirements in West Virginia.

Findings

Based on 2016 ACS data, there about 530,000 Medicaid beneficiaries in West Virginia. Of these, about 280,000 are non-elderly adults. About 57,000 beneficiaries further receive SSI, and some 41,000 are dually eligible for Medicaid and Medicare. These groups are exempt from the waiver. Overall, then just over 201,000 West Virginia Medicaid beneficiaries would be subject to work or community engagement requirements under the conditions outlines above.

Those affected by work requirements further divide into the four aforementioned categories as follows (Figure 2). About 70,000 beneficiaries (35 percent) would likely be exempt from work requirements because they are students or primary caregivers. Another 36,000 beneficiaries (18 percent) would likely not be exempt but are in compliance with the minimum work requirements, while some 17,000 (9 percent) are non-exempt and working, but likely do not work enough to come into compliance. Finally, about 78,000 beneficiaries (39 percent) fall into the third group, i.e. they would not be exempt from work requirements, are not working, and thus do not fulfill the compliance requirements.

Table 1 provides detailed information on the four groups subject to work requirements.

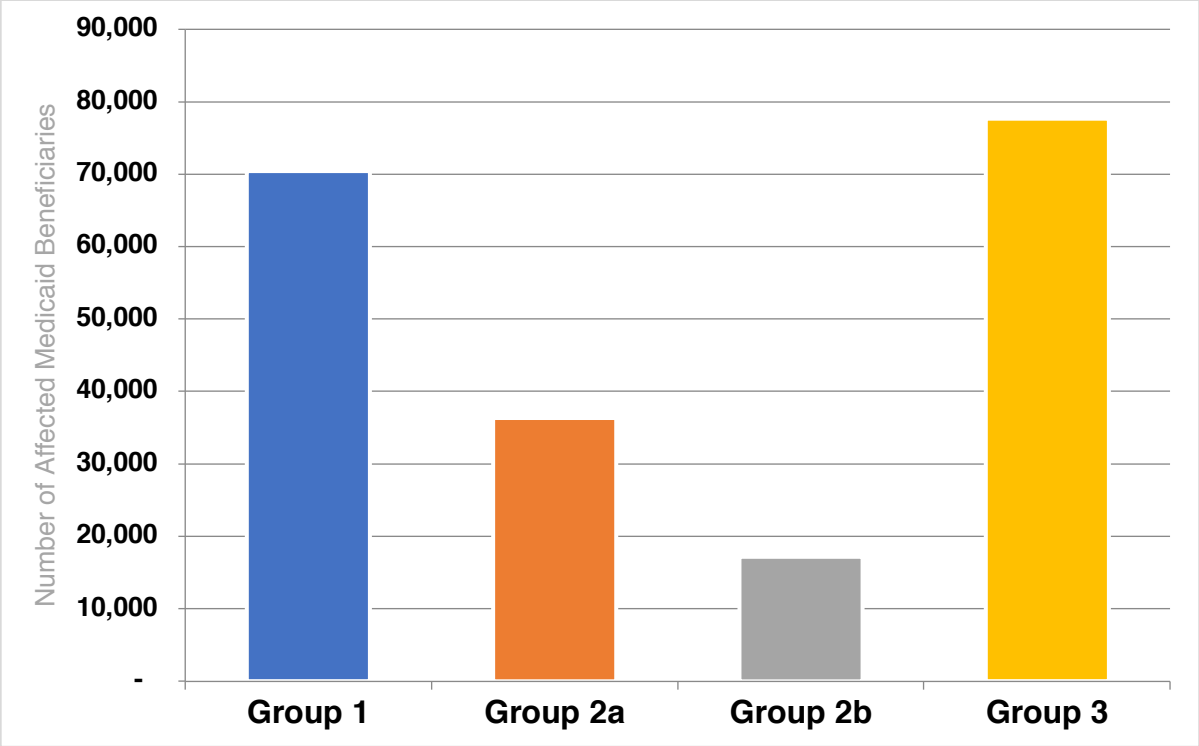

Figure 2: Distribution of Medicaid Beneficiaries by Group

Table 1: Beneficiary Break Down by Group

	All	Group 1 Beneficiaries	%	Group 2a Beneficiaries	%	Group 2b Beneficiaries	%	Group 3 Beneficiaries	%
Overall	201,661	70,435	34.9	36,357	18.0	17,202	8.5	77,667	38.5
Age									
19–29	68,058	30,441	43.2	10,716	29.5	5,505	32.0	21,396	27.5
30–39	51,389	23,555	33.4	10,933	30.1	3,421	19.9	13,480	17.4
40–49	39,813	12,091	17.2	7,551	20.8	5,307	30.9	14,864	19.1
50–64	42,401	4,348	6.2	7,157	19.7	2,969	17.3	27,927	36.0
Race and Ethnicity									
White	186,247	63,602	90.3	33,542	92.3	15,905	92.5	73,198	94.2
Black	9,422	4,839	6.9	1,559	4.3	968	5.6	2,056	2.6
Hispanic	2,009	968	1.4	597	1.6	33	0.2	411	0.5
Gender									
Male	86,916	22,758	32.3	17,549	48.3	7,665	44.6	38,944	50.1
Female	114,745	49,483	68.4	17,760	50.2	9,719	55.5	37,783	49.4
Family Status									
Married	69,740	23,733	33.7	17,017	46.8	8,553	49.7	21,120	27.2
Never married	79,495	29,906	42.5	11,781	32.4	4,883	28.4	32,925	42.4
Divorced, separated, or widowed	52,426	16,796	23.8	7,559	20.8	6,669	38.8	23,622	30.4
Parents of children age 6 and under	61,974	34,070	48.4	11,513	31.7	5,125	29.8	11,266	14.5
Parents of children age 18 and under	106,659	59,050	83.8	19,831	54.5	8,447	49.1	19,331	24.9
Education & Income									
Less than high school education	35,101	8,299	11.8	4,199	11.5	3,012	17.5	19,591	25.2
High school degree	112,442	35,276	50.1	23,260	64.0	9,823	57.1	44,083	56.8
Greater than high school education	54,118	26,860	38.1	8,898	24.5	4,367	25.4	13,993	18.0
Income <50% FPL	55,438	20,249	28.7	2,513	6.9	4,380	25.5	28,296	36.4
Income <100% FPL	100,958	36,905	52.4	11,044	30.4	9,363	54.4	43,646	56.2
Income <138% FPL	128,060	46,727	66.3	19,524	53.7	11,094	64.5	50,715	65.3

	All	Group 1 Beneficiaries	%	Group 2a Beneficiaries	%	Group 2b Beneficiaries	%	Group 3 Beneficiaries	%
Health Limitations									
Reports one or more serious health limitations	40,216	11,368	16.1	3,438	9.5	1,975	11.5	23,435	30.2
Serious difficulty concentrating, remembering, or making decisions	24,406	6,371	9.0	2,086	5.7	1,384	8.0	14,565	18.8
Serious difficulty walking or climbing stairs	24,833	5,579	7.9	2,191	6.0	1,591	9.2	15,472	19.9
Serious difficulty doing errands	15,820	3,387	4.8	625	1.7	875	5.1	10,933	14.1
Serious difficulty bathing or dressing	6,457	1,450	2.1	176	0.5	363	2.1	4,468	5.8
Blind or serious vision or hearing difficulty	13,994	4,687	6.7	1,203	3.3	701	4.1	7,403	9.5
Labor Market									
Usually work at least 20 hours	104,582	38,411	54.5	36,357	100.0	11,821	68.7	17,993	23.2
Usually work at least 30 hours	85,337	30,300	43.0	31,145	85.7	9,134	53.1	14,758	19.0
Worked more than 40 weeks last year	74,235	25,281	35.9	36,357	100.0	6,743	39.2	5,854	7.5
Worked more than 50 weeks last year	62,220	20,263	28.8	36,357	100.0	2,990	17.4	2,610	3.4
Worked at least 20 hours & more than 50 weeks	52,943	16,586	23.5	36,357	100.0	-	0.0	-	0.0
Looking for work	30,324	10,092	14.3	2,105	5.8	-	0.0	18,127	23.3
Not in labor force	86,360	31,071	44.1	366	1.0	154	0.9	54,769	70.5
Internet & Vehicle Access									
Household has no phone access	12,747	4,470	6.3	1,569	4.3	711	4.1	5,997	7.7
Household has no internet access	33,194	7,001	9.9	4,074	11.2	2,532	14.7	19,587	25.2
Household has no broadband (cable/DSL/fiber-optic) internet access	81,052	23,691	33.6	14,109	38.8	6,182	35.9	37,070	47.7
Household has no access to vehicle	28,513	7,557	10.7	4,004	11.0	1,605	9.3	15,347	19.8

Group 1: Medicaid Beneficiaries Likely Exempt from Work Requirements

As described above, Group 1 is comprised of about 70,000 Medicaid beneficiaries. About two thirds of the groups is female, and just over 90 percent are white. In terms of age, close to 43 percent are between 19 and 29, 33 percent are between 30 and 39, 17 percent are between 40 and 40, and 6 percent are between 50 and 64. The vast majority of individuals have children under the age of 18 (84 percent) and more than half have children under 6. Approximately, one third are married, 43 percent have never been married, and 24 percent are divorced, separated, or widowed.

In terms of educational attainment, almost 90 percent of beneficiaries at least finished high school, with close to 40 percent having more than a high school education.

Economically, about two thirds of individuals fall below 138 percent of the Federal Poverty Line, and close to one third fall below 50 percent. At the same time, just over half usually work more than 20 hours per week and more than 40 percent work more than 30 hours. Over the past year, close to 36 percent of individuals in the group worked 40 weeks and just under 30 percent worked more than 50 weeks.

Health is a concern in Group 1. Close to 2 in 10 beneficiaries in the group have at least one serious health limitation. About 9 percent each report "serious difficulty concentrating, remembering, or making decisions," 8 percent report "serious difficulty walking or climbing stairs," about 5 percent report "serious difficulty doing errands," and 7 percent fall into the "blind or serious vision or hearing difficulty" category.

Finally, about 6 percent have no access to a phone while 10 percent have no access to the internet. One third do not have access to broadband internet and 11 percent do not have access to a vehicle in the household.

Group 2: Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Working

As mentioned above, all individuals in Group 2 are actively participating in the labor market. However, not all individuals would be in compliance with the requirement of a Kentucky-style 1115 waiver. Characteristics between the two groups, Group 2a and 2b, are generally similar, although demographics for those individuals in Group 2b are becoming more in line with those in Group 3 in terms of age, income, education, and health limitations.

Compared to Group 1, individuals in Group 2a trend older. Distribution of race and ethnicity are similar. However, this group contains a larger percentage of male beneficiaries, approaching 50 percent. About half of beneficiaries are married while about a third have never been married. Moreover, about 50 percent have children under age 18. Almost two- thirds of beneficiaries in the group at least finished high school, while an additional 25 percent went beyond high school.

In terms of income, just under half fall below 138 percent of the Federal Poverty

Line, while 7 percent fall below 50 percent of it in Group 2a. As aforementioned, individuals Group 2b are somewhat older, poorer, and less educated.

Health limitations are somewhat lower as compared to Group 1 in Group 2a, approaching about 1 in 10, while slightly exceeding that number for Group 2b. Access to phone, internet, broadband internet, and vehicles is slightly improved as compared to Group 1, as well.

Group 3: Medicaid Beneficiaries Potentially Non-Exempt from Work Requirements Who Are Not Working

The general patterns comparing Group 1 to Group 2 are exacerbated in comparison to Group 3, which trends slightly older, more white, and more male than Group 2. Moreover, only about a quarter of individuals are married, while 42 percent have never been married. Additionally, one in three are divorced, separated, or widowed, and only a quarter of individuals have children under age 18; only 15 percent have children under age 6.

Individuals in Groups 3 generally have lower levels of educational attainment, as a quarter did not complete high school, and only 18 percent went beyond high school. This is reflected in income, with about two thirds of individuals falling below 138 percent of the Federal Poverty Line and 36 percent falling below 50 percent. It is also reflected in labor market participation, which, by definition, is limited in this group. Less than a quarter of individuals reported usually working 20 hours or more per week, and less than 20 percent reported working 30 hours or more. Strikingly, only 8 percent worked more than 40 weeks in the past year, and a mere 3 percent worked for more than 50 weeks. Overall, more than two thirds report not being in the labor force.

Health limitations also play an important role in explaining these statistics, as more than 30 percent report suffering from at least one health limitation. Particularly common are limitations with regard to "serious difficulty concentrating, remembering, or making decisions" and "serious difficulty walking or climbing stairs," both of which affect abut 20 percent of individuals. "Serious difficulty running errands" approaches 15 percent.

Finally, individuals in Group 3 also fare worse with regard to access to phone, internet, broadband, and vehicles than all other groups. Strikingly, close to 50 percent of individuals do not have access to broadband internet, and a quarter do not have access to any internet at all. In addition, close to 20 percent do not have access to a vehicle.

Distribution of Groups Across the State

Even a relatively small state like West Virginia exhibits significantly different social, economic, and demographic environments across its various regions (Table 2 and Figure 3). Table 3 presents an overview of the distribution of groups across the state using the U.S. Census Bureau's public use microdata areas (PUMAs). PUMAs are the lowest level of geographic information for which detailed ACS data are available. There are 13 such areas in West Virginia.

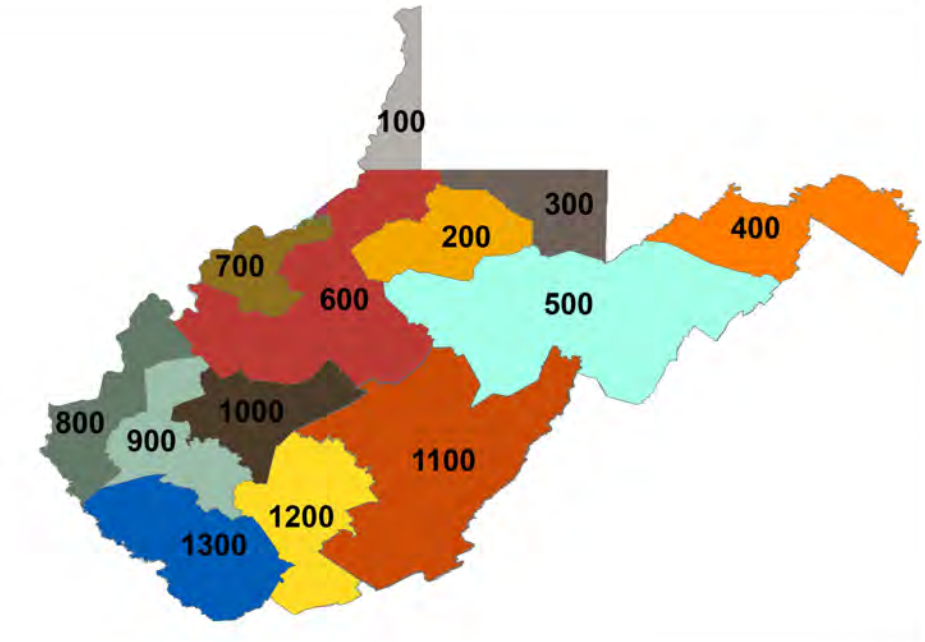

Figure 3: West Virginia Public Use Micro Areas (PUMAs)

Table 2: West Virginia Public Use Micro Areas (PUMAs)

PUMA	Counties
100	Ohio, Marshall, Hancock and Brooke
200	Harrison, Marion, Taylor and Doddridge
300	Monongalia and Preston (Morgantown City)
400	Berkeley, Jefferson, Mineral, Hampshire and Morgan
500	Randolph, Upshur, Barbour, Lewis, Hardy, Grant, Pendleton and Tucker
600	Jackson, Wetzel, Roane, Braxton, Ritchie, Tyler, Gilmer and Calhoun
700	Wood, Pleasants and Wirt
800	Cabell, Wayne and Mason (Huntington City)
900	Putnam, Boone and Lincoln
1000	Kanawha and Clay (Charleston City)
1100	Greenbrier, Nicholas, Summers, Monroe, Webster and Pocahontas
1200	Raleigh, Mercer and Fayette
1300	Logan, Mingo, Wyoming and McDowell

Table 3: Beneficiary Break Down by PUMA

PUMA	Name	Total	Group 1		Group 2a		Group 2b		Group 3	
			Beneficiaries	% of PUMA	Beneficiaries	% of PUMA	Beneficiaries	% of PUMA	Beneficiaries	% of PUMA
100	Ohio, Marshall, Hancock & Brooke Counties	15,007	6,522	43.5	1,802	12.0	1,925	12.8	4,758	31.7
200	Harrison, Marion, Taylor & Doddridge Counties	14,287	4,612	32.3	3,414	23.9	1,620	11.3	4,641	32.5
300	Monongalia & Preston Counties--Morgantown City	10,669	4,334	40.6	2,053	19.2	956	9.0	3,326	31.2
400	Berkeley, Jefferson, Mineral, Hampshire & Morgan Counties	20,444	7,687	37.6	3,432	16.	1,510	7.4	7,815	38.2
500	Randolph, Upshur, Barbour, Lewis, Hardy, Grant, Pendleton & Tucker Counties	13,913	4,401	31.6	2,558	18.4	1,016	7.3	5,938	42.7
600	Jackson, Wetzel, Roane, Braxton, Ritchie, Tyler, Gilmer & Calhoun Counties	12,613	3,771	29.9	1,791	14.2	1,414	11.2	5,637	44.7
700	Wood, Pleasants & Wirt Counties	8,574	3,798	44.3	1,498	17.5	272	3.2	3,006	35.1
800	Cabell, Wayne & Mason Counties--Huntington City	20,190	7,778	38.5	4,671	23.1	1,825	9.0	5,916	29.3
900	Putnam, Boone & Lincoln Counties	10,110	4,100	40.6	1,303	12.9	422	4.2	4,285	42.4
1000	Kanawha & Clay Counties--Charleston City	24,342	6,396	26.3	3,920	16.1	2,679	11.0	11,347	46.6
1100	Greenbrier, Nicholas, Summers, Monroe & Pocahontas Counties	14,475	4,545	31.4	2,397	16.6	1,236	8.5	6,297	43.5
1200	Raleigh, Mercer & Fayette Counties	16,367	6,208	37.9	5,169	31.6	1,198	7.3	3,792	23.2
1300	Logan, Mingo, Wyoming & McDowell Counties	16,981	5,592	32.9	2,120	12.5	825	4.9	8,444	49.7

The percentage of beneficiaries in Group 1 ranges from 26 percent in the Charleston area to 44 percent in Wood, Pleasants and Wirt Counties and the Northern Panhandle, with a regional average of 36 percent. Group 2a ranges from 12 percent in the Northern Panhandle to 32 percent in Raleigh, Mercer and Fayette Counties, with an average of 18 percent. At the same time, Group 2b averages 8 percent regionally, including a low of 3 percent in Wood, Pleasants and Wirt Counties and a high of 13 percent in the Northern Panhandle. Finally, Group 3, averaging 38 percent regionally, ranges from 23 percent in Raleigh, Mercer and Fayette Counties to 47 percent in the Charleston area. Overall, Wood, Pleasants and Wirt Counties have the lowest number of beneficiaries with about 8,500 while the Charleston area has the most, with just over 24,000 individuals. The regional average exceeds 15,000.

Alternative Scenarios

The aforementioned results are based on the assumptions of a Kentucky-style 1115 waiver, i.e. a waiver that provides exemptions for caregivers of children up to age 18 or SSI beneficiaries, and for students. It also requires a work effort of at least 20 hours per week, and applies to the entire Medicaid population. In order to provide some perspective, various alternatives are conceivable. Two important scenarios involve altering the age of children permissible to obtain exemptions, as well as the work effort required. Table 4 provides the relevant statistics for a number of these scenarios, alternating the work effort between 10, 20, and 30 hours per week, as well as allowing for child-based exemptions for children up to ages 1,6, and 18 (see also Figure 4).

Table 4: Distribution of Beneficiaries Subject to Work Requirements Based on Alternative Scenarios

	Work Effort Required per Week	Affected Beneficiaries			
		Group 1	Group 2a	Group 2b	Group 3
Exemption for Children under 19	**10 hours**	70,435	38,662	14,897	77,667
	20 hours	70,435	36,357	17,202	77,667
	30 hours	70,435	31,145	22,414	77,667
Exemption for Children under 6	**10 hours**	50,888	43,767	17,035	89,971
	20 hours	50,888	41,225	19,577	89,971
	30 hours	50,888	35,353	25,449	89,971
Exemption for Children under 1	**10 hours**	32,523	47,911	20,243	100,984
	20 hours	32,523	45,676	22,478	100,984
	30 hours	32,523	39,235	28,919	100,984

Lowering child-based exemptions from age 18 to age 6 or even age 1 significantly alters the number of individuals in the various groups. While just over 70,000 individuals fall into Group 1 if the child-based exemptions is based on children up to age 18, the number drops to 51,000 for age 6, and 33,000 for age 1. At the same time, Group 2 increases from 54,000 to 61,000 and to 68,000 while Group 3 increases from 78,000 to 90,000 and to 101,000 individuals, respectively.

By definition, changes to the work effort required shift individuals only between groups 2a and 2b. Based on a child-based exemption up to age 18 and a required work effort of 20 hours per week, about 36,000 individuals fall into Group 2a, while another 17,000 fall into Group 2b. If the work requirement is reduced to 10 hours 2,300 individuals shift from Group 2b into Group 2a, whereas if the work requirement is increases to 30 hours per week, 5,200 individuals shift from Group 2a into Group 2b. The results for 10 hour work efforts are similar in extent if child-based exemptions are based on ages 1 or 6. However, the number of individuals shifting from Group 2a to Group 2b increases to 5,800 and 6,400, respectively.

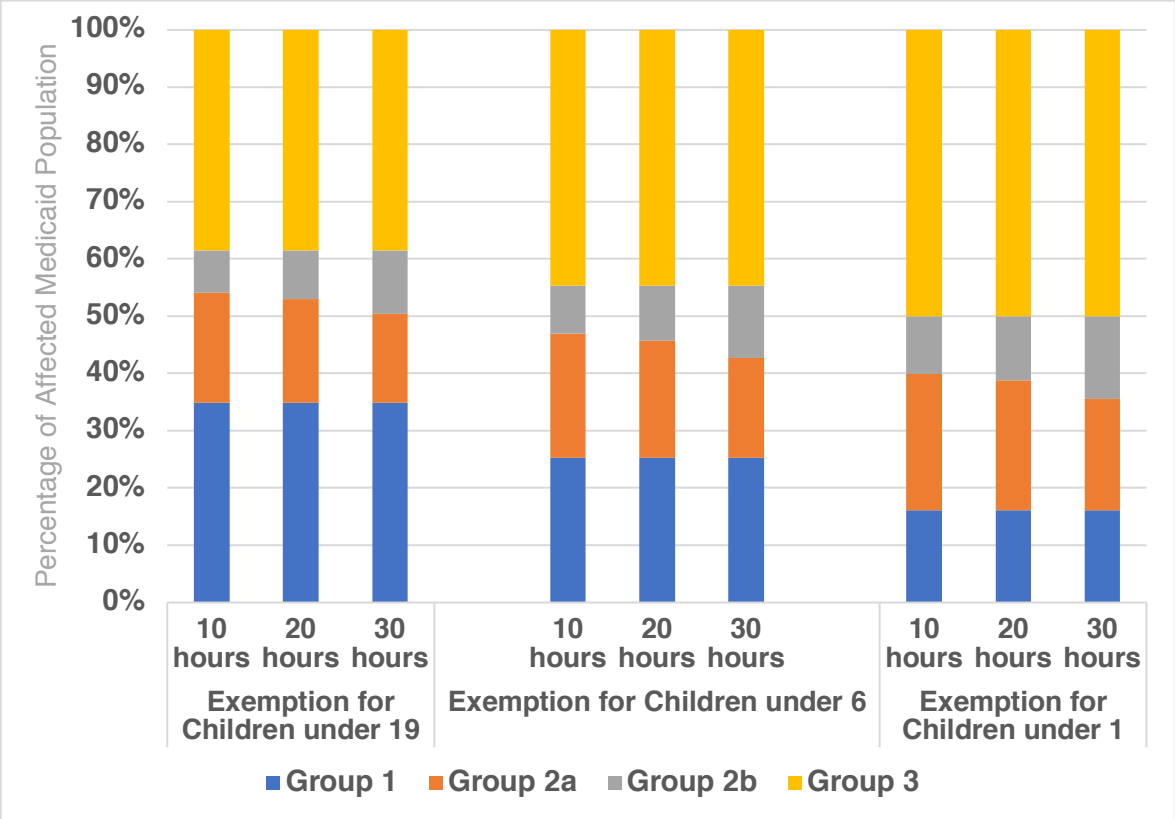

Figure 4: Percentage Distribution of Groups Based on Alternative Scenarios

DISCUSSION

As illustrated in Figure 4, the implementation of work requirements for West Virginia's Medicaid population would affect a significant number of beneficiaries and their families. Depending on the scenarios presented, about 15,000 to 29,000 individuals would have to increase their hours worked and an additional 78,000 to 101,000 individuals would have to find employment in order to avoid losing benefits. The combined number of individuals thus ranges from about 93,000 to 130,000, not counting the 33,000 to 70,000 individuals with exemptions. Those already working, 35,000 to 48,000, would at least have to maintain their current efforts.

Based on evidence from the implementation of work requirements in other public assistance programs[12] and early indications from the Arkansas 1115 waiver,[48, 55] it is likely that a significant number of individuals will lose coverage as a result. Indeed, coverage losses will be almost immediate. For one, analysis from the SNAP program,[12] with a very similar target population, has shown coverage loses of 50 to 85 percent within the first year. Evidence from the implementation of TANF in West Virginia also indicates large coverage losses without sustained elimination of poverty.[31, 32] While these numbers are much higher than indicated by states in their 1115 waiver applications, they seem very much in line with the first reported results from Arkansas,[48, 55] where about 1 in 4 targeted beneficiaries have already fallen out of compliance immediately, and are thus locked out of the program.

Applied to the previous analyses for West Virginia, this would entail coverage losses in the range of 54,000 to 144,000 West Virginians for Groups 2 and 3 alone in the first year of implementation. For a Kentucky-style waiver, coverage losses range from 66,000 to 112,000 for Groups 2 and 3. With a population of about 1.8 million, this extent of coverage losses would be devasting far beyond the affected individuals and their families.

Compliance Challenges for Beneficiaries

Individual Barriers Facing Medicaid Beneficiaries

Several potential barriers exists that may impeded the ability of beneficiaries to comply with work requirements (Figure 5). Not surprisingly, beneficiaries in Group 3 consistently fare worse than individuals in other groups.

Serious health limitations may prove particularly challenging when seeking to participate in the labor market. Limitations listed in the ACS include "serious difficulty concentrating, remembering, or making decisions," "serious difficulty walking or climbing stairs," "serious difficulty doing errands," "serious difficulty bathing or dressing," "blind or serious vision or hearing difficulty." Overall, about 16 percent of individuals in Group 1 report at least one such difficulty. The numbers are 10, 12 percent, and 30 percent, respectively, for Groups 2a, 2b, and 3. The high number for non-exempt individuals in Group 3 may prove particularly problematic. There may be underreporting, so the numbers could potentially be higher.

Participation in the labor market may also be impeded by limited levels of education. Overall, about 12 percent in Group 1 did not finish high school. The same holds for 12 percent in Group 2a and 18 percent in Group 2b. The number reaches 25 percent for Group 3.

Moreover, in order to fulfill reporting or exemption requirements, beneficiaries must report their compliance efforts either in person, by phone, or via internet. Hence access to a vehicle, a phone, or high-speed internet is crucial for all three groups. Lack of access to a phone ranges from 4 to 8 percent, and lack of internet access ranges from 10 to 25 percent across groups. For broadband access, deficiencies range from 34 to 48 percent. Nine to 20 percent of beneficiaries are without access to a vehicle in their household. Group 3 again fares particularly poorly with 8 percent having no phone access, 25 percent having no internet access, 48 percent having no broadband internet access, and 20 percent having no vehicle access.

Cumulatively, the extent of the barriers becomes even more evident. In Group 1, 38 percent of beneficiaries do not have access to at least one of the following: vehicle, phone, or high-speed internet access is crucial for all three groups. The number increases to above 42 percent for Groups 2a and 2b, and above 52 percent for Group 3. The numbers increase to 45 percent, 47 percent, 47 percent, and 62 percent, respectively, for individuals who either have access limitations or do not have at least a high school degree. For individuals who either have an access limitation or have at least one severe health limitation the number increase to 48 percent, 46 percent, 48 percent, and 66 percent, respectively. Finally, 53 percent, 50 percent, 53 percent, and 72 percent of individuals in each group suffer from at least one of the aforementioned limitations.

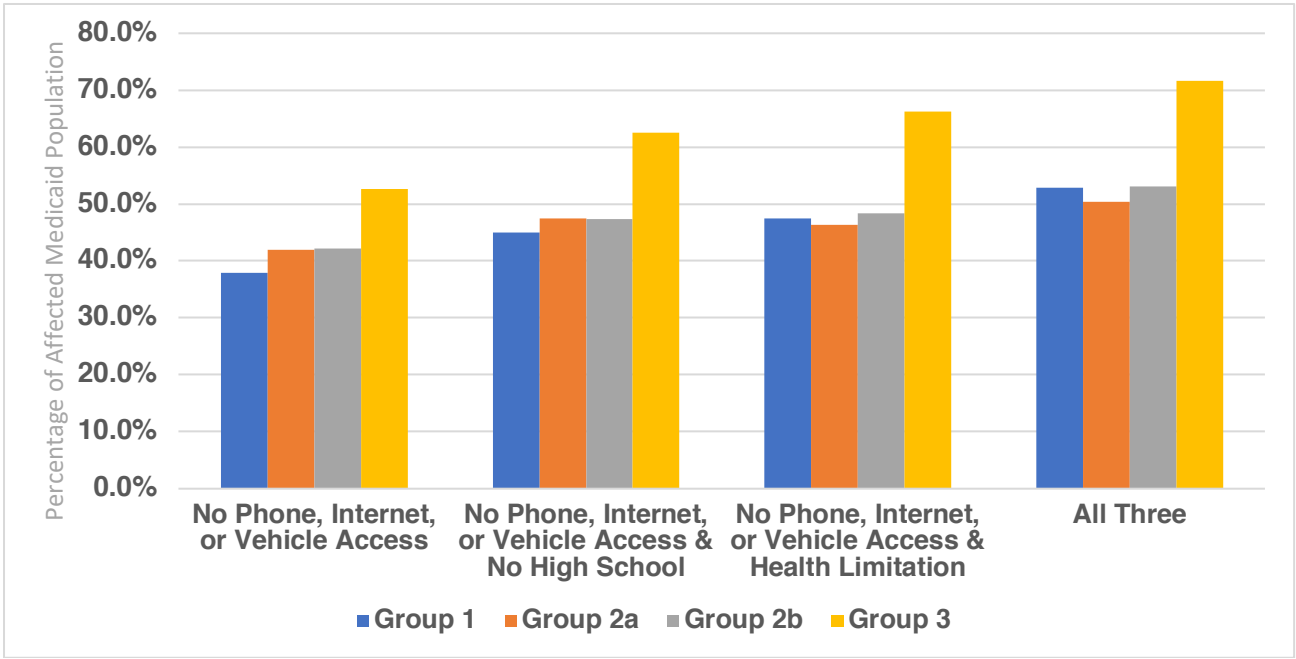

Figure 5: Cumulative Barriers for Medicaid Beneficiaries

Table 5: Common Industries of Medicaid Beneficiaries in West Virginia

Industry	Percentage of Medicaid Beneficiaries
Accommodation and Food Services	14.17%
Retail Trade	12.65%
Health Care and Social Assistance	12.63%
Construction	5.44%
Administrative and Support and Waste Management and Remediation Services	4.88%
Other Services, Except Public Administration	4.87%
Manufacturing	4.14%
Educational Services	2.88%

Finally, most Medicaid beneficiaries in the labor market are currently employed in professions with low pay and limited benefits. For those current Medicaid beneficiaries that will exceed eligibility guidelines and lose their Medicaid coverage, no employer-sponsored insurance coverage is likely to be available. When it is offered, it may be financially out-of-reach. This means that they will have to obtain less comprehensive and more expensive coverage from healthcare.gov, or go without coverage. Given the uncertainty created by the Trump Administration surrounding the insurance marketplaces, and the known problems with out-of-pocket expenses for marketplace coverage, these beneficiaries' access to health care will likely diminish.

Systemic Barriers Facing Medicaid Beneficiaries

In addition to individual barriers, Medicaid beneficiaries subject to work requirements will be confronted with a series of systemic barriers to compliance in West Virginia. Most crucially, the state's persistent underdeveloped labor market raises significant concerns. Despite recent positive developments nationally and locally, the situation continues to remain challenging in many parts of the state.

One of the biggest problems in many counties will be consistently high rates of unemployment. While unemployment rates have generally fallen since 2010, certain areas of the state are still confronted with rates in excess of 6 percent. Certain local clusters exceed this numbers further. The high unemployment rates will make it hard for individuals to find jobs to allow them to come into compliance with program requirements.

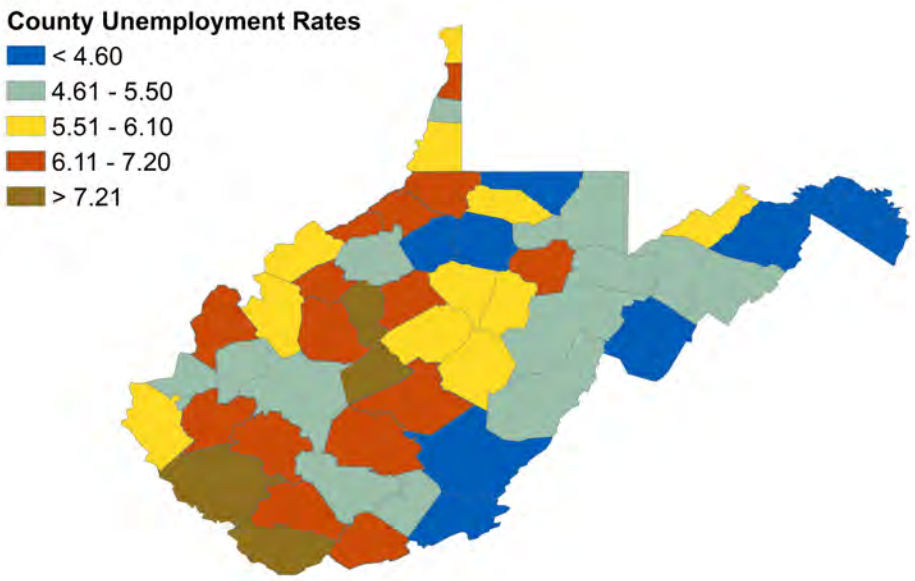

Figure 6: West Virginia Unemployment Rates by County

In addition, 33 of the state's 55 counties are so-called Labor Surplus Areas. These areas, as defined by the U.S. Department of Labor, are those counties in which the civilian average annual unemployment rate is at least 20 percent in excess of the nationwide annual average. Again, individuals residing in these counties will find it particularly challenging to fulfill any work requirements imposed upon them.

Figure 7: West Virginia Labor Surplus Areas

Another indicator of persistent employment and poverty problems is what the U.S. Department of Agriculture refers to as *Areas with Persistent Poverty*. This definition applies to those counties in which poverty rates have persistently, i.e. for multiple decades, exceeded 20 percent. Using the most recent data available, 12 of West Virginia's 55 counties fall into this category.

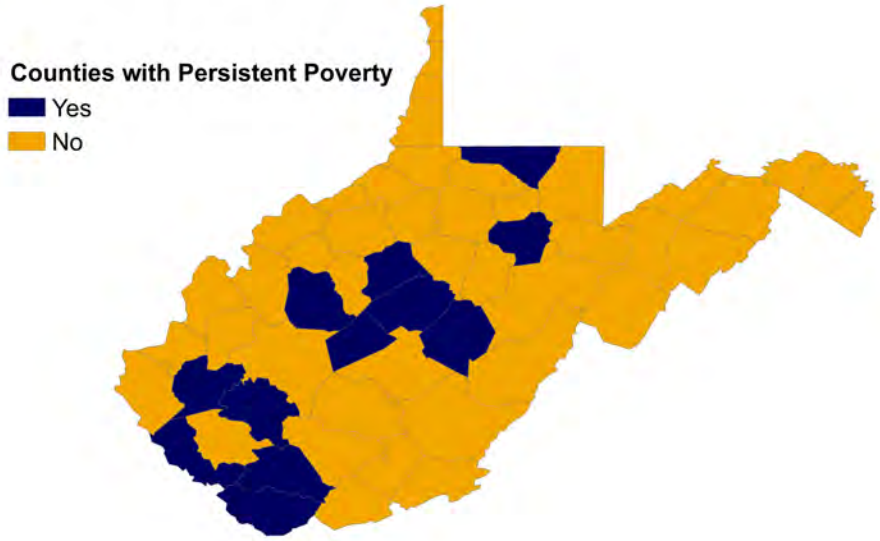

Figure 8: West Virginia Counties with Persistent Poverty

Challenges for the State

The implementation of work requirements does not come without costs to the state. Some of the most obvious costs would hail from IT requirements and the administration of the work requirements themselves. The infrastructure upgrades would certainly require outside support, and significant upgrades to the state's limited Medicaid IT systems. Given experiences with the Affordable Care Act, these would likely run in the tens of millions of dollars.[8]

Moreover, the state would have to track exemptions and compliance by individuals. For the roughly 131,000 beneficiaries in Groups 2 and 3, this would amount to potentially 126 million hours per year. Processing only the initial exemptions for Group 1, using the estimates developed by the State of Minnesota, amounts to 62,000 hours or 1,555 work weeks for state bureaucrats. Importantly, many exemptions will only be temporary and thus require frequent recertification. Again relying on the Minnesota estimates, referring beneficiaries of Group 2b and 3 to employment and training will amount to 35,000 hours or 870 work weeks for West Virginia caseworkers. Termination of benefits for non-compliance, assuming a 50 percent non-compliance rate for Groups 2 and 3, amounts to 92,000 hours or 2,300 work weeks. Again, many of these actions will be repeated over

time. It is unlikely that the West Virginia Department of Health and Human Resources could stem these demands without significantly augmenting its capacity.

Finally, as mentioned above, effective work supports have shown to cost between $7,500 to $14,000 per enrollee. Even if the state were only to provide these supports for individuals in Group 3, the costs would range from $580 million to 1.1 billion.

Challenges for the Broader Health Care System

The expansion of Medicaid has been a lifeline for the state's broader health care system. While it has served to significantly reduce bad debt and charity expenses for all hospitals, it is the state's rural hospitals that have particularly benefitted.[97] Rural hospitals nationwide have seen tremendous financial strain due to changing demographic developments and challenging market dynamics. Closures have been frequent,[86, 97] particularly in states that have not expanded their Medicaid programs. A vulnerability analysis indicates that about half of West Virginia's hospitals in rural areas are facing severe financial challenges and are at risk of closure.[98] Increases in bad debt due to losses in Medicaid coverage could prove too burdensome to overcome for these institutions, affecting all West Virginians and their communities. Similarly, Federally Qualified Health Centers, which serve about a quarter of West Virginians, overwhelmingly rely on Medicaid reimbursement to survive.[99] Coverage losses due to work requirements could prove devastating for these essential providers, as well. At the same time, albeit to a lower extent, private health providers would be confronted with increases in inability to pay for care by patients. Finally, West Virginia University Medicine faces significant exposure to the Medicaid population and estimates current Medicaid shortfalls and other financial assistance at close to 150 million annually.[100] Reduction in Medicaid coverage rates would thus have severe financial repercussions for the state's flagship university.

CONCLUSION

As one of the nation's poorest states, West Virginia disproportionately relies on Medicaid to provide health coverage to hundreds of thousands of West Virginians. While crucial for these individual beneficiaries, Medicaid also serves as the backbone of the larger health care infrastructure in the state, including for hospitals, Federally Qualified Health Centers, and Rural Health Clinics, as well as major health systems like West Virginia University Medicine and CAMC Health System. Any changes, including the implementation of work requirements, block grants, or a reversal of the Medicaid expansion, that limit enrollment or reimbursement will have significant detrimental effects on the health and well-being of West Virginians.

The stated goal of many proponents of work and community engagement requirements, i.e. the alleviation of poverty and the transition of Medicaid beneficiaries into stable work environments, is laudable and supported by many Americans. Yet, taking away medical coverage indeed runs contrary to that goal, as an expert consensus universally emphasizes the strong positive effects that sustained health coverage has in supporting the work efforts of beneficiaries.[28] Recent studies assessing the effect of the Medicaid expansions have affirmed these findings.[33] Identifying those individuals who are taking undue advantage of the current configuration of benefits is challenging and costly. Perhaps most crucially, it may expose all rightful beneficiaries to excessive burdens and even disenrollment, with significant health, emotional, and financial consequences. It seems likely that these detrimental effects may well outweigh, ethically and financially, any other concerns. Moreover, the unclear legal and political environment may expose the state to costly court challenges and policy reversals. Crucially, with the challenging labor market environment in the state, it seems unlikely that large-scale disruptions to the extent outlined in the analysis above would not lead to major upheaval. Most importantly, it is unclear whether the West Virginia economy could offer additional employment opportunities to tens of thousands of individuals in any reasonable amount of time.

Given these limitations, the most prudent approach to increasing workforce participation while protecting the health of West Virginians includes a multi-pronged strategy that increases coverage, reduces premiums, and helps West Virginians lead healthier lives. An incomplete list of actions includes passing a state-based individual mandate, seeking approval from CMS to establish a reinsurance program, and banning or strictly limiting short-term, limited duration health plans. All three actions will reduce premiums and expand enrollment. The state should also expand eligibility for the Children's Health Insurance Program and encourage West Virginians to enroll in individual coverage during the Fall 2018 open enrollment period by funding outreach and enrollment activities. Raising the tobacco tax and implementing a soda tax with the resulting funding going to smoking cessation and addiction treatment

programs are proven ways to improve population health. More generally, we need to encourage West Virginians to be healthier and provide them with a healthy environment including clean air and water. Finally, the state should take extensive, evidence-based steps to reign in the sweeping opioid epidemic.

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WORKS CITED

1. Social Science Research Council. Mapping the Measures of America. New York: Social Science Research Council,; 2018.
2. Haeder SF. Beyond Path Dependence: Explaining Healthcare Reform and Its Consequences. Policy Stud J. 2012;40(S1):65-86.
3. Haeder SF. Making the Affordable Care Act Work: High-Risk Pools and Health Insurance Marketplaces. The Forum. 2013;11(3):499-511.
4. West Virginia Department of Health and Human Resources. Expanding Medicaid: West Virginia's Best Choice in a Dynamic Healthcare Landscape. Charleston, WV: West Virginia Department of Health and Human Resources; 2013.
5. Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Data Book. Washington, DC: Medicaid and CHIP Payment and Access Commission 2017.
6. Haeder SF. Balancing Adequacy and Affordability?: Essential Health Benefits under the Affordable Care Act. Health Policy. 2014;118(3):285-91.
7. Haeder SF, Weimer DL. You Can't Make Me Do It, but I Could Be Persuaded: A Federalism Perspective on the Affordable Care Act. J Health Polit Policy Law. 2015 February 2, 2015;40(2):281-323.
8. Haeder SF, Weimer DL. You Can't Make Me Do It: State Implementation of Insurance Exchanges under the Affordable Care Act. Public Adm Rev. 2013;73(s1):S34-S47.
9. Haeder SF, Weimer DL. Inching Toward Universal Coverage: State-Federal Health-Care Programs in Historical Perspective. J Policy Hist. 2015;27(4):746-70.
10. Slavitt AM. Letter to Thomas, Betlach, Director Arizona Health Care Cost Containment System Baltimore, MD: Centers for Medicare & Medicaid; 2016.
11. Neale B. Letter to Adam Meier, Deputy Chief of Staff, Office of Governor Matthew Bevin. Baltimore, MD: Centers for Medicare & Medicaid Services; 2018.
12. Waters ET, Escoriaza PA. Brief for Deans, Chairs and Scholars as Amici Curiae in Support Of Plaintiffs. Washington, DC: United States District Court for the District of Columbia; 2018.
13. Verma S. Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference. Baltimore, MD: Centers for Medicare & Medicaid Services; 2018.
14. Dickson V. New law may be necessary for Medicaid mandatory work requirements, White House says. Mod Healthc. 2018 July 12.
15. Goldberg D. Verma: Court Ruling Won't Close Door on Other Medicaid Work Requests. Politico. 2018 July 17.
16. Minemyer P. Azar: HHS 'Undeterred' by Court Decision Striking Down Kentucky's Medicaid Work Requirements. FierceHealthcare. 2018 July 26.
17. Rosenbaum S. What's Behind CMS' Decision To Open A New Comment Period For Kentucky's 1115 Medicaid Work Demonstration? Health Affairs Blog2018.
18. Diamond D, Pradhan R. CMS plots path forward for Kentucky work requirements after court setback. Politico. 2018 July 18.

19. Falk G, McCarty M, Aussenberg RA. Work Requirements, Time Limits, and Work Incentives in TANF, SNAP, and Housing Assistance. Washington, DC: Congressional Research Service; 2014.
20. Hahn H, Pratt E, Allen E, Ken ney G, Levy DK, Waxman E. Work Requirements in Social Safety Net Programs. Washington, DC: Urban Institute; 2017.
21. McClaurin I. Making Ends Meet: How Single Mothers Survive Welfare and Low-wage Work. American Anthropologist. 1998;100(1):231-2.
22. Murray C. Losing Ground: American Social Policy 1950-1980. New York1984.
23. Wogan JB. Do Americans Support Work Requirements? Depends on How You Ask. Governing. 2018 February 9.
24. Ingram J, Horton N. The Power of Work: Proposed Medicaid Eligibility Restrictions Have Costly Unintended Consequences. Naples, FL: Foundation for Government Accountability; 2016.
25. Feulner EJ. A Hand Up, Not a Handout. Washington, D.C.: The Heritage Foundation; 2010.
26. Rosenbaum D. House Farm Bill's SNAP Changes Are a Bad Deal for States and Low-Income Households. Washington, DC: Center on Budget and Policy Priorities; 2018.
27. Loprest P. How Are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers. Washington, DC: The Urban Institute; 2001.
28. Moffitt RA. From Welfare to Work: What the Evidence Shows. Washington, DC: The Brookings Institution; 2002.
29. Medicaid and CHIP Payment and Access Commission. Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF. Washington, DC: Medicaid and CHIP Payment and Access Commission,; 2017.
30. Grogger J, Haider SJ, Klerman J. Why Did the Welfare Rolls Fall During the 1990's? The Importance of Entry. American Economic Review. 2003;93(2):288-92.
31. Dilger RD, Blakely EH, Latimer M, Locke BL, Mencken FC, Plein LC, et al. Welfare Reform in West Virginia. Morgantown, WV: West Virginia University Press; 2004.
32. Latimer M, Plein LC. Responding to Welfare Reform: Competing Perspectives of Social Service Delivery in an Economically Disadvantaged Rural State. Journal of Applied Social Science. 2013;7(1):3-23.
33. Musumeci M, Zur J. Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience. Menlo Park, CA: Kaiser Family Foundation; 2017.
34. Pavetti L. Work Requirements Don't Cut Poverty, Evidence Shows. Washington, DC: Center on Budget and Policy Priorities; 2016.
35. MaCurdy T, Marrufo G, O'Brien-Strain M. What Happens to Familes When They Leave Welfare. San Francisco, CA: Public Policy Institute of California; 2003.
36. Loprest P. Families Who Left Welfare: Who Are They and How Are They Doing? Washington, DC: The Urban Institute; 1999.
37. Shaefer HL, Edin K. Welfare Reform and the Families It Left Behind. Pathways. 2017(Winter).

38. Solomon J, Aron-Dine A. Non-Expansion States Can't Fix "Catch-22" in Their Proposals to Take Medicaid Coverage Away From Parents Not Meeting Work Requirements. Washington, DC: Center on Budget and Policy Priorities; 2018.
39. Dickson V. States face big costs, coverage losses from Medicaid work requirements. Mod Healthc. 2018 May 23.
40. Wolfe A. Mississippi Medicaid Adds Back Beneficiary Protections in Work Requirement Proposal. Mississippi Clarion Ledger. 2018 July 6.
41. Rosenbaum S, Gunsalus R, Schmucker S, Velasquez M, Rothenberg S. Medicaid Work Demonstrations: What Is at Stake for Older Adults? Washington, DC: The Commonwealth Fund; 2018.
42. Badger E, Sanger-Katz M. Which Poor People Shouldn't Have to Work for Aid? New York Times. 2018 May 15.
43. Aron-Dine A, Chaudhry R, Broaddus M. Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Washington, DC: Center on Budget and Policy Priorities; 2018.
44. Cross-Call J. Revised Michigan Medicaid Proposal Would Still Reduce Coverage and Access to Care. off the charts: Center on Budget and Policy Priorities; 2018.
45. Meyer H. States Face Big Costs, Coverage Losses from Medicaid Work Requirements. Mod Healthc. 2018 May 23.
46. Gomez AM. As Kentucky rushes to remake Medicaid, advocates try to protect health care for the homeless. ThinkProgress. 2018 May 30.
47. Edelen A. Matt Bevin's Medicaid work requirements: Costly, intrusive and doomed. Courier-Journal. 2018 June 6.
48. Greene J. Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement. Health Affairs Blog2018.
49. Hardy B. Scrubbed from the System: Why Medicaid Enrollment Has Dropped by Almost 60,000 People in 18 Months. Arkansas Times. 2018 August 9.
50. Wagner J, Solomon J. States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries. Washington, DC: Center on Budget and Policy Priorities; 2018.
51. Williams M. Medicaid Work Debate Gets a Tennessee Twist. Rollcall. 2018 April 9.
52. Williams M. Medicaid Changes Require Tens of Millions in Upfront Costs. Roll Call. 2018 February 26.
53. Kim E, Rowan R. Medicaid Waiver Actions Limit US States' Cost Controls. New York: Fitch Ratings; 2018.
54. Ollstein A. Arkansas Pulls The Trigger On Nation's First- Ever Medicaid Work Requirement. Talking Points Memo. 2018 June 5.
55. DeMillo A. 7,000 people fail to meet Arkansas Medicaid work requirement. AP News. 2018 July 13.
56. Katch H, Wagner J, Aron-Dine A. Medicaid Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Washington, DC: Center on Budget and Policy Priorities; 2018.

57. Musumeci M, Garfield R, Rudowitz R. Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues. Menlo Park, CA: Kaiser Family Foundation; 2018.
58. Musumeci M, Rudowitz R, Hinton E. Approved Changes to Medicaid in Kentucky. Menlo Park, CA: Kaiser Family Foundation; 2018.
59. Pavetti L. Opportunity-Boosting Job Preparedness Takes Significant Investment, Evidence Shows. Washington, DC: Center for Budget and Policy Priorities; 2018.
60. Meckstroth A, Burwick A, Moore Q, Ponza M. Teaching Self-Suffi ciency Through Home Visitation and Life Skills Education. Princeton, NJ: Mathematica Policy Research, Inc.; 2009.
61. Scholas P. Per Scholas Annual Report 2017. Silver Springs, MD: Per Scholas; 2017.
62. Rolston H, Copson E, Gardiner K. Valley Initiative for Development and Advancement: Implementation and Early Impact Report. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services; 2017.
63. Elliot M, Roder A. Escalating Gains: Project QUEST'S Sectoral Strategy Pays Off. New York: Economic Mobility Corporation, Inc.; 2017.
64. Haeder SF, Weimer DL, Mukamel DB. California Hospital Networks Are Narrower In Marketplace Than In Commercial Plans, But Access And Quality Are Similar. Health Aff (Milwood). 2015 May 1, 2015;34(5):741-8.
65. Haeder SF, Weimer DL, Mukamel DB. Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans. Health Aff (Milwood). 2016 July 1, 2016;35(7):1160-6.
66. Grogger J. The Effects of Time Limits, the EITC, and Other Policy Changes on Welfare Use, Work, and Income Among Female-Headed Families. Review of Economics and Statistics. 2003;85(2):394-408.
67. Solomon J. More Evidence That Complex Medicaid Waivers Will Likely Cause Harm. off the charts: Center for Budget and Policy Priorities; 2018.
68. Garfield R, Rudowitz R, Musumeci M, Damico A. Implications of Work Requirements in Medicaid: What Does the Data Say? San Francisco, CA: Kaiser Family Foundation; 2018.
69. Garfield R, Rudowitz R, Damico A. Understanding the Intersection of Medicaid and Work. Menlo Park, CA: Kaiser Family Foundation; 2018.
70. Haeder SF, Plein C. The Successes of Children's Health Insurance in West Virginia and the Challenges that Lie Ahead. Charleston, WV: West Virginia Kids Count; 2018.
71. Dunkelberg A, O'Malley M. Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2004.
72. Summer L, Mann C. Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies. Washington, DC: The Commonwealth Fund; 2006.

73. Herndon JB, Shenkman EA, Bruce Vogel. The Impact of Renewal Policy Changes in the Florida Healthy Kids Program. Gainesville, FL: University of Florida, Institute for Child Health Policy; 2007.
74. Seifert R, Kirk G, Oakes M. Enrollment and Disenrollment in MassHealth and Commonwealth Care. Boston, MA: Massachusetts Medicaid Policy Institute; 2010.
75. Edwards J, Duchon L, Ellis E, Caroline Davis, Kellenberg R, Bitterman J, et al. Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States. Portland, ME: National Academy for State Health Policy; 2010.
76. Hudson JL, Moriya AS. Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children. Health Aff (Milwood). 2017;36(9):1643-51.
77. Haider SJ, Jacknowitz A, Schoeni RF. Welfare Work Requirements and Child Well-Being: Evidence From the Effects on Breast-Feeding. Demography. 2003;40(3):479-97.
78. Kaestner R, Chan Lee W. The Effect of Welfare Reform on Prenatal Care and Birth Weight. Health Economics. 2005;14(5):497-511.
79. Bitler MP, Gelbach JB, Hoynes HW. Welfare reform and children's living arrangements. Journal of Human resources. 2006;41(1):1-27.
80. Musumeci M, Foutz J, Garfield R. How Might Older Nonelderly Medicaid Adults with Disabilities Be Affected By Work Requirements in Section 1115 Waivers? Menlo Park, CA: Kaiser Family Foundation; 2018.
81. Provenzano AM. I Treat Patients on Medicaid, and I Don't See Undeserving Poor People. The Conversation. 2018 June 1.
82. Spangler T. 4 Things to Know About Michigan's Medicaid Work Requirements. Detroit Free Press. 2018 June 14.
83. Michigan House Fiscal Agency. Healthy Michigan Plan Work Requirements and Premium Payment Requirement. Lansing, MI: Michigan Legislature; 2018.
84. Aron-Dine A. Proposed Medicaid Eligibility Restrictions Have Costly Unintended Consequences. off the charts: Center on Budget and Policy Priorities; 2018.
85. Rector R. Work Requirements in Medicaid Won't Work. Here's a Serious Alternative. Washington, DC: The Heritage Foundation; 2017.
86. Haeder SF. The Demise of Community Responsibility: Unintended Consequences of Coverage Expansions on California Public Hospitals. J Health Polit Policy Law. Forthcoming.
87. Glied SA, Snowden S. Adding a Work Requirement to Medicaid Could Hurt Kentucky's Economy. To the Point: The Commonwealth Fund; 2018.
88. Godoy M, Aubrey A. Trump Wants Families On Food Stamps To Get Jobs. The Majority Already Work. NPR. 2018 May 24.
89. Rocco P, Haeder SF. How Intense Policy Demanders Shape Postreform Politics: Evidence from the Affordable Care Act. J Health Polit Policy Law. 2018;43(2):271-304.
90. Haeder SF. Beyond the CBO Score: How Trump Budget and the AHCA Are Dismantling America's Safety Net. The Conversation. 2017 May 25.
91. Haeder SF. Not Just for the Poor: The Crucial Role of Medicaid in America's Health Care System. The Conversation. 2017 June 7.

92. Haeder SF. How the Latest Effort to Repeal Obamacare Would Affect Millions. The Conversation. 2017 September 19.
93. Haeder SF, Blake V. Republicans Attacking Obamacare, One More Time. The Conversation. 2018 March 5.
94. Haeder SF. Time to Stop Using 9 Million Children as a Bargaining CHIP. The Conversation. 2018 January 18.
95. Haeder SF. US Health Care System: A Patchwork that No One Likes. The Conversation. 2017 October 18.
96. Gangopadhyaya A, Kenney GM. Updated: Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them? Washington, DC: Urban Institute; 2018.
97. North Carolina Rural Health Research Program. 87 Rural Hospital Closures: January 2010 – Present. Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research; 2018.
98. Topchik M. Rural Relevance 2017: Assessing the State of Rural Healthcare in America. New York: The Chartis Group; 2018.
99. Shin P, Sharac J, Gunsalus R, Rosenbaum S. Changes in Health Center Patients Served, 2010-2016. Washington, DC: Geiger Gibson/RCHN Community Health Foundation Research Collaborative; 2018.
100. WVU Medicine. Community Benefits. Morgantown, WV: WVU Medicine; 2018.

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