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Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care

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ABSTRACT In June 2018 Arkansas became the first US state to implement work requirements in Medicaid, requiring adults ages 30–49 to work twenty hours a week, participate in "community engagement" activities, or qualify for an exemption to maintain coverage. By April 2019, when a federal judge put the policy on hold, 18,000 adults had already lost coverage. We analyze the policy's effects before and after these events, using a telephone survey performed in late 2019 of 2,706 low-income adults in Arkansas and three control states compared with data from 2016 and 2018. We have four main findings. First, most of the Medicaid coverage losses in 2018 were reversed in 2019 after the court order. Second, work requirements did not increase employment over eighteen months of follow-up. Third, people in Arkansas ages 30–49 who had lost Medicaid in the prior year experienced adverse consequences: 50 percent reported serious problems paying off medical debt, 56 percent delayed care because of cost, and 64 percent delayed taking medications because of cost. These rates were significantly higher than among Arkansans who remained in Medicaid all year. Finally, awareness of the work requirements remained poor, with more than 70 percent of Arkansans unsure whether the policy was in effect.

The Centers for Medicare and Medicaid Services (CMS) has authorized ten states to implement "community engagement" requirements in Medicaid as of July 2020.[1] Commonly known as work requirements, these policies require Medicaid beneficiaries either to spend a certain number of hours each month working or in other activities such as community service or job training or to qualify for an exemption. Then, beneficiaries must report those activities or their qualifying exemption to the state to maintain coverage. The effect of these policies on long-term employment and beneficiaries' ability to navigate the reporting requirements are important areas of study, with implications for the nineteen states that have had waivers approved or under consideration by CMS as of July 2020.

The first and only state to fully implement this policy to date was Arkansas, which, starting in June 2018, required adults ages 30–49 to file monthly online reports on their employment or other activities to maintain coverage. By early 2019, 18,000 adults had been removed from the program by the state for noncompliance, most of whom never submitted any reports to the state.[2–4] An evaluation conducted using data from late 2018 revealed a significant increase in the uninsurance rate in the target population, with no change in employment or community engagement.[5] In April 2019 a federal judge halted the state's work requirements, ruling that the program did not satisfy the primary objective of Medicaid and should not have been approved

by CMS. Since then, a federal appeals court upheld the ruling, and a separate March 2020 federal ruling blocked Michigan's community engagement policy, but several other states continue with their plans for work requirements.[6,7] In defending Arkansas's work requirements, CMS and state officials argued that the program needed to be evaluated over a longer follow-up period to determine whether it increased employment and speculated that many of those initially losing coverage would obtain private insurance later on.[8]

Our objective was to examine the second-year impacts of Arkansas's work requirements. We assessed changes in coverage and employment in late 2019, eighteen months after the policy was first implemented and nine months after it was blocked by the courts. We also examined the implications of Medicaid disenrollment in Arkansas on the affordability of care and medical debt, as well as awareness of and experiences with the state's work requirements among low-income Arkansans.

Study Data And Methods

STUDY DESIGN AND SETTING We conducted a random-digit-dialing telephone survey to measure outcomes in late 2016 before the implementation of work requirements in Arkansas, in late 2018 while the policy was in effect, and in late 2019 after the policy had been reversed by the courts. We compared outcomes among Arkansans ages 30–49 with outcomes among Arkansans ages 19–29 and 50–64 (who were not affected by the 2018 policy), as well as among adults in three comparison states: Kentucky, Louisiana, and Texas. These states were originally chosen to study various approaches to Medicaid expansion because of their geographic proximity to each other and their similar demographic profiles. In 2018 Kentucky's planned work requirement was blocked by the courts before implementation, and in 2019 newly elected Gov. Andy Beshear (D) withdrew the state's proposal.[9] Louisiana and Texas have not implemented work requirements.

Our baseline data from 2016 and 2018 come from a survey instrument that has been previously compared with data from the American Community Survey and the Behavioral Risk Factor Surveillance System, which showed similar estimates for coverage and access to care over time in these states.[10] This project was approved by the Institutional Review Board of the Harvard T. H. Chan School of Public Health.

SAMPLE AND SURVEY Our survey was conducted via landlines and cellular telephones, in English and Spanish, from November 6, 2019, to January 3, 2020. For brevity, we refer to data from this wave of the survey as "2019 data"; fewer than 2 percent of respondents were interviewed in early January 2020, and excluding those observations has no effect on the results. Survey respondents were US citizens ages 19–64 who reported 2018 household incomes below 138 percent of the federal poverty level; we defined the sample based on the prior year's income because if work requirements led more people to get jobs in 2019, then this would bias a sample defined by 2019 income. Most respondents (95.7 percent) were contacted via random-digit dialing; a subset (4.3 percent) of respondents were contacted by the survey vendor after participating in a different survey, to improve efficiency in screening for the target population and facilitate oversampling of Arkansans ages 30–49. These data were then combined with data from 2016 and 2018.[5] The average three-year response rate (according to the American Association for Public Opinion Research Response Rate 3 definition) was 15 percent, which is similar to or better than other rapid-turnaround survey data sources used for timely policy analysis of Medicaid and the Affordable Care Act.[11,12] We used survey weights based on demographic benchmarks from the Census Bureau and National Health Interview Survey to yield results representative of the low-income population in each state.

OUTCOMES The primary outcomes were the percentage of respondents who were uninsured, the percentage of respondents with Medicaid coverage, and the percentage of respondents who worked at least twenty hours a week.

Each respondent's coverage status was categorized into one of seven mutually exclusive categories using the following hierarchy: uninsured, Medicaid, Medicare, Marketplace, employer-sponsored insurance, nongroup insurance, and other. Because Arkansas's Medicaid expansion in 2014 used Medicaid funds to purchase private Marketplace plans through the Affordable Care Act (ACA) exchange for enrollees, we combined Marketplace coverage and Medicaid coverage into a single category for analysis.

Secondary outcomes included the percentage of respondents with employer-sponsored insurance, the number of hours worked per week, and the percentage of respondents not engaged in any activity (including exemptions) that would meet the work requirement. We asked respondents about their participation in the following activities that would meet the state's work requirement: eighty hours of work per month, job search, job training, or community service. We also assessed the following potential exemption categories: pregnant women, people with disabilities, full-time students, and people car-

ing for a child or other household member who could not care for themselves.

To examine the potential consequences of disenrolling from Medicaid after work requirements were implemented, we assessed the amount of medical debt and the percentage of respondents who reported that their medical debt was a serious problem for them. We also assessed the percentages of respondents who reported delays in care or who had skipped taking prescribed medications because of cost. To identify people who had disenrolled in the prior year, respondents were asked whether they had ever lost Medicaid or Marketplace coverage in the previous twelve months. Finally, we asked respondents in Arkansas about their awareness of and experience with work requirements.

ANALYSIS Our main study design was a triple-difference approach, using variation in year, age, and state to identify the impacts of Arkansas's work requirement policy and its subsequent reversal by the court. Our model tested whether the change in outcomes among Arkansans ages 30–49, relative to the change among those ages 19–29 and 50–64, was larger than the comparable change in the comparison states. The policy estimate for 2019 is the coefficient on the three-way interaction of indicators for state (Arkansas), age group (ages 30–49), and year (2019). Previous research has assessed stability in trends of coverage and employment before the implementation of work requirements for our study's relevant state and age groups, using data from the American Community Survey, and has found no signs of divergence before the implementation of work requirements in 2018, which offers support for our study design.[5]

For coverage outcomes, we analyzed repeated cross-sectional data from the three waves of our survey (2016, 2018, and 2019), each of which contains a distinct sample of respondents. We estimated linear regression models, clustering standard errors by state–age group (twenty clusters in total, with age groups 19–29, 30–39, 40–49, 50–59, and 60–64). Models adjusted for sex, race/ethnicity, education, interview language (English or Spanish), marital status, residence area (urban or rural), and year, as well as interactions between year and covariates to replicate previously published estimates with data for 2016 and 2018 (see the online appendix for regression models).[13]

For employment outcomes, respondents in 2018 were asked about 2017 and 2018 employment, and respondents in 2019 were asked about 2018 and 2019 employment. This approach of asking about previous- and current-year employment was used because we did not have baseline employment data from before 2018. Because of the longitudinal nature of the data and nonindependent observations across time, we used a multilevel mixed model with random effects for age groups in each state and for each respondent.

Significant confusion and misinformation about the policy still remain, even though the policy is no longer in place.

For both coverage and employment models, we conducted a sensitivity analysis including only respondents ages 30–49.

For affordability outcomes after disenrollment, we calculated survey-weighted means and medians to compare results among Arkansans ages 30–49 who had disenrolled from Medicaid or Marketplace coverage in the past year with Arkansans ages 30–49 who had remained enrolled in that coverage. We asked respondents to estimate their amount of medical debt, and responses were coded as discrete categories: $0, $1–$1,000, $1,001–$2,000, $2,001–$5,000, $5,001–$10,000, and more than $10,000. To compute the mean and median debt, we conservatively used the lower bound of the applicable range for each respondent to impute a specific debt amount. Some respondents offered a specific debt value, as opposed to a category; when available, the specific dollar value amount was used in our calculations. We also calculated average medical debt using values top-coded at $20,000 to test the effect of potential outliers.

As noted, all analyses were survey weighted to reflect the target population in each state.

LIMITATIONS Our study had several limitations. First, our survey response rate was 15 percent, which is lower than the response rates for government surveys. However, we used demographic weighting to address nonresponse bias, and our survey instrument has been previously compared with government survey data, with similar results.[10] Respondents may be prone to survey biases, such as recall bias and social desirability bias, which may lead to inaccurate estimates of the amount of medical debt or overreporting of current employment status. Another bias in our survey appears to be the result of a telescoping phenomenon where people recall

higher employment rates in the past, likely beyond the twelve-month period about which they were being asked. For this reason, we also tested our employment using only current-year results (without the look-back question), and our findings for 2018 versus 2019 employment were similar to those in our main model.

Some survey items were answered by only a small percentage of respondents, such as questions asked of those who reported disenrolling from Medicaid or Marketplace coverage or those not meeting the work requirement.

Importantly, we could not determine which coverage losses and affordability changes were due directly to the work requirement policy, as there was substantial confusion about the policy among respondents and we did not have administrative enrollment data to which we could link our results. In models comparing access and affordability challenges for people losing Medicaid in Arkansas, presumably not all of these people lost coverage because of work requirements (as all states have a baseline level of churning). Thus, our results for these outcomes are descriptive, rather than the stronger quasi-experimental analysis for our insurance coverage and employment outcomes.

In addition, our survey asked respondents whether they had disenrolled from Medicaid or Marketplace coverage in the past twelve months (that is, since November/December 2018). This period imperfectly overlaps with the state's disenrollment of people not meeting work and reporting requirements from August through December 2018. As a result, our estimate of the number of people who disenrolled from Medicaid or Marketplace coverage after work requirements went into effect is imprecise.

Although our quasi-experimental analysis for the study's primary outcomes was a strong design that used both within-state and out-of-state control groups, the study was still potentially subject to unobserved time-varying confounders that differed across state and age groups.

Finally, in terms of external validity, Arkansas's work requirements implementation, as well as the characteristics of its residents, may differ from those of other states.

Study Results

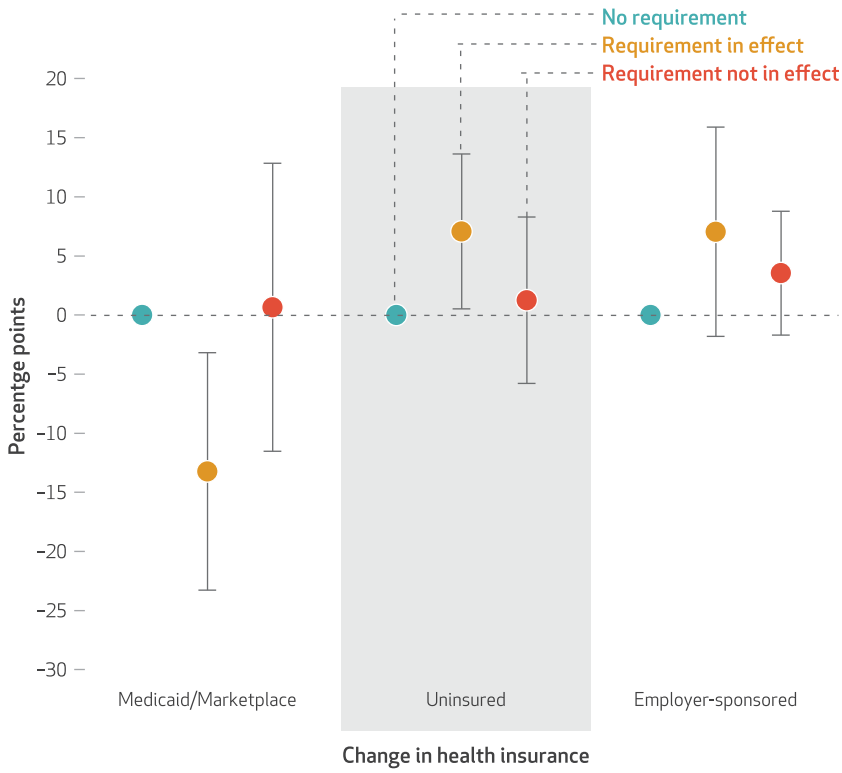
STUDY SAMPLE AND DESCRIPTIVE STATISTICS Our overall sample included 8,661 respondents (2,706 from 2019, 3,004 from 2018, and 2,951 from 2016), and each year of the sample was independent from the other years. We oversampled in Arkansas and in the 30–49 age group, the group targeted by work requirements; overall, 45.4 percent of the sample came from Arkansas. Appendix exhibit A1 presents demographic characteristics of the respondents.[13]

COVERAGE The percentage of Arkansans ages 30–49 with Medicaid or Marketplace coverage dropped from 70.5 percent in 2016 (before the work requirements) to 63.7 percent in 2018 (during the time the work requirements were active) and rose to 66.1 percent in 2019 (when the work requirements were no longer in effect) (appendix exhibit A2).[13] The uninsurance rate for Arkansans ages 30–49 rose from 10.5 percent in 2016 to 14.6 percent in 2018 and then went back down to 12.5 percent in 2019. Meanwhile, the uninsurance rate for adults ages 30–49 in our comparison states was fairly stable for all three years.

Exhibit 1 shows regression estimates of cover-

EXHIBIT 1

Changes in health insurance associated with Arkansas's 2018 Medicaid work requirements, by source of coverage

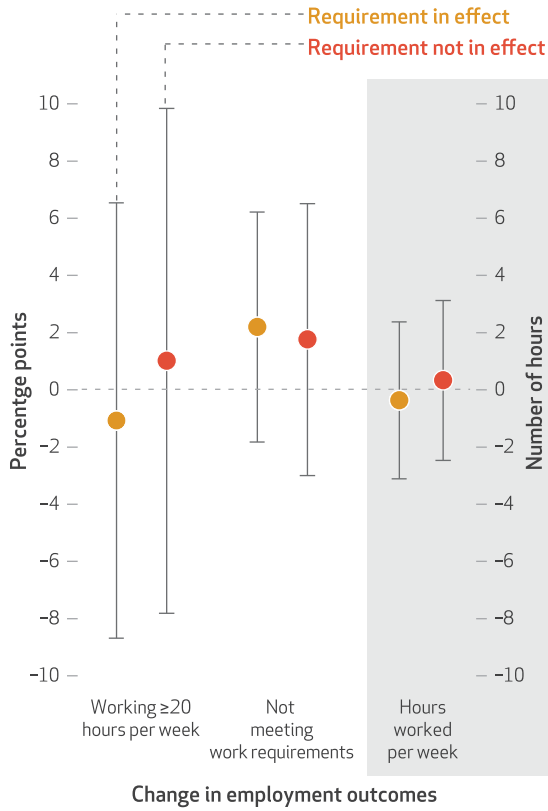


SOURCE Authors' analysis of cross-sectional survey data from low-income adults ages 19–64 in Arkansas, Kentucky, Louisiana, and Texas, 2016, 2018, and 2019. **NOTES** $N = 8,661$. Medicaid work requirements were in effect during the 2018 study period and not in effect during the 2019 study period. Data points indicate the coefficients from a triple-difference model, comparing adults in the target age range for Arkansas's 2018 work requirements (30–49) versus other age groups, in Arkansas versus other states, for each year (2018, 2019) compared to the baseline year (2016). The bars indicate 95% confidence intervals for each estimate (based on state–age group clustered standard errors). Models were survey weighted and adjusted for year of interview interacted with the following covariates: sex, race/ethnicity, marital status, education, interview language (English or Spanish), and place of residence (urban or rural). Medicaid and Marketplace coverage were combined into a single outcome, as in Arkansas most Medicaid expansion beneficiaries are enrolled in free Marketplace coverage.

age outcomes as a function of the work requirement policy changes, using a triple-difference model. Work requirements in 2018 led to a significant drop in Medicaid or Marketplace coverage of 13.2 percentage points for Arkansans ages 30–49, relative to other age groups and states.

EXHIBIT 2

Changes in employment outcomes associated with Arkansas's 2018 Medicaid work requirements



SOURCE Authors' analysis of longitudinal survey data from low-income adults ages 19–64 in Arkansas, Kentucky, Louisiana, and Texas, 2017–18 and 2018–19. **NOTES** *N* = 3,004 individuals for 2017–18 and 2,706 individuals for 2018–19, minus item nonresponse for each outcome. The Medicaid work requirement was not in effect in 2017, was in effect in 2018 during the study period, and was not in effect in 2019 during the study period. Each person in the sample provided information on these outcomes for two consecutive years (asked about these outcomes for prior year and then again for current year). Data points indicate the coefficients from a triple-difference model, comparing adults in the target age range for Arkansas's 2018 work requirements (30–49) versus other age groups, in Arkansas versus other states, for the current year versus the prior year. The bars indicate 95% confidence intervals for each estimate (based on state–age group clustered standard errors). Given the repeated observations for each person, we used a random effects model. Models were survey weighted and adjusted for sex, race/ethnicity, marital status, education, interview language (English or Spanish), and place of residence (urban or rural). Individuals were identified as not meeting work requirements if they did not report working at least twenty hours per week, disability status, full-time student status, participation in job training, actively seeking work, community service, pregnancy, or caring for a child or household member who could not care for themselves.

But in 2019, after the court reversed the policy, Medicaid or Marketplace coverage rates for Arkansans ages 30–49 (the treatment group) compared with control groups did not differ significantly, which suggests that coverage losses from work requirements were mostly reversed after the court order. For the uninsurance outcome, the policy estimate of work requirements led to a significant increase in the uninsured rate of 7.1 percentage points for Arkansans ages 30–49, relative to other age groups and states, consistent with previous research.[5] But in 2019, after the court reversed the policy, uninsurance rates for the treatment group compared with control groups did not differ significantly, which suggests that that overall uninsurance rates returned to levels seen before the work requirement.

There was a fairly large but nonsignificant change in employer-sponsored insurance associated with work requirements in 2018 and a smaller nonsignificant change in 2019. Results were similar using models including only respondents ages 30–49 (appendix exhibit A3).[13]

EMPLOYMENT AND COMMUNITY ENGAGEMENT The share of respondents working at least twenty hours a week ranged from 36.7 percent to 48.4 percent, depending on the year, age group, and state (appendix exhibit A4).[13] Mean hours worked per week ranged from 14.7 to 19.5. Combining all qualifying working and community engagement activities, plus potential exemptions, more than 95 percent of the target population was already meeting the work requirements or should have qualified for an exemption (see appendix exhibit A4).[13] Note that there are two estimates for 2018, as we asked 2018 respondents to report current-year employment and 2019 respondents to report previous-year employment. The look-back employment measure is higher for all groups, which is likely a result of the telescoping bias discussed in the Limitations section.

Exhibit 2 presents estimates for the changes in employment outcomes associated with work requirements from our regression models. Comparing Arkansans ages 30–49 with other age groups and other states, we found no significant changes in employment (as measured by working more than twenty hours a week), community engagement status (as measured by meeting or not meeting the work requirement), or number of hours worked between 2018 (during work requirements) and 2019 (after work requirements were put on hold). Results were similar using models including only adults ages 30–49 (appendix exhibit A5).[13]

AFFORDABILITY AND ACCESS TO CARE AFTER DISENROLLMENT Of Arkansans ages 30–49 who

reported disenrolling from Medicaid or Marketplace coverage at any point in the past year ($N = 117$), 55.6 percent re-enrolled and were covered by Medicaid or Marketplace coverage by the time of the survey, 8.2 percent had employer-sponsored coverage, 10.1 percent had other insurance, and 26.1 percent were uninsured (data not shown). Exhibit 3 presents results for medical debt and financial barriers to care, comparing Arkansans ages 30–49 who reported disenrolling from Medicaid or Marketplace coverage in the prior year with those who maintained that coverage. Arkansans ages 30–49 who had lost Medicaid or Marketplace coverage frequently reported adverse consequences: 49.8 percent reported serious problems paying off medical debt, 55.9 percent delayed needed care in the past year because of cost, and 63.8 percent delayed taking medications because of cost. These rates were all significantly higher than among Arkansans who had maintained their Medicaid or Marketplace coverage all year ($p < 0.01$).

Arkansans ages 30–49 who disenrolled in the prior year had an average medical debt of $2,261 compared with $1,752 for those who reported continuous enrollment ($p = 0.35$). Results when top-coding debt values above $20,000 were marginally significant ($p = 0.07$). The median medical debt amount was $1,001 for those who disenrolled compared with $0 for those who did not ($p < 0.05$ using quantile regression) (data not shown).

AWARENESS OF AND EXPERIENCE WITH WORK REQUIREMENTS Exhibit 4 describes Arkansas residents' awareness of and experiences with work requirements as of late 2019. Of Arkansans ages 30–49 with Medicaid or Marketplace coverage in the past year, 34.9 percent had heard nothing at all about the work requirements policy. Multivariate analysis showed that those without a high school diploma, men, unmarried people, and those living in an urban setting were significantly less likely to have heard of the policy relative to those with a high school diploma, women, people who were married or partnered, and those living in rural areas, respectively (appendix exhibit A6).[13]

Of respondents who had heard of work requirements, 46.2 percent reported that their main source of information about the policy was a letter or call from the state or Medicaid office (exhibit 4), whereas smaller numbers (in the range of 11–17 percent) had heard from friends or family, health care providers, news sources, or the internet.

Knowledge about the status of work requirements was poor, with 70.8 percent of all Arkansas residents unsure whether the policy was currently in effect and only 5.7 percent correctly answering that the requirements were not in effect as of late 2019.

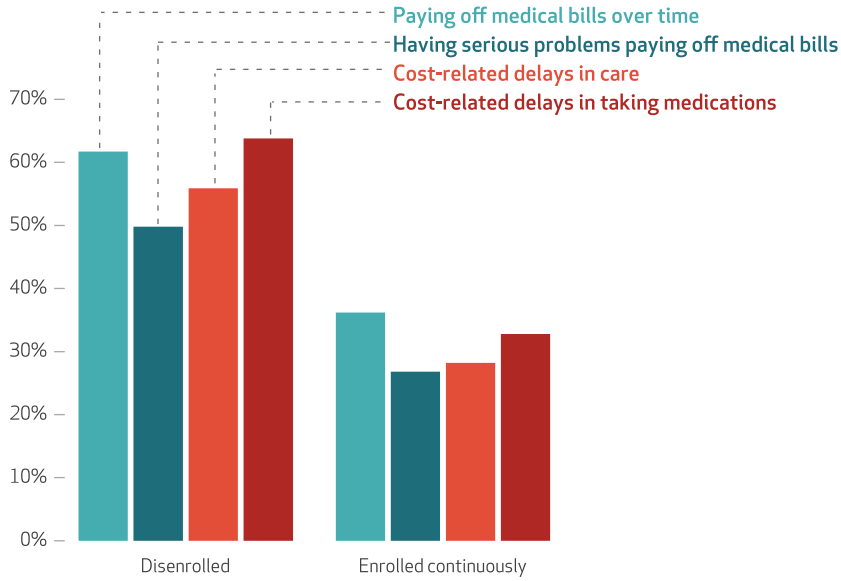
When asked for their preferred method of reporting work activities to the state, only 11.3 percent of Arkansans specified an internet website using a computer, which was the state's only available option for most of 2018 (before adding a telephone option in December of that year). The most popular option was a website using a smartphone or smartphone app (32.6 percent), followed by telephone (27.8 percent).

Given that many who disenrolled in 2018 never reported any information to the state despite the state's outreach efforts,[14] we also asked Arkansans who dropped out of Medicaid ($n = 110$) whether they had changed their phone numbers or addresses in the past year, which may be why state outreach efforts were not received. Among these, 35.6 percent reported a change in contact information, and fewer than half (45.6 percent) of those respondents said that they had notified the state Medicaid office about the change (appendix exhibit A7).[13]

Of the small percentage of Arkansas residents who were not meeting the work requirement or an exemption to the policy ($n = 106$), 28.1 percent reported that they would like to start work-

EXHIBIT 3

Medical debt and access to care after Medicaid or Marketplace coverage disenrollment compared to continuous enrollment among low-income Arkansans targeted by work requirement (ages 30–49)



SOURCE Authors' analysis of 2019 survey data from low-income Arkansans ages 30–49 who reported disenrolling from Medicaid or Marketplace coverage in the past year ($n = 117$) versus those without any disruption in coverage ($n = 376$). **NOTES** All four outcomes are significantly different between the disenrolled group and the continuously enrolled group ($p < 0.01$). All results are based on survey-weighted chi-square tests. The outcome "Having serious problems paying off medical bills" is calculated as a percentage of the total sample (including those with no medical bills).

EXHIBIT 4

Awareness of and experience with work requirements among Arkansas residents, 2019

Variables	Percent
Heard of work requirements ("a lot" or "a little," versus "nothing at all")	
All Arkansas residents (N = 1,700)	53.0
Arkansas residents ages 30–49 with Medicaid/Marketplace in past year (n = 493)[a]	65.1
Main source of information about work requirements	
Arkansas residents who had heard of work requirements (n = 921)	
Letter or call from state or Medicaid office	46.2
Family or friend	16.9
Social media or internet	14.6
Television or newspaper	13.1
Health care provider, hospital, or doctor's office	11.3
Community organization, church, or place of worship	4.6
Knowledge of current status of work requirements (as of November–December 2019)	
All Arkansas residents	
Correctly said requirements were not in effect	5.7
Incorrectly said requirements were in effect	23.5
Not sure	70.8
Arkansas residents who had heard of work requirements	
Correctly said requirements were not in effect	7.6
Incorrectly said requirements were in effect	40.0
Not sure	52.5
Preferred method of reporting work and qualifying activities	
All Arkansas residents	
Internet, using smartphone or smartphone app	32.6
Calling a telephone number	27.8
Paper form in the mail	14.5
In person at doctor's office or Medicaid office	13.9
Internet website, using a computer	11.3

SOURCE Authors' analysis of 2019 survey data from low-income Arkansas residents. **NOTE** All analyses were survey weighted. [a]This subsample is composed of those reporting current Medicaid or Marketplace coverage and those reporting disenrollment from that coverage over the past year.

ing if a job were available. When these respondents were asked about whether various state services would help them find a job, 80.6 percent specified job training or more education, and 72.2 percent specified transportation to and from work (appendix exhibit A7).[13]

Discussion

Arkansas was the testing ground for the nation's first work requirement in Medicaid in 2018. It subsequently became a de facto test of the effects of reversing this policy when a federal judge blocked the requirement in 2019. In this analysis of new survey data from Arkansas and several comparison states, we found that the state's 2018 coverage losses in the work requirement's target population (low-income adults ages 30–49) were largely reversed by the end of 2019 after the court order. Meanwhile, at eighteen months of follow-up after initial implementation of the work requirement, we found no evidence that low-income adults had increased their employment or other community engagement activities either in the first year when the policy was still in effect or in the longer term, after the policy was blocked.

Although coverage rates had recovered, our analysis of various affordability measures indicates that disenrollment during the study period was associated with adverse outcomes in terms of poorer medication adherence, delayed care, and medical debt that averaged over $2,200 and was a "serious problem" for nearly half of respondents. This is consistent with prior evidence on the harmful effects of churning in coverage,[15–17] although for these outcomes, we are using a descriptive analysis only and are not able to definitively tie churning among all of these adults to work requirements.

Meanwhile, Arkansas Medicaid beneficiaries and other low-income adults remain confused about work requirements, with 70.8 percent unsure whether the policy was in effect and only 5.7 percent correctly aware that the policy had been put on hold. This raises concerns that even though the policy is not in effect, it may still be leading some potentially eligible people to not apply for or renew their Medicaid coverage because of concerns about the work requirement.

We found no evidence that the policy succeeded in its stated goal of promoting work.

Despite low levels of awareness about the policy's legal status, coverage rates nonetheless rebounded after the work requirement was no longer in effect.

Overall, these findings are consistent with qualitative data from Arkansas,[14] as well as New Hampshire,[18] showing that misinformation and confusion are major barriers to implementing work requirements in Medicaid. Our findings suggest that some of the logistical decisions made by Arkansas policy makers made it harder for people to report data to the state, as almost 90 percent of respondents reported that they would have preferred a method of reporting work activities to the state other than a computer web-based system, which was Arkansas's exclusive approach for the first several months of the policy. Smartphone, telephone, mail, and in-person options would have facilitated data reporting for many.

As noted previously, more than 95 percent of Arkansas beneficiaries in our survey already met the state's Medicaid work requirements or should have been eligible for an exemption. This suggests that barriers to reporting data to the state, rather than not meeting the requirements themselves, were the main cause for coverage losses in 2018.[3,14] For the small number of Arkansas residents in our survey who were not employed but wanted to work, two potential state services were identified by respondents as factors that would most help them find a job: job training or education and transportation to work. The lack of Medicaid payment for job supports in these areas further complicates efforts to obtain employment under work requirements and may explain in part why we found no changes in this outcome. Although Arkansas has tried offering referrals to work supports in the past with little success, other states have had more success with more intensive outreach programs, such as Montana's Health and Economic Livelihood Partnership Link (HELP-Link), a targeted outreach program to unemployed Medicaid beneficiaries that entails individual career counseling on the telephone, in-person job training, tuition assistance, and transportation support (and notably, no reporting requirement or disenrollment penalty for nonemployment).[19,20]

Finally, although this was not directly assessed in our analysis, any consideration of work requirements in Medicaid should consider administrative costs as well. Implementation of this policy cost an estimated $26.1 million, with 17 percent of the cost paid for by the state and 83 percent paid for by the federal government.[21]

In conclusion, our study showed that Arkansas's work requirements led to coverage losses associated with important negative impacts on medical debt and affordability of care without improving employment. Significant confusion and misinformation about the policy still remain, even though the policy is no longer in place. Thus, we found no evidence that the policy succeeded in its stated goal of promoting work and instead found substantial evidence of harm to health care coverage and access. Our results should provide a strong note of caution for federal and state policy makers considering work requirement policies in the future. ■

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13 To access the appendix, click on the Details tab of the article online.

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