"Unfit" to Work? How Medicaid Work Requirements Hurt People with Disabilities

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Medicaid critics are once again trying and take health care away from low-income people, this time by imposing a work-requirement. Just five years ago, Arkansas implemented a work requirement for some Medicaid enrollees and proceeded to cut coverage for over 18,000 participants in just 7 months, or roughly 23 percent of the targeted population in 2018.[1] The results were clear: employment did not increase, but the number of uninsured Arkansans did.[2] Many of the terminated Arkansans never heard about the work requirement or had difficulty reporting their hours or seeking an exemption.[3] Despite the plain evidence, House Republicans have returned to this policy. They recently passed a bill that would impose an even more expansive work requirement on low-income individuals and families.[4]

People with disabilities will suffer the harsh impacts of any work requirement, even with exemption processes in place. Medicaid work requirements misconstrue the problems low-income people face and so represent inappropriate and actually harmful policy "solutions." These misguided policies assume that people have low incomes because they lack incentive to work, when actually other factors play far larger roles in creating barriers for low-income people to earn income, including people with disabilities: systemic instabilities and exploitation in the low-wage workplace; inadequate supports for childcare, transportation and access to health care; and outright discrimination.[5] And despite these barriers, the vast majority of Medicaid-enrolled adults are already in the workforce, serving as caregivers, enrolled as students, or have mental or physical impairments that create barriers to work.[6]

Medicaid helps people with disabilities work, but work requirements undermine access to employment for people with disabilities. Work requirements harm people with disabilities because they fail to capture the complexity of how Medicaid facilitates employment for people with disabilities who work. Medicaid-funded services can provide transportation, health care, and other services that help people with disabilities who seek to obtain and maintain employment in their communities. As explained below, vague exemptions, no matter how they are implemented, create disincentives for people with disabilities to work by adding risks while imposing unnecessary administrative burdens that threaten their access to vital services.

Ultimately, Medicaid work requirements would cut Medicaid for hundreds of thousands of people with disabilities who depend on its services to live – and work – in the community. Work requirements are wrong for Medicaid and they will never work for people with disabilities.

Medicaid offers vital employment supports

Millions of adults with chronic conditions and disabilities rely on Medicaid coverage to get treatment they need to remain healthy, active members of their communities. This can range from regular supplies of insulin for people with diabetes to medications for mental health conditions to home health aides that help people with disabilities with activities of daily living, basic chores, cooking, and getting around in the community. Participants eligible through the adult Medicaid expansion have repeatedly reported that in addition to improving their health, Medicaid helped them either find a job or maintain their employment.[7] That support goes well beyond standard medical care for chronic conditions. In one multi-state study, employment rates for adults with disabilities increased by nearly six percentage points after their states implemented Medicaid expansion compared to similar adults in non-expansion states.[8] The share of people with disabilities reporting they did not work due to their disability declined by five percentage points in expansion states. In short, expanding Medicaid coverage meant more people with disabilities who want to work are able to work.

Congress has over time added programs to Medicaid designed to provide more flexibilities and supports so people with disabilities can work and build careers without jeopardizing their access to vital care. These options, such as the Ticket to Work program or the Medicaid Buy-in for Workers with Disabilities, allow participants with disabilities to pay sliding scale premiums to pay for Medicaid coverage even as their incomes rise.[9] That allows them to continue receiving critical home and community-based services (HCBS) they need to stay in the workforce. These programs are limited in scope and often underutilized, but they form part of a broader push to support people with disabilities who want access competitive employment opportunities in their communities.[10] Many states have also added employment supports as available services in HCBS programs, including habilitative and rehabilitative services, that help people with disabilities prepare for and find job opportunities. The services reflect a tenet of disability rights movement that people with disabilities have a right to determine how they live in the community and should have access to the same opportunities afforded to people without disabilities, including opportunities to work for competitive wages alongside other community members.

A common thread among these joint efforts to promote competitive community employment recognizes the need to reduce the multiple barriers to employment that people with disabilities

face – including inadequate accommodations, complex and changing work schedules common to low-wage jobs that make it difficult to arrange for necessary services like aides to help a person get ready to leave the house, disincentives due to the need to preserve access to key social benefits programs like Medicaid and Social Security, and outright workplace discrimination.[11] They reflect the conviction that people with disabilities should have every opportunity to engage in community living, including employment if they choose it. The Medicaid program has long been a key driver toward overcoming these barriers, but policies like work requirements threaten to reverse these efforts.

Exemptions for people with disabilities do not work

Work requirements are rooted in the (very false) presumption that low-income people lack incentive to work. Proponents of Medicaid work requirements face a logistical and political problem that stems from this presumption: many people have very good reasons for not being in the formal labor force. Some are caregivers for children or for adults with disabilities. Others are students. Others live with disabilities or chronic conditions that create substantial barriers to employment or other forms of community engagement.[12] Simply forcing everyone to work is politically untenable, so proponents inevitably include exemptions for certain groups they deem worthy. In practice, these exemptions inevitably fail.

First, the exemptions fundamentally misconstrue how participants with disabilities connect to the workforce. The new bill's language exempts people with disabilities deemed "unfit for employment." This reinforces an outdated, paternalistic view of people with disabilities as helpless and passive. It wrongly presupposes that there is an easily identifiable portion of the population that is "too disabled" to work, and ignores that some people with the most significant disabilities can and do work – provided they have the appropriate supports. Work requirements in Medicaid cannot accommodate the complexity of why people with disabilities do or do not engage in paid employment. That decision involves addressing various intersecting factors: an individual's health conditions, which may vary over time; the types of educational and workforce opportunities available; the other demands on their time and energy including caregiving needs; and the accommodations and supports available to support working. Work requirements neglect the reality that any person with a disability in the workforce still faces huge barriers to steady employment relative to the general population – barriers no exemption policy has or could adequately address. And they suggest that people eligible for Medicaid's essential health coverage should have to prove that they are among the deserving poor. In this sense, people with disabilities should see such proposals for what they are: offensive and dangerous.

People with disabilities experience discrimination at various stages of employment. In one study, applicants mentioning disabilities that would not affect their job performance received 26% fewer responses from employers.[13]

The very idea of a work requirement in Medicaid puts people with disabilities in a bind. They must either assert that they are "unfit" to work – which does not comport with people's real world experience and the way in which people with all kinds of disabilities can engage in competitive employment – or reject the exemption. But forgoing the exemption means facing the possibility that they will lose access to vital Medicaid services if they cannot overcome the very real and ongoing employment barriers in our existing labor market. Thus the likely consequence of any federal Medicaid work requirement is the exact opposite of what House Republicans claim they want to encourage. People with disabilities would hesitate to seek employment due to the existential risk of losing their benefits.

Those who do seek an exemption for disability must navigate an uncertain and often burdensome process to secure one. Work requirements create more red tape for all Medicaid enrollees, **including people with disabilities who the policy would exempt**. The standard for an exemption due to being "unfit for employment" does not match any existing designation in Medicaid eligibility. Every exemption will require someone to fill out a form, complete a screen, see a clinician, or any number of other requirements that add red tape and make it harder to stay enrolled. Those who do not seek an exemption could likewise lose their access to their services due to not meeting the work requirement or getting tripped up by administrative reporting requirements. Many people will not even know they have to file paperwork, others will struggle to get the verification documents.

For real world examples of how work requirements operate, we can look to past programs. The examples are not intended to show ways that work requirements might be implemented better, but rather to show that these policies have always failed, and in some ways, are designed to fail. Arkansas' Medicaid work requirement included a ten-step on-line exemption process for individuals not automatically exempted by the state, with no clear process to request accommodations.[14] Consequently, although thirty percent of the target population reported one or more serious health limitations, only eleven percent obtained a long-term exemption to the state's work requirement.[15] Focus group participants described a poorly functioning web-based reporting portal, inadequate outreach, and widespread confusion. This led to the following conclusions:

> The new requirements are not incentivizing new work or other activities in which enrollees were not already engaged, but are layering on one more thing to deal with in enrollees' already complex lives and causing added stress because no one wants to lose their coverage.[16]

In SNAP, which uses an "unfit for employment" exemption similar to the new proposed legislation, an estimated 700,000 enrollees with disabilities remained subject to the requirement despite their disability.[17] That amounts to nearly 20 percent of all SNAP participants subject to work requirements.[18] Local studies support this analysis. In Franklin County, Ohio, about one-third of individuals required to participate in a SNAP employment and training program to keep their benefits reported a physical or mental limitation. Additionally, almost twenty percent of the individuals had filed for SSI or SSDI within the previous two years.[19] When Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that sixty-two percent of nearly 12,000 individuals subject to the requirement were disenrolled after only three months.[20] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[21]

Numerous studies of TANF work requirements have documented disproportionate sanctioning of participants with physical and mental health conditions.[22] Others show how bureaucratic processes have narrowed interpretations of exceptions and established high burdens of proof on participants seeking relief from work requirements.[23] It should come as no surprise that participants in "poor" or "fair" health were more likely to lose their TANF benefits than those who reported good health.[24]

These same studies found that Black participants were also more likely to be sanctioned for failure to comply with TANF work requirements, suggesting that racial and ethnic bias may compound the negative impact of work requirements for people of color with disabilities.[25] Black and Indigenous people experience significantly higher rates of disability than the general population and so the role of such compounding inequities should always be factored in.[26] Based on the assumptions embedded in the very idea of a work requirement – that people with low income are poor because they lack work incentive – there is no reason to believe that similarly harsh and discriminatory interpretations of the rules would not occur in Medicaid.

Conclusion

The evidence from Medicaid and other programs all point to the same conclusion: work requirements do not work for people with disabilities. Hand-waving toward exemption processes cannot wish away those negative impacts, nor mask the ableist assumptions

embedded in these policies. Work requirements purport to solve a nonexistent problem. If the goal is to increase employment, providing better health coverage and more employment supports are the proven policy options.

So why push an already failed policy? Perhaps it is because the real goal of the policy is not to increase employment, but rather to cut the Medicaid program and shift costs onto the states. Making Medicaid harder to access and use has long been a go-to strategy for opponents of this critical and effective health care program. Medicaid work requirements suit this strategy perfectly, precisely because they create more hurdles to keeping coverage but they pin the blame on individual participants, not on the system. In short, work requirements are designed to trip people up, and then blame them for falling.

Endnotes

[1] Robin Rudowitz, MaryBeth Musumeci & Cornelia Hall, Kaiser Fam. Found., *February State Data for Medicaid Work Requirements in Arkansas*, (2019), https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/; Joan Alker, Georgetown Ctr. For Children & Families, *Arkansas' Medicaid Work Reporting Rules Lead to Staggering Health Coverage Losses*, Say Ahhh! (2019), https://ccf.georgetown.edu/2019/01/18/arkansas-staggering-health-coverage-losses-should-serve-as-warning-to-other-states-considering-medicaid-work-reporting-requirement/.

[2] Benjamin D. Sommers et al., *Medicaid Work Requirement -- Results from the First Year in Arkansas*, 381 NEW ENG. J. MED. 1073 (2019).

[3] MaryBeth Musumeci, Robin Rudowitz & Barbara Lyons, Kaiser Fam. Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees*, (2018), https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/.

[4] Specifically, the House bill applies to a larger age range – 19-55 years as opposed to Arkansas' 18-49 target population. Disabilities are more prevalent in older age gropus. The House bill language is also not restricted to only the Medicaid expansion eligibility group, while Arkansas' requirement applied only to the adult expansion group.

[5] *See, e.g.* Rebecca Ullrich, Stephanie Schmit & Ruth Cosse, Ctr. for Law & Soc. Pol'y (CLASP), *Inequitable Access to Child Care Subsidies*, (2019), https://www.clasp.org/publications/report/brief/inequitable-access-child-care-subsidies; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, (2015), https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf.

[6] Madeline Guth et al., Kaiser Fam. Found., *Understanding the Intersection of Medicaid & Work: A Look at What the Data Say*, (2023), https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say-issue-brief/.

[7] John R. Kasich & Barbara R. Sears, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*, (2016), https://www.jmoc.state.oh.us/Assets/documents/reports/Group%20VIII%20Statutory%20Report_12-2016_final.pdf; John R. Kasich & Barbara R. Sears, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*, (2018), https://medicaid.ohio.gov/static/Resources/Reports/Annual/Group-VIII-Final-Report.pdf; Renuka Tipirneni et al., Inst. for Healthcare Pol'y and Innovation at the Univ. of Mich., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (2017), http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.

[8] Jean P. Hall et al., *Medicaid Expansion as an Employment Incentive Program for People with Disabilities*, 108 AM. J. PUB. HEALTH 1235 (2018).

[9] 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII) & (XV).

[10] Alison Barkoff et al., *Federal Joint Communication to State and Local Governments: Resource Leveraging & Service Coordination to Increase Competitive Integrated Employment*

for Individuals with Disabilities (Aug. 3, 2022), https://www.dol.gov/sites/dolgov/files/ODEP/pdf/ResourceLeveragingServiceCoordinationToIncreaseCIE8-12-22.pdf.

[11] Mason Ameri et al., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior*, (2015), http://www.nber.org/papers/w21560 (finding that job applicants mentioning a disability received 26% fewer responses than comparable applicants who did not mention a disability).

[12] Madeline Guth et al., Kaiser Fam. Found., *Understanding the Intersection of Medicaid & Work: A Look at What the Data Say*, (2023), https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say-issue-brief/ (finding that 91% of Medicaid adults not eligible through SSI are either working (61%); caregiving (13%); not working due to an illness or disability (11%); or attending school (6%).)

[13] Mason Emeri et al., *supra* note 11, at 15.

[14] Anna Bailey & Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Medicaid Work Requirements Don't Protect People with Disabilities*, (2018), https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities.

[15] *Id.*

[16] MaryBeth Musumeci, Robin Rudowitz & Barbara Lyons, Kaiser Fam. Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees*, (2018), https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/.

[17] Michael Morris & Nanette Goodman, Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities*, (2014), https://www.researchgate.net/publication/274006096_Impact_of_the_Work_Requirement_in_Supplemental_Nutrition_Assistance_SNAP_on_Low-Income_Working-Age_People_with_Disabilities.

[18] *See Id.* at 15 (The authors note that their estimates, based on the Current Population Survey, likely undercounts participants in this category of so-called Able-Bodied Adults Without Dependents (ABAWDs) by nearly 30 percent. Also this estimate only includes adults under 50, while the proposed Medicaid requirement would extend to 55 and so would include a higher share of older adults more likely to have a disability).

[19] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

[20] *Correction: Benefits Dropped Story*, U.S. News & World Report, (May 26, 2017), https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps.

[21] *Id.*

[22] *See, e.g.*, Yeheskel Hasenfeld et al., Univ. of Pennsylvania School of Social Policy and Practice, *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* Departmental Paper (2004), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

[23] Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REV. 199 (2008).
[24] Andrew J. Cherlin et al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 SOC. SERV. REV. 387 (2002).
[25] *Id.*; *See also*, Hasenfeld et al. *supra* note 22.
[26] Elizabeth A. Courtney-Long et al., *Socioeconomic Factors at the Intersection of Rae and Ethnicity Influencing Health Risks for People with Disabilities* 4 J. RACIAL AND ETHNIC HEALTH DISPARITIES 213 (2017). (Finding that 31.0 percent of American Indian/Alaska Native adults and 22.7 percent of Black adults have disabilities, which is significantly higher than the 21.0 percent rate for the general population.)