



RESEARCH REPORT

Lessons from Launching Medicaid Work Requirements in Arkansas

Ian Hill

Emily Burroughs

October 2019



ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Contents

Acknowledgments	iv
Executive Summary	v
Lessons from Launching Work Requirements in Arkansas	1
Methods	2
Background on Arkansas and Passage of Medicaid Work Requirements	5
Outreach and Consumer Education	7
Supporting Arkansas Works Beneficiaries' Transition to Employment	12
Reporting Work and Community Engagement	15
Obtaining Exemptions	20
Implications of Disenrollment for Providers, Hospitals, Health Plans, and the Beneficiaries They Served	23
Conclusions and Lessons Learned	27
Notes	32
References	34
About the Authors	35
Statement of Independence	36

Acknowledgments

This report was funded by the David and Lucille Packard Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The authors would like to thank the many Arkansas Department of Human Services and Department of Workforce Services officials, health care providers, consumer advocates, health plan representatives, and health policy analysts and researchers with whom we spoke for their time and input for our report. We also want to extend special thanks to MaryBeth Musumeci of the Kaiser Family Foundation, Joan Alker of the Georgetown University McCourt School of Public Policy, and Craig Wilson of the Arkansas Center for Health Improvement, for their review and comments on our draft report. We are particularly indebted to the Arkansans who volunteered their time to participate in our focus groups and shared with us their personal experiences with Medicaid and its work requirements. Finally, we thank our colleagues: Genevieve Kenney for her extensive input on the design of our study and her review and input on earlier drafts; and Fiona Blackshaw for her expert editorial assistance. Any errors or omissions are our own.

Executive Summary

In June 2018, Arkansas imposed work requirements as a condition of eligibility on beneficiaries of the state's Medicaid expansion program, called Arkansas Works. Adults between the ages of 30 and 49 with incomes up to 138 percent of the federal poverty level (FPL) had to report 80 hours a month of work or community engagement activities to the Arkansas Department of Human Services (DHS) or risk losing their health coverage. For those not exempt from the requirement, failure to complete and report sufficient work activity for three consecutive months resulted in disenrollment from Arkansas Works for the remainder of the calendar year. By December 30, 2018, more than 18,000 beneficiaries were disenrolled from the program.

To learn more about the implementation and implications of Arkansas's Medicaid work requirement, we visited Little Rock for two days and interviewed a wide range of stakeholders—including state Medicaid and Department of Workforce Services officials, health care providers, health plans, consumer advocates, and policy researchers—and held two focus groups with people who were either currently enrolled in Arkansas Works or had been enrolled but lost coverage after not complying with the state's work requirements.

We found that focus groups participants, and even many system stakeholders, did not clearly understand the rules of the work requirements and that structural barriers and administrative challenges further inhibited compliance. As a result of state outreach efforts that some people we interviewed described as “robust,” all focus group participants reported having heard of the work requirements. Yet, the majority either didn't understand the requirements or thought the requirements didn't apply to them. Furthermore, most stakeholders believed that state outreach efforts—which relied heavily on traditional mail and phone calls—did not reach many Arkansas Works beneficiaries.

Stakeholders praised the Department of Human Services' effort to conduct data matches to proactively identify the roughly two-thirds of Arkansas Works beneficiaries who were exempt from reporting. But both key informants and focus group participants agreed that the state's primarily online system to report work and community engagement activities was poorly designed and presented many difficulties that caused consumers a lot of frustration. Further, though the Department of Workforce Services was positioned to help beneficiaries transition to employment, people we interviewed reported that beneficiaries had difficulty accessing employment and training services and that knowledge of those services was not widespread. Some focus group participants said that challenges related to confusion, poor access to a computer and the internet, and difficulty using the online

reporting system caused them to lose Medicaid coverage, and losing Medicaid affected their ability to obtain needed care. Many participants who were disenrolled from Medicaid for noncompliance only found out when they tried to seek medical care or fill a prescription at a pharmacy; they all claimed they had not received notices from the state. Losses of coverage also appear to hold implications for health care systems; for example, public health care providers, hospitals, and Medicaid health plans all expressed concern over increases in “self-pay” and charity care (i.e., uninsured) patients and decreases in coverage.

Though the federal courts have yet to determine the fundamental legality of Medicaid work requirements, key informants and focus group participants identified several lessons learned and potential strategies to address the challenges surrounding Arkansas’s Medicaid work requirements—strategies that could help reduce coverage losses and promote individuals’ ability to work—including expanding the scope, depth, and intensity of community-based outreach and education efforts; expanding and simplifying the means and methods available for reporting work and community engagement activities; and increasing funding for work support agencies and infrastructure so they have the expanded capacity to help Medicaid enrollees gain employment. However, many stakeholders we spoke with believed that beneficiaries would face barriers to compliance even if these strategies were implemented.

Lessons from Launching Work Requirements in Arkansas

In June 2018, the State of Arkansas launched Arkansas Works, the first program of its kind in the history of Medicaid. With a Section 1115 waiver approved by the federal Centers for Medicare & Medicaid Services (CMS), Arkansas began requiring adults between the ages of 30 and 49 with incomes up to 138 percent of the federal poverty level to work 80 hours a month and report those hours monthly to the state Department of Human Services or risk losing their health coverage. Beneficiaries could perform a range of other “community engagement” activities in addition to work, including volunteering, going to school, performing community service, searching for work, and attending job training. Beneficiaries could also qualify for an exemption from the requirements if they met certain criteria, such as medical frailty, having a dependent child in the home, or pregnancy. The new initiative’s rules stipulated, however, that for those subject to the requirement, failure to complete and report sufficient work activity for three consecutive months would result in disenrollment from Arkansas Works for the remainder of the calendar year.

Despite state outreach to inform Arkansas Works enrollees of the new requirements—efforts that policy and research organizations have described as “robust” (Musumeci, Rudowitz, and Hall 2018)—4,300 Medicaid beneficiaries were disenrolled in early September, the first month enrollees could face this consequence.¹ By October, disenrollment had nearly doubled to just under 8,500, spurring the Medicaid and CHIP Payment and Access Commission (MACPAC) to write a letter to Secretary of Health and Human Services Alex Azar urging him to “pause” Arkansas’ work requirements while awareness of the rules could be increased and reporting systems improved.² MACPAC’s suggestion was not taken, however, and by the end of December 2018 disenrollment had more than doubled once again. Disenrollments from Arkansas Works through December 2018 totaled 18,164—a remarkable 30 percent of the enrollees subject to work requirements at the end of that year.³

In January 2019, the state reset the clock on Arkansas Works and allowed people who had been disenrolled to reenroll. Meanwhile, Arkansas extended work requirements to a group of younger enrollees, those ages 19 through 29. But by March 2019, only about 10 percent of the more than 18,000 disenrolled people had reenrolled,⁴ raising questions about why. Secretary Azar told the Senate

Finance Committee that this low rate was “a fairly strong indication that the individuals who left the program...got a job.” But data from Arkansas’s New Hires Database suggest otherwise: less than 2,000 of the 18,164 people who had lost coverage were shown to have found employment.⁵ With April 1 looming and the prospect of another 5,492 people losing coverage for 2019 after not reporting work activity during January, February, and March, US District Judge James Boasberg halted Arkansas from continuing its work requirements (he also blocked the State of Kentucky a second time from implementing its program). The court ruled that CMS’s approvals of the states’ waivers was “arbitrary and capricious” because the waivers did not sufficiently address how work requirements supported the “core objective of Medicaid: the provision of medical coverage to the needy.”⁶ The US Department of Justice responded to Boasberg’s ruling by filing an appeal that is pending as of October 2019.

Now, the future of Medicaid work requirements is uncertain. Federal courts have halted programs in Kentucky, Arkansas, and, most recently, New Hampshire saying, essentially, that the Medicaid statute does not permit them. Yet, 16 states continue to pursue Medicaid work requirement waivers: 9 waivers have been approved, and 7 more are pending at CMS.⁷

Given this uncertainty, we closely examine the early implementation experiences of Arkansas and analyze the strengths and weaknesses of the state’s efforts related to outreach, facilitating beneficiaries’ transition to employment, reporting systems, and exemptions. We also explore the implications of widespread coverage loss for beneficiaries, health care providers, and health plans. Drawing on the input of a broad range of system stakeholders and consumers, we identify lessons learned as reported by Arkansas officials who were overseeing implementation and by other stakeholders and enrollees who participated in interviews and focus groups in Little Rock.

Methods

We began by reviewing scores of articles and reports on Arkansas Medicaid work requirements from news and policy research sources. We conducted phone interviews with a range of researchers and analysts that had been studying the program to understand what they had learned.⁸ We also studied the monthly reports that the Arkansas Department of Human Services (DHS) had produced throughout implementation of the Medicaid work requirements and that were available on the DHS website. (The state tracked and released summary-level data on beneficiary engagement with the work requirements, as well as enrollment data.)

Then, over three consecutive days in May 2019, we conducted nine interviews with 21 key informants and two focus groups with 29 Medicaid beneficiaries in Little Rock, Arkansas. Our interviewees represented a wide range of stakeholders, including state Medicaid and Department of Workforce Services officials, health care providers, health plan representatives, consumer advocates, and policy researchers. Our focus groups consisted of adults who were enrolled in Arkansas Works or who had been enrolled but lost coverage because of noncompliance with the state’s work and community engagement requirement. Semistructured interviews and focus groups captured reflections on experiences with Arkansas’s work requirements and obtained perspectives and opinions on the program’s strengths and weaknesses.

Our interview protocol and moderator’s guide included a core set of questions that explored stakeholders’ and enrollees’ experiences and opinions across eight domains:

- outreach and education efforts
- training and employment resources
- work reporting systems
- exemptions from work requirements
- enrollee understanding of work requirements
- implications of Medicaid coverage loss for health care providers and health plans
- overall opinions of the Medicaid work requirement
- lessons learned

Focus group participants were recruited with the assistance of a federally qualified health center (FQHC). The FQHC engaged participants in person at their clinics, as well as with fliers and phone calls using protocols provided by Urban to ensure neutral and systematic recruitment. FQHC staff invited clients who met the following criteria to participate:

- age 19–49;
- received Medicaid coverage any time in the past year and have been subject to new Medicaid work requirements as a condition of eligibility;
- lost Medicaid eligibility in the past six months by not meeting Arkansas’s work requirement rules and reporting procedures; or
- regained Medicaid coverage by reporting work activities; or
- received employment assistance at one of the state’s Workforce Centers; and
- spoke English as a primary language and were comfortable participating in a group discussion conducted in English.

We conducted two focus groups with 29 total participants. Before the start of each focus group and interview, we followed informed consent procedures approved by the Urban Institute institutional review board. All interview and focus group participants spoke to us voluntarily and were assured that their identities would be protected. Interview and focus group proceedings were digitally recorded and transcribed; recordings were destroyed upon completion of transcription and cleaning of notes. Each focus group lasted 90 minutes and included a light meal. All participants received \$60 to thank them for their participation.

Focus group participants also voluntarily completed a questionnaire that gathered basic demographic characteristics and information on program participation, and food and housing insecurity (table 1). The questionnaires were anonymous and not linked to focus group participant responses. Twenty-five participants completed the questionnaire.

TABLE 1
Focus Group Participant Questionnaire Responses

	Responses
Gender	
Male	12
Female	13
Age in years	
18–24	5
25–29	2
30–39	9
40–49	8
50 and above	1
Race (all that apply)	
American Indian/Alaska Native	0
Asian	1
Black or African American	21
Hawaiian Native/Pacific Islander	0
White	5
Educational attainment	
Less than high school	2
High school/GED	11
Some college	10
Completed college	2
Employment status	
Not employed	11
Working < 20 hours a week	4
Working 20+ hours a week	10

Note: Twenty-five of the 29 focus group participants completed the questionnaire.

We used commonly accepted qualitative research methods to analyze the focus group results. We carefully reviewed interview and focus group notes and unabridged transcripts, and we categorized

responses using a thematic analytical framework that mirrored the content of the interview protocol and focus group moderator’s guide. We noted and summarized dominant themes, divergent opinions, and participant experiences. Finally, we selected relevant quotations based on frequency and richness to illustrate key points.

Background on Arkansas and Passage of Medicaid Work Requirements

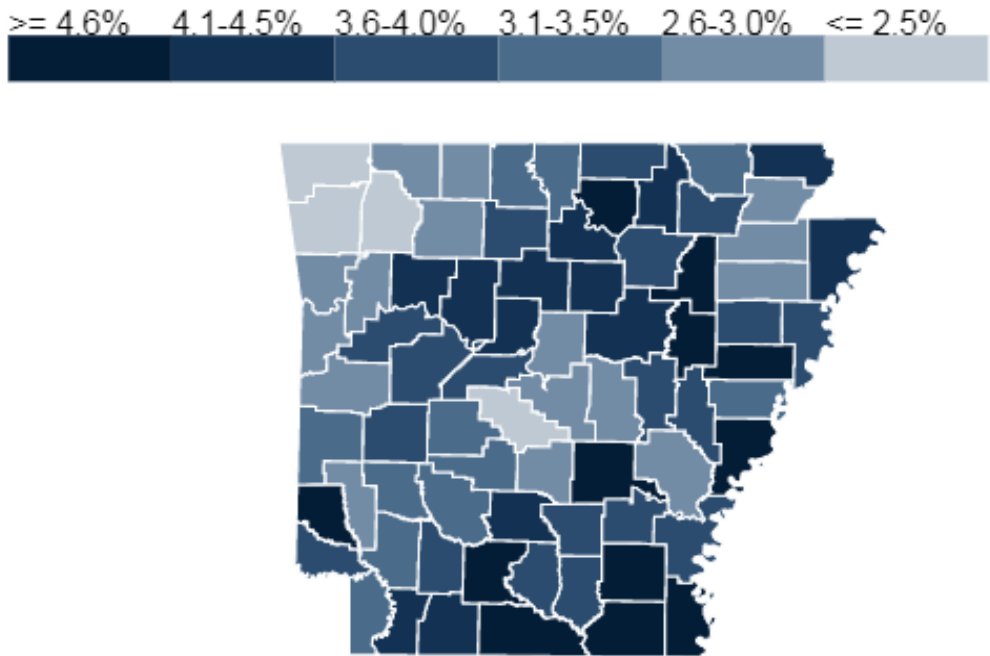
Arkansas is one of just four southern states to expand Medicaid under the Affordable Care Act.⁹ In 2013, to secure buy-in from legislators who would otherwise oppose expansion, Democratic Governor Mike Beebe and the legislature designed a “private option” approach, where the state uses Medicaid funds to purchase private insurance for beneficiaries in the federal health insurance marketplace. Even with the private option compromise, expansion legislation narrowly passed the Republican-dominated legislature. The Arkansas House of Representatives needs a supermajority—75 of 100 votes—to pass budget appropriations for all purposes except education, highways, and paying down the state debt (Hiltz and Martel 2015). The state also needs a supermajority every year to reauthorize Medicaid.

In 2016, the state legislature changed the program’s name from Health Care Independence Program to Arkansas Works to emphasize personal responsibility and work. In 2017, reauthorization of the Medicaid expansion was reportedly in serious doubt until new Republican Governor Asa Hutchinson proposed three changes to Arkansas Works: adding a work requirement for adults, reducing retroactive coverage from 90 days to 30 days, and capping Medicaid eligibility at 100 percent of the federal poverty level (FPL).¹⁰ Though the income cap was not approved by CMS, the legislature agreed to continue the Medicaid expansion with the other two provisions. The work requirement was passed by the Arkansas General Assembly in May 2017, and CMS approved the state’s waiver amendment in March 2018. DHS began sending out notices to Medicaid beneficiaries about the new work requirement in March and began officially implementing the new rules on June 1, 2018.

Arkansas’s statewide unemployment rate was 3.6 percent in May 2019 compared with 3.7 percent nationally.¹¹ However, this rate varies considerably by region (figure 1) from 2.1 percent in Madison County, where Huntsville is located, to 6.4 percent in rural Chicot County in the Arkansas Delta.¹² In Pulaski County, where Little Rock is located and where we conducted our interviews and focus groups, the unemployment rate is 3.0 percent.¹³ According to the stakeholders we interviewed, the northwest, central, and northeast regions of Arkansas generally have stronger employment bases—because of the

presence of large employers such as Walmart, Tyson Foods, and J.B. Hunt—than the southern, more rural parts of the state. Unemployment rates also vary substantially by race and ethnicity; for example, the unemployment rate for black Arkansans—6.9 percent—is well above the state average.¹⁴

FIGURE 1
Arkansas County Unemployment Rates



URBAN INSTITUTE

Source: “Unemployment Rate Rankings for Arkansas Counties: May 2019,” Arkansas Division of Workforce Services, accessed June 21, 2019, <http://www.discover.arkansas.gov/>.

Note: Data are taken from the Local Area Unemployment Statistics program; they are preliminary and not seasonally adjusted.

Urban Institute analysis of national data shows that the population targeted by Medicaid work requirements faces numerous barriers to obtaining and maintaining employment, including low educational attainment, health problems, limited transportation and internet access, criminal records, and residence in high-unemployment or high-poverty neighborhoods (Karpman 2019). Stakeholders we spoke with cite transportation and poor internet access as perhaps the two biggest barriers Arkansans face, particularly in rural areas. These informants also identify substance abuse and other social challenges as important barriers to employment. Among enrollees who are subject to the new work requirements and not currently working, an estimated 78 percent have at least one of the following characteristics: no access to a vehicle, no internet access, less than a high school education, a serious health limitation, or a household member with a serious health limitation (Gangopadhyaya et al. 2018).

Despite these barriers, the same Urban Institute analysis estimates that 31,000 (or 44 percent) of Medicaid enrollees subject to the work requirement are already working—but not necessarily working enough weeks and hours to be in compliance. Attainable jobs for Medicaid enrollees tend to be low-wage and unsteady (Hahn 2019a). In many low-wage positions, employer-sponsored insurance is either unavailable or unaffordable (Karpman, Hahn, and Gangopadhyaya 2019). Few private firms in Arkansas offer health insurance to part-time employees, and employees at most small firms are not eligible for coverage. For Medicaid beneficiaries who are eligible for employer coverage, costs would constitute a larger share of income than deemed affordable under the Affordable Care Act.¹⁵ As a result, workers often still rely on Medicaid for coverage. Such workers may struggle to comply with Medicaid work requirements because of their nonstandard work schedules, fluctuations in weekly hours worked, lack of advance notice of work schedules, and lack of control over their own hours. Further, Medicaid enrollees complying with the work requirements were still at risk of losing coverage if they were unable to report their hours because, for example, they lacked internet or transportation access.

Outreach and Consumer Education

From the outset, numerous challenges made outreach and consumer education surrounding Arkansas's Medicaid work requirements particularly arduous. Arkansas received approval to implement work requirements in March 2018, and set an ambitious goal of starting implementation on June 1. As such, the state had a very small window to inform the sizable Arkansas Works population about the requirements, whether they were exempt, and how to comply.

On top of a tight timeframe, all stakeholders we interviewed agree that the Arkansas Works population is “transient,” highly mobile, and hard to reach. According to one interviewee, “Just finding them proves to be quite difficult. That has been a historical issue...for any and all information, that has been a barrier.” Beneficiaries were described as frequently moving and changing their addresses and phone numbers; thus, the state's contact information is often out of date. Indeed, DHS officials indicated that the agency received a very high volume of returned and undelivered mail. Many beneficiaries also reportedly have government-provided “burner” phones with very limited minutes, so they tend to not pick up calls from unfamiliar numbers. And, many beneficiaries do not have internet access—and their government-issued phones cannot access the internet—making it very challenging to regularly check email or social media, if they even have such accounts. Key informants doubted mass media strategies would reach many Arkansas Works enrollees either; as one interviewee commented, “Not everyone watches the news or reads the paper. Not everyone has a TV.”

In addition, the information the state was attempting to convey was highly complex. During the run-up to program launch, state officials sought guidance from the University of Arkansas for Medical Sciences health literacy team on how to improve the readability of their letters and educational materials. That effort seems to have been unsuccessful; key stakeholders and beneficiaries universally raised concerns that the letters produced by DHS were still too dense and confusing. One health care case manager described a letter from DHS as a “blanket of words” that was “very hard to understand.” Several other key informants, despite completing college and being highly literate, expressed that they found the information confusing and commented that they could certainly understand how enrollees might struggle with the materials.

Further, DHS’s budget dictates how funds can and cannot be used for Arkansas Works outreach, including explicit language prohibiting the use of state dollars to promote enrollment. Thus, when the annual Arkansas Works clock reset, the state could not pay for targeted outreach to inform disenrolled beneficiaries that they could regain their coverage.

Despite these obstacles, the state launched what has been described by policy and research organizations as a “robust” education campaign (Musumeci, Rudowitz, and Hall 2018). DHS attempted to reach consumers directly as well as indirectly through community groups, health care providers, and health care payers. The state made a particularly high volume of direct contact efforts through letters, emails, and phone calls. DHS reported using eight major outreach methods as of February 2019; the totals listed below are for the entire implementation period.¹⁶

- **Letters.** DHS sent multiple letters to all Arkansas Works beneficiaries informing them of the new work requirements and how to comply. Letters were also sent after every month of noncompliance. DHS included information about work support services available at Workforce Centers in its letters. In total, the department sent 807,452 letters.
- **Emails.** The state sent 435,841 total emails to beneficiaries for whom they had email addresses. Multiple emails were sent each month, including reporting reminders at the end of each month. DHS officials ultimately worried they were sending too many emails and scaled back to two or three a month.
- **Phone calls.** Through a contract with DHS, the Arkansas Foundation for Medical Care expanded the scope of its call center to inform Medicaid beneficiaries of the new work requirements. The group made more than 300,000 calls and received more than 31,000 calls.
- **Text messages.** DHS sent 63,928 text messages to Arkansas Works enrollees who were subject to Medicaid work requirements.

- **Social media posts.** State DHS officials have made 1,252 posts on social media as of February 2019. For most of the implementation period, DHS posted infographics about Arkansas Works virtually every day on multiple platforms, including Twitter, Facebook, Instagram, and YouTube (see figure 2 for an example). As of September 2019, DHS has received the most engagement on its Facebook account, with around 15,000 followers. Its Twitter and Instagram accounts have around 3,000 and 500 followers, respectively. Based on our analysis of the past 12 months, DHS Facebook posts typically receive 0–25 likes and 0–10 shares while Twitter and Instagram posts typically receive 0–5 likes and no comments or responses. Arkansas Works–related YouTube videos have been removed from the site since the court order halting the Medicaid work requirements. Most of DHS’s other YouTube videos have fewer than 50 views.
- **Interviews with media outlets.** Leading up to and after implementation, state officials participated in informational interviews on both radio and television news and public affairs programs.
- **Direct outreach to community groups.** Medicaid officials reported making informational presentations at such places as libraries, churches, colleges, and technical schools. Other stakeholders, such as consumer advocacy groups, conducted outreach independently.
- **Direct outreach to health care providers and payers.** DHS invited health plans and providers to implement their own outreach campaigns. DHS shared names of people who were at risk of losing coverage (e.g., had not reported work hours for two consecutive months) with providers, payers, and pharmacists and encouraged them to reach out to those beneficiaries. These parties did report that they performed some outreach to staff and clients, but key informants agreed they could not invest time or resources in more robust campaigns, given the relatively small numbers of beneficiaries affected by the work rules relative to the consumer population.

DHS officials summarized expenditures associated with some of the above outreach activities. The contract with Arkansas Foundation for Medical Care to support its call center activities was \$959,399, with the cost evenly split between federal and state dollars (\$479,699 and \$479,700, respectively). The state also paid \$42,010 for advertising and \$17,348 to conduct beneficiary focus groups. DHS did not have data on the additional administrative costs associated with the written notices specific to the Medicaid work requirements or the staff time dedicated to the outreach campaign.

FIGURE 2

Arkansas DHS Social Media Outreach—Instagram Post



Source: Arkansas Department of Human Services Instagram Account (@arkansasdhs).

Despite its scale, the state’s outreach campaign was ultimately insufficient. This fact became clear during implementation of the work requirements in the low level of both knowledge and reporting among consumers and was documented by academic researchers.¹⁷ As state officials realized they were not reaching their target audience, they tried to bolster outreach in the midst of implementation. DHS continued to try to identify community groups that could support outreach efforts. For example, state officials reported asking grocery stores and laundromats in low-income neighborhoods if they could post fliers. Additionally, for the 19–29-year-old cohort that was phased in starting January 2019, the state provided information on the requirements to colleges, universities, and technical schools and offered to lead in-person trainings for staff of these institutions. Aside from reaching out to schools, the state did no targeted outreach to the 19–29-year-old cohort; it used the same outreach methods as those used to inform the 30–49-year-old cohort.

Even with these additional efforts, consumer and stakeholder knowledge remained low throughout implementation (Sommers et al. 2019). Partnerships with community groups, health care providers, and payers seem to have been insufficient. The representatives of health care providers we interviewed

reported they had not received training from DHS and did not clearly understand the work requirements. Some said that they knew nothing about the requirements until after implementation was under way. One provider said, “Most patients did not know about the requirements...I didn’t even know. I hadn’t heard of it until after there was this huge issue and it was all over the news that all these people in the state had lost their Medicaid.” These providers felt they should have received more direct and intensive education from DHS. Key informants and focus group participants also reported that staff at local DHS offices were ill-equipped to help beneficiaries navigate the requirements, suggesting they had not received sufficient education and training either (box 1).

BOX 1

What Focus Groups Said about Outreach and Education Efforts

Overall, knowledge and understanding of Arkansas’s Medicaid work requirements among consumers was low. Though all focus group participants reported having heard of the work requirements and some said that they had received letters, the majority either didn’t understand the requirements or thought the requirements didn’t apply to them. Participants in both our focus groups agreed that the state had not explained the requirements clearly. Many participants who were disenrolled from Medicaid for noncompliance only found out when they attempted to seek medical care or fill a prescription at a pharmacy; they all claimed that they had not received notices from the state. None of the participants we spoke with knew about the “clock reset” on January 1, 2019, that permitted them to reapply to Arkansas Works, thus extending their period of uninsurance longer than necessary.

“I heard about it on the news and then I got a letter.”

“I don’t remember getting a letter.”

“I didn’t know it was a requirement. That [meeting the work requirement] is the only way you keep your insurance...The lady at the clinic told me.”

“I don’t know about it...I guess it goes over my head. I am oblivious to it.”

“[DHS] said [they] sent the letter and it didn’t come, but who’s fault is that? It might not be my fault or their fault, but you need to make sure I know.”

“I found out about [the work requirements] when [my coverage] got turned off... If they are going to disconnect you, they need to guarantee correspondence from you before doing that.”

Source: Urban Institute focus groups, May 2019.

Overall, outreach and education efforts appear to have lacked the diversity of methods needed to successfully reach the target audience. While the state’s direct contact efforts were high in volume, key informants with whom we spoke thought that making such contact at the community level, in person,

and through organizations beneficiaries more regularly interact with and trust, might have been more effective than mail and phone calls. In addition, the beneficiaries that were reached had difficulty understanding the complex information they were presented with. Continued efforts to simplify the messaging and the program itself may have made the information more digestible.

Supporting Arkansas Works Beneficiaries' Transition to Employment

If the rationale behind Medicaid work requirements is to promote employment and, by extension, better health outcomes among beneficiaries by helping them rise out of poverty, then it reasonably follows that such an initiative should balance its requirements surrounding work and reporting with a system for supporting consumers as they seek work or gain new skills to improve their prospects.

Arkansas DHS officials have been referring Arkansas Works enrollees to the state's Department of Workforce Services (DWS) since June 2017—well before CMS officially approved the waiver—as required by the state statute that reauthorized the Medicaid expansion and created work requirements. Since then, the two agencies have been coordinating efforts, developing referral language, estimating potential demand for DWS services, and anticipating whether DWS capacity would be sufficient to meet demand.

DWS officials describe their infrastructure as comprising 10 Workforce Development Districts, each containing one “comprehensive workforce center,” and 27 additional satellite offices that offer more limited services. Supported primarily by federal funding under the Workforce Innovation and Opportunity Act, the state's workforce centers operate under a “no wrong door” approach and accept “soft” referrals from 16 different partner agencies in state government with which DWS shares memoranda of understanding. “Universal” services provided in workforce centers are available to anyone and have no eligibility requirements; they include such supports as job search assistance, help with developing a résumé, interview skills training, and helping people secure “certificates of career readiness” at various qualification levels. Beyond universal services, workforce centers also offer intensive, job-specific training (e.g., skills needed for a commercial truck driving license), but these programs require people to meet stricter eligibility criteria, including evidence documenting the need, utility, and appropriateness of providing the training. DWS also maintains a website on which employers post jobs, but agency staff also rely on commercial job sites—like Monster.com and Indeed—to help identify opportunities for their customers.

Medicaid beneficiaries who are also enrolled in the Supplemental Nutrition Assistance Program (SNAP) can access services through the SNAP employment and training (SNAP E&T) program. The SNAP E&T program similarly aims to help its enrollees comply with work requirements and secure long-term employment. SNAP E&T providers primarily offer soft-skills training and basic work readiness supports (Hahn 2019b).

DHS referrals to DWS primarily take the form of language, included in all notices and messages to beneficiaries about the work requirements, that encourages enrollees to take advantage of the services available at regional DWS offices. For example, an infographic posted on DHS social media account included the following message, as well as a link to the DWS website: “Apprenticeships, on-the-job-training, vocational training, work experience, the GED program, and more. DWS staff members will help you find the right training to help you get ahead.”¹⁸

State officials expected the work requirements to generate a huge response and estimated that between 80 and 90 percent of the roughly 40,000 Arkansas Works’ enrollees subject to the work requirements in summer 2018¹⁹ would seek help from DWS. DWS officials were, in fact, quite concerned by this possibility—worried that centers would be overwhelmed and unable to meet the demand—and planned for how they might accommodate large numbers of new customers. However, “the flood never came,” according to one official. At its peak during summer 2018, the proportion of Arkansas Works enrollees that acted on DHS referrals was “between 25 percent and 35 percent, and it tapered off from there.”

Advocates speculate that inaccessibility and barriers like lack of transportation drove this low response. They point out that Arkansas has 75 counties, many of them rural, and just 37 DWS workforce centers. Similarly, though DHS officials reported that the SNAP E&T program “has statewide coverage across all 75 counties,” many of those counties do not have a physical SNAP E&T location. Twelve counties only offer virtual case management; in others, the provider must travel to the client’s county of residence to meet at an agreed-upon location.²⁰ But state officials chalked it up to the much broader challenges surrounding reaching enrollees in the first place. In other words, if the state’s letters, phone calls, and emails failed to reach a large share of Arkansas Works enrollees to tell them about the program’s new work requirements, then these methods also failed to reach these same consumers with the message that work support assistance was available from DWS. (See box 2 for consumers’ views on employment, job opportunities, and experiences with DWS workforce centers.)

Perhaps the best source of data available on the number of Arkansas Works recipients entering employment is the state’s New Hires Database. These data show that roughly 2,000 of the 18,000

beneficiaries that lost coverage had found new work. However, the New Hires Database was described as an imperfect source for several reasons: people may have only been employed for hours or days; jobs may be part-time or seasonal, as opposed to full-time and permanent; and employees may have just changed jobs, as opposed to having been previously unemployed.²¹ In addition, there is no evidence that the 2,000 people who found jobs were able to secure employer-sponsored health insurance coverage.

BOX 2

What Focus Groups Said about Training and Employment Resources

Fourteen of our 29 focus group participants told us they were already working: 10 were working 20 or more hours a week, and 4 were working less than 20 hours a week. Eleven beneficiaries reported being unemployed, and several were students. Of those who were unemployed, many said they were looking for work, but several told us they were having difficulties finding a job. Only a handful of beneficiaries had heard of employment support services available from the state or had received a referral to a DWS workforce center. Just five focus group participants had received services, including workforce center staff reviewing their résumés, preparing them for interviews, and connecting them with potential job opportunities. For two beneficiaries, the jobs they were connected with did not match their abilities. One beneficiary reported obtaining employment as a result of DWS services. Several participants reported barriers getting to the workforce centers, such as transportation and limited parking.

“It is hard enough for me to get a job...I have a part-time job but when they added on all this...It is a big hassle.”

“I live in Pine Bluff and...there aren't really too many job opportunities down there. I go and fill out [job applications], but there aren't many things I can fill out for.”

“I probably got [a letter referring me to a workforce center], but I move so much.”

“I went in and talked to [the workforce center staff]. They gave me websites to go to and set me up with interviews and he helped me prepare myself. Now I have a job. He helped me do a résumé, and he helped me with interview questions like how to get the right answers together and communicate better and smarter to be able to actually get the job and do the interviews. He told me to smile more.”

“He set me up with job interviews. He made sure I had everything I needed.”

“They helped me do the résumé and helped me put it together and everything...But the jobs they had I could not do because they are extremely physical like warehouse work.”

“He took my résumé and went over it and...he said ‘go over to Kroger’s.’ I went there, but the jobs they were hiring for was the bakery and the deli. They weren't hiring cashiers. So it didn't lead to a job.”

“I had to catch two buses to get there. It was not convenient. And the way the bus lets you out, you have to run through traffic. You can ride it all the way around, but you have to pay \$1.40 more.”

Source: Urban Institute focus groups, May 2019.

Reporting Work and Community Engagement

Complying with Arkansas's Medicaid work requirements compels program enrollees to not just complete at least 80 hours of work or other community engagement activities a month, but to *report* those efforts each month. The state DHS set up an online portal as its primary mechanism for beneficiary reporting. The process requires beneficiaries to (a) have an email address, (b) set up an online, password-protected account on the portal, and (c) access the portal at least once each month to report work and engagement activities. One key informant paraphrased the state government's implicit rationale for promoting this method of reporting: "It was their attitude that 'We live in the digital age; everyone needs to be able to use the internet if they are going to succeed at work.'" Unfortunately, several challenging circumstances undermined the state's effort to promote widespread internet literacy and use.

First, Arkansas is ranked last among US states in the share of residents with broadband internet;²² many rural communities in the state have no internet access at all.²³ Second, most people enrolled in Arkansas Works do not own their own computers. Combined, these factors meant that the state's assumption that everyone would be able to access the online reporting system was mistaken; in fact, a large share of beneficiaries reportedly could not easily access the state's website and had to travel to places like public libraries to find a computer. But as we learned in our focus groups, beneficiaries often lack reliable means of transportation, and public transportation systems are inadequate, so even regularly getting to a public library to access a computer can be difficult (box 3).

Third, the web portal was problematic. Described by key informants as "clunky" at best and "horrible" at worst, the website was reportedly slow, confusing, and not user-friendly. (For example, when users access the site, the first page they face is filled with a large banner that asks, "Would you like to register to vote?" which suggests that users have reached the wrong site.) Setting up an online account requires a complicated, multistep registration process (Musumeci, Rudowitz, and Hall 2018). Health care professionals and advocates told us that they tried to navigate the reporting system and found it "very complicated" and "nearly impossible." When users did report hours, no message was sent back to them indicating that they had successfully submitted their information, according to one report, leaving a seed of doubt in the mind of the beneficiary. Focus group participants reported that the fact that the online portal was not available 24 hours a day—it was only accessible from 7:00 a.m. to 9:00 p.m.—presented another obstacle to reporting hours. The website also occasionally crashed, which caused beneficiaries attempting to report hours to either start over again when the site was back up and running or call the state by phone for help. Some beneficiaries, having never had an email account

before, said they forgot their email addresses and passwords and would also have to call the state on the phone to get a new password.

Circumstances like these—requiring consumers to contact the state by phone—highlighted a fourth weakness of the system: long waits to get help over the phone from either state DHS staff or the Arkansas Foundation for Medical Care call center. Informants told us that low-income people usually had phone plans with limited minutes—so they were reluctant to burn their minutes waiting on hold—or government phones that had low minute allowances and were not “smart” and thus unable to access the internet. Beneficiaries who owned smart phones and could access the DHS website on them needed to use their phone’s internet browser (e.g., Safari) since there was no app developed for Apple or Android phones. Reportedly, navigating the site on a phone was even more difficult than doing so on a computer.

DHS officials dispute the widespread characterization of its Medicaid work requirement reporting system as “internet only”; they say beneficiaries always had the option of reporting their hours by phone to DHS through a registered reporter. DHS’s registered reporter system allowed beneficiaries to designate someone (e.g., a care manager at their health clinic or health plan) to report hours on their behalf. Moreover, DHS officials say enrollees could also get one-on-one help reporting hours at their local DHS or DWS office.

Key informants wondered, however, how well these options were publicized or understood by consumers, given the limitations of the state’s outreach effort and reliance on mailed letters, emails, and phone calls to convey information. Indeed, health care providers and health plan staff said that, while they understood they could assist enrollees with reporting, they received no direct outreach on how they could register or training on how to fulfill the reporter role. Plus, the relatively small share of their patients faced with reporting requirements made setting up registered reporter systems in any systematic or widespread manner impractical and inefficient. In the small number of cases where we heard from someone that did help clients with reporting, we were told they struggled to successfully navigate the system. As for reporting hours in person at DHS offices, people could only do so when local offices were open—that is, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Still, amid increasing negative publicity surrounding the growing numbers of people disenrolled from Arkansas Works for not complying with reporting requirements, state officials started increasing the reporting options available to beneficiaries and making the system more accessible.

- First, DHS expanded the call center hours to seven days a week, 7:00 a.m. to 9:00 p.m. in August 2018.

- Second, DHS allowed call center staff to receive calls from consumers and report hours into the DHS website on their behalf in December 2018.
- Third, DHS simplified reporting for students using the portal in December 2018.

However, information about these new options was conveyed to Arkansas Works enrollees by the routine mail and phone calls from the state, so key informants speculated they were not widely understood.

Overall, although the state adjusted its reporting system to create more options and methods for reporting, no adjustments made the process truly accessible, seamless, or effective. This, combined with outreach efforts that appeared to have failed in reaching and informing the majority of Arkansas Works enrollees of new Medicaid work requirements, help explain the low rates of reporting work and community engagement hours. Box 3 illustrates beneficiaries' experiences with the Arkansas Works reporting system, and box 4 provides data on beneficiaries who met the program's 80-hour requirement and the kinds of work and community engagement activities they completed.

BOX 3

What Focus Groups Said about Work Reporting Systems

Our focus group participants agreed that the system established by the state to report work and other community engagement activities presented many difficulties and caused a lot of frustration. Ten participants said they had attempted to report their hours online but experienced challenges navigating the website. A handful reported getting locked out of their accounts and having to call DHS to reset their passwords. In addition, the web portal was only open when the call center was open, so beneficiaries could only report hours from 8:00 a.m. to 4:30 p.m. (during the early months of implementation) and 7:00 a.m. to 9:00 p.m. (when hours were extended in August 2018).

Participants faced numerous other barriers to reporting work or community engagement hours. For example, few focus group participants had computers or internet access; therefore, they had to go to libraries, DHS offices, or the Salvation Army to get online. Many told us they had difficulty accessing transportation to get to these places. Additionally, participants were often unaware of reporting options other than the online portal. A handful had success reporting over the phone, but three of these beneficiaries complained of long hold times. Some received help reporting hours in person at local DHS offices, though six beneficiaries commented that staff were condescending or unwilling to help. No focus group participants knew that a registered reporter could report hours on their behalf.

“I had to use a friend’s computer and they had to help me...they are pretty smart and it took us over 10 and a half hours just to set [my account] up in the first place.”

“By the time I got the letter I only had one day to [report my hours] and I tried to get online to do it and it wouldn’t let me. So, I don’t even know if I have [health insurance] right now.”

“You have to call to reset [your password]. If you try three times, it locks you out. They put you on hold and then you talk to someone and then you are on hold again.”

“I don’t have [internet access]. I have to go on the bus to get to the library and a lot of times I don’t have a bus pass. The library is pretty far away, not walking distance.”

“I go to [the] Salvation Army but their Wi-Fi is up and down. I am there from 7:00 at night to 7:00 in the morning, but... [during the day] I have to check on my 17-month-old. It is hard to get to the library. I had my purse stolen so I don’t have an ID. So I can’t get a new bus pass or a new library card to be able to use the computers there. It is hard.”

“If I am trying to go on the website to get anything accomplished...something goes wrong and I can’t go any further or it has to reload and then ‘bam!’ it is denied...You are forced to use the telephone and then every time I can actually get through to someone...I have to stay on hold for 45 minutes to an hour and then sometimes you will get hung up on.”

“I didn’t know you could call someone and they would report it.”

“The people at DHS are rude. They won’t help you with [reporting hours].”

“The people at DHS are very condescending...Like you are bothering them to be there.”

“That is jargon—we have not heard of [registered reporters].”

Source: Urban Institute focus groups, May 2019.

BOX 4

How Many Arkansas Works Enrollees Met Medicaid Work Requirements, and What Work and Community Engagement Activities Did They Report?

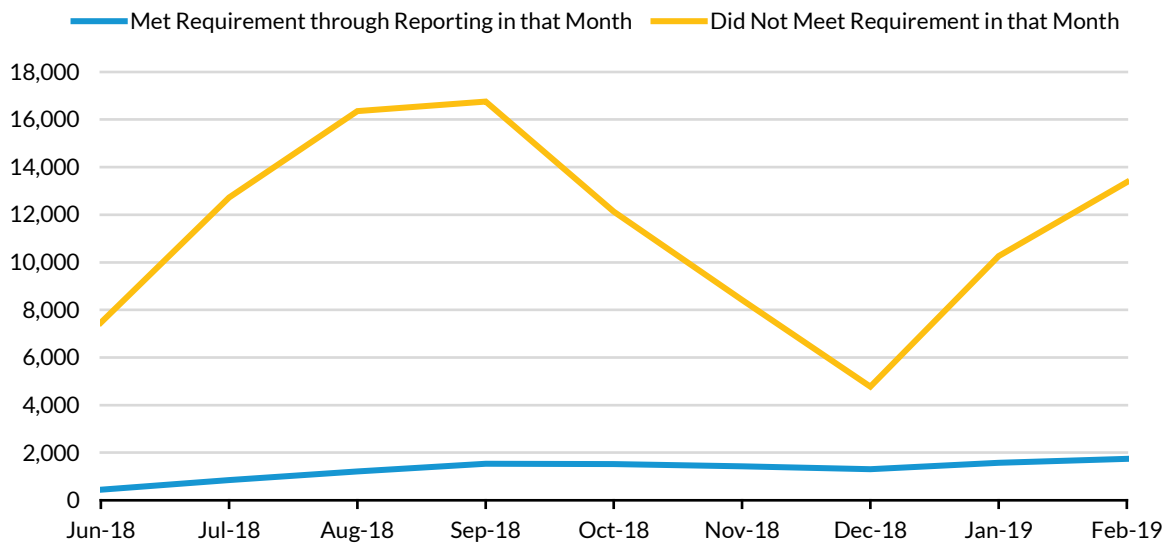
According to DHS, 18,164 people were disenrolled from Medicaid for not meeting the state’s work requirements. These people either did not report sufficient activity (e.g., their hours were less than 80 per month) or did not report hours at all. But how many Arkansas Works enrollees *did* report hours and met the 80-hour requirement, and what kinds of activities did they engage in?

Just 445 enrollees successfully reported more than 80 hours of activity in June 2018, the first month of the program, (figure 3, blue line). This number steadily climbed each month, topping out at 1,741 people in February 2019, the month before the program was halted. Over the same period, many more people failed to meet the work requirement (yellow line), starting with 7,464 in June 2018 and ending with 13,373 in February 2019. In every month, more than 98 percent of beneficiaries subject to work requirements reported no activity; less than 2 percent reported some activity, but not enough to meet the 80-hour requirement.

Among those who met Medicaid work requirements in February 2019, the largest portion did so by meeting SNAP work requirements (53 percent), followed by those working (25 percent), volunteering (12 percent), going to school or receiving training (4 percent), and conducting a job search (<1 percent; figure 4).

FIGURE 3

Monthly Beneficiary Compliance and Noncompliance through Reporting, June 2018–February 2019

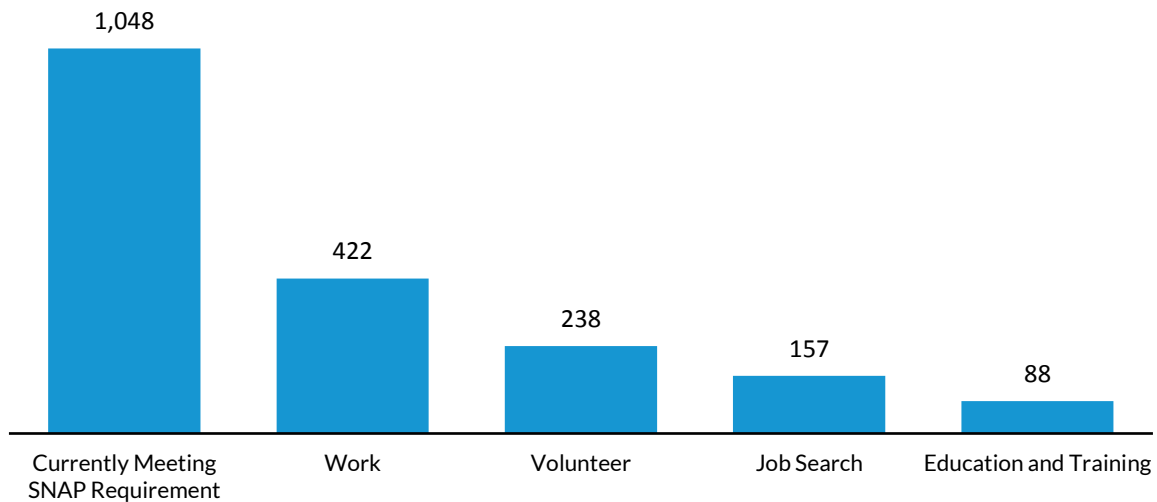


URBAN INSTITUTE

Source: Arkansas Department of Human Services, *February 2019 Arkansas Works Program Report*, accessed September 17, 2019, https://humanservices.arkansas.gov/images/uploads/190315_February_AWRReport.pdf.

FIGURE 4

Beneficiaries Who Met Work Requirements through Reporting by Activity Type, February 2019



URBAN INSTITUTE

Source: Arkansas Department of Human Services, *February 2019 Arkansas Works Program Report*, accessed September 17, 2019, https://humanservices.arkansas.gov/images/uploads/190315_February_AWRReport.pdf.

Note: Beneficiaries could engage in more than one type of activity.

Obtaining Exemptions

Stakeholders universally praised DHS's effort to conduct data matches to proactively identify Arkansas Works beneficiaries between the ages of 19 and 49 who qualified for an exemption from reporting work or community engagement hours. These aggressive matching efforts identified roughly two-thirds of all Arkansas Works beneficiaries who would be exempt from reporting work or community engagement hours, leaving one-third who would have to comply when implementation began in June 2018 (Musumeci, Rudowitz, and Hall 2018). Data matches were conducted primarily with

- DWS work systems, to identify beneficiaries already working sufficient hours; and
- SNAP systems, to identify beneficiaries already in compliance with SNAP reporting requirements.

State DHS officials said they continued to explore additional data-matching opportunities throughout implementation of the Medicaid work requirements. In March 2019, for example, DHS partnered with the Arkansas Department of Higher Education to identify and exempt students meeting Medicaid work requirements through education-related activities. Because this data match was completed just before the court decision to halt the program, there is little evidence of its impact.

Despite DHS's efforts to identify exempt beneficiaries, advocates and various stakeholders were concerned that many enrollees were "falling through the cracks." They were particularly concerned about beneficiaries with medical conditions that prevented them from working. Two providers we spoke with told us they had patients with disabilities who should have received exemptions but had not. Several of those beneficiaries had been disenrolled from Arkansas Works.

Beneficiaries not identified as exempt by DHS's data matches could request an exemption. Table 3 lists the total number of people who qualified for exemptions, either through data matches or exemption requests, in February 2019.

DHS officials noted that beneficiaries could qualify for more than one exemption group, but they were counted in one group. Those beneficiaries' exemption classifications were based on which exemption status lasted the longest. One DHS official gave the following example: "full-time school is one of our longest exemptions, so while that person may have other things that qualify them for an exemption, we would...apply that exemption to their case." Of the 102,856 beneficiaries who met the requirement in February 2019, 98 percent were in compliance due to exemptions.²⁴

TABLE 3

Arkansas Works Beneficiaries Qualified for Reporting Exemptions, February 2019

Reason for exemption	Number of beneficiaries
Employed >80 hours/month	52,571
Currently exempt in SNAP	16,503
Dependent child in home	14,077
Medically frail	10,645
American Indian/Alaska Native	2,570
Education and training	1,531
Short-term incapacitation	1,271
Caring for incapacitated person	928
Receives unemployment benefits	613
Alcohol or drug treatment	279
Pregnant	127
Total	101,115

Source: Arkansas Department of Human Services, *February 2019 Arkansas Works Program Report*, accessed September 17, 2019, https://humanservices.arkansas.gov/images/uploads/190315_February_AWRReport.pdf.

“Good cause exceptions” could also be requested in the event of temporary, unforeseen circumstances that precluded beneficiaries from working 80 hours in a given month. For example, DHS officials said that a temporary illness or even a flat tire that prevented someone from getting to work could qualify for an exception. If the “good cause exception” was granted, then the number of required work or community engagement hours for that month was reduced. All requests were reviewed case by case, and hour reductions were based on the duration of each beneficiary’s circumstance. In total, 676 “good cause exceptions” were granted of the 1,017 requested between June 2018 and March 2019.²⁵ According to DHS officials, “good cause exceptions” were available from the beginning of implementation, but consumer awareness was initially low. In response, DHS officials said they “ramped up” efforts to publicize these exceptions. However, key informants thought consumer awareness remained low throughout the implementation period.

DHS officials reported that exemptions and “good cause exceptions” could be requested by email, web portal, or phone, in county offices, and through providers and health plan staff. Key informants agreed that medical providers were often called on to assist beneficiaries with the exemption process, in particular for medical conditions that hindered a patient’s ability to work. The providers we spoke with had a range of experiences: one doctor submitted a request on behalf of a patient who obtained an exemption; another doctor was asked to fill out a request but felt uncomfortable doing so because he believed that patient was able to work.

According to state officials, beneficiaries typically were not required to submit documentation or evidence supporting their exemption or exception requests. In the words of one DHS official, “We told our staff to err on the side of the client—if [clients] are reaching out and have an explanation [for why

they can't work], we use that as an opportunity to help them get on track." Additionally, if a medical provider reported a need for an exemption for one of their patients, DHS officials said they did not require further verification of the patient's medical condition. These policies were viewed positively by key informants.

Still, key informants worried that because beneficiaries had little knowledge and understanding of the Medicaid work requirements generally, they would not have a clear understanding of the exemption process. Additionally, key informants raised concerns that the methods for requesting exemptions were the same as the methods for reporting hours, therefore beneficiaries might experience the same challenges doing so as outlined above.

Obtaining an exemption was further complicated by the fact that different qualifying circumstances result in exemptions of different lengths (table 4). For example, beneficiaries who were attending an alcohol or drug treatment program were required to demonstrate they were still exempt every two months, whereas those receiving unemployment benefits were required to do so every six months (Arkansas DHS 2018). According to stakeholders and focus group participants, these stipulations were unclear to beneficiaries and caused confusion and possible loss of Arkansas Works coverage (box 5).

TABLE 4
Exemption Criteria and Associated Duration of Exemption

Criteria	Duration
Beneficiary's income is consistent with being employed or self-employed at least 80 hours a month	Valid until a change in circumstances or renewal
Beneficiary attends high school, an institution of higher education, vocational training, or job training full time	Valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is exempt from SNAP work requirements	Valid for duration of SNAP exemption
Beneficiary is receiving TEA Cash Assistance	Valid for duration that individual is receiving TEA Cash Assistance
Medically frail/disabled	Valid until a change in circumstance
Beneficiary is incapacitated in the short term or is medically certified as physically or mentally unfit for unemployment	Valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is caring for an incapacitated person	Valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary lives in a home with a dependent child age 17 or younger	Valid until a change in circumstances

Criteria	Duration
Beneficiary is receiving unemployment benefits	Valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is currently participating in a treatment program for alcoholism or drug addiction	Valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is pregnant	Valid until 60 days postpartum

Source: Arkansas Department of Human Services, “Arkansas Works Work Requirement Evaluation Design and Strategy” (Little Rock: Arkansas Department of Human Services, 2018).

BOX 5

What Focus Group Said about Exemptions from Work Requirements

Very few focus group participants had obtained exemptions from the Arkansas Works work requirements. Of the 29 participants with whom we spoke, three reported applying for and receiving an exemption. Of those beneficiaries, two said staff at a local DHS office handled it for them, and one said they requested an exemption online, per the advice of a provider. All three exemptions were for medical reasons. Generally, focus group participants did not thoroughly understand the exemption process. One participant expressed confusion about how long exemptions lasted.

“I [got an exemption]. I went to DHS and she handled it for me and told me to get a letter from my doctor and then [I did] and brought it back and they made me exempt. They didn’t hassle me.”

“I got kicked off [the program] and I talked to my psychiatrist office and they said just go back in there and put exempt and I did and they reinstated me.”

“One problem is you go [online] to put things in and it might need you to do it the next month and then sometimes I wouldn’t have to do it for two or three months...They need to send you an email or text to tell you how long the exemption lasts.”

Source: Urban Institute focus groups, May 2019.

Implications of Disenrollment for Providers, Hospitals, Health Plans, and the Beneficiaries They Served

By many measures, Arkansas’s expansion of Medicaid under the Affordable Care Act has been a significant success. As mentioned in the background section, state officials’ original decision to implement Medicaid expansion as “private option” drew the support of conservative lawmakers since

that would provide premium subsidies to consumers who could then purchase private insurance in the state's marketplace. Within a year of passage, nearly 210,000 previously uninsured Arkansas adults gained coverage (Arkansas DHS 2014), and by July 2018, that number had risen to over 320,000, accounting for a 51 percent decrease in the state's uninsurance rate (Berchick, Hood, and Barnett 2018).²⁶ Further, the newly insured Arkansans enjoyed improvements in access to care, use of preventive services, and self-reported health (Sommers et al. 2017).

Medical providers liked the private option approach because they would receive commercial rates; according to the stakeholders we interviewed, this persuaded many private physicians to accept new expansion patients when they might not have otherwise. Medicaid expansion was also a boon to hospitals in the state, as previously uninsured patients that had been "charity care" patients for these institutions were now fully insured. Pharmacies, too, benefited from expanded coverage and increased revenue. Meanwhile, the state's three qualified health plans participating in Medicaid—Blue Cross/Blue Shield, Centene (known as Ambetter in Arkansas), and Qualchoice—gained tens of thousands of new "covered lives" in their risk pools. Indeed, the state's dominant payer, Blue Cross/Blue Shield, insured over 186,000 (roughly 60 percent) people eligible under the Medicaid expansion.²⁷

In total, Arkansas's ACA/Medicaid expansion has brought in just under \$8 billion in federal funds since program launch in 2013.

Medicaid work requirements, unfortunately, appear to have reversed some of these gains, and the full implications of these reversals may not be known for some time. Most notably, more than 18,000 beneficiaries were disenrolled from Arkansas Works between June 1 and December 30, 2018. Almost nothing is known about the 18,000 people who lost coverage, whether they possessed good or poor health status, or were high or low users of care. DHS officials and contractors speculate that "as many as half" of these people may have been healthier beneficiaries and point to low rates of reenrollment starting in January 2019 as evidence that they "may not have needed health care." (Arkansas Works enrollment increased by just 30 people in January 2019 and by just under 2,100 in February; it did, however, increase by another 4,200 in March.)²⁸ But a majority of key informants said things like, "We just don't know that [that they were healthier]," given the lack of credible data and a belief that widespread confusion surrounding the work requirements offered a better explanation for why reenrollment rates were so low.

There is no question, however, about what lack of health insurance means for consumers. Research has well documented that lack of coverage is associated with delays in seeking needed care, higher rates of chronic illness, and overall increased morbidity and mortality, as well as other negative

consequences, such as higher medical debt (Katch, Wagner, and Aron-Dine 2018). Indeed, participants in our focus groups told us how losing Medicaid affected their ability to obtain needed care, as well as their peace of mind, because they no longer knew how they would cope if they experienced a serious illness (box 6).

Public health care providers expressed concern over recent utilization trends. Administrative staff at one large FQHC pointed to preliminary data that showed a three-month downward trend in Medicaid billings, from a monthly average of \$100,000–\$120,000 to about \$80,000, suggesting fewer Medicaid-covered individuals were being served. Over the same period, the FQHC saw a 4 percent increase in “self-pay” (i.e., uninsured) patients. Overall declining Medicaid enrollment in Arkansas, on top of disenrollment for noncompliance with the work requirement, could be contributing to this decrease in revenue. Officials said that it was common for patients with new commercial coverage to no longer rely on the FQHC as their usual source of care and instead seek care from private physicians in their health plans’ networks. But these same patients typically return to the health center for care if they lose coverage because private physicians “absolutely” won’t serve the uninsured, in their experience. Providing care to increased numbers of uninsured patients puts pressure on the FQHC’s federal grant funds to cover costs, officials explained, pulling funds away from such important functions as hiring new staff, raising salaries, purchasing supplies, or providing extra services.

Hospital industry representatives explained that Arkansas’s Medicaid expansion had been extremely beneficial to their members. Until this year, the state had not seen a single hospital closure since 2012, the year before Medicaid expansion. Rural hospitals, in particular, had been “really propped up” by the expansion, said one observer, as they were relieved from large charity care burdens. Over the past year, however, a growing number of hospitals had begun reporting increases in rates of uncompensated care. Hospital officials admitted, however, that 18,000 fewer insured adults was a relatively small number “in the overall scheme” and might not dramatically impact their bottom lines, depending on disenrollees’ health status. But according to hospital industry representatives, accurate data on uncompensated care will not be available until December 2019 at the earliest.

Health plan officials said that they were “proud” of their product and of the large numbers of Arkansans they had helped through the Medicaid expansion. They also expressed concern that the state was reversing course in its coverage trends; as one official put it, “How does taking coverage away from people help our society?” Enrollment drops in health plans have occurred since the start of the work requirements, but health plan officials have “no idea” yet whether disenrollees were high or low users of care. While some key informants interviewed for this study expressed hope that disenrollees might be healthier individuals who were less likely to be impacted by a loss of coverage, for health plans, this

dynamic is reversed. If the people who lost Medicaid as a result of the work requirements were disproportionately healthy, then health plans' risk pools could be adversely affected as proportionally sicker, higher users of care remain and risk cannot be spread across as many healthier enrollees. However, like the hospitals, health plans did not have any data yet to inform whether and how shrinking enrollment might affect their financial circumstances.

BOX 6

What Focus Group Said about Implications for Beneficiaries

Eleven of our 29 focus group participants reported unexpected disruptions in their Arkansas Works coverage. The majority found out their coverage had been terminated when they were seeking care or attempting to fill a prescription. In one focus group, we asked participants if they had forgone needed care or medication because they did not have coverage; 7 of the 14 participants said that they had. In the other group, we discussed possible consequences of not having coverage and how it might affect their health and ability to keep a job. Participants acknowledged that they need things like medications to maintain their health and shared that, in dire circumstances, they sought care from emergency rooms since they were unable to see their usual providers. These beneficiaries also recognized that the quality of their care was significantly worse when they did not have health insurance than when they did.

“I went to pick up my prescription and they said I couldn't get it...It was a big shock. At first, I was upset and then I was worried because I need my medicine. I shouldn't find out the day I need my medicine.”

“I had a doctor's appointment and I was trying to check in and she ran my insurance and said I didn't have it. I was worried. Going to the doctor is important for your health.”

“I woke up from seizures in the hospital and one day my Medicaid was active and the next day it wasn't. When you wake up from a seizure you are already disoriented and then you are telling me I have to pay out of pocket before being seen?”

“I have to have my medication because I am epileptic, and I take three different seizure medicines. If I don't take it, I can't work...I had to be stable and if I was not stable I was going to lose my job.”

“Whenever my insurance gets cut off, I go to the ER and fake like I am dying so they will fill my prescription...They know me there. I do not like going to the hospital and when I go there it is because I need my medicine. They know I am there for a reason.”

“[I didn't go because of] cost and coverage. I got sicker, mentally. I wasn't taking my mental meds.”

“If you don't have coverage, the way you are treated in hospitals changes tremendously and that is a hurting feeling.”

“[The hospital] put me out at 2:00 AM. No buses running. I didn't have a cab or anything.”

Source: Urban Institute focus groups, May 2019.

Conclusions and Lessons Learned

A federal court halted Arkansas's Medicaid work requirement program on March 27, 2019, just days before the state would have disenrolled additional Arkansas Works beneficiaries who failed to report work or community engagement activities during the first three months of 2019. At the time, 5,492 adults were at risk of losing Medicaid for not having reported hours in January and February, on top of the roughly 16,000 who had been disenrolled in 2018 for not meeting the Medicaid work requirements and had not reenrolled.²⁹

The court ruling was “not a surprise to anyone,” according to one key informant interviewed for this study. Indeed, the state legislature had discussed its possibility during its 2019 session. The 35-member Arkansas Senate voted to continue the state's Medicaid expansion on the same day as the court ruling, but the 100-member House of Representatives only provided its 75-vote supermajority approval of continuance after Arkansas Governor Asa Hutchinson pledged to legislators that he would wage a “vigorous appeal” of the decision. Governor Hutchinson immediately asked the federal Department of Justice to appeal and, on April 10, it filed notice of its appeal and asked for expedited review.³⁰ Seema Verma, administrator of the Centers for Medicare & Medicaid Services issued a strong statement of support, saying the agency would “vigorously support [states'] innovative, state-driven effort to develop and test reforms that will advance the objectives of the Medicaid program.”³¹

DHS officials had been preparing for months for the possibility of such an outcome, putting systems and procedures in place that would allow them to “flip a switch” and “turn off” the reporting requirements. After the ruling, the agency immediately issued notices to Arkansas Works enrollees that they no longer needed to report hours spent on work and community engagement activities; it also issued call scripts for local DHS offices and the state's call center so staff could inform consumers of the change in policy. Importantly, the federal judge did not rule that Arkansas needed to reenroll people who had lost Medicaid during the program. And, because state law prohibits DHS from spending money to promote enrollment, no mass media or other campaign publicized the news to the 18,000+ previously insured program beneficiaries, though Medicaid health plans and provider associations were reportedly active in informing their members of the federal court ruling and its implications for customers.

In the months following the halt of Arkansas's program, new analysis emerged that the state's work requirements were associated with significant losses in health insurance coverage in the initial six months of implementation with no accompanying significant improvement in employment (Sommers et

al. 2019). And, once again, there is no evidence that disenrolled adults who did find jobs were able to obtain employer-sponsored health insurance.

At the time of our site visit, stakeholders were left with many as-yet unanswered questions, including, Who are the 18,000 individuals who lost Medicaid coverage in 2018? Are they in good or poor health, and high or low utilizers of care? When will claims data from the period before disenrollment be available to help answer those questions? Did the disenrolled have medical conditions that prevented them from working? Did they find work? If so, did that employment bring with it health insurance benefits? What were the total costs to the state associated with implementing Medicaid work requirements? And what were the opportunity costs associated with that policy choice? (For example, could state resources have been better used to address Arkansas's substance use disorder problem?) Section 1115 demonstration waivers, like that granted to allow Arkansas to experiment with Medicaid work requirements, are supposed to have rigorous evaluations attached to them. But no evaluation contract was ever awarded to analyze the implementation and impacts of Arkansas's waiver. Groups like the Arkansas Center for Health Improvement are planning various analyses of state and health plan data to investigate some of these questions, but as of September 2019, these questions remain unanswered.

Not surprisingly, attitudes surrounding the federal court's ruling vary across stakeholders. Supporters of the goals of work requirements believe that the program is a "legitimate experiment" to determine if "incentivizing work" by threatening loss of health coverage can lift people out of poverty. Key informants expressed opinions like, "It's not asking too much to have people take some personal responsibility," and "These people are our neighbors; we have to work, why shouldn't they?" In fact, focus group participants generally agreed that beneficiaries should take personal responsibility for their lives and work when they can. Participants did not think it was unreasonable to expect able-bodied enrollees to work or participate in community engagement activities, but they also insisted that exceptions should be made for people who are unable to work for reasons of poor health, disability, and other valid reasons.

Opponents of the work requirements were pleased and relieved by the court's decision to halt the program, expressing such opinions as, "It's just not Christian," and "We were not being our 'brothers' keepers.'" Virtually no one with whom we spoke believed that work requirements had, thus far, proved an effective means for promoting work; as mentioned above, data from the DWS New Hires Database indicated that only a small fraction of adults disenrolled from Arkansas Works had gained steady employment. But proponents argued that the requirements had not been in place long enough to conclusively determine their impacts on employment. Finally, attorneys interviewed for this study

expressed the opinion that Medicaid work requirements were ultimately doomed, saying that they did not see any legal basis in the Medicaid statute for requiring work.

Yet, waivers to implement Medicaid work requirements have been approved in nine other states, and waiver applications from seven more states are pending at CMS. For now, at least, the prospect of more states implementing Medicaid work requirements in the future is very real. Therefore, it could be useful to identify lessons learned in Arkansas that might help these states implement work requirements in a manner that reduces coverage losses and promotes individuals' ability to work. Key informants, based on their experiences in Arkansas, proffered many suggestions for policymakers and program administrators in other states:

Outreach and Education

- Expand the scope, depth, and intensity of community-based outreach and education efforts, targeting the providers and agencies that serve Medicaid populations, to inform consumers and staff about what work requirement rules entail and how beneficiaries should comply

Reporting and Disenrolling

- Expand the means and methods available for reporting work and community engagement activities so individuals have many different options—phone, in-person, online, by mail—for reporting hours
- Make any web-based reporting system simple and user-friendly
- Design systems with the end user in mind, and involve consumers in the testing phase
- Test and retest all reporting systems before they go “live” so problems can be identified and addressed before consumers are faced with unnecessary challenges
- Create a mobile app so consumers can easily report work hours on their phones
- Make “live chat” available to users attempting to report hours online so questions can be answered and challenges addressed immediately and in real time
- Exhaust all means available before disenrolling beneficiaries from coverage, including (if necessary) home visits to inform them of work requirement rules and reporting methods
- Shorten the duration of lockout periods so people who lose Medicaid can regain that coverage more quickly once they comply with work requirements

Exemptions

- Expand data-linking efforts to proactively identify even more adults who should be exempt from work requirements by, for example, mining health plan claims data to identify people with diagnoses that would interfere with their working (e.g., substance use disorders and physical limitations)
- Exempt adults from work requirements who live in counties with higher-than-average unemployment rates
- Implement a risk screen to detect social determinants of health and identify adults who should be exempt from work requirements because of social needs (such as lack of transportation, child care, and housing) or behavioral and emotional factors
- Simplify the structure and duration of exemptions and good cause exceptions so they are easily understood and implementable

Monitoring and Evaluation

- Following Arkansas's positive example, be transparent with the public as a work requirement program is rolled out by regularly issuing detailed monitoring data and reports
- Put an objective, third-part evaluation in place—ideally, before, but at least at the start of a Medicaid work requirements demonstration—so the implementation and impacts can be rigorously evaluated

Another set of recommendations focused on strengthening systems that facilitate Arkansans' transitions to employment. Although these recommendations can be applied in the context of improving a Medicaid work requirement program, they also represent broader systems improvements that do not necessarily have to be paired with the threat of losing Medicaid coverage.

- Increase funding of work support agencies and infrastructure so they have the expanded employment and training capacity to help adults gain employment
- Work to address identified barriers to employment, such as lack of transportation and child care

While the above suggestions may help reduce coverage losses and promote people's ability to work, these strategies would certainly require additional resources, in both money and state staff time.

In discussing the merits of Medicaid work requirements, some informants made a strong pragmatic argument that, politically, Arkansas needed to adopt the program to ensure the continuance of the state's Medicaid expansion. Because a supermajority is needed in the House each year to continue the expansion, work requirements were necessary to bring more conservative members of the legislature on board. One viewpoint expressed was, "Isn't it worth the trade-off...to accept the loss of coverage for 18,000 individuals in order to keep coverage for 300,000 Arkansans?" It must be noted, though, that those losses were experienced in just the first six months of Arkansas's program and would likely have continued to climb had the program not been halted by the courts.

Other stakeholders pointed out that Arkansas's Medicaid expansion initially passed without work requirements, and the state has greatly benefited from drawing down nearly \$8 billion in federal Medicaid dollars since 2013. So, a countervailing argument was also made, asking, "Can the state walk away from all that federal financial support, and is it fair to hold the Medicaid expansion 'hostage' in return for work requirements?"

The debate surrounding these issues will continue in the coming months, and possibly years, as more states implement Medicaid work requirements and as courts are asked to judge their legality.

Notes

- ¹ Arkansas Department of Human Services (DHS), *February 2019 Arkansas Works Program Report*, accessed September 17, 2019, https://humanservices.arkansas.gov/images/uploads/190315_February_AWReport.pdf.
- ² Penny Thompson (chair, Medicaid and CHIP Payment and Access Commission), letter to Alex Azar (secretary, US Department of Health and Human Services), regarding work requirements implementation, November 8, 2018, <https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf>.
- ³ Arkansas DHS, *February 2019 Arkansas Works Program Report*.
- ⁴ Jennifer Wagner, “New Arkansas Data Contradict Claims That Most Who Lost Medicaid Found Jobs,” *Off the Charts* (blog), Center on Budget and Policy Priorities, March 19, 2019, <https://www.cbpp.org/blog/new-arkansas-data-contradict-claims-that-most-who-lost-medicaid-found-jobs>.
- ⁵ Wagner, “New Arkansas Data Contradict Claims.”
- ⁶ Civil Action No. 18-1900 Memorandum Opinion. March 27, 2019. https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
- ⁷ “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” Henry J. Kaiser Family Foundation, August 21, 2019, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state>. The following state waivers have been approved: Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Ohio, Utah, and Wisconsin. The following state waivers are pending: Alabama, Mississippi, Oklahoma, South Carolina, South Dakota, Tennessee, and Virginia.
- ⁸ We interviewed experts from the Kaiser Family Foundation, Georgetown Center for Families and Children, and the Center on Budget and Policy Priorities.
- ⁹ “Status of State Medicaid Expansion Decisions: Interactive Map,” Henry J. Kaiser Family Foundation, August 2, 2019, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>. The four southern states that expanded Medicaid are Arkansas, Kentucky, and West Virginia (all implemented January 1, 2014), and Louisiana (implemented July 1, 2016).
- ¹⁰ Louise Norris, “Arkansas and the ACA’s Medicaid Expansion,” *Healthinsurance.org*, May 7, 2019, <https://www.healthinsurance.org/arkansas-medicaid/>.
- ¹¹ “Local Area Unemployment Statistics,” Bureau of Labor Statistics, last modified August 16, 2019, <https://www.bls.gov/web/laus/laumstrk.htm>.
- ¹² “Unemployment Rate Rankings by Arkansas County,” Arkansas Division of Workforce Services, accessed June 21, 2019, <http://www.discover.arkansas.gov/Employment/Unemployment-Rate-Rankings-by-Arkansas-County>
- ¹³ “Local Area Unemployment Statistics,” <https://www.bls.gov/web/laus/laumstrk.htm>.
- ¹⁴ “Employment Status of the Civilian Non-Institutional Population by Age and Race Based on Current Population Survey—Not Seasonally Adjusted,” Arkansas Division of Workforce Services, accessed September 16, 2019, <http://www.discover.arkansas.gov/Portals/194/Publications/Minority%20Unemployment%20Rates/Minority.xls>.
- ¹⁵ Emily Johnston, Anuj Gangopadhyaya, Genevieve M. Kenney, and Stephen Zuckerman, “Arkansans Losing Medicaid Due to Work Requirements Are Likely to Face Limited Private Insurance Options,” *Urban Wire* (blog), Urban Institute, October 29, 2018, <https://www.urban.org/urban-wire/arkansans-losing-medicaid-due-work-requirements-are-likely-face-limited-private-insurance-options>.
- ¹⁶ Arkansas DHS, *February 2019 Arkansas Works Program Report*.

- ¹⁷ Jessica Greene, “Medicaid Recipients’ Early Experience with the Arkansas Medicaid Work Requirement,” *Health Affairs* blog, September 5, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.
- ¹⁸ Arkansas Department of Human Services Facebook account, March 22, 2019, <https://www.facebook.com/ArkDHS/>.
- ¹⁹ Arkansas DHS, *February 2019 Arkansas Works Program Report*.
- ²⁰ Arkansas DHS, “SNAP Employment Coordinators,” accessed May 17, 2019, <https://humanservices.arkansas.gov/images/uploads/dco/SNAPETCoordinators.pdf>.
- ²¹ Wagner, “New Arkansas Data Contradict Claims.”
- ²² “Percent of Households with a Broadband Internet Subscription—United States,” 2017 American Community Survey 1-year estimates, US Census Bureau, accessed September 23, 2019, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_GCT2801.US01PR&prodType=table.
- ²³ Anuj Gangopadhyaya, Emily Johnston, Genevieve M. Kenney, and Stephen Zuckerman, “Under Medicaid Work Requirements, Limited Internet Access in Arkansas May Put Coverage at Risk,” *Urban Wire* (blog), Urban Institute, October 29, 2018, <https://www.urban.org/urban-wire/under-medicaid-work-requirements-limited-internet-access-arkansas-may-put-coverage-risk>. Data are for nonelderly, nondisabled Medicaid recipients ages 19–49, the Arkansans subject to the work requirement.
- ²⁴ Arkansas DHS, *February 2019 Arkansas Works Program Report*. Both through data match exemptions and beneficiary-submitted exemption requests.
- ²⁵ Arkansas DHS, *February 2019 Arkansas Works Program Report*.
- ²⁶ Norris, “Arkansas and the ACA’s Medicaid Expansion,” <https://www.healthinsurance.org/arkansas-medicaid/>.
- ²⁷ Louise Norris, “Arkansas Health Insurance Marketplace: History and News of the State’s Exchange,” *Healthinsurance.org*, May 9, 2019, <https://www.healthinsurance.org/arkansas-state-health-insurance-exchange/>.
- ²⁸ Arkansas DHS, “Monthly Enrollment and Expenditures Report,” June 2019, https://humanservices.arkansas.gov/images/uploads/newsroom/Monthly_Enrollment_and_Expenditure_Report_20190617.pdf
- ²⁹ Arkansas DHS, *February 2019 Arkansas Works Program Report*.
- ³⁰ The Associated Press, “Trump Administration Appeals on Medicaid Work Requirements,” April 10, 2019, <https://www.apnews.com/2ae55802bed042af81e3d6883d56964b>; Amy Goldstein, “Arkansas Governor Seeks Appeal of Decision Voiding Medicaid Work Rules,” *Washington Post*, March 28, 2019, https://www.washingtonpost.com/national/health-science/arkansas-governor-seeks-appeal-of-decision-voiding-medicaid-work-rules/2019/03/28/7d88461c-516f-11e9-a3f7-78b7525a8d5f_story.html?utm_term=.47f30accd54b.
- ³¹ Phil Galewitz, “Federal Judge Again Blocks Medicaid Work Requirements,” *Kaiser Health News*, March 27, 2019, <https://khn.org/news/federal-judge-again-blocks-medicaid-work-requirements/>.

References

- Arkansas DHS (Department of Human Services). 2014. *Arkansas Private Option 1115 Demonstration Waiver Quarterly Report October 1, 2014, to December 31, 2014*. Little Rock: Arkansas DHS.
- . 2018. *“Arkansas Works Work Requirement Evaluation Design and Strategy.”* Little Rock: Arkansas DHS.
- Berchick, Edward R., Emily Hood, and Jessica C. Barnett. 2018. *Health Insurance Coverage in the United States: 2017*. Current Population Report P60-264. Washington, DC: US Census Bureau.
- Gangopadhyaya, Anuj, Genevieve M. Kenney, Rachel A. Burton, and Jeremy Marks. 2018. *Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know about Them?* Washington, DC: Urban Institute.
- Hahn, Heather. 2019a. *Navigating Work Requirements in Safety Net Programs: Potential Pathways for Parents*. Washington, DC: Urban Institute.
- . 2019b. *SNAP Work Requirements in Arkansas for Adults without Dependents or Disabilities*. Washington, DC: Urban Institute.
- Hiltz, Allison, and Luke Martel. 2015. *“Supermajority Vote Requirements to Pass the Budget.”* *LegisBrief* 23 (4).
- Karpman, Michael. 2019. *“Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment.”* Washington, DC: Urban Institute.
- Karpman, Michael, Heather Hahn, and Anuj Gangopadhyaya. 2019. *“Precarious Work Schedules Jeopardize Access to Safety Net Programs Targeted by Work Requirements.”* Washington, DC: Urban Institute.
- Katch, Hannah, Jennifer Wagner, and Aviva Aron-Dine. 2018. *Taking Medicaid Coverage Away from People Not Meeting Work Requirements Will Reduce Low-Income Families’ Access to Care and Worsen Health Outcomes*. Washington, DC: Center on Budget and Policy Priorities.
- Musumeci, MaryBeth, Robin Rudowitz, and Cornelia Hall. 2018. *“An Early Look at Implementation of Medicaid Work Requirements in Arkansas.”* San Francisco: Henry J. Kaiser Family Foundation.
- Sommers, Benjamin D., Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein. 2019. *“Medicaid Work Requirements—Results from the First Year in Arkansas.”* *New England Journal of Medicine* 381:1073–82. doi: <https://www.doi.org/10.1056/NEJMSr1901772>.
- Sommers Benjamin D., Bethany Malone, Robert J. Blendon, John Orav, and Arnold M. Epstein. 2017. *“Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health among Low-Income Adults.”* *Health Affairs* 36(6). doi: <https://www.doi.org/10.1377/hlthaff.2017.0293>.

About the Authors

Ian Hill is a senior fellow in the Health Policy Center at the Urban Institute. He has over 25 years of experience directing evaluation and technical assistance projects on health insurance programs for disadvantaged children and families. He is a nationally recognized qualitative researcher with extensive experience developing case studies of health program implementation and conducting focus groups with health care consumers, providers, and administrators. Hill currently directs the Strong Start for Mothers and Newborns Evaluation, which measures the impact of innovative prenatal care strategies on birth outcomes. He also leads various qualitative assessments of the Affordable Care Act's implementation, focusing on outreach and enrollment strategies and provider access. Hill led the qualitative components of two congressionally mandated evaluations of the Children's Health Insurance Program and directed Urban's work on the *Insuring America's Children* evaluation and *Covering Kids and Families* evaluation.

Hill did his undergraduate work at the University of California, Santa Barbara, and received MAs in public administration and social work from Syracuse University.

Emily Burroughs is a research assistant in the Health Policy Center. She primarily conducts research and analysis focused on access to health care coverage, as well as child and maternal health. She has been involved in data collection and analysis for a number of projects, including the national evaluation of Strong Start for Mothers and Newborns, an enhanced prenatal care program targeting Medicaid beneficiaries. Her qualitative data collection experience includes conducting key informant interviews and focus groups with a wide range of participants, such as health care consumers, providers, and administrators. Burroughs received undergraduate degrees in global health and psychology from Duke University.

STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org