

RESEARCH REPORT

New Hampshire's Experience with Medicaid Work Requirements

New Strategies, Similar Results

Ian Hill

Emily Burroughs

Gina Adams

February 2020



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
New Hampshire’s Experience with Medicaid Work Requirements: New Strategies, Similar Results	1
Introduction	1
Methods	3
Background on New Hampshire’s Passage of Medicaid Work Requirements	6
Reaching Out to and Educating Medicaid Beneficiaries	9
Promoting Work through the Granite Workforce Pilot Program	15
Reporting Work and Community Engagement	17
Obtaining Exemptions	21
Child Care Implications of Exempting Only Parents with Children Younger Than 6	25
Implications of Disenrollment for Providers, Hospitals, and the Beneficiaries They Serve	28
Diverging Opinions of Medicaid Work Requirements	30
Conclusions	32
Notes	36
References	38
About the Authors	40
Statement of Independence	41

Acknowledgments

This report was funded by the Robert Wood Johnson 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 New Hampshire Department of Health and Human Services and Department of Employment Security officials, health care providers, consumer and legal 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 Henry Lipman, New Hampshire Medicaid Director; Dawn McKinney and Kay Drought of New Hampshire Legal Assistance; Holly Stevens of New Futures; Jo Porter and Lucy Hodder of the University of New Hampshire; Kathy Hempstead of the Robert Wood Johnson Foundation; and Jessica Schubel of the Center on Budget and Policy Priorities for their review and comments on our draft report. We are particularly indebted to the New Hampshire residents who volunteered their time to participate in our focus groups and share with us their personal experiences with Medicaid and its work requirements. Finally, we thank our colleagues Genevieve Kenney, Steve Zuckerman, and Heather Hahn for their helpful input on the design of our study and review of early drafts and Rachel Kenney, for her expert editorial assistance. Any errors or omissions are our own.

Executive Summary

In June 2019, New Hampshire required Medicaid beneficiaries to report compliance with work requirements in its Medicaid expansion program, Granite Advantage Health Care Program (hereafter called Granite Advantage), becoming just the second state to do so after Arkansas. Specifically, these rules required adults between ages 19 and 64 earning incomes up to 138 percent of the federal poverty level to work 100 hours per month and report those hours monthly to the New Hampshire Department of Health and Human Services (DHHS) or risk losing their health coverage. Exemptions were available for people who are disabled, deemed medically frail by a provider, or pregnant or fewer than 60 days postpartum and for one parent or caretaker (per household) of a dependent child under age 6, among others. Several of these rules were considerably more stringent than those in other state Medicaid work requirement waivers, notably requiring 100 hours of work or community engagement per month and subjecting people up to age 64 and parents of school-age children (ages 6 and above) to the requirements.

Leading up to program implementation, New Hampshire officials repeatedly made statements like, “We are doing things differently in New Hampshire,” and “We are not Arkansas, we can do better,” expressing confidence that their program would avoid the problems of Arkansas’s first-in-the-nation Medicaid work requirement waiver that disenrolled over 18,000 adults during only its first six months of implementation.¹ These officials pointed to strategies that would make New Hampshire’s requirements kinder and more flexible and accommodating than those of Arkansas, including broader, more multifaceted outreach efforts; a “no wrong door” policy that allowed enrollees to report their activities online, by phone, in writing, or in person at a local DHHS office; a “curing” process that allowed enrollees who fell short of 100 hours to make up the missing hours the following month; and reestablishment of eligibility at any time once a person meets the 100-hour threshold after their coverage was suspended. Indeed, even consumer and legal advocates with whom we spoke expressed sincere belief that “no one in New Hampshire pursued this policy because they wanted to disenroll people from Medicaid.”

Yet by late June, less than one month after Granite Advantage beneficiaries had to start reporting work and community engagement hours, state officials worried that they had not succeeded in reaching the target population. News reports described confused beneficiaries who could not understand the state’s letters and were puzzled by the new rules and unsure about how to comply. More importantly, data showed extremely low compliance rates; of the nearly 25,000 Granite Advantage enrollees without an exemption and subject to work requirements, only about 8,000 (or 32 percent) were in

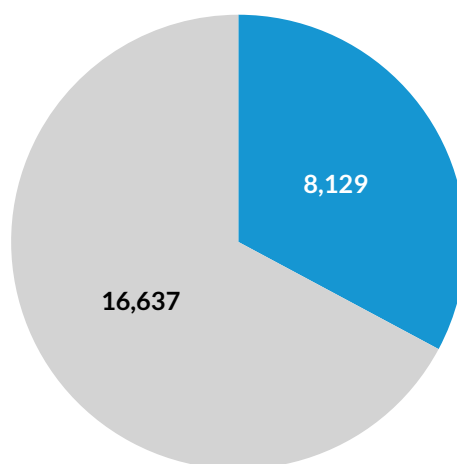
compliance with the 100-hour target. Thus, in early July, an estimated 17,000 Granite Advantage enrollees (about one-third of the program’s total enrollment) were scheduled to start receiving letters saying they were out of compliance with Medicaid work rules and could lose Medicaid in August (figure ES.1).

FIGURE ES.1

Granite Advantage Beneficiaries Subject to the Medicaid Work Requirement, by Compliant or Noncompliant Status, June 2019

Of 24,776 beneficiaries subject to the requirement

■ Compliant ■ Noncompliant



URBAN INSTITUTE

Source: DHHS Community Engagement Report: June 2019, New Hampshire Department of Health and Human Services, accessed January 27, 2020, <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.

Note: Noncompliant beneficiaries include those who may have complied with the 100-hour work requirement but failed or were unable to report their hours to DHHS.

On July 7, DHHS Commissioner Jeffrey Meyers suspended implementation of Granite Advantage’s work requirement for three months, citing the agency’s difficulty reaching program beneficiaries. An array of stakeholders applauded the move, saying the state government demonstrated both good faith and a desire to avoid unfairly causing beneficiaries to lose coverage. A few weeks later, on July 29, and to the relief of many, New Hampshire’s Medicaid work requirements were halted by a federal district court presided over by the same judge who had halted such programs in Arkansas and Kentucky. Shortly thereafter, Governor Chris Sununu and the Centers for Medicare & Medicaid Services appealed the decision.

This case study, which builds on our prior Arkansas-focused study, provides additional evidence, based on a series of key informant interviews and focus groups with Medicaid beneficiaries, of the numerous problems associated with implementing Medicaid work requirements:

- **Outreach.** Though New Hampshire was eager to avoid repeating Arkansas’s implementation mistakes, it succumbed to many of the same outreach errors. The state did not allow enough time to publicize and educate beneficiaries about new work rules before implementation, and outreach efforts were not sufficiently funded. The state relied too heavily on mail- and telephone-based communication that failed to reach a population who is transient, moves frequently, possesses limited-minute phone plans, and faces numerous social challenges related to mental health, substance use, and homelessness. Information conveyed was overly complex and left beneficiaries confused and bewildered about how the rules affected them. As one focus group participant explained, “I got 10 letters right in a row...I didn’t know how to read them. I don’t know how to read. [My husband] don’t know how to read either. He doesn’t understand.” Though the state conducted a door-to-door outreach campaign in late June to address these shortcomings, the effort was largely unsuccessful. Community-based service providers interviewed for this study told us a more effective strategy would have been to fully fund comprehensive outreach and education, including paying for health and social service providers, who regularly assist these populations, to provide hands-on help. However, one interviewee felt that even if these strategies were adopted, they would not have fully informed and educated this hard-to-reach population.
- **Promoting work.** New Hampshire launched a pilot work support program, Granite Workforce, in tandem with its Medicaid work requirements to help the Medicaid expansion population gain important skills and to incentivize employers to hire beneficiaries. But the program was crippled by eligibility restrictions because of the Temporary Assistance for Needy Families funding used to support it—it could only help people between ages 19 and 24 or parents of dependent children under age 18—and the pilot period lasted just six months. Stakeholders, including state officials, agreed that an effective work support effort would need more time to become established and would need to be available to people of all ages. Further, such an effort would have to more rigorously address common barriers to employment, such as lack of transportation, affordable child care, and housing.
- **Reporting work and community engagement.** Here, too, New Hampshire officials tried to avoid mistakes made in Arkansas by designing a no-wrong-door approach to reporting work and community engagement hours, allowing beneficiaries to report online, by mail, over the

phone, or in person. But beneficiaries and key informants reported that paper forms were poorly designed, the state's web portal was "glitchy," there were long waits when trying to get help over the phone, and staff members of the state's contracted call center were sometimes rude. The state's curing system—which allowed beneficiaries who fell short of the 100-hour threshold an extra month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause—was confusing to stakeholders and consumers alike. One beneficiary with whom we spoke described his confusion, saying, "I didn't make the hour requirement, so I figured, 'Why report it?' So I don't know how the system worked to report the hours...I got very close. I had upper 90s, so just a few hours short." Focus group participants and many key informants, including those at community agencies, believed reporting might have been less onerous for beneficiaries if providers and community-based organizations had received funding to support assisters or navigators to provide hands-on help to affected enrollees. However, some voiced concern that reporting challenges would still cause people who were in compliance to lose coverage even with this additional support.

- **Obtaining exemptions.** Like Arkansas, New Hampshire attempted to proactively exempt as many Granite Advantage members as possible from Medicaid work requirements, doing so for those deemed compliant with or exempt from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program work requirements or who were disabled, pregnant or fewer than 60 days postpartum, or parents of children under age 6. But also like Arkansas, New Hampshire did not use claims data from health plans or other sources to automatically exempt people with medical frailty, and because the state legislature required beneficiaries to get providers to certify their inability to work, this proved to be the most problematic aspect of the state's exemption system. Beneficiaries with physical and behavioral health problems reportedly struggled when applying for exemptions, often because primary care providers resisted signing forms declaring that their patients were unable to work. A woman in our focus groups described the difficulties she faced, saying, "I had six brain aneurysms...but [the doctor] said, 'If you can walk, you can work.' Then they got me another doctor and...she signed the form." Meanwhile, parents with school-age children subject to work requirements likely would have faced challenges finding child care, struggled to afford child care, and confronted barriers to getting assistance to defray some of the costs of such care. State-based policy researchers, legal advocates, and beneficiaries with whom we spoke agreed that New Hampshire should have made exemptions simpler and more data driven, exempting broader groups from work requirements, including all parents of children younger than 18, homeless people, people with opioid and/or substance use disorders, and people over age 49.

- **Implications of disenrollment.** Medicaid beneficiaries told us their health coverage was critical, that it kept them healthy and able to work, and that loss of Medicaid would have been devastating. As one focus group participant said, “When you are looking at not getting your medicine or not being able to go to the doctor, that is a really scary thing.” Providers and health plans, too, said that Medicaid expansion had helped increase people’s financial access to care and decreased uncompensated care. They also expressed concern over how coverage losses would affect patient health and increase use of expensive emergency room care.

Though New Hampshire officials implemented numerous strategies to differentiate their program from that of Arkansas, they found themselves at nearly the same end point: on the brink of disenrolling a large share of the state’s Medicaid expansion population. Moreover, New Hampshire reached this point in a fraction of the time; Arkansas disenrolled 18,000 people over six months of implementation, but New Hampshire might have disenrolled up to 17,000 after just two months, a startling 67 percent of those subject to the requirements. The unique feature of New Hampshire’s program not present in Arkansas’s—state authority to suspend the program if undue harm to beneficiaries was expected—was added by the state legislature just in time to save 17,000 people from potentially losing health coverage.

At the time of this writing, no date has been set to hear oral arguments on the federal government’s appeal of the lower court ruling that halted the state’s Medicaid work requirements, so the program’s ultimate resolution is uncertain. Still, setting aside the fundamental question about the legality of work requirements in Medicaid, which the courts are currently considering,² and based on the experiences of the first two states to implement Medicaid work requirements (using different approaches and under different circumstances), evidence suggests such programs cause significant harm to Medicaid beneficiaries while not appreciably supporting their ability to work.

New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results

Introduction

In June 2019, New Hampshire required Medicaid beneficiaries to report compliance with work requirements in its Medicaid expansion program, Granite Advantage Health Care Program (hereafter called Granite Advantage), becoming just the second state to do so after Arkansas.³ In the fall of 2018, the state's Department of Health and Human Services (DHHS) had started sending letters to Granite Advantage enrollees informing them of new reporting and eligibility rules, as specified in New Hampshire's Section 1115 waiver approved by the Centers for Medicare & Medicaid Services (CMS) in November 2018.⁴ Specifically, these rules required adults between ages 19 and 64 earning incomes up to 138 percent of the federal poverty level to work 100 hours per month and report those hours monthly to DHHS or risk losing their health coverage. Besides work, enrollees could meet the 100-hour threshold through various "community engagement" activities, including job training, attending a secondary school or college, searching for work, and volunteering community or public service. Exemptions were available for people who were disabled, deemed medically frail by a provider, pregnant or fewer than 60 days postpartum, a parent or caretaker of a dependent child under age 6 (one per household), or compliant with or exempt from work requirements under either Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program.

Several of these rules were more stringent than those in other approved state Medicaid work requirement waivers; requiring 100 hours per month and subjecting people up to age 64 to the rules are the strictest work requirements of any state in the nation.⁵ New Hampshire's exemption of one parent per household with dependent children only up to age 6, which leaves most parents with school-age children exposed to the work requirements, was also stricter than many states' parental exemptions (Adams et al. 2019).

Leading up to program implementation, New Hampshire officials in both the state legislature and government repeatedly made statements like, "We are doing things differently in New Hampshire," and "We are not Arkansas, we can do better,"⁶ expressing confidence that their program would avoid the problems of Arkansas's first-in-the-nation Medicaid work requirement waiver that disenrolled over

18,000 adults during only its first six months of implementation (Hill and Burroughs 2019). These officials pointed to strategies that would make New Hampshire's requirements kinder and more flexible and accommodating than those of Arkansas, including broader, more multifaceted outreach efforts; a "no wrong door" policy that allowed enrollees to report their activities online, by phone, in writing, or in person at a local DHHS office; a "curing" process that allowed enrollees who fell short of 100 hours to make up the missing hours the following month; and reestablishment of eligibility at any time once a person meets the 100-hour threshold after their coverage was suspended. Indeed, consumer and legal advocates and progressive Democratic legislators interviewed for this study expressed sincere belief that "no one in New Hampshire pursued this policy because they wanted to disenroll people from Medicaid." A Republican legislator was quoted as saying, "None of us wants...inadvertent denial of benefits."⁷

Yet by late June, less than one month after Granite Advantage beneficiaries had to start reporting work and community engagement, state officials worried that they had not successfully reached the target population. News reports described confused beneficiaries who could not understand the state's letters and were baffled by the new rules and unsure about how to comply.⁸ More importantly, data showed extremely low compliance rates; of the nearly 25,000 Granite Advantage enrollees without an exemption and subject to work requirements (about one-half of the program's total enrollment), only about 8,000 (or 32 percent) were counted as having met the 100-hour target, and three-quarters of those did not actually *report* their own activity but were proactively deemed compliant by DHHS based on its analysis of state labor data.⁹ Thus, in early July, an estimated 17,000 Granite Advantage enrollees were scheduled to start receiving letters saying they were out of compliance with Medicaid work rules and could lose Medicaid in August if they did not cure their missing hours (figure ES.1).

A month earlier, the Democratically controlled state Senate had been putting the finishing touches on S.B. 290,¹⁰ a bill that would loosen some of Granite Advantage's strictest rules. Early versions of the bill proposed lowering the upper age limit to 49, lowering the hour requirement to 80, exempting parents and caretakers of children under 16 (instead of 6), and creating a trigger that would automatically suspend the work requirements if 500 people (i.e., roughly 1 percent of Granite Advantage's total enrollment) were disenrolled.¹¹ Bill sponsors, however, were told that Republican Governor Chris Sununu would not sign a bill with such drastic changes. But Republican legislators already saw the growing risk of substantial Medicaid disenrollment and signaled a willingness to compromise. In the end, S.B. 290 did not include many of the proposed changes but contained more flexible language that gave authority to the DHHS commissioner to suspend the work requirements if "a substantial number" of enrollees were "more likely than not" to be suspended from the program

because of circumstances like DHHS's inability to communicate with and counsel all beneficiaries on the rules.¹² On July 7, DHHS Commissioner Jeffrey Meyers suspended implementation of Granite Advantage's work requirements for three months, citing the agency's difficulty reaching program beneficiaries. An array of stakeholders applauded the move, saying the state government demonstrated both good faith and a desire to avoid unfairly causing beneficiaries to lose coverage. A few weeks later, on July 29, New Hampshire's Medicaid work requirements were halted by a federal district court presided over by the same judge who halted such programs in Arkansas and Kentucky. Governor Sununu and CMS appealed the decision shortly thereafter.¹³ As of this writing, no date has been set for oral arguments on the appeal.

In the end, despite intentionally adopting policies designed to avoid negative consequences, New Hampshire, like Arkansas, faced the prospect of disenrolling a large share of its Medicaid expansion population for not meeting new work requirements. This paper analyzes the structure and implementation of the state's work requirements and identifies the challenges that surrounded its roll-out, based on interviews with key stakeholders and focus groups with Granite Advantage beneficiaries. Building on our earlier report that examined Arkansas's experience with work requirements in Medicaid, this analysis explores New Hampshire's experiences with outreach, work supports, reporting work and community engagement, and exemptions (including an in-depth exploration of issues surrounding access to child care), and the implications of work requirements for consumers, health care providers, and health plans. We finish with concluding observations comparing and contrasting the experiences of the first two states to implement Medicaid work requirements.

Methods

We began by reviewing articles and reports on New Hampshire's Medicaid work requirements from news and policy research sources and by conducting phone interviews with researchers and analysts who had been studying the program to understand what they had learned. We also studied materials that New Hampshire DHHS had produced before and during implementation of the Medicaid work requirements, including summary-level data on beneficiary engagement with the requirements.

In July 2019, we conducted eight telephone interviews with 11 key informants. Then, over three consecutive days in October 2019, we conducted a site visit to New Hampshire, where we completed seven more interviews with 13 key informants and two focus groups with 11 Medicaid enrollees. Also in October 2019, we spoke with 11 additional key informants by phone, many of whom focused more deeply on issues surrounding child care and how Medicaid work requirements affect parents with

dependent children. Our interviewees represented a range of stakeholders, including state DHHS and Department of Employment Security (NHES) officials, health care providers, health plan representatives, consumer and legal advocates, policy researchers, and child care experts. Our focus groups consisted of adults enrolled in Granite Advantage. Semistructured interviews and focus groups captured reflections on experiences with New Hampshire’s work requirements and perspectives on their strengths and weaknesses.

Our core interview protocol and focus group moderator’s guide included 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
- opinions of the Medicaid work requirements

We also developed a targeted interview protocol for child care stakeholders to explore the child care implications of the requirement for parents with school-age children. This protocol included sections on the respondent’s knowledge of the Medicaid work requirements and the supply and affordability of child care, and it solicited respondents’ suggestions regarding what policies could help avoid loss of Medicaid eligibility.

We recruited focus group participants with the assistance of a federally qualified health center (FQHC), a family health center, and consumer and legal advocates. The health center staff and advocates engaged participants in person and with fliers and phone calls, using protocols and scripts provided by Urban to ensure neutral and systematic recruitment. The clients they recruited met the criteria to participate, which included

- being between ages 19 and 64,
- having received Medicaid coverage any time in the past year and having been subject to the Medicaid work requirements as a condition of eligibility, and

- speaking English as a primary language and/or being comfortable participating in a group discussion conducted in English.

We conducted two focus groups with 11 participants total. 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. We digitally recorded and transcribed interview and focus group proceedings and destroyed notes when we finished transcribing and cleaning them. Each focus group lasted 90 minutes and included a light meal. All participants received \$60 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. All 11 participants completed the questionnaire.

To analyze the interview and focus group results, we used commonly accepted qualitative research methods. We systematically reviewed interview and focus group notes and unabridged transcripts, and we categorized the 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. Though focus groups provided valuable and nuanced insight into people's experiences with Granite Advantage, by their nature they obtain information from relatively few people and thus do not represent the entire population of interest.

TABLE 1

Focus Group Participants' Questionnaire Responses

Characteristics	Number of participants
Gender	
Male	5
Female	6
Age	
18–24	1
25–29	0
30–39	3
40–49	2
50 and above	5
Race/ethnicity (all that apply)	
American Indian/Alaska Native	1
Asian	0
Black or African American	0
Hawaiian Native/Pacific Islander	0
White	10
Educational attainment	
Less than high school	2
High school/GED	3
Some college	5
College degree	1
Employment status	
Not employed	5
Working < 20 hours a week	4
Working 20+ hours a week	1

Source: Urban Institute focus groups, October 2019.

Notes: GED = general education diploma. Though all 11 focus group participants filled out the questionnaire, they may not have completed all parts.

Background on New Hampshire's Passage of Medicaid Work Requirements

After garnering bipartisan support in the state legislature, New Hampshire expanded Medicaid in April 2014. The expansion added more than 50,000 beneficiaries, pushing the state's total Medicaid population over 180,000 by 2016 (NH DHHS 2019). Key informants interviewed for this study noted two possible reasons why Republicans supported the expansion: First, like Arkansas, New Hampshire designed its program, the New Hampshire Health Protection Program, as a private option, meaning the state would use Medicaid funds to purchase private insurance for beneficiaries in the federal health insurance marketplace. All expansion beneficiaries were enrolled in the marketplace, except those who were American Indian or Alaska Native or had self-attested as being medically frail. Stakeholders in New Hampshire, just as in Arkansas, told us the private option was viewed as a way to appeal to

conservative lawmakers who otherwise might have voted against expansion. Second, the legislation included language requiring DHHS to pursue work requirements in its 2014 Section 1115 waiver application. Democratic lawmakers indicated that they went along with this provision because they believed the Obama administration would not approve work requirements and, indeed, it did not authorize this portion of the waiver.

Initially, New Hampshire lawmakers authorized Medicaid expansion for two years and thus had to continue brokering political compromises to keep the program in place. Upon reapproving the program for two additional years in 2016, lawmakers again sought a waiver to add work requirements. Once again, CMS rejected it. However, by 2018, the Trump administration had publicly encouraged states to pursue Medicaid work requirements. The New Hampshire legislature passed S.B. 313 in July 2018,¹⁴ which called for adopting work requirements and eliminating the 90-day retroactive eligibility. Additionally, the bill included provisions to switch expansion beneficiaries out of private insurance and into Medicaid managed care, under the newly named Granite Advantage Health Care Program. According to state officials, the shift to managed care was both a cost-saving measure, because it was projected to save \$200 million, and a response to rapidly rising premiums on the exchange. CMS approved the waivers effective January 1, 2019.

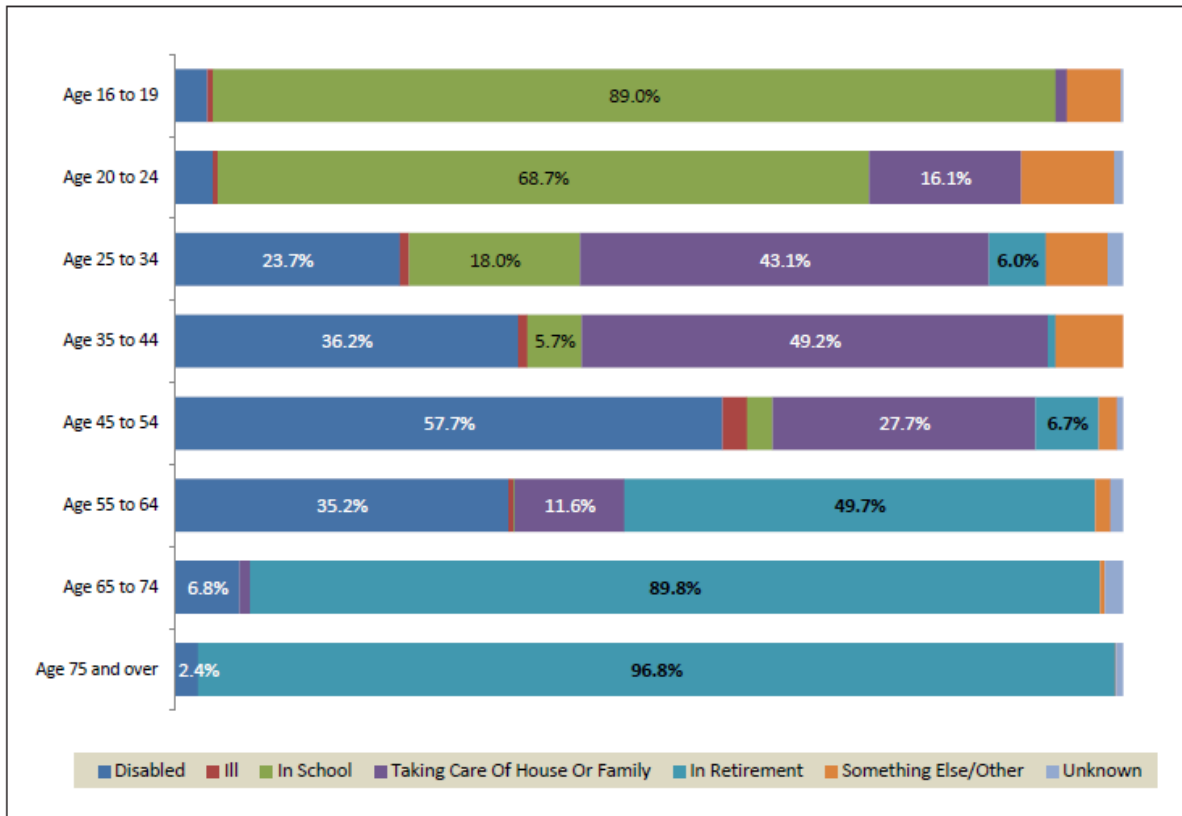
Among New Hampshire Medicaid beneficiaries, an estimated 65 percent were working part- or full-time in 2017 (Garfield et al. 2019). Generally, the stakeholders we interviewed agreed that the vast majority of Medicaid beneficiaries who could work were working. Those who were un- or underemployed, according to key informants, were either participating in other community engagement activities (e.g., attending school), would qualify for an exemption (e.g., for being medically frail or having serious mental health or substance use challenges), or faced insurmountable barriers to employment (such as lack of transportation or affordable child care). Statewide data from NHES appear to corroborate these beliefs; reasons reported for not being in the labor force almost entirely fall within the categories identified by stakeholders (figure 1). In addition, Urban Institute analysis of national data shows that the population subject to Medicaid work requirements faces particular barriers to securing and maintaining stable employment. These obstacles include low educational attainment, health problems, limited transportation and internet access, criminal records, and residence in high-unemployment or high-poverty neighborhoods (Karpman 2019).

Stakeholders told us the instability of seasonal work or self-employment and the lack of child care and transportation were especially common obstacles to finding and maintaining stable employment for New Hampshire residents. These problems are amplified for residents in rural areas and the North Country, the northern tip of the state. Finding affordable housing poses a challenge to maintaining employment

as well; according to a 2019 New Hampshire Housing Finance Authority report, the state's vacancy rate was less than 1 percent, compared with 7 percent nationally. The report also found that in the past five years, the statewide median gross rent increased over 20 percent (NHHFA 2019). As stated, low educational attainment is another significant barrier to employment for Medicaid beneficiaries. Data presented in early 2019 suggest the job market for people possessing less than a college degree in New Hampshire is unfavorable; though 13,380 people with less education than a college degree were seeking jobs in the state, there were just 6,132 job openings for people with that education level (NHFPI 2019). Urban Institute findings show that many of the jobs attainable for Medicaid enrollees are unsteady, pay low wages, and either do not offer employer-sponsored insurance or only offer unaffordable insurance.¹⁵ Consequently, many workers in these positions may continue to rely on Medicaid for health insurance. They also may struggle to be deemed compliant with work requirements because of nonstandard work schedules, lack of control over their own hours, or difficulties reporting their hours because, for example, they lacked access to transportation.

FIGURE 1

New Hampshire's Reasons for Not Being in the Labor Force, by Age Cohort, 2017



Source: State of New Hampshire, *New Hampshire 2018 Workforce Analysis in Review* (Concord, NH: State of New Hampshire, 2018).

Note: Data are for the entire state and not specific to the Medicaid population.

Reaching Out to and Educating Medicaid Beneficiaries

Though New Hampshire state officials were eager to avoid repeating Arkansas's implementation mistakes, the two states experienced similar outreach challenges. For example, both states allowed themselves inadequate time to ramp up and publicize their Medicaid work requirements before implementation. One DHHS official explained that after receiving CMS's approval to implement the work requirements on November 30, 2018, "the program [start date] was announced for March 1 [yet] the first set of rules were not passed until late February." Thus, the state began planning outreach and education activities before the program design was finalized.

This insufficient ramp-up period was particularly problematic because of the obstacles associated with reaching this population. Stakeholders in New Hampshire, like those in Arkansas, feared that

because beneficiaries are often transient, traditional outreach methods, such as letters and phone calls, would not be effective. They mentioned that beneficiaries' phone numbers and home addresses may change, and their phones may have limited minutes. One interviewee commented, "It is a transient population...Identifying and locating them is part of the challenge." Further, stakeholders believed that beneficiaries may distrust the government.

Even when the state could reach beneficiaries, the information they tried to convey was overly complex. A policy and advocacy organization attempted to create a brochure for beneficiaries but struggled to distill the information down to a clear, concise message; as one staff member said, "The department wanted us to use certain language...but that language would have taken its own brochure [to explain]. We tried to simplify it as much as possible, but [the language] was still very confusing." Focus group participants said the communications they received were unclear and occasionally contradictory (box 1). One participant reported that she received letters stating that she was exempt and letters that said she was subject to the requirement. Several changes to the Medicaid expansion program happening simultaneously further complicated this already complex information; not only was DHHS implementing work requirements, but they were switching the same beneficiaries out of private insurance plans and into managed care, and they renamed the Medicaid expansion program.

From the outset, DHHS also faced legislatively limited funding for outreach and enrollment. DHHS was prohibited from using general funds to support outreach efforts and thus had to find alternative funding streams. Given the difficulties associated with reaching this population, stakeholders felt the state did not have adequate resources to be successful.

Despite these hindrances, the state developed an outreach and education strategy they believed would be more robust and successful than Arkansas's.¹⁶ DHHS communications included letters, phone calls, public forums and targeted information sessions, radio advertisements, text messages, and emails, each of which we discuss in more detail below.

BOX 1

What Focus Groups Said about Outreach and Education Efforts

Though 8 of the 11 focus group participants reported having heard about the Medicaid work requirements, confusion was widespread. Six participants confirmed that they received a letter in the mail, but several reported difficulty understanding the letter's content. Other participants said they never received any letters. Participants reported seeking further explanation from DHHS by phone or in person but complained of long hold times and judgmental staff. Two participants reported receiving conflicting letters: some saying they were subject to the requirement and others saying they were exempt. Only one participant said they had been contacted by phone. A handful of others did not think phone calls were an effective way to reach this population. Participants were generally aware that the work requirements had been halted.

"I got 10 letters right in a row...I didn't know how to read them. I don't know how to read. [My husband] don't know how to read either. He doesn't understand."

"I got a letter and then...I called the state office. I said 'What is going on here? What is this?'"

"You'll get one [letter] that says you are required to do it and then get one that [says] you are exempt. It was very confusing."

"I never heard of it [and never got a letter]...I was couch surfing, completely homeless."

"Half the time [the mail I receive] doesn't apply to me, or I can't understand what they are trying to say, so why open it? You can't understand what they are saying so you have to go there and listen to them try to explain it."

"You go to the welfare office and you are sitting there talking to a person and...it feels judgmental. Like you are supposed to understand these big words...Sometimes they put things way over your head."

"They did call me a couple times. They explained that I needed to do 100 hours of work or community service. Around June 1st, they alerted me that it was starting and gave me a number to call at the end of the month to let them know how many hours I accumulated. That was all the contact they had with me."

"I don't like people calling me. I get scam calls. My phone blows up enough as is. I don't need more people adding to it."

"Not everyone answers their phone; I don't."

Source: Urban Institute focus groups, October 2019.

Letters. From April through June 2019, the state mailed 48,280 letters to Granite Advantage enrollees subject to work requirements.¹⁷ Four versions of a letter were sent: one for beneficiaries subject to the requirements, one for beneficiaries who were subject to the requirements but already

complying with the 100-hour requirement (according to state calculations), one for exempt beneficiaries, and one for beneficiaries the state believed were medically frail. Of these letters, 10,798 went to medically frail people and included an exemption request form (discussed in the Obtaining Exemptions section). Several stakeholders thought the volume of mail may have been too high; one interviewee commented, “People came in to see me with collapsible file folders that were thick from DHHS and Social Security and other assistance programs they are on. It is absolutely overwhelming [and] staggering for these people that I work with.”

Phone calls. The state contracted with MAXIMUS, an out-of-state call center, to place over 50,000 phone calls to beneficiaries. However, the phone campaign was seriously flawed. DHHS reported that less than 10 percent of people called by the center answered their phones.¹⁸ At first, the calls showed up on beneficiaries’ caller IDs as an out-of-state number, thus beneficiaries reportedly ignored them as spam. Then DHHS instructed MAXIMUS to change the number so it would appear as coming from “State of New Hampshire.” This didn’t help much, because beneficiaries were just as wary of calls from the government. One stakeholder sympathized, saying, “I don’t pick up my phone if it is not someone I know. And these clients have prepaid or limited minutes.” When people answered, call center staff could only proceed if beneficiaries verified their identities by providing their Medicaid ID or Social Security numbers, because they needed to discuss personal information. Only 10 percent of those who answered the phone provided this information; very few beneficiaries knew their Medicaid numbers, and the rest refused to give out their Social Security numbers over the phone. In total, the state reported spending \$108,723 on outbound calling.¹⁹

Public forums and targeted information sessions. DHHS reported holding 11 public forums across the state between November 2018 and March 2019, as well as close to 50 targeted information sessions for “providers, agencies, managed care organizations, and other stakeholder organizations” through June 2019.²⁰ The forums were hosted in public locations such as a city hall, a community college, and a public library. Officials from both DHHS and NHES presented information on the transition from premium assistance to managed care, the new Medicaid work requirements, and a new work-supports pilot program called Granite Workforce (discussed further in the Promoting Work through the Granite Workforce Pilot Program section). However, stakeholders said these forums were not well attended; one stakeholder said she attended a session with just six beneficiaries. The state also led a handful of additional community outreach sessions at hospitals in late July but reported assisting just 14 people.

Radio advertisements. According to state officials, DHHS ran radio advertisements on 98 radio stations for eight weeks in spring 2019. DHHS said these advertisements intended to prompt beneficiaries to seek out counseling and answers to their questions about work requirements at DHHS

district offices. State officials told us that at these offices, DHHS staff members were available for two to three hours three days per week to provide one-on-one assistance.

Text messages and emails. Though DHHS sent text messages and emails, it reportedly only had cell phone numbers and email addresses for some of the Granite Advantage population; state officials said they had cell phone numbers for 10,000 nonexempt enrollees and email addresses for 12,000.

As described above, by June 2019 DHHS officials realized their outreach activities had been insufficient and unsuccessful. With the deadline for the first month of reporting looming, they decided to scale up outreach efforts over the summer and concentrated most of their resources (approximately \$43,000) on a door-to-door campaign beginning in late June.²¹ But it, too, was largely unsuccessful: DHHS and NHES staff members went to 2,011 beneficiaries' homes in communities with high concentrations of Granite Advantage enrollees (like Manchester and Nashua) and went to the homes of beneficiaries from whom they had not received any information (e.g., reported hours or exemption requests), but just 13 percent of these visits resulted in in-person contact.²² Multiple stakeholders pointed out that this strategy was poorly designed, because state officials only knocked on doors between 10:00 a.m. and 3:00 p.m., when people would mostly likely be at work or school. The strategy was also undermined by many beneficiaries' frequent address changes, because significant numbers of Granite Advantage beneficiaries are unstably housed or homeless. Lastly, when officials increased outbound calling to medically frail beneficiaries, they only reached 528 participants.

Because funding for outreach was legislatively limited, the state relied on other entities, such as professional organizations, health plans, providers, and nonprofits, to bolster outreach efforts with their own resources. Stakeholders said the New Hampshire Hospital Association pushed out information on the work requirements to their members and tried to ensure that providers at hospitals were informed. We were also told that a health plan gave a script to their community outreach team, so that they could inform Granite Advantage clients about the requirements at their own outreach events. In addition, under new contracts developed in 2019, managed care organizations were required to assist with implementation of the work requirements. However, these contract provisions were not supposed to take effect until after the program was halted, so stakeholders said this assistance never came into play. In addition, we were told that state Medicaid officials never reached out to the child care community to inform them of the work requirements and seek their support of parents affected by the requirements.

Perceptions of whether providers were informed and engaged varied widely. On one hand, we heard that on either organizational or individual levels, some health centers and employees took it upon

themselves to champion work requirement outreach; stakeholders mentioned that some organizations (primarily FQHCs) created their own outreach materials, described as more user friendly than DHHS's, and translated them into more languages than DHHS did. We also spoke with several health center employees serving as navigators or application assisters who felt it was their job to educate clients and help them report hours or apply for exemptions. On the other hand, stakeholders and focus group participants also spoke of many instances where providers did not have sufficient knowledge of the work requirements and could not help their patients.

Stakeholders reasoned that this variation might have owed to the state not providing financial support to these providers or organizations; these organizations took on outreach efforts at their own expense, and these efforts fell onto their employees' already full plates. One health plan representative emphasized that they would have worked to help their clients maintain coverage as their capacity allowed, but he "did not feel like it was going to be all that realistic for care managers, at their current level of caseload and understanding," to help much. Finally, federal funding cuts had greatly reduced the number of navigators and application assisters, who may have been best positioned to help beneficiaries navigate work requirements.

Despite these financial investments and staff time, stakeholders agreed that, like Arkansas, New Hampshire conducted ineffective outreach efforts. This sentiment is underscored by (1) the state not having any information for 17,000 beneficiaries who, by the end of June, were facing loss of Medicaid coverage, and (2) some of our focus group participants saying they had never even heard of the requirements. Several interviewees commented on the problematic nature of placing phone calls to people with limited phone minutes, mailing letters to people who were homeless or moved around frequently, and visiting homes during work hours.

However, many also agreed that DHHS made a good-faith effort and "did the best they could, given very limited resources." One interviewee felt that even if these issues were somehow addressed, a successful outreach campaign for Medicaid work requirements was impossible, "because this population is busy, overstretched, skeptical of government, moves around a lot, is difficult to reach, and might have limited literacy for how to navigate the system."

Promoting Work through the Granite Workforce Pilot Program

To accompany their adoption of Medicaid work requirements, New Hampshire policymakers created a companion Granite Workforce pilot program to encourage and facilitate work by addressing known barriers to employment and incentivizing employers to hire Granite Advantage beneficiaries. However, the program's scope was quite narrow because of restrictions on its funding stream, and it fell far short of expectations.

Granite Workforce diverted \$3 million from TANF reserves to NHES to support impressive benefits, including up to \$5,000 per enrollee in tuition assistance, mileage reimbursement up to \$160 a month for four months, emergency housing support up to \$650, adult basic education assistance up to \$450, and \$4,000 in incentives to employers for hiring Granite Workforce enrollees (half paid after three months of employment, the second half paid after nine months).²³ Each Granite Workforce enrollee also received case management support from staff at NHES's 12 NH Works/American Job Centers across the state. The pilot program lasted just six months, from January through June 2019.

However, because of federal restrictions on how TANF funding could be spent, Granite Workforce was limited only to Granite Advantage beneficiaries between ages 19 and 24 and who were parents of children under age 18, therefore excluding most people subject to work requirements. DHHS and NHES officials jointly promoted the pilot during 11 public forums and 50 targeted information sessions held at such places as FQHCs, hospitals, refugee assistance centers, homeless shelters, and Job Corps events.²⁴ During these sessions, attendees over age 24 reportedly expressed surprise and frustration that the program could not help them. Still, state officials estimated that they would assist between 1,200 and 1,500 Medicaid expansion beneficiaries. However, they ended up only serving 120, or just 10 percent of the target population. By extension, Granite Workforce spent only a fraction of its \$3 million budget, roughly \$390,000 (table 2). Stakeholders attributed low uptake to the program's eligibility restrictions and limited outreach.

TABLE 2

Granite Workforce Expenditures, by Activity Type

Activity	Expense
NHES memorandum of understanding for staff provided to DHHS	\$226,770.41
Barrier-reduction costs	\$8,400.00
Transportation reimbursement	\$2,476.62
Employer subsidy	\$0.00
Fees and supplies	\$296.41
Child care registration fees	\$100.00
Emergency housing support	\$3,336.75
Tuition	\$147,739.69
Basic education	\$100.00
Outreach calling	\$0.00
Total	\$391,219.88

Source: New Hampshire Department of Health and Human Services, letter to Senators Feltes and Rosenwald and Representative Wallner, RE: Costs to implement the community engagement requirement for Granite Advantage, October 24, 2019.

Notes: NHES = Department of Employment Security. DHHS = Department of Health and Human Services.

Beyond Granite Workforce, NHES has long operated its work support program, NH Works, across New Hampshire. Supported primarily by federal Workforce Innovation and Opportunity Act funds, NH Works accepts referrals from several state and local agency partners and provides services ranging from job search assistance to help with developing a résumé, as well as more intensive job-specific training for people meeting stricter eligibility criteria (including evidence documenting the need, utility, and appropriateness of providing training). Box 2 summarizes what focus group participants said about help they have received from NHES.

NHES leadership had long viewed the Medicaid expansion as a golden opportunity to extend NHES services to people who could benefit from the assistance. When Granite Workforce was authorized, it allowed NHES to promote to Granite Advantage enrollees not only the benefits of the pilot program but NH Works services more broadly. Though NHES and DHHS officials jointly publicized the work requirements and Granite Workforce, and all work requirement–related letters and materials mailed to beneficiaries included information about NHES assistance, the state did not successfully raise awareness about these work supports, according to key informants and focus group participants.

BOX 2

What Focus Groups Said about Training and Employment Resources

Of the 11 focus group participants, only 2 had received services through NHES. Both reported very positive experiences with those services. However, none of the participants knew about or had received services from the Granite Workforce pilot program.

“They do job search, they help you with your résumé. If you want to go back to school, they help you do that. It has been very helpful. [The staff members] are great. Not at all [judgmental]. They help pay for a lot; if your car breaks down, they will help to pay to fix that. It is a really good program. They are awesome. They help you learn how to interview properly and be prepared.”

“I went there and made a résumé, and they paid for my nursing training a while ago...They will help you find a job.”

“I don’t recall [seeing information about employment services] on the website. But that could be because I was already working two jobs, so they didn’t send it to me.”

Source: Urban Institute focus groups, October 2019.

Stakeholders agreed that the Granite Workforce pilot program failed to extend meaningful job support to the entire Medicaid expansion population. Pivoting off this experience, and independent from the state’s Medicaid work requirements, the state legislature authorized an expanded NHES job training program and tripled NHES’s budget from \$2 million to \$6 million by diverting a portion of unemployment compensation tax revenues from administrative contributions to the new program. Starting January 2020, this program provides expanded services to Granite Advantage enrollees, including job training and transportation assistance, and provides subsidies to employers who hire enrollees. The program also helps people transitioning out of prison find meaningful employment along with their Medicaid coverage. Whether this expanded program will fully meet the needs of un- and underemployed New Hampshire residents is unclear, but NHES officials expressed excitement over the increased funding.

Reporting Work and Community Engagement

Based on the experiences of Arkansas (Hill and Burroughs 2019), New Hampshire officials intentionally set out to design a reporting system for its Medicaid work requirements that was more flexible and not primarily dependent on online submission. Instead, the state’s no-wrong-door approach intended to allow Granite Advantage enrollees to report their hours online, by mail, over the phone, or in person at

any of New Hampshire's 11 DHHS district offices. Further, reporting required limited documentation or verification; in some situations, only self-attestation of hours worked or spent in community engagement was necessary.

Still, just one month of experience during June 2019 indicates that the reporting system did not work as planned. Most notably, the paper form beneficiaries received in the mail did not have a field where they could enter their work hours. Rather, it only allowed entry of hours spent on other community engagement activities.²⁵ This surprising omission was the result of state officials trying to save beneficiaries a step, because most Granite Advantage enrollees had been sent letters by DHHS telling them how many hours they had worked—having accessed those data from a state labor department database—and whether they had met the state's 100-hour threshold. But this inability to report work hours was understandably confusing for beneficiaries, and DHHS officials admitted, "We tried to make things easier, but we inadvertently made them harder and more confusing." This was especially problematic for self-employed workers, whose work hours were not known or available to the state and thus not shared in advance with enrollees, and for people who had worked some hours but less than the 100 required. Though such people were at first stymied from accurately filling out the form, DHHS ultimately added spaces at the bottom of the form for people to report self-employment and additional work hours.

Other challenges with the reporting system, according to key informants, included the web portal being "glitchy" at times, long wait times for beneficiaries reporting hours by phone, and staff at the state's contracted call center reportedly being rude to clients (including one anecdote of a consumer being told, "Maybe you should just get another job"). On the bright side, enrollment specialists at FQHCs and other agencies could access DHHS's NH EASY online eligibility system and help beneficiaries report their hours. According to one staff person we interviewed, this was an easy process, once she had been trained to use the system. On the other hand, interviewees repeatedly said resources in the community for providing hands-on help to consumers were limited. Hospital and health plan representatives told us they were not set up to provide such assistance, and health care providers, including FQHCs, noted that they had many fewer staff members to provide help because navigator and application assister funding, originally provided by the Affordable Care Act, had been dramatically cut in recent years. One key informant summed up DHHS's no-wrong-door approach as follows:

"If you have to go to the library or pick up the phone and wait on hold for 10 minutes to verbally report your hours or fill out a form and get it to a mailbox...the doors are there, but to get through them is not easy."

Another component of New Hampshire’s reporting system, its curing feature, was also confounding. People who fell short of reaching the 100-hour threshold were given one month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause. But this process, though well intentioned, confused both stakeholders and consumers, partly because it was unclear whether beneficiaries only needed to make up the shortfall from the previous month, or whether they were required to work a full 100 hours *plus* the hours needed to meet the prior month’s shortfall.

Box 3 summarizes what focus group participants told us about their experiences with reporting.

BOX 3

What Focus Groups Said about Work Reporting Systems

The 11 focus group participants had limited experience with reporting work or community engagement hours. Only 1 participant completed the process; he opted to bring a letter stating his hours to a district office. Another participant reported using NH EASY, which she found to be user friendly, but ultimately received an exemption and did not need to report hours. Notably, a third participant said he did not report his hours because he knew he would be a few hours short of the 100-hour requirement, not understanding that he could have made up the hours shortage the following month through the curing process. None of the participants had attempted to report hours by phone, though several participants reported general difficulties reaching the state office by phone. They cited issues such as long hold times and having their calls transferred many times.

“I already had my hours done, and I had a letter prewritten, brought in, stating how many hours I had done of volunteering, and they took it.”

“I started to fill out the paperwork and then I got a gut feeling, and I was like, ‘I am going to wait on this because I don’t need to stress myself out until I find out what is going on.’”

“I have NH EASY. It is easier for me to download my information into the computer instead of running into the offices...The website is pretty user friendly.”

“I didn’t make the hour requirement, so I figured, ‘Why report it?’ So I don’t know how the system worked to report the hours...I got very close. I had upper 90s, so just a few hours short.”

“If you have time to wait on hold for 20 minutes, then [calling] is the way to do it.”

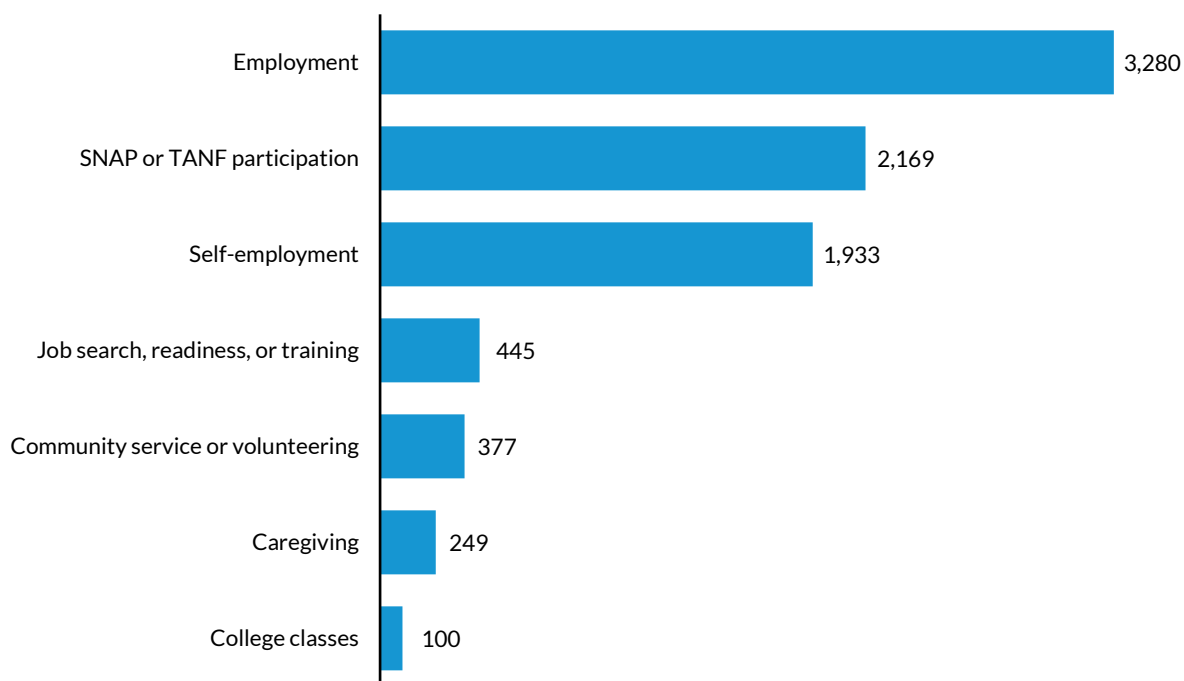
“You call one number and have to transfer to 84 different departments until you get to the one you need.”

Source: Urban Institute focus groups, October 2019.

In the end, 8,129 people, 33 percent of the 24,766 people subject to mandatory reporting, complied with the requirement during June 2019, the first month reporting was required.²⁶ However, of these, only a small fraction, just 663 people, actually reported their hours either online, by phone or mail, or in person. The state automatically deemed the remaining 7,466 beneficiaries compliant. Figure 2 presents DHHS data on beneficiaries classified as having met the program’s 100-hour requirement—either because they reported hours or the state deemed them compliant—and the work and community engagement activities through which they complied. The state determined that the largest subset of these beneficiaries were working sufficient hours by matching their information with NHES earnings data and then estimating how many hours they worked by dividing beneficiaries’ wages by the federal minimum wage.

FIGURE 2

Number of Granite Advantage Beneficiaries Complying with Work Requirements, by Activity Type, June 2019



URBAN INSTITUTE

Source: New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.

Notes: SNAP = Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. Numbers do not total to 8,129 because beneficiaries could report activity in more than one category.

Obtaining Exemptions

In June 2019, DHHS exempted 15,941 beneficiaries from the work requirements,²⁷ 33 percent of the total 47,619 Granite Advantage enrollees.²⁸ DHHS automatically granted 81 percent of these exemptions by identifying beneficiaries in state databases for people who were disabled, enrolled in the Health Insurance Premium Payment program, compliant with or exempt from TANF or Supplemental Nutrition Assistance Program work requirements, the parent or caretaker of a child under 6, the parent or caretaker of a child with a developmental disability, or pregnant or fewer than 60 days postpartum.²⁹ As shown in table 3, several hundred more beneficiaries applied for exemptions for these same reasons. Others applied for exemptions because they were

- a caretaker residing with a family member with a disability;
- a caretaker of a family member who had a serious illness or had been hospitalized;
- ill, incapacitated, or receiving outpatient treatment;
- in inpatient hospitalization;
- medically frail; or
- participating in a state-certified drug court program.

TABLE 3

Number of Granite Advantage Beneficiaries Qualified for Reporting Exemptions, June 2019

Reason for exemption	Number of Beneficiaries		Total
	With automatic exemptions	Who requested exemptions	
Parent or caretaker of child under 6	4,515	307	4,822
Disability	4,401	176	4,577
Exempt in SNAP/TANF	3,698	—	3,698
Medically frail	—	1,951	1,951
Pregnant or 60 or fewer days postpartum	217	—	217
Parent or caretaker of family member needing care	—	201	201
Illness, incapacitation, or outpatient treatment	—	186	186
Parent or caretaker of child with developmental disability	110	36	146
Caretaker of family member with disability	—	54	54
Caretaker of family member with serious illness or hospitalization	—	32	32
State-certified drug court program	—	23	23
Enrolled in HIPP	21	—	21
Inpatient hospitalization	—	13	13
Total automatic and requested exemptions	12,962	2,979	15,941

Source: New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.

Notes: SNAP = Supplemental Nutrition Assistance Program. TANF = Temporary Assistance for Needy Families. HIPP = Health Insurance Premium Payment program. Cells are marked with a dash when the row does not apply to the column head.

Far more beneficiaries applied for medical frailty exemptions than any other category, accounting for 1,951 (65 percent) of the requests. However, this number did not come close to the amount stakeholders expected. Years earlier, thousands more beneficiaries had self-attested to being medically frail under the initial private-option Medicaid expansion program, and as stated in the outreach section, DHHS mailed 10,798 letters to people they believed to be medically frail based on these past self-attestations.

Additionally, beneficiaries could submit a request for a good cause exemption if they could not fulfill the hour requirement because of unforeseen circumstances in a given month. DHHS developed a separate form specifically for these requests, which includes the following categories: birth or death of a family member, severe inclement weather, family emergency or life-changing event, parent or caretaker of a child 6 to 12 years old unable to secure child care, and other. Beneficiaries checked the appropriate box and, for some categories, were asked to provide additional information; for example, for a birth or death of a family member, DHHS asked the name of the family member, the date of the event, and the beneficiary's relationship to that person. Other reasons, such as hospitalization or serious illness, required copies of medical records. Parents could self-attest good cause requests for inability to find child care without providing proof or documentation. DHHS only granted 89 good cause exemptions for the June reporting period.³⁰

To try to automatically exempt more beneficiaries, state officials included in S.B. 290 (passed June 27, 2019) alterations to several exemption policies: For the month of June, parents and caretakers of children up to age 6 were exempted, but the new bill raised the age to 13. People experiencing homelessness were also automatically exempted or could apply for a long-term exemption, as opposed to a one-month good cause exemption.³¹ However, because the work requirements were suspended immediately after the bill passed, and then the court halted the program at the end of July, these exemption policies never took effect.

Though stakeholders praised the breadth of exemptions, obtaining them proved challenging. Because beneficiaries needed a medical professional to complete the medical frailty exemption request, as required by the state law enacting Medicaid work requirements, it was critical that providers be informed of and willing to engage in the process. However, stakeholders said many providers were confused or did not want to participate at all. One interviewee said, "We heard that some doctors would

say, ‘I don’t know what to do,’ and others would say, ‘I don’t agree with this [work requirement] program, so I won’t sign the certification.’” Stakeholders said that in some cases, doctors were unsure whether their patients could work and were uncomfortable certifying that they could not, and others did not want to participate because they did not want to enforce a policy they disagreed with. Other providers reportedly did not understand that they needed to determine whether their patient could work 100 hours every month, not whether they could work *at all*. If they felt their patients could work 10 hours per week—not enough to meet the requirement—some hesitated to certify medical frailty. Another interviewee sympathized, saying, “I don’t think [DHHS] understood the pressure this put on physicians.”

Though focus group participants and stakeholders both mentioned pushback from primary care doctors, they said behavioral health providers were more consistently willing to abet exemptions (box 4). This may be because the medical frailty form specifies that physical health conditions must “significantly impair the ability to perform one or more activities of daily living,” whereas behavioral health providers only had to confirm diagnoses of mental health conditions. Further, one stakeholder speculated that the recent shift to Medicaid managed care may have inadvertently autoassigned enrollees to new primary care providers with whom they did not have established relationships. As one key informant explained:

“If beneficiaries don’t have a relationship with their doctors, that might have been a disconnect. If I just walk into my doctor’s office and they don’t know me, and I say, ‘Sign this medical frailty form,’ how is the doctor going to do that?”

Consequently, primary care doctors may not have felt they knew their patients well enough to confirm the impact patients’ health had on activities of daily living, whereas behavioral health providers did not have to make that determination.

BOX 4

What Focus Groups Said about Exemptions from Work Requirements

Six of the 11 focus group participants received exemptions from the work requirements. Five of those participants requested the exemption, and the other received the exemption request form while seeking behavioral health care. This participant filed for an exemption but felt he could work and was offended when the provider assumed he needed the exemption. Three participants reported that their primary care provider would not sign their exemption form, two of whom ultimately got signatures from behavioral health providers. The third had a particularly difficult time receiving an exemption; after experiencing six brain aneurysms and consequently undergoing multiple brain surgeries in another state, her surgeon could not sign the form because the hospital prohibited it. Back in New Hampshire, a different primary care physician refused to sign the form. She sought out a third provider who finally signed and approved her exemption. Several participants reported that it took between one and three months to get their exemption request signed and approved. Though a handful of participants successfully obtained exemptions, there was general confusion surrounding exemption policies and processes.

“I called the state office to find out what was going on, and I explained all my disabilities and that I was on Social Security. And she said that because of my disabilities and I am on [Supplemental Security Income], that I am exempt. So I could work if I wanted to, but it wouldn’t affect me if I didn’t want to.”

“I explained to my therapist that as I have worked, things have bubbled up and become worse. Going to work was giving me a lot of anxiety, I was losing weight, and it was a huge struggle for me to get up in the morning...I was awarded the letter and I sent it in.”

“I had six brain aneurysms...but [the doctor] said, ‘If you can walk, you can work.’ Then they got me another doctor and...she signed the form.”

“I had to go to my neurologist to get my paperwork signed. My doctor wouldn’t sign it, so my neurologist did it.”

“I brought my [exemption] paper to my doctor...and she knows me personally and knows that I try to do as much as I can, but she said, ‘Technically you don’t qualify for any exemptions on this, but I know you are taxed.’ My therapist ended up signing it because I have major depression. It took a few months [to get the exemption], after...all the back and forth.”

Source: Urban Institute focus groups, October 2019.

Stakeholders and focus group participants also agreed that filling out and submitting exemption forms was excessively complex, as were the forms. Beneficiaries had to determine which exemption they might qualify for, obtain the associated form—from among three forms for medical frailty, good cause, and all other exemptions—and for most exemptions, find a provider willing to fill out the form.

Beneficiaries were also often asked to submit documentation with the request (e.g., an exemption for hospitalization or serious illness required copies of discharge summaries or billing information). Only a select few good cause exemptions, such as inability to find child care and homelessness, could be self-attested. In addition, different exemptions had varying durations, so forms had to be submitted at different intervals. Good cause exemptions lasted up to one month, whereas medical frailty exemptions lasted up to one year. State officials admitted that though they worked with physicians to design the forms, they were ultimately still too complex.

Child Care Implications of Exempting Only Parents with Children Younger Than 6

One noteworthy policy in New Hampshire's initial Medicaid work requirement legislation was only exempting one parent per household with children younger than age 6. With this policy, New Hampshire joined eight other states who similarly proposed to require parents with school-age children at home to comply with work requirements (Adams et al. 2019). This raises questions of whether New Hampshire parents could have found child care, how many parents would have been able to comply, and to what extent work requirements would have adversely affected child and family well-being.

Our interviews suggest that though some child care stakeholders raised questions about the child care implications of work requirements as the law took shape, many others were unaware of the potential effects that the policy would have had on the well-being of children and the child care system. This section examines two critical questions about child care challenges that might have faced New Hampshire families subject to the work requirement with children over age 6: Would parents have been able to find child care? And would parents be able to afford care if they could have found it?

WOULD PARENTS HAVE BEEN ABLE TO FIND CHILD CARE?

Respondents described the child care landscape for school-age children as a mix of school-based programs, programs in community organizations, local child care centers, family child care homes, and arrangements with family, friends, and neighbors. The settings families use vary within and across different communities and parts of the state and vary based on needs. When asked about the options available to parents subject to work requirements, one respondent suggested that finding care would depend on "the luck of the draw." Specifically, respondents suggested that though some parents might have been able to find care, others would have confronted barriers related to the following:

- **Statewide staffing crisis.** Child care programs are struggling to staff their classrooms and therefore cannot serve to their capacity. One respondent suggested that this problem is resulting in a loss of overall supply, particularly in rural areas.
- **Rural areas.** Rural regions across the country face child care supply constraints (Henly and Adams 2018), and more than a third of New Hampshire’s population lives in rural areas.³² As one respondent noted, “North of Concord, you have these tiny towns that only have a few people, and you might only have one or two children that need child care. You aren’t going to have a child care center [in these places].”
- **Lack of transportation.** Transportation challenges confront families in areas lacking afterschool programs in their schools. As one interviewee said, “Students live in one area, parents work in another area, and then [the kids] are bused to yet a different area for afterschool...There is no transportation to get the kids home or back to their school.”
- **Care for nontraditional schedules.** It is likely that some families subject to the work requirements would be engaged in activities that do not fit a 9–5 schedule, and respondents highlighted the challenges of finding care for parents who work nontraditional, irregular, or part-time schedules; one interviewee noted, “There is almost no child care in New Hampshire available in those times.”
- **Care on short notice or for specific times of the year.** Respondents discussed the challenges of finding care quickly, because programs can have waiting lists and available spaces tend to fill up quickly. One respondent noted that it “requires significant advanced planning by families to reserve a slot in any quality program.” Interviewees also discussed challenges finding care during summer months, when many programs are closed.
- **Care for young school-age children.** Respondents suggested that elementary school programs fill up quickest, meaning supply challenges are more acute for families with younger school-age children.
- **Care for middle- and high-school students.** The child care subsidy system cuts off at age 12, and our respondents worried about older students’ needs. They noted the gap in programming and safe places for adolescents after school and were concerned that the work requirements would push parents to leave their older kids alone. One respondent noted, “It would be nice to not have an end date to childhood. You should be around other people and cared for and in a good pace to do homework or learn or do activities.”

- **Variation in quality.** Families can also face challenges finding quality care. This is concerning because research has shown that participation in high-quality afterschool programs is linked to higher test scores, improved work habits, and reduced behavior problems (Durlak and Weissberg 2007; Vandell, Reisner, and Pierce 2007), and differences in program quality can shape outcomes (Pierce 2010; Vandell, Shumow, and Posner 2005).

COULD PARENTS AFFORD CARE IF THEY COULD FIND IT?

Respondents indicated that the cost of child care varies widely in New Hampshire, from free—if parents can find family members or friends willing to help for a sustained period or an opening in a highly subsidized program—to between \$50 and \$125 per child a week during the school year. These costs would be significantly higher during the summer, when children would need care for more hours.

Clearly, families with low incomes will likely find it challenging to afford higher-cost care if they cannot access free or low-cost care. Therefore, parents may seek public child care assistance (known as scholarships in New Hampshire) to help them defray some or all of the costs of such care. These scholarships are funded by the Child Care and Development Fund, the primary child care source for families with low incomes, and they are difficult to obtain.

Consequently, a key question is whether parents would likely have been able to get a scholarship, which respondents said depends on two issues. First, would they be eligible? The activities parents must engage in to comply with the Medicaid work requirements and the activities that make parents eligible for child care subsidies/scholarships only partially align. Though parents are eligible for scholarships if they are working or looking for work (though job search is limited to 92 days), the kinds of education and training that meet the eligibility criteria for child care assistance are limited, and volunteering is not an approved activity.

Second, even if eligible, can families get a scholarship? Nationally, limited Child Care and Development Fund funding means the program only serves a fraction of those eligible for services (Chien 2019). Though New Hampshire did not have a waitlist for subsidized child care at the time of our interviews, respondents worried that under work requirements, the lack of surplus funding for new applicants would result in a waitlist, further delaying assistance to families.

Finally, some respondents suggested the scholarship may not sufficiently reduce the cost of care for low-income families. Depending on parents' income, the sliding-scale scholarship copayment may equal the cost of care. A recent study found that in 2019, New Hampshire parents in the scholarship program

with incomes at the poverty level would pay \$133 per month, or about \$30 per week (Schulman 2019), for subsidized care—exceeding the costs of some unsubsidized school-age child care programs.

Respondents also noted that some child care providers seemed less interested in accepting scholarship clients given the state’s new scholarship-related licensing and health and safety requirements. They suggested that the high demand for child care, due to the tight labor market, may be making providers less willing to take the steps necessary to meet the new, stricter requirements for serving scholarship clients, because they can easily fill slots with private-paying parents.

Implications of Disenrollment for Providers, Hospitals, and the Beneficiaries They Serve

New Hampshire expanded Medicaid under the Affordable Care Act in 2014, successfully extending coverage to tens of thousands of previously uninsured residents. By 2016, new Medicaid enrollees numbered more than 52,000, representing 28 percent of total program enrollment at the end of that year (NH DHHS 2019). By 2017, New Hampshire’s uninsurance rate had decreased by 45 percent (Berchick, Hood, and Barnett 2018). To date, the state’s Affordable Care Act/Medicaid expansion has brought in approximately \$2.1 billion in federal funds.³³

Medicaid work requirements, however, were poised to reverse some of these gains. As discussed above, nearly 17,000 Granite Advantage beneficiaries were due to receive letters from DHHS in July 2019 notifying them that they had not met the state’s 100-hour work/community engagement threshold and would lose coverage if they did not cure their shortfall and come into compliance by August. But this potential crisis was averted when, on July 7, the DHHS commissioner announced a three-month suspension of the requirement, and the federal courts followed suit later that month by halting the state’s work requirement indefinitely. Interestingly, DHHS officials pointed out that Granite Advantage enrollment had slipped below 50,000 (to 49,783) for the first time in years in May 2019 (NH DHHS 2019). Key informants interviewed for this study speculated that work requirements might have contributed to this decline, even though the program was stopped before any formal disenrollment occurred. As we learned in our focus groups, confusion and concern surrounding work requirements caused some people to think they might have already lost coverage and discouraged others from renewing their coverage, because they did not think they would meet the 100-hour requirement in the future. However, publicity for the Medicaid work requirements and the federal proposal to make

receipt of Medicaid benefits a “public charge” coincided, and some stakeholders believed the latter reduced enrollment more than the work requirements.

Beneficiaries participating in our focus groups told us how they depended on Medicaid for maintaining their health and how work requirements might affect, or had already affected, them (box 6).

BOX 6

What Focus Groups Said about Implications of Disenrollment for Beneficiaries

Though the work requirements were only implemented for a brief period and no one was disenrolled, focus group participants still felt their impact. Of the participants that had heard of the work requirements, most reported feeling stressed upon learning about them. One participant even decided to forgo needed care because he knew he was not going to meet the hour requirement for June and thought he no longer had coverage (even though he did). Several participants felt they were doing as much as they could and expressed that the imposition of a 100-hour work requirement affected their feelings of self-worth. Other participants spoke about the ramifications of losing insurance, and many voiced that they would have to go without needed care and medications.

“I was like, ‘What am I going to do?’ This [health coverage] is how I survive.”

“I went for a physical, and we concluded I was depressed and should be seeing a therapist. I wasn’t sure if I would still have insurance, [so] I have been putting it off...because I was going to be a couple hours short of the 100-hour requirement.”

“I often feel like I can’t really do enough. Even at less than 100 hours, the limited hours I had, it still felt like a lot of work for me and left me in a bad state of mind.”

“How did it make me feel [when they said I needed more hours]? I felt like I was not good enough...like what I had going on wasn’t enough.”

“When you are looking at not getting your medicine or not being able to go to the doctor, that is a really scary thing.”

“I had one medication that, without insurance, costs 150 bucks a month. And would probably cost my life if I couldn’t get it.”

“Here is the kicker: I work three days per week at the office I work at. I was working two days on the weekend as a waitress until [the state] said I was making too much money to get medical assistance. So one extra day of work made my income too high, and one less day made me ineligible because I didn’t work enough [to meet the 100-hour requirement]. It is a trap. If I had the ability to work full time and get insurance, I would.”

Source: Urban Institute focus groups, October 2019.

Hospital representatives said New Hampshire's Medicaid expansion had been important to the state's 26 hospitals: uncompensated care dropped significantly, no hospitals had closed for many years, and emergency department utilization had dropped dramatically. Though no formal analysis of potential impacts of work requirements in Medicaid had been conducted, these stakeholders expressed concern about the implications of coverage losses, citing potential deterioration in patient health and increased use of expensive emergency room care.

FQHC officials said one of their greatest concerns was insufficient funding to cover the cost of caring for people who lost coverage because of the Medicaid work requirements. New Hampshire officials adopted a less punitive policy for its program than Arkansas and other states; technically, rather than formally disenrolling people who did not report enough hours, they would have suspended enrollees' coverage until they could make up hour shortfalls, and then the state would reactivate enrollees' Medicaid coverage if they complied. But this approach left FQHCs vulnerable; they could not bill Medicaid for services rendered to people with suspended coverage, nor could they use federal Section 330 grant funds to cover the cost of such care, because those with suspended coverage would still be officially "enrolled" in Medicaid. FQHC representatives estimated that if 10 percent of their patients had suspended coverage, they would lose approximately \$350,000 in revenue annually.

Three qualified health plans currently participate in Granite Advantage: Well Sense Health Plan, NH Healthy Families/Centene, and Amerihealth Caritas New Hampshire. For them, Medicaid expansion meant expanded membership given the more than 50,000 newly covered lives. Like hospitals, health plans had yet to conduct formal analyses of how high disenrollment rates might have affected their bottom lines. But before the requirements were stopped, plan administrators had become increasingly concerned about losing up to 10 percent of their members and how those losses would affect their risk pools.

Diverging Opinions of Medicaid Work Requirements

Opinions about Medicaid work requirements remain mixed in New Hampshire. Legal advocates and many state-based policy researchers strongly believe they are wrong headed and illegal under the Medicaid statute, and that they will ultimately be stopped by the courts. Republican lawmakers maintain that work requirements represent a legitimate experiment worth conducting and point to the popularity of the policy among the voting public. Though Granite Advantage participants in our focus groups believed in the merits of work, they also felt strongly that if someone cannot work, or cannot work 100 hours each month, they should not be punished with loss of health coverage (box 7).

BOX 7

What Focus Group Said about Work and the Work Requirements

Focus group participants generally agreed that beneficiaries capable of working should do so; most of our participants were either working or unable to work because of physical or mental health limitations. Participants not working enough to meet the 100-hour requirement generally felt they were incapable of doing more, though they wished they could. Generally, participants thought the work requirement was not a fair policy and that it was excessively harsh. Consequently, they expressed frustration and defeat.

“People that could work, should work...But yanking health insurance for not complying is harsh because people need their medications and doctors’ appointments.”

“I like to work. I wish I had the stamina to work more...I would work more if I could.”

“I just remember thinking, ‘I am doing all I can do. How can I do more? How can I squeeze in where they want me to do it?’ I already had two jobs and was working as much as I could work, physically and mentally.”

“I see what they are going for, but there are people like me who just...in the state I am in, it would be very difficult for me mentally. I see that they don’t want people sitting around and getting [health coverage] for free, but I am currently one of those people...That is difficult to think about.”

“Fundamentally, I understand why it needs to be implemented. [But] on the fairness issue, one shoe doesn’t fit all.”

“You can’t [kick people off Medicaid]. That is traumatic. For people who qualify for the help, they have already gone through the process of qualifying...and now you are adding more stipulations on them. They changed the rules of the game while the game is in play.”

“The state likes to keep us in the dark and up the creek without a paddle.”

“[The state] just throws everyone to the wolves and says, ‘Let’s get some popcorn.’”

Source: Urban Institute focus groups, October 2019.

Some stakeholders we interviewed occupy middle ground; they may object to the requirements’ punitive nature but feel politically compelled to accept the requirements in return for the benefits of Medicaid’s coverage expansion. One stakeholder suggested an alternative to work requirements could be a voluntary work support program for adults newly covered by Medicaid expansion, like that originally adopted in Montana, saying, “People need to be healthy to work. Taking away their health insurance is not going to make that easier.”

Conclusions

A federal court halted New Hampshire's Medicaid work requirement program on July 29, 2019, just a few weeks after state officials had temporarily suspended it and roughly two months before the suspension would have expired had the court not intervened. No one interviewed for this study was surprised by the court's decision, given that the presiding judge had previously halted programs in Arkansas and Kentucky. Most stakeholders were greatly relieved and some even speculated that conservative state lawmakers might also be secretly comforted, because it "gave them cover" from having to continue pushing for a program that was poised to disenroll large numbers of Granite Advantage members. Once the program was halted, DHHS stopped all activities related to the work requirements; they suspended door-to-door outreach, sent letters notifying beneficiaries that work requirements were no longer in place, displayed a prominent banner with the same message on the DHHS website, and reinstated a 90-day retroactive reimbursement for providers. For the time being, at least, upwards of 17,000 beneficiaries were shielded from losing Medicaid coverage.

At the time of our case study, stakeholders had many of the same as-yet unanswered questions as Arkansas stakeholders, including the following: Who could have lost Medicaid? Were they in good or poor health? Were they high or low utilizers of care? How many of the people at risk of disenrollment suffer medical and/or behavioral conditions that prevented them from working? When the work requirements were halted, the state had already spent \$6.1 million (GAO 2019). What other needs could that money have been spent on?

For now, this case study's findings provide several insights into the multiple and complex problems surrounding implementation of Medicaid work requirements:

- **Outreach.** Though New Hampshire was eager to avoid repeating Arkansas's implementation mistakes, it succumbed to many of the same outreach errors. The state did not allow enough time to publicize and educate beneficiaries about new work rules before implementation, and outreach efforts were not sufficiently funded. The state relied too heavily on mail- and telephone-based communications that failed to reach a population who is transient, moves frequently, possesses limited-minute phone plans, and faces numerous social challenges related to mental health, substance use, and homelessness. The information conveyed was overly complex and left beneficiaries confused and bewildered about how the rules affected them. Though the state conducted a door-to-door outreach campaign in late June to address the above shortcomings, the effort was largely unsuccessful. Community-based service providers interviewed for this study told us a more effective strategy would have been to fully fund

comprehensive outreach and education, including paying for health and social service providers, who regularly assist these populations, to provide hands-on help. However, one interviewee felt that even if these strategies were adopted, they would not have fully informed and educated this hard-to-reach population.

- **Promoting work.** New Hampshire launched a pilot work support program, Granite Workforce, in tandem with its Medicaid work requirements to help the expansion population gain important skills and to incentivize employers to hire Medicaid enrollees. But the program was crippled by eligibility restrictions because of the TANF funding used to support it—it could only help people between ages 19 and 24 or parents of dependent children under age 18—and the pilot period lasted just six months. Stakeholders, including state officials, agreed that an effective work support effort would need more time to become established and would need to be available to people of all ages. Further, such an effort would have to more rigorously address common barriers to employment, such as lack of transportation, affordable child care, and housing.
- **Reporting work and community engagement.** Here, too, New Hampshire officials tried to avoid mistakes made in Arkansas by designing a no-wrong-door approach to reporting hours spent working, going to school, receiving job training, or participating in other community engagement activities. Under this approach, beneficiaries could report hours online, by mail, over the phone, or in person. But key informants and focus group participants reported that paper forms were poorly designed, the state’s web portal was sometimes “glitchy,” there could be long wait times when trying to get help over the phone, and staff members at the state’s contracted call center were sometimes rude to customers. The state’s curing system—which allowed beneficiaries who fell short of the 100-hour threshold an extra month to cure the shortfall through work or community engagement or by obtaining an exemption for good cause—was confusing to stakeholders and consumers alike. Focus group participants and many key informants, including those at community agencies, believed reporting might have been less onerous for beneficiaries if providers and community-based organizations had received funding to support assisters or navigators to provide hands-on help to affected enrollees.
- **Obtaining exemptions.** Like Arkansas, New Hampshire attempted to proactively exempt as many Granite Advantage members as possible from its Medicaid work requirements, doing so for those deemed compliant with or exempt from Supplemental Nutrition Assistance Program or TANF work requirements, disabled, pregnant or fewer than 60 days postpartum, and parents or caretakers of children under age 6. But also like Arkansas, New Hampshire did not use claims

data from health plans or other sources to automatically exempt people with medical frailty, instead requiring beneficiaries to get their health care providers to certify their inability to work. This proved to be the most problematic aspect of the state's exemption system. As noted, beneficiaries with physical and behavioral health problems reportedly struggled when applying for exemptions, often because primary care providers resisted signing forms declaring them unable to work. Meanwhile, parents with school-age children subject to work requirements likely would have faced challenges finding child care, struggled to afford it, and confronted barriers to getting assistance to defray some of the costs. State-based policy researchers, legal advocates, and beneficiaries with whom we spoke agreed that New Hampshire should have made exemptions simpler and more data driven, exempting broader groups from work requirements, including all parents of children younger than 18, homeless people, people with opioid and/or substance use disorders, and people over age 49.

- **Implications of disenrollment.** Medicaid beneficiaries told us their health coverage was critical, that it kept them healthy and able to work, and that losing Medicaid would have been devastating. Providers and health plans, too, said that Medicaid expansion had helped increase people's financial access to care and decreased uncompensated and care. They also expressed concern over how loss of coverage would affect patient health and increase use of expensive emergency room care.

In conclusion, though New Hampshire officials implemented numerous strategies to differentiate their Medicaid work requirements program from Arkansas's, they found themselves at nearly the same end point: on the brink of disenrolling a large portion of the state's Medicaid expansion population. Moreover, New Hampshire reached this point in a fraction of the time; Arkansas disenrolled 18,000 people over six months of implementation, whereas New Hampshire might have disenrolled up to 17,000 after just two months, a startling 67 percent of those subject to the requirements. The unique feature of New Hampshire's program not present in Arkansas's—state authority to suspend the program if undue harm to beneficiaries was expected—was added by the state legislature just in time to save 17,000 enrollees from potentially losing health coverage.

At the time of this writing, no date has been set to hear oral arguments on the federal government's appeal of the lower court ruling that halted New Hampshire's Medicaid work requirements, so the program's ultimate resolution is uncertain. Meanwhile, waivers to implement Medicaid work requirements have been approved in seven other states, and waiver applications from eight more states are pending at CMS (though, notably, implementation of approved programs in Indiana and Arizona has been postponed pending further decisions by the courts, and the newly elected Democratic governor of

Kentucky rescinded the state's waiver to impose work requirements).³⁴ Still, setting aside the fundamental question about the legality of work requirements, which the courts are currently considering, and based on the experiences of the first two states to implement Medicaid work requirements (using different approaches and under different circumstances), evidence suggests such programs cause significant harm to Medicaid beneficiaries while not appreciably supporting their ability to work.

Notes

- ¹ Arkansas Department of Human Services, *February 2019 Arkansas Works Program Report*, accessed January 24, 2020, https://humanservices.arkansas.gov/images/uploads/190315_February_AWReport.pdf.
- ² “Work Requirements Tracker,” Urban Institute, updated December 20, 2019, <https://www.urban.org/features/work-requirements-tracker>.
- ³ Jessica Schubel, “NH Medicaid Work Requirement Suspension Confirms: Policy Can’t Be Fixed,” *Off the Charts* (blog), Center on Budget and Policy Priorities, July 9, 2019, <https://www.cbpp.org/blog/nh-medicaid-work-requirement-suspension-confirms-policy-cant-be-fixed>.
- ⁴ New Hampshire Department of Health and Human Services, letter to Granite Advantage Health Care Program beneficiaries, mandatory community engagement status, February 25, 2019, <https://www.dhhs.nh.gov/medicaid/granite/documents/mandatory-status-letter.pdf>; Centers for Medicare & Medicaid Services, letter to Henry D. Lipman (Medicaid director, New Hampshire Department of Health and Human Services), approval of New Hampshire’s Section 1115 demonstration, November 30, 2018, <https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-approval-letter-11302018.pdf>.
- ⁵ “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” Henry J. Kaiser Family Foundation, January 23, 2010, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2>.
- ⁶ Jason Moon, “N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise,” New Hampshire Public Radio, July 9, 2019, <https://www.nhpr.org/post/nh-said-its-medicaid-work-requirement-would-be-different-early-numbers-suggest-otherwise#stream/0>.
- ⁷ Dave Solomon, “Spreading the Word on Medicaid Work Requirement Proves Challenging,” *New Hampshire Union Leader*, June 16, 2019, https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html.
- ⁸ Jason Moon, “Confusing Letters, Frustrated Members: NH’s Medicaid Work Requirement Takes Effect,” New Hampshire Public Radio, June 18, 2019, <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0>; Jason Moon, “Patients and Providers Anxiously Prepare for Medicaid Work Requirement,” New Hampshire Public Radio, March 19, 2019, <https://www.nhpr.org/post/patients-and-providers-anxiously-prepare-medicaid-work-requirement#stream/0>.
- ⁹ Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Chris Sununu (governor, New Hampshire), RE: Determination and findings relative to the Granite Advantage community engagement requirement, July 8, 2019, <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>.
- ¹⁰ S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).
- ¹¹ S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (as introduced March 14, 2019).
- ¹² S.B. 290, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).
- ¹³ Jason Moon, “N.H. to Appeal Medicaid Work Requirement Ruling,” New Hampshire Public Radio, August 1, 2019, <https://www.nhpr.org/post/nh-appeal-medicaid-work-requirement-ruling#stream/0>.
- ¹⁴ S.B. 313, 2018 Leg., Reg. Sess. (N.H. 2018) (enacted).
- ¹⁵ Emily M. Johnston, Anuj Gangopadhyaya, Genevieve M. Kenney, and Steven Zuckerman, “New Hampshire Residents Who Lose Medicaid under Work Requirements Will Likely Face Limited Employer-Sponsored Insurance Options,” *Urban Wire* (blog), Urban Institute, May 13, 2019, <https://www.urban.org/urban-wire/new-hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options>.

[hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options.](#)

- ¹⁶ Moon, “N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise,” New Hampshire Public Radio.
- ¹⁷ This number does not include initial letters and the status change letters sent to people when their circumstances change; it is only for the generic letters sent to participants regarding community engagement compliance. This was calculated by adding the 37,482 letters mailed to Granite Advantage participants subject to the work requirements and the 10,978 letters mailed to those who are medically frail, as reported by DHHS; Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.
- ¹⁸ *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services, accessed January 27, 2020, <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.
- ¹⁹ Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.
- ²⁰ *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.
- ²¹ Jeffrey Meyers (commissioner, New Hampshire Department of Health and Human Services), letter to Jeb Bradley (senator, New Hampshire), RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program, September 3, 2019.
- ²² Meyers, letter to Bradley, RE: Request by the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.
- ²³ For more information, see the New Hampshire Department of Employment Security’s Granite Workforce web page, available at <https://www.nhes.nh.gov/services/granite-workforce/index.htm>.
- ²⁴ *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.
- ²⁵ Beneficiaries could report both work and community engagement hours online through the NH EASY system.
- ²⁶ *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.
- ²⁷ This number does not include the 7,466 people deemed compliant through the state’s earnings calculation, discussed in the prior section.
- ²⁸ *DHHS Community Engagement Report: June 2019*, New Hampshire Department of Health and Human Services.
- ²⁹ New Hampshire Department of Health and Human Services, email to Kay Drought (managing attorney and litigation director, New Hampshire Legal Assistance), RE: Your right to know request, August 22, 2019.
- ³⁰ New Hampshire Department of Health and Human Services, email to Drought, RE: Your right to know request, August 22, 2019.
- ³¹ *S.B. 290*, 2019 Leg., Reg. Sess. (N.H. 2019) (enacted).
- ³² See the Rural Health Information Hub’s New Hampshire guide, available at <https://www.ruralhealthinfo.org/states/new-hampshire>.
- ³³ Center on Budget and Policy Priorities’ calculation using CMS’s administrative Medicaid expenditure data from the CMS-64 form.
- ³⁴ “Work Requirements Tracker,” Urban Institute.

References

- Adams, Gina, Eva Allen, Anuj Gangopadhyaya, and Genevieve M. Kenney. 2019. *Child Care Challenges for Medicaid Work Requirements*. Washington, DC: Urban Institute.
- Berchick, Edward R., Emily Hood, and Jessica C. Barnett. 2018. *Health Insurance Coverage in the United States: 2017*. Suitland, MD: US Census Bureau.
- Chien, Nina. 2019. "Fact Sheet: Estimates of Child Care Eligibility and Receipt for Fiscal Year 2015." Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- Durlak, Joseph A., and Roger P. Weissberg. 2007. *The Impact of After-School Programs That Promote Personal and Social Skills*. Washington, DC: US Department of Education, Education Resources Information Center.
- Garfield, Rachel, Robin Rudowitz, Kendal Orgera, and Anthony Damico. 2019. "Understanding the Intersection of Medicaid and Work: What Does the Data Say?" San Francisco: Henry J. Kaiser Family Foundation.
- Hahn, Heather. 2019. *Navigating Work Requirements in Safety Net Programs: Potential Pathways for Parents*. Washington, DC: Urban Institute.
- Henly, Julia R., and Gina Adams. 2018. "Insights on Access to Quality Child Care for Families Living in Rural Areas." Washington, DC: Urban Institute.
- Hill, Ian, and Emily Burroughs. 2019. *Lessons from Launching Medicaid Work Requirements in Arkansas*. Washington, DC: Urban Institute.
- Karpman, Michael. 2019. "Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment." 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.
- NH DHHS (New Hampshire Department of Health and Human Services). 2019. "New Hampshire Medicaid Enrollment Demographic Trends and Geography." Concord, NH: New Hampshire Department of Health and Human Services.
- NHFPI (New Hampshire Fiscal Policy Institute). "New Hampshire's State Budget and Families in the Post-Recession Economy." Presentation given at the Sixth Annual Conference, Investments to Sustain a Vibrant Economy, Concord, NH, February 22, 2019.
- NHHFA (New Hampshire Housing Finance Authority). 2019. *2019 Residential Rental Cost Survey Report*. Manchester, NH: New Hampshire Housing Finance Authority.
- Pierce, Kim M. 2010. "Specific Features of After-School Program Quality: Associations with Children's Functioning in Middle Childhood." *American Journal of Community Psychology* 45 (3-4): 381-93. <https://doi.org/10.1007/s10464-010-9304-2>.
- Schulman, Karen. 2019. *Early Progress: State Child Care Assistance Policies 2019*. Washington, DC: National Women's Law Center.
- Vandell, Deborah Lowe, Elizabeth R. Reisner, and Kim M. Pierce. 2007. *Outcomes Linked to High-Quality Afterschool Programs: Longitudinal Findings from the Study of Promising Afterschool Programs*. Washington, DC: US Department of Education, Education Resources Information Center.
- Vandell, Deborah Lowe, Lee Shumow, and Jill Posner. 2005. "After-School Programs for Low-Income Children: Differences in Program Quality." In *Organized Activities As Contexts of Development: Extracurricular Activities, After-*

School and Community Programs, edited by J. L. Mahoney, R. W. Larson, and J. S. Eccles, 437–56. Mahwah, New Jersey: Lawrence Erlbaum Associates Inc.

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.

Gina Adams is a senior fellow in the Center on Labor, Human Services, and Population at the Urban Institute and directs the Low-Income Working Families project and the Kids in Context initiative. She is a national expert on factors that shape the affordability, quality, and supply of child care and early education services and the ability of low-income families to benefit from them. Her recent work focuses on the importance of stabilizing families to support healthy child development, the impact of Medicaid work requirements on the child care needs of parents, and strategies to meet the child care needs of parents seeking education and training.

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