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The Future Of Medicaid Reform: **Empowering Individuals Through Work**

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Executive Summary

Medicaid spending and enrollment has skyrocketed in recent years, crowding out resources for all other state priorities. The number of people dependent on Medicaid has more than doubled since 2000, with nearly 75 million individuals currently enrolled in the program. Nowhere is this growth more evident than among able-bodied adults. Nearly 28 million able-bodied adults are now dependent on the program, up from fewer than 7 million in 2000.

This enrollment explosion is fueling a massive spending surge. Total Medicaid spending has nearly tripled since 2000 and spending on able-bodied adults has increased by a jaw-dropping 700 percent.

The implications of this Medicaid explosion are clear: fewer dollars are available for truly vulnerable individuals who depend on the Medicaid program to survive. Fewer dollars are available for important budget priorities like infrastructure, law enforcement, and education. Taxpayers are on the hook for an ever-increasing bill, with no end in sight.

The status quo is unsustainable and unacceptable. But thankfully, policymakers have commonsense options that can not only reduce dependency but improve the lives of individuals who are currently stuck in the Medicaid program.

To turn the tide and help individuals improve their lives, states should pursue commonsense work requirements for Medicaid. These requirements have been wildly successful in other major welfare programs at reducing dependency, increasing incomes, and freeing up resources for those in need.

Unlike other welfare programs, Medicaid does not currently require able-bodied adults to work, train, or volunteer as a condition of eligibility. But a new federal landscape and a presidential administration focused on moving people from welfare to work has created the opportunity for the most meaningful Medicaid reform in generations. Federal law provides that the purpose of Medicaid is “to help such families and individuals attain or retain capability for independence.” Numerous states are now moving forward with Medicaid work requirements to help move more able-bodied adults to independence. More are sure to follow, driving the nation into a new welfare reform frontier.

The Evolution of Medicaid

Medicaid was designed as a safety net for the truly vulnerable—the elderly and individuals with disabilities. Because these groups were generally either not working age or had limited work capacity due to their disabilities, work requirements and time limits were never included in the Medicaid program. But over time, the program has grown to cover new groups, changing the fabric of the program and creating new challenges for policymakers and enrollees alike.

As part of welfare reform in 1996, Congress infused work requirements and time limits into the nation's food stamp and cash assistance programs.¹ This bipartisan reform led to remarkable results, helping millions of individuals out of the welfare trap and leading to higher incomes.²⁻³

But Congress also delinked Medicaid eligibility from cash assistance, cementing pre-welfare reform Medicaid eligibility criteria for non-disabled parents.⁴ Had the programs stayed connected, work requirements in cash assistance programs might have served as a de facto Medicaid work requirement: able-bodied adults would need to work in order to receive cash assistance and failing to do so would remove them from both programs. States do retain the option to remove adults from Medicaid if they're also enrolled in cash assistance and refuse to meet that program's work requirement, but few states actually enforce this policy and it applies to only a fraction of able-bodied adults on Medicaid.⁵⁻⁷

As a result, the number of able-bodied adults dependent on Medicaid has skyrocketed over the last two decades. Worse yet, many states increased eligibility for able-bodied adults beyond federal minimums. Some states—including Arizona and Maine—even expanded eligibility to able-bodied, childless adults in the early 2000s.⁸

Fast forward to 2014. ObamaCare's Medicaid expansion went live across the country in states that chose to implement it. This opened the flood gates even further, adding millions of able-bodied, childless adults to Medicaid.⁹

As a result, Medicaid has rapidly evolved from a safety net for the truly needy into a lifestyle for far too many able-bodied adults and this shift in focus has culminated into numerous problems across the program.

■ **PROBLEM: Medicaid fosters dependency**

Many major welfare programs require able-bodied adults to participate in at least some level of "work activity" in order to maintain eligibility. For example, able-bodied, childless adults on food stamps must work, train, or volunteer at least 20 hours per week in order to receive benefits.¹⁰ Able-bodied adults with children are required to register for work and not turn down job offers in order to keep their benefits.¹¹ Even the Temporary Assistance for Needy Families (TANF) cash assistance program requires parents to engage in some level of work-related activities.¹² Both programs also incorporate time limits on benefits.

But when it comes to work requirements, Medicaid is well outside the mainstream. Able-bodied adults can enroll without any requirements related to work or time limits. As long as they keep their incomes below certain thresholds, they can receive Medicaid welfare indefinitely. Without this requirement in place, most able-bodied adults in Medicaid do not work at all.¹³

► **PROOF: Most able-bodied adults on Medicaid do not work at all**

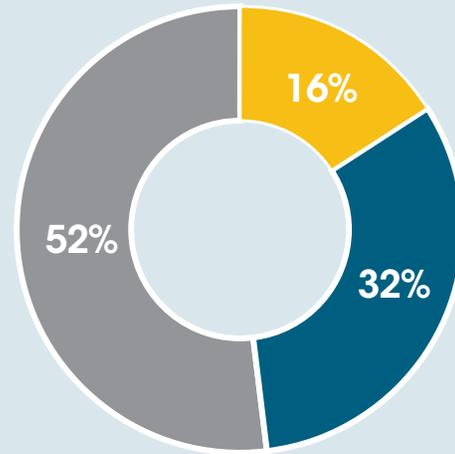
Despite the fact that Medicaid’s able-bodied adults have no physical disabilities keeping them from pursuing gainful employment, very few actually work full-time jobs.¹⁴ According to the Census Bureau, most non-disabled adults on Medicaid do not work at all.¹⁵

► **PROOF: Many ObamaCare expansion enrollees do not work at all**

Further evidence from states that expanded Medicaid through ObamaCare suggests the problem is even more widespread than just traditional Medicaid. In Michigan, half of all able-bodied adults in the expansion are not working.¹⁶ In Illinois, 54 percent of expansion adults report no income at all.¹⁷ In Ohio, 57 percent of able-bodied adults enrolled in the ObamaCare expansion are not working.¹⁸ In New Hampshire, 58 percent of enrollees do not work at all.¹⁹ And in Nevada, a staggering 60 percent of enrollees report no income.²⁰

JUST 16 PERCENT OF ABLE-BODIED MEDICAID ENROLLEES WORK FULL-TIME, YEAR-ROUND

Work status of non-disabled, working-age Medicaid enrollees, 2015



- Full-time, year-round workers
- Part-time or part-year workers
- Non-workers

Source: Census Bureau

OBAMACARE EXPANSION ENROLLEES ARE NOT WORKING

Share of expansion enrollees not working, by state



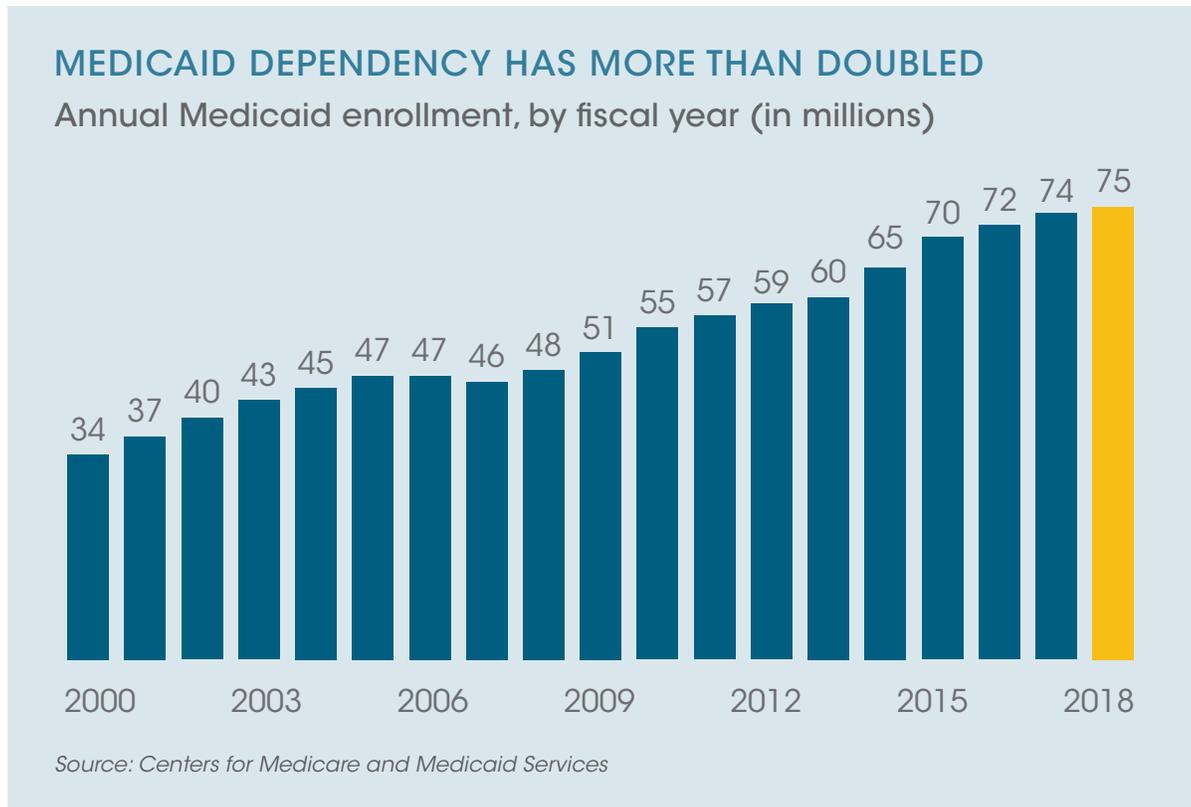
Sources: Illinois Department of Healthcare and Family Services; Michigan Department of Health and Human Services; Nevada Department of Health and Human Services; New Hampshire Department of Health and Human Services; Ohio Department of Medicaid.

PROBLEM: Medicaid enrollment is exploding

With no work requirements or time limits, able-bodied adults have few reasons to leave Medicaid. As a result, combined with expanded eligibility, Medicaid enrollment has soared to record levels.

PROOF: Medicaid enrollment has more than doubled since 2000

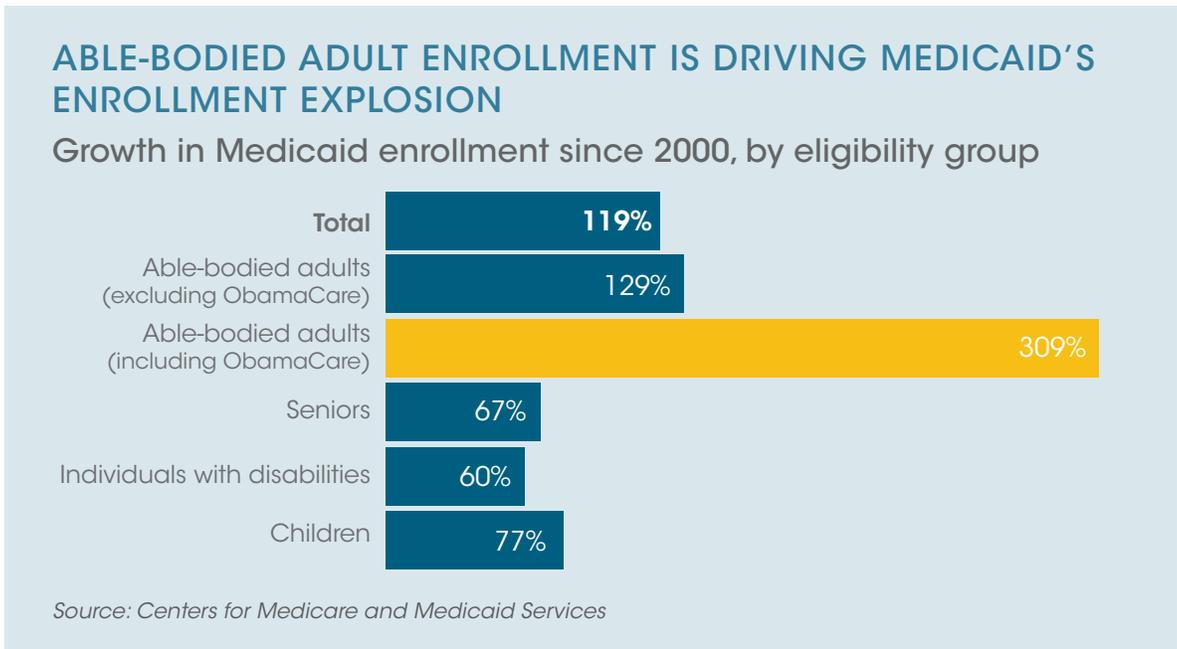
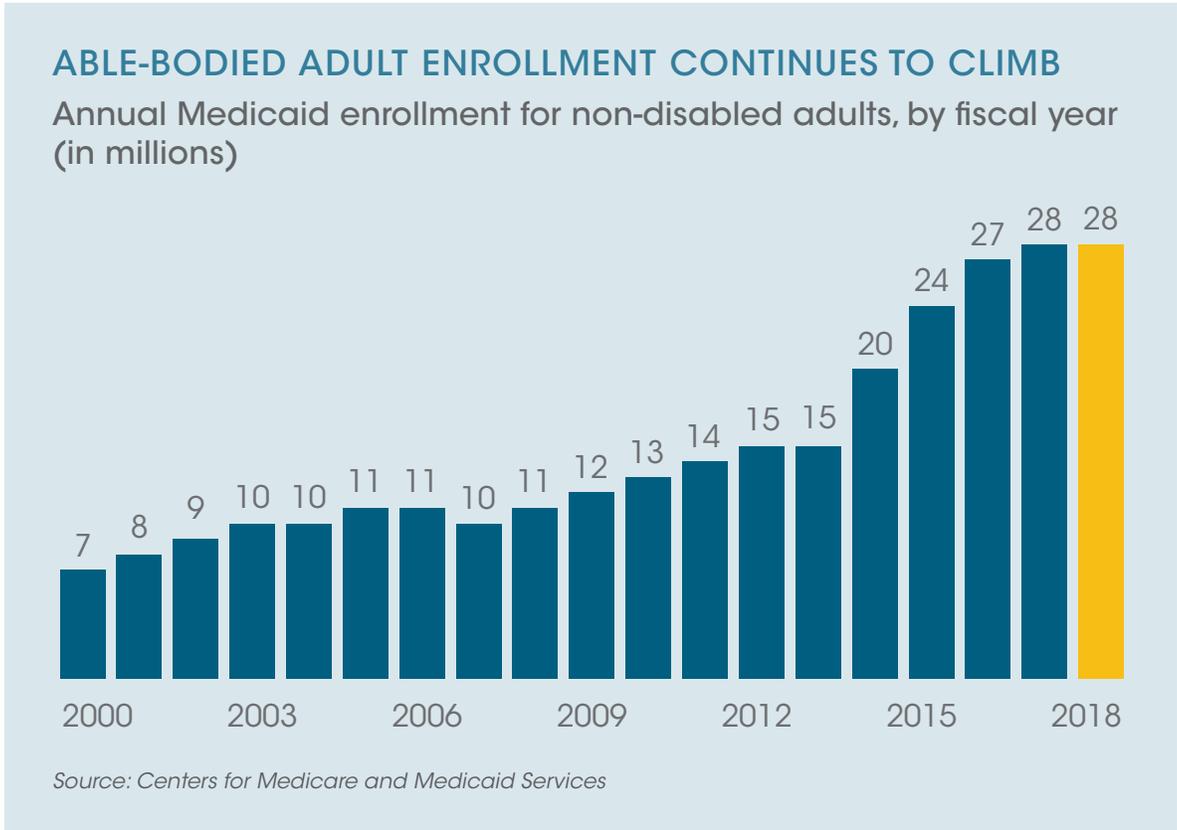
Today, nearly 75 million individuals are now dependent on Medicaid—more than twice as many as 2000.²¹⁻²⁵



And while all Medicaid categories have experienced significant enrollment growth since 2000, one group is by far outpacing the rest—able-bodied adults.

► **PROOF: The number of able-bodied adults on Medicaid has quadrupled since 2000**

Since 2000, non-ObamaCare able-bodied adult enrollment in Medicaid has more than doubled.²⁶ But when accounting for newly-eligible adults who have enrolled through ObamaCare’s Medicaid expansion, the numbers are even more shocking: the number of able-bodied adults on Medicaid has more than quadrupled since 2000.²⁷



■ **PROBLEM:** Medicaid spending is surging

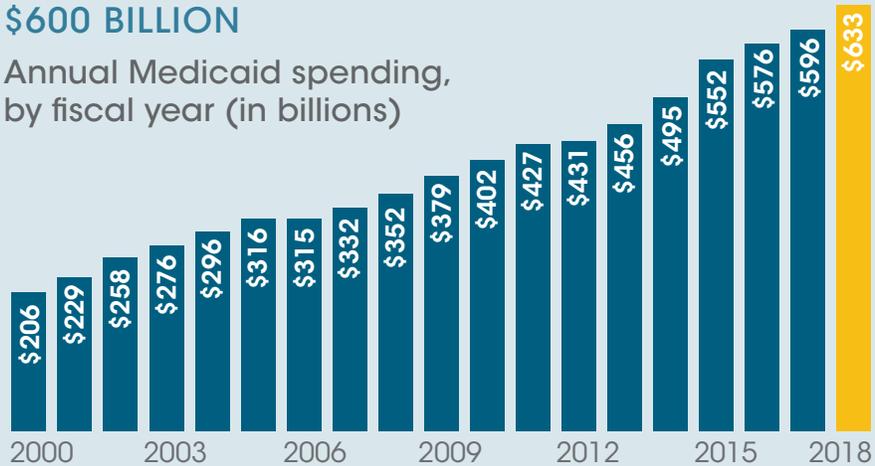
Record enrollment in Medicaid is fueling an even more alarming spending surge, leaving taxpayers on the hook for an unprecedented level of welfare spending. This leaves fewer dollars for other budget priorities, including education, public safety, and infrastructure. It also means fewer dollars are available for truly vulnerable individuals who depend on the Medicaid program to survive.

▶ **PROOF:** Medicaid spending has more than tripled since 2000

Actuaries at the Centers for Medicare and Medicaid Services estimate that taxpayers will spend more than \$632 billion on Medicaid this year—more than triple the \$206 billion spent in 2000.²⁸ Skyrocketing enrollment—including in ObamaCare’s Medicaid expansion—is responsible for more than 70 percent of that growth in spending, with the rest stemming from growing per capita costs and other factors.²⁹

MEDICAID SPENDING HAS SURGED TO UNPRECEDENTED LEVELS, NOW TOPPING \$600 BILLION

Annual Medicaid spending, by fiscal year (in billions)



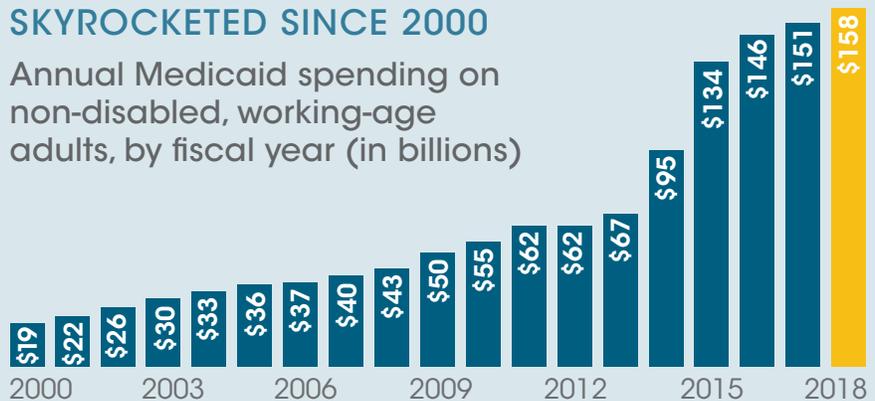
Source: Centers for Medicare and Medicaid Services

▶ **PROOF:** Medicaid spending on able-bodied adults has increased by more than 700 percent

And like enrollment, while spending is growing across all categories, none is growing as fast as spending on able-bodied adults. Since 2000, spending on able-bodied adults has increased from just \$19 billion to nearly \$158 billion—an increase of more than 700 percent.³⁰

SPENDING ON ABLE-BODIED ADULTS HAS SKYROCKETED SINCE 2000

Annual Medicaid spending on non-disabled, working-age adults, by fiscal year (in billions)



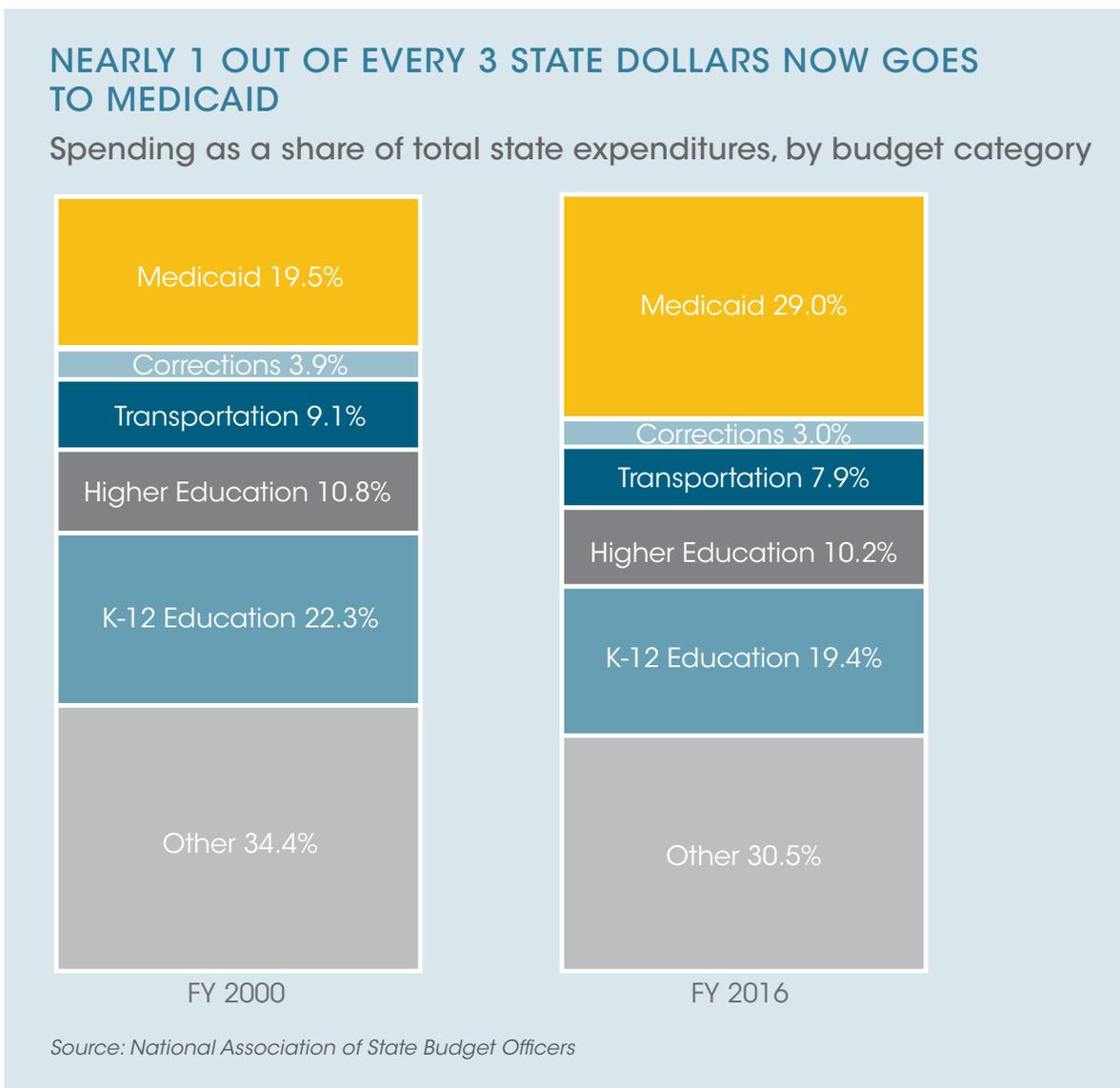
Source: Centers for Medicare and Medicaid Services

■ PROBLEM: Medicaid is consuming state budgets

To make matters even worse, Medicaid spending is not just growing quickly—it is growing faster than state revenues and faster than any other line-item in state budgets. As Medicaid continues to devour resources, fewer and fewer dollars are left over for other important budget items, including education, public safety, and infrastructure.

► PROOF: Medicaid spending as a percent of state expenditures has skyrocketed

Medicaid spending accounted for just 19.5 percent of state budgets in 2000.³¹ But by 2016, nearly 30 percent of state budgets was being devoted to Medicaid, crowding out funding for other critical priorities.³² Over that same time, the share of state spending devoted to other priorities such as elementary and secondary education, corrections, higher education, and transportation all declined.³³ In real terms, this means that nearly one out of every three dollars a state spends goes to fund Medicaid.³⁴



THE SOLUTION: Work Requirements

Medicaid is clearly on an unsustainable path. As able-bodied adult enrollment continues to surge and drive up spending, fewer and fewer dollars are available for truly vulnerable individuals such as poor children, seniors, and individuals with disabilities. With so few able-bodied enrollees working, it is clear that something must change in order to help these individuals back into independence and preserve limited public resources for those who truly need help. Thankfully, there is a simple solution: work requirements.

Work requirements have proven to be a highly effective way to not only reduce caseloads but increase incomes. After Kansas implemented work requirements for able-bodied, childless adults on food stamps, caseloads dropped by 75 percent and the average amount of time spent on welfare was cut in half.³⁵ Individuals who left welfare went back to work in more than 600 different industries and saw their incomes skyrocket, more than doubling on average.³⁶ Even better, this increased income more than offset their lost welfare benefits.³⁷ When Maine implemented the same change, it saw similarly impressive results: incomes of former enrollees more than doubled and caseloads declined by 90 percent.³⁸

Similar results occurred after work requirements were implemented for able-bodied parents. In Kansas, for example, stronger work requirement sanctions were followed by lower cases, more employment, and higher incomes.³⁹

The research is clear: work requirements are a proven, effective way to help reduce dependency and improve the lives of millions of individuals who are currently trapped in welfare.

Medicaid work requirements have become a major focal point in Washington D.C., having been included in every proposal to repeal and replace ObamaCare in 2017.⁴⁰⁻⁴² But rather than waiting for Washington to implement Medicaid work requirements, states should utilize the waiver process to move the ball forward. Thankfully, many states are already doing just that.

Proposals to implement Medicaid work requirements have already been submitted to the Trump administration or enacted in state law in Arkansas, Arizona, Kansas, Kentucky, Indiana, Maine, New Hampshire, Ohio, and Wisconsin, with more states joining soon.⁴³⁻⁵¹ These states are on the cutting edge of a new welfare reform revolution that is just beginning.

Additional states that are interested in pursuing these commonsense requirements should consider a 20-hour-per-week requirement to work, train, or volunteer. This standard would mirror the work requirement for childless adults on food stamps that was created more than two decades ago and has been a massive success. By mirroring the requirement in this way, states would ease any administrative burden of implementation, as eligibility systems are already structured to track and enforce the same standard in food stamps.

Work requirements have been absent from the Medicaid program for far too long. As a result, the truly needy and taxpayers are paying a high price. But through commonsense work requirements, states have the opportunity to help welfare enrollees improve their lives while reducing dependency and protecting the truly needy.

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APPENDIX

TABLE 1: MEDICAID ENROLLMENT SINCE 2000, BY CATEGORY (IN MILLIONS)

	Aged	Disabled	Children	Adults	Newly eligible
FY 2000	3.6	6.7	16.1	6.9	0.0
FY 2001	3.7	6.9	17.3	7.7	0.0
FY 2002	4.0	7.2	19.1	8.9	0.0
FY 2003	4.3	7.5	20.9	9.7	0.0
FY 2004	4.4	7.7	21.9	10.1	0.0
FY 2005	4.6	8.0	22.5	10.5	0.0
FY 2006	4.5	8.2	22.6	10.5	0.0
FY 2007	4.5	8.3	22.3	10.2	0.0
FY 2008	4.6	8.6	22.8	10.8	0.0
FY 2009	4.7	8.9	24.4	11.9	0.0
FY 2010	4.9	9.2	26.4	13.1	0.0
FY 2011	5.1	9.7	27.2	13.8	0.0
FY 2012	5.3	10.0	27.9	14.7	0.0
FY 2013	5.4	10.4	28.0	15.0	0.0
FY 2014	5.5	10.4	28.2	15.2	4.3
FY 2015	5.6	10.5	28.1	15.2	9.1
FY 2016	5.7	10.6	28.1	15.3	11.2
FY 2017	5.8	10.6	28.2	15.5	12.0
FY 2018	6.0	10.7	28.5	15.8	12.4
FY 2019	6.2	10.9	29.0	16.0	12.5
FY 2020	6.4	11.0	29.5	16.2	12.7
FY 2021	6.6	11.1	29.9	16.4	12.8
FY 2022	6.9	11.2	30.3	16.5	13.0
FY 2023	7.1	11.3	30.6	16.6	13.0
FY 2024	7.3	11.4	30.9	16.7	13.1
FY 2025	7.5	11.5	31.1	16.8	13.2

Source: Centers for Medicare and Medicaid Services

**TABLE 2:
PER PERSON MEDICAID SPENDING, BY CATEGORY**

	Aged	Disabled	Children	Adults	Newly eligible
FY 2000	\$14,124	\$12,218	\$1,741	\$2,805	\$0
FY 2001	\$14,720	\$13,016	\$1,860	\$2,901	\$0
FY 2002	\$14,817	\$14,471	\$2,030	\$2,975	\$0
FY 2003	\$14,401	\$15,035	\$2,040	\$3,090	\$0
FY 2004	\$14,700	\$15,157	\$2,079	\$3,245	\$0
FY 2005	\$15,254	\$16,405	\$2,247	\$3,407	\$0
FY 2006	\$15,023	\$15,743	\$2,348	\$3,503	\$0
FY 2007	\$15,124	\$16,589	\$2,591	\$3,894	\$0
FY 2008	\$15,631	\$17,013	\$2,640	\$3,987	\$0
FY 2009	\$15,738	\$17,744	\$2,723	\$4,162	\$0
FY 2010	\$15,577	\$18,172	\$2,731	\$4,225	\$0
FY 2011	\$15,757	\$18,295	\$2,865	\$4,517	\$0
FY 2012	\$15,235	\$17,824	\$2,762	\$4,192	\$0
FY 2013	\$15,130	\$18,416	\$2,958	\$4,490	\$0
FY 2014	\$14,626	\$18,649	\$3,126	\$4,695	\$5,511
FY 2015	\$14,323	\$19,478	\$3,389	\$4,986	\$6,365
FY 2016	\$14,451	\$20,082	\$3,458	\$5,215	\$5,926
FY 2017	\$14,939	\$20,934	\$3,579	\$5,475	\$5,551
FY 2018	\$15,617	\$21,877	\$3,755	\$5,764	\$5,370
FY 2019	\$16,294	\$22,899	\$3,939	\$6,067	\$5,662
FY 2020	\$16,969	\$24,003	\$4,130	\$6,381	\$5,981
FY 2021	\$17,626	\$25,207	\$4,328	\$6,709	\$6,309
FY 2022	\$18,326	\$26,487	\$4,538	\$7,057	\$6,659
FY 2023	\$19,083	\$27,854	\$4,761	\$7,425	\$7,027
FY 2024	\$19,910	\$29,321	\$4,997	\$7,815	\$7,421
FY 2025	\$20,780	\$30,877	\$5,246	\$8,227	\$7,838

Source: Centers for Medicare and Medicaid Services

TABLE 3: TOTAL MEDICAID SPENDING BY CATEGORY (IN BILLIONS)

	Aged	Disabled	Children	Adults	Newly eligible	Total
FY 2000	\$50.8	\$81.9	\$28.0	\$19.4	\$0.0	\$206.2
FY 2001	\$54.5	\$89.8	\$32.2	\$22.3	\$0.0	\$229.0
FY 2002	\$59.3	\$104.2	\$38.8	\$26.5	\$0.0	\$258.2
FY 2003	\$61.9	\$112.8	\$42.6	\$30.0	\$0.0	\$276.2
FY 2004	\$64.7	\$116.7	\$45.5	\$32.8	\$0.0	\$296.3
FY 2005	\$70.2	\$131.2	\$50.6	\$35.8	\$0.0	\$315.9
FY 2006	\$67.6	\$129.1	\$53.1	\$36.8	\$0.0	\$315.1
FY 2007	\$68.1	\$137.7	\$57.8	\$39.7	\$0.0	\$332.2
FY 2008	\$71.9	\$146.3	\$60.2	\$43.1	\$0.0	\$351.9
FY 2009	\$74.0	\$157.9	\$66.4	\$49.5	\$0.0	\$378.6
FY 2010	\$76.3	\$167.2	\$72.1	\$55.3	\$0.0	\$401.5
FY 2011	\$80.4	\$177.5	\$77.9	\$62.3	\$0.0	\$427.4
FY 2012	\$80.7	\$178.2	\$77.1	\$61.6	\$0.0	\$431.2
FY 2013	\$81.7	\$191.5	\$82.8	\$67.4	\$0.0	\$455.6
FY 2014	\$80.4	\$193.9	\$88.2	\$71.4	\$23.7	\$494.7
FY 2015	\$80.2	\$204.5	\$95.2	\$75.8	\$57.9	\$552.3
FY 2016	\$82.4	\$212.9	\$97.2	\$79.8	\$66.4	\$575.9
FY 2017	\$86.6	\$221.9	\$100.9	\$84.9	\$66.6	\$595.5
FY 2018	\$93.7	\$234.1	\$107.0	\$91.1	\$66.6	\$632.9
FY 2019	\$101.0	\$249.6	\$114.2	\$97.1	\$70.8	\$672.0
FY 2020	\$108.6	\$264.0	\$121.8	\$103.4	\$76.0	\$713.8
FY 2021	\$116.3	\$279.8	\$129.4	\$110.0	\$80.8	\$757.4
FY 2022	\$126.4	\$296.7	\$137.5	\$116.4	\$86.6	\$801.9
FY 2023	\$135.5	\$314.8	\$145.7	\$123.3	\$91.4	\$850.1
FY 2024	\$145.3	\$334.3	\$154.4	\$130.5	\$97.2	\$901.5
FY 2025	\$155.9	\$355.1	\$163.2	\$138.2	\$103.5	\$957.5

Source: Centers for Medicare and Medicaid Services

Total expenditures also include administrative costs and territories' expenditures.



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