

Conclusions

About two out of every five working-age Medicaid beneficiaries can be classified as having a disability. Only one of those two would be readily identified through administrative data as having a disability, by virtue of either SSI or SSDI reciprocity. In states that have not expanded Medicaid, the disability population is an even larger share of beneficiaries.

For most of this broader disability population, the disability or underlying chronic health conditions limit their ability to work. For many, chronic pain and illness truly prevent work.

These beneficiaries, many of whom have a pressing need for healthcare to prevent worsening health and functioning, must not be dropped from the rolls in a rush to implement new requirements.

Instead, states need to carefully consider the ramifications of imposing work requirements on beneficiaries who cannot be readily identified as having disabilities. How will those not administratively classified as “disabled” qualify for exemptions or modifications to such rules in connection with disability or chronic health conditions, without unduly burdening them with bureaucratic barriers that will, inevitably, result in loss of coverage for many? Straightforward procedures must be in place to exempt as many beneficiaries with work-limiting disabilities as possible, and to give others the benefit of the doubt in the face of imperfect evidence of their limitations.

More than half of working-age Medicaid beneficiaries are already working or looking for work. More than one-quarter will need an exemption due to disability. Most of the rest are already engaging in other valuable activities, such as caregiving, attending school, or training for a job. A reasonable target population for work or community engagement requirements is about 6 percent, or 1 out of every 17 working-age Medicaid beneficiaries.

Considering the larger picture, one must wonder what states would gain from imposing work and community engagement requirements on Medicaid beneficiaries, when those requirements would probably cause only a tiny fraction of beneficiaries to transition to employment. Is it worthwhile for states to create a bureaucracy to certify the labor force, disability, and health status of all beneficiaries, not to mention other community engagement activities such as getting an education or job training, caring for family members, and volunteering?

It is hard to imagine any financial incentive for states to invest in an extensive infrastructure to enforce a work requirement, when so few beneficiaries would end up getting jobs. And it is hard to imagine that measurable health benefits would accrue as a result of new requirements, which would probably increase economic and community engagement for so few at the possible expense of dropping from the rolls many others who need health coverage but do not or cannot prove their disability status, labor force participation, or other community activities. States must tread very cautiously when contemplating such a substantial and potentially harmful policy change.

References

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