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Monday Morning Medicaid Must Reads

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July 1st, 2019

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In this issue...

Article 1: *Trump's Medicare chief, in Chicago, slams 'Medicare for All' plan: 'We're not going to see savings. It's actually going to cost more. Chicago Tribune, June 11, 2019. Lisa Schencker*

Clay's summary: Bbbbbut- Bernie! He promised me it'll work.

Key Excerpts from the Article:

Q: The doctors who support Medicare for All say it would allow doctors and hospitals to spend less money on administration because they wouldn't be dealing with multiple insurance companies. What are your thoughts on that argument?

A: One of the things I hear a lot is we should go to Medicare for All because of the lower administrative costs. The reality is we're not spending enough on administration within Medicare. There's a lot of bureaucracy that goes on with the Medicare program in terms of access to technology, protecting taxpayers against fraud and abuse and it's because we haven't made those investments in administering the program like you would see in the private sector.

The main issue with Medicare for All and having the government take over the entire program, is that we're not going to see savings. It's actually going to cost more, which means taxpayers are going to pay more, and when they're paying more, that's going to lead to rationing of care and problems with access to care.

Article 2:

Puerto Rico has a post-Maria Medicaid crisis — and Congress and the White House refuse to do anything about it, RawStory,

Clay's summary: We now have this in regular rotation in Medicaid news cycles. The key factors all center around statehood status (which ties back to the secondary issue of the federal match). Why does no one point out that the path forward on this either involves another star on the flag or independence?

Key Excerpts from the Article:

Puerto Rico has its own definition of what constitutes poverty level and that, it turns out, is much lower than the federal level. In order to qualify for Medicaid, a family of four in Puerto Rico must show a yearly income of under the amount set as the poverty level on the island, or $10,200. That's $850 or less a month on an island where the cost of living is higher than in most of the continental U.S. If Puerto Ricans were to qualify for Medicaid under federal poverty guidelines, they would do so as long as their income (for a family of four) did not exceed $25,750, or a little over $2,000 a month.
This means that a large number of Americans living in Puerto Rico can qualify for Medicaid if they leave the island and move to the 50 states even if their income more than doubles. Puerto Rico government officials are well aware of the problem, but lack resources to address it.

Luz E. Cruz, Medicaid director for the government of Puerto Rico acknowledged that the federal cap on Medicaid funds gives Puerto Rico limited funds and if the poverty level was raised to the level in the 50 states, more people would qualify for the program. "And that would mean that the matching portion from the government of Puerto Rico would be higher and that's money that we don't have right now," she said during a brief telephone interview.

Article 3: *Requiring People To Work To Get Medicaid Went Really Well In Arkansas Until A Judge Stopped It, The Federalist, June 10th, Victoria Eardley*

Clay's summary: Not what you wanted to hear, I know.

Key Excerpts from the Article:

Since 2000, the number of able-bodied adults using Medicaid quadrupled nationwide. The program is one of the chief costs for state governments, squeezing other priorities.
When last summer Arkansas became the first state to require Medicaid recipients to work in exchange for taxpayer-provided health care, welfare advocates would have had you believing the world was ending: health coverage for the needy was being slashed, the reporting process was too complex, and those who lost coverage didn't even know about the requirement. On and on the hysteria went.

But those apoplectic claims were far from reality. Arkansas' work requirement was a big step towards restoring the state Medicaid program to its objective. It was saving taxpayers money, freeing up resources for the truly needy, and—notably—changing people's lives for the better.

What critics of the requirement neglected to disclose were the thousands of people who found work as a result of the reform—some for the first time in years. These folks went from a life of government dependency to a life of independence, an undeniably better future for both themselves and their families. These are real people, with real stories, reported by the Arkansas Department of Workforce Services in late 2018.

Trump's Medicare chief, in Chicago, slams 'Medicare for All' plan: 'We're not going to see savings. It's actually going to cost more.'

SourceURL: https://www.chicagotribune.com/business/ct-biz-seema-verma-on-medicare-for-all-20190606-story.html

Trump's Medicare chief, in Chicago, slams 'Medicare for All' plan: 'We're not going to see savings. It's actually going to cost more.'

Seema Verma, administrator of the Centers for Medicare & Medicaid Services, was in Chicago June 10, 2019, to speak at the annual meeting of the American Medical Association, and she discussed health care issues in an interview. (Ron Sachs/Zuma Press 2018)

Lisa SchenckerChicago Tribune

As the nation inches closer to the 2020 presidential election, issues with the U.S. health care system are moving into the spotlight.

At stake: the future of the Affordable Care Act, also known as Obamacare; proposals to expand "Medicare for All"; and ideas to target high drug prices. They're all topics sure to spark fierce debate in coming months.

The Tribune sat down with Seema Verma, head of the federal Centers for Medicare & Medicaid Services and an appointee of President Donald Trump, to discuss those issues Monday. Verma was in Chicago to speak at the annual meeting of the American Medical Association.

Verma opposes Medicare for All, the idea of expanding Medicare to cover all Americans, and the administration said earlier this year it supports a Texas judge's ruling that Obamacare is unconstitutional. The administration also has taken a number of somewhat controversial steps toward attacking drug prices.

This interview has been edited for length and clarity.

Q: The doctors who support Medicare for All say it would allow doctors and hospitals to spend less money on administration because they wouldn't be dealing with multiple insurance companies. What are your thoughts on that argument?

A: One of the things I hear a lot is we should go to Medicare for All because of the lower administrative costs. The reality is we're not spending enough on administration within Medicare. There's a lot of bureaucracy that goes on with the Medicare program in terms of access to technology, protecting taxpayers against fraud and abuse and it's because we haven't made those investments in administering the program like you would see in the private sector.

The main issue with Medicare for All and having the government take over the entire program, is that we're not going to see savings. It's actually going to cost more, which means taxpayers are going to pay more, and when they're paying more, that's going to lead to rationing of care and problems with access to care.

Q: According to some surveys, most Americans support a government-run health insurance system. How do you respond to that kind of public opinion?

A: When you dig a little bit deeper into those surveys and people understand that it means that they're going to be stripped of their private coverage, that they're not going to be able to make choices, that innovation is going to be impacted, that they may have longer wait times — when you put all those pieces together, Americans are not supportive of that.

Q: For a lot of people, the bottom line is that seniors look forward to being on Medicare. People are eager to turn 65 so they can be on Medicare and no longer have to have private insurance. If seniors like it so much, why can't it work for everyone?

A: We need to have a solution that provides affordable health care coverage and that all Americans have access to that. But the Medicare program was uniquely designed for seniors and those seniors have paid into the program their entire lives, and we need to make sure that program is protected and preserved for those beneficiaries, and address access to affordable coverage for other Americans.

Q: When it comes to the Affordable Care Act, a lot of people are unhappy with the way prices for health insurance have increased. But they're happy

about the rules barring discrimination based on preexisting conditions and the disappearance of caps on how much insurers will pay for coverage. There's a feeling among some people that regulation is needed, that competition among insurers alone is not going to result in the best outcomes for people.

A: This administration supports protections for people with preexisting conditions and we understand there is some regulation that works well. I think the issue is government overreach and going too far. While the (Affordable Care Act) has provided protection that we support, it has also driven up health insurance premiums.

Q: Should Americans continue to buy insurance through the Affordable Care Act exchange when the Trump administration has made it clear that it wants the law to disappear?

A: The law is not working. What we want to do is provide more affordable options for individuals.

Q: Would you encourage people to still buy on the exchange at this point?

A:For people that are eligible, we want to make sure they have as many options as possible, so if that works for them, then that's certainly something that they might want to pursue.

Q: When it comes to drug prices, insurers, pharmacy benefit managers and pharmaceutical companies all point the finger at one another. Does the Trump administration believe in primarily directing its efforts toward the drug companies?

A:As we are talking about efforts to make health care more affordable, one of the things we're looking at is drug pricing because that is one of the fastest growing areas of health care spending in the United States. That being said, I do think there are fingers to be pointed in a lot of different directions. Some of the concerns we have with pharmaceutical companies is that Americans are not getting the best deals.

We also have a lot of concerns with the rebates that are going on in terms of (pharmacy benefit managers) and the rebates that are kind of behind the scenes deals that don't result in seniors getting the best price possible. One of the things we recently did was require pharmaceutical companies to actually put the prices

of their drugs on TV ads. We're tackling drug pricing from a lot of different angles.

Puerto Rico has a post-Maria Medicaid crisis — and Congress and the White House refuse to do anything about it

SourceURL: https://www.rawstory.com/2019/06/puerto-rico-has-a-post-maria-medicaid-crisis-and-congress-and-the-white-house-refuse-to-do-anything-about-it/

Puerto Rico has a post-Maria Medicaid crisis — and Congress and the White House refuse to do anything about it

Mc Nelly Torres

For years, the level of U.S. federal funding for Puerto Rico's Medicaid program has not been anywhere near enough to provide the island's needy with a level of medical care comparable to that of other American citizens.

The federal government guarantees the several states at least $1 in federal funds for every $1 the states spend on Medicaid. But Puerto Rico does not enjoy the same guarantees. Neither do Guam, American Samoa and the U.S. Virgin Islands. Instead, the U.S. funds the island's Medicaid program with a block grant: $347.4 million in 2017 against an actual expenditure of $1.63 billion.

This lower funding persists despite the fact that Puerto Ricans are twice as likely to report fair to poor health when compared to other U.S. residents, according to the Henry J. Kaiser Family Foundation.

Low funding also means doctors are underpaid. Some physicians are paid only $10 a visit for Medicaid patients, which is less than what a hair stylist typically charges to cut and style hair.

The government of Puerto Rico has found itself obligated to finance its disproportionate share of the bargain out of general funds and the revenue from municipalities. This massive shortfall has contributed to the island's $70 billion debt.

> The poverty rate in Puerto Rico, 44%, is more than three times the rate in the 50 states.

The Trump administration has repeatedly proposed block grants to the states, which critics worry would result in reduced federal support for Medicaid, the nation's basic healthcare plan for poor people.

Jorge Duany, a professor at Florida International University in Miami and author of the 2017 book "Puerto Rico: What Everyone Needs to Know," said that the contentious relationship between Puerto Rico and the U.S. has created a system where Puerto Ricans are treated as second-class American citizens.

He said Washington's domination of Puerto Rico militarily, politically and economically for much of its recent history extends to social services.

Unfair and Unequal

"The situation of Puerto Rico with healthcare is reflective of the general situation with the federal government, which is unfair treatment and unequal access of the same kind of benefits and funding that the people in the other 50 states have taken for granted," Duany said.

This unequal funding has contributed to a chronically under-funded Medicaid system, where the needy, old, and disenfranchised in Puerto Rico do not enjoy the same access to health care as other Americans.

Twenty-one months after Hurricane Maria caused mass destruction on the island, the increasingly impoverished population is facing critical economic and health challenges.

The poverty rate in Puerto Rico, 44%, is more than three times the rate in the 50 states.

The federal government uses a formula known as the Federal Medical Assistance Percentage (FMAP) to allocate funds for Medicaid to the several states. It's based on each state's average income relative to the national average so that states with the lowest average personal incomes have a higher FMAPs.

Mississippi, for example, has the lowest per capita income of any state. In 2016 it received $2.87 in federal funds for every $1 it spent on its Medicaid program. Puerto Rico, which is much poorer, received only 55 cents.

Inadequate to Begin With

The Center on Budget and Policy Priorities, a nonprofit research and advocacy organization for poor people based in Washington, D.C., said absent a huge increase in money a fixed block grant can't replace entitlement funding because the funding is inadequate to begin with. The center said current funding falls short of meeting the needs of those who need it most and "it ignores the federal commitment to help vulnerable individual families" in the 50 states.

Last year, Congress approved a total of $4.8 billion in special funding for the island. This included a $3.6 billion for Medicaid disaster relief with a 100 percent federal match for the Medicaid program and $1.2 billion to build a Medicaid data system and Medicaid Fraud Unit.

The funds, a temporary remedy to supplement Puerto Rico's inadequate funding after the hurricane, run out on Sept. 30, 2019. This means that if Congress doesn't act to address the inequities in the system, Puerto Rico will go back to the block grant funding, which is not sustainable at a time when the island continues to face its fiscal crisis and recovering from the massive destruction left by Hurricane Maria.

Health care advocates and Puerto Rico leaders have been raising the alarm in Washington, D.C.

On Feb. 26, Governor Ricardo Rosselló explained to members of the U.S. Senate Committee on Energy and Natural Resources the dangerous threat the Medicaid funding shortfall poses to the most vulnerable people on the island, if Congress doesn't act soon.

"It is time for urgent action by Congress to fully fund Puerto Rico's Medicaid program and put an end to territorial inequality once and for all," he told the committee.

Rosselló noted that if Congress fails to act in a timely fashion more than 425,000 children will not have guaranteed access to their pediatricians, 305,000 of the elderly and disabled will have to get by without the care they need, 17,000 pregnant women will not be able to receive prenatal care and 12,000 newborns will enter this world without the assurance that they will survive their first year of life.

Health care advocates say the uncertainty regarding the funding is destroying an already vulnerable system and the current gridlock in Washington, D.C. is causing more anxiety.

> Washington's domination of Puerto Rico militarily, politically and economically for much of its recent history extends to social services.

"The whole health care system will collapse if we can't obtain more funding after September," said Víctor M. Ramos, president of the College of Physicians and Surgeons of Puerto Rico. A variety of health care advocates, local politicians and others are lobbying Congress for renewed funding. "Is not only Medicaid recipients but also any health care provider, and businesses will be hit hard as well."

Edwin Park, a research professor at the Georgetown University McCourt School of Public Policy, said the cap imposed by Congress has always been inadequate and comes at a great cost to the government and the health care system.

By giving block grants Congress in effect puts a cap on federal support for the health care of Puerto Rico, which provides funding far below what the health status of the island residents require to maintain a reasonably healthy population and minimize premature death and disability.

"The program and the health care system were under a lot of stress before the hurricane," Park said. "Hospitals were closing floors and they were not investing in

new technology and deferring maintenance weren't keeping up the normal capital spending.

"The one thing that relieved some of the pressure was the Affordable Care Act and Puerto Rico's draw from the money ($6.3 billion) to make the block grant from Medicaid more adequate, but it was a one-time pot of money."

Different Treatment and Rules

Puerto Rico's Medicaid program uses a managed care system by which insurance companies contract with health care providers to create a network, but the program doesn't cover all the benefits required by the Medicaid program and provides less funding per enrollee than in the 50 states.

The funding approved by Congress in 2018 mandated that the island develop a Medicaid management information system and also create a Medicaid Fraud and Abuse Unit, under the U.S. Department of Justice oversight.

The island's Medicaid program provides only 10 of Medicaid's 17 mandatory benefits because of the lack of funding and infrastructure, according to a 2016 report from the Government Accountability Office, the investigative arm of the U.S. Congress.

The program covers dental services but doesn't cover nursing homes, or non-emergency medical transportation, for example. Doctors and hospitals get lower reimbursement rates than in the 50 states even though medical facilities must meet federal standards of care.

Critics said the managed care program that provides health care services to Medicaid recipients has forced many limitations, and that in turn has prevented enrollees from having a choice of plans, access to some health care services, cheaper prescription drugs and providers.

Spending per enrollee in Puerto Rico is estimated at $2,144 for 2020 while the median state is expected to spend three times ($6,763) more per enrollee than Puerto Rico, according to CBPP data estimates.

Low payment rates have prompted many providers to leave the island in recent years, according to the Center on Budget and Policy Priorities.

Wendy Matos, a physician and executive director of the Medical Science School at the University of Puerto Rico, said the consolidation of providers by insurance companies' managed care systems has hurt the health care system in Puerto Rico for decades.

"The insurance companies have put in place more barriers by reducing the number of specialists, specialized pharmacies and physical therapy," Matos said.

On Dec. 13, 2018, the Medicaid and CHIP Payment and Access Commission or MACPAC held public meetings to address the problems of grossly inadequate health care in Puerto Rico.

Ángela Ávila Marrero, executive director of Puerto Rico Health Insurance Administration (ASES in Spanish) was among several health care officials from Puerto Rico who testified. ASES is a non-profit organization that administers and contracts with health care insurers on the island including those managing the Medicaid program.

> Some physicians are paid only $10 a visit for Medicaid patients, which is less than what a hair stylist typically charges to cut and style hair.

Ávila Marrero painted a dire picture of Puerto Rico's Medicaid program as it stands right now, and the challenges it faces if the funding structure doesn't improve.

She said Puerto Rico has a large population enrolled in the Medicaid program yet the funding is among the lowest in the nation. "That's the type of disparity that we are talking about," Ávila Marrero said.

Inadequate funding has led to long delays in making payments to providers. In turn, that – has caused anxiety throughout the health care system for years prompting an alarming number of physicians and other health care workers to leave the island.

Between 2009 and 2014 the total number of physicians available in Puerto Rico dropped from 13,452 to 11,888. That's an average of 472 physicians leaving per year, or more than nine per week, according to data presented during the public meeting.

Ramón Ruiz, a family physician, said he moved to Jacksonville, Fla. in 2016 because he could no longer afford to work under the cuts in services and

mandates imposed by the health insurance companies managing Medicaid and Medicare.

“Unfortunately, it is a business, but it’s supposed to be an honest business,” he said. “How can I go to an old lady who is like my grandmother and tell her that her health insurance doesn’t want to cover this or that?”

Leaving for Florida was a difficult decision to make, Ruiz said. It was hard on his family – three children and a wife who is also a family doctor – and for the patients, he had known for a long time, in some cases two and three generations of the same family.

Orlando González Rivera is the president of Medicare and Mucho Más (a health insurance company) and former executive director of ASES during former Governor Sila Calderón’s administration. González Rivera joined Ávila Marrero in presenting a bleak picture of an island where people are sicker and poorer and how Hurricane María made it worse, but also of an outdated and under-funded health care system in desperate need of adequate funding.

“For example, to get an appointment with an endocrinologist, it could take up to two to three months. You are talking about diabetic patients,” González Rivera said.

To emphasize how problematic this is, the number of specialists dropped from 8,452 in 2009 to 6,713 in 2014. That means every fifth specialist left Puerto Rico during those years.

Witnesses also detailed a dire need for emergency physicians, neurosurgeons, and ear, nose and throat specialists among other specialties.

Ávila Marrero echoed the same sentiment noting that the island no longer has providers willing to accept any further reductions to their already-low rates.

“A doctor for a visit gets like $10 and when you go to do your hair [at a hair salon], you spend more than $50,” Ávila Marrero said. “That’s the disparity we are confronting.”

People Without Healthcare

Puerto Rico has its own definition of what constitutes poverty level and that, it turns out, is much lower than the federal level.

In order to qualify for Medicaid, a family of four in Puerto Rico must show a yearly income of under the amount set as the poverty level on the island, or $10,200. That's $850 or less a month on an island where the cost of living is higher than in most of the continental U.S.

If Puerto Ricans were to qualify for Medicaid under federal poverty guidelines, they would do so as long as their income (for a family of four) did not exceed $25,750, or a little over $2,000 a month.

This means that a large number of Americans living in Puerto Rico can qualify for Medicaid if they leave the island and move to the 50 states even if their income more than doubles.

Puerto Rico government officials are well aware of the problem, but lack resources to address it.

Luz E. Cruz, Medicaid director for the government of Puerto Rico acknowledged that the federal cap on Medicaid funds gives Puerto Rico limited funds and if the poverty level was raised to the level in the 50 states, more people would qualify for the program.

"And that would mean that the matching portion from the government of Puerto Rico would be higher and that's money that we don't have right now," she said during a brief telephone interview.

Gloria Amador Fernández, executive director of Salud Integral en la Montaña Inc., one of 20-federally funded community health centers in Puerto Rico, said the poverty level used by the government of Puerto Rico has pushed more people out of the system, resulting in lower Medicaid enrollment.

Federally funded community health centers are required to provide primary health care services to patients regardless of their ability to pay.

"Those patients are now uninsured and most of them are coming to our health centers because nobody else is giving them health care services if they can't pay," Amador Fernández said during the December meeting in Washington. "An unexpected increase of uninsured patients in Puerto Rico will translate in more

patients into our system and we don't have the total federal funding to cover them."

Plan Vital Launches

Last November the government of Puerto Rico launched a new managed health care program known as the Vital plan. It was a restructuring of the old plan, called Mi Salud.

The new structure consolidated Mi Salud's eight regions into a single island-wide system under which Medicaid enrollees can choose from five for-profit insurance companies and their managed care networks.

Austerity measures dictated by an unelected oversight board appointed to restructure the island's debt for at least five years included deep spending cuts at government agencies, including realigning Medicaid enrollment, cutting visits to emergency rooms and replacing costly drugs with generic ones to cut costs, regardless of impact on public health, records show.

These cuts were made even though the number of people needing these services was rising and inadequate care, or lack of any care, increased need.

The ability to sustain the Medicaid program worries health care advocates who wonder how the proposed cuts will impact Puerto Ricans at a time when they rely disproportionally on Medicaid for health coverage.

Based on the U.S. poverty guidelines, more than 44 percent of the population of Puerto Rico lives in poverty, compared to the national U.S. average of about 12 percent.

About 71 percent of the 1.4 million Medicaid recipients in Puerto Rico are unemployed and 66 percent do not have a high school diploma, according to the data provided during the December meeting.

A 2018 Washington Post/Kaiser Family Foundation survey suggests many Puerto Ricans have even more health care needs after Hurricane Maria.

One in four of respondents said the storm brought physical and mental health challenges while 41 percent said they already had a chronic condition or a

disability that got worse. And 26 percent reported problems getting needed care after the hurricane.

Health care advocates said building a health care system based on fair and equal funding to the rest of the nation is vital for Puerto Rico's overall recovery.

Ávila Marrero, of ASES, said: "We have been confronting an underfunded system for more than 20 years and no matter what changes we can include or implement if we don't have the right funding we would not accomplish that sustainability and continuity of the program."

Professor Park, of Georgetown's McCourt School of Public Policy, agreed.

"Puerto Rico can't have a strong health care system without a strong Medicaid program," Park said. "And you can't have a strong Medicaid program in Puerto Rico without permanently fixing this inequitable treatment because Puerto Rico should have uncapped funding like all the states and the District of Columbia."

This article was produced as a project for the Dennis A. Hunt Fund for Health Journalism, a program of the USC Annenberg Center for Health Journalism.

Requiring Work For Medicaid Went Well In Arkansas Until A Judge

Requiring People To Work To Get Medicaid Went Really Well In Arkansas Until A Judge Stopped It

Without the work requirement, Julia wouldn't have had the opportunity—or the push—to take the next step in her career, changing her life through education and work.

Since 2000, the number of able-bodied adults using Medicaid quadrupled nationwide. The program is one of the chief costs for state governments, squeezing other priorities.

When last summer Arkansas became the first state to require Medicaid recipients to work in exchange for taxpayer-provided health care, welfare advocates would have had you believing the world was ending: health coverage for the needy was being slashed, the reporting process was too complex, and those who lost coverage didn't even know about the requirement. On and on the hysteria went.

But those apoplectic claims were far from reality. Arkansas' work requirement was a big step towards restoring the state Medicaid program to its objective. It was saving taxpayers money, freeing up resources for the truly needy, and—notably—changing people's lives for the better.

What critics of the requirement neglected to disclose were the thousands of people who found work as a result of the reform—some for the first time in years. These folks went from a life of government dependency to a life of independence, an undeniably better future for both themselves and their families. These are real people, with real stories, reported by the Arkansas Department of Workforce Services in late 2018.

Consider Jeff, who was unemployed for more than nine months when he found he was subject to the Medicaid work requirement. He worked with his local workforce center to look for a job, immediately matching with employers in the area.

Now Jeff makes more than $17 an hour in an industry where he'll likely grow, further increasing his income. That's the power of work.

Take it from Jeff himself: "I now work with a great company—in a job that I actually would not have gotten without the help from Department of Workforce Services. They have given me an opportunity to provide a better life for my family and I can't and won't be able to thank them enough."

Then there's Julia, who decided to use education to fulfill the work requirement. She enrolled at North Arkansas College and now attends class four days a week, working once a week as a certified nursing assistant at a local long-term care facility.

Without the work requirement, Julia wouldn't have had the opportunity—or the push—to take the next step in her career, changing her life through education and work. Her story also serves as a reminder that those subject to the requirement had more than 12 different ways to meet it, a fact critics ignored time and time again.

Here's the truth: Jeff and Julia's stories aren't anomalies. After the requirement went into action, more than 9,200 expansion adults found jobs.

Only a small fraction of case closures were the result of non-compliance. Instead, more than 14,000 individuals left the program due to increased incomes. The work requirement empowered them to move from government dependency to financial independence.

There's a reason Arkansans—and the majority of Americans—support Medicaid work requirements. Simply put, they work. Arkansans have seen the effects first-hand. They don't need liberal judges and outsiders telling them otherwise: they've seen the proof.

By the end of 2018, Arkansans were on track to save at least $300 million per year because of the decline in enrollment. This was welcome news, given that Arkansas' Medicaid budget has increased by nearly 60 percent since 2013 and is now more than double the state's entire education budget. The work requirement put the state on a path towards a more sustainable program. Had the work requirement remained intact, there's no doubt that the savings would have continued.

Unfortunately, a court halted the life-changing success of the Medicaid work requirement, thwarting budget savings and leaving thousands of Arkansans without the opportunity to lift themselves from welfare. More than 4,000 able-bodied adults immediately returned to the program once the work requirement was paused.

But Arkansans should take hope. The state has committed to fighting for work requirements, and the Trump administration has appealed the ruling. That's great news for Arkansans—and Americans everywhere: they'll soon be empowered to change their lives once again.