order to detect and identify poliovirus infections. We still need to maintain a stockpile of polio vaccine for outbreak response. The existence of immunodeficient people who chronically excrete VDPV virus also necessitates an effective means of detection and intervention. Many of these issues will require additional research and development, including a better vaccine that produces mucosal immunity without the risk of VDPV, antivirals to treat chronic infections, and better surveillance tools for a world that will quickly forget about polio after eradication is achieved. Clearly, persistence and patience will be needed, not only to complete eradication of WPV, but also for the polio endgame.

An audio interview with Dr. Pallansch is available at NEJM.org

The views expressed in this article are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Mitigating the Risks of Medicaid Work Requirements

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In January 2018, the Centers for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors "to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement."[1] As of June 2018, four states — Arkansas, Indiana, Kentucky, and New Hampshire — had received CMS approval for Section 1115 waivers to implement and evaluate work requirements for nonelderly adults enrolled in Medicaid.

Work requirements are moving forward in Arkansas, Indiana, and New Hampshire. However, a federal district court blocked Kentucky's implementation of such requirements, determining that the secretary of Health and Human Services had not adequately considered how the waiver would affect the state's ability to provide coverage to Medicaid enrollees. Six other states have proposed new Medicaid work requirements in pending waiver applications to CMS, and Virginia recently approved Medicaid expansion with plans to implement work requirements through a Section 1115 waiver.

The four states that have received CMS approval to implement work requirements require at least 20 hours per week or 80 hours per month of engagement in employment, job training, job searching, or community service, or enrollment in an educational program.[2] In Indiana, Kentucky, and New Hampshire, caregiving for a person with a disability satisfies the work requirement, as does receiving ongoing treatment for a substance use disorder. Indiana and Kentucky apply work requirements to both traditional Medicaid enrollees and people who are enrolled under Medicaid expansion; enrollees under 61 and 65 years of age, respectively, are subject to the requirements. Arkansas and New Hampshire limit work requirements to Medicaid expansion enrollees under 50 and 65 years of age, respectively. In Indiana, Kentucky, and New Hampshire, noncompliant enrollees are locked out of Medicaid coverage until the next month when they satisfy work requirements or qualify for an exemption, whereas in Arkansas, they are locked out until the next coverage year begins.

We believe there are several important policy questions related to Medicaid work requirements that deserve more attention. First, what are the potential health consequences of work requirements for Medicaid enrollees? Second, what role will physicians play in determining whether enrollees are exempted from work requirements for medical reasons? Finally, how can policymakers mitigate the medical risks associated with work requirements for enrollees who could be harmed by losing Medicaid coverage?

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In its letter to state Medicaid directors, CMS noted that work and community engagement are associated with better health, and supporters of work requirements suggest that working will improve the health of Medicaid enrollees. However, if the association between work and better health is due mainly to healthier adults being better able to find and maintain employment — rather than employment resulting in improved health — then the health harms associated with rescinding Medicaid coverage for nonworking adults will probably far outweigh the uncertain health benefits for enrollees who gain jobs.

The health consequences of Medicaid work requirements will vary widely among enrollees. In a 2016 survey of more than 4000 Medicaid expansion enrollees in Michigan, we found that 48.8% of enrollees were employed, 27.6% were out of work, and 11.3% reported being unable to work (the remainder were students, homemakers, or retirees).[3] Relative to employed enrollees, those who were out of work or unable to work were significantly more likely to be older than 50 years of age and to report being in fair or poor health, having a mental health condition, or having health-related functional limitations.[3] Nationally, 30% of nonelderly adults enrolled in Medicaid have a disability that interferes with their hearing, vision, cognitive functioning, mobility, self-care, or independent living, but only 43% of these adults with a disability are receiving Supplemental Security Income (SSI) that would exempt them from work requirements.[4]

A work requirement could potentially help motivate young, healthy adults to seek employment. However, the same requirement could harm older adults or those with chronic conditions if they lose Medicaid coverage and become unable to afford effective medical care. The four states that have received approval to implement work requirements all allow exemptions for Medicaid enrollees who are deemed "medically frail," those with acute medical conditions that prevent them from working, and those who are caregivers for young children or for adults with disabilities.[2] However, the standards and processes for authorizing these exemptions remain undefined.

Physicians will probably play an important role in determining whether their patients are eligible for health-related exemptions from work requirements. Will physicians receive clear guidance from state Medicaid programs on the severity of medical conditions or functional limitations that exempt enrollees from work requirements? Or will these determinations be left up to individual physicians, thereby allowing greater flexibility but also unevenness in how work requirements are applied? How frequently will states require physicians to document patients' eligibility for exemptions?

Along with creating new administrative burdens and costs for physicians and enrollees, work requirements may oblige physicians to be involved in determining whether patients maintain or lose insurance coverage. This expectation places physicians' responsibility to provide honest documentation in stark tension with their primary obligation to serve patients' interests.[5] Without explicit state guidance on health circumstances that qualify patients for exemptions, physicians may face an ethical dilemma when choosing between two objectionable options: doing harm to patients and providing inaccurate assessments.

Given existing data about the health and medical needs of Medicaid enrollees and our experience as primary care physicians serving this population, we believe there are four ways that federal and state policymakers could mitigate the medical risks associated with Medicaid work requirements (see box). Most important, work requirements could be limited to adults under 50 years of age who are covered by Medicaid expansion, as they are under Arkansas's policy. Older adults and those covered by traditional Medicaid are much more likely than younger adults and those covered by Medicaid expansion, respectively, to have chronic health conditions and functional limitations that could worsen if they lost access to medical care and prescription-drug coverage. Unemployed older adults and people with serious health conditions also face greater challenges in gaining and maintaining employment.

Second, state Medicaid officials could offer clear guidance to physicians on the physical and mental health conditions and functional limitations that will exempt Medicaid enrollees from work requirements. They could also define the caregiving responsibilities for a household member with a disability that would exempt enrollees and specify the duration of such exemptions. This guidance would enable physicians to determine more effectively and fairly which enrollees should be protected from losing Medicaid coverage.

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Third, for people required to work to maintain Medicaid coverage, states could provide job training, employment referrals, and support for work-related transportation and childcare, if needed. Because federal Medicaid funds cannot be used to pay for these services,[1] state funding would be needed to support such programs.

Finally, we believe state officials should not mandate monthly reporting of compliance with work requirements. Less frequent reporting will reduce the costs of overseeing enrollee compliance and the administrative burdens for physicians who are charged with evaluating health-related exemptions. It will also allow more flexibility for Medicaid enrollees who make good-faith efforts to seek work. In Indiana, for example, enrollees are required to have met the work requirement during 8 of the previous 12 months or face having their coverage suspended. In contrast, enrollees in Kentucky may be dropped from Medicaid after just 1 month of not meeting the state's work requirement, which poses particular burdens for seasonal workers.

Work requirements represent uncharted territory for Medicaid enrollees and their physicians. If these requirements survive ongoing legal challenges, their effects on health will depend on how well they focus on enrollees who are healthy and functionally able to work and on whether effective work-related training and supports are implemented. Without such tailoring and support, the health risks for enrollees who lose Medicaid coverage are likely to substantially outweigh the economic and health benefits of blunt incentives for enrollees to work.

Recommendations for State and Federal Policymakers to Reduce the Health Risks Associated with Medicaid Work Requirements

Limit the initial implementation to adults under 50 years of age who are covered by Medicaid expansion, since they are less likely than older adults and those covered by traditional Medicaid to have chronic health conditions and functional limitations that will be adversely affected by loss of Medicaid coverage.

Provide clear guidance to physicians on health conditions, functional limitations, and caregiving responsibilities for household members with disabilities that will exempt enrollees from work requirements.

Provide job training, employment referrals, and support for work-related transportation and childcare for enrollees subject to work requirements.

Make the reporting of compliance with work requirements less frequent and more flexible to account for fluctuating work hours, seasonal employment, and temporary gaps in employment.

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