The Economics of Mutual Obligation: Who Pays, Who Saves, Who Bears the Risk

The state budget director stares at two spreadsheets that refuse to reconcile. The first shows projected federal savings from work requirements: fewer people enrolled means lower costs, simple arithmetic that has driven policy enthusiasm since 2017. The second spreadsheet tells a different story. It includes lines the first one ignores: verification system procurement, appeals processing staff, MCO contract renegotiations to address enrollment volatility, and a troubling entry from the state hospital association projecting uncompensated care increases that would offset a third of the projected savings.

She has learned to ask the question her predecessors avoided: what happens to the people who lose coverage? Some will find jobs with employer insurance. Some will qualify for marketplace subsidies. But the modeling from Arkansas and Georgia suggests most will simply become uninsured, cycling back onto Medicaid months later with conditions that progressed during the gap, or presenting at emergency departments that cannot refuse them. The savings on her first spreadsheet assume these people disappear from the healthcare system entirely. They do not.

The Expansion Economy Today

Before examining what work requirements will disrupt, we must understand what currently exists. The 18.5 million adults covered through Medicaid expansion represent a substantial economic engine that flows revenue to managed care organizations, hospital systems, physician practices, federally qualified health centers, and pharmacies. Each stakeholder has built operational capacity and financial projections around this population. Each faces different exposure when coverage becomes volatile.

Managed Care Organizations

Medicaid managed care has become the dominant delivery model, with over 70% of all Medicaid beneficiaries enrolled in MCOs and an even higher percentage among expansion adults. MCOs receive per-member-per-month capitation payments that vary significantly by state, typically ranging from $350 to $550 for expansion adults depending on regional costs and benefit design. These rates are set through actuarial processes that assume relatively stable enrollment and predictable population health status.

MCO margins on Medicaid business are thin by insurance industry standards, typically running 2-4% before taxes in well-managed plans. This means a plan with 500,000 expansion adult members generating $250 million monthly in capitation revenue operates on perhaps $5-10 million in monthly margin. The business model depends on predictability: stable enrollment allows accurate forecasting, appropriate network contracting, and care management programs that generate returns over 12-24 month horizons.

The revenue MCOs receive is not simply a function of enrollment counts. Risk adjustment mechanisms attempt to match payment to expected costs based on documented health conditions. Members with diabetes, heart failure, serious mental illness, or other chronic conditions generate higher capitation payments than healthy members because their care costs

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more. This risk adjustment depends entirely on documented encounters: a condition that exists but is not captured in claims data does not increase the MCO's payment.

Hospital Systems

For hospitals, Medicaid expansion represented a financial transformation. Before 2014, hospitals in expansion states provided roughly $7.4 billion annually in uncompensated care to low-income uninsured adults. Expansion converted much of this charity care and bad debt into paid claims. Studies consistently show uncompensated care dropping 30-50% in expansion states while remaining flat in non-expansion states.

Hospital revenue from Medicaid expansion adults flows through multiple channels. Inpatient stays generate DRG-based payments that typically cover 80-90% of costs. Outpatient services receive facility fees that vary by state. Emergency department visits are reimbursed regardless of ability to pay, but collection rates differ dramatically between insured and uninsured patients.

The hospital financial model for Medicaid patients differs fundamentally from commercial insurance. Commercial payers might reimburse 150-200% of Medicare rates; Medicaid typically pays 70-90% of Medicare. Hospitals accept these lower rates because volume is guaranteed and collection is certain. A Medicaid patient generates less revenue per encounter than a commercially insured patient but more net revenue than an uninsured patient who cannot pay.

ACOs and Value-Based Arrangements

Accountable Care Organizations and other value-based payment models have expanded significantly in Medicaid, with many states requiring MCOs to move substantial percentages of payments into value-based contracts with providers. These arrangements share savings when providers keep attributed populations healthy and reduce unnecessary utilization.

The economics of value-based care depend on attribution stability. An ACO that manages a diabetic patient for 18 months, investing in medication adherence and lifestyle coaching, captures savings when that patient avoids hospitalization. If the patient loses coverage at month 12 and returns at month 18 with diabetic ketoacidosis, the ACO bears none of the gap period costs but also loses the savings it was generating. Worse, the hospitalization occurs during an attributed period, damaging quality metrics.

Value-based arrangements also incorporate risk adjustment. ACOs receive benchmarks based on their attributed population's documented health status. Coverage gaps that interrupt documentation create the same risk score degradation that affects MCO capitation.

Physician Practices

Primary care physicians accepting Medicaid face reimbursement rates that average 72% of Medicare nationally, though this varies dramatically by state. Some states pay primary care at near-Medicare rates; others pay barely half. Specialty care reimbursement runs somewhat higher but still below Medicare and far below commercial rates.

Physicians respond to these economics in predictable ways. Many limit the percentage of their panel that can be Medicaid patients, accepting some for mission reasons but capping exposure to protect practice economics. Others, particularly in safety-net settings and underserved areas, build practices around Medicaid populations and accept the lower per-visit revenue in exchange for community relationships and reliable volume.

For practices that do serve expansion adults, the patients represent a particular economic profile. They are generally healthier than traditional Medicaid populations (disabled, elderly) but have more unmet needs than commercially insured patients due to prior periods without coverage. The first years of managing a newly covered expansion adult often involve catch-up care: screenings that were deferred, chronic conditions that went unmanaged, specialist referrals that were previously unaffordable.

Physicians also play a crucial role in MCO economics through their documentation. The diagnosis codes they submit drive risk adjustment. A physician who thoroughly documents a patient's diabetes, hypertension, depression, and chronic pain generates higher risk scores than one who documents only the presenting complaint. MCOs invest heavily in provider education and medical record review to ensure complete capture.

Federally Qualified Health Centers

FQHCs occupy a unique position in the expansion economy. They are required to serve all patients regardless of ability to pay, using sliding-scale fees for uninsured patients. But their economics have been transformed by expansion. FQHCs receive enhanced Prospective Payment System rates for Medicaid patients that typically exceed their costs, generating margins that cross-subsidize uncompensated care.

A typical FQHC might have seen its payer mix shift from 25% Medicaid to 45% Medicaid after expansion, with corresponding decreases in uninsured patients. This payer mix improvement strengthened the financial foundation of community health centers, enabling expanded hours, additional providers, and new service lines. Some FQHCs have Medicaid-dependent revenue models where expansion population coverage is essential to organizational sustainability.

Pharmacies and Pharmacy Benefit Managers

Prescription drug coverage for expansion adults generates substantial volume for retail pharmacies and revenue for PBMs managing MCO drug benefits. Expansion adults fill maintenance medications for chronic conditions, generating predictable monthly volume. Generic medications for hypertension, diabetes, and mental health conditions have modest per-prescription margins but reliable demand.

The pharmacy economics of coverage gaps are immediate and visible. A patient who loses coverage stops filling prescriptions unless they can pay cash, which most cannot for medications costing $50-500 monthly. The pharmacy loses the transaction; the PBM loses the administrative fee; the drug manufacturer loses the sale. More importantly, the patient loses the medication, often with clinical consequences that generate costs elsewhere in the system.

The Risk Adjustment Problem

Risk adjustment is intended to prevent MCOs from profiting by enrolling healthy members and avoiding sick ones. It works by increasing capitation payments for members with documented health conditions. The theory is sound: an MCO enrolling a diabetic patient with heart failure should receive more money than one enrolling a healthy 30-year-old because the sick patient costs more to serve.

In practice, risk adjustment depends on continuous documentation through healthcare encounters. A member's risk score is calculated from diagnosis codes submitted over a lookback

period, typically 12-24 months. Every encounter where a physician documents a chronic condition contributes to the risk score. Every gap in care is a gap in documentation.

Coverage volatility breaks this model in several ways. When a member loses Medicaid coverage, they typically stop receiving care except for emergencies. An emergency department visit for chest pain might document the presenting complaint but miss the diabetes, depression, and chronic back pain that a primary care physician would have captured. Months of documentation gaps mean months of risk score degradation.

When that member returns to coverage, their risk score does not reflect their actual health status. It reflects their documented health status, which is now stale and incomplete. The MCO receives payment for a relatively healthy member while inheriting a member whose conditions have likely worsened during the coverage gap. The member who returns after six months without diabetes medication is not the same actuarial risk as the member who maintained continuous coverage and medication adherence.

This mismatch between payment and actual risk persists for 12-24 months as new documentation accumulates. During this period, the MCO is systematically underpaid for the care these members require. A member who returns with uncontrolled diabetes might cost $1,200 per month to serve while generating only $450 in capitation because their risk score reflects their pre-gap documentation.

State rate-setting processes compound the problem. Medicaid capitation rates are set through actuarial analysis of historical cost and utilization data, assuming population characteristics remain relatively stable. If work requirements cause substantial enrollment churn, the historical data no longer predicts future costs. Rate-setting based on stable enrollment periods will systematically underestimate costs in volatile enrollment periods.

This creates a perverse incentive that states and MCOs rarely discuss publicly. For an MCO with inadequate risk adjustment, a high-cost member with incomplete risk capture is a financial loss. If that member loses coverage and does not return, the MCO stops incurring costs it was not being adequately paid to cover. The MCO's financial interest may diverge from the member's coverage interest, particularly for members with serious health conditions and incomplete documentation.

MCOs with value-based contracts face amplified uncertainty. If attributed members churn off coverage, quality metrics become unreliable. Did the diabetic patient's A1C worsen because of poor care management or because they lost coverage for four months? Performance-based payments calculated on unstable populations create noise that obscures signal, making it difficult to identify which interventions actually work.

The Cost Ledger Nobody Publishes

Proponents of work requirements project savings from reduced enrollment. These projections rarely include comprehensive implementation costs because those costs are distributed across multiple budgets and stakeholders, none of whom has incentive to aggregate them.

State Administrative Costs

States must build or procure verification systems capable of tracking 80 hours monthly across employment, education, training, and qualifying activities for millions of members. Georgia's Pathways system required multi-year development and ongoing maintenance. States choosing

vendor solutions face procurement timelines of 6-12 months and implementation costs in the tens of millions.

Beyond technology, states need staff to process exemption applications, adjudicate appeals, and manage the inevitable exceptions that automated systems cannot handle. Arkansas's 2018 implementation required dozens of additional eligibility workers despite its online-only reporting model. Appeals processing alone can require substantial staff: if even 5% of coverage terminations are appealed, a state with one million expansion adults facing 100,000 annual terminations would process 5,000 appeals yearly.

Oversight costs include auditing verification submissions for fraud, monitoring community engagement partners, and managing federal reporting requirements. States must demonstrate to CMS that their programs operate as approved, requiring data collection and analysis infrastructure.

MCO Operational Burden

MCOs face costs that do not appear in state budgets but ultimately flow back through capitation rate negotiations. Care coordinators must track member work requirement status and intervene before coverage loss. Facilitation programs helping members find qualifying activities require staff, technology, and community partnerships. Claims systems must handle coverage gaps and retroactive reinstatements that disrupt normal adjudication.

Actuarial uncertainty is itself a cost. MCOs price risk into their capitation bids; when enrollment volatility makes risk unpredictable, MCOs either build in margins to protect against downside scenarios or negotiate risk corridors that shift uncertainty back to states. Either approach increases program costs relative to stable enrollment assumptions.

Provider Documentation Costs

Every provider interaction with work requirements takes time. Physicians asked to certify medical exemptions must review criteria, examine patients, and complete attestations. Practices must modify workflows to identify patients at risk of coverage loss and flag upcoming redetermination dates. EHR systems may require configuration to capture work requirement status and generate appropriate documentation.

These costs are diffuse and largely unmeasured. A physician spending 10 additional minutes per encounter on work-requirement-related documentation across a panel of 200 expansion adults generates costs that appear nowhere in work requirement budget projections but are real. Multiply across thousands of practices and the aggregate is substantial.

Community Organization Costs

Navigation infrastructure requires investment before it generates results. Training navigators on work requirement rules, exemption categories, and verification systems takes time and money. Community organizations must build relationships with employers willing to verify hours and education programs willing to certify enrollment. Technology systems connecting CBOs to state eligibility infrastructure require development and maintenance.

These costs fall on organizations with limited resources. Community health centers, social service agencies, and faith-based organizations often absorb navigation functions without dedicated funding, cross-subsidizing from other programs or simply stretching staff thinner.

Member Compliance Costs

The costs members bear to demonstrate compliance are economically real even if they appear in no government budget. Time spent documenting activities, traveling to appointments, and gathering verification materials has opportunity cost. Transportation to job training or employment itself costs money. Childcare during work hours is expensive.

For members with unstable housing, mental health challenges, or limited English proficiency, compliance costs multiply. A member who must take three buses to reach a workforce office, wait two hours for assistance, and return home has invested a full day in compliance. That day cannot be spent working, caring for family, or managing health conditions.

The Benefit Assumptions

Projections of savings from work requirements rest on assumptions about behavioral response that the evidence does not strongly support.

Coverage Reduction as Savings

The primary projected benefit is straightforward: if fewer people are enrolled, states spend less on their Medicaid share. Federal projections of work requirement savings assume coverage reductions of 10-25% among affected populations, generating billions in combined federal and state savings.

This arithmetic is correct as far as it goes. If a state covers one million expansion adults at $5,000 per member annually, removing 200,000 members saves $1 billion in combined federal and state spending, with the state share depending on the matching rate.

The assumption embedded in these projections is that coverage reduction represents real savings rather than cost shifting. If removed members remain healthy, access care through other means, or simply defer care without consequence, the savings are real. If removed members become sicker, access care through emergency departments, or generate uncompensated care that states ultimately subsidize, the savings are partially or fully illusory.

Employment Effects

Some proponents argue work requirements will increase employment, generating economic benefits beyond Medicaid savings. Members who would not otherwise seek work will respond to coverage conditions by finding jobs, increasing household income and tax revenue while reducing program dependency.

The evidence for employment effects is weak. Studies of Arkansas's work requirement found no significant increase in employment among affected members. Members who lost coverage were no more likely to be employed than those who maintained coverage through exemptions or compliance. The employment rate in the affected population remained essentially unchanged while coverage dropped substantially.

This finding is consistent with what we know about the expansion population. Most expansion adults who can work already do: roughly 60% are employed at any given time, with many of the remainder facing barriers like disability, caregiving responsibilities, or local labor market limitations that work requirements cannot address. The population available to respond to work incentives by increasing employment is smaller than aggregate statistics suggest.

Behavioral Change Projections

A more modest version of the employment argument focuses on behavioral change: work requirements might not increase employment but could increase engagement with workforce development services, education, and job training. Members might acquire skills that improve long-term economic outcomes even if immediate employment effects are minimal.

This theory has surface plausibility but limited evidence. Georgia's Pathways program includes community engagement options beyond employment, and early data suggests members do engage with training programs. Whether this engagement translates to improved employment outcomes remains to be demonstrated, and the administrative costs of tracking diverse qualifying activities may exceed the value generated.

The Coverage Gap Economy

The financial analysis must examine what happens when members lose and potentially regain coverage. These dynamics differ fundamentally from steady-state enrollment.

When the Member Returns

Most members who lose coverage due to work requirements eventually return to Medicaid. They may regain employment, qualify for exemptions, or successfully navigate appeals. The coverage gap might last two months or twelve months, but the individual often reappears in the system.

States face direct costs from this churn. Re-enrollment processing is not free; each application requires eligibility determination, system updates, and often manual intervention when records are incomplete. Members returning after gaps frequently need catch-up care: screenings that were due, prescriptions that lapsed, specialist appointments that were cancelled. The state pays for care that would have been unnecessary had coverage been continuous.

Condition progression during gaps generates excess costs. A diabetic member who maintains coverage and medication adherence costs the system relatively predictable amounts for maintenance care. The same member returning after six months without medication may present with complications: retinopathy requiring specialist treatment, nephropathy requiring monitoring, or ketoacidosis requiring hospitalization. The costs of managing these progressions exceed what continuous coverage would have cost.

MCOs receiving returning members face the risk adjustment mismatch described earlier. They inherit members whose actual health status exceeds their documented health status, creating systematic underpayment until documentation catches up. Care management programs must restart relationships, rebuild care plans, and re-establish medication adherence.

Hospitals see returning members in their most expensive settings. Deferred care presents as emergencies. Conditions that could have been managed in primary care arrive in emergency departments. Members who return to coverage after hospitalization generate readmissions at higher rates than continuously covered members because continuity of care was interrupted.

Physicians lose the longitudinal relationships that enable effective chronic disease management. A physician who has managed a patient's diabetes for three years understands their barriers to adherence, their medication sensitivities, and their life circumstances. After a coverage gap, that physician may never see the patient again, or may restart the relationship without access to records from care obtained elsewhere during the gap.

FQHCs often continue serving patients during coverage gaps, providing sliding-scale care that generates no margin. When coverage returns, the FQHC has provided months of effectively uncompensated care while waiting for the payer mix to normalize.

Members bear costs that compound other disadvantages. Medical debt accumulated during gaps affects credit scores and housing eligibility. Worsened health status affects employability. Time spent navigating coverage loss and reinstatement cannot be spent on work, education, or family.

When the Member Does Not Return

Some members who lose coverage do not return to Medicaid. They may find jobs with employer coverage, transition to marketplace plans, or simply remain uninsured. Each outcome has different economic implications.

Members who obtain employer coverage represent a genuine transition. The Medicaid program no longer bears their costs; their employer and the commercial insurance market do. This is the outcome work requirement proponents envision, though evidence suggests it occurs for a minority of those losing coverage.

Members who transition to marketplace plans shift costs to federal premium subsidies rather than Medicaid matching funds. The individual still receives publicly subsidized coverage, though the federal share may be lower depending on income level. This is a budget shift rather than genuine savings.

Members who remain uninsured generate costs that appear elsewhere. Uncompensated care at hospitals increases, ultimately flowing back to state budgets through DSH payments or direct hospital subsidies. Emergency department utilization rises as the uninsured lack alternatives for acute care. Public health programs bear costs of untreated communicable diseases and unmanaged chronic conditions.

For MCOs, members who leave and do not return represent genuine cost reduction. The MCO no longer receives capitation but also no longer incurs costs. For high-cost members with inadequate risk adjustment, this may actually improve MCO margins. This creates an incentive misalignment where MCOs may not invest heavily in retention for members whose documented costs exceed their risk-adjusted payments.

Hospitals face a different calculation. ***They must treat everyone who presents regardless of coverage.*** Members who remain uninsured generate the same care needs but far less revenue. A hospital that saw uncompensated care drop after expansion may see it rise again, unwinding financial improvements gained over the past decade.

FQHCs maintain mission commitment regardless of coverage status, but their finances suffer. A patient converting from Medicaid to sliding-scale represents lost revenue with no reduction in service obligation. FQHCs in states with substantial coverage loss may face sustainability challenges.

The member who does not return may simply exit the healthcare system for extended periods. ***This is not cost savings; it is cost deferral.*** The diabetic who goes years without care presents eventually with complications far more expensive than continuous management would have been. The person with treatable cancer who avoids care due to cost presents with advanced disease requiring aggressive treatment or palliative care. The mental health condition that could have been managed with outpatient therapy becomes a crisis requiring hospitalization or incarceration.

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Who Feels the Pain Most

The economic impact of work requirements distributes unevenly across stakeholders. Understanding this distribution illuminates why different actors advocate different positions.

Hospitals Bear Concentrated Risk

Hospitals cannot refuse patients regardless of coverage status. This legal obligation means hospitals absorb uncompensated care increases that other stakeholders can avoid. A physician can limit Medicaid panels; an MCO can exit markets; a hospital must treat whoever arrives.

Safety-net hospitals face the greatest exposure. Institutions that serve disproportionate shares of low-income patients already operate on thin margins with high uncompensated care burdens. Coverage losses among expansion adults directly threaten financial viability. Several rural hospitals that achieved stability after Medicaid expansion would face renewed closure risk if coverage gains reverse.

Hospital systems with diverse payer mixes have more cushion. An academic medical center with substantial commercial and Medicare revenue can absorb some Medicaid disruption. But even well-resourced systems feel the impact in emergency departments, where coverage status affects nothing about care delivered but everything about payment received.

MCOs Face Mixed Incentives

MCO exposure depends heavily on their member composition and risk adjustment adequacy. Plans with favorable risk adjustment that accurately captures member acuity have aligned interests in retention. Plans that are systematically underpaid for high-cost members may benefit financially when those members churn off.

Large MCOs with diversified books across multiple states and programs can absorb volatility in any single market. Smaller regional plans with concentrated Medicaid exposure face greater risk from enrollment instability. ***Some plans may exit markets if work requirements create unacceptable unpredictability.***

MCOs also face reputational and regulatory considerations beyond immediate financial impact. Plans that appear to be shedding high-cost members or providing inadequate support for compliance face scrutiny from state regulators and advocacy organizations. These non-financial factors may encourage MCO investment in retention even when narrow financial calculations suggest otherwise.

FQHCs Absorb Burden Without Compensation

FQHCs cannot turn away patients and cannot realistically exit markets. Their mission commitment means they continue serving patients regardless of coverage status, absorbing the financial consequences. This makes FQHCs uniquely exposed to coverage losses.

The FQHC model assumes a certain payer mix to achieve financial sustainability. Too many sliding-scale patients without enough Medicaid and Medicare revenue makes the math unworkable. FQHCs in states with aggressive work requirements and limited exemptions may face structural deficits that threaten operations.

Some FQHCs will respond by seeking additional grant funding, which shifts costs to federal programs or philanthropic sources. Others will reduce services or staffing to match reduced revenue. Neither response serves patients well.

Physicians Have Exit Options

Physician practices can limit Medicaid exposure in ways hospitals and FQHCs cannot. If work requirements create administrative burden and coverage volatility that makes Medicaid patients unprofitable, practices can reduce their Medicaid panels and seek commercially insured patients instead.

This response is individually rational but collectively harmful. Members losing coverage need more physician access, not less. If work requirements cause physicians to reduce Medicaid participation, members who maintain coverage face narrower networks and longer wait times. The program becomes less attractive, potentially accelerating exits by healthier members and worsening the risk pool.

Practices in underserved areas have fewer alternatives. If the patient population is predominantly Medicaid, there is no commercially insured population to pivot toward. These practices face the same difficult math as FQHCs: mission commitment and community need that persist regardless of payer mix realities.

Rural and Urban Differences

Rural providers face amplified challenges from work requirements. Limited employers mean members have fewer options to satisfy work requirements. Limited transportation means accessing workforce services or verification appointments requires greater effort. Limited broadband means online reporting systems may be inaccessible.

Rural hospitals and clinics often serve as anchors for their communities. ***Their closure creates cascading effects beyond healthcare: lost jobs, reduced local spending, diminished community viability.*** Work requirements that destabilize rural provider finances threaten these broader community effects.

Urban providers face different challenges. Higher volume means administrative burden scales up. More complex patient populations mean more exemption documentation. But urban providers also have more resources, larger staffs, and more sophisticated systems to manage complexity.

Safety-Net Versus Commercial Focus

Providers that deliberately serve low-income populations carry the most risk. Safety-net systems built around Medicaid revenue face existential questions if that revenue becomes unstable. Systems that dabble in Medicaid while focusing on commercially insured populations can absorb losses or simply reduce Medicaid participation.

This creates a perverse selection effect. The providers most committed to serving vulnerable populations bear the most risk from policies affecting those populations. The providers with capacity to serve more Medicaid patients have the least incentive to do so.

The Counterargument: Why Costs May Be Justified

Critics will note that the analysis above focuses heavily on costs while treating potential benefits skeptically. A fair accounting requires engaging the strongest arguments for why work requirements might be worth their costs.

The Reciprocity Principle

The philosophical argument for work requirements is not primarily economic. It holds that able-bodied adults receiving public benefits should contribute to society in return. This reciprocity principle has deep roots in American political culture and commands broad public support in polling across partisan lines.

From this perspective, some administrative cost is acceptable to enforce a social norm. We do not evaluate child support enforcement purely on whether collections exceed administrative costs; we enforce child support because it is right for parents to support their children. Similarly, work requirements might be justified even if narrow cost-benefit analysis is unfavorable, because it is right for people who can work to do so as a condition of receiving public benefits.

This argument has force, but it does not eliminate the empirical question of whether work requirements actually increase work or merely increase administrative burden while removing coverage from people who were already working or legitimately unable to work.

Moral Hazard Concerns

Economists worry that unconditional benefits create moral hazard: if people receive healthcare coverage without any expectation of work, some will choose not to work who otherwise would. Work requirements address this moral hazard by ensuring that coverage does not subsidize able-bodied non-work.

The empirical question is how large this moral hazard effect actually is. If substantial numbers of expansion adults are choosing non-work because Medicaid is available without conditions, work requirements could increase employment. If most non-working expansion adults face genuine barriers to employment, work requirements simply punish people for circumstances they cannot change.

The evidence from Arkansas suggests the moral hazard effect is small. Employment did not increase when work requirements were imposed, suggesting few people were choosing non-work due to unconditional coverage availability. But one state's experience may not generalize, and longer implementation periods might reveal different effects.

Long-Term Dependency Reduction

A forward-looking argument holds that work requirements, even if costly in the short term, reduce long-term dependency by encouraging people to build skills, establish work histories, and transition to self-sufficiency. The costs of implementation and coverage volatility might be investments that pay off over decades.

This argument is difficult to evaluate because the relevant time horizon extends beyond any study period. It requires assumptions about behavioral change, skill acquisition, and economic mobility that are contested. But it cannot be dismissed as unreasonable. Policies that increase near-term costs while generating long-term benefits are common, and work requirements might fall into this category.

State Laboratory Benefits

The coming implementation across many states with different designs will generate evidence about what works and what does not. This learning has value that should be weighed against implementation costs. If state experimentation reveals approaches that successfully increase

employment while maintaining appropriate coverage, the lessons would benefit future policy design.

Net Analysis and Honest Uncertainty

An honest assessment acknowledges substantial uncertainty about net effects. We can identify costs and benefits; we cannot yet quantify them precisely or establish definitively which predominates.

The costs that can be estimated with some confidence include:

- State administrative investments in the hundreds of millions of dollars nationally
- MCO operational disruptions that will flow through to capitation rates
- Provider documentation burden that will affect practice economics
- Coverage losses that historical evidence suggests will substantially exceed employment gains

The costs that are harder to estimate but likely substantial include:

- Health consequences of coverage interruption that manifest over years rather than months
- Risk adjustment distortions that create systematic MCO underpayment
- Community organization investments that are diffuse and unmeasured
- Member compliance costs that appear in no government budget

The benefits that might materialize include:

- Genuine transitions to employer coverage for some members
- Engagement with workforce development services that improves long-term prospects
- Satisfaction of reciprocity norms that maintain political support for the underlying program
- Learning from state experimentation that improves future policy.

The distribution of costs and benefits matters as much as the totals. Costs fall heavily on the most vulnerable members and the providers most committed to serving them. Benefits accrue to state budgets and taxpayers while the costs of coverage loss are externalized to individuals and the broader healthcare system.

Reasonable people can weigh these considerations differently. Those who place high value on reciprocity norms may find work requirements justified even if narrow cost-benefit analysis is negative. Those who prioritize coverage stability and health outcomes may find the costs unacceptable regardless of administrative efficiency gains.

What is not reasonable is to project savings from coverage reduction while ignoring the costs that coverage reduction generates. The question is not whether work requirements cost money; they do. The question is whether those costs are justified by the goals they serve.

Conclusion

The budget director closes her spreadsheets, knowing that the numbers she presents will not drive the decision. Work requirements will be implemented because they satisfy political demands that transcend cost-benefit analysis. Her job is to make the implementation as cost-effective as possible while managing the financial risks her healthcare system will absorb.

She begins drafting recommendations: ***invest in automated verification to minimize administrative costs, build robust exemption processes to protect the most vulnerable, ensure MCO contracts include risk corridors that share volatility fairly, and establish***

monitoring systems that will detect problems before they become crises. None of this prevents the disruption ahead. It merely manages that disruption within the constraints of a decision already made.

The economics of mutual obligation are not primarily about economics. They are about values: how we balance reciprocity against vulnerability, how we weigh administrative efficiency against coverage stability, how we distribute costs and risks across stakeholders with different capacities to bear them. The numbers matter, but they are not the only thing that matters, and perhaps not even the most important thing.

What the numbers reveal is that work requirements are not free. Someone pays: states in administrative costs, MCOs in actuarial uncertainty, providers in documentation burden, communities in coverage gaps, and members in lost care. The policy choice is not between spending and saving. It is about who spends, who saves, and who bears the consequences when systems built for stability confront mandated volatility.

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