Healthy *People*, *Healthy* Economy:

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Why Adding Barriers to Medicaid is Bad for Business

A Cautionary Case Study of Arkansas and Georgia's Failed Medicaid Work Reporting Requirement Programs

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Executive Summary

With control of the House, Senate, and White House, Washington Republicans are currently pushing to pass a massive bill that they claim will energize the economy. Yet again, Republicans plan to massively cut taxes for the wealthiest Americans. However, Congressional Republicans have a dilemma. How will they pay for these tax cuts for millionaires and billionaires? **By planning to cut up to $880 billion from Medicaid.**

This report describes how such massive cuts will undermine the alleged economic growth from their tax cuts. Decades of research show that investing in Medicaid – not cutting it – is what actually grows the economy. And on the flip side, research shows that constricting the Medicaid program and taking away resources result in loss of health care coverage, loss of jobs, and lower economic growth.

The leading proposal to restrict Medicaid coverage is to impose onerous work reporting requirements for Medicaid enrollees. Two states have already tried and failed to successfully implement these restrictions: Arkansas and Georgia. Arkansas, a Medicaid expansion state, had to halt its program after 18,000 people lost coverage in the span of seven months. Georgia, a non-expansion state, has only enrolled 7,000 people after 20 months. As this report details, the experiences of these states show how such policies can harm the economy:

- In states that have expanded Medicaid, like Arkansas, excessive reporting requirements kick working people off Medicaid.
- In states that have not expanded Medicaid, like Georgia, there is no evidence that these reporting requirements increase employment. Rather, Georgia's experience shows that such onerous requirements preclude working people from accessing health care.

These two case studies are a cautionary tale. They show that work reporting requirements are not effective. Instead of getting more people working, they simply kick people off their health care, many of whom were already working full-time.

Rather than depriving working Americans of healthcare coverage to pay for a tax cut for the wealthy, Congress should make additional investments in the Medicaid program and encourage the remaining non-expansion states to finally provide lifesaving health care coverage to families – **leading to healthy people and a healthy economy**.

Background

In 2025, Medicaid will celebrate 60 years of providing lifesaving care to millions of Americans. Created in 1965 as part of the same law that established Medicare, the program for the elderly and people with disabilities, Medicaid serves a diverse population of Americans who for various reasons often cannot access or afford reliable private health care coverage. [1] This includes children, people with disabilities, veterans, seniors, and pregnant women.[2]

Before the establishment of Medicaid and Medicare[3], only one in eight Americans had health insurance, and the average life expectancy in the U.S. was 69.7 years.[4] In 2023, 92 percent of Americans had health insurance for at least part of the year,[5] and life expectancy was 78.4 years.[6]

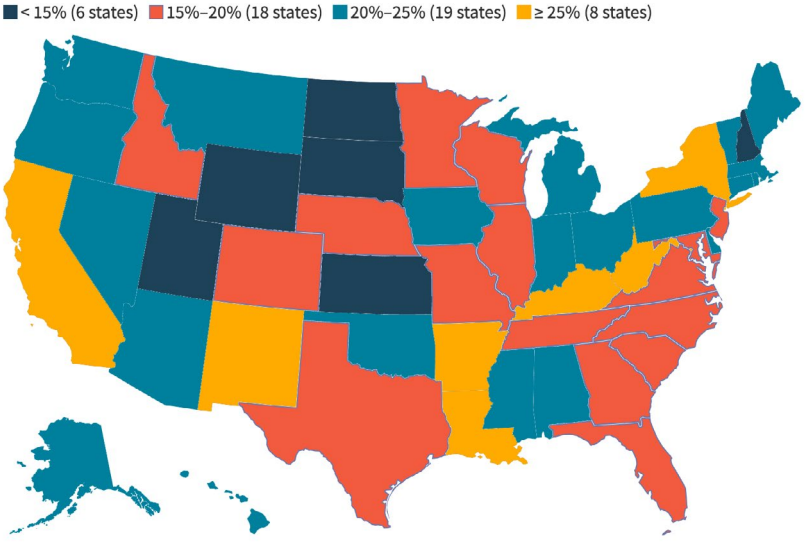
Unlike Medicare, which is funded by the federal government, Medicaid is a state-federal partnership. The federal government pays a share of the cost to run Medicaid programs – as low as 50 percent and as high as 80 percent, depending on the state's per capita income - while state governments pay for the remainder.[7] States have considerable flexibility in how to structure and run their Medicaid programs.[8]

Who Benefits from Medicaid?

Every one in five people in the United States has Medicaid coverage.[9] In seven states, more than **25 percent of the population is enrolled in Medicaid**: Kentucky (28 percent), West Virginia (26 percent), Louisiana (32 percent), Arkansas (25 percent), New Mexico (34 percent), California (27 percent), and New York (29 percent).[10]

Figure 1

Nationally, One in Five People Have Medicaid, but This Varies Across the States.



Source: KFF State Health Facts, Health Insurance Coverage of the Total Population • Get the data • Download PNG

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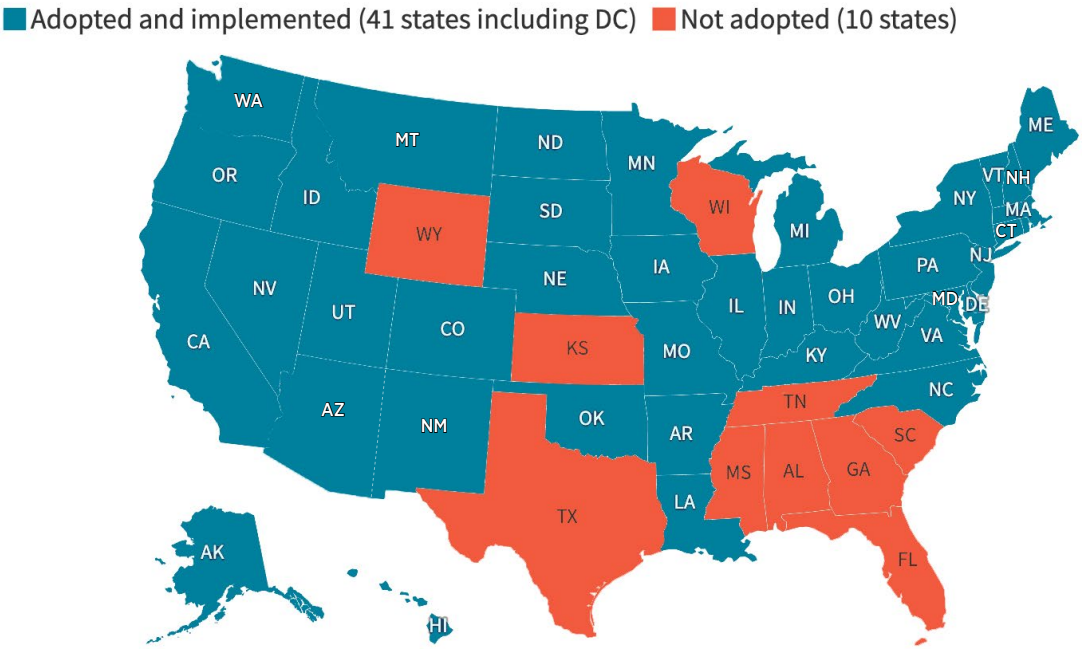
When it was first created, Medicaid only covered people who received cash assistance from the federal government, but eligibility has broadened over the decades since its creation.[11] Before the Affordable Care Act (ACA), children, pregnant women, parents of dependents, people with disabilities, and adults over the age of 65 who met income requirements were eligible for Medicaid.[12] In 2010, the ACA required[13] states to expand Medicaid and provide services covered by Medicaid to new a population: adults between 19-64 earning under 138 percent of the federal poverty level,[14] i.e., an annual income of $21,500 for a single person and $36,700 for a family of three.[15]

People in this expanded population include but are not limited to parents, family caregivers, gig-economy workers, early retirees, people with disabilities, and students in school.[16] For this population, 92 percent are already working part-time or full-time, are enrolled in school, provide care for a child, disabled family member or older adult, or themselves have a disability and are too sick to work. Of the remaining 8 percent who did not provide a reason, many face significant barriers that prevent them from working.[17]

States that opted to expand Medicaid and close the health care coverage gap receive a higher level of federal funding. However, over a decade later and despite evidence pointing to the lifesaving benefits of this expansion, **ten states continue to reject increased federal support and leave millions of people without access to affordable coverage.**[18]

Figure 2

Status of State Action on the Medicaid Expansion Decision



Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion • Get the data • Download PNG

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Medicaid Expansion Works

In the 15 years since the passage of the ACA, overwhelming evidence illustrates that Medicaid expansion is good for people and good for the economy. The 40 states (and Washington, D.C.) that have expanded Medicaid ("expansion states") have seen improved health outcomes, financial stability for hospitals, and economic growth due to expansion.

Medicaid expansion dramatically increases the rate of health insurance and positive health outcomes, because when people can afford preventive health care, their health outcomes improve. Studies demonstrate that access to health care through Medicaid expansion has improved mortality rates – including reduced opioid deaths, reduced maternal mortality rates, and greater survival for those with various types of cancers.[19] For example, one study discovered that Americans covered by Medicaid expansion are less likely to die from cardiovascular and respiratory diseases than those without expansion coverage.[20] That same study found that a reduction in uninsured rates was correlated with a reduction in all-cause mortality.[21]

Maternal mortality rates have also decreased in Medicaid expansion states, compared to states like Georgia, where maternal mortality and morbidity rates are some of the highest in the country.[22] One study found that Medicaid expansion was significantly associated with lower maternal mortality rates compared to states that did not expand Medicaid.[23] Another study found that there was a 17 percent reduction in hospitalizations during the postpartum period in states that expanded Medicaid,[24] likely attributed to long-term insurance coverage of new parents.

"Being recently unemployed, I was very thankful to be able to receive my health insurance through Medicaid to get the maternal health care I needed. During my first trimester, I was diagnosed with Oligohydramnios, a condition characterized by low amniotic fluid, which can cause a lot of other complications if left untreated. Yet, because I received my health insurance through Medicaid, I was able to receive the treatment and tests I needed without having to worry about cost. Medicaid allowed me to see the necessary doctors as frequently as needed to navigate my high-risk pregnancy. I eventually gave birth to a healthy baby, who is now 12 years old and thriving." - Medicaid Matters for Me (Natasha's Story), National Partnership for Women & Families (Apr. 17, 2025)

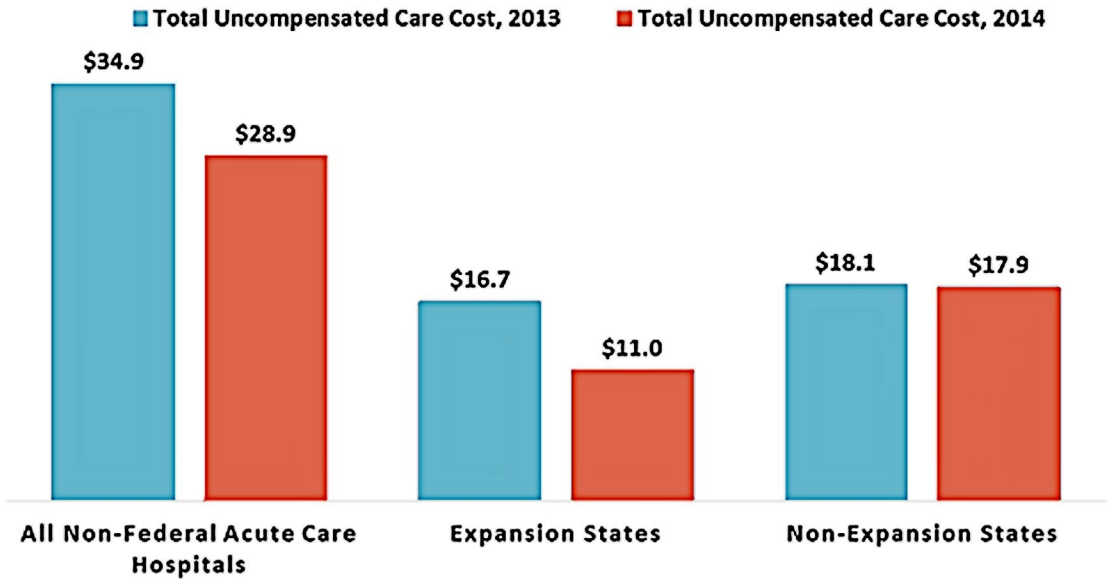
As Medicaid is the largest payor of substance use disorder care, Medicaid expansion has also helped to reduce the rising rates of opioid use-related deaths. [25] In fact, one study found that Medicaid expansion was associated with a 6 percent reduction in total opioid overdose rate compared to non-expansion states.[26]

These better health outcomes for Medicaid expansion enrollees are because they are more likely to receive medical care. Americans who benefit from Medicaid expansion are more likely to schedule regular medical visits and to get early care for health concerns, thus reducing the likelihood of a condition becoming chronic or resulting in death. Two studies found that expansion led to an increase in primary care appointments for Medicaid enrollees,[27] and a decrease in adults avoiding doctors' appointments due to cost.[28]

Figure 3

Hospitals in expansion states saw a reduction in uncompensated care costs from 2013 to 2014.

$ in billions



Source: KCMU analysis of the Medicare Cost Reports, 2013 and 2014.

Medicaid expansion has also helped stabilize the healthcare system. According to one study, hospitals in expansion states were 84 percent less likely to close than hospitals in non-expansion states, an effect magnified in rural communities.[29] Rural hospitals benefit in particular, according to a study by the Kaiser Family Foundation (KFF).[30] This is because federal law requires that hospitals treat everyone who shows up at the emergency room, regardless of whether they have healthcare coverage. The cost of treating uninsured individuals—termed "uncompensated care costs" —can be substantial. KFF found that

hospitals in expansion states saw a decrease in uncompensated care costs, resulting in a net positive effect for hospitals in expansion states.[31] Furthermore, a separate study found that the median operating margin for rural hospitals in non-expansion states was 2.2 percent, compared to 3.9 percent in expansion states.[32] Community Health Centers, which receive federal funding and serve a larger proportion of uninsured and underinsured individuals, also saw increased revenue post-expansion. [33]

Finally, Medicaid expansion is good for the economy—both by reducing costs to states and by improving individual outcomes. In Michigan, after full expansion in 2014, the increase in personal income associated with new employment raised hundreds of millions annually in state tax revenue.[34] This additional state tax revenue almost completely offset the state cost of the new expansion population in Medicaid.[35] In Kentucky, expanding Medicaid reduced the state's uncompensated care costs by 59.7 percent, from $1.9 billion in 2013 to $766 million in 2014.[36] And in Arkansas, before its disastrous attempt to roll back expansion through work reporting requirements, full expansion reduced the state's uncompensated care costs by 55 percent.[37]

Increased health coverage also benefits individuals' economic stability. One study discovered that due to increased health coverage from Medicaid expansion, mortality rates decreased, resulting in increased expenditures from lives saved, ranging from $20.97 billion to $101.8 billion annually.[38] Another study found that evictions in expansion states fell 20 percent, while there was no change in non-expansion states over the same time period.[39] In the two years following Medicaid expansion, analysis shows that medical debt collections dropped by $3.4 billion across expansion states.[40] In the seven years after states were able to expand Medicaid, between 2013 and 2020, new instances of medical debt dropped by 34 percent more in expansion states than in states that did not expand.[41]As demonstrated throughout this report, when people have robust health coverage, they're able to free up their pocketbooks to pay for other essentials and contribute to the economy.

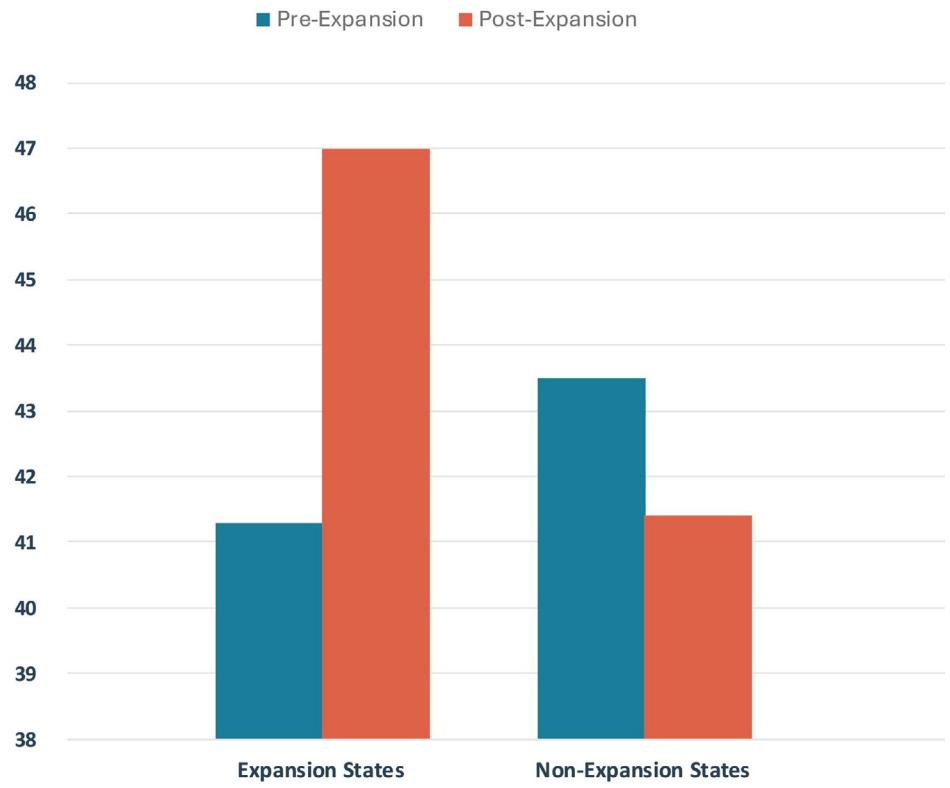
Health Coverage Incentivizes Work

Health care coverage is a prerequisite to being able to work, because when people are healthy, they're able to work. When they are sick, they often can't.[42] Health care coverage, like Medicaid, helps keep people healthy. Researchers looking at the effect of health coverage on employment found employees with health coverage missed roughly 77 percent fewer workdays per year than employees without health coverage.[43]

Numerous studies have also shown a similar pattern within the Medicaid population. One study, for example, compared individuals with disabilities in expansion and non-expansion states. In expansion states, employment rates for adults with disabilities increased from 41.3 percent pre-expansion to 47 percent post-expansion. In non-expansion states, meanwhile, employment rates for adults with disabilities decreased from 43.5 percent to 41.4 percent over the same period.[44]

Figure 4

Employment Rates for Adults with Disabilities in Expansion States and Non-Expansion States



"[Medicaid] allows me to get surgery which has allowed me to return to work." -The Ohio Department of Medicaid Survey, 2018

Data from individual states like Ohio, Michigan, Montana, and Idaho demonstrate the same trend. In 2018, Ohio conducted a detailed survey of its Medicaid expansion population and found that 83.5 percent of enrollees said that Medicaid coverage made it easier to work and 60 percent of enrollees who were unemployed said Medicaid made it easier to look for work.[45]

> ***"Medicaid has helped me in my situation because when my lungs collapsed, I lost my job and I couldn't work, so when I got on the program it helped out tremendously." - The Ohio Department of Medicaid Survey, 2018***

Michigan demonstrated a similar pattern. A study found that 69 percent of enrollees who had jobs said they did better at work once they had health insurance.[46] Additionally, 55 percent of Michigan Medicaid enrollees who were unemployed said having access to health care helped them look for a job.[47]

Another expansion state, Montana, introduced workforce support programs for newly eligible Medicaid enrollees. Instead of harsh requirements with punitive measures, Montana helped Medicaid-eligible adults get connected to resources. Post-expansion, participation in the workforce for the low-income expansion population increased by 6 to 9 percentage points.[48]

In Idaho, one doctor noted that many of his patients who rely on Medicaid work on farms, ranches, or local mines.[49] Before the state expanded Medicaid in 2019, these hardworking Americans were uninsured and avoided doctor visits due to the cost.[50] One patient avoided seeing the doctor for abdominal pain for months and ended up hospitalized for a severe gallbladder infection.[51] Not only is a hospital visit more expensive to the health care system than preventive care and access to insurance, due to his hospitalization this patient could not work and likely stayed out of the workforce for much longer than he would have if he had access to Medicaid.

Washington Republicans' Plan to Cut Medicaid

Despite overwhelming evidence that Medicaid is beneficial for people's health and our economy, Washington Republicans are determined to gut Medicaid to pay for tax cuts to the wealthy, resulting in fewer people having coverage and making it less likely that they will be healthy enough to work.

On April 4, 2025, the U.S. Senate passed the budget blueprint for their massive tax cut legislation – with all Democratic Senators and two Republicans opposing.[52] On April 10, 2025, the U.S. House of Representatives passed the same budget blueprint, unlocking negotiations to begin on what will ultimately be included in the final bill. [53]

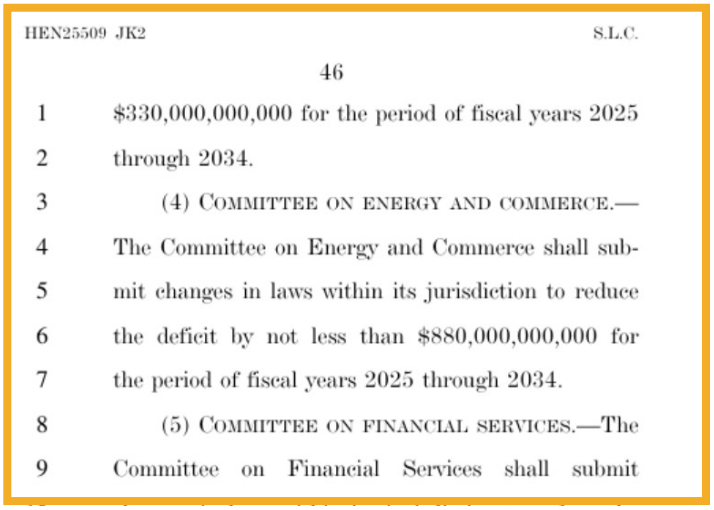
By passing the blueprint, Republicans committed to finding up to $880 billion in cuts under the jurisdiction of the House Committee on Energy and Commerce.[54] The Congressional Budget Office has stated that it is impossible to find **$880 billion** without gutting Medicaid and eliminating health care coverage for millions of Americans.[55]

While Republicans have not yet decided how these cuts will take shape, reporting indicates they are likely to take two paths: (1) remove federal support that allows expansion states to maintain coverage of the expansion population and for non-expansion states to expand for the first time and (2) kick hundreds of thousands of eligible Americans off Medicaid by imposing onerous work reporting requirements. Neither proposal will help grow the economy.[56] Rather, they will leave Americans sicker and poorer.

Disincentivizing States to Extend Health Coverage to the Uninsured

According to public reporting, Republicans have a two-part plan to remove federal support to states that have expanded or are considering expanding Medicaid.

For the 40 Medicaid expansion states, Republicans are allegedly considering making it more expensive for states to provide health care coverage for their residents through Medicaid.[57] With the passage of the ACA, the federal government agreed to pay 90 percent of the costs to provide health care to their residents who were newly eligible for health care coverage. Rolling back this federal support would be a significant financial burden on states and result in millions of people losing health care coverage.[58]



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$330,000,000,000 for the period of fiscal years 2025 through 2034.

(4) COMMITTEE ON ENERGY AND COMMERCE.—The Committee on Energy and Commerce shall submit changes in laws within its jurisdiction to reduce the deficit by not less than $880,000,000,000 for the period of fiscal years 2025 through 2034.

(5) COMMITTEE ON FINANCIAL SERVICES.—The Committee on Financial Services shall submit

Figure 5, This is the text from the budget blueprint that outlines $880 billion in cuts - by reducing the deficit - in the jurisdiction of the House Energy and Commerce Committee. The Congressional Budget Office has confirmed it is impossible to reduce the deficit by this amount through House Energy and Commerce Committee programs without cutting Medicaid.

Claim: House Republicans estimate that reducing federal payments for Medicaid expansion coverage 'saves' the federal government $690 billion.[59]

Truth: There are no savings. The cost is transferred to states or to individuals who lose their health care coverage. Twelve expansion states have "trigger laws," so that if the federal match for the expansion population ever drops below 90 percent, these states will either immediately roll back expansion or start the process of rolling back coverage.[60] An estimated 4.3 million Americans live in these trigger law states and would be at risk of losing their health coverage.[61] The massive reduction in federal support for this population would result in an increase of 17 percent, or $626 billion, in state spending across all states over 10 years.[62]

To target the 10 non-expansion states, Republicans are reportedly planning to repeal incentives for states to expand Medicaid. The American Rescue Plan Act of 2021 incentives increased the federal match for total Medicaid spending by 5 percent for the first two years of expansion.[63] For Georgia, that would mean if the state decided to expand Medicaid in Fiscal Year 2026, the federal government would pay 71.4 percent of the cost of the state's Medicaid program for two years, instead of the current 66.4 percent.[64] The federal government would also cover 90 percent of the cost of the Georgia expansion population under current law.[65]

Claim: House Republicans estimate repealing the additional federal payment for Medicaid coverage 'saves' the federal government $18 billion.[66]

Truth: As demonstrated earlier in this report, expanding in Medicaid saves money in the long-term by reducing mortality and increasing economic growth. Since the passage of the American Rescue Plan Act in March 2021, four states have expanded their Medicaid programs and received the enhanced federal incentives: Oklahoma (July 2021), Missouri (October 2021), South Dakota (July 2023), and North Carolina (December 2023).[67] Advocates and supporters of Medicaid in the remaining ten non-expansion states have been able to make progress in convincing state leaders to expand, armed with the added benefit of the incentives from the American Rescue Plan Act.[68]

Creating Barriers to Health Coverage for Working Adults

The planned Republican cuts to Medicaid will incentivize states to reduce Medicaid coverage for those who need health care to go to work, support their families, and be active members of their communities. In addition to disincentivizing states from providing Medicaid health care coverage, Republicans are also allegedly looking at imposing onerous requirements on individuals that will kick hundreds of thousands of people off Medicaid.[69] These requirements—misleadingly labeled 'work requirements'—are actually paperwork or "work reporting" requirements that involve so much red tape that even working Americans will not be able to comply.

The misguided policy of requiring Medicaid enrollees to report their work status is based on the false premise that people enrolled in Medicaid do not work or do not want to work. The reality is that over **90 percent of adult Medicaid enrollees not eligible through Supplemental Security Income (SSI) already work, attend school, serve as caregivers, or have a disability**.[70] And of the remaining 10 percent, many may be too sick to work and need access to health care coverage so they can improve their health and get back to work. If they don't have access to health care, they will go to the hospital when it's an emergency, costing more than if they had access to preventative care.

Contrary to the claims of some Washington politicians, work reporting requirements do not save money by increasing employment.[71] Rather, **Washington politicians want to cut federal costs by kicking working people off Medicaid**. In fact, it's people who work the hardest—the mom with two part-time jobs, or a son who is providing full-time care for his aging parents—who may struggle the most to jump through the bureaucratic work reporting hoops that Washington politicians plan to impose.

On April 26, 2023, the non-partisan Congressional Budget Office (CBO) estimated that adding work reporting requirements to Medicaid would likely reduce federal spending by $109 billion over ten years. It also concluded that mandatory work reporting requirements "would have a negligible effect on employment status or hours worked by people who would be subject to the work requirements."[72]

> ***"I don't think you need to use paperwork to prove work requirements, and I don't think that should be used as an obstacle, disingenuous effort to block people from getting on Medicaid." – Dr. Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services (CMS) at Senate Finance Hearing on March 14, 2025***

How is that possible? Because work reporting requirements do not lead to more work—they lead to kicking working people off Medicaid. Indeed, the same CBO analysis projected that imposing work reporting requirements would put at least 1.5 million individuals at risk of having their health coverage terminated, unless the state chose to cover the full cost of coverage.[73]

However, this CBO analysis likely **overestimates** federal 'savings' and **undercounts** the number of people who may lose coverage.

On the savings front, the CBO report does not consider the increase in spending due to higher uninsured rates or the cost of implementing a work reporting verification system. For example, during Arkansas's 2018 experiment with work reporting requirements, the state estimated work reporting requirements would save nearly $50 million.[74] Instead, it cost taxpayers $26.1 million.[75] Additionally, for individuals who lost coverage due to the bureaucratic paperwork requirements, 50 percent reported "serious problems" paying off medical debt and 56 percent reported that they delayed care due to the cost.[76]

A U.S. Government Accountability Office (GAO) study of five states that attempted work reporting requirements found that these states spent millions of taxpayer dollars for programs that ultimately failed.[77] In fact, four of the five states below abandoned their work reporting requirement programs before they even started.[78]

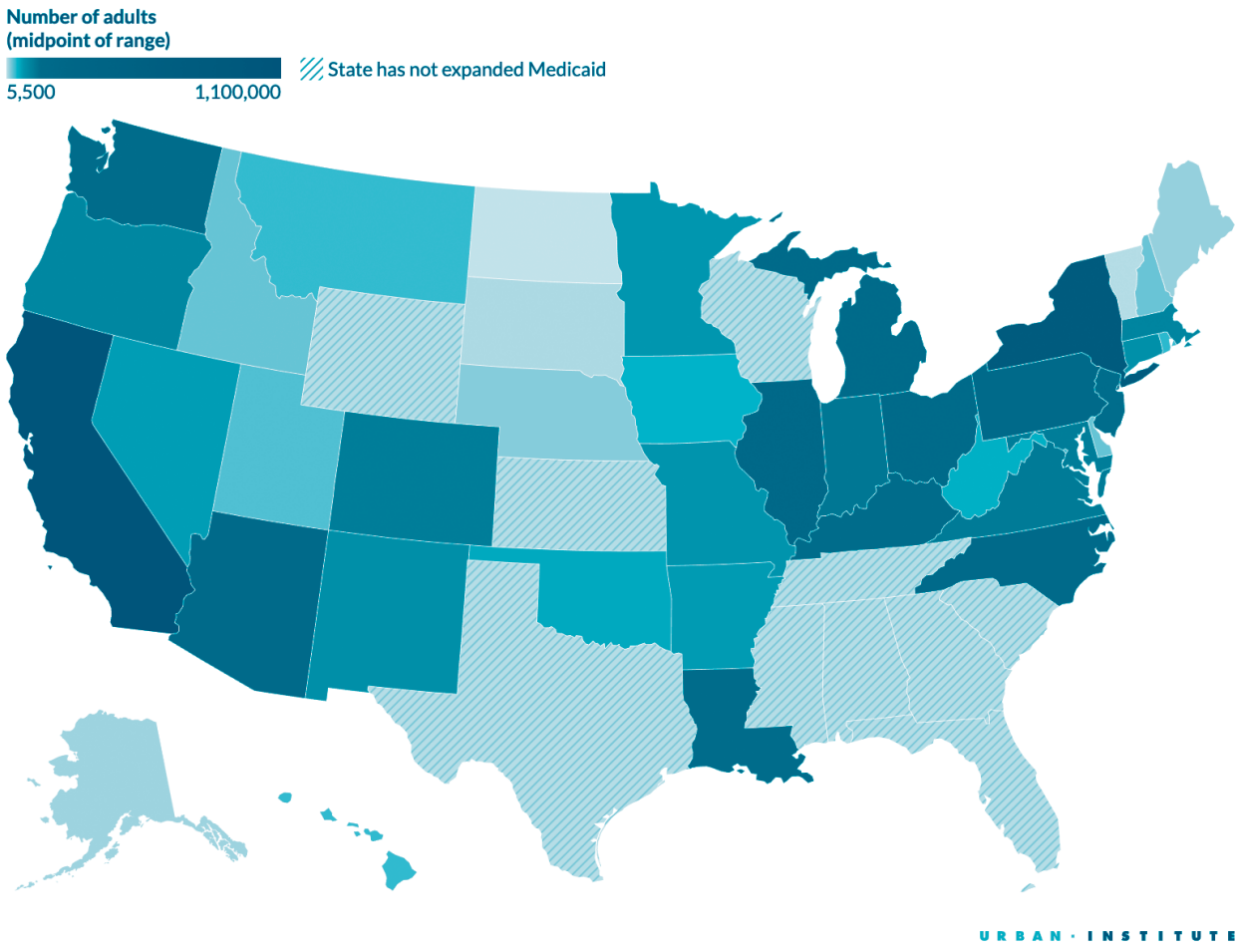
Kentucky offers a particularly illustrative example of why these reporting requirements so frequently fail. In Kentucky, nearly all the Medicaid enrollees the state was targeting with work reporting requirements were already working or participating in activities that would qualify for the 80 hours per month requirement. In fact, only 3 percent of Medicaid enrollees in Kentucky reported that would be unable to meet the work reporting requirements.[79] Despite the evidence showing the vast majority of Medicaid enrollees already work, Kentucky was ready to move forward on this program until it was halted by a court — and was projected to cost over $271 million just for implementation.[80]

Beyond the staggering implementation costs and limited benefits, these work reporting requirements would likely also harm hospital systems. A 2019 study analyzed states with planned work reporting requirements, and assuming full implementation, found that in 16 of the 18 states, hospital operating margins decreased.[81] In Kentucky, hospitals' operating margins were projected to decrease by an estimated 1.5 percent.[82]

The Center on Budget and Policy Priorities estimates that 36 million Medicaid enrollees would be at risk of losing coverage under national work reporting requirements.[83] An Urban Institute report found that based on past reporting and data, an estimated 4.6 to 5.2 million Americans would lose coverage under national work reporting requirements similar to the policy that CBO scored.[84]

Figure 6

About 5 Million Medicaid Expansion Enrollees Could Lose Medicaid under Federal Work Requirements



A Cautionary Tale: A Case Study of Work Reporting Requirements in Arkansas and Georgia

> ***The finding that Medicaid work requirements are ineffective in promoting work is consistent with other data suggesting opportunities to increase employment are limited, as nearly all Medicaid enrollees are already working, looking for a job, enrolled in school, caring for a family member, or have health conditions or disabilities that prevent them from working. It also reflects challenges with the design of work requirements, in which people are often disenrolled because they are unaware or confused about the policy or have trouble navigating state reporting systems." - Urban Institute Report from April 23, 2025, New Evidence Confirms Arkansas's Medicaid Work Requirement Did Not Boost Employment***

Likely because most states realize that imposing additional barriers to healthcare access can harm people's health and their states' economy, only two states have fully implemented significant work reporting requirements on their Medicaid population. In 2018, Arkansas applied work reporting requirements to adults between ages 19 to 49 enrolled in Medicaid through the state's expansion. In 2023, Georgia launched a program that allows people not currently covered due to the state's non-expansion to apply for Medicaid if they meet the 80-hour per month work reporting requirement. As described below, both efforts are failures that offer a cautionary tale for the nation.

Doomed for Failure in Arkansas

Adrian McGonigal, a nonelderly adult from Arkansas, had a full-time job at a chicken plant. Adrian also suffered from COPD, but luckily had Medicaid coverage through the state's expansion to keep his prescription costs low. However, in 2018 after the work reporting requirements launched in his state, McGonigal was not sure what he needed to do to prove he was working. He was able to borrow his family's phone to report his month one time, but did not realize that he had to report his work every month, only after he went to the pharmacy and was told he had no insurance. He couldn't afford the medicine he needed to treat his COPD and he ended up in the emergency room, leaving him unable to work.[85]

In 2014, Arkansas fully expanded Medicaid to cover more than 250,000 individuals. The expansion lowered the state's uninsured rate from 27.5 percent to 15.6 percent.[86] Four years later, Arkansas sought and received a waiver[87] from the Trump Administration's Centers for Medicare & Medicaid Services (CMS) to apply bureaucratic work reporting requirements to its Medicaid population. Specifically, these requirements would apply to adults between the ages of 19 and 49 earning under 138 percent of the federal poverty level.

Under the new requirements, tens of thousands of Arkansans who had gained coverage from the 2014 expansion now had to complete onerous government paperwork each month to report 80 hours to the state's health department or risk losing health coverage.[88] Should an individual fail to report their work for any three months in a calendar year, then they would be locked out of the health program for the rest of the year—even if they were employed for the remaining nine months![89]

Within seven months of the waiver, nearly 18,000 people—25 percent of the targeted enrollees—in Arkansas had their health insurance terminated.[90] According to an Urban Institute analysis, individuals who lost coverage reported challenges related to transportation access and lack of internet as reasons for being unable to regularly report their work.[91] Additionally, Urban Institute found that out of the individuals who could not work, "78 percent [had] at least one of the following characteristics: no access to a vehicle, no internet access, less than a high school education, a serious health limitation, or a household member with a serious health limitation."[92]

I woke up from seizures in the hospital and one day my Medicaid was active and the next day it wasn't. When you wake up from a seizure you are already disoriented and then you are telling me I have to pay out of pocket before being seen? — Urban Institute Focus Group Participant #1, May 2019

Among those who were working but still unable to meet the 80 hour per month requirement, individuals cited issues with "nonstandard work schedules, fluctuations in weekly hours worked, lack of advance notice of work schedules, and lack of control over their own hours."[93] One survey showed that more than 95 percent of the targeted population through the work reporting requirement program in Arkansas either met the requirement already or should have been exempt.[94]

"I don't have [internet access]. I have to go on the bus to get to the library and a lot of times I don't have a bus pass. The library is pretty far away, not walking distance. I go to [the] Salvation Army but their Wi-Fi is up and down. I am there from 7:00 at night to 7:00 in the morning, but… [during the day] I have to check on my 17-month-old. It is hard to get to the library. I had my purse stolen so I don't have an ID. So I can't get a new bus pass or a new library card to be able to use the computers there. It is hard." - Urban Institute Focus Group Participant #2 , May 2019

If the goal of work reporting requirements was to incentivize work, Arkansas' results fell flat. Researchers found that among Medicaid-eligible individuals in Arkansas, employment rates decreased after the implementation of the work reporting requirements program.[95]

In 2019, a federal court vacated the approval of the work reporting requirement waiver in Arkansas, citing the failure of the waiver's ability to "promote the objectives of the Medicaid program."[96] If the program had been allowed to continue, one study estimated that the reduction in Medicaid enrollment would cause the state to lose an equivalent of 5 percent of its total state tax revenue every year in federal funding.[97]

Georgia's Bureaucratic Nightmare

If Arkansas offers an example of why work reporting requirements will reduce coverage in Medicaid expansion states, Georgia's experience illustrates how work reporting requirements are a backdoor way to prevent expansion in the first place.

Georgia Health Coverage Landscape

Georgia unfortunately falls behind on most other states on health outcomes metrics. As of 2021, Georgia had the twelfth highest death rate in the country, at 997.6 age-adjusted deaths per 100,000 people.[98] Georgia also has the fifth-highest share of people under 65 who are uninsured, at 13.6 percent of the population, which is well above the national average of 9.5 percent.[99]

Maternal mortality rates are also exceedingly high in Georgia. The March of Dimes 2024 Report Card gave Georgia an "F" on access to maternal and infant health care.[100] Georgia is ranked in the bottom quartile among states for both maternal and infant mortality.[101]

In October 2024, Forbes Advisor released a ranking of the least accessible states for health care.[102] Georgia was ranked fifth, citing high uninsured rates and second-highest percent of people who avoided the doctor due to cost.[103]

That said, Georgia has sadly long dragged its feet when it comes to increasing access to health care.

In 2014, then-Governor Nathan Deal signed legislation into law that took the decision to expand away from the Governor's office and placed it instead into the hands of the General Assembly.[104] At the time, Governor Deal cited that expanding Medicaid would be "too costly."[105]

Ten years later, the state legislature came the closest ever to passing full Medicaid expansion.[106] A bill that would have allowed Georgia to expand Medicaid by purchasing private health plans for people in the coverage gap narrowly failed by a vote of 7 to 7.[107] Republican members of the committee, State Senators Matt Brass and Carden Summers, joined the Democrats on the committee, signaling for the first time bipartisan support for full expansion in Georgia.[108]

Georgia Pathways

Despite years of activism calling for full Medicaid expansion, the Georgia General Assembly has yet to acknowledge the benefits of affordable access to health care for all Georgians. Bowing to immense public pressure, in 2019, Georgia Governor Brian Kemp led the creation of a program called "Georgia Pathways to Coverage."[109] Georgia Pathways was initially approved by the Trump Administration in 2020, then disapproved by the Biden Administration, before a federal judge allowed it to move forward.[110] The program finally went live in July 2023.[111] As of 2025, **Georgia is the only state in the country with work reporting requirements in place for Medicaid**.[112]

In Georgia Pathways, adults with incomes below the federal poverty guideline ($15,650 per year for a single adult in 2025) are newly eligible for Medicaid if they also meet the state's work reporting requirement (80 hours of qualifying activities per month) and pay mandatory premiums (premiums apply to those earning between 50 to 100 percent of the federal poverty level).[113]

Neither caregiving nor caring for children qualify as a permissible activity for the work reporting requirement.[114] This means that, according to the State of Georgia, neither a father with a seven-year-old with special needs who is unable to work, nor a mom of two caring for her own elderly mother is 'working' enough to merit Medicaid coverage.[115]

Heather Payne from Dalton worked as a traveling nurse for over a decade where she worked throughout Georgia and across the country serving patients and saving lives, including during the COVID-19 pandemic. Ironically, while she was providing care to others, Heather fell into the health care coverage gap, making too much to qualify for Medicaid but not earning enough to cover the cost of her health insurance. Her health care options were anywhere between $500 to $1,200 a month. In fall of 2022, Heather started getting headaches and noticed actions as simple as swallowing water were difficult. After saving up to pay out-of-pocket to visit a neurologist, she was told she'd had a series of small strokes. Heather is waiting to get approved for Social Security Disability Insurance, which can take years, and has no health care coverage in the meantime. She cannot work as an Emergency Room or Labor and Delivery nurse, which often requires intensive 12-hour shifts that she can no longer manage, and she has to put off essential medical procedures because she cannot afford to pay out of pocket.

As of March 31, 2025, only 7,000 individuals were actively enrolled in the program , far short of the over 600,000 people who could benefit under full expansion and even the State's own prediction of 25,028 for program enrollment.[116] In a detailed evaluation of Georgia Pathways' first year, the Georgia Budget and Policy Institute found that "66 of Georgia's 159 counties still had fewer than 10 residents who had ever been enrolled in the program" with 56 of those counties experiencing higher uninsured rates compared to Georgia's state average.[117] That same study found that the administrative cost of implementing the program was five times higher than the amount spent on actual health services through the first year of the program, averaging roughly **$13,000 per enrollee**.[118]

As a full-time caretaker for her 84-year-old father Thomas, Amanda has put her own life on hold to ensure that he receives the care he needs.

When Amanda left her two jobs in New York in October 2019 to move back to Georgia and care for her father, she knew it was the right thing to do. Thomas had suffered a hip injury and Amanda felt a duty to step up and take care of him. She recalled, "that injury was kind of a wakeup call that it was going to be necessary to have someone, one of his daughters go and be with him because he was having more trouble." What started as a temporary arrangement quickly became a full-time job.

Amanda has taken on all the household responsibilities, from appointment scheduling to bill paying, to driving and grocery shopping. She ensures that Thomas has nutritious meals, stays hydrated, and that he gets plenty of fresh air and sunshine, even if it is just by sitting on the porch or taking a walk around the neighborhood.

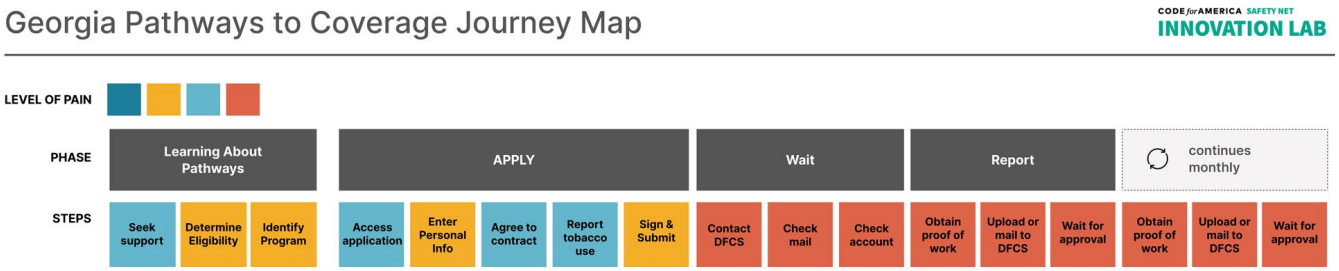
With no income, no healthcare coverage and no job prospects that allow her to adequately care for her dad, Amanda is living off her savings. Skin cancer is a major concern of hers. She also worries about what would happen to Thomas if she were to fall ill. When asked how she feels about not having access to preventative care and cancer screenings, Amanda shared, "I don't usually think about it because it is upsetting. If anything happened, it would just be very expensive, and I wouldn't know what to do."

Why the Lackluster Enrollment?

> ***"I'm fairly young. I'm 24. I'm supposed to be this technologically-savvy person and I am. But... Gateway is always changing, it's super slow, and, because they are so backed up, they'll call you one time. Your phone might only ring twice, and then all of a sudden you're getting notification that you missed your interview" - Georgia Budget and Policy Institute Interview, October 2024***

Figure 7

Georgia Pathways to Coverage Journey Map



Once individuals decide to apply, there are 11 separate steps before they get to the approval or denial stage of the program.[119] Additionally, issues with the eligibility system called Gateway, including glitches and slowness, have led to people abandoning the application process partway through.[120]

One Georgian, Kelsey, a single mother from outside Macon, said that Gateway crashed three times while she tried to enroll.[121] She tried calling the state office responsible for enrollment for help but just got passed from one voicemail to another, eventually giving up after a month of trying to get in touch with a real person.[122]

Another Georgian, Paul from outside Atlanta, said it takes him more than an hour to upload his monthly reporting data to the state to stay enrolled in the program.[123] Like Kelsey, Paul experienced glitches with the Gateway portal recounting that "he waited eight days for customer support to retrieve a password and restore his access."[124]

Some individuals who found a job, perhaps a job that did not offer health coverage, said that their income then pushed them over the edge of eligibility – set at roughly $15,500 for one person – and they were disqualified.[125]

> ***"So, they told me to get a job working at least 20 hours, so I end up getting a job. Once I got the job, they told me I'm disqualified because I make too much. So I'm like, 'Wow. This is crazy.' If someone's trying, at least, you know, help them, meet them halfway if they're trying. I can see if it's because I'm not doing anything and I'm just asking for help and just not trying to, you know, work or not trying to do something that's productive. I can understand that, but if a person is trying to do something, I feel like you shouldn't disqualify them." - Georgia Budget and Policy Institute Interview, October 2024***

Just like in Arkansas,[126] the most vulnerable people had the most difficult time enrolling in Georgia Pathways.[127] Using data from the U.S. Census Bureau,[128] the Agency for Toxic Substances and Disease Registry,[129] the Department of Health and Human Services,[130] and the Georgia Budget and Policy Institute,[131] we examined the relationship between Pathways enrollment and the vulnerability measures of that were associated with lower work reporting requirement compliance in Arkansas – lower internet access, lower vehicle access, lower high school educational attainment, and higher prevalence of people living with disabilities.[132]

We found that Pathways enrollment was extremely low in all Georgia counties regardless of their social vulnerability. The highest estimated enrollment rate was in Screven County at 2.8%. On the other end of the spectrum, Baker, Quitman, Taliaferro, and Webster Counties had no enrollees and, thus, 0% rates. Still, we found that the counties where people are most vulnerable tended to have lower enrollment rates. Figure 8 shows that as a county has less internet access, less vehicle access, lower high school educational attainment, and higher rates of people living with disabilities, the Pathways enrollment rate in the county tends to decrease.[133]

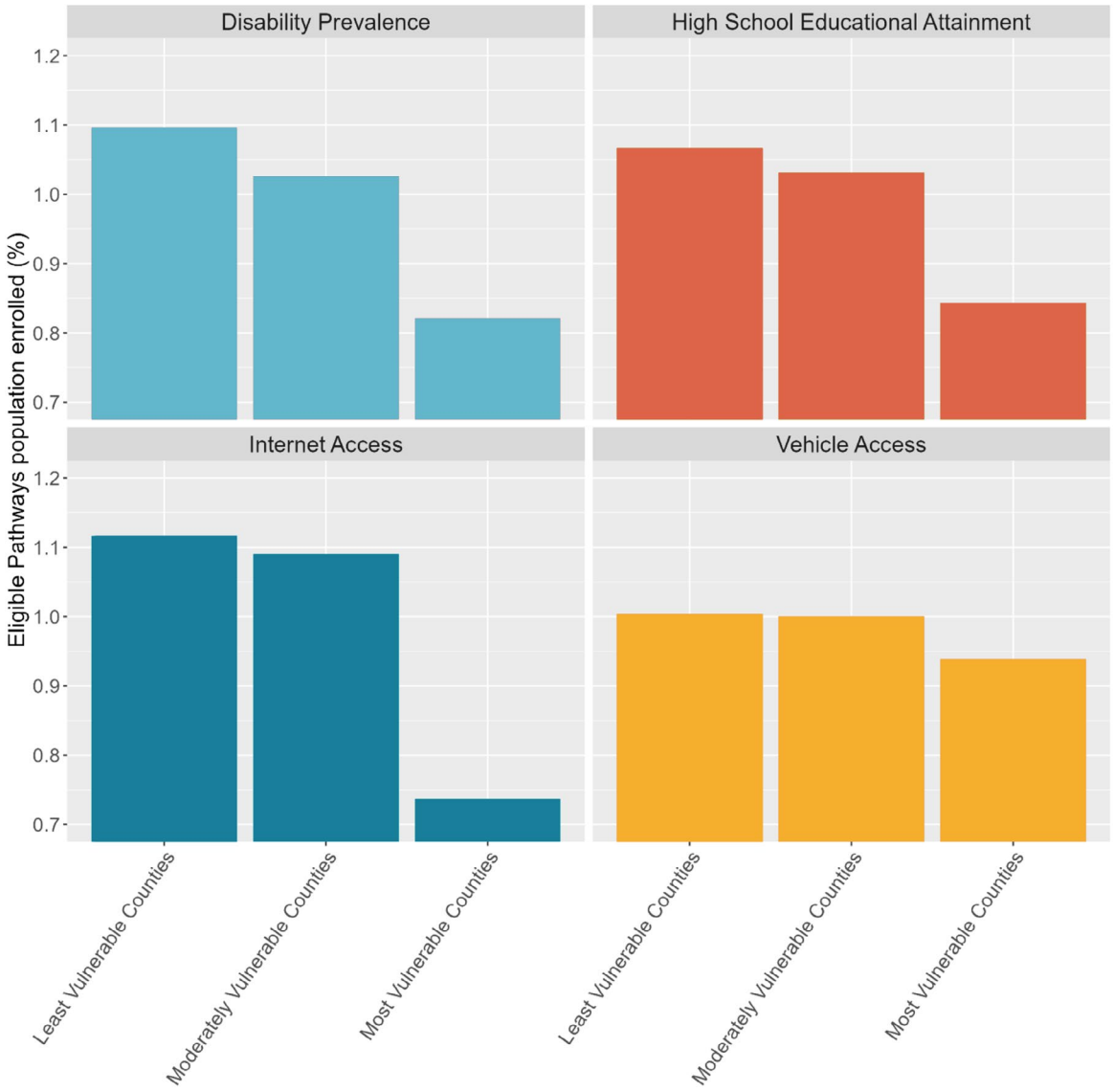


Figure 8: Georgia counties with greater social vulnerability had lower Pathways enrollment[134]
Sources: U.S. Census Bureau, Agency for Toxic Substances and Disease Registry, Department of Health and Human Services, and Georgia Budget and Policy Institute

Since Georgia Pathways was only approved for five years, the waiver is set to expire in September 2025.[135] However, despite the program's shortcomings, the Governor has already begun the process of applying for a renewal of the waiver, with some modifications to allow more people to access health coverage.[136] In announcing them, Georgia's Republican Governor Brian Kemp acknowledged that "**providing health insurance** to a family or individual with young children **may be the last piece they need to restart a career** and be on the path for a brighter future" (emphasis added).[137]

Put another way? Health coverage helps people work.

By Opting into Work Reporting Requirements, Georgia Opted Out of Growing Its Economy

If Georgia had chosen to fully expand Medicaid, rather than imposing its own onerous work reporting requirements, Georgia could have avoided extreme administrative costs and seen its economy grow.[138]

A 2024 study from the Georgia Health Initiative found that Medicaid expansion would allow Georgia to see "an increase of $3.6 billion in personal income in an average year, representing an average increase of almost $900 per household."[139] Additionally, the rural communities in Georgia who often depend the most on programs like Medicaid, would see "an average of 5,611 new rural jobs" every year in the first three years post-expansion.[140]

By contrast, imposing work reporting requirements cost the state roughly $13,000 per enrollee.[141] All told, Georgia spent $84,670,765 to insure about 1% of the individuals who might be eligible for full Medicaid expansion.[142] Had Georgia simply opted for full expansion, researchers estimate that in each of the first three years alone, Georgia's economy would grow by $9.4 billion in economic output and $5.5 billion in Gross Domestic Product (GDP) each year.[143]

Georgia versus North Carolina: A Public Policy Comparison

Georgia and North Carolina have similar demographics.

- Both states have around 10.5 million residents according to the 2020 Census.[144]
- The average median household income in Georgia is $74,632 and $70,804 in North Carolina.[145]
- In 2019, when both Georgia and North Carolina had no coverage in its Medicaid expansion population, the states' uninsured rate was 13.4 percent and 11.3 percent respectively.[146]

However, both states in the last few years have reached a fork in the road about decisions on Medicaid expansion.

Georgia – 4,323 Enrollees (in first year)	**North Carolina – 590,331 Enrollees (in first year)**
While Georgia launched onerous work reporting requirements, North Carolina decided to fully expand Medicaid. And after one year of Georgia's Medicaid waiver program, only **4,323** people were enrolled in Medicaid, well short of the state's own projected goal of between 31,000 to 100,000 people.[147]	One year after expanding Medicaid, North Carolina has enrolled **590,331** people into its Medicaid program.[148]

"A couple years ago, I was in a car accident. I was hospitalized for 2 months, and could not work after the accident.... I knew I was going to be uninsured again. I didn't know what I was going to do, and frankly, I was terrified. I still had several medical issues and unable to return to work. [Then], in October 2023, I found out that North Carolina was expanding Medicaid... To say it was relief would be an understatement. Medicaid is literally saving my life. Not only do I have regular care under a primary care provider, but I'm able to see a neurologist and other specialty medical providers. Medicaid pays for my medical equipment. I am able to receive medication at a price I can afford." - Darcy from North Carolina

Applying Work Reporting Requirements Nationwide

The work reporting requirement experiments in Arkansas and Georgia show that the people most at risk of losing healthcare coverage are vulnerable populations that lack reliable access to transportation and internet connections, have low educational attainment, and are living with disabilities. In a national analysis, we found that counties in every corner of the country face similar vulnerabilities and that healthcare access for thousands of people would be at risk if work reporting requirements were applied nationwide. Figure 9 shows a vulnerability rating for each county that reflects whether it was below the state's median county for internet access, transportation access, high school educational attainment, and the prevalence of disabilities. Counties that performed below the state's median county on all measures receive a score of 5 while counties above the state's median county on all measures score as 1. All other counties fall between 1 and 5 based on the number of measures for which they are below the state's median county.[149]

County Vulnerability to Work Reporting Requirements

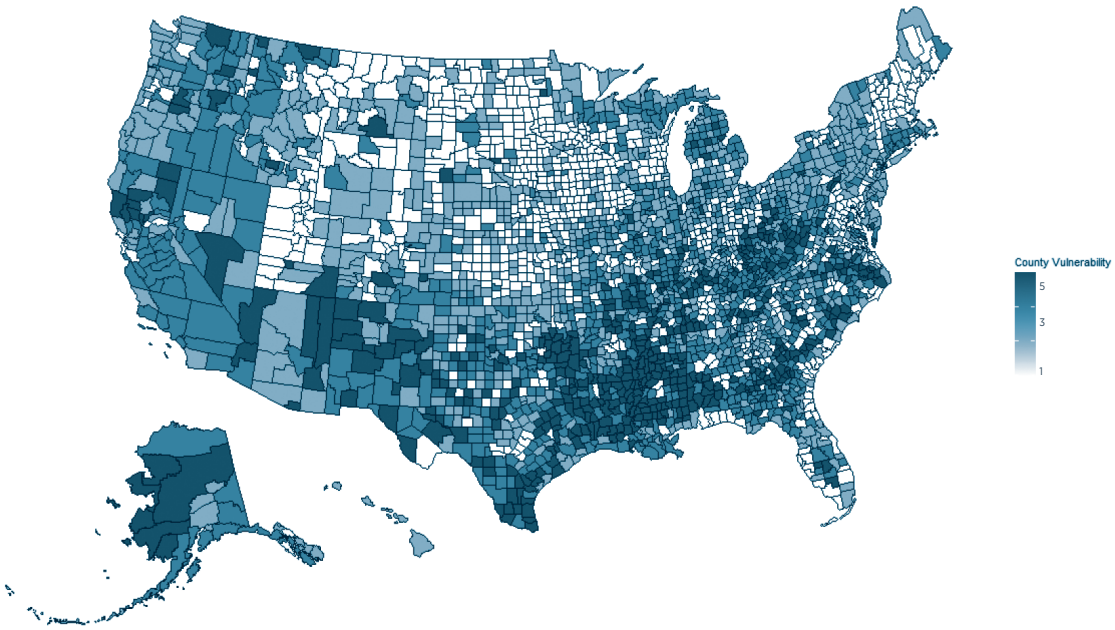


Figure 9: Counties across the country are vulnerable to Medicaid work reporting requirements
Sources: U.S. Census Bureau and the Agency for Toxic Substances and Disease Registry

We identified 458 counties that are extremely vulnerable because they are below the state's median county for all four measures. 49 states have at least one extremely vulnerable county, and more than 17 million people live in extremely vulnerable counties.[150]

- 352 extremely vulnerable counties (77%) have Medicaid coverage rates above 21% – the coverage rate in the national median county[151]

- 377 extremely vulnerable counties (82%) are mostly rural[152] counties[153]
- 370 extremely vulnerable counties (81%) were designated as full or partial geographic Health Professional Shortage Areas,[154] meaning they have a shortage of primary care, dental, and mental health providers[155]

Beyond the human cost of people losing health insurance, the administrative costs for states to implement work reporting requirements would be significant. States would have to update their eligibility systems and hire additional staff to process the increased amount of paperwork and verification requirements.[156] Arkansas spent $26.1 million[157] on its work reporting requirements program for a population of 171,000 people,[158] or $152 per person.[159] Table 1 shows the estimated cost to set up work reporting requirements at $152 per person for the currently enrolled Medicaid population in 10 states.[160] We show the 10 states with the highest estimated costs here; the estimated costs for all states are in the appendix. Altogether, states would pay more than $6 billion to implement work reporting requirements.[161]

State	Administrative cost of implementation
California	-$1,279,791,208
New York	-$633,667,632
Illinois	-$272,425,800
Ohio	-$252,009,312
Pennsylvania	-$246,597,352
Michigan	-$218,383,720
North Carolina	-$209,432,136
Florida	-$204,365,368
Arizona	-$168,469,200
Washington	-$151,363,424

Table 1: Medicaid work requirements would cost states millions of dollars in administrative costs
Source: GAO, Health Affairs, and CMS

The economic costs of work reporting requirements and other Republican proposals to cut Medicaid would also be significant and likely deplete state budgets even further. The Commonwealth Fund has estimated the impact of $880 billion in Medicaid cuts on each state's GDP and employment.[162] Altogether, the cuts would cost states nearly $100 billion in economic output and almost 900,000 jobs.[163] Again, we show the 10 states with the greatest GDP (Table 2) and job losses (Table 3); the full list of states can be found in the appendix.

State	State GDP loss
California	-$14,645,100,000
New York	-$9,061,800,000
Texas	-$5,400,100,000
Pennsylvania	-$4,427,600,000
Ohio	-$3,774,600,000
Florida	-$3,177,000,000
North Carolina	-$3,061,200,000
Illinois	-$3,033,200,000
Michigan	-$2,877,400,000
Arizona	-$2,521,400,000

Table 2: Medicaid work reporting requirements and other cuts would negatively impact state economic growth
Source: Commonwealth Fund

State	Job losses
California	-121,800
New York	-72,000
Texas	-54,600
Pennsylvania	-41,800
Ohio	-38,200
Florida	-33,200
North Carolina	-30,800
Michigan	-29,400
Illinois	-27,400
Kentucky	-24,400

Table 3: Medicaid work reporting requirements and other cuts would cost states thousands of jobs
Source: Commonwealth Fund

What Should Congress Do instead?

Health care coverage is a proven tactic that is good for the health of Americans and the health of our economy. Rather than cutting health programs, Congress should be doubling down on expanding health care access.

For example, to address concerns about low reimbursement rates for Medicaid providers, Congress could set a floor for certain essential services, like in the *Kids' Access to Primary Care Act* introduced by Senators Warnock and Murray.[164] Lawmakers should also consider finding a federal solution for the roughly 1.4 million Americans left in the coverage gap due to their states not expanding Medicaid.[165] Senator Warnock has pushed legislation, like the *Medicaid Saves Lives Act* and the *Bridge to Medicaid Act*, to do just that.[166]Additionally, Congress should consider extending or making permanent the enhanced premium tax credits for marketplace plans, as outlined in the *Health Care Affordability Act* introduced by Senator Shaheen.[167] These tax credits have shown to be even more important to providing affordable health coverage in Medicaid non-expansion states.[168]

Conclusion

States are the laboratories of democracy. Congress must pay attention to these experiments' results.

Fifteen years since the ACA have proven that Medicaid expansion is a boon for the economy and gives Americans the leg up they need to get back to work or continue caring for their loved ones.

By contrast, the costly and deadly experiences of Arkansas and Georgia show that work reporting requirements result in fewer people with health care coverage and more costs at taxpayer expense. Nationwide Medicaid work reporting requirements would terminate health care for millions of hardworking families, shutter rural hospitals, increase burden on state economies, and result in the unnecessary and preventable deaths of countless Americans.

If Republicans in Congress truly believe in policies that energize the economy, they must reject proposals to nationalize these failed experiments.

Appendix

Methodology

Figure 8

We use data from various sources to capture the factors that the Urban Institute found were associated with low compliance with work reporting requirements in Arkansas – limited vehicle access, limited internet access, low educational attainment, and serious health limitations, i.e. disability.[169] To estimate county level educational attainment, vehicle access, and disability prevalence, we used measures from the 2022 Social Vulnerability Index (SVI) from the Agency for Toxic Substances and Disease Control.[170] We use the percentage of persons with no high school diploma (25+)[171], the percentage of households with no vehicle available,[172] and the percentage of the civilian noninstitutionalized population with a disability.[173] For a measure of county level internet access, we used the U.S. Census Bureau's 2022 Local Estimates of Internet Adoption.[174]

To measure county-level compliance with Georgia Pathway's work reporting requirement, we used two sources.

- Data from the Georgia Budget and Policy Institute on the number of people who had enrolled in Georgia Pathways in each county as of June 30, 2024.[175]
- Estimates from the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services of the number of people in each county without health insurance and whose household incomes are below 100% of the federal poverty level (FPL). [176] This is our best estimate for how many uninsured people in each county would be eligible for Georgia Pathways as it expands Medicaid to most people under 100% FPL.

For each measure, we divided counties into three buckets based on their vulnerability ranking (e.g. 53 counties with the lowest access to internet were in Bucket 1, the 53 counties above them were in Bucket 2, and the 53 counties with the highest internet access were in Bucket 3). We then determined the average value for the vulnerability measures across the counties in each bucket (e.g. average internet access across the 53 counties in Bucket 1) and the average value for the Pathways enrollment measure across the counties in each bucket (e.g. average Pathways enrollment across the 53 counties in Bucket 1). The values for all three buckets across the four vulnerability measures are displayed in Figure 8.

Figure 9

To show county-level vulnerability to Medicaid work reporting requirements in each state, we use the same data as we used in Figure 8 on vehicle access, internet access, high school educational attainment, and the prevalence of disability. Then, for each state, we calculated the median county for internet access, high school education, vehicle access, and the prevalence of disability. Next, for each county, we calculated a score from 1-5 based on the number of factors where the county was below the state median. If a county was never below the state median, it received a 1, while if it was always above the state median, it received a 5. All other counties fall between 1 and 5 based on the number of measures for which they are below the state's median county.

Tables 1, 2, and 3

To estimate the cost of administering work reporting requirements in each state (Top 10 states shown in Table 1), we used data from the Center for Medicare and Medicaid Services on the number of Medicaid enrollees per state[177] and the $152 per-person cost of administering Arkansas's work reporting requirements program. We use $152 per person as this is the total cost of Arkansas's program ($26.1 million)[178] divided by the number of people subject to the requirements (171,000).[179] Local sources have also used the $152 per-person estimate.[180] We used the number for Arkansas because unlike Georgia Pathways, which was a policy to expand Medicaid, Arkansas's work reporting requirements applied to the existing Medicaid population, which is more similar to what Republicans in Congress are trying to do. To obtain the estimate of the Medicaid population that might be subject to work reporting requirements, we subtract the column "Child Enrollment (Medicaid Child + CHIP Enrollment)" from the column "Total Medicaid and CHIP Enrollment." We then multiplied the estimated population for each state by $152.

The estimates for state GPD and job losses from an $880 billion Medicaid cut come directly from a report published by the Commonwealth Fund.[181]

Table 4 shows that estimated GDP and job losses from an $880 billion Medicaid cut and the expected administrative costs of implementing work reporting requirements for all states and Washington, D.C.

State	State GDP loss	Job losses	Administrative cost
Alabama	-$897,300,000	-9700	-$42,074,056
Alaska	-$322,100,000	-3000	-$22,977,840
Arizona	-$2,521,400,000	-24100	-$168,469,200
Arkansas	-$938,700,000	-10300	-$60,442,496
California	-$14,645,100,000	-121800	-$1,279,791,208
Colorado	-$1,297,900,000	-12000	-$101,197,952

Connecticut	-$984,200,000	-8200	-$85,201,472
Delaware	-$321,800,000	-3000	-$21,099,272
District of Columbia	-$441,000,000	-3500	-$24,469,416
Florida	-$3,177,000,000	-33200	-$204,365,368
Georgia	-$1,623,800,000	-16800	-$84,813,416
Hawaii	-$322,200,000	-2800	-$37,944,368
Idaho	-$451,500,000	-4600	-$24,164,808
Illinois	-$3,033,200,000	-27400	-$272,425,800
Indiana	-$2,168,500,000	-21300	-$144,797,480
Iowa	-$865,000,000	-9000	-$51,158,488
Kansas	-$483,700,000	-4900	-$19,765,928
Kentucky	-$2,368,500,000	-24400	-$114,835,240
Louisiana	-$1,878,700,000	-20300	-$121,525,976
Maine	-$452,400,000	-4300	-$31,349,088
Maryland	-$1,519,300,000	-14300	-$124,849,608
Massachusetts	-$2,088,600,000	-17300	-$142,956,152

Michigan	-$2,877,400,000	-29400	-$218,383,720
Minnesota	-$1,791,700,000	-16800	-$86,517,944
Mississippi	-$857,500,000	-9900	-$30,791,856
Missouri	-$2,160,300,000	-21600	-$99,457,096
Montana	-$268,900,000	-2800	-$18,715,456
Nebraska	-$499,400,000	-5000	-$25,058,264
Nevada	-$969,300,000	-9200	-$65,796,392
New Hampshire	-$228,900,000	-2000	-$14,408,232
New Jersey	-$2,257,700,000	-19300	-$145,332,672
New Mexico	-$1,165,800,000	-11900	-$62,659,112
New York	-$9,061,800,000	-72000	-$633,667,632
North Carolina	-$3,061,200,000	-30800	-$209,432,136
North Dakota	-$127,800,000	-1300	-$8,130,784
Ohio	-$3,774,600,000	-38200	-$252,009,312
Oklahoma	-$1,159,500,000	-12300	-$70,360,800
Oregon	-$1,797,800,000	-16800	-$125,554,432

Pennsylvania	-$4,427,600,000	-41800	-$246,597,352
Rhode Island	-$381,400,000	-3500	-$27,781,192
South Carolina	-$1,025,800,000	-10700	-$61,056,728
South Dakota	-$164,200,000	-1700	-$9,241,600
Tennessee	-$1,693,600,000	-15700	-$90,165,792
Texas	-$5,400,100,000	-54600	-$149,734,440
Utah	-$651,100,000	-6900	-$24,868,264
Vermont	-$189,200,000	-1800	-$14,860,584
Virginia	-$2,289,600,000	-21600	-$143,606,104
Washington	-$2,031,900,000	-16600	-$151,363,424
West Virginia	-$580,600,000	-5800	-$45,991,096
Wisconsin	-$1,094,400,000	-11000	-$95,173,432
Wyoming	-$61,100,000	-800	-$3,064,320

Table 4: Estimates for all states for GDP and job loss from an $880 billion Medicaid cut and for administrative costs of implementing work requirements
Sources: GAO, Health Affairs, CMS, and Commonwealth Fund

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