

# Health Care in Motion

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## Working Mythology: A Deeper Dive on the Folly of Work Requirements in Medicaid

Back in January, we wrote about the Trump Administration's [invitation](#) for states to deny Medicaid benefits to people that can't satisfy new work requirements. In January, the Centers for Medicare and Medicaid Services (CMS) sent [a letter to State Medicaid Directors around the country](#), encouraging them to apply for a waiver of normal Medicaid rules. The waiver process, [as established in the Social Security Act](#), is designed to give states the flexibility to test drive innovative ways to further the purpose of Medicaid. But with the January letter, CMS invited states to use the waiver process as a means to stray far outside of the guardrails that constitute minimum safeguards for Medicaid beneficiaries and further a harmful and likely illegal policy instead.

Despite the fact that the approval of work requirements rests on [very shaky legal grounds](#), the Trump Administration has already approved work requirements for three states—Kentucky, Indiana, and Arkansas. [At least seven other states have already applied for waivers](#) to impose similar requirements in their Medicaid schemes, and a number of other states, such as [Connecticut](#) and [Louisiana](#), are discussing the possibility of following suit. This trend will not go unchallenged. Advocates are proceeding with a [class action lawsuit](#) against both the federal government and Kentucky officials for their implementation of work requirements in that state's Medicaid program.

In this Health Care in Motion, we'll do a deep dive on the folly of work requirements. We'll go through the January ["Dear State Medicaid Director" letter](#), section-by-section, to pick out the myths CMS relies on to support its endorsement of work requirements and debunk them one at a time.

### **CMS Myth #1: Imposing a work requirement is a "shift from prior agency policy," but the shift is "anchored in historic CMS principles that emphasize work to promote health and well-being"**

On page 3 of its January letter, CMS concedes that the imposition of a work requirement is indeed a shift from prior agency policy. CMS rushes to reassure the public, however, that that shift is still anchored in historic CMS principles. ["The lady doth protest too much, methinks."](#)

We'll get to whether the shift really is "anchored in historic CMS principles" in a minute. But here's why it matters at all: the legality of administrative agency action is governed by [the Administrative Procedure Act \(APA\)](#). The APA prohibits government agencies (like CMS) from acting in a way that is, amongst other things, arbitrary, capricious or an abuse of discretion. **That means CMS can't just make things up as it goes.** Its decisions must be thoughtful and supported by substantial evidence.

Indeed, the Kentucky [lawsuit pending](#) against CMS raises this exact point—plaintiffs assert that federal approval of the Kentucky waiver request was an unlawful action, as defined by federal law, specifically the APA.

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## Reality: Imposing a work requirement on Medicaid eligibility is a dramatic and unprecedented shift away from historic CMS principles

The clearest evidence that approving state requests to impose a work requirement diverges from “historic CMS principles” is that CMS explicitly rejected such requests in the past! For example, CMS sent letters to [Pennsylvania](#) (2014), [Indiana](#) (2015), and [Arizona](#) (2016), rejecting their requests to impose work requirements on their respective programs (or indicating such requests would be rejected). It said, point blank, that work requirements had the potential to [“undermine access to care and do not support the objectives of \[Medicaid programs\].”](#)

Additionally, a [comparison](#) of the 2015 CMS Waiver Approval Criteria and the [2017 Revised CMS Waiver Approval Criteria reveals noticeable differences](#). If CMS’s shift is anchored in historic principles, they shouldn’t be that different, right?

Take a look for yourself:

### 2015 CMS Waiver Approval Criteria:

1. Increase and strengthen overall coverage of low-income individuals in the state;
2. Increase access to, stabilize and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. Improve health outcomes for Medicaid and other low-income populations in the state; or
4. Increase the efficiency and quality of care for Medicaid and other low-income populations through invitations to transform service delivery networks.

### 2017 Revised CMS Waiver Approval Criteria:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
2. Promote efficiencies that ensure Medicaid’s sustainability for beneficiaries over the long term;
3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Pretty big jump, right?

All 4 criteria in the 2015 list made mention of serving low-income individuals and populations. In 2017? **0 mentions**. This is particularly shocking given that the [statutory language](#) that defines Medicaid’s purpose specifically requires that Medicaid “furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, **whose income and resources are insufficient to meet the costs of necessary medical services.**”

Instead, the 2017 list of criteria is filled with corporate buzzwords like “promote efficiencies,” “strengthen beneficiary engagement,” and “enhance alignment between Medicaid policies and commercial health insurance products to facilitate

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smoother beneficiary transition.” Moreover, with phrases like “[promoting] upward mobility, greater independence...[and] responsible decision-making” at its core, the 2017 list smacks of the kind of [morality politics](#) that places blame for health outcomes squarely on the shoulders of vulnerable populations, without consideration of the systemic and institutional barriers that might be at play too.

Thus, the second part of CMS’ statement—that its shift is rooted in historic CMS principles—is self-serving, conclusory and unsupported.

## CMS Myth #2: It’s unambiguously legal for CMS to approve states’ requests for waivers that condition Medicaid eligibility on fulfilling a work requirement

Underlying the entire January letter is the assumption that CMS has the legal authority to approve a state’s proposal to condition Medicaid eligibility on work.

## Reality: A judge could rule otherwise—by finding that HHS does not have the authority to approve states’ requests for waivers that condition Medicaid eligibility on a work requirement

As we mentioned in the introduction, the CMS approvals of the Kentucky, Indiana, and Arkansas’s waiver requests rest on [shaky legal ground](#). For one, CMS cannot arbitrarily implement a sudden shift in policy that undermines the purpose of the statute, as discussed above. But even asides from the sudden shift, allowing a work requirement is substantively illegal in and of itself.

Let’s be clear: it’s not so unusual to grant waivers of normal Medicaid rules and approving waiver requests *can* be perfectly legal. For example, [states have used waivers](#) to expand Medicaid eligibility to certain targeted populations, like people living with HIV, and to expand certain classes of services such as increasing the scope of covered mental health services. Waiving federal Medicaid requirements for certain states is the idea that [states are laboratories of democracy](#) come to life. It lets states test an idea out to see if it would be a good candidate to roll it out nationally.

In fact, a [provision in the Social Security Act](#) specifically allows the federal government to waive the requirements of the Medicaid statute, in order to allow states to undertake “demonstration projects.” The federal government can give states permission to deviate from normal Medicaid rules if those states want to “test drive” creative initiatives that are likely to further the objectives of Medicaid.

But that’s just it! **It’s *only* legal to grant this kind of waiver if the demonstration project is likely to further the [objectives of Medicaid](#)** and there’s a persuasive argument that work requirements do *not* further Medicaid’s ultimate objectives. As we saw above, it’s such a strong argument CMS has explicitly made it itself: in its [2016 rejection of Arizona’s work requirement proposal](#), CMS wrote that adding such a requirement to its program could “undermine access to care and [would not] support the objectives of the program.”

So what *are* the objectives of Medicaid? In 1965, Congress authorized the creation of Medicaid by enacting [Title 19 of the Social Security Act](#), which allows federal dollars to be spent by states, as far practicable under the conditions there:

1. [Providing medical assistance](#) to families with children and to aged, blind, or disabled individuals, whose income and resources are limited; AND
2. Helping people attain or retain [capability for independence or self-care](#).

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In 2010, Congress enacted the Affordable Care Act, which included a provision called “Role of Public Programs,” explicitly mandating that state plans must provide a minimum level of essential health care coverage to even able-bodied adults without children, if their income falls below 133% of the federal poverty line. You have probably read that the Supreme Court held that the federal government can’t enforce this mandate by withholding federal Medicaid funding if states failed to comply, effectively rendering this a state option rather than a mandate.

CMS itself [translated all of this](#) into plain language: these statutes make it permissible to enroll “very-low income individuals who are not otherwise eligible under mandatory eligibility categories” in Medicaid coverage. The CMS [webpage explaining the history of Medicaid](#), puts it best: Medicaid programs provide health coverage for low-income people.

And don’t let the Social Security Act’s “independence or self-care” language confuse you. In context—namely, within a statute creating a medical assistance program—that independence refers to [physical independence that can be achieved through rehabilitation and other such medical services](#). Those words shouldn’t be twisted to mean the *economic* independence or “upward mobility” that [CMS is suddenly talking about](#).

**All this to say: If work requirements are *not* likely to further these objectives, it would be illegal for CMS to approve waiver requests.**

**And of course, studies show that work requirements would most likely achieve the exact opposite result. [The most common effect of work requirements is that recipients lose benefits](#).** For an example of this, let’s look at data from the federal government’s Temporary Assistance for Needy Families (TANF) program, which provides cash assistance to low-income families. TANF imposes work requirements like the ones being proposed for Medicaid. The data shows that the work requirements led to [reduced program enrollment](#)—not because fewer families needed public support, but because the rigid work requirements imposed a barrier to access. In fact, [a 2014 report from the Congressional Research Service](#) noted that “the TANF caseload reduction generally resulted from **fewer eligible families actually receiving benefits.**”

## CMS Myth #3: Work requirements can improve health outcomes

On page 2 of the January letter, CMS writes that “while high-quality health care is important” for health and well-being, “productive work and community engagement...may improve health outcomes.” Translation: CMS believes that going to work makes us healthier. It points to data that shows higher earnings are positively correlated to longer lifespans and that unemployment leads to poorer health outcomes.

## Reality: Conditioning health care benefits on fulfilling work requirements can have dangerous outcomes

Correlation between two factors does not mean that one causes the other. [After all, no one reasonably believes that ice cream causes people to drown](#). The principle that correlation does not necessarily imply causation is why CMS’s premise that work requirements can improve health outcomes requires a closer look.

In fact, a closer look reveals that the chain of causation likely flows the other way—being healthy enables you to work. For instance, [a study by Ohio’s Department of Medicaid](#) found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.

It is precisely because Medicaid meets enrollees’ health needs that enrollees are able to focus on finding and keeping employment. Taking away Medicaid benefits without any legitimate commitment—or even lip-service—to increasing the

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availability of jobs across the state or assisting beneficiaries with finding and keeping employment could lead to fewer people being able to hold a steady job. That's the exact opposite result of what CMS is supposedly aiming for.

Finally, although the CMS letter nominally requires states to describe the strategies they would implement to help beneficiaries meet work requirements, CMS explicitly states it is prohibited from using Medicaid dollars to fund those strategies. If encouraging people to work has enough of a direct causal relationship with health outcomes that states can condition healthcare coverage upon a work requirement, why can't they use Medicaid dollars to help people find work?

The Administration might try to argue that the Social Security Act defines "medical assistance" and lists things that fall under that definition—none of which cover services to help people find work. (Spoiler alert: it's probably because services that help people find work don't have much to do with health care and Congress didn't think to include—or even exclude—it...).

But, that same definition has a catch-all provision. Medical assistance can include "any other medical care and any other type of remedial care recognized under State law," specified by the Secretary of Health and Human Services. So if the federal government is so convinced that helping people find work is a way to directly improve health outcomes in a state, it may deem it so—and pay for it using federal dollars.

In fact, there is even a [provision in the Social Security Act](#) that specifically [authorizes CMS to allow federal Medicaid dollars](#) to go towards costs that would otherwise not be eligible, if those costs are associated with an approved waiver request. So if CMS is sure that work requirements can improve health outcomes, why don't they invest in that?

**Now, don't get us wrong.** We're not saying work is bad for you. Quite the opposite: Work, as well as helping people become independent, is important and valuable. But conditioning health care coverage on fulfilling a work requirement gets the chain of causation backwards.

## CMS Myth #4: Work requirements will "promote work and other community engagement"

Ok, so we've established that working probably doesn't, by itself, make you healthy. But to take a step back, is it even true that that work requirements will make people work?

On page 3 of the January letter, CMS writes that work requirements present a "new opportunity for promoting work and other community engagement." Translation: CMS believes that by holding a basic human need like health care hostage, people will be motivated to start working.

## Reality: Work requirements don't actually increase employment

The facts don't hold up on this one. For example, let's look at data from TANF again. The [2014 report by the Congressional Research Service](#) found that TANF's work requirements didn't improve work participation rates! Under TANF, the rate of participation in work and related activities has stayed around 30% during the life of the program. What does this mean? Imposing work requirements puts a huge burden on state administrators and beneficiaries alike, and doesn't even have the desired effect of increasing employment! High effort, low reward.

And here's why it makes sense that employment rates won't increase as a result of work requirements. First off, [most Medicaid recipients already work](#), so they don't need the government to "encourage" them to do so. Next, the economics show that, [from a financial standpoint, working is nearly always substantially better than not working](#). If people *can* work and earn more money, you can bet they will!

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In addition, as the Center for Law and Social Policy puts it, “cutting people off from public benefits because of arbitrary [work requirements make it harder to work](#) because people will be hungrier, less healthy, and more stressed.” As discussed above, [a study by Ohio’s Department of Medicaid](#) found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs. In fact, [work requirements may reduce people’s ability to work](#), “by putting health coverage out of reach and causing them to have more (or more serious) health problems.”

And lastly, if public “handouts” discouraged people from working, you’d think Medicaid expansion would reduce employment, right? Quite the opposite: a 2018 study found that [Medicaid expansion had positive or neutral effects on employment](#) in the states that did expand their programs. For example, [a study of Michigan’s Medicaid expansion](#) found that 55% of new beneficiaries who were out of work said Medicaid coverage made them better able to look for a job.

## **CMS Myth #5: Aligning Medicaid work requirements with SNAP or TANF requirements could “reduce the burden on both states and beneficiaries”**

Conveniently ignoring the fact that TANF’s work requirements haven’t helped increase workforce participation, CMS proposes that states further replicate the TANF model. On page 5 of the January letter, CMS proposes that states might align their proposed Medicaid work requirements with the requirements of TANF and the Supplemental Nutrition Assistance Program (SNAP), a federal program that provides nutritional assistance to low-income individuals. The letter implies that this alignment will streamline the administrative process for both state administrators and Medicaid beneficiaries themselves.

## **Reality: SNAP and TANF requirements are poorly administered and aligning Medicaid work requirements would have disastrous outcomes**

There’s [plenty of evidence](#) that shows the imposition of work requirements to be an administrative nightmare. Many working Medicaid beneficiaries are likely to face obstacles verifying their work status. In today’s labor market, the lowest-paid Americans have to take jobs that give limited benefits and have [volatile work schedules](#) that might mean working enough hours one month and not enough the next.

And perhaps more compelling for lawmakers is the fact that verifying work requirements is costly for the states themselves. It takes administrative time and resources to track and verify beneficiaries’ workforce participation and it’s unclear that the administrative cost would be offset by any savings in funding Medicaid. In fact, government reports on the SNAP and TANF programs have shown that [verification takes significant time and collaboration between program staff and employers](#) and that [implementation of complex requirements can be error-prone](#), often leading to eligible recipients being denied benefits and ineligible people being granted them!

## **CMS Myth #6: States are able to “ensure that individuals with disabilities are not denied Medicaid for their inability to meet work requirements”**

On page 6 of the January letter, CMS explicitly acknowledges that some individuals may be “classified for Medicaid purposes as non-disabled” and yet may have a disability as per the definitions in the Americans with Disabilities Act or other laws that would prevent such individuals from meeting work requirements. The letter assumes States will ensure that those persons are not denied Medicaid coverage by including “reasonable modifications” to the work requirements, implying that states will be able to adjust its requirements for certain populations.

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## Reality: Historical data shows that states cannot ensure that intricate work requirements are applied correctly, and administrative errors can have a severe impact on vulnerable populations

As we saw above, [a government study](#) has shown that implementation of complex requirements can be error-prone and can lead to eligible recipients being denied benefits and ineligible people being granted them.

This risk of administrative error is particularly dangerous because of the disproportionately large impact an error would have on vulnerable populations like those with chronic illnesses and disabilities—populations protected by the Americans with Disabilities Act and other civil rights laws.

Again, we can look to historical data to support this. A [study by professors at UCLA and the University of Pennsylvania](#) found that individuals with physical and mental health issues are disproportionately likely to be sanctioned for failing to meet public benefit programs' work requirements. Their study cited a [federal government report](#) finding that TANF recipients are seldom made aware of the good-cause exemptions they might qualify for. Further, it may be difficult for these individuals to navigate the bureaucracy or even travel to appointments to be assessed for exemption.

A [study using data from the federal government's 2015 National Health Interview Survey](#) estimates that almost half of the 11 million Medicaid enrollees at risk of losing coverage due to work requirements have serious health problems, even though that number excludes those on disability programs. Other analyses of TANF show that “most participants facing significant barriers to employment (such as physical or mental health limitations) never found work, and the requirements left some recipients and their children worse off because they wound up with neither earnings nor cash assistance. The consequences mean that these families [fell deeper into poverty.](#)”

## CMS Myth #7: States will take care to “respond to the local employment market,” as well as other “market forces and structural barriers”

On page 7 of the January letter, CMS suggests that States will ensure that their proposed work requirements are suitably adapted to the realities of the labor market in their respective states. States will take into consideration whether beneficiaries may be in regions with limited employment opportunities or facing particular economic stress, as well as structural barriers that certain individuals may face in complying with a work requirement.

## Reality: Imposing work requirements at all shows an acute lack of awareness about the realities of today's labor market and other structural barriers to employment

Unfortunately, imposing a work requirement that reflects the realities of today's labor market is something of an oxymoron. The United States' lowest income workers have two common characteristics that make this the case: (1) they are [more likely to work for employers that don't provide health care coverage](#) (and therefore more likely to need Medicaid) and (2) they have the [most irregular work schedules](#), with spikes and dips in hours, due to working jobs that are seasonal or otherwise can't guarantee a stable number of hours per week.

In short: imposing work requirements reflects, in itself, a [“profound misunderstanding of the realities of low-wage jobs.”](#)

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To underscore just how backwards these work requirements can be, take a look at the internal inconsistencies in a proposal like [Kansas' December 2017 proposal](#). Kansas wants to require 80 hours of work per month. But since the income-based eligibility threshold for Medicaid is so low in Kansas, some beneficiaries would get pushed out of Medicaid eligibility as soon as they worked 80 hours of a minimum-wage paying job. For example, based on the [Kansas Medicaid eligibility thresholds for parents or caretakers](#), a single parent with one child who earns more than \$522 per month is ineligible for Medicaid, and a person working 20 hours at minimum wage would earn [\\$580](#). Thus, if a single parent with one child meets the proposed work requirement, he or she will not only lose Medicaid coverage, but will also be pushed into the “[Medicaid coverage gap](#).” He or she will earn too much to be Medicaid-eligible, but will earn too little to qualify for [private insurance subsidies from the federal government](#), which are only available to individuals who earn at least 100% of the federal poverty line (in 2018, [\\$1,372 per month](#) for a family of 2). And as discussed above, a worker earning minimum wage is [unlikely to be able to get health care coverage from their employer](#). After deducting the [added costs often associated with employment for this population](#), such as the costs of transportation, uniforms, and childcare, our hypothetical single parent would have very little leftover for health insurance, but would have **nowhere else to turn for health coverage**.

**Finally, work requirements do not address the structural barriers faced by individuals living with chronic illnesses and/or episodic disabilities** (conditions associated with unpredictable periods of illness or disability). People living with disabilities continue to [experience disparate employment and economic outcomes](#), relative to their non-disabled peers. A study from the United States Government Accountability Office suggests this is not because of their lack of effort—the most significant barrier may be [“attitudinal, which can include bias and low expectations for people with disabilities.”](#) And there’s plenty of evidence to support such a suggestion. For example, the Equal Employment Opportunity Commission (EEOC) reports that between 1997 and 2014, the EEOC received over 4,000 allegations of discriminatory workplace practices against people living with HIV and has filed several lawsuits against [employers that refused to hire or terminated people, due to their HIV status](#). And for plainer evidence, take a look at this article in a human resources industry publication; it’s titled [Chronic Conditions—Frustrating, Annoying? Yes, But You Must Accommodate](#), illustrating the negative attitudes individuals with chronic illnesses face in the labor market.

## **CMS Myth #8: CMS will support “reasonable public input processes...to consider the views of Medicaid beneficiaries, applicants, and other stakeholders”**

Page 7 of the January letter pledges that CMS will consider the views of various Medicaid stakeholders in reviewing a state’s application for a waiver, as required by [federal regulations](#). The regulations mandate that CMS solicit public comment regarding the state’s application and that CMS will not render a final decision until it has had 45 days to receive and consider public comments.

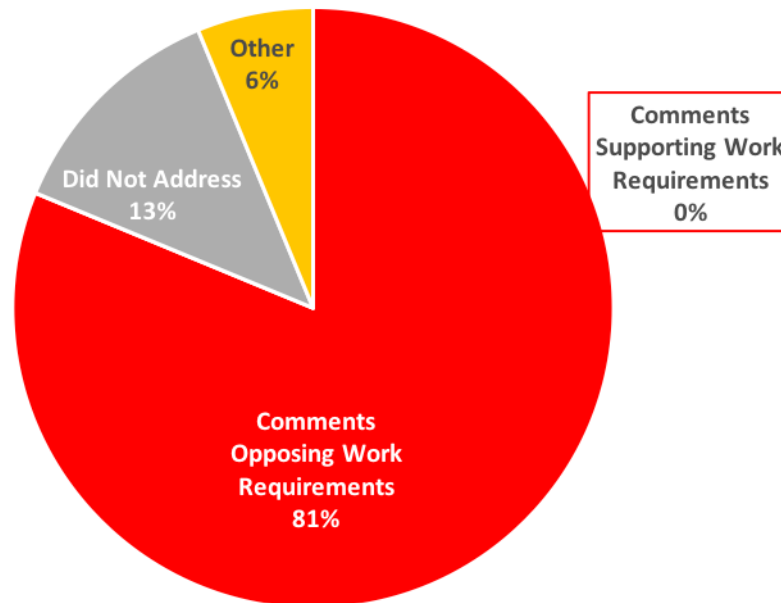
## **Reality: CMS has ignored staunch and near-unanimous calls from stakeholders to reject requests to incorporate work requirements into state Medicaid programs**

In June 2017, [Arkansas submitted a request](#) to, among other changes, incorporate a work requirement into its Medicaid program. During the federally mandated 30-day public comment period, 28 organizations submitted 16 comments about Arkansas’s application. [13 of those 16 comments strongly opposed the inclusion of work requirements](#). The 3 remaining comments either did not speak to the work requirement proposal or urged Arkansas to define the requirement more precisely. *See Chart 1 below; see also Appendix A.*



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Chart 1: Breakdown of Public Comments on Proposal Incorporating Work Requirements to the Arkansas Medicaid Program



The public comments reveal almost unanimous disapproval of the work requirements, supported by explanations and data suggesting that the work requirements [would constitute a radical change in the Medicaid program and not increase sustained employment](#); [undermine access to care and not support the objectives of Medicaid](#); [disproportionately impact rural Arkansas communities with higher than average unemployment rates](#); [create gaps in coverage that will lead to more expensive treatment when eligibility is eventually regained](#); [create administrative burden and complexity that can often lead to eligible people inadvertently losing coverage](#); and so on. Basically everything catalogued above in Myths #1-7. Comments on other state’s piggybacking proposals are similarly distributed heavily towards opposition.

But in March 2018, [CMS approved the request](#). The approval letter tries to cover its bases by including a “Consideration of Public Comments” section. Not surprisingly, the letter strategically avoids mentioning this overwhelming opposition and simply notes “opposing commenters expressed general disagreement” and that “other comments expressed concerns that these requirements would be burdensome on families or create barriers to coverage.” CMS pays lip service by “acknowledging” these concerns and assuring the public that it has conditioned its approval upon Arkansas’s promise to implement mitigating procedures such as reaching out to beneficiaries to educate them on how to comply with the new requirements and “using an online reporting system to make reporting easy for enrollees.”

Long story short—it doesn’t look like CMS put much stock in the views of Medicaid stakeholders or the public input process.

## Putting it all together

A closer look at the January letter from CMS reveals the agency’s dangerous disregard for the realities facing many Medicaid beneficiaries, the harmful implications of work requirements, and the legal limitations of its authority. Conditioning Medicaid eligibility on fulfilling a work requirement ignores the fact that [most Medicaid beneficiaries who can work already do so](#) and

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that the administrative burden simply puts another hurdle between those individuals and the public assistance Medicaid was designed to deliver.

Further, work requirements fail to address [the nuanced economics of being a low-income American family](#). The nature of low-wage employment in today's labor market can make hour-based work requirements difficult to meet, push families into the "Medicaid gap" where they are ineligible for Medicaid or private insurance subsidies, and increase invisible costs (such as childcare and transport) that quickly offset the limited wages of such employment.

Conditioning Medicaid eligibility on fulfilling a work requirement also ignores data that shows that [work requirements don't actually increase employment](#). CMS fails to acknowledge evidence that work requirements accomplish neither their purported goal of increasing "community engagement" nor Medicaid's ultimate objective of providing medical assistance to those who can't afford it. Instead, precedent suggests that the requirements will have a net negative impact due to [poor administration](#) and a [disparate impact on vulnerable populations](#).

At best, CMS displays profound misunderstanding—and at worst, dangerous indifference—about the impact work requirements will have on the Medicaid population and about work requirements' ability to further the objectives of Medicaid. And what's worse, CMS is pursuing this transformation in an effort to further the [political narrative](#) of the current administration. In any event, by authorizing work requirements without properly assessing their potential implications, CMS may be acting illegally and [beyond the scope of its statutorily granted authority](#).

Advocates need not stand idly by and watch this weaponization of a safety-net program. Readers should use the facts, data and empirical information discussed in this article and to advocate against additional proposals to condition of Medicaid eligibility on satisfying punitive work requirements. Using the arguments presented above, readers should participate in state and federal comment periods and educate state legislators and executives about the dangers such work requirements pose.

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