HEALTH POLICY

Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations

National and State Estimates for 2028

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Executive Summary

The One Big Beautiful Bill Act (OBBBA) or H.R.1, the budget reconciliation bill signed into law in July of 2025, included many important changes to the Medicaid program, including the mandatory implementation of work requirements for adults ages 19 to 64 who have Medicaid coverage through the Affordable Care Act (ACA) expansion in the 41 states (including the District of Columbia) that have expanded Medicaid under the ACA.[1] The work requirements will also apply to Medicaid waiver programs in some nonexpansion states.[2] OBBBA requires that expansion/waiver applicants and enrollees work, attend school, or participate in other specified activities as a condition for receiving Medicaid coverage unless they qualify for an exemption, such as being parents of children age 13 or younger or being medically frail. States have the option to implement work requirements in 2026, but must begin implementing them by January 1, 2027, unless they have sought and obtained permission from the Secretary of Health and Human Services to delay implementation.

The law gives states some flexibility in implementing work requirements, and forthcoming guidance from the Centers for Medicare & Medicaid Services (CMS) is expected to further clarify the extent of states' choices. Variation in state decisions and operational capacity will likely lead to variation in how work requirements are implemented, including on the extent to which states rely on existing data sources to determine compliance and exemptions through ex parte processes (i.e., automatic verification or data-matching); how medical frailty and other exemptions are defined; what documentation for compliance or exemptions may be required; the number of months applicants must meet work requirements before enrolling; the number of months enrollees must comply between eligibility redetermination periods; and how frequently verification of compliance or exemption is required.

In this analysis, we consider potential national, state, and subgroup implications for Medicaid expansion enrollment (and waiver enrollment for people below 100 percent of the federal poverty level in Wisconsin, a nonexpansion state) of OBBBA's work requirements. We project enrollment in 2028, the second year of implementation, assuming all states implement work requirements by January of 2027. We build on a new analysis of the OBBBA provision that mandates Medicaid expansion enrollees' eligibility be redetermined every six months, which found that it would lower Medicaid expansion enrollment in an average month by 2.0 to 3.1 million in 2028 relative to the annual redeterminations

that were required under prior law (Buettgens et al. 2026).[3] We then use the Urban Institute's Health Insurance Policy Simulation Model to estimate the impacts of work requirements on retention of Medicaid coverage among expansion and waiver enrollees (hereafter, expansion enrollees), potential reenrollment, and new applications.

Given the flexibilities states have with respect to implementation and likely variation in their administrative approaches and capabilities, we provide estimates of coverage changes among expansion enrollees under three potential scenarios:

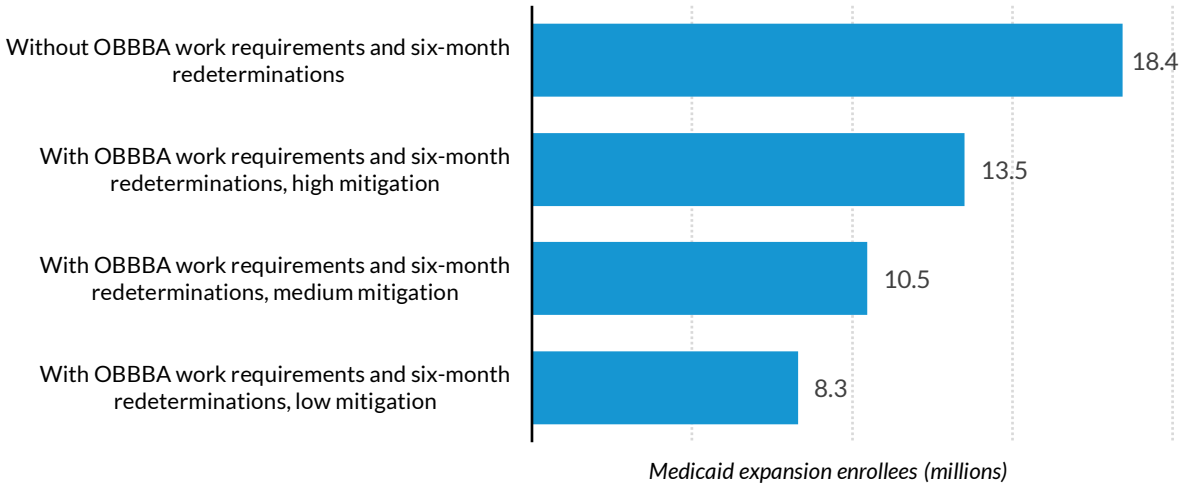
1. ***High mitigation***, which is defined as implementation and policy choices that would use extensive automatic data-matching for eligibility redeterminations and for assessing compliance with work requirements, along with imposing the minimum allowable work effort and broader definitions of exemptions such as medical frailty, to maintain Medicaid coverage among people who are meeting work requirements or exempt from them;
2. ***Low mitigation***, which is defined as implementation and policy choices that would use less automatic data-matching for redeterminations and for assessing compliance with work requirements which would, in turn, require that more enrollees take action to maintain coverage such as providing the state with documentation of their work hours, along with imposing greater levels of work effort and narrower definitions of exemptions; and
3. ***Medium mitigation***, in which the scope and effectiveness of automatic data-matching and definitions of exemptions are between the high and low mitigation scenarios.

Under all three scenarios, we project that the OBBBA work requirement would result in much lower Medicaid expansion enrollment in 2028 relative to under prior law, compounding the coverage losses resulting from more-frequent redeterminations. Our key findings are as follows:

- Combining the effects of six-month redeterminations and work requirements, we project that between 4.9 and 10.1 million fewer people will be enrolled in Medicaid expansion coverage in an average month in 2028 than under a scenario without either of these two policies, an enrollment decline of between 27 and 55 percent among those subject to work requirements.
    - » Under both policies, enrollment would be 8.3 million, 10.5 million, and 13.5 million under low, medium, and high mitigation, respectively, compared with 18.4 million without either policy (figure ES.1).

FIGURE ES.1

Medicaid Expansion Enrollment: Projected Average Monthly Enrollment in 2028, With and Without OBBBA's Work Requirements and Six-Month Redeterminations, Under High, Medium, and Low Mitigation Scenarios



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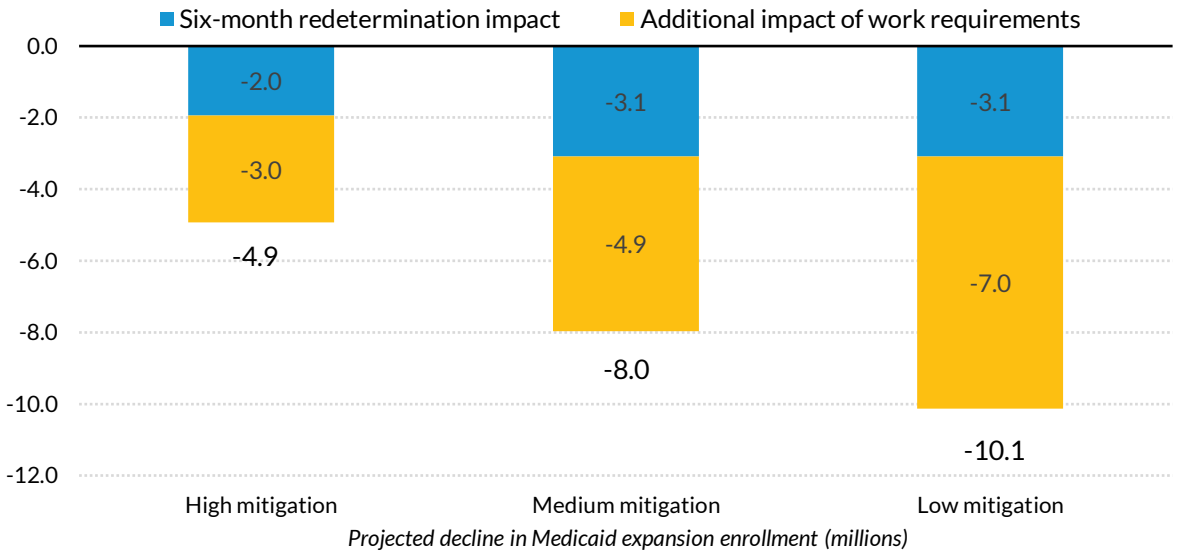
Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: Enrollment refers to average monthly enrollment. Estimates are rounded to the nearest hundred thousand. Estimates include waiver enrollment in Wisconsin. See executive summary page vi for the definition of high, medium, and low mitigation scenarios.

- We project coverage losses of between 3.0 and 7.0 million expansion enrollees because of work requirements alone, on top of the declines in expansion enrollment of between 2.0 and 3.1 million in 2028 from six-month redeterminations (figure ES.2).[4]
  - » Even with the most robust mitigation efforts in maintaining enrollment for people who are exempt from or are fulfilling the work requirements in every state, the incremental effect of OBBBA's work requirements would reduce average monthly Medicaid expansion enrollment in 2028 by 3.0 million relative to a scenario without them.
  - » Enrollment would be much lower with more limited mitigation efforts regarding work requirements. We project that Medicaid expansion enrollment would decline due to work requirements by an additional 7.0 million under the lowest mitigation scenario and by 4.9 million under the medium mitigation scenario relative to a scenario with six-month redeterminations but without work requirements.

FIGURE ES.2

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA's Work Requirements and Six-Month Redeterminations, By Mitigation Scenario



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Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: Enrollment refers to average monthly enrollment. Estimates include waiver enrollment in Wisconsin. Estimates are rounded to the nearest hundred thousand. See executive summary page vi for the definition of high, medium, and low mitigation scenarios.

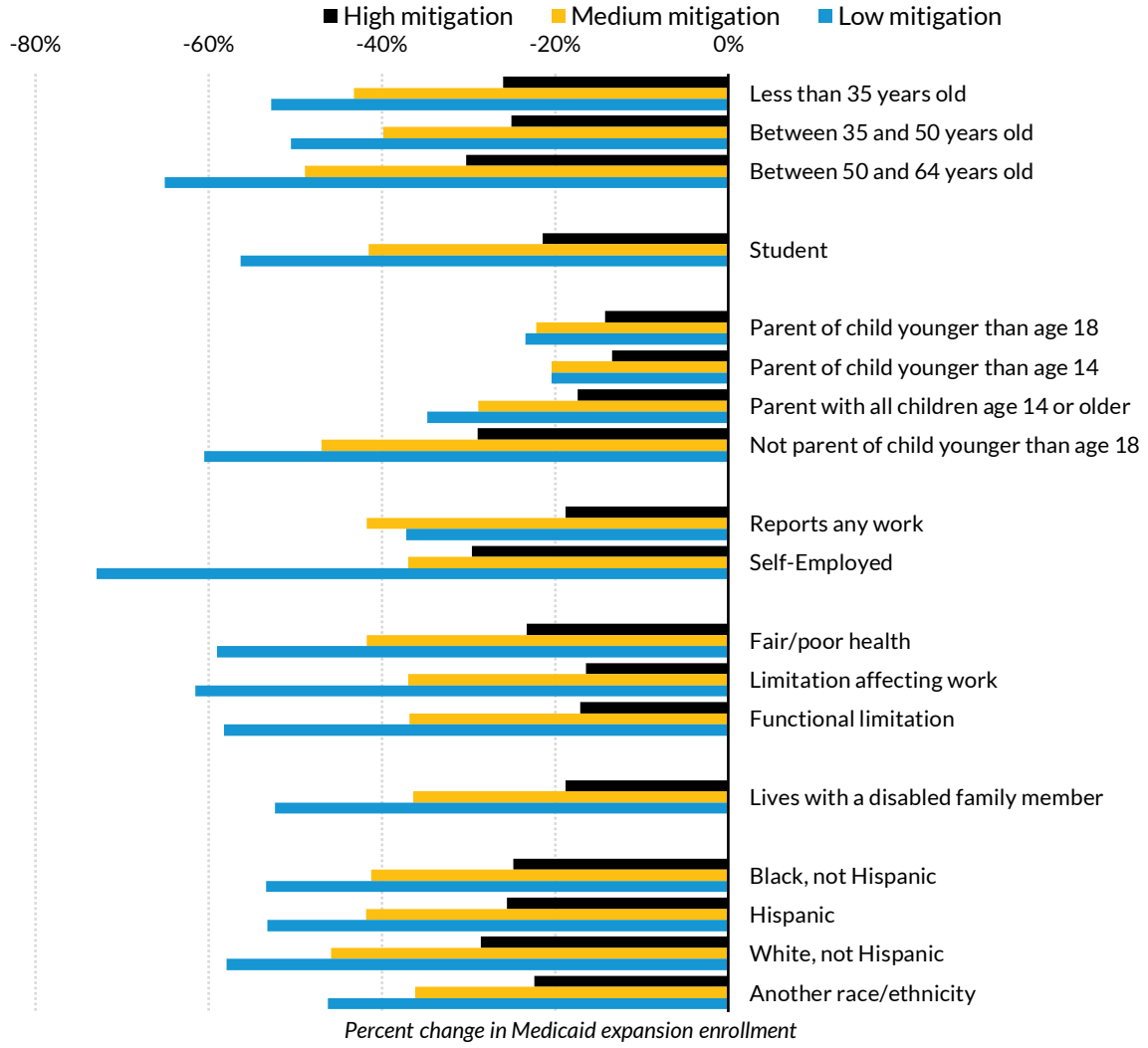
- Our projections find that the work requirement and six-month redetermination provisions of OBBBA would result in lower enrollment in every expansion state, with the relative size of state-level enrollment declines varying within a given scenario based on differences in the characteristics of each state's Medicaid expansion population and certain pre-OBBBA state policy decisions.[5]
  - » The combined effects of these two provisions would result in lower Medicaid enrollment in every expansion state, with expansion enrollment falling by 37 to 68 percent in the low mitigation scenario, by 30 to 54 percent in the medium mitigation scenario, and by 18 to 33 percent in the high mitigation scenario.
  - » Because states are currently still devising implementation plans, our state-level coverage projections assume each state makes the same policy and operational choices within each of the three mitigation scenarios. Ultimately, the actual enrollment change in each state will depend on individual state choices and capacities regarding the robustness of mitigation efforts.

- With more limited mitigation with respect to work requirements, we find that many people who may qualify for an exemption or who are working will go without Medicaid coverage due to their states' more limited efforts and/or capacities to conduct automatic data matches, challenges they face complying with reporting requirements, and instability in their participation in approved activities over time. But even with robust mitigation efforts, we project that many will lose Medicaid despite potentially meeting work requirements or qualifying for an exemption.
  - » Under both work requirements and six-month redeterminations, enrollment would fall by 19/37 percent with high/low mitigation among those who are working because some who are meeting the work requirement would be unable to manually verify compliance and because others are working less than 80 hours per month but do not have monthly income equivalent to 80 work hours at the federal minimum wage (figure ES.3). The increased frequency of redeterminations would also reduce workers' coverage.
  - » Other subgroups face the prospect of even larger coverage losses if states cannot address gaps in available data. Because self-employment income is particularly difficult for states to automatically verify, we estimate that between 30/73 percent of self-employed people subject to work requirements would lose Medicaid with high/low mitigation.
  - » Though states must provide exemptions for adults who are medically frail or have special medical needs, these exemptions may be difficult for states to verify using available data, or states may define them narrowly, excluding many enrollees and applicants with disabilities[6] or serious health conditions. We estimate that enrollment would fall for many people who may qualify for a medical frailty exemption but would not receive one, including declines between 16/62 percent among those with an impairment or health condition that they report inhibits their ability to work, and between 17/58 percent among those with a functional limitation under high/low mitigation, respectively. Enrollment would fall by between 23/59 percent among those reporting they are in fair or poor health. Although self-reported health status and ability to work are not conditions for defining medical frailty, this highlights the impact that the policy would have on those with higher health care needs.
  - » States are also required to exempt caregivers for people with disabilities. However, because of states' limited ability to automatically determine caregiving status, we estimate that Medicaid expansion enrollment would decline by 19/52 percent under high/low mitigation scenarios among those living with a family member with a disability, for whom they may serve as a caregiver.

» We project that people ages 50 to 64 would disproportionately lose Medicaid under work requirements and six-month redeterminations, with enrollment losses of between 30/65 percent under high versus low mitigation, mainly because they are less likely to be parents living with dependent children younger than age 13 and less likely to be automatically found to have satisfied the work requirement through employment.

FIGURE ES.3

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Selected Subgroups, by Mitigation Scenario



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Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: Enrollment refers to average monthly enrollment in thousands. See executive summary page vi for the definition of high, medium, and low mitigation scenarios. Expansion enrollment here refers to all enrollees subject to work requirements, including Medicaid waiver enrollees in Wisconsin.

As implementation continues beyond 2028, the magnitude of the coverage drops of these two provisions would be expected to increase as the cumulative effects are felt. At the same time, coverage drops could be attenuated if states introduce new processes, such as increasing ex parte renewals or expanding the data sources they use to determine compliance and exemptions, which would yield more robust mitigation than modeled in our high mitigation scenario. However, the frequency of ex parte renewals declined nationwide in 2025 as fewer states used flexibilities provided by CMS related to the unwinding of the Medicaid continuous coverage requirement and made other state-specific policy changes (Buettgens et al. 2026). If state ex parte renewal rates decline further across most states in advance of these Medicaid changes, enrollment losses would increase and could be closer to our low mitigation scenario.

These results point to the need for several actions by both states and CMS. For instance, states that want to minimize coverage losses under the new requirements will need to quickly develop and upgrade data systems to facilitate data-matching. CMS guidance will also need to clarify several issues, including how certain qualifying activities and exemption criteria will be defined, allowable data sources for assessing compliance and exemption, and documentation requirements for applicants and enrollees who must provide additional information to the state. CMS guidance could also set specific standards to serve as a "floor" for efforts states are expected to make to ensure people are not wrongfully denied coverage or disenrolled. However, while OBBBA requires CMS to issue such guidance by June 2026, states are already making changes to their data systems to be ready to implement on schedule, reinforcing the need for the timely release of these regulations. CMS could also require that states track how enrollment changes in response to work requirements and consider pausing implementation in states where coverage losses indicate compliance and exemption determinations may not be working as intended.

It is important to note that these projections are based on publicly available information about the implementation of OBBBA's work requirements at the time of our research in late 2025/early 2026. Projections could change as new CMS guidance dictates policy and practice options for states and vendors, or as new information about state implementation plans and new investments by vendors or other partners becomes available.[7] Moreover, our analysis has several limitations, detailed below, including the lack of information in our model on the full range of activities and characteristics needed

to determine compliance with and exemptions from the requirements. The limited prior experience with Medicaid work requirements also introduces considerable uncertainty in our estimates.

This analysis finds that millions will go without Medicaid coverage under OBBBA's work requirements and six-month redeterminations, even under the most robust implementation scenario we consider, including many people who appear to meet or be exempt from work requirements but may face challenges documenting their compliance or exemption. In addition, it shows that the Medicaid coverage of several million people will depend on state implementation choices, including those related to data-matching.

Reductions in Medicaid coverage could reduce adults' access to care, place financial burdens on their families and health care providers, cause psychological distress, increase morbidity and mortality, and, in opposition to work requirements' stated purpose, ultimately make it harder for them to maintain employment (McMorrow et al. 2016, 2017; Pandey et al. 2025; Schpero, Zhang, and Civelek 2025; Sommers 2013; Sommers, Gawande, and Baicker 2017; Wherry, Kenney, and Sommers 2016; Wherry and Miller 2016).[8] Coverage losses could also extend beyond the expansion/waiver group to other Medicaid enrollees and affect managed care organizations, local health care systems, and state and local economies (Haught et al. 2025; Ku et al. 2025; Musumeci et al. 2025).[9]

Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations

In this report, we use the Health Insurance Policy Simulation Model (HIPSM) to project national, state, and subgroup implications in 2028 of the One Big Beautiful Bill Act's (OBBBA) work requirements for adults ages 19 to 64 who have Medicaid coverage through Affordable Care Act (ACA) expansions (as well as waiver enrollees in Wisconsin). Analyses of coverage losses because of work requirements build on analyses of coverage losses under OBBBA's six-month eligibility redeterminations for expansion enrollees (Buettgens et al. 2026). Given the flexibilities states will have with respect to implementation and likely variation in their administrative approaches and capabilities, we present a range of projections representing high, medium, and low mitigation of work requirements. The following section provides background on OBBBA and prior experience with Medicaid work requirements. Subsequent sections describe our data and methods, present key results, and discuss implications.

Background

OBBBA's Work/Community Engagement Requirement

OBBBA, also known as H.R.1, establishes "Medicaid community engagement requirements for certain individuals."[10] To qualify for ACA expansion coverage or for coverage under certain 1115 waivers,[11] applicants and enrollees will have to work or participate in a work program (such as job training)[12] or community service for at least 80 hours per month, be enrolled in an educational program at least half-time, engage in a combination of these activities for 80 hours per month, or have monthly income equivalent to working 80 hours at the federal minimum wage unless they qualify for an exemption.[13] Exemptions to the work requirement are specified for certain groups, including the following:

- American Indians/Alaska Natives (AIAN)

- parents, guardians, or caretaker relatives for children 13 years or younger or for people with disabilities
- foster care youth and former foster care youth younger than age 26
- veterans with total disability ratings
- those complying with Temporary Assistance for Needy Families (TANF) work requirements
- people in households receiving Supplemental Nutrition Assistance Program (SNAP) benefits who are not exempt from SNAP work requirements
- those who are medically frail or otherwise have special medical needs as defined by the Department of Health and Human Services Secretary, including those who are blind or disabled, have a substance use disorder, have a disabling mental disorder, have physical, intellectual, or developmental disabilities that significantly impair their abilities to perform activities of daily living, or have serious or complex medical conditions
- those who are pregnant or entitled to postpartum medical assistance
- those who are participating in a drug addiction or alcohol treatment/rehabilitation program
- those who are currently or have recently been incarcerated

States may also elect to grant temporary "hardship" exemptions for those receiving inpatient care,[14] traveling outside the community for an extended period to get treatment for a serious or complex medical condition, or living in areas with emergencies or disasters declared by the President or high unemployment rates (i.e., the lower of 8 percent or 1.5 times the national rate).

Applicants must be found compliant with or exempt from the requirement in at least one month immediately before applying for the program to enroll, and enrollees will have to be found compliant or exempt for at least one of the six months between eligibility redeterminations to remain enrolled. However, states have discretion to require compliance or exemption for up to three consecutive months before applying and for up to six months (whether consecutive or not) between redeterminations for those already enrolled.

According to OBBBA, states shall verify compliance and exemptions using "reliable information available to the State (such as payroll data or payments or encounter data…) without requiring, where possible, the applicable individual to submit additional information." CMS has emphasized that states are expected to take a "data-first"[15] approach to implementation of work requirements, and recent

guidance from CMS clarified that "States must establish processes and first attempt to use reliable information available to the state, including from the individual case record or information obtained through reliable data sources, to establish whether an individual met the community engagement requirement or was not required to do so" (Brillman 2025). Moreover, states must deem an individual as having met the work requirement if he/she qualifies for a mandatory exemption and, according to the statute, are not required to seek verifying information resulting in such deeming from the individual (Steinberg 2025).

OBBBA does not address the processes that states must use to identify exemptions and does not explicitly require that states use specific data sources to assess compliance or exemptions. Moreover, OBBBA includes no new funding for job or skills training or assistance with job search or placement, and provides no new resources to help address barriers to work, such as transportation, lack of access to stable housing, or limited job availability.

States face several operational choices under OBBBA, including the extent of reliance on data sources to determine compliance and exemptions through ex parte (i.e., automatic verification) processes; how medical frailty and other exemptions are defined; whether and what additional documentation will be required and how it can be provided; whether to adopt any of the hardship exemptions; and the number of months that nonexempt applicants and enrollees will be required to comply with work requirements before enrolling in Medicaid expansion coverage and between redetermination periods. Some of these choices will be at the states' discretion, while others may be limited by CMS. OBBBA requires CMS to issue guidance by June of 2026, which is expected to identify processes that states can or must use to identify compliance and exemptions. At the time of writing, while CMS has shared initial guidance about work requirements implementation (Brillman 2025), it has not offered detailed guidance on flexibilities states will have, and key questions remain, including about verification for people whose compliance or exemptions cannot be determined automatically, the length of medically related exemptions, and how compliance activities such as community service and part-time education will be defined (Diana and Mudumala 2026).[16] Presently, states are preparing for implementation based on available information.[17]

States must begin enforcing the work requirements by January 1, 2027, unless they have sought and obtained permission from the Secretary of Health and Human Services to delay implementation. At this point, no state has applied for a delay, as far as we know. States may also enforce work requirements earlier than January 1, 2027, via a waiver or state plan amendment. So far, only Nebraska has announced a plan to begin implementing Medicaid work requirements under OBBBA earlier, having committed to beginning by May of 2026.[18] The law appropriates $400 million for implementation: $200

million to CMS and $200 million to states ($100 million equally among all states to which the requirements apply and $100 million based on states' Medicaid population size) in fiscal year 2026.

The Congressional Budget Office (CBO) estimated that the work requirements provision of OBBBA would reduce Medicaid enrollment in the expansion category by approximately 5.7 million in 2034, with 2.9 million people subject to the requirement not being exempt or compliant and an additional 2.8 million people losing Medicaid because of the additional steps in the application process, and increase the number of people without health insurance by 5.3 million.[19] Though it is unclear how many people CBO estimates would be subject to work requirements in 2034, the baseline used in a CBO analysis of an earlier version of the bill assumed 18.5 million Medicaid expansion enrollees would be subject to them once fully implemented in all states and that work requirements would reduce Medicaid expansion enrollment by 28 percent.[20] Because our estimates differ from CBO's in several important ways (e.g., they pertain to a different time period and are modeled conditional on the new six-month redetermination requirements), the projections in this report are not comparable to those made by CBO.[21]

Though CBO does not provide state-level projections, we would expect the extent of coverage losses under work requirements to vary substantially across states, including because of state variation in traditional (Section 1931) eligibility thresholds for parents and thus the size and composition of adults eligible for expansion coverage; the level of each state's minimum wage relative to the federal minimum wage and thus how many workers would have monthly income equivalent to working 80 hours at the federal minimum wage; the health and economic characteristics of each state's expansion population; and state implementation capacity (e.g., extent of automatic data-matching to determine compliance and exemptions, including whether Medicaid and SNAP data systems are integrated) and policy choices (e.g., length of time applicants and enrollees must be compliant or exempt before enrolling or between redeterminations).

A RAND report projecting state-level budget and enrollment impacts of OBBBA's Medicaid provisions estimates 19.7 million adults will be subject to work requirements in 2027 and that Medicaid enrollment will decline by 5.3 million by 2034 because of this provision, based primarily on analysis of 2023 American Community Survey (ACS) data (Rao et al. 2026). Their estimate includes approximately 3.5 million people who could not be identified as compliant or exempt in their data and were assumed not to increase their work hours to meet the requirement, as well as additional individuals who would be compliant or exempt but would lose coverage because of administrative and informational barriers. Variation in their state-level estimates reflects differences in employment and other characteristics of states' expansion populations as well as differences in rates of procedural disenrollment in 2025. Their

approach differs from ours in several ways, for instance, by assuming state mitigation efforts will mirror current procedural disenrollment patterns and identifying medical frailty exemptions based on reports of having two or more of the six functional limitations that the ACS asks about, whereas we model medical frailty exemptions based on the relevant federal statute and prior state policies. They also anticipate more than 900,000 people will lose Medicaid by 2034 because of six-month redeterminations, though estimates for each individual provision do not account for overlap with other OBBBA provisions.

Prior Experience with and Motivations for Medicaid Work Requirements

Proponents of Medicaid work requirements argue that requiring adults to work or engage in community service as a condition of Medicaid enrollment will increase their self-sufficiency and self-esteem, and lead to greater employment and incomes, which, in turn, will improve their health and well-being.[22] According to current CMS leadership, the new community engagement requirements will "restore the dignity of work and lift people out of poverty" and put them on a "path to purpose and prosperity."[23] In contrast, those opposing work requirements in Medicaid contend that they run counter to Medicaid's central purpose, which is to provide affordable health insurance and access to needed health care among low-income and disabled people, and argue that they will undermine people's health by reducing access to health care without increasing employment or income.[24] Prior research has found that most adults enrolled in Medicaid expansion coverage already work or attend school and that nearly all the remainder have characteristics such as illness or disability that should exempt them from work requirements (Hinton et al. 2025; Karpman et al. 2025b).

Research based on the limited prior experience with work requirements in Medicaid found that they reduced health insurance coverage without increasing employment in the single state, Arkansas, that fully implemented them for people enrolled in an existing Medicaid expansion program (Gangopadhyaya and Karpman 2025; Sommers et al. 2019, 2020). In addition, enrollees in several states that began advancing work requirements reportedly experienced several barriers to successfully reporting their work and exemptions (Engel-Rebitzer et al. 2024; Hill and Burroughs 2019; Hill, Burroughs, and Adams 2020; Musumeci, Rudowitz, and Hall 2018; Rudowitz, Musumeci, and Hall 2019; Sommers et al. 2019, 2020). Following new guidance released in 2018, under the first Trump administration, 13 states sought and received CMS approval to make employment or participation in work-related activities a condition of Medicaid eligibility for nonpregnant, nondisabled, working-age adults as part of Section 1115 demonstration projects (Chan 2025; Guth and Musumeci 2022; MACPAC 2020; Musumeci, Garfield, and Rudowitz 2018). Of the states seeking to apply work

requirements to expansion enrollees, only Arkansas had fully implemented its Medicaid work requirements for an initial cohort of adults, and New Hampshire had implemented to the point where it was poised to begin suspending coverage because of the work requirements, but then halted implementation before anyone was disenrolled.

The experiences in both Arkansas and New Hampshire demonstrate the importance of states determining enrollees' compliance and exemption automatically using data-matching to minimize enrollment impacts. Arkansas and New Hampshire automatically exempted or deemed compliant between half and two-thirds of enrollees subject to work requirements using information available from Medicaid applications and state databases, such as parental status, medical frailty, wages consistent with working the minimum required number of hours, or being compliant with work requirements in other means-tested benefit programs (Arkansas Department of Human Services 2018c; Gillespie 2017; Hill and Burroughs 2019; Hill, Burroughs, and Adams 2020; Karpman, Haley, and Kenney 2025b; Musumeci, Rudowitz, and Hall 2018). Among the remaining adults who were not automatically exempted or deemed compliant and were therefore required to take action (i.e., report their work activities or request an exemption), 72 percent in Arkansas and 82 percent in New Hampshire were classified as "noncompliant" in the first month of the reporting requirement, and this basic pattern held as implementation advanced in Arkansas (Arkansas Department of Human Services 2018a,b).[25] Overall, Arkansas disenrolled more than 18,000 adults ages 30 to 49, or approximately 1 in 4 of those initially subject to the work requirements, for noncompliance over four months in 2018, and then paused disenrollment because of a court decision in early 2019 (Wagner and Schubel 2020). New Hampshire was on the verge of disenrolling close to one-third of its Medicaid expansion population before suspending implementation (Karpman, Haley, and Kenney 2025b; Wagner and Schubel 2020).[26]

Enrollees in Arkansas and New Hampshire faced a range of barriers to compliance with the work requirements, including low awareness or understanding of the policy, confusion related to state notices, and difficulties accessing or using online portals and other reporting systems (Greene 2019; Hill and Burroughs 2019; Hill, Burroughs, and Adams 2020; Musumeci, Rudowitz, and Hall 2018; Musumeci, Rudowitz, and Lyons 2018; Sommers et. al 2019). Of note, Arkansas allowed monthly attestation of work activities or exemptions without requiring enrollees to submit documentation, but still did not achieve high reporting rates among enrollees who were required to submit reports.

Subsequent research found that more than 95 percent of enrollees who had been subject to Arkansas's work requirement appeared to qualify for an exemption or were working the required number of hours (Sommers et al. 2019). Moreover, three independent studies, drawing on different data sources, found that Arkansas's work requirement was associated with an increase in the number of

uninsured adults and no increase in employment (Engel-Rebitzer et al. 2024; Gangopadhyaya and Karpman 2025; Sommers et al. 2019).[27]

Currently, Georgia, a state that did not adopt the ACA's Medicaid expansion, is the only state applying work requirements to its Medicaid program. Under Georgia's Pathways program, a Section 1115 waiver, Medicaid coverage is available to adults with incomes up to 100 percent of the federal poverty level (FPL) who provide documentation showing they are already working or participating in work-related activities for 80 hours per month. Enrollment in Georgia's Pathways program in the program's first year of 4,231 fell far short of the over 31,000 estimated to be enrolled that year in the state's approved waiver application, despite significant spending on systems changes, outreach, and administration of the program (Chan 2024, 2025). By the end of the second year, enrollment in Pathways reached just over 8,000 people, constituting between six and seven percent of the target population, and an independent analysis found that the program has not led to a statistically significant decrease in uninsurance or a statistically significant increase in employment in the state (Johnson et al. 2025). Georgia has recently made changes to its waiver in its renewal request, including the elimination of the monthly reporting requirement of qualifying activities and the addition of caregiving for a child younger than age 6 as a qualifying activity, but it may need to make further modifications to comply with OBBBA.[28] As noted above, OBBBA's work requirements are assumed to apply to certain Section 1115 applicants and enrollees with incomes below 100 percent of FPL in both Georgia and Wisconsin (Meuse 2025); however, CMS has not yet definitively indicated to which programs they will apply.

Data and Methods

Baseline Medicaid Expansion Enrollment

This analysis uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to project Medicaid enrollment effects of OBBBA's work requirements and six-month redeterminations for adults with expansion coverage and, in Wisconsin, 1115 waiver coverage, in 2028.[29] HIPSM is a microsimulation model of the US health care system, focused on the nonelderly, noninstitutionalized population, and designed to estimate the cost and coverage effects of proposed policy changes. It is based on 2012–13 American Community Survey data and draws on the Medical Expenditure Panel Survey (MEPS) and Current Population Survey, among other data sources. The model's baseline is regularly updated to reflect changes in relevant federal and state laws and policies, premium increases, population growth, changes in the composition of the population, general inflation, and the most recent

published Medicaid and Marketplace enrollment and costs in each state. In this analysis, we assess the enrollment effects of OBBBA's work requirements in every state as if their implementation were complete by 2028 (without good-faith waivers from CMS). More information on HIPSM is available from Buettgens and Banthin (2020).

This analysis updates estimates of state-level Medicaid expansion enrollment from prior HIPSM baselines, incorporating the most recent administrative data since states completed unwinding of the Medicaid continuous coverage requirement in place during the COVID-19 public health emergency, to project enrollment in 2028. Our primary sources for postunwinding enrollment were adult and child enrollment from CMS monthly enrollment reports[30] and state websites. We obtained enrollment data—particularly Medicaid expansion enrollment—from several state websites, reflecting state-reported enrollment as of the third quarter of 2025 (most commonly August 2025).[31] For the 29 expansion states that reported publicly available data on ACA expansion enrollment, we use the most recently reported total as of September 2025. For the remaining 12 expansion states, we estimated the expansion population using CMS monthly enrollment data for adults, adjusting for the historical trend of enrollment for adults qualifying through disability-based eligibility pathways and those older than age 64 (which are generally very stable over time), and other adults not in the expansion groups.[32] We compared these estimates to expansion enrollment in December 2024 (the most recent available at the time of our analysis), collected by CMS from the Medicaid Budget and Expenditure System (MBES). (These numbers are not directly applicable because the unwinding of the Medicaid continuous coverage requirement was still in progress when these were submitted.) In this analysis, we only consider waiver enrollment in one nonexpansion state, Wisconsin, and do not assess potential changes in enrollment in Georgia's Pathways program, where enrollment impacts would depend on the extent to which the state is required to align work requirements under its existing waiver with the provisions of OBBBA. We project that enrollment in Wisconsin's Section 1115 waiver program will be about 166,000, reflecting 2025 enrollment. After calibrating our model, total Medicaid enrollment was modestly higher than in the previous baseline from last year, but a larger share of adult enrollees was in the Medicaid expansion group. Our analysis assumes that about 18.4 million people would be subject to work requirements in 2028.[33] Our definition of the Medicaid expansion population excludes sample members who appear to be entitled to or enrolled in Medicare Part A or Medicare Part B, a group specified in OBBBA as exempted from work requirements.

We model the effects of OBBBA's Medicaid work requirements for expansion enrollees and applicants on Medicaid expansion enrollment by comparing reported or imputed characteristics of sample members to OBBBA's mandated work requirement compliance activities and exemption

categories. We do not include optional short-term hardship exemptions that states may choose to adopt for certain individual and community scenarios (described below under limitations).

Our analysis draws on prior research projecting coverage losses under an earlier proposal to establish federal Medicaid work requirements (Karpman, Haley, and Kenney 2025a, b). That analysis was informed by implementation experiences in Arkansas and New Hampshire in 2018–19, which showed the importance of states using available data to automatically verify compliance and exemptions and the risks of coverage loss among people who face challenges navigating reporting processes (Hill and Burroughs 2019; Hill, Burroughs, and Adams 2020).[34]

Modeling Compliance Activities

Table 1 lists compliance and exemption categories for OBBBA's work requirements, along with whether and how they are measured in our model. It also describes the extent to which these characteristics and activities could be automatically identified via data matches that state Medicaid agencies could likely access.

TABLE 1

OBBBA Work Requirement Compliance and Exemption Activities/Characteristics

Availability in the HIPSM model and examples of data sources available to states for automatic verification

Compliance activities	Availability in the HIPSM model	Examples of existing data sources that may be available for automatic verification by states
Working at least 80 hours per month	x	Commercial databases such as The Work Number; SNAP administrative data
Monthly income equivalent to 80 hours per month at federal minimum wage[a]	x	State quarterly wage data; commercial databases such as The Work Number; SNAP administrative data
Enrolled in educational program at least half-time	x	Application form (for full-time students); local colleges, universities, and educational programs; National Student Clearinghouse data[b]
Seasonal worker with average monthly income over past six months equivalent to at least 80 hours at federal minimum wage		Income sources above; tax data[c]
Participating in a work program at least 80 hours per month		WIOA programs; SNAP Employment and Training programs
Participating in community service at least 80 hours per month		

Compliance activities	Availability in the HIPSM model	Examples of existing data sources that may be available for automatic verification by states
Participating in a combination of work, education, work programs, or community service for at least 80 hours per month		
Exemption activities and characteristics		
Parents, guardians, caretaker relatives, or family caregivers of a dependent child 13 years of age and younger[d]	Parents/guardians only	Application form; state eligibility system
Medically frail/special medical needs	x	Application form; enrollment in state-specific programs (e.g., behavioral health managed care plan or Intellectual and Developmental Disability program participation); claims and encounter data
Participating in a drug or alcohol treatment program	x	Claims and encounter data
In household receiving SNAP and not exempt from a SNAP work requirement	x	SNAP administrative data
Disabled veterans[e]		Department of Veterans Affairs (VA) data
American Indians, Alaska Natives, and California Indians	x	Application form; state eligibility system[f]
Parent, guardian, caretaker relative, or caregiver of a disabled individual[g]		
Meeting work requirements in TANF		TANF administrative data
Pregnant individuals		Application form; state eligibility system; claims and encounter data
Individuals entitled to postpartum medical assistance[h]	x	State eligibility system; claims and encounter data
Foster youth or former foster youth younger than age 26		Application form; state eligibility system
Inmate of public institution or recently released from incarceration		State correctional facilities; state eligibility system

Sources: Jennifer Wagner, Symonne Singleton, and Maani Stewart. "A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement," Washington, DC: CBPP, November 3, 2025; and Kinda Serafi, Lisa Sbrana, and Liz Dervan, "Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions," Washington, DC: Manatt Health, November 4, 2025; Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: Optional state hardship exemptions not shown. OBBBA=One Big Beautiful Bill Act. HIPSM = Health Insurance Policy Simulation Model; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families; WIOA = Workforce Innovation and Opportunity Act.

a. Available for most nonself-employed workers in state or commercial wage databases. States may also use information from application forms, including on self-employed status, but likely would need to verify. Thus, the model only assumes automatic data-matching for nonself-employed workers in our "low" and "medium" mitigation scenarios; the "high" mitigation scenario assumes states can use data-matching and/or self-attestation for self-employment. See executive summary page vi for definition of high, medium, and low mitigation scenarios.
b. States may need to establish data-sharing agreements with local colleges, universities, and educational programs. States may also use information from application forms, but would need to verify.
c. We are unaware of any data sources that identify seasonal workers and their work effort.
d. Appears to apply to any parent/guardian, not only primary caregivers.
e. Total disability according to VA service-connected disability rating.
f. Medicaid applications may collect race/ethnicity data, but with an unknown nonresponse rate. Exemption definition is based on affiliation with a federally recognized tribe.
g. Likely applies to a primary caregiver. The RAISE Family Caregivers Act defines "family caregiver" as an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation. The bill text does not define "disabled" for this provision.
h. Grouped with parents of children age 13 or younger in our model.

First, the model identifies for each sample member whether they meet certain compliance parameters for OBBBA's work requirements.

Working 80 hours per month or having a monthly income equivalent to 80 work hours per month at the federal minimum wage. States can access quarterly wage databases and other sources to automatically verify earnings for nearly all traditional W-2 employees. We use 2018–19 and 2023–24 Survey of Income and Program Participation (SIPP) data (reporting work and income in the 2017–18 and 2022–23 period) to assess how many expansion enrollees meet wage standards ($580 in earnings for a given month or months),[35] for two time periods (one of six months or three of six months, as described further below). We impute these values to HIPSM expansion enrollees who are nonself-employed workers.

Though OBBBA's work requirements apply to all types of workers, states may have difficulty automatically identifying earnings or work hours for self-employed workers based on existing sources of wage data. This may change as some states and the federal government are piloting consent-based verification tools that can access information from payroll providers, gig platforms, digital wallets, and bank accounts of both traditional employees and self-employed or gig workers (Wagner et al. 2025). In this analysis, we assume that states will have access to data on the self-employed (through data-matching and/or self-attestation) only in the high mitigation scenario described further below. In the other scenarios, we assume that states can access only self-employed workers' income data that are already collected by SNAP agencies if those workers live in households receiving SNAP.[36] As we discuss below, the efficacy of state data matches between Medicaid and SNAP is uncertain.

Along with identifying earnings, states may be able to access information about many employees' work hours through commercial databases such as Equifax's The Work Number,[37] SNAP agencies, and other data sources. We separately assessed an alternative measure of how many nonself-employed expansion enrollees met OBBBA's work requirements through employment by examining how many worked 80 hours per month in at least one month or three months in the first and second half of each year for the same time periods. We found that this alternative measure had little impact on our results. Including adults who reported working the minimum number of hours without meeting the wage standard would increase estimated compliance rates by approximately 1 percentage point (data not shown).[38]

Being enrolled in an educational program at least half-time. Qualifying educational programs include institutions of higher education and career and technical education programs. We assess school attendance using reported school or college attendance, though we lack data on whether individuals are enrolled as students on at least a half-time basis. The extent to which states can verify students' compliance with work requirements is unclear, given that part-time school attendance is not collected on many Medicaid applications, and enrollment would be expected to change, so information would be needed on an ongoing basis, not just at initial enrollment. State university system data and the National Student Clearinghouse may be potential data sources, though we do not yet know to what extent states could use these data to automatically verify student enrollment status (Serafi, Sbrana, and Dervan 2025). Given the uncertainty about data matches and lack of information on whether reported school enrollment in the ACS is at least half-time, we assume that half of reported students would receive exemption in the high mitigation scenario described below.[39] Because some states may be unable to implement procedures to identify students, particularly at the start of implementation, we assume that, under the low mitigation scenario, states will be unable to automatically identify students (that is, even if full-time student status is reported on Medicaid applications, states would be unable to automatically assess compliance and would require students to manually verify their status). In the medium mitigation scenario, we assume states could automatically identify 20 percent of students, and in the high mitigation scenario, we assume states could automatically identify 50 percent. We will update these assumptions if CMS and states develop data-matching solutions that identify school enrollment status for a larger share of students.

Other compliance activities. Because of data limitations, we are unable to model the following compliance activities:

- being a seasonal worker with an average monthly income over six months, equivalent to 80 hours work per month at the federal minimum wage[40]

- participating in a work program for at least 80 hours per month
- participating in community service for at least 80 hours per month
- participating in a combination of work, education, work programs, or community service for at least 80 hours per month

However, even if states can access data on these activities, the enrollment impact of utilizing this information may be limited. For instance, though several million adults participate in Workforce Innovation and Opportunity Act programs annually, they make up a relatively small share of the labor force and are more likely to receive less intensive employment services than participate in training programs.[41]

Modeling Exemptions

Next, the model identifies for each sample member whether they meet certain mandatory exemption criteria. Our analysis already excludes certain individuals who are exempt from work requirements because they are younger than age 19 or enrolled in Medicaid through an eligibility pathway other than the ACA expansion. Below are the additional exemption parameters and whether and how they can be assessed in HIPSM:

Being Parents, Guardians, Caretaker Relatives, or Family Caregivers of a Dependent Child 13 Years of Age and Younger (including individuals entitled to postpartum medical assistance)

We use reported family relationships and ages of children to identify parents and likely guardians (i.e., householders or their spouses living with children who did not live with a mother or father but were related to the householder/spouse [child-in-law, sibling, grandchild, other relative]) of children age 13 and younger. We are, however, unable to identify possible caretaker relatives or family caregivers who are not parents or guardians.

OBBBA also defines individuals entitled to postpartum medical assistance as being exempt from the Medicaid work requirement. We identify postpartum individuals as women with a child younger than age 1 and include these women in the parental exemption category.

Being Medically Frail (including individuals participating in a drug or alcohol treatment program)

OBBBA identifies five categories of exemption for medical frailty or otherwise having special medical needs: (1) being blind or disabled as defined under Section 1614 of the Social Security Act; (2) having a substance use disorder; (3) having a disabling mental disorder; (4) having a physical, intellectual, or

developmental disability that significantly impairs the ability to perform activities of daily living (ADLs); and (5) having a serious or complex medical condition. These categories are largely consistent with the definition of medical frailty codified in federal regulations that determine whether Medicaid enrollees must be exempt from mandatory enrollment in alternative benefit plans (ABPs), which may offer fewer benefits than traditional Medicaid state plans.[42] Currently, eight states must determine medical frailty for their Medicaid expansion group because they offer ABPs that differ from the traditional state benefit package (AR, IA, ID, IN, MA, ND, NM, and WV; Hartly 2025) and additional states that have had to make these determinations for this reason in previous years include California, Michigan, Montana, New Hampshire, New Jersey, and Nevada (Hartly 2025; Musumeci, Chidambaram, and O'Malley Watts 2019). States such as Nebraska have also exempted medically frail enrollees from work requirements and other provisions of prior demonstration waivers.[43]

Under federal guidelines, states have had significant flexibility to operationalize both the definition and process for identifying medical frailty (e.g., through self-attestation, claims data, and required documentation from providers or managed care organizations), and approaches have varied widely (Musumeci, Chidambaram, and O'Malley Watts 2019). For instance, Indiana, Michigan, Nebraska, and New Mexico have developed lists of diagnosed medical conditions that individuals must have or may have to be designated as medically frail, with Michigan and Nebraska providing applicable ICD-10 diagnosis codes for all conditions, and New Mexico doing the same for substance use disorder (SUD) and serious mental illness.[44] Other states, such as Arkansas, have used health care needs screening questionnaires to identify beneficiaries whose risk of incurring high health care expenditures exceeds a specified threshold (Hartly 2025; Silvestri, Gluck, and Ross 2020). Arkansas and Michigan have also allowed people to self-attest to medical frailty based on application questions about having health conditions that cause limitations in ADLs or needing help with such activities.

Our analysis identifies expansion enrollees whom states could automatically deem to be medically frail based on a review of claims data and/or self-attestation. Because medical conditions are not reported in the ACS, we rely on imputation using pooled 2018–19 and 2022–23 data from the MEPS and pooled 2022–23 data from the National Survey on Drug Use and Health (NSDUH). We map diagnosis codes from states with publicly available lists of conditions used in medical frailty determinations (IN, MI, NE, and NM) to the MEPS Medical Conditions file, which includes three-digit level ICD-10 categories for conditions for which survey participants received treatment during the year (i.e., office-based or outpatient visits, emergency room visits, inpatient stays, home health care, or prescription medications), as well as clinical classification software refined codes that group conditions into clinically meaningful categories (AHRQ and CFACT 2023). We use an inclusive definition that

designates individuals as medically frail if they were treated for a condition that would meet the qualifying criteria used by any of these four states. Nevertheless, this approach may understate the number of people who could be deemed medically frail based on diagnosed conditions, as we discuss below (see limitations).

Because SUD is underreported in the MEPS (in part because some ICD-10 codes are suppressed to protect respondent confidentiality), we impute claims-visible SUD diagnoses or treatment from NSDUH to the MEPS. We first identify nonelderly adult NSDUH respondents with Medicaid/CHIP coverage, no dual Medicare coverage, and not receiving SSI (and therefore potentially enrolled through the expansion pathway) with any SUD as those who matched DSM-V-based criteria for having a past year drug or alcohol use disorder, including cocaine, hallucinogens, heroin, inhalants, marijuana, methamphetamine, pain reliever misuse, sedatives, stimulants, and tranquilizers, but not including tobacco use disorder or nicotine dependence. We then define claims-visible SUD treatment as those who received SUD treatment in the past year in an inpatient setting, emergency department, residential rehabilitation/treatment center, or mental health treatment center/hospital; outpatient treatment at a general medical office, hospital, rehabilitation/treatment center, or mental health treatment center; detox services for substance use withdrawal symptoms; or medication (prescription or dispensed) for alcohol, heroin, or pain reliever use. An estimated 6 percent of the NSDUH sample reported claims-visible SUD based on this definition, which is largely consistent with prior analyses of Medicaid claims data for nondisabled adult eligibility groups (Saunders 2023). We use hot-deck imputation, drawing on common demographic, socioeconomic, health status, functional limitation, and health care use measures available in both datasets.

Along with treated medical conditions that may appear in state claims data, we also identify MEPS participants who receive help or supervision with ADLs (e.g., bathing, dressing, or getting around the house) or instrumental activities of daily living (e.g., doing laundry, shopping, preparing meals)[45] because of a health problem, or who have difficulty dressing, bathing, or doing errands alone. Some states may consider these adults to be medically frail based on self-attestation, if allowed by CMS. For instance, Medicaid applications often include questions asking whether people have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or need help with such activities, which may facilitate screening for medical frailty exemptions, though obtaining such exemptions will depend on whether additional documentation is required.

We use hot-deck methods to impute key indicators from the MEPS (and indirectly, from NSDUH) to expansion enrollees in the HIPSM data, including treated conditions used in state medical frailty determinations, claims-visible SUD, and receipt of help or difficulty with ADLs or instrumental activities

of daily living (IADLs). We also impute any SUD and presence of a health-related work limitation, which are not included in our definition of medical frailty exemptions, that may be identifiable in state data systems, but provide important information on the health and disability status of the expansion enrollees population that may not be captured in claims data or application forms. Our donor sample includes MEPS participants ages 19 to 64 who reported Medicaid coverage in any month during the year, did not receive Medicare or SSI, and did not have diagnosis codes associated with pregnancy or childbirth. Though this sample includes adults enrolled in Medicaid through traditional eligibility pathways for low-income parents, the distribution of imputed outcomes is similar when limiting the sample to nonparents, who are most likely to be enrolled through the expansion pathway.

A key limitation of this approach is that MEPS data available for public use provides ICD-10 diagnosis codes at the three-digit level rather than fully specified codes. As a result, our results are highly sensitive to the inclusion of certain diagnoses, particularly with respect to mental health conditions that states may or may not classify as a "disabling mental disorder." Because we cannot distinguish the level of severity for depressive disorders, anxiety disorders, and stress reaction and adjustment disorders, we provide a range of estimates.[46] Under a conservative definition that excludes these conditions (used in the medium mitigation scenario, as described below), we estimate that 8 percent of expansion enrollees could be identified as medically frail in claims data, serving as a lower bound. Under a broader definition including these conditions,[47] as well as adults self-attesting to having difficulty with or receiving help with ADLs or IADLs, we estimate states could automatically identify 21 percent of enrollees as medically frail (as used in the high mitigation scenario described below).[48] These estimates are similar to the shares of medically frail expansion enrollees reported in prior years for states such as AR, IA, IN, and MT (Musumeci, Chidambaram, and O'Malley Watts 2019; Silvestri, Gluck, and Ross 2020; Simon and Co. 2017), as well as the wide range of proportions reported or estimated more recently for AR, IN, and OH (FSSA 2025).[49]

We also acknowledge that the work requirement provisions of OBBBA suggest the definition of medical frailty should be broader than the definition used to guide prior state approaches, which were developed in the context of offering choices between ABPs and traditional state plans. The criteria used to classify "serious or complex medical conditions" will be particularly important for providing exemptions to applicants and enrollees who face heightened risks of losing access to critical treatment if they are denied or disenrolled from Medicaid. Table 5 in the results section shows that coverage changes are sensitive to these criteria, both overall and among adults in fair or poor health or with functional limitations. If conditions are defined as serious or complex in a way that is consistent with

how these terms have been applied under other federal laws and programs, 34 percent or more of expansion enrollees would meet the criteria for a medical frailty exemption.

OBBBA contains a separate exemption category for people who are participating in a drug or alcohol treatment and rehabilitation program. As discussed above, participation in drug and alcohol treatment programs is not measured in the underlying HIPSM data. We impute receipt of any claims-visible SUD treatment, regardless of whether it was received through a treatment program or another setting.

Being Members of Households Receiving SNAP Who Are Not Exempt from a SNAP Work Requirement

We use 2018-19 and 2023-24 SIPP data to identify people living in households receiving SNAP who were not exempt from SNAP work requirements for one of six months or three of six months. Notably, OBBBA defines this exemption from Medicaid work requirements based on whether individuals are "not exempt from" a SNAP work requirement, without specifying that they must be compliant with a SNAP work requirement. The law also does not specify that those who are exempt from SNAP work requirements must also be exempt from the Medicaid work requirement, even though many of the exemption categories in both programs overlap.

SNAP has two work requirements. The first is a general work requirement that individuals ages 16 to 59 must register for work, participate in SNAP Employment and Training programs or workfare if assigned by the state SNAP agency, accept a suitable offer of employment, and not quit a job or reduce work hours below 30 per week without a good reason.[50] Adult SNAP enrollees are exempt from this general work requirement if they (1) already work 30 hours per week or have wages equivalent to 30 hours at the federal minimum wage; (2) meet work requirements for TANF or unemployment insurance; (3) are parents or caregivers of a dependent child younger than age 6 or a disabled person; (4) are unable to work because of physical or mental health conditions; (5) participate in an alcohol or drug treatment program; or (6) are enrolled in school at least half time.

The second SNAP work requirement, referred to as the able-bodied adult without dependent (ABAWD) requirement, requires certain individuals to work or participate in a work program for 80 hours per month. Those who are noncompliant are subject to a three-month time limit for receipt of SNAP over three years. Before OBBBA, the ABAWD requirement applied to adults ages 18 to 54 who were not living with dependent children. OBBBA expanded this requirement to 55-to-64-year-olds and adults living with children if none of the children are younger than age 14, while eliminating exemptions for veterans, homeless individuals, and former foster youth. Under current law, people are exempt if

they are (1) parents or caregivers of a dependent child younger than age 14; (2) medically certified as physically or mentally unfit for employment; (3) pregnant; (4) exempt from the general work requirement; or (5) AIAN.

The share of SNAP recipients who could be automatically considered exempt from Medicaid work requirements is uncertain because of limitations in our underlying survey data, real-world uncertainty in the effectiveness of data matches between the SNAP and Medicaid administrative systems, and uncertainty in how the law's text will be interpreted. We identify SNAP participants who are likely nonexempt from one or both SNAP work requirements based on parental status and age of children in the household, school attendance, monthly earnings, TANF participation, and functional limitations (as a proxy for potential health-related exemptions from the ABAWD requirement).[51]

We also make varying assumptions about the extent to which states can match SNAP and Medicaid data. A KFF survey found that approximately half of states have integrated SNAP and Medicaid eligibility systems (Brooks et al. 2025). We assume higher data-matching rates in states with integrated eligibility systems under high, medium, and low mitigation scenarios, as described further below.

Being AIAN[52]

We use reported race/ethnicity in the ACS to identify individuals who identify as AIAN, either alone or with another race.

Our model does not currently assess the following exemption criteria:

- parent, guardian, caretaker relative, or family caregiver of a disabled individual[53]
- being a disabled veteran[54]
- compliance with TANF work requirements
- pregnancy (as noted above, we include individuals entitled to postpartum medical assistance with parents)[55]
- foster youth or former foster youth younger than age 26
- inmate in a public institution or recently released from incarceration

Assessing the Likelihood of Automatic Data-Matching for Enrollees and New Applicants

We base our projections of the effects of work requirements on the extent to which enrollees' compliance activities and exemption characteristics are likely identifiable to states in available data to automatically deem people as satisfying the work requirements or being exempt from them without action on the part of the enrollee. For instance, states already use quarterly wage databases (Brooks et al. 2024) and information enrollees provide on family structure and other characteristics in Medicaid applications to determine and redetermine eligibility, so it is likely they can continue to use these data sources to assess compliance with or exemption from work requirements. On the other hand, automatic data-matching for other characteristics, such as medical frailty, would rely on additional data matches, such as connecting enrollment systems to claims data, which may be more challenging for some states.

Work Requirement Verification for New Applicants

After we assess Medicaid-enrolled sample members for each characteristic and activity in table 1 that we can measure, we assess these characteristics among those we model as likely Medicaid expansion applicants. Some characteristics, including those in Medicaid applications such as AIAN identification and parental status, as well as information that states use to determine eligibility, like income, would be identifiable for applicants as they are for enrollees. However, we anticipate that states will have access to much less data for identification of medical frailty and SUD treatment among applicants than enrollees (we note, however, that some "new" enrollees at any given time are, in fact, prior enrollees for whom states may have some additional information, such as past medical claims). In addition, we anticipate that the administrative burden of work requirements will discourage some potentially eligible nonenrollees from applying for the program. Thus, we model a constriction of new enrollment based on the potential for discouragement effects.

The OBBBA work requirements differ from some previous state programs in that new applicants must also verify compliance or exemptions for at least one month before application to enroll in expansion coverage. We model three ways in which their process would differ from that of existing enrollees as described above. First, the state will have less information on these people. SNAP enrollment and data matching for identifying medical frailty will be most affected. We therefore model the reduced effectiveness of mitigation efforts for new enrollees relative to existing enrollees. Second, the period for verifying compliance is more restrictive, either the prior month or the previous several months. We use SIPP data to estimate differences in compliance rates between new applicants and existing enrollees due to different requirements for new applicants. Third, the additional administrative

burdens of applying for Medicaid could discourage new applicants. Extensive application assistance by the state or community organizations could mitigate this, so we assume that this deterrent effect will be smaller in the high mitigation scenario and larger as mitigation efforts decrease, and thus that the number of applicants attempting to enroll in expansion coverage will be higher in the high mitigation scenario and lower in the low and medium mitigation scenarios.

Projecting Enrollment Rates

Finally, based on sample members' status as Medicaid expansion enrollees or potential applicants, as well as their reported or imputed activities and characteristics as described in table 1, we project how enrollment levels in the program are expected to change under OBBBA implementation in 2028.

Given inherent uncertainty in how states will implement these provisions, we project enrollment rates under high, low, and medium mitigation scenarios defined as follows:

1. *High mitigation* is defined as implementation and policy choices that would use extensive automatic data-matching for eligibility redeterminations and for assessing compliance with work requirements, along with imposing the minimum allowable work effort and broader definitions of exemptions, such as medical frailty, to maintain Medicaid coverage among people who are meeting work requirements or exempt from them.
2. *Low mitigation* is defined as implementation and policy choices that would use less automatic data-matching for redeterminations and for assessing compliance with work requirements, which would, in turn, require that more enrollees take action to maintain coverage, such as providing the state with documentation of their work hours, along with imposing greater levels of work effort and narrower definitions of exemptions.
3. *Medium mitigation* is defined as when the scope and effectiveness of automatic data-matching and definitions of exemptions are between the high and low mitigation scenarios.

Under all three scenarios, we assume that all states will conduct data matches for the activities and characteristics for which they are already likely to have available data, including information collected on initial Medicaid applications and at renewal. For instance, we assume states will be able to identify whether applicants and enrollees are parents living with dependent children age 13 or younger, and to verify monthly income equivalent to 80 hours per month at the federal minimum wage for nonself-employed workers.[56] We also assume states conduct verifications at six-month intervals (not more frequently).

Notably, the mitigation scenarios represent a range of potential implementation choices and do not reflect individual state policy decisions regarding work requirements, which at the time of writing have not been fully formulated. Rather, because we assume uniform implementation choices across states within each scenario, variation in enrollment impacts across states reflects differences in the composition of each state's Medicaid expansion enrollees by parental status, income, work status, medical conditions, and other factors. The only exception relates to states' ability to share data regarding SNAP work requirements with Medicaid agencies, where we use information on integration between these two systems in each state[57] and apply higher rates of likely SNAP matches in states with integrated systems compared with states without integrated systems. (The impact of the six-month redetermination also incorporates information on state procedural disenrollment rates and state data checks during the 12 months between redeterminations; Buettgens et al. 2026).

Appendix table A.1 describes policy and implementation choices that vary under each of these scenarios. In our *high mitigation* scenario, we assume that states would apply work requirements for the minimal allowable time (one month between redeterminations for enrollees and one month before application for applicants). We further assume that states would develop processes for data-matching or accepting self-attestation of employment or income of self-employed workers, and identifying a significant share of enrollees and applicants who are enrolled in school at least half-time. In states with integrated Medicaid-SNAP eligibility systems, we assume nearly all individuals in households receiving SNAP who are subject to a SNAP work requirement (and therefore exempt from the Medicaid work requirement) could be identified through data-matching, and that approximately two-thirds of these individuals could be identified in states without integrated systems. The high mitigation scenario also applies our most expansive definition of medical frailty based on previous state approaches, with all states drawing on claims data and accepting self-attestation of difficulty with ADLs/IADLs. Finally, we assume lower enrollment impacts from the imposition of six-month eligibility redeterminations; higher rates of reporting exemptions and compliance among those who are not identified through data-matching; and higher reenrollment among people who are disenrolled or denied coverage and subsequently reapply.

Conversely, our *low mitigation* scenario assumes states would apply work requirements for three months between redeterminations for enrollees and three months before application for applicants (though states would be allowed to apply work requirements for up to six months between redeterminations for enrollees, we do not expect states to be able to conduct checks this frequently, and exploratory analysis found that using a three-month versus six-month standard would not have a large effect on our results). We assume states will not assess medical frailty, self-employment, or

student status automatically and will instead require some combination of self-reporting and external verification. This scenario also projects greater enrollment impacts from more frequent redeterminations, lower rates of reporting exemptions and compliance manually (i.e., not through data-matching), and lower reenrollment rates, as described in appendix table A.1.

The *medium mitigation* scenario applies parameters roughly between these two extremes.

The range of manual verification rates for those not identified through data-matching is based on rates of reporting under prior waivers in Arkansas and New Hampshire. In our high mitigation scenario, we assume approximately two-thirds of enrollees and applicants do not successfully report qualifying activities and exemptions, slightly lower than the noncompliance rates in those prior waiver states. In our low mitigation scenario, we assume 87 percent of those required to verify compliance or exemptions manually are unable to do so, slightly higher than the rates observed in Arkansas and New Hampshire.

Our projections assume that six-month redeterminations are in effect (as required by OBBBA) in every state program that includes work requirements, except for Wisconsin (where work requirements will be applied but where six-month redeterminations are not required by OBBBA). We first model enrollment changes caused by the six-month redetermination provision and then estimate the additional enrollment impacts resulting from work requirements.

Estimating Average Monthly Enrollment

Simply applying the compliance and exemption rules to a population of existing enrollees is not enough to estimate changes in eventual enrollment levels. Some of those who are disenrolled may re-enroll, particularly those who were compliant with or exempt from work requirements, but were not successfully identified to states automatically or verified manually. Previous work by Fiedler (2025) assessing the rate at which people who were disenrolled from Arkansas's Medicaid expansion program because of noncompliance with work requirements returned to the program, as well as observed transitions between compliant and noncompliant status based on data from monthly state program reports, informs our approach to modeling reenrollment dynamics.

To estimate the impact on average monthly Medicaid enrollment, we simulated the impact of flows into and out of Medicaid over time resulting from the enactment of work requirements. When enrollees face redetermination of eligibility, some will fail to verify their work requirement compliance or exemptions. Of these, some would regain eligibility in the near term and re-enroll. We estimated this share based on analysis of 2018–19 and 2023–24 SIPP data, which follow Medicaid enrollees over time.

Along with the impact on existing enrollees, work requirements would apply to new applicants, reducing the flow of new people into Medicaid, as described above. We use SIPP to estimate how much more restrictive the verification period for new applicants would be compared with existing enrollees. Given the more limited information available to the state for new applicants, we use values from the lower mitigation scenario for that group. For the discouragement of new applicants, we assume that this will be very small in the high mitigation scenario, and that it will be larger in the other scenarios, though we assume that this component will be small compared with other factors, given the high demand for coverage as reflected in high Medicaid expansion take-up rates (Buettgens and Ramchandani 2023). We operationalize the flows in and out of Medicaid expansion coverage by assigning probabilities to each of them and iterating them over time, using a Markov chain model, as shown in the Appendix in Figure A.1.[58]

Analysis

Combining information for enrollees, new applicants, and reenrollment patterns, we compute: (1) what share of expansion applicants and enrollees can be automatically deemed compliant or exempt according to information available in HIPSM, (2) changes in average monthly Medicaid expansion enrollment for 2028 under each mitigation scenario, (3) how enrollment changes vary by state, and (4) how enrollment changes for certain groups, including those who may be meeting the work requirements or who could potentially qualify for an exemption that would not be visible to states relying on existing data systems.

Limitations

Our analysis has several limitations. First, Medicaid expansion enrollment in 2028 may differ from our projections, which, as described above, are based on enrollment data reported by about half of the states available as of the third quarter of 2025 (most commonly reflecting August 2025) and national enrollment data for the remaining states reported as of late 2025. Some states have reported declining overall Medicaid enrollment throughout 2025.[59] Differences between expansion enrollment as modeled in HIPSM and actual expansion enrollment in each state in 2028 would lead to differences in projections of changes under these policies. In addition, after June 2025, nationwide ex parte rates declined from 57 to 50 percent, and procedural termination rates rose from 11 to 14 percent (CMS 2025). Much of this was likely because of changes in the adoption of flexibilities that CMS gave states during the Medicaid unwinding, though some states made additional changes. For instance, California reinstated an asset test for people older than 65 and people eligible for Medicaid based on disability,

and saw a particularly large drop in ex parte rates and an increase in disenrollment rates (DHCS 2025). The characteristics of expansion enrollees and eligibles in 2028 (e.g., parents of children younger than age 14 who would all be exempt versus enrollees with other characteristics who would be less likely to be automatically exempted) may also differ from what we have modelled. There is also uncertainty about which individuals enrolled in the modified adjusted gross income-based eligibility groups through a Section 1115 demonstration waiver would be subject to work requirements.[60]

Second, several characteristics and activities we assess are measured imprecisely. For instance, our lack of granular data on diagnosed medical conditions that may be visible to states in claims and encounter data results in a wide range of estimates of the share of enrollees who could meet medical frailty criteria based on previous state definitions. In addition, states may be able to identify diagnoses in claims that would not be available in the more limited data reported by participants in the MEPS and NSDUH. For instance, the MEPS identifies only the diagnosis codes for conditions for which individuals received treatment and typically provides a single code for each service received, whereas claims and encounter data available to states may contain additional information on patients' diagnosed conditions. Moreover, claims-visible SUD treatment may be underreported, and our analysis of the NSDUH indicates that a much larger share of the Medicaid expansion population (up to one-quarter) meets diagnostic criteria for SUD, with most not receiving any type of treatment.

There is additional measurement error associated with imputing characteristics from survey data that cannot be used to fully distinguish whether participants reporting Medicaid coverage are enrolled through the expansion or through traditional eligibility pathways (i.e., defining the expansion population based on family structure and reported receipt of Medicaid, SSI, and/or Medicare). Studies have also found that respondents tend to underreport Medicaid coverage in the SIPP and other surveys (Card, Hildreth, and Shore-Sheppard 2004; Davern et al. 2009). The underreporting may be even larger in survey data collected during the COVID-19 public health emergency, when the Medicaid undercount grew (Ding, Sommers, and Glied 2024). SIPP data are also subject to seam bias, in which transitions into and out of coverage and employment are reported more frequently between panel waves, but we do not expect this to have a meaningful impact on our analysis, which focuses on coverage and employment patterns within each calendar year (Bennett, Klee, and Munk 2022; Moore 2007). Our imputation of monthly employment and income from the SIPP and medical frailty from the MEPS and NSDUH also relies on data collected before and after the unwinding of the Medicaid continuous coverage requirement in place during the COVID-19 public health emergency, which significantly affected Medicaid enrollment trends and the characteristics of enrolled individuals. However, we found similar patterns in outcomes of interest when using prepandemic data. Survey data, including the underlying

data in HIPSM, are subject to multiple sources of measurement error and exclude or underrepresent certain groups, such as homeless and institutionalized populations.

Third, we make several simplifying assumptions in our model, including a uniform rate of manual verification of exemptions and work activities among people who are not automatically deemed exempt or compliant through data-matching, regardless of their characteristics. However, prior evidence from Arkansas suggests healthier adults were more likely to be disenrolled because of noncompliance with work requirements, and other studies have found adverse selection from other programmatic barriers such as premiums (ACHI 2019; Cliff et al. 2022). Additional evidence that emerges on whether and how health status affects retention of coverage under work requirements may lead us to refine our assumptions in future analyses.

Other assumptions reflect significant uncertainty about the policy and implementation choices that CMS will allow and that states will make. At the time of writing, CMS has released preliminary guidance that has left many questions unanswered.[61] Our modeling of the effects of work requirements draws on evidence from a limited number of states that implemented work requirements under demonstration waivers in 2018–19, as well as Georgia's current Pathways to Coverage waiver program launched in 2023. These initial experiments differ in important ways from the work requirements in OBBBA. For instance, the earlier waivers in Arkansas and New Hampshire applied the work requirements only to adults who were already enrolled in expansion coverage, whereas OBBBA also applies the requirements to adults applying for coverage. Though applicants for Georgia's Pathways program must demonstrate participation in qualifying work activities, the state has not established data-matching processes or offered exemptions that are consistent with OBBBA, so enrollment patterns in that program may not be indicative of patterns under OBBBA. Our analysis also draws on prior state practices to define medical frailty, but CMS and states may adopt different definitions and processes for identifying medically frail adults who are exempt from work requirements.

We assume that all states will have implemented work requirements by January 1, 2027, without receiving good-faith waivers to delay implementation as late as January 2029; any delays in implementation would affect our projections for 2028. We also do not account for optional exemptions for short-term hardship events that states may allow, including inpatient hospitalization or receipt of other high-acuity services; residence in a county experiencing an emergency or disaster; residence in a county with an unemployment rate of 8 percent or 1.5 times the national average (whichever is lower); or the need to travel outside of the community for medical services (Bell, Tolbert, and Cervantes 2025; CBPP 2020; Zhang and Lukens 2025).[62]

We also acknowledge that other shifts since our underlying data were gathered could affect our results. For instance, changes in the labor market, such as increases in state-level minimum wages, could affect patterns of who is eligible and deemed to be compliant.

Fourth, we are unable to identify several compliance activities (e.g., work programs, community service) and exemption characteristics (e.g., former foster youth status, pregnancy status, recent release from incarceration, caregiving for disabled individuals) in our data. If a large share of enrollees and applicants were found compliant or exempt for these reasons, and states had access to data that could automatically assess these activities and characteristics, coverage losses could be smaller than we project. On the other hand, interactions with other provisions of OBBBA and spillover effects of Medicaid work requirements on groups other than the expansion population are beyond the scope of our analysis. For instance, we do not model the effect of the law's SNAP changes, which could result in lower SNAP enrollment and thus lower data-matching capabilities for Medicaid enrollees, nor do we account for potential Medicaid enrollment declines among children associated with loss of expansion coverage for their parents which would be expected given the documented association between parental and children's coverage (Hudson and Moriya 2017). Incorporating these additional changes would increase the projected coverage losses.

Finally, we do not attempt to predict individual states' implementation decisions or assess how the enrollment impacts of work requirements will change over time, as states refine implementation processes and enrollment and reenrollment patterns shift among people who are disenrolled or denied coverage.

Results

National Changes in Medicaid Expansion Enrollment

Table 2 shows projected national declines in average monthly Medicaid expansion enrollment (and waiver enrollment in Wisconsin, referred to collectively as expansion enrollment) under OBBBA's six-month redeterminations and work requirements provisions relative to a scenario without these policies. As described above, we consider three implementation scenarios, high, medium, and low mitigation, where lower mitigation indicates policies and practices that would lead more enrollees who remain eligible at redetermination to lose coverage and more of those who are complying with or exempt from work requirements to lose coverage or not be enrolled. With the implementation of six-month

redeterminations alone, we project that average monthly enrollment in the expansion group will decline in 2028 by between 2.0 and 3.1 million under high and low/medium mitigation, respectively.[63] With the additional implementation of work requirements on top of six-month redeterminations, we project that average monthly Medicaid enrollment will drop by between another 3.0 and 7.0 million, depending on implementation scenarios.

With both policies combined, we project that average monthly expansion enrollment would be between 4.9 and 10.1 million lower than under a scenario without either policy in 2028. With low mitigation implementation in every state, we project that Medicaid expansion enrollment will be cut by more than half (55 percent) under OBBBA's work requirements and six-month redeterminations. But even with high mitigation implementation in every state, we project that enrollment in expansion coverage would drop by 27 percent nationally.

TABLE 2

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, by Mitigation Scenario

	High mitigation scenario	Medium mitigation scenario	Low mitigation scenario
Six-month redetermination and work requirements			
Decline in average monthly expansion enrollment (millions)	-4.9	-8.0	-10.1
Percent decline in average monthly expansion enrollment	-27%	-43%	-55%
Six-month redetermination only			
Decline in average monthly expansion enrollment (millions)	-2.0	-3.1	-3.1
Percent decline in average monthly expansion enrollment	-11%	-17%	-17%
Incremental effect of work requirements on top of the six-month redetermination			
Decline in average monthly expansion enrollment (millions)	-3.0	-4.9	-7.0
Percent decline in average monthly expansion enrollment	-16%	-27%	-38%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: OBBBA=One Big Beautiful Bill Act. Enrollment refers to average monthly enrollment. Estimates are rounded to the nearest hundred thousand. See executive summary page vi for definition of high, medium, and low mitigation scenarios. The medium and low mitigation scenarios apply the same parameters with respect to coverage losses under six-month redeterminations. Expansion enrollment here refers to enrollees subject to work requirements, including Medicaid waiver enrollees in Wisconsin.

Regardless of the implementation scenario, in our model, which applies the effects of six-month redeterminations before the effects of work requirements, we find that 60 to 70 percent of the coverage declines under these two provisions are because of the work requirements provision.

State-Level Changes in Medicaid Expansion Enrollment

Table 3 shows projected changes in Medicaid expansion enrollment in 2028 for each state under OBBBA's six-month redeterminations and work requirements provisions, again under each of three mitigation scenarios, sorted by the share of expansion enrollment declines under the high mitigation scenario.[64] In each state, we project that six-month redeterminations and work requirements would result in lower expansion enrollment regardless of the implementation scenario. As shown in appendix table A.2, enrollment declines because of work requirements are at least twice as high under low mitigation than under high mitigation in most expansion states.

TABLE 3

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Number and Percent, by State and Mitigation Scenario

	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	Number (thousands)	Percent	Number (thousands)	Percent	Number (thousands)	Percent
Total	-4,926	-27%	-7,970	-43%	-10,131	-55%
Massachusetts	-99	-33%	-161	-54%	-202	-68%
Vermont	-13	-32%	-20	-50%	-26	-63%
Connecticut	-95	-32%	-155	-51%	-197	-65%
Virginia	-178	-31%	-269	-47%	-332	-59%
Maryland	-102	-31%	-172	-51%	-207	-62%
New York	-594	-30%	-955	-48%	-1,220	-62%
Minnesota	-54	-29%	-91	-49%	-113	-61%
California	-1,256	-29%	-1,995	-46%	-2,552	-58%
Rhode Island	-23	-29%	-34	-43%	-44	-55%
Colorado	-108	-28%	-165	-43%	-201	-53%
New Jersey	-155	-28%	-242	-44%	-304	-56%
Delaware	-17	-28%	-28	-45%	-35	-56%
West Virginia	-40	-28%	-61	-42%	-75	-52%
Arizona	-123	-27%	-197	-44%	-246	-55%
New Hampshire	-14	-27%	-23	-44%	-29	-56%
Missouri	-95	-27%	-169	-47%	-222	-62%
Illinois	-194	-26%	-324	-44%	-415	-57%
Hawaii	-34	-26%	-57	-43%	-72	-54%
Washington	-158	-26%	-260	-43%	-330	-54%
Maine	-17	-25%	-28	-41%	-38	-55%
Kentucky	-103	-25%	-166	-41%	-200	-49%
Idaho	-20	-25%	-30	-38%	-34	-44%
Louisiana	-123	-25%	-205	-41%	-264	-54%

	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	Number (thousands)	Percent	Number (thousands)	Percent	Number (thousands)	Percent
Ohio	-176	-25%	-285	-40%	-356	-50%
District of Columbia	-27	-25%	-46	-41%	-60	-55%
Iowa	-44	-24%	-72	-40%	-92	-50%
Michigan	-171	-24%	-287	-40%	-355	-50%
Nevada	-71	-24%	-113	-38%	-145	-49%
Montana	-18	-23%	-28	-36%	-34	-43%
Wisconsin	-39	-23%	-70	-42%	-100	-60%
Utah	-19	-23%	-33	-40%	-40	-48%
Arkansas	-50	-23%	-78	-36%	-98	-45%
Pennsylvania	-173	-23%	-276	-37%	-348	-47%
Nebraska	-16	-22%	-25	-35%	-30	-42%
North Carolina	-152	-22%	-249	-36%	-330	-48%
Indiana	-121	-21%	-201	-35%	-269	-47%
Alaska	-14	-21%	-23	-36%	-30	-46%
Oregon	-112	-21%	-185	-34%	-248	-46%
New Mexico	-49	-20%	-87	-36%	-109	-45%
Oklahoma	-48	-20%	-87	-37%	-105	-44%
South Dakota	-6	-19%	-11	-34%	-16	-48%
North Dakota	-4	-18%	-8	-30%	-9	-37%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: OBBBA=One Big Beautiful Bill Act. States are sorted from highest to lowest percent change in expansion enrollment under the high mitigation scenario. Enrollment refers to average monthly enrollment in thousands. See executive summary page vi for definition of high, medium, and low mitigation scenarios. Expansion enrollment here refers to enrollees subject to work requirements, including Medicaid waiver enrollees in Wisconsin.

Combining the effects of both the six-month redetermination and work requirement provisions, enrollment would fall across states by 18 percent to 33 percent in the high mitigation scenario, by 30 percent to 54 percent in the medium mitigation scenario, and by 37 percent to 68 percent in the low mitigation scenario.

With low mitigation, eight states (CT, MA, MD, MN, MO, NY, VT, and WI) are projected to experience Medicaid expansion enrollment declines of over 60 percent in 2028 under the combined effects of six-month redeterminations and work requirements, while the eight states (AR, ID, MT, ND, NE, NM, OK, and OR) with the lowest percent declines still projected to see enrollment losses ranging between 37 and 46 percent. With high mitigation, North Dakota and South Dakota are projected to experience the smallest percent declines of 18 and 19 percent, respectively, while six states (CT, MA, MD, NY, VA, and VT) would experience declines above 30 percent. Assuming uniform mitigation efforts across states under each scenario, North Dakota would experience the lowest estimated enrollment decline (ranging from 18 to 37 percent under the high and low mitigation scenarios, respectively), while Massachusetts is at risk of the largest enrollment decline (ranging from 33 to 68 percent).

Because states are still developing their implementation plans, our projections assume each state makes the same policy and operational choices and, with limited exceptions, has the same administrative capacities for each mitigation scenario. The finding that projected coverage losses are generally higher in states that have not expressed interest in pursuing work requirements (e.g., through Section 1115 waiver requests) may be counterintuitive, but it reflects differences in the characteristics of their Medicaid expansion populations, among other factors, rather than differences in state implementation strategies. For instance, state variation in the share of expansion enrollees who are parents is one of the primary factors explaining differences in estimated coverage losses by state. In states with high income eligibility thresholds for parents under traditional Medicaid eligibility pathways that existed before ACA implementation, expansion programs are disproportionately composed of nonparents, who would not be automatically deemed exempt as caregivers for children ages 13 and younger. Among the 14 states with the highest projected coverage losses under our high mitigation scenario (i.e., the top third), traditional eligibility thresholds for parents average 92 percent of FPL (Brooks et al. 2025), and, accordingly, only 6 percent of expansion enrollees subject to work requirements are parents living with children age 13 and younger (data not shown). In contrast, in the 14 states with the lowest projected coverage losses (i.e., the bottom third), traditional eligibility thresholds for parents average 34 percent of FPL (Brooks et al. 2025), and 27 percent of expansion enrollees subject to work requirements are parents living with children in this age group (data not shown).

Additional differences in state-level coverage losses are driven by state variation in employment rates among Medicaid expansion enrollees. In states with higher minimum wages, workers may be more likely to have incomes above the Medicaid eligibility threshold of 138 percent of FPL, which may result in expansion programs with disproportionate shares of nonworking enrollees. We find that states in the top third of projected coverage losses have higher minimum wages[65] and lower employment rates on average than those in the bottom third, resulting in differences in the share who can be automatically deemed compliant based on earnings (data not shown).

In addition, in some states with lower projected coverage losses, such as Alaska, New Mexico, Oklahoma, North Dakota, and South Dakota, large shares of the expansion populations are AIAN, many of whom would be eligible for an exemption. States with lower coverage losses also tend to have slightly larger average shares of expansion enrollees who could be automatically exempted based on medical frailty criteria compared with states with higher projected coverage losses.

Another factor explaining differences across states in projected enrollment declines is the integration of Medicaid and SNAP eligibility systems, which we assume would facilitate data-matching

to identify enrollees and applicants who are exempt from Medicaid work requirements because they live in households receiving SNAP and are subject to a SNAP work requirement.

In practice, coverage losses in each state will depend heavily on state policy decisions, implementation choices, and data-matching capacities. As shown in table 3, states that pursue low mitigation strategies will experience larger declines in enrollment than states employing high mitigation efforts.

Changes in Medicaid Expansion Enrollment for Select Subgroups

Table 4 shows projected changes in average monthly Medicaid expansion enrollment under six-month redeterminations and work requirements in 2028, under low, medium, and high mitigation for select subgroups of the population (appendix table A.3 shows projected changes for six-month redeterminations and work requirements separately).

TABLE 4

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Number and Percent, for Selected Subgroups and by Mitigation Scenario

	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	Number (thousands)	Percent	Number (thousands)	Percent	Number (thousands)	Percent
Total	-4,926	-27%	-7,970	-43%	-10,131	-55%
Younger than 35 years old	-2,615	-26%	-4,265	-42%	-5,306	-53%
Between 35 and 49 years old	-1,089	-25%	-1,732	-40%	-2,197	-51%
Between 50 and 64 years old	-1,223	-30%	-1,973	-49%	-2,627	-65%
Student	-782	-21%	-1,513	-41%	-2,054	-56%
Parent of child younger than age 18	-395	-14%	-614	-22%	-648	-23%
Parent of child younger than age 14	-294	-13%	-446	-20%	-446	-20%
Parent with all children age 14 or older	-101	-17%	-168	-29%	-202	-35%
Not parent of child younger than age 18	-4,531	-29%	-7,356	-47%	-9,483	-61%
Reports any work	-1,880	-19%	-3,122	-31%	-3,718	-37%
Self-employed	-405	-30%	-693	-51%	-999	-73%
Fair/poor health	-773	-23%	-1,387	-42%	-1,964	-59%

	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	Number (thousands)	Percent	Number (thousands)	Percent	Number (thousands)	Percent
Limitation affecting work	-210	-16%	-471	-37%	-784	-62%
Functional limitation	-326	-17%	-701	-37%	-1,109	-58%
Lives with a disabled family member	-351	-19%	-680	-36%	-979	-52%
Black, not Hispanic	-672	-25%	-1,116	-41%	-1,446	-53%
Hispanic	-949	-26%	-1,551	-42%	-1,973	-53%
White, not Hispanic	-2,829	-29%	-4,534	-46%	-5,729	-58%
Another or multiple race/ethnicity	-477	-22%	-770	-36%	-984	-46%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: OBBBA=One Big Beautiful Bill Act. Enrollment refers to average monthly enrollment in thousands. See executive summary page vi for definition of high, medium, and low mitigation scenarios. Expansion enrollment here refers to enrollees subject to work requirements, including Medicaid waiver enrollees in Wisconsin.

We project Medicaid coverage losses across a range of groups, including those who could comply with work requirements or be exempt from them but experience fluctuations in their circumstances or challenges navigating state reporting processes. For instance, expansion enrollment would fall by 19/37 percent among working expansion enrollees under the high/low mitigation scenarios, because of factors such as irregular work schedules, lack of data available to states to automatically verify work status, employment below 80 hours per month (and lack of monthly income equivalent to 80 work hours at the federal minimum wage), and the impact of more frequent eligibility redeterminations. Though most parents of children ages 13 and younger should be automatically exempted from OBBBA's work requirements, parents whose children are all ages 14 or older would not be eligible for this exemption. Expansion enrollment would fall by between 14 and 23 percent of all parents living with children younger than age 18, primarily because of more frequent eligibility redeterminations, with the majority of enrollment declines among those with children younger than age 14.

Projected enrollment declines are even higher—and the range of potential enrollment impacts is wider across mitigation scenarios—among groups less likely to have compliance or exemption characteristics that are captured through automatic data-matching using current eligibility and enrollment systems. Federal and state investments to build capacity for identifying these groups through ex parte verification processes will be a critical factor in their ability to maintain coverage.

In all three scenarios, those who are ages 50 to 64, many of whom experience elevated health challenges[66] that will not necessarily be reflected in the exemptions that are defined by states, and those who are self-employed experience the highest projected enrollment declines among the

subgroups we examined. With low mitigation, we project a drop in average monthly enrollment of 65 percent among those who are ages 50 to 64 and of 73 percent among those who are self-employed under the combined effects of six-month redeterminations and work requirements. Even with high mitigation, these two groups are projected to experience expansion enrollment declines of about 30 percent. Overall, the most common way expansion enrollees are projected to meet OBBBA's work requirements is through employment, as indicated by earnings data available to states (data not shown). However, both the 50- to 64-year-old age group and the self-employed are less likely than younger enrollees and traditional employees to be automatically found to have satisfied the community engagement requirement based on employment and earnings data. The 50- to 64-year-old age group is more likely to have health issues that limit their ability to work (CBPP 2020), while the self-employed are less likely to have earnings that show up in databases that are readily available to states and thus would be required to take action to prove their compliance (data not shown).

We also project high enrollment losses for other subgroups, such as students and those potentially caring for a disabled family member[67] who would be compliant with or exempt from OBBBA's work requirements, but for whom states may lack the information to automatically deem them as such. Under low mitigation, we project that expansion enrollment among students or those living in families with disabled members would decline by over 50 percent, even though many would comply with work requirements by being in school or exempt due to caring for a disabled family member, but would have to report their compliance or exemption characteristics manually rather than being automatically determined. Even under our high mitigation scenario, where states would have access to data to identify up to half of students as compliant on that basis, we project enrollment among students would fall by 21 percent.

We also project that many enrollees with health issues and limitations would lose Medicaid coverage under both low and high mitigation scenarios. With low mitigation, enrollment would decline by 62 percent among those with a work limitation, 58 percent among those with a functional limitation, and 59 percent among those who report fair or poor health. Even with high mitigation, we project that enrollment would decline by 16 percent among those with a limitation that affects their ability to work, by 17 percent among those with a functional limitation, and by 23 percent among those in fair or poor health.

We project roughly similar percent coverage declines by race/ethnicity, with expansion enrollment falling by between 29 and 58 percent for White, non-Hispanic adults, 26 to 53 percent for Hispanic adults, 25 to 53 percent for Black, non-Hispanic adults, and 22 to 46 percent for those in another

racial/ethnic group or with multiple racial/ethnic identities. However, regardless of scenario, about 57 percent of the coverage losses we project would be among non-Hispanic white people.

These coverage changes assume state definitions of medical frailty include diagnosed health conditions specified previously in states such as Indiana, Michigan, Nebraska, and New Mexico. However, to the extent states are allowed to adopt a more expansive definition of "serious or complex medical conditions" that is consistent with other federal laws and regulations, a larger number of people with chronic health issues and disabilities would be protected from coverage loss, as described below.

Effect of a Broader Definition of 'Serious or Complex Medical Conditions' on Medical Frailty Exemptions

OBBBA specifies that adults who are exempt from Medicaid work requirements based on medical frailty or other special medical needs include those "with a serious or complex medical condition," raising questions about the criteria that will be used to determine whether a condition is serious or complex. The statutory language for identifying the five categories of medical frailty in OBBBA is similar to the language used in prior regulations issued in 2013 for identifying medically frail individuals who must be exempted from mandatory Alternative Benefit Plan (ABP) enrollment.[68] In developing those rules, CMS sought to establish a minimum standard without providing an exhaustive list of qualifying conditions, giving states flexibility to develop their own definitions.[69] Reviews of state ABPs and demonstration waivers highlight the wide range of approaches used to make medical frailty determinations (Hartly 2025; Musumeci, Chidambaram, and O'Malley Watts 2019),[70] including several that are inconsistent with federal regulations.[71] One notable difference between OBBBA and prior regulations is that OBBBA exempts people from work requirements if they have serious *or* complex conditions, rather than serious *and* complex conditions, allowing states to go beyond existing definitions of medical frailty and protect coverage for people with a broader range of health issues.[72]

CMS officials have indicated they will review existing federal regulations that may inform forthcoming guidance on defining medical frailty.[73] It is therefore important to consider how the terminology in OBBBA has been defined in other contexts. For instance, under the Family and Medical Leave Act, a "serious health condition" refers to an illness, injury, impairment, or physical or medical condition requiring (1) an overnight hospitalization, or (2) continuing treatment by a health care provider for chronic conditions that may cause episodic or continuing incapacity (e.g., inability to work, attend school, or perform regular daily activities) or would result in incapacity if left untreated.[74] Under the No Surprises Act, a "serious and complex condition" refers to one that requires specialized treatment to avoid the reasonable possibility of death or permanent harm, or a chronic condition that is

life-threatening, degenerative, potentially disabling, or congenital.[75] CMS has also identified examples of chronic conditions that place individuals "at significant risk of death, acute exacerbation or decompensation, or functional decline" in its coverage of chronic care management in Medicare[76] and "medically complex chronic conditions" in developing Chronic Condition Special Needs Plans.[77]

Additional research, including reports by the National Academy of Medicine (formerly the Institute of Medicine), have also identified criteria to consider for defining serious and complex medical conditions or serious illness, including not only risks of mortality and impacts on functioning but also pain or discomfort, strain on caregivers, required monitoring, and coordination across multiple specialties (Joynt et al. 2017; Kelley, et al. 2016; National Academy of Medicine 2017; Sharfstein 1999). A recent analysis focuses on conditions that are chronic and require ongoing management through clinical care or prescription drugs; tend to show up in clusters among older, low-income, working-age adults; pose serious risks if unmanaged; and require levels of health care substantially above the norm.[78]

Our main model (including our "high mitigation scenario") applies medical frailty definitions that are consistent with lists of qualifying health conditions identified under prior state approaches in Indiana, Michigan, Nebraska, and New Mexico because of uncertainty in how CMS will interpret OBBBA. Table 5 shows the sensitivity of our results to a broader definition of medical frailty, which includes additional chronic conditions provided as examples of what may be considered serious or complex under other federal regulations and programs, such as asthma, diabetes,[79] epilepsy, chronic obstructive pulmonary disease (including chronic bronchitis or emphysema), hypertension, and arthritis. If CMS and states adopt this broader definition and have the capacity to identify all enrollees treated for these conditions through a review of claims and encounter data, our estimated overall coverage losses would decline from 4.9 million under our high mitigation scenario to 4.3 million. Coverage losses driven by the incremental effect of work requirements would decline from 3.0 million to 2.3 million.

Using the broader definition of medical frailty would help alleviate coverage impacts for older adults ages 50 to 64, who would experience coverage losses of 1.0 million (24 percent, data not shown), compared with 1.2 million (30 percent) under our high mitigation scenario with the narrower state definition, as well as adults with self-reported fair or poor health status (0.6 million versus 0.8 million).

However, much of the remaining coverage loss for groups with health issues or disabilities would be attributable to six-month redeterminations. Under our high mitigation scenario with the narrower definition of medical frailty based on prior state approaches, the incremental effect of work requirements (i.e., beyond the impact of six-month redetermination) would result in disenrollment of 9 percent of people with a functional limitation and 13 percent of those reporting fair or poor health

status (data not shown). Under the broader definition of medical frailty, those percentages would decline by nearly half to 6 percent and 8 percent, respectively. Even with this definition, however, the combined effect of six-month redeterminations and work requirements would still cause more than half a million people reporting fair or poor health status to lose coverage.

TABLE 5

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Under High Mitigation Scenario With and Without Broader Medical Frailty Definition

	High mitigation scenario with a broader definition of medical frailty	High mitigation scenario
Six-month redetermination and work requirements		
Decline in average monthly expansion enrollment (millions)	-4.3	-4.9
Percent decline in average monthly expansion enrollment	-23%	-27%
Six-month redetermination only		
Decline in average monthly expansion enrollment (millions)	-2.0	-2.0
Percent decline in average monthly expansion enrollment	-11%	-11%
Incremental effect of work requirements on top of the six-month redetermination		
Decline in average monthly expansion enrollment (millions)	-2.3	-3.0
Percent decline in average monthly expansion enrollment	-13%	-16%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025

Notes: Expansion enrollment here refers to all enrollees subject to work requirements, including Medicaid waiver enrollees in Wisconsin. Estimates are rounded to the nearest hundred thousand. Medical frailty under the high mitigation scenario is defined based on anticipated claims data matching for diagnosed health conditions specified in previous state criteria for medical frailty determinations in Indiana, Michigan, Nebraska, and New Mexico, as well as self-reported receipt of help with or difficulty with activities of daily living or instrumental activities of daily living, which could be accepted as evidence of medical frailty based on self-attestation. The broader definition of medical frailty includes additional conditions that may be considered serious or complex based on how these terms are defined in other federal laws and programs.

These results underscore the importance of adopting a broader definition of medical frailty that includes a more expansive set of conditions considered serious or complex under other federal regulations. Defining these terms too narrowly would result in larger coverage losses among adults who could face severe and even life-threatening consequences from forgoing medical treatment that would no longer be covered by Medicaid.

Discussion

This analysis finds that, together, OBBBA's work requirements and six-month redeterminations will lead to Medicaid coverage losses in each expansion state and in Wisconsin's waiver program, with the size of the coverage losses dependent on policy and implementation choices. With minimal reliance on data-matching to make automatic determinations of eligibility, compliance, and exemptions; more stringent rules pertaining to the number of months with qualifying work activities; and more narrow definitions of exemptions, we find that 55 percent or 10.1 million fewer adults would be enrolled in Medicaid expansion coverage. But even under much greater reliance on data-matching, more flexible work rules, and broader exemption definitions, 27 percent or 4.9 million fewer adults would be enrolled in Medicaid expansion coverage. Under all three implementation scenarios that we consider, many who are likely to be in compliance with or who could qualify for an exemption from work requirements are at risk of losing coverage, with particularly high risks facing the self-employed, those with irregular work schedules, students, those who are caring for disabled family members, and those who are 50 or older.

Importance of State Data-Matching Capabilities and Policy Choices

Our analysis finds that the extent of projected Medicaid coverage losses under OBBBA in each state will depend heavily on reliance on data-matching to ensure that people who are eligible and in compliance with or exempt from work requirements successfully retain and enroll in Medicaid coverage, with higher rates of data-matching and other policy choices resulting in much lower declines in expansion enrollment. That said, the implementation timeline will make it difficult, if not impossible, for states to have systems in place by January of 2027 that maximize the use of data for eligibility determinations and the implementation of work requirements (Meuse 2025; Serafi, Sbrana, and Dervan 2025; Wagner et al. 2025). Doing that will require new, time-consuming investments that involve procurement and hiring, negotiating data use agreements, new programming to match applicants and enrollees with the different data sources that can assess compliance and exemptions, and alterations to enrollment and redetermination processes and forms (Serafi et al. 2025).

Our analysis shows that CMS' focus on a "data-first"[80] approach to implementing work requirements would involve states having current data that reflect many disparate types of activities and characteristics, including: (1) work hours and/or income, including for the self-employed and gig workers; (2) the full range of potential health exemptions; (3) school enrollment; (4) exemption for SNAP work requirements; (5) caregiving status; (6) presence of children age 13 and younger in the household; and (7) community service activities. We find that the narrower the exemption criteria are

for specific health diagnoses, the greater the potential coverage losses, including among those with chronic care needs who rely on ongoing care to maintain their health and functioning. Conversely, adopting a broad definition of serious or complex medical conditions could expand exemptions to more adults with ongoing chronic care needs who would face serious health risks if they lose coverage.

The scale of coverage losses under OBBBA will also depend on each state's policy choices. These decisions include how many months of compliance or exemption activities applicants must fulfill before enrolling and how many months enrollees must meet these requirements in the six months before each eligibility redetermination; whether the state has adopted the allowable hardship exemptions; how medical frailty, including serious or complex health conditions, are defined and how associated exemptions are granted (i.e., to the extent that self-attestation will be permitted, based on what is allowed by CMS); in cases where self-attestation is not used, what documentation and reporting will be required and by whom; and how effective outreach and enrollment efforts are at helping people understand whether they are affected by the new rules and what they have to do to maintain their coverage or successfully enroll.

Some compliance/exemption activities will be much harder for states to track electronically. For instance, it seems unlikely that all states will have systems to track community service statewide by 2028. Thus, developing user-friendly interfaces for applicants and enrollees to report information not already available to the state, notifying people on how to use those systems, and ensuring the systems are accessible and functional will also be critical to minimizing unnecessary coverage losses.

Role of CMS

Implementation guidance. As noted above, CMS is required to issue guidance about work requirements by June 2026. Along with clarifying which nonexpansion states this provision of OBBBA applies to, this guidance will be critical for determining qualifying activities related to work programs and community service; identifying the number of credits used to determine half-time enrollment and hours engaged in educational programs; defining medical frailty exemption criteria, the "lookback" period for identifying those exemptions in claims and encounter data (i.e., how recent the data must be), and how frequently those exemptions must be reverified; determining allowable data sources for ex parte processes; and establishing documentation requirements for people who must verify their exemptions or compliance manually.[81] However, states are already building systems to be ready for implementation in January 2027. Releasing the guidance as soon as possible would put states in a stronger position for implementation by that point. Moreover, guidance that provides states key flexibilities, such as allowing self-attestation of certain activities and characteristics, and sets specific standards that states must

follow (e.g., that they must use certain data sources or allow self-attestation for specific activities and characteristics) could reduce state administrative burdens and minimize unnecessary coverage loss among people who are in compliance or who qualify for an exemption that is prescribed in the statute.

Implementation delays. It remains to be seen whether CMS will permit delayed implementation in cases where states do not have all the key data sources ready to assess compliance and exemptions by late 2026. CMS has indicated that extensions, if any, would be limited to "states that are making meaningful efforts toward implementation and experience severe and/or unexpected issues that hinder their progress" (Brillman 2025). However, with our analysis finding that declines in coverage because of work requirements alone could be much higher under lower use of data-matching, and that several different data sources will be important for determining compliance and exemptions, some states may need more time to develop working systems to collect data on all relevant factors.

Oversight. The OBBBA statute includes no reporting requirements, and at this point, it is unclear whether states will be required to submit implementation plans to CMS that detail which data sources they plan to use, how many months of compliance/exemption they are requiring of new applicants and between redetermination periods, how they are defining and providing for health exemptions, or whether they intend to implement the available hardship exemptions. Nebraska, which indicated that it has plans to implement work requirements beginning May 1, 2026, has released only limited information on its implementation plan;[82] for instance, it is not known which data sources Nebraska plans to use to automatically assess compliance and exemptions. CMS could help ensure that people who are exempt and in compliance do not lose coverage by assessing states' implementation readiness and delaying implementation when states cannot conduct key data matches.

Reporting and monitoring. It is also unclear whether CMS will require states to report any indicators on enrollment and disenrollment related to OBBBA's work requirements. It will be essential that "real-time" (i.e., with a minimal lag) information be released on what is happening to new enrollment and disenrollment under this provision, and the reasons why people are disenrolling or applicants are not successfully enrolling in the first place, for both the expansion group and other enrollee groups. At a minimum, it will be important to know how many current enrollees and new applicants are subject to work requirements each month; how many are found exempt or compliant and on what basis; the extent to which these exemptions are verified automatically through data-matching or manually; the number who are verified based on self-attestation versus providing documentation; how many are denied coverage or disenrolled because they are able to prove they are working or completing other community engagement activities but fall short of the required number of hours; and how many are denied or disenrolled because they do not submit required documents or respond to state notices or

requests for information related to the work requirements.[83] It will also be critical to understand who is being disenrolled and denied coverage within the expansion group (e.g., their age and county of residence), as well as changes in enrollment in other eligibility groups. CMS already collects several indicators from states that could be used to monitor and evaluate the implementation of OBBBA's work requirements, but additional metrics would be needed to comprehensively assess the impacts of these provisions (MACPAC 2026).[84]

Tracking changes in enrollment among the expansion population and affected waiver populations will help states and CMS identify specific exemptions and compliance factors that are not operating as intended, and make appropriate adjustments. In cases where a subgroup experiences steeper enrollment declines than other groups or where declines are steep among those that should be able to maintain Medicaid at high rates or whose health or other needs would be harmed by going without coverage (such as those who have a SUD or serious mental health issues, are pregnant or postpartum, are age 50 or older, or are reentering the community from carceral settings), CMS may want to consider pausing disenrollment to allow states to improve data systems to ensure that people who qualify for exemptions are receiving them and that those who are in compliance are maintaining coverage.

Implications of Coverage Losses for Access, Affordability, Employment, and Health

Reductions in Medicaid coverage are expected to reduce access to needed health care and place greater financial burdens on families and providers (McMorrow et al. 2016, 2017; Sommers 2013; Wherry, Kenney, and Sommers 2016).[85] Given the chronic and acute health needs of those we project will lose coverage, the adverse morbidity and mortality impacts could be swift as people lose access to prescription drugs and clinical care on which they depend (Pandey et al. 2025; Schpero, Zhang, and Civelek 2025; Sommers, Gawande, and Baicker 2017). In addition, the loss of health care access could make it more difficult for people to maintain employment and undermine their ability to work.[86] The loss of Medicaid coverage risks increasing psychological distress and forgone care, which could cause harm even among adults who are not being treated for chronic health problems or an acute condition, as they will have fewer opportunities to receive preventive services and have health problems detected in a timely way (McMorrow et al. 2016, 2017; Wherry and Miller 2016).

Implications for Other Eligibility Groups and Stakeholders

Although these OBBBA policies target ACA Medicaid expansion and specific waiver eligibility categories, they could have spillover effects on other population groups. To the extent that other

groups of Medicaid enrollees and applicants mistakenly believe that they too must meet a work requirement, people could be discouraged from applying for or renewing Medicaid coverage altogether. Coverage losses occurring among parents because of the more frequent redeterminations and work requirements could also reduce enrollment of both younger and older children in public health insurance coverage and reduce their access and use of health care given the interconnection between parental and child coverage and access to care (Davidoff et al. 2003; Dubay and Kenney 2003; Gifford, Weech-Maldonado, and Short 2005; Hudson and Moriya 2017; Suendelman et al. 2006; Venkataramani, Pollack, and Roberts 2017).[87] Moreover, the demands placed on enrollment assistors and navigators, state and county Medicaid eligibility workers who process applications and redeterminations, and state call centers will be much higher with six-month redeterminations and work requirements, which in turn could make it harder for other groups to get the help they need with enrollment and retention and increase processing times, delaying or reducing their access to coverage. The expansion of SNAP work requirements and the shifting of SNAP administrative and benefit costs to states under OBBBA are expected to exacerbate administrative burdens, particularly in states with integrated Medicaid and SNAP eligibility systems and workforces.

Although our analysis shows that OBBBA's work requirement poses greater enrollment risks than six-month redeterminations, the latter policy on its own could lower expansion enrollment by 16 percent in states with low ex parte renewal rates. States may want to consider taking up more available flexibilities for conducting ex parte renewals and otherwise taking steps to support the use of timely and comprehensive wage and income data to make ex parte eligibility determinations (Tsai 2024a,b). Such steps would also benefit other eligibility groups beyond expansion enrollees. Moreover, our estimates focus on the impacts on average monthly enrollment from six-month redeterminations and work requirements, but additional people will experience disruptions in coverage and care, as our model predicts that churn in and out of expansion coverage will rise.

Higher levels of churn will also raise the administrative costs associated with maintaining Medicaid enrollment and introduce more unpredictability for providers and managed care plans (Musumeci et al. 2025).[88] In addition, impacts of declines in coverage will extend to health care providers, including hospitals, and affect states' and localities' economic activity and tax revenues (Haught et al. 2025; Ku et al. 2025).

Role of Research

Our analysis projects that how OBBBA's six-month redeterminations and work requirements are implemented will have a major impact on the extent and nature of Medicaid coverage losses. Beyond

tracking changes in enrollment nationally and by state, to inform future policy, it will be critical that researchers assess the impacts of these policies and whether and how they vary with state implementation choices. Such assessments would ideally address impacts on health insurance coverage, access to and receipt of health care, morbidity and mortality, out-of-pocket spending burdens, medical debt, employment, income, poverty, and the solvency of safety net providers. Research could also assess whether people subject to work requirements feel they have higher self-sufficiency and agency, as anticipated by proponents of the policy (Greibrok and Ingram 2025),[89] or conversely, whether the challenges obtaining and maintaining coverage or loss of access to needed care reduce their physical and mental well-being and self-sufficiency.

Moreover, research should consider effects for different subgroups, especially those who would suffer greater harm under loss of ongoing medical care or who are at greater risk of losing coverage, including young and older adults, those in historically marginalized communities, those who are self-employed or work irregular or informal jobs, caregivers for family members with disabilities, and those who have health issues or limitations.

Appendix A. Supplemental Exhibits

APPENDIX TABLE A.1

Factors That Vary by Mitigation Scenario in Projecting Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations

	High mitigation scenario	Medium mitigation scenario	Low mitigation scenario
Compliance activities			
Wage compliance—State-selected compliance period	1 month	3 months	3 months
Self-employed wages—Use of available data and/or self-attestation	Yes	No	No
Share of students assumed to be identifiable in available data	Yes, 50%	Yes, 20%	No
Exemption activities and characteristics			
SNAP match, integrated states	95%	75%	67%
SNAP match, other states	67%	33%	20%
Medical frailty (including SUD)[a]	Use of claims data and self-attestation of difficulty with ADLs, with medical frailty broadly defined	Use of claims data, with medical frailty narrowly defined, no use of self-attestation	No use of claims data or self-attestation
Model parameters			
Six-month redetermination impact[b]	High mitigation	Low mitigation	Low mitigation
Share of manual verifiers who do not respond	65%	75%	87%
Share of those disenrolled from work requirements who would regain eligibility and re-enroll[c]	30%	25%	20%
Downward enrollment adjustment for new enrollees relative to current enrollees[d]	85%	75%	75%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.

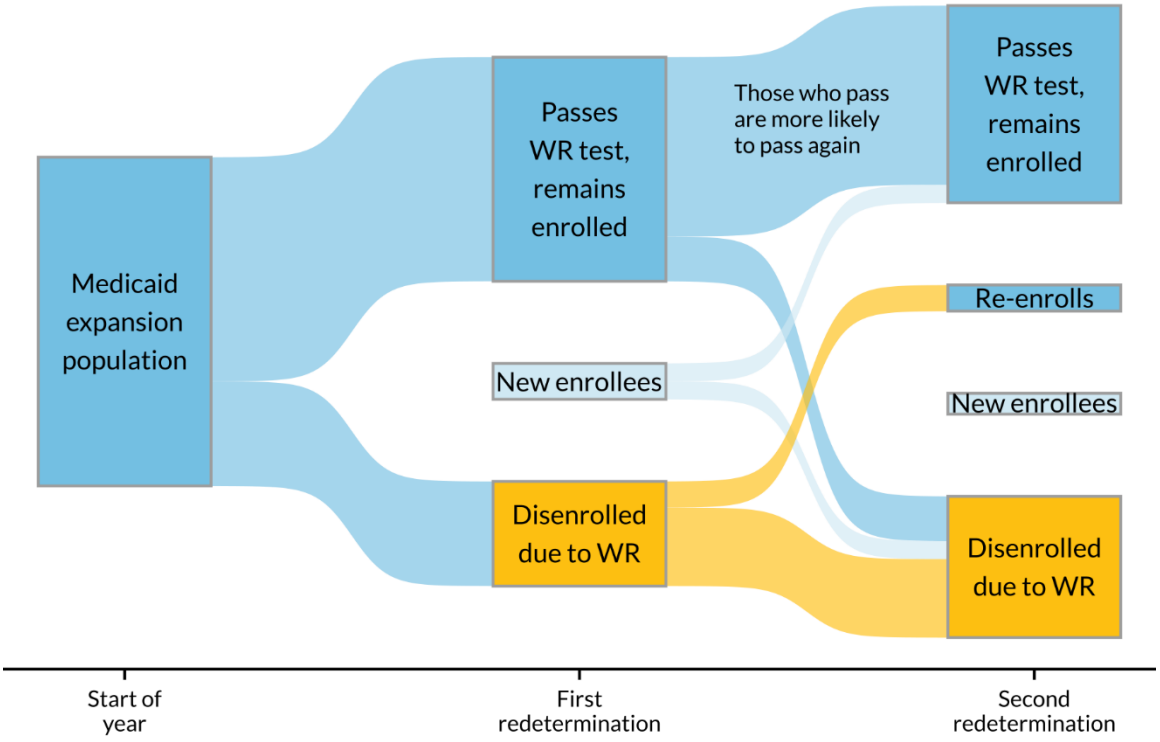
Notes: OBBBA=One Big Beautiful Bill Act; SUD; substance use disorder; ADLs=activities of daily living. Also includes those who have difficulty with IADLs (instrumental activities of daily living). Estimates are rounded to the nearest hundred thousand.

a. Based on prior state approaches. Definitions of medical frailty vary based on inclusion or exclusion of selected mental health conditions that may or may not be considered a "disabling mental disorder" for the purpose of providing work requirement exemptions under OBBBA. However, as discussed in the main report on page 34, CMS guidance may allow or require states to

adopt broader definitions of medical frailty under the work requirement provisions of OBBBA compared with prior state approaches.
b. Low impact assumes that all states can minimize procedural disenrollment due to six-month redetermination, while high impact assumes procedural disenrollment rates similar to current ones. For more details on the scenarios, see Buettgens et al. (2026).
c. Based on our analysis of Survey of Income and Program Participation data, enrollees whose compliance with work requirements has already been verified are highly likely to remain in compliance, with less than 10 percent no longer being compliant (appendix figure A.1).
d. Represents how much less chance a new applicant would have of verifying compliance or exemption than a current enrollee. This considers that data matches will be more difficult, the look-back period more restrictive, and the new requirements may discourage some applicants. The medium and high scenario values are essentially the same because while the high scenario assumes more discouragement, it makes much less use of data matches, so the potential lack of data on new applicants has less effect.

APPENDIX FIGURE A.1

Schematic of Potential Coverage Changes Under OBBBA Among Medicaid Expansion Enrollees Over One Year



URBAN INSTITUTE

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.
Notes: WR = work requirement; OBBBA=One Big Beautiful Bill Act. This schematic does not display real relative probabilities of the population entering or exiting each category over time. For readability purposes, this only roughly displays the relative size of each group. Each flow for a group occurring from one period to the next represents an aspect of the Markov chain that needs to be modeled. For instance, a probability is applied to model whether a person who has been disenrolled will re-enroll in the ensuing (or following) periods. Generally, new enrollment will be reduced from current levels because of work requirement verification for applicants. Future enrollment will therefore consist of individuals who persistently pass work requirement tests over time and are never disenrolled, new enrollees, and individuals who re-enroll after becoming disenrolled at least once.

APPENDIX TABLE A.2

Projected Changes in Average Monthly Medicaid Expansion Enrollment (in thousands) in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, by State and Mitigation Scenario

	Six-Month Determinations Only						Incremental Difference of Work Requirements After Six-Month Redetermination					
	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario		High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.
Alaska	-6	-9%	-11	-17%	-11	-17%	-8	-12%	-13	-20%	-19	-30%
Arizona	-56	-12%	-91	-20%	-91	-20%	-67	-15%	-106	-24%	-155	-35%
Arkansas	-25	-11%	-37	-17%	-37	-17%	-25	-12%	-41	-19%	-61	-28%
California	-391	-9%	-587	-13%	-587	-13%	-864	-20%	-1,408	-32%	-1,965	-45%
Colorado	-56	-15%	-79	-21%	-79	-21%	-52	-14%	-86	-23%	-122	-32%
Connecticut	-34	-11%	-47	-16%	-47	-16%	-61	-20%	-108	-36%	-150	-50%
District of Columbia	-8	-7%	-14	-13%	-14	-13%	-19	-17%	-32	-29%	-46	-42%
Delaware	-8	-13%	-14	-22%	-14	-22%	-9	-15%	-15	-24%	-22	-34%
Hawaii	-14	-10%	-17	-13%	-17	-13%	-21	-16%	-40	-30%	-54	-41%
Idaho	-14	-17%	-21	-26%	-21	-26%	-6	-8%	-9	-11%	-14	-17%
Illinois	-59	-8%	-109	-15%	-109	-15%	-135	-18%	-214	-29%	-306	-42%
Indiana	-57	-10%	-87	-15%	-87	-15%	-64	-11%	-115	-20%	-183	-32%
Iowa	-23	-13%	-37	-20%	-37	-20%	-22	-12%	-36	-20%	-55	-30%
Kentucky	-56	-14%	-96	-24%	-96	-24%	-46	-11%	-71	-17%	-105	-26%
Louisiana	-57	-12%	-81	-17%	-81	-17%	-66	-13%	-123	-25%	-183	-37%
Maine	-8	-12%	-12	-18%	-12	-18%	-9	-14%	-16	-24%	-26	-38%
Maryland	-41	-12%	-91	-27%	-91	-27%	-62	-18%	-81	-24%	-116	-35%
Massachusetts	-35	-12%	-49	-17%	-49	-17%	-65	-22%	-111	-37%	-153	-51%
Michigan	-71	-10%	-133	-19%	-133	-19%	-100	-14%	-154	-22%	-222	-31%
Minnesota	-22	-12%	-38	-20%	-38	-20%	-32	-17%	-53	-28%	-75	-40%
Missouri	-35	-10%	-81	-23%	-81	-23%	-60	-17%	-88	-25%	-141	-39%
Montana	-10	-13%	-17	-22%	-17	-22%	-8	-10%	-11	-14%	-17	-22%
Nebraska	-10	-13%	-15	-21%	-15	-21%	-6	-9%	-10	-13%	-14	-20%
Nevada	-30	-10%	-47	-16%	-47	-16%	-41	-14%	-66	-22%	-98	-33%
New Hampshire	-7	-14%	-12	-22%	-12	-22%	-7	-13%	-12	-22%	-18	-34%
New Jersey	-64	-12%	-94	-17%	-94	-17%	-91	-17%	-149	-27%	-211	-39%
New Mexico	-24	-10%	-57	-24%	-57	-24%	-25	-10%	-31	-13%	-52	-22%
New York	-220	-11%	-319	-16%	-319	-16%	-374	-19%	-636	-32%	-901	-46%
North Carolina	-59	-9%	-100	-15%	-100	-15%	-92	-13%	-148	-22%	-230	-33%
North Dakota	-3	-12%	-6	-24%	-6	-24%	-1	-5%	-2	-6%	-3	-13%
Ohio	-88	-12%	-138	-19%	-138	-19%	-88	-12%	-147	-21%	-218	-31%

	Six-Month Determinations Only						Incremental Difference of Work Requirements After Six-Month Redetermination					
	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario		High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.
Oklahoma	-25	-11%	-59	-25%	-59	-25%	-22	-9%	-28	-12%	-46	-19%
Oregon	-46	-8%	-71	-13%	-71	-13%	-66	-12%	-114	-21%	-176	-33%
Pennsylvania	-77	-10%	-122	-16%	-122	-16%	-96	-13%	-155	-21%	-226	-30%
Rhode Island	-10	-12%	-14	-17%	-14	-17%	-13	-16%	-20	-25%	-30	-37%
South Dakota	-4	-12%	-6	-19%	-6	-19%	-2	-6%	-5	-15%	-9	-29%
Utah	-12	-14%	-24	-29%	-24	-29%	-7	-9%	-9	-11%	-16	-19%
Vermont	-4	-10%	-6	-14%	-6	-14%	-9	-22%	-15	-36%	-20	-49%
Virginia	-88	-15%	-115	-20%	-115	-20%	-90	-16%	-154	-27%	-218	-38%
Washington	-68	-11%	-98	-16%	-98	-16%	-90	-15%	-162	-27%	-231	-38%
West Virginia	-23	-16%	-37	-26%	-37	-26%	-17	-12%	-24	-16%	-38	-26%
Wisconsin	0	0%	0	0%	0	0%	-39	-23%	-70	-42%	-100	-60%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: OBBBA=One Big Beautiful Bill Act. Enrollment refers to average monthly enrollment in thousands. See executive summary page vi for definition of high, medium, and low mitigation scenarios.

APPENDIX TABLE A.3

Projected Changes in Average Monthly Medicaid Expansion Enrollment (in thousands) in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Selected Subgroups, by Mitigation Scenario

	Six-Month Determinations Only						Incremental Difference of Work Requirements After Six-Month Redetermination					
	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario		High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.	#	Pct.
Less than 35 years old	-1,073	-11%	-1,700	-17%	-1,700	-17%	-1,542	-15%	-2,564	-25%	-3,606	-36%
Between 35 and 50 years old	-478	-11%	-752	-17%	-752	-17%	-610	-14%	-980	-23%	-1,445	-33%
Between 50 and 64 years old	-395	-10%	-634	-16%	-634	-16%	-828	-21%	-1,339	-33%	-1,993	-49%
Student	-382	-10%	-609	-17%	-609	-17%	-400	-11%	-904	-25%	-1,445	-40%
Parent of child younger than age 18	-363	-13%	-564	-20%	-564	-20%	-32	-1%	-51	-2%	-84	-3%
Not parent of child younger than age 18	-1,584	-10%	-2,523	-16%	-2,523	-16%	-2,947	-19%	-4,833	-31%	-6,960	-44%
Reports any work	-1,270	-13%	-1,967	-20%	-1,967	-20%	-610	-6%	-1,155	-12%	-1,751	-18%
Self-Employed	-170	-12%	-254	-19%	-254	-19%	-235	-17%	-439	-32%	-745	-54%
Fair/poor health, work limitation, and/or functional limitation												
Fair/poor health	-325	-10%	-528	-16%	-528	-16%	-448	-13%	-859	-26%	-1,436	-43%
Limitation affecting work	-120	-9%	-192	-15%	-192	-15%	-90	-7%	-278	-22%	-592	-46%
Functional limitation	-151	-8%	-258	-14%	-258	-14%	-176	-9%	-444	-23%	-852	-45%
Lives with a disabled family member	-61	-3%	-138	-7%	-138	-7%	-289	-15%	-542	-29%	-840	-45%

Source: Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: OBBBA=One Big Beautiful Bill Act. Enrollment refers to average monthly enrollment in thousands. See executive summary page vi for definition of high, medium, and low mitigation scenarios.

Notes

[1] One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025).

[2] Analysts and state officials anticipate the policy will apply to the 40 states (and the District of Columbia) that expanded Medicaid under the ACA, as well as nonexpansion states such as Wisconsin and Georgia that expanded Medicaid for adults under 1115 Waivers (Meuse 2025). See Beatricer Lawson, "Wisconsin Medicaid Director: New Federal Requirements Would Affect 'The Whole Health Care Economy,'" *Wisconsin Public Radio*, June 6, 2025, https://www.wpr.org/news/wisconsin-medicaid-director-federal-requirements-health-care-economy; "Impact of Federal Budget Reconciliation Bill on Wisconsinites," Wisconsin Department of Health Services, updated August 28, 2025; Christopher Alston, "Georgia Pathways to Undergo Changes Under New Federal Medicaid Work Requirements," *NPR*, December 11th, 2025, https://www.wabe.org/georgia-pathways-to-undergo-changes-under-new-federal-medicaid-work-requirements/; and CMS, "GA Pathway to Coverage CMS Temporary External Approval," September 23, 2025.

CMS has indicated that it is continuing to evaluate the demonstrations to which the law applies (Brillman 2025). In this analysis, we classify adults in Wisconsin's waiver program who have incomes up to 100 percent of the federal poverty level as subject to OBBBA's work requirements, but we do not include Georgia's Pathways waiver program. Future analysis may refine these as needed.

[3] The range of results for six-month redetermination depends on two major state decisions, procedural disenrollment rates and the frequency of existing data checks between redeterminations. The high mitigation scenario assumes that all states can minimize new procedural disenrollment, while the other scenarios are based on state procedural disenrollment rates reported to CMS in early 2025. States that already conduct data matches between redeterminations and then require those who may have lost eligibility to provide documentation will see less impact from the six-month redetermination, particularly in states where enrollees have only 10 days to respond. Results from future iterations of our model could differ, both based on new information about federal and state implementation, and for a longer run period of implementation.

[4] As described in the Data and Methods, we first model enrollment changes caused by the six-month redetermination provision and estimate the additional enrollment impacts resulting from work requirements.

[5] State-level projections do not attempt to incorporate anticipated state policy decisions related to OBBBA implementation but do incorporate certain pre-OBBBA policy decisions, The projected impact of six-month redeterminations incorporates the most recently available state-level procedural disenrollment rates and rates of state data checks during the 12 months between redeterminations to project the share of enrollees who will have to verify their eligibility to retain coverage during redeterminations. The projected impact of work requirements reflects prior state decisions regarding coverage of parents and whether states currently integrate SNAP and Medicaid eligibility systems (projecting that those that do will have lower shares of people required to verify compliance).

[6] In this report, we use the terms "people with disabilities" and "disabled people" interchangeably to reflect variation in how people refer to themselves using person-first or identity-first language. In addition, definitions of disability in this report vary based on the context in which they are used, such as disability-based eligibility pathways for Medicaid, participation in federal disability insurance programs, the presence of functional limitations as measured in underlying survey data, and service-connected disability ratings for veterans. These definitions do not fully represent the population with disabilities, including those affected by the provisions of OBBBA.

[7] CMS, "Fact Sheet: Pledges from Medicaid Technology Companies to Support Community Engagement Implementation and Related Medicaid System Improvements," January 29, 2026,

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-pledges-medicaid-technology-companies-support-community-engagement-implementation-related.

[8] Sara Rosenbaum, Feygele Jacobs, and Kay Johnson, "Nearly 5.6 Million Community Health Center Patients Could Lose Medicaid Coverage Under New Work Requirements, with Revenue Losses Up to $32 Billion," *To the Point (blog)*, Commonwealth Fund, May 30, 2025, https://www.commonwealthfund.org/blog/2025/community-health-center-patients-medicaid-coverage-work-requirements; and Karpman, Michael, "Medicaid Work Requirements Would Do Little or Nothing to Increase Employment, but Would Harm People's Health," *Urban Wire (blog)*, Urban Institute, May 15, 2023, https://www.urban.org/urban-wire/medicaid-work-requirements-would-do-little-or-nothing-increase-employment-would-harm.

[9] Rosenbaum, Jacobs, and Johnson, "Nearly 5.6 Million Community Health Center Patients Could Lose Medicaid Coverage Under New Work Requirements, with Revenue Losses Up to $32 Billion," and Mark Meiselbach and Matthew Lavalee, January 27, 2026, "H.R.1 Threatens The Stability Of Medicaid Managed Care," *Health Affairs Forefront*, https://www.healthaffairs.org/content/forefront/h-r-1-threatens-stability-medicaid-managed-care.

[10] One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025).

[11] See endnote 2.

[12] Work programs are defined based on the Food and Nutrition Act of 2008 and include SNAP employment and training programs, Workforce Innovation and Opportunity Act programs, job training under the Trade Act of 1974, employment and training programs for veterans, and workforce partnerships with private-sector and nonprofit entities. Food and Nutrition Act of 2008, Pub. L. No. 88–525 Stat. 703 (2008). Though this definition includes some supervised job search activities, it does not include job searches conducted independently (USDA 2023; Wroblewksa et al. 2022).

[13] Seasonal workers with an average monthly income over six months equivalent to 80 hours/month at the federal minimum wage would also be considered to be compliant.

[14] The statute refers to short-term hardship events that include receiving "inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause) as the Secretary determines appropriate." See U.S. Congress, One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025).

[15] Landi, Heather, "JPM26: Dr. Oz, CMS Leaders Make Their Pitch to Hospitals, Payers on Trump Admin Healthcare Policies," Fierce Healthcare, January 13, 2026, https://www.fiercehealthcare.com/regulatory/jpm26-dr-oz-cms-leaders-make-their-pitch-hospitals-payers-trump-admin-policies.

[16] Kinda Serafi and Elizabeth Dervan, "CMS Issues Initial Guidance on Work Reporting Requirements, Leaves Key Questions Unanswered," Manatt Health, December 17, 2025, https://www.manatt.com/insights/insight/cms-issues-initial-guidance-on-work-reporting-requirements-leaves-key-questions-unanswered.

[17] "Five Key Takeaways from the 2025 National Association of Medicaid Directors (NAMD) Conference," *HMA Insights (blog)*, Health Management Associates, December 4, 2025, https://www.healthmanagement.com/blog/five-key-takeaways-from-the-2025-national-association-of-medicaid-directors-namd-conference/.

[18] Office of Governor Jim Pillen, "Gov. Pillen, Dr. Oz Announce Nebraska is First in the Nation to Pursue Medicaid Work Requirements," December 17, 2025, https://governor.nebraska.gov/gov-pillen-dr-oz-announce-nebraska-first-nation-pursue-medicaid-work-requirements.

[19] They further assume that 5 percent of people who are not exempt or compliant would maintain their coverage due to errors and "less rigorous enforcement." See CBO (Congressional Budget Office), "Public Law 119-21, to

Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid," October 28, 2025.

[20] As described below, our model assumes 18.4 million people would be subject to work requirements in 2028. A new CBO baseline released in early 2026 projects that 17 million adults would be in the expansion group in 2026, before work requirements and six-month redeterminations are implemented. See Phillip L. Swagel, "Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R.1, the One Big Beautiful Bill Act," Congressional Budget Office, June 4, 2025; and CBO, "Baseline Projections," February 2026.

[21] The projections in this report are not comparable to those made by CBO, including because we present a range of estimates representing implementation scenarios rather than a single projection, we project impacts in a different time period, and our projections of impacts of work requirements build on top of impacts of six-month redeterminations (as opposed to those from CBO, who we believe simulated work requirements before six-month redeterminations). CBO's estimates of the share of people subject to six-month redeterminations who would lose coverage are at the low end of our simulated range: 10 percent versus our range of 11.9 percent to 21.1 percent (Buettgens et al. 2026). The difference between these estimates may partly reflect differences in whether the impacts of six-month redeterminations or work requirements were simulated first. States can apply for a waiver to delay the implementation of work requirements, so the situation in which only a six-month redetermination is in place is possible for some states, at least temporarily. Simulating the impact of six-month redeterminations first results in a larger share of the total loss of coverage being attributed to the increased frequency of redeterminations in our estimates. CBO estimated that six-month redeterminations would increase the number of uninsured people by 700,000. If we simulated six-month redetermination after work requirements, our range for the same statistic would be between 800,000 and 1.5 million people (Buettgens et al. 2026).

[22] Doug Badger, "Medicaid Work Requirements Could Help the Poor," The Heritage Foundation, January 9, 2019, https://www.heritage.org/medicaid/commentary/medicaid-work-requirements-could-help-the-poor; "CMS Issues New State Guidance on Transformative Medicaid Reforms," CMS.gov, December 8, 2025, https://www.cms.gov/newsroom/press-releases/cms-issues-new-state-guidance-transformative-medicaid-reforms; and Council of Economic Advisers, "Medicaid Community Engagement Requirements and the Value of Work," The White House, accessed February 26, 2026.

[23] "CMS Issues New State Guidance on Transformative Medicaid Reforms," CMS.gov.

[24] Mara Youdelman and David Machledt, "Top 10 Reasons Why Work Requirements Are Bad for Medicaid," National Health Law Program (blog), April 26, 2023, https://healthlaw.org/top-10-reasons-why-work-requirements-are-bad-for-medicaid/.

[25] New Hampshire Department of Health and Human Services, "DHHS Community Engagement Report: June 2019," June 20, 2019, accessed February 4, 2025 via Internet Archive.

[26] These estimates reported for Arkansas and New Hampshire are consistent with the experience of Michigan, where approximately one-third of those subject to the state's work requirement did not report their work activities in the first month of reporting and were at risk of losing coverage before a court ruling blocked the state's waiver from advancing; Robert Gordon, "More Than 100,000 Michigan Residents Nearly Lost Medicaid Coverage Under Work Requirements," The Commonwealth Fund (blog), May 12, 2025, https://www.commonwealthfund.org/blog/2025/michigan-residents-nearly-lost-medicaid-coverage.

[27] In Arkansas, people who were disenrolled for noncompliance with work requirements would have to wait until the next calendar year and then reapply for Medicaid to receive an eligibility determination. They could reapply earlier if they qualified for Medicaid through another eligibility pathway or had received a good cause exemption

because their failure to comply "was the result of a catastrophic event or circumstances beyond the beneficiary's control." See Seema Verma, "Arkansas Works," CMS, March 5, 2018.

New Hampshire's waiver required people to "cure" their deficient hours from one month in the subsequent month. If they failed to cure, their eligibility was suspended until they (1) cured the deficiency in work/community engagement hours, (2) obtained an exemption from the work requirement, (3) qualified for a good cause exemption, or (4) became eligible for Medicaid under another eligibility category. If they were still not compliant by the time of their redetermination period, their eligibility would be terminated. People whose eligibility was terminated at redetermination could reapply for Medicaid at any time, and their previous noncompliance would not be factored into the eligibility determination; CMS, "New Hampshire Health Protection Program Premium Assistance 1115 Demonstration," May 7, 2018.

[28] "Georgia Pathways to Coverage 1115 Demonstration Waiver Extension Notice," Georgia Department of Community Health, accessed January 21, 2026, https://dch.georgia.gov/announcement/2025-01-21/georgia-pathways-coverage-1115-demonstration-waiver-extension-notice; Leonardo Cuello and Joan Alker, "States Pursuing Medicaid Work Requirements Waivers Must Make Changes: How the OBB Changed the Landscape for Medicaid Work Requirements," *Say Ahhh!* (blog), Georgetown University McCourt School of Public Policy Center for Children and Families, July 23, 2025, https://ccf.georgetown.edu/2025/07/23/states-pursuing-medicaid-work-requirement-waivers-must-make-changes-how-the-obb-changed-the-landscape-for-medicaid-work-requirements/.

[29] Urban Institute, "The Health Insurance Policy Simulation Model," accessed February 26, 2026, https://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm.

[30] CMS, "Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Data," accessed January 24, 2026, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data.

[31] These states include Alaska, Arizona, Arkansas, California (though these included people enrolled regardless of immigration status), Colorado, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Virginia, and Washington.

[32] Using the most recent state-reported expansion enrollment results in a total number of expansion enrollees that is slightly lower than it would be if we used the December 2024 MBES solely, likely due in part to differences in reporting for MBES compared with state reports or declines in Medicaid enrollment during 2025. For most states, the differences are small, but in some states, including Louisiana and Massachusetts, state-reported expansion enrollment is considerably lower than reported in MBES (61 and 40 percent, respectively). This could mean a smaller number of enrollees are projected to become disenrolled in those states than if the underlying number of expansion enrollees were larger.

[33] As noted above, a new CBO baseline released in early 2026 projects that 17 million adults would be in the expansion group in 2026, before work requirements and six-month redeterminations are implemented (CBO 2026).

[34] Gordon, "More Than 100,000 Michigan Residents Nearly Lost Medicaid Coverage Under Work Requirements."

[35] Survey-reported dollar amounts are inflated to 2025 dollars based on the CPI-U.

[36] States could also leverage data from other social service programs that collect income data, such as TANF. However, our analysis only models this for SNAP.

[37] "The Work Number," Equifax, accessed February 26, 2026, https://theworknumber.com.

[38] We also assessed an alternative measure of how many expansion enrollees met monthly income standards using an income measure that included not only earnings but also other sources of cash income such as unemployment insurance and TANF (the statutory language in OBBBA refers to "monthly income that is not less than the applicable minimum wage requirement" and does not explicitly refer only to earnings). This alternative measure changed our results by less than one percentage point (data not shown).

[39] This assumption has considerable uncertainty. In 2015–16, 43 percent of all undergraduates were enrolled full-time exclusively, 19 percent were enrolled half-time exclusively, and the remainder were enrolled less than half-time or experienced changes in status over that period. See: "Understanding College Affordability," Urban Institute, accessed February 26, 2026, https://collegeaffordability.urban.org/what-is-college/students/#/by_attendance_pattern. However, these estimates are not specific to the Medicaid expansion population and do not include other types of students.

[40] Though the SIPP provides monthly income data, we lack information to determine whether workers would be classified as having seasonal employment. Prior analyses of the SIPP have found patterns of seasonal employment concentrated in industries such as agriculture, recreation, and education, but the ability to identify seasonal workers is limited because some individuals transition from seasonal work to other sources of employment (Coglianese and Price 2020).

[41] DOL, "PY 2023 WIOA National Performance Summary Narrative (Program Year 2023: July 1, 2023 – June 30, 2024)," accessed January 24, 2026; US Department of Education, "PY2023-24 AEFLA SPR National Summary 508," accessed February 26, 2026; Rehabilitation Service Administration, "Statewide Performance Report," accessed February 26, 2026; and DOL, "WIOA Adult Performance Report," accessed February 26, 2026.

[42] There are some notable differences between the OBBBA definition of medical frailty and the definition used in prior regulations. For instance, OBBBA only refers to individuals "with a substance use disorder" instead of individuals "with chronic substance use disorders." See "Code of Federal Regulations, Title 42, § 440.315 (2026)," Office of the Federal Register, accessed January 23, 2026, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-C/section-440.315.

[43] Sarah Maresh, "How Nebraska's Unnecessary and Complicated Medicaid Expansion Waiver Works," Nebraska Appleseed, November 12, 2020, https://neappleseed.org/33538.

[44] Having a certain medical condition does not always automatically qualify a person for a medical frailty exemption in each of these states. For instance, Indiana required people to have certain conditions and meet specified thresholds based on Milliman Underwriting Guidelines for the severity of their conditions.

[45] Advocates have noted that some people with disabilities may need assistance with IADLs but do not need help with ADLs and should be captured by other medical frailty categories related to "disabling mental disorders" and/or "serious or complex medical conditions." See Justice in Aging, National Health Law Program, and Bazelon Center for Mental Health Law, "Recommendations from Mitigating Harms to People with Disabilities, Older Adults, and Caregivers from Medicaid Work Requirements," December 2025.

[46] States, such as Iowa, New Jersey, New Hampshire, and Pennsylvania, include psychotic disorders, such as schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, and obsessive-compulsive disorder in their definitions of disabling medical disorders used for medical frailty determinations. New Jersey also includes "a chronic behavioral health condition and the Global Assessment Functioning score is 50 or less," New Hampshire includes "other mental health condition" with a write-in field for providers to specify the condition, and Pennsylvania includes "anxiety disorder (obsessive compulsive disorder, post-traumatic stress disorder, or severe panic disorder)." There is also variation among the states that have more specific lists of conditions and/or diagnosis codes. For instance, unlike Michigan and Nebraska, New Mexico's criteria for serious mental illness include diagnosis codes for mild depression and generalized anxiety

disorder, but the conditions must also result in functional impairment, be expected to last for six months or more, and meet strict criteria for symptom severity or co-occurring disorders.

[47] Mental health advocates have recommended that medical frailty exemptions for disabling mental disorders should be interpreted broadly to include any person with a diagnosis of, or needing services and supports for, a mental health condition, to ensure individuals with conditions that could be disabling are able to access services. See Steinberg et al. (2025).

[48] In our MEPS donor sample of nonelderly adults with Medicaid who are potentially enrolled through the expansion pathway, we estimate this ranges between 10 and 25 percent.

[49] Samantha Liss and Sam Whitehead, "Medicaid Work Rules Exempt the 'Medically Frail.' Deciding Who Qualifies Is Tricky," *KFF Health News*, December 1, 2025, https://kffhealthnews.org/news/article/medicaid-work-rules-exempt-medically-frail-who-qualifies/.

[50] US Department of Agriculture Food and Nutrition Services, "SNAP Work Requirements," USDA, August 29, 2025, https://www.fns.usda.gov/snap/work-requirements.

[51] States with integrated Medicaid-SNAP eligibility systems may also be able to leverage existing data to identify SNAP work requirement exemptions that overlap with the Medicaid work requirement exemptions. However, we do not incorporate this into our analysis because the exemptions are already modeled, because of data limitations, or because of insufficient information on the degree of overlap (e.g., for health-related exemptions). See "Comparing Medicaid and Supplemental Nutrition Assistance Program Work Reporting Requirements Exemptions," Mannatt Health, October 6, 2025.

[52] OBBBA defines this group as including a person who: "(aa) is an Indian or an Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act); (bb) is a California Indian described in section 809(a) of such Act; or (cc) has otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary. Self-identification as AIAN in survey data may not always align with this definition, and thus, our identification of exemption under this category may be measured with error.

[53] Automatic exemption for this group would likely require states to assess caregiver status on application or renewal forms and allow for self-attestation.

[54] It is not clear how well states will be able to provide exemptions for veterans with service-connected disability ratings. Some could be exempted on the basis of medical frailty or special medical needs if states use claims data and/or self-attestation for this purpose. States may need to obtain data from the Department of Veterans Affairs or consider adding questions on whether a person is a disabled veteran to application/renewal forms to identify this exemption category. CMS could also help facilitate states' access to Department of Veterans Affairs data.

[55] The share of pregnant enrollees in expansion coverage varies widely across states. States may need to develop new systems to identify pregnancy status among expansion enrollees to ensure that pregnant enrollees are automatically exempted from work requirements (Gordon et al. 2026).

[56] Because state quarterly wage databases include employment and wages reported by employers covering more than 95 percent of US jobs, we assume states can determine whether Medicaid expansion enrollees and applicants with traditional employment have income equivalent to 80 work hours at the federal minimum wage. See "Quarterly Census of Employment and Wages," US Bureau of Labor Statistics, accessed February 26, 2026, https://www.bls.gov/cew/; and "Quarterly Census of Employment and Wages," US Bureau of Labor Statistics, accessed February 26, 2026, https://www.bls.gov/cew/reporting-rates/.

However, several factors may result in lower identification rates than we model: (1) some workers in our data may be misclassified as working for employers when they are actually independent contractors or in other nonstandard work arrangements (Abraham et al. 2018; Abraham and Houseman 2022); (2) wage databases are

not comprehensive and data-matching will be imperfect, resulting in work requirement compliance of some traditional workers not being identified automatically by states; (3) time lags and/or mismatches between the quarters for which earnings are reported and the months for which states verify earnings could result in additional data-matching challenges. Modifying our assumptions about the share of nonself-employed workers whose earnings could be automatically identified would result in larger enrollment declines, as some would face difficulty reporting and documenting their employment and/or earnings. For instance, if we assume an 85 percent data-matching rate for non-self-employed workers meeting the earnings test, estimated coverage losses resulting from work requirements would increase by 285,000, and if we assume a 95 percent data-matching rate for non-self-employed workers meeting the earnings test, estimated coverage losses resulting from work requirements would increase by 57,000.

[57] "Integration of Medicaid and Non-health Program Eligibility Systems," KFF, accessed January 24, 2026, https://www.kff.org/affordable-care-act/state-indicator/integration-of-medicaid-and-non-health-program-eligibility-systems/.

[58] Based on our analysis of SIPP data, enrollees whose compliance with work requirements has already been verified are highly likely to remain in compliance, with less than 10 percent no longer being compliant (appendix figure A.1).

[59] According to CMS, overall adult Medicaid enrollment has been falling during 2025. Total adult Medicaid/CHIP enrollment was 41.8 million in September 2024, 41.4 million in January 2025, and 40.3 million in September 2025, a decline in Medicaid enrollment among adults by 1.5 million or 4 percent over 12 months. See CMS (2025b).

[60] CMS recently released a letter to state Medicaid directors regarding six-month continuous eligibility, but it does not specify how the eligibility criteria apply in individual states, and eligibility may differ for work requirements. See Dan Brillman, "SMD #26-001 RE: Implementation of 'Eligibility Redeterminations' Section 71107 of the 'Working Families Tax Cut' Legislation (Public Law 119-21)," CMS, March 6, 2026.

[61] Joan Alker, "CMS Guidance on Medicaid Work Requirements Leaves States Hanging," *Say Ahhh!* (blog), Georgetown University McCourt School of Public Policy Center for Children and Families, December 11, 2025, https://ccf.georgetown.edu/2025/12/11/cms-guidance-on-medicaid-work-requirements-leaves-states-hanging/.

[62] Researchers have found between 2 and 7 percent of expansion enrollees live in counties with unemployment rates that would meet the criteria for an optional hardship exemption, with estimates varying based on whether the county consistently had high unemployment for 12 months versus having average 12-month unemployment rates that exceeded 8 percent or were 1.5 times the national average.

[63] As noted above, the medium and low mitigation scenarios apply the same parameters with respect to coverage losses under six-month redeterminations.

[64] The size of the range of projected enrollment changes for Wisconsin is relatively large. This is because enrollees in waiver programs in Wisconsin are expected to be subjected to work requirements but not to more frequent redeterminations, and thus, the range depicts only variation by work requirements mitigation.

[65] "Consolidated Minimum Wage Table," DOL, accessed February 16, 2026, https://www.dol.gov/agencies/whd/mw-consolidated.

[66] Sara Rosenbaum, Jane Tavares, Marc A. Cohen, Alison Barkoff, and Feygele Jacobs, "Implementing Medicaid Work Reporting Requirements: Defining A 'Serious Or Complex Medical Condition,'" *Health Affairs Forefront* (blog), January 12, 2026, https://www.healthaffairs.org/do/10.1377/forefront.20260107.138444/full/.

[67] We define those who are living with a disabled family member as those who live with someone receiving SSI. However, this is an imperfect measure of potential caregiving roles, since many people with disabilities who

need caregiving assistance do not receive these benefits, some who do receive these benefits may not receive such assistance, and we lack data on caregiver relationships within the family.

[68] Code of Federal Regulations, "440.315 Exempt individuals." Office of the Federal Registry, accessed January 23, 2026, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-C/section-440.315.

[69] "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," *Federal Register* 78 (135), July 15, 2013.

[70] Center for Health Law and Policy Innovation, "State ABP and 1115 Medical Frailty Definitions," November 17, 2025.

[71] Elizabeth Kaplan and Carmel Shachar, "Work Requirement Exemptions Based on Medical Frailty: We'd Better Get Them Right This Time." *Health Affairs Forefront,* January 12, 2026, https://www.healthaffairs.org/do/10.1377/forefront.20260108.344162/full/.

[72] Rosenbaum et al., "Implementing Medicaid Work Reporting Requirements: Defining A 'Serious Or Complex Medical Condition'"; and Kaplan and Shachar, "Work Requirement Exemptions Based on Medical Frailty."

[73] "How Will States Implement Medicaid Work Requirements?," Virtual event transcript, KFF, The Health Wonk Shop, September 11, 2025.

[74] U.S. Department of Commerce, "FMLA: Serious Health Conditions," Office of Human Resources Management, accessed January 23, 2026, https://www.commerce.gov/hr/employees/leave/fmla/serious-health-condition; Code of Federal Regulations, "§ 630.1202 Definitions," Office of the Federal Registry, accessed January 23, 2026, https://www.ecfr.gov/current/title-5/chapter-I/subchapter-B/part-630/subpart-L/section-630.1202.

[75] Legal Information Institute, "42 U.S Code § 300gg-113–Continuity of Care," Cornell Law School, accessed January 23, 2026, https://www.law.cornell.edu/uscode/text/42/300gg-113.

[76] "Chronic Care Management for Complex Conditions," CMS, accessed January 23, 2026, https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/chronic-care-management-complex-conditions.

[77] "Chronic Conditions Special Needs Plans (C-SNPs)," CMS, accessed January 24, 2026, https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/chronic-conditions.

[78] Rosenbaum et al. "Implementing Medicaid Work Reporting Requirements."

[79] Indiana only provided medical frailty designations to people who had diabetes and experienced specified complications. New Mexico's ABP medically frail exemptions applied to people with insulin-dependent diabetes.

[80] Landi, "JPM26: Dr. Oz, CMS Leaders Make Their Pitch to Hospitals, Payers on Trump Admin Healthcare Policies."

[81] Alker, "CMS Guidance on Medicaid Work Requirements Leaves States Hanging,"; and Serafi and Dervan, "CMS Issues Initial Guidance on Work Reporting Requirements, Leaves Key Questions Unanswered."

[82] For instance, the state's Department of Health and Human Services has indicated it is planning to adopt all allowable temporary hardships and that it will require applicants to meet the requirement for the month immediately before enrolling and will require enrollees to meet the requirement for at least one month between redeterminations. See: Diana and Mudumala (2026) and DHHS (2026).

[83] Tricia Brooks, "Let's Start a Conversation about Data to Monitor the Impact of H.R. 1's Work Reporting Requirements," Georgetown University Center for Children and Families (blog), February 4, 2026, https://ccf.georgetown.edu/2026/02/04/lets-start-a-conversation-about-data-to-monitor-the-impact-of-h-r-1s-work-reporting-requirements/.

[84] Brooks, "Let's Start a Conversation about Data to Monitor the Impact of H.R. 1's Work Reporting Requirements."

[85] Rosenbaum, Jacobs, and Johnson, "Nearly 5.6 Million Community Health Center Patients Could Lose Medicaid Coverage Under New Work Requirements."

[86] Karpman, "Medicaid Work Requirements Would Do Little or Nothing to Increase Employment, but Would Harm People's Health."

[87] Georgetown Center for Children and Families, "Healthy Parents and Caregivers are Essential to Children's Healthy Development," December 2016.

[88] Meiselbach and Lavalee, "H.R.1 Threatens The Stability Of Medicaid Managed Care."

[89] Badger, "Medicaid Work Requirements Could Help the Poor;" "CMS Issues New State Guidance on Transformative Medicaid Reforms," CMS.gov; and Council of Economic Advisers, "Medicaid Community Engagement Requirements and the Value of Work."

References

Abraham, Katherine G., John C. Haltiwanger, Kristin Sandusky, and James R. Spletzer. 2018. "Measuring the Gig Economy: Current Knowledge and Open Issues." Working Paper 24950. Cambridge, MA: National Bureau of Economic Research.

Abraham, Katherine G., and Susan N. Houseman. 2022. *What Do We Know about Alternative Work Arrangements in the United States? A Synthesis of Research Evidence from Household Surveys, Employer Surveys, and Administrative Data*. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.

ACHI (Arkansas Center for Health Improvement). 2019. *Arkansas Medicaid Work and Community Engagement Requirements: Community Response*. Little Rock, AR: ACHI.

AHRQ and CFACT (Agency for Healthcare Research and Quality and Center for Financing, Access, and Cost Trends). 2025. *MEPS HC 249: 2023 Medical Conditions*. Rockville, MD: AHRQ and CFACT.

Arkansas Department of Human Services. 2018a. *Arkansas Works Section 1115 Demonstration Waiver: Quarterly Report*. Little Rock, AR: Arkansas Department of Human Services.

———. 2018b. *Arkansas Works Section 1115 Demonstration Waiver: Quarterly Report.* Little Rock, AR: Arkansas Department of Human Services.

———. 2018c. *Arkansas Works Work and Community Engagement Requirements: Medicaid Section 1115 Demonstration Project Work Requirement Evaluation Design and Strategy.* Little Rock, AR: Arkansas Department of Human Services.

Bell, Clea, Jennifer Tolbert, and Sammy Cervantes. 2025. *A Look at the Potential Impact of the High Unemployment Hardship Exception to Medicaid Work Requirements*. San Francisco: KFF.

Bennett, Neil, Mark Klee, and Robert Munk. 2022. "A Stitch in Time: Evaluating Seam Bias in the Redesigned SIPP." Presentation for the Federal Committee on Statistical Methodology. Suitland, MD: US Census Bureau.

Brillman, Dan. 2025. "Section 71119 of the 'Working Families Tax Cut' Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement, Requirements for Certain Individuals." *CMCS Informational Bulletin*. Baltimore, MD: CMS.

Brooks, Tricia, Jennifer Tolbert, Allexa Gardner, et al. 2024. *A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond*. San Francisco: KFF.

Brooks, Tricia, Jennifer Tolbert, Anna Mudumala, et al. 2025. *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations*. San Francisco: KFF.

Buettgens, Matthew, Jameson Carter, and Fernando Hernandez. 2026. "OBBBA's Six-Month Redetermination Could Reduce Medicaid Expansion Enrollment by 2.0 to 3.1 Million in 2028." Washington, DC: Urban Institute.

Buettgens, Matthew, and Jessica Banthin. 2020. *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology*. Washington, DC: Urban Institute.

Buettgens, Matthew, and Urmi Ramchandani. 2023. *2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility*. Washington DC: Urban Institute.

Card, David, Andrew K.G. Hildreth, and Lara D. Shore-Sheppard. 2004. "The Measurement of Medicaid Coverage in the SIPP. Evidence from a Comparison of Matched Records." *Journal of Business and Economic Statistics* 2 (4): 410–20. https://doi.org/10.1198/073500104000000208.

CBPP (Center on Budget and Policy Priorities). 2020. "Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans." Washington, DC: CBPP.

CMS (Centers for Medicare & Medicaid Services). 2025. "September 2025: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot." Presentation. Baltimore, MD: CMS.

Chan, Leah. 2024. "Georgia's Pathways to Coverage Program: The First Year in Review." Atlanta, GA: Georgia Budget and Policy Institute.

———. 2025. "Pathways to Coverage: Looking Back Two Years and Into the Future." Atlanta, GA: Georgia Budget and Policy Institute.

Cliff, Betsy Q., Sarah Miller, Jeffrey T. Kullgren, John Z. Ayanian, and Richard A. Hirth. 2022. "Adverse selection in Medicaid: evidence from discontinuous program rules." *American Journal of Health Economics* 8 (1). https://doi.org/10.1086/716464.

Coglianese, John, and Brendan M. Price. 2020. "Income in the Off-Season: Household Adaptation to Yearly Work Interruptions." Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. https://doi.org/10.17848/pb2020-32.

Davern, Michael, Jacob Alex Klerman, David K. Baugh, Kathleen Thiede Call, and George D. Greenberg. 2009. "An Examination of the Medicaid Undercount in the Current Population Survey: Preliminary Results from Record Linking." *Health Services Research* 44 (3): 965–87. https://doi.org/10.1111/j.1475-6773.2008.00941.x.

Davidoff, Amy, Lisa Dubay, Genevieve Kenney, and Alshadye Yemane. 2003. "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children." *Journal of Health Care Organization, Provision, and Financing*, 40 (3): 254–68. https://doi.org/10.5034/inquiryjrnl_40.3.254.

DHCS (California Department of Health Care Services). 2025. "Department of Health Care Service (DHCS) Medi-Cal Enrollment and Renewals Dashboard—October 2025." DHCS, October 2025.

DHHS (Nebraska Department of Health and Human Services). 2026. "Medicaid Advisory Committee (MAC)." Presentation. Lincoln, NE: DHHS.

Diana, Amaya, and Anna Mudumala. 2026. "A Closer Look at Nebraska, the First State Planning to Implement a Medicaid Work Requirement." San Francisco: FF.

Ding, Dong, Benjamin D. Sommers, and Sherry A. Glied. 2024. "Unwinding and the Medicaid Undercount: Millions Enrolled in Medicaid during the Pandemic Thought They Were Uninsured." *Health Affairs* 43 (5): 725–31. https://doi.org/10.1377/hlthaff.2023.01069.

Dubay, Lisa, and Genevieve Kenney. 2003. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid." *Health Services Research* 38 (5): 1283–302. https://doi.org/10.1111/1475-6773.00177.

Engel-Rebitzer, Eden, Lucas Marinacci, ZhaoNian Zheng, and Rishi K. Wadhera. 2024. "Changes in Coverage, Access, and Health Status Among Adults with Cardiovascular Disease After Medicaid Work Requirements." *American Heart Journal* 279: 104-106. https://doi.org/10.1016/j.ahj.2024.10.014.

Fielder, Matthew. 2025. *How Would Implementing an Arkansas-Style Work Requirement Affect Medicaid Enrollment?*. Washington, DC: Brookings Institution.

Gifford, Elizabeth J., Robert Weech-Maldonado, and Pamela Farley Short. 2005. "Low-Income Children's Preventive Services Use: Implications for Parents' Medicaid Status." *Health Care Financing Review* 26 (4): 81–94. https://pmc.ncbi.nlm.nih.gov/articles/PMC4194911/.

Gillespie, Cindy. 2017. "Arkansas Medicaid." Presentation given September 2017. Little Rock, AR: Arkansas Department of Human Services.

Gordon, Sarah, Amelia Whitman, Thomas Buchmueller, and Benjamin D. Sommers. 2026. "Medicaid Eligibility Category Among Enrollees With Medicaid-Paid Births in 2018." *HSR* e70053. https://doi.org/10.1111/1475-6773.70053.

Greene, Jessica. 2019. "Medicaid Work Requirements: Who Will the New State Policies Impact?." *Journal of General Internal Medicine* 34: 532-534. 10.1007/s1160 six-018-4764-4.

Greibrok, Michael, and Jonathan Ingram. 2025. *Medicaid Work Requirements Would Help Move Millions Of Able-Bodied Adults From Welfare to Work*. Naples, FL: Foundation for Government Accountability.

Guth, Madeline, and MaryBeth Musumeci. 2022. "An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?." San Francisco: KFF.

Hartly, Shandra. 2025. *Checking All the Boxes: A Survey of Medical Frailty Definitions in Alternative Benefit Plans and Section 1115 Work Requirements Demonstrations*. Washington, DC: National Health Law Program.

Haught, Randy, Akeiisa Coleman, Allen Dobson, Carson Richards, and Collin McGuire. 2025. "The Impact of Proposed Federal Medicaid Work Requirements on Hospital Revenues and Financial Margins." New York: The Commonwealth Fund.

Hill, Ian, and Emily Burroughs. 2019. *Lessons from Launching Medicaid Work Requirements in Arkansas*. Washington, DC: Urban Institute.

Hill, Ian, Emily Burroughs, and Gina Adams. 2020. *New Hampshire's Experiences with Medicaid Work Requirements: New Strategies, Similar Results*. Washington, DC: Urban Institute.

Hinton, Elizabeth, and Robin Rudowitz. 2025. "5 Key Facts About Medicaid Work Requirements." San Francisco: KFF.

Hudson, Julie L., and Asako S. Moriya. 2017. "Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children." *Health Affairs* 36 (9). https://doi.org/10.1377/hlthaff.2017.0347.

FSSA (Indiana Family and Social Services Administration). 2025. "State of Indiana, Family and Social Services Administration—April 2025 Medicaid Forecast Update." Indianapolis, IN: FSSA.

Johnson, Daniel Y., Stephen A. Mein, Lucas X. Marinacci, Michael Liu, and Rishi K. Wadhera. 2025. "Insurance Coverage and Employment After Medicaid Expansion with Work Requirements: Quasi-Experimental Difference-in-Differences Study." *BMJ* 390: e086792. https://doi.org/10.1136/bmj-2025-086792.

Joynt, Karen E., Jose F. Figueroa, Nancy Beaulieu, et al. 2017. "Segmenting High-Cost Medicare Patients into Potentially Actionable Cohorts." *Healthcare* 5 (1–2): 62–7. https://doi.org/10.1016/j.hjdsi.2016.11.002.

Karpman, Michael, Jennifer M. Haley, and Genevieve M. Kenney. 2025a. "Many Working People Would Be Shut Out of Medicaid under Proposed Work Requirements." Washington, DC: Urban Institute.

———. 2025b. *Assessing Potential Coverage Losses among Medicaid Expansion Enrollees under a Federal Medicaid Work Requirements*. Washington DC: Urban Institute.

Kelley, Amy S., Kenneth E. Covinsky, Rebecca J. Gorges, et al. 2016. "Identifying Older Adults with Serious Illness: A Critical Step Toward Improving the Value of Health Care." *Health Services Research* 52 (1): 113–31. https://doi.org/10.1111/1475-6773.12479.

Ku, Leighton, Taylor Gorak, Kristine Namhee Kwon, et al. 2025. "How National Medicaid Work Requirements Would Lead to Large-Scale Job Losses, Harm State Economies, and Strain Budgets." New York: The Commonwealth Fund.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2020. "Medicaid Work and Community Engagement Requirements." Washington, DC: MACPAC.

———. 2026. "Considerations for Implementing Community Engagement Requirements: Principles and Policy Option." Presentation. Washington, DC: MACPAC.

McMorrow, Stacey, Genevieve M. Kenney, Sharon K. Long, and Dana E. Goin. 2016. "Medicaid Expansion from 1997 and 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents." *Health Services Research* 51 (4): 1347–67. https://doi.org/10.1111/1475-6773.12432.

McMorrow, Stacey, Jason A. Gates, Sharon K. Long, and Genevieve M. Kenney. 2017. "Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents." *Health Affairs* 36 (5). https://doi.org/10.1377/hlthaff.2016.1650.

Meuse, Dan. 2025. "Medicaid Work Reporting Requirements: Implementation Basics and State Decision Points." Princeton, NJ: State Health and Value Strategies.

Moore, Jeffrey C. 2007. "Seam Bias in the 2004 SIPP Panel: Much Improved, but Much Bias Still Remains." Paper prepared for the US Census Bureau/PSID Event History Calendar Research Conference. Ann Arbor, MI: University of Michigan.

Musumeci, MaryBeth, Priya Chidambaram, and Molly O'Malley Watts. 2019. "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults." San Francisco: KFF.

Musumeci, MaryBeth, Caitlin Murphy, Elizabeth Leiser, Hannah Silverman, and Kian Azimpoor. 2025. "Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care." New York: The Commonwealth Fund.

Musumeci, MaryBeth, Robin Rudowitz, and Cornelia Hall. 2018. "An Early Look at Implementation of Medicaid Work Requirements in Arkansas." San Francisco: KFF.

Musumeci, MaryBeth, Robin Rudowitz, and Barbara Lyons. 2018. "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees." San Francisco: KFF.

National Academy of Medicine. 2017. *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Values, and Health*. Washington, DC: National Academies Press.

Pandey, Abhishek, Yang Ye, Carolyn Bawden, Burton H. Singer, and Alison P. Galvani. 2025. "Quantifying the Mortality and Morbidity Impact of Medicaid Work Requirements: A Modeling Study." *The Lancet Regional Health–Americas* (51). https://doi.org/10.1016/j.lana.2025.101232.

Rao, Preethi, Lawrence Baker, Federico Girosi, et al. 2026. *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act.* Santa Monica, CA: RAND Corporation.

Rudowitz, Robin, MaryBeth Musumeci, and Cornelia Hall. 2019. *February State Data for Medicaid Work Requirements in Arkansas.* San Francisco: KFF.

Saunders, Heather. 2023. "A Look at Substance Use Disorders (SUD) Among Medicaid Enrollees." San Francisco: KFF.

Schpero, William L., Manyao Zhang, and Yasin Civelek. 2025. "Diagnosed Health Conditions and Health Care Use Among Medicaid Expansion Enrollees, 2019 and 2022." *Health Affairs Scholar* 3 (9). https://doi.org/10.1093/haschl/qxaf172.

Serafi, Kinda, Lisa Sbrana, and Liz Dervan. 2025. *Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions*. Washington, DC: Manatt Health.

Serafi, Kinda, Lisa Sbrana, Gini Morgan, Mindy Lipson, and Ellen Montz. 2025. *Medicaid Work Requirements: Implementation Planning Milestones*. Washington, DC: Manatt Health.

Sharfstein, Steven. 1999. *Definition of Serious and Complex Medical Conditions*. Washington, DC: National Academies Press.

Silvestri, David M., Abbe R. Gluck, and Joseph S. Ross. 2020. "Assessment of Health Status and Barriers to Employment Among Medicaid Beneficiaries Not Meeting Work Requirements After Accounting for State Medical Frailty Exemptions." *JAMA Internal Medicine* 180 (7):1008–10. https://doi.org/10.1001/jamainternmed.2020.1039.

Simon & Co. 2017. *Assessing the Medically Frail Among Medicaid Expansion Beneficiaries: Protecting Access to Nonemergency Medical Transportation*. Washington, DC: Simon & Co.

Sommers, Benjamin D. 2013. "The Poverty-Reducing Effect of Medicaid." *Journal of Health Economics* 32 (5): 816–32. https://doi.org/10.1016/j.jhealeco.2013.06.005.

Sommers, Benjamin D., Atul A. Gawande, and Katherine Baicker. 2017. "Health Insurance Coverage and Health–What the Recent Evidence Tells Us." *New England Journal of Medicine* 377 (6). https://doi.org/10.1056/NEJMsb1706645.

Steinberg, Deborah. 2025. *Protecting People with Substance Use Disorders and Formerly Incarcerated Individuals from Losing Medicaid Coverage: Recommendations on Implementing the H.R.1 Work Reporting Requirements*. Washington, DC: Legal Action Center (LAC).

Steinberg, Deborah, Teresa Miller, Candace Ball, et al. 2025. *Work Reporting Requirements and Mental Health*. Washington, DC: NAMI and LAC.

Suendelman, Sylvia, Megan Wier, Veronica Angulo, and Doug Oman. 2006. "The Effects of Child-Only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings among Low-Income Children in California." *Health Services Research* 41 (10): 125–47. https://doi.org/10.1111/j.1475-6773.2005.00460.x.

Tsai, Daniel, 2024a. "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes." *CMCS Informational Bulletin*. Baltimore, MD: CMS.

———. 2024b. "Basic Requirements for Conducting Ex Parte Renewals of Medicaid and CHIP." *CMCS Informational Bulletin*. Baltimore, MD: CMS.

GAO (US Government Accountability Office). 2019. *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements*. GAO-20-149. Washington, DC: GAO.

USDA (US Department of Agriculture). 2023. Supplemental Nutrition Assistance Program (SNAP) Able-Bodied Adults Without Dependents (ABAWD) Policy Guide. Washington, DC: USDA.

Venkataramani, Maya, Craig Evan Pollack, and Eric T. Roberts. 2017. "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services." *Pediatrics* 140 (6): e20170953. https://doi.org/10.1542/peds.2017-0953.

Wagner, Jennifer, Symonne Singleton, and Maani Stewart. 2025. *A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement*. Washington, DC: CBPP.

Wagner, Jennifer, and Jessica Schubel. 2020. "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements." Washington, DC: CBPP.

Wherry, Laura R., Genevieve M. Kenney, and Benjamin D. Sommers. 2016. "The Role of Public Health Insurance in Reducing Child Poverty." *Academic Pediatrics* 16 (3): S98–104. https://doi.org/10.1016/j.acap.2015.12.011.

Wherry, Laura R., and Sarah Miller. 2016. "Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-Experimental Study." *Annals of Internal Medicine* 164 (1): 795–803. https://pubmed.ncbi.nlm.nih.gov/27088438/.

Wood, Elizabeth G. 2025. "Early Findings on the Impact of Medicaid Work Requirements." *BMJ* 391. https://doi.org/10.1136/bmj.r2124.

Wroblewksa, Kathy, Chrissy Steigelman, Jennifer Pooler, Diana Cassar-Uhl, and Megan Worden. 2022. *The Use of Supervised Job Search, Job Search Training, and Integrated Job Search in SNAP E&T: Three Case Studies.* Washington, DC: USDA.

Zhang, Elizabeth, and Gideon Lukens. 2025. *Medicaid Work Requirements Will Take Away Coverage From Millions: State and Congressional District Estimates*. Washington, DC: CBPP.

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