

MEDICAID WORK REQUIREMENTS: THE PAPERWORK TEST

Medicaid's work requirement arrives January 1, 2027. The early evidence shows the real test is paperwork, not work.



92%

of Nebraska's work requirement coverage losses at renewal came from unanswered paperwork, not a finding of noncompliance

68

days from publication to the national January 1 deadline

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Policy and data current through October 25, 2026

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Executive Summary

In 68 days, on January 1, 2027, adults covered through the Affordable Care Act's Medicaid expansion in 40 states and the District of Columbia, along with certain waiver enrollees in Georgia and Wisconsin, will have to show 80 hours a month of work, school, job training, or community service, or show that they qualify for an exemption, to get or keep their health coverage [1, 2]. It is the largest change to Medicaid eligibility since the ACA itself. It also lands on top of a second shock: ACA marketplace open enrollment begins November 1 with a median proposed premium increase of about 15 percent, following the expiration of the enhanced premium tax credits at the end of 2025 [3, 4].

This report examines what the law and the June 2026 federal rule require, what the competing projections say, and, most importantly, what the first states to implement the policy are actually showing. The central finding is counterintuitive. In Nebraska, the first state to enforce the new federal rules, early coverage losses have been smaller than many advocates feared. But almost none of the people who lost coverage were found to be avoiding work. They lost coverage because a form was not returned [2, 5].

KEY FINDINGS

- 1. The policy is measuring documentation as much as employment.** In Nebraska's first renewal cycle, 7 percent of the 7,280 enrollees subject to the requirement lost coverage. Of those 533 people, 92 percent did not respond to verification requests; only 8 percent were affirmatively found noncompliant. Among 557 denied applicants, 84 percent were denied for nonresponse [2].
- 2. Most people subject to the rule already work or qualify for an exemption.** In 2023, 64 percent of adult Medicaid enrollees ages 19 to 64 were working, and 92 percent were either working or not working because of caregiving, illness, disability, or school [6].
- 3. The size of the coming loss is genuinely contested.** CMS projects 2.3 million fewer enrollees in fiscal year 2027 and 3.1 to 3.3 million in later years [7]. The Congressional Budget Office projected 5.2 million fewer Medicaid enrollees and 4.8 million more uninsured by 2034 [8]. Urban Institute modeling put losses at 5.5 to 6.3 million under full implementation [9].
- 4. Earlier experiments removed people without raising employment.** Arkansas removed more than 18,000 adults in 2018 and 2019 with no measurable employment gain

[10]. Georgia's Pathways program spent more than twice as much on administration as on health care through early fiscal 2025 [11].

5. **There is no off-ramp.** People denied or disenrolled for not meeting the requirement are ineligible for ACA premium tax credits, so the marketplace cannot serve as a fallback [12].
6. **The federal rule is stricter than many states planned for.** It narrows the medical frailty exemption, limits self-attestation after 2027, and restricts claims lookback to 12 months. A multistate lawsuit failed to win a preliminary injunction, and five governors have asked for a delay [13, 14].
7. **Hospitals and clinics will absorb what coverage no longer pays for.** Modeling projects hospital operating margins in expansion states falling 11.7 to 13.3 percent once the policy is fully in place, and 25.9 to 29.6 percent at safety-net hospitals [9]. Community health centers could lose up to \$32 billion over five years [15].
8. **Readiness, not intent, will decide outcomes.** States that verify compliance automatically using wage, nutrition assistance, and claims data keep eligible people covered. The national median share of renewals left pending has already risen for three straight quarters [16].

BOTTOM LINE

The question for leaders is no longer whether the requirement is coming. It is. The question is how many eligible people, people who work or qualify for an exemption, will lose coverage because of process, and who will pay for their care when they do.

1. Introduction: Sixty-Eight Days

For most of its history, eligibility for Medicaid has turned on two questions: does a person fall into a covered group, and is household income low enough. The 2025 budget reconciliation law, signed July 4, 2025, adds a third question for working-age adults in the expansion group: can they prove, month after month, that they are engaged in work or an approved activity, or that they are excused from it [1, 12].

States were given until January 1, 2027 to comply, with the option to start sooner. Nebraska began on May 1, 2026. Montana and Arkansas began July 1, with Montana starting to deny and disenroll on October 1 and Arkansas holding penalties until January. Iowa begins December 1 [2, 17, 18, 19]. Everyone else starts in 68 days.

That timing makes this the right moment for an investigation. The policy has been debated for a decade as a question of values. It is now an operational fact with real data behind it. The investigative question this report asks is simple: **when the requirement is applied, is it testing whether people work, or whether they can complete paperwork?** The answer determines how many people lose coverage, what that costs hospitals and clinics, and what leaders can still do in the weeks that remain.

SCOPE AND APPROACH

This report synthesizes the statute and the June 2026 interim final rule, federal and independent projections, peer-reviewed evidence from earlier state programs, state administrative data released through September 2026, and policy and industry analyses. It does not take a position on whether work requirements are good policy. It examines how they are being implemented and what the evidence shows about who loses coverage and why. The strongest arguments made by supporters are presented in Section 10. Policy and data are current through October 25, 2026.

2. What the Law and the Rule Require

The statute sets the frame, and the Centers for Medicare & Medicaid Services (CMS) filled in the operating details through an interim final rule issued June 1, 2026 and effective July 31, 2026. Because Congress directed CMS to use an interim final rule, the agency was not required to complete notice-and-comment rulemaking before states begin enforcement [1, 20]. Table 1 summarizes the provisions that matter most for patients and providers.

Table 1. Core provisions of the federal Medicaid work requirement

Provision	What it requires
Who is subject	Nonpregnant adults ages 19 to 64 in the ACA expansion group and certain Section 1115 waiver groups who are not enrolled in Medicare. CBO estimated 18.5 million people would be subject each year [12].
Monthly standard	80 hours of work, community service, a work program, or a combination; or at least half-time enrollment in school; or monthly income of at least 80 times the federal minimum wage (\$580). Seasonal workers may average income over six months [2].
Mandatory exclusions	Pregnant and postpartum individuals; American Indians and Alaska Natives; parents and caretakers of children under 14 or of a person with a disability; veterans with a total disability rating; people who are medically frail; people meeting SNAP or TANF work requirements; recently incarcerated people [2, 21].
Look-back at application	Applicants must show compliance for one to three consecutive months before applying, at state option [21].
Verification order	States must first try to verify exclusions and compliance using data they already hold (ex parte). If they cannot, they send a notice and the person has 30 days to respond before denial or disenrollment [2, 22].
Self-attestation	States may accept self-declaration through 2027. Starting January 2028, documentation is generally required when the state lacks data, with special limits for medical frailty [2].
Renewals	Eligibility is redetermined every six months for expansion adults, and states may check compliance more often [23, 21].
Optional hardship exceptions	States may excuse people during hospitalization, travel for medical care, natural disasters, or high county unemployment. 29 states planned to use at least one [23].
Consequence of noncompliance	Denial or disenrollment, plus ineligibility for ACA marketplace premium tax credits [12].
Deadlines and money	States must implement by January 1, 2027. HHS may grant good-faith extensions through December 31, 2028. The law provided \$200 million to states for implementation; CMS estimates systems costs of about \$15 million per state, or \$660 million nationally [1, 20].

Source: Author synthesis of the statute, CMS-2454-IFC, and cited analyses.

From law to deadline: the work requirement timeline

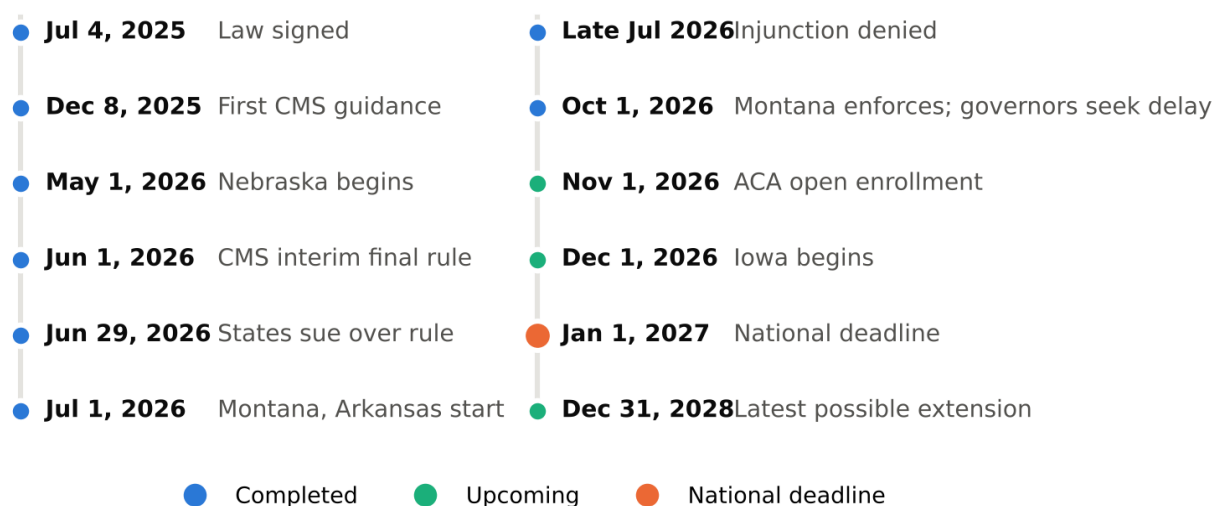


Figure 1. Key dates from enactment to the national deadline.

Sources: CHCS; KFF; NPR; Arkansas DHS; Iowa HHS; Georgetown Law Litigation Tracker; Healthcare Dive.

Two design choices deserve attention because they recur throughout the evidence. First, verification runs in a fixed order: the state checks exclusions and data matches before it asks the person for anything. When that automated step works, most people never see a form. When it fails, the burden shifts to the enrollee, who must respond within 30 days. Second, the consequences extend beyond Medicaid. A person who loses coverage for noncompliance cannot buy subsidized marketplace coverage, which removes the safety valve that cushioned earlier coverage losses [12].

3. The Numbers: Three Projections, One Argument

Every major projection agrees that coverage will fall. They disagree, sometimes sharply, about how much and why.

The Congressional Budget Office estimated that the work requirement would reduce Medicaid enrollment by 5.2 million people and increase the uninsured population by 4.8 million by 2034 [8]. CBO's August 2025 update reaffirmed a total of about 10 million more uninsured from the law, with the work requirement as the largest single driver [24]. CBO expects few people who lose coverage to find employer coverage and none to qualify for marketplace subsidies [12].

CMS, in the regulatory impact analysis accompanying its rule, projected 2.3 million fewer enrollees in fiscal year 2027 and 3.1 to 3.3 million in later years, with \$350.3 billion in federal savings and \$41.6 billion in state savings over 10 years [7]. CMS assumes a combined disenrollment rate of about 15 percent: 9 percent for failing to meet the requirement and 6 percent for administrative or paperwork reasons [25]. It also projects that up to 4.4 million people will meet the requirement, a shift it expects to improve economic and health outcomes [20].

The Urban Institute, modeling from the observed noncompliance rates in Arkansas and New Hampshire, estimated losses of 5.5 to 6.3 million people under full implementation [9].

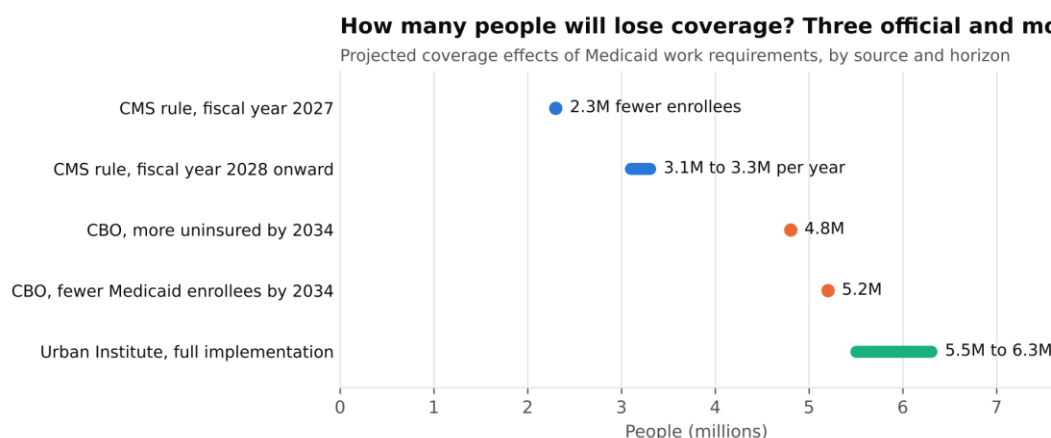


Figure 2. Projected coverage effects of Medicaid work requirements.

Sources: CMS regulatory impact analysis as summarized by Applied Policy; CBO as reported by FactCheck.org; Urban Institute estimates as reported by the Commonwealth Fund.

The gap is not arithmetic. It is a disagreement about human behavior. CMS's smaller coverage loss rests on the assumption that roughly one-third of affected people will become newly engaged in work or other activities. Richard Frank of the Brookings Institution argues that this assumption is more than six times larger than the largest estimate in the research literature, and notes that CMS projects larger federal savings than CBO despite projecting a smaller loss of coverage [26]. The Urban Institute's formal comment similarly concluded that the analysis understates likely coverage losses and overstates employment gains [27].

Table 2. How the major projections differ

Source	Estimate	Key assumption
CBO (2025)	5.2M fewer enrollees; 4.8M more uninsured by 2034	Little employment response; disenrolled people barred from subsidies
CMS rule (2026)	2.3M fewer in FY2027; 3.1M to 3.3M per year after	15% disenrollment; about one-third of affected adults become engaged
Urban Institute (2025)	5.5M to 6.3M lose coverage	Noncompliance rates observed in Arkansas and New Hampshire

Sources: FactCheck.org; Holland & Knight; Applied Policy; Commonwealth Fund; Brookings.

For planning purposes, the honest reading is a range. Leaders should build budgets that can absorb the higher estimates while tracking the early state data described below, which will reveal within months which set of assumptions is closer to reality.

4. Who Is Actually Subject

The public debate often describes the affected population as adults who could work but choose not to. The data describe a different group. KFF's analysis of federal survey data found that in 2023, 64 percent of adults ages 19 to 64 covered by Medicaid were working, and 92 percent were either working or not working because of caregiving, illness or disability, or school attendance [6].

Age matters. Among young adults ages 19 to 26, 72 percent were already working at least 80 hours a month or attending school. Adults ages 50 to 64 were least likely to meet the hours test, with fewer

than half (48 percent) working 80 or more hours in a month [28]. Nebraska officials estimated before launch that 60 to 72 percent of expansion enrollees would meet the requirement or qualify for an exemption [29].

Nebraska's early data also shows *how* people meet the requirement. Among renewing enrollees who satisfied it through qualifying activities, 97 percent did so by working 80 hours or meeting the \$580 monthly income threshold [2]. Georgetown's Center for Children and Families observes that income data the state already holds is the most efficient way to confirm compliance without asking people for more paperwork [5].

WHAT THIS MEANS

The people most likely to fall through are not primarily those refusing to work. They are older adults, hourly and gig workers whose hours swing from month to month, caregivers whose responsibilities do not appear in any database, and people with health conditions that limit work but do not show up in recent claims. These are exactly the groups for whom automated data matching works least well.

5. The Evidence So Far: Four States, One Pattern

5.1 Arkansas, 2018: the first test

Arkansas became the first state to implement a Medicaid work requirement in June 2018, requiring monthly online reporting. By the time a federal judge halted the program in 2019, more than 18,000 adults had lost coverage [10]. Peer-reviewed research led by Benjamin Sommers found no change in employment and a rise in the uninsured rate among adults ages 30 to 49, from 10.5 percent in 2016 to 14.5 percent in 2018 [30]. Researchers attributed much of the loss to confusion and lack of awareness of the rules [31]. Two-year follow-up found that most coverage losses reversed after the court order, that employment did not increase over 18 months, and that the policy was associated with more medical debt and less affordable care [10].

5.2 Georgia, 2023 to present: the longest-running program

Georgia's Pathways to Coverage program, the only work requirement operating before the federal mandate, offers coverage to adults up to the poverty line who document qualifying hours. The state projected 25,000 enrollees in the first year. After two years, about 8,077 Georgians were enrolled as of June 2025 [32].

The program's costs have drawn as much attention as its enrollment. A Government Accountability Office review found that from fiscal year 2021 through the second quarter of fiscal year 2025, Georgia reported \$54.2 million in administrative spending and \$26.2 million in health care spending, with nearly 90 percent of administrative costs paid by federal taxpayers [11]. The administrative share has declined over time, from 96.5 percent in fiscal 2023 to 58.8 percent in fiscal 2024 [33]. The Georgia Budget and Policy Institute's latest analysis puts total program costs since approval at \$165.7 million, about \$8,945 per active enrollee, with administration accounting for 46 percent [34].

Georgia Pathways: the costliest way to cover the fewest people

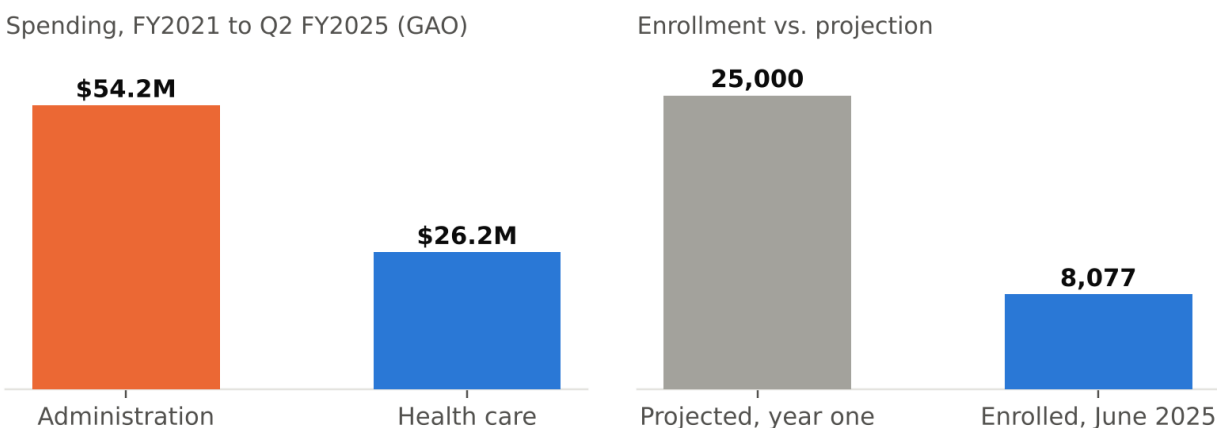


Figure 3. Georgia Pathways spending and enrollment.

Sources: GAO as reported by *The Current* and *North Carolina Health News*; Emory University Rollins School of Public Health.

5.3 Nebraska, 2026: the first state under the new federal rules

Nebraska began applying the requirement to new applicants on May 1, 2026 and to renewing enrollees on July 1 [5]. Advocates reported that the state hired no new staff and secured no additional technology funding for the rollout [35]. A community health center association that typically enrolls about 15 people a month in Medicaid enrolled none in May [22].

The first official data, presented to the state's Medicaid Advisory Committee in September, covers applications through August and renewals through mid-August 2026 [2]:

- **Renewals.** Of 7,280 renewals subject to the requirement, 93 percent were renewed: 34 percent met qualifying activities, 57 percent qualified for an exclusion, and 2 percent received a hardship exception. The remaining 7 percent, or 533 people, lost coverage. Of those, 92 percent had not responded to verification requests, and 8 percent were found noncompliant.
- **Applications.** Of 4,089 applications needing a work requirement determination, 46 percent met qualifying activities, 39 percent qualified for an exclusion, and 14 percent were denied. Of the 557 denials, 84 percent were for nonresponse and 16 percent for affirmative noncompliance.
- **Exclusions.** Among renewing enrollees who were excluded, medically frail individuals (39 percent) and parents or caregivers (31 percent) made up the majority.

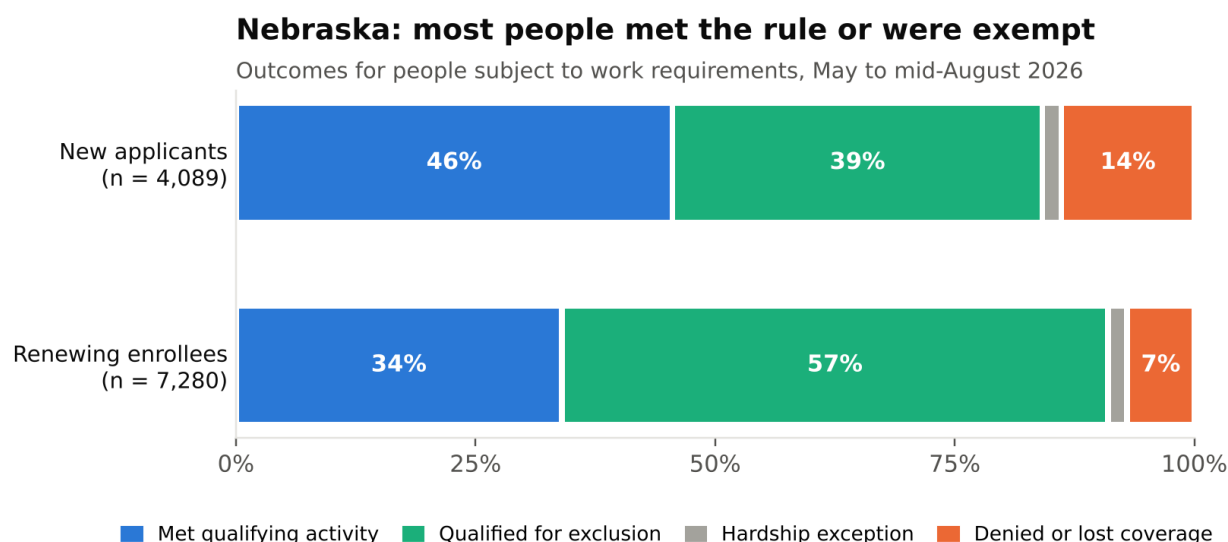


Figure 4. Nebraska outcomes for people subject to work requirements. Application shares sum to 101 percent because of rounding.

Source: KFF analysis of Nebraska DHHS Medicaid Advisory Committee data, September 2026.

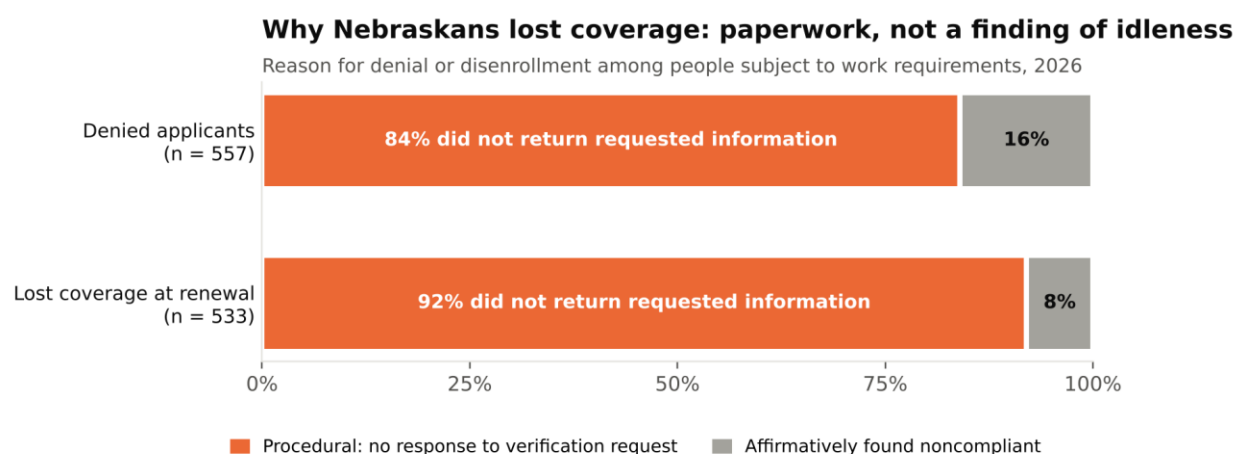


Figure 5. Reasons for denial or disenrollment in Nebraska.

Source: KFF analysis of Nebraska DHHS Medicaid Advisory Committee data, September 2026.

Two cautions temper the relatively low loss rate. First, 4,434 additional applications were denied for reasons the state classified as unrelated to the work requirement, such as income. Georgetown's Joan Alker notes that it is not yet clear whether some of those denials reflect procedural barriers, and estimates that more than half of all new applicants (52 percent) are now being denied [5]. Second, Nebraska has been accepting self-attestation and was operating before the federal rule tightened the medical frailty standard. CMS has notified the state that it must change its frailty verification process, and documentation requirements arrive in 2028 [2].

INTERPRETATION

Nebraska's early losses are smaller than feared, but they point in a revealing direction. When the state could confirm work or exemption from its own data, people kept coverage. When it

had to ask, more than nine in ten of the people who lost coverage were lost to the asking, not to a finding that they were not working.

5.4 Montana, Arkansas, and Iowa: the next wave

Montana applied the requirement to nearly 71,000 expansion adults beginning July 1 with a three-month grace period and began denying and disenrolling on October 1 [17]. A Montana Healthcare Foundation estimate suggests about 29,000 people could lose coverage [36]. The state enters the policy with Medicaid enrollment already at its lowest point in about a decade after pandemic-era redeterminations [37].

Arkansas launched a soft implementation on July 1, using wage data, other program data, and medical claims to classify enrollees and send status notices, with no coverage losses until January 1, 2027 [18, 38]. **Iowa** applies the requirement to new applicants on December 1, 2026 and to current members at renewals beginning in early 2027 [19].

Table 3. State implementation snapshot, October 2026

State	Start	Population or scale	Status and notes
Georgia	July 2023	About 8,077 enrolled (June 2025)	Longest-running program; coverage to 100% of poverty
Nebraska	May 1, 2026	About 70,000 expansion adults	First state under federal rules; at least 1,090 lost or denied through August
Montana	July 1, 2026; enforcement Oct 1	Nearly 71,000 subject	About 29,000 could lose coverage (foundation estimate)
Arkansas	July 1, 2026 soft launch	ARHOME expansion adults	Automated checks and notices; penalties begin Jan 1, 2027
Iowa	Dec 1, 2026	Iowa Health and Wellness Plan members	Applicants first; current members at renewal in 2027
Missouri	Jan 1, 2027	344,669 expansion adults (Sept 2026)	Declined optional hardship exceptions
Other expansion states	Jan 1, 2027	Varies	Five governors seek delay; none reported approved as of early October

Sources: Emory; NHA; Georgetown CCF; NPR; Medicaid Work Check; Arkansas DHS; Iowa HHS; Missouri Independent; Healthcare Dive; Freedinsure.

6. The Medical Frailty Fight

If any single provision determines how many vulnerable people lose coverage, it is the medical frailty exclusion. Congress excluded people who are medically frail. The June rule added a condition that many states did not expect: the person's condition must significantly impair their ability to comply with the requirement. The rule also limits self-attestation of frailty after 2027, bars states from relying on claims data older than 12 months, and requires frailty to be reverified every 12 months [39, 21].

On June 29, 2026, 23 states, the District of Columbia, and the governors of Kentucky and Pennsylvania sued in federal court in Massachusetts, arguing that the rule unlawfully narrows the statute [39]. In late July, the court denied a preliminary injunction, leaving the rule in force while the case proceeds on an expedited schedule [13, 40]. The American Medical Association and a coalition of about 70 organizations filed briefs supporting the states. The National Health Law Program cites projections that the frailty restrictions alone could cause an average of 1.8 million additional people to lose Medicaid each year from 2027 through 2034 [41].

CMS issued additional frailty guidance in September offering states an optional three-tier framework, but the guidance does not change the requirement that a condition significantly impair a person's ability to comply [40]. On October 1, the governors of Oregon, California, Maine, New Mexico, and Virginia asked HHS to tie the compliance date to demonstrated state readiness. They cited three changes in the rule: the frailty definition, new compliance activities requiring form and system changes, and a verification order that requires states to determine work status before evaluating exemptions [42, 14]. As of early October, no state delay had been reported as approved [43].

WHY IT MATTERS

In Nebraska, medical frailty accounted for 39 percent of exclusions at renewal [2]. That pathway is carrying real weight. Narrowing it does not remove those people from Medicaid directly; it moves them out of the automated lane and into the paperwork lane, where the evidence shows most losses occur.

7. Are the States Ready?

The single variable that best predicts whether eligible people keep coverage is a state's ability to confirm eligibility automatically, known as the *ex parte* rate. The warning signs are already visible.

Georgetown's Center for Children and Families tracks federal performance data for every state. The national median share of pending renewals rose for three consecutive quarters, from 4.3 percent in the second quarter of 2025 to 7.0 percent in the first quarter of 2026, with 30 states reporting an increase in the most recent quarter [16]. When temporary pandemic-era flexibilities expired, *ex parte* rates fell sharply in some states: New Hampshire dropped from 74.4 percent to 26.8 percent and California from 78.0 percent to 35.7 percent [16]. Before those flexibilities ended, the national median *ex parte* rate was 52.6 percent, and states in the bottom quartile were below 37.9 percent [44].

A system under strain before the clock starts

National median share of Medicaid and CHIP renewals left pending, by quarter

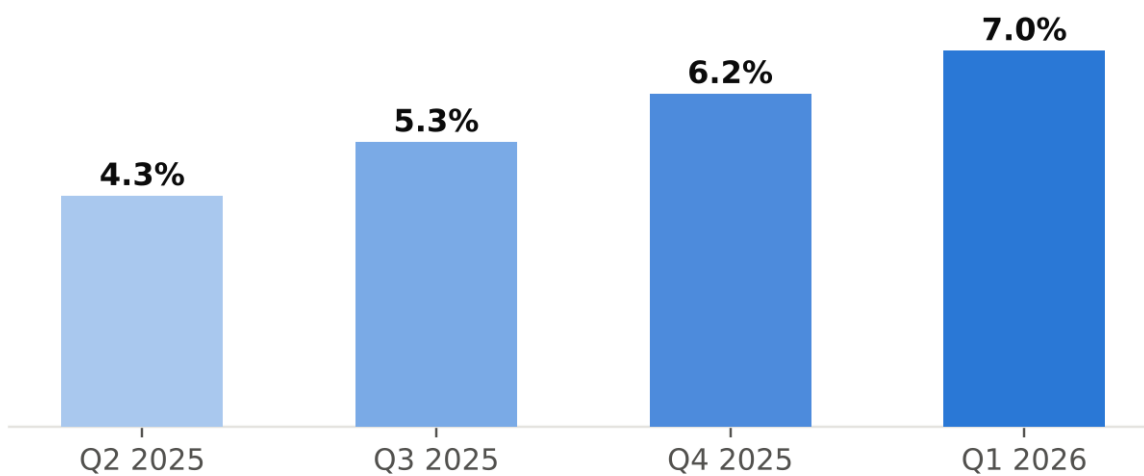


Figure 6. National median share of Medicaid and CHIP renewals pending, by quarter.

Source: Georgetown University Center for Children and Families H.R. 1 Readiness Tracker.

State choices diverge. In a survey of state Medicaid officials, 34 states said they would verify compliance every six months at renewal, while Indiana and New Hampshire planned quarterly checks; 29 states planned at least one optional hardship exception, and six planned to use artificial intelligence for data matching or staff support [23]. Missouri, which renewed 52.3 percent of enrollees ex parte in the first quarter of 2026, declined the optional hardship exceptions [45]. In Nebraska, the state hospital association estimated before launch that 30 to 40 percent of enrollees would need manual verification of their hours [46].

The money is thin relative to the task. The law provided \$200 million for state implementation, while CMS itself estimates systems costs of roughly \$660 million nationally [1, 20]. States are building new verification logic against a rule that arrived seven months before the deadline, while still absorbing the administrative load of the pandemic unwinding.

8. No Off-Ramp: The Double Hit

In past coverage disruptions, the ACA marketplace served as a partial landing place. That will not be true here. People denied or disenrolled for failing the work requirement are ineligible for marketplace premium tax credits [12].

Even for people who remain eligible, the marketplace has become more expensive. Insurers raised benchmark premiums by more than 20 percent for 2026 and proposed a median 15 percent increase for 2027 [3]. Paid marketplace enrollment fell from 21.8 million in February 2025 to 19.2 million in February 2026 [47], and policy experts expect enrollment to keep falling after the expiration of the enhanced subsidies [4]. Open enrollment for 2027 coverage runs November 1, 2026 through January 15, 2027 on HealthCare.gov [4].

Other provisions compound the timing. Missouri, for example, lists six-month eligibility reviews for expansion adults and a reduction in retroactive coverage from up to three months to one month for that group [48]. Retroactive coverage has long allowed hospitals to be paid for care delivered to people who enroll after an emergency. Shortening it means that a patient who loses coverage on a paperwork technicality and reenrolls later may leave uncovered bills behind.

THE CONVERGENCE

In the first quarter of 2027, hospitals, clinics, and outpatient providers will face falling marketplace enrollment, new Medicaid disenrollments, six-month renewals, and shorter retroactive coverage at the same time. Each is manageable in isolation. Together they form a double hit to payer mix arriving in a single quarter.

The financial backdrop leaves little room. About 43 percent of hospitals were operating in the red in 2026, compared with 33 percent before the pandemic [49]. HCA Healthcare raised its estimate of the cost of the ACA changes to up to \$1.2 billion in 2026, and the American Hospital Association estimates that the law's Medicaid cuts put more than 300 rural hospitals at risk of closure, conversion, or service reductions [50].

9. What It Means for Hospitals, Clinics, and Imaging

The Commonwealth Fund, using a hospital finance simulation model and Urban Institute coverage estimates, projected the effects across 2,958 acute-care hospitals in expansion states assuming full implementation in 2027 [9]:

- Medicaid revenue would fall by \$12.2 billion to \$13.8 billion, and uncompensated care costs would rise by \$7.0 billion to \$8.0 billion, an increase of 29.5 to 33.6 percent.
- Operating margins across all hospitals would fall by 11.7 to 13.3 percent in relative terms.
- At 567 safety-net hospitals, margins would fall by 25.9 to 29.6 percent. Safety-net hospitals in 14 states could see Medicaid revenue decline by 10 percent or more.
- At 316 rural safety-net hospitals, net operating income would fall by 24.6 to 28.0 percent.

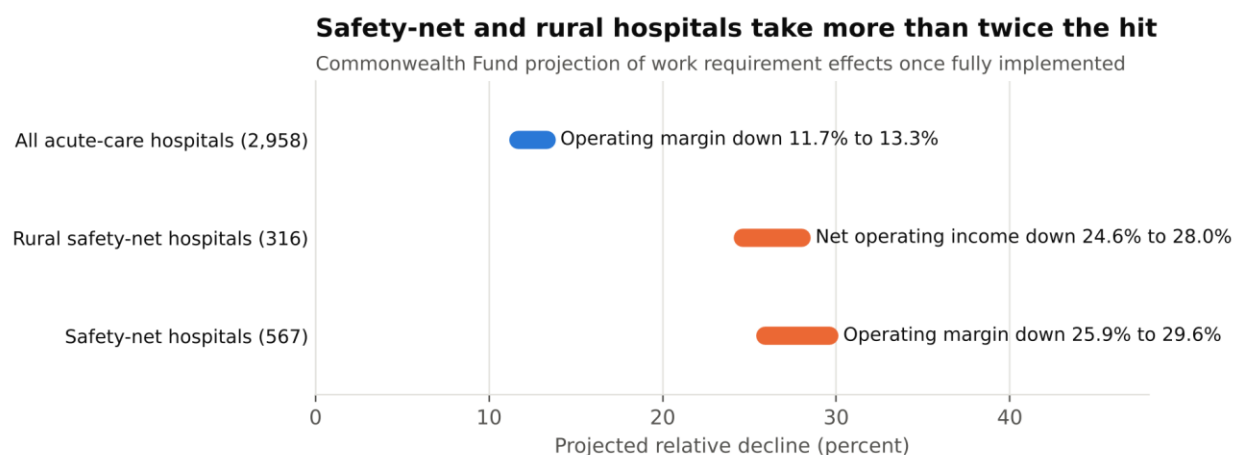


Figure 7. Projected relative decline in hospital finances from Medicaid work requirements.

Source: Haught R, et al., Commonwealth Fund, September 2025. Projection assumes full implementation in 2027.

Community health centers face a parallel shock. Researchers estimate that nearly 5.6 million health center patients could lose Medicaid coverage over five years, with revenue losses of \$15.7 billion to \$32 billion [15]. In Lincoln, Nebraska, the chief executive of Bluestem Health projected that 10 to 15 percent of its 8,400 Medicaid patients could be disenrolled, costing the clinic \$400,000 to \$600,000 a year [46]. Rural health experts warn that people who lose coverage tend to delay care and arrive at emergency departments sicker and costlier to treat [51].

9.1 The imaging and outpatient diagnostics exposure

For outpatient imaging and other scheduled diagnostic services, the operational risk is timing. A study may be scheduled weeks before the date of service. Under six-month renewals and monthly compliance standards, a patient who was eligible on the day of scheduling may not be eligible on the day of the scan. Shorter retroactive coverage reduces the ability to recover payment after the fact. The practical implications for imaging leaders include:

- **Eligibility verification must move closer to the date of service.** A single check at scheduling is no longer sufficient for expansion-group patients; a second check within a few days of the appointment becomes a standard control.
- **Self-pay conversion conversations must happen earlier.** Patients flagged at risk should receive a good-faith estimate and financial counseling before the exam, not a bill afterward.
- **Ordering clinicians can protect coverage.** Accurate, complete diagnosis coding on claims supports automated identification of medical frailty, because states rely on recent claims and encounter data to grant exclusions without paperwork [21].
- **Patient communication is a clinical service.** Front-desk and scheduling staff are often the last people to see a patient before coverage lapses. A short prompt about renewal notices and the 30-day response window can prevent avoidable loss.

9.2 A simple revenue-at-risk framework

Leaders can estimate their own exposure with a transparent formula that will also anchor the companion interactive infographic:

REVENUE AT RISK

Annual revenue at risk = (expansion-group patients) × (share subject after exclusions) × (expected loss rate) × (average annual net revenue per patient) × (1 minus the share who find other coverage)

The expected loss rate is the critical input. Nebraska's early renewal experience (7 percent) offers a lower bound under self-attestation, while CMS's own planning assumption (15 percent) offers a reasonable upper scenario for 2027 [2, 25]. As an illustration only, using hypothetical inputs: an organization serving 10,000 expansion-group patients, with all of them subject, a 7 to 15 percent loss rate, \$2,000 in average annual net revenue per patient, and 8 percent finding other coverage, would place roughly \$1.3 million to \$2.8 million of annual revenue at risk, before counting the added cost of uncompensated care for patients who continue to seek treatment. The 8 percent figure reflects CBO's assumption that about 92 percent of people who lose coverage become uninsured [9].

10. The Case for Work Requirements

A fair investigation must state the strongest version of the argument for the policy, because it is held sincerely and by a majority of the public when the question is first asked.

Supporters argue that work requirements restore Medicaid's focus on the most vulnerable. The Paragon Health Institute contends that the requirements protect finite program resources for people who cannot work because of disability, frailty, or caregiving, while promoting independence for those who can; that work is essential to economic opportunity and long-term well-being; and that relying on self-attestation alone, particularly for medical frailty, risks the kind of improper enrollment seen in other programs when verification is weakened [52]. Paragon also points out that the federal government pays a much higher matching rate for expansion adults than for traditional enrollees such as children, pregnant women, seniors, and people with disabilities [52]. Arkansas officials have framed their approach in similar terms, describing it as a way to *ensure that our finite Medicaid resources support those who need them* [53].

CMS's own analysis reflects this view, projecting that up to 4.4 million people will meet the requirement and that the shift will yield improved economic and health outcomes for participants [20]. Supporters also cite the welfare reforms of the 1990s, which tied cash assistance to work, as evidence that well-designed requirements can increase employment.

Public opinion offers support, with important nuance. In KFF polling, about six in ten adults (62 percent) initially favored requiring nearly all adults to work or look for work to receive Medicaid. Support rose to 77 percent when respondents heard that the requirement could ensure Medicaid is reserved for the elderly, people with disabilities, and low-income children [54]. Support fell to 40 percent when respondents heard the requirement would not significantly increase employment but

would raise state administrative costs, and to 32 percent when they heard most enrollees already work or are unable to work [54]. A 2026 poll found 59 percent of Montana voters supported the requirements [55].

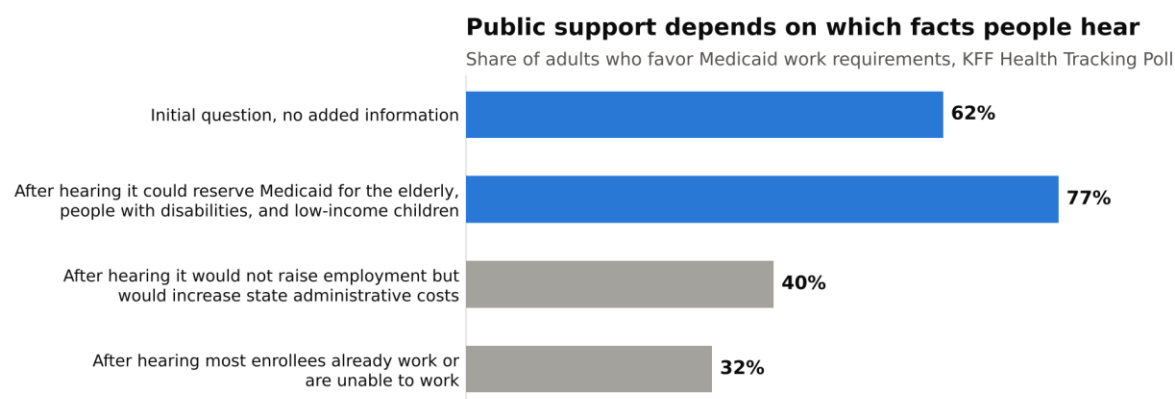


Figure 8. Support for Medicaid work requirements under different framings.

Source: KFF Health Tracking Poll, as reported by KFF and state news outlets.

The evidentiary counterweight is the record described in Section 5: Arkansas produced coverage losses without employment gains, Georgia enrolled a fraction of its projection at a high administrative cost, and Nebraska's early losses are overwhelmingly procedural [10, 11, 2]. Critics also argue that CMS's employment assumption is far above the research literature [26].

A FAIR READING

The two sides agree more than the rhetoric suggests. Both say the policy should reach adults who can work and are not doing so, while protecting people who work, care for others, or are too sick to work. The disagreement is empirical: whether reporting systems can find the first group without removing the second. The early data will answer that question faster than the debate will.

11. A Readiness Playbook: The Next 68 Days

Whatever one's view of the policy, the operational priorities for health care leaders are the same: keep eligible people covered, protect access, and prepare for the patients who lose coverage anyway. Table 4 translates the evidence into actions.

Table 4. Actions before January 1, 2027, by stakeholder

Stakeholder	Priority actions	Metric to watch
Hospitals and health systems	Identify expansion-group patients in the payer file; model uncompensated care scenarios at 7% and 15% loss rates; update financial assistance policies; train financial counselors on exclusions and the 30-day response window	Self-pay share of registrations; uncompensated care per month
Physicians and clinical teams	Complete diagnosis coding to support automated frailty identification; prepare a standard frailty documentation template for 2028 requirements	Frailty exclusion rate among your patients

Stakeholder	Priority actions	Metric to watch
Imaging and outpatient diagnostic centers	Re-verify eligibility within days of service for expansion-group patients; give good-faith estimates before exams; add renewal reminders to scheduling scripts	Eligibility denials and same-day self-pay conversions
Community health centers and navigators	Help patients respond to notices within 30 days; track notice dates; partner with employers and schools for hours documentation	Notices received versus responses returned
State Medicaid agencies	Maximize ex parte verification using wage, nutrition assistance, and claims data; publish monthly procedural and substantive losses separately; staff call centers	Ex parte rate; procedural share of losses; pending renewals
Employers and workforce boards	Provide simple hours verification letters; connect workers with variable schedules to reporting help	Requests for verification letters

Source: Author analysis based on the evidence presented in this report.

12. Indicators to Watch

The coming months will reveal which projections were right. These indicators, most of them public, will show whether the requirement is functioning as a work test or a paperwork test.

Table 5. Early-warning indicators for the work requirement rollout

Indicator	Why it matters
Procedural share of coverage losses	If most losses stay procedural, the policy is removing eligible people; Nebraska's renewal figure is 92%
Ex parte renewal rate by state	The strongest predictor of whether eligible people keep coverage without paperwork
New applicant denial rate	Shows whether the policy deters or blocks entry, not only exits
Reenrollment within 90 days	High reenrollment signals people were eligible all along
Pending renewals and call center wait times	Early signs of administrative overload
Frailty exclusion share after 2027	Will reveal the effect of documentation requirements and the narrowed definition
Hospital self-pay and uncompensated care trends	The downstream financial signal for providers
Massachusetts v. Oz and HHS extension decisions	Could change the frailty rules or the timeline

Source: Author analysis.

13. Conclusion

The Medicaid work requirement was argued for as a test of personal responsibility and argued against as a threat to coverage. The first months of real-world evidence suggest that it is, in practice, a test of administrative capacity. Where states can confirm work and exemptions from data they already hold, people keep coverage. Where states must ask, many people who are working, caregiving, or sick lose coverage because a notice went unanswered.

That finding should unite rather than divide. If the goal is to encourage work while protecting people who cannot work, then every eligible person lost to paperwork is a failure of the policy on its own

terms. The 68 days that remain are not enough to rebuild state eligibility systems. They are enough for hospitals, clinics, imaging centers, and state agencies to identify their exposed patients, strengthen verification at the point of service, and prepare for the uncompensated care that will follow. The organizations that treat January 1 as an operational deadline, not a political event, will be the ones that protect both their patients and their margins.

Methods and Limitations

This investigative report is a structured synthesis of primary and secondary sources: the federal statute and CMS interim final rule as summarized by legal and policy analysts; projections from CBO, CMS, and the Urban Institute; peer-reviewed research on Arkansas; government audit findings on Georgia; state administrative data from Nebraska presented in September 2026; state agency announcements from Montana, Arkansas, Iowa, and Missouri; and published analyses from KFF, the Georgetown University Center for Children and Families, the Commonwealth Fund, the Brookings Institution, and others. Sources were accessed through October 25, 2026.

Several limitations apply. Nebraska's data covers only the first months of implementation, under self-attestation and before the tightened frailty rules took effect, and may not predict experience in larger or less prepared states. Projections differ substantially because of differing assumptions about behavior and implementation. Hospital financial modeling assumes full implementation in 2027 and does not account for management responses. Some state-level figures come from news reports of state data rather than primary datasets. The revenue-at-risk example uses hypothetical inputs for illustration only. Nothing in this report constitutes legal or financial advice.

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