May 7, 2025

Submitted electronically via Medicaid.gov

The Honorable Robert F. Kennedy, Jr.
Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: APHA and Public Health Deans and Scholars' Comments on Arizona Section 1115 Waiver Amendment Request: AHCCCS Works

Dear Mr. Secretary:

The American Public Health Association (APHA), along with 65 public health and health policy deans, chairs, and scholars (in their individual capacity), appreciate the opportunity to submit these comments on Arizona's proposed AHCCCS Works Section 1115 waiver amendment request. We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we respectfully request that the full text of each of the studies cited, along with the full text of our comments, along with each of the individual studies, reports, and other documents cited within our comments, be considered part of the formal administrative record on this waiver application for purposes of the Administrative Procedure Act.

APHA is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and health-related businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

The individual signatories are deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals known for their expertise in research regarding health insurance coverage, access to care, health outcomes, and social determinants of health, particularly for underserved populations, including low-income people, people with disabilities, and other vulnerable populations covered by state Medicaid programs. The complete list of individual commenters is included at the end of this letter.

APHA and the individual deans, chairs, and scholars recommend that the Centers for Medicare and Medicaid Services (CMS) reject Arizona's request to require individuals to work in order to qualify for and maintain eligibility in the Medicaid expansion group, to impose a five year lifetime limit on Medicaid benefits, to lock certain expansion adults out of coverage for 12 months, and to impose cost-sharing on non-emergency use of emergency department and ambulance services. These proposals are contrary to

the program's primary objective of providing coverage to low-income people and the public health research evidence base. Research shows that work requirements do not result in measurable increases in employment (since most Medicaid enrollees who can work are already working), and instead result in coverage loss among low-income working people, increases in the number of uninsured people, and a "chilling" effect on Medicaid enrollment due to administrative burdens and red tape.

I. Work requirements result in substantial numbers of eligible people losing coverage and becoming uninsured, which is contrary to the primary objective of Medicaid.

Arizona's work requirements is likely to result in coverage loss, an outcome that directly conflicts with the Medicaid program's primary objective of providing health coverage to low-income people. Arizona reports 414,689 expansion adults ages 19 to 55, and estimates that 190,000 of these enrollees will be subject to its work requirement and will not qualify for an exemption.[1] Notably, Arizona does not estimate the number of enrollees likely to lose coverage after the work requirement is implemented. However, KFF researchers estimated that 10 percent (44,000 out of 441,000 expansion adults in Arizona) would lose coverage if Congress adopted a national Medicaid work requirement for expansion adults ages 19-55.[2] KFF based its estimate using Congressional Budget Office assumptions, which it acknowledged are "highly uncertain." KFF also noted that 25 percent coverage loss experienced by Arkansas enrollees subject to its work requirement, "suggesting that the percent who lose eligibility could be well above the 10% assumed by CBO."[3]

Other researchers "suggest that CBO may be underestimating the effect of such a policy"[4] and that coverage loss could be even higher. Researchers at the Urban Institute project coverage loss of 34 to 39

[1] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 6 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[2] Burns A, Williams E, Rudowitz R. Tough tradeoffs under Republican work requirement plan: some people lose Medicaid or states could pay to maintain coverage. Appendix Table 1. KFF. (May 5, 2023) https://www.kff.org/medicaid/issue-brief/tough-tradeoffs-under-republican-work-requirement-plan-some-people-lose-medicaid-or-states-could-pay-to-maintain-coverage/

[3] *Id.*

[4] Fielder M. How would implementing an Arkansas-style work requirement affect Medicaid enrollment? Brookings Institution Center on Health Policy (April 2025), https://www.brookings.edu/articles/how-would-implementing-an-arkansas-style-work-requirement-affect-medicaid-enrollment/ ; *see also* https://www.brookings.edu/wp-content/uploads/2026/04/ArkansasStyleWorkRequirementEnrollmentEffects-FINAL.pdf

percent[5] – amounting to 166,000 to 189,000 Medicaid expansion adults ages 19 to 55 in Arizona[6] -- under a Medicaid work requirement, based on experience in Arkansas and New Hampshire. Using a different methodology, the Brookings Institution developed a model that estimates a 27 percent reduction in Medicaid enrollment by the end of the first year of work requirement implementation and a 34 percent reduction over the long run.[7]

Federal law requires Section 1115 demonstrations to be "likely to assist in promoting the objectives of" the Medicaid Act.[8] Congress created the Medicaid program "to furnish medical assistance" to "individuals[] whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[9] Thus, "[t]he provision of Medicaid coverage is indisputably a central objective of the Act."[10]

Work requirements have resulted in substantial coverage loss in other states. Over 18,000 people lost Medicaid coverage in Arkansas during the seven months that its work requirement was in effect.[11] This amounts to one in four individuals who were subject to Arkansas's work requirement losing their health insurance coverage.[12] Importantly, an estimated 95 percent of the people who lost coverage in Arkansas nevertheless had met the work requirement or were exempt and therefore should have remained

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[5] Karpman M Haley JM, Kenney GM. How many expansion adults could lose Medicaid under federal work requirements? Urban Institute. (March 2025), https://www.urban.org/sites/default/files/additional-materials/How-Many-Expansion-Adults-Could-Lose-Medicaid-under-Federal-Work-Requirements.pdf ; *see also* Karpman M, Haley JM, Kenney GM. Assessing potential coverage losses among Medicaid expansion enrollees under a federal Medicaid work requirement. Urban Institute. (March 2025). https://www.urban.org/research/publication/assessing-potential-coverage-losses-among-medicaid-expansion-enrollees-under; *see also* https://www.urban.org/sites/default/files/2025-03/Assessing-Potential-Coverage-Losses-among-Medicaid-Expansion-Adults-under-a-Federal-Medicaid-Work-Requirement.pdf

[6] Karpman M Haley JM, Kenney GM. State-by-state estimates of Medicaid expansion coverage losses under a federal work requirement. Urban Institute (April 14 2025), https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work ; *see also* https://www.urban.org/sites/default/files/2025-04/State-by-State-Estimates-of-Medicaid-Expansion-Coverage-Losses-under-a-Federal-Work-Requirement.pdf

[7] Fielder M. How would implementing an Arkansas-style work requirement affect Medicaid enrollment? Brookings Institution Center on Health Policy (April 2025), https://www.brookings.edu/articles/how-would-implementing-an-arkansas-style-work-requirement-affect-medicaid-enrollment/ ; *see also* https://www.brookings.edu/wp-content/uploads/2026/04/ArkansasStyleWorkRequirementEnrollmentEffects-FINAL.pdf

[8] 42 U.S.C. § 1315.

[9] 42 U.S.C. § 1396-1.

[10] *Stewart v. Azar,* 366 F. Supp. 3d 125, 145 (D.D.C. 2019).

[11] Robin Rudowitz, MaryBeth, Musumeci, and Cornelia, Hall, "February state data for Medicaid work requirements in Arkansas." *KFF*. March 25, 2019. https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[12] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," *Center on Budget and Policy Priorities*, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be

enrolled.[13] The decrease in Medicaid/Marketplace coverage among people subject to Arkansas's work requirement (those ages 30 to 49) was statistically significant compared to other age groups.[14] Specifically, the percentage of Arkansans ages 30 to 49 with Medicaid/Marketplace coverage dropped from 71 percent in 2016 (pre-work requirements) to 64 percent in 2018 (during work requirements), and rose to 66 percent in 2019 (when work requirements were no longer in effect).[15] Most of the Medicaid coverage loss in Arkansas was reversed after a federal court ended the work requirement in 2019, as people were able to regain the coverage for which they remained eligible.[16]

New Hampshire sought to "avoid the problems" that plagued Arkansas' demonstration.[17] Nevertheless, an estimated 17,000 people -- two in three enrollees -- would have lost Medicaid coverage in the two months that New Hampshire's work requirement waiver was in effect, had the state not suspended the program to avoid this "undue harm" to enrollees.[18] In Michigan, 80,000 beneficiaries – nearly one-third of those subject to the work requirement – were slated to lose coverage before the work requirement was blocked by a federal court.[19]

Research shows that the extent of coverage loss under Arkansas's previous work requirement could have been even more widespread if the policy had remained in effect. A 2025 study developed a model to forecast the effects of Arkansas's work requirement on Medicaid enrollment over the longer-term, if the work requirement had not been stopped by the courts.[20] This study found an estimated 27 percent reduction in Medicaid enrollment by the end of the first year of implementation and a 34 percent reduction over the long run.[21]

Similarly, research examining the impact of work requirements in the SNAP and TANF programs demonstrates that "many [enrollees] quickly lost benefits."[22] Work requirements in SNAP have existed

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[13] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care," *Health Affairs* 39, no. 9 (September 1, 2020): 1522–30, https://doi.org/10.1377/hlthaff.2020.00538.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] Ian Hill, Emily Burroughs, and Gina Adams, "New Hampshire's Experiences with Medicaid Work Requirements: New Strategies, Similar Results," *Urban Institute*, February 10, 2020, https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results.
[18] *Id.*
[19] ASPE Office of Health Policy, *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence* (ASPE, 2021), https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence.
[20] Fielder M. How would implementing an Arkansas-style work requirement affect Medicaid enrollment? Brookings Institution Center on Health Policy (April 2025), https://www.brookings.edu/articles/how-would-implementing-an-arkansas-style-work-requirement-affect-medicaid-enrollment/.
[21] *Id.*
[22] Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?* (Commonwealth Fund, Nov. 2018), https://www.commonwealthfund.org/sites/default/files/2018-11/Ku_Medicaid_work_requirements_ib.pdf (citing Jeffrey Grogger, Steven Haider, and Jacob Alex Klerman, *Why*

long enough for researchers to conduct numerous studies "using data from states across the country, collected over many years," all of which "find harmful effects of work requirements on [enrollee] participation and little or no benefit for employment."[23] For example, a study examining over 2,400 counties between 2013 and 2017 found that SNAP work requirements "rapidly reduce caseloads and benefits" and "caused over one-third of able-bodied adults without dependents to lose benefits."[24] A 2020 study found that SNAP work requirements led to a 52 percent reduction in program participation but no appreciable increase in employment earnings.[25] This established body of research makes clear that substantial coverage loss is an inherent feature of work requirements and is not the result of "start-up jitters or chaotic implementation in one state."[26] Medicaid work requirements are even less likely to be successful since, unlike TANF and SNAP, Medicaid funds cannot be used to pay for supportive services that enable people to work such as child care, transportation, or job training.[27]

A significant share of people who lose Medicaid due to work requirements become uninsured. A study evaluating the impact of Arkansas's work requirement after six months and published in the *New England Journal of Medicine* found that "loss of Medicaid coverage was accompanied by a significant increase in the percentage of adults who were uninsured, indicating that many persons who were removed from Medicaid did not obtain other coverage."[28] At the same time, the use of employer-sponsored insurance did not significantly increase.[29] As the study authors explain, "[a]lthough point estimates suggest a potential increase in the use of employer-sponsored insurance, confidence intervals for this measure included no effect."[30] These findings suggest that people who lost Medicaid could not access employer-sponsored insurance.

Did the Welfare Rolls Fall During the 1990s? The Importance of Entry, draft (RAND Corporation, 2003), https://www.rand.org/pubs/drafts/DRU3004.html ; MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience* (Henry J. Kaiser Family Foundation, Aug. 2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/).

[23] Erin Brantley et al., "As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful," *Health Affairs*, February 17, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210216.717854/full/.

[24] Leighton Ku, Erin Brantley, and Drishti Pillai, "The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017," *American Journal of Public Health* 109, no. 10 (October 1, 2019): 1446–51, https://doi.org/10.2105/AJPH.2019.305232.

[25] Colin Gray, Adam Leive, Elena Prager, Kelsey Pukelis, and Mary Zaki, "Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply," August 18, 2020, SSRN, https://ssrn.com/abstract=3676722 or http://dx.doi.org/10.2139/ssrn.3676722.

[26] Erin Brantley et al., "As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful," *Health Affairs*, February 17, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210216.717854/full/.

[27] *Id.*

[28] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements — Results from the First Year in Arkansas," *New England Journal of Medicine* 381, no. 11 (September 12, 2019): 1073–82, https://doi.org/10.1056/NEJMsr1901772.

[29] *Id.*

[30] *Id.*

Another study evaluating the impact of Arkansas' work requirement after 18 months and published in *Health Affairs* found that "work requirements led to a significant increase in the uninsured rate of 7.1 percentage points for Arkansans ages 30–49 [the group subject to the work requirement], relative to other age groups and states, consistent with previous research."[31] The "uninsurance rate for Arkansans ages 30–49 rose from 10.5 percent in 2016 [pre-work requirement] to 14.6 percent in 2018 [during the work requirement] and then went back down to 12.5 percent in 2019 [after work requirements were no longer in effect]."[32] At the same time, the "uninsurance rate for adults ages 30–49 in [the study's] comparison states was fairly stable for all three years."[33] These findings are consistent with multiple government and independent analyses that conclude that work requirement programs skyrocket the uninsured rate.[34]

A 2025 study published in *Health Services Research* found that Arkansas's previous work requirement "reduced the number of adults with health insurance coverage and had no effect on employment—failing to achieve its intended outcome."[35] The study authors found that the share of uninsured adults ages 30-49 in Arkansas (those subject to the work requirement) increased from 22.6 percent in 2016 to 29.9 percent in 2019.[36] Arkansas's work requirement was "associated with a 4.4 percentage-point increase in uninsurance, concentrated among those with incomes below 100% FPL" while Medicaid/private nongroup coverage declined, and employer coverage did not significantly change.[37] During this same period, "[n]o coverage impacts were observed for unaffected or exempt groups."[38] According to the authors, "Arkansas's experience suggests nearly all adults losing Medicaid would become uninsured, leading to worse health outcomes and increased financial strain on health care providers facing higher uncompensated care costs."[39]

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[31] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care," *Health Affairs* 39, no. 9 (September 1, 2020): 1522–30, https://doi.org/10.1377/hlthaff.2020.00538.
[32] *Id.*
[33] *Id.*
[34] Work Requirements and Work Supports for Recipients of Means-Tested Benefits, Publication 57702 (Congressional Budget Office, June 2022), https://www.cbo.gov/publication/57702; *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence, Issue Brief HP-2021-03*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 2021, https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence
[35] Karpman M, Gangopadhyaya A. New evidence confirms Arkansas's Medicaid work requirement did not boost employment. Urban Institute. (April 23, 2025). https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment; *see also* Gangopadhyaya A, Karpman M. The impact of Arkansas Medicaid work requirements on coverage and employment: estimating effects using national survey data. Health Services Research. e14624. April 9, 2025. https://doi.org/10.1111/1475-6773.14624
[36] Gangopadhyaya A, Karpman M. The impact of Arkansas Medicaid work requirements on coverage and employment: estimating effects using national survey data. Health Services Research. e14624. April 9, 2025. https://doi.org/10.1111/1475-6773.14624
[37] *Id.*
[38] *Id.*
[39] Karpman M, Gangopadhyaya A. New evidence confirms Arkansas's Medicaid work requirement did not boost employment. Urban Institute. (April 23, 2025). https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment

Though most Medicaid enrollees already are working, they face a substantial risk of becoming uninsured if they lose Medicaid, due to the characteristics of their employers. More than two in five (42.7%) nonelderly working adults with Medicaid in Arizona are employed by a small firm (less than 50 employees).[40] These employers "are not subject to ACA penalties for not offering affordable health coverage and are less likely to offer health insurance to their workers than larger firms."[41] For example, "[i]n 2022, just over half (53%) of firms with fewer than 50 employees offered health insurance to their workers compared to 98.7% of firms with 100 or more employees."[42] Additionally, 41.3 percent of nonelderly working adults with Medicaid in Arizona are employed in the agriculture and service industries (including agriculture, construction, leisure and hospitality services, wholesale and retail trade), which have "historically low [employer sponsored insurance] offer rates."[43] Despite being employed, these low-income workers are likely to rely on Medicaid because their employer does not offer health insurance at all or does not offer insurance that is affordable.[44]

People with disabilities are especially at risk of losing coverage due to work requirements. A KFF study concluded that "people with disabilities were particularly vulnerable to losing coverage under the Arkansas work and reporting requirements, despite remaining eligible."[45] Another study found that SNAP work requirements led to drops in participation among people with disabilities, despite being targeted to "able-bodied" non-disabled adults and exempting those unable to work due to a disability.[46] Coverage loss is especially harmful to individuals with disabilities, who rely on regular care to manage chronic conditions and meet daily needs.[47]

II. Work requirements do not increase employment because the vast majority of Medicaid enrollees are already working.

[40] This analysis excludes enrollees receiving Social Security Disability Insurance, Supplemental Security Income, or Medicare. Tolbert, Jennifer, Sammy Cervantes, Robin Rudowitz, and Alice Burns. "Understanding the Intersection of Medicaid and Work: An Update." *Kaiser Family Foundation*, February 4, 2025. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/

[41] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz, and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," *Kaiser Family Foundation*, February 4, 2025, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," Kaiser Family Foundation, June 11, 2019, https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.

[46] Erin Brantley, Drishti Pillai, and Leighton Ku, "Association of Work Requirements With Supplemental Nutrition Assistance Program Participation by Race/Ethnicity and Disability Status, 2013-2017," *JAMA Network Open* 3, no. 6 (June 26, 2020): e205824–e205824, https://doi.org/10.1001/jamanetworkopen.2020.5824.

[47] "Taking Away Medicaid for Not Meeting Work Requirements Harms People with Disabilities," *Center on Budget and Policy Priorities*, updated March 10, 2020, https://www.cbpp.org/research/health/harm-to-people-with-disabilities-and-serious-illnesses-from-taking-away-medicaid-for.

Allowing Arizona to condition Medicaid eligibility on meeting a work requirement will not advance the state's goal of increasing employment among expansion adults because the vast majority of Arizona Medicaid enrollees already are working. According to KFF, 57.8 percent of non-elderly Medicaid adults in Arizona already work full or part-time.[48] Another 10.4 percent are not working due to illness or disability, 14.4 percent are not working due to caretaking responsibilities, and 9 percent are not working because they are attending school.[49] The data show that nearly all Arizona Medicaid enrollees already are engaged in work or another qualifying activity, making Arizona's proposed work requirement meaningless. While the potential gain in the number of working enrollees is negligible at best, the potential harm to all enrollees is great in light of the research detailed above that establishes the risk of substantial coverage loss among eligible enrollees posed by work requirements.

Research demonstrates that work requirements do not increase employment. A study published in the *New England Journal of Medicine* evaluating the impact of Arkansas's Medicaid work requirement after six months "did not find any significant change in employment. . . or in the related secondary outcomes of hours worked or overall rates of community engagement activities."[50] The authors noted that "more than 95% of persons who were targeted by the policy already met the requirement or should have been exempt."[51] A study published in *Health Affairs* evaluating the impact of Arkansas's Medicaid work requirement after 18 months "found no evidence that low-income adults had increased their employment or other community engagement activities either in the first year when the policy was still in effect or in the longer term, after the policy was blocked" by a federal court.[52] A 2025 study published in *Health Services Research* found that Arkansas's previous work requirement was associated with "no significant change in employment or work effort."[53] The "association between work requirements and employment among [those subject to the work requirement] was negative, small, and statistically

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[48] This analysis excludes people receiving Social Security Disability Insurance, Supplemental Security Income, or Medicare benefits. *See* Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz, and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update," *Kaiser Family Foundation,* February 4, 2025, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[49] *Id.*

[50] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements — Results from the First Year in Arkansas," *New England Journal of Medicine* 381, no. 11 (September 12, 2019): 1073–82, https://doi.org/10.1056/NEJMsr1901772.

[51] *Id.*

[52] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs*, 39 , no. 9 (2020): 1528, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.00538 (last visited Feb. 13, 2025).

[53] Gangopadhyaya A, Karpman M. The impact of Arkansas Medicaid work requirements on coverage and employment: estimating effects using national survey data. Health Services Research. e14624. April 9, 2025. https://doi.org/10.1111/1475-6773.14624

insignificant."[54] Focus groups of Arkansas Medicaid enrollees also found that most were already working and were highly motivated to work due to economic pressures.[55]

Multiple government and independent analyses conclude that work requirement programs do not result in sustainable employment gains.[56]A Cochrane review of 12 randomized control trials of "welfare to work" initiatives (such as work requirements) found that these programs have no meaningful, long-lasting effects on employment or income.[57] Research also finds that TANF enrollees "work regardless of whether they are required to do so, suggesting that a work requirement has little impact on increasing employment over the long-term."[58] Notably, "[a]fter five years, those who were not required to work were just as likely or more likely to be working compared to those who were subject to a work requirement."[59]

People subject to Medicaid work requirements experience adverse financial consequences. Among the people who had lost Medicaid in the prior year due to Arkansas's work requirement, "50 percent reported serious problems paying off medical debt; 56 percent delayed care due to cost; and 64 percent delayed medications due to cost."[60] All of these rates were significantly higher compared to people who remained enrolled in Medicaid.[61] People who lost coverage in the prior year because of Arkansas's work

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[54] *Id.*

[55] MaryBeth Musumeci, Robin Rudowitz, and Barbara Lyons, "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees," *Kaiser Family Foundation*, December 18, 2018, https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/.

[56] "Work Requirements and Work Supports for Recipients of Means-Tested Benefits", Congressional Budget Office, Publication 57702, June 9, 2022, https://www.cbo.gov/publication/57702; Issue Brief No. HP-2021-03. "Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Washington, DC: March 2021, https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence ; "Work Requirements: What Are They? Do They Work?", Robert Wood Johnson Foundation, May 11, 2023, https://www.rwjf.org/en/insights/our-research/2023/05/work-requirements-what-are-they-do-they-work.html.

[57] Marcia Gibson, Hilary Thomson, Kasia Banas, Vittoria Lutje, Martin J McKee, Susan P Martin, Candida Fenton, Clare Bambra, and Lyndal Bond,, "Welfare-to-Work Interventions and Their Effects on the Mental and Physical Health of Lone Parents and Their Children," *Cochrane Database of Systematic Reviews*, no. 2 (2018): https://doi.org/10.1002/14651858.CD009820.pub3.

[58] MaryBeth Musumeci and Julia Zur, 'Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience", *Kaiser Family Foundation*, August 18, 2017, https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/ (citing Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective are Difference Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs", *Manpower Demonstration Research Corporation*, December 2001, http://www.mdrc.org/sites/default/files/full_391.pdf).

[59] *Id.* (citing Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective are Difference Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs", *Manpower Demonstration Research Corporation*, December 2001, http://www.mdrc.org/sites/default/files/full_391.pdf).

[60] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs*, 39 , no. 9 (2020): 1522, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.00538 (last visited Feb. 13, 2025).

[61] *Id.*

requirement also had higher medical debt (averaging over $2,200) compared to those who maintained coverage, and half of those who lost coverage reported serious problems paying off their debts.[62]

III. Work requirements do not improve health outcomes.

Researchers "caution against using [evidence of an association between unemployment and poor health outcomes] to infer that the opposite relationship (work causing improved health) exists."[63] A KFF literature review of the relationship between work and health concludes that "[w]hile unemployment is almost universally a negative experience and thus linked to poor outcomes. . . , employment may be positive or negative, depending on the nature of the job (e.g., stability, stress, hours, pay, etc.)."[64] Moreover, "[s]election bias in the research (e.g., healthy people being more likely to work) and other methodological limitations restrict the ability to determine a causal work-health relationship."[65] Importantly, "[e]ffects found for the general population may not apply to Medicaid, as the link between work and health is not universal across populations or social contexts," while the "low-wage, unstable, or low-quality jobs" typically held by Medicaid enrollees "may moderate any positive health effects of employment."[66] A Cochrane review of 12 randomized control trials of "welfare to work" initiatives (such as work requirements) found that these programs do not improve physical health among parents or children.[67]

Arizona's proposal cites studies that are not relevant to the population that would be impacted by work requirements. For example, the studies cited by Arizona are focused on the larger U.S. population as well as international populations[68]; they do not focus on low-income people in the U.S. Arizona's reliance on these studies is based on the faulty assumption that the very small subset of Medicaid enrollees that are not employed (and not caregivers and students) have the same characteristics and employment opportunities as the larger US population or international population -- and therefore would

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[62] *Id.*

[63] Larisa Antonisse and Rachel Garfield. "The Relationship Between Work and Health: Findings from a Literature Review," *Kaiser Family Foundation*, August 7, 2018, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] Marcia Gibson, Hilary Thomson, Kasia Banas, Vittoria Lutje, Martin J McKee, Susan P Martin, Candida Fenton, Clare Bambra, and Lyndal Bond,, "Welfare-to-Work Interventions and Their Effects on the Mental and Physical Health of Lone Parents and Their Children," *Cochrane Database of Systematic Reviews*, no. 2 (2018): https://doi.org/10.1002/14651858.CD009820.pub3.

[68] Paul KI, Geithner E, Moser K. Latent deprivation among people who are employed, unemployed, or out of the labor force. Journal of Psychology, 143 (5), 477-491. https://pubmed.ncbi.nlm.nih.gov/19943399/ ; Hergenrather K, Zeglin R, McGuire-Kuletz M, and Rhodes S. Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Mental Health. Rehabilitation Research, Policy, and Education. 2015; 29 (30): 261-290. https://www.researchgate.net/publication/273333771_Employment_as_a_Social_Determinant_of_Health_A_Systematic_Review_of_Longitudinal_Studies_Exploring_the_Relationship_Between_Employment_Status_and_Physical_Health

have the same mental health/physical health outcomes. In reality, the small subset of the low-income population being targeted by the work requirements likely has far fewer employment opportunities available, and it is possible that the only work opportunities available to this population would not benefit but instead would be detrimental to their health. Studies showing the benefits of employment among the larger population cannot be applied to a very small subset of low-income individuals -- because it is possible that the only opportunities available may take a deep toll on physical or mental health, and would not improve long-term financial stability.

On the other hand, health coverage is an important precursor to and support for Medicaid workers. Research shows that access to affordable health insurance has a positive effect on the ability to obtain and maintain employment.[69] Having access to regular preventive health care to manage chronic conditions, access medications, and address health issues before they worsen can help support work.[70] This is especially true for Medicaid enrollees, as "[m]any of the jobs held by people with low incomes involve walking, standing, lifting and carrying objects, repetitive motions, and other physical labor."[71]

People who lose Medicaid often end up uninsured - with adverse health effects. As noted above, Medicaid enrollees who lost coverage due to Arkansas's work requirement were significantly more likely to delay obtaining healthcare due to cost (56%) and delay obtaining medications due to cost (64%), compared to those who remained enrolled in coverage.[72] Arkansas Medicaid enrollees also reported that the work requirement created heightened stress and fear that they might lose coverage.[73] The adverse health effects of being uninsured are well established: compared to those with insurance, uninsured adults are "more likely to forgo needed care," "less likely. . . to receive preventive care and services for major health conditions and chronic diseases," and "more likely to be hospitalized for avoidable health problems and to experience declines in their overall health."[74]

Work requirements also harm healthcare providers' financial standing due to the increase in uninsured people. A 2019 study by the Commonwealth Fund found that decreased Medicaid enrollment from work

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[69] Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020", *Kaiser Family Foundation*, March 17, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/.
[70] MaryBeth Musumeci and Julia Zur, "Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience", *Kaiser Family Foundation*, August 18, 2017, https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/.
[71] *Id.*
[72] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs*, 39 , no. 9 (2020): https://doi.org/10.1377/hlthaff.2020.00538 PMID: 32897784 (last visited Feb. 13, 2025).
[73] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model Policy Took Away Health Coverage, Added Stress and Red Tape to People's Lives", Center on Budget and Policy Priorities, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.
[74] Jennifer Tolbert, Sammy Cervantes, Clea Bell, and Anthony Damico, "Key Facts about the Uninsured Population", *Kaiser Family Foundation*, December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

requirements would significantly harm hospital revenues: researchers estimated that hospitals' operating incomes would have declined by up to $2 billion across 18 states if work requirements had been implemented.[75] The number of individuals estimated to become uninsured as a result of work requirements would drive up uncompensated care costs for hospitals and other healthcare providers.[76] Since many rural hospitals are already operating at a loss, they will be hit especially hard by coverage losses from Medicaid work requirements.[77] A 2025 study used an economic model to estimate the impact of Medicaid work requirements on state economies.[78] This model found that Medicaid work requirements will result in substantial adverse impacts to state economies, including job loss among non-Medicaid enrollees (such as health care workers), reductions in state economic activity, and reductions in state and local tax revenue.[79]

IV. Data matching will not protect eligible people from losing coverage.

Arizona appears to propose to use data matching at least to some extent to verify compliance with its work requirement,[80] but data matching did not prevent eligible people from losing coverage due to Arkansas's work requirement. As noted above, an estimated 95% of the people who lost coverage in Arkansas nevertheless had met the work requirement or were exempt and therefore should have remained enrolled.[81] Arkansas's data matching program was supposed to exempt people who were known to be workers, caregivers, students, or disabled, but failed to identify many of these individuals for exemptions.[82]

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[75] How Will Medicaid Work Requirements Affect Hospitals' Finances?" The Commonwealth Fund, 3 September 17, 2019, https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/how-will-medicaid-work-requirements-affect-hospital-finances-update.

[76] "Medicaid Work Requirements Wouldn't Increase Employment and Could Imperil Future Labor Market Participation", The Commonwealth Fund, May 24, 2023, https://www.commonwealthfund.org/blog/2023/medicaid-work-requirements-wouldnt-increase-employment-and-could-imperil-future-labor.

[77] How Will Medicaid Work Requirements Affect Hospitals' Finances?" The Commonwealth Fund, 3 September 17, 2019, https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/how-will-medicaid-work-requirements-affect-hospital-finances-update.

[78] Ku L, et al. How national Medicaid work requirements would lead to large-scale job losses, harm state economies, and strain budgets. Commonwealth Fund. May 2025. https://doi.org/10.26099/6tcv-fh75

[79] *Id.*

[80] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 4-5, 10 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[81] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein "Medicaid Work Requirements — Results from the First Year in Arkansas." *New England Journal of Medicine* 381, no. 11 (2019): 1073–82. https://doi.org/10.1056/NEJMsr1901772.

[82] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model Policy Took Away Health Coverage, Added Stress and Red Tape to People's Lives", Center on Budget and Policy Priorities, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

Data matching puts people with disabilities at substantial risk of erroneously losing coverage. A KFF analysis of Arkansas's work requirement found that "[p]eople with disabilities were particularly vulnerable to losing coverage. . ., despite remaining eligible."[83] Arkansas's process for exempting people who were "medically frail" "did not identify all enrollees whose disabilities or health conditions prevented them from complying."[84] There is no reason to expect that Arizona's experience will be different. The application contains vague and incomplete information about how data matching will work, particularly for identifying people with disabilities who should be exempt. For example, Arizona's application lists separate exemptions for "[i]ndividuals determined to have a serious mental illness (SMI)" and "[i]ndividuals who have a qualifying SMI diagnosis."[85] It is unclear how these exemptions differ or which diagnoses will be considered "qualifying." Additionally, Arizona's proposed list of conditions that qualify as medically frail does not align with the federal definition of medical frailty at 42 C.F.R. § 440.315 (f).

A substantial number of people with disabilities are eligible for Medicaid as expansion adults and therefore at risk of losing coverage due to data matching errors. Among all non-elderly Medicaid enrollees with a disability, nearly seven in 10 (68%) do not receive Social Security Disability Insurance or Supplemental Security Income.[86] This means that they likely qualify for Medicaid through a MAGI pathway, such as the ACA expansion. Data confirm that the ACA expansion group accounts for 20 percent of Medicaid enrollees who use institutional long-term services and supports, and 10 percent of Medicaid enrollees who use home and community-based services.[87]

Data matching can be especially problematic and inaccurate for low-wage earners, because work hours change so frequently. Household income fluctuation is common among low-income populations.[88] These include hourly and seasonal workers, young adults, individuals leaving incarceration, and households with

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[83] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018", *Kaiser Family Foundation*, June 11, 2019, https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.

[84] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018", *Kaiser Family Foundation*, June 11, 2019, https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.

[85] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 5 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[86] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz, and Alice Burns, "Understanding the Intersection of Medicaid and Work: An Update." *Kaiser Family Foundation*, February 4, 2025, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[87] Priya Chidambaram, Alice Burns, and Robin Rudowitz, "Who Uses Medicaid Long-Term Services and Supports?" *Kaiser Family Foundation*, December 14, 2023, https://www.kff.org/medicaid/issue-brief/who-uses-medicaid-long-term-services-and-supports/.

[88] Bauer L, East C, Howard O. Low-income workers experience – by far – the most earnings and work hours instability. Brookings. Jan. 9, 2025. https://www.brookings.edu/articles/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/

young children.[89] Among parents working hourly jobs, 70 percent to 80 percent have erratic schedules, causing income fluctuations throughout the year. [90] One study found that 74 percent of individuals in the lowest income quintile have more than a 30-percent, month-to-month change in total income.[91] Low-wage workers often lack control over the hours they work and may be unaware of what their schedule will be even a week out. [92] Additionally, data matching will not identify earnings for self-employed workers.[93]

Arizona already experiences a high rate of procedural disenrollments. Sixty-nine percent of people who lost Medicaid in Arizona during the post-COVID unwinding were disenrolled for procedural reasons and not because they were actually determined ineligible.[94] Arizona's proposal would impose additional eligibility criteria requiring additional verification which will only increase the risk that eligible people will lose coverage.

Data matching does not obviate the need for enrollees to verify and report information to maintain eligibility, risking erroneous coverage loss due to confusion and administrative errors. During the post-COVID unwinding, 30 percent of Arizona Medicaid enrollees who ultimately retained coverage had to complete a renewal form because the state could not renew their coverage ex parte.[95]

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[89] Jennifer Wagner and Judith Solomon, "Continuous Eligibility Keeps People Insured and Reduces Costs", Center on Budget and Policy Priorities, May 4, 2021, https://www.cbpp.org/sites/default/files/5-4-21health.pdf; Sarah Sugar, Christie Peters, Nancy De Lew, Benjamin D. Sommers, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy, Issue Brief, HP-2021-10 (April 12, 2021) https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

[90] Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits", Center for Law and Social Policy, September 16, 2015, https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf.

[91] Anthony Hannagan and Jonathan Morduch, "Income Gains and Month-to-Month Income Volatility: Household evidence from the US Financial Diaries", U.S. Financial Diaries, March 16, 2015, https://www.usfinancialdiaries.org/paper-1/; Diana Farrell and Fiona Greig, "Paychecks, Paydays, and the Online Platform Economy, Big Data on Income Volatility", JPMorgan Chase & Co. Institute, February 2016, https://www.jpmorganchase.com/institute/all-topics/careers-and-skills/report-paychecks-paydays-and-the-online-platform-economy.

[92] Michael Karpman, Heather Hahn, and Anuj Gangopadhyaya, "Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements", Urban Institute, June 11, 2019, https://www.urban.org/research/publication/precarious-work-schedules-could-jeopardize-access-safety-net-programs-targeted-work-requirements (last visited March 31, 2025).

[93] *Id.*

[94] "Medicaid Enrollment and Unwinding Tracker," *Kaiser Family Foundation,* March 31, 2025, https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-unwinding-data-archived/#:~:text=Overall%2C%2061%25%20of%20People%20who,as%20of%20September%2012%2C%202024&text=93%25-,Note:%20Based%20on%20the%20most%20recent%20state%2Dreported%20unwinding%20data,on%20the%20process%20for%20renewal.

[95] *Id.*

When Medicaid work requirements were in effect, enrollees who were working or exempt lost coverage due to administrative errors and confusion about reporting requirements. An APSE report found that "largescale difficulties with meeting reporting requirements have posed risks of coverage loss for many beneficiaries across multiple states implementing work requirements."[96] A report analyzing experience with work requirements by the Robert Wood Johnson Foundation noted that "[m]any studies find that the red tape is often prohibitive and strips people of vital benefits."[97] Work requirements put significant and confusing reporting burdens on enrollees, and enrollees risk losing their coverage if they are unable to verify their compliance.[98] [99] Verifying work hours can be especially difficult for people with multiple jobs, people without internet or computer access, and people with limited English proficiency.[100]

Arkansas used mail or phone calls to communicate with enrollees about data matching exemptions from its work requirement, and state agency officials reported that they encountered extensive issues reaching enrollees, and the agency received a high volume of returned and undelivered mail.[101] Populations that were particularly affected included college students and people with unstable housing, who were more likely to have frequent changes in their address and less likely to receive notices.[102] Confusion about the work requirement in Arkansas was common, with 44 percent of the target population reporting that they were unsure whether the requirements applied to them.[103] Awareness of the work requirement among enrollees also was poor even after the work requirement was over, as more than 70 percent of Arkansans were unsure whether the policy was in effect at that time.[104]

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[96] *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence, Issue Brief HP-2021-03*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 2021, https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence

[97] "Work Requirements: What Are They? Do They Work?," *Robert Wood Johnson Foundation*, May 2023, https://www.rwjf.org/en/insights/our-research/2023/05/work-requirements-what-are-they-do-they-work.html; Heather Hahn, "What Research Tells Us About Work Requirements," *Urban Institute*, April 2018, https://www.urban.org/sites/default/files/publication/98425/what_research_tells_us_about_work_requirements_21.pdf.

[98] Jennifer Wagner and Jessica Schubel, "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements," *Center on Budget and Policy Priorities*, last modified November 18, 2020, https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements.

[99] MaryBeth Musumeci, Robin Rudowitz, and Barbara Lyons, "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees," *Kaiser Family Foundation*, December 18, 2018, https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/.

[100] Jennifer Wagner and Jessica Schubel, "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements," Center on Budget and Policy Priorities, Updated November 18, 2020, https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements.

[101] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," *Center on Budget and Policy Priorities*, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[102] *Id.*

[103] Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements — Results from the First Year in Arkansas," *New England Journal of Medicine* 381, no. 11 (September 12, 2019): 1073–82, https://doi.org/10.1056/NEJMsr1901772.

[104] Benjamin D. Sommers et al., Medicaid Work Requirements in Arkansas: Two–Year Impacts on Coverage, Employment, and Affordability of Care, Health Affairs (Sept. 2020), https://doi.org/10.1377/hlthaff.2020.00538 . PMID: 32897784 (last visited Feb. 13, 2025)

Evidence shows that the administrative burden and complexity of work requirements deters eligible individuals from even applying for Medicaid. Focus groups in Arkansas revealed enrollees' extreme frustrations and challenges with complex enrollment processes under the prior work requirement.[105] In Arkansas and Georgia, potential applicants reported numerous barriers to Medicaid enrollment, due to complex rules and burdensome application processes.[106] [107] Focus groups conducted by the Georgia Budget and Policy Institute found that potential enrollees have encountered widespread challenges obtaining needed support during the enrollment process, frustration with eligibility denials due to paperwork issues, and persistent technology challenges with the enrollment system.[108] [109] Georgia's enrollment numbers have been extremely low since its work requirement began: 18 months into the program, only 6,500 individuals were successfully enrolled, out of the 240,000 uninsured people estimated to be eligible.[110] [111] Application data suggests that in some months, upwards of 40 percent of people who started applications for Georgia's program gave up.[112] Focus groups also suggest that many individuals do not feel comfortable applying, because they are concerned their application would not be approved, likely due to the complex process and high denial rates in the first year of the program.[113, 114]

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[105] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," *Center on Budget and Policy Priorities*, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[106] Laura Harker, "Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care," *Center on Budget and Policy Priorities*, December 19, 2024, accessed April 3, 2025, https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care.

[107] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," *Center on Budget and Policy Priorities*, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[108] Leah Chan, *Pathways to Coverage: Program Overview and Project Impetus*, Georgia Budget & Policy Institute, October 2024, https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf.

[109] Margaret Coker, "Georgia's Medicaid Work Requirement Blocks Its Most Vulnerable From Coverage," *ProPublica*, February 19, 2025, https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles.

[110] "Data Tracker," GeorgiaPathways, Georgia Budget and Policy Institute, Updated 2025, https://www.georgiapathways.org/data-tracker ; Grant Thomas, "Georgia Pathways to Coverage," Georgia Department of Community Health, September 5, 2024, https://dch.georgia.gov/document/document/comprehensive-health-coverage-meeting-slide-deckdch-presentation-002/download

[111] Laura Harker, "Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care," *Center on Budget and Policy Priorities*, December 19, 2024, accessed April 3, 2025, https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care.

[112] Margaret Coker, "Georgia's Medicaid Work Requirement Blocks Its Most Vulnerable From Coverage," *ProPublica*, February 19, 2025, https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles.

[113] Laura Harker, "Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care," *Center on Budget and Policy Priorities*, December 19, 2024, accessed April 3, 2025, https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care.

[114] Leah Chan, *Pathways to Coverage: Program Overview and Project Impetus*, Georgia Budget & Policy Institute, October 2024, https://gbpi.org/wp-content/uploads/2024/10/PathwaystoCoverage_PolicyBrief_2024103.pdf.

This experience is consistent with the impact of work requirements in other programs. One study found that SNAP work requirements discouraged many people from applying for benefits.[115] And, potential enrollees have been deterred from applying for TANF due to adverse publicity.[116]

Arizona's proposal lacks important detail about what enrollees will have to do to meet the work requirement. Most notably, Arizona's proposal does not explain specifically what people will have to do to verify that they have met the work requirement or have good cause for non-compliance or how often reporting will be required. It also is unclear how an enrollee will claim one of the exemptions and what verification, if any, will be required to establish that someone has a serious mental illness, is in active substance use disorder treatment, is medically frail, has an acute physical or mental health condition, is a student, is a victim of domestic violence, is homeless or recently homeless, has experience the death of a family member, is caring for a family member with serious mental illness or receiving long-term care services, was recently incarcerated, etc. The same is true for the list of good cause exemptions. Arizona estimates the number of people it believes meet an exemption "for which AHCCCS currently has data," but it does not explain how it arrived at that number or which exemptions were included or excluded.[117] Arizona says that people who "face a significant barrier to employment" can satisfy the work requirement through community service, but it does not define what circumstances will meet that standard, how people will establish that they meet them, and what type of community service will qualify.[118]

V. State employment training and support programs are inadequate to meet the needs of Medicaid enrollees who face barriers to work.

Without sufficient funding, states are unable to provide adequate services to help unemployed low-income people find work. State workforce development programs are primarily funded by the federal Workforce Innovation and Opportunity Act (WIOA), and WIOA funding levels have not kept pace with inflation, population growth, or gross domestic product.[119] Successfully increasing employment among low-income people requires "resources to help develop job skills" as well as "job training, education, and earnings supplements."[120] None of these components are funded by Medicaid, and it does not appear

[115] Colin Gray, Adam Leive, Elena Prager, Kelsey B. Pukelis, and Mary Zaki, "Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply," *National Bureau of Economic Research*, Working Paper 28877, June 2021, https://www.nber.org/papers/w28877.

[116] Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?* (Commonwealth Fund, Nov. 2018), https://www.commonwealthfund.org/sites/default/files/2018-11/Ku_Medicaid_work_requirements_ib.pdf.

[117] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 6 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[118] *Id.* at 7.

[119] Veronica Goodman, "Recommendations for Reauthorizing the Workforce Innovation and Opportunity Act," *Center for American Progress*, February 19, 2025, https://www.americanprogress.org/article/recommendations-for-reauthorizing-the-workforce-innovation-and-opportunity-act/.

[120] Leighton Ku, Erin Brantley, Erika Steinmetz, Brian Bruen, and Drishti Pillai, "Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?" *The Commonwealth Fund*, November 2018,

that Arizona's existing workforce development programs can meet these needs. For example, Arizona's proposal acknowledges that it "will require an investment to scale existing programs," without explaining how this will be accomplished.[121] "Employment and training services [already] have limited resources to assist people in addressing. . . barriers to job search and employment," and "[e]xisting resources will be stretched over a much larger pool of people in states that implement Medicaid work requirements."[122] Arizona says that it will "promote synergies between existing workforce development programs. . . and will also create new supports to empower members" without providing any further explanation or detail.[123]

Many individuals who are not working face significant employment barriers that Medicaid work requirements do not address.[124] These barriers include "physical and mental health conditions, addiction, low educational attainment, limited work experience, criminal histories that impede hiring, domestic violence, and lack of affordable reliable childcare."[125] Offering little else but low-intensity services, such as job search, is unlikely to be successful.[126] An assessment of SNAP employment and training services concluded that providing a large mandatory population with low-touch services such as job search is unlikely to increase employment very much.[127] For the small number of Arkansas residents who were not employed and could work, two potential state services were identified by respondents as

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https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/medicaid-work-requirements-will-they-help-jobs-health.

[121] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 4 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[122] Leighton Ku, Erin Brantley, Erika Steinmetz, Brian Bruen, and Drishti Pillai, "Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?" *The Commonwealth Fund*, November 2018, https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/medicaid-work-requirements-will-they-help-jobs-health.

[123] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 4 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[124] MaryBeth Musumeci & Julia Zur, Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience, Kaiser Family Foundation, August 2017, https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

[125] *Id.* (citing Kelley Bowden and Daisy Goodman, "Barriers to Employment for Drug Dependent Postpartum Women," *Work* 50, 3(2015): 425-32; Dan Bloom, Pamela J. Loprest, and Sheila R. Zedlewski, *TANF Recipients with Barriers to Employment* (Washington, DC: Urban Institute, May 2012), http://www.urban.org/research/publication/tanf-recipients-barriers-employment; Benjamin G. Druss and Elizabeth Reisinger Walker, *Mental disorders and medical comorbidity,* (Princeton, NJ: The Robert Wood Johnson Foundation, February 2011), http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf; Judith A. Cook, "Employment Barriers for Persons with Psychiatric Disabilities: Updated of a Report for the President's Commission," *Psychiatric Services* 57, 10(2006):1391-405; Ellen Meara, "Welfare Reform, Employment, and Drug and Alcohol Use Among Low-Income Women," *Harvard Review of Psychiatry* 14, 4(2006): 223-32.)

[126] Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?* (Commonwealth Fund, Nov. 2018), https://www.commonwealthfund.org/sites/default/files/2018-11/Ku_Medicaid_work_requirements_ib.pdf.

[127] *Id.*

factors that would most help them find a job – job training/education and transportation to work.[128] However, respondents reported these programs were not accessible, and inadequate outreach led to relatively low usage of existing state job search and training programs by people in Arkansas subject to the work requirement.[129]

VI. Work requirements result in substantial state administrative burdens and spending on third party contractors, instead of focusing limited dollars on providing coverage to low income people

For states, implementing work requirements involves costly and complex systems changes (e.g., developing or adapting eligibility and enrollment systems), enrollee outreach and education, and staff training. The Government Accountability Office examined selected states' estimates of the administrative costs to implement work requirements and found costs varied from under $10 million to over $270 million.[130] Georgia's work requirement program was originally estimated to cost $2,490 per enrollee in the first year. However, the actual cost in the first year alone was $13,360 per enrollee; 92 percent of these costs have gone to program administration and not healthcare costs.[131] As of the end of 2024, Georgia's work requirement program has cost federal and state taxpayers more than $86.9 million, three-quarters of which has gone to consultants.[132] Implementation of Arkansas' work requirement cost an estimated $26.1 million in federal and state funds.[133]

Research on SNAP and TANF demonstrate that work requirements are an inefficient use of limited state administrative resources.[134] The administrative resources needed to verify enrollees' compliance with work requirements are substantial and often require significant caseworker time.[135] As noted above,

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[128] Benjamin D. Sommers et al., "Medicaid Work Requirements in Arkansas: Two–Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs*, September 2020, https://doi.org/10.1377/hlthaff.2020.00538, PMID: 32897784 (last visited February 13, 2025).

[129] Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," *Center on Budget and Policy Priorities*, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[130] U.S. Government Accountability Office, *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements*, GAO-20-149, October 1, 2019, https://www.gao.gov/products/gao-20-149.

[131] Benjamin D. Sommers, Lauren R. Gullett, and Shira B. Hornstein, "Medicaid's Edge Case — Potential Expansion and Work Requirements in Mississippi," *JAMA Health Forum* 5, no. 10 (2024): e244523, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2825861.

[132] Margaret Coker, "Georgia's Medicaid Work Requirement Blocks Its Most Vulnerable From Coverage," *ProPublica*, February 19, 2025, https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles.

[133] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav, and Arnold M. Epstein, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs* 39, no. 9 (September 1, 2020): 1522–30, https://doi.org/10.1377/hlthaff.2020.00538.

[134] Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?* (Commonwealth Fund, Nov. 2018), https://www.commonwealthfund.org/sites/default/files/2018-11/Ku_Medicaid_work_requirements_ib.pdf.

[135] *Id.*

Arizona's proposal appears to require reporting and verification, beyond data matching, to ensure that eligible people are enrolled in coverage. This is likely to overwhelm the limited resources of eligibility case workers and risks substantial numbers of eligible low income workers losing essential health coverage.

VII. Imposing a lifetime limit on Medicaid benefits and locking people out of coverage is contrary to Medicaid's primary purpose of providing health coverage to low-income people.

Arizona's proposal to impose a five-year lifetime limit on Medicaid expansion enrollees who do not meet the work requirement will result in coverage loss, an outcome that directly conflicts with the Medicaid program's primary objective of providing health coverage to low-income people. People who lose coverage and become uninsured suffer adverse health and financial consequences. According to KFF, "[u]ninsured adults are more likely to forgo needed care than their insured counterparts," with "nearly half (46.6%) of uninsured adults ages 18 to 64 reported not seeing a doctor or health care professional in the past 12 months compared to 15.6% with private insurance and 14.2% with public coverage" in 2023.[136] "Studies repeatedly demonstrate that uninsured individuals are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases."[137] Moreover, "[b]ecause people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health."[138] And, "[w]hen they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance."[139] Furthermore, "[u]ninsured individuals often face unaffordable medical bills when they do

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[136] Tolbert J, Cervantes S, Bell C, Damico A. Key facts about the uninsured population. KFF. (Dec. 18, 2024). https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[137] *Id.* (citing Hailun Liang, May A. Beydoun, and Shaker M. Eid, Health Needs, "Utilization of Services and Access to Care Among Medicaid and Uninsured Patients with Chronic Disease in Health Centres," Journal of Health Services Research & Policy 24, no. 3 (Jul 2019): 172-181; Laura Hawks, et al, "Trends in Unmet Need for Physician and Preventive Services in the United States, 1998-2017," JAMA Internal Medicine 180, no.3 (Jan. 2020): 439-448, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2759743 ; Megan B. Cole, Amal N. Trivedi, Brad Wright, and Kathleen Carey, "Health Insurance Coverage and Access to Care for Community Health Center Patients: Evidence Following the Affordable Care Act," Journal of General Internal Medicine 33, no. 9 (September 2018): 1444-1446; Veri Seo, et al., "Access to Care Among Medicaid and Uninsured Patients in Community Health Centers After the Affordable Care Act," *BMC Health Services Research* 19, no. 291 (May 2019)).

[138] *Id.*

[139] *Id.* (citing Marco A Castaneda and Meryem Saygili, "The health conditions and the health care consumption of the uninsured," Health Economics Review (2016); Steffie Woolhandler, et al., "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?" Annals of Internal Medicine 167 (June 2017): 424-431; Travis Campbell, Alison P Galvani, Gerald Friedman, Meagan C Fitzpatrick, "Exacerbation of COVID-19 mortality by the fragmented United States healthcare system: A retrospective observational study" (Lancet Reg Health Am., May 2022) https://pmc.ncbi.nlm.nih.gov/articles/PMC9098098/ ; Andrea S. Christopher, et al., "Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured," American Journal of Public Health 106, no. 1 (January 2016): 63-69; Michael G. Usher, et al., "Insurance Coverage Predicts Mortality in Patients Transferred

seek care[, which can quickly translate into medical debt since most people who are uninsured have low or moderate incomes and have little, if any, savings."[140]

The adverse impacts of losing health insurance are well documented in a series of reports issued by the National Academies Committee on the Consequences of Uninsurance, including lesser use and lack of preventive services, less access to a regular source of care, greater likelihood of substandard hospital care, less likelihood of receiving professionally recommended standard of care, diminished health-related quality of life, increased risk for adverse events, decreased life expectancy, and potential for bankruptcy, among others.[141] In addition to the impact of being uninsured on general health, lack of insurance also adversely affects the health of people with chronic conditions including cancer, cardiovascular disease, diabetes, end-stage renal disease, HIV, and mental illness.[142]

Imposing a lifetime limit on Medicaid is contrary to federal health insurance law and policy. Congress adopted the Affordable Care Act (ACA) to expand access to affordable health insurance, primarily by reforming the small group market and expanding Medicaid to nonelderly adults up to 138% FPL.[143] The ACA "solidified Medicaid's health insurance credentials, moving it farther along a path it had been traveling for three decades."[144] Prior to the ACA, Congress expanded Medicaid to additional populations at various points, evidencing "a break in the relationship between Medicaid and welfare."[145] Eliminating lifetime limits in private health insurance coverage – which never have existed in Medicaid – is one of the ACA's fundamental reforms.[146]

Arizona's proposal to lock certain Medicaid expansion adults out of coverage for one year also is contrary to program objectives. Specifically, Arizona proposes to "ban an eligible person from enrollment for one year if it is determined the eligible person knowingly failed to report a change in

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Between Hospitals: a Cross-Sectional Study," Journal of General Internal Medicine 33, no. 12 (December 2018): 2078-2084.).

[140] *Id.*

[141] Institute of Medicine of the National Academies. Board on Health Care Services. Committee on the Consequences of Uninsurance. Insuring America's health: principles and recommendations at ch. 2, pp. 40-50. (2004) https://nap.nationalacademies.org/read/10874/chapter/1#ii ; *see also* McWilliams JM. Health consequences of uninsurance among adults in the United States: recent evidence and implications. Millbank Q. 87(2): 443-494 (2009) https://doi.org/10.1111/j.1468-0009.2009.00564.x

[142] Institute of Medicine. Committee on the Consequences of Uninsurance. Care without coverage: too little, too late at ch. 3 (2002) https://www.ncbi.nlm.nih.gov/books/NBK220636/

[143] Silvers JB. The Affordable Care Act: objectives and likely results in an imperfect world. Ann. Fam. Med. 11(5): 402-405 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3767707/; *see generally* Ortaliza J, Cox C. The Affordable Care Act 101. KFF. (Updated July 29, 2024). https://www.kff.org/health-policy-101-the-affordable-care-act/?entry=table-of-contents-what-is-the-affordable-care-act

[144] Mann C, Bachrach D. Medicaid as health insurer: evolution and implications. The Commonwealth Fund Blog, July 2015. https://www.commonwealthfund.org/blog/2015/medicaid-health-insurer-evolution-and-implications

[145] *Id.*

[146] *See, e.g.,* Adler L, Ginsburg PB. Health insurance as assurance: the importance of keeping the ACA's limits on enrollee health costs. Brookings. Jan. 17, 2017. https://www.brookings.edu/articles/health-insurance-as-assurance-the-importance-of-keeping-the-acas-limits-on-enrollee-health-costs/

family income or made a false statement regarding compliance with" the work requirement.[147] This proposal will likely result in coverage loss and should be rejected for the reasons stated above. Arizona does not include any research hypothesis or evaluation plan for this proposal, nor does it cite any evidence to support its proposal. Notably, there are no individual enrollees included in the DOJ/HHS-OIG report describing Medicaid fraud prosecutions, indicating that the "problem" that Arizona seeks to address is minimal to non-existent.[148] HHS OIG's annual summary of cases brought by state Medicaid fraud control units shows that "beneficiary fraud is negligible [accounting for] two percent of the reported convictions and one tenth of one percent of the recoveries."[149]

VIII. Imposing copayments on non-emergency use of the emergency department and ambulance transport is contrary to established research and harmful to low-income income people.

The harm to Medicaid enrollees' health and finances that would result from Arizona's proposed copayments for non-emergency use of the emergency department (ED) and ambulance transport already has been established by existing research. A study examining the impact of Medicaid copayments for non-emergency use of the emergency department (ED), employing "difference-in-difference analysis of data over a 10-year period" found that copayments "did not demonstrate a reduction in ED" and "no evidence that ED copayments were associated with increased use of outpatient medical providers."[150] A study that "examined state changes in emergency department cost sharing from a national perspective" concluded that "[p]olicymakers should use caution when imposing cost sharing on low-income Medicaid enrollees," after finding that "requiring copayments for nonemergency visits did not decrease emergency department use by Medicaid enrollees."[151] The American College of Emergency Physicians (ACEP) "is concerned that copayments may deter our patients from seeking appropriate emergency care, ultimately leading to worse health outcomes."[152] ACEP cites studies "show[ing] that higher levels of [ED] cost-sharing. . . are associated with unmet healthcare needs."[153]

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[147] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 7 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

[148] Schneider A. The truth about fraud against Medicaid. Georgetown Center for Children and Families. Jan. 10, 2025. https://ccf.georgetown.edu/2025/01/10/the-truth-about-fraud-against-medicaid/

[149] *Id.*

[150] Siddiqui M, Roberts ET, Pollack CE. The effect of emergency department copayments for Medicaid beneficiaries following the Deficit Reduction Act of 2005. JAMA Internal Med. 75(3):393–398 (March 2015). doi: 10.1001/jamainternmed.2014.7582.

[151] Mortensen K. Copayments did not reduce Medicaid enrollees' nonemergency use of the emergency department. Health Affairs. 29(9): 1643-1650 (2010), https://doi.org/10.1377/hlthaff.2009.0906

[152] American College of Emergency Physicians. Medicaid ED copayments: effects on access to emergency care and the practice of emergency medicine at 3. (2018), https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/medicaid-ed-copayments---effects-on-access-to-emergency-care-and-the-practice-of-emergency-medicine.pdf

[153] *Id.* (citing Wright, B., et al. Raising premiums and other costs for Oregon Health Plan enrollees drove many to drop out." *Health Affairs*. (Dec. 2010), https://doi.org/10.1377/hlthaff.2010.0211).

These findings are consistent with a large long-standing body of research which establishes that imposing cost-sharing on low income people "is associated with reduced use of care, worse health outcomes, and increased financial burden."[154] This research dates back to the 1970s, when the landmark RAND Health Insurance Experiment "concluded that cost sharing should be minimal or nonexistent for the poor, especially those with chronic disease" because it "can be a blunt tool, reducing both needed and unneeded health services in roughly equal proportions."[155] Arizona does not propose any research hypothesis to be tested by its proposal nor does it provide baseline data or explain why it has selected the "top 20% of ED utilizers."[156]

Conclusion

For the foregoing reasons, APHA and the individual public health deans and scholars listed below urge HHS to reject Arizona's Section 1115 demonstration waiver application. Thank you for your consideration of our comments. If you need any additional information, please contact MaryBeth Musumeci at marybethm@gwu.edu.

A. Public Health Organizations

1. American Public Health Association, Georges C. Benjamin, MD, Executive Director

B. Public Health Deans

1. El-Mohandes, Ayman, MBBCh, MD, MPH, Dean, CUNY Graduate School of Public Health & Health Policy

2. Fried, Linda P., MD, MPH, Dean and DeLamar Professor of Public Health, Mailman School of Public Health, Professor of Epidemiology and Medicine, Columbia University

3. Goldman, Lynn R., MD, MPH, MS, Michael and Lori Milken Dean of Public Health, Milken Institute School of Public Health, The George Washington University

4. Hyder, Adnan, MD, MPH, PhD, Senior Associate Dean for Research, Professor of Global Health Milken Institute School of Public Health, The George Washington University

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[154] Guth M, Ammula M, Hinton E. Understanding the impact of Medicaid premiums & cost-sharing: updated evidence from the literature and Section 1115 waivers. KFF. (Sept. 9, 2021), https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[155] RAND. 40 years of the RAND Health Insurance Experiment. Accessed May 4, 2025. https://www.rand.org/health-care/projects/HIE-40.html

[156] Arizona Health Care Cost Containment System. Arizona Section 1115 waiver amendment request: AHCCCS Works at 8 (March 2025, posted March 31, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa-03312025.pdf

5. LaVeist, Thomas A., PhD, Dean and Professor, Tulane University School of Public Health and Tropical Medicine

6. Lu, Michael C., MD, MS, MPH, Dean, UC Berkeley School of Public Health

7. Thorpe, Jane, JD, Professor and Sr. Associate Dean for Academic, Student & Faculty Affairs, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

8. Vermund, Sten H., MD, PhD, Dean, College of Public Health, University of South Florida

C. Health Professions, Public Health, Health Law and Policy Scholars

9. Barkoff, Alison, JD, Professor, Harold and Jane Hirsh Associate Professor of Health Law and Policy, Director, Hirsh Health Law and Policy Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

10. Beckerman, Julia Zoe, JD, MPH, Teaching Professor & Vice Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

11. Berwick, Donald M., MD, MPP, Lecturer, Department of Health Care Policy, Harvard Medical School

12. Bindman, Andrew, MD is Professor Emeritus of Medicine, Philip R. Lee Institute for Health Policy Studies, University of California San Francisco

13. Blewett, Lynn A., PhD, MA, Professor, Division of Health Policy and Management, University of Minnesota School of Public Health

14. Braaten, Kari P., MD, MPH, Assistant Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School

15. Brindis, Claire D., DrPH, Distinguished Professor, Departments of Pediatrics and Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, Emerita Director, Philip R. Lee Institute for Health Policy Studies

16. Byrnes, Maureen, MPA, Teaching Instructor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

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18. Cleary, Sean, MPH, PhD, Associate Professor, Epidemiology, Milken Institute School of Public Health, The George Washington University

19. Cohen, Alan B., Sc.D., Research Professor (Retired), Markets, Public Policy and Law, Boston University Questrom School of Business, and Professor of Health Law, Policy and Management (Retired), Boston University School of Public Health

20. Ecker, Jeffrey L., MD, Joe V. Meigs Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Chief, Obstetrics and Gynecology, Massachusetts General Hospital

21. Feder, Judith, PhD, Professor, McCourt School of Public Policy, Georgetown University

22. Frankford, David M., JD, Professor of Law, Rutgers University School of Law

23. Ganguli, Ishani, MD, MPH, Assistant Professor of Medicine, Harvard Medical School

24. Glied, Sherry, PhD, MA, Dean, Robert F. Wagner Graduate School of Public Service, New York University

25. Hamilton, Bethany, JD, Director, National Center for Medical-Legal Partnership, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

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27. Horton, Katherine, RN, MPH, JD, Research Professor in the Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

28. Huberfeld, Nicole, Edward R. Utley Professor of Health Law, Co-Director, BU Program on Reproductive Justice, Chair, BU Health Law Program, Boston University School of Law and School of Public Health

29. Jost, Timothy Stoltzfus, JD, Emeritus Professor, Washington and Lee University School of Law

30. Katz, Ingrid, MD, MHS., Assistant Professor of Medicine, Harvard Medical School

31. Ku, Leighton, PhD, MPH, Professor, Department of Health Policy and Management, Director, Center for Health Policy Research, Milken Institute School of Public Health, The George Washington University

32. Lantz, Paula, PhD, Interim Associate Director, International Policy Center, James B. Hudak Professor of Health Policy, BA Program Director, Gerald R. Ford School of Public Policy, Professor of Health Management and Policy, University Professor of Diversity and Social Transformation, School of Public Health, University of Michigan

33. Law, Sylvia A., JD, Elizabeth K. Dollard Professor Emerita of Law, Medicine and Psychiatry, NYU Law School

34. Levi, Jeffrey, PhD, Professor Emeritus, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

35. Lewis-O'Connor, Annie, PhD, NP, MPH, Instructor in Medicine, Harvard Medical School, Founder and Director, C.A.R.E. Clinic-Brigham and Women's Hospital

36. Magnus, Manya, PhD, MPH, Professor and Chair, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

37. Mariner, Wendy K., JD, LLM, MPH, Professor of Health Law, Ethics and Human Rights Emerita, Boston University School of Public Health

38. Markus, Anne R., PhD, MHS, JD, Professor and Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

39. McCarthy, Melissa L., ScD, MS, Professor of Health Policy and Emergency Medicine, Milken Institute School of Public Health, The George Washington University

40. Michaels, David, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University

41. Michener, Jamila, PhD, Assistant Professor of Government, Cornell University

42. Murphy, Caitlin, MPP, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

43. Musumeci, MaryBeth, JD, Associate Teaching Professor, Milken Institute School of Public Health, The George Washington University

44. Oberlander, Jonathan, PhD, Professor, Department of Social Medicine, Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill

45. Parmet, Wendy E., JD, Matthews University Distinguished Professor of Law, Northeastern University

46. Perrin, James M., MD, Professor of Pediatrics Emeritus, Harvard Medical School, John C. Robinson Distinguished Chair in Pediatrics, MassGeneral for Children

47. Price, Olga Acosta, Associate Professor and Vice Chair, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

48. Regenstein, Marsha, PhD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

49. Rich-Edwards, Janet, ScD, MPH, Associate Professor of Medicine, Harvard Medical School, Associate Professor in Epidemiology, Harvard T.H. Chan School of Public Health

50. Rittenberg, Eve, MD, Assistant Professor of Medicine, Harvard Medical School

51. Rocco, Philip, PhD, Associate Professor of Political Science, Marquette University

52. Rosenbaum, Sara, JD, Professor Emerita, Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

53. Sage, William, MD, JD, Professor of Law, Medicine, and (by courtesy) Government, Associate VP, Health Science Center, Texas A&M University

54. Seiler, Naomi, JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

55. Silverman, Hannah, MPH, Senior Research Associate, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

56. Silberman, Pam, JD, DrPH, Professor Emerita, Director, Executive Doctoral Program in Health Leadership, Department of Health Policy and Management, UNC Gillings School of Global Public Health

57. Sparer, Michael, JD, PhD, Professor and Chair, Health Policy and Management, Mailman School of Public Health, Columbia University

58. Swartz, Katherine, PhD, MS, Professor of Health Policy and Economics, Emerita, Harvard T.H. Chan School of Public Health, Harvard University

59. Tavrow, Paula, Ph.D., Adjunct Professor, Department of Community Health Sciences, University of California Los Angeles Fielding School of Public Health

60. Vyas, Amita N., PhD, MHS, Professor, Director, Maternal & Child Health Program, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

61. Warren, Keegan, JD, LLM, Executive Director, Institute for Healthcare Access, Texas A&M University Health Science Center

62. Watson, Sidney D., JD, Jane and Bruce Robert Professor of Law, Center for Health Law Studies, Saint Louis University School of Law

63. Westmoreland, Timothy M., JD, Professor from Practice, Emeritus, Georgetown University School of Law

64. Wise, Paul H., Richard E. Behrman Professor of Child Health and Society, Senior Fellow, Freeman Spogli Institute for International Studies, Core Faculty, Center on Democracy, Development and the Rule of Law, Affiliated faculty at the Center for International Security and Cooperation, Stanford University

65. Young, Heather A., PhD, MPH, Vice Chair/Professor, MPH Epidemiology CoDirector/PhD Epidemiology Director, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University