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 Arkansas's Request to Amend the ARHOME Section 1115 Demonstration Project

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 Arkansas's request to amend the ARHOME Section 1115 demonstration project. 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 Arkansas's request to require Medicaid expansion adults to meet a work or community engagement requirement as a condition of eligibility. Despite the state's assertion that its current proposal differs from its earlier work requirement, Arkansas projects that the extent of coverage loss under its proposal – 25 percent of enrollees subject to the program -- is likely to be the same share

as the coverage loss experienced under its earlier work requirement. Work requirements in any form result in substantial numbers of eligible people losing health coverage, which directly contravenes the purpose of Medicaid. 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. While Arkansas claims that its new proposal differs from its previous work requirement, the proposal contains the same fundamental flaws, including data matching that risks eligible people losing coverage, required monthly contacts between enrollees and "Success Coaching entities," and inadequate protections for people with disabilities.

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

Despite Arkansas's assertion that its proposal differs from its previous work requirement, Arkansas nevertheless projects that 25 percent of enrollees subject to its proposal will lose Medicaid coverage.[1] Arkansas estimates that half of this group will have coverage suspended for an average of three months, and half of this group will have coverage terminated.[2] Arkansas notes that its estimates are based on "reasonable assumptions to reflect a mid-point in a range of participation."[3] Arkansas does not explain these assumptions, though it does acknowledge that "[a]ctual results over a five-year period will likely vary," indicating a risk of even more widespread coverage loss.[4] Arkansas estimates $122.8 million in net savings over the five years of the proposed demonstration due to coverage loss.[5]

Suspending or terminating coverage for 25 percent of enrollees subject to a demonstration undermines rather than furthers Medicaid's core purpose as a health insurance program. Arkansas's projected coverage loss under its proposal is an outcome that directly conflicts with the Medicaid program's primary objective of providing health coverage to low-income people. Federal law requires Section 1115 demonstrations to be "likely to assist in promoting the objectives of" the Medicaid Act.[6] 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."[7] Thus, "[t]he provision of Medicaid coverage is indisputably a central objective of the Act."[8]

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[1] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 25 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf
[2] *Id.* at 25-26.
[3] *Id.* at 25.
[4] *Id.*
[5] *Id.* at 25, 26.
[6] 42 U.S.C. § 1315.
[7] 42 U.S.C. § 1396-1.
[8] *Stewart v. Azar,* 366 F. Supp. 3d 125, 145 (D.D.C. 2019).

Arkansas's acknowledgement that its proposal will result in substantial coverage loss is consistent with the actual adverse impact of its earlier Medicaid work requirement. Despite the state's assertion that its current proposal differs from its earlier work requirement, Arkansas projects that the extent of coverage loss under this proposal is likely to be the same share as the coverage loss experienced under its earlier work requirement. Arkansas estimates that one in four enrollees subject to the new work requirement will lose coverage,[9] and research has found that one in four individuals who were subject to Arkansas's earlier work requirement lost coverage.[10] Importantly, an estimated 95 percent of the people who previously lost coverage in Arkansas nevertheless had met the work requirement or were exempt and therefore should have remained enrolled.[11]

The decrease in Medicaid/Marketplace coverage among people subject to Arkansas's work requirement (those ages 30 to 49) was statistically significant compared to those who were not (other age groups).[12] 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).[13] Most of the Medicaid coverage loss in Arkansas was reversed after a federal court ended the previous work requirement in 2019, as people were able to regain the coverage for which they remained eligible.[14]

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.[15] 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.[16]

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[9] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 25 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[10] 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; *see also* 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/

[11] 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.

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] 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

[16] *Id.*

Arkansas's acknowledgement that its proposal will result in substantial coverage loss is consistent with the outcome of Medicaid work requirements in other states. New Hampshire sought to "avoid the problems" that plagued Arkansas' prior 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 its work requirement – were slated to lose coverage before the work requirement was blocked by a federal court.[19]

Similarly, research examining the impact of work requirements in the SNAP and TANF programs demonstrates that "many [enrollees] quickly lost benefits."[20] Work requirements in SNAP have existed 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."[21] 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."[22] A 2020 study found that SNAP work requirements led to a 52 percent reduction in program participation but no appreciable increase in employment earnings.[23] 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-

[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] 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 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/).
[21] 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/.
[22] 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.
[23] 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.

up jitters or chaotic implementation in one state."[24] Despite Arkansas's assertions in its proposal, the harm caused by work requirements results from fundamental flaws that cannot be remedied. 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.[25]

A significant share of people who lose Medicaid due to work requirements become uninsured. A study evaluating the impact of Arkansas's previous 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."[26] At the same time, the use of employer-sponsored insurance did not significantly increase.[27] 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."[28] These findings suggest that people who lost Medicaid could not access employer-sponsored insurance.

Another study evaluating the impact of Arkansas' previous 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."[29] 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]."[30] 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."[31] These findings are consistent with multiple government and independent analyses that conclude that work requirement programs skyrocket the uninsured rate.[32]

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[24] 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/.
[25] *Id.*
[26] 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.
[27] *Id.*
[28] *Id.*
[29] 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.
[30] *Id.*
[31] *Id.*
[32] 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

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."[33] 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.[34] 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.[35] During this same period, "[n]o coverage impacts were observed for unaffected or exempt groups."[36] 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."[37]

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. Over one-third (36.3%) of nonelderly working adults with Medicaid in Arkansas are employed by a small firm (less than 50 employees).[38] 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."[39] 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."[40] Additionally, 38.5 percent of nonelderly working adults with Medicaid in Arkansas 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."[41] These data disprove

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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

[33] 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

[34] 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

[35] *Id.*

[36] *Id.*

[37] 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

[38] 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/

[39] *Id.*

[40] *Id.*

[41] *Id.*

Arkansas's assertion that "[e]nrolling in the Medicaid program itself reflects economic instability."[42] Instead, despite being employed, these 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.[43]

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."[44] 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.[45] Coverage loss is especially harmful to individuals with disabilities, who rely on regular care to manage chronic conditions and meet daily needs.[46]

An existing body of research establishes that a sizeable share of adults who leave Medicaid become uninsured. In addition to the multiple studies discussed above, a KFF national survey found that about a quarter (23%) of people who lost Medicaid during unwinding remain uninsured."[47] A study surveying people disenrolled from Medicaid in Iowa for failure to pay premiums found that 45% of those disenrolled were still uninsured nine months later.[48] A study surveying people disenrolled from Medicaid in Indiana for failure to pay premiums found that over half (53%) were uninsured.[49] Arkansas' claim that "empirical evidence" and research in this area are "limited"[50] is inconsistent with the existing body of research.

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[42] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 32 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[43] *Id.*

[44] 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/.

[45] 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.

[46] "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.

[47] Lopes L, et al. KFF survey of Medicaid unwinding. KFF. (April 12, 2024) https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/

[48] Askelson NM et al. Purged from the rolls: a study of Medicaid disenrollment in Iowa. Health Equity. 3(1): 637-643 (Dec. 2019). https://doi.org/10.1089/heq.2019.0093

[49] Rudowitz R, Musumeci MB, Hinton E. Digging into the data: what can we learn from the state evaluation of Healthy Indiana (HIP 2.0) premiums. KFF. (March 2018). https://www.kff.org/affordable-care-act/issue-brief/digging-into-the-data-what-can-we-learn-from-the-state-evaluation-of-healthy-indiana-hip-2-0-premiums/

[50] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 9 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

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

Allowing Arkansas to condition Medicaid eligibility on meeting a work requirement will not advance the state's goal of enrollees "experienc[ing] an increase in household income"[51] because the vast majority of Arkansas Medicaid enrollees already are working. According to KFF, 55 percent of non-elderly Medicaid adults in Arkansas already work full or part-time.[52] Another 19.6 percent are not working due to illness or disability, and 11.8 percent are not working due to caretaking responsibilities.[53] State-level data for the share of Arkansas Medicaid enrollees who are not working because they are attending school are not available, though this group accounts for 6.5 percent of enrollees nationally.[54] The data show that virtually all Arkansas Medicaid enrollees already are engaged in work or another qualifying activity, making Arkansas'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 previous 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."[55] The authors noted that "more than 95% of persons who were targeted by the policy already met the requirement or should have been exempt."[56] A study published in *Health Affairs* evaluating the impact of Arkansas's previous 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.[57] A 2025 study published in *Health Services Research* found that Arkansas's previous work requirement was

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[51] *Id.* at 22.
[52] 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/.
[53] *Id.*
[54] *Id.*
[55] 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.
[56] *Id.*
[57] 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).

associated with "no significant change in employment or work effort."[58] The "association between work requirements and employment among [those subject to the work requirement] was negative, small, and statistically insignificant."[59] Focus groups of Arkansas Medicaid enrollees also found that most were already working and were highly motivated to work due to economic pressures.[60]

Multiple government and independent analyses conclude that work requirement programs do not result in sustainable employment gains.[61]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.[62] 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."[63] 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."[64]

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 previous 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."[65] All of these rates were significantly higher compared to

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[58] 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

[59] *Id.*

[60] 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/.

[61] "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.

[62] 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.

[63] 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).

[64] *Id.*

[65] 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*,

people who remained enrolled in Medicaid.[66] People who lost coverage in the prior year because of Arkansas's work 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.[67]

Research has found that "earnings and hours volatility for low-income workers are not due to their preferences but rather reflect the nature of the low-wage labor market."[68] Arkansas says its proposal will "help provide a bridge over the 'benefits cliff.'"[69] The state claims that Medicaid expansion enrollees are incentivized to limit their work hours because individuals who work 37 hours per week at minimum wage are eligible for Medicaid expansion, while individuals who work 38 hours per week are not.[70] However, Arkansas does not cite any evidence in support of its claim that low income workers decide how many hours to work based on whether they will continue to qualify for Medicaid. This is not surprising because research has found that "for most low-income households, hours volatility is not voluntary."[71] One study found that "almost 40 percent of low-income households reported having irregular schedules, two-thirds of which were driven by the employer."[72] Moreover, working 38 hours per week at $11 per hour for 52 weeks per year (as Arkansas assumes) is insufficient to realize the state's goal of promoting economic independence; instead, researchers at the Massachusetts Institute of Technology have determined that the minimum amount that a single worker in Arkansas must earn to meet their basic needs is substantially higher at $19.29 per hour.[73]

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."[74] A KFF literature review of the relationship between work and health concludes that "[w]hile unemployment

39 , no. 9 (2020): 1522, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.00538 (last visited Feb. 13, 2025).

[66] *Id.*

[67] *Id.*

[68] 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/

[69] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 3 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[70] *Id.* at 31.

[71] 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/

[72] *Id.*

[73] Living wage calculator. Living wage calculation for Arkansas. (Feb. 10, 2025) https://livingwage.mit.edu/states/05

[74] 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/.

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.)."[75] 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."[76] 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."[77] 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.[78]

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.[79] Having access to regular preventive health care to manage chronic conditions, access medications, and address health issues before they worsen can help support work.[80] 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."[81]

People who lose Medicaid often end up uninsured - with adverse health effects. As noted above, Medicaid enrollees who lost coverage due to Arkansas's previous 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.[82] Arkansas Medicaid enrollees also reported that the previous work requirement created heightened stress and fear that they might lose coverage.[83] The adverse health effects of being uninsured are well established: compared to those with

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[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] 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.
[79] 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/.
[80] 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/.
[81] *Id.*
[82] 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).
[83] 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

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."[84]

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 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.[85] 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.[86] Since many rural hospitals are already operating at a loss, they will be hit especially hard by coverage losses from Medicaid work requirements.[87] A 2025 study used an economic model to estimate the impact of Medicaid work requirements on state economies.[88] 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.[89]

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

Arkansas proposes to use data matching to verify compliance with its work requirement, but data matching did not prevent eligible people from losing coverage under its previous work requirement. Arkansas's proposal identifies "over-reliance on technology" as one of the "lessons learned" from its prior work requirement, and in the very next sentence says that it "will use data-matching to identify individuals" and assess their compliance in its new program.[90] However, when Arkansas previously used

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Policy Priorities, August 8, 2023, https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.

[84] 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/.

[85] 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.

[86] "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.

[87] 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.

[88] 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

[89] *Id.*

[90] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 3 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

data matching to try to exempt people who were known to be workers, caregivers, students, or disabled, the state failed to identify many of these individuals for exemptions.[91] As noted above, an estimated 95% of the people who previously lost coverage in Arkansas nevertheless had met the work requirement or were exempt and therefore should have remained enrolled.[92]

Data matching puts people with disabilities at substantial risk of erroneously losing coverage. A KFF analysis of Arkansas's previous work requirement found that "[p]eople with disabilities were particularly vulnerable to losing coverage. . ., despite remaining eligible."[93] As noted above, nearly 20 percent of nonelderly Medicaid adults in Arkansas report that a disability or illness that prevents them from working.[94] Arkansas's previous process for exempting people who were "medically frail" "did not identify all enrollees whose disabilities or health conditions prevented them from complying."[95] There is no reason to expect that the experience under this proposal will be different. Additionally, Arkansas's proposal does not address its obligations under the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and ACA Section 1557 to provide reasonable modifications and otherwise avoid illegal disability based discrimination.

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.[96] 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

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[91] 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.

[92] 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.

[93] 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/.

[94] 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/.

[95] 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/.

[96] 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/.

of Medicaid enrollees who use institutional long-term services and supports, and 10 percent of Medicaid enrollees who use home and community-based services.[97]

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. These include hourly and seasonal workers, young adults, individuals leaving incarceration, and households with young children.[98] Among parents working hourly jobs, 70 percent to 80 percent have erratic schedules, causing income fluctuations throughout the year. [99] 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.[100] 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. [101] Additionally, data matching will not identify earnings for self-employed workers.[102] During the post-COVID unwinding, 30 percent of Arkansas Medicaid enrollees who ultimately retained coverage had to complete a renewal form because the state could not renew their coverage ex parte, indicating the limits of data matching.[103] Arkansas already experiences a high rate of procedural disenrollments. An astonishing 76 percent of people in Arkansas who lost Medicaid during the post-

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[97] 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/.

[98] 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.

[99] 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.

[100] 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.

[101] 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).

[102] Michael Karpman, Jennifer M. Haley, and Genevieve M. Kenney, "Assessing Potential Coverage Losses among Medicaid Expansion Enrollees under a Federal Medicaid Work Requirement", Urban Institute, March 17, 2025, https://www.urban.org/research/publication/assessing-potential-coverage-losses-among-medicaid-expansion-enrollees-under.

[103] "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.

COVID unwinding were disenrolled for procedural reasons and not because they were actually determined ineligible.[104] This is higher than the national average of 69 percent.[105]

Data matching does not obviate the need for enrollees to report information to maintain eligibility, risking erroneous coverage loss due to confusion and administrative errors. Arkansas explains that, unlike its prior program, enrollees will not have to report their hours worked each month; however, Arkansas's proposal makes clear that enrollees in the new program are still required to complete monthly contacts, in person or virtually, with their "Success Coaching entity."[106] Specifically, the proposal states that "[b]eneficiaries will not be required to work a minimum number of hours per month, *nor will they be required to report any activities to DHS outside of their required contacts with their Success Coaching entity."*[107]

When Medicaid work requirements were in effect, enrollees who were working or exempt lost coverage due to administrative errors and confusion. 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."[108] 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."[109] Arkansas previously 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.[110] 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.[111] Confusion about the previous work requirement in Arkansas was common, with 44 percent of the target population reporting that they were

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[104] *Id.*
[105] *Id.*
[106] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 17-18 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf
[107] *Id.* (emphasis added).
[108] *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
[109] "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.
[110] 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.
[111] *Id.*

unsure whether the requirements applied to them.[112] 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.[113] Arkansas's proposal acknowledges many of these previous shortcomings, but it lacks a detailed explanation for how similar problems will be avoided; instead it says it will rely on "personal communication" between enrollees and "Success Coaching entities" to fill data gaps.[114]

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.[115] In Arkansas and Georgia, potential applicants reported numerous barriers to Medicaid enrollment, due to complex rules and burdensome application processes.[116] [117] 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.[118] [119] 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

[112] 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.
[113] 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)
[114] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 28 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf
[115] 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.
[116] 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.
[117] 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.
[118] 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.
[119]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.

estimated to be eligible.[120] [121] Application data suggests that in some months, upwards of 40 percent of people who started applications for Georgia's program gave up.[122] 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.[123, 124] 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.[125] And, potential enrollees have been deterred from applying for TANF due to adverse publicity.[126]

Furthermore, Arkansas's proposal lacks important detail about how the program will work and what enrollees must do to maintain coverage. For example, Arkansas says that it "will use a combination of data to identify individuals most at risk for poor health outcomes due to long-term poverty" such as those enrolled up to six months; those with income at or below 20% FPL; those with income from 21-80% FPL and enrolled for 24 or more months; and those with income from 81-138% FPL and enrolled for 36 or more months, but it does not explain why or how it identified these groups.[127] Arkansas also says that medical claims data will identify people with chronic illnesses as "on track" if they are receiving medical services, but it does not explain if these people also will be required to work, especially if they fall into one of the groups listed above.[128] Arkansas has not determined who the "Success Coaches" (which it

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[120] "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

[121] 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.

[122] 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.

[123] 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.

[124] 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.

[125] 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.

[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] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 16 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[128] *Id.* at 16-17, 28.

presents as integral to the program's success) will be; instead, it says it is "currently assessing public and private sector options for acquiring talent to fulfill these functions."[129]

Arkansas's proposal envisions imposing wide-ranging and burdensome requirements on enrollees, without clearly defined parameters to determine compliance. Personal development plan goals may include those related to physical, mental and social well-being; employment; advancement such as career training and workforce development; formal education, vocational education, and enhancing skills; and serving by supporting others in one's home and community.[130] Goals "to become or remain healthy may include engaging in a wide range of activities, including quitting smoking, increasing physical activity, and improving nutrition."[131]

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.[132] Successfully increasing employment among low-income people requires "resources to help develop job skills" as well as "job training, education, and earnings supplements."[133] None of these components are funded by Medicaid, and it is unlikely that Arkansas's existing workforce development programs can meet these needs. "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."[134]

Arkansas's proposal says that it will "leverage resources available through. . . state agencies such as Arkansas Workforce Centers and Arkansas Career and Technical Education."[135] However, according to the Arkansas Division of Workforce Services, "insufficient funding for workforce development" is among the

[129] *Id.* at 11.
[130] *Id.*
[131] *Id.* at 17.
[132] 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/.
[133] 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.
[134] *Id.*
[135] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 11 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

"[k]ey barriers to employment growth in Arkansas."[136] Moreover, according to the Association for Career and Technical Education (CTE), "[m]ore investment is needed to scale CTE programs across Arkansas to ensure that all learners, including historically underserved learners, have access to high-quality CTE programs in high-skill, high-wage and in-demand career fields."[137] A report from Advance CTE found that Arkansas is among the states with the lowest state CTE funds per full time employee ($0-$499).[138]

Arkansas says that "Success Coaching *might* connect the individual to a variety of community resources," but it does not explain the extent to which those resources actually exist or what will happen if a needed resource is unavailable.[139] Arkansas says that its QHPs already "are required to offer incentives to improve the appropriate use of preventive and primary care services" but notes that "there is a low take-up rate of these opportunities" without explaining why.[140] Arkansas also says that its QHPs already must "offer incentives to participate in health improvement and economic independence activities," but it does not explain how effective these services have proved to be or how they will differ from the "focused care coordination services" to be offered under the new program.[141]

Many individuals who are not working face significant employment barriers that Medicaid work requirements do not address.[142] 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."[143] Offering little else but low-intensity

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[136] Ark. Div. of Workforce Services. Annual Report at 2. (2023). https://dws.arkansas.gov/wp-content/uploads/2023-Annual-Report-Pages-Comp-View-7.8.24.pdf

[137] Association for Career and Technical Education. CTE in Arkansas (Feb. 2024). https://www.acteonline.org/wp-content/uploads/2024/03/Arkansas-CTE-Fact-Sheet-2024.pdf

[138] Advance CTE and Walton Family Foundation. The state of career technical education: an analysis of state secondary CTE funding models at 3 (2023). https://careertech.org/wp-content/uploads/2023/09/2023_State_of_CTE_Research_Report_Advance_CTE.pdf

[139] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 11, 17 (emphasis added) (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[140] *Id.* at 21.

[141] *Id.* at 11.

[142] 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/.

[143] *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.)

services, such as job search, is unlikely to be successful.[144] 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.[145] For the small number of Arkansas residents who were not employed and could work, two potential state services were identified by respondents as factors that would most help them find a job – job training/education and transportation to work.[146] 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.[147] In this proposal, Arkansas says "[d]ata suggests that the greatest need for services are for nutritional assistance, transportation, and housing" but does not describe how these needs will be met other than by asserting that enrollees "will receive an appropriate intervention if they screen positive for a [health-related social need]"[148] and referring to unspecified "local community resources."[149]

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.[150] Implementation of Arkansas' previous work requirement cost an estimated $26.1 million in federal and state funds.[151] 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

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[144] 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.

[145] *Id.*

[146] 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).

[147] 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.

[148] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 24 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[149] *Id.* at 11, 17, 19.

[150] 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.

[151] 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.

percent of these costs have gone to program administration and not healthcare costs.[152] 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.[153] Arkansas estimates that its proposal will cost $42.8 million over five years, though it estimates $122.8 million in net savings due to saved member months – that is, from coverage loss.[154]

Research on SNAP and TANF demonstrate that work requirements are an inefficient use of limited state administrative resources.[155] The administrative resources needed to verify enrollees' compliance with work requirements are substantial and often require significant caseworker time.[156] As noted above, Arkansas's proposal will require regular monthly contacts to ensure that eligible people remain 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.

Conclusion

For the foregoing reasons, APHA and the individual public health deans and scholars listed below urge HHS to reject Arkansas's request to amend its ARHOME Section 1115 demonstration waiver. 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

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[152] 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.

[153] 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.

[154] Ark. Dept. of Human Servs., Request to amend the ARHOME Section 1115 demonstration project at 25, 26 (March 26, 2025, posted April 10, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf

[155] 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.

[156] *Id.*

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

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

17. Cartwright-Smith, Lara, JD, MPH, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

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

26. Heinrich, Janet, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

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

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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