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Analysis Justifying Trump Administration's Medicaid Work Requirement Rule Is Deeply Flawed

The 2025 reconciliation law instituted a harmful policy taking Medicaid coverage away from people not meeting a harsh work requirement, and the Trump Administration recently finalized a rule that will make the policy even more harmful.[1] In particular, the new rule makes it harder for people to qualify for an exemption from the work requirement due to medical frailty, which includes: blindness or disability; substance use disorder; disabling mental disorder; physical, intellectual, or developmental disability that significantly impairs a person's ability to perform one or more activities of daily living; and serious or complex medication condition. As a result, people with these conditions will likely experience significantly more coverage loss.[2]

Major federal rules require a Regulatory Impact Analysis (RIA) to help policymakers and the public understand the benefits and costs of the rule and determine whether the benefits are likely to justify the costs. The RIA for the Medicaid work requirement rule is deeply flawed: it greatly inflates the benefits of the rule while ignoring most of the costs.

The Analysis Ignores Impacts of Coverage Loss and Disregards Research and Evidence

The RIA ignores societal costs of taking away Medicaid coverage. Without health coverage, people are more likely to die, be in poorer health, and accumulate medical debt.[3] Omitting the impacts of coverage loss, which are large and strongly supported by the research literature, is indefensible and runs counter to federal guidance for regulatory analysis.[4]

Three peer-reviewed studies found that Medicaid work requirements in Arkansas had no impacts on employment or hours worked but led to large-scale disenrollment and increased uninsurance.

The RIA ignores all studies assessing the impact of Medicaid work requirements. There are three peer-reviewed studies analyzing the impacts of Medicaid work requirements in Arkansas, the only state to follow through with taking coverage away from people who didn't meet the harsh requirements, disenrolling 1 in 4 enrollees subject to them.[5] The studies found that Medicaid work requirements had no impacts on employment or hours

worked but led to large-scale disenrollment and increased uninsurance. Rates of coverage loss were similar in other states that attempted Medicaid work requirement policies. New Hampshire halted its policy after being on the verge of disenrolling about 1 in 3 Medicaid expansion enrollees, implying an even higher rate of coverage loss than in Arkansas.[6] Similarly, Michigan was set to disenroll nearly 1 in 3 enrollees subject to its requirement before its program was blocked by a court ruling.[7] Instead of engaging with the evidence, the RIA states, "We have not relied on these previous demonstrations for data or assumptions used in this analysis." It's striking that an RIA for the Medicaid work requirement would ignore studies of Medicaid work requirements.

The RIA assumes the work requirement will increase employment and result in low disenrollment, contrary to evidence. The research on Medicaid work requirements finds no impact on employment and much higher rates of disenrollment than assumed in the RIA. The RIA's estimate of net Medicaid coverage loss of 3.3 million people in 2034 is far below the Congressional Budget Office (CBO) estimate of about 5.7 million, in large part because CBO incorporates the relevant research and data that the RIA ignores.[8]

Analytically Unsound Assumptions Drive RIA Results

In addition to the obvious flaws discussed above, the RIA relies on assumptions that are weakly supported, arbitrary, or unrealistic. These assumptions are complex and technical but important drivers of the RIA's results.

> "The RIA for the Medicaid work requirement rule is deeply flawed: it greatly inflates the benefits of the rule while ignoring most of the costs."

The RIA assigns implausibly large net social benefits to employment. The RIA assumes that the societal benefits and costs of the Medicaid work requirement derive overwhelmingly from the impact on employment and other forms of community engagement (e.g., volunteering, education). The RIA values the time *benefit* of work as the additional output of the work done by people subject to the requirement (the marginal product of labor), which it estimates by using their assumed pre-tax compensation of $25 per hour as a proxy.

But it values the time *cost* of the work requirement using a different approach: a person's net private return to working, or the wage a person requires to choose to work. The RIA approximates this amount using a Trump Administration estimate of the *economy-wide average effective marginal tax rate*[9] and subtracts $12 per hour of purported taxes and transfers from its assumed $25 per hour rate of pre-tax compensation. The result is an estimated $13 per hour time cost of work, only about half of the $25 per hour estimated time benefit.

The RIA counts the entire $12 per hour gap between the two approaches as a net social benefit, an assumption that is inconsistent with federal guidelines and best practice for benefit-cost analysis, which call for careful examination of the affected population's employment decisions and market conditions.[10]

Treating the full gap as a net social benefit is also an extreme assumption given economic research showing that such gaps can arise for many reasons.[11]

Even aside from the RIA's thin conceptual basis, the calculated gap is more than double what it should be, according to Department of Health and Human Services (HHS) estimates of *population-specific effective marginal tax rates* for a population similar to the one subject to the work requirement (i.e., low-income households, mostly without children).[12]

The RIA is even weaker in its valuation of non-work activities such as volunteering and education. It assumes the same inflated net benefit of $12 per hour as it did for its valuation of work, even though the conceptual basis for such a valuation does not apply. For example, the value of volunteer time depends on the volunteer activities and whether the person derives satisfaction from them, while the value of education depends on the type of education and impacts on earnings.[13]

The RIA overestimates "human capital" benefits of employment, such as work knowledge and relationships, for former Medicaid enrollees who it assumes become employed and remain working after they are no longer enrolled. The RIA bases its estimate on a study of a 1990s Canadian policy that offered extra income for people who chose to take up full-time work, a policy that is poorly suited for understanding the Medicaid work requirement, which will block or take away health coverage from people not working (or participating in other qualified activities) at least 80 hours per month.[14]

The Canadian study itself stated that due to the policy's unusual design, a more fulsome model is needed to evaluate "even minor variants" of an income subsidy program (much less a completely different policy like the Medicaid work requirement). Moreover, the study showed benefits falling rapidly after 15 months and having "no lasting impact." But the RIA's assumptions imply that benefits persist well beyond what was found in the Canadian study. Finally, the RIA combines its overestimates of human capital benefits derived from the Canadian study with a largely arbitrary assumption about how many former Medicaid enrollees would benefit.

The RIA inflates budgetary savings by unrealistically assuming immediate, fully phased-in impacts. This assumption is inconsistent with the policy design of the work requirement and runs counter to state experience and research.[15] By assuming immediate, fully phased-in impacts, the RIA overestimates cumulative ten-year budgetary savings without increasing its maximum annual estimate of coverage loss.

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[1] Interim final rule text available at Federal Register, "Medicaid Program: Community Engagement Requirement for Certain Individuals," Vol. 91, No. 106, June 3, 2026, https://www.federalregister.gov/public-inspection/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals; Jennifer Wagner and Allison Orris, "Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement," CBPP, June 3, 2026, https://www.cbpp.org/research/health/administrations-last-minute-restrictions-likely-to-worsen-impact-of-medicaid-work.

[2] Wagner and Orris, 2026.

[3] Angela Wyse and Bruce Meyer, "Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults," NBER Working Paper 33719, May 2025, https://www.nber.org/papers/w33719; Sarah Miller, Norman Johnson, and Laura Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," Quarterly Journal of Economics, Vol. 135, Issue 3, January 30, 2021, https://doi.org/10.1093/qje/qjab004; Melissa McInerney *et al.*, "ACA Medicaid Expansion Associated With Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence From the Health and Retirement Study," Inquiry, July 28, 2020, https://pmc.ncbi.nlm.nih.gov/articles/PMC7388087/; Luojia Hu *et al.*, "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," Journal of Public Economics, Vol. 163, May 7, 2018, https://pmc.ncbi.nlm.nih.gov/articles/PMC6208351/.

[4] Office of Management and Budget (OMB), "Circular A-4, Regulatory Analysis," September 17, 2003, https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf.

[5] Anuj Gangopadhyaya and Michael Karpman, "The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment: Estimating Effects Using National Survey Data," Health Services Research, Vol. 60, Issue 5, October 2025, https://doi.org/10.1111/1475-6773.14624; Jennifer Wagner and Jessica Schubel, "States' Experience Confirm Harmful Effects of Medicaid Work Requirements," CBPP, updated November 18, 2020, https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements; Benjamin Sommers *et al.*, "Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, and Affordability of Care," Health Affairs, Vol. 39, No. 9, September 8, 2020, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538; Benjamin Sommes *et al.*, "Medicaid Work Requirements – Results from the First Year in Arkansas," New England Journal of Medicine, Vol. 381, No. 11, June 19, 2019, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[6] Michael Karpman, Jennifer Haley, and Genevieve 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; Ian Hill, Emily Burroughs, and Gina Adams, "New Hampshire's Experience 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.

[7] Wagner and Schubel, 2020.

[8] CBO, 2025.

[9] The estimated effective marginal tax rate includes both taxes and government benefits that are forgone when income increases. White House Council of Economic Advisers, "Economic Report of the President," March 2019, https://www.govinfo.gov/content/pkg/ERP-2019/pdf/ERP-2019.pdf.

[10] Robert Haveman and David Weimer, "Public Policy Induced Changes in Employment: Valuation Issues for Benefit-Cost Analysis," Journal of Benefit-Cost Analysis, Vol. 6, Issue 1, April 22, 2015, https://doi.org/10.1017/bca.2015.5; OMB, 2003.

[11] Lini Zhang, "Credit Crunches, Individual Heterogeneity and the Labor Wedge," Journal of Macroeconomics, Vol. 56, June 2018, https://doi.org/10.1016/j.jmacro.2018.01.002; Patrick Kehoe, Virgiliu Midrigan, and Elena Pastorino, "Debt Constraints and the Labor Wedge," American Economic Review, Vol 106, No. 5, May 2016, https://www.aeaweb.org/articles?id=10.1257/aer.p20161088; Anton Cheremukhin and Paulina Restrepo-Echavarria, "The Labor Wedge as a Matching Friction," Vol. 68, May 2014, https://doi.org/10.1016/j.euroecorev.2014.02.008; Loukas Karabarbounis, "The Labor Wedge: MRS vs. MPN," Review of Economic Dynamics, Vol. 17, Issue 2, April 2014, https://doi.org/10.1016/j.red.2013.07.003.

[12] The Trump Administration estimate that underlies the RIA's effective marginal tax rate is a single economy-wide value. The HHS estimates, which are not used for the RIA, are more relevant because they are derived from a population similar to people who will be subject to the work requirement. Nina Chien and Suzanne Macartney, "What Happens When People Increase Their Earnings? Effective Marginal Tax Rates for Low-Income Households," Office of the Assistant Secretary for Planning & Evaluation (ASPE), U.S. Department of Health & Human Services, March 2019, https://aspe.hhs.gov/sites/default/files/private/aspe-files/260661/brief2-overviewmtranalyses.pdf.

[13] Aidan Vining and David Weimer, "An Assessment of Important Issues Concerning the Application of Benefit-Cost Analysis to Social Policy," Journal of Benefit-Cost Analysis, Vol. 1, Issue 1, January 19, 2015, https://doi.org/10.2202/2152-2812.1013.

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[15] Matthew Fiedler, "How Would Implementing an Arkansas-Style Work Requirement Affect Medicaid Enrollment?" April 30, 2025, https://www.brookings.edu/articles/how-would-implementing-an-arkansas-style-work-requirement-affect-medicaid-enrollment/.