# December 31st Financial Cliff Analysis: When Medicaid Ends and Nothing Replaces It

Marcus reviews the termination letter with his patient, a 34-year-old warehouse worker whose Medicaid coverage will end in three weeks. The letter cites failure to document 80 hours of qualifying activities, though Marcus knows the man works full-time. The documentation failure was technical: his employer uses a staffing agency whose records did not match the state's verification system.

The patient asks the obvious question: what now? Marcus pulls up the healthcare.gov calculator. At $38,000 annual income, marketplace coverage would cost $340 monthly after subsidies, with a $4,000 deductible. The patient's insulin alone costs $400 monthly without insurance. The math does not work.

Then Marcus remembers the provision he read about in the implementation guidance. People who lose Medicaid coverage due to work requirement non-compliance are barred from receiving premium tax credits. The $340 monthly figure assumed subsidies. Without them, the same bronze plan costs $580 monthly. The patient would spend $6,960 annually on premiums before receiving any coverage for his $400 monthly insulin.

The patient stares at the numbers. He was working. He has always worked. A documentation error in a system he never understood is about to cost him healthcare coverage with no affordable alternative. The marketplace exists but is priced beyond reach. Employer coverage is not offered at the staffing agency. He will join the uninsured, rationing insulin until something breaks.

Marcus has seen this before. It ended badly then. He expects it will end badly now.

## The Cliff Architecture

The One Big Beautiful Bill Act creates a financial cliff unprecedented in American healthcare policy. Previous coverage losses offered alternative pathways. Medicaid beneficiaries who aged out could access Medicare. Those whose incomes rose could transition to marketplace coverage with premium subsidies. Even the uninsured had emergency Medicaid as backstop for acute needs.

OB3 / HR1 changes this architecture. Section 71119 specifies that individuals who lose Medicaid coverage due to work requirement non-compliance are ineligible for premium tax credits through the ACA marketplace. The provision closes the escape hatch that might otherwise soften coverage loss. Someone terminated for failing to document 80 hours faces not a coverage transition but a coverage void.

The policy logic is coherent if harsh: if someone loses Medicaid for refusing to meet work requirements, they should not receive federal subsidies through an alternative program. Allowing marketplace subsidies would undermine the behavioral incentive work requirements are designed to create. Why comply with Medicaid work requirements if non-compliance simply shifts you to subsidized marketplace coverage?

The logic assumes behavioral rather than administrative failure. It imagines a person consciously choosing not to work, facing coverage loss as consequence, and seeking to evade that consequence through an alternative subsidy. For this person, closing the marketplace escape hatch makes sense. The consequence reinforces the behavioral incentive.



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

But the logic assumes that coverage loss reflects genuine non-compliance rather than documentation failure. Evidence from Arkansas found that most people who lost coverage were working, exempt, or both. They failed to prove compliance, not to achieve it. For these individuals, the premium tax credit bar punishes administrative dysfunction rather than behavioral choices.

The person who works 80 hours but cannot get their employer to provide verification faces the same cliff as the person who refuses to work at all. The staffing agency that does not track hours by individual creates the same consequence as deliberate non-compliance. The member with limited English proficiency who did not understand the verification requirement falls alongside the member who understood and refused.

The financial cliff also assumes marketplace coverage is affordable without subsidies. For most expansion adults, it is not. Medicaid covers people with incomes up to 138% of the federal poverty level, roughly $20,800 annually for an individual. At this income, unsubsidized marketplace coverage would consume 25-35% of gross income before any healthcare is actually received. No rational actor makes this choice. They become uninsured instead.

## The Affordability Gap

Medicaid expansion adults pay little or nothing for comprehensive coverage. Most states charge no premiums for expansion adults. Cost-sharing is minimal, often $1-4 copays for prescriptions and office visits. Deductibles are rare. Out-of-pocket maximums, where they exist, are capped at levels far below marketplace plans.

The marketplace operates on fundamentally different economics. Even subsidized coverage requires meaningful premium contributions. Cost-sharing through deductibles and copays shifts substantial expense to enrollees. Bronze plans with lower premiums carry deductibles of $5,000-8,000, meaning enrollees pay thousands before insurance covers non-preventive care.

For someone at 138% FPL losing Medicaid with premium tax credit eligibility, marketplace coverage would cost roughly $50-80 monthly in premiums for a silver plan with cost-sharing reductions. This is manageable if not trivial. The deductible might run $500-1,500, and copays would be modest. The coverage is less generous than Medicaid but functional.

For someone at 138% FPL losing Medicaid without premium tax credit eligibility, the same silver plan costs $500-650 monthly depending on age and geography. Annual premiums of $6,000-7,800 represent 30-40% of gross income. The deductible adds another $3,000-5,000 in exposure before coverage applies. No one at this income level can afford this coverage.

The bronze plan alternative reduces premiums to $400-500 monthly but increases deductibles to $7,000-9,000. The annual premium plus deductible exposure of $12,000-15,000 exceeds half of annual income. The coverage is nominally available but economically inaccessible.

This affordability gap creates the cliff. With premium tax credits, marketplace coverage offers a soft landing for those whose incomes exceed Medicaid limits or who lose Medicaid eligibility for other reasons. Without premium tax credits, the landing is concrete.

## Who Falls Off the Cliff

The population at risk of falling off the financial cliff includes everyone who loses Medicaid coverage due to documented work requirement non-compliance. Estimating this population requires assumptions about compliance rates, documentation success, and exemption coverage.



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

CBO projections estimate work requirements will reduce Medicaid enrollment by 8-10 million people over the decade following implementation. Not all of these individuals lose coverage due to non-compliance; some transition to employer coverage, some move to marketplace plans, some become ineligible for other reasons. But CBO's analysis suggests the majority become uninsured.

The Brookings analysis of Arkansas-style requirements projected 34% long-run enrollment reduction among affected populations. Applied to the 18.5 million expansion adults subject to OB3 / HR1 requirements, this suggests 6-7 million people losing coverage, most through the non-compliance pathway that triggers premium tax credit exclusion.

The temporal distribution matters. Coverage losses will not occur uniformly across time. The December 2026 implementation date creates a cliff within the cliff: a surge of terminations as systems activate and members who have not established compliance documentation face immediate consequences. States with robust pre-implementation outreach may smooth this surge. States that activate requirements without adequate preparation will see concentrated losses in early 2027.

Demographic analysis suggests the population losing coverage will skew toward those with unstable employment, complex health needs, and limited administrative capacity. People with steady jobs and organized documentation will maintain coverage. People with episodic employment, informal work arrangements, or barriers to system navigation will lose it. The cliff claims those least equipped to land safely.

Geographic patterns will emerge. Rural areas with limited broadband access, fewer employers providing documentation, and longer distances to verification assistance will see higher coverage loss rates. Urban areas with robust navigation infrastructure and dense service provider networks will retain coverage more effectively. The cliff falls unevenly across the landscape.

Health status matters too. Members with chronic conditions requiring ongoing care face the greatest consequences from coverage loss. A healthy 28-year-old who loses Medicaid might go years without significant healthcare needs. A 45-year-old with diabetes, hypertension, and depression will face immediate medication access problems, progressing conditions, and eventual acute episodes that generate emergency department visits.

The intersection of health needs and documentation capacity creates particular risk. Members with serious mental illness may struggle to maintain consistent documentation despite genuine work activity. Members with substance use disorders in recovery may face treatment interruptions that trigger relapse. Members with cognitive limitations may not understand requirements well enough to comply. These populations fall off the cliff not through behavioral choice but through incapacity to navigate administrative systems.

The population falling off the cliff is not random. It is selected for vulnerability by the same characteristics that made work requirement compliance difficult in the first place.

## Individual Financial Impact

The individual financial impact of losing Medicaid without marketplace subsidy access can be modeled across scenarios representing common situations.

### Scenario 1: Young Healthy Adult

A 26-year-old earning $22,000 annually loses Medicaid coverage. Without chronic conditions, immediate healthcare needs are modest. Preventive care that was free under Medicaid now



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

requires out-of-pocket payment. An annual physical costs $150-250. Basic labs add $100-200. Vaccinations run $50-150 each.

The young adult might reasonably forgo these services, accepting increased health risk for reduced expense. This is rational in the short term. The long-term risk is undetected conditions that progress during uninsured periods.

If an unexpected health event occurs, perhaps an accident, infection, or acute illness, the financial impact escalates immediately. An emergency department visit for a broken arm might generate $3,000-8,000 in charges. Hospitalization for appendicitis could reach $25,000-50,000. These amounts exceed annual income and create medical debt that persists for years.

### Scenario 2: Adult with Chronic Condition

A 42-year-old with Type 2 diabetes earning $24,000 annually loses Medicaid coverage. Monthly medication costs include: metformin ($15-30 generic), insulin ($300-600 without insurance), glucose monitoring supplies ($50-100), and quarterly A1C testing ($50-100). Annual medication and monitoring costs run $5,000-10,000.

Without insurance, this individual faces immediate impossible choices. Full medication adherence would consume 20-40% of gross income. Rationing insulin is dangerous but economically necessary. Skipping monitoring saves money but increases risk of undetected complications.

The predictable trajectory involves medication rationing, deteriorating glucose control, and eventual acute complications. Diabetic ketoacidosis requires hospitalization costing $20,000-40,000. Foot infections from poor circulation can lead to amputation. Kidney failure requires dialysis that costs $90,000 annually and qualifies for Medicare, shifting costs to federal programs after preventable deterioration.

### Scenario 3: Family with Children

A 35-year-old parent earning $32,000 annually loses Medicaid coverage while children retain coverage through CHIP. The parent's individual marketplace premium without subsidies runs $450-550 monthly. Family budget cannot absorb $5,400-6,600 in annual premiums.

The parent becomes uninsured while maintaining children's coverage. Parental health conditions go untreated. Mental health needs, common among low-income working parents, receive no professional attention. Physical health conditions that would respond to early intervention progress until acute episodes occur.

The family financial impact extends beyond healthcare costs. Medical debt from eventual emergency care affects credit scores, limiting housing and employment options. Bankruptcy, though it discharges medical debt, creates long-term financial consequences. The coverage gap for one family member destabilizes the entire household.

## State Fiscal Implications

States face complex fiscal implications from the Medicaid-to-uninsured transition. The immediate effect is reduced Medicaid spending as enrollment declines. But costs do not disappear; they shift to other programs and eventually return to state budgets through indirect pathways.

### Immediate Medicaid Savings

States pay 10% of expansion adult coverage costs, with federal matching funds covering 90%. When an expansion adult loses coverage, the state saves roughly $540 annually (10% of



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

approximately $5,400 average annual cost). Multiply by projected coverage losses, and state savings appear substantial.

For a state with 500,000 expansion adults, 15% coverage loss (75,000 people) would generate $40.5 million in annual state savings. This figure appears in budget projections as work requirement benefit.

## Administrative Cost Increases

Work requirement implementation generates administrative costs that offset savings. States must build verification systems, process exemption applications, manage appeals, and handle the enrollment churn that work requirements create.

Georgia spent over $90 million implementing Pathways to Coverage, generating administrative costs that exceeded coverage savings given the program's low enrollment. Arkansas estimated $26 million in implementation costs for a program that disenrolled 18,000 people before court intervention.

Ongoing administrative costs include: verification system operation, employer and educational institution data matching, exemption processing, appeals management, and re-enrollment processing when terminated members regain eligibility. These costs scale with the number of people cycling through compliance determination.

## Uncompensated Care Increases

People who lose Medicaid coverage do not stop needing healthcare. They defer care until conditions become acute, then present at emergency departments that cannot refuse them. The costs of this uncompensated care flow through the healthcare system and ultimately to state budgets.

Hospital uncompensated care is partially offset by federal Disproportionate Share Hospital (DSH) payments. But DSH allocations are capped and do not fully cover uncompensated care costs. States with higher uninsured rates see hospitals absorbing losses that affect financial stability, employment, and community healthcare capacity.

Some uncompensated care costs appear directly in state budgets through safety net funding. States support public hospitals, FQHCs, and free clinics that absorb uninsured patients. As uninsured populations grow, demand on these systems increases, requiring either expanded state funding or service rationing.

## Cost Shifting to Other Programs

Coverage loss shifts costs to programs that remain accessible. Emergency Medicaid covers true emergencies regardless of work requirement status. Individuals who lose coverage for non-compliance but face acute needs generate emergency Medicaid claims that states must pay.

Mental health crises among the uninsured often involve law enforcement and emergency psychiatric services funded through county or state mental health budgets. Substance use relapses among people who lost coverage for treatment access generate criminal justice costs. Housing instability exacerbated by medical debt increases demand for housing assistance.

The fiscal analysis must account for these cost shifts to determine net state impact. States may save on Medicaid while spending more on emergency services, mental health systems,

corrections, and housing programs. The net effect depends on population characteristics and the specific cost-shifting pathways that predominate.

## System Cost-Shifting

Beyond state fiscal effects, coverage loss creates cost-shifting throughout the healthcare system. Different stakeholders absorb costs based on their position and the policies they face.

### Hospitals

Hospitals bear concentrated risk from coverage loss because they cannot refuse emergency patients regardless of insurance status. When expansion adults become uninsured, hospitals see payer mix deteriorate as previously covered patients present without coverage.

The financial impact varies by hospital type. Safety-net hospitals with high Medicaid populations face the largest absolute increase in uncompensated care. These hospitals often operate on thin margins already and may face viability threats from substantial coverage loss.

Suburban and rural hospitals with lower Medicaid shares face smaller absolute impact but may have less financial capacity to absorb losses. Rural hospitals have been closing at accelerating rates; additional uncompensated care burden could push marginal facilities into closure.

Hospital responses to increased uncompensated care include: aggressive collection efforts that generate patient financial distress, cost-shifting to commercial payers through higher negotiated rates, service reductions that affect community access, and in extreme cases closure or conversion to limited-service facilities.

### Physicians

Physicians have more flexibility than hospitals in responding to coverage loss. They can limit uninsured patients in their practices, require payment at time of service, or reduce Medicaid panel sizes in anticipation of enrollment volatility.

Primary care physicians who built practices around Medicaid expansion populations face particular challenges. Their patient panels may shrink as coverage terminates, reducing revenue. Patients who lose coverage may continue seeking care, creating difficult conversations about payment and potentially unpaid bills.

Specialists face different dynamics. Many already limit Medicaid patients due to low reimbursement. Coverage loss simply removes the possibility of seeing these patients at all, concentrating specialty care among the insured and leaving complex conditions in the uninsured population untreated.

### MCOs

Managed care organizations face revenue loss as enrollment declines but also cost avoidance as high-need members lose coverage. The net financial impact depends on the risk profile of members who lose coverage versus those who remain.

If work requirements disproportionately disenroll high-cost members, MCOs might benefit financially even as enrollment declines. If the members who lose coverage are relatively healthy while medically complex members maintain exemptions, MCO margins might compress as the remaining population becomes sicker on average.

Risk adjustment degradation compounds MCO challenges. Members who lose and later regain coverage return with undocumented conditions and inadequate risk scores, generating capitation



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

that does not reflect actual cost. MCOs bear this risk adjustment gap until documentation catches up with reality.

### Employers

Employers whose workers lose Medicaid face indirect costs through workforce effects. Employees managing untreated health conditions have reduced productivity and higher absenteeism. Employees with medical debt face financial stress that affects work performance. Turnover increases as workers seek jobs with health benefits, even at lower wages.

Employers who offer health coverage may see enrollment increases as workers losing Medicaid seek employer plans they previously declined. This increases employer costs but may improve workforce stability. Employers who do not offer coverage gain no benefit from Medicaid losses and bear the full workforce productivity impact.

## The Marketplace That Cannot Help

The ACA marketplace was designed as the coverage alternative for people with incomes above Medicaid eligibility levels. Premium tax credits make marketplace coverage affordable for people earning 100-400% of the federal poverty level. Cost-sharing reductions further improve affordability for people earning 100-250% FPL.

OB3 / HR1's premium tax credit exclusion removes this alternative for people who lose Medicaid through work requirement non-compliance. The marketplace still exists. Plans can still be purchased. But without subsidies, the coverage is unaffordable for virtually everyone at Medicaid income levels.

The exclusion applies specifically to individuals who "lose eligibility for, or are denied, medical assistance" due to failure to meet work requirements. The language is precise: someone who loses Medicaid because their income rose above 138% FPL retains premium tax credit eligibility. Someone who loses Medicaid for work requirement non-compliance does not.

This distinction creates perverse outcomes. An individual who stops working entirely and reports income of $15,000 might lose Medicaid for non-compliance with work requirements. They cannot access premium tax credits despite income well below the normal 400% FPL threshold. Meanwhile, an individual who gets a raise pushing income to $25,000 loses Medicaid for income reasons but gains access to subsidized marketplace coverage. The person with higher income receives federal assistance; the person with lower income does not.

The marketplace becomes a theoretical rather than practical option. Coverage exists on paper but not in economic reality. This creates the cliff: Medicaid on one side, uninsurance on the other, with no bridge between.

The duration of premium tax credit exclusion is not specified in the legislation. Does someone lose subsidy eligibility permanently, or only until they demonstrate compliance with work requirements? The law suggests the exclusion persists until the individual requalifies for Medicaid and then loses eligibility for a non-work-requirement reason. In practice, this may mean years without affordable coverage options.

The policy could have been designed differently. Premium tax credits could have remained available to anyone regardless of why they lost Medicaid. This would create the "escape hatch" that policymakers wanted to close but would also ensure that coverage remained accessible for those willing to pay their share.



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

Alternatively, the premium tax credit exclusion could have been time-limited, allowing access after a waiting period that preserved behavioral incentives while eventually restoring coverage options. Someone who lost Medicaid for non-compliance in January might become subsidy-eligible in July, creating consequence for non-compliance without permanent exclusion.

The design choice reflected in OB3 / HR1 prioritizes behavioral incentive over coverage access. The cliff is not an accident; it is the intended consequence for non-compliance. Whether the behavioral effects justify the coverage consequences is the policy question the design embodies.

## Modeling the Fiscal Reality

Comprehensive fiscal modeling requires integrating immediate savings with downstream costs across programs and time horizons. The challenge is that benefits appear immediately in Medicaid budgets while costs materialize gradually across multiple budgets that may not be visible to Medicaid budget analysts.

A simplified model for a state with 500,000 expansion adults might project:

Immediate effects (Year 1):

- 75,000 members lose coverage (15% disenrollment rate)
- State saves $40.5 million in Medicaid costs (10% state share)
- State spends $18 million on work requirement administration
- Net immediate savings: $22.5 million

Downstream effects (Years 2-5):

- Uncompensated care increases by $120 million annually (hospital data)
- State DSH and safety net costs increase by $25 million annually
- Emergency Medicaid costs increase by $15 million annually
- Mental health and corrections costs increase by $10 million annually
- Annual downstream costs: $50 million

Net fiscal impact: Initial savings of $22.5 million become net costs of $27.5 million annually as downstream effects materialize.

This model is illustrative rather than predictive. Actual impacts depend on state-specific factors including hospital finances, safety net capacity, and cost-shifting pathways. But the pattern is consistent: immediate savings create downstream costs that accumulate over time.

The timing mismatch creates political economy challenges. Legislators can claim credit for Medicaid savings that appear in the first budget cycle after implementation. The downstream costs materialize in hospital budgets, mental health systems, and corrections departments that have different legislative overseers and budget cycles. The connection between work requirement implementation and these increased costs may never be explicitly drawn.

Hospital associations will track uncompensated care increases and attribute them to coverage losses. Mental health advocates will document the connection between coverage loss and crisis system utilization. But these voices compete with budget analysts celebrating Medicaid savings. The political narrative may favor the simple story of reduced Medicaid spending over the complex story of cost-shifting across systems.

States that recognize this pattern might invest savings in navigation infrastructure that reduces coverage loss, generating better fiscal outcomes than allowing the cliff to claim maximum

casualties. The $22.5 million in first-year savings could fund navigation capacity preventing 20,000-30,000 coverage losses, with net positive fiscal impact.

The ROI on navigation investment, detailed in Article 12C, demonstrates that coverage retention typically costs less than coverage loss. States choosing to pocket Medicaid savings rather than reinvesting in navigation are making a fiscal choice that may prove costly over time. But the benefits of that reinvestment accrue to hospital balance sheets and mental health systems rather than Medicaid budgets, creating incentive misalignment that works against optimal decisions.

Federal policymakers could address this misalignment by allowing states to count navigation investment as Medicaid administrative expense eligible for federal matching funds. This would shift incentives toward retention rather than termination. Whether such flexibility emerges from CMS rulemaking remains to be seen.

## Conclusion

The December 31st financial cliff is a policy choice, not an inevitable consequence. OB3 / HR1's premium tax credit exclusion creates the cliff; different legislative design could have softened it. The question is whether the behavioral incentives the cliff creates justify the coverage losses and healthcare costs it generates.

The fiscal analysis suggests the cliff may cost more than it saves. Immediate Medicaid savings from coverage loss generate downstream costs in uncompensated care, safety net utilization, and cross-program cost-shifting. States that project work requirement savings may find actual fiscal impact neutral or negative as effects materialize over time.

The individual impact is clearer and more severe. People who lose Medicaid coverage for work requirement non-compliance lose access to affordable healthcare with no practical alternative. They become uninsured not because they refused to work but because they failed to document work in systems designed to verify compliance. They ration medications, defer care, and eventually present with conditions that have progressed beyond what earlier treatment would have required.

The cliff particularly punishes documentation failure rather than behavioral failure. Someone working 80 hours monthly but unable to prove it through employer records loses coverage and subsidy eligibility. Someone not working at all but qualifying for an exemption they successfully documented maintains coverage. The cliff does not distinguish between those who refused to comply and those who could not prove compliance. Both fall the same distance.

Healthcare providers will see the consequences of the cliff in their exam rooms and emergency departments. Patients who were managing chronic conditions will present with complications. Patients who were stable on psychiatric medications will arrive in crisis. Patients who had primary care relationships will appear as strangers in emergency departments that cannot refuse them. The continuity of care that produces good outcomes at reasonable cost will be disrupted for millions of people.

The health system will absorb these costs, invisibly at first and then visibly as uncompensated care burdens accumulate. Hospitals will negotiate higher rates from commercial payers to offset charity care losses. Insurers will pass these costs through in premiums. Employers will see health benefit costs rise. The costs do not disappear when someone loses coverage; they redistribute through channels that obscure their origin.



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

Marcus watches his patient leave the clinic, termination letter in hand, no path forward. The warehouse continues operating. The staffing agency continues its documentation practices. The state system continues requiring verification the employer does not provide. Someone working full-time loses healthcare coverage because administrative systems could not confirm what everyone involved knows to be true.

*The cliff claims another casualty. The spreadsheet records a savings. The emergency department will eventually record a cost. The system balances through human suffering that appears in no budget but shapes millions of lives. The policy design that created this outcome could have created different outcomes. The choice was made, and now the consequences unfold.*

## References

1. Congressional Budget Office. "Budgetary Effects of H.R. 1, One Big Beautiful Bill Act." June 2025.
2. Kaiser Family Foundation. "Premium Tax Credit Eligibility and Medicaid Work Requirements." August 2025.
3. Sommers BD, et al. "Medicaid Work Requirements in Arkansas: Two-Year Impacts." Health Affairs. 2020;39(9):1522-1530.
4. Gangopadhyaya A, Karpman M. "The Impact of Arkansas Medicaid Work Requirements on Coverage and Employment." Health Services Research. April 2025.
5. Brookings Institution. "How Would Implementing an Arkansas-Style Work Requirement Affect Medicaid Enrollment?" April 2025.
6. Urban Institute. "What Would Happen to Medicaid Enrollees' Health Coverage After Work Requirements?" June 2018.
7. Commonwealth Fund. "The Financial Burden of Health Care Spending." October 2023.
8. American Hospital Association. "Uncompensated Hospital Care Cost Fact Sheet." January 2024.
9. Garfield R, Orgera K, Damico A. "The Coverage Gap: Uninsured Poor Adults in States that Did Not Expand Medicaid." Kaiser Family Foundation. January 2021.
10. MACPAC. "Medicaid's Role in Health Care Coverage." March 2023.
11. Goldman AL, Sommers BD. "Among Low-Income Adults Enrolled in Medicaid, Churning Decreased After the ACA." Health Affairs. 2020;39(1):85-93.
12. Himmelstein DU, et al. "Medical Bankruptcy: Still Common Despite the Affordable Care Act." American Journal of Public Health. 2019;109(3):431-433.
13. Tolbert J, Orgera K, Damico A. "Key Facts about the Uninsured Population." Kaiser Family Foundation. November 2020.
14. Cross-Call J, Solomon J. "Medicaid Work Requirements Cannot Be Fixed." Center on Budget and Policy Priorities. November 2018.
15. Government Accountability Office. "Medicaid: State Perspectives on CMS's Enhanced Oversight of Work Requirements." GAO-20-149. December 2019.



Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*