NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Submitted electronically

RE: Iowa Health and Wellness Plan—Amendment Request Demonstration

The National Women's Law Center (NWLC) writes to comment on Iowa's § 1115 demonstration application. Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society. We have worked to advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and compounding forms of discrimination. Through our work to preserve and strengthen Medicaid programs, we have seen their impact on the health and wellbeing of women and LGBTQI+ people, and we firmly believe in the value of robust Medicaid enrollment and access to services.

We urge the Centers for Medicare and Medicaid Services (CMS) to reject the Iowa demonstration application as proposed. The proposed work requirements are contrary to the requirements of § 1115 of the Social Security Act. Further, they would reduce Medicaid access for eligible individuals and result in tens of thousands of fewer enrollees, with particular harms for women, women of color, and disabled women.

I. Medicaid coverage is critical for enrollees' health and wellbeing.

For millions of people, Medicaid is a lifeline, offering access to coverage that they otherwise may not be able to afford. As of January 2025, 588,601 people living in Iowa relied on Medicaid coverage for their health care.[1] Women, people of color, and disabled people in Iowa are all disproportionately likely to participate in Medicaid, making the program especially crucial for ensuring that these communities can access care and reducing the health disparities they face. For example, women make up the majority of Medicaid enrollees in Iowa,[2] with approximately one in five, or nearly 170,000, nonelderly women enrolled in 2023.[3] Among Iowan women with

[1] Medicaid.gov, *January 2025 Medicaid & CHIP Enrollment Data Highlights* (accessed Jun. 25, 2025), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights.
[2] Kaiser Family Foundation, *Distribution of Adults Ages 19-64 with Medicaid by Sex* (accessed Jun. 26, 2025), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-adults-19-64-by-sex.
[3] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 12, 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage.

incomes below 200% of the federal poverty line, 40% were enrolled in Medicaid.[4] Women of color made up a quarter (25.1%) of women enrolled in Medicaid, despite making up only 17.4% of women in the general population.[5] Among nonelderly Medicaid enrollees of any gender, Black enrollees represented 9.5%, 2.5 times their share of the overall population in Iowa (3.8%), and Latine people made up 12.7% of enrollees, nearly double their share of the overall population (7.3%).[6]

Medicaid coverage is vital for improving access to care, health outcomes, and economic stability.[7] Without Medicaid coverage, individuals would have to either incur medical expenses beyond their means or forgo critical care. Medicaid expansion in particular—which Iowa's application seeks to undermine—has undisputedly benefited those who qualify through this pathway. The overwhelming weight of research shows that the expansion program has increased access to and utilization of preventive and primary care; decreased reliance on emergency rooms as a source of low-acuity care; and reduced cases of catastrophic out-of-pocket medical costs.[8] This in turn has improved health outcomes across the spectrum.[9] For example, Medicaid expansion is associated with earlier detection, diagnosis, and treatment of conditions such as breast cancer.[10] And by improving coverage before and after pregnancy, Medicaid expansion has helped combat the maternal mortality crisis that disproportionately impacts Black and Indigenous women[11]: Medicaid expansion is associated with lower mortality rates for pregnant women, particularly among Black women.[12]

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[4] *Id*.

[5] NWLC calculations based on U.S. Census Bureau, 2023 American Community Survey (ACS), 1-year estimate, using *IPUMS USA, University of Minnesota, www.ipums.org*. ACS survey respondents self-identify their sex, race, and whether they are of Hispanic, Latino, or Spanish origin. Women of color are all those who did not self-identify as white, non-Hispanic.

[6] Kaiser Family Foundation, *Distribution of People Ages 0-64 with Medicaid by Race/Ethnicity* (Jun. 25, 2025), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-people-0-64-by-raceethnicity. Data for overall population is from NWLC calculations based on 2023 American Community Survey (ACS) via *IPUMS USA, University of Minnesota, www.ipums.org*.

[7] Gideon Lukens & Elizabeth Zhang, *Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage* (Feb. 5, 2025), https://www.cbpp.org/sites/default/files/1-16-25health.pdf.

[8] Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021* (May 6, 2021), https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021; Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020* (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review.

[9] *Id.*; Kevin N. Griffith & Jacob H. Bor, *Changes in Health Care Access, Behaviors, and Self-Reported Health Among Low-income US Adults Through the Fourth Year of the Affordable Care Act*, 38 MEDICAL CARE 574 (Jun. 2020), https://doi.org/10.1097/MLR.0000000000001321.

[10] Justin M. Le Blanc et al., *Association of Medicaid Expansion Under the Affordable Care Act with Breast Cancer Stage at Diagnosis*, 155 JAMA SURGERY 752 (Jul. 1, 2020), http://doi.org/10.1001/jamasurg.2020.1495.

[11] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them* (Oct. 25, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them.

[12] Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, 20 WOMEN'S HEALTH ISSUES 1049 (Feb. 25, 2020), https://doi.org/10.1016/j.whi.2020.01.005; Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* 7 May 2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf.

In Iowa, high rates of maternal morbidity and avoidable pregnancy-related deaths underscore the need to improve access to care rather than impose more barriers to coverage. For example, severe maternal morbidity (SMM) is higher in Iowa than in the rest of the country and in fact increased in 2020-2022 compared to 2017-2019—with Black, Indigenous, Latina, and Asian and Pacific Islander Iowans significantly more likely to experience SMM than white Iowans.[13] Similarly, a review of maternal mortality in Iowa revealed substantial rates of avoidable pregnancy-related deaths: Out of all pregnancy-related deaths in the state between 2019 and 2021, 95% were determined to have been preventable.[14] The review also found stark racial and ethnic disparities in mortality. Women of color made up 21% of pregnant individuals but represented 35% of all pregnancy-related deaths.[15] While the pregnancy-related mortality ratio for non-Hispanic white women was 15.4 deaths per 100,000 live births, among Latinas this ratio was 26.5 deaths and among Black women it was 39.7 deaths per 100,000 live births.[16] Medicaid enrollees made up the majority of pregnancy-related deaths,[17] further demonstrating the need for improved access to care in the Medicaid program. Indeed, Medicaid coverage has proven critical for reducing maternal mortality and morbidity, not only during and immediately after pregnancy, but before an individual becomes pregnant; the latter improves management of underlying conditions before pregnancy, resulting in better outcomes for pregnant individuals.

Stripping enrollees of their access to Medicaid by imposing work requirements, like those that Iowa proposes, will deny them these lifesaving benefits, threatening their health and financial security. Most people who lose Medicaid coverage do not transition to private insurance: Rather, many will end up uninsured or experience gaps in coverage.[18] The consequences of losing insurance are multifold. Numerous studies have demonstrated that uninsured individuals are less likely to receive preventive care or access services for major health conditions and chronic diseases.[19] Uninsured women—disproportionately Black, Latina, and Indigenous women—are less likely to have a regular doctor and to receive services like mammograms, Pap tests, and blood pressure checks.[20] They also get less adequate and lower quality care.[21] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[22] to later-stage cancer diagnoses.[23]

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[13] Iowa Maternal Mortality Review Committee, *Iowa 2024 Maternal Mortality Report, 2019-2021 Deaths, Abridged Version* 2 (2024), https://publications.iowa.gov/52471/1/MMRC%20Report%202025%20-%20Abridged%20FINAL.pdf.
[14] *Id*.
[15] *Id*. at 8.
[16] *Id*. at 5.
[17] *Id*. at 7.
[18] Bradley Corallo et al., *What Happens After People Lose Medicaid Coverage?* (Jan. 25, 2023), https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage.
[19] Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Dec. 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.
[20] Kaiser Family Foundation, *supra* note 3.
[21] *Id*.
[22] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.
[23] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, 40 HEALTH AFFAIRS 754 (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.

Uninsured adults broadly are more likely to forgo needed care than those who are insured: In 2023, nearly half (47%) of uninsured people aged 18 to 64 reported that they had not seen a health care professional in the previous year, approximately three times the rate among insured people.[24] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[25] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[26] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[27] which itself leads to wide-ranging impacts on health and wellbeing.[28]

II. Iowa's application contravenes the Medicaid statute.

Iowa's application must be rejected as contrary to the requirements of § 1115. Although § 1115 allows states to apply for waivers of Medicaid's statutory requirements, such waivers must:

- propose an "experiment[], pilot or demonstration";
- waive compliance only with requirements in 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[29]

Iowa's application is inconsistent with the central objective of the Medicaid statute: namely, to enable states to furnish medical assistance to individuals who are unable to meet the costs of care.[30] Even with the 119th Congress' recent addition of Medicaid work requirements through H.R. 1,[31] it remains true that "[t]he statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care,"[32] a fact that courts have repeatedly emphasized.[33] While Congress may wish to incentivize "secondary benefits" through the Medicaid program, the fundamental objective of providing health care coverage is still the same.[34] And while the statute also refers the goal of providing "rehabilitative and other services to help…families and individuals attain or retain capability for independence or self-care,"[35] this reference to "independence" clearly appears "in the context of assisting beneficiaries in achieving functional independence through rehabilitative and other services, not financial independence from government welfare programs."[36]

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[24] Tolbert et al., *supra* note 19.
[25] *Id*.
[26] *Id*.
[27] *Id*.
[28] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[29] 42 U.S.C. § 1315(a).
[30] 42 U.S.C. § 1396a-1.
[31] *See* One Big Beautiful Bill Act, Pub. L. No. 119-21 (2025).
[32] *Gresham v. Azar*, 950 F.3d 93, 100 (D.C. Cir. 2020), vacated and remanded on unrelated grounds sub nom. *Becerra v. Gresham*, 142 S. Ct. 1665, 212 L. Ed. 2d 576 (2022), and vacated and remanded sub nom. *Arkansas v. Gresham*, 142 S. Ct. 1665, 212 L. Ed. 2d 576 (2022).
[33] *See id.* (summarizing prior Supreme Court and circuit court decisions regarding the primary purpose of Medicaid).
[34] *Id*.
[35] 42 U.S.C. § 1396a-1.
[36] *Gresham*, 950 F.3d at 102.

As explained below, rather than providing medical assistance to those who need it, Iowa's application serves to undermine access to coverage by imposing work requirements, making it more difficult for individuals to achieve independence and self-care. And the application offers no legitimate experimental purpose: The outcomes in other states that have implemented work requirements have already demonstrated that it is a failed policy.

Additionally, Iowa failed to meaningfully engage in the required public comment period. The Iowa Department of Health and Human Services received numerous comments laying out core problems and unavoidable harms in its proposed project. But it did little to respond beyond acknowledging receipt of the comments and offering vague indications that it will consider the issues raised in implementation[37]—even though many of those issues are fundamental to work requirements and cannot be cured by merely adjusting implementation. By treating the notice-and-comment process as a mere formality, the agency has raised serious concerns about whether it has adequately complied with the public comment requirements.

Because the application is contrary to the statute and does not further its objectives, CMS does not have the authority to approve it.

III. The proposed work requirements threaten access to Medicaid.

Iowa seeks to impose sweeping work requirements on Medicaid enrollees. Specifically, Iowa's application would require individuals enrolled through its Medicaid expansion program to work at least 100 hours per month or be enrolled in an educational or job skills program, unless they fall into certain exemptions. This policy would lead to widespread loss of coverage—including for those who are working or who fall under one of the exemptions—with particular harms for women of color, disabled women, and women overall.

Iowa's own projections indicate if its application is approved, between 30,000 and 60,000 fewer people would be enrolled in its Medicaid expansion program, depending on the demonstration year.[38] This loss represents between approximately one-fifth and one-third of the average baseline of those enrolled through the Medicaid expansion.[39] As described in this section, the barriers that otherwise eligible people would likely face to documenting employment or obtaining an exemption would likely result in even higher rates of disenrollment.

a. Evidence from other states demonstrates the high risk of disenrollment.

Work requirements like those proposed by Iowa lead to widespread termination of coverage for eligible individuals, a fact demonstrated by data from other states' attempts to implement similar requirements. For example, Arkansas imposed work requirements in 2018. In the seven months the work requirement was in operation before a federal court stopped the program,[40] over 18,000

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[37] *See* Iowa Health and Human Services*, Iowa Health and Wellness Plan Section 1115 Demonstration Amendment* 16-17 (Jun. 6, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ia-wellness-plan-pa-06062025.pdf (hereinafter Amendment Proposal).
[38] *Id*. at 14.
[39] *See id*.
[40] *See Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019).

people lost coverage—amounting to one in four of those subject to the work requirement.[41] This included many people who were working, qualified for an exemption, or were otherwise eligible.[42] Indeed, most people who lost coverage did not lose it because they failed to work or qualify for an exemption, but rather because of extensive administrative hurdles, red tape, and confusion.[43] The impacts on coverage were lasting. The vast majority—89%—of those who lost Medicaid coverage in 2018 did not regain it the following year, leaving many uninsured.[44] Arkansans who lost coverage in this time period faced significant repercussions: 50% reported serious problems paying off medical debt, 56% delayed care because of cost, and 64% delayed taking medication because of cost.[45]

A work requirement in Georgia has had similar impacts since it was launched in 2023. Although 240,000 uninsured people were estimated to be potentially eligible for Georgia's Pathways to Coverage program,[46] just over 7,000—less than 3%—have been enrolled as of April 30, 2025.[47] Georgians have been subject to burdensome reporting requirements, where many have struggled to navigate the technical and bureaucratic language and faced difficulties obtaining and uploading documents to verify their employment or education.[48]

Another case in point is New Hampshire. Despite promising more flexibility in reporting requirements and pursuing more robust outreach efforts than other states, New Hampshire's 2019 work requirements threatened to disenroll large numbers of beneficiaries. Amid widespread confusion about how to comply with the new policy, about two thirds of enrollees subject to the requirements were anticipated to lose coverage after just two months.[49] New Hampshire suspended the work requirement as a result, and a federal court ultimately halted the program.[50]

b. Work requirements will lead to loss of coverage for individuals regardless of their employment status.

Iowa's work requirements are unlikely to increase employment rates among Medicaid enrollees: Most enrollees who can work already do.[51] Rather the most probable result is the same

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[41] Laura Harker, *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model* (Aug. 8, 2023), https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.
[42] *Id*.
[43] Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements* (Nov. 18, 2020), https://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf.
[44] Harker, *supra* note 41.
[45] Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFAIRS 1522 (Sep. 2020), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.00538.
[46] Lukens & Zhang, *supra* note 7.
[47] Georgia Pathways, Current Enrollment (last accessed Jun. 26, 2025), https://www.georgiapathways.org/data-tracker.
[48] Laura Harker, *Georgia's Medicaid Experiment Is the Latest to Show Work Requirements Restrict Health Care Access* (Dec. 19, 2024), https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care.
[49] Lukens & Zhang, *supra* note 7.
[50] *Id*.
[51] *Id*.

widespread disenrollment that occurred in other states, including for individuals who are employed or otherwise engaged in qualifying activities.

Many enrollees, including those who are employed, may be unaware of the new requirements or unsure whether they are subject to them. In other states that have implemented work requirements, many people only learned of those requirements when they were seeking care and found out that they had already been disenrolled.[52] Inadequate outreach, barriers enrollees face to receiving notice of their reporting obligations, and the inherent complexity of these policies all contribute to widespread uncertainty. Iowa's application does not detail how it will overcome these barriers, but a clearer outreach plan would not prevent these problems: Confusion about meeting work requirements has persisted even in states that have prioritized robust outreach.[53]

Many enrollees who do become aware of these requirements would struggle to navigate the administrative burdens of the proposed policy or face barriers to obtaining and submitting the necessary documentation. These barriers may be especially pronounced for those who face language or literacy barriers, have limited internet access, or who have certain disabilities. Navigating the documentation requirement would likely be pose particular challenges for women, people of color, and people with low incomes—all of whom are more likely to work multiple jobs or have precarious employment[54] and thus have more complex documentation requirements and less predictable income.

c. The proposed exemptions will not prevent widespread disenrollment.

Iowa proposes a small number of exemptions from the work requirements.[55] These exemptions, however, do not cure the fundamental problems in its proposal. First, as demonstrated by the experience of other states that implemented work requirements, many individuals will be unaware of the exemptions or uncertain whether the exemptions apply to them; others may face barriers to applying for the exemptions or documenting their eligibility.[56] As a result, many of those who are purportedly exempt from the work requirements may face disenrollment.

Second, the proposed exemptions are overly narrow. For example, Iowa proposes to exempt individuals "determined disabled by the United States Social Security Administration." This limited exemption excludes people with a wide range of disabilities and health conditions that affect their access to employment but who may not fall within the SSA's restrictive criteria.[57] It also disregards the barriers that many people face to receiving disability benefits or an SSA

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[52] Harker, *supra* note 41.
[53] Lukens & Zhang, *supra* note 7.
[54] U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey: Multiple Jobholders by Selected Characteristics (Jan. 29, 2025), https://www.bls.gov/cps/cpsaat36.htm; Vanessa M. Oddo et al., *Changes in Precarious Employment in the United States: A Longitudinal Analysis*, 47 SCANDINAVIAN JOURNAL OF WORK, ENVIRONMENT & HEALTH 171 (Dec. 7, 2020), www.doi.org/10.5271/sjweh.3939; Urban Institute, *Unstable Work Is All Too Common, Especially for Black Women* (Sep. 12, 2024), https://www.urban.org/data-tools/black-women-precarious-gig-work.
[55] Amendment Proposal, *supra* note 37 at 8.
[56] *See, e.g.,* Harker, *supra* note 41.
[57] Justin Schweitzer et al., *How Dehumanizing Administrative Burdens Harm Disabled People* (Dec. 5, 2022), https://www.americanprogress.org/article/how-dehumanizing-administrative-burdens-harm-disabled-people.

disability determination. The process for receiving federal disability benefits is often so complex many are unable to complete it without professional legal assistance; it requires onerous paperwork often exceeding hundreds of pages; and a final determination can take months or even years.[58] It is thus unsurprising that many eligible individuals are unable to receive disability benefits or even complete the application process.[59] Iowa's proposed exemption based on SSA determinations is therefore grossly inadequate. Indeed, like other states that have tried and failed to apply carve-outs for disabled people, Iowa's work requirements would harm numerous disabled people in the expansion population.[60]

Iowa also proposes to exempt individuals who are pregnant, but only when the pregnancy is "high-risk"—a vague criteria that many pregnant people may struggle to document. The narrowness of this exception could lead many individuals enrolled in the Medicaid expansion program to be disenrolled during pregnancy. While some of these individuals may ultimately be eligible to reenroll in traditional Medicaid for the duration of their pregnancy, the potential delays to time-sensitive care can increase risks related to maternal mortality and morbidity.

Iowa further proposes to exempt only caretakers of children ages 5 or younger, an extreme limitation that would leave out many individuals with other unpaid caregiving responsibilities. These include parents of children ages 6 or older, as well as people who provide support to aging or disabled adults in their household. For many of these individuals, inadequate access to caregiving services represents a significant barrier to employment, and especially so for single parents who may have limited support when juggling caregiving and work responsibilities. Under this exemption, however, they would still be required to have a job or engage in other qualifying activities in order to maintain their Medicaid eligibility.

The inadequate exemption process will disproportionately impact women, who are more likely to require an exemption due to employment barriers. Women, in particular women of color and disabled women, face greater barriers to employment, such as high rates of discrimination, harassment, lack of accommodations for pregnancy or disability, and lack of caregiving support.[61] Inadequate access to childcare and other caregiving services represents a particularly significant barrier to employment for women in Medicaid programs. Among Medicaid enrollees, 19% of women did not work due to caregiving responsibilities, compared to 4% of men.[62] Nearly three in ten (28%) women enrollees with children under the age of 18 were not working due to caregiving responsibilities, seven times the rate among men with children under the age of 18

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[58] *Id*.
[59] *Id*.
[60] David Machledt, *How Medicaid Work Requirements Hurt People with Disabilities* (Dec. 16, 2024), https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2.
[61] *See, e.g.,* Isabela Salas-Betsch, *Ending Discrimination and Harassment at Work* (Mar. 14, 2024), https://www.americanprogress.org/article/playbook-for-the-advancement-of-women-in-the-economy/ending-discrimination-and-harassment-at-work.
[62] Ivette Gomez et al., *Medicaid Work Requirements: Implications for Low Income Women's Coverage* (Apr. 30, 2025), https://www.kff.org/womens-health-policy/issue-brief/medicaid-work-requirements-implications-for-low-income-womens-coverage.

(4%).[63] Given these barriers to employment, it therefore unsurprising that nationally women enrolled in Medicaid were less likely to be working than men.[64]

d. Work requirements do not increase employment.

While Iowa suggests that its work requirements will incentivize employment for Medicaid enrollees, the evidence demonstrates otherwise. Work requirements are based on the false premise that Medicaid enrollees choose not to work and are taking advantage of the program's benefits—a narrative that is driven by stereotypes based on race, gender, disability, and class. In fact, about two thirds of Medicaid enrollees ages 19-64 already work; the remaining do not work primarily due to caregiving responsibilities, illness or disability, or school attendance.[65] Threatening enrollees' Medicaid coverage actually makes it *more* difficult for them to sustain employment: Access to Medicaid makes it possible for enrollees to get the care and supports they need to be able to work, particularly for those with health conditions and disabilities.[66] Those who are insured are more likely to become and remain employed.[67]

Other states' experiences with Medicaid work requirements demonstrate the policy's failure to incentivize or increase employment. In Arkansas, for example, the work requirement did not result in significant changes to employment while it was in effect.[68] Similarly, work requirements in public benefit programs like Temporary Assistance for Needy Families (TANF)—often used as a model for such requirements in Medicaid—have failed to improve employment rates or move people out of poverty. Research has found that TANF work reporting requirements made little difference in long-term employment rates. Regardless of whether individuals were subject to the requirements, at least 75% of TANF recipients worked by the fifth year of leaving the program.[69] These ineffective requirements came at a cost: The share of families living in deep poverty increased in states with these requirements.[70] The large majority of individuals subject to work reporting requirements remained poor and worked in low-quality, low-wage jobs with high volatility.[71] Requirements in the Supplemental Nutrition Assistance Program (SNAP), which impose time limits on program eligibility conditioned on documentation of work or training, similarly failed to increase employment, while significantly decreasing participation in SNAP.[72] This evidence clearly indicates that work requirements are not only harmful, but also wholly unjustified.

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[63] *Id*.
[64] *Id*.
[65] Lukens & Zhang, *supra* note 7.
[66] Machledt, *supra* note 60.
[67] Larisa Antonisse & Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review* (Aug. 7, 2018), https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review.
[68] Harker, *supra* note 41.
[69] LaDonna Pavetti & Ali Zane, *TANF Cash Assistance Helps Families, But Program Is Not the Success Some Claim* (Aug. 2, 2021), https://www.cbpp.org/research/income-security/tanf-cash-assistance-helps-families-but-program-is-not-the-success-some.
[70] *Id*.
[71] *Id*.
[72] Lauren Bauer & Chloe N. East, *A Primer on SNAP Work Requirements* (Oct. 2023), https://www.hamiltonproject.org/wp-content/uploads/2023/10/20231004_THP_SNAPWorkRequirements.pdf.

IV. Conclusion

Iowa's application fails to meet the statutory requirements for § 1115 waivers and would create unwarranted hardships for Medicaid enrollees, harming communities that already face disparities in access to care. We urge CMS to reject it.

We request that the supporting documentation we have made available through direct links in our citations be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS does not intend to consider these materials part of the record as requested, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

For further information, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice, at manafi@nwlc.org.