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

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August 14, 2025

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

RE: Utah's Medicaid Reform 1115 Demonstration: Amendment Request

The National Women's Law Center (NWLC) writes to comment on Utah'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 those 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 Utah's demonstration application. 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, 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 April 2025, 302,130 people living in Utah relied on Medicaid coverage for their health care.[1] Women, people of color, and disabled people in Utah 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 Utah,[2] with one in ten, or approximately 97,000, nonelderly women enrolled in 2023.[3] Among Utahn women with incomes

[1] Medicaid.gov, *April 2025 Medicaid & CHIP Enrollment Data Highlights* (accessed Jul. 29, 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.

below 200% of the federal poverty line, 28% were enrolled in Medicaid.[4] Women of color made up a third (33.5%) of women enrolled in Medicaid, despite making up only 25.3% of women in the general population.[5] Among nonelderly Medicaid enrollees of any gender, Latine people represented 26.0% while their share of the overall population in Utah was 20.9%, and Indigenous people made up 2.2%, nearly three times their share of the overall population (0.8%).[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 Utah'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 affects Black and Indigenous women[11]: Medicaid expansion is associated with lower mortality rates for pregnant women.[12] 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.

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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* (last accessed Jul. 29, 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.

Comprehensive care before pregnancy improves management of underlying conditions, resulting in better outcomes for pregnant individuals.

Robust Medicaid coverage is particularly critical in Utah, where women of color face stark health disparities. For example, a national study found that Indigenous women in Utah experience a higher rate of maternal mortality than any racial group in any state.[13] Data from the Utah Department of Health also documents racial disparities in maternal health. Severe maternal morbidity rate was elevated for all non-white racial and ethnic groups, with particularly high rates for Native Hawaiian/Pacific Islander and Black women.[14] Women of color were also more likely to experience postpartum depression. For example, more than a third (35.5%) of Native Hawaiian/Pacific Islander women had signs of postpartum depression, with rates also high among American Indian/Alaska Native women (27.9%) and Black women (21.9%), compared with 14.8% among Utahns overall.[15] Racial disparities also persisted in access to prenatal care. While 75.9% of pregnant people overall received first-trimester prenatal care, the rate was only 58.4% for Black women and 44.8% for Native Hawaiian/Pacific Islander women.[16] The study also indicated significant racial and ethnic disparities in health coverage rates[17] and cost-related barriers to care[18]—underscoring the role that uninsurance has in driving negative health disparities among women of color in Utah and the dangers of a policy that would further weaken Medicaid access.

Stripping enrollees of their access to Medicaid by imposing work requirements, like those that Utah proposes, will deny them 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.[19] 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.[20] 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.[21] They also get less adequate and lower quality care.[22] As a result, uninsured women are

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[13] Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JAMA 52 (June 3, 2023), http://doi.org/10.1001/jama.2023.9043. *See also* Erin Alberty, *Utah's Explosive Rise in Indigenous Maternal Deaths*, AXIOS SALT LAKE CITY (Jul. 12, 2023), https://www.axios.com/local/salt-lake-city/2023/07/12/utah-indigenous-maternal-death-rate.

[14] Utah Department of Health Office of Health Disparities, *A Utah Health Disparities Profile: Maternal Mortality and Morbidity Among Utah Minority Women* 12 (Jan. 2021), https://healthequity.utah.gov/wp-content/uploads/2022/02/UtahHealthDisparitiesProfileMaternalMortalityMorbidity2021.pdf.

[15] *Id*. at 21.

[16] *Id*. at 14.

[17] *Id*. at 9.

[18] *Id*. at 2.

[19] 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.

[20] 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.

[21] Kaiser Family Foundation, *supra* note 3.

[22] *Id*.

more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[23] to later-stage cancer diagnoses.[24]

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.[25] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[26] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[27] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[28] which itself leads to wide-ranging impacts on health and wellbeing.[29]

II. Utah's application contravenes the Medicaid statute.

Utah'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.[30]

Utah's application is inconsistent with the central objective of the Medicaid statute: to enable states to furnish medical assistance to individuals who are unable to meet the costs of care.[31] Even with the 119th Congress' recent addition of Medicaid work requirements through H.R. 1,[32] 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,"[33] a fact that courts have repeatedly emphasized.[34] While Congress may wish to incentivize "secondary benefits" through the Medicaid program, such as those that work requirements purportedly promote, the fundamental objective of providing health care coverage is still the same.[35] And while the statute also refers to the goal of

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[23] 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.
[24] 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.
[25] Tolbert et al., *supra* note 20.
[26] *Id*.
[27] *Id*.
[28] *Id*.
[29] 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.
[30] 42 U.S.C. § 1315(a).
[31] 42 U.S.C. § 1396a-1.
[32] *See* One Big Beautiful Bill Act, Pub. L. No. 119-21 (2025).
[33] *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).
[34] *See id.* (summarizing prior Supreme Court and circuit court decisions regarding the primary purpose of Medicaid).
[35] *Id*.

providing "rehabilitative and other services to help…families and individuals attain or retain capability for independence or self-care,"[36] 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 public assistance programs."[37]

As explained below, rather than providing medical assistance to those who need it, Utah'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.

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.

Utah seeks to impose sweeping work requirements on Medicaid enrollees. This policy would lead to widespread loss of coverage, including for those who are working or would otherwise qualify for an exemption, with particular harms for women of color, disabled women, and women overall.

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

Work requirements like those proposed by Utah 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,[38] over 18,000 people lost coverage—amounting to one in four of those subject to the work requirement.[39] This included many people who were working, qualified for an exemption, or were otherwise eligible.[40] 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.[41] 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.[42] Arkansans who lost coverage in this time period faced significant repercussions: 50% reported

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[36] 42 U.S.C. § 1396a-1.
[37] *Gresham*, 950 F.3d at 102.
[38] *See id*.
[39] 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.
[40] *Id*.
[41] 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.
[42] Harker, *supra* note 39.

serious problems paying off medical debt, 56% delayed care because of cost, and 64% delayed taking medication because of cost.[43]

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,[44] a mere 8,078 were enrolled as of June 30, 2025.[45] 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.[46]

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.[47] New Hampshire suspended the work requirement as a result, and a federal court ultimately halted the program.[48]

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

Utah's work requirements are unlikely to increase employment rates among Medicaid enrollees: Most enrollees who can work already do.[49] Rather the most probable result is the same 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 health care and found out that they had already been disenrolled.[50] Inadequate outreach, barriers enrollees face to receiving notice of their reporting obligations, and the inherent complexity of these policies all contribute to widespread uncertainty. Confusion about meeting work requirements has persisted even in states that have prioritized robust outreach.[51]

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[43] 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.
[44] Lukens & Zhang, *supra* note 7.
[45] Georgia Pathways, Current Enrollment (last accessed Jul. 24, 2025), https://www.georgiapathways.org/data-tracker.
[46] 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.
[47] Lukens & Zhang, *supra* note 7.
[48] *Id*.
[49] *Id*.
[50] Harker, *supra* note 39.
[51] Lukens & Zhang, *supra* note 7.

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[52] and thus have more complex documentation requirements and less predictable income.

c. The proposed exemptions will not prevent widespread disenrollment.

The exemptions listed in Utah's application do not cure the fundamental problems in its proposal. As demonstrated by the experience of other states that have implemented work requirements, many individuals will be unaware of the exemptions or uncertain whether the exemptions will apply to them; others may face barriers to applying for the exemptions or documenting their eligibility.[53] Utah notes that its exemptions are generally modeled after federal exemptions for the Supplemental Nutrition Assistance Program (SNAP), but the results of the SNAP exemptions in fact demonstrate how administrative burdens prevent eligible individuals from receiving exemptions.[54] For example, one study found that people who reported a disability (and thus likely should have been exempted from the SNAP work requirements) lost SNAP at the same rate as people without a disability.[55] Like Medicaid work requirements in other states, SNAP represents a cautionary tale rather than a model to emulate.

Many of Utah's proposed exemptions are also vague or unclear, adding to the difficulties Medicaid enrollees would face in navigating them. For example, Utah seeks to exempt those who are "physically or mentally unable to meet the requirements" with no explanation of how this standard will be assessed. Medicaid enrollees are therefore left with little guidance on demonstrating eligibility for this exemption. Meanwhile, its application would be left up to the discretion of agency officials, who may interpret it in inconsistent or overly restrictive ways. Utah also proposes to exempt caregivers for people with a disability "as defined the [Americans with Disabilities Act], section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act." Enrollees who seek this exemption would not only need to document their caregiving activities, but would also bear the onus of demonstrating that a particular condition would qualify as a disability under these statutes—requiring expertise of a fluctuating and frequently inaccessible area of law.

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[52] 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.

[53] *See, e.g.,* Harker, *supra* note 39.

[54] Katie Bergh et al., *Worsening SNAP's Harsh Work Requirements Would Take Food Assistance Away from Millions of Low-Income People* (Apr. 30, 2025), https://www.cbpp.org/research/food-assistance/worsening-snaps-harsh-work-requirement-would-take-food-assistance-away.

[55] Erin Brantley et al., *Association of Work Requirements with Supplemental Nutrition Assistance Program Participation by Race/Ethnicity and Disability Status, 2013-2017*, 3 JAMA NETWORK OPEN e205824 (Jun. 26, 2020), http://dx.doi.org/10.1001/jamanetworkopen.2020.5824.

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.[56] Inadequate access to 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.[57] 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 (4%).[58] Given these barriers to employment, it therefore unsurprising that women enrolled in Medicaid were less likely to be working than men.[59] In Utah, where the gender gap in employment among enrollees is even more pronounced than it is nationally, 59% of women enrolled in Medicaid were working, compared to 82% of men.[60]

d. Work requirements do not increase employment.

While Utah 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.[61] 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.[62] Simply put, those who are insured are more likely to become and remain employed.[63]

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.[64] Similarly, work requirements in public benefit programs like Temporary Assistance for Needy Families (TANF) have failed to improve employment rates or move people out of poverty. Research has found that TANF work

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[56] *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.
[57] 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.
[58] *Id*.
[59] *Id*.
[60] *Id*. Data is among nonelderly Medicaid enrollees who do not receive benefits from Supplemental Security Income or Social Security Disability Insurance programs and are not also covered by Medicare.
[61] Lukens & Zhang, *supra* note 7.
[62] 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.
[63] 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.
[64] Harker, *supra* note 39.

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.[65] This ineffective policy came at a cost: The share of families living in deep poverty increased in states with these requirements.[66] The large majority of individuals subject to work requirements remained poor and worked in low-quality, low-wage jobs with high volatility.[67] Requirements in 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.[68] This evidence clearly indicates that work requirements are not only harmful, but also wholly unjustified.

IV. Conclusion

Utah'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. It is therefore not approvable and CMS must 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.

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[65] 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.
[66] *Id*.
[67] *Id*.
[68] 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.