Who stands to lose: Future faces of the Medicaid work requirement cuts

Kate Randall
7 June 2026

The Trump administration and its ideological allies have constructed an elaborate fiction around the Medicaid work requirements embedded in the "One Big Beautiful Bill" signed into law July 4, 2025—that the policy targets lazy, able-bodied adults who prefer leisure to labor, and that only those who fail to "prove that they matter"—in the words of Centers for Medicare & Medicaid Services (CMS) administrator Dr. Mehmet Oz—will lose their coverage.

The reality documented by researchers, advocates and the experience of earlier state-level implementations is categorically different. The Congressional Budget Office (CBO) projects that work requirements will strip coverage from 5.2 million adults by 2034. More expansive analyses from the Center on Budget and Policy Priorities warn the number at risk could reach nearly 15 million. In every prior implementation—most comprehensively in Arkansas in 2018 and 2019—the majority of those who lost coverage were already working, were legally exempt, or were victims of administrative failure rather than genuine noncompliance.

The following profiles are hypothetical composites drawn from the documented demographic patterns of the Medicaid expansion population and the known mechanisms by which work requirements produce coverage loss. While they represent no single individual, they exemplify the situation facing millions.

Maria works 32 hours a week for a private home care agency, bathing and feeding elderly clients in a county where the nearest hospital is 45 minutes away and the broadband connection at her apartment drops out several times a week. She has earned slightly above the poverty line for three years, too much to qualify for other assistance, not enough to afford the private insurance her employer does not offer.

Under the new law, Maria must document her 80 monthly hours of qualifying work through an online portal. Her employer—a small agency with four employees—does not use a payroll software system that integrates with the CMS verification database. She must submit pay stubs manually. In February, during a week of ice storms that knocked out power to her building for five days, her upload did not go through. She received a termination notice six weeks later.

Maria has Type 2 diabetes and takes metformin daily. Without Medicaid, she cannot afford the quarterly blood tests that monitor her condition. She is not lazy; she is ensnared by a ruthless state.

DeShawn drives for two platforms simultaneously, typically working between 60 and 90 hours a month depending on demand, surge pricing patterns, and whether his 2017 Honda Civic—purchased with a personal loan—is operational. His income fluctuates from $900 to $1,600 a month. He has no employer, no pay stubs, and no single entity responsible for documenting his work hours.

Gig workers occupy a treacherous position under the new requirements. The law requires documentation of qualifying work activities, but platform-based work is notoriously difficult to verify through official channels. DeShawn must compile earnings summaries from multiple apps, translate them into hour equivalents, and submit them every six months—or more frequently if his state opts for monthly verification.

In the month his transmission failed and he worked only 22 hours while scrambling to get the car repaired and find substitute income, he fell below the 80-hour threshold. His exemption application for a short-term hardship was denied because he could not produce a letter from an employer—he has no employer. He lost coverage for three months, during which an untreated ear infection spread to require emergency care he is now repaying at $40 a month.

Ruth worked for the Sunflower County school district for 24 years before a cost-cutting consolidation eliminated her position. She has applied for nine jobs in the two years since. Her county's unemployment rate has remained above 9 percent for most of that period, which should trigger an exemption under the law—but only if the state correctly identifies and applies the county-level data, and only if Ruth successfully navigates the process to claim it.

Ruth was diagnosed with Stage II breast cancer eight months ago. Her oncologist submitted paperwork documenting her treatment status, which should qualify her for a medical exemption. The paperwork arrived at the state Medicaid office seven days after the quarterly deadline. Her coverage was terminated. The appeal process requires three separate forms, a physician's letter, and documentation of the original submission—materials Ruth is gathering with the help of a volunteer legal aid organization whose next available appointment is three weeks away.

Without Medicaid, Ruth cannot continue the hormone therapy that is central to her treatment protocol.

Kevin Kowalski, 51, worked on the line at a Flint assembly plant for 19 years before it was idled indefinitely during a wave of layoffs. His wife, Sandra, 48, works part-time at a pharmacy earning $14 an hour, 25 hours a week—income that keeps the family above the Medicaid expansion threshold most months but not all.

Kevin has been enrolled in Medicaid since the plant closure. He has applied for 14 positions. He attends retraining sessions at the local community college twice a week, which qualifies as an educational activity under the work requirements. But the documentation process requires him to obtain signed certification from the college's administrative office each reporting period—a process that took three months to set up because the college had never interfaced with the state's Medicaid verification system before.

Kevin has hypertension and early-stage coronary artery disease. He takes two medications daily. A gap in coverage of even three months, his cardiologist has warned, meaningfully increases his risk of a cardiac event.

Amara emigrated from Somalia 11 years ago and became a citizen in 2019. She works 20 hours a week at a hospital cafeteria and spends the remaining weekday hours caring for her mother, who has advanced Parkinson's disease and lives in the same apartment. Her mother requires assistance with bathing, meals and medication management.

The law includes an exemption for caregivers of dependent adults—but

© World Socialist Web Site

the exemption requires documentation from a physician certifying that the person being cared for requires the level of care Amara provides. Her mother's neurologist is part of a large health system that is processing a backlog of such certifications. The letter took four months to arrive. During that interval, Amara's eligibility was flagged for noncompliance.

Tyler graduated from a Fresno high school last June and has spent the year working on the harvest circuit—lettuce in the Imperial Valley through the winter, stone fruit in the San Joaquin Valley through spring and early summer. During peak season he works 60-hour weeks. Between harvests, he works zero hours.

The law includes a seasonal worker exemption, but its definition is narrow and its application uncertain. Tyler must meet a specific occupational definition and demonstrate average monthly income equivalent to 80 hours of work over the preceding six months. In the shoulder months—April and October—when he is between harvests and earning nothing, his hours fall to zero. Whether those months will trigger termination or whether his average income over six months will satisfy the threshold depends on how his state implements the provision, which has not yet been definitively clarified by CMS guidance.

Tyler has no chronic conditions at present, but at 19 he has never had a regular doctor. Medicaid is his only point of access to preventive care. If he loses it during a gap period, he will join the roughly 30 million Americans with no health coverage at all.

Gloria works 22 hours a week at a big-box retail store and cares for her adult son Marcus, 29, who has an intellectual disability and lives at home. Marcus receives Medicaid through a disability pathway and is exempt from the work requirements. Gloria, who is not classified as his legal caregiver because Marcus's services are administered through a separate support coordinator, is not automatically exempt.

Her youngest child turned 14 last year. The work requirement's caregiver exemption covers only those caring for children under 14 or dependent adults who are officially classified as such through Medicaid's disability determination process. Marcus does not have a formal caregiver designation attached to Gloria's account. Establishing one requires paperwork that the county developmental disabilities office is taking six to eight months to process.

Gloria earns $18,200 a year. She has arthritis in both hands that has worsened over the past two years and will eventually require treatment she cannot afford out of pocket. She is already more or less at her 80-hour monthly threshold, if her retail hours are counted. But in any month that her store cuts her schedule—as it does routinely in the slow post-holiday weeks—she falls short.

James works for a small roofing contractor in Lawrence County, where unemployment has run chronically above the national average for a decade. His work is seasonal and weather dependent. From April through October, he typically logs 50 to 70 hours of work a month. From November through March, he may work 10 to 20 hours, or nothing at all.

Lawrence County's unemployment rate has hovered between 6 and 7.5 percent for the past year—below the 8 percent threshold that would trigger an automatic county-level exemption, but well above any reasonable description of a functioning labor market. James has a back injury from a fall two years ago that makes sustained physical labor increasingly difficult and for which he has received no surgical treatment because he cannot afford it.

When the months of low or zero work hours trigger a compliance failure, James will face a three-to-six-month coverage gap. During that gap, his back condition will go untreated.

Destiny is in her second year of a nursing assistant certification program at Baltimore City Community College. She works 20 hours a week at a grocery store and attends class 15 hours a week. Under the work requirements, her combined work and education hours should qualify her for compliance—but only if the state counts her educational enrollment correctly and only if the verification system can link her community college enrollment records to her Medicaid file in time for each reporting deadline.

In her first reporting period under the new rules, there was a data mismatch between the college's enrollment database and the state's Medicaid verification system. The discrepancy was resolved three weeks later, but by then her coverage had been suspended. She missed a required clinical rotation—a condition of her enrollment—because she could not afford the $200 in supplies it required without her Medicaid-covered income supplement.

Destiny is studying to become a healthcare worker who will care for Medicaid patients. The system that will benefit from her labor is, at this moment, actively working to deny her the coverage she needs to complete the training that will make that labor possible.

The policy, as designed

The profiles above share a common thread: the people who will lose Medicaid under the new work requirements are not people who refuse to work. They are people for whom the work requirement's documentation regime is incompatible with the actual conditions of their lives—the unpredictability of gig work, the seasonality of agricultural and construction labor, the invisibility of caregiving, the bureaucratic inaccessibility of rural and under-resourced communities, the complexity of exemption processes that assume a level of institutional support most low-income workers do not have.

This is not an accident. It is, as the experience of Arkansas and Georgia has already demonstrated, precisely how work requirements function. They do not encourage work; they terminate coverage. The administrative maze is not a bug in the design; it is the mechanism by which the savings are generated and the rolls are reduced.

The CBO projects that the work requirements will account for the largest share of the $793 billion in Medicaid cuts over the next decade. That money does not disappear. It flows upward—through the tax provisions of the same legislation, to corporations and the wealthy—while the people whose labor makes American society function are left to manage illness, disability and economic precarity without the most basic guarantee of medical care.

Their stories are not exceptional. Instead, they will become the reality in 21st century America.

To contact the WSWS and the Socialist Equality Party visit:

wsws.org/contact

© World Socialist Web Site