

26 States Sue to Block Medicaid Work Requirements, Citing Access Concerns

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Medicaid, the cornerstone of healthcare for millions of low-income Americans, faces a renewed challenge as 26 states initiated legal action to block the implementation of work requirements. This policy, championed by some federal and state administrations, mandates that certain beneficiaries engage in work or work-related activities to maintain coverage. Opponents contend these requirements erect unnecessary barriers to care, disproportionately affecting those already struggling with health issues, poverty, and disability.

KEY TAKEAWAYS

- **The Pivot:** A broad coalition of states is challenging Medicaid work requirements in court, arguing they violate federal law and undermine the program's intent.
- **The Data:** Previous attempts at work requirements in states like Arkansas led to tens of thousands of beneficiaries losing coverage.
- **The Action:** Clinicians should be aware of the ongoing legal battles and potential shifts in Medicaid eligibility, which may impact patient access to essential services.

Medicaid provides health coverage to over 80 million low-income adults, children, pregnant women, elderly adults, and people with disabilities across the United States. Its fundamental purpose is to ensure access to necessary medical care for those who cannot afford it. The introduction of work requirements, first gaining traction under the previous presidential administration, represents a significant departure from this core principle, shifting the program's focus from health access to employment incentives. This policy has consistently drawn criticism from medical professional organizations and patient advocacy groups, who argue it creates administrative hurdles that lead to coverage loss rather than increased employment.¹

The current legal challenge, spearheaded by states with Democratic attorneys general, targets the federal government's authority to approve these requirements. The lawsuit asserts that the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) overstepped their statutory authority by allowing states to implement these conditions. The plaintiffs contend that the Social Security Act, which established Medicaid, does not grant the federal government the power to approve waivers that impose work requirements, as such conditions do not promote the objectives of the Medicaid program: providing medical assistance.²

The Policy's Clinical Impact

The debate over Medicaid work requirements is not merely a legal or political one; it carries substantial clinical implications. Experience from states that previously implemented these policies offers a stark preview. In Arkansas,

for example, the state implemented work requirements in 2018. Within months, over 18,000 adults lost their Medicaid coverage, not primarily because they refused to work, but due to administrative complexities and a lack of awareness about the new rules.³ Many of these individuals were already working but failed to report their hours through the state's online portal, or they qualified for exemptions but did not navigate the bureaucratic process successfully. The loss of coverage led to documented delays in care, missed appointments, and a decline in overall health status for many affected beneficiaries.³

Patients with chronic conditions, mental health disorders, or disabilities are particularly vulnerable to these policies. Managing chronic diseases often requires frequent medical appointments, adherence to complex medication regimens, and sometimes, reduced work capacity. Imposing work requirements without robust support systems for these populations can disrupt continuity of care, leading to exacerbations of illness and increased emergency department visits. For individuals with mental health conditions, the stigma and challenges associated with employment can be significant, and the added stress of losing health coverage can worsen their symptoms.⁴ The policy also disproportionately affects rural populations, who often face limited employment opportunities and significant barriers to transportation, making compliance with reporting requirements even more difficult.⁵

The lawsuit specifically highlights the administrative burden placed on both beneficiaries and state agencies. States must develop complex systems to track work hours, verify exemptions, and process appeals, diverting resources that could otherwise be used to improve healthcare delivery. For beneficiaries, the process of documenting work activities, reporting changes in employment status, and navigating exemption criteria can be overwhelming, particularly for those with limited literacy, internet access, or English proficiency. The federal government's approval of these waivers, the states argue, fails to adequately consider these practical challenges and their direct impact on access to care.²

But the legal challenge also points to the broader economic and public health consequences. When individuals lose Medicaid coverage, they often defer necessary medical care, leading to more severe health crises down the line. This not only harms individual patients but also increases uncompensated care costs for hospitals and other providers, which can ultimately be passed on to other payers. Public health initiatives, such as vaccination campaigns and chronic disease management programs, also suffer when a significant portion of the population loses access to primary care. The plaintiffs argue that the federal government's actions are arbitrary and capricious, failing to consider these well-documented negative outcomes.¹

The legal precedent for challenging these requirements is strong. Federal courts have previously struck down similar work requirements in other states, including Arkansas, Kentucky, and New Hampshire. In those cases, judges ruled that the work requirements did not align with Medicaid's primary objective of providing medical assistance. The courts found that the waivers, by causing significant numbers of people to lose coverage, undermined the very purpose of the program. These prior rulings provide a substantial foundation for the current coalition of states, suggesting that the federal government's approvals may once again be found unlawful.⁶

The ongoing litigation creates uncertainty for millions of Medicaid beneficiaries and the clinicians who serve them. Should the states succeed, it would reinforce the program's original intent as a health coverage safety net, free from employment-based conditions. But if the federal government prevails, it could pave the way for widespread implementation of work requirements, potentially leading to a significant reduction in Medicaid enrollment and a corresponding increase in the uninsured population. The trial was not powered to detect differences in long-term health

outcomes, and that gap matters. The ultimate decision will have profound implications for healthcare access and public health across the nation.²

For an in-depth exploration of healthcare system management, policy, and public health implications, readers may consult The Oxford Handbook of Health Care Management.

CLINICAL IMPLICATIONS

The legal battle over Medicaid work requirements is more than a policy dispute; it is a direct challenge to the foundational principles of public health. Clinicians should anticipate potential disruptions in patient care, particularly for those with chronic conditions or mental health needs, if these requirements are allowed to proceed. The administrative burden alone has proven sufficient to disenroll thousands, regardless of their actual work status.

For primary care physicians and specialists, this means a likely increase in uninsured patients presenting with advanced disease, having deferred care due to lost coverage. This shift will strain emergency departments and safety-net clinics, further exacerbating existing access issues. The focus should remain on patient health outcomes, not on bureaucratic hurdles that demonstrably lead to coverage loss.

The pharmaceutical industry and medical device manufacturers should also take note. A significant reduction in Medicaid enrollment translates directly to a smaller insured patient population, impacting market access for essential medicines and devices. The financial implications for providers, who will face higher rates of uncompensated care, are also substantial and unsustainable.

Ultimately, the courts must weigh the stated goals of these policies against their documented impact on health access. Previous judicial decisions have consistently sided with the program's original intent. Any policy that demonstrably causes vulnerable populations to lose health coverage cannot reasonably be argued to promote the objectives of Medicaid.

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