

Medicaid Community Engagement Requirements and the Value of Work

The Council of Economic Advisers

June 2025





Key Takeaways

- Work is beneficial for adults and their children. It promotes well-being, mental health, physical health, and longevity.
- Past reforms that linked eligibility for social welfare programs to working have succeeded. They promoted working, private health insurance coverage, household income, financial stability, financial independence, and stronger families.
- Half of working-age adults (age 19-64) on Medicaid worked 20 hours or fewer per week in 2024. Even among able-bodied adults on Medicaid without children, 44 percent worked less than 20 hours per week in 2024, with 88 percent of this group not working at all.
- We estimate that federal taxpayers spent \$56.1 billion on Medicaid for childless, working-age, able-bodied adults working 20 hours a week or less in 2024 alone, amounting to 11 percent of total federal Medicaid spending.
- This spending was concentrated among a few states, with California and New York costing federal taxpayers \$13.5 billion and \$6.4 billion in 2024 alone, respectively, accounting for over one third of the total nationwide.



Summary

Medicaid community engagement requirements, which condition eligibility on work, training, or volunteering, are being discussed as a part of [broader efforts](#) to develop the American workforce and equip America's workers to meet the needs of our dynamic economy. In this report, we assess the evidence on the benefits of work to individuals and their children. We then evaluate social welfare programs' effects on labor market participation and private health insurance coverage. Finally, we estimate the extent to which able-bodied, working-age Americans are not participating in the labor force or serving as primary caregivers and are on Medicaid and their cost to federal taxpayers.

We find substantial evidence that work is beneficial and unemployment is harmful for individuals across a range of domains, including mental and physical health, drug dependency, and even mortality. The mechanisms include not only the value of earned income and employee benefits but also the social interaction, structure, and sense of purpose that come from working. Furthermore, research shows that parental employment is beneficial to children along multiple dimensions that persist into adulthood, including educational and employment outcomes.

With regard to social welfare programs' effects on working and private insurance coverage, research finds substantial evidence of "crowd out" in which social welfare programs, including Medicaid, replace labor force participation and private health insurance. Engagement requirements can help to mitigate crowd out by reducing disincentives to work, albeit to varying degrees depending on program design and implementation.

Finally, we document the long-term decline in labor force participation among working-age men, the more recent stagnation among women, and the extent to which those not in the labor force are currently covered by Medicaid. We use U.S. Census Bureau's Current Population Survey Annual Social and Economic Supplement (CPS ASEC) from 2024 and estimate that half of working-age adults (age 19-64) on Medicaid worked 20 hours or fewer per week in 2024. Overall, 27.2 million able-bodied, working-age adults (19-64) are enrolled in Medicaid. Most of them (16.8 million) have no children under age 19 at home. Of those 16.8 million, 7.4 million (44 percent) reported working less than 20 hours per week on average, with 6.5 million reporting no earned income at all. This means that 27 percent of working-age, able-bodied adults on Medicaid are childless and working less than 20 hours a week, and nearly 90 percent of those are not working at all. We estimate that federal taxpayers spent \$56.1 billion on Medicaid for childless, working-age, able-bodied adults working 20 hours a week or less in 2024 alone, amounting to 11.0 percent of total federal Medicaid spending. This spending was concentrated among a few states, with California and New York alone costing federal taxpayers \$13.5 billion and \$6.4 billion, respectively.



The Benefits of Work

"We do not get dignity from power or money or culture. We get dignity from work."

- Pope Francis

"It is the working man who is the happy man."

- Benjamin Franklin

"Without labor, nothing prospers."

- Sophocles

"No work is insignificant. All labor that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence."

- Martin Luther King Jr.

"The lessons of history, confirmed by the evidence immediately before me, show conclusively that continued dependence upon relief induces a spiritual and moral disintegration fundamentally destructive to the national fiber. To dole out relief in this way is to administer a narcotic, a subtle destroyer of the human spirit. It is inimical to the dictates of sound policy. It is in violation of the traditions of America. Work must be found for able-bodied but destitute workers."

- [Franklin D. Roosevelt](#)

*"I always believed that welfare had to be changed. I was much more concerned ten years ago when President Clinton initially signed the bill that this could have disastrous results...it worked better than, I think, a lot of people anticipated. And, you know, one of the things that I am absolutely convinced of is that **we have to work as a centerpiece of any social policy** (emphasis added). Not only because – not only because ultimately people who work are going to get more income, but the intrinsic dignity of work, the sense of purpose. We were made for work, and the sense that you are part of a community, because you're making a contribution, no matter how small to the well-being of the country as a whole."*

- [Barack Obama](#)

Community engagement requirements condition eligibility for social welfare programs on some combination of work, school and training programs, and volunteering. Of these three pathways to compliance with such requirements, most of the research has focused on the value of working specifically. In contrast, a [recent review](#) shows that relatively little high-quality [evidence](#) exists on the benefits of volunteering, while the benefits of education, including training programs,



primarily come through the human capital that [equips people](#) for subsequent work, i.e., labor markets mediate the link between education and income, health, and well-being.¹

In addition to the value to individuals from the income and employee benefits from work, employment can contribute positively to physical and mental health, social relationships, and overall well-being. In fact, economists have a widespread, longstanding approach of using labor force participation and other labor market outcomes as evidence of success of various intervention programs, indicating that working is viewed as a positive outcome.² Similarly, psychologists and their patients have viewed future employment as a primary goal of treatment and evidence of recovery from episodes of mental illness (e.g., [Secker et al. 2001](#)).

Existing economic research on the benefits of work has relied on a range of metrics for both work and its benefits. A set of papers have evaluated the negative consequences of unemployment, while others have focused on the positive benefits of employment. The scope of the outcomes includes survey-based, self-reported figures on mental and physical health and well-being; measures from administrative data on substance abuse, mental illness, and physical health; as well as statistics on life expectancy and mortality rates. This broad literature also varies in research design, with some being descriptive, documenting associations between employment and well-being or health and longevity, while others adopt causal designs to identify the benefits of working per se.

Employment and Health

We summarize research on the relationship between employment and well-being and health, including mortality, which may exist through several channels including income. [Case and Deaton](#) (2020) analyze how mortality across individuals in the United States differs by education and point to the role of labor markets in mediating this link. Analyzing U.S. mortality data up to the COVID-19 pandemic, they observe that “[annual] mortality has risen for those without a 4-year degree while continuing to fall for those who have one.” Mental health appears to be central in this relationship, as they find notable and increasing differences in suicide rates across the education gradient. Specifically, they conclude that, among white Americans age 25-74, the suicide rate almost doubled from 1992 to 2019, increasing from 17.6 to 31.1 per 100,000. Notably, very little change occurred among degree holders, meaning the rate of increase was even more drastic for the less educated. In their causal discussion, Case and Deaton attribute these trends to economic challenges for the less educated beginning around 1970, when real wages and job opportunities, particularly in manufacturing, began to decline for non-degree holders. Factors such as globalization, automation, and rising healthcare costs exacerbated this decline. Their [book](#) on the same topics links these economic shifts to domestic social dysfunction and, ultimately, to morbidity and mortality, suggesting that stable employment is a critical buffer against poor mental and physical health.

[Jin et al.](#) (1995) review the literature and similarly find that the unemployed (broadly defined) experience higher rates of overall mortality, particularly due to suicide and cardiovascular disease. The research points to a variety of potential causal

¹ The few exceptions provide evidence on a direct link between education and health. For example, [Goldman and Smith \(2002\)](#) find that more educated patients, conditional on other factors, are better at self-managing diabetes and HIV, and [Smith \(2007\)](#) finds [additional evidence](#) for diabetes. To the extent that engagement requirements promote education, this represents another avenue by which they may improve the health and well-being of affected individuals.

² For example, as a measure of good outcomes from the food stamps program, [Bailey et al. \(2020\)](#) develop a “Self-Sufficiency Index,” which they define as: “in labor force; worked last year; weeks worked last year; usual hours worked per week; labor income; other income not from public sources; income-to-poverty ratio; not in poverty; reverse coded income from welfare, supplemental security, and other government sources.”



mechanisms, including stress from job loss directly as well as indirect effects such as decreased social engagement and economic strain. For instance, they find that workers laid off because of factory closure have reported more symptoms and illnesses than employed people.

A large set of research focuses on the link between employment and health outcomes besides mortality rates and life expectancy. For example, [Nolte-Troha et al.](#) (2023) review research on the connection between unemployment and use of alcohol, tobacco, and illicit drugs. They find that unemployed individuals had significantly higher rates of smoking and vaping and alcohol and drug use problems. They conclude that individuals likely resort to substance use as a means of coping with the psychological strain of being unemployed.

[Rosenthal et al.](#) (2012) provides further insights about the link between employment and other health outcomes. Specifically, they find that full-time employment is “associated with lower levels of stress and depressive symptoms, more frequent healthy eating, less frequent unhealthy eating, more physical activity, less cigarette smoking, and less alcohol consumption, compared with being unemployed or working part-time.” Additional results showed that stress and depressive symptoms mediated these outcomes, suggesting that unemployment and underemployment trigger unhealthy coping mechanisms.

These generalized results apply to older working-age adults as well. For example, [Bonavitacola](#) (2020) examines self-perceived well-being among adults aged 50 and older who remain in the workforce. In this sample, 67 percent reported benefits to their physical health, 71 percent noted benefits to mental health, and 78 percent stated that work improved their overall well-being. These findings reinforce the view that work brings self-perceived benefits even beyond what might be measured in administrative data or income.

[Krueger and Mueller](#) (2012) use time-use survey data measures of self-reported well-being and find that the unemployed are significantly less happy than their employed counterparts, reporting worse emotional well-being despite spending much more time on leisure. Within-person estimates show that when individuals re-entered employment, they reported increases in sadness. While exploring a broader multi-decade trend in declining labor force participation, [Krueger](#) (2016) similarly finds that prime-age men out of the labor force are more likely to take pain medication and report significantly worse mental and emotional well-being due to lack of meaning in their day-to-day life. Even beyond self-reported well-being, long-term unemployment specifically (i.e., an episode of 12 weeks or more) has been documented to precede mental illness, particularly depression and anxiety ([Zhang and Bhavsar 2013](#)).

Children’s Benefits from Parental Employment

Research establishes that not having at least one working parent during childhood and adolescence is associated with worse health, well-being, educational attainment, and labor market outcomes that persist into adulthood. For example, [Mooi-Reci and Wooden](#) (2022) find a connection between parental joblessness and negative effects on children’s mental health and general health that last beyond childhood, with limited evidence of mediation by other factors. Some research points to fathers’ work as particularly impactful on children of any age. Joblessness among fathers is associated with childhood [well-being](#), [cognitive development](#), and long-term impacts on children’s [labor force participation](#) and attitudes towards work as adults. Maternal employment has also been shown to be beneficial for low-income children’s [long-term development](#) and for [daughters’ adult employment](#). Similarly, [Chase-Landsdale et al.](#) (2003) find no evidence of harms to preschoolers from having a mother transition from welfare to work and some mental health improvements among adolescents.



Evidence from Random and Quasi-Random Experiments

The research summarized above relies on a mix of descriptive and causal designs. Causal methods are important because it is widely understood that poor health can lead to poor labor market outcomes and lower income, i.e., the causality may run in the other direction. As a result, economists have often leveraged changes in eligibility for social welfare programs, including randomized experiments, to identify the causal effects of income and of working on various measures of well-being and health of individuals and their children.

In one randomized experiment known as [The New Hope Project](#), low-income working parents were randomly assigned to receive supplements to their earned wages that moved their families above the poverty threshold for benefits. This resulted in increased employment for the parents who were not previously working full-time (30+ hours per week) and increased health insurance coverage. While benefits to daughters were not observed, for school-age sons it led to improved academic achievement, classroom behavior, social skills, and future expectations for themselves in terms of education and jobs.

Much of the remaining causal research has evaluated the expansions of the earned income tax credit (EITC), which increases individuals' net income contingent on working. Using a quasi-experimental design based on federal EITC expansions, [Hoynes et al.](#) (2015) provide causal evidence that increasing low-income parents' earned income significantly improves infant health as observed in vital statistics birth records. They find that an additional \$1,000 in after-tax income for low-income working mothers leads to a roughly 2–3 percent reduction in the incidence of low birth weight and a corresponding increase in average birth weight. In a subsequent study, [Courtin et al.](#) (2020) analyze the effects in a randomized trial in New York City, finding that an increase in income was correlated with a moderate increase in employment and, in turn, improved self-reported health among women.

Finally, causal research has evaluated the effect of randomly assigned “windfall” income, i.e., that which is given without being earned from work. For example, [Raschke](#) (2018), studied lottery winners and found immediate, sustained declines in self-reported health, worse mental health, and less productivity among winners with low levels of education, and no improvements among high-educated winners. These results contrast with those from the benefits linked to increased earnings from work summarized above, highlighting the important differences in the effects of earned versus windfall income on mental health, particularly among lower socioeconomic status individuals.



Discussion

Research provides causal evidence of a positive influence that working has on individual well-being and health across multiple domains, including self-reported well-being, mental health, physical health, lower rates of chronic illness, and lower mortality. The documented mechanisms include not only the value of income and employee benefits, but also the social interactions, structure, and sense of purpose and value that come from working. The evidence from studying unemployment specifically underscores the protective role of work for individuals across many dimensions.

The evidence relating to the relationships between parental working, child well-being, and health are more nuanced, with differences in magnitude and direction across parental and child gender and child age. Overall, parental employment is associated with better outcomes for childhood development, educational attainment, and employment outcomes in adulthood. The reverse is also true: parental joblessness is associated with worse outcomes for childhood development, mental and physical health, educational attainment, and labor force participation in adulthood.

Effects of Social Welfare Programs on Labor Force Participation and Other Outcomes

In this section, we review the literature regarding social welfare programs' influence on labor supply, private health insurance coverage, and general health and well-being. Social welfare programs embed tradeoffs between risk protection and moral hazard. In addition to the benefits of transfers, whether in-kind or as cash, such programs benefit individuals by offering protection against poverty due to job loss or unforeseen medical expenses, for example. However, the benefits of risk protection come at the costs of moral hazard. For instance, social welfare programs collectively may create high implicit tax rates on earnings, undermining the incentives for individuals to work. These effects can occur at the extensive margin—whether to work at all or not—as well as the intensive margin, meaning how many hours to work. On the intensive margin, there are cases where the net lost value from losing eligibility for social welfare programs due to additional work offsets the income from that additional work. This phenomenon is known as a “benefits cliff” or, more generally for low-income people, “poverty trap,” as it represents a substantial disincentive for beneficiaries to increase how much they work.

The phenomenon by which publicly provided benefits, such as cash transfers or health insurance, lead to changes in behavior from moral hazard such that they replace private sources like income from work and employer-based health insurance, is known as “crowd out.” Crowd out is notable because it affects any given policy’s “target efficiency,” or the extent to which a public program reaches its full scope of intended recipients and only its intended recipients. When public insurance becomes available, individuals may opt for it over private coverage tied to employment, leading some to drop their employer-based health insurance, reduce their work hours or income from work in other ways, or exit the labor force altogether.

Conditional on being employed, two additional steps are required for individuals and their families to be covered by an employer-sponsored health plan. First, the employer must offer one or more plans to employees of their type (e.g., full time or part time). The extent to which employees are offered coverage by their employers is known as the “offer rate.” Next, employees must choose to enroll in a plan. Conditional on being offered employer-based health insurance, the degree to which employees choose to enroll in it is known as the “takeup rate.” Recent [BLS estimates](#) show that in the private sector, health insurance was offered to 87 percent of full-time workers, and taken up by 65 percent of those who were offered it. Among part time workers, the offer rate was 26 percent and the takeup rate was 45 percent. Labor force participation, the mix of part-time and full-time workers, the offer rate, and the takeup rate may all be influenced by the presence of social welfare programs.



Effects of Medicaid without Work Requirements

A set of studies have examined the effects of various changes in Medicaid eligibility on labor supply and crowd out of private health insurance. For example, [Dave et al.](#) (2020) investigate the labor market effects of Medicaid expansions for pregnant women during the late 1980s and early 1990s using data from the Current Population Survey (CPS). They find approximately 50 percent crowd out, meaning that one out of two individuals newly covered by Medicaid was previously covered by private insurance. Crowd out was particularly high among low-income and less-educated populations. The authors link this crowd out of insurance to a decline in employment, noting that the 20-percentage point increase in Medicaid eligibility during the sample period was associated with a 6 percent to 7 percent decrease in the probability that newly-eligible individuals were employed. Effects were even more substantial for less-educated individuals, for whom Medicaid eligibility may in many cases have been more attractive than available employment prospects. For instance, in unmarried women with less than a high school diploma, Medicaid expansion was correlated with a 13 percent to 16 percent decrease in employment.

Other research finds that the extent of Medicaid-induced crowd out varies by population and policy context. For instance, [Gruber and Simon](#) (2007) find that the rates of crowd out of private insurance from Medicaid (and the Children's Health Insurance Program) expansions between 1996-2002 tend to average around 60 percent, depending on income levels and eligibility criteria.

Further evidence of crowd out comes from [Garthwaite et al.](#)'s analysis of the 2005 Tennessee's Medicaid (TennCare) disenrollment. Eligibility for the TennCare expansion programs was independent of income until July of 2005, when the state policy changed, resulting in 170,000 working-age, able-bodied adults over the age of 19 and above the poverty line losing eligibility. The results show a 2.5 percentage point increase in employment rate following the TennCare disenrollment. The primary gains were concentrated in full-time employment, with those newly ineligible moving into positions that provided employer-sponsored health insurance. In total, 63 percent of individuals who lost eligibility for TennCare increased their labor supply along the extensive margin. These changes were notably observed within the first six months following the disenrollment, with job search behaviors surging immediately after the policy change and continuing to rise as individuals secured stable employment. [Dague et al.](#) (2017) also find crowd out of labor supply due to a previously more generous Medicaid eligibility in Wisconsin scheme, an effect which was smaller than that observed in Tennessee, but larger than that which was found in the [Oregon Health Insurance Experiment](#). Dague et al. point to differences in Medicaid program design and labor market conditions as being the most likely sources of this variation in the estimated magnitudes.

[Dave et al.'s](#) (2015) review of the literature synthesizes the available information, concluding that "almost all studies of crowd out [report] finding that Medicaid expansions are associated with a decline in employer-sponsored health insurance coverage" due to some combination of changes in labor supply, offer rates, and take-up rates of employer-sponsored insurance. The effects on labor supply indicate that the availability of Medicaid reduces labor force participation among able-bodied, working-age adults by decreasing the necessity of employment for accessing health insurance.

One notable study of a social welfare program without an engagement requirement besides Medicaid is [Robins'](#) (1985) analysis of the Negative Income Tax (NIT) experiments run across the U.S. from 1968-1982 which provided guaranteed minimum income to some individuals from 1968- 1972. He found "remarkably consistent" results: in response to NIT programs, "husbands reduced labor supply by about the equivalent of two weeks of full-time employment," wives and single female heads-of-households reduced their labor supply by about three weeks, and youth reduced their labor supply



by three-to-four weeks. Although NIT differs from Medicaid, the unconditional nature of the transfers parallels Medicaid's provision of benefits without work mandates. This provides additional evidence that social welfare programs without engagement requirements can disincentivize work.

Evidence from Adding Engagement Requirements to Social Welfare Programs

Whereas programs that have means-tested eligibility without engagement requirements inherently embed disincentives to work, programs with engagement requirements can enhance incentives for work. By combining exemptions and compliance requirements—e.g., for those who have disabilities or are primary caregivers for young children—to determine eligibility, well-designed programs can help limit moral hazard while preserving risk protection and improving the program's target efficiency. Importantly, this directs federal tax dollars toward the most deserving recipients under the program goals, as determined by statute and regulations.

Evidence from past additions of community engagement requirements to social welfare programs indicates that such requirements can benefit program participants along multiple dimensions, although the success depends on their design and implementation. Most of the research on engagement requirements for U.S. social welfare programs come from the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This Act replaced the New Deal-era Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program. Central to this reform was the introduction of community engagement requirements, albeit with substantial room for states to waive the requirement for certain geographic areas. The added requirement for [TANF](#) eligibility constituted an engagement of at least 20 hours weekly, which could include traditional employment, subsidized employment, on-site training, job search or job readiness programs, vocational education or training, community service, or work experience programs. [Han et al.](#) (2021) assess the effects of TANF on low-educated single mothers and their children, finding that as of 2017-2019, individuals in this group had higher consumption and higher rates of health insurance coverage than their pre-reform (1990-1992) counterparts, relative to contemporaneous gains among populations not affected by the reforms.

Research indicates that the design of TANF's work requirements generated other benefits as well. For example, [Schoeni and Blank](#) (2000) evaluate a variety of indicators of success using CPS data on adult women from 1977 through 1999 and conclude that, "the policy changes of the 1990s reduced caseloads, but also increased income, reduced poverty, and reduced female headship." Their analysis, which incorporates data from early 1990s welfare waivers, further reveals increases in work and marriage rates as well as total family income, fostering household economic stability. These outcomes indicate that work requirements spurred employment, increased financial independence, and strengthened family structures.

Other research has studied the effects of these reforms on family structure and children's educational outcomes specifically. [Vaughn's](#) (2022) longitudinal study finds that children who received coverage after to PRWORA welfare reform scored higher on a composite test performance index later in life, driven by improved reading achievement. As these children matured, Vaughn observes that they are more likely to complete college and be married, suggesting PRWORA's imposition of work requirements in TANF was successful in its goal of promoting two-parent families and improved child outcomes. These findings provide additional evidence on the benefits of social welfare programs with work requirements beyond any immediate financial gains.

The effects of other engagement requirements emphasize the importance of design and implementation in determining the program's success or failure. Arkansas implemented Medicaid engagement requirements from June 2018 until March 2019. [Sommers et al.](#) (2020) point to poor rollout, design, and limited awareness leading to a [disenrollment](#) of more than 18,000 individuals with no observed change in labor force participation during an 18 month window. Similarly, the



administrative burdens on individuals to apply for coverage and verify their eligibility in [Georgia's](#) Medicaid engagement requirement for new enrollees beginning in July 2023 led to enrollment being far [below projections](#), with attrition occurring at each step from interest to application to processing to eligibility and ultimately enrollment. Looking forward, [federal leadership and resources will be committed](#) to improve design, implementation, and awareness relative to these prior state-led experiences.

Discussion

Although it was not included in CBO's [discussion](#) of factors that affect labor force participation, substantial evidence demonstrates that social welfare programs influence people's decisions about whether and how much to work. By providing in-kind income and an alternative to employment-based insurance, Medicaid can reduce the incentive to maintain or seek jobs offering such benefits, particularly in low-wage sectors. Evidence from social welfare programs besides Medicaid, particularly the 1996 welfare reforms, makes clear that adding engagement requirements benefits the affected individuals and their children.

Labor Force Participation Rates Overall and Among Medicaid Enrollees

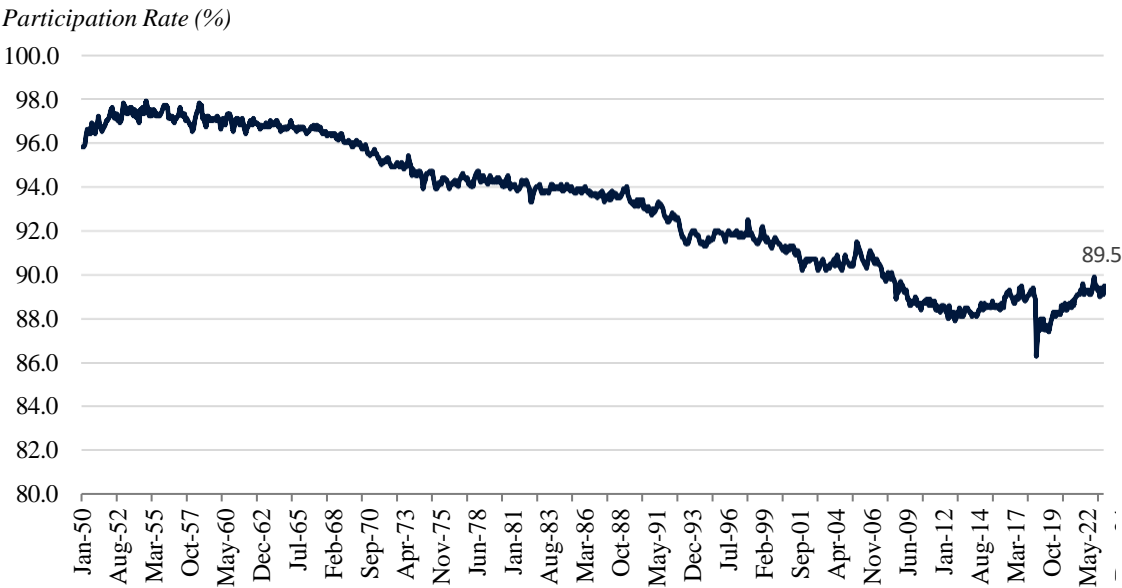
We first assess current labor force participation rates in the US overall and by demographic group and compare it against historical benchmarks. Second, we evaluate the extent to which Medicaid is covering able-bodied, working-age adults who are not working yet have no documented reason for being out of the workforce (a disability or being the primary caregiver for a young child).

As Figure 1 shows, between 1950-1970, less than 1 in 30 prime age men (25-54) were out of the labor force. Since then, however, participation declined steadily until around 2010, leveling off (apart from the shock from COVID-19 in 2020) and remains just above 1 in 10 today. This represents nearly 7 million prime-age men absent from the workforce (Figure 2). Using CPS data, described below, we estimate that 2.8 million (41 percent) of these men are on Medicaid. Furthermore, 3.5 million of these (51 percent) are able-bodied and not in school or training, of whom we estimate that approximately 1.2 million (33 percent) are on Medicaid.

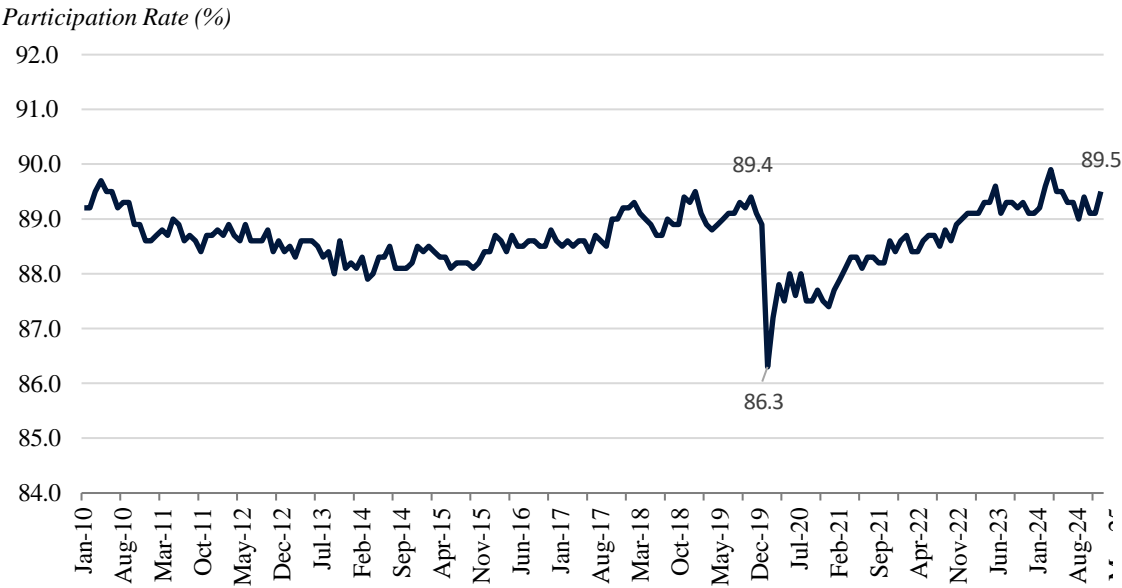


Figure 1. Labor Force Participation Rates among Prime Age Men, Seasonally Adjusted

Labor Force Participation Rate: Men 25-54 (1950-2025)



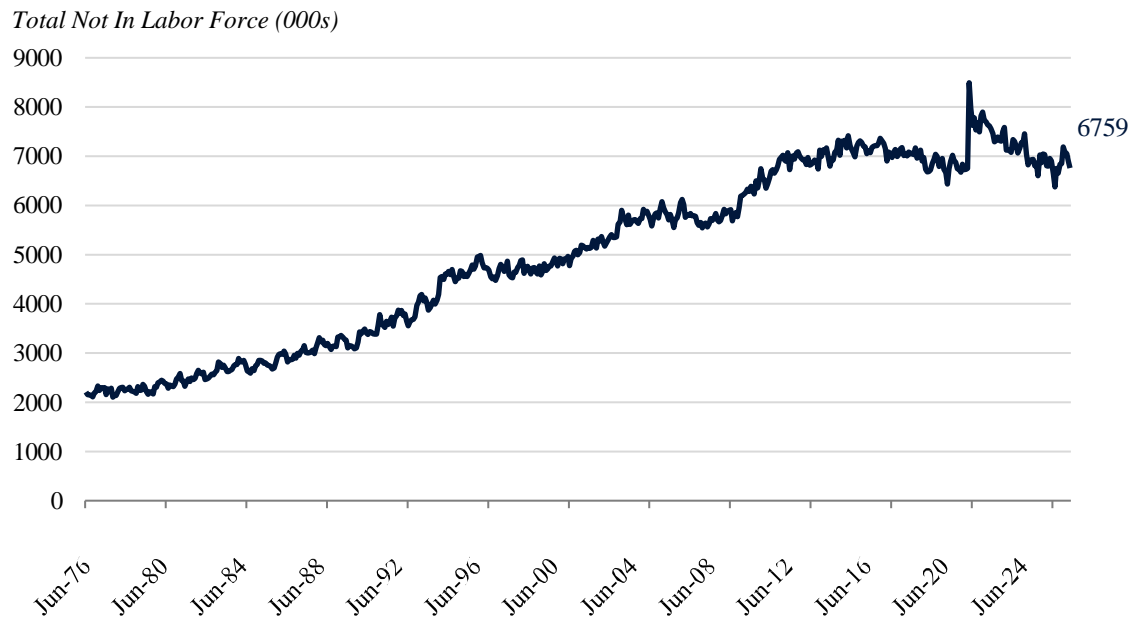
Labor Force Participation Rate: Men 25-54 (2010-2025)



Source(s): United States Bureau of Labor and Statistics



Figure 2. Number of Prime Age Men not in the Labor Force, Seasonally Adjusted
Not in Labor Force: Men: 25-54 Years (1976-2025)



Not in Labor Force: Men: 25-54 Years (2010-2025)



Source(s): United States Bureau of Labor and Statistics, Haver Analytics

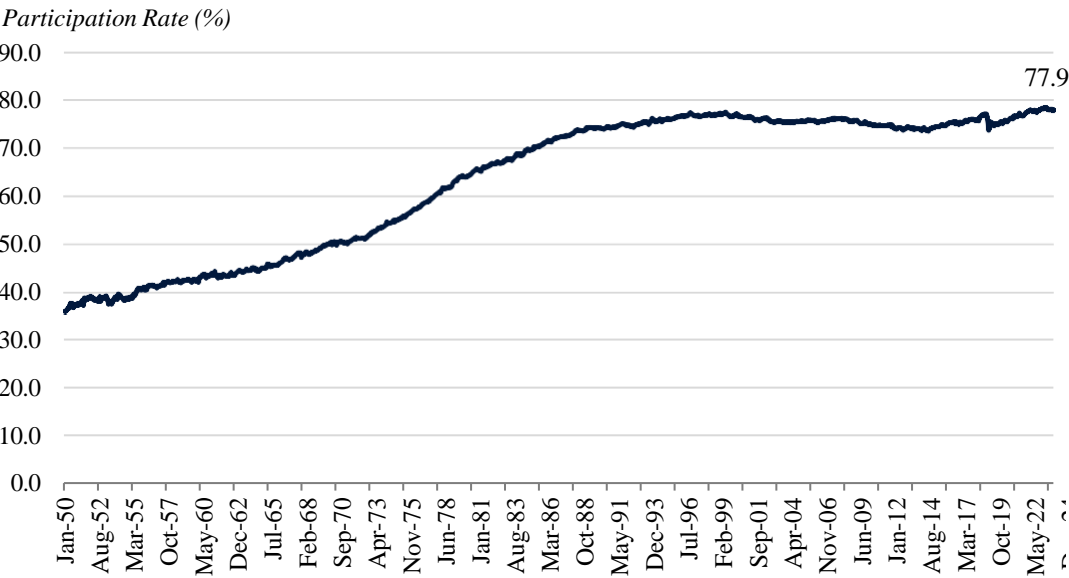
Female labor force participation followed a different long-run trend, increasing steadily until the 1990s (Figure 3). Their trend stabilized at that and remains near 78 percent today. This translates to approximately 14 million prime-age women



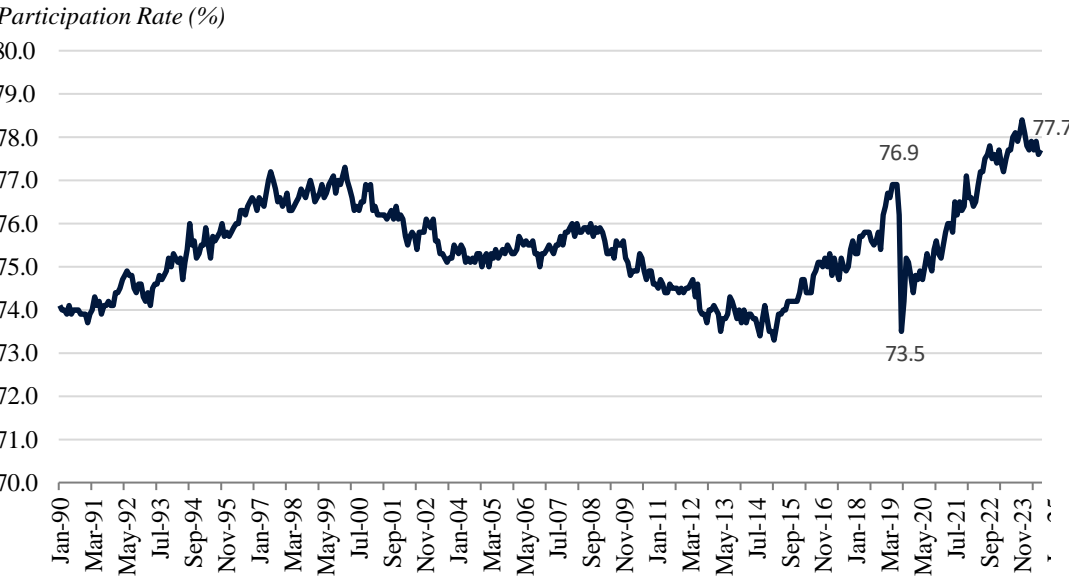
absent from the workforce in 2024. Using CPS data, we estimate that 5.6 million (39 percent) of these women are on Medicaid. Furthermore, 10.7 million of these (75 percent) are able-bodied and not in school or training, of whom we estimate that approximately 3.4 million (32 percent) are on Medicaid.

Figure 3. Labor Force Participation Rates for Prime Age Women

Labor Force participation Rate: Women 25-54 (1950-2025)



Labor Force participation Rate: Women 25-54 (1990-2025)







We use the U.S. Census Bureau’s Current Population Survey 2024 Annual Social and Economic Supplement (CPS-ASEC) data to provide insights about the relationship between work and Medicaid coverage. While the Survey of Income and Program Participation (SIPP) provides similar measures as well as more granular analysis of participation in social welfare programs, we prefer the CPS ASEC for our purposes because it is more recent (2024 vs. 2022) and has nearly three times the sample size, permitting state-level analysis and demographic subgroup analysis with less uncertainty due to sampling error. We provide additional details in the appendix.

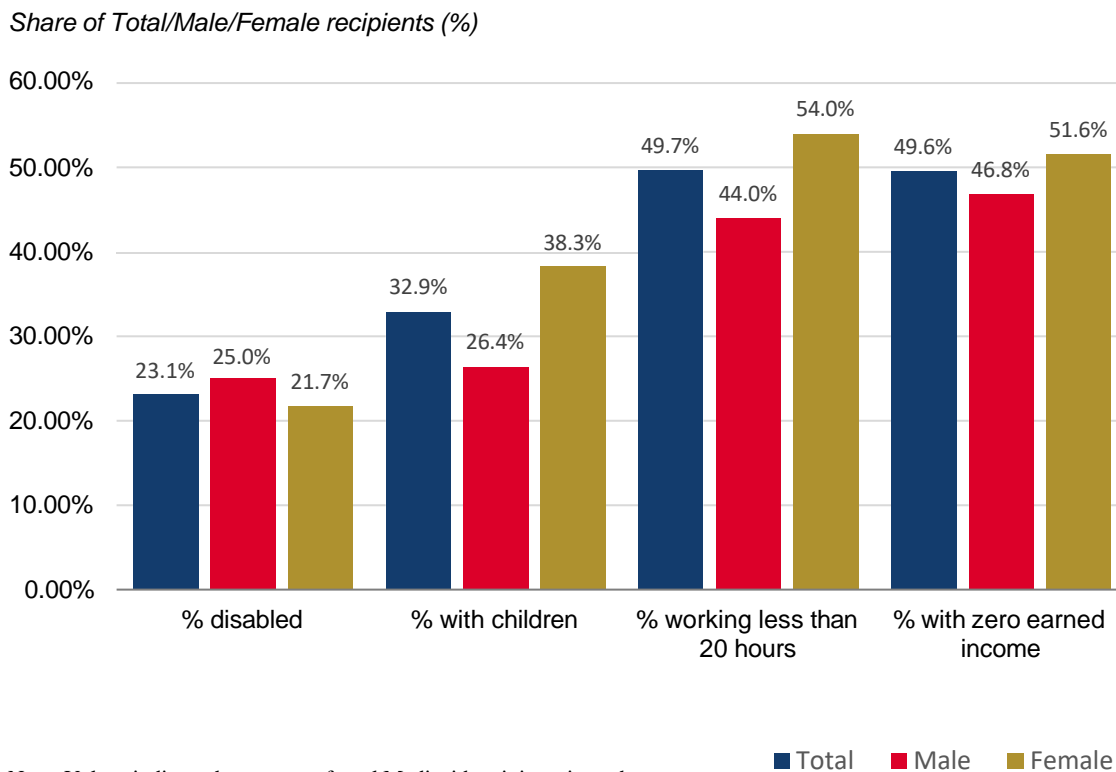
In the 2024 CPS ASEC, 19.1 percent (27,507 of 144,265) reported being enrolled in Medicaid in the prior year. Comparing against administrative data from the Centers for Medicare & Medicaid Services (CMS) for 2024 indicates that this represents an undercount. We correct for this by re-weighting the survey weights for the Medicaid population to equal administrative Medicaid enrollment.

We use additional information in CPS-ASEC to define other characteristics of interest of the working-age Medicaid population. Figure 4 presents the results. First, we define “able-bodied” as those who do not have “a health problem or a disability which prevents him/her from working or which limits the kind or amount of work.” With this definition, we estimate that in 2024, half of all Medicaid recipients (35.5 million) are working age (19-64), and that 27.2 million able-bodied, working-age adults (age 19-64 without a reported disability) are currently enrolled in Medicaid (95 percent confidence interval (CI) of 26.5-27.9 million). 23.3 percent of working age adults on Medicaid (8.3 million, 95 percent CI 7.9-8.6 million) report having a disability that limits ability to work. We also estimate that 32.9 percent (11.7 million, 95 percent CI 11.3-12.1 million) of working-age adults on Medicaid have children under 19 living at home, with the rate higher for women (38.3 percent) than for men (26.4 percent).³ Third, just under half of working age adults on Medicaid (49.7 percent) report working 20 hours per week or fewer, amounting to 17.7 million individuals (95 percent CI 17.2-18.2 million). The rate of working age adult Medicaid recipients who report no wage income is not much lower, at 49.6 percent (17.5 million individuals 95 percent CI 16.9-18.0 million).

³ Having children is defined by the head of household or the spouse of the head of household having a child under the age of 19 in the same household.



Figure 4. Characteristics of Medicaid Enrollees age 19-64 in 2024, Overall and by Sex



Note: Values indicate the percent of total Medicaid recipients in each category

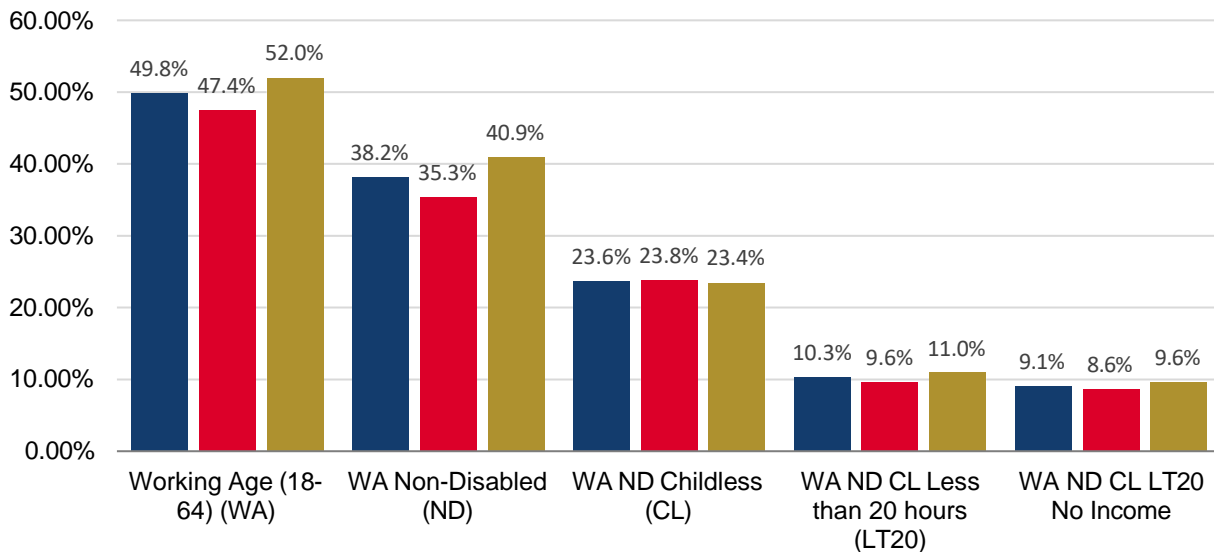
Source(s): CPS ASEC, CEA Analysis

Next, we put the extent of coverage and spending on these subpopulations of Medicaid enrollees in the broader context of Medicaid, which also covers children and elderly individuals. Figure 5 incrementally expands the set of criteria to show the share of total Medicaid enrollees who meet multiple criteria that are relevant for community engagement requirement proposals. We estimate that almost exactly half of all Medicaid recipients (35.5 million) are working age (19- 64). In total, 27.2 million (38.1 percent) of all Medicaid recipients are able-bodied, working-age adults (age 19-64 without a reported disability). Of these, 16.8 million have no children under 19 living at home (95 percent CI 16.3-17.4 million), and approximately 44 percent (7.4 million, 95 percent CI 7.0-7.7 million) of those reported working less than 20 hours per week on average in any job at any time over the past year, including temporary, part time, or seasonal work. Among those reporting working less than full time, a large share (~88 percent, or 6.5 million, 95 percent CI 6.2-6.8 million) reported no earned income at all over the same time frame. This amounts to approximately 27.2 percent (95 percent CI 25.1-29.0 percent) of total working-age, able-bodied adults on Medicaid (10.3 percent of total recipients) both being childless and working less than 20 hours a week. The presence of this population on Medicaid represents a departure from the populations that were originally prioritized by the program, namely low-income elderly people, mothers and their children, and those with disabilities.



Figure 5. Share of Total Medicaid Enrollees in 2024, Overall and by Sex

Share of Recipients in Category (%)



Note: Values indicate category as share (%) of total Medicaid Recipients

■ Total ■ Male ■ Female

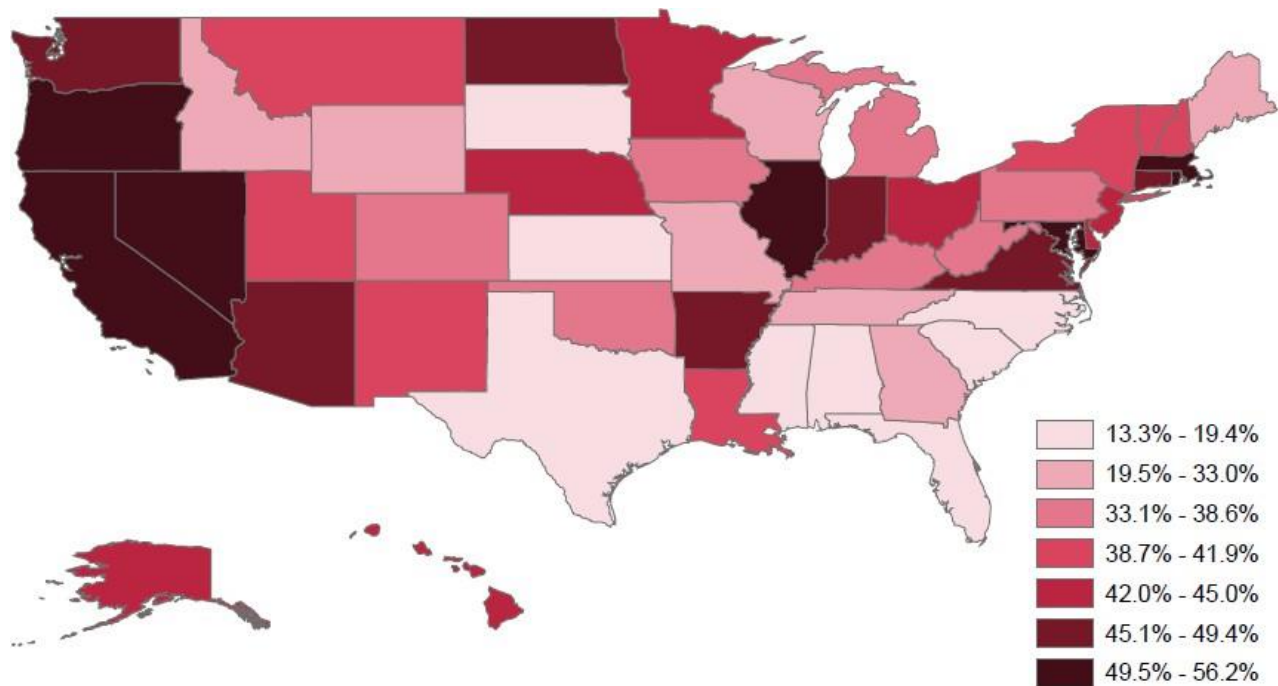
Source(s): CPS ASEC, CEA Analysis

We apply the [Congressional Budget Office's 2024 Medicaid per capita spending estimate](#) for adult recipients made eligible by the Affordable Care Act (ACA) to determine how much federal taxpayers spent on different subpopulations nationwide in 2024. We further generate state-specific estimates by using state level per capita spending estimates from CMS for 2022, applying the corresponding federal match rates (90 percent for adults made eligible by the ACA, Federal Medical Assistance Percentage (FMAP) rates for non-expansion states), and adjusting for increased spending using the rate implied by CBO's 2024 per capita federal spending estimates relative to 2022.

Including those with children under 19 in the same household, we estimate that able-bodied, working-age adults account for \$205.3 billion (40.3 percent) of federal Medicaid spending, with notable differences across states (Figure 6). A significant share of this spending, \$144.1 billion (70.2 percent), is attributable to childless, working age, able-bodied adults specifically. Of these adults, 7.9 million are males, accounting for \$69.2 billion, and 8.5 million are females, accounting for \$74.9 billion.



Figure 5. State's Share of Total Federal Medicaid Dollars Spent on Working Age (19-64) Able Bodied Adults

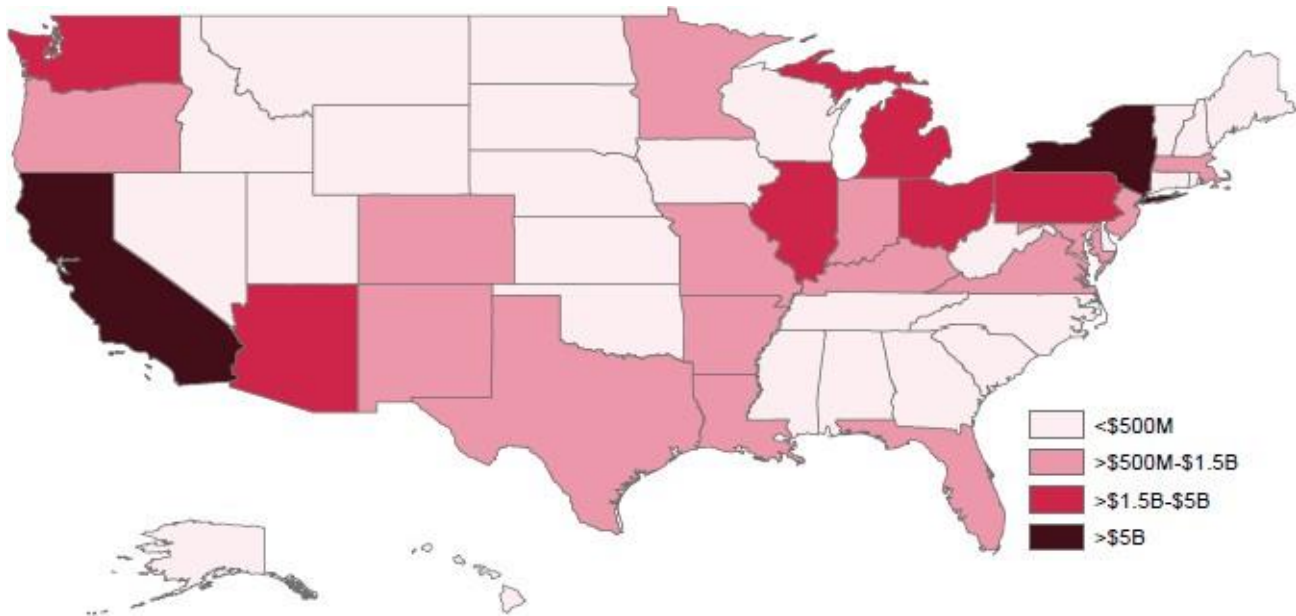


Source(s): Centers for Medicare and Medicaid Services, IPUMS, U.S. Census Bureau Current Population Survey, CEA Calculations

Finally, we estimate that federal taxpayers spent \$56.1 billion (95 percent CI \$53.4–\$58.8 billion) on Medicaid for childless, working-age, able-bodied adults working 20 hours a week or less in 2024 alone. This amounts to 11.0 percent of total federal Medicaid spending, with \$49.6 billion spent on these not working at all. This spending was concentrated among a few states, with California and New York alone costing \$12.0 billion and \$5.7 billion, respectively (Figure 6).



Figure 6. Total Federal Medicaid Dollars Spent (\$) on Childless, Non-Working, Able Bodied Adults (19-64)



Source(s): Centers for Medicare and Medicaid Services, IPUMS, U.S. Census Bureau Current Population Survey, CEA Calculations

Conclusions

Research demonstrates that work has broad-based benefits to individuals and their children, yet a substantial share of able-bodied, working-age Americans are neither participating in the labor force nor serving as primary caregivers to their children. Many of these individuals are on Medicaid and account for a substantial share of federal Medicaid spending. This is consistent with prior research that shows that social welfare programs can crowd out labor force participation and private health insurance coverage. Evidence from implementation of well-designed community engagement requirements for social welfare programs in the U.S. show that they can play an important role in promoting individuals to work, to the benefit of themselves and their children.



Appendix. Comparing SIPP and CPS ASEC Demographic Estimates

Because prior research on social welfare programs has often relied on the SIPP in addition to or instead of CPS, we assess whether the demographic variables that we rely upon are similar in 2022 CPS data and the 2022 SIPP. We construct an annual sample from the SIPP data relying on the most recent data published in 2023, reflecting data collected in 2022 across several different longitudinal panels.

Analyzing demographic markers of the Medicaid population in SIPP, we do not find evidence of demographic-driven bias between SIPP and CPS. In the SIPP, working-age adults make up 49 percent of the reported Medicaid enrollees in 2022, nearly identical to the 50 percent in CPS in 2024 and 49 percent in 2022.

Of these adult enrollees, we find a similar share who are disabled, not working, and do not have children living with them. Table 1 presents the results. There are some relatively small differences in the surveys. For instance, the questions differ between the two surveys. In SIPP, the variable that we used (named “EJOBCANT”) refers more narrowly to a disability that prevents the respondent from working. The variable that we used in CPS (named “DISABWRK”) refers to a disability that prevents or limits kind or amount of work, which may elicit a broader response. Overall, similarity in the relevant demographic measures between the two sources reinforces our preference for CPS given that it is more recent and has a larger sample size.

Appendix Table 1

Comparisons of the Demographics of Working-Age Adult Medicaid Enrollees in the 2022 SIPP and 2022 CPS ASEC Data			
Demographic Indicator	SIPP (2022 data)	CPS ASEC (2022 data)	CPS ASEC (2024 data)
Parents	29%	35%	33%
Work-limiting Disability	20%	24%	23%
Able-bodied	80%	76%	77%
Able-bodied, working less than 20 hours	36%	31%	30%
	[of able-bodied adults, 46% work less than 20 hours]	[of able-bodied adults, 41% work less than 20 hours]	[of able-bodied adults, 39% work less than 20 hours]
Able-bodied, working less than 20 hours, with children	11%	10%	9%
	[of able-bodied adults working less than 20 hours, 29% are parents]	[of able-bodied adults working less than 20 hours, 33% are parents]	[of able-bodied adults working less than 20 hours, 30% are parents]
Able-bodied, working less than 20 hours, without children	26%	21%	21%