Exemption Systems and the Boundaries of Obligation

Who shouldn't have to work, who decides, and how do we know?

The Line That Defines Everything

Article 2A examined how states verify that people meet work requirements. This article addresses the more fundamental question: who should be exempt from having to meet them at all?

This isn't a technical question with technical answers. It's a boundary-drawing exercise that reveals our deepest assumptions about capacity, disability, obligation, and human worth. Every exemption category creates a distinction between those who must demonstrate reciprocity through work and those who don't. Every documentation requirement determines whether exemptions protect vulnerable populations or create barriers that exclude them.

The challenge is designing exemption systems that are simultaneously protective and accessible. Too narrow, and people who cannot work lose coverage for failing to do the impossible. Too broad, and work requirements become symbolically significant but practically meaningless. Too burdensome to access, and well-documented exemption categories don't protect anyone. Too lenient, and exemptions become avoidance mechanisms rather than accommodations.

States have 14 months to resolve these tensions in operational systems that will determine healthcare access for millions. Arkansas's experience demonstrated these risks: studies estimated only 3-4% of those subject to requirements were neither working nor eligible for exemptions, yet 25% lost coverage – primarily because people who should have been exempted couldn't navigate the documentation requirements. Georgia's 2025 refinements to Pathways, adding caregiver exemptions for parents of children under six and creating reasonable modification frameworks, illustrate how states learn from implementation challenges. The choices states make will operationalize competing visions of who deserves unconditional care versus who must earn it through economic participation.

The Categories: Drawing Lines Through Human Complexity

OB3 provides federal parameters but leaves substantial definitional discretion to states. Most state proposals include similar exemption categories, but the boundaries vary dramatically.

Medical Frailty and Disability

This is the most contested exemption category because it requires distinguishing between people who can work and people who cannot – a distinction that's rarely as clear as policy assumes.

The traditional framework divides the world into "able-bodied" and "disabled," with work requirements applying only to the former. But disability isn't binary. It's a spectrum of functional limitation that varies by individual, by context, and over time. Someone with diabetes might work full-time with proper medication and stable housing but cannot work when insulin access is disrupted or they're experiencing homelessness. Someone with anxiety disorder might handle routine work but not job interviews or public-facing roles. Someone with chronic pain might manage sedentary work but not physical labor.

States must decide: Do exemptions require documentation of specific diagnosed conditions from an approved list? Do they require functional assessments of work capacity regardless of diagnosis? Do they accept provider attestation that the individual cannot work? Do they require Social Security disability determination, which can take years?

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The documentation burden matters enormously. Requiring extensive medical records, specialist evaluations, and standardized forms advantages people with regular healthcare access, established provider relationships, and familiarity navigating medical bureaucracies. People with episodic care, recent immigration, homelessness, or rural isolation struggle to obtain qualifying documentation even when their functional limitations are real.

Georgia's initial Pathways program required specific documentation for medical exemptions but provided limited guidance about what conditions qualified. The result was predictable: people with severe chronic conditions lost coverage because their providers didn't know how to document exemptions properly, while people with milder but well-documented conditions received exemptions readily.

Age-Based Exemptions

Most proposals exempt people under 19 and over some upper age threshold – typically 50, 55, or 60. These bright-line rules avoid complex individual assessments and acknowledge general patterns: teenagers are often students, older adults face age discrimination in hiring and higher rates of disability.

But age thresholds are inevitably both over-inclusive and under-inclusive. Some 18-year-olds are full-time workers supporting families. Some 62-year-olds are healthy and employed. Age proxies for capacity imperfectly.

The upper age threshold decision is revealing. Setting it at 50 acknowledges that age discrimination and health decline create work barriers well before traditional retirement age. Setting it at 60 or higher assumes most people remain capable of work into their sixties. The choice reflects assumptions about labor market reality and societal obligation to older workers.

States must also decide whether age exemptions are automatic or require application. Automatic exemptions based on date of birth eliminate documentation burden but may include people who don't need them. Application-based exemptions ensure only those who want exemptions claim them but create friction and potential for people to slip through cracks.

Pregnancy and Postpartum Period

Pregnancy exemptions are nearly universal, but their scope varies significantly. Some states exempt only during pregnancy itself. Others extend through the postpartum period – but definitions of "postpartum" range from six weeks to twelve months.

This variation reflects different understandings of pregnancy, recovery, and caregiving. A six-week postpartum exemption assumes physical recovery is rapid and primary caregiving for newborns doesn't conflict with work requirements. A twelve-month exemption acknowledges that infant care, breastfeeding, postpartum depression, and medical complications often extend well beyond initial physical recovery.

The documentation burden also varies. Some states accept medical provider attestation of pregnancy. Others require ongoing verification of pregnancy status and estimated due dates. Some automatically extend exemptions postpartum. Others require new applications with documentation of delivery and continuing need.

The intersection with caregiving exemptions creates complexity. If states exempt parents of children under six months (caregiving) but only exempt pregnant individuals through six weeks postpartum (medical), the coverage is identical but the documentation pathways differ. If states exempt pregnancy but not caregiving of infants, new mothers must return to work before their babies are three months old or document a separate medical exemption.

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Caregiving Responsibilities

Whether and how much caregiving counts as legitimate exemption reveals fundamental values about unpaid labor, family structure, and gender roles.

Some states don't exempt caregivers at all – the assumption being that caregiving is a choice that shouldn't excuse work obligations. Others exempt parents of young children, recognizing that childcare costs often exceed low-wage earning capacity. Still others exempt caregivers of elderly or disabled family members, acknowledging that formal care is expensive and often unavailable.

The boundary drawing is revealing. States that exempt parents of children under one year old but not under six years old implicitly claim that work and care of toddlers are compatible while work and care of infants aren't. States that exempt caregivers of disabled children but not elderly parents distinguish between caregiving responsibilities by relationship rather than care intensity.

Documentation requirements determine whether exemptions are accessible. Requiring birth certificates for children is straightforward. Requiring medical documentation that an elderly parent "needs care" is much harder – what level of need qualifies? How do you document that formal care isn't available? States demanding this documentation often create barriers that deny exemptions to people providing substantial care.

Georgia's addition of caregiver exemptions for parents of children under six in their 2025 refinement acknowledged that their initial policy created impossible choices: work to keep coverage, or care for young children. But limiting the exemption to parents specifically excludes grandparents raising grandchildren, older siblings caring for younger ones, and other kinship care arrangements common in low-income families.

Student Status

Education and training usually qualify as activities that satisfy work requirements, but some states also exempt full-time students entirely. This recognizes that combining full-time coursework with 80 hours monthly of qualifying activities may be infeasible for students in rigorous programs.

The question is what counts as "student." Only degree-seeking programs at accredited institutions? Adult education and GED programs? Vocational training? Online courses? Part-time enrollment? The broader the definition, the more accessible the exemption but the greater the risk that people claim student status to avoid work requirements without educational engagement.

Documentation is relatively straightforward – enrollment verification, class schedules – but timing matters. Students between terms, waiting for program start dates, or recently graduated may lose coverage during transitional periods when they're not actively enrolled but also not yet working full-time.

Unemployment and Labor Market Conditions

Some states exempt people receiving unemployment benefits or living in high-unemployment areas. This acknowledges that not everyone who wants to work can find employment in economically depressed regions.

High unemployment exemptions reveal tension at the heart of reciprocity frameworks. If work requirements are about mutual obligation – society provides coverage, you provide work – what happens when society cannot provide work opportunities? Punishing people for unemployment they didn't cause undermines the reciprocity logic.

But operationalizing these exemptions is complex. What unemployment rate triggers exemptions? County-level, ZIP code-level, statewide? Do exemptions apply automatically or require application? How frequently

are unemployment rates updated? What happens when someone lives near the boundary of high and normal unemployment areas?

The perverse incentive is obvious: counties benefit from maintaining high unemployment to protect residents' healthcare access. This isn't theoretical – local officials will face pressure to avoid economic development that might disqualify residents from exemptions.

Substance Use Disorder Treatment

Many proposals exempt people actively engaged in substance use disorder treatment. This recognizes that early recovery is often incompatible with employment stability and that treatment itself requires time commitment.

The challenge is defining "actively engaged." Does it require residential treatment? Intensive outpatient programs? Weekly counseling? Medication-assisted treatment? Mutual aid group attendance? Different definitions advantage people with access to formal treatment programs while excluding those in peer support or self-directed recovery.

Documentation requirements determine accessibility. Programs can verify enrollment easily, but verification may stigmatize and create privacy concerns. Some people in recovery don't want documentation of substance use history in government systems. The exemption meant to support them becomes a barrier they can't safely access.

Time limits add complexity. Exempting people during treatment assumes treatment has defined endpoints, but addiction is chronic and relapsing. Someone who completes 30-day residential treatment then loses coverage when their exemption expires may relapse without ongoing support.

Domestic Violence Survivors

Some states exempt people fleeing domestic violence, recognizing that finding employment while relocating, obtaining protective orders, and ensuring personal safety is unrealistic. But accessing these exemptions requires documentation that may endanger survivors.

Requiring protective orders excludes survivors who haven't gone through legal processes – because they're undocumented, fear law enforcement, face geographic barriers to courts, or simply haven't taken that step yet. Requiring police reports creates similar problems. Even requiring documentation from domestic violence advocates assumes survivors have connected with formal support services.

The most protective approach is provider attestation: healthcare providers, counselors, or social workers can document that someone is fleeing domestic violence without requiring proof that would compromise safety. But this relies on survivors accessing care providers and providers understanding exemption processes.

Temporary versus permanent exemptions also matter. Domestic violence situations don't resolve on predictable timelines. Exemptions that expire after three or six months force survivors to either seek extensions with ongoing documentation of continuing danger or return to compliance before they're safely able to work.

The Documentation Burden: Access Determines Protection

Well-designed exemption categories provide no protection if people can't successfully claim them. Documentation requirements determine whether exemptions serve their purpose or become barriers.

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The Provider Bottleneck

Medical exemptions typically require healthcare provider documentation. This creates immediate barriers for populations with limited healthcare access – precisely the populations most likely to need Medicaid.

Safety-net clinics serving high Medicaid populations become overwhelmed with exemption documentation requests. Patients need appointments specifically to obtain exemption letters. Providers must learn what documentation is required – which varies by state and sometimes by condition. Clinic administrative staff process paperwork instead of providing care. Wait times for appointments extend from weeks to months.

People lose coverage while waiting for exemption appointments. Even when providers want to help, appointment availability becomes the limiting factor. The system creates perverse pressure: people seek medical appointments not for care but for documentation.

The provider experience matters too. Physicians didn't train to serve as gatekeepers for government benefits. Requests to document that someone "cannot work" require judgments that aren't strictly medical. Can someone with moderate arthritis work? It depends on the job, the support systems, and the workplace accommodations available. Providers face impossible choices: be lenient and undermine program integrity or be strict and potentially harm patients by denying exemptions they need.

The Invisible Disability Problem

Invisible disabilities – mental health conditions, chronic pain, autoimmune disorders, neurological conditions – are harder to document than visible physical impairments. Documentation standards designed for visible disabilities don't transfer well.

Someone with bipolar disorder may function normally when stable but experience episodes of complete incapacity. Someone with chronic fatigue syndrome may appear fine in a brief medical appointment but cannot sustain employment. Someone with severe anxiety may work in some contexts but not others.

Traditional documentation approaches ask: "Does this person have a qualifying condition?" But the more relevant question is: "Can this person consistently meet 80-hour monthly work requirements given their health status and available accommodations?" That's a functional assessment, not a diagnostic one – and it's much harder to standardize.

States emphasizing diagnostic documentation exclude people whose conditions are real but don't fit neat categories. States emphasizing functional assessment require more sophisticated provider evaluation but better match policy intent to operational reality.

The Time Dimension: Episodic Versus Chronic Conditions

Some conditions are stable. Someone who lost a leg has a permanent disability that exemption processes can document once and maintain indefinitely. But many conditions are episodic or progressive.

Someone with multiple sclerosis has periods of relative function and periods of severe limitation. Someone with major depressive disorder cycles through episodes. Someone recovering from cancer treatment gradually regains capacity but not on a predictable schedule. Someone with chronic pain has good days and bad days.

Exemption systems designed for stable conditions fail episodic populations. Requiring documentation at application captures a single moment in time. When someone's condition improves temporarily, they lose exemptions – but when it worsens again, reapplying requires new documentation, new provider appointments, new processing time. The coverage gaps during transitions create exactly the instability that undermines both health and work capacity.

States must decide: Should exemptions be permanent until proven changed, or temporary with periodic revalidation? Should they adjust automatically based on healthcare utilization patterns, or require active renewal? Should episodic conditions qualify for permanent exemptions acknowledging that capacity fluctuates, or should people reapply each time limitations prevent work?

The Appeals Challenge

When exemptions are denied – whether because documentation was inadequate, conditions didn't fit categories, or processing errors occurred – appeals processes determine whether people have meaningful recourse.

Formal appeals require understanding dense regulatory language, gathering additional documentation, meeting deadlines, and often attending hearings. These requirements advantage people with education, stable housing, advocacy support, and time. They exclude people overwhelmed by life circumstances, unfamiliar with bureaucratic processes, or already exhausted from fighting for coverage.

The timeline matters enormously. If appeals take months while coverage is suspended, people go without care during the process – potentially worsening the conditions that made them unable to work. Even successful appeals don't undo harm from months without medication, treatment, or preventive care.

Presumptive eligibility during appeals – maintaining coverage while disputes are resolved – prevents this harm but creates potential for extended coverage based on denied exemptions. States balance protecting people against inappropriate terminations versus providing coverage beyond what policy allows.

The Automation Question: Can Technology Help or Harm?

Exemption determination seems like a candidate for automation. Machine learning algorithms could analyze medical records, flag qualifying conditions, and approve exemptions without human processing. This promises efficiency and consistency.

But automation risks encoding existing biases and creating new barriers. Algorithms trained on historical data replicate patterns where certain populations were approved or denied at different rates. Natural language processing of medical records misses nuance – someone with "mild" depression documented might have severe functional impairment; someone with "severe" arthritis by imaging might function well with treatment.

Certain exemptions resist automation entirely. Domestic violence situations don't appear in medical records with convenient diagnostic codes. Caregiving responsibilities rarely show up in healthcare data. Substance use disorder treatment engagement is sensitive information that individuals may not want in automated systems.

The middle ground is algorithmic flagging with human review. Systems can identify people likely to qualify for exemptions based on diagnoses, medications, healthcare utilization, or demographic factors, then flag them for proactive outreach rather than waiting for applications. This moves from reactive approval toward proactive identification.

Healthcare providers could have simplified exemption portals where they check boxes indicating conditions that clearly qualify without writing detailed letters. "I attest this patient has medical conditions that preclude meeting 80-hour monthly work requirements." State systems accept these attestations for most cases, reserving detailed documentation requests for unusual situations or random audits.

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State Variation: The Laboratory of Exemption Design

Different states are experimenting with dramatically different exemption approaches. This variation reveals competing values and creates natural experiments.

Georgia's Evolution

Georgia's initial Pathways program had narrow exemptions: age, pregnancy, medical frailty, student status. No caregiver exemptions initially, requiring parents of young children to find 80 hours monthly while arranging childcare. The 2025 refinement added caregiver exemptions for parents of children under six, acknowledging this was impossible for many.

The evolution shows responsive adjustment: when exemption categories prove too narrow and create predictable hardship, expand them. But the expansion is incremental – why children under six but not under twelve? The choice reflects balancing protection with program scope rather than any clear principle about when children can safely be left while parents work.

Georgia's reasonable modifications framework creates individualized exemptions outside standard categories. Someone who can't meet 80 hours due to disability but can work some might get requirement reduced to 40 hours with employer verification. This flexibility accommodates edge cases but creates complexity and relies on caseworker discretion.

Arkansas's Proposed Model

Arkansas's 2025 proposal includes broader exemptions than their 2018 program: age, pregnancy, medical frailty, caregiver status, student status, unemployment benefits, substance use disorder treatment. The expansion reflects lessons learned from their previous implementation failure.

The "success coach" model pairs exemption processes with support. Someone struggling to meet requirements or qualify for exemptions gets assigned a coach who helps navigate both work opportunities and exemption applications. This acknowledges that many people straddle boundaries – they have some capacity limitations but could work with support and accommodations.

The suspension rather than termination approach for non-compliance also affects exemptions. If someone loses coverage but claims they should have been exempt, they can apply for exemption retroactively and regain coverage through the end of the calendar year rather than starting from scratch with new application.

Ohio's Automated Approach

Ohio's emphasis on automated verification through data matching extends to exemptions where possible. Social Security disability determination data automatically exempts people. Unemployment insurance receipt automatically exempts people. Birth records automatically identify parents of young children for caregiver exemptions.

This reduces burden for exemptions that are data-verifiable but does nothing for exemptions requiring clinical judgment, self-reported circumstances, or situations not captured in administrative data. The risk is creating two-tier exemption access: automatic for people with qualifying data trails, burdensome for everyone else.

Design Principles for Accessible Exemptions

Several principles emerge from examining what works and what fails in exemption system design.

Presume Eligibility During Processing

The time between exemption application and approval should not be coverage-gap time. Presumptive eligibility while exemptions are processed prevents the cascade where someone loses coverage, their health deteriorates, their work capacity further declines, and they're worse off even when exemption is eventually approved.

This requires faith that most exemption applications are legitimate and that fraud in exemption claims won't overwhelm program integrity. States prioritizing enforcement over access will resist presumptive eligibility. States prioritizing access will embrace it.

Default to Provider Attestation

For medical exemptions, simple provider attestation should suffice for most cases: "I attest that due to medical conditions, this patient cannot consistently meet 80-hour monthly work requirements." Reserve detailed documentation for random audits or unusual circumstances, not universal screening.

This respects provider expertise and clinical judgment while dramatically reducing documentation burden on both providers and patients. It also avoids requiring providers to quantify unquantifiable questions – exactly how disabled is too disabled to work? It instead asks yes/no questions they can answer with clinical confidence.

Create Safe Harbor Categories

Some exemptions should be automatic without application: children under 19, adults over 60, anyone receiving Social Security disability benefits. If administrative data confirms these statuses, no individual action is required.

This eliminates application burden for exemptions that are objectively verifiable and uncontroversial. It also prevents situations where people who clearly qualify lose coverage because they didn't know they needed to apply for exemptions.

Build in Grace Periods for Transitions

Exemption status changes aren't instantaneous. Someone recovering from surgery gradually regains capacity. Someone completing substance use disorder treatment transitions back to work. Someone's child turns six and ages out of caregiver exemption qualification.

Grace periods – three months, six months – during transitions prevent cliff effects where people lose exemptions and coverage simultaneously without time to find work or transition to employment-based insurance. These transitions are when people are most vulnerable; system design should protect them during that vulnerability.

Enable Episodic Exemptions

People with conditions that fluctuate between work capacity and incapacity need exemption processes that accommodate that reality. This might mean:

- Exemptions that automatically reinstate when healthcare utilization suggests exacerbation
- Simplified reapplication for people with documented episodic conditions
- Partial-month exemptions for people who work when able but can't consistently meet monthly thresholds

- Provider authority to adjust exemption status based on clinical assessment without full reapplication

The goal is preventing the exhausting cycle of lose exemption, try to work, condition worsens, reapply for exemption, wait for approval, lose coverage in the interim.

Minimize Stigma and Privacy Risk

Exemption applications should collect only information necessary for determination. Medical details beyond "qualifying condition exists" shouldn't be required. Domestic violence specifics beyond "fleeing abuse" shouldn't be documented. Substance use history beyond "engaged in treatment" shouldn't be recorded.

The less sensitive information collected, the less risk from data breaches and the lower the barrier to applying. People shouldn't have to choose between privacy and healthcare access.

The Philosophical Tensions

Exemption policy forces confrontation with questions the broader work requirements debate often obscures.

The Capacity Question

Work requirements assume most Medicaid expansion adults can work. Exemptions acknowledge some cannot. But capacity isn't binary – it's contextual, fluctuating, and deeply shaped by structural factors.

Someone "can" work if jobs are available, accessible by transportation, pay enough to cover childcare, accommodate their disability, provide schedules compatible with their treatment needs, and don't require skills they lack. Remove any of these conditions and capacity vanishes.

Narrow exemptions implicitly claim most barriers are individual – the person's medical condition, their lack of skills, their caregiving responsibilities. Broad exemptions acknowledge structural barriers – labor market failures, childcare deserts, disability discrimination, insufficient healthcare access.

States designing exemption systems are operationalizing their assumptions about whether poverty and unemployment primarily stem from individual limitations or structural barriers. Neither design proves the assumption true, but both embed it in how millions of people's lives are governed.

The Reciprocity Question

If the social contract is reciprocal – society provides coverage, you provide work – what about people who cannot work? Are they outside the social contract? Do they receive care based on need rather than contribution?

One perspective says yes: exemptions create a category of people for whom the reciprocal framework doesn't apply. They receive benefits without contributing because contribution isn't possible. This preserves reciprocity by limiting its scope to the capable.

Another perspective resists this bifurcation. It says human dignity and social membership don't require economic productivity, that care should flow based on need regardless of capacity to contribute, and that framing some people as exempt from reciprocity implicitly devalues them.

Exemption design navigates this tension. Narrow exemptions extend reciprocity obligations broadly, risking harm to people who cannot meet them. Broad exemptions protect more people but potentially undermine the reciprocity framework itself by exempting such large proportions that requirements become primarily symbolic.

The Desert Question

Who deserves care without having to demonstrate reciprocity? This is ultimately a question about worthiness and deservingness that American social policy has never fully resolved.

Children clearly deserve care regardless of contribution – they're not capable of reciprocity. Elderly people have already contributed through lifetime work – reciprocity extends across lifespans, not just current moments. Severely disabled people cannot contribute economically – we recognize obligations to care for the incapable.

But the boundaries are contested. Do parents of young children deserve exemption because caregiving is contribution, or should they demonstrate reciprocity through paid work? Do people with mental health conditions deserve exemption because illness isn't their fault, or should they demonstrate reciprocity through whatever work they can manage? Do people in recovery from addiction deserve exemption because treatment is what society wants them doing, or should reciprocity apply once they're stable enough?

These questions have no policy-neutral answers. Every exemption category operationalizes moral judgments about deservingness.

What States Should Do

Despite philosophical contestability, states must build exemption systems that work. Several practical recommendations emerge:

Start broader than minimum. It's politically and operationally easier to narrow exemptions later than to expand them. Narrow categories at launch cause predictable harm to vulnerable populations, create political backlash, and require subsequent expansion. Broad categories allow learning about who needs exemptions without causing immediate harm.

Invest in provider infrastructure. If medical exemptions require provider documentation, providers need training, simplified forms, clear guidance about qualifying conditions, and reasonable timelines. Overwhelming providers with complex documentation requests in addition to clinical work guarantees system failure.

Create proactive exemption identification. Use available data – diagnoses, medications, healthcare utilization patterns – to identify people likely to qualify and reach out rather than waiting for applications. "We noticed you have qualifying medical conditions. You may be exempt from work requirements. Here's how to apply."

Build in appeals transparency. Exemption denials should include clear explanations of why, what additional documentation might change the decision, and how to appeal. Generic denial letters provide no actionable information and ensure appeals focus on procedural rather than substantive issues.

Monitor exemption access by demographics. If certain populations apply for exemptions at much lower rates than their prevalence of qualifying conditions suggests, that indicates access barriers. If approval rates differ dramatically by race, geography, or other factors, that suggests bias in determination processes.

The Coverage Reality

Exemptions determine who the work requirements actually affect. If 60% of Medicaid expansion adults qualify for exemptions and another 20% can verify work through automated systems, work requirements with documentation burden primarily affect the remaining 20% – but exemption accessibility determines whether that 60% successfully claims exemptions or loses coverage trying.

The projected coverage losses under OB3 reflect assumptions about exemption accessibility. If states build accessible exemption systems with broad categories and low documentation burdens, coverage losses will be lower. If states build restrictive systems with narrow categories and high documentation burdens, losses will be higher.

These aren't technical details. They're choices about how many people lose healthcare and which populations bear that burden. These choices are not simple or binary. They span multiple dimensions and complex consequences.

The next 14 months will reveal whether states design exemption systems to protect vulnerable populations or to minimize program costs through narrow eligibility. The human consequences will measure in millions.

Acknowledging the complexities – the philosophical, political, social and economic realities – is essential. We need iterative approaches that aren't quick to judgment or to 'doom and gloom' narratives. The human consequences are painfully real, but we cannot ignore the need for experimentation and iteration as pathways to optimization.

Next in this series: Building the Human Layer (Article 2C). Together these three articles provide comprehensive perspectives on what needs to be operationalized.

Following Soon: What health insurers can do – turning enrollment volatility into care continuity when work requirements make coverage conditional

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