

The Exemption Architecture

How rulemaking choices determine who gets protected

State regulators writing exemption rules for December 2026 face a philosophical question disguised as an administrative task. Every decision about who qualifies for exemptions, what documentation proves eligibility, and how long protections last reveals assumptions about human capacity, bureaucratic trust, and the purpose of safety nets. These choices determine whether Medicaid work requirements function as employment promotion or coverage restriction.

The rulemaking process offers states extraordinary discretion within federal parameters. This discretion matters enormously. Arkansas in 2018 chose restrictive exemption rules and lost 25% of expansion coverage despite only 3-4% being ineligible due to work capacity. Georgia's 2025 approach embraced expansive exemptions and maintained coverage stability. The difference lies not in populations served but in regulatory philosophy embedded in hundreds of granular policy choices.

Four principles should guide exemption rulemaking, though states will balance them differently based on local politics and administrative capacity. Presumptive access suggests that when in doubt, presume people qualify and verify later through audits rather than creating documentation barriers upfront. Functional over categorical focuses on whether someone can consistently work 80 hours monthly rather than whether they fit rigid diagnostic categories. Proactive over reactive identifies likely-exempt populations through data and reaches out rather than waiting for applications. Grace over enforcement builds transition periods and second chances into every process.

These principles conflict with each other and with other policy goals. Presumptive access risks false positives where ineligible people receive exemptions. Functional assessment creates subjective variation across providers. Proactive identification requires sophisticated data systems. Grace periods extend beyond what enforcement-focused legislators may tolerate. States must decide how to balance these competing values, and those decisions shape who maintains coverage.

The Architecture of Automatic Exemptions

Some exemptions can function automatically through data matching without individual applications. ***These automatic exemptions determine baseline protection levels and reveal state priorities about administrative burden.*** The question is not whether certain populations qualify but whether states will identify them proactively or force them through application processes.

Age provides the clearest example of automatic exemption potential. Federal law permits states to exempt adults under 19 and over a specified age between 50 and 65. The lower threshold is universal, but ***the upper threshold becomes a statement about age discrimination realities, workforce participation expectations for aging populations, and administrative philosophy.*** A state choosing age 50 acknowledges hiring discrimination and physical limitations making work increasingly difficult with age. Age 60 mirrors Social Security early retirement, creating policy alignment. Age 65 aligns with Medicare eligibility and reflects confidence that people aged 60-64 can find and maintain employment.

The transition rules matter as much as the thresholds. Someone turning 19 needs time to understand requirements, complete exemption applications if qualifying, and establish employment or qualifying activities. A state giving 90 days signals patience with learning curves. Thirty days suggests administrative efficiency takes priority over successful compliance. The choice reveals whether the goal is supporting employment transitions or identifying noncompliance quickly.

Social Security disability recipients present automatic exemption potential since states already receive SSI data for Medicaid eligibility determinations. The question becomes whether states expand exemption rules to cover SSI automatically or require separate applications. SSDI recipients require additional data matching through Medicare Entitlement Data showing disability as the basis for Medicare qualification. States choosing automatic exemption for all Social Security disability beneficiaries eliminate application burdens for populations with established work limitations. States requiring separate disability verification despite existing federal disability determinations reveal skepticism about whether Social Security standards align with state work requirement philosophies.

The technical implementation is straightforward: data sharing agreements with Social Security Administration, quarterly data refresh, automatic exemption flags. The rulemaking question is whether states trust existing disability determinations or create parallel verification processes. This choice carries cost implications as well, since manual exemption applications require far more administrative processing than automated data matches.

Caregiver exemptions for parents of young children reveal fundamental tensions between work promotion and family structure preferences. Federal flexibility permits states to exempt parents of children under 1, under 6, or under 13, with Georgia choosing age 6 and Arkansas proposing 13. ***The choice reflects assumptions about childcare availability, parental employment capacity while raising young children, and whether work requirements should apply to primary caregivers.***

States choosing restrictive thresholds (children under 1) assume childcare availability or extended family support enables employment once children pass infancy. States choosing expanded thresholds (children under 13) acknowledge childcare costs, school schedule complications, and the reality that many expansion adults cannot afford market-rate childcare on entry-level wages. The gap between these approaches is not evidence-based but philosophical, rooted in different views about maternal employment, family structure, and safety net purposes.

Special needs extensions add complexity. Parents of children with disabilities face ongoing caregiving demands regardless of child's age. States can exempt these caregivers automatically if the child receives SSI, participates in disability waivers, or has IEPs documenting substantial limitations. The data exists in other state systems, making automatic identification feasible. States choosing to require manual applications despite available data send signals about administrative priorities and assumptions about whether disabled children's parents should maintain employment.

Medical Exemption Frameworks

Medical exemptions require states to define what conditions prevent someone from working 80 hours monthly. ***Three fundamental approaches exist, each with different administrative complexity, cost implications, and coverage outcomes.***

Diagnosis-based exemptions specify qualifying conditions in regulation. A state might list schizophrenia, intellectual disability, advanced cancer, severe COPD requiring oxygen, advanced heart failure, end-stage renal disease, and cirrhosis as automatic qualifiers. Anyone with documented diagnoses qualifies without functional assessment. This approach provides certainty and simplifies documentation, since providers simply confirm diagnosis rather than assess capacity.

The problems are familiar to anyone who has worked with diagnosis-based disability systems. Conditions vary enormously in severity. Mild schizophrenia managed with medication may not prevent work. Advanced cancer creates clear work barriers, but someone in remission may have full capacity. The diagnosis list becomes either over-inclusive, exempting people who could work, or under-inclusive, excluding conditions that clearly prevent work but aren't listed. States face constant pressure to expand lists, creating administrative complexity and fiscal exposure.

Functional assessment exemptions focus on provider attestation that someone cannot consistently meet 80 hours monthly regardless of diagnosis. This aligns with the "functional over categorical" principle, allowing clinical judgment about actual capacity. Providers complete streamlined forms confirming functional limitations rather than cataloging diagnoses. The approach captures diverse situations where conditions prevent work even if diagnoses don't appear severe on paper.



The administrative challenge is subjectivity. Different providers assess capacity differently. Some err toward generous exemptions, others toward restrictive standards. Audit processes become complex since questioning provider judgment requires medical expertise. States concerned about improper exemptions find functional approaches harder to police than diagnosis lists. States prioritizing access over enforcement embrace the flexibility despite audit challenges.

Hybrid approaches combine automatic exemptions for severe conditions with functional assessment for others. Someone receiving hospice care, undergoing active cancer treatment, recently hospitalized for mental illness, or in organ failure qualifies automatically. Other medical conditions qualify through provider attestation of functional limitations. This creates two-tier complexity but captures benefits of both approaches: certainty for clear cases, flexibility for ambiguous situations.

States must also address temporary disabilities and recovery trajectories. Someone undergoing surgery faces temporary incapacity, but duration varies by procedure complexity and complications. Organ transplant recipients need 12 months to stabilize. Joint replacements may require six months for rehabilitation. Cancer surgery recovery depends on treatment protocols. States can automate temporary exemptions using claims data to identify qualifying procedures, then apply standard exemption periods based on procedure type.

The challenge becomes graduated return for conditions where capacity increases over time. Someone recovering from surgery may manage 40 hours monthly after two months but not 80 until four months post-surgery. States can require reduced hours during recovery periods, creating partial compliance pathways. Alternatively, states can maintain full exemptions with longer grace periods before requirements resume. The first approach is theoretically more aligned with capacity, but administratively complex. The second is simpler but extends exemptions beyond strict necessity.

Pregnancy and postpartum exemptions expose stark differences in state philosophies about maternal employment and child development. Federal guidance is vague, leaving states to define exemption duration. Some states exempt only during pregnancy, assuming immediate return to work capacity postpartum. Others exempt for 12 months after delivery, acknowledging infant care demands, breastfeeding, postpartum recovery complexity, and childcare availability challenges.

The medical evidence supports longer exemptions. Postpartum recovery extends beyond the traditional six-week checkup. Complications like C-sections, postpartum depression, or NICU stays require extended time. Breastfeeding creates scheduling constraints for employment. Infant care without affordable childcare creates practical barriers. States choosing six-week exemptions privilege theoretical work capacity over practical realities.

Episodic conditions present the hardest exemption design challenge. Bipolar disorder, multiple sclerosis, rheumatoid arthritis, migraines, Crohn's disease, and lupus feature unpredictable good and bad periods. Someone may work full-time for six months, then face three months of incapacity, then return to partial capacity. Traditional exemption frameworks fail because they assume static capacity.

States have several imperfect options. Variable hour accommodations reduce requirements to 40 or 60 hours during documented bad periods, allowing continued compliance at reduced capacity. This requires determining when capacity declines and when it recovers, creating ongoing assessment burdens. Averaging approaches let people meet 60 hours over six-month periods, allowing flexibility for good and bad months

without requiring real-time capacity assessment. But averaging violates federal monthly compliance requirements unless states obtain explicit waivers.



Automated exemption triggers offer an elegant solution. Healthcare utilization patterns predict episodic exacerbations. Hospitalizations, emergency department visits, and rescue medication fills indicate acute phases when work capacity drops. States can program eligibility systems to activate temporary exemptions automatically when these utilization patterns occur, without requiring manual applications. A psychiatric hospitalization triggers 60-day exemption. An ED visit activates 14 days. Increased rescue medication prescriptions activate 30 days. The person's treating physician can extend exemptions through simple portal submission if exacerbations persist longer than automated periods.

This approach removes application burdens during precisely the moments when people lack capacity to navigate bureaucracy. It relies on existing claims data rather than new documentation. It provides flexibility while maintaining oversight through provider attestation when extensions are needed. The cost is system complexity and potential for automation errors, but these seem manageable compared to forcing people experiencing disease exacerbations to complete exemption paperwork.

Caregiver Complexity Beyond Children

Parents of young children get policy attention, but adult caregiving creates equally significant work barriers with less recognition. Someone caring for a spouse with Alzheimer's, a parent after stroke, or an adult disabled sibling faces hour-intensive responsibilities incompatible with 80-hour monthly employment. States must decide whether to exempt caregivers broadly or restrict exemptions narrowly, and how to verify caregiving responsibilities without enabling fraud.

The eligibility standard matters enormously. Some states exempt only caregivers of people who cannot be left alone safely. This captures severe dementia, recent stroke, terminal illness, but excludes caregiving for people with disabilities who need assistance but not constant supervision. Other states exempt caregivers providing 30+ hours weekly of essential care, regardless of whether care recipients could be left alone. This broader standard captures intensive caregiving not meeting the "cannot be left alone" threshold.

Documentation requirements determine practical access. States can require physician attestation confirming the care recipient needs substantial assistance with activities of daily living. This professional verification reduces fraud but creates burdens for caregivers to obtain medical documentation about their relatives' conditions. Alternatively, states can accept caregiver self-attestation with random audits, shifting fraud prevention from upfront gatekeeping to backend verification.

The verification challenge intensifies because care recipients may receive services through other programs. Someone on Medicaid long-term care waivers already has documented needs. Someone receiving Social Security disability benefits has established limitations. Someone getting Medicare home health has verified care needs. States can cross-reference these programs to automatically identify situations where Medicaid expansion adults are likely providing intensive family caregiving, then reach out proactively rather than waiting for applications.

Domestic violence situations require carefully designed exemptions balancing safety, verification, and fraud prevention. Someone fleeing abuse faces employment barriers from safety concerns, legal proceedings, housing instability, and trauma. Traditional employment becomes impossible during crisis periods. States can exempt domestic violence survivors automatically during protective order validity, using court data to identify qualifying situations. Extensions beyond protective order expiration require attestation from domestic violence service providers, creating verification without requiring victims to provide detailed abuse documentation to Medicaid caseworkers.

Time limits on domestic violence exemptions create tension between recognizing that recovery takes time and preventing indefinite exemptions. Some states limit exemptions to six months, assuming safety and stability sufficient for employment by that point. Others maintain exemptions for 24 months, acknowledging that legal proceedings, custody battles, housing searches, and trauma recovery extend far beyond immediate crisis. The difference reflects assumptions about abuse recovery trajectories and skepticism about potential abuse of exemptions.

Edge Cases Revealing Policy Priorities

Edge cases at regulatory margins reveal state priorities more clearly than mainstream exemptions.

Veterans with disability ratings present straightforward exemption potential since VA disability data exists through interagency sharing. States can exempt anyone with 30% or higher VA disability rating automatically, without requiring veterans to apply separately for Medicaid work requirement exemptions. But some states question whether VA disability standards align with state work requirement philosophies, creating separate assessment processes despite existing federal disability determinations.

Reserve and National Guard members face irregular employment from monthly drill weekends and annual training periods. States can count military service hours toward work requirements or exempt service members entirely during service years. The choice reveals whether states prioritize military service as valuable to communities or view military obligations as interfering with employment expectations. Accommodation approaches allow drill time to count hour-for-hour, while exemption approaches recognize that managing civilian employment alongside military service creates complication warranting relief from requirements.

Immigration status creates exemption complexity for mixed-status families where some members are documented and others aren't. Fear of government interaction pervades these families, making exemption applications unlikely even when qualifying conditions exist. States can design exemption processes accepting verification through trusted community organization intermediaries rather than requiring direct disclosure to state agencies. This creates access while respecting reasonable fears about immigration consequences. Alternatively, states can require direct disclosure, accepting that many qualifying people won't apply due to immigration concerns.

DACA recipients face employment authorization but work restrictions and uncertainties about authorization continuity. States can create streamlined verification accepting employment authorization documents without additional questioning, or can scrutinize work capacity skeptically despite federal authorization. The difference reflects broader state policies toward immigration rather than anything specific to Medicaid work requirements.

Language and literacy barriers create access problems distinct from exemption qualification. Non-literate populations exist in every language, including English. Someone who cannot read or write in any language cannot complete written exemption applications regardless of how simplified. States can accommodate by accepting verbal applications recorded by navigators, video submissions explaining circumstances, or facilitated applications through community organizations. These accommodations cost more than standard processing but prevent literacy from becoming a barrier to legitimate exemptions.

Process Architecture Across All Exemptions

Exemption categories matter less than process architecture determining how people access exemptions. Presumptive eligibility during processing prevents coverage loss from bureaucratic delay. Universal application of this principle means all exemption applications automatically maintain coverage during state review, typically 30 days. If states cannot complete reviews within 30 days, coverage continues

automatically for additional 30-day periods. After 60 days without determination, exemptions approve automatically.

This standard prevents coverage gaps from processing backlogs but creates potential for extended exemptions during bureaucratic delays. States prioritizing coverage continuity embrace automatic approvals after processing delays. States concerned about improper exemptions resist automatic approvals, preferring coverage suspension during extended reviews. The choice reveals whether states view coverage loss from bureaucratic failure as more problematic than potential temporary exemptions for people later determined ineligible.

Appeals architecture determines whether exemption denials can be challenged effectively. Coverage continuation during appeals prevents harm from erroneous denials but extends coverage during dispute periods. States allowing 90 days for appeal filing and 45 days for state review, with coverage continuing throughout, prioritize protecting people from wrongful denials. States imposing shorter timelines and terminating coverage during appeals prioritize administrative efficiency.

Medical exemption denials particularly require independent review. Having state eligibility workers overturn physician assessments creates tension, since workers lack medical training to evaluate functional capacity determinations. States can require medical exemption denials be reviewed by medical professionals not employed by state, creating independent assessment. This costs more than standard appeals but provides legitimate medical expertise in disputes about work capacity.

Grace periods after exemption expiration recognize that transitions from protected status to requirements take time. Someone recovering from surgery needs time after medical clearance to find employment. Someone whose caregiving responsibilities end needs time to seek work. States can match grace periods to original exemption duration, creating proportional transitions. Six-month treatment exemption gets six-month grace period, totaling 12 months before requirements fully apply. Thirty-day surgical recovery gets 30-day grace period. This proportionality acknowledges that longer exemptions indicate more significant barriers requiring extended transition time.

Provider payment for exemption attestation determines participation in medical exemption processes. Physicians completing functional assessments without compensation do so as favor to patients, creating capacity limits and access barriers. States can pay flat fees, perhaps \$35 per attestation, regardless of whether completed during billable visits. This incentivizes participation and compensates physician time, but increases administrative costs. The financial calculation is straightforward: paying for attestations costs far less than covering the administrative burden of people who cannot obtain medical documentation and lose coverage, then require coverage reinstatement.

The Data Architecture Question

Automation potential exists throughout exemption systems, but automation requires data sharing agreements, system interfaces, and sophisticated eligibility platforms. States can identify exemption-qualifying situations automatically through existing data: SSI receipt, Social Security disability, age, unemployment insurance claims, incarceration status, hospice enrollment, recent hospitalizations, pregnancy, and more. The question is whether states will invest in automated identification or require manual applications despite available data.

Algorithmic flagging presents a middle ground. Systems can identify people likely qualifying for exemptions based on multiple chronic condition medications, frequent psychiatric hospitalizations, cancer diagnoses, or caregiving-related service patterns. Rather than automatically approving exemptions, algorithms flag people for proactive outreach. Navigators contact flagged individuals explaining exemption options and facilitating applications if desired. This combines automation benefits with human oversight, but requires navigation capacity to respond to algorithmic flags.

Audit protocols determine whether automation creates accountability or just complexity. Random audits of 5% of automated exemptions annually can validate system accuracy and identify problems without requiring universal verification. Audit findings feed back to improve algorithms rather than focusing primarily on recoupment from improper exemptions. This continuous improvement approach treats automation as evolving rather than static, accepting that early iterations will have errors requiring correction.

States have eight months between OB3 passage and December 2026 implementation. The regulatory choices made during this period determine whether exemption systems protect vulnerable populations effectively or create documentation barriers that restrict coverage regardless of legitimate inability to work. The difference between approaches like Arkansas 2018 and Georgia 2025 demonstrates that administrative philosophy matters as much as population characteristics or economic conditions.

The fundamental question is whether states design exemption processes with the assumption that most people seeking exemptions have legitimate barriers, or with the assumption that most people seeking exemptions are trying to avoid work. That assumption pervades hundreds of granular regulatory choices about documentation requirements, processing timelines, grace periods, and automation investment. States choosing the first assumption will build different systems than states choosing the second, with dramatically different coverage outcomes.

Next in series: Article 7B, "The Verification Architecture"

Previous in series: Article 6B, "Managing Dual Eligibles Under Work Requirements"

References

1. Centers for Medicare & Medicaid Services. "State Medicaid Director Letter #18-002: Opportunities to Promote Work and Community Engagement." CMS.gov, January 2018.
2. Sommers, Benjamin D., et al. "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care." *Health Affairs*, vol. 39, no. 9, 2020, pp. 1522-1530.
3. Georgia Department of Community Health. "Pathways to Coverage Section 1115 Demonstration." DCH.Georgia.gov, 2023-2025 Updates.
4. Arkansas Department of Human Services. "Arkansas Works Program Section 1115 Waiver Revision." DHS.Arkansas.gov, May 2025.
5. Kaiser Family Foundation. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." KFF.org, October 2025.
6. Substance Abuse and Mental Health Services Administration. "42 CFR Part 2: Confidentiality of Substance Use Disorder Patient Records." SAMHSA.gov, 2024.
7. National Health Law Program. "Protecting the Right to Health Care: State Exemption Policy Issues." HealthLaw.org, September 2025.
8. Government Accountability Office. "Medicaid Demonstrations: Evaluations Yielded Limited Results." GAO-24-106490, March 2024.
9. Center on Budget and Policy Priorities. "Taking Away Medicaid for Not Meeting Work Requirements Harms People with Disabilities." CBPP.org, June 2018.
10. Georgetown University Health Policy Institute. "Medicaid Work Requirements: Implementation Lessons from Multiple States." Georgetown.edu, October 2025.