

The New Stakeholders: Who Implements the Distributed Social Contract

When work becomes a condition of healthcare coverage, responsibility spreads far beyond government agencies

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The Distributed Social Contract

Traditional welfare programs operated through a clear chain: federal policy, state agencies, individual recipients. The new social contract under OB3's work requirements creates something fundamentally different: a distributed implementation network where employers, insurers, community organizations, educational institutions, and healthcare providers all become essential infrastructure for citizenship itself.

This isn't an accident. It reflects a deeper transformation in how we understand social welfare: not as government services delivered to passive recipients, but as a complex ecosystem where multiple institutions share responsibility for helping people meet their obligations while the state verifies compliance.

Understanding these roles requires the same philosophical nuance we applied to work requirements themselves. Each stakeholder faces genuine tensions, competing obligations, and no perfect answers.

Employers: Gatekeepers or Partners?

The New Reality

Under OB3, employers aren't just providing jobs-they're providing the documentation that determines whether 18.5 million people keep healthcare coverage. A paystub, a letter on company letterhead, or a wage verification form becomes the difference between coverage and loss.

This creates unprecedented responsibilities for businesses that never asked to be part of the social safety net.

Three Perspectives on Employer Role

The Efficiency Perspective: Employers should streamline verification as a civic obligation and business necessity. Healthy workers are productive workers. A simple API integration with state Medicaid systems could automate verification for W-2 employees, reducing administrative burden while ensuring workers maintain coverage. The ROI is clear: reduced absenteeism, lower turnover, better productivity.

The Boundaries Perspective: Employers shouldn't become extensions of government enforcement. Small businesses especially lack HR infrastructure for complex verification processes. Adding "healthcare documentation provider" to employer responsibilities increases costs, creates liability, and transforms the employment relationship into a surveillance mechanism. There's a reason we separate employment from social services.

The Partnership Perspective: Employers have self-interest in worker health and can be valuable partners if properly supported. The key is making participation easy (standardized forms, automated systems, clear liability protections) while keeping it voluntary. Employers who want to help their workers should have simple tools; those who don't shouldn't face penalties.

Emerging Models

Some forward-thinking employers are experimenting with:

- Integrated HR systems that automatically report hours worked to state Medicaid agencies (with employee consent)
- On-site navigation support helping workers understand requirements and gather documentation
- Flexible scheduling policies allowing time for verification appointments without lost wages
- Educational programs explaining how work hours, overtime, and other activities qualify

Others are taking a minimalist approach: providing required documentation only when explicitly requested but offering no proactive support.

Neither approach is inherently wrong. They reflect different philosophies about the employer's role in the broader social contract.

Health Insurers: Care Coordinators or Compliance Monitors?

The Fundamental Tension

Medicaid managed care organizations face a profound identity crisis under work requirements. Their mission is improving health outcomes and managing care for complex populations. Now they must also navigate members through compliance systems that create enrollment volatility-the opposite of care continuity.

Strategic Responses

The Care Continuity Strategy: Some insurers are treating work requirements as a social determinant of health to be addressed through care coordination. They're building:

- Predictive analytics identifying members at risk of non-compliance
- Proactive outreach and reminder systems
- Navigation services helping members gather documentation
- Partnerships with employers and community organizations
- "Care bridges" maintaining relationships during coverage gaps

This approach says: We succeed when members stay covered and healthy. Work requirements are part of our environment, so we adapt.

The Risk Mitigation Strategy: Other insurers focus on minimizing their own exposure to the volatility work requirements create. They're:

- Tightening care management for members expected to lose coverage
- Avoiding long-term investments in relationships that will churn
- Building flexible contracting with states accounting for enrollment fluctuations
- Focusing resources on stable populations

This approach says: We can't fix systemic problems. We optimize within constraints while protecting our sustainability.

The Advocacy Strategy: Still others are publicly documenting the health impacts and administrative costs of work requirements, building evidence for future policy change. They're calculating:

- The cost per verification (\$25-50 per member per check)
- Emergency department utilization increases among those who lose coverage
- Administrative burden on care coordination teams
- Long-term health outcome deterioration

This approach says: We comply with current law while documenting why it should change.

The Innovation Opportunity

The most sophisticated insurers are doing all three simultaneously: building care continuity systems, mitigating risk, and documenting impact. They recognize that work requirements create a new category of "socially complex" members requiring intensive support-and that this support is both a cost and a competitive advantage in value-based payment environments.

Community Organizations: Service Providers or Resistance Infrastructure?

The Moral Dilemma

Community-based organizations face perhaps the most acute philosophical tension. Many have missions rooted in unconditional dignity and universal access. Now they must decide: Do we help people comply with a system we believe is unjust, or do we refuse to legitimize that system through our participation?

Four Strategic Postures

The Pragmatic Helper: "We help people navigate the system that exists, not the system we wish existed." These organizations provide:

- Documentation assistance (gathering paystubs, exemption letters, volunteer logs)
- Transportation to verification appointments
- Translation services
- Appeals support when people are wrongly terminated
- Connection to employers and training programs

They argue: People need coverage today. Our moral purity doesn't help anyone if they lose healthcare.

The Systemic Resister: "We document failures, support legal challenges, and refuse to normalize unjust systems." These organizations:

- Collect data on denials, barriers, and harms
- Support litigation challenging work requirements
- Organize political pressure for repeal
- Connect people to alternative care sources when they lose coverage

They argue: Helping people comply makes the system work better, which extends its life. Better to hasten its failure through documented dysfunction.

The Both/And Advocate: "We help individuals while fighting the system." These organizations:

- Provide navigation support as harm reduction
- Simultaneously document systematic barriers for advocacy
- Partner with legal aid on individual appeals and systemic challenges
- Build power through organizing people affected by work requirements

They argue: False choice. We can walk and chew gum. Individual service and systemic advocacy reinforce each other.

The Alternative Builder: "We create new models outside the existing system." These organizations:

- Develop community health worker programs
- Build sliding-scale clinics
- Create mutual aid networks for healthcare access
- Design technology tools for tracking exemptions and compliance

They argue: Neither compliance nor resistance changes fundamental power dynamics. We build alternatives.

The Funding Question

Each posture has different funding implications. Government contracts often prohibit advocacy. Foundation funding may prioritize systemic change over service delivery. Fee-for-service models (states paying CBOs to provide navigation) create different incentives than voluntary community organizing.

The most successful organizations are diversifying funding to maintain strategic flexibility-providing contracted navigation services while keeping separate advocacy capacity funded through independent sources.

Educational Institutions: Opportunity Pathways or Compliance Boxes?

The Dual Role

Under most work requirement frameworks, education and training count toward hour requirements-often with multipliers (1 hour of class = 1.5 hours of "work" credit). This makes community colleges, vocational schools, and training programs essential infrastructure for both compliance and actual skill development.

The Quality vs. Quantity Dilemma

The Credential Focus: Some institutions emphasize short-term credentials that help people meet hour requirements while building marketable skills:

- Industry-recognized certifications
- Stackable credentials allowing part-time progress
- Accelerated programs minimizing time to employment
- Evening and weekend classes for working students

The Education Focus: Others prioritize deeper learning that may take longer but provides more durable opportunity:

- Associate degrees requiring fuller engagement
- Remedial education addressing foundational gaps
- Comprehensive support services (childcare, tutoring, counseling)
- Slower pace accommodating complex life circumstances

Both are valuable. The tension is between "get people compliant quickly" and "build human capital deeply."

Emerging Innovations

- Forward-thinking institutions are creating:
- Integrated enrollment systems automatically reporting attendance to Medicaid agencies
- Flexible credentialing allows students to "bank" hours toward both compliance and degrees
- Employer partnerships creating direct pathways from training to employment with built-in verification
- Exemption support services helping students with chronic illnesses or disabilities document their status

Some are also addressing a fundamental equity question: Should students receiving Medicaid pay the same tuition as others, or should work requirement compliance credit come with tuition support recognizing the additional burden?

Healthcare Providers: Clinical Care or Administrative Gatekeepers?

The Boundary Question

- Should physicians, nurses, and clinics be involved in work requirement verification? The medical community is divided.
- The Clinical Separation View: Healthcare providers should focus exclusively on medical care. Asking them to document work exemptions, verify disability status, or explain compliance requirements:
- Compromises the therapeutic relationship
- Consumes clinical time better spent on care
- Creates ethical conflicts (denying exemptions vs. patient advocacy)
- Turns trusted healers into government bureaucrats

The Whole-Person View: Healthcare providers are already addressing social determinants. Work requirements are another SDOH requiring clinical attention:

- Medical exemption documentation is inherently clinical
- Providers see health impacts of coverage loss first
- Care coordination already includes benefits navigation
- Integrated care means addressing all barriers to health

The Pragmatic View: Providers will be involved whether they like it or not (patients will ask for help), so the question is how to do it efficiently:

- Standardized exemption forms minimize burden
- Care team members (social workers, navigators) handle non-clinical aspects
- EMR integration automates documentation where possible
- Clear protocols separate clinical judgment from administrative function

The Revenue Impact

For safety-net providers serving high Medicaid populations, work requirements create financial risk. Coverage losses mean:

- More uncompensated care
- Reduced patient volume
- Disrupted chronic disease management

- Increased emergency department utilization

Some are responding by building robust navigation programs to minimize coverage loss. Others are diversifying payer mix or pursuing alternative funding (FQHCs, grants, philanthropy) to buffer against Medicaid instability.

Technology Platforms: Enablers or Enforcers?

The Infrastructure Question

Someone needs to build systems that track hours, verify activities, process exemptions, and determine compliance. This creates opportunities for:

Government Technology: State-built platforms maximizing control and customization

Vendor Solutions: Private companies offering standardized compliance systems

Open-Source Tools: Community-developed platforms prioritizing user experience and privacy

Platform Integrations: APIs connecting existing systems (payroll, education, volunteer management)

Each approach embeds different values:

- Government systems prioritize accountability and auditability
- Vendor solutions prioritize efficiency and cost
- Open-source tools prioritize accessibility and transparency
- Integration approaches prioritize convenience and reduced burden

The Design Ethics Question

Technology choices have profound impacts.

Mobile-first vs. desktop: Recognizes smartphone penetration but assumes data plans and digital literacy

Automated verification vs. human review: Efficiency vs. accommodation of edge cases

Real-time integration vs. manual upload: Convenience vs. privacy and employer participation burden

Plain language vs. legal precision: Accessibility vs. compliance protection

There's no neutral design. Every interface choice reflects assumptions about users' capabilities, resources, and needs.

Faith Communities: Moral Voice or Service Infrastructure?

The Unique Position

Religious organizations occupy distinctive space in the work requirements ecosystem. They can simultaneously:

- Provide practical support (documentation help, transportation, job training)
- Offer moral frameworks for thinking about work, dignity, and mutual obligation
- Convene diverse perspectives in trusted community spaces
- Advocate based on religious values (though interpretations vary widely)

Theological Diversity

Different faith traditions approach work requirements through different lenses:

The Stewardship Tradition: Work as calling and faithful use of gifts. Requirements align with religious teaching about contribution and responsibility. Religious organizations can help people discover their gifts and find meaningful ways to contribute.

The Justice Tradition: Prophetic critique of systems that burden the vulnerable. Work requirements as structural sin requiring resistance. Religious organizations as advocates for those the system excludes.

The Care Tradition: Emphasis on mercy, compassion, and meeting human need regardless of "worthiness." Religious organizations as alternative care providers when people fall through cracks.

The Community Tradition: Focus on relationship and mutual aid within communities. Work requirements as opportunity to strengthen local bonds through neighbor helping neighbor.

None of these is the "religious" position. Faith communities are as philosophically diverse as any other sector.

The Human Factor: Individuals Within Institutions

Behind every institutional response to work requirements are individual professionals navigating their own philosophical tensions-often at odds with their organization's official stance or their personal values.

The HR Director's Dilemma: She knows that automating verification reporting would help workers keep coverage. But she also worries about privacy, the precedent of employers as government data providers, and whether her small team can handle the technical integration. At home, she watches her sister struggle with the same Medicaid requirements. The professional and personal collide.

The Health Plan Care Coordinator: He entered healthcare to help people get well, not to track whether they've worked enough hours. When he calls members to remind them about work verification deadlines, he hears the stress in their voices. Some thank him profusely; others resent the surveillance. He wonders if he's part of the solution or part of the problem. His performance metrics say "reduce churn." His values say something different.

The Community Organizer: She built her career on "meeting people where they are." But where they are now is desperate for help navigating work requirements she philosophically opposes. Her board wants her to accept a state contract for navigation services-much-needed funding. Her activist colleagues call it collaboration with oppression. She lies awake wondering: Is helping people comply an act of care or an act of complicity?

The Community College Administrator: He spent decades building pathways to opportunity through education. Now he's being asked to report student attendance for Medicaid verification. Part of him celebrates that education finally "counts" as work. Part of him hates that learning has been reduced to compliance hours. He knows some students are enrolling just to meet requirements, not to learn. Others are learning but can't finish because they also need to work for income. The mission he signed up for has become more complicated.

The Primary Care Physician: She went to medical school to heal people, not to gatekeep access to insurance. When patients ask her to document medical exemptions, she faces impossible choices: Is their diabetes "severe enough"? Their anxiety "disabling enough"? Too lenient, and she undermines program

integrity. Too strict, and her patient loses coverage and gets sicker. There's no clinical guideline for this decision-it's a values judgment dressed up as a medical determination.

The Benefits Navigator: He came to this work after his own mother lost Medicaid coverage during the unwinding. He knows the labyrinth from the inside. But he also knows that for every person he helps keep coverage, ten others never reach him. The system succeeds based on his individual effort, but the volume of need makes success impossible. He oscillates between pride in the lives he touches and despair at the scope of the challenge.

These individuals share a common experience: institutional roles that demand philosophical reconciliation. They must operationalize policy they may not have chosen, serve populations whose struggles they witness intimately, and navigate the gap between organizational capacity and human need. Their daily decisions-whether to go above and beyond, whether to bend rules in service of spirit, whether to document failures for advocacy-collectively determine what the policy becomes in practice.

The implementation of work requirements isn't just organizational strategy. It's thousands of individual professionals making micro-decisions every day about how much to care, how much to stretch, how much to accommodate, and how much to enforce. These human factors are the implementation-everything else is just infrastructure.

Toward Ecosystem Governance

- Some states are experimenting with coordination mechanisms:
- Regional hubs connecting stakeholders and sharing information
- Multi-stakeholder collaboratives developing shared protocols
- Data sharing agreements allowing appropriate information flow
- Ombudsman functions helping individuals navigate the system
- Feedback loops allowing frontline stakeholders to inform policy refinement
- Others are taking a hands-off approach, assuming market forces and voluntary coordination will suffice.

The coming years will test which model better serves the dual imperatives of verification integrity and human dignity.

Conclusion: Stakeholders as Social Contract

The stakeholders implementing work requirements aren't just service providers. They're collectively defining what reciprocal obligation means in practice, what counts as reasonable accommodation, and who deserves to be part of the community of care.

Their choices-about system design, resource allocation, relationship boundaries, and philosophical positioning-will determine whether OB3's work requirements promote dignity through participation or create barriers that exclude the vulnerable.

There are no simple answers, only stakeholders wrestling with genuine tensions while trying to serve the people caught in the middle of America's evolving social contract.

This article is part of a series examining work requirements as a fundamental recasting of the American social contract.