

July 31, 2026

Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**Re: Medicaid Program; Community Engagement Requirement for Certain Individuals
[CMS-2454-IFC]**

Dear Administrator Oz,

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) interim final rule with comment period (IFC) on the Medicaid Program: Community Engagement Requirement for Certain Individuals. Below, we offer comments on the Regulatory Impact Analysis: Coverage-Loss and Federal-Savings Estimates for the Medicaid Community Engagement Requirement and some key features of the exemption policy.

This analysis examines the Regulatory Impact Analysis (RIA) accompanying the IFC implementing Medicaid community engagement (work) requirements. Our comments address five aspects of the analysis.

1. The RIA assumes that the work requirement will lead 29% of those subject to it to begin working but offers no empirical justification for this assumption. This assumption is inconsistent with the findings of three separate, well-developed strands of research, which all imply that the requirement will cause little or no increase in employment.
2. This unsupported assumption of substantial increases in community engagement reduces predicted coverage loss associated with the work requirement. Achieving the IFC's assumed budgetary impact given this coverage loss estimate would require that CMS disenroll an implausibly high number of very high-cost Medicaid beneficiaries.
3. The RIA asserts that work makes people healthy. Specifically, it assumes that the increase in community engagement that is assumed to occur will generate benefits to those newly participating in community engagement activities. This assertion is based on correlational evidence that cannot establish causal linkages and fails to account for the substantial causal evidence that work does not consistently or uniformly improve health.
4. The RIA fails to address the costs to beneficiaries of coverage losses. A substantial literature now exists showing quantitatively large health benefits of the specific coverage gains that the work requirement will reverse through the IFC.

5. The IFC’s exemption list fails to recognize the key features of behavioral health disorders (mental illness and substance use disorders) in the design of the exemptions.

The remainder of this comment letter examines each of these issues in turn.

1. Employment effects will be close to zero

The key parameter required to estimate the costs and benefits of Medicaid work requirements is an estimate of the effect of the requirement on employment. To make this estimate, CMS specifies four implementation scenarios, each reflecting different state policy choices; it uses actuarial judgment to assign weights to each scenario. For each scenario, CMS makes assumptions about how the implementation of the work requirement will affect the labor market and other community engagement outcomes. On average across the four scenarios, CMS assumes that around 29% of non-exempt beneficiaries will be moved into work by the requirement, with another 4% being moved into other forms of qualifying community engagement (Table 42). The subsequent estimates of effects on employment, hours worked, earnings, fiscal effects, and IFC benefits are all mechanical outgrowths of these assumed behavioral responses.

CMS offers no empirical basis for these assumed behavioral responses. This approach to modeling the effects of the IFC is inconsistent with the requirements of the Office of Management and Budget (OMB) Circular A-4, as it is not based on “[best reasonably obtainable scientific, technical, and economic information available](#),” and there are three distinct, well-developed strands of research that CMS could have used as a basis for predicting the effects of the community engagement requirements in the IFC:

HHS/ASPE review of the literature

There is an extensive literature on the impact of work promotion strategies in health and welfare programs. In June 2026, the Department of Health and Human Services (HHS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) released an [issue brief](#) that synthesizes 132 rigorous studies (randomized controlled trials and quasi-experimental designs) drawn largely from the Pathways to Work Evidence Clearinghouse, sorted into nine distinct work-promotion strategies. The review’s consensus estimate for welfare-to-work programs, the category with the largest impacts on work, was an increase in employment participation of approximately 4.2 percentage points, a figure achieved only in programs that paired the requirement with substantial work supports (childcare, transportation, case management) and conditioned cash assistance on work.

Effects of Medicaid expansion

The employment effects of adding work requirements to Medicaid should be similar to, but of opposite sign, as the employment effects of making Medicaid available without such requirements, as the Medicaid expansion under the Affordable Care Act (ACA) and several earlier policy reforms did. There is an extensive research literature on the employment effects of

the ACA Medicaid expansion and prior expansions. Table 1 summarizes the ACA literature. The results reported by studies identified in Table 1 center on the expansion having no impact on employment in the overall population or in key subpopulations. Reported results ranged from a 1.3 percentage point decrease to a 3-percentage point increase in employment.

Table 1: Causal evidence on ACA Medicaid expansion and labor supply

Study	Population and design	Magnitude of estimated effect
Hall, Shartzter, Kurth, and Thomas (2018)	DiD using expansion-state variation among working-age adults with disabilities	No significant increase in employment among adults
Callison and Sicilian (2018)	DiD/DDD using expansion status and racial/ethnic subgroups	Employment increases of between 1 and 3 pp
Leung and Mas (2018)	DiD using childless adults in expansion versus non-expansion states	Employment effect statistically indistinguishable from zero and small in magnitude
Gooptu, Moriya, Simon, and Sommers (2016)	DiD using CPS data, 2013 to 2014	Effects of about ±1 pp and statistically insignificant
Garrett and Kaestner (2015)	DiD using CPS/ACS-type national data	Effects generally less than 1 pp and statistically insignificant
Kaestner, Garrett, Chen, Gangopadhyaya, and Fleming (2017)	DiD and DDD among low-income and low-education adults	Estimates 0 to +1 pp and statistically insignificant
Buchmueller, Levy, and Valletta (2021)	DiD and individual labor-market-transition models for unemployed adults	Estimate close to zero and insignificant
Peng, Guo, and Meyerhoefer (2019)	Border-county/distributed-lag design using QCEW data	Employment –1.3% one year after expansion , returning to baseline within two years
Aslim (2019)	DiD comparing low-educated adults ages 55 to 64 in expansion and non-expansion states	Retirement increased approximately 0.6 pp among childless women ; no significant effect for men
Levy, Buchmueller, and Nikpay (2018)	DiD using older adults and variation in ACA exposure	<1 pp and statistically insignificant average retirement effect
Gustman, Steinmeier, and Tabatabai (2020)	HRS-based DiD/model using access to employer and retiree insurance	Estimated effects are small and generally statistically insignificant
Wood (2019)	DiD/event study exploiting ACA implementation and differential exposure of near-elderly adults	Decline of 2 pp in labor force participation among newly-eligible near-elderly adults
Duggan, Goda, and Li (2021)	DDD using age, geography, and pre-ACA uninsurance to identify effects among near-elderly adults	Effects of 0 to 1pp on labor force participation and employment
Clemens, Mahajan, and Sabia (2026)	Pre-committed long-run extensions of DiD and DDD event studies, using ACS data through 2024	Employment effects 7-10 years after expansion near zero (estimates lie between roughly –1 and +1 pp).

Note: Difference-in-Differences (DiD); Difference-in-Difference-in-Differences (DDD); Current Population Survey (CPS); percentage points (pp); Quarterly Census of Employment and Wages (QCEW); Health and Retirement Study (HRS); American Community Survey (ACS); Affordable Care Act (ACA)

Table 2 summarizes the literature on the employment effects of expansions that took place before the ACA. Many estimated effects are close to zero; the largest, at 5.2 percentage points, is about one-sixth as large as the assumed effect in the RIA.

Table 2: Causal estimates of employment effects of pre-ACA Medicaid coverage changes (Percentage-point change in employment associated with gaining Medicaid coverage)

Study	Policy/population	Research design	Employment effect of Medicaid expansion (percentage points)
Garthwaite, Gross, and Notowidigdo (2014)	Tennessee TennCare rollback (2005); low-income working-age adults	DiD and DDD using CPS	-2.5 (broad sample); -4.6 (preferred childless-adult estimate)
Ham and Ueda (2021)	Reanalysis of TennCare rollback	Analyses of ACS, CPS and MCPS	Approximately 0
DeLeire (2019)	Reanalysis of TennCare rollback using SIPP	Longitudinal panel analysis	Approximately 0
Baicker, Finkelstein, Song, and Taubman (2014)	Oregon Medicaid lottery; uninsured low-income nondisabled adults	Randomized lottery	-1.6 (not statistically significant)
Dague, DeLeire, and Leininger (2017)	Wisconsin expansion to poor childless adults	Administrative data; regression discontinuity and DiD	-5.2
Bradley and Sabik (2019)	State adult Medicaid expansions before the ACA	DiD	Little overall effect

Note: Difference-in-Differences (DiD); Difference-in-Difference-in-Differences (DDD); Current Population Survey (CPS); CPS March Supplement (MCPS); American Community Survey (ACS); Affordable Care Act (ACA); Survey of Income and Program Participation (SIPP)

Recent work requirement experience

There is peer-reviewed research evidence on recent work requirements, very similar in nature to those in H.R. 1, from Arkansas, which implemented Medicaid work requirements under a waiver, as well as from recent Supplemental Nutrition Assistance Program (SNAP) work requirement provisions. Three distinct peer-reviewed studies of the Arkansas work-requirement waiver found no measurable impact on employment or hours worked (Sommers et al., 2019; Sommers et al., 2020; Gangopadhyaya and Karpman, 2025). A recent analysis of the Georgia Pathways program likewise found that work requirements under a Medicaid expansion did not increase employment in the state (Johnson et al., 2025). Similarly, Gray, Leive, Prager, Pukelis, and Zaki (2023) find no employment effects of recent SNAP work requirements. Preliminary results from a Randomized Controlled Trial (RCT) (Layton, Leive, and McIntyre, 2026) find that work requirements induce a 1 to 2 percentage point increase in employment.

In sum, three entirely distinct strands of research literature find that the employment effects of work requirements in programs similar to Medicaid are on the order of zero to 2 percentage points, with all Medicaid work requirement studies and many SNAP work requirement studies finding no significant effects. Even the largest estimates in the published literature, those from

programs with cash benefits and work supports, are only around one-sixth as large as those assumed by the RIA.

2. Achieving the IFC's assumed budgetary impact, given its coverage loss estimate, requires that CMS disenroll an implausibly high number of very high-cost Medicaid beneficiaries

Building from the incorrect assumption that community engagement will increase substantially, the RIA's assumptions about Medicaid coverage loss (3.1 to 3.3 million beneficiaries annually) are well below those of other analysts, including the CBO ([5.7 million](#)). These estimates are far lower than the experience of Arkansas (Gangopadhyaya and Karpman, 2025). However, in Table 41, the IFC reports that the ten-year federal savings associated with the regulation will be \$350.3 billion, substantially higher than CBO's federal savings estimate of [\\$317 billion](#).

Federal savings under the rule are approximately equal to the number of people disenrolled multiplied by the average federal cost per disenrolled beneficiary, summed over the years in the budget window. Thus, the IFC must be assuming much larger federal savings per person disenrolled. Concretely, the IFC's estimates imply an average annual federal cost per disenrolled beneficiary of about \$11,000, while CBO's estimate implies a much lower \$5,600 figure.

This difference requires that the IFC and CBO make very different assumptions about who is likely to disenroll from the program under the work and administrative requirements. The IFC's \$11,000 estimate is close to the projected average federal cost of the entire Medicaid expansion population, without taking into account any of the statutory exemptions or the short-term hardship exemption in H.R. 1. By contrast, CBO's estimate accounts for its assessment of the effects of these exemptions.

The difference in mean spending, however, understates the implausibility of the CMS assumption. The distribution of Medicaid spending (as of all health spending) is highly skewed. About 30% of beneficiaries subject to the requirement (or about 5 million beneficiaries, based on scaled calculations from the 2023 MEPS, without taking into account the statutory exemptions) have no or minimal Medicaid-paid spending at all in any given year. Fewer than 10% of those in this group have federal Medicaid expenses at or above \$11,000. To achieve an average federal savings of \$11,000 per beneficiary while assuming that only 3.1 to 3.3 million people will disenroll, CMS must believe that a large share of those who do not use their Medicaid benefits will be among the roughly 4 million the IFC assumes will begin working and will meet significant paperwork obligations because of the new work requirements. Conversely, CMS must assume that many of those in the highest cost 10% of spenders will fail to obtain exemptions and will be shifted off Medicaid.

It is not at all clear that there are enough such high expense people to disenroll, even under the restrictive frailty requirements in the rule, to generate the federal savings indicated.

3. The RIA's assertion that work makes people healthy is not grounded in credible evidence

As noted above, OMB Circular A-4 states that an RIA “should provide documentation that the analysis is based on the best reasonably obtainable scientific, technical, and economic information available.” The IFC’s claim that work requirements improve health also fails to meet this standard.

The IFC grounds this claim in studies that show that people who work are, on average, in substantially better health than those who do not. But this correlation between work and health may not be causal, both because poor health diminishes work prospects and because unobserved third factors may affect both work and health. The studies cited to make the case that work makes people healthy fail to account for these effects.

Gerdes et al. (2026) provide a systematic review of reviews, but the authors explicitly note that the studies they review do not provide evidence of a causal link between work and health. Virtanen et al. (2005) describe largely cross-sectional and observational studies and emphasize the challenges of occupational confounding and health selection. Kim and von dem Knesebeck (2016) summarize prospective studies, which can at least establish that work sometimes precedes improvements in health, but do not rule out situations where improvements in both employment and health are generated by some third factor, nor scenarios where an anticipated change in health spurs a change in labor market behavior. Indeed, they find that the estimated effects of unemployment on health are largest in those studies that make no effort to address selection. Han (2024) describes longitudinal patterns in health and employment, but lacks any basis for establishing causality and does not describe their estimates as causal. Zafar et al. (2024) likewise have no source of causal identification.

There are a small number of research studies that use exogenous variation in work unrelated to other benefit changes (mostly through changes in retirement rules) to examine the impacts of working on health (see Garrouste and Perdrix, 2022, for a summary). The results are inconsistent across studies, with a few finding short-term reductions in mortality from delaying retirement among older men (although these effects are often confounded by changes in health insurance coverage), while most studies find that health declines.

We emphasize that even if work did improve health, community engagement requirements would only improve health to the extent that they increase employment. However, as discussed above, a robust evidence base implies that there will be little or no increase in employment.

4. The RIA fails to address the health costs to beneficiaries of coverage losses

In contrast to the limited evidence establishing a causal relationship of employment on health, there is a large and robust literature documenting improvements in health from insurance coverage. This literature relies on changes in exactly the kind of coverage that beneficiaries will lose through the IFC’s work requirement. Table 3 provides estimates of these impacts from multiple studies, including those that examine the ACA and those that examine other coverage settings. These estimates suggest that the loss of coverage will, on average, generate significant adverse health effects. This robust literature provides ample sources for monetizing the likely

impact of losing Medicaid coverage on the health of beneficiaries. In conjunction with the much smaller impacts on employment and the limited impact of work on health, the costs associated with these adverse effects would likely greatly exceed any benefits of the requirements for enrollees, and, as such, should clearly be quantified in the RIA.

Table 3: The effects of health insurance on health

Study	Intervention and identification	Magnitude of first stage	Health outcome (Effect)
Panel A. Randomized experiments			
RAND Health Insurance Experiment (Manning et al., 1987; Newhouse, 1993)	RCT; reduced patient cost-sharing	Cost-sharing ↓ substantially; utilization ↑	Improved hypertension control and vision among low-income, high-risk participants
Oregon Health Insurance Experiment (Baicker et al., 2013)	Medicaid lottery	Medicaid coverage ↑ ≈25 percentage points	Depression ↓ (~9 percentage points)
Goldin, Lurie, and McCubbin (2021)	RCT; Mandate penalty outreach	Enrollment ↑	Mortality ↓
Panel B. Medicaid expansions			
Currie and Gruber (1996)	Medicaid eligibility expansions for children	Medicaid eligibility ↑	Infant and child mortality ↓
Sommers, Baicker, and Epstein (2012)	State Medicaid expansions	Medicaid enrollment ↑	Adult mortality ↓
Miller, Johnson, and Wherry (2021)	ACA Medicaid expansion	Medicaid coverage ↑	Adult mortality ↓
Wyse and Meyer (2025)	ACA Medicaid expansion	Medicaid enrollment ↑ ≈12 percentage points	Mortality ↓ (~2.5% overall; substantially larger among new enrollees)
Panel C. Medicare			
Card, Dobkin, and Maestas (2009)	Medicare eligibility at age 65 regression discontinuity	Medicare coverage ↑ sharply at age 65	Mortality following emergency admissions ↓; treatment intensity ↑
Goodman-Bacon, Lleras-Muney, Price, and Yue (working paper)	Introduction of Medicare	Medicare coverage ↑	Life expectancy ↑ among older adults
Panel D. Universal insurance			
Hanratty (1996)	Provincial implementation of Canadian universal health insurance	Insurance coverage ↑	Infant mortality ↓, particularly post-neonatal mortality

Note: Randomized Control Trial (RCT); Affordable Care Act (ACA)

5. The behavioral health exemptions in the IFC fail to recognize the characteristics of these illnesses

One group that is particularly vulnerable to loss of coverage and worse health because of work requirements is those with behavioral health conditions (mental illnesses and substance use disorders (SUDs)). To address this possibility, Congress excluded people with certain behavioral health conditions, as part of a broader set of exclusions for people who are “medically frail.”

Section II.E.5—“An Individual Who is Medically Frail or Otherwise has Special Medical Needs”—establishes administrative practices to implement these statutory exemptions, which are out of step with evidence on the fundamental characteristics of substance use disorders and disabling mental disorders. This begins with the Federal Register discussion of the specified excluded individual category for people who are medically frail or have special medical needs. CMS states that this category includes people with: SUD; disabling mental disorder; physical, intellectual, or developmental disability impairing activities of daily living; serious or complex medical condition; or blindness/disability under section 1614. CMS’s key interpretive move is to require that a person must have a qualifying health condition *and* that condition must significantly impair the individual’s ability to comply with the community engagement requirement. In contrast to the statute, diagnosis alone is not sufficient.

The nature of these conditions compounds the problem. Behavioral health conditions are often underdiagnosed or episodically treated—they are not simple binary states. Moreover, by their particular nature, they specifically impair a person’s ability to document eligibility, respond to notices, keep appointments, and navigate state portals (Millan et al., 2012). Recognizing the fluctuating nature of these conditions and the need for continuous treatment, the statute establishes exemptions for these conditions defined by diagnosis alone. The state must verify both the qualifying condition and impairment in an individual’s ability to comply. This makes the exemption as implemented through the IFC more restrictive than the statute intended.

This restrictive definition will have two major consequences. First, the exemption will tend to disadvantage those with untreated SUD, intermittent treatment, unstable housing, justice involvement, relapse, or poor continuity of care, who may be least likely to have the necessary documentation (Millan et al., 2012). People with recent, documented, coded encounters are more likely to meet the criterion, though their conditions may be inherently less serious. Second, it forces states and clinicians to make a functional-capacity judgment: not “Does this person have OUD, bipolar disorder, schizophrenia, major depression, PTSD, or alcohol use disorder?” but “Does this condition significantly impair compliance with 80 hours per month of work or equivalent activities, and can that be documented?” That turns the exemption into something closer to a mini-disability determination, but without the full procedural structure of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). This new extra-statutory provision will be quite costly to the states and threaten the ability to administer exemptions efficiently and fairly. The RIA’s estimate of state administrative costs, which is based on information submitted by states prior to the IFC, fails to consider the new mini-disability-determination process states will need to establish.

A further challenge is that chronic recurring conditions, such as addiction and serious mental illness, do not fit six-month or annual administrative snapshots. The National Institute on Drug Abuse (NIDA) defines addiction as a chronic, relapsing disorder involving compulsive drug

seeking and use despite adverse consequences, with changes in reward, stress, and self-control circuits (NIDA, n.d.). Similarly, schizophrenia, bipolar disorder, recurrent major depression, PTSD, and co-occurring SUD often involve periods of relative stability interrupted by relapse, hospitalization, medication discontinuity, homelessness, incarceration, or functional deterioration. That creates a mismatch with the IFC's operational logic. A person may be stable enough to work part-time in March, relapse in May, miss reporting in June, and lose coverage by July. Or a person may be in remission but only because Medicaid is financing antipsychotics, medications for opioid use disorder (MOUD), therapy, case management, or peer support. Because regaining Medicaid is likely to be much more challenging than losing it under the IFC's conditions, errors of timing will lead to losses of coverage that persist. Treating current stability as evidence that the person does not need the exemption can be exactly backwards.

The symptoms of SUD and serious mental disorders, themselves, often impair executive functioning, memory, planning, attention, motivation, trust in institutions, and social stability. The rule's requirement to demonstrate such impairment—beyond diagnosis—may therefore select against the very people most impaired: those least able to obtain records, request an exemption, or persist through denials.

The administrative navigation challenges facing people with behavioral health problems are not incidental; they are part of the impairment, so adding further hurdles, such as showing functional impairment, will be particularly debilitating.

For this population, the ability to comply with a work requirement is not just the ability to perform paid work. It is the ability to understand notices, gather documentation, access online systems, maintain phone or internet access, respond within deadlines, coordinate with providers, and contest errors. Moreover, behavioral health conditions and the systems that treat them commonly display fluctuating levels of functional impairment, symptom severity, inconsistent diagnostic coding, variable engagement in care, and insufficient documentation in administrative datasets. Claims may lag weeks or months; managed-care encounter data may be delayed; claims disputes, denials, or bundled services may obscure diagnoses; and outdated state data systems may increase reliance on manual reporting. In Arkansas, data matching identified about two-thirds of enrollees as exempt or already compliant, leaving many people to navigate reporting themselves (Musumeci et al., 2018).

The administrative-burden problem will affect many of those people that the statute aimed to protect. Medicaid is a primary coverage pathway for people with behavioral health conditions: among Medicaid-covered adults with diagnosed SUD, 59% qualify through ACA expansion; among those with opioid use disorder (OUD), 61%; among those with any mental health disorder, 51%; and among those with serious mental illness, 45% (Saunders et al., 2025). That means the work-requirement machinery is aimed directly at a coverage pathway heavily used by people with these conditions.

These are especially important concerns because continuous Medicaid coverage supports ongoing treatment for mental health and SUD, and many adults with mild or moderate conditions

already work or engage in qualifying activities while relying on Medicaid-covered treatment to maintain employment (Saunders et al., 2025).

An alternative criterion for exemption proposed by the IFC is participating in SUD treatment. The IFC states that only care delivered by nonprofit treatment providers will count as qualifying treatment. There is no justification for this condition; it is contrary to over a decade of practice, and it will significantly compromise access to treatment. Currently, 45% of all SUD patients are treated by for-profit providers (SAMHSA, 2021), and the proportion is even higher among Medicaid beneficiaries and for those requiring methadone for treatment of OUD, of whom [roughly 67%](#) were for-profit organizations (Abraham et al., 2024). This provision is likely to be particularly problematic in rural areas, which have thinner provider networks, exacerbating existing inequities. Moreover, ownership is a poor proxy for quality of care. Quality would be better assured by applying quality- and access-based criteria such as Medicaid participation, use of FDA-approved medications for OUD where clinically indicated, low-barrier intake, care coordination, co-occurring disorder capability, harm-reduction linkage, retention metrics, and anti-patient-brokering safeguards across ownership forms.

The biggest implementation risk: false negatives.

The main practical risk is not that too many people with behavioral health conditions will be exempted. The bigger risk is false negatives: people who should qualify but are not identified or cannot prove it. Likely false-negative groups include people with untreated SUDs or serious mental disorders, people receiving harm reduction services, people relying on behavioral health services that do not generate Medicaid claims, people with intermittent treatment, people with cognitive impairments, and people who are unhoused or justice-involved.

The impact of work requirements depends critically on how they are implemented. The best implementation would make behavioral health exemptions as automatic, durable, and reversible as possible. States should use data matching first, including Medicaid claims, managed-care encounters, pharmacy data, MOUD prescriptions, behavioral health case management, crisis service use, hospital/emergency department records, Opioid Treatment Program (OTP) participation, residential treatment, and state behavioral health agency data. They should allow multiple proof pathways, including provider attestation, managed-care plan attestation, peer/case manager attestation, recent prescriptions, treatment plan records, crisis records, and self-attestation pending verification.

They should avoid a narrow “currently in treatment” rule. SUD and disabling mental disorders are chronic, recurring conditions. Medicaid coverage may be what keeps a person stable enough to work. They should build in rapid reinstatement and good-cause protection for relapses, hospitalization, incarceration transitions, homelessness, medication interruption, or documented inability to respond.

Bottom line: The SUD and disabling mental disorder exemptions are essential, but their value depends almost entirely on implementation. Because these are chronic, recurring, often under-documented conditions that directly impair administrative functioning, a system that requires

beneficiaries to repeatedly prove both diagnosis and functional impairment will predictably miss many eligible people. The most defensible policy approach would be broad *ex parte* identification, no nonprofit-only treatment restriction, clinically realistic recognition of remission and relapse, low-burden provider or case-manager attestation, and rapid reinstatement when coverage loss results from the very illness the exemption is supposed to protect.

Thank you for your attention.

Sincerely,

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