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# Differential Access to Health Insurance

## Structural Barriers & Their Ethical Implications

by

Julie Ann Stein  
A.B. (Princeton University) 2002

A thesis submitted in partial satisfaction of the requirements for the degree of

Master of Science  
in  
Health & Medical Sciences

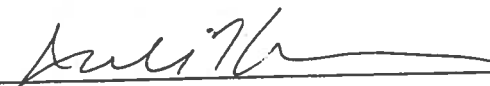
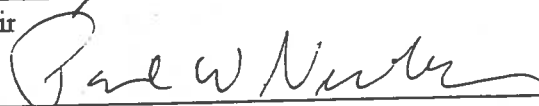

in the  
GRADUATE DIVISION  
of the  
UNIVERSITY OF CALIFORNIA, BERKELEY

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Spring 2006

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**Differential Access to Health Insurance**  
Structural Barriers & Their Ethical Implications

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by

Julie Ann Stein

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Table 1. Divergent Approaches to Public Health Insurance (p.16)

AFDC: Aid to Families with Dependent Children  
CMS: Center for Medicare and Medicaid Services  
CBO: Congressional Budget Office  
EPDT: Early and Periodic, Screening, Diagnostic, and Treatment  
FPL: Federal Poverty Line  
HCFA: Health Care Financing Administration  
HEW: Department of Health, Education, & Welfare  
HHS: Department of Health and Human Services  
HMO: Health Maintenance Organization  
MMA: Medicare Prescription Drug, Improvement, and Modernization Act  
SCHIP: State Children's Health Insurance Program  
SSA: Social Security Administration  
TANF: Temporary Assistance for Needy Families

## Acknowledgements

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There were several people without whom I could not have completed this thesis. Thank you first to my committee members. Jodi Halpern became more than an advisor or mentor; she challenged me intellectually and encouraged me to explore this topic in the depth that it deserves. Ann Keller provided invaluable guidance and support. Paul Newacheck helped give shape to my ideas. With their help, I was able to pursue both my interest in policy and my passion for justice. They helped give my work meaning.

There are also several people who have shaped my career in medical school thus far and whose impact on my life is immeasurable. The entire JMP faculty and staff have made the fifth floor of University Hall a second home. To my twelve classmates, I am grateful for your inspiration, for your trust, and for the daily reminder of how much there is to learn from others. A special thank you to Sarah Dixon, whose presence in my life gives me hope and whose friendship has made these last three years unforgettable. You never cease to impress me with your kindness, intelligence, and strength.

Finally, and most importantly, I would like to take this opportunity to thank my family. George, your daily, unconditional support keeps me going. You are my escape and your love gives me strength—you bring out the best in me. Mom and Dad, thank you inspiring my continuing commitment to the “fairness police.” You have taught me importance of hard work and good fortune and have provided the grounding for both. I love you.

## PART 1

### **Under-Enrollment in Medicaid: The Philosophical & Structural Impact of the Welfare-Approach to Health Insurance**

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Current estimates indicate that over 40 million Americans do not have health insurance.<sup>1,2</sup> Many complex issues lie beneath this statistic—declining employee-based coverage, prohibitively expensive individual insurance, the repeated failure to enact a national, universal healthcare plan are just a few of the reasons why our health insurance system is failing millions of Americans.<sup>3</sup> Still, an additional weakness in our piece-meal healthcare system is the inability of existing government health insurance programs to enroll those individuals already deemed eligible. In this country, there are two principal forms of public health insurance: Medicare and Medicaid. Of the 40 million uninsured individuals, 14 million are eligible for one or both of these programs but not enrolled.<sup>1</sup> It is Medicaid that suffers disproportionately from this problem of under-enrollment. As I will argue, despite many practical barriers to enrollment, it is the fundamental philosophical and structural difference between Medicare and Medicaid that is responsible for the problem of chronic low uptake. Using the contrasting example of Medicare, I will show that under-enrollment is embedded in the welfare-approach to public assistance. Moreover, this paper highlights the effect of this limitation on ensuring access to health care for the most needy populations.

In the first section of this paper, I describe the philosophical and programmatic differences between Medicare and Medicaid. I then show how these differences have had a significant impact on the enrollment in each program. There are those who argue that it is the stigma attached to Medicaid, the burdensome application procedures, and the dependence on state administration and financing that are primarily responsible for chronic under-enrollment. I argue that each of these factors, although significant, can be traced back



to the structure and philosophy of the welfare model. In the last section, I discuss how the welfare model continues to play out in recent legislative reforms like the State Children's Health Insurance Program (SCHIP). This most recent attempt to insure needy children highlights the limitations of a welfare approach to health insurance. Despite specific attempts to maximize enrollment, SCHIP remains plagued by difficulties in up-take and retention. This most recent failure of the welfare-model speaks more broadly to the need to re-examine our approach to providing health care to dependent children.

### **Medicaid & Medicare – Conflicting Approaches to Public Assistance:**

Medicare and Medicaid are this country's primary means of filling the identifiable gaps in an employment-based system. These two distinct social welfare programs aim to provide health insurance to those populations without meaningful access to employment—Medicare covering the elderly and disabled and Medicaid targeting dependent children and the impoverished. These programs are distinct not only in the populations they cover but also in their approach to public assistance. Medicare follows a social insurance model, guaranteeing limited benefits to the general aged population. Medicaid is based on a welfare model, offering more complete coverage but only to those judged to be in need. These two theories of state-funded assistance differ in structure, in administration, and in purpose.

The social insurance model and the welfare model emerged as the two dominant theories of welfare politics in the early 20<sup>th</sup> century. American welfare programs prior to 1935 almost exclusively followed a welfare model.<sup>4</sup> This model has its origins in the Elizabethan poor laws and operates from the basic assumption that most people will protect themselves from poverty through personal savings, leaving the government to provide for only those few who are unable.<sup>5</sup> Accordingly, welfare programs are usually focused on cash

relief. Moreover, a logical consequence of this initial assumption is that there are identifiable groups who are unable to protect themselves from economic disaster through no fault of their own, the “deserving poor.” This deserving population includes impoverished elderly, dependent children, and the unemployable blind (and later disabled).<sup>6</sup> The welfare model is also known as a “targeted” approach in that it targets an especially needy population.<sup>7</sup> Assistance programs for such individuals are primarily administered through local and state authorities, which allowed for the necessarily specific eligibility determinations, in order to ensure that only those in extreme financial need and only those appropriately classified as deserving were enrolled. This leads to substantial variability in coverage and eligibility between states. Additionally, the personally invasive nature of the application process enhances the stigma associated with needing government assistance.

The social insurance model began in Germany during the late 19<sup>th</sup> century as an alternate approach to public assistance and quickly spread throughout most of Europe prior to the First World War. This model is connected to the idea of “enlightened capitalism,” with the primary goal of protecting the working population from unexpected misfortune.<sup>6</sup> Thus, workmen’s compensation, health insurance, contributory old-age pensions, and unemployment insurance are the traditional aims of the movement. Administration is on a national level and eligibility is defined by involvement in the workforce. As opposed to the welfare model, which uses public assistance as a means of public charity to those already destitute, the social insurance model is a means of preempting poverty among the working class. It is a more “universal” approach—benefiting everyone in the designated population, not just those in economic need.<sup>7</sup> Also, the basic concept of social insurance offers a sense of legitimacy that appeals to American individualistic values. Instead of a call for collective solidarity by taking care of the needy, the focus is on the individual worker and the “rights”

afforded by participation in the workforce.<sup>8,9</sup> This legitimacy replaces the stigma of public assistance and has important implications for public acceptance as well as enrollment.

The national debate surrounding public health insurance, beginning just prior to the First World War and culminating in the creation of Medicare and Medicaid in 1965, exemplifies the dichotomy in purpose between the welfare model and the social insurance model and helps to explain the division of coverage for dependent populations. Through the welfare model, health insurance is a way to disconnect disease from poverty, offering the possibility of redistributing income and opportunity. Children are thus the most deserving population within this model. Improving their health care status has the greatest potential impact on their future opportunity.<sup>10,11</sup> The elderly too can be covered, but only those impoverished elderly are deserving of assistance. Alternatively, those following a social insurance model viewed securing access to health care as a component of protecting individuals against unforeseen catastrophe, primarily by decreasing the cost of illness, and thus a step toward greater income security for the working population.<sup>9</sup> Here, there is no logical place for children. The cost of care for most children does significantly impact the income of most working Americans. Moreover, the individualistic social insurance model does not instill an obligation to care for children; instead its focus is on the rights of the worker. The elderly, most of whom were once part of the working population, could receive health care coverage as a part of a fringe benefit connected to employment. Additionally, health care costs for the elderly are substantially higher and have the potential to greatly impact income security. As the nature of this country's "welfare state" developed through the Progressive Era, the New Deal, and the Fair Deal, these distinctions became ingrained in various forms of public assistance, effectively separating these two populations in both the minds of Americans and in the policies created.<sup>6,12,13</sup>

### **Building the Tri-Layered Cake:**

By 1965, the United States had come to embrace the social insurance model as a legitimate method of providing health insurance to the elderly and the welfare model for the impoverished and dependent children. There were three major events leading up to this separation. First, the 1935 Social Security legislation, second the rising cost of healthcare for the elderly, and finally, the failure of the Kerr-Mills Act.

The legislative history leading up to the passage of Medicare and Medicaid paved the way for the political and public acceptance of a health insurance program specifically for the elderly, with coverage for the impoverished as secondary. Early in the 20<sup>th</sup> century, the elderly were included in the categorically needy, determined to be unable to protect themselves from economic disaster through no fault of their own.<sup>6</sup> Then during the New Deal, Title II of the 1935 Social Security Act made a radical departure from this classification, separating the elderly as deserving not in relation to their income, but rather as an effect of their contribution to the workforce. Title II created a federal, contributory old-age pension program, known now as Social Security. This pension program is intimately linked to employment as it is based on employer as well as employee contributions; it is federally administrated with all changes determined by Congress, and it is portrayed as a right, giving it intrinsic legitimacy.<sup>6</sup> Early on, its administrators deliberately emphasized Social Security as an “earned right,” earned through contributions which workers and employers had paid in taxes for a given number of years prior to becoming eligible for receiving benefits, earned through participation in the workforce.<sup>8</sup> This landmark 1935 Act not only set the foundation for the American welfare state but also served to connect the elderly to the working population, model the social insurance approach, and validate both the connection and the approach to public assistance for the elderly.

Within the same legislation, the welfare model was used to provide assistance to dependent children, unemployed adults and the impoverished elderly. Titles I, III, IV, and X used the welfare model to address the needs of these “categorically needy” populations. Title I provided cash assistance to impoverished elderly; Title III offered unemployment benefits to those out-of-work; Title IV was aid for dependent children; and Title X was assistance for the blind.<sup>14</sup> All were administered at the lowest levels of government, all associated with restrictive eligibility determinations and all carried with them the stigma of welfare. There was a clear effort to minimize the federal government’s financial responsibility for welfare programs by placing up to two-thirds of the cost onto the states and thus encouraging financially hard-pressed states to tighten eligibility.<sup>15</sup> Even though health insurance for these populations would not be firmly established for another 30 years, this legislation confirmed the categories of the “deserving poor” and modeled the welfare approach as a means of addressing their needs. Thus, the 1935 Social Security Act was the first step, symbolically, financially, and politically, in separating government assistance by population and by approach. Only the elderly could be linked to the workforce and thus only old-age insurance could follow a social insurance model. Social Security was reserved for the upright and employed, while welfare was intended for the “barely deserving poor.”<sup>13</sup>

Although public health insurance was strategically left out of the 1935 legislation in order to guarantee other benefits, the next 30 years of healthcare debate paralleled the basic structure of the American “welfare state” created during the New Deal.<sup>16</sup> After the Wagner-Murray-Dingell bill in 1943, followed closely by Truman’s failed attempt at national, universal health insurance, the emphasis shifted from a universal health insurance program to focus on providing benefits to the particular groups that had already been made categorically deserving. The defeat of a national health insurance plan in the 1940s

compounded the earlier exclusion of health insurance from Social Security legislation. The absence of a separate health insurance benefit created a link between health services and income-maintenance.<sup>6</sup> Health insurance was not viewed as a social responsibility, but only in relation to its potential economic impact on an individual. In this context, targeting the elderly for health benefits was seen as a logical and politically feasible step. There had been several well-publicized studies regarding the rising costs of health care for the aged.<sup>17,18</sup> It was estimated that individuals over the age of 65 were twice as likely to need medical care than their younger counterparts and simultaneously less likely to be insured.<sup>19</sup> Health care for children, on the other hand, was seen as relatively inexpensive and did not represent a significant threat to income for the general population.<sup>6</sup> If the purpose of health insurance is seen as securing individuals against the cost of illness, the elderly bear the greatest risk, having little income and high medical costs. Thus in the 1950s, in the face of a Republican administration and continued interest group opposition, reformers turned to the idea of incrementalism and began advocating for old-age health insurance.

By 1957, the popularity and acknowledged dignity of Social Security propelled the elderly to the foreground of political thought. At this time, there were two competing proposals for providing health insurance to the aged population. Rhode Island Representative Forand, advocating for the social insurance model, proposed to increase the Social Security tax “so as to provide hospital, surgical, and skilled nursing home care [for the aged] without the stigma of welfare.”<sup>20</sup> Despite the obvious limitations in benefits, health care for the elderly under the Forand bill would be provided as a right, without a means test requirement. The hope was that by building upon the success of Social Security and using the elderly as a jumping off point would eventually lead to a more universal policy.<sup>12</sup> In direct opposition, the Kerr-Mills Act, offered broader health insurance coverage, but only to

the impoverished elderly. This program, which was ultimately enacted in 1960, increased federal funds for the medical care of those receiving old-age assistance through Title I of the 1935 Social Security Act. The Kerr-Mills Act also created a new welfare category, the medically indigent, for those elderly who had been impoverished as a result of their medical costs.<sup>20</sup> Thus, individuals who were not receiving public assistance could still receive health benefits if their medical costs were sufficiently high. Building upon already existing welfare programs, Kerr-Mills had a federal-state cost sharing design, with the degree of federal funds dependent on each state's income. Offering healthcare benefits to only low-income elderly, only those most in need of assistance for whom health care costs represent a serious threat to income security, the Kerr-Mills Act was designed to weaken the case for a contributory health insurance plan for all the aged.<sup>7</sup> Kerr-Mills gained popular appeal for, in theory, the program could provide extensive coverage to the most needy population and simultaneously, shift the financial burden to the states rather than the federal government.

The Kerr-Mills welfare approach to health insurance was implemented slowly, with only 28 states offering Kerr-Mills programs by 1962.<sup>6</sup> As the states had been given primary fiscal responsibility for the program, they had a considerable amount of discretion in its implementation. The lower-income states, even with up to 80 percent federal assistance, were unable to afford the costs of the program. Georgia and Mississippi, for example, authorized the program, but never appropriated state funds.<sup>20</sup> After 3 years the subcommittee on the Health of Elderly of the US Senate Special Committee on Aging found that the program had been "at best an ineffective and piecemeal approach to the health problems of the nation's 18 million older citizens."<sup>21</sup> The committee identified the means tests and the program's "welfare aspects," including the costs to the states, as significantly limiting participation.<sup>20</sup> Additionally, it became clear that Kerr-Mills had done little to curb health care costs,

particularly hospital costs.<sup>22</sup> The growing disappointment with the Kerr-Mills programs, in combination with organized pressure from the elderly, kept the issue of public health insurance actively debated during the early 1960s. Kerr-Mills' failure represented the weakness of the welfare approach, predicting problems currently seen in Medicaid.

Building upon decades of debate, the established categories of needy populations, and the failure of the Kerr-Mills Act to solve the health care problem, in 1965, Congress added Title XVII and XIX to the Social Security Act. These additions, created the “tri-layered cake” known as Medicare Part A, Medicare Part B, and Medicaid.<sup>9</sup> There was extensive lobbying, powerful interest groups, and strong political personalities that shaped the legislation.<sup>5</sup> The three layers came to represent an amalgamation of policies and philosophies, combining the remnants of both the Forand bill and the Kerr-Mills bill and adding in voluntary physician services to appease the AMA and the Republicans in Congress. Medicare, piggybacking on the existing and accepted contributory old-age pension program, embodied a social insurance model. Medicaid, as an expansion of the welfare model and the Kerr-Mill Act, provided additional funds to states for the medical care of poor.<sup>23</sup> Medicaid extended the concept of medical indigence beyond just the elderly to encompass all categorically needy, including dependent children. Thus, the tri-layered cake successfully offered coverage to each of the identifiably “needy” populations, as defined 60 years earlier and as legitimized by the New Deal. Still, it failed to resolve the conflict in the American approach to welfare, opting instead to use both the social insurance model and the welfare model to provide a safety net for its needy populations. The existence of these two programs, each following different models of government assistance, provides an imperfect, real-world experiment, allowing us to measure the success of each model in addressing the needs of the population it serves.



## Medicare & Medicaid Today:

Medicare remains an almost perfect model of social insurance.<sup>24</sup> As it was originally designed, the 1965 Title XVII addition to the Social Security Act, it is a universal program for the elderly. Regardless of their income status or need, this population is automatically deemed eligible. The elderly as a population is perfectly matched to the philosophical underpinnings of social assistance. Most elderly are tied to the workforce, thus the original intention of the social insurance model to provide a safety net to the working population is retained. They have more acute and more expensive health care costs. Medicare benefits were originally restricted to more catastrophic coverage—lengthy hospital stays and unexpected physician’s services. Although preventive services and additional physicians’ services have slowly been added, long term care remains notably absent, which is consistent with the belief that Medicare is responsible for only unexpected, acute health care costs.<sup>5</sup> These benefits are applied consistently across the country, established by Congress, and administered through the Social Security Administration (SSA).<sup>a</sup> Medicare Part A offers a compulsory hospital insurance program to all individuals who paid Medicare taxes for at least ten quarters. Part B is a voluntary insurance program for the elderly, primarily offering coverage for physician’s services. Individuals chose to participate in Part B by paying monthly contributions.<sup>25</sup> Both Part A and Part B are financed through regressive taxation—individuals with less income pay a larger portion of their income in taxes, deductibles, coinsurance, and Part B contributions. Finally, and importantly, beneficiaries are determined eligible not by establishing that they are in “need,” but rather through their contribution to

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<sup>a</sup> The SSA was originally an agency in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under HEW to coordinate Medicare and Medicaid. In 1980, HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

the workforce. This solidifies the premise that Medicare recipients have “earned” their benefits.<sup>8,9</sup>

Since it was first implemented in 1966, Medicare has undergone few substantial changes in eligibility or coverage. The number of people covered by Medicare has almost doubled, with 39.6 million receiving benefits as of 2000. This number is expected to double again by 2030, with an estimated enrollment of 77 million.<sup>26</sup> This is in large part due to the increased proportion of the population over the age of 65. In addition, as of 1972, eligibility was extended to individuals under the age of 65 with long-term disabilities and individuals with end-stage renal disease (ESRD). Most recent estimates indicate that there are approximately 6 million individuals with ESRD or otherwise disabled receiving Medicare, making up 14.6% of the Medicare population.<sup>26</sup> Up until recently, coverage changes had been minimal. In 1980, home health care benefits were broadened. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which will go into effect in January 2006, incorporated a prescription drug benefit through a voluntary Part D. This is a departure from the more acute healthcare coverage traditionally covered by Medicare. Nevertheless, the prescription drug coverage is aimed at providing coverage for individuals with burdensome drug costs, rather than providing comprehensive coverage.<sup>27</sup>

The basic structure of Medicare, as it was outlined in Title XVII, remains the same. Medicare Part A is free as long as the individual or their spouse has worked (and paid Medicare taxes) for at least 40 quarters. Individuals over 65, without sufficient work history, have the opportunity to purchase Part A. As of 2005, for those individuals with between 30-39 quarters of work-history the Part A monthly premium is \$206 and for those with less than 30 quarters the premium is \$375 each month. Part A, as hospital insurance, covers inpatient hospital stays (up to 150 days), skilled nursing care (up to 100 days), and limited

home health care for homebound individuals.<sup>b</sup> Part B costs each enrolled individual \$78.20 per month. This amount is automatically deducted from the individual's social security check if they have elected to enroll. Part B covers physician's services including, outpatient hospital services, durable medical equipment, and preventive care. There is \$110 deductible each year in addition to a 20% co-insurance for all Medicare-approved services.<sup>28</sup> Between the premiums, deductibles, coinsurance, and payment for benefits not covered under traditional Medicare, the average elderly individual without supplemental insurance spends an estimated 56% of his or her annual income on out-of-pocket health related expenses.<sup>29</sup>

Almost every aspect of Medicare follows a social insurance model. Eligibility is independent from income, administration is federal, financing is regressive, and benefits are primarily targeted at reducing the financial costs of health care. There are many intricacies of Medicare beyond the scope of this paper, including Medi-gap plans that provide supplemental insurance and Medicare HMOs that can offer additional benefits and mitigate the out-of-pocket expenses. In truth, the majority of Medicare beneficiaries do supplement their coverage with retirement benefits, Medi-gap plans or an HMO.<sup>30</sup> Low-income Medicare recipients receive assistance through Medicaid and Medicare Savings Programs.<sup>c</sup> The need for supplemental insurance is an important limitation of the social insurance model. The impact on the health of the elderly and disabled forced to limit their service use due to out-of-pocket expense is significant and should not be underestimated.<sup>30</sup> However, I have chosen to focus this paper on the problem of under-enrollment rather than under-insurance.

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<sup>b</sup> Additionally, there is a Part A deductible of \$912 for the first 60 days and co-payment (between \$228 and \$456 per day) for hospital stays that last between 60 and 150 days. The individual is responsible for all costs after 150 days. There is also a \$114/day co-payment for days 21 through 100 in skilled nursing facilities.

<sup>c</sup> The Medicare Savings Programs and low-income benefits within the MMA are targeted at low-income beneficiaries, who do not meet the requirements for Medicaid. These programs follow a welfare-model, are administered through Medicaid and play a crucial role in alleviating the cost-sharing burden of Medicare.

As I will show, the social insurance model, and consequently Medicare, does not suffer from low uptake. Eligibility is without stigma and enrollment is without effort.

Medicaid provides a stark contrast. This program, along with all later low-income health insurance programs, follows a federal welfare model. It offers coverage that is more comprehensive to targeted needy populations—specifically those impoverished individuals who fall within categorically needy classifications of aged, blind and disabled, pregnant and children under the age of 21. Title XIX of the Social Security Act originally limited Medicaid beneficiaries to those already receiving cash assistance from the federal government. Since then, eligibility criteria have expanded but remain targeted to individuals in need by virtue of both their income and their status as “deserving.”

Medicaid covers all “medically necessary” care. This includes inpatient hospital care, outpatient services, diagnostic tests, and nursing home care. The expanded nature of this benefit package follows from the welfare model’s goal of minimizing the impact of financial poverty on access to health care. These benefits, however, are not applied nationally. There are federal guidelines, but states can provide optional services like home health care, physical therapy, prescription drug benefits, and rehabilitation services. One of the key differences between Medicare and Medicaid is the benefit package. Already defined as more comprehensive, Medicaid further expanded their coverage in 1989, targeting children. Through the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) service, Medicaid provides comprehensive and preventive child health services for individuals under the age of 21. This includes periodic screening, immunizations, vision, dental and hearing services.<sup>31</sup> This coverage decision is consistent with the welfare approach to health insurance, and the guarantee of comprehensive health care services (with little to no out-of-pocket costs for the individual) is a significant advantage of the welfare approach.

States have always played a large role in both administrating and financing Medicaid coverage. Financed through general revenue from the state as well as federal government, the welfare approach is a more progressive financial strategy, as revenue is collected through progressive income taxation. The federal-state cost sharing arrangement defers some of the expense of these programs from the federal government onto the states, with the federal government providing between 50 and 80 percent, depending on the resources available to each state.<sup>5</sup> This encourages financially hard-pressed states to restrict eligibility in order to control costs.<sup>15</sup> Along with financial responsibility, states are also given administrative control. Administering the program through local and state authorities allows for the necessarily specific eligibility determinations, ensuring that only those in extreme financial need and only those appropriately classified as deserving are enrolled. Eligibility determination is thus a central component of cost control in addition to being an important part of confirming “deservingness.” As the next section of this paper will discuss they are also crucial to understanding the limitations of the welfare model.

As of 2004, there are over 44.3 million people enrolled in Medicaid. Over the last decade, this number has increased by over 10 million.<sup>32</sup> Unlike Medicare, this number does not reflect changing age demographics or expanded eligibility requirements. There were some eligibility modifications including mandatory coverage of pregnant women and children up to 133 percent of the federal poverty line in 1989. There was also one substantial change to Medicaid, which came indirectly through welfare reform in 1996. The Temporary Assistance for Needy Families (TANF) block grant replaced the Aid to Families with Dependent Children (AFDC) entitlement program. Prior this point those individuals receiving AFDC were considered eligible for Medicaid. TANF placed new restrictions on cash assistance, putting a maximum of 5 years on the benefit. Medicaid had no such limit

and thus enrollment and termination of Medicaid was no longer automatic with receipt and loss of welfare cash assistance. However, as I will discuss later, even this significant change in eligibility and perceived disconnect from welfare had little impact on enrollment. Finally, in 1997, Title XXI was added to the Social Act, creating the State Children's Health Insurance Program (SCHIP). This program aimed to expand coverage for low-income children. The final section of this paper will address SCHIP more specifically.

Medicaid enrollment is complicated by eligibility determination. The exact application procedure and specific eligibility requirements vary across the country, at a statewide and sometimes countywide level. In its simplest form, applying for Medicaid benefits requires a mail-in application documenting family income, citizenship status, and enrollment criteria. More complicated versions include an in-person interview at a local Medicaid office, as well as a 16 page application, complete with copies of original birth certificates, social security cards, monthly income stubs, and annual bank statements.<sup>d,33, 34</sup> Typically, if the beneficiary's income is less than the Medicaid limits, there is no cost-sharing component to the benefit. Alternatively, those individuals with incomes above the limit have the option of "spending down" to the level required. Medicaid has clearly grown from its original purpose, moving from providing health care only to those individuals already receiving cash assistance to covering individuals no longer eligible for welfare and those individuals with incomes just above requirements. Still, Medicaid has held to its welfare roots, with eligibility remaining intimately connected to income.

Medicare and Medicaid are both government health insurance programs, both were created as amendments to the Social Security Act, both fall under the administrative

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<sup>d</sup> In New York, an individual must go to the department of social services for an interview and provide an *original* birth certificate as proof of age, recent paycheck stubs, Social Security statements, etc. as proof of income, any bank statements as proof of resources, and a rent receipt as proof of address. In California, a 4-page application can be mailed-in with copies of one's proof of age, address, income, and resources.

umbrella of the Center for Medicare and Medicaid Services (CMS) and both offer assistance for designated deserving populations. Yet, these programs clearly represent two very distinct approaches to public assistance. Table 1 highlights many of the differences discussed in the previous section. Yet, one significant aspect of these programs is missing. Moving beyond the structure, the financing, and the benefit packages—an important aspect of any health insurance program is the ability to enroll those individuals deemed eligible. As I will argue, enrollment is a direct consequence of structure, financing, and purpose and an essential measure of the success of any program.

	<u>Social Insurance Model</u> <i>Medicare</i>	<u>Welfare Model</u> <i>Medicaid</i>
<i>Beneficiaries</i>	Aged & disabled who have paid Medicare and Social Security taxes	Dependent children, their families, disabled, blind, aged – without financial resources
<i>Benefits</i>	Acute care + optional insurance for outpatient care and prescription drugs	Comprehensive benefits for acute and preventive care
<i>Financing</i>	Regressive Social Security/Medicare taxes	Progressive federal income taxes+ state matching funds
<i>Administration</i>	National standards set by the federal government and administered by CMS	Standards vary by state and county, CMS sets federal guidelines with state & local administrative authority.
<i>Purpose</i>	Decrease the <i>financial burden</i> of the health care	Decrease the <i>financial barriers</i> to health care

Table 1: Divergent Approaches to Public Health Insurance<sup>5</sup>

## Under-Enrollment – Structural Barriers to Medicaid:

Given the goals of Medicare and Medicaid and looking at these two programs together, one might assume that the most vulnerable segments of our population are adequately insured. Although neither program addresses the escalating dilemma of the uninsured working population, they do, at least symbolically, provide a safety net for those who are unable to work (whether due to age or disability) or impoverished (for whom health care would be prohibitively expensive). Still, we are left with that disheartening statistic: over 40 million Americans are uninsured, 14 million of which are eligible for Medicare or Medicaid and not enrolled.<sup>1</sup> There are various attempts to explain the problem of under-enrollment. These arguments are usually specifically applied to Medicaid, as low uptake has plagued Medicaid since its inception. Most analyses focus on three types of enrollment barriers: stigma, application procedures, and the dependence on state and local administration and financing. Few study these barriers in the broader context of a welfare-model. I will illustrate how under-enrollment distinctly affects Medicaid and the welfare-model for health insurance, explaining why, despite many attempts to correct for these enrollment barriers, under-enrollment persists. Although stigma, applications procedures, and decentralized control each represent formidable obstacles to enrollment, I argue that all three can be seen as a direct consequence of the structural and philosophical framework of a welfare-approach.

Current estimates indicate that the elderly, as an age-defined population, have the lowest percentage of uninsured individuals.<sup>4</sup> Over 98% of eligible elderly are enrolled in Medicare Part A and nearly 95% in Part B.<sup>35</sup> Although this statistic does not include the disabled population, it does speak to the success of the Medicare program in enrolling and retaining its targeted population. In striking comparison, only 40 percent of the poorest



adults with incomes less than 50 percent of the federal poverty line are enrolled in Medicaid.<sup>36,e</sup> Amongst the elderly and disabled who have Medicare coverage, studies have estimated that only 60% of those dually eligible for low income programs are actually enrolled.<sup>37,f</sup> Even dependent children, a population that continues to be singled out as uniquely deserving, suffers from under-enrollment. As of September 2004, there were 9 million children under the age of 19 without health insurance, with 6 million living in poverty and eligible for Medicaid.<sup>38</sup> In other words, approximately one out every five children eligible for Medicaid remains uninsured.<sup>39</sup> This statistic is compounded by the fact that it does not include those children who had discontinuous coverage. In a recent study, it was estimated that in addition to the 6.6% of all children who are uninsured, 7.7% of children do not have insurance for a continuous 12 months. These children are disproportionately poor with over 60% of them coming from families with incomes below 200% of the federal poverty line.<sup>40</sup> Over all, recent estimates for Medicaid enrollment range between 40 to 70 percent.<sup>41</sup>

It is important to recognize that these numbers are only estimates, as it is very difficult to determine which individuals are eligible and not enrolled. These statistics do not speak to the impact of low uptake on the lives of the 14 million eligible, unenrolled individuals. Although this paper does not address the health effects of being uninsured, it is important to note that these individuals are more likely to postpone healthcare, not seek necessary medical care, and not receive regular preventive services.<sup>42</sup> Still, despite the limitations of these statistics, they do provide a glimpse into the problem of low uptake. They reveal a universality of under-enrollment in all low-income health insurance programs,

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<sup>e</sup> Although this statistic includes those individually who are chronically mentally ill and cognitively impaired, this paper does not address the enrollment issues unique to these populations. These populations require a separate discussion regarding societal obligation and capacity to enroll.

<sup>f</sup> This includes individuals dually eligible for Medicare and the Medicare Saving Programs or Medicaid.

regardless of the population targeted—welfare model programs for children, adults, and elderly are all affected. Moreover, the discrepancy between enrollment in Medicare and enrollment in low-income programs is apparent.

### **The Impact of Welfare Stigma:**

Many have argued that at the heart of the enrollment differences between Medicare and Medicaid lies the issue of stigma. Stigma is a social construct, commonly defined as any discrediting attribute in society.<sup>43</sup> There are two common forms. *Identity-stigma* is associated with individual attributes, specifically negative stereotypes. This stigma relates to how an individual comes to view him or herself. *Treatment-stigma* arises from the way society behaves toward stigmatized individuals. This concept reflects how others view the stigmatized population.<sup>44</sup> Welfare, and specifically cash assistance, has long suffered from both identity and treatment stigmatization. The negative stereotypes associated with means-tested programs stem from American ideas that equate social status with personal achievement.<sup>45</sup> Being poor equates with failure and recipients of government assistance are undeserving.<sup>46, 47</sup> Beneficiaries are labeled as lazy, lacking ambition, dishonest, morally weak, and bad parents.<sup>48, 49</sup> Consequently, the process of seeking assistance is associated with demeaning and unsympathetic behavior. Research has shown that local administrators are often hostile, angry, and disrespectful toward those individuals applying for welfare.<sup>50</sup> Potential beneficiaries internalize these negative stereotypes, and the fear of being labeled and treated poorly prevents individuals from enrolling in Medicaid.<sup>51</sup>

Stigma, as an enrollment barrier, is most intimately connected to the means-testing requirement of the welfare-model.<sup>52</sup> In the welfare-approach to public assistance, income is the distinguishing factor used to determine eligibility. Only those truly in need, those unable

to avoid abject poverty are eligible—it is this fact that qualifies these individuals for government assistance. Therefore, to receive the benefit requires the disclosure of one’s poverty and the application process demands that the individual prove their impoverishment. It is this fact that is truly stigmatizing. Given Americans’ value system—equating poverty with failure, applying to Medicaid or any means tested program, requires the individual in many ways “not merely to admit, but to make out a convincing case, that [he or she] is a failure.”<sup>53,§</sup> Stigma is thus an inherent component of the welfare-model.

Some argue separating Medicaid from its historical connection to welfare can reduce the associated stigma.<sup>54</sup> Historically, Medicaid was a program aimed at providing health care benefits to the recipients of welfare. Thus, the potentially demeaning stereotypes of cash assistance were automatically incorporated into Medicaid. Recent legislative efforts have “de-linked” health insurance and welfare. The expansions in Medicaid eligibility during the late 1980s made it possible for certain populations, particularly pregnant women and children, to be eligible for Medicaid without receiving cash assistance. For these populations, welfare income guidelines were separated from Medicaid limits. Later welfare reform reinforced this separation, making it possible for more individuals to receive health insurance independent of their welfare status.

Still, studies show enrollment and its associated stigma remains linked. The continued administrative connections between the two programs results in a large overlap population of individuals both receiving cash assistance through TANF and health insurance through Medicaid. The application procedure for the two programs is similar.<sup>55</sup> In one study, 38 percent of potential beneficiaries never tried to enroll because they did not want to go to the welfare offices to apply. Even more (42 percent) feared unfriendly treatment at the

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<sup>§</sup> Part 2 discusses the ethical foundation and consequences of this belief.

enrollment office.<sup>42</sup> More importantly, even if one were to remove all overt associations with welfare—if eligibility determinations occurred in distinct locations, if populations of categorically needy did not overlap—Medicaid, through its adherence to the welfare-model, still relies on income. Thus, the attempt to de-link Medicaid and welfare was not only unsuccessful, but also ignores the more basic root of stigma—means-testing. This requirement originates not in the programs link to cash assistance, but rather more broadly to the welfare-model.

The association between the welfare-model, stigma, and under-enrollment is not accidental. Some have argued that stigma improves the efficiency of these programs in targeting those truly in need, thus “efficiently rationing scarce resources.”<sup>44</sup> Only those in need will not be deterred by negative stereotypes and poor treatment. Stigma is thus a tool used to ensure that the eligibility determinations are effective. Under-enrollment is an unfortunate, but necessary consequence.

Additionally, the impact of stigma on enrollment was known prior to the enactment of Medicaid and in fact, helped shape the decision to use an alternate approach for the elderly. The original advocates of Medicare supported a social insurance approach in part due to the skepticism that a means-tested assistance program would be fully utilized.<sup>5</sup> The social insurance alternative does not suffer from the same problems of stigmatization.<sup>56</sup> Medicare benefits are not discussed in terms of a safety net but rather in terms of obligation. The structure of the social insurance model allows individuals to “earn” their benefits by paying into the system, providing legitimacy to the program and avoiding the attack that beneficiaries are receiving a “free-ride.” Accordingly, Medicare beneficiaries are not lazy, undeserving, or dishonest. This complete lack of stigma associated with Medicare serves to highlight the connection between stigma and the welfare-model.

## **The Complexity of the Application Procedure:**

A complex and burdensome enrollment process is often cited as the greatest barrier to enrollment in Medicaid. Studies have shown eligible individuals find the application process confusing and intimidating.<sup>42, 44, 57</sup> Application barriers include transportation difficulties, documentation requirements, language differences, in-person interviews and an overall time consuming process. People are reluctant to go to the Medicaid office, which is often inconveniently located and difficult to access through public transportation. Individuals experience long waits at the Medicaid office and are often met with hostility, confusion, and contempt by the over-worked, under-paid Medicaid officials. Application requirements are seen as intrusive and arduous. They are time consuming and often involve missing work and securing childcare. One study estimated nearly half (46%) of eligible individuals interviewed did not complete the enrollment process because the forms and information were not translated into their language.<sup>42</sup> The same study reported “difficulty in getting required documentation” to be one of the most cited barriers to completing the enrollment process.<sup>42</sup> Similar studies have shown that difficult verification requirements lead to a large number of eligible individuals being dropped from coverage.<sup>58, 59</sup> Thus procedural barriers not only prevent eligible individuals from enrolling in health insurance programs, they also prevent enrolled individuals from retaining coverage.

A general lack of knowledge of Medicaid eligibility rules compounds the difficulties of completing the enrollment process. Many eligible individual are unaware of or misinformed about the programs and their eligibility status.<sup>60</sup> Many individuals still believe that they have to be on welfare to receive Medicaid; others think Medicaid is only for pregnant women.<sup>61</sup> The 1996 welfare reform created additional confusion about eligibility, particularly regarding time limits.<sup>55</sup> The existence of multiple programs, each with different eligibility rules and

benefit packages “inherently and unavoidably creates confusion and frustration” both of which are deterrents to enrollment.<sup>62,63</sup> Finally, even if an individual manages to get to the Medicaid office, fill out an application, obtain all the necessary documentation, and meet with the Medicaid officer—applications are often lost or misplaced, and benefits are delayed without a means of monitoring progress.<sup>57</sup> This complicates enrollment even further and discourages many eligible individuals from beginning as well as completing the enrollment process.

Once an individual is enrolled in Medicaid, he or she is usually required to re-enroll annually. The re-enrollment process is not automatic and is often plagued by the same barriers as the original application procedure. A recent study of documenting retention rates in California’s Medicaid program, known as Medi-Cal, suggested that the primary reasons for non-renewal, and subsequent loss of Medicaid coverage, was that the individual or family did not re-apply or that the application was incomplete.<sup>64</sup> Even with efforts to minimize the application barriers to re-enrollment, such as mail in applications and telephone contact, a 2002 RAND study estimated that disenrollment rates are on average 50 percent, ranging from 22 to 82 percent.<sup>65</sup> The impact of disenrollment is well documented. The term “churning” refers to when individuals do not renew their coverage during their eligibility re-determination period. Instead, they re-apply after they have already been dropped from Medicaid. Studies show that “churning” increases administrative costs and consumes limited staff time. Moreover, continuous coverage improves overall quality of health care – longer periods of continuous coverage allow for preventive care, replacing more costly hospitalizations and emergency room visits.<sup>66-68</sup> Thus in addition to the burdens of applying for Medicaid, eligible individuals must re-apply each year, creating another potential source of under-enrollment.

Some of the barriers to enrollment and to re-enrollment represent implementation failures. For example, lack of knowledge about the availability of low-income programs can be corrected by improved outreach and applications can be translated into additional languages. However, the fundamental premise of an application is intrinsic to the welfare approach to assistance. The application is an essential component to eligibility determination, and eligibility determination is a key feature in the welfare model as a means of verifying need. From its inception, Medicaid was not designed to serve the entire poor population, but rather was reserved for certain groups of categorically needy. Thus need is dependent on both income and a defining characteristic (age, disability, medical expenses).<sup>52</sup> A social insurance model does not have application requirements as eligible individuals have already proven their status through participation in the workforce.

Importantly, it is possible to determine need-based eligibility without placing the burden of proof on the applicant. Many of the most difficult application barriers, such as in-person interviewing, resource documentation, and original document requirements do little to differentiate between eligible individuals but can have a significant impact on enrollment.<sup>57, 69, 70</sup> Alternatively, one could administer a means-tested program without any application. One such method would be to automatically enroll those individuals who file income taxes with an income below a pre-determined eligibility level. The welfare approach, however, demands that each individual earn his or her benefit. By relying on local administration and emphasizing the idea of deservingness—in effect, the welfare model ensures that means testing is an arduous process by which individuals earn their benefit and states can exert control over enrollment.

The use of application procedures to control enrollment and thereby cost is key to the welfare-model. The welfare model's reliance of state matching funds means that states have

the flexibility and incentive to decrease costs. This can be done through either a reduction in benefits or a reduction in the number of enrollees.<sup>71</sup> States have long used the inverse relationship between procedural burdens and enrollment to limit their financial exposure for the cost of covered benefits, especially in times of economic crisis.<sup>72</sup> Even as income eligibility levels remain constant, one study documented that between April 2003 and July 2004, 23 states took steps to make it more difficult for eligible children and families to enroll in existing programs.<sup>69</sup> State revenues are more vulnerable to economic downturn. Unlike the federal government, which can spend into a deficit, most states must balance their budgets and thus are forced to cut social welfare programs during economic crises.<sup>73,h</sup> Unlike a social insurance program, funded and administered only through the federal government, the welfare structure allows states the administrative control to alter application procedures and imposes fiscal constraints that demand such methods of cost control.

The welfare approach also emphasizes the concept of deservingness. As I argue in the second section of this paper, the application process moves beyond proving one's eligibility, but also involves earning it. Deservingness is central to both Medicare and Medicaid.<sup>47</sup> Medicare recipients earn their benefits through the participation in the workforce; Medicaid recipients earn their benefits through the arduous application process. Although the two approaches to providing health insurance result in significantly different benefits, financing, administration, and eligibility, there is a common underlying principal that each individual must earn his or her benefit. Lengthy enrollment and burdensome applications are the welfare model's way of requiring eligible individuals to work for their reward. This requirement of effort and how it connects to American ideas of fairness and

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<sup>h</sup> All states (except Vermont & D.C.) are constitutionally prohibited from running a deficit. This does not mean that states never run deficits, however generally speaking, they have much less financial flexibility. It is also important to note that deficit spending has its own problems, but it does mean that benefits do not change appreciably from one year to the next. For the time being, enrollees can count on their Medicare benefits.



desert are discussed in Part 2 of this paper. Importantly, both the idea of earning one's benefit and the reliance on state administrative control are central features of the welfare model. Together, they help to explain why application barriers remain and thus why under-enrollment plagues welfare-model health insurance programs like Medicaid.

### **The Effect of Decentralized Control:**

State administrators have considerable discretion in the design and implementation of Medicaid. States set eligibility standards within the limits of federal guidelines, implement federal reforms (including those related to welfare), expand the generosity of the Medicaid benefit package, and modify the Medicaid enrollment process. All of these factors define enrollment, determining who is eligible, what they are eligible for, and how they enroll. As I showed in the previous section, without changing in eligibility levels, states can make it more difficult for individuals to enroll by influencing the application process thus perpetuating the problem of under-enrollment. The welfare approach places much of the decision-making power in the hands of individual states. This kind of decentralized control allows states to both control and promote under-enrollment as they see fit. Medicaid, although federally legislated, is in many ways a state-level policy and becomes prey to state-level politics. State politics are often more influenced by public opinion, party and interest group activity, as well as fiscal constraints.<sup>74</sup> Accordingly, enrollment in Medicaid potentially vulnerable to party politics, fluctuations in public favor, and most significantly, economic downturn.

States tighten enrollment during economic hardship. This is mediated through changes in application procedures, eligibility, and benefit packages. The welfare approach places a large portion of the financial burden on states, which provide matching funds for the benefits associated with the program as well as its administration. As of 2002, the federal

government was responsible for approximately 51 percent of the costs of the Medicaid program.<sup>75</sup> States thus shoulder a considerable portion of the financial burden and are forced to cut costs, especially when there are competing economic interests or during times of economic decline. Ironically, it is during times of economic crisis that such safety net programs like Medicaid are most needed. Moreover, the welfare model, in contrast to the social insurance program, allows the federal government to continue to transfer financial responsibility to states, relieving their own share of the costs. Such transfers of fiscal responsibility are accompanied by administrative responsibility.<sup>10</sup> This creates increased funding variability between states and additional fluctuations in enrollment.<sup>10, 73</sup>

The most recent recession following the economic boom of the 1990s highlights the states' authority to manipulate enrollment. During 2003-05, states faced some of the largest budget shortfalls since World War II.<sup>76</sup> Compounding the problems of decreasing state revenues and increasing Medicaid spending, the federal government transferred additional cost sharing requirements onto the states. The loss of federal matching funds is cited as the motivating factor for state-level Medicaid cuts.<sup>77</sup> Even though most states have been able to stave off large cuts in Medicaid, many have still cut programs and reduced funding in ways that have hurt some beneficiaries.<sup>78</sup> Florida ended its medically needy program for adults, tightened eligibility standards for older persons and disabled beneficiaries from 90 percent to 88 percent of the federal poverty level, and eliminated planned coverage of certain persons with disabilities who are working.<sup>77</sup> Oregon increased member cost-sharing requirements for many of their benefits. Early results from an ongoing study suggest that such cost-sharing increases led to a large reduction in Medicaid enrollment.<sup>79</sup> Additionally, many states have opted not to take advantage of new coverage expansion opportunities, such as parental coverage under Section 1931(b) of the Social Security Act or SCHIP waivers.<sup>78</sup> These

changes have the effect of either restricting eligibility or increasing the number of individuals who are eligible but not enrolled.

The structure of the welfare model, placing states in a position of administrative and financial control explains why economic fluctuations effect Medicaid enrollment and not Medicare enrollment. During this same economic downturn, Medicare enrollment has not decreased and eligibility has not changed. In 2003, right in the middle of the recession, the Medicare Modernization Act expanded preventive coverage and added a costly prescription drug benefit. The Congressional Budget Office (CBO) estimates that 87 percent of Medicare beneficiaries will participate in the drug benefit once it becomes available in January 2006.<sup>80</sup> This estimate is based on historical rates of participation in Medicare's other voluntary component, Part B. Participation in Part D will most likely be lower than that in Part B because many active workers and federal retirees enrolled in Part B are expected not to sign up for the drug benefit. Given this level of enrollment, the direct cost to the federal government is estimated to be \$407 billion for the next 10 years, without a specific budgetary cap.<sup>80</sup> The decision to expand coverage during a recession reflects not only the choices of this administration and the political influences of the time – but also the structural consequences of a social insurance approach. The social insurance model relies solely on federal administration and federal financing.<sup>5</sup> Increases in costs are not transferred onto the states. The federal government can spend into an increasingly large deficit and does not have to cut back on politically popular programs like Medicare. Moreover, enrollment is not influenced by state-level adjustments, but rather the CBO's estimates reveal that enrollment in Medicare is not a viewed not as consequence of policy but rather the presence of available alternatives. The fiscal realities of state-level policy promotes under-enrollment in welfare-

model programs like Medicaid; the social insurance model protects Medicare from such economic vulnerabilities, making enrollment less variable.

Chronic under-enrollment has plagued Medicaid since its creation. Much research has been done articulating the various emotional, practical, and administrative barriers to enrollment. Yet, stigma, enrollment barriers, and decentralized control are all a consequences of the welfare approach underlying the basic design of Medicaid. Each can be traced back to a fundamental component of the welfare model. Stigma, although partially attributable to Medicaid's association with traditional welfare, is also a byproduct of the welfare model's use of income to determine eligibility. In this country, poverty is associated with its own stigma and any program that requires a declaration of impoverishment is stigmatizing. Application barriers result from both the authority states have to manipulate enrollment procedures and the American emphasis on earning one's benefit. Decentralized control creates fiscal vulnerability as the cost-sharing arrangement inherent in the welfare model leaves states vulnerable to absorb rising costs and the ability to cut benefits to control these costs. The effect of the welfare model on enrollment is emphasized by the availability of an alternative approach, the social insurance model, embodied by Medicare. Medicare is not plagued by the same problems of stigma, application procedures, and fiscal vulnerability and does not suffer from chronic under-enrollment. Rather, even the new (and relatively controversial) drug benefit is estimated to enroll almost 90 percent of those eligible.<sup>80</sup> Enrollment in Medicaid hovers at between 40 to 70 percent, with rates continuing to decline.<sup>41</sup> As the next section illustrates, even the most recent targeted effort to enroll uninsured children through the 1997 State Children's Health Insurance Program (SCHIP) suffers from low uptake as it too uses a welfare approach.

## **State Children's Health Insurance Program – The Welfare Model Revisited:**

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), enacted as Title XXI of the Social Security Act.<sup>81</sup> SCHIP was a compromise. After the failure of the Clinton health plan, there was widespread consensus among most policy analysts and politicians that future health reform efforts should proceed incrementally.<sup>63</sup> Children were an easily identifiable, "deserving" population that remained plagued by uninsurance and poverty. SCHIP was thus designed to provide health coverage for uninsured, low-income children, and particularly children of the working poor. Like Medicaid, SCHIP follows a welfare approach to public assistance. Recognizing the need to overcome the application barriers and welfare stigma that comes with the welfare model, states employed a variety of techniques to increase enrollment.<sup>82</sup> As I will show, despite the outreach efforts and application reforms, under-enrollment remains. SCHIP thus hints at the limitations of the welfare model and the need for broader policy changes.

Like the elderly did during the 1950s and 60s, during the 1990s, uninsured children came to represent a deserving and needy population. Traditionally, the very young and the very old have two things in common: both have disproportionate needs for assistance and both are often affected poverty. During the 1970s and 80s income and social benefits for the elderly grew while the services and income of families with children declined.<sup>83</sup> Children's uninsurance rates increased sharply between 1977-1987, most strikingly for children in families with incomes below the federal poverty line.<sup>84</sup> In the 1980s and early 90s, rising poverty rates, declining private insurance coverage, and growing concern about the costs of low-birth weight babies helped move children's health to the forefront of the political agenda.<sup>55</sup> During this time, the percentage of children under the age of 21 without health insurance increased from 13.1 to 15.4 percent. This increase in uninsured children was the

result of fewer children being covered through employer-sponsored health insurance.<sup>85</sup> By 1997, health insurance for low-income children not covered through Medicaid was a politically feasible and popular policy initiative.

With broad support for the targeted expansion of children's health insurance, the debate regarding SCHIP focused not on who would be covered, but the best way to provide such coverage. This discussion was framed only within the context of the welfare model. Children have long been identified as the most deserving population within this model. Improving their health care status has the greatest potential impact on their future opportunity.<sup>10</sup> Their poverty is without blame and a focus on preventive care is appropriate, as most children do not have acute health care costs. Thus, the two alternatives discussed, expanding Medicaid and offering a separate block grant to states, assigned states both the administrative control and at least some the financial risk for covering this population.

As an expansion of Medicaid, SCHIP would be subject to federal oversight, implemented at a statewide level, and financed through Medicaid cost-sharing guidelines. A block grant program would give states full authority over the program, with less financial risk, as the primary funding is federal. Ultimately, the legislation represents a compromise between these versions of the welfare model. Like Medicaid, SCHIP requires states to contribute the cost of care with an "enhanced federal match," 30 percent higher than that for Medicaid.<sup>86, 87</sup> Yet importantly, SCHIP is not an open-ended entitlement like Medicaid, rather there is a capped federal grant of \$40 billion over the next ten years. This cap has important implications for enrollment and clearly limits financial risk to both the federal government and states.<sup>87</sup> Each state had three options for implementing the coverage expansion: they could create a separate child health program, they could expand their existing Medicaid program, or they could use a combination of both. In all three, the state

retains primary administrative control but must follow federal guidelines to extend coverage for children, under the age of 19, living in families with income below 200% of the federal poverty line or whose family has an income 50% higher than the state's Medicaid eligibility threshold.

SCHIP expanded eligibility and increased health insurance coverage for poor and near-poor children. Between 1996 and 2002, the number of children eligible for public coverage, through either Medicaid or SCHIP, rose from 21.4 million to 36.0 million. This translates into 47.1 percent of all children being eligible for free or highly subsidized health insurance and is almost entirely attributable to the introduction of SCHIP.<sup>88</sup> Logically, this massive expansion in eligibility led to a decrease in the number of uninsured children. During the same time period, the number of uninsured children in the United States declined by approximately 2.6% (1.7 million children).<sup>89</sup> Yet, there is a discrepancy between the increase in eligibility and the number of uninsured children. Over 6.5 million low-income children remain uninsured. Within this population of low-income, uninsured children, over 60 percent are thought to be eligible for Medicaid with an additional 25 percent eligible for SCHIP.<sup>i,90,91</sup> As of 2002, the best estimates put SCHIP take-up rates (the number of enrolled individuals divided by the number eligible) at just over 77 percent.<sup>88</sup>

There are particular problems in enrolling SCHIP-eligible children and states have made efforts to overcome these. Enrollment rates tend to decline with age and the SCHIP

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<sup>i</sup> This estimate was derived from The Urban Institute's Assessing the New Federalism project. The National Survey of America's Families (NSAF), a nationally representative survey of the noninstitutionalized population that samples the low-income population in 13 states. For this estimate, NSAF data were analyzed to examine eligibility and participation in Medicaid and SCHIP based on a simulation model that mimics the eligibility-determination process. First, eligibility units were created from the household survey data based on which individuals in the household would be considered in the eligibility-determination processes for Medicaid and SCHIP. Second, state-specific Medicaid and SCHIP eligibility rules in place as of 2000 were applied regarding eligibility thresholds, family composition, and work status of the parents. Third, children were categorized into two eligibility groups: (1) those eligible for Medicaid and (2) those eligible for SCHIP. For more information, see <http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm>.

population is on average older than that of Medicaid. SCHIP parents are often working and unfamiliar with the process of applying for public benefits.<sup>88</sup> Decades of enrollment difficulties with Medicaid led to concerns about enrollment in SCHIP.<sup>92</sup> Many states thus tried to ameliorate some of the recognized problems with Medicaid enrollment. This includes reducing the stigma associated with public assistance and eliminating many application barriers. Well-publicized enrollment campaigns attempted to separate the public image of SCHIP from welfare and Medicaid.<sup>52</sup> States shortened application forms, limited documentation requirements and tried to streamline the enrollment process.<sup>87, 93</sup> Many states opted for a mail-in application. This eliminates the burden on both the beneficiaries and the welfare office. All but one state has eliminated the asset-test requirement for determining eligibility.<sup>94, 95</sup>

By tracing SCHIP enrollment since its origins in 1998, it is clear that states' outreach and simplification efforts lead directly to increase in enrollment. One study documented the percentage increase in enrollment associated with various state level reforms, showing that the presence of an asset test reduces children's enrollment by 6.2 percent while reducing the documentation required to verify income increased enrollment by 3.5 percent.<sup>94</sup> The structure of program also influenced enrollment. Expanding Medicaid eligibility to SCHIP led to higher enrollment levels—2.7 percent higher than those using a combination program or separate SCHIP program. States can take advantage of existing Medicaid benefit packages and pay structures with established providers. Those states that opted to create a separate SCHIP program ran into difficulties with administration. They had to establish new benefit packages and new relationships with managed care organizations and providers. The resulting complex structure causes many families to cycle in and out of Medicaid and SCHIP eligibility. Those states that designed a combination approach had similar administrative and



enrollment problems.<sup>94, 96</sup> As data regarding the effectiveness of design reforms become available, more states have adopted such simplifications to increase enrollment and reduce administrative costs.<sup>95</sup>

With the success of innovative enrollment reforms, some policy analysts hold up SCHIP as a model of the welfare approach. These reforms represent one of the advantages to state-level control. The structure of SCHIP offers individual states the flexibility to tailor the program to meet the specific needs of their beneficiaries.<sup>87</sup> It is unlikely that states would have chosen to expand coverage by as much as SCHIP did without having state control over the design and implementation of the program.<sup>h97</sup> States use this flexibility to experiment with new policy designs, new simplifications, and new outreach programs. Federal control would not have allowed for the same diversity in approach or in effort. Thus in many ways SCHIP is the model of a welfare approach to health insurance. It offers state-controlled comprehensive, preventive care for dependent children with limited financial risk to the federal government. SCHIP is generally thought of as a policy success story.

Yet, given that SCHIP is perhaps the ideal form of the welfare model, important enrollment limitations remain. Most significantly, the downside of increased state control is two-fold—variability between states and vulnerability of the benefit during times of economic crisis.<sup>87</sup> Eight states have enrollment rates of less than 35 percent, while states like California and others that have implemented many of the enrollment reforms have rates greater than 60 percent.<sup>94</sup> Although these statistics are complicated by the fact that private insurance coverage varies between states, of the 32.1 million SCHIP eligible children about 19 percent are uninsured.<sup>94</sup> Furthermore, during economic downturns states can limit costs

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<sup>j</sup> The enhanced federal matching rate and the large budget surpluses of the late 1990s also helped secure the passage of SCHIP.

and coverage by capping or freezing enrollment, even if a child meets the eligibility standards for coverage.<sup>98</sup> Last year, 14 states took steps to make enrollment more difficult, either by cutting eligibility levels, increasing premiums, or adopting policies that make it more difficult to enroll or renew.<sup>95</sup> Despite the states best efforts at outreach and education, attention to application procedures, and the increased separation of cash assistance from health insurance, under-enrollment remains endemic in the welfare model.

### **Conclusion:**

Medicare and Medicaid take dramatically different approaches to providing health insurance to dependent, needy populations. Neither is a perfect model of public assistance, however, it is Medicaid and the welfare model that suffers from chronic under-enrollment. As I have shown in this paper, under-enrollment is a direct result of the welfare model itself. This approach leads to the stigmatization of its beneficiaries, onerous application requirements, and potential vulnerability to state-level manipulation. SCHIP, as the most recent incarnation of the welfare model, serves to highlight its limitations. Even with impressive state-level innovation and outreach, under-enrollment persists. Despite efforts to reduce stigma, stigma remains a deep-seated component of the program. Despite mail-in applications and decreased documentation requirements, the existence of an application remains a barrier. And despite the flexibility offered by state control, economic hardship continues to put restrictions on enrollment. In the end, under-enrollment is not only a policy failure. For millions of impoverished children and adults, under-enrollment means that they go without much needed health care. The uninsured have less access to health care services; they are more likely to postpone care, not fill a prescription, not get a vaccine, and not see a dentist.<sup>42</sup> Such sacrifices in a child's early health care can have lasting effects.<sup>99</sup>

Moreover, the impact on the health care system in general—through increased emergency room usage, end-organ damage, and prescription drug costs—is immeasurable. As I argue in the second part of this paper, given the inherent limitations of the welfare model and this country's distinctive understanding of equality, we need to re-evaluate our efforts to provide health insurance to disadvantaged populations, including children and the impoverished. The welfare model is not the appropriate structure, at it leaves millions of vulnerable individuals without health insurance and without meaningful access to care.

## PART 2

### **Ethical Implications of Under-Enrollment: Reevaluating Luck Egalitarian Notions of Access to Health Insurance**

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Of the estimated 40 million uninsured Americans, 14 million are eligible for public health insurance but not enrolled.<sup>1</sup> In this country, the term “public health insurance” is synonymous with Medicare and Medicaid, and Medicaid suffers disproportionately from under-enrollment. As I argued in the first part of this paper, Medicare, following a system of social insurance, has relatively unconditional political support and enrolls over 90 percent of those eligible. In contrast, under-enrollment is chronic in Medicaid’s welfare approach to public assistance. The welfare model imposes welfare stigma even after the legislative ties to cash assistance have been severed. This approach to assistance demands lengthy and burdensome application procedures to guarantee only those eligible are enrolled. Finally, this model allows for and encourages state financial and administrative control, creating an environment that supports enrollment barriers as a means of cost containment. Given the apparent certainty of under-enrollment, the question becomes why have we maintained—and recently expanded—this approach to providing health insurance to vulnerable populations? Although important economic arguments regarding the efficiency of under-enrollment could be examined, part two of this paper focuses on the philosophical foundation that lies beneath the welfare approach to health care and its uniquely American application and acceptance. This paper does not seek to reform this country’s overall “system” of health insurance. It is not an argument for basic health coverage and does not attempt to define what “basic” means. Nor is it a discussion about the right to health care. Instead, it is an ethical argument for guaranteeing access to those health insurance programs already available.

I argue that the American understanding of equality, autonomy, and deservingness supports and maintains the welfare approach to health insurance. I first describe the American version of equality in terms of its philosophical foundation, luck egalitarianism. This theory emphasizes autonomy and choice, appealing to the American commitment to individualism, democracy and capitalism. I then explain why both the social insurance model and the welfare approach are applications of this philosophical theory. However, I contend that there are significant limitations in this theory as it applies to health insurance for the poor. Specifically, luck egalitarianism fails to distinguish those cases in which individuals might choose insurance by have difficulty acting on their own choice from those situations where individuals chose not to value health insurance. As I will show, this failure has important ramifications for the welfare model in the context of poverty. I offer an alternative approach that distinguishes effort from choice by making enrollment more automatic. This guarantees access to health insurance for vulnerable populations while still upholding choice and equality. Although this paper does not address the issue of political feasibility nor provide an economic analysis, the philosophical critique has clear implications for our current health insurance system as well as any future alternatives to providing health insurance for one of our most vulnerable populations.

### **The Welfare Model & Luck Egalitarianism—The Concept of Deservingness:**

There are many reasons why programs like Medicaid are not challenged to live up to their legislative promises. Edelman argues that “symbolic policies” that do not meet their stated goals are rarely compelled to change. He attributes this acquiescence to three characteristics: first, the existence of economic hardship for the intended beneficiaries of the policy; second, the absence of strong and organized advocates; and third, an inaccurate,

oversimplified and distorted perception of the issue.<sup>100</sup> In the case of Medicaid, its implicit goal is to provide a social safety net for those individuals deemed eligible, and as a symbolic policy, it suffers from all three of Edelman's characteristics. Its beneficiaries are, by definition, economically vulnerable. There is little organized effort aimed at improving access to health insurance, especially in comparison to the political giants in elderly health advocacy.<sup>10</sup> Finally, ignorance and oversimplification of the problem of under-enrollment perpetuates Medicaid and the welfare model. Despite research emphasizing the problem of under-enrollment, public attention remains focused on access to health care for the already insured, the decline of employment based coverage, and the shift to managed care to counteract rising costs.<sup>101</sup> Moreover, there is a general lack of appreciation for the funding disparities present in today's public programs. One study found that despite the fact that total public spending for the health care of the elderly exceeds spending on children by 8:1, the public views spending on these two populations as relatively equal.<sup>102</sup> Each of these misperceptions may be correctable, through strong advocacy and public education. Yet, over the past 40 years since its enactment, they have remained important barriers to full implementation and coverage through Medicaid.

In addition to Edelman's three perpetuating factors, there is also a more fundamental appeal for the welfare model that attracts politicians and voters, in spite of under-enrollment. The continued use of the welfare model to provide health insurance coverage for vulnerable populations, despite its repeated failure, speaks to an underlying attraction to the welfare model in the eyes of decision makers and the public. After all, the problems of the welfare model were clear before the 1965 enactment of Medicaid legislation. In 1960, the Kerr-Mills Act was meant to provide health insurance to the impoverished elderly. It was the precursor to Medicaid, following an identical model but limiting the beneficiaries to the aged.<sup>20</sup> By

1963, the subcommittee on the Health of Elderly of the US Senate Special Committee on Aging found that the means tests and the programs “welfare aspects,” including the costs to the states, as responsible for significantly limiting participation.<sup>20</sup> Nevertheless, in 1965 Medicaid was enacted following the same welfare model and more than 30 years later, the 1997 State Children Health Insurance Program (SCHIP) expanded coverage for children once again using the welfare approach to health insurance. As discussed in the first part of the paper, under-enrollment persists and 6.5 million low-income children remain uninsured, of which 85 percent are eligible for either Medicaid or SCHIP.<sup>90, 91</sup> Thus despite well-documented and predictable enrollment difficulties, the welfare approach remains the preferred method of insuring dependent children and the impoverished. Under-enrollment is an acceptable consequence of the welfare model.

I argue that the American understanding of equality is an important contributing force in the continued acceptance of under-enrollment. Although theories of justice are not often used in the public support of the welfare approach, this analysis offers insight into why this approach has particular American appeal and why the failure of Medicaid and its related programs to enroll all eligible individuals is a tolerable consequence. Ultimately, this paper shows that as it applies to health insurance for the poor and particularly poor children, the welfare model is inappropriate and inconsistent with the desired goals of promoting both equality and autonomy.

Before continuing this argument, there are several assumptions that need to be made explicit. First, for the purposes of this paper, I will assume that justice, although not the sole organizing factor in society, is a valuable and desirable goal. Second, working within an egalitarian framework, I will assume that the concept of justice requires some form of distributive equality. Finally, up to this point, I have been abstractly referring to a uniform

notion of “American” equality. I must clarify: I am not implying that everyone in the United States has the same conception of a very complex idea. Nor do I assume that the legislature is guided solely by principles of equity or justice. Pretending that there is some overarching principle or philosophical theory guiding the decisions made about who and what is covered or the program’s design in how best to enroll these individuals would be overly simplistic and perhaps even idealistic. However, there are some common beliefs about equality that are consistent with our political and economic systems of democracy and capitalism. I argue that these fundamental beliefs work to uphold and justify current policies, like Medicaid. Although philosophy rarely frames actual policies, it can inform and perhaps change them.

There are a variety of conflicting ideas on how best to serve the principle of equality and how best to distribute resources fairly. Some argue that equality is measured by welfare, others, that it is measured by resources; and still others, that it is measured by opportunity. There are distributional schemes based on maximization, overall and those based on the maximization for the least well off. There are many ways to describe what Kymlicka terms the “egalitarian plateau”—the “social, economic, and political conditions required to treat all individuals as equals.”<sup>103</sup> I will argue that the dominant American ideal of equality and fairness lends itself to one particular theory of equality of opportunity.

Most people in the United States see equality as equal effort resulting in equal outcomes.<sup>104</sup> Disparities in wealth are justified if they result from disparities in effort. Even individuals from the most disadvantaged groups have been shown to believe that distributions are fair when they reflect the recipient’s own contributions.<sup>105</sup> Thus, deservingness is derived from effort or contribution to a reward. This interpretation of desert is a reflection of the American commitment to a capitalistic “merit rule,” rewarding individuals based on their hard work. As such, the merit rule is a theory of equal



opportunity. A more socialist model follows a “needs approach,” distributing resources based on need. Individuals are considered deserving by the fact that they are in need, irrespective of the forces that contributed to that need. Alternatively, the strictest interpretation of equality results in an “equality rule,” which requires all individuals to receive similar outcomes regardless of need or contribution.<sup>105</sup> Let me now review the competing views of equality and show the logical benefits of the American ideal.

### **The Welfare Dilemma:**

There is admittedly a logical attraction to the simple definition of equality: equal outcomes would mean that everyone was equally wealthy, equally talented, equally healthy – and thus equally happy. This concept of equalizing happiness is a welfarist approach to equality. Importantly, the term ‘welfare’ in this context does not refer to cash assistance or to the welfare model that this paper focuses on, but rather to well-being more generally. There are in fact many coexisting philosophical definitions of this term. The two most common uses include hedonic welfare, meaning welfare derived from enjoyment or a desirable state of consciousness. Jeremy Bentham and John Stuart Mill originally articulated this version of welfare as simply “happiness.”<sup>106,k</sup> A more complex understanding of welfare is preference satisfaction.<sup>107</sup> One can have personal, political, and social preferences—all of which contribute to one’s welfare. These interpretations of the concept of welfare are clearly not entirely separate; one’s hedonic welfare will be affected by one’s preference satisfaction or disappointment. Outcomes can act as proxy for welfare; equal outcomes will result in equal welfare and therefore a fair distribution.<sup>108</sup>

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<sup>k</sup> Bentham and Mill were concerned with maximization of welfare through a utilitarian approach, rather than an equal distribution of welfare. Still, their definition remains and is applicable to discussion of distributive justice.

Yet, equality of welfare is both practically impossible and ethically problematic. Clearly individual happiness is difficult to measure and equal outcomes would require constant government interference. Most importantly for our purposes, equality of welfare and thereby equality of outcomes leaves no room for the impact of individual choice. There are two primary philosophical critiques of equality of welfare, each of which centers on this concept of individual choice. John Rawls first articulated the expensive tastes critique in *A Theory of Justice*. In a welfarist approach, individuals with expensive tastes must be provided with more to achieve the same degree of satisfaction or happiness. Yet, all individuals have some degree of agency in the preferences they develop and sustain. It is not reasonable to compensate these 'expensive individuals' for their champagne and caviar taste buds.<sup>109, 110</sup> This critique extends to outcomes as well. It seems unreasonable that the wealth of an individual who takes great monetary risks should not be affected by the outcome of that risk. It is unnecessary to require equality of welfare or outcomes when differences may be the result of voluntary choices.

Ronald Dworkin added a second crucial critique. Regardless of whether welfare is defined as preference satisfaction or more simple enjoyment: welfare should not be the only value that is equally distributed.<sup>107</sup> Simply put, just because the concept of welfare is a good measure of overall wellbeing does not mean that equality should be measured by welfare alone. Dworkin uses the example of a disabled individual who may have an equal level of happiness, but can still not afford his wheelchair. Intuitively, it seems that this individual deserves his wheelchair regardless of its impact on his happiness.<sup>107</sup> Thus, it seems that certain characteristics demand certain resources or distribution. Robert Nozick also argued that circumstances or actions create differential entitlements.<sup>111</sup> In other words, all outcomes should not be distributed equally – there are certain conditions that may deserve more.

These critiques emphasize that choice, circumstance, and individual differences must be incorporated into a theory of equality.

### **Rejecting the Difference Principle:**

There is a more intuitive appeal for equalizing opportunity—that is, for allowing an individual's choices to affect the distribution of outcomes. It is generally accepted as fair if individual success or failure is dependent on choices, risks, and personal initiative—making outcomes ambition-sensitive. However, it is seen as unjust for success or failure to be dependent on uncontrollable circumstances—thus outcomes should be endowment-insensitive.<sup>103</sup> John Rawls recognized the appeal of equality of opportunity. He argues that instead of being concerned about the distribution of welfare, society should concern itself with the just distribution of primary goods. Rawls defines primary goods as “liberty and opportunity, income and wealth, and the basis of self-respect.”<sup>109</sup> Individuals can then use these primary goods as they see fit, holding individuals accountable for the choices that affect the use of one's primary goods. However, Rawls argues that although the traditional view of equality of opportunity takes into account differences in social circumstance, wealth, race, gender, it ignores the potential positive value of circumstances—the impact of natural talents or intelligence for example. As these are equally uncontrollable and morally arbitrary, it is unjust that these would affect the success or failure of an individual—allowing the naturally talented to receive an unequal share of social goods. As there is no practical way to correct for natural talent, Rawls adds the “difference principle” as a means of justifying inequality. He asserts that social goods should be distributed equally unless an unequal distribution favors the least advantaged.<sup>109</sup> Thus, as long as inequality benefits everyone or

benefits the least well-off preferentially, it is morally justified. Rawls thus offers a modified version of equality of opportunity with special consideration for those most in need.

There are two primary critiques of Rawls' theory. First, although he is careful to include natural goods (intelligence, talent, etc.) in his description of morally arbitrary circumstances, he defines "least well-off" only in terms of social goods. Two people are equally "well-off" despite differences in IQ, health, or talent. However, it remains a fact that people require different amounts of goods to satisfy the same needs. By focusing solely on the good itself, there is no recognition of what the goods bring to the individual. The standard example involves a severely disabled person who is forced to spend the majority of his or her allocated primary goods on a wheelchair and other assistive devices, while individuals without disabilities are able to use their resources for food, shelter, and luxuries.<sup>112, 113</sup> Once again, there seems to be something inherently unequal about a distributional scheme that does not consider such consequences. It seems that a full application of the difference principle would require extra compensation for natural disabilities, yet Rawls leaves this out. This critique is a flaw of omission and is not an assault directly on the use of primary goods or the difference principle.

The second critique is more damaging. The difference principle does not make a distinction between chosen and unchosen inequalities. Although Rawls rejects a distribution based on welfare because of the "capacity to assume responsibility for our ends," he does not apply this same emphasis on choice within the difference principle.<sup>114</sup> He directly states that his conception of justice aims to "regulate inequalities that affect people's life chances, not the inequalities that arise from people's life choices."<sup>115</sup> Yet, Rawls does not specify the type of inequality that should be distributed to benefit the least advantaged—the difference principle applies to both inequalities due to circumstance and inequalities due to choice. As

a result, in certain circumstances the difference principle demands that an individual pay for another person's choice. Kymlicka provides a common illustration. Imagine two individuals of equal natural talent and equal social backgrounds. One individual works only enough to sustain himself. The other works hard, earns money, and quickly gains resources. The difference principle, applied to inequality regardless of origin, states that this individual's unequal amount of resources is justified only if it is to the benefit of the least well-off, in this case his self-sustaining neighbor.<sup>103</sup> If the poorer neighbor did not benefit from his wealthier neighbor's resources, the difference principle demands that the government tax the wealthy neighbor. Yet, the poor neighbor had the same natural talents and social circumstances, but chose not to pursue a profitable career. Again, it seems unjust that the wealthier neighbor should be taxed for his poorer neighbors preference. Thus although the difference principle aims at compensating for inequalities in natural and social circumstances, it also has the potential to incorrectly compensate individuals for the effects of personal choice and effort. In a truly ambition-sensitive model, individuals would reap the benefits of their choice and pay the costs.

### **Arriving at Luck Egalitarianism:**

Americans have a strong commitment to the idea of rewarding effort, thus Rawls' difference principle is too expansive, not allowing for an individual to reap the rewards of his or her hard work – a deeply held American ideal. Ronald Dworkin, in his theory of equality of resources, offers an important change to Rawls' proposal of primary goods. His theory, commonly known as luck egalitarianism, aims to meet Rawls' goal of an endowment-insensitive, ambition-sensitive distribution. Luck egalitarianism is a starting gate theory, emphasizing equal initial conditions, leading to equal opportunity and therefore just

distributions. Dworkin, by arguing for an equal distribution of resources, attempts to equalize circumstances while allowing individuals to benefit from and pay the costs of their freely made choices.<sup>53</sup> Importantly, luck egalitarianism acts as theoretical confirmation that individuals deserve the outcomes of their effort.

Dworkin argues for the primacy of freedom; choice is paramount. Accordingly, the only just way to divide resources among various individuals is by auction, guaranteeing that each individual can choose the bundle of resources that is most desirable to him or her. This distribution would meet what Dworkin refers to as the 'envy test.'<sup>116</sup> Equality does not demand a uniform distribution, but rather that each individual is equally satisfied with his or her own lot in life. The envy test treats all individuals as equals, as no one is entitled to more consideration in the distribution of resources. Importantly, as a starting gate theory—unlike equality of welfare—this distribution is not readjusted, but rather once the resources are distributed, differences in happiness are assumed to be due to differences in personal choice. There is thus an implicit emphasis on individuality and autonomy. Individuals are seen as unique entities with specific desires and aptitudes, held accountable for the choices. In the absence of Rawls' difference principle, individuals are entitled to the rewards of their choices and effort. This is the definition of an ambition-sensitive theory.

To make the distribution endowment-insensitive, individuals should not be held accountable for unchosen circumstances. Unlike Rawls, who ignored natural assets in determining advantage, Dworkin highlights that not all demands are by made by choice. He includes an individual's physical and mental endowments, disabilities and talents alike, in the circumstances that are beyond the control of the individual.<sup>116</sup> He allows for the fact that natural inequalities may impact choice. The disabled man's need for a wheelchair comes from his disability not from his desire. Thus, it is unjust that he use his resources to pay for

wheelchair, or that severely ill spend their resources on prescription medications. There is an ethical obligation to provide compensation for disparities in characteristics that are circumstantial, which can be used as resources.

It is necessary now to define a few key terms. First, the term “choice” refers to the desire an individual has—this is derived from Rawls’ key point that an individual can choose his or her preferences to some degree. Dworkin uses choice in reference to an individual’s life-plan. Effort is the amount of work that the individual does to accomplish his choice. In the example above, each neighbor chose the career path that met his preference. The wealthier neighbor had to put in additional effort to achieve this choice. As I discuss later, Dworkin does little to differentiate between effort and choice. Finally, I use the term ‘self-efficacy’ to refer to the belief in one’s ability to perform the required effort necessary to fulfill one’s choices.

Dworkin’s theory of luck egalitarianism is complex, with many intricacies that are beyond the scope of this paper. However, there are two specific points within luck egalitarianism that are particularly relevant and demand attention. First, there is a theoretical and practical problem with compensating individuals for their natural disabilities. Certain disabilities cannot be compensated with money or resources. Paying for the best wheelchair can allow the physically disabled man to be as mobile and active as an able-bodied person. No amount of resources will make the severely mentally disabled individual “equal” in terms of natural endowments.<sup>103</sup> Practically, society would be forced to devote all of its resources to those with severe illness or disability in order to compensate them for their innate inequality.<sup>116, 117</sup>

Dworkin recognizes this flaw in his endowment-insensitive logic. Not only is the compensation of these differences problematic, determining which inequalities are truly

circumstantial is nearly impossible. Thus, Dworkin devotes himself to describing a practical alternative to his theoretical ideal, minimizing the impact of circumstances and maximizing individual autonomy. He outlines a complex insurance scheme, where individuals would estimate the amount resources they are willing to devote to insuring themselves against disability or other circumstantial disadvantage. These resources would then be devoted to compensating those individuals who ended up with the misfortune. Income tax would serve as a way of collecting premiums and social service programs, like welfare and Medicaid that would provide the necessary compensation.<sup>116</sup> This is not a perfectly endowment insensitive distribution scheme, but does attempt to ensure that all individuals are equally spared certain circumstantial impediments to opportunity.<sup>118</sup>

The second notable point in Dworkin's theory relates to his use of choice. Dworkin goes to great lengths to distinguish between those differences in equality that arise from choice from those that arise from circumstance. Individuals are held accountable for their choices, their extravagant desires, and their expensive tastes. There is no obligation to equally distribute those individual characteristics that are chosen, like individual visions of success or desires for champagne. Yet, as I hinted at before, Dworkin does not distinguish between effort and choice. In the ideal form of luck egalitarianism, once all circumstantial inequalities have been compensated for and an individual has chosen a life-path, the effort required to achieve this choice is an outward display of exercising choice. Critically, according to Dworkin, there are no circumstances—natural or social—to prevent that individual from making the effort to realize his choices. Thus, to Dworkin effort and choice are interchangeable.

Although I will argue against this implicit connection between choice and effort, it is important to note that the idea that an individual's effort represents his or her choice is



central to the appeal of luck egalitarianism. Dworkin's conception of choice parallels the ideals of democracy and capitalism and Americans' commitment to rewarding effort. In its ideal form, democracy demands that individual preferences are counted equally. Dworkin's theory holds individual preferences as vital, a central component in determining distribution and in justifying resulting inequality. According to capitalist theory, rewarding effort promotes personal responsibility, drives innovation, and promises economic growth. Dworkin's theory reinforces this commitment to individual choice and responsibility. Thus, there is a clear rejection of both the "equal outcomes" rule as well as a "needs approach." Luck egalitarianism entitles an individual to the consequences, both positive and negative, of his or her choices. Yet, society must not punish those who, due to circumstances beyond their control are unable to achieve or succeed. To uphold choice and individual autonomy, luck egalitarianism places inherent value on effort as a means of distinguishing those inequalities that result from choice and those that result from circumstance. As I will show, this has critical implications in the realm of health insurance.

### **Luck Egalitarianism & Health Insurance:**

If one considers health insurance a resource, according to luck egalitarian theory all individuals must have access to the choice of enrollment. Luck egalitarianism does not demand universal health insurance; rather it requires equal resources to allow an individual to choose to enroll. Given the ambition-sensitive component of Dworkin's theory, access to health insurance is by definition not automatic. Individuals must choose to enroll; those who do not value health should not be forced to spend resources on it. However, given the endowment-insensitive aspect to the theory, it is the obligation of the government to compensate individuals for the circumstances that may put them at a disadvantage toward

accessing this resource. In this way, “the welfare state [is] a giant insurance company that insures its citizens against all forms of bad brute luck.”<sup>119</sup> This distribution recognizes that there is inequality in allowing only employed individuals access to the health insurance market. Poverty is a recognized prohibitive circumstance, as the impoverished are unable to purchase health insurance. Similarly, in the United States, advanced age and disability are circumstances, which exclude individuals from the employment-based system of health insurance. According to Dworkin, age, disability and poverty are all circumstances that prohibit access to an employee-based health insurance system, and thus demand that the government provide alternate means of accessing health care coverage.

The strength of Dworkin’s theory comes in its direct correlation to the issue of access, as resources can be considered tools. An equal distribution of resources requires that there be alternative options available for those excluded from the employee-health insurance market. Medicare and Medicaid are the primary means of fulfilling the luck egalitarian commitment to equal opportunity, with these programs acting as resources. The elderly and disabled are offered coverage through Medicare, while Medicaid covers both poor adults and children. Each of these populations is excluded from the workforce and thus is entitled to alternative means of accessing the resource of health insurance. Importantly, there are two different programs covering distinct populations, which have been separated and covered under these two very different forms of public assistance. Although there are countless factors that affect the policy alternatives available and political decisions ultimately made, including the power of interest groups, voting patterns, historical institutions, and the simple timing policy,<sup>12, 13</sup> the division of these deserving populations into two different approaches to coverage can also be viewed as an extension of luck egalitarianism. Both Medicare and Medicaid aim at guaranteeing that enrollment is a reflection of effort—and thereby choice.

Medicare follows a social insurance model—with no means testing and federal administrative control. Similar to Dworkin’s insurance scheme, individuals put in a percentage of their wages to ensure that when they are no longer working they will have access to health care. Eligibility is dependent on 10 quarters of work-history. These individuals put in effort to work. In a luck egalitarian framework, this effort is indistinguishable from a choice. Thus, working individuals are entitled to reap the rewards of their effort, both in terms of a Social Security pension and in terms of Medicare’s health insurance coverage. They have “earned” their benefits. In the social insurance model eligibility automatically reflects effort, and thus choice.

Medicaid, following a welfare model, is structured very differently but still fits within Dworkin’s schematic. Medicaid is the government’s effort to compensate impoverished individuals for the potential side effect of their poverty, specifically the inability to afford health care. Means testing is therefore a central component to the welfare model, for poverty defines eligibility. Moreover, the enrollment process provides individuals with an opportunity to ‘choose’ to enroll. The existence of the program is an attempt to correct for the inequalities of circumstance, but according to Dworkin, the individual must still *choose* to enroll. Using effort as a proxy for choice, the effort involved in applying for the benefit comes to represent such a choice. Thus, the lengthy eligibility determination process serves two goals. First, it ensures that only those individuals who meet the standards of entitlement are enrolled. Only those truly impoverished are worthy of this government benefit. Simultaneously, eligibility requirements place a premium on individual responsibility—making sure that the impoverished also chose to enroll, with effort acting as proof of their choice.

Both the welfare model and social insurance model seem to uphold choice while mitigating circumstance, and are thus considered “fair” according to luck egalitarian ideals. Medicare, through the social insurance model, uses work-history and income contributions to reflect effort and thus choice. It provides coverage to alleviate the circumstances of old age and disability. Medicaid, through the welfare model, compensates individuals for the circumstances of poverty but maintains a commitment to choice through the effort required to enroll. Accordingly, those individuals who are eligible but unenrolled are so by choice, and under-enrollment is therefore justifiable. As I will argue, the reliance on effort to reflect choice is inappropriate and the welfare model is an inappropriate application of luck egalitarianism. The circumstances of poverty are such that applying a luck egalitarian vision of equality actually results in further inequality.

### **The Limitations of Choice—How Luck Egalitarianism Fails:**

Before discussing the limitations of luck egalitarianism in its application to welfare-model health insurance programs, there are two preliminary qualifications that help frame my argument. First, I am not arguing that active enrollment is Dworkin’s desired vision of a just distribution of health insurance. (In fact, his writing on the subject seems to indicate otherwise.)<sup>120</sup> Rather, the above description of active enrollment is a Dworkinian interpretation of our current enrollment system, which helps to explain the emphasis on choice as distinct from circumstance. Second, my argument does not fall within the extensive literature regarding special demands on justice in the “sphere of health” or the unique obligations to justice in health care, as articulated by Michael Walzer and Norman Daniels.<sup>118, 121, 122</sup> Like Dworkin, I do not argue for the “ideal of insulation,” which maintains that health care is the most important resource to distribute and should always be done so

equally.<sup>120</sup> Rather, I will argue that it is the state of poverty that requires an exception to the rules of luck egalitarianism, not the particular social good of health care.

At first glance, the current low-income welfare-model programs seem to meet the demands of luck egalitarianism. The total “bundle of resources” available is made equal by the presence of assistance programs compensating for the deficit in financial resources. There is no further ethical obligation, as long as there are no other deficits in resources that would impede access. It is here the conflict between choice and circumstance surfaces. The low-income programs are ethically sound only if the individual can truly choose to avail him or herself of the resource available and enroll in the program. If there are circumstances outside the realm of choice, which prevent enrollment, the theory requires that these be considered in the distribution of goods. True equality of resources hinges upon one question: when is a choice a genuine choice?

A system based in choice has power and potential. It allows for freedom and plurality, while at the same time demands that all individuals are treated with equal concern, each choice having equal weight. Acknowledging each individual’s choices, values, and ideas of happiness equally, is Dworkin’s way of ensuring that people are treated as equals and still maintain their freedom to determine their own happiness. Choice embodies both autonomy (or freedom) and equality; two commanding ethical constructs that are constantly balanced. The veracity of this choice is therefore essential. As I will show, due to the circumstances inherent in poverty, the choice involved in the welfare-model fails both to reflect autonomy and to treat people equally. Additionally, I will argue that in the context of poverty, effort acts as poor proxy for choice and does not adequately distinguish circumstance and choice. Thus, the distinction between choice and circumstance should not be used at the level of a social safety net and luck egalitarianism fails to justify differential enrollment.

## Sen & Cohen's Critique of Choice:

Amartya Sen and Gerald Cohen both argue against Dworkin's version of equality of opportunity and his dependence on choice to reflect autonomy, and thereby treat individuals with equal respect. A choice is autonomous only if the actor is capable of acting autonomously. Dworkin assumes that once all natural and social circumstances have been made equal, all individuals are autonomous and thus all choices worthy of respect. Although their theories vary slightly, Sen and Cohen both argue there are basic conditions necessary for freedom, without which choices do not reflect autonomy. Their theories stress the importance of a baseline of function, necessary to make autonomous choice, beneath which no individual should fall. Instead of Dworkin's emphasis on equalizing resources, Sen and Cohen turn to this concept of 'functioning.' Although functionings may arise as a consequence of resources, it is the ability to function that must be defended. The value of a good is not simply in the good itself and nor in the satisfaction it brings to an individual, but also in its ability to enable functionings.<sup>123</sup> These "functionings" or "capabilities" are necessary to uphold freedom and equality, and functioning should therefore hold normative value, rather than welfare or resources. To Sen and Cohen, functioning connects directly to autonomy.<sup>1</sup>

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<sup>1</sup> Sen uses the term functioning to describe both those things a person is capable of doing and desirable states of being. The state of good health, for example, holds value not only in itself or in the satisfaction and individual gains from not being ill, but also in the opportunity and functioning good health provides that individual. Functionings provide an individual with capabilities or opportunity. Cohen modifies Sen's definition of functioning to separate the value of the good and its function. He describes the value of goods as "midfare," falling between the actual value of the resource—the amount of food for example—and the person's subjective well-being—feeling well fed and satisfied. In this example, nutritional status is mid-fair. Mid-fair is the value a good holds separate from its impact on satisfaction and separate from its nominal value. Cohen then uses this concept of midfare to argue for an emphasis on the advantages that states of midfare promote. Building upon Sen's argument for functioning, Cohen uses the term 'advantage' to highlight the desirable nature of these states. He then modifies Sen's use of capability to the use the term access. Thus, Sen argues for an equal distribution of capability and Cohen goes further to argue for equal access to advantage. Both theories are revisions of equal opportunity and both are attempts to get closer to the true goal—that any inequality represents genuine autonomous choice.

In all three theories, Dworkin's, Sen's and Cohen's, the emphasis on opportunity reflects a commitment to autonomy. Dworkin's theory reinforces the importance of freedom in that, given adequate compensation for inequalities of circumstance, individuals are free to do what they want with the available resources. For Sen and Cohen, freedom is embedded in functionings. Functionings enable an individual to have the freedom to make choices. Basic functionings, not resources, are prerequisites for freedom. Thus unlike Dworkin's luck egalitarianism, Sen and Cohen do not describe starting gate theories. Rather, equality of capability and equality of access to advantage demand that functionings are continually redistributed and maintained. Individuals cannot be held captive by poverty, starvation, or illness. Regardless of the 'bad choices' individuals make, they must retain this capacity to ensure genuine autonomy. Autonomy—most simply defined as self-determination—is what makes choice morally important.<sup>106</sup> If the choice does not stem from an autonomous action, the choice has no ethical value

Following Sen and Cohen's reasoning, the question of whether the choice to enroll in Medicaid is a genuine choice changes. Do the eligible individuals have the basic functionings or access to advantage required to make an autonomous choice to enroll? There is a long tradition of recognizing adequate health care as a necessary condition for freedom and functioning.<sup>118, 124</sup> Thus it can be argued that no one can choose to forgo access to health care. Poverty is often associated with poor health. The poor have minimal access to daily fresh fruits and vegetables, greater exposure to toxins, and decreased access to preventive care—all of which contribute to a decline in health.<sup>101</sup> Still, being poor does not necessarily mean that one is necessarily also in poor health. There are additional conditions of poverty that complicate the choice to enroll. The impoverished and disadvantaged often have a long-standing mistrust of government.<sup>125, 126</sup> In addition to not understanding the

complicated eligibility requirements, many individuals in this population are unable to appreciate the significance of insurance as protection against future calamities, when there are so many immediate difficulties.<sup>127</sup> The circumstances of poverty are such that many are unable to cope with anything other than the numerous, immediate threats to their well-being. As Abraham clearly states in her investigative look at one family's struggle with Medicaid and welfare, "people who can barely afford food and shelter may not think they have much to gain from spending scarce dollars and time to secure a doctors' visit."<sup>128</sup> The substantial cost in the time spent applying, in securing child-care, in transportation may influence an individual's choice to enroll or not. Sustained poverty and economic oppression have been shown to have significant psychological effects—diminishing self-efficacy and making these individuals less effective in advocating for themselves and their interests.<sup>129, 130</sup> Considering these factors, it is difficult to maintain that the choice to enroll in Medicaid is equivalent to the choice to enroll in employer-based health insurance.

If we accept Sen and Cohen's idea that freedom requires functioning or access to advantage, including adequate health, adequate information, and ability to cope, then it follows that the choice involved in enrollment is not fully autonomous. The characteristics of poverty do not meet Sen and Cohen's conditions for freedom. This raises an important implication of Sen and Cohen's emphasis on functioning. Underlying the idea that there are functionings required for autonomy and that these functionings—basic food, shelter, health care—is the fact that the impoverished may not be capable of autonomous choice. This is a dangerous line of reasoning that is over-inclusive and perhaps insulting. Can poverty really take away one's autonomy, self-determination, and moral identity? Sen and Cohen conflate the ideas of autonomy, effort and choice. Autonomy holds normative value because it is a way of treating all individuals with equal regard. According to Kant, the "unconditional



worth” of an individual originates in the capacity to determine one’s own destiny—an individual’s autonomy.<sup>131, 132</sup> For the luck egalitarian, embedding choice—and thereby autonomy—in the enrollment process for welfare-model health insurance programs is a means of treating everyone equally. Each individual’s capacity for autonomy has equal power; the poor are therefore considered equals because their choice to opt out of health insurance has the same validity as that of the wealthy. Sen and Cohen’s theory has the potential to be interpreted in a way that renders an impoverished individual *incapable* of autonomous choice. This is an assault on the Kantian dignity and worth of that individual. It is possible that a poor individual would *choose* not to enroll in Medicaid. Thus, despite their important critique of luck egalitarianism, Cohen and Sen do not offer a realistic alternative to problem of under-enrollment in so far as their theory does little to separate effort, choice and capacity for autonomy.

### **The Problem of Effort:**

In truth, our argument does not need to be as expansive as Sen and Cohen’s. It does not need to be argued that poverty precludes choice, only that it obscures it. There may be poor individuals who chose not enroll in Medicaid, the choice here being an autonomous one in the full Dworkinian sense. There are, however, circumstantial factors of poverty that can influence this choice without hindering an individual’s autonomy. These circumstances do not affect an individual’s ability to make a choice, but rather impact the amount and meaning of effort required to act on that choice.

Underlying the distinction between choice and circumstance is the idea of effort. Circumstance is a passive state; choice is active in that choice requires effort to convert a desire into a tangible benefit. This is key to understanding Dworkin version of equality of

opportunity—allowing individuals to reap the rewards of their efforts and requiring individuals to work for their benefits. Moreover, the commitment to effort speaks directly to the ideal of a meritocracy, with equal effort equating with equal outcomes. The weakness in luck egalitarianism, as it is applied in the context of poverty, is twofold. First, there is an assumption that equal choices require equal effort. More specifically, luck egalitarianism ignores the amount and meaning of this effort. Second and interrelated, effort is assumed to be a pure reflection of choice, yet there is an intrinsic connection between effort and circumstance.

The effort involved in the application procedure and the enrollment process is assumed to reflect the desire for health insurance, fulfilling the requirement of choice. Yet, the intangible components of this effort are overlooked. Although it is nearly impossible to calculate a monetary value for the time and inconvenience of enrolling in a low-income health insurance program, the combination of a lengthy application and a prolonged eligibility determination in addition to the loss of wages and cost of child-care and transportation is substantial. The amount of this effort required to enroll in Medicaid is not encompassed in the simple reliance on choice. The choice to enroll in an employment-based health insurance is assumed to encompass the effort involved in working, yet once employed, there is minimal effort required in making the choice to enroll in health insurance.

This burden is compounded by the fact that the effort an individual is able to make is influenced by the very circumstance for which these programs aim to compensate. In other words, the ability of an impoverished individual to complete the tasks of enrollment for Medicaid is influenced by circumstances of poverty. Effort, therefore, acts as poor proxy for choice, in that it does not adequately distinguish circumstance and choice. Rawls originally recognized the dilemma in classifying effort as a reflection of choice without

regard for the impact of natural abilities or circumstance. He argues, “the effort a person is willing to make is influenced by his natural abilities and skills and the alternatives open to him.”<sup>109</sup> This conflict of effort being both an active choice and a result of circumstance is at the core of much of the current egalitarian theory. Sen and Cohen’s emphasis on functioning is an attempt to recognize the influencing factors as they relate to an individual’s ability to choose. Yet, neither Cohen nor Sen directly address the issue of effort. Their arguments focus on the circumstances that affect the capacity for autonomy. Functionings relate only to choice not to the effort required to implement a choice. Like Dworkin, Sen and Cohen do not separate the effort required to act on a choice from the choice itself.

Separating effort from choice is the idea of self-efficacy—the belief in one’s ability to “organize and execute a course of action.”<sup>133</sup> Self-efficacy influences the effort an individual puts forth and his or her willingness to overcome obstacles.<sup>134</sup> Importantly, self-efficacy does not influence an individual’s capacity to choose, thus does not undermine her capacity for autonomy. Thus, the concept of self-efficacy disconnects the capacity for autonomous choice from the ability or willingness to act on that choice. As I will argue in the next section, since circumstance can impact self-efficacy, and self-efficacy impact the effort, choice and effort are not interchangeable as Dworkin suggested. The act of not enrolling in Medicaid represents both the choice to enroll and the effort involved in applying. There are situations in which the individual would like to enroll in Medicaid, but his circumstances are such that effort required impedes his choice. Thus, this choice should not be viewed as an indication of freedom and is not an adequate basis for treating individuals with equal regard. As I will show, the effect of negative circumstances on self-efficacy and effort has important implications for providing a safety net and for the welfare model.

## An Alternative Model—What We Owe Vulnerable Populations:

We do not need to completely disregard the luck egalitarian approach to equal opportunity—not only is it ingrained in our culture but it can serve us well. Luck egalitarianism promotes hard work, encourages competition, and allows for compensation when appropriate. Still, we need to distinguish choice and effort when applying luck egalitarianism to the most vulnerable populations. The weakness of luck egalitarianism is that it fails to consider the impact of circumstance on the effort involved in choice. The weakness of Sen and Cohen's theories is that they connect circumstance directly to autonomy—through the concept of functioning. Alternatively, I argue that circumstances do not affect one's ability to make a choice, but rather the effort a person can make on her own behalf—her self-efficacy. The negative impact of circumstances on self-efficacy makes the luck egalitarianism the wrong model for providing health insurance to both the impoverished and dependent children.<sup>m</sup> In place of the welfare-model, and its reliance on active enrollment, I argue for an effortless-model, where enrollment is automatic and choice is not muddled by the impact of circumstance. Instead of luck egalitarianism, I argue for equality of capacity for action. This combines Sen and Cohen's emphasis on functioning, but shift the focus from those functionings required for autonomy to those functionings required for self-efficacy.

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<sup>m</sup> The issue of providing health insurance to children is worthy of its own paper. However, it is important to recognize the dilemma children pose in regards to using luck egalitarianism as a justification for the welfare-model. Children are excluded from the work force regardless of the income status, and thus there is similar to the elderly, it is their age (not their income), which is the circumstance that should be compensated. Accordingly, the luck egalitarian model fails as a justification for the continued use of the welfare-model provide coverage for children and the chronic under-enrollment in the State Children's Health Insurance Program. Additionally, the position of choice as the underlying validation for this theory has no meaning for children. Children do not have the capacity for normative choice. It is not children who apply, but rather their parents, thus the choice is clearly not autonomous and is not even aimed at treating this population equally. Similarly, effort as a reflection of choice is meaningless. This paper discusses health insurance for children only as it relates to their inclusion in the welfare-model and thus is restricted to impoverished children.

Circumstances, both natural and social, affect an individual's self-efficacy.<sup>129, 130</sup>

Certain circumstances act to decrease self-efficacy, lowering self-confidence, decreasing an individual belief that he or she can succeed. Other circumstances work to increase an individual's belief and willingness to act autonomously. For example, observing others' in similar social conditions fail despite great effort, lower observers' judgments of their own efficacy, which undermines their effort. Seeing people similar to oneself succeed through effort raises observers' sense of self-efficacy—believing that they too can succeed. This belief in success then translates into increased effort and increased effectiveness of the effort put forth.<sup>134</sup> In the context of poverty and especially in the context of applying for public assistance, the example of failure is a common and repeated occurrence.<sup>42, 129, 130</sup> This breeds doubt, lowers self-efficacy, and reduces the effectiveness of future effort. When an individual's circumstances have a positive impact on her self-efficacy, effort acts as an ideal proxy for choice. One is able to act one's autonomous choice without the hindrance of circumstance. However, if an individual's circumstances have a negative impact on her self-efficacy, effort is no longer a reflection of choice. Thus, luck egalitarianism, which uses effort as proxy for choice, is only valid in those circumstances that positively impact one's willingness to act.

The differential impact of circumstance on effort becomes particularly poignant at the level of a safety net. The ideal of a safety net, in luck egalitarian terms, is to level the playing field, equalizing resources, compensating individuals for unchosen circumstances. In terms of health insurance, this means providing access to programs for those who are left out of employee-based health insurance market. The circumstance deemed worthy of compensation, namely poverty, has a known negative impact on self-efficacy.<sup>129, 130</sup> There are social, historical, and practical influences on self-efficacy that disproportionately affect the

poor, disadvantaged populations.<sup>129, 130, 135</sup> Accordingly, effort does not accurately reflect choice and thus it is unjust to require effort to access the benefit. Instead, there is an obligation to provide unhindered access to enrollment.<sup>n</sup>

The goal of both Medicare and Medicaid is to provide health insurance coverage to those individuals left out of the employer-based system. Yet, under-enrollment in Medicaid means that millions are still without health insurance. I have argued that although luck egalitarianism—the philosophical theory most aligned with popular American beliefs—seems to allow for this under-enrollment, and thus the continued use of the welfare model, its failure to consider the implications of effort make it inappropriate and unjust. Since the effort required to enroll in Medicaid, and other low-income programs, cannot be separated from circumstance of poverty, effort cannot represent an autonomous choice. The choice to enroll therefore has no normative value, and should not be upheld at the expense of under-enrollment. Equality of capacity for action would demand that the poor have same capacity to access health care as the well-off. Factoring in the impact of effort and the limitations of self-efficacy, this would equate with an effortless-model. The impoverished would not be required to work to prove their eligibility, as their capacity for action required to enroll in Medicaid is hindered by their circumstance, but once enrolled their capacity to access health care is not impeded. This is not an argument against means-testing in general, and although it has implications for universal health care, is not directly tied to this goal. Instead, this model purposes that if we have decided that poverty is one of the “deserving categories,” worthy of compensation, we should not make it necessary for people to work to enroll. Automatic enrollment, as discussed later in the paper, would serve to eliminate the

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<sup>n</sup> Although not the focus of this paper, one could go further to argue that these individuals should be compensated for the lack of self-efficacy (as it results from un-chosen circumstance) and it should require less effort for the poor to enroll in health insurance than the wealthy. Because of the implications on self-efficacy, providing equal opportunity demands that the least well off are given an advantage in terms of effort.

effort of enrollment, thereby reducing the impact of self-efficacy and circumstance, and still uphold choice, autonomy, and equality.

### **Counterarguments Against Reducing the Burden of Effort:**

The deep commitment to the merit rule (and accordingly luck egalitarianism) seems to run counter to the idea of providing an effortless safety net. How does a society reward hard work, if those who do not work are compensated regardless? There are three primary counterarguments to removing the effort requirement from the enrollment process.

The prototypical argument against reducing, or eliminating, the barriers to enrollment, is known as “the problem of the welfare mom.” This argument stems from a fear that if there is no disincentive to be enrolled in Medicaid (or welfare or cash assistance), individuals will remain in poverty so as to retain their benefits. The “welfare mom” takes advantage of the safety net because there are no practical or emotional barriers. The essential criticism revolves around the idea of changing incentives. Part of the appeal of luck egalitarianism, and by consequence, the effort requirement, is that all individuals are working for their benefits. Not only does this effort connote desert, but it also creates a reward system where benefits are derived from work. Removing the effort of the enrollment process disrupts this incentives-based structure, for the benefit of health insurance is given without the work of the application process. Disrupting this incentive to work seems to insult the very foundation of capitalism, leaving the eligible individuals with less reason to work and thereby extricate themselves from poverty.

The second counterargument flows from the first – “the problem of the working poor.” There is a significant and growing population of individuals who work at low-paying, minimum wage jobs with annual incomes just above the Medicaid eligibility limit.

Unfortunately, these individuals are not guaranteed health insurance through their employers. Eliminating the barriers to enrollment in Medicaid would not change their eligibility status nor would it have any direct effect on their benefits, or lack thereof. However, these individuals have been made inadvertently worse-off. They are now being penalized for their work, for if they were unemployed, or made less money, they would automatically receive health insurance. Under the current system of active enrollment, there is a disincentive to qualify for Medicaid, as these individuals must go through the humiliating and time-consuming application process. In the absence of this humiliating process, the poor are better-off because they both have health insurance and do not have to suffer through the application process. However, the near-poor do not benefit from either health insurance or the reduction of effort required to enroll. They would in fact be better-off, at least in terms of health insurance status, if they were unemployed. Furthermore, if poverty has a negative impact on self-efficacy, does “near-poverty” have a similarly negative impact? If so, is there not an ethical obligation to provide compensation for the circumstance of being “near-poor?” This touches upon the larger issue on how to determine the impact of circumstance on self-efficacy, but raises an important critique of an effortless-model—when, if ever, should effort factor into desert. In other words, when is effort an appropriate proxy for autonomous choice?

Finally, there is a practical argument that eliminating the effort involved in enrollment will allow for and promote fraud and abuse. Eliminating the stigma and the burdens of enrollment will make countless more individuals want to enroll – and this will undoubtedly include individuals who are not eligible. There will therefore be much more fraud and abuse in the system and by definition it will be more difficult to prevent. This is the unfortunate consequence of making it easier for those eligible to enroll; it will



simultaneously be easier for those who are not eligible to fraudulently enroll. Although it seems that this third counterargument is primarily practical, there are also ethical implications. One must consider the consequences of a national policy that promotes fraud, rewarding those who cheat and punishing those who remain honest.

### **A Response to the Counterarguments:**

Each of the above counterarguments is appropriately critical of this seemingly drastic proposal; however, I maintain that none are sufficient to discredit the idea of placing those least well-off in at advantage in terms of the effort required to access benefits.

The “problem of the welfare mom” does not fully address the impact of poverty on self-efficacy. Rather, this critique centers on the potential secondary impact on work-incentives. Still, this argument is severely weakened once the lack of access to health insurance is viewed as only one aspect of poverty. Although this paper focuses on the importance of health insurance, and the health care that is assumed to follow from adequate insurance, there are a multitude of impediments to functioning which the poor, and near-poor, face daily. There are immediate issues of food and shelter; there are issues of safety and education. These in fact contribute to the impact of poverty on self-efficacy—the very reason why unhindered access is an obligation. Although health insurance is clearly an important and significant benefit, it is naïve, and perhaps even irresponsible, to think that health insurance alone will be enough of an incentive for individuals to remain in poverty.

The “problem of the working-poor” poses the most significant challenge to my argument for reducing the effort requirements for the least well off. In truth, the distinction between 87 percent of the federal poverty line (the qualifying rate in most states) and 100 percent or even 200 percent is largely insignificant. Why should those individuals who are

only marginally better-off not have access to the same, much needed health insurance benefit? This question has no easy solution. However, this is an argument for either expanding the definition of “compensatory” poverty to include the working-poor or mandating employer health coverage. Dworkin himself addresses this issue of the “near poor” and comes to a similar conclusion. Although he proposes a different, more universal, health insurance system, the near-poor still pay more for their benefit than is justified. However, he argues that this is a structural issue of tax reform rather than a justice issue.<sup>120</sup> In the same way, I argue that the problem of the working poor speaks to the larger necessity to close all the gaps in our health insurance system and is not a flaw in the theory separating effort from choice in the context of poverty.

The problem of fraud has both a practical and an ethical component. Practically, fraud is usually considered expensive – especially with regard to welfare benefit. More enrolled individuals translates into more government resources spent on benefits. Insuring more individuals with better coverage will encourage preventive care, save money on long term chronic illness, and at the very least, decrease the use of overburden emergency rooms.<sup>136</sup> For example, individuals who receive consistent treatment of hypertension are less likely to require dialysis due to end stage renal failure.<sup>137</sup> Therefore, fraud may not be as costly to the government as it is assumed and will simultaneously offer coverage to individuals who despite their eligibility status, are clearly in need. Ethically, the “problem of fraud” is no greater than the problem of existing income tax fraud. We as a society have already determined that a limited amount of fraud is an acceptable cost of a more just society and have devised ways to limit this type of abuse. There is already a great deal of financial and administrative resources spent on reducing fraud within Medicaid. Therefore, automatic enrollment does not represent a substantial deviation from the current

requirements to protect against fraud. Rather, it offers a more just way of managing fraud as both poor and wealthy will be subject to the same scrutiny through income tax evaluation, rather than the poor undergoing an additional inquiry during the application process.

Furthermore, these critiques—especially the problems of the ‘welfare mom’ and fraud—speak to a broader issue of the social perceptions of the poor and disadvantaged. Underlying both of these critiques are negative assumptions about the poor—that they are lazy or dishonest. These assumptions lie at the heart of whether a poor individual ‘deserves’ public assistance and the requirement to ‘prove’ one’s deservingness. Importantly, this conception of deservingness is not an issue of distributive justice. Up to this point, I have focused my argument within the confines of distributing opportunity equally. This philosophical structure enables all individuals to exercise autonomy and thus treats individuals equally. Yet, the context of Medicaid brings out additional injustices beyond the scope of the distributional equality, beyond the issue of choice and effort. These are issues of relational justice. Relational justice concerns itself with securing equal respect, not through a distribution of resources or opportunity, but through avoiding humiliation and oppression.<sup>53, 119, 138</sup>

Theories of relational justice are concerned with respecting individuals. The assumptions implicit in the problem and the welfare-mom and the problem of fraud are clearly disrespectful. The impoverished are no more likely to ‘cheat-the-system’ than hospitals that abuse government re-imburements or tax-evaders who save money overseas. Moreover, the requirements of enrollment are disrespectful. Anderson argues that luck egalitarianism itself is disrespectful as it creates categories of ‘deserving,’ which disrespects the ‘undeserving’ automatically.<sup>119</sup> In determining specific populations as worthy of compensation, individuals are given benefits “in virtue of their inferiority to others, not in

virtue of their equality to others.”<sup>119</sup> It can be argued that in many circumstances, respecting each individual’s choices is sufficient to avoid humiliation and oppression. Yet, are the circumstances of applying to Medicaid sufficient?

Jonathan Wolff argues that that welfare-model’s enrollment process is inherently disrespectful. In defining respect, Wolff uses the term “respect-standing” to convey the degree of respect other people have for an individual.<sup>53</sup> Wolff outlines three conditions that reduce an individual’s “respect-standing” – failures in common courtesy, failures in trust, and shameful disclosures.<sup>53</sup> The enrollment process for low-income health insurance programs is disrespectful to the eligible individual in all three aspects. First, these individuals are often treated rudely at the Medicaid office; they are stigmatized as “free-riders.”<sup>44, 45</sup> Second, the burdensome application process requires proof to document resources and income, a proof not required of the wealthy. The well-off do not have to explain how they obtained the financial resources to pay for health insurance, yet the impoverished must prove their poverty. Like the critique of fraud, this burden represents a mistrust of the poor, assumed to be cheating the system.<sup>47</sup> Finally, and most damagingly, the process of active enrollment requires a “shameful revelation” of personal information, which is disrespectful and disheartening.<sup>53</sup> In essence, in order to be considered deserving, an individual is “required not merely to admit, but to make out a convincing case, that [he or she] is a failure.”<sup>53</sup> It is by virtue of their failure that individuals are deemed eligible for welfare programs like Medicaid, not by their useful participation in society as in Medicare.<sup>53</sup> Wolff, like Anderson, sees proving one’s deservingness by virtue of inferiority as disrespectful and thus a system based on such fails to treat individuals with equal regard.

The effortless-model I have proposed is not subject to the critiques of relational injustice. There is no inherently disrespectful or humiliating application process. Claiming

that poverty reduces an individual's self-efficacy is not an assault on dignity. Self-efficacy is an individual's own evaluation of his or her capability and is not a reflection of self-worth. Moreover, the counterarguments of the 'welfare-mom' and fraud are disrespectful and should not be considered justified.

### **Policy Implications:**

The ethical obligation to provide an “effortless” safety net has significant implications for the welfare model. As I discussed in the first part of this paper, reducing the application barriers and documentation requirements does not sufficiently address the problem of under-enrollment.<sup>9</sup> This is due to the stigma and financial incentives that are also deeply ingrained in the welfare-model and serve to keep eligible individuals unenrolled. Therefore, it is not enough to simply reduce the barriers to enrollment – rather there is a requirement to eliminate such physical and emotional barriers. One possible solution would be to provide a more “universal”-type health insurance that acts a true safety net below the current employee-health insurance. In such a system, all individuals would receive Medicaid at birth - through their social security number. Thus, all children would be covered automatically. Once an individual (child or adult) is covered through an alternate policy, he or she is no longer covered by Medicaid. Of course this does not cover individuals who do not have social security numbers, but does cover the 14 million eligible individuals as well as a majority of the 40 million uninsured. This universal system also addresses the issue of the “working-poor” and the “near-poor,” expanding the safety net so as to not disadvantage these individuals.

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<sup>9</sup> See Part 1: Under-Enrollment in Medicaid—The Structural Impact of the Welfare-Approach to Health Insurance, Section III: State Children's Health Insurance Program for full discussion.

Alternatively, one could cover only children through this program, with coverage expiring at the age of 18 and provide coverage for poor adults through a system of automatic enrollment tied to income taxes. This way the means-testing component remains; only those with an income below a designated level are offered Medicaid. However, these individuals are not unduly burdened to enroll; there is no extra effort required. Automatic enrollment, tied to income taxes, would require no additional revelations beyond those that already asked of all members of society. The major limitation of a system tied to income taxes is that assets are not accounted for appropriately, thus it is possible that an otherwise wealthy individual with a minimal annual income will take advantage of this government program.

I have left both of the alternatives described here intentionally vague. There is no discussion of the political feasibility, financing, or administration. Neither tackle the problem of differential access to adequate health care in a government program compared to private insurance.<sup>42, 139</sup> Rather, these alternatives are meant only to highlight the potential implementation of my theory. Both alternatives offer a solution to the problems of luck egalitarianism in the context of poverty. Both continue to respect choice. Ensuring enrollment has no effect on an individual's choice to access health care. It remains an individual's choice to see a doctor. Thus there is no assault on individual freedom, leaving the choice to obtain health care an individual one. In fact, it ensures access to a more meaningful choice. Both alternatives are not excessively burdensome to the poor and are not by nature disrespectful. Eliminating the stigma and shameful disclosures involved in the application process makes great strides toward treating individuals with equal respect. Therefore, removing effort from the choice to enroll does not damage choice, freedom, autonomy, or equality. In fact—it enables choice, allowing individuals to act on their autonomous decisions, and it promotes equality, both distributional and relational.

## **Conclusion:**

This paper has attempted to show that the welfare model is not only an imperfect application of luck egalitarianism but also that luck egalitarianism fails to adequately justify the endemic problem of under-enrollment in low-income health insurance programs. Dworkin's ideal of equal opportunity offers hope for a society that allows all individuals, regardless of circumstance, to achieve and develop their own conception of a happy life. Yet, the welfare model, and its insistence on upholding choice through requiring effort, overlooks the impact of the circumstances of poverty on self-efficacy, thus further disadvantaging the worst-off. Instead, I have argued that equal opportunity demands equality of the capacity for action—compensating people for systemic barriers to self-efficacy. The requirement of active enrollment within the welfare-model aims to provide all individuals, even those most disadvantaged, with the choice to enroll in health insurance. However, this choice is not reflective of the freedom and autonomy it claims to protect. In protecting this choice, individuals are subject to a disrespectful and unjust application process. This process is unjust as it incorrectly uses effort to represent the choice of enrollment. I have argued that in the context of poverty effort does not adequately reflect choice and thus cannot be held as a standard for enrollment.

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