

## **“Everybody Knows I’m Not Lazy”: Medicaid Work Requirements and the Expressive Content of Law**

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Abstract:

In a first for the Medicaid program, the Department of Health and Human Services under President Trump allowed states to establish work requirements for program participants who are considered “able-bodied adults.” These mandates were halted by litigation, and President Biden’s administration is now in the process of withdrawing the waivers. But early experiences with Medicaid work requirements suggested that they can produce widespread losses of benefits. In addition to affecting access, work requirements and other conditions on public benefits can serve an *expressive* purpose: they provide a source of information about a state’s values, goals, and beliefs about beneficiaries. Beneficiaries are one audience for this expressive message, but we know little about what they hear when their state makes benefits more difficult to access.

This Article presents an original empirical study of more than 9,000 Medicaid beneficiaries in the Commonwealth of Kentucky, the first state approved for a work requirement program. Using a mix of survey data and qualitative interviews, this Article demonstrates that Medicaid beneficiaries understand work requirements as providing information about the state’s values and priorities. But

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depending on their priors, beneficiaries interpreted these messages very differently. Many found work requirements unfair and expressive of disregard toward themselves and other beneficiaries; others believed, however, that the state had validated their identities as taxpayers.

This Article presents these findings and considers implications for expressive theories of law, shifting the paradigm to emphasize that the expressive impacts of law will depend on who is listening.

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## INTRODUCTION

*“Community engagement requirements are not some subversive attempt to just kick people off of Medicaid . . . Instead, their aim is to put beneficiaries in control with the right incentives to live healthier, independent lives.”*<sup>1</sup>

*“[P]eople who [are] mentally ill, people who didn’t graduate from high school. I’ve got no idea what they’re going to do. There’s nothing for them. You tell them to go out and get a job and pay a premium or else we’ll take away your health care, and they’ll just disappear into the streets.”*<sup>2</sup>

*“If you make these changes, you will kill people.”*<sup>3</sup>

Medicaid has had a close call with work requirements. Requiring program beneficiaries to fulfill quotas of work or education is a longstanding part of the Supplemental Nutrition Assistance Program (SNAP, or food stamps) and Temporary Assistance for Needy Families (TANF, or cash welfare).<sup>4</sup> These requirements have been absent from the Medicaid program, which pays for health care for low-income and certain disabled people. But starting in 2018,<sup>5</sup> the Centers for Medicare & Medicaid Services (CMS) approved waivers that would allow states to require beneficiaries deemed “able-bodied” to meet quotas of work or education to keep their health care. The programs were halted in litigation; although the Supreme Court review granted certiorari and scheduled oral arguments in March of this year, arguments were canceled while the Biden Administration reviewed the approval of work requirement waivers.<sup>6</sup> CMS is now

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1 Jessie Hellman, *Trump Administration Defends Medicaid Work Requirements*, HILL (Sept. 27, 2018), <https://thehill.com/policy/healthcare/408724-trump-administration-defends-medicaid-work-requirements-after-coverage> (quoting CMS Administrator Seema Verma).

2 John Cheves, *Are Bevin’s New Medicaid Rules “All About Putting Up Roadblocks for Poor People?”*, LEXINGTON HERALD LEADER (Feb. 2, 2018), <https://www.kentucky.com/news/politics-government/article198087454.html> (quoting Ronnie Stewart, lead plaintiff in *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018)).

3 Matthew Cortland & Karen Tani, *Reclaiming Notice and Comment*, YALE J. ON REG. NOTICE & COMMENT (Aug. 13, 2019), <https://www.yalejreg.com/nc/reclaiming-notice-and-comment-by-matthew-cortland-and-karen-tani/> (quoting a public comment on Kentucky’s § 1115 waiver).

4 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. 104–193, 110 Stat. 2105 (1996).

5 A 2017 effort to introduce a state option to impose work requirements was rejected as part of Affordable Care Act (ACA) repeal-and-replace legislation. See Laura D. Hermer, *What to Expect When You’re Expecting . . . TANF-Style Medicaid Waivers*, 27 ANN. HEALTH L. 37, 38–39 (2018).

6 Megan B. Cole et al., *What the New Biden Administration May Mean for Medicaid*, JAMA

in the process of issuing withdrawals, which will be numerous.<sup>7</sup> During the Trump Administration years, twenty states sought (and ten received) federal approval to require work as a condition of participation.<sup>8</sup>

Medicaid operates as a federal-state partnership, whereby states receive federal money and match it with state funds to purchase health care for low-income individuals. States have discretion in their Medicaid programming, as long as they abide by baseline federal requirements.<sup>9</sup> Under § 1115 of the Social Security Act, however, states can waive out of certain federal rules for experimental programs that are budget-neutral and “likely to assist in promoting the objectives” of the Medicaid statute. Prior waivers have often supported programs that expanded categories of coverage, changed payment models, or funded optional benefits.<sup>10</sup> Breaking from past interpretations by the Department of Health and Human Services (HHS), the Trump Administration supported new conditions on Medicaid participation. Early in the Administration, HHS announced its intention to approve “meritorious innovations that build on the human dignity that comes with training, employment, and independence.”<sup>11</sup> After repeal-and-replace efforts failed in Congress, CMS extended a formal invitation to state Medicaid directors, providing guidance for waivers that would condition Medicaid eligibility for able-bodied

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HEALTH FORUM (Jan. 13, 2021), <https://jamanetwork.com/channels/health-forum/fullarticle/2775343> (describing pending oral arguments in the Supreme Court); *Justices Call Off Arguments Over Medicaid Work Requirements*, AP NEWS (March 11, 2021), <https://apnews.com/article/politics-elections-medicaid-courts-presidential-elections-ecee56622ae33da95196249fb8095b68>; Jessie Hellman, *Supreme Court Cancels Arguments in Medicaid Work Requirements Case*, MODERN HEALTHCARE (March 11, 2021), <https://www.modernhealthcare.com/medicaid/supreme-court-cancels-arguments-medicaid-work-requirements-case>.

<sup>7</sup> Sidney D. Watson, *Roll Back Harmful Section 1115 Waivers: Charting the Path Forward*, BILL OF HEALTH (May 12, 2021), <https://blog.petrieflom.law.harvard.edu/2021/05/12/section-1115-waiver-withdrawals/> (describing withdrawal of Arkansas and New Hampshire waivers in March 2018, and noting that nine other states have now received letters stating that CMS has “preliminarily determined their work requirement waivers did not promote the objectives of the Medicaid Act”).

<sup>8</sup> HENRY J. KAISER FAM. FOUND., MEDICAID WAIVER TRACKER: APPROVED AND PENDING SECTION 1115 WAIVERS BY STATE, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/> (last updated Jan. 23, 2020).

<sup>9</sup> See generally JAMILA MICHENER, FRAGMENTED DEMOCRACY 8 (2018) (describing the structure of Medicare and the allocation of authority between states and the federal government).

<sup>10</sup> See 42 U.S.C. § 1315 (2018); see also NAT’L CONFERENCE OF STATE LEGISLATURES, UNDERSTANDING MEDICAID SECTION 1115 WAIVERS 4 (2017), [http://www.ncsl.org/Portals/1/Documents/Health/Medicaid\\_Waivers\\_State\\_31797.pdf](http://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf) (noting that waivers prior to the ACA were often used to expand coverage).

<sup>11</sup> Letter from Thomas E. Price, Sec’y, U.S. Dep’t of Health & Hum. Servs., & Seema Verma, Adm’r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Hum. Servs., to State Governors (Mar. 14, 2017), <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf> [hereinafter Letter from Sec’y Price & Adm’r Verma].

adults on work requirement quotas.<sup>12</sup> Beginning with Kentucky,<sup>13</sup> CMS approved Medicaid work requirements reaching 80 to 100 hours per month.<sup>14</sup>

Courts consider the legality of Medicaid waivers on a case-by-case basis, but all work requirement waivers reviewed thus far have been struck down.<sup>15</sup> The United States District Court for the District of Columbia twice vacated CMS's approval of Kentucky's waiver as arbitrary and capricious, on the grounds that the Secretary of HHS did not adequately consider the program's impacts on 95,000 individuals projected to lose coverage.<sup>16</sup> New Hampshire's program received the same decision.<sup>17</sup> Only Arkansas implemented work requirements with penalties for noncompliance; after nine months of operations and a loss of Medicaid coverage for nearly 18,000 people,<sup>18</sup> the District of D.C. likewise struck down the

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12 Letter from Brian Neale, Dep. Adm'r & Dir., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., to State Medicaid Dirs. (Jan. 11, 2018), <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf> [hereinafter Letter from Brian Neale to State Medicaid Dirs.]. This has aligned with broader efforts to expand work requirements throughout public benefits programs, including other "non-cash welfare programs" like federal housing assistance and SNAP. See Exec. Order No. 13,828, Reducing Poverty in America by Promoting Opportunity and Economic Mobility, 83 Fed. Reg. 15,941, 15,941–43 (Apr. 13, 2018); COUNCIL OF ECON. ADVISERS, EXPANDING WORK REQUIREMENTS IN NON-CASH WELFARE PROGRAMS (July 2018); Supplemental Nutrition Assistance Program: Requirements for Able-Bodied Adults Without Dependents, 84 Fed. Reg. 66,782 (Dec. 5, 2019); see also Lola Fadulu, *Cities Prepare for the Worse as Trump's Food Stamp Cuts Near*, N.Y. TIMES (Jan. 25, 2020), <https://www.nytimes.com/2020/01/25/us/politics/trumps-food-stamp-cuts.html> (quoting the administration's estimate that 700,000 people will lose food stamps under the new rules). The term "welfare" has powerful negative resonance in U.S. political speech and popular culture. See MARTIN GILENS, WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTIPOVERTY POLICY 63, 66 (1999) (describing nuanced views on welfare); DEBORAH STONE, THE SAMARITAN'S DILEMMA: SHOULD GOVERNMENT HELP YOUR NEIGHBOR? 12–16 (2008) (providing a historical overview of welfare stigma); Emily Badger, *The Outsize Hold of the Word "Welfare" on the Public Imagination*, N.Y. TIMES (Aug. 6, 2018), <https://www.nytimes.com/2018/08/06/upshot/welfare-and-the-public-imagination.html>.

13 Letter from Brian Neale, Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., to Adam Meier, Deputy Chief of Staff, Governor Matthew Bevin (Jan. 12, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>.

14 HENRY J. KAISER FAM. FOUND., *supra* note 8.

15 See Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 375 NEW ENGL. J. MED. 788 (2018) [hereinafter Huberfeld, *Can Work Be Required*]. The ethical basis of demonstrations that impose such requirements has been similarly disputed. See Harald Schmidt & Allison K. Hoffman, *The Ethics of Medicaid's Work Requirements and Other Personal Responsibility Policies*, 319 JAMA 2265 (2018).

16 *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019); *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (D.D.C. 2018).

17 *Philbrick v. Azar*, 397 F. Supp. 3d 11, 33 (D.D.C. 2019).

18 Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 N. ENGL. J. MED. 1073 (2019).

state's waiver.<sup>19</sup> In February 2020, the D.C. Circuit upheld both the lower court's decisions,<sup>20</sup> halting work requirement activity. The following month, Judge Boasberg also vacated a work requirement waiver in Michigan.<sup>21</sup> The Supreme Court granted certiorari in the Arkansas and New Hampshire cases in December 2020.<sup>22</sup> By that time, an additional 1.7 million people had newly enrolled in Medicaid amid the COVID-19 crisis, while CMS Administrator Seema Verma reiterated her support for work requirement waivers.<sup>23</sup> After the change of administration, however, new HHS Secretary Xavier Becerra requested in March 2021 that the Court remand the case to the agency.<sup>24</sup> By then, President Biden's CMS had withdrawn its approvals of both the Arkansas and New Hampshire waivers, determining that "testing those requirements is not 'likely to assist in promoting the objectives of Medicaid.'"<sup>25</sup> The Court agreed to hold the proceedings in abeyance as of April 2021,<sup>26</sup> and CMS withdrawal of state Medicaid work requirement waivers is in progress.<sup>27</sup>

Work requirements transform Medicaid from a statutory entitlement into an *incentive* to motivate specific behaviors required by the state. Work requirements also present hurdles to accessing benefits, with consequences that depend not only on motivation, but also on structural barriers to fulfilling program terms (e.g., awareness of the requirement, transportation, childcare, access to systems for reporting compliance). The effects of these conditions on program participation and long-term health demand rigorous evaluation,<sup>28</sup> and this Article originated in

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19 Gresham v. Azar, 363 F. Supp. 3d 165, 185 (D.D.C. 2019).

20 Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020), *cert. granted*, 141 S. Ct. 890 (2020); Abby Goodnough, *Appeals Court Rejects Trump Medicaid Work Requirements in Arkansas*, N.Y. TIMES (Feb. 14, 2020), <https://www.nytimes.com/2020/02/14/health/medicaid-work-requirements.html>. The Kentucky waiver was not included in this decision because it had already been canceled by a new state administration. Arian Campo-Flores, *Kentucky's New Governor Ends Medicaid Work Requirement*, WALL ST. J. (Dec. 16, 2019), <https://www.wsj.com/articles/kentuckys-new-governor-ends-medicaid-work-requirement-11576533315>.

21 Young v. Azar, 1:19-cv03526 (D.D.C. Mar. 4, 2020) (vacating CMS's approval of Michigan's work requirements).

22 See Gresham, 950 F.3d at 93; Amy Howe, *Justices Agree to Review Legality of Medicaid Work Requirements*, SCOTUSBLOG (Dec. 4, 2020), <https://www.scotusblog.com/2020/12/justices-agree-to-review-legality-of-medicaid-work-requirements/>.

23 Robert King, *Verma Doubles Down on Supporting Medicaid Work Requirements as Enrollment Swells*, FIERCE HEALTHCARE (Oct. 7, 2020), <https://www.fiercehealthcare.com/payer/verma-doubles-down-supporting-medicaid-work-requirements-as-enrollment-swells>.

24 Reply Brief for the Federal Petitioners at 2, *Becerra v. Gresham*, 141 S. Ct. 2461 (2021) (Nos. 20-37 and 20-38).

25 *Id.*

26 *Becerra*, 141 S. Ct. 2461.

27 See Watson, *supra* note 7 (describing ongoing withdrawals).

28 Kristen Underhill et al., *Fulfilling States' Duties to Evaluate Medicaid Waivers*, 379 N. ENGL. J. MED. 1985 (2018).

one such effort.

But beyond the effects of program terms on work activity and access to benefits, work requirements in benefits programs may also exert *expressive* impacts.<sup>29</sup> A robust line of research proposes that law serves as a source of information, emphasizing how the communicative impacts of law can foster compliance and the entrenchment of norms. Here, I show that work requirements communicate information about the goals of Medicaid, the abilities and lives of beneficiaries, and the relationship between beneficiaries and the state.

This Article recasts work requirements as a source of information to beneficiaries, presenting an original qualitative study with beneficiaries in Kentucky in the months before the planned rollout of Kentucky HEALTH. I argue that these signals matter—and specifically, that they are in fact *co-produced* by states and beneficiaries themselves, filtered through beneficiaries’ normative priors. This contributes a new theoretical dimension to scholarship on law’s expressive impacts, which has made few forays into the problem of how listeners’ prior commitments may affect their interpretation of the expressive content of law. In this study, I found that Medicaid beneficiaries interpreted work requirements as information about the state’s intentions and beliefs, the state’s perception of beneficiaries generally, and the state’s views about them personally. Specifically, participants tended to interpret work requirements in relation to how they thought *other* program participants behaved. Some viewed other Medicaid beneficiaries as like themselves—participating in Medicaid due to accidents and hardship, and likely to be harmed by work requirements. But others viewed their peers as character-driven, lacking in work effort, and demanding a response by the state. Prior research has demonstrated the central role of racism and racial stereotypes in the design and perception of means-tested programs,<sup>30</sup> and these stereotypes were relevant here as well. Several White participants invoked racial stereotypes specifically when discussing benefits eligibility, implicitly distancing themselves from other beneficiaries. But the large majority of participants across racial groups did not speak openly on race—we did not interrogate race-related beliefs specifically, and social norms may have prevented more open disclosures.

Narratives that focus primarily on how law impacts *others*—and particularly narratives that dissociate oneself from similarly situated peers—challenge public choice theory, which suggests that we reason through law based on our own self-

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29 For an overview of expressive theories of law, see RICHARD H. MCADAMS, *THE EXPRESSIVE POWERS OF LAW* (2016).

30 See GILENS, *supra* note 12, at 60-79 (identifying racist stereotypes implicated in opposition to welfare); MICHENER, *supra* note 9, at 33-59 (charting a history of public assistance and describing how states used flexibilities in their administration of Medicaid in ways that disadvantaged people of color; noting at page 54 that “by dint of federalism, Medicaid policy produces *unequal politics* and deepens already yawning racial, class, and geographic disparities in the United States” (emphasis in original)).



interest, rather than the impact of law on others.<sup>31</sup> But on a deeper look, the results may also *align* with public choice theory for beneficiaries whose dominant perspective is that of taxpayers, rather than beneficiaries. Although these beneficiaries' material self-interest may lie in access to health care benefits, they may view their own character and identity interests as better served by a work requirement policy. These findings resonate with psychological research on fundamental attribution bias: the phenomenon by which we view others' decisions as evidence of their character, while we view our own choices as informed by circumstance.<sup>32</sup> These findings also invoke past research on benefits uptake<sup>33</sup> and welfare stigma,<sup>34</sup> where many participants seek to distinguish their uptake from that of other beneficiaries.

Finally, this Article contributes nuanced descriptive findings to work on Medicaid work requirements. I highlight that even without any explanatory information from the state, beneficiaries make independent efforts to interpret what the law conveys, drawing on their prior beliefs and experiences. And, although recent research on work requirements has emphasized opposition to new requirements among beneficiaries,<sup>35</sup> I find a more complex story in Kentucky.

This Article proceeds in the following Parts. Part I introduces expressive legal theory. Part II describes the landscape of work requirement conditions on Medicaid participation, with particular attention to § 1115 waivers. Part III sets forth the empirical study, focusing on narratives in which Medicaid beneficiaries describe their reasons for Medicaid participation, their perceptions of other participants, their awareness of conditions planned in the state § 1115 program, and their interpretation of the purposes and messages underlying these new program elements. Part IV draws lessons from these findings, considering implications for expressive theories of law, as well as for compliance with conditions on public benefits programs.

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31 1 THE OXFORD HANDBOOK OF PUBLIC CHOICE 6-8, 17-20 (Roger D. Congleton et al. eds., 2019).

32 See *infra* Part IV.

33 See generally JOE SOSS, UNWANTED CLAIMS (2000) (drawing on in-depth interviews with participants in two public benefits programs to identify how program uptake is political action that can simultaneously empower claimants and reinforce their marginalization).

34 GILENS, *supra* note 12, at 63, 66.

35 Jessica Greene, *Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement*, HEALTH AFF. (Sept. 5, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/> [hereinafter Greene, *Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement*]; Jessica Greene, *What Medicaid Recipients and Other Low-Income Adults Think about Medicaid Work Requirements*, HEALTH AFF. (Aug. 30, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170830.061699/full/> [hereinafter Greene, *What Medicaid Recipients and Other Low-Income Adults Think about Medicaid Work Requirements*].

A word on language may be helpful. Despite an imperfect fit, I follow popular and scholarly language in using the term “work requirements” to refer to Medicaid conditions that require beneficiaries to spend time in paid employment, job seeking, training, education, or caregiving.<sup>36</sup> I have also quoted the terminology “able-bodied,” which is used by states and CMS to designate individuals who qualify for work requirements. State § 1115 waivers define able-bodied individuals by reference to what they are not: not pregnant, elderly, children, disabled, or “medically frail” (a regulatory term that encompasses people with serious or complex health conditions).<sup>37</sup> I note, however, that “able-bodied” is a fraught term with historical resonance and connotations on the basis of race and class,<sup>38</sup> and which conveys moral judgments about nondisabled people who receive public aid.<sup>39</sup> My intention here is not to invoke these judgments, but rather to participate in conversation with advocates, scholars, agency personnel, and states using the term.

### I. EXPRESSIVE THEORIES OF LAW

Expressive theories of law, which emphasize the pathways by which legal rules encode and convey information, have an extensive reach.<sup>40</sup> The focus of this work tends to be how the information communicated through legal rules—typically information about morality, social norms, or risk/reward calculus—can

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36 “Work requirements” is misleading for this purpose, and may even be harmful, because it obscures the range of alternative activities by which beneficiaries may fulfill their hourly quotas. CMS and states that have proposed these conditions in Medicaid have used the term “community engagement requirements” instead.

37 42 C.F.R. § 440.315(f) (2021) (“[T]he State’s definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter [regarding certain categories of children], individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.”); HENRY J. KAISER FAM. FOUND., KEY STATE POLICY CHOICES ABOUT MEDICAL FRAILTY DETERMINATIONS FOR MEDICAID EXPANSION ADULTS (2019), <https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicare-expansion-adults-issue-brief/>.

38 Emily Badger & Margot Sanger-Katz, *Who’s Able-Bodied, Anyway?*, N.Y. TIMES (Feb. 3, 2018), <https://www.nytimes.com/2018/02/03/upshot/medicaid-able-bodied-poor-politics.html>. The term dates at least back to Elizabethan poor laws, which required work as a condition of assistance. Hermer, *supra* note 5, at 41, 41 n.24.

39 Badger & Sanger-Katz, *supra* note 38. The Supplemental Nutrition Assistance Program (SNAP) uses the term as well, sometimes using the acronym ABAWDs (able-bodied adults without dependents) to designate the group that qualifies for work requirements.

40 See, e.g., RICHARD H. MCADAMS, THE EXPRESSIVE POWERS OF LAW (2015).

motivate or deter compliance among those who are subject to the new rules.<sup>41</sup> One insight of expressive legal theories is that laws can lead subjects to internalize the norms expressed, thereby facilitating compliance and minimizing enforcement burdens.<sup>42</sup> But expressive legal theories are capacious enough to consider “expression” that may be unintended or unreflective of lawmakers’ actual beliefs.<sup>43</sup> On their own, even without any deliberate intentions by the legislature, governor, or any other speaker, laws “always ha[ve] expressive meaning.”<sup>44</sup> When interpreting the expressive impacts of laws, we should therefore contemplate not only what the speakers of such laws intend, but also what the laws themselves express as detached from the intentions of their drafters.

A deep scholarly literature has considered how laws express information.<sup>45</sup> Richard McAdams, a central theorist in this area, recently surveyed the field with attention to the ways in which law “influences beliefs, emotions, or behavior by what it expresses”<sup>46</sup>—noting a broader emphasis across scholars on how the expressive content of law affects compliance. On this view, law communicates information, which affects beliefs, which then shape individual behavior.<sup>47</sup> Law can exert this impact through multiple pathways. One such pathway draws on decision theory: where people must coordinate their behavior—such as when many people drive or consume a common nonexcludable resource—law can signal a

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41 *Id.* at 3–6.

42 *Id.*

43 See Elizabeth S. Anderson & Richard L. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1506–08 (2000) (clarifying what is meant by “expression”). In expressive legal theories, expression refers to “the ways an action or a statement . . . manifests a state of mind.” *Id.* But that state of mind may not in fact be shared by the speaker. As Anderson and Pildes write, “not everything that expresses a state of mind is caused by that state of mind”—such as “the musician who plays sad songs without feeling sad oneself.” *Id.*

44 *Id.* at 1508.

45 See, e.g., LAWRENCE M. FRIEDMAN, *IMPACT: HOW LAW AFFECTS BEHAVIOR* ch. 1 (2016); MCADAMS, *supra* note 40; Matthew D. Adler, *Expressive Theories of Law: A Skeptical Overview*, 148 U. PA. L. REV. 1363 (2000); Anderson & Pildes, *supra* note 43; Robert Cooter, *Expressive Law and Economics*, 27 J. LEGAL. STUD. 585 (1998); David DePianto, *Sticky Compliance: An Endowment Account of Expressive Law*, 2014 UTAH L. REV. 327 (2014); Alex Geisenger, *A Belief Change Theory of Expressive Law*, 88 IOWA L. REV. 35 (2002); Alex C. Geisenger & Michael Ashley Stein, *Expressive Law and the Americans with Disabilities Act*, 114 MICH. L. REV. 1061 (2016); Dan M. Kahan, *Social Influence, Social Meaning, and Deterrence*, 83 VA. L. REV. 349 (1997); Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943 (1995); Richard H. McAdams, *A Focal Point Theory of Expressive Law*, 86 VA. L. REV. 1649 (2000); Richard H. McAdams, *An Attitudinal Theory of Expressive Law*, 79 OR. L. REV. 339 (2000); Richard McAdams & Janice Nadler, *Coordinating in the Shadow of the Law*, 42 L. & SOC’Y REV. 865 (2008); Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021 (1996); Maggie Wittlin, *Buckling Under Pressure: An Empirical Test of the Expressive Effects of Law*, 28 YALE J. ON REG. 419 (2011).

46 MCADAMS, *supra* note 40, at 13.

47 *Id.*

“focal point” that facilitates coordination.<sup>48</sup> Namely, law *suggests* a choice that then becomes salient, and different actors with competing interests can organize their activity accordingly (e.g., avoiding crashes or preserving scarce resources).<sup>49</sup>

Where coordination among actors is not a significant demand, however—such as when Medicaid-eligible individuals enroll in benefits—a different pathway of *direct* signaling may more relevant. Law communicates information directly to people who are bound by its mandates, because when people become aware of a law (regardless of whether the law applies to them personally), they draw conclusions about *how* and *why* the law exists. This Article focuses on ways in which these conclusions embed people’s prior views of law, lawmakers, social norms, and empirical facts. These conclusions can affect people’s behavior (as most expressive legal theorists discuss), as well as affecting people’s attitudes about the law or the world around them. The ways that people identify signals in law have been arranged in three categories: attitudinal signaling, risk signaling, and violations signaling.

“Attitudinal signaling” occurs when laws express suggestions about social norms or attitudes. Individuals who interpret law as conveying attitudinal signals might reasonably conclude that if the law requires a behavior (say, paying taxes or refraining from discriminatory behavior), public attitudes concur with the law. If social norms matter—if we fear social costs of nonconformity, or if being like others is of intrinsic importance to us—we may update our own practices accordingly.<sup>50</sup>

Another category of information is “risk signaling,” by which the law implies facts about hazards that exist in the world. For example, if I know I will incur legal penalties for driving my child around without a car seat, I may usefully conclude that lawmakers think this is a dangerous choice. I may rationally update my behavior to reflect this new risk information because I care about my child’s safety.

But perversely, realizing that the law takes steps to penalize my reckless choices might also raise my suspicion that *others* do not behave safely: a mechanism known as “violations signaling.” If I conclude that legislators adopted a car seat law because *other* parents drive around with their kids loose in the back seat, I will receive perverse information about permissive social norms. A well-known example of violations signaling can occur when lawmakers raise sanctions

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48 *Id.* at 22; THOMAS SCHELLING, *THE STRATEGY OF CONFLICT* (1963); Richard H. McAdams, *A Focal Point Theory of Expressive Law*, *supra* note 40; Richard H. McAdams, *Beyond the Prisoners’ Dilemma*, 82 S. CAL. L. REV. 209 (2009); McAdams & Nadler, *supra* note 45.

49 McADAMS, *supra* note 40, at 22, 62 (noting limitations on the scope of this theory).

50 For some pushback on this point, see Robert E. Scott, *The Limits of Behavioral Theories of Law and Social Norms*, 86 VA. L. REV. 1603, 1621–37 (2000) (arguing that expressive theories explaining how law influences social norms are imprecise and lacking in mechanisms to explain internalization).

for tax evasion, which may prompt us to believe that many others shirk paying their taxes. None of us wants to be the chump who pays her taxes while others shirk—so violations signaling may paradoxically *increase* violations.<sup>51</sup>

The impacts of expression are distinct from the direct incentive impacts of law. For instance, if I know my state is raising taxes for sugary soda, I might purchase less soda simply because it is more expensive (direct incentive impacts). But when I learn about this law, the fact that my legislature made this choice may also cause me to update my beliefs (expressive impacts). I may conclude that my fellow citizens disfavor soda (or, worse, soda-drinkers), and I may be concerned about drinking a disfavored beverage; this mechanism may be stronger if we view laws as reflecting popular preferences (which may be a stronger connection for legislation or popular referenda as compared to agency regulation). I may also conclude that the legislature thinks that soda is bad for me, and is actively trying to put it further out of reach. Or, perversely, I may conclude that the legislature raised soda taxes because soda is wildly popular (particularly true for taxes, where I might believe that the legislature is motivated to raise as much revenue as possible), and thereby take the opposite lesson about peer norms. These new beliefs may affect my choices, wholly apart from the fact that soda is more expensive than it was before.

Of course, another possible expressive interpretation is that legislators (and, by extension, the voters in my state) simply have it out for me, as well as for my fellow soda drinkers, and that we have lost a battle that implicates our identity. When this is true, laws convey not only information about social norms and risk, but also information about the relative standing of social groups. Dan Kahan and Donald Braman's work on cultural cognition has been a formative contribution to this field, which McAdams has called the "expressive-politics theory of law."<sup>52</sup> A soda tax, for example, may teach the soda drinker that others think she is irresponsible, that she is deserving of punishment, or that she is an expedient means of raising revenue for the state. Individuals who resent or cheer laws may thus view the enactment of legal rules as elevating or undermining their own cultural identities—such as the enactment of Prohibition as a symbolic victory for Protestant advocates,<sup>53</sup> or the regulation of firearms as a threat to hierarchical and

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51 McADAMS, *supra* note 40, at 162.

52 *Id.* at 13.

53 See generally McADAMS, *supra* note 40, at 14 (drawing on JOSEPH GUSFIELD, *SYMBOLIC CRUSADE: STATUS POLITICS AND THE AMERICAN TEMPERANCE MOVEMENT* (1982) to note the view that "law is a symbol over which political groups struggle").

individualistic cultural values.<sup>54</sup>

Given the focus on compliance behavior in expressive legal literatures, expressive-political effects such as feeling validated or “disrespected” by legal rules have played a supporting role in behavioral analyses of expressive law.<sup>55</sup> But a separate thread of literature on incentives and motivation can draw links between these emotions and behavior. “Motivation crowding” theory rests on the premise that offering individuals incentives, penalties, or mandates can interfere with their intrinsic motivation to behave as requested.<sup>56</sup> Many possible messages that can exert this effect: if individuals interpret a legal rule as insulting,<sup>57</sup> distrustful,<sup>58</sup> hostile,<sup>59</sup> arbitrary,<sup>60</sup> evidence of reprehensible values,<sup>61</sup> evidence of detrimental social norms,<sup>62</sup> or negative information about the task,<sup>63</sup> the rule may interfere with intrinsic motivation to behave as desired. I therefore view the distinction between expressive impacts on *identity* (“expressive-politics” theory, per McAdams) and expressive impacts on *behavior* as highly collapsible, and I will consider both as potential pathways to behavior.

Expressive legal theories have limits. For instance, such theories only function well when individuals know the law, or when *enough* individuals are aware of law

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54 MCADAMS, *supra* note 40, at 14 (drawing on a body of work by Dan Kahan and Don Braman to note that “social groups view regulation as a political test of their cultural values . . . . There being symbolic competition among social groups, the members of one group will favor the laws they perceive as expressing their social standing”).

55 *See, e.g.*, MCADAMS, *supra* note 40, at 13 (“If one subjectively feels respected by the law, that gain is an expressive consequence. If one feels disrespected, that loss is an expressive harm . . . [B]ut the main event here is behavior.”).

56 Kristen Underhill, *Money that Costs Too Much*, 94 IND. L.J. 1109 (2019); Kristen Underhill, *When Extrinsic Incentives Displace Intrinsic Motivation: Designing Legal Carrots and Sticks to Confront the Challenge of Motivational Crowding-Out*, 33 YALE J. ON REG. 213 (2016).

57 Roland Bénabou & Jean Tirole, *Intrinsic and Extrinsic Motivation*, 70 REV. ECON. STUD. 489, 491 (2003).

58 Ernst Fehr & Simon Gächter, *Fairness and Retaliation: The Economics of Reciprocity*, 14 J. ECON. PERSP. 159, 177 (2000); Bruno S. Frey, *A Constitution for Knaves Crowds out Civic Virtues*, 443 ECON. J. 1043 (1997);

59 Tore Ellingsen & Magnus Johannesson, *Pride and Prejudice: The Human Side of Incentive Theory*, 98 AM. ECON. REV. 990, 992 (2008) (noting the difference between profit-maximizing and mission-oriented motivations).

60 *See* Robert Eisenberger & Judy Cameron, *Detrimental Effects of Reward: Reality or Myth?*, 51 AM. PSYCHOLOGIST 1153, 1162–63 (1996) (“When reward is presented independently of performance, people may learn they cannot influence reward presentation, resulting in reduced motivation.”).

61 Antoine Beretti et al., *Using Money to Motivate Both “Saints” and “Sinners”: A Field Experiment on Motivational Crowding-Out*, 66 KYKLOS 63, 66 (2013); Uri Gneezy et al., *When and Why Incentives (Don’t) Work to Modify Behavior*, 25 J. ECON. PERSP. 191 (2011).

62 Dan M. Kahan, *The Logic of Reciprocity: Trust, Collective Action, and Law*, 102 MICH. L. REV. 71, 79 (2003)

63 Roland Bénabou & Jean Tirole, *Incentives and Prosocial Behavior*, 96 AM. ECON. REV. 1652, 1654 (2006).

to shift prevailing norms.<sup>64</sup> The interviews for this study gave participants information about the legal rules before exploring their interpretations, but other sources of information may be lacking.<sup>65</sup> Moreover, little is known about the half-life of law's expressive signals—although learning about law may affect beliefs, little research has considered the durability of those changes. Beliefs do not always drive action. But despite these limitations, expressive theories provide useful frameworks for understanding how people bound by law may interpret legal rules.

## II. CONDITIONS IN MEDICAID

Through the lens of expressive law, Medicaid conditions can convey both intended and inadvertent expressive meanings. CMS and states have explained their intended rationale for these waiver terms in guidance, state applications, and CMS approval letters, as well as public statements by state governors and CMS leadership. These messages use the language of beneficiary dignity, income, and health. Commentators in academia and advocacy, however, have interpreted Medicaid conditions as expressing states' disregard of beneficiaries, animus towards some or all individuals receiving public assistance, or misunderstanding of the social and economic constraints that beneficiaries experience.<sup>66</sup> Largely absent from the conversation have been the messages received by beneficiaries themselves. This Part will introduce Medicaid waivers through an expressive lens, considering particularly the signals proffered by states and CMS.

### *A. Work Requirement Waivers*

Medicaid is an open-ended public assistance program financed jointly by state and federal revenues, and operated by states in compliance with federal regulations under the Social Security Act (SSA).<sup>67</sup> Medicare and Medicaid were established via amendment to the SSA in 1965; because the legislation principally focused on the enactment of Medicare,<sup>68</sup> the Medicaid program was little-noticed at the time,

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<sup>64</sup> See Kristen Underhill, *Perceptions of Protection under Nondiscrimination Law*, 46 AM. J.L. & MED. 21 (2020).

<sup>65</sup> See Greene, *Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement*, *supra* note 35; Margot Sanger-Katz, *One Big Problem with Medicaid Work Requirement: People are Unaware It Exists*, N.Y. TIMES (Sept. 24, 2018), <https://www.nytimes.com/2018/09/24/upshot/one-big-problem-with-medicaid-work-requirement-people-are-unaware-it-exists.html>.

<sup>66</sup> See *infra* Section III.D and accompanying notes.

<sup>67</sup> LAURA KATZ OLSON, *THE POLITICS OF MEDICAID* (2008).

<sup>68</sup> *Id.* at 23.

and mandatory populations and benefits were initially narrowly defined.<sup>69</sup> But in the decades since its enactment, Medicaid has expanded into the largest federal health insurance program,<sup>70</sup> covering 75 million children and adults on average per month.<sup>71</sup> Federal legislation throughout the 1980s and 1990s expanded eligible populations and benefits,<sup>72</sup> and the Affordable Care Act expansion was a transformative step nudging Medicaid toward a social insurance program<sup>73</sup>—one of near universal applicability,<sup>74</sup> although still under state control. Many scholars have considered the origins and impacts of local control over public benefits programs,<sup>75</sup> including Medicaid,<sup>76</sup> and although local control has created opportunities to identify the impact of policy features, decentralization has also contributed to access disparities on the basis of race and class.<sup>77</sup>

Two sources of variation—§ 1115 waivers and optional Medicaid expansion—have driven heterogeneity in Medicaid programming, yielding unprecedented new conditions for Medicaid eligibility.

First, a majority of states are now using § 1115 waivers to implement experimental or demonstration programming, which reflects decades of waiver approvals. Under § 1115 of the Public Welfare Amendments, added to the SSA in 1962, states who wished to experiment with new models of welfare programming

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69 MICHENER, *supra* note 9, at 42; OLSON, *supra* note 67, at 26; ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 57-72 (2003) (describing the initial design of Medicaid, and noting at page 57 that it “was not a sweeping program of assistance to all those who were poor, even within a state . . . [T]he federal subsidy followed . . . existing welfare classifications”).

70 OLSON, *supra* note 67, at 8.

71 Medicaid also covers close to 5 million each month through the Children’s Health Insurance Program (CHIP), Medicaid programming specifically for children. CMS FAST FACTS, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html> (last updated Mar. 12, 2021). These figures do not exclude individuals with dual eligibility, who receive both Medicare and Medicaid.

72 MICHENER, *supra* note 9, at 44–45.

73 Nicole Huberfeld & Jessica L. Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOLEDO L. REV. 545, 545 (2015).

74 Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL’Y L. & ETHICS 67 (2014). Large exclusions continue to be enforced, however, for recent migrants and long-term migrants who do not meet “qualified” standards (including undocumented migrants). Recent “public charge” regulations also allow citizenship determinations to consider Medicaid uptake as a factor suggesting that a migrant is likely to become a “public charge” in the U.S., which is expected to deter uptake among many migrants who are legally qualified to use the program.

75 See, e.g., KAREN TANI, *STATES OF DEPENDENCY: WELFARE, RIGHTS, AND AMERICAN GOVERNANCE, 1935-1972* (2016); SOSS, *supra* note 33.

76 MICHENER, *supra* note 9; David A. Super, *Laboratories of Destitution*, 157 U. PA. L. REV. 541 (2009).

77 MICHENER, *supra* note 9, at 54.



could seek permission for temporary waivers of federal requirements.<sup>78</sup> The Secretary of the Department of Health, Education and Welfare (now HHS) had authority to approve waivers for an “experimental, pilot, or demonstration project,” as long as she judged those programs “likely to assist in promoting the objectives” of the statute.<sup>79</sup> States could initially seek waivers to modify the Aid to Families with Dependent Children (AFDC) welfare program; when Medicaid was added to the SSA in 1965, § 1115 extended to some provisions of Medicaid as well.

Initial state waivers for both AFDC<sup>80</sup> and Medicaid programming<sup>81</sup> were restricted in scope, rarely statewide, and directed toward administrative changes. But the 1980s brought a new wave of waivers to AFDC under President Reagan, including new conditions for beneficiaries such as job training and welfare-to-work programming.<sup>82</sup> In 1982 and 1983, HHS facilitated these waivers by exempting § 1115 experiments from oversight by institutional review boards, which review research protocols for compliance with federal research ethics standards.<sup>83</sup> AFDC waivers expanded further under Presidents Bush and Clinton, culminating in program-wide work requirements for TANF (the replacement for AFDC) and SNAP under welfare reform in 1996.<sup>84</sup>

Until recently, waiver terms in state Medicaid programs have been qualitatively different from those tested in AFDC and TANF, and many tended to broaden eligibility, expand benefits, or improve care delivery. Medicaid waivers

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78 Lucy A. Williams, *The Abuse of § 1115 Waivers*, 12 YALE L. & POL’Y REV. 8, 10-11 (1994).

79 Public Welfare Amendments of 1962, Pub. L. No. 87-543, 76 Stat. 172, 192 (codified as amended at 42 U.S.C. § 1315 (2018)); Williams, *supra* note 78.

80 Williams, *supra* note 78, at 14.

81 Sidney Watson, *Out of the Black Box into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act’s Medicaid Expansion*, 15 YALE J. HEALTH POL’Y L. & ETHICS 213, 215 (2015) [hereinafter Watson, *Out of the Black Box into the Light*].

82 Williams, *supra* note 78, at 16.

83 *Id.* at 19–24; *see also* 47 Fed. Reg. 9208 (Mar. 4, 1982) (giving notice that “the Secretary has decided to waive the requirements . . . relating to protection of human subjects, as they pertain to demonstration projects, approved under section 1115 of the Social Security Act, which test the use of cost-sharing . . . in the Medicaid program”). This waiver was expanded in 1983 to include all section 1115 demonstrations. Williams, *supra* note 78, at 22.

84 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. 104-193, 110 Stat. 2105 (1996). The PRWORA requirements differed markedly from the welfare-to-work experiments in prior § 1115 waivers. Section 1115 waivers had been structured to offer unpaid work to recipients of public benefits, and refusal to accept the proffered work resulted in a penalty. The PRWORA provisions did not require states to generate work opportunities for participants, who were expected to find jobs independently. *See, e.g.*, ; David A. Super, *A Hiatus in Soft-Power Administrative Law*, 65 UCLA L. REV. 1590 (2018) [hereinafter Super, *A Hiatus*]; David A. Super, “*Work Requirements for Public Benefits Are Really Just Time Limits*,” LA TIMES (Jan. 15, 2018), <https://www.latimes.com/opinion/op-ed/la-oe-super-work-requirements-20180115-story.html>.

grew under the Clinton and Bush administrations,<sup>85</sup> and they focused on expanded eligibility, coverage of optional benefits, increased cost-sharing for beneficiaries, and managed care approaches.<sup>86</sup> In the absence of any Medicaid statutory authority for programmatic waivers, statewide experimental waivers have come to fill this gap, and large-scale waivers (many with thin evaluations and extensive policy similarity to other states) have become the norm.<sup>87</sup> Medicaid was exempted from work requirements in the 1996 welfare reform, primarily because Medicaid was largely restricted to populations considered less capable of working.<sup>88</sup> Although states continued to seek flexibility in the early years of the Obama Administration,<sup>89</sup> these continued to expand eligibility and to seek payment and organizational reform, rather than placing new conditions on benefits.

The most recent wave of § 1115 waivers has ushered in an unprecedented degree of flexibility, brought about due to the extension of Medicaid to a new category (adults deemed “able-bodied”) and the ability of states to refuse Medicaid expansion. The ACA mandated the expansion of Medicaid to all individuals below 138% of the federal poverty level,<sup>90</sup> enforced via the same mechanism that had been in place since 1965: states that failed to cover any mandatory population, including the new expansion group, would be ineligible for all Medicaid funds.<sup>91</sup> Challenges to this provision culminated in the Supreme Court’s 2012 decision in *National Federation of Independent Business v. Sebelius*<sup>92</sup> (*NFIB*), which stripped the statute of its enforcement mechanism.

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85 MICHENER, *supra* note 9, at 46; Hermer, *supra* note 5, at 42-45; Watson, *supra* note 81, at 214.

86 Expansions in cost-sharing were also enabled by the Deficit Reduction Act of 2005, along with permission for states to offer more limited benefits to some groups of beneficiaries. Hermer, *supra* note 5, at 44-45.

87 Watson, *supra* note 94, at 215 (“[By the time of the ACA], waivers no longer seemed to be about testing new and innovative ideas likely to further the purpose of the Medicaid Act. Instead, waiver approvals seemed to reflect a particular administration’s policy preferences: President Clinton’s for simply allowing states more flexibility from federal rules to pursue their own priorities and President George W. Bush’s for promoting private insurance models with thinner benefits and higher cost-sharing. Successive federal administrations seemed chronically unconcerned about whether waivers were budget neutral for the federal government. Some waivers have continued for decades with no public evaluation of their impact on Medicaid access, cost, or quality.”).

88 *Id.*

89 *Id.*

90 Patient Protection and Affordable Care Act, Pub. L. 111-148 § 2001(a), 124 Stat. 119, 271 (Mar 23, 2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018)). The statutory language extends the limit to 133% of the federal poverty level, and a separate provision of the ACA allows an income eligibility disregard in the amount of 5 percentage points of the federal poverty level. *Id.* § 2002(a) (as modified by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, § 1004(e)(2), 124 Stat. 1029, 1034 (March 30, 2010) (codified at 42 U.S.C. § 1396a(e)(14)(I) (2021))).

91 42 U.S.C. § 1396c (2018).

92 Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

The *NFIB* decision was an inflection point in the history and purpose of § 1115 waivers.<sup>93</sup> States after *NFIB* had a valuable political bargaining chip—they could choose to expand Medicaid to the new population, but in exchange they demanded new concessions from CMS in approving waiver terms. Eager to secure Medicaid expansion, the Obama Administration approved waivers from states with expanded copayment requirements, premiums as a condition of participation,<sup>94</sup> and stick-based incentives that required individuals to participate in healthy behavior activities to retain certain benefits. Indiana’s waiver was the most demanding, which allowed program lockouts (disenrollment) for beneficiaries who did not make premium payments.<sup>95</sup> HHS continued to disallow other waiver terms, however, including work requirements proposed by Indiana, Utah, Arizona, and Pennsylvania.<sup>96</sup>

The Trump Administration changed the emphasis of § 1115 waivers. Under criteria released in November 2017, the Administration’s goals for experimental Medicaid programming included “support[ing] coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life,” and “incentive structures that promote responsible decision-making.”<sup>97</sup> These emphases, combined with the expansion of Medicaid to populations considered “able-bodied,” resulted in the approval of waiver terms that more closely resembled conditions used in TANF and SNAP.<sup>98</sup>

Foremost among these terms was work requirements (or in HHS terms, community engagement requirements). A joint letter from CMS Administrator Seema Verma and HHS Secretary Tom Price announced the department’s policy change in 2017, welcoming applications with work requirements.<sup>99</sup> In January 2018, CMS issued new waiver guidelines in a letter to state Medicaid directors.<sup>100</sup> The agency invited programs “designed to promote better mental, physical, and emotional health,” and asked states to “consider a variety of activities” for meeting work hour quotas in high-unemployment areas. Unlike the early AFDC

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93 MICHENER, *supra* note 9, at 46; Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1729 (2018); Super, *A Hiatus*, *supra* note 84; Watson, *supra* note 81, at 214.

94 Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 ST. LOUIS UNIV. SCH. L. HEALTH L. & POL’Y 265, 271 (2016).

95 Montana, Arizona, and Iowa also gained approval for lockouts, but allowed re-enrollment if outstanding premiums were paid. Watson, *supra* note 94, at 267.

96 *State Waivers List*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html> (last visited Nov. 22, 2021).

97 ELIZABETH HINTON ET AL., HENRY J. KAISER FAM. FOUND., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS 9 (2019).

98 Hermer, *supra* note 5, at 58–64.

99 Letter from Sec’y Price & Adm’r Verma, *supra* note 11.

100 Letter from Brian Neale to State Medicaid Dirs., *supra* note 12.

experiments, however, Medicaid funds could not be used to pay for job training or “work supports” such as commuting or childcare.<sup>101</sup> Ten states received approvals to institute work requirement terms, and ten more states had applications pending at the end of the Trump Administration.<sup>102</sup> Only Arkansas implemented penalties for work requirement noncompliance, lasting from June 2018 until the program was halted in March 2019.<sup>103</sup>

The Trump Administration’s emphasis on expanding work requirements for benefits programming reached beyond Medicaid. In April 2018, President Trump signed the “Executive Order Reducing Poverty in America by Promoting Opportunity and Economic Mobility,” which describes benefits programs as “delay[ing] economic independence, perpetuat[ing] poverty, and weaken[ing] family bonds” through “long-term Government dependence.”<sup>104</sup> The order sets forth new “Principles of Economic Mobility,” which begin with “strengthening existing work requirements for work-capable people and introducing new work requirements when legally permissible.”<sup>105</sup> A 2018 report by the president’s Council of Economic Advisers echoed the executive order, advocating the extension of work requirements to “non-cash welfare programs”<sup>106</sup> like Medicaid, federal housing assistance, and SNAP for adults with dependents. HHS also reversed guidance by the Obama administration that had signaled a willingness to *wave* work requirements in § 1115 waivers applicable to TANF.<sup>107</sup> A White House plan for reorganizing federal agencies, announced in summer 2018, would have consolidated federal benefits programming in one agency, tasked in part with setting “uniform work requirements to be implemented across all welfare

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101 *Id.*

102 HENRY J. KAISER FAM. FOUND., *supra* note 8. Several states with pending waivers also have incoming governors or legislatures who have publicly opposed these terms, so ongoing progress is uncertain. Todd Leeuwenburgh, *New Democratic Governors May Block Medicaid Work Requirements*, BLOOMBERG L., (Dec. 27, 2018), <https://news.bloomberglaw.com/health-law-and-business/new-democratic-governors-may-block-medicaid-work-requirements>.

103 *See* Sommers et al., *supra* note 18.

104 Exec. Order No. 13,828, Reducing Poverty in America by Promoting Opportunity and Economic Mobility, 83 Fed. Reg. 15,941, 15,941 (Apr. 13, 2018).

105 *Id.*

106 COUNCIL OF ECON. ADVISERS, EXPANDING WORK REQUIREMENTS IN NON-CASH WELFARE PROGRAMS 2 (2018).

107 Information Memorandum TANF-ACF-IM-2017-01 from Clarence H. Carter, Dir. Office of Family Assistance, to State and Territorial Agencies Administering TANF on Rescinding Guidance Concerning Waiver and Expenditure Authority under Section 1115 of the Social Security Act (Aug. 30, 2017), <https://www.acf.hhs.gov/ofa/resource/tanf-acf-im-2017-01> (“More than just a means of income, work creates opportunities for individual growth, instills personal dignity, and provides low-income families with a clear pathway to financial self-sufficiency.”).

programs.”<sup>108</sup> Other regulations also tightened work requirements in SNAP, which was projected to end benefits coverage for approximately 700,000 recipients.

CMS’s approval of state work requirement waivers was immediately challenged in the District of D.C. by a group of Medicaid beneficiaries in Kentucky, who argued that the state’s waiver was not likely to assist in promoting the primary objective of the Medicaid Act, defined in the statute as “furnishing medical assistance . . . [to] individuals[] whose income and resources are insufficient to meet the costs of necessary medical services.”<sup>109</sup> The waivers, argued advocates for beneficiaries, were projected to lead to large losses of coverage, which is incompatible with Medicaid’s central goal. The District of D.C. (Judge Boasberg) vacated the Kentucky waiver and a series of others, deciding that CMS had failed to consider the impacts on coverage, and in so doing failed to assess whether the waivers were likely to assist in promoting the objective of furnishing medical assistance.<sup>110</sup> The D.C. Circuit later upheld the decision with respect to Arkansas and New Hampshire, echoing this reasoning.<sup>111</sup> The Supreme Court granted certiorari to hear the consolidated Arkansas and New Hampshire cases,<sup>112</sup> but as of April 2021 is holding the case in abeyance.<sup>113</sup> President Biden’s HHS is now in the process of reviewing and rescinding waivers that granted permission for states to use work requirements in Medicaid,<sup>114</sup> and has already rescinded its approval of the Arkansas and New Hampshire programs.<sup>115</sup>

Given these decisions and the change of administration, work requirements are unlikely to take effect in Medicaid in the near future, particularly during the COVID-19 recovery. The Families First Coronavirus Response Act suspended

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108 GEN. SERVS. ADMIN. & THE OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT OF THE U.S., *DELIVERING GOVERNMENT SOLUTIONS IN THE 21ST CENTURY* 29 (2018), <https://usace.contentdm.oclc.org/digital/collection/p16021coll11/id/2520/>.

109 42 U.S.C. § 1396-1 (2018); *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (D.D.C. 2018).

110 *See Young v. Azar*, 1:19-cv03526 (D.D.C., March 4, 2020) (vacating the waiver in Michigan); *Philbrick v. Azar*, 397 F. Supp. 3d 11, 33 (D.D.C. 2019) (vacating the waiver in New Hampshire); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019) (vacating the waiver in Kentucky); *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019) (vacating the waiver in Arkansas).

111 *Philbrick v. Azar*, No. 19-5293, 2020 WL 2621222, at \*1 (D.C. Cir., May 20, 2020) (affirming vacatur of the waiver in New Hampshire); *Gresham v. Azar*, 950 F.3d 93, 104 (D.C. Cir. 2020) (affirming vacatur of the waiver in Arkansas).

112 *Azar v. Gresham*, 141 S. Ct. 890 (2020).

113 *Becerra v. Gresham*, 141 S. Ct. 2461 (2021).

114 *Watson*, *supra* note 7; *see also* Erin Brantley et al., *As the Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary, and Harmful*, HEALTH AFF., Feb. 17, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210216.717854/full/> (summarizing political and legal developments in work requirement waivers during the first months of the Biden Administration).

115 Reply Brief for the Federal Petitioners at 5, *Becerra v. Gresham*, 141 S. Ct. 2461 (2021) (Nos. 20-37 and 20-38).

enforcement of SNAP work requirements during the public health emergency,<sup>116</sup> and the HHS Office of Children and Families urged states to give TANF recipients good-cause exemptions from work requirements, and expanded non-recurrent short-term benefits that are exempt by design.<sup>117</sup> But among conservative lawmakers, work requirements as a condition of participation in means-tested programs are very much alive.<sup>118</sup> As of May 2021, for example, thirty-six or more states have announced an intention to reinstate work search requirements as a condition of receiving unemployment insurance benefits.<sup>119</sup> As COVID-19 recedes, interest in work requirements seems likely to increase once more.

### *B. Proffered and Observed Signals of Medicaid Work Requirements*

New conditions in Medicaid § 1115 waivers encode a range of values, norms, and information about states and their citizens. This Section will consider the *intended* messages (e.g., messages that lawmakers *intend* to convey to beneficiaries, political actors, and the general public) of new § 1115 conditions, as proffered by CMS and waiver states, as well as some of the messages identified by observers. The variation in signals here foreshadows what the study demonstrated: the expressive impact of law is largely in the eye of the beholder, and in fact co-produced by the law and the normative priors of the observer. This Part discusses the public messaging that waiver proponents sought to encourage, followed by the signals read into the laws by observers with very different normative viewpoints.

#### *1. Signals Proffered by CMS and States*

CMS and states proffered several purposes for Medicaid work requirements.

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116 Families First Coronavirus Response Act, Pub. L. 116-127, § 2301, 134 Stat. 177, 188 (2021); *see also* U.S. DEP'T AGRIC., FNS-GD-2020-0016, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) – FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND IMPACT ON TIME LIMIT FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWDS) (2020) (providing guidance to state administrators to implement the suspension of work requirements in the SNAP program).

117 U.S. DEP'T HEALTH & HUM. SERVS., TANF-ACF-PI-2020-01 (QUESTIONS AND ANSWERS ABOUT TANF AND THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC) (2020).

118 Jeff Stein and Matt Viser, *White House to Work with States on Reimposing Work-Search Requirements Following GOP Outcry*, WASH. POST (May 10, 2021), <https://www.washingtonpost.com/us-policy/2021/05/10/biden-unemployment-benefits/> (describing GOP arguments that unemployment benefits are discouraging labor force participation, as well as Democrats' rejoinders that child care and COVID-19-related barriers are still preventing many from working).

119 Sydney Ember, *Unemployment Pay May Again Require a Job Search. Is It Too Soon?*, N.Y. TIMES (May 16, 2021), <https://www.nytimes.com/2021/05/16/business/unemployment-job-search-requirements.html>; Sarah Hansen, *At Least 36 States Are Reimposing Work Search Requirements on Unemployment Benefits Recipients*, FORBES (May 17, 2021), <https://www.forbes.com/sites/sarahhansen/2021/05/17/at-least-36-states-are-reimposing-work-search-requirements-on-unemployment-benefits-recipients/?sh=5d0dbcb158f8>.

Foremost is the goal of advancing public health, on the theory that completing work or other qualifying activities will raise incomes, self-esteem, and dignity, which will in turn drive health improvements. In their 2017 letter to state governors, Verma and Price argued that “the best way to improve the long-term health of low-income Americans is to empower them with skills and employment . . . [through] innovations that build on the human dignity that comes with training, employment, and independence.”<sup>120</sup> In an address to the National Association of Medicaid Directors in November of 2017, Verma further clarified the administration’s position on work requirements:

The Medicaid program is a promise to help individuals live up to their highest potential, leading healthier, more fulfilling, and more independent lives . . . . [States] . . . want to develop programs that will help them break the chains of poverty and live up to their fullest potential . . . . For the future of our country, we need all Americans to be active participants in their communities . . . . [M]eaningful work is essential to . . . economic self-sufficiency, self-esteem, wellbeing, and improving [ ] health . . . . Believing that community engagement requirements do not support or promote the objectives of Medicaid is a tragic example of the soft bigotry of low expectations consistently espoused by the prior administration. Those days are over.<sup>121</sup>

Verma later elaborated on this justification by invoking compassion for Medicaid beneficiaries, writing, “True compassion is lifting Americans most in need out of difficult circumstances . . . . We owe it to these Americans to try whatever may help them achieve the dignity and self-sufficiency they deserve.”<sup>122</sup>

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120 Letter from Sec’y Price & Adm’r Verma, *supra* note 11. Before her appointment as CMS, Verma had previously designed § 1115 waivers for Kentucky and Indiana, both of which had proposed work requirements but were not approved under the Obama Administration.

121 Seema Verma, Adm’r, Remarks at the National Association of Medical Directors (NAMD) 2017 Fall Conference (Nov. 7, 2017), <https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall> [hereinafter Verma Remarks].

122 Seema Verma, *Making Medicaid a Pathway Out of Poverty*, WASH. POST (Feb. 4, 2018), [https://www.washingtonpost.com/opinions/making-medicaid-a-pathway-out-of-poverty/2018/02/04/4570736a-0857-11e8-94e8-e8b8600ade23\\_story.html](https://www.washingtonpost.com/opinions/making-medicaid-a-pathway-out-of-poverty/2018/02/04/4570736a-0857-11e8-94e8-e8b8600ade23_story.html) (“the compassionate nature of [states seeking approval for “work and community-engagement incentives”] encouraged the creativity to design a system to help the new able-bodied, working-age Medicaid population unlock their fullest potential . . . . The new flexibility requested by states will allow them to partner with us to help program beneficiaries live healthy, fulfilling lives as independently as possible.”). In

CMS statements focused not only on promoting health, dignity, and higher incomes, but on a range of other objectives as well. Promoting state flexibility as a good in itself is among them, and CMS communications have stressed the desirability of acceding to state preferences. Invoking national economic interests and social interests (“for the future of our country”) provides a separate purpose for such waivers, on the theory that work requirements will motivate more economic participation, and that this participation will be meaningful on a national scale. Multiple CMS communications, as well as Trump’s executive order promoting work requirements,<sup>123</sup> have also evinced a purpose of returning the Medicaid program to its “original” intentions at the time of enactment, in contrast to fulfilling the expansionist intentions of the ACA Congress. Another stated goal has been to use new Medicaid conditions—such as premiums, waivers of benefits, and waivers of retroactive eligibility—to “creat[e] greater alignment between Medicaid’s design and benefit structure with common features of commercial health coverage, to help working age, non-pregnant, non-disabled adults prepare for private coverage.” This latter goal implies that private coverage is normatively more desirable than public benefits, and that it appropriate for the state to educate beneficiaries about this coverage. Finally, both CMS and states have invoked a purpose of cost control. Verma has noted that “[w]ith Medicaid being an open-ended entitlement, the program has grown and grown and states have spent more and more . . . diverting state resources from other areas such as education and economic development.”<sup>124</sup> Reducing program costs, whether for its own sake or to reallocate funds to other priorities, is here a similar intention.<sup>125</sup>

Each of these justifications communicates attitudes about beneficiaries and their lives, as well as beliefs about the causal relationships between program requirements and beneficiaries’ choices. For example, the income- and health-

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a blog post after approval of Wisconsin’s waiver, Verma again advocated that the requirements reflect “true compassion,” arguing, “It is not compassionate to lower our expectations such that we are content to leave Americans with inherent worth on the sidelines of life.” Seema Verma, Adm’r of Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Hum. Servs., *CMS Approves Innovative Wisconsin Plan to Improve Health and Lift Individuals from Poverty*, CTRS. FOR MEDICARE & MEDICAID SERVS. BLOG (Oct. 31, 2018), <https://www.cms.gov/blog/cms-approves-innovative-wisconsin-plan-improve-health-and-lift-individuals-poverty>; see also Letter from Brian Neale to State Medicaid Dirs., *supra* note 12 (describing the purposes of work requirements as “to promote better physical, mental, and emotional health” and “to help individuals and families rise out of poverty and attain independence”).

123 See Exec. Order No. 13,828, Reducing Poverty in America by Promoting Opportunity and Economic Mobility, 83 Fed. Reg. 15,941, 15,941 (Apr. 13, 2018).

124 Verma Remarks, *supra* note 121.

125 This is also part of the ostensible reasoning behind recent guidance allowing states to convert their Medicaid expansion programs into block grants, which will allow states to impose premiums and work requirements. Letter from Calder Lynch, Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. (Jan. 30, 2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.



promotion rationales communicate that CMS and states place a high premium on work, as well as a central belief that waivers are needed to align individual-level incentives to increase beneficiaries' economic activity. These justifications support a particular view of able-bodied Medicaid beneficiaries (i.e., that they can engage in work or volunteering, but do not because they lack appropriate individual incentives), as well as a view of social context (i.e., that employment and volunteer opportunities are available—such that work requirements may be described as compassionate rather than unrealistic). Each justification also suggests a set of social norms that may be present among the general population, as well as embodying the normative views of CMS with respect to the social desirability of qualifying activities for the low-income population specifically. The expressions of compassion and the language of obligation also highlight a message about government-citizen relationships: namely, that the government's role as Medicaid programmer includes caretaking for beneficiaries (“we owe it to these Americans”), and that beneficiaries owe reciprocal duties in response (“we need all Americans to be active participants”).

From CMS's intended purposes, observers might also deduce information about the extent to which Medicaid beneficiaries currently work, and the extent to which working (or not working) results from actions within beneficiaries' capacity and control—such that a work requirement enforced by Medicaid exclusion could in fact change behavior by supplying powerful extrinsic motivation. For instance, CMS's approval letter for Kentucky noted the strength of the disenrollment incentive as a feature that distinguished Kentucky from prior demonstrations that provided only “referrals to employment services or encouragement to seek employment.”<sup>126</sup> As CMS noted, “Kentucky HEALTH's community engagement incentive is likely to be more effective than other incentives or referrals to employment services, as it provides for the consequence of eligibility suspension for non-compliance.”<sup>127</sup> The agency's focus on the importance of individual motivation is particularly salient given the structural feature that federal Medicaid funds cannot be used for the purposes of providing work support services like childcare, transportation for work duties, or “workfare” job slots.<sup>128</sup>

States echoed CMS's characterization of work requirements as

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126 Letter from Demetrios L. Kouzoukas, Principal Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., to Stephen Miller, Comm'r, Cabinet for Health and Fam. Servs., Ky. 3 (Jan. 12, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-cms-appv1-011218.pdf>.

127 *Id.*

128 States that choose to provide these services must use their own funds to do so.

compassionate,<sup>129</sup> dignity-building,<sup>130</sup> and health-promoting.<sup>131</sup> States' § 1115

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129 See *Arkansas's Work and Community Engagement Requirement Update*, ARKANSAS.GOV (Sept. 14, 2018), [https://governor.arkansas.gov/news-media/weekly-address/arkansas\\_s-work-and-community-engagement-requirement-update](https://governor.arkansas.gov/news-media/weekly-address/arkansas_s-work-and-community-engagement-requirement-update).

130 Letter from Heather K. Smith, Medicaid Dir., Wis. Dep't of Health Servs., to Brian Neale, Deputy Adm'r, Ctrs. for Medicare and Medicaid Servs. 32 (Jan. 12, 2018) [hereinafter Wisconsin Application] (enclosing the state's application for a § 1115 waiver) ("Project Goals [include] . . . Help[ing] more Wisconsin citizens become independent and rely less on government-sponsored health insurance"). Governor Walker also described her goal of adding 30-hour-per-week work requirements to all public benefits programs to transition people from "government dependence to true independence through the dignity of work." Scott Bauer, *Walker Signs 9 Bills Limiting Wisconsin Welfare Into Law*, AP NEWS (Apr. 10, 2018), <https://www.apnews.com/053c515a4f6b4d519965c145deeb0f3a>; see also Letter from Matthew G. Bevin, Governor, Ky., to Sylvia Burwell, Sec'y, U.S. Dep't of Health and Hum. Servs. 6 (Aug 24, 2016) [hereinafter Kentucky Application] (enclosing the state's application for a § 1115 waiver) ("Kentucky HEALTH [is] a demonstration project designed to provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance"); Letter from Christopher T. Sununu, Governor, N.H., to Alex Azar, Sec'y, U.S. Dep't of Health and Hum. Servs. 1 (July 23, 2018) [hereinafter New Hampshire Application] (enclosing the state's application for a § 1115 waiver) ("The attached amendment is designed to provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance.").

131 See, e.g., Kentucky Application, *supra* note 130, at 4 ([T]he program encourages members to improve their health by incentivizing preventive care, participation in disease management programs, and healthy lifestyles."); Letter from Eric Holcomb, Governor, Ind., to Norris Cochran, Acting Sec'y, U.S. Dep't of Health and Hum. Servs. 5 (Jan. 31, 2017) [hereinafter Indiana Application] (enclosing the state's application for a § 1115 waiver) ("the State seeks to increase participation in the Gateway to Work initiative to connect members to gainful employment, in a way that improves physical and mental health" and the individual's overall financial stability and well-being"); New Hampshire Application, *supra* note 130, at 18, (testing whether community engagement requirements "will lead to improved health outcomes and greater independence through improved health and wellness"); State of Alabama, Medicaid Workforce Initiative, Section 1115 Demonstration Application 3 (September 10, 2018) [hereinafter Alabama Application] ("Alabama Medicaid believes that increasing employment through employment and job training requirements, will improve health outcomes."); Letter from Thomas J. Betlach, Dir., Ariz. Health Care Cost Containment System, to Seema Verma, Adm'r, Centers for Medicare and Medicaid Servs. 5 (Dec. 19, 2017) [hereinafter Arizona Application] (enclosing the state's application for a § 1116 waiver) ("The gains and employment that will result from this initiative will facilitate and enhance positive health outcomes for Arizonans."); State of Mississippi, Medicaid Reform Demonstration Project, Medicaid Workforce Training Initiative, 1115 Revised Waiver Demonstration Application 6 (Jan. 16, 2018) [hereinafter Mississippi Application] ("[The Division of Medicaid] is seeking this waiver to assist individuals with building a foundation for success – both in their personal life and their health. Our goal is to begin building a future of healthy citizens in the state of Mississippi."); Letter from Barbara R. Sears, Dir., Ohio Dep't of Medicaid, to Alex Azar, Sec'y, U.S. Dep't of Health and Hum. Servs. 6 (April 30, 2018) (enclosing the state's application for a § 1115 waiver) ("The goals of this 1115 Demonstration waiver are (i) to promote economic stability and financial independence, and (ii) to improve health outcomes via participation in work and community engagement activities."); Utah Dep't of Health, Medicaid, State of Utah 1115 Primary Care Network Demonstration Waiver, Adult Expansion Amendment Request 5 (June 22, 2018) [hereinafter Utah Application] ("The State's goals [include] . . . Improv[ing] the health and well-being of individuals through incentivizing work engagement.").

waiver applications have also uniformly presented the goal of promoting financial independence,<sup>132</sup> including incentivizing beneficiaries to find “meaningful employment”<sup>133</sup> and positions with employer-sponsored insurance.<sup>134</sup> Some states have also extended health-promotion and financial stability arguments to the children of beneficiaries, arguing that work requirements will improve the lives of members’ children through increased parental income.<sup>135</sup> Many states and governors explicitly characterized employment, or the lack thereof, as a “social determinant of health”<sup>136</sup> that can be remedied by requiring beneficiaries to engage

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132 Letter from Asa Hutchinson, Governor, Ark., to Thomas Price, Sec’y, U.S. Dep’t of Health and Hum. Servs. 8 (June 30, 2017) [hereinafter Arkansas Application] (enclosing the state’s application for a § 1115 waiver) (“Arkansas proposes to . . . Promot[e] independence through employment.”); Arizona Application, *supra* note 131, at 4 (“[Arizona] seeks to support Arizonans in pursuing their educational goals, building their technical skills, and gaining the income, independence, and fulfillment that come with employment.”); Letter from Jeffrey Colyer, Lieutenant Governor, Kan., to Eric D. Hargan, Acting Sec’y, U.S. Dep’t of Health and Hum. Servs. 4 (Dec. 26, 2017) [hereinafter, Kansas Application] (enclosing the state’s application for a § 1115 waiver). ([T]he goal . . . is to help Kansans achieve healthier, more independent lives by coordinating service and supports for social determinants of health and independence in addition to traditional Medicaid benefits.”).

133 See, e.g., Letter from Lynne A. Valenti, Cabinet Sec’y, S.D. Dep’t of Soc. Servs., to Timothy Hill, Center for Medicare and Medicaid Services 39 (Aug. 10, 2018) [hereinafter, South Dakota Application] (enclosing the state’s application for an § 1115 waiver) (“Career Connector will encourage participants to obtain meaningful employment.”); Arizona Application, *supra* note 131, at 1 (“[T]his waiver is designed to provide low-income, able-bodied adults with the tools needed to gain and maintain meaningful employment.”)

134 See, e.g., Wisconsin Application, *supra* note 130, at 40 (aiming to “increase participants’ ability to obtain and maintain employment and employer-sponsored health care”); Arizona Application, *supra* note 131, at 1 (“For able-bodied adults, Medicaid is an important solution for temporary life circumstances, but should not be a long-term substitute for private health insurance.”); Utah Application, *supra* note 131, at 5 (“The State’s goals [include] . . . Support[ing] the use of employer-sponsored insurance by encouraging work engagement and providing premium reimbursement for employer-sponsored health plans.”); Letter from Ricker Hamilton, Acting Comm’r, Maine Dep’t of Health and Hum. Servs., to Tom Price, Sec’y, U.S. Dep’t of Health and Hum. Servs. 1 (Aug. 1, 2017) [hereinafter Maine Application] (enclosing the state’s application for a § 1115 waiver). (“[G]oals of this demonstration [include] . . . to promote financial independence and transitions to employer sponsored or other commercial health insurance” (1); “DHHS must be able to prioritize limited resources for children, elderly, and the disabled, instead of turning Medicaid into an entitlement program for working-age, able-bodied adults” (4)).

135 Alabama Application, *supra* note 131, at 4 (“[Key objectives include] improv[ing] the health outcomes of children enrolled in Medicaid, by assisting their parents in finding and succeeding at employment activities.”).

136 Kansas Application, *supra* note 132, at 12 (“Employment plays a major role in adult life, frequently bringing with it a sense of accomplishment personal satisfaction, self-reliance, social interaction, and integration into the community, which can ultimately impact an individual’s social determinants of health and independence.”); New Hampshire Application, *supra* note 130, at 10 (“It

in work requirement activities, and by enforcing the requirement through exclusion from Medicaid benefits. Encouraging beneficiaries to raise their incomes enough to leave public benefits programs was another common goal,<sup>137</sup> as was reserving benefits for those at greatest disadvantage.<sup>138</sup> Others emphasized cost control<sup>139</sup> as a subsidiary objective,<sup>140</sup> and a few highlighted that work requirements will strengthen the state workforce.<sup>141</sup>

## 2. *Observed Signals*

Commentators have suggested alternative interpretations for work requirements and other conditions on benefits eligibility. Conservative commentators have explicitly noted the expressive nature of these conditions,

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is in New Hampshire's economic and financial interest to facilitate sustained employment or a return to sustained employment for as many participants as possible. Gaining financial stability will enable some participants to mitigate negative environmental factors and economic factors that can contribute to poor health."); Arizona Application, *supra* note 131, at 4 ("It is well-recognized that determinants of health include social and economic factors such as education and employment. A number of studies have shown that employed individuals are both physically and mentally healthier, as well as more financially stable, as compared to unemployed individuals.").

137 New Hampshire Application, *supra* note 131, at 1 ("the robust work and community engagement component [of the approved application] will work to lift thousands of Granite Staters towards independence and self-sufficiency."); Wisconsin Application, *supra* note 130, at 42 ("[O]ut-of-pocket requirements are designed to prepare members for the norms of the private marketplace and ease transitions from public to private insurance . . . Wisconsin encourages Medicaid as a temporary solution rather than a replacement for employer-sponsored and private health insurance as a long term coverage source."); Arkansas Application, *supra* note 132, at 1 ("Together, these amendments to the [§ 1115] demonstration seek to test innovative approaches to . . . encouraging movement up the economic ladder, and facilitating transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage.")

138 Maine Application, *supra* note 134, at 1 ("[G]oals of this demonstration [include] . . . to preserve limited financial resources for the State's most needy individuals, ensuring long-term fiscal sustainability for the MaineCare program.")

139 Wisconsin Application, *supra* note 130, at 40 ("Wisconsin is seeking the opportunity for further innovation by establishing policies that will . . . slow down the rising costs of health care spending."); Mississippi application, *supra* note 131, at 5 ("With each passing year, [the Mississippi Division of Medicaid] finds it more difficult to provide the array of services necessary for the population we are charged to serve . . . with few resources at our disposal.")

140 This is mindful of prior case law on § 1115 waiver authority, which has noted that mere cost control via a benefits cut is an insufficient basis for granting waivers. *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011); *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994).

141 Indiana Application, *supra* note 131, at 8 ("The State believes [the work requirement] will lead to improved overall health for members, as the correlation between employment and better physical and mental health has been documented, as well as a better-trained workforce within the State of Indiana with individuals who are able to transition to the private market.")

noting that they “send a message” or embody appropriate social norms.<sup>142</sup> Observers on both the right and left have also framed work requirements as a response to popular anger about the cost and coverage of Medicaid compared to ACA exchange plans. ACA-compliant plans commonly have high deductibles despite federal tax subsidies,<sup>143</sup> and premiums are contentious. As Atul Gawande has noted, “Anger about Medicaid is not surprising. We have taxpayers with jobs that provide no health coverage paying for poorer people to have coverage they couldn’t dream of—with no premiums, copays, or deductibles . . . . This is bound to create bitterness about who is deserving and who is not.”<sup>144</sup> Beyond these views, some have approached work requirements from a pragmatic perspective, suggesting that the most important purpose of work requirements is to allow the brokering of compromises between the expansion and non-expansion camps. On this view, work requirements can enable productive political compromises; for jurisdictions where unconditional benefits are not politically palatable, coupling Medicaid expansion with work requirements may be the only viable path to maintain or initiate Medicaid expansion.<sup>145</sup>

For many commentators, however, beliefs about states’ rationales for Medicaid work requirements have been sharply negative. Some argue that work

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142 See, e.g., Michael R. Strain, *A Work Requirement for Medicaid Isn't 'Cruel,'* BLOOMBERG OPINION (Jan 17, 2018), <https://www.bloomberg.com/opinion/articles/2018-01-17/medicaid-work-requirement-should-be-given-a-chance>; RON HASKINS, MERCATUS CENTER, GEO. MASON UNIV., USING GOVERNMENT PROGRAMS TO ENCOURAGE EMPLOYMENT, INCREASE EARNINGS, AND GROW THE ECONOMY 24 (Nov. 21, 2017), <https://www.mercatus.org/publications/using-government-programs-encourage-employment-increase-earnings-and-grow-economy> (“Americans strongly believe that able-bodied people on welfare should be required to work . . . . Americans expect government to require work when some citizens are taxed so that other citizens who are able-bodied can receive welfare.”); Ron Haskins, *Trump's Work Requirements Have Been Tested Before. They Succeeded,* WASH. POST (July 25, 2018), [https://www.washingtonpost.com/opinions/trumps-work-requirements-have-been-successful-before--under-bill-clinton/2018/07/25/cbfbcdc0-9039-11e8-8322-b5482bf5e0f5\\_story.html?utm\\_term=.9950a3cace40](https://www.washingtonpost.com/opinions/trumps-work-requirements-have-been-successful-before--under-bill-clinton/2018/07/25/cbfbcdc0-9039-11e8-8322-b5482bf5e0f5_story.html?utm_term=.9950a3cace40).

143 Rachel Dolan, *High-Deductible Health Plans*, HEALTH AFF. (Feb. 4, 2016), <https://www.healthaffairs.org/doi/10.1377/hpb20160204.950878/full/>.

144 Austin Frakt, *Upshot extra: Medicaid work requirements edition*, INCIDENTAL ECONOMIST (Jan. 22, 2018), <https://theincidentaleconomist.com/wordpress/upshot-extra-medicaid-work-requirements-edition/>. See also Atul Gawande, *Is Health Care a Right?*, NEW YORKER (Oct. 2 2017), <https://www.newyorker.com/magazine/2017/10/02/is-health-care-a-right> (noting a neighbor’s view that “basic services like trash pickup, a sewer system, roadways, police and fire protection, schools, and health care . . . can be provided only through collective effort and shared costs. When people get very different deals on these things, the pact breaks down. And that’s what has happened with American health care.”).

145 Jeff Stein, *How Trump May End Up Expanding Medicaid, Whether He Means to or Not*, WASH. POST (Jan. 28, 2018), [https://www.washingtonpost.com/business/economy/how-trump-may-end-up-expanding-medicaid-whether-he-means-to-or-not/2018/01/28/df2ee6e8-01e1-11e8-8acf-ad2991367d9d\\_story.html](https://www.washingtonpost.com/business/economy/how-trump-may-end-up-expanding-medicaid-whether-he-means-to-or-not/2018/01/28/df2ee6e8-01e1-11e8-8acf-ad2991367d9d_story.html).

requirements are simply efforts to cut benefits enrollment; in the Kentucky waiver case before the District of D.C., an amicus group of deans and scholars argued that work requirements “will lead millions to lose Medicaid under untested conditions designed to drive people off the program—a blatantly political agenda that is directly counter to Medicaid’s purpose.”<sup>146</sup> This argument is based on the premise that there are steep or insurmountable structural barriers that prevent many Medicaid beneficiaries from working twenty-plus hour weeks; Andy Slavitt, Acting Administrator for CMS during the end of the Obama administration, was outspoken in opposition to the requirements as threatening coverage for workers with irregular hours, people with unrecognized disabilities, and people who are unable to comply with administrative reporting burdens.<sup>147</sup> Some have attributed more sinister intentions to waiver designs; for example, state-granted exemptions from work requirements have been identified as evidence of racial animus (or at the least, conscious discriminatory impact),<sup>148</sup> while others identify work requirements as a means of controlling beneficiaries.<sup>149</sup> Finally, some see the

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146 Brief for Deans, Chairs, and Scholars as Amici Curiae in Support of Plaintiffs, *Stewart v. Azar*, No. 1:18-cv-152, (D.D.C. Jan. 18, 2019). Scholar David Super has described benefits as “time limits” on participation, particularly in jurisdictions that do not provide beneficiaries with work supports or offer workfare slots. Super, *A Hiatus*, *supra* note 84. Similarly, Medicaid scholar Sara Rosenbaum has argued, “[T]he consequences of using work, reporting requirements, and lock-outs [is] not to temper the reach of an expansion but [to] strip benefits away.” Sara Rosenbaum, *Experimenting on the Health of the Poor: Inside Stewart v. Azar*, HEALTH AFF. (Feb. 5, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180204.524941/full/>. Economist Paul Krugman has argued that “pain is the point,” rather than financial sustainability of the program: “[I]t’s about stigmatizing those who receive government aid.” Paul Krugman, *Dollars, Cents and Republican Sadism*, N.Y. TIMES (Jan. 11, 2018), <https://www.nytimes.com/2018/01/11/opinion/dollars-cents-republican-sadism.html>; see also Michael Hiltzik, *Trump Storms Ahead with Medicaid Work Rules, Even Though They’re Disastrous for Enrollees*, L.A. TIMES (Nov. 26, 2018), <https://www.latimes.com/business/hiltzik/la-fi-hiltzik-medicaid-work-20181126-story.html> (“This is such a cynical and malevolent policy . . . Their programs aren’t designed to ‘extend coverage’ as they claim, but narrow it. Their goal is to save money, and if that means sentencing the nation’s lowest-income residents to lives of poor health and joblessness, to them that’s just gravy.”).

147 Andy Slavitt, *JAMA Forum: Work Requirements for Health Coverage*, NEWS@JAMA (July 18, 2018), <https://newsatjama.jama.com/2018/07/18/jama-forum-work-requirements-for-health-coverage/>. As Slavitt wrote, “The implication is that some people with lower incomes need an incentive to work, and that access to medical services is such an incentive. This is an inference, even setting aside the moral value judgment, that is without the facts to back it up.” *Id.*

148 Nicholas Bagley & Eli Savit, *Michigan’s Discriminatory Work Requirements*, N.Y. TIMES (May 8, 2018), <https://www.nytimes.com/2018/05/08/opinion/michigan-medicaid-work-requirement.html>; Emily Badger & Margot Sanger-Katz, *Which Poor People Shouldn’t Have to Work for Aid?*, N.Y. TIMES (May 15, 2018), <https://www.nytimes.com/2018/05/15/upshot/medicaid-poor-michigan-work-requirements.html>.

149 Laura D. Hermer, *Medicaid: Welfare Program of Last Resort, or Safety Net?*, 44 WM. MITCHELL L. REV. 1203, 1224 (2018); see also Hermer, *supra* note 5, at 53–54; Huberfeld, *supra* note 15; Amicus Brief of Deans and Scholars, *Stewart v. Azar*, No. 1:18-cv-152, (D.D.C. Jan. 18, 2019).

potential purpose of such waivers as having little to do with beneficiaries, but much to do with the political currency of waivers to undermine the intent of Congress with respect to Medicaid eligibility.<sup>150</sup> Waivers on this view are political end runs—ways in which an administration and states hostile to Congressional intent can evade legislative restrictions.

On these views, the expressive content of Medicaid conditions is far different from the way that CMS and the states have articulated their intentions. For many observers, the role of the state is not to empower citizens or to act as a compassionate custodian, but instead to control and punish those who are disadvantaged by poverty.<sup>151</sup>

### III. A STUDY OF KENTUCKY MEDICAID BENEFICIARIES

Thus far, there has been little study of how work requirements and their expressive content are interpreted by beneficiaries. Two studies identified preliminary views of work requirements in Kentucky<sup>152</sup> and Arkansas,<sup>153</sup> largely documenting negative views and contextual factors that may make compliance impossible. This Part reports a large-scale, representative study that brings scholarship on expressive law to the new territory of public benefits conditions.

A brief summary of findings is as follows: When beneficiaries found meaning in work requirements, their interpretations rested on their prior beliefs. Beneficiaries had divergent beliefs about the work requirement, and their existing views about themselves and other Medicaid participants accounted for much of this heterogeneity. Specifically, they viewed conditions not just through the lens of their own Medicaid participation, but instead based on their beliefs about why *other beneficiaries* receive Medicaid. Beneficiaries almost uniformly described their own Medicaid participation as a matter of circumstance. Participants differed, however, in how they viewed Medicaid uptake by others. Although many beneficiaries viewed other Medicaid participants to have similar (circumstantial) motivations, some instead described other beneficiaries as motivated by character, including a willingness to “take advantage” of public benefits and unwillingness to work.

This heterogeneity led to divergent beneficiary interpretations of waiver terms

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150 Jessica Bulman-Pozen, *Preemption and Commandeering Without Congress*, 70 STAN. L. REV. 2029, 2036-37 (2018).

151 See Nicole Huberfeld, *Federalism in Health Care Reform*, in HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197 (Ezra Rosser, ed., 2019).

152 Greene, *What Medicaid Recipients and Other Low-Income Adults Think about Medicaid Work Requirements*, HEALTH AFF. (Aug. 30, 2018).

153 Greene, *Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFF. (Sept. 5, 2018).

like work requirements. Those who viewed other Medicaid participants as motivated by (undesirable) character traits found confirmation of their beliefs in the work requirement conditions. Many such participants also saw their identities—as taxpayers, not as beneficiaries—affirmed by the state’s perceived concern about reciprocity between taxpayers and Medicaid participants. But in contrast, beneficiaries who viewed others’ participation as similar to their own—that is, driven by contextual factors—were more likely to view themselves as personally implicated by the state’s view that Medicaid beneficiaries lack work motivation. For this group, work requirements communicated unrealistic expectations, disregard, racial animus, and punitive goals of the state. These divergent views may drive different patterns of responsive behavior, different attitudes about compliance, different perceptions of the legitimacy of the regulations, and different long-term views about inclusion or exclusion. Although the requirements in this study did not take effect, the views described here have crucial relevance to expressive legal theories and identify compelling hypotheses for studying the expressive content of laws can shape their consequences.

#### *A. Kentucky HEALTH*

Kentucky faces many public health challenges. Eight of the U.S. counties with the greatest declines in life expectancy since 1980 are located in southeastern Kentucky.<sup>154</sup> This region has elevated mortality from cancer, cardiovascular disease, and substance use disorder, as well as heightened risk factors including smoking, physical inactivity, and obesity. The state ranks 42<sup>nd</sup> in overall health, 47<sup>th</sup> in health behavior, 49<sup>th</sup> in smoking and substance use, and last in preventable hospitalizations<sup>155</sup> Unemployment and intergenerational poverty<sup>156</sup> drive health outcomes throughout the state.

Under Governor Steven Beshear, Kentucky expanded Medicaid in 2014. The expansion has been widely considered a public health success, leading to a 20% reduction in the uninsured population and alleviation of health insurance coverage disparities based on age, marital status, education, and income.<sup>157</sup> Governor Matt

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154 Olga Khazan, *Kentucky Is Home to the Greatest Declines in Life Expectancy*, THE ATLANTIC, May 8, 2017, <https://www.theatlantic.com/health/archive/2017/05/kentucky/525777/>.

155 UNITED HEALTH FOUND., AMERICA’S HEALTH RANKINGS: ANNUAL REPORT 2017 (2017).

156 Raj Chetty et al., *Where is the land of opportunity? The geography of intergenerational mobility in the United States*, 129 Q. J. ECON. 1553 (2014).

157 See, e.g., Joseph Benitez et al., *Did Health Care Reform Help Kentucky Address Disparities in Coverage and Access to Care among the Poor*, 53 HEALTH SERV. RES. 1387 (2017); Benjamin Sommers et al., *Three-Year Impacts of the ACA: Improved Medical Care and Health among Low-Income Adults*, 36 HEALTH AFF. 1119 (2017); Benjamin Sommers et al., *The Impact of State Policies on ACA Applications and Enrollment*, 34 HEALTH AFF. 1010 (2015); Benjamin Sommers et al., *Changes in Utilization and Health among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INTERNAL MED. 1501 (2016).



Bevin, who took office in 2016, ran on a program to “repeal and replace” the ACA, and vowed to restructure Medicaid or end the expansion. The state initially applied for a § 1115 waiver, and the application estimated that approximately 428,000 beneficiaries—a third of statewide program participants—would qualify as non-disabled adults.<sup>158</sup> Before Verma became CMS Administrator, her consulting firm SVC Inc. advised the state on the development of the Kentucky HEALTH waiver, including the work requirement design.<sup>159</sup> Governor Bevin eventually committed to end the Medicaid expansion if the waiver was rejected, and he issued a provisional executive order reversing the expansion if any part of the Kentucky HEALTH program was struck down.

In 2018, CMS approved Kentucky HEALTH. The waiver required beneficiaries deemed “able-bodied” to complete eighty hours per month of employment, job searching, education, training, volunteering, or caregiving.<sup>160</sup> Beneficiaries who failed to comply after a one-month grace period would have their coverage suspended. Beneficiaries were also required to pay monthly premiums, set in tiers ranging from \$1 to \$15 depending on income. Beneficiaries who missed too many consecutive payments would be automatically disenrolled and locked out of the program for six months, if they made more than the federal poverty limit.

A roller coaster of vacatur and reapprovals ensued. Beneficiaries challenged the program as arbitrary and capricious, led by 62-year-old beneficiary and former social worker Ronnie Stewart.<sup>161</sup> The plaintiffs faced health problems and contextual barriers to work, and urged vacatur of the waiver for failing to advance the purposes of Medicaid. Amid few precedents on § 1115 waiver authority,<sup>162</sup> Judge Boasberg’s first decision focused on whether the Secretary of HHS had abused his discretion in approving the new waiver elements as “likely to assist in promoting” the program goals.<sup>163</sup> Although Boasberg suggested that CMS had some leeway to interpret the purposes of Medicaid, the Social Security Act specifies that the program must at least “furnish[] medical assistance” to beneficiaries.<sup>164</sup> Kentucky had projected that 95,000 Kentucky beneficiaries would lose Medicaid coverage under the waiver. With no evidence that CMS had

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158 Kentucky Application, *supra* note 130, at 4.

159 Jessica Glenza, *Trump’s Pick for Key Health Post Known for Punitive Medicaid Plan*, THE GUARDIAN (Dec. 4, 2016), <https://www.theguardian.com/us-news/2016/dec/04/seema-verma-trump-centers-medicare-medicaid-cms>.

160 Kentucky Application, *supra* note 130, at 18.

161 *See* Cheves, *supra* note 2.

162 Only a few cases to date have decided challenges to Medicaid experimental waivers on the merits, including *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994), and *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011).

163 *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018).

164 42 U.S.C. § 1315 (2012).

considered how the waiver would help furnish medical assistance, Judge Boasberg found the approval arbitrary and capricious; the decision remanded the waiver to CMS for reconsideration.<sup>165</sup>

CMS re-issued the waiver for public comment,<sup>166</sup> and within months re-approved the program with all terms intact. The new decision letter further detailed CMS's proffered purposes of the Medicaid program,<sup>167</sup> including not only "furnishing medical assistance," but also "advanc[ing] the health and wellness needs of . . . beneficiaries," "increas[ing] beneficiaries' financial independence," and to "ensur[ing] the fiscal sustainability of the Medicaid program."<sup>168</sup> In March 2019, Judge Boasberg once again struck down the waiver, finding that the Secretary had again failed to consider whether the program would help furnish medical assistance.<sup>169</sup> The decision also addressed the Secretary's other suggested goals, finding that they were not "independent objectives" of the act—rather, Judge Boasberg concluded that the primary objective of the Medicaid statute is to furnish medical assistance, and the Secretary's consideration of other goals was an insufficient substitute when this goal is lacking.<sup>170</sup>

While the decision as on appeal in the D.C. Circuit, Kentucky had a change of state administration, as voters brought Democratic governor Andy Beshear to office as Bevin's successor. Beshear canceled the Kentucky HEALTH portion of the state's § 1115 waiver in December 2019.<sup>171</sup>

### *B. Study Methods*

This Article presents baseline survey data and qualitative results from a study that was intended to evaluate Kentucky HEALTH, for which I was one of the principal investigators.<sup>172</sup> Section 1115 requires waivers to include an evaluation.

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<sup>165</sup> *Stewart*, 313 F. Supp. at 272.

<sup>166</sup> Cortland & Tani, *supra* note 3.

<sup>167</sup> Letter from Paul Mango, Chief Principal Deputy Adm'r and Chief of Staff, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., to Carol H. Steckel, Comm'r, Dep't for Medicaid Servs., Commonwealth of Ky., Nov. 20, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>.

<sup>168</sup> *Id.* at 2.

<sup>169</sup> *Stewart v. Azar*, 366 F. Supp. 3d 125 (2019).

<sup>170</sup> *Id.* at 270-72.

<sup>171</sup> Governor Andy Beshear, Commonwealth of Ky., Executive Order Relating to the Kentucky Medicaid Expansion Program, 2019-00, Dec. 16, 2019 (rescinding Executive Order 2018-040, in which Governor Bevin directed the cancellation of the Medicaid expansion program in Kentucky in the event that the Kentucky HEALTH work requirement waiver was struck down in court).

<sup>172</sup> Other principal investigators were Kevin Volpp and Atheendar Venkataramani at the University of Pennsylvania.

Although past evaluations were often of low methodological quality,<sup>173</sup> regulations issued after the ACA specify a set of outcome criteria for § 1115 programs,<sup>174</sup> as well as evaluation expectations.<sup>175</sup> The goals of the evaluation in Kentucky were to identify the impact of the § 1115 program on insurance coverage, health care utilization, health behaviors, socioeconomic outcomes, and health outcomes.

This Article draws on two sources of data.<sup>176</sup> First was a statewide survey of 9,396 Medicaid beneficiaries, which gathered data between April-September 2018.<sup>177</sup> Participants were drawn from the state's Medicaid enrollment roster, sampled to mirror the population of waiver-eligible Medicaid beneficiaries statewide based on geographical distribution, race, ethnicity, and sex. The overall response rate was approximately 17%.<sup>178</sup> This response rate is comparable to other studies of the Medicaid population, and we reduced nonresponse bias by analyzing a weighted dataset that adjusted for the sociodemographic characteristics of the Medicaid expansion population eligible for the waiver.<sup>179</sup> Demographic characteristics of the sample can be found in Table 1.

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173 U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS 1 (2018), <https://www.gao.gov/products/GAO-18-220> [hereinafter GAO Report].

174 42 CFR § 431.428 (2018).

175 42 CFR § 431.424 (2018).

176 Funding for this study was provided by the Commonwealth of Kentucky through Medicaid expenditures, which include both state and federal funding at the 50% match rate for administrative expenses. Procedures in this study were approved by the Institutional Review Board of NORC, the Columbia IRB, and the University of Pennsylvania IRB.

177 We invited participants to take part in the survey by both mail and phone. NORC sent mailings to participants in hard copy first, along with three reminder mailings for non-responsive participants, and then followed up by phone. Participants were given the option to complete the survey themselves by web, or to complete the survey by phone with a trained interviewer calling from NORC. The survey took approximately 30 minutes and included questions in the domains listed above. All data were de-identified and cleaned before being transmitted to the evaluation team, and the final dataset was weighted to account for survey nonresponse and the distribution of the overall waiver-eligible beneficiary population by age, sex, race and ethnicity, federal poverty level, and employment status. Participants were each paid \$25 in cash by mail to compensate them for their time spent on the survey, and each participant completed an informed consent process by phone or by web before answering any survey questions. All participants were informed that their participation would have no effect on their Medicaid benefits, and that the researchers are independent from the state. Participants were permitted to refuse to answer any questions that they wished to leave blank.

178 For a full description of study methods, see Atheendar Venkataramani et al., *Assessment of Medicaid Beneficiaries Subject to Community Engagement Requirements in Kentucky*, 2 JAMA NETWORK OPEN e197209 (2019); Kristin Linn et al., *The Design of a Randomized Controlled Trial to Evaluate Multi-Dimensional Effects of a Section 1115 Medicaid Demonstration Waiver with Community Engagement Requirements*, 98 CONTEMP. CLINICAL TRIALS 106173 (2020).

179 Venkataramani et al., *supra* note 178, at 10.

Table 1. Demographic Characteristics of Survey Sample

	Overall (n = 9,396)
<b>Age</b> , mean (SD)	36.1 (11.9)
<b>Female</b>	47.1%
<b>Race</b>	
Non-Hispanic White	78.4%
Non-Hispanic Black	11.3%
Hispanic	3.8%
Other	5.5%
<b>Education</b>	
< High School	10.9%
High School	53.8%
Some College	18.1%
4-yr College or more	16.6%
<b>Employed</b>	58.1%

Second, this Article draws on 127 qualitative interviews, which took place May-November 2018. All of the interview participants would have been enrolled in Kentucky HEALTH if it had taken place. The study recruited qualitative participants from among the survey respondents, ensuring variation in geography, age, race and ethnicity, and sex.<sup>180</sup> Interviews were audio-recorded, transcribed, and analyzed using the NVivo qualitative data analysis program.<sup>181</sup> Interviews followed a pre-set agenda of open-ended questions, including a section on awareness and perceptions of the waiver. Interviewers described waiver elements using language that was designed to be neutral in content and tone, including information about the community engagement requirement and premiums. Interviewers did not provide any information about the perceptions or goals of CMS or the state. Demographic characteristics of the qualitative sample can be found in Table 2.

Many of the findings of this study draw on participants' normative

<sup>180</sup> Survey respondents were asked if they would be willing to participate in a one-hour qualitative follow-up call, which was compensated by an additional \$25 for their time if they were selected. Survey participants who were willing to participate were entered into a separate database, and qualitative researchers from NORC reached out to those participants by phone to schedule a qualitative interview. Participants provided separate informed consent to the qualitative interview by phone before answering any interview questions, and they were told that participation is voluntary and would have no effect on their Medicaid benefits.

<sup>181</sup> Analysis involved generating a thematic coding structure and applying codes to transcript text.

commitments and self-identification in categories like “taxpayer,” “beneficiary,” “worker,” and “conservative.” If we had unlimited time and resources for interviews in this study, it would have been helpful to include measures of normative commitments (e.g., the group-grid questionnaire measuring individualist/communitarian and hierarchist/egalitarian commitments,<sup>182</sup> measures of political party affiliation, etc.), as well as including specific interview agenda models focusing on how participants described their economic and political identities. It would also have been helpful to include an interview module on race and Medicaid eligibility. But the primary goals of this study were originally to evaluate the § 1115 waiver, so we dedicated the bulk of interview time to health care access and experiences, health status, Medicaid perceptions, family finances, and perceptions of the waiver. Where the findings below discuss aspects of participants’ identities (e.g., taxpayer, beneficiary), they are drawn on the frequency and enthusiasm with which participants described particular aspects of their personal experience (e.g., comments on paying taxes, working, and contributing to government funding; comments on using Medicaid, relying on Medicaid, or fearing that Medicaid will change in a way that is detrimental to them personally). The process by which participants elevate particular aspects of their identity when discussing public benefits is of great interest here, and it merits a separate study.

Table 2. Demographic Characteristics of Qualitative Sample

	Overall (n = 127)
<b>Age</b> , mean (SD)	40.6 (12.7)
<b>Female</b>	51.9%
<b>Race</b>	
Non-Hispanic White	69.2%
Non-Hispanic Black	21.3%
Hispanic	2.4%
Other	7.1%
<b>Education</b>	
< High School	9.4%
High School	52.0%

<sup>182</sup> See, for instance, the scale used to assess group-grid commitments in Dan M. Kahan et al., *Culture and Identity-Protective Cognition: Explaining the White-Male Effect in Risk Perception*, 4 J. EMP. LEGAL STUD. 465 (2007).

Some College	17.3%
4-yr College or more	20.5%
<b>Employed</b>	<b>44.1%</b>

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### C. Views About Medicaid Participation

Beneficiaries' beliefs about Medicaid and waiver terms are reported in Table 3. Across all participants, approximately 65% believed that health care is a right, and 68% believed it should be "free for everyone." A majority of beneficiaries agreed that it is the responsibility of the state (55%) and federal government (61%) to "make sure everyone has health care." Most participants believed that Medicaid is "like a health insurance program" (76%), although 46% agreed that Medicaid is "like a welfare program."<sup>183</sup> Approximately 67% reported that "a lot of people in this country don't respect people on Medicaid." This resonates with past research on stigma in means-tested public benefits: although Medicaid differs from cash welfare in some respects (e.g., benefits can only be used for insurance, enrollment can take place through venues other than welfare offices, and many people are aware that working often does not provide access to health insurance<sup>184</sup>), people eligible for Medicaid have reported concerns about being perceived as "lazy" and being treated poorly by others due to Medicaid uptake.<sup>185</sup> Participants in means-tested programming are also exposed to a more general stigma attaching to poverty, with the implication that poverty is due to personal deficiency such as a lack of motivation to work.<sup>186</sup>

Participants diverged in their beliefs about work requirements in Medicaid. Approximately 52% supported work requirements to any extent, but only 29% believed that employed people are more deserving of health care, and only 23% agreed that Medicaid should "only be for people who cannot work." A large majority (78%) opposed premiums.

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<sup>183</sup> This question draws on a Kaiser Family Foundation survey asking people to classify Medicaid as health insurance or welfare.

<sup>184</sup> Jennifer Stuber & Mark Schlesinger, *Sources of Stigma for Means-Tested Government Programs*, 63 SOC. SCI. & MED. 933 (2006); Jennifer Stuber & Karl Kronebusch, *Stigma and Other Determinants of Participation in TANF and Medicaid*, 23 J. POL'Y ANALYSIS & MGMT. 509 (2004).

<sup>185</sup> *Id.*

<sup>186</sup> Sung Hyun Yun & Robert D. Weaver, *Development and Validation of a Short Form of the Attitude toward Poverty Scale*, 11 ADVANCES IN SOC. WORK 174 (2010); see also Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 1 (2016) (describing how people who use Medicaid and other public benefits are viewed as "dependent" and lacking in self-sufficiency, while noting the irony that private health insurance is heavily subsidized by less-visible tax breaks, such that "all Americans lead subsidized lives and could move from the private to the public system").

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These findings provide an initial framework for understanding beneficiaries' views of the Medicaid program. The following Sections synthesize quantitative and qualitative findings to explore how participants described their own and others' participation in Medicaid.

Table 3. Beneficiary Beliefs: Percentage Agreeing by Race and Gender (N=9,396)

	All	By Race				By Gender		By Employment Status		
		Non-Hispanic White (N=7,316)	Non-Hispanic Black (N=1,108)	Hispanic (N=368)	Non-Hispanic Other (N=251)	Male (N=4,042)	Female (N=5,341)	Employed (N=5,553)	Unemployed (N=3,400)	Retired, Disabled, Don't Know (N=441)
<b>Work</b>										
If people are able, they should be required to spend time volunteering or working to stay on Medicaid.	51.8	53.1	53.3	58.7	50.5	50.8	53.1	56.6	45.6	42.7
People who work are more deserving of health care.	28.7	26.5	31.6	36.8	42.3	30.7	26.5	30.8	26.4	21.8
Medicaid should only be for people who cannot work, like children, disabled people, and the elderly.	23.4	21.7	24.8	31.2	28.8	24.9	21.7	22.1	24.4	31.8
I am satisfied with the opportunity for a person in this country to get ahead by working hard.	73.5	74.6	78.2	81.5	77.3	72.7	74.6	74.7	72.9	65.5
<b>Premiums</b>										
People should be required to pay some money out of pocket each month to have Medicaid.	22.3	20.6	19.6	29.7	23.3	23.8	20.6	24.6	19.6	16.9
<b>Rights and Duties in Health Care</b>										
Health care is a right, not a privilege	65.0	66.3	66.6	74.1	66.8	63.9	66.3	65.4	65.7	56.4
Health care should be free for everyone.	68.1	68.6	75.7	77.8	71.9	67.6	68.6	67.2	70.4	60.0
It is the responsibility of the state government to make sure everyone has health care.	54.8	55.5	67.2	67.5	65.6	54.2	55.5	54.9	55.1	52.8



It is the responsibility of the federal government to make sure everyone has health care.	60.8	61.7	72.3	71.5	68.1	60.0	61.7	61.2	61.2	53.8
<b>Medicaid and Perceived Stigma</b>										
Medicaid is like a health insurance program, like Medicare, that helps people pay for health care.	76.4	78.6	78.9	80.0	67.4	74.5	78.6	77.6	75.3	71.1
Medicaid is like a welfare program, like food stamps to help people pay for food	46.3	46.0	42.8	53.2	49.5	46.6	46.0	46.1	47.1	42.7
A lot of people in this country don't respect people on Medicaid.	67.2	71.2	55.3	68.4	53.6	63.7	71.2	67.0	67.8	66.0

### *1. Personal Uptake*

Participants invariably described their Medicaid participation in terms of the contextual factors that motivated the choice. Many participants anticipated and sought to rebut the idea that their own participation in Medicaid arose from low motivation to work, or from a preference for Medicaid over employer-sponsored or privately purchased insurance.

When interpreting these findings, it is important to be mindful of social desirability bias—the desire to report answers that signal good character, avoid embarrassment, and minimize the disclosure of negative information.<sup>187</sup> Given the high awareness of Medicaid stigma reported above, participants may have been keen to give an impression of being industrious, of desiring to work, and of qualifying for Medicaid due to their circumstances rather than their character. Social desirability bias is inescapable in this type of study design. Notably, participants' reports of past work history and current workforce participation found support in survey data on employment, as 44% of qualitative and 58% of survey respondents were in fact working. Reports of disability-related and caretaking-related reasons for not working were also bolstered by our survey findings.<sup>188</sup>

Although participants cited circumstantial reasons for participating in Medicaid, the specific reasons varied. A substantial number of participants explained that they had to join Medicaid due to the individual mandate provision of the Affordable Care Act. Some welcomed enrollment, but others who opposed using Medicaid signed up out of fear that they would be fined.

I signed up when Obamacare went into effect . . . Legally I had to have this insurance, or they were going to fine me . . . [T]hey seem to think I should get everything for free and not have to do any work. Which I can honestly say, that's been great for me. I still don't think it's right . . . I hated Barack Obama (Laughter). I think you should have skin in the game.

A few participants had attempted to obtain individual health insurance through the ACA exchange—with the intention of purchasing commercial plans—but instead were directed to Medicaid. One described this experience as follows, taking care to explain that it would have been her preference to “try and pay something”

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187 See, e.g., Robert J. Fisher, *Social Desirability Bias and the Validity of Indirect Questioning*, 20 J. CONSUMER RES. 303 (1993); Maryon F. King & Gordon C. Bruner, *Social Desirability Bias: A Neglected Aspect of Validity Testing*, 17 PSYCHOL. & MARKETING 79 (2000). This bias may be stronger when data are collected by phone (as here), rather than by web. See, e.g., Frauke Kreuter et al., *Social Desirability Bias in CATI, IVR, and Web Surveys: The Effects of Mode and Question Sensitivity*, 72 PUB. OPINION Q. 847 (2009).

188 See Venkataramani et al., *supra* note 178, at 5.

instead of getting benefits at no cost:

I actually was going to try and get an individual health plan through the ACA, but there's a criterion that says, "If you meet requirements for Medicaid, then they will not give you a subsidy." . . . It was either you take Medicaid or you pay full price for insurance on the market without any government subsidy at all . . . . I originally thought, "Well, we can try and pay something," and that wasn't a choice . . . . I couldn't [pay full price] because I was unemployed.

Many others explained that they had chosen to participate in Medicaid as a result of a layoff or an extended period without employment ("Oh, I didn't have no choice, I needed some insurance, and . . . Well, like I said, I was outta work."; "We didn't really have any other choice just since neither of us were working."). These participants described ACA plans as too expensive, or they noted that they worked in jobs that did not offer health insurance. Comments like one respondent's statement, "I couldn't afford nothing else," were common. As one participant noted, "Well, we needed insurance, but we never could afford it. When we signed up for this, I could afford this."

A number also described the choice to participate Medicaid in terms of family need, which they prioritized above any of their own objections to participating; several had children or spouses with intensive medical needs, such as diabetes or autism, and had signed up for insurance as a family. As one participant described, "Because of my son's diabetes we can't afford his health care under our private pay . . . So, we applied for the health care . . . I have to have insurance because of my son. I cannot go without." Another participant described needing insurance during a time when he was unemployed and his wife's diabetes escalated:

I'll be honest with you, we're a poor working family. Nobody's working at the moment, but poor working family, and if we would've had to try to come up with the money to get the [insulin] pump or even part of it, [we couldn't have gotten it.] . . . Medicaid approved it . . . . Without them, I don't know what we would have done.

Some had gone without insurance for years, but then enrolled in Medicaid after experiencing an unexpected illness, sometimes requiring expensive testing and repeated appointments. Importantly, Medicaid expansion applies retroactive eligibility to the expansion population, meaning that at the time of sign-up, the prior three months of their qualifying medical expenses are paid for by the

Medicaid program.<sup>189</sup> As one participant described, “[I signed up] because I needed the help with figuring out what was wrong with me . . . . I didn’t know I had [irritable bowel syndrome] and I was going to a free clinic at that time and the doctors there put me through so many tests.” Enrolling in Medicaid both made it possible for this participant to see additional specialists, and enabled her to pay for recent medical expenses incurred before joining.

Many participants voiced uneasiness about Medicaid stigma. They sometimes described evolution in their own views about Medicaid participation, or they explained why they did not fit stereotypes about Medicaid participants. For example, one participant said, “I want to be able to take care of myself. I don’t want the state to take care of me.” Or as another argued, “I do all of the right things, I report my income, I’m not cheating any systems, I’m not doing anything wrong, but I’m still not getting a leg up either.” Some participants described how stigma varies according to politics; as one noted, “[D]efinitely people view you differently if you have [Medicaid]. But I have pretty liberal friends, so they’re not really like that.” Another put the point in terms of her own changing views:

[W]hen I was younger growing up in a fairly well-to-do family, there was seemingly a prejudice against [Medicaid] because it seemed like it was a hand-out. Looking back at it, it was very foolish for me to feel that way. But with age and experience comes a different perspective . . . . I think it’s a great benefit[.]

A few participants noted that they participated in Medicaid *in order* to work. These respondents argued that Medicaid made them more productive because they were healthy enough to carry out their jobs. One participant drew on this experience to challenge the assumptions behind Medicaid stigma:

I know that there are people that think I shouldn’t have it . . . that I should be working harder for my health care or suffering more (chuckles) . . . . I don’t share that . . . I think especially somebody with a chronic illness . . . who want[s] to be a productive member of society . . . . [I]t’s the only way I can be a productive member really . . . . But, yes, I have family members who are very insulted by the fact that I’ve stooped low enough to go onto public aid.

Throughout these narratives of Medicaid participation, the common thread

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189 MaryBeth Musumeci & Robin Rudowitz, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States*, KAISER FAMILY FOUND. MEDICAID (Nov. 10, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/>; *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited Nov. 22, 2021).

was therefore the contextual and situational factors that motivated participation choices. Where participants sought to characterize their own traits, particularly work motivation, they often defined themselves in distinction to perceived Medicaid stereotypes of individuals willing to accept public benefits without working.

## *2. Uptake by Others*

Participants viewed uptake by others in three ways: (1) some believed that others used Medicaid due to (undesirable) character traits; (2) some believed that other Medicaid participants were divided between those who sincerely needed help and those who were using benefits unnecessarily; and (3) some believed that other Medicaid beneficiaries were similar to themselves, or even worse off in terms of income, opportunity, and ability. In contrast to explanations of their own participation, respondents were more likely to rely on character attributions, personality, and demographic factors such as age or race when describing Medicaid participation by others.

Throughout these conversations, explanations resting on character attributions were not phrased in terms of positive characteristics (e.g., resourcefulness) but rather in terms of negative character traits such as laziness, non-reciprocity, willingness to take advantage of collective goodwill, inability to prioritize expenses and time, and selfishness in the consumption of benefits that are paid for by taxpayers and intended for individuals in worse circumstances. Descriptions of beneficiaries who “abuse the system” were common, and many participants bolstered these comments with reference to individuals that they knew, or individuals living in Kentucky generally.

[P]eople are just sitting around not working and using Medicaid. And they're not wanting to work . . . . [T]here are a lot of people that are just not really making any kind of an effort to get a job or work or not be using the system, or abusing the system.

It's not people who can't afford anything . . . . I guarantee you if you looked at the everyday lives of those people, they still had Cokes, and cigarettes, and gas. If you can afford all of those things, you can afford 15 dollars to go and see a doctor that the state's paying 5,000 for you to see.

I look at welfare, I've been around people a lot in my life that abused the system. And I mean, there are people that need it . . . . But, there's got to be a limit. And I've known way, many people

that just, they want to do nothing. Because they don't have to. Because the government's going to come in and wipe their butt for them.

Many participants who described others' participation as ill-motivated believed that work was indeed available to those who sought it; the perceived availability of work was a central premise in the view that other beneficiaries did not need to rely on Medicaid. Some participants also argued that generous benefits design allowed other beneficiaries to make self-serving choices instead of seeking work.

We have a ton of available jobs. People just don't think they want them. They have too much pride. But I don't understand if you have too much pride to go work in a factory place, but you don't have too much pride to live off the state.

I think that [Medicaid] should be a stepping stone. But I think that, especially in our state, too many years have gone by where people are dependent on it. I think they're taking advantage of it . . . . [I]t's a lot easier to just stay on those programs . . . . I think that's wrong . . . . I work very, very hard to take care of myself and my family, and to move forward, and to finish school. And I just don't have the heart to use my time and my tax dollars to take care of people that won't even meet themselves in the middle.

As the latter quote reflects, some participants deliberately distinguished between their own participation compared to that of others. These participants tended to prioritize their identities as taxpayers contributing to Medicaid benefits, over their identities as beneficiaries receiving benefits. Other participants sought to draw explicit distinctions between themselves and others on the program, such as the following:

Now, you and I both know there's people out there that draw checks all their lives that ain't . . . not able to work. They could work . . . . They could do things . . . . 'Course like in my own case, the doctor says I'm not able to work.

Everybody knows I'm not lazy. I've always worked for my living and I still would be today if I hadn't had all those [health] problems . . . . [My husband and I] always worked for our living (laughter). Some of these young people don't like working.

(laughter) . . . They're not having to pay the taxes me and him did, so for the money pot, there won't be as much money in there for things if everyone doesn't work . . . .

A few participants conflated character-based explanations with race or national origin, which aligns with a large body of prior research on public views of welfare stereotypes and race-based perceptions of work motivation.<sup>190</sup> Racism has long been a cornerstone of Americans' views on need-based public assistance, driving much of the stigma associated with participation and shaping views on access.<sup>191</sup> It was rare for participants to speak outright about race, particularly when describing their views of people on Medicaid. Where they did discuss race, it was with disclaimers trying to distance themselves from racism (and for one participant, these disclaimers were the only indication that he was alluding to race). These revealed underlying assumptions that connected beliefs about race with assumptions about work and deservingness for benefits. Given longstanding and ingrained stereotypes about race, poverty, and public benefits, it is likely that many of participants' comments about other Medicaid beneficiaries had an underlying subtext involving race—particularly when White participants were distinguishing themselves from beneficiaries generally. We did not ask about race explicitly, however, and social desirability bias may have limited participants' openness about race.<sup>192</sup> The participants in our sample who were people of color did not discuss race-based stereotypes when talking about Medicaid participation, but again, racism and stigma may have been an underlying theme of comments referencing poverty and benefits eligibility.<sup>193</sup> Two participants identifying as White invoked racial stereotypes in the following quotes:

I'm not trying to put down any race, but one time when I did try to go get food stamps, two black girls was [there] . . . one was pregnant then, and they was bragging about how much they got

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190 See, e.g., JOE SOSS, RICHARD C. FORDING & SANFORD F. SCHRAM, *DISCIPLINING THE POOR* (2011); GILENS, *supra* note 12; Richard C. Fording, Joe Soss & Sanford F. Schram, *Race and the Local Politics of Punishment in the New World of Welfare*, 116 *AM. J. SOCIOLOGY* 1610 (2011); RACE AND THE POLITICS OF WELFARE REFORM (Sanford F. Schram, Joe Brian Soss & Richard Carl Fording, eds.) (2003); ROBERT C. LIEBERMAN, *RACE AND THE AMERICAN WELFARE STATE* (2001); Martin Gilens, "Race Coding" and White Opposition to Welfare, 90 *AM. POLIT. SCI. REV.* 593 (1996).

191 See MICHENER, *supra* note 9; GILENS, *supra* note 12.

192 Interviewers for this study were women familiar with the Medicaid context and/or cultural characteristics of Southern states. Interviewers included several women of color and several White women.

193 If there had been more room and flexibility in the interview agenda, we would have liked to include race as a specific topic of conversation in all interviews. Given time constraints (and the need to cover multiple topics, including health care, finances, health status, and the waiver), that was not possible in this study.

per month . . . . [T]hat just hit me the wrong way . . . . And according to what I hear on the news and everything, every one of the, uh, illegal aliens is coming in and getting help, and we've got people here that's Americans that's needing more help, and I just don't agree with all that.

I hope they only do [work requirements] for these people that are like, faking [eligibility], you know . . . but they don't have any distinction about [i.e., they don't distinguish between] me and the next guy. You know, "[Name of Respondent]'s hurt. [Name of Respondent]'s got a bad back. [Name of Respondent] can't do this," as opposed to the guy just sitting out here, soaking up the benefits. So, I was going to be lumped in with everyone and be made to do the same thing. There was no distinction, as far as the way it was writ . . . . So, I was confused [about the work requirements]. Like I said, kind of hurt. Kind of aghast by the fact that if I could, I would be out there working right now. I'd love to be out there working right now. I've worked my whole life. But I've got neighbors who've never struck a lick at nothing. You know, get \$6,000 a month—or, a year—back on their income taxes because they have a bunch of kids. And I'm going to be lumped in with these people? . . . And I'm not biased or racist or any—bigotist, or anything like that. But I'm in a position to where I feel like I'm in a different position, but lumped in with one situation. If that makes sense.

The prior descriptions show participants who were skeptical of others' rationales for participating in Medicaid, often reflecting broader stereotypes of low-income people and people of color. Other respondents saw a more mixed picture, in which some beneficiaries may "take advantage" but others use Medicaid due to situational factors more analogous to their own reasons for participating. These participants often expressed frustration that individuals who participate in Medicaid due to negative character attributes were consuming resources that should be going towards needier cases, as well as burdening taxpayers who contribute to the Medicaid budget.

[T]here are some folks who do take advantage, but then there are folks that genuinely need help. Otherwise, they're not able to really comfortably make it or even just make it, meaning afford all of the other necessities, like power, food. I know from my family and I, we cut corners . . . . The things that we can control are not mortgage, are not electricity . . . . Folks are needing



assistance versus just riding that free ride.

[P]eople take advantage of what's there for the needy. I mean, we don't choose to need all of this. I don't choose to have to depend on the government to help with my son. But life happens . . . . When there are idiots that do stupid things like taking advantage of [Medicaid], they're hurting families, they're hurting children . . . . Or they're hurting elderly people . . . or they're hurting families like mine. It's not fair to us that we have to reap what they sow.

If there was a way to magically know who needs it and who doesn't, that'd be wonderful, but there's not.

Finally, some participants avoided character-driven explanations for why other beneficiaries participate in Medicaid. Instead, this group argued that other Medicaid beneficiaries may be equivalently needy or *worse* off than they were personally. These participants tended to explain other beneficiaries' choices in situational terms analogous to their own, often referring to age, disability, or difficulties finding employment, securing transportation, and maintaining health in rural environments.

[O]lder people that are on a fixed income [couldn't afford Medicaid premiums] . . . . Especially in this part of the state, unemployment [i.e., the proportion of people unemployed] is great. It is twice, double, the national average. So, I don't see a lot of people being able to afford it. Not just the elderly but a lot of people.

I know how to advocate for myself but a lot of people don't . . . . [P]eople . . . are already in precarious economic conditions. Precarious health conditions . . . I know I'm more educated than most.

There's people, their situations aren't as decent as mine . . . [work requirements and premiums] would have been challenging for people because a lot of people don't have transportation . . . Shoo! The cost of public transportation is on their legs because two dollars up and two dollars back, that's four dollars a day . . . . You have people in these rural areas that are in the mountains, they really—there's barely a fricking grocery store. But you want them to go and volunteer and work . . . .

For many participants, there was a sharp distinction in how they viewed their own Medicaid uptake as driven by contextual explanations, while they viewed other beneficiaries as participating due to a lack of motivation to work. These perceptions are consonant with a body of psychological research describing fundamental attribution bias (also known as “correspondence bias” or “the actor-observer effect”). Under this bias, individuals attribute their own behavior to context and situational factors, while they attribute others’ behavior to character and personality characteristics.<sup>194</sup> Given participants’ keen awareness (and, often, internalization) of Medicaid stigma, they may have been reluctant to challenge the stigma wholesale, but eager to distinguish themselves from other beneficiaries on character grounds.

Beliefs about the beneficiaries of public benefits programs as undeserving and unwilling to work are also a central part of more recent scholarship seeking to explain what Arlie Hochschild has described as “the Great Paradox”: residents of Republican-leaning states have had greater uptake of federal aid and often health and economic problems of greater severity than in Democratic-leaning states. The voters and cultural norms of such states, however, express greater political resistance to public funds and public programming.<sup>195</sup> Hochschild has shown how Kentucky exemplifies this trend—considered a red state since the early 1990s, Kentucky saw rates of federal social benefits rise to approximately 23% of the average citizen’s income by 2015, while the average ideological position of the state’s Congressional representatives has moved markedly rightward.<sup>196</sup> Interviews by Hochschild and others document frustration and resentment toward beneficiaries of TANF, Social Security disability benefits, SNAP, and Medicaid who are perceived as taking advantage of public funding.<sup>197</sup> Some participants in

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194 *Attribution Theories*, ENCYCLOPEDIA OF PSYCHOLOGY VOL. 1 (2004); Daniel T. Gilbert & Patrick S. Malone, *The Correspondence Bias*, 117 PSYCHOL. BULL. 21 (1995); Edward E. Jones & Victor A. Harris, *The Attribution of Attitudes*, 3 J. EXPERIMENTAL SOC. PSYCHOL. 1 (1967). For treatments of this bias in legal academic writing, see Jon Handon & David Yosifon, *The Situation: An Introduction to the Situational Character, Critical Realism, Power Economics, and Deep Capture*, 152 U. PA. L. REV. 129 (2003); Jon Hanson & David Yosifon, *The Situational Character: A Critical Realist Perspective on the Human Animal*, 93 GEO. L.J. 1 (2004).

195 ARLIE RUSSELL HOCHSCHILD, STRANGERS IN THEIR OWN LAND 8-10 (2016); see also SUZANNE METTLER, THE GOVERNMENT-CITIZEN DISCONNECT 1-26 (2018) (stating on page 5 that “[c]ollectively, Americans rely increasingly on a wide array of policies to aid them in times of need . . . and yet elections produce growing numbers of public officials whose principal aim is to terminate, restructure, or sharply reduce the size of several of those very programs”; noting that in the 2012 and 2016 presidential elections as well as local elections, voters in jurisdictions most dependent on federal aid tended to support GOP candidates).

196 *Id.* at 14.

197 Hochschild, *supra* note 195, at 1156–161; see also Eduardo Porter, *Where Government is a Dirty Word, but Its Checks Pay the Bills*, N.Y. TIMES (Dec. 21, 2018), <https://www.nytimes.com/2018/12/21/business/economy/harlan-county-republican-welfare.html> (documenting similar sentiments in Kentucky).

the present study reflected similar frustrations, even though they were all on the receiving end of Medicaid support. In recent work, Suzanne Mettler has shown that “social identities and political affiliations” tend to “compete with or overwhelm the impact of firsthand experiences of social policies”<sup>198</sup>—a dynamic that also lies at the bedrock of expressive-politics theories about law.

Our findings also demonstrate a second important source of divergence: *some* of the participants in our study relied on negative character inferences when describing other beneficiaries, while *others* tended to see other beneficiaries as similar to themselves (or in some cases, facing even worse circumstances). Why were some participants inclined to see other beneficiaries in contextual terms, while other participants sought character explanations for benefits uptake? Literature on fundamental attribution bias has shown variation according to some personal characteristics, with lower levels of bias among people with lower beliefs in free will,<sup>199</sup> lower levels of personal stress,<sup>200</sup> and membership in non-cohesive or discordant groups.<sup>201</sup> We have separately considered political ideology and employment status, in data reported elsewhere.<sup>202</sup>

#### *D. The Expressive Content of Work Requirements*

Exploring how beneficiaries viewed others’ participation in Medicaid is indispensable for understanding the messages they saw in the Kentucky HEALTH conditions. As this Section will show, participants tended to reason through the meaning and desirability of premiums and work requirements based on their views about other Medicaid participants. Where participants viewed others as motivated primarily by character, they tended to identify Medicaid conditions as expressing messages that reinforced these beliefs—such as the belief that many other beneficiaries abuse the system, that work is a desirable corrective, and that other program participants would benefit from character education promoted by the new rules. When participants viewed others as similar to themselves—resorting to Medicaid due to their context—they tended to express reservations about the feasibility of fulfilling the new requirements, and they tended to impute state attitudes that were more invidious.

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198 METTLER, *supra* note 195, at 6-7.

199 Oliver Genschow et al., *Belief in Free Will Affects Causal Attributions When Judging Others’ Behavior*, 114 PNAS 10071 (2017).

200 Jennifer T. Kubota et al., *Stressing the Person: Legal and Everyday Person Attributions Under Stress*, 103 BIOL. PSYCHOL. 117 (2014).

201 Anouk Rogier & Vincent Yzerbyt, *Social Attribution Correspondence Bias, and the Emergence of Stereotypes*, 58 SWISS J. PSYCHOL. 233 (1990).

202 Kristen Underhill et al., *Hours and Penalties for Approved Medicaid Work Requirement Policies Differ from Public Preferences: Results from a Statewide Survey in Kentucky* (Dec. 8, 2021) (unpublished manuscript) (on file with author).

We elicited these data by asking participants about what they believed to be the state's purposes in enacting new Medicaid terms. Although *perceived purposes* are conceptually distinct from *expressive* messages, we used this framing to keep the conversation concrete enough for discussion. We did not supply the participants with any information about state or CMS rationales; all results were offered spontaneously by respondents.

Finally, although most participants treated “the state” as monolithic, a few also attributed attitudes and intentions to specific state actors—usually the governor, who had claimed Medicaid work requirements as a signature policy goal. We did not provide participants with any information about the distribution of authority over Medicaid; we simply described the waiver as a project of “the state.”

### *1. Reciprocity and Accountability to Taxpayers*

Among participants who viewed other Medicaid participants as ill-motivated, most believed that the purpose of Medicaid conditions was to exclude the undeserving. These accounts viewed the state as sending strong expressive messages that affirmed the value of work, such that work effort could (and *should*) serve as an appropriate criterion for rationing claims by able-bodied people to public assistance. This signaling of social norms is a prime example of “attitudinal signaling” that prioritizes a particular social norm, along with the “risk signaling” message that work is intrinsically good for individuals enrolled in public assistance. These participants also saw the work requirement as an *informational* signal that affirmed their belief that many Medicaid participants were sitting idle (what McAdams might call “violations signaling”). These signals also suggest a role for confirmation bias in the expressive impacts of law; confirmation bias suggests that we readily identify and believe information that aligns with our prior views.<sup>203</sup>

For example, one participant believed work requirements are “a good way to start to filter out the people that are just taking advantage of [Medicaid]”; another suggested that “it’s going to deter a lot of lazy people.” As these quotes suggest, participants often took work requirements as an invitation to discuss other beneficiaries’ motivations.

[Work requirements will provide] proof, I guess, that you’re actually doing what you’re supposed to be doing to keep your coverage and your Medicaid and not just mooching the system like a lot of people seem to do . . . . [I]t just kind of seems like some people get content with Medicaid and they just keep, you

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203 Raymond S. Nickerson, *Confirmation Bias: A Ubiquitous Phenomenon in Many Guises*, 2 REV. GEN. PSYCHOL. 175 (1998).

know, not working or whatever.

I really feel like they're making all these changes because a lot of people are just comfortable . . . . [I]f they have Medicaid . . . they can go to the doctor. They don't have to pay for much of anything, if anything . . . . They don't care if they work . . . . Now, they're trying to kind of change that and make people be more like get them back to work and contribute and, you know, be a functional normal member of society . . . . They're making you get up and be [productive], you know, go to the doctor or making sure you're not just going to the ER for, you know, pain pills, or whatever.

These participants tended to characterize (and justify) work requirements as promoting norms of reciprocity, such that individuals who accept public assistance owe duties of social productivity to taxpayers in return. On this view, the state plays a dual role: the state uses its authority to incentivize and educate Medicaid beneficiaries in social norms, but also serves as a guardian to prevent taxpayers from being “taken advantage of” by beneficiaries who do not reciprocate their contribution to the program.

This view was particularly popular among participants who prioritized their own identities as taxpayers, rather than as Medicaid beneficiaries. These participants were simultaneously both beneficiaries and taxpayers, but when they discussed their views of the Medicaid program, they talked first and primarily about their role as taxpayers. They described their contributions to state taxes, and agreed that Medicaid beneficiaries should owe work effort as a condition of benefits. Only secondarily did this group reflect on how the work requirements would affect them personally, if at all. Many participants were themselves working (about 44% in the qualitative sample), and more had worked in the past before becoming disabled or unemployed. For participants who were aware of Medicaid stigma, the taxpayer identity was also a more socially desirable selection than the identity of beneficiary. Some also interpreted the state's actions as information suggesting that taxpayers—including themselves—had become increasingly frustrated with the program.

I feel like people were getting tired of—they feel like they're taking care of other people. Their tax money is going to waste on helping other people instead of what they want it to be used for.

Health care is not really free even though people think it's free. Somebody's paying for it. Taxpayers are paying for it and it's not really unreasonable to have some accountability [for] the people

that are receiving the benefits of the government program. There needs to be some accountability for those people that are receiving. Or I should say, for those people receiving it to the taxpayers because that's who they're responsible to . . . [I work] 60 hours [a week] . . . [T]here's a lot of people that do abuse the system.

[T]here's got to be accountability somewhere with receiving the free service.

Further emphasizing the state's role in guarding taxpayers' investments, some participants expressed the worry that conditions would not be adequately enforced:

[I]f it does get implemented, I think they need to put some checks and balances in place so that it doesn't get abused. How easy would it be if I put in my own hours for the community service I've done, to just say, "You know what? I put in my 20 hours," and I didn't put in a single hour this week . . . [I'd want] more information on maybe what checks and balances they have in place.

Recall that every participant in these qualitative interviews would be expected to fulfill the work requirements—they would *themselves* be subject to enforcement. Calling for more rigorous enforcement may seem to run counter to their interests. But these participants' views were animated by their perceptions of others on Medicaid, and by their choice of their own taxpayer identity as the lens through which they viewed the purpose and content of work requirement conditions. Terms like "accountability," "responsibility," and "contributing to society" animated these discussions, and reflected messaging advanced by Governor Bevin.<sup>204</sup> Many participants cited their own economic productivity, either current or past, to illustrate the desirable behavior that they believed the state wanted to induce among other beneficiaries. These perceptions again called to mind the expressive-politics theory—through setting Medicaid conditions, the state confirms (or denigrates) the social standing of groups with congruent beliefs. Participants viewed their social standing as taxpayers to be affirmed by the state's

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204 See, e.g., Deborah Yetter, *Bevin Unveils Plan to Reshape Medicaid in Ky.*, Courier Journal, Jun. 22, 2016, <https://www.courier-journal.com/story/news/politics/2016/06/22/bevin-unveils-plan-reshape-medicaid-ky/86211202/> (quoting Bevin's statement, "We are robbing people of the ability to do for themselves [without the waiver]"); Governor Matthew Bevin, Executive Order Relating to Medicaid Expansion, 2018-040, Jan. 12, 2018, at 1–2 (citing CMS's goal of "promot[ing] responsible decision-making," and Kentucky's goal of "empower[ing] and incentiviz[ing] individuals to improve their health outcomes, ameliorate their socioeconomic standing, and gain employer sponsored coverage or other commercial health coverage").

new conditions on Medicaid, and viewed their identities as Medicaid beneficiaries to be secondary.

Among individuals who opposed the program overall, some also expressed sympathy for the state's perceived rationale for requiring work effort as a means of deterring unnecessary uptake of benefits. They, too, saw the conditions as violations signaling, showing that some others take unfair advantage of the Medicaid program. Among this group, opposition to the work requirements generally invoked the situational factors that beneficiaries thought would make compliance difficult, such as the lack of transportation or childcare. A few participants summed up this tension:

Maybe [the work requirement] is a little more reasonable, because (sigh) maybe they're just trying to get less people to take advantage of it. But if they have to do 20 hours of work, then maybe they won't even try to get on [Medicaid] . . . . [M]y husband and I are both able-bodied people, and we don't have the time or money; it would cost us money to volunteer . . . . And then losing benefits because of that I don't think is fair.

I think 20 extra hours a week out of someone else's week is a lot. And if it's someone that doesn't have a car or the transportation to get where they need to get for it, that's going to be kind of difficult. Or if they have children, they're already taking the time out for a job or whatever, I think 20 hours a week is a lot . . . . I think that if they lowered the amount of hours . . . . And it made sense for whatever they were including job-wise or whatever the activity was. I think that would be okay for a penalty . . . . I would stick with [my] job anyways. But if that job didn't count, I don't, then it would be hard to do that extra 20 hours a week.

These participants viewed Medicaid beneficiaries as complex and varied. By remarking on the reciprocity rationale for program conditions, they interpreted the requirements as confirming that some beneficiaries lack work motivation, and therefore the program requirements may not signal a negative motivation by the state. But these participants also relied on personal knowledge to identify contextual barriers that will make compliance difficult or impossible for many beneficiaries, including themselves. Participants in this group tended to suggest reduced penalties or requirements, but did not oppose work requirements in all forms.

## 2. *Character Education for Beneficiaries*

Among participants who viewed other beneficiaries as likely to abuse the system, many also believed that the purpose of work requirements was to educate beneficiaries in social norms (namely, work ethic). For this group, work requirements signaled that many beneficiaries *currently* lack motivation or character traits that are normatively desirable. A further signal, however, was that these character traits are malleable and capable of being shaped by incentive design. Many participants characterized Medicaid as a “stepping stone”—a training program that should be a pathway to higher incomes—making it an appropriate and desirable role for the state to educate beneficiaries in prosocial character traits.

Notably, this is a slightly different idea of state purpose than the reciprocity point. On the reciprocity explanation, the state is enforcing terms of an agreement between beneficiaries and taxpayers. Character education is distinct—on this view, the state is incorporating education as part of a custodial role toward Medicaid beneficiaries, who have learned (wrongly) to use public benefits instead of working. Participants who saw work requirements as a means of education viewed them not as exclusionary, but rather as instilling the social norms and character traits that other beneficiaries need to participate in society.

I think that it is to build up people that aren't meeting the requirements. There are a lot of people that will go down to the food stamp office and they'll sign up for everything. And then, they don't hold up their end of anything. So, I think the responsibility is a part of that educating the society and the community like that to maintain these things . . . . You don't just grow up and have four kids, and not get married, and the state will take care of you . . . . [T]hat's what our communities are being taught.

[I]f you are an able-bodied adult, you should be working, period. These are a stepping stone. All of these programs are stepping stones until you get to a point where you take care of these things on your own. You need to be working. You need to be going to school.

A few participants contrasted the work requirements in Kentucky HEALTH with current Medicaid policy, under which Kentucky offers benefits to all individuals below 138% the federal poverty level without conditions on participation. These participants noted that the Medicaid program currently lacks education for beneficiaries, which they viewed as an integral part of the state's



custodial role.

[Right now] people are just doing whatever, and no one's following up, and there isn't any type of education. There isn't any kind of building, or any foundation, or anything like that . . . I think that's costing the state a lot of money. I think that it's not helping.

Sometimes when people are just constantly given something it's "I want, I want" and then they get an entitlement mentality. Whereas if we have to work for something we tend to take a little bit more pride in it and we own it more . . . Unfortunately, I don't know if that's possible in this day and age because people get more and more "I want."

As these quotes suggest, Medicaid conditions communicated norms about desirable work behavior (attitudinal signaling), norms about the value of work (risk signaling), and the prevalence of idleness among beneficiaries (violations signaling). And although many beneficiaries experienced these signals as a personal affront, others found that the laws confirmed their priors about *others* in the program. Recall also that these participants had carefully distinguished their own Medicaid participation (due to context) from the character-driven participation by others. As a result, this group of respondents had insulated themselves from the negative character implications of work requirements.

### *3. Promoting Social Inclusion and Dignity*

A few participants viewed the purpose of work requirements as promoting the social inclusion of beneficiaries in community life. These participants tended to see the state as affirming their own beliefs that "involvement" or "community" is an important part of social life. This message again entailed a descriptive inference about Medicaid beneficiaries—namely, that they are isolated. It also aligned with participants' views about the role of the state as custodial, on the idea that it is appropriate for the state to require social inclusion for beneficiaries' own good.

Maybe [the new requirements are] to give people a sense of involvement . . . I just feel like maybe it's the state's way of saying, "There are people out there that maybe don't really feel like they're part of what's going on." . . . [I]f you want to keep receiving the benefits, then come to be a part of the community, and be a part of the discussion, and be a part of everything that's going on.

This participant explicitly identified the waiver terms as a signal—“the state’s way of saying” that community participation is desirable, and perhaps even *owed* by recipients of public assistance.

A related custodial purpose was to promote beneficiaries’ dignity. Many participants perceived work requirements as announcing social norms about the intrinsic value and dignity inherent in work. There was substantial overlap between these participants and those who viewed the purpose of the waiver as encouraging accountability or character education. For these participants, work requirements not only expressed the value of work, but also provided an incentive for participants to realize dignitary gains *for their own good*. One participant argued, for instance, that for participants who do work, “You’ll feel better about yourself. You’ll feel better about your home. You’ll set an example for your children and it will change generations as time goes on.” As another noted, “I think that it’s very, very important for [work requirements] to be put into place so that someone can feel more prideful in themselves and their family. And they can set a better example.”

Premiums, too, were sometimes interpreted as having a dignity-promoting rationale; as one participant noted, these requirements “are just to . . . let people, you know, just pay a little and feel like they’re worthy.” This aligns with some statements that beneficiaries had made about their own preferences to purchase plans on the ACA exchanges rather than using Medicaid benefits; for these participants, self-paying for health insurance was normatively desirable, and it was appropriate for the state to use benefits conditions so that other beneficiaries would realize this sense of dignity.

#### 4. *Coercion and Exclusion*

I now turn to participants who viewed other beneficiaries as similarly situated to themselves. This group was more likely to view work requirements and other conditions as a *personal* affront. They saw work requirements as evidence of the coercive and arbitrary power of the state. These participants also resisted the informational inference that work requirements meant that many beneficiaries lack work ethic—instead, they viewed the state as (at best) inattentive, and (at worst) disingenuously aware that participants would be unable to comply. Even when these participants believed that *some* other beneficiaries abused the program, they believed that the large majority of beneficiaries were, like themselves, in genuine need of assistance.

In this group, some simply resented that the state would require them to take actions that they may have chosen to do anyways, out of intrinsic willingness, which is a prime example of motivational crowding-out. As one participant said, “It doesn’t bother me if I had to volunteer to work. But it’s the fact that you were

trying to make me volunteer [that bothers me].” As another participant put it,

People do things because the government forces them into it . . . .  
[T]he government practicing behavior modification to get the citizens to do what it wants them to do somehow just sounds evil . . . I don't trust government. Any time any government starts running in there trying to control your actions because they know better than you do, yeah, that's how we start Hitler, you know?

Beyond sheer resistance to coercion via incentive, however, many participants also viewed work requirements and other conditions as punitive, in large part because they viewed the requirements as expressing moral inferences about themselves and other beneficiaries.

[E]verybody says Kentuckians are lazy and—I don't know. We're like one of the poorest states in the United States . . . . You make one of the poorest states in the United States pay a premium and all of this stuff . . . you're taking just a small group of people [who abuse the system] and you're penalizing a whole larger group of people . . . I don't see anything other than a moral judgment and a stereotype that's driving this, and profit margins.

My eyebrow kind of went up when you said you lose insurance for six months [for not paying a premium] because it's, well . . . . Arguably, that's punishing but to what end is that punishment? Is it the reactive, “Let's get them”? Or is it a general reminder or helping? I would think it would be the first. It would be the more predatory and, “Let's get them for that.”

Some expressed concerns not in terms of coercion and punishment, but also in terms of outright exclusion. On this view, rather than viewing waiver terms as compassionate or setting high expectations, participants perceived waiver conditions as expressive of disregard, misunderstanding and intentional harm.

You'll have more people off of Medicaid than who are on Medicaid, which is probably what they want anyway.

To me, it felt like them trying to get out of paying [benefits] is like, “We'll make it so difficult that [you won't use the program]” . . . I feel like that money's been mishandled, and they want to make it harder and harder, and you get less back of what they promised.

I mean, it's absolutely inhumane and incomprehensible . . . . It doesn't provide any kind of incentive at all. It causes added stress and panic . . . . That does not motivate me to be productive. Motivating me to be productive is I do the best I can and I know I will get the help I need whenever I need it . . . I think rather than being an incentive it's a punishment . . . . People who can't pay—it's not, again, that they're lazy. Perhaps something else is happening. I mean, again, I don't always have the money at the right moment . . . . It's supposed to be a safety net, not, "We're going to judge and punish you."

In the latter quote, the participant views work requirements as a sign that the state is insensitive to beneficiaries' situational constraints. She also takes a strong view of the appropriate role of the state in administering public assistance programs—the role is not to educate, or to incentivize behavior change, but rather to supply services that enable individual health and productivity.

This participant also suggests another interpretation of waiver terms as expressing the state's distrust of beneficiaries, including her personally; she discusses how the incentive of losing her benefits does not "motivate her to be productive," but instead notes that she is already independently (intrinsically) motivated to be productive. She needs health care, not extrinsic motivation to work. Like many of the participants above, she has interpreted work requirements as communicating that beneficiaries lack motivation. But, unlike some of the prior speakers, this participant views the messages as a personal indictment.

##### *5. Racism and Animus*

A few participants interpreted the waiver as expressing animus by the state towards low-income individuals, including racial animus toward poor people of color. These participants described and criticized longstanding stereotypes about people of color as lacking in work motivation.<sup>205</sup> Through this lens, participants viewed work requirements as targeting public assistance recipients of color. Participants also referred to stigma associated with poverty generally, including moral judgments about the reasons why people are poor. As one participant argued,

[The state chose these terms] [b]ecause [the governor] is a racist person who is full of entitlement and believes that poverty is tied to immoral judgment on somebody's worth. I mean, it's that Protestant work ethic . . . if you are poor you have brought it on yourself. And good people tend to make enough money and be

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205 See GILENS, *supra* note 12.

fine. So, if you are poor, there is some moral issue . . . . He believes the stereotype that anybody on Medicaid is on Medicaid because they're lazy and don't want to work . . . . We're doing the best we can. Many of us have complicated health issues that if not treated would then force us to have to stop working . . . . Social programs take away from their profit margin and they're prejudiced to think that this is out of laziness. Which is what my family says too.

Other participants echoed these views, naming racism outright as a motivation:

Facilitator: What are some of the reasons the state might be making these changes?

Respondent: Negative opinions about our former president. Add racist views to that, too. I want to add that. Racist stereotypes, yeah.

Here, the participant's interpretation of the waiver is set in context of their views about the permeation of social stereotypes into government generally, and they particularly attribute those stereotypes to state leadership. It was rare, however, for participants to interpret Medicaid requirements as revealing racial animus on the part of the state. Approximately 30% of qualitative interview respondents were people of color,<sup>206</sup> but only one spoke openly about racism when reacting to the program. Non-Hispanic White participants were the remainder of the sample, and again, only one or two interpreted the requirements as revealing racism. But many people of color, as well as many Non-Hispanic White participants, understood the requirements as revealing insensitivity or disregard of poor people. Views about race and racial stereotypes may lie under the surface in these statements, as they did when participants discussed their own views of Medicaid beneficiaries. Again, social desirability or fears about confidentiality may have made it difficult for participants of all races to discuss racism or race-based beliefs openly in this study.

#### *6. Arbitrariness*

A few participants characterized waiver terms as purely arbitrary, signaling disregard. Rather than interpreting any signals with relevance to beneficiaries, they viewed waiver terms as evidence that the state makes choices "for no reason."

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206 See *supra* Table 2.

Some attributed this decision to an exercise of power by the governor personally, while others attributed it to the state as a whole.

Because [the governor] decided that poor people need to pay for their stuff and—that's it . . . See, I don't understand it. If all these other countries that aren't as, quote unquote, "rich" as the United States can have free universal health care, why the heck haven't we gotten free universal health care? . . .

I don't understand why they want to do all that and make the changes anyway. Really, I mean if you're out trying to do what you know, the best you can do and then they take it away from you . . . I know some people abuse it. I understand that, but as long as I'm able to work, I'm going to work, you know . . . I'm just sorry that I can't afford health care.

Some participants who believed new Medicaid conditions to be arbitrary drew the conclusion that the state was acting with indifference to beneficiaries unable to afford health care. This message tended to alienate beneficiaries who expected or desired a different role for the state, which was reflected in statements about feeling powerless, overlooked, or misunderstood by the government.

There's some people that can't work, you know. Because there is actually some people here that can't work. (pause) But it don't do me no good to have my own opinion. (chuckle) They don't give a shit about what I think.

Our government doesn't seem to want to understand regular people and what goes on, and what the implications are.

They're going to do it anyway, so I really don't have an opinion on it . . . [I]f they voted, and a lot of people said no, they probably would do it anyway.

I think they need to go back to the drawing board and come up with something better . . . Because, you know, there's other people in this world beside the people with money, you know . . . The emergency rooms all don't halfway want to, you know, treat them right. You know what I'm saying? They won't give them the care that they need because they don't have insurance. You know it's hard. You know. People deserve to be able to live.

Some participants in this study were surprised that the state was funding

research about their perceptions and beliefs, and some were energized by the chance to express their opinion about state decisions. Others, however, expressed the belief that that their views would be of no importance to the state; as one participant noted, “it doesn’t do me much good to think anything about it, because it’s going to happen whether I like it or not.” Where participants viewed Medicaid conditions as arbitrary, they tended to view these conditions as a sign of disregard.

### *7. Politics*

Some participants perceived the state’s purpose in Medicaid waivers as a matter of pure politics; although this rationale was distinct from arbitrariness, participants interpreted a similar level of disregard for beneficiaries. These participants connected the Kentucky HEALTH program to national politics, and they situated Medicaid conditions in the broader frame of repealing the Affordable Care Act, citing the change in state leadership from a Democratic to a Republican governor. Others suggested that state leaders simply wanted to develop a unique Medicaid program to raise their national reputation.

I was really pleased after Obamacare got introduced . . . . [T]hat was the first time I had insurance since forever . . . . And KY Connect [the state’s ACA exchange platform under the prior governor’s administration], I thought that was handled brilliantly . . . . But then they scrapped it, and it feels like now they’re trying to cram in quickly this other program . . . . I feel a lot of it has to do with the political level on the national level. They decided they wanted to erase everything Obama did . . . . So I feel a lot of it is just rushed-out policy that they’re forcing upon people just because of this innate hatred for everything he did, whether it was good or bad.

[I]t’s all caught up right now in political BS . . . . I hate talking about the country I live in. I was born in the greatest country on the planet and I still believe that. But right now we’ve got political stuff that’s gotten so far divided that we’re not fighting about issues any more. We’re fighting about political ideology that doesn’t allow for getting things done.

Regardless of how participants interpreted the state’s specific political goal—including a desire to be novel, a desire to replace policies enacted by the Obama administration, or a desire to promote specific political ideas—participants who saw the waiver as purely political viewed the consequences of policy choices for

Medicaid beneficiaries as unimportant to the state. This was particularly true among participants who anticipated negative results from waiver terms.

Folks are playing politics with other human beings' lives.

The governor said he wants to follow the path of our president and "I'm going to help him get rid of affordable health care," and for political reasons. I guess if you want to do that and get votes, it's not about whether or not people are well or not . . . . It's politics and I know it is.

I think it's because they're wanting to do something unprecedented . . . I feel like you're making a poor state even poorer by doing that . . . . Because you're going to have all these people who are sick. Not going to be able to get their medicine and get Medicaid because of these requirements that you're doing . . . . I feel like it's unfair and it's unjust.

For participants who viewed the waiver terms as having an exclusively political rationale, the policy terms seemed to convey few messages about beneficiary choices, character, or social norms. Instead, for these participants, the only relevant signal was that that beneficiaries' interests had been absent from the waiver's objectives.

#### *8. Financial Sustainability*

I have thus far focused on state purposes proffered by participants who viewed other beneficiaries as dissimilar from themselves, compared to participants who viewed other beneficiaries as similarly context-driven. But a final explanation cut across both of these groups, and this was the idea that the state was needed work requirements or premiums to make the program financially sustainable. Participants interpreted the new requirements as a credible signal that the Medicaid program had gotten too expensive for the state.

Throughout many of the interviews, participants reiterated that Kentucky is a poor state, and they perceived the Medicaid program as oversubscribed and underfunded. A few blamed this on spending decisions by the state legislature—in the words of one participant, "They were trying to reduce their losses for the budgets and stuff. A lot of governmental crap." As another participant described, "I think they've used the money . . . that's set aside for the seniors . . . I know they've used it for other things." Participants believed that Medicaid would be financially burdensome to the state, and a few blamed physicians as well as beneficiaries for adding to program costs.



I think that one of the aspects would be to cut back on some costs, to have some revenue generated back into the system . . . . Fifteen dollars per person [per month, as a Medicaid premium] is going to add up really fast. The majority of our state is on government assistance. The majority. So, that would add up very, very quickly in our state.

I guess they're trying to put a limit toward the budget on the funding that they funded to these health care providers and stuff. Making sure that they're not gunning up the money . . . . Because since Obamacare and stuff has been around, I noticed there's a whole lot of doctors that are taking advantage . . . . They tack on extra stuff because they know that Obamacare is going to pay for it.

These explanations tended to be acceptable to most participants, and embodied messages that they found unobjectionable and largely separate from views about beneficiaries. A few of these participants also commented that the Medicaid program was valuable to them. As one noted, "[I]f \$3 is what they need to keep that program going, I'm willing to do that \$3." To these participants, efforts to keep the program sustainable expressed concern for beneficiaries and the durability of benefits.

I don't know how healthy this program is right now . . . . But if it gets to be where there's not enough money to cover everyone, then they might just have to cancel, you know. You can't keep on if you don't have the money . . . . [I]f it gets cancelled for everybody then it hurts everybody . . . . [T]hey need to make changes to it to make it to where it can be solid and not just lose tons of money.

Although the costs of Medicaid featured most prominently in discussions about premiums, some also described cost-saving as a primary rationale for work requirements, including not only likely disenrollment from the program, but also the economic value of work and community service activities provided by people complying with the requirements. Others drew a connection between employment or volunteer activities and the state economy.

They need more able-bodied people to work and do community service or something along those lines to help pay for their Medicaid . . . . [T]hat would pay money that's going to other organizations for helping hire people to do these things. So then you would take more money out of one budget and just be able to

put it towards another.

In addition to financial sustainability, a few participants also perceived that employment or volunteer activities were intended to aid third parties, including businesses or elderly people in need of help. On this view, the waiver was not only about modifying beneficiary behavior, but also about mobilizing beneficiaries' time as a resource to meet third parties' needs. As one participant noted, "Businesses or whatever, that could use some help . . . It's kind of free labor on their end . . . kind of a win-win, I guess." Another participant (who had previously worked as a condition of SNAP benefits) noted, "I think it would be nice like that . . . Because it'll help other peoples . . . Old people they can't get out . . . A lot of young people are here and they can do it."

Other participants acknowledged state revenue-raising as a possible goal, but doubted that these funds would go toward sustainability of the Medicaid program. Some believed instead that premiums would be "big money" intended for state legislators, and expressed frustration with state representative salaries and spending decisions. Others characterized savings as a fig leaf to mask political ends.

They said they're low on funds I guess in the medical area or whatever . . . But I don't think so. I think this is just a big old money scheme thing. That they're just trying to get more money out of people than usual.

Oh, the optics of, you know, we're saving the state money . . . because we're not having to pay for these people.

[T]hey trying to save money. That's all. Save money. I just think it's pretty messed up, putting all these stipulations on people, you know. And some people just can't do it. And it's because they can't do it, you're going to not give them health benefits? You're not going to allow them to see a doctor, dental? Teeth need pulling, you'll let them suffer and be in pain because they can't afford to see a dentist? Come on. That don't make sense. It don't make sense. It's not right. You know? . . . [I]t's hard times right now . . . The politicians are covered. Believe that. They probably get the best benefits in the world. They gonna let the little person suffer.

On this skeptical view, the expressive message of waiver requirements would again be one of general disregard for beneficiaries, casting the state in the position of extracting beneficiary resources rather than acting in other roles.

*E. Summary of Study Results*

Beneficiaries held variable views about Medicaid conditions, which were framed by their beliefs about other beneficiaries' choices to participate in the program. Those who viewed others' participation as motivated by (negative) character attributes were more likely to interpret conditions as evidence confirming those beliefs, and supported work requirements and, to a lesser extent, premiums, as a means of intervening. This group tended to deflect the personal relevance of the messages sent by work requirements. In fact, they were more likely to reach for other identities that they found more meaningful and affirming—such as the identity of taxpayer—when reasoning about the expressive content of these conditions.

But those who viewed others' participation as similar to their own, though the lens of contextual factors such as poverty, disability, and difficulty finding work, saw a far different set of messages. This group was more likely to perceive work Medicaid conditions as punitive, exclusionary, coercive, and communicative of animus. They were also more likely to view conditions as arbitrary and expressive of the state's disregard toward the beneficiary population. These two views clashed not only in beliefs about the purposes and expressive content of conditions, but also in beneficiaries' own support for the conditions.

These findings lend support to ideas about the expressive content of law, but add the key insight that expressive content depends on the beholder—and specifically, it is mediated by the ways that the beholder views other regulated people.

IV. WHAT WORK REQUIREMENTS TELL US

As the prior Part described, beneficiaries' views about Medicaid conditions in this study were richly nuanced and attentive to a range of communicative signals expressed by the waiver, which were largely informed by their beliefs about the lives and decisions of other beneficiaries. Many participants in this study exhibited fundamental attribution bias, in which they interpreted their own uptake of public health insurance in terms of their circumstances, while interpreting others' uptake as evidence of character and purposeful choice. This Article does not answer the question of whether work requirements are helpful (they were not, in Arkansas<sup>207</sup>),

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207 The most recent assessment the Arkansas work requirements suggest that this program feature may have resulted in widespread losses of insurance coverage in Arkansas, but it did not affect employment. Many adults subject to the new regulations reported confusion about the policy requirements. Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 N. ENGL. J. MED. 1073 (2019), <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

or whether they are desirable. But these findings contribute a textured view of how beneficiaries may interpret work requirements as a condition of health care.

This Part will consider two conclusions. The first is a theoretical contribution to expressive legal theory, which must contend with heterogeneity in how individuals deduce information content from the law—and, indeed, with the larger issue that expressive content is not set by states, but is rather co-produced by the state and the listener, who brings her own normative priors. I then draw on crowding-out theory to suggest that expressive messages previously considered tangential to compliance, such as identity affirmation or communications of distrust, may in fact be important mediators of compliance behaviors.

#### *A. Heterogeneity in the Expressive Impacts of Law*

Expressive legal theory moves the focus of law from its incentive impacts (the extent to which laws adjust the costs and benefits of different choices) to its expressive impacts, by which law communicates information to others, including those who are subject to its mandates. Although work in expressive law has deduced a wide range of plausible messages that law might send—including messages about social norms, risk and benefits of different choices, and the pervasiveness of rule violation—this body of research has not yet pursued the problem of heterogeneity in how subjects understand the signals sent by new rules. Moreover, we have long thought about expressive law as a communication from state to subject, or from state to observer. We have done little, however, to grapple with the issue of whether these communications are co-produced by the state and the listener, and whether they depend in part on the listener's own normative commitments.

This Article offers a new view of how people who are subject to the law draw inferences about its expressive content. First, even without proffered information about a law's intentions, people interpret law as a source of information about social norms, state beliefs about risks and benefits, the prevalence of behavior among a regulated population, and the relationship between citizens and the state. This expressive content is separate from the incentive impacts of these laws—although many participants discussed how they would manage the new behavioral requirements, they focused more directly on what they believed these conditions meant about themselves, others, and the state. The participants in this study were not given any information about why the state or CMS sought to include the waiver terms. They nonetheless drew inferences from the content of the new conditions. Some of these were aligned with the purposes proffered by the state and CMS, but others were opposed—this suggests that both intended and unintended messages are relevant to understanding the expressive impacts of law.

Second, findings show that when a state places new conditions on public

benefits, people subject to the law may deduce expressive messages through the lens of how they view *other* beneficiaries. Where people saw other beneficiaries as motivated by character, they were likely to view the expressive content of conditions as affirming those beliefs. But where people saw other beneficiaries as motivated by context—deserving in the same way that they themselves were—they were likely to identify messages that were invidious, coercive, exclusionary, and personally threatening. Expressive legal theory has made few efforts to identify how regulated individuals vary when interpreting new rules. Other research on phenomena like motivated reasoning,<sup>208</sup> biased assimilation,<sup>209</sup> confirmation bias,<sup>210</sup> and the credibility heuristic<sup>211</sup> have suggested that once we hold normative priors, we seek out and prioritize information that we believe confirms our ideas.

This finding extends prior work. Scholars in politics and sociology have noted that Americans' views of welfare are largely shaped by views of moral desert (often driven by race),<sup>212</sup> and that perceptions of beneficiaries are key determinants of support for welfare policy.<sup>213</sup> This Article confirms these insights, extends them to the beneficiary population, and explains the applicability of these views to an expressive theory of the law.

An important corollary is that participants who viewed themselves as dissimilar from other beneficiaries were somewhat insulated against the negative character implications of new benefits conditions. Although these participants were Medicaid beneficiaries, they selected the role of taxpayers when reasoning through benefits conditions, and they explained their own Medicaid participation as driven by circumstances separate from their character. When these participants interpreted conditions as revealing negative information about beneficiaries' work ethic, they were then primed to separate themselves from these judgments—the bad information confirmed their view of other beneficiaries, but it was not personally threatening because the respondents had already done the cognitive work of distinguishing themselves from this group. Messages that we might assume to present an affront therefore made little personal impact—and indeed, they appeared affirming to such participants for other identity reasons, such as an expressive-politics victory for their political or taxpayer identity.

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208 See EYAL ZAMIR & DORON TEICHMAN, *BEHAVIORAL LAW AND ECONOMICS* 58 (2018).

209 See Charles G. Lord et al., *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37 *J. PERSONALITY & SOC. PSYCHOL.* 2098 (1979).

210 See Nickerson, *supra* note 203 (reviewing research evidence for confirmation bias).

211 Chanthika Pornpitakpan, *The Persuasiveness of Source Credibility: A Critical Review of Five Decades' Evidence*, 34 *J. APPL. SOC. PSYCHOL.* 243 (2004).

212 GILENS, *supra* note 12, at 60–79.

213 METTLER, *supra* note 195, at 106.

Participants who viewed themselves as *similar* to other beneficiaries did not readily dissociate themselves from others. As a result, they saw the negative expressive content of Medicaid conditions as an indictment of their own work ethic. And conversely, they did not reason through the impact of requirements from the perspective of the taxpayer, but rather considered how the law would affect beneficiaries in circumstances similar to their own.

Because people bring their prior normative commitments into their interpretation of law, there is also a limit to how much lawmakers can do to ensure that law conveys their intended meaning. *All* of the participants here thought work requirements expressed a rich set of expectations, intentions, and facts. From this perspective, benefits conditions serve as a form of communication that can either affirm or affront those who are subject to the new rules. Drawing on the expressive-politics theory, this also suggests that the expressive impacts of laws produce paradoxes, such that people who are *both* regulated *and* validated in different ways may react unpredictably to law.

Further work is needed to identify other sources of heterogeneity in expressive impacts of law, as well as the operation of cognitive biases in the types of lessons that people draw from legal rules. But this Article provides a starting point for understanding how the expressive content of law depends in part on the priors of the listener—even when that listener is someone subject to the new rule.

### *B. Compliance Motivation*

Moving from theoretical to practical insights, the expressive content of benefits conditions may predict compliance with the new benefits terms. Much scholarship in expressive law is concerned with compliance, and notably how expressive signals can motivate compliance behavior. But this scholarship has largely dismissed certain signals—such as signals that convey distrust, disrespect, or an unexpected relationship between government and citizens—as only tangentially relevant to compliance.<sup>214</sup> Based on the literature of motivational crowding-out, however, these signals may be highly relevant to compliance motivation. Crowding-out theories suggest pathways by which incentives, penalties, or mandates interfere with intrinsic motivation for engaging in a given task.<sup>215</sup> Work requirements transform the Medicaid program from a public entitlement into an incentive for working—or more precisely, because people begin *ex ante* with Medicaid eligibility that is then put at risk for noncompliance, the prospect of losing Medicaid serves as a stick (a negative incentive) that penalizes the failure to work. Crowding-out can result when incentives signal information about the task, the principal's views of the agent, the principal's moral

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214 MCADAMS, *supra* note 40, at 13–16, 260–61.

215 *Id.* at 162–65.

values, and the supportiveness of social norms.<sup>216</sup>

The participants in this study believed that work requirements and premiums expressed a number of messages; any of which might affect crowding-out. This was particularly true of the beneficiaries who opposed work requirements. Many such participants read this condition to mean that the state had negative views of Medicaid beneficiaries, or that the state had wholly disregarded beneficiary well-being—each of which could lead to undermine compliance motivation. Some believed that the state's adoption of new terms was coercive, "unjust," "unfair," or "inhumane," revealing moral values that could prompt disengagement. Crowding-out theory would predict that participants who perceive hostile, coercive, or personally insulting expressive content will have greater difficulty complying with the new terms. But those who viewed the conditions as congruent with their own identities and beliefs may not be susceptible to crowding-out effects.

#### CONCLUSION

This Article provides an in-depth view of how Medicaid beneficiaries interpret the expressive content of conditions on benefits, focusing on work requirements and premium terms common to emerging § 1115 waivers. Part III of this Article described the methods and results of a mixed-methods study of Medicaid beneficiaries eligible for a planned work requirement waiver; results relied on surveys and qualitative interviews to construct a nuanced view of how beneficiaries understand work requirements as revealing information about themselves, the state, or other beneficiaries. The study's findings suggest that beneficiaries interpret Medicaid conditions to express information, but they perceive variable signals depending on their normative commitments. These views were framed by how participants viewed *other* Medicaid beneficiaries. Participants who viewed other beneficiaries as character-driven (i.e., ill-motivated and lazy) saw work requirements as affirming their view, and as affirming their own value as taxpayers. Conversely, respondents who viewed others as circumstance-driven saw work requirements as a signal of coercion, punitive intent, and disregard, and they identified the requirements as a personal threat.<sup>217</sup>

These findings make several contributions: a descriptive account of Medicaid

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<sup>216</sup> See Underhill, *When Extrinsic Incentives Displace Intrinsic Motivation*, *supra* note 56 (citing literature).

<sup>217</sup> This study is not without limitations. Like all qualitative studies, it is vulnerable to social desirability bias. It may not generalize beyond the Commonwealth of Kentucky, or, given ongoing public discussion of Medicaid conditions, beyond the moment in time when data were collected. But this work also has numerous strengths, including the triangulation of qualitative and survey findings, the collection of a statewide representative sample for both types of data collection, and the use of trained, unbiased interviewers to collect primary data.

beneficiaries' perceptions of work requirements, a theoretical contribution to expressive legal theory, and a set of practical considerations for compliance motivation. Descriptively, this work presents a vivid picture of how Medicaid beneficiaries perceive work requirements. Findings demonstrate heterogeneity in perceptions, wherein some participants are energetically opposed to work and premium requirements for themselves and others, while other participants recognized personal downsides but unequivocally supported work requirements for other program beneficiaries. As a matter of theory, this Article suggests that heterogeneous interpretations can complicate expressive theories of law, and that biases such as confirmation bias, fundamental attribution bias, and prior views of the regulated population may shape how people understand legal rules as signals. Finally, as a practical matter, this Article has explored the implications of findings for behavior, with implications for access and equity; specifically, participants who view the expressive content of work requirements to be personally threatening or insulting may experience more compliance challenges, while participants who viewed the requirements as targeting *other* beneficiaries may be somewhat protected from these reactions.

The issue of work requirements in means-tested public programs is not resolved. Work requirements are a structural feature of many public assistance programs already, including SNAP, TANF, and unemployment insurance benefits. The interaction between public benefits and work motivation continues to be a matter of interest for conservative lawmakers, demonstrated most recently in public discussion regarding COVID-19 relief benefits.<sup>218</sup> Interest in work requirements persists for the Medicaid expansion population, and although these requirements are presently unlawful, shifts in political power may bring renewed interest in future years. The descriptive findings of this work with Medicaid beneficiaries, therefore, can help to explain public perceptions and acceptability of program conditions in future years.

This study has also yielded a new way to understand the expressive impacts of law. In short, law does not produce a unilateral communication from state to subject—instead, the message carried by law is co-produced between the state and the listener, and it is understood against the deep context of the listener's prior beliefs. Here, participants' views reflected their personal identity choices compared to others enrolled in Medicaid (e.g., as taxpayers vs. beneficiaries; as contextually motivated vs. character-motivated; as like vs. unlike other beneficiaries). These choices, in turn, drove support or opposition for the waiver policies. This can result in views that at first seem incongruous (e.g., support for a waiver that would make personal access to Medicaid more difficult), but on a

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218 Sarah Jones, *The Return of the Welfare Queen Myth*, N.Y. MAG (May 11, 2021), <https://nymag.com/intelligencer/2021/05/biden-unemployment-benefits-and-the-welfare-queen-myth.html>.



"EVERYBODY KNOWS I'M NOT LAZY": MEDICAID WORK REQUIREMENTS AND THE  
EXPRESSIVE CONTENT OF LAW

closer look make sense given how participants interpret the message behind the policy. It is daunting to confront questions of expressive law in a way that accommodates heterogeneous signals, but this approach opens exciting questions of how we interact with law as subjects, observers, and lawmakers.