

1-28-2016

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Recommended Citation

Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C.L. Rev. 1 (2016), <http://lawdigitalcommons.bc.edu/bclr/vol57/iss1/2>

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HEALTH CARE AND THE MYTH OF SELF-RELIANCE

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Abstract: *King v. Burwell* asked the Supreme Court to decide if, in providing assistance to purchase insurance “through an Exchange established by the State,” Congress meant to subsidize policies bought on the federally run exchange. With its ruling, the Court saved the Patient Protection and Affordable Care Act’s (“ACA”) low-income subsidy. But *King* is only part of a longer, more complex story about health care access for the poor. In a move toward universal coverage, two pillars of the ACA facilitate health insurance coverage for low-income Americans, one private and one public: (1) the subsidy and (2) Medicaid expansion. Although both have been subject to high-profile Supreme Court cases, the Court upheld one but gutted the other. This Article hypothesizes that the preference for private “hidden” government assistance over public “visible” government assistance stems from the American myth of self-reliance. Yet this analysis reveals that the line between hidden and visible benefits breaks down on both theoretical and empirical levels. Drawing from vulnerability theory and demographic data, this Article demonstrates that all Americans lead subsidized lives and could move from the private to the public system. It concludes that a single government program for the poor would be more economically and administratively efficient.

But there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.

—Lyndon B. Johnson¹

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** Director of the Health Law & Policy Institute and Associate Professor of Law, University of Houston Law Center. Thank you to the participants in the Emory Workshop on Vulnerability, especially Martha Fineman, and in the University of Houston Law Center Works-in-Progress Series. My appreciation likewise goes to Emily Lawson for library assistance and to Elaine Fiala for administrative aid.

Dependency is death to initiative, risk-taking and opportunity. Dependency is culture killing. It's a drug. We've got to fight it like the poison it is.

—Mitt Romney²

INTRODUCTION

In 2015, the U.S. Supreme Court decided *King v. Burwell*, one of the Term's most-watched cases.³ In what was widely regarded as another attempt to dismantle the Patient Protection and Affordable Care Act ("ACA"), the petitioners challenged the applicability of the statute's low-income subsidy to health insurance policies purchased on the federally run exchange.⁴ To allow low-income Americans to comply with the law's individual insurance mandate, Congress included a tax credit to purchase subsidized coverage for individuals enrolled through an "Exchange established by the State."⁵ Thirty-four states did not establish their own exchanges, though, opting instead to have their residents rely on the insurance exchange run by the federal government.⁶ *King* therefore came down to simple statutory interpretation: did Congress intend the low-income subsidy to apply only to the state exchanges? Although this issue might seem like lawyerly quibbling, experts estimated that the insurance coverage of up to thirteen million Americans hung in the balance.⁷ Ultimately, the Court decided in favor of the government, rescuing a key feature of the ACA and preserving coverage for millions of low-income Americans who purchased insurance through the federal marketplace.⁸ But the low-income subsidy is only part of the ACA's attempt to patch together health insurance coverage for all Americans.

¹ Lyndon B. Johnson, President of the U.S., Remarks at the Signing of the Independence of the Medicare Bill (July 30, 1965), in *CTRS. FOR MEDICARE & MEDICAID SERVS., CMS HISTORY PROJECT: PRESIDENTS' SPEECHES* 18, 22 (n.d.), <https://www.cms.gov/About-CMS/Agency-Information/History/downloads/CMSPresidentsSpeeches.pdf> [<http://perma.cc/XV4G-Z4GJ>].

² Mitt Romney, Former Governor of Mass., Speech at the Conservative Political Action Conference (Feb. 7, 2008), in *Associated Press, Mitt Romney Suspends Campaign*, N.Y. TIMES (Feb. 7, 2008), <http://www.nytimes.com/2008/02/07/us/politics/08romney-transcript.html> [<https://perma.cc/EH33-BURY>].

³ *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015); see James Taranto, Opinion, *Unconstitutional After All?*, WALL STREET J. (Feb. 27, 2015, 4:25 PM), <http://www.wsj.com/articles/unconstitutional-after-all-1425072324> (referring to *King* as one of the Term's most-watched cases).

⁴ *King*, 135 S. Ct. at 2487–88.

⁵ I.R.C. § 36B (2012); *King*, 135 S. Ct. at 2487 (discussing tax credit goals of I.R.C. § 36B).

⁶ *King*, 135 S. Ct. at 2487.

⁷ *E.g.*, Drew Altman, *How 13 Million Americans Could Lose Insurance Subsidies*, WALL STREET J.: WASH. WIRE (Nov. 19, 2014, 10:09 AM), <http://blogs.wsj.com/washwire/2014/11/19/how-13-million-americans-could-lose-insurance-subsidies> [<https://perma.cc/6CJP-C6EB>].

⁸ See *King*, 135 S. Ct. at 2496 (adopting reading of I.R.C. § 36B that allows the low-income subsidy for those who purchased insurance through federal marketplace).

Until recently, American health care was grounded in exclusion.⁹ People who had health insurance could access needed health care and those without health insurance often could not. The ACA reversed that norm, espousing a principle of inclusion or “universality” by facilitating universal health insurance coverage.¹⁰ Populations long excluded from coverage were embraced by two pillars of the statute: the low-income subsidy that was subject to the challenge in *King* and Medicaid expansion. Both have been subject to high-profile Supreme Court cases. Although the low-income subsidy survived its legal challenge, expanding Medicaid has been a far more contentious legal and political issue.

Congress designed the low-income subsidy and Medicaid to work together to provide health insurance to poorer Americans. Medicaid would catch those individuals who could not afford health insurance but were previously ineligible for the program, while tax subsidies would be available to people earning too much for Medicaid to assist them with purchasing private health insurance on newly created health insurance exchanges.¹¹ If the ACA were being measured by lives covered, then this architecture appears to be successful so far, notwithstanding ongoing debate. As of March 20, 2015, the Medicaid expansion covered an estimated 11.2 million lives,¹² and the private insurance available through health insurance exchanges covered an estimated eleven million lives, at least 86% of whom qualified for tax credit subsidies.¹³

⁹ See generally Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL’Y L. & ETHICS 67 (2015) (detailing the fragmented and exclusionary nature of health care in the United States).

¹⁰ The authors have called this important statutory principle “universality” in several prior works. See Nicole Huberfeld & Jessica L. Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 TOLEDO L. REV. 545, 546 (2015) [hereinafter Huberfeld & Roberts, *Empirical*]; Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 1 ILL. L. REV. SLIP OPS. 1, 2 (2014), <http://www.illinoislawreview.org/slip-opinions/Huberfeld/> [<https://perma.cc/7GA5-BMLD>] [hereinafter Huberfeld & Roberts, *Great Society*]; see also Huberfeld, *supra* note 9, at 68.

¹¹ RACHEL GARFIELD & ANTHONY DAMICO, KAISER FAMILY FOUND., THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID—AN UPDATE 1 (2015), <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update> [<https://perma.cc/E2N7-CZSS>].

¹² OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICAID ENROLLMENT AND THE AFFORDABLE CARE ACT 1 (2015), http://aspe.hhs.gov/sites/default/files/pdf/139236/ib_MedicaidEnrollment.pdf [<https://perma.cc/2K2J-AENG>].

¹³ Matthew Buettgens et al., *Marketplaces Make Significant Progress in 2015*, URBAN INST., <http://datatools.urban.org/features/marketplace-enrollment> [<https://perma.cc/8L7C-BJ2U>] (last updated Apr. 8, 2015) (projecting eleven million enrollees at the end of 2015 open enrollment); Robert Pear, *86 Percent of Health Law Enrollees Receive Subsidies, White House Says*, N.Y. TIMES (Mar. 11, 2015), <http://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html> [<https://perma.cc/7QJX-NBWP>]. If the measure is premiums paid, a more recent report indicates that about 10.2 million lives were covered as of the end of March 2015. See Press Release, U.S. Dep’t of Health & Human Servs., March Effectuated Enrollment Consistent

After the first round of enrollment under the ACA, approximately twenty million Americans gained health insurance that would have otherwise been unattainable,¹⁴ and that number appears to be even larger after the second round of enrollment.¹⁵ According to a Gallup analysis, uninsured rates in the first half of 2015 were the lowest they have been since 2008, at 11.4%, and the National Health Interview Survey indicated the rate of uninsurance was 9% of the population as of June 2015.¹⁶

The Medicaid expansion, though, has generated ongoing friction and negotiation within state political branches, as well as between the states and the federal government.¹⁷ When the Supreme Court left the decision to expand Medicaid to the states in the 2012 case *National Federation of Inde-*

with Department's 2015 Goal: Nearly 8.7 Million People Nationwide Received an Average Tax Credit of \$272 per Month to Make Their Health Coverage More Affordable (June 2, 2015), <http://www.hhs.gov/news/press/2015pres/06/20150602a.html> [<https://perma.cc/5RB2-B2FE>] (indicating 10.2 million persons had "paid for [m]arketplace coverage and still ha[d] an active policy" on March 31, 2015).

¹⁴ David Blumenthal & Sara R. Collins, *Health Care Coverage Under the Affordable Care Act—A Progress Report*, 371 NEW ENG. J. MED. 275, 280 (2014).

¹⁵ *See id.* at 277–78 (reporting eight million total enrollees through all marketplaces as of May 1, 2014); OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACES 2015 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT 1 (2015), https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf [<https://perma.cc/PT94-GB6Z>] (reporting nearly 11.7 million total enrollees through all marketplaces as of February 22, 2015).

¹⁶ MICHAEL E. MARTINEZ & ROBIN A. COHEN, CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2015, at 1 (2015), <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf> [<https://perma.cc/5UFF-F3SF>] (calculating uninsurance rates based on a poll of 54,097 individuals); Stephanie Marken, *U.S. Uninsured Rate at 11.4% in Second Quarter*, GALLUP (July 10, 2015), <http://www.gallup.com/poll/184064/uninsured-rate-second-quarter.aspx> [<https://perma.cc/98UF-Q8DX>] (reporting uninsurance rates based on a poll of 44,000 people over three months in 2015). Both reports are reliable, but the Centers for Disease Control ("CDC") estimate probably is more accurate because it relies on extensive Census Bureau data that are collected from all members of a household on a monthly basis rather than the single data point collection by a phone call performed by Gallup. CDC also measures health insurance coverage across three different time measures to account for the fluctuation in coverage that occurs regularly, especially among low-income populations. *See* MARTINEZ & COHEN, *supra*, at 9.

¹⁷ *See, e.g.*, Josh Barro & Margot Sanger-Katz, *Election Will Leave Medicaid Policies Largely Unchanged*, N.Y. TIMES: THE UPSHOT (Nov. 4, 2014), <http://www.nytimes.com/2014/11/05/upshot/election-results-2014-the-effect-on-medicaid-expansion.html> [<https://perma.cc/L7SC-ZCDY>]; Jason Millman, *The Election Might Keep Millions of People from Getting Health Insurance*, WASH. POST: WONKBLOG (Nov. 5, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/11/05/the-election-might-keep-millions-of-people-from-getting-health-insurance> [<https://perma.cc/C6PB-RFHP>]; Sam Stein & Jeffrey Young, *Medicaid Expansion for Millions Hinges on Key Governors' Races*, HUFFINGTON POST (Nov. 4, 2014, 10:59 AM), http://www.huffingtonpost.com/2014/11/04/medicaid-expansion-governors_n_6097024.html [<https://perma.cc/LK83-RPDB>]; John Tozzi, *Another Election Loser: Obamacare's Medicaid Expansion*, BUSINESSWEEK (Nov. 5, 2014), <http://www.businessweek.com/articles/2014-11-05/another-midterm-election-loser-obamacares-medicaid-expansion> [<https://perma.cc/4S3C-9JPP>].

pendent Business v. Sebelius (“*NFIB*”),¹⁸ many state politicians denounced expanding the program in an effort to solidify their political positions and to distance themselves from both health care reform and President Obama.¹⁹ Opponents of Medicaid expansion openly declared that providing health care to the “able-bodied” poor could encourage dependency, leading to antagonism toward Medicaid expansion in particular.²⁰ In this rhetoric, politicians implicitly employ an ideal of self-reliance, a value long embedded in the American political psyche.²¹ According to this widely held belief, any help from the government entails dependency, which conflicts with the ideals of freedom and self-sufficiency.²² Because autonomy has been a central value in American political culture, individuals who rely on state assistance face stigma labeling them as “dependent and failures.”²³

Those who oppose Medicaid expansion have capitalized on this trope, arguing that the program hurts, rather than helps, its beneficiaries and cre-

¹⁸ 132 S. Ct. 2566 (2012).

¹⁹ For a review of the reasons not to expand Medicaid cited by governors, see generally Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion—No Quick Resolution in Sight*, 368 NEW ENG. J. MED. 496 (2013). Not all Republican governors opposed Medicaid expansion in their states. *Id.* at 497. Eight states with Republican leadership agreed to the expansion. *Id.* For a deeper exploration of states’ decisions to expand Medicaid eligibility, juxtaposed with their decisions regarding health insurance exchanges, see generally Tom Baker et al., *The New Health Care Federalism: An Empirical and Theoretical Assessment of Federalism Dynamics in Health Care and Beyond* (Univ. of Pa. Law Sch., Pub. Law Research Paper No. 14-34, Yale Law Sch., Pub. Law Research Paper No. 525, 2014), <http://ssrn.com/abstract=2511003> [<https://perma.cc/Y4YL-RN4S>].

²⁰ See, e.g., Gray Rohrer, *House Kills Senate’s Health Care Expansion*, ORLANDO SENTINEL (June 5, 2015, 8:23 PM), <http://www.orlandosentinel.com/news/politics/os-special-session-day-five-20150605-story.html> [<https://perma.cc/KBT5-JKZK>] (“Opponents objected to the [Medicaid] bill because it relied too much on federal funds and would expand coverage to what they called ‘single, able-bodied adults.’”).

²¹ See, e.g., HENRY DAVID THOREAU, *Resistance to Civil Government*, in WALDEN AND RESISTANCE TO CIVIL GOVERNMENT 226 (William Rossi ed., W.W. Norton & Co. 2d ed. 1992) (1849). This essay produced such well-known thoughts as: “That government is best which governs not at all,” *id.*, “For government is an expedient by which men would fain succeed in letting one another alone; and, as has been said, when it is most expedient, the governed are most let alone by it,” *id.* at 227, “The progress from an absolute to a limited monarchy, from a limited monarchy to a democracy, is a progress toward a true respect for the individual. . . . There will never be a really free and enlightened State, until the State comes to recognize the individual as a higher and independent power, from which all its own power and authority are derived, and treats him accordingly,” *id.* at 245. Some perceive this not as anti-government but anti- “unjust” government. See, e.g., AARON BARLOW, *THE CULT OF INDIVIDUALISM* 138–39 (2013) (discussing Thoreau’s essay as a contemplation of the role of government in supporting the individual).

²² Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State*, 60 EMORY L.J. 251, 258–59, 258 n.26 (2011) (“The importance of the idea of independence to the construction of an autonomous and equal individual may be traced to the fact that the very existence of the United States begins with a document entitled ‘The Declaration of Independence.’”).

²³ *Id.* at 259.

ates a socially undesirable state of dependency.²⁴ In states that have already expanded Medicaid, politicians have sought ways to link Medicaid to work requirements,²⁵ even though Medicaid was delinked from welfare in 1996 and two-thirds of the people who qualify for expansion have at least one worker in the household.²⁶ In their rhetoric and proposed policies, politicians have therefore mirrored many either-or dichotomies associated with the American myth of self-reliance, such as construing individuals as either workers or paupers who either work or receive benefits, respectively.

Exclusionary policymaking is nothing new,²⁷ but undermining the ACA's attempt at universal coverage has substantial consequences beyond grandiloquence. The reluctance of some states to expand Medicaid has led

²⁴ See Sommers & Epstein, *supra* note 19, at 498 (“For instance, Dennis Dugaard (R-SD) declared that ‘able-bodied adults should be self-reliant’—in contrast to children or people with disabilities, the traditional Medicaid beneficiaries.”); see also Tara Culp-Ressler, *Scott Walker: Denying Health Care to Low-Income People Helps Them ‘Live the American Dream,’* THINKPROGRESS (Nov. 14, 2014, 11:18 AM), <http://thinkprogress.org/health/2014/11/14/3592511/scott-walker-medicaid-expansion> [<https://perma.cc/L5JR-KFPX>] (“Wisconsin Gov[ernor] Scott Walker (R) on Friday suggested that denying health coverage to additional low-income Americans helps more people ‘live the American Dream’ because they won’t be ‘dependent on the American government.’”); Brendan Kirby, *Governor Bentley Offers Unapologetic Defense of Decision to Reject Medicaid Expansion*, AL.COM: BLOG (Jan. 14, 2014, 8:35 PM), http://blog.al.com/wire/2014/01/governor_bentley_offers_unapol.html [<https://perma.cc/E6P6-QTW7>] (quoting Governor Robert Bentley of Alabama as saying “[a]nd under Obamacare, Medicaid would grow even larger—bringing millions more people to a state of dependency on government”).

²⁵ The first state to seek a Medicaid-work linkage in its expansion waiver was Pennsylvania. Associated Press, *Pennsylvania Awaits Ruling on Proposal to Link Work Requirements to Medicaid Benefits*, PBS NEWS HOUR (Apr. 27, 2014, 1:06 PM), <http://www.pbs.org/newshour/rundown/pennsylvania-awaits-ruling-proposal-link-work-requirements-medicaid-benefits> [<https://perma.cc/W28R-DGXA>]. Even though the U.S. Department of Health and Human Services (“HHS”) rejected the linkage between work and Medicaid, other states have continued to push it; for example, Missouri’s Governor touted work requirements while considering expansion. Jordan Shapiro, *Missouri Gov. Endorses Work Requirement as Part of Medicaid Expansion Plan*, KAISER HEALTH NEWS (Mar. 12, 2015), <http://khn.org/news/missouri-gov-endorses-work-requirement-as-part-of-medicaid-expansion-plan> [<https://perma.cc/MKC4-8MBH>]; see also Letter from Marilyn Tavenner, Office of the Adm’r, Ctrs. for Medicare & Medicaid Servs., to Beverly Mackereth, Sec’y, Pa. Dep’t of Pub. Welfare 2 (Aug. 28, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf> [<https://perma.cc/R6P7-VWPJ>] (approving a demonstration waiver but not work requirements related to Medicaid expansion). Most recently, Montana expanded its Medicaid program through a § 1115 waiver, and it included job training (but not work requirements per se) in the rules for newly eligible enrollees. Sanjay Talwani, *Montana Medicaid Expansion Earns Key Federal Approval*, KRTV.COM (Nov. 2, 2015, 7:44 PM), <http://www.krtv.com/story/30414878/montana-medicaid-expansion-earns-key-federal-approval> [<https://perma.cc/5FVL-MKPB>].

²⁶ KAISER COMM’N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., KEY FACTS ABOUT THE UNINSURED POPULATION 5 fig.4 (2014), <http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet> [<https://perma.cc/LRU4-95BR>] [hereinafter KEY FACTS ABOUT THE UNINSURED] (noting that in 2013, 71% of nonelderly uninsured households had one or more full-time workers).

²⁷ See generally Huberfeld, *supra* note 9 (discussing exclusionary practices in health care).

to an insurance coverage gap for individuals who make too much to be eligible for a non-expanded Medicaid program yet not enough to qualify for the ACA's premium assistance tax subsidies—what one of the authors has dubbed the problem of the penultimate poor.²⁸ As a result of states' opting out of the expansion, more than six million people are not eligible for Medicaid.²⁹

In contrast, hidden government assistance—which is to say, subsidies funneled through the tax system—invites far less of what this Article will call “self-reliance scrutiny” than visible public assistance. Tax-free employer-provided benefits are rarely discussed as a government subsidy for purchasing health insurance.³⁰ Likewise, the ACA's low-income subsidy has garnered far less criticism than Medicaid expansion. In fact, Congress designed the ACA to push most people into private insurance—even when that insurance is highly subsidized by the government—because it seems more politically desirable.³¹ Yet despite their perceived differences, Medicaid and the low-income subsidy are substantially similar in nature. They are both government programs designed to secure health insurance for low-to-middle income individuals with minimal cost-sharing for those who are too poor to buy into the system.

Despite the vitriol directed at Medicaid and the relative acceptance of the low-income subsidy, both government programs serve largely the same populations. This Article argues that Medicaid expansion and the low-income subsidy are effectively the same: they have similar goals and operate in sim-

²⁸ See Garfield & Damico, *supra* note 11 (discussing the coverage gap); Nicole Huberfeld, *Penultimate Poor and the Individual Mandate*, HEALTHLAWPROF BLOG (Jan. 31, 2013), http://lawprofessors.typepad.com/healthlawprof_blog/2013/01/penultimate-poor-and-the-individual-mandate.html [<https://perma.cc/LY3A-HYB4>].

²⁹ See CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 3 (2012), <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> [<https://perma.cc/HF3U-2DEG>].

³⁰ See Joseph Antos, Opinion, *End the Exemption for Employer-Provided Health Care*, N.Y. TIMES (Apr. 14, 2015, 6:45 AM), <http://www.nytimes.com/roomfordebate/2015/04/14/the-worst-tax-breaks/end-the-exemption-for-employer-provided-health-care> [<https://perma.cc/P5QL-DP3L>]. As one scholar explained,

The largest tax break in the federal tax code is a stealth subsidy that is both unfair and inefficient. Premiums paid for employer-sponsored health insurance are excluded from taxable income, reducing the amount workers owe in income and payroll taxes by about \$250 billion annually. In effect, the exclusion is the third largest health program after Medicare and Medicaid, yet it has been largely ignored as Congress has tried to rein in federal health spending.

Id.

³¹ PAUL STARR, REMEDY AND REACTION 20–21, 194 (rev. ed. 2013) (describing the choice to build health care reform on private insurance coverage).

ilar ways. First, this Article disputes, on a theoretical level, the American myth of self-reliance and the perceived divide between good citizens with private insurance and socially undesirable dependents with public benefits. Vulnerability theory challenges the notion that human beings are autonomous, independent actors, instead arguing that we are all susceptible to illness, injury, and disability.³² Viewed through this lens, the Medicaid expansion and the low-income subsidy are examples of the state responding to the same universal needs of its citizens. Next, this Article challenges the dividing line between visible and hidden government assistance on a practical level. Research indicates that, under the current system, the same individuals bounce back and forth between the public and private systems. In fact, the difference between being labeled a socially undesirable dependent who must rely on Medicaid and a good working citizen who purchases private—albeit highly subsidized—coverage can be as little as a few days of pay per year. Hence, this Article asserts that no principled, meaningful difference exists between government assistance in health insurance via a visible benefit, like Medicaid, and government assistance in health insurance via a hidden benefit, like the low-income subsidy.

Having demonstrated that the line between hidden and visible benefits is both theoretically and empirically unsound, this Article contemplates a unified government program for providing health insurance for low-income Americans. Not only would a single system break down some of the stigma associated with dependency, it would also be more financially and administratively efficient, as individuals would no longer need to cycle between public and private benefits. Importantly, this Article does not answer the question of whether Medicaid and the low-income subsidies create economic dependence or facilitate economic independence. That question is better left to social scientists and economists.³³ Instead, this Article simply argues that a single benefits system for low-income individuals—whether Medicaid-based or subsidy-based—would have meaningful social and practical benefits.

³² See *infra* notes 188–269 and accompanying text (examining vulnerability theory and what it can teach about the flawed dichotomy between dependence and self-reliance).

³³ Research finds that social insurance programs facilitate financial independence for beneficiaries as well as tax benefits for government. See generally, e.g., David W. Brown et al., *Medicaid as an Investment in Children: What Is the Long-Term Impact on Tax Receipts?* (Nat'l Bureau for Econ. Research, Working Paper No. 20,835, 2015), <http://www.nber.org/papers/w20835.pdf> [<https://perma.cc/2XMR-N2EB>] (discussing Medicaid's significant long term economic benefits for beneficiaries and for the government); Laura R. Wherry et al., *Childhood Medicaid Coverage and Later Life Health Care Utilization* (Nat'l Bureau for Econ. Research, Working Paper No. 20,929, 2015), http://harris.uchicago.edu/sites/default/files/WherryMillerKaestnerMeyer_9-25-2015.pdf [<https://perma.cc/84XY-4T4Y>] (finding that extended coverage for children under Medicaid's 1983 amendments correlated with lower medical utilization as adults).

This Article proceeds in three Parts. Part I considers the history of exclusion in American health care that led to our divided system of government assistance, made up of highly visible direct funding and hidden tax subsidies.³⁴ This Part asserts that despite their substantive similarities, one has been stigmatized while the other has not. Part II outlines the American myth of self-reliance and its associated assumptions and dichotomies, demonstrating how the division between visible and hidden government benefits for health insurance parallels those dyads.³⁵ Part II goes on to debunk the myth of self-reliance, both theoretically and empirically, arguing that the dividing line explored in Part I is unprincipled at best and harmful at worst. Finally, Part III concludes that it would be more efficient both economically and administratively for individuals to be covered by one program, contrary to the current structure of the law, which facilitates needless bouncing between two unconnected and complex systems for people in already fragile circumstances.³⁶ Part III considers possibilities for unified coverage, exploring the benefits and drawbacks of either an all-subsidy program or an all-Medicaid program in light of the principle of universality.

I. DIVIDED GOVERNMENT ASSISTANCE IN HEALTH CARE

This Part presents the origins of our divided system of visible and hidden government assistance in health insurance. Despite the substantial similarities between these two kinds of government aid, one is highly stigmatized while the other is socially and politically accepted. The dividing line between visible public health insurance and hidden subsidies in private health insurance has facilitated a story of self-reliance for people who are in the private market, and that dividing line remains powerful even in the new era of universality in health insurance access and coverage. This Part will explore the visible and hidden supports for health insurance access and the narratives regarding self-reliance that they have encouraged over time.

A. Visible Government Assistance

Direct federal funding is the most familiar form of government assistance because it is the most visible. The federal government has created various medical safety net programs since the New Deal, and today every

³⁴ See *infra* notes 37–104 and accompanying text (examining the historical development of the current bifurcated government assistance systems).

³⁵ See *infra* notes 105–270 and accompanying text (exploring current government supports for health insurance in light of the self-reliance myth and vulnerability theory).

³⁶ See *infra* notes 271–320 and accompanying text (advocating a move to one healthcare-support system and exploring possibilities therefor).

American has a family member, friend, or coworker who benefits from them, particularly Medicare and Medicaid. Although Medicare, Medicaid, and other more minor federal health care programs are not cohesive as a cohort of federal statutes,³⁷ they still manage to cover a significant portion of the American population's health care needs. Combined, Medicare and Medicaid cover 37% of the nation's total population, 43% of the insured population,³⁸ and represent approximately 35% of national health expenditures.³⁹ Medicaid now covers more insureds than Medicare, at nearly 71 million lives and 16% of national health expenditures,⁴⁰ whereas Medicare covers 55 million lives (46.3 million elderly and 9 million people with disabilities) and accounts for approximately 22% of national health expenditures.⁴¹ Each program is worth considering in its own right and in comparison to the other.

Medicare is a national social insurance program that covers people aged sixty-five and over and those who are permanently disabled, regardless of their wealth, state of residence, or other status.⁴² Impoverishment of the elderly was commonplace by the 1950s; by attacking the risk represented by that basic, economic measure from its passage in 1965 until today, Medicare has been demonstrably successful in lifting most of our elderly population out of poverty caused by medical expenses.⁴³ Despite being the closest thing Americans have to the oft-vilified "socialized medicine," Med-

³⁷ See Abbe R. Gluck, *Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 1, 16 (2015) (suggesting that Congress's committee structure may be responsible for this lack of coherence).

³⁸ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., FISCAL YEAR 2014 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 2, <http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf> [<https://perma.cc/XU2P-N2VP>] (stating Medicare, Medicaid, and Children's Health Insurance Program cover 116 million beneficiaries).

³⁹ See *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> [<https://perma.cc/TL34-RTG8>] (last updated July 28, 2015). National Health Expenditure data indicate that as of 2013, Medicare paid 20% of national health expenditures and Medicaid paid 15%, but that includes the states' contribution to Medicaid funding. *Id.*

⁴⁰ JULIA PARADISE, KAISER FAMILY FOUND., MEDICAID MOVING FORWARD 1 (2015), <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward> [<https://perma.cc/62KD-SYTL>].

⁴¹ JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., A PRIMER ON MEDICARE 1 (2015), <http://files.kff.org/attachment/report-a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers> [<https://perma.cc/59AS-8HP4>] (number of lives covered); *id.* at 30 fig.26 (percentage of national health expenditures).

⁴² 42 U.S.C. § 1395c (2012) (establishing eligibility criteria for Medicare's hospital and hospice care provisions).

⁴³ Ezekiel Emanuel, *Symposium Keynote Speech*, 15 YALE J. HEALTH POL'Y L. & ETHICS 27, 30 (2015) ("[I]n 1964, just about 30% of the elderly were living in poverty . . . , even with Social Security [W]ith the combination of Medicare and the increases in Social Security, . . . 9% of the elderly are in poverty. It is the lowest demographic in the United States in poverty.").

icare is also politically popular.⁴⁴ In fact, Congress intentionally removed medical care for the elderly from welfare-based state control due to effective lobbying by the elderly, who argued that they should not be subject to the whims of states' welfare-oriented programming, which was often financially inconsistent and sometimes punitive in attitude.⁴⁵ Medicare thus created a national, universal approach to insuring the elderly by recognizing the commonly shared risk related to vulnerability in old age and creating a program that would respond at a low cost to beneficiaries' medical needs.

Medicare's universal approach does not allow for stigma. In part, this may result from the fact that people must have paid work-related taxes for forty quarters in order to automatically qualify for Medicare Part A at age sixty-five.⁴⁶ For all of its universalism, Medicare is still a work-related program.⁴⁷ But it also draws on the public's understanding and hope that all of us will become elderly, and none of us want to be impoverished when that day comes. Medicare draws on a principle of solidarity, the polar opposite of stigma, in addition to universality. In its inclusive approach to medical care, Medicare could be viewed as an exceptional program in America's pantheon of health care legislation and policy, which typically has drawn on the American ideal of self-reliance to create limited, non-universal benefits, discussed in the context of Medicaid below.

In contrast, Congress designed Medicaid to facilitate health care access for specific groups deemed worthy of public assistance.⁴⁸ Medicaid was enacted with the same pen stroke as Medicare, but the two programs are structurally and politically dissimilar. Medicare is administered and funded entirely by the federal government (with the help of regional private contractors), and it is structured as federal spending subject to federal policy. In

⁴⁴ The American Medical Association ("AMA") and free-market-oriented politicians always have challenged health care reform that would cover more of the population with government assistance by issuing the rallying cry of "socialized medicine." See, e.g., ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* 52 (1974) (describing fear that Medicaid would establish "socialized medicine"); Am. Med. Ass'n, *Ronald Reagan Speaks Out Against Socialized Medicine*, YOUTUBE (Aug. 1, 2007), <https://www.youtube.com/watch?v=fRdLpemaAAs> (initially distributed by AMA in 1961 to rally opposition to Medicare by decrying socialized medicine). See generally STARR, *supra* note 31 (recounting the AMA's fight against health care reform through the twentieth century and up to the passage of the ACA).

⁴⁵ See STEVENS & STEVENS, *supra* note 44, at 45–47 (describing various predecessors and contemporary counterproposals to Medicare).

⁴⁶ See 42 U.S.C. § 1395c (granting Medicare eligibility to, among others, those age sixty-five or over who are eligible for Social Security).

⁴⁷ Those who do not meet the forty-quarter minimum can purchase Part A coverage upon turning sixty-five, but the point remains the same—America's social insurance is still a program for those who have played by the rule of self-sufficiency by working.

⁴⁸ See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 432 (2011) (describing Medicaid as "the caboose to Medicare's train").

contrast, Medicaid has been considered a quintessential cooperative federalism program, a joint state-federal endeavor, underwritten and designed by the federal government but administered by each state with some state funding as well as state options to expand the program beyond the federal minimum requirements.⁴⁹

Medicaid differs dramatically from Medicare not only from governance and funding perspectives but also in the principles the program historically embodied. When Congress enacted Medicaid in 1965, the program covered only the “deserving poor,” meaning the elderly, disabled, pregnant women, and children.⁵⁰ The original Medicaid eligibility rules reflected the Elizabethan notion that only those blameless for their circumstances were worthy of aid.⁵¹ The deserving poor were not deemed to be culpable for their inability to care for themselves and, consequently, were “deserving” of government assistance.⁵² Not surprisingly, Medicaid did not render eligible childless, non-disabled, working-age adults.⁵³

The idea that social policies should discourage dependence is nothing new; self-reliance is a long-standing American ideal, as discussed at greater length in Part II.⁵⁴ The narrative of dependence as culturally undesirable is so strong, though, that at the same time “deserving” status rendered Medicaid enrollees worthy of redistributive federal assistance, it imposed stigma even beyond that typically attributable to poverty.

Further, states’ fiscal policies have facilitated the prejudice Medicaid enrollees have faced. Historic efforts to address poverty through responsive governmental support show that states consistently have underfunded programs designed to assist the poor.⁵⁵ In the case of Medicaid, this has meant

⁴⁹ 42 U.S.C. §§ 1396a–1396f (2012) (establishing a federalist structure in part through funding from Comptroller General of the United States and review of state policies).

⁵⁰ STEVENS & STEVENS, *supra* note 44, at 8, 24, 51–53 (discussing the formation of Medicaid).

⁵¹ Huberfeld, *supra* note 48, at 439–40 (describing the evolution of the concept of the “deserving poor”).

⁵² *Id.* at 439 (stating that “[c]ertain categories of blameless or ‘deserving’ poor have been assisted by local, state, or federal government since the turn of the twentieth century”).

⁵³ See STEVENS & STEVENS, *supra* note 44, at 57 (describing those eligible for Medicaid as “families with dependent children and . . . aged, blind or permanently disabled individuals [unable to afford medical care]”).

⁵⁴ See *infra* notes 105–187 and accompanying text (examining self-reliance as an enduring American mythological ideal).

⁵⁵ See generally Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, in THE URBAN UNDERCLASS 411 (Christopher Jencks & Paul E. Peterson eds., 1991) (discussing how many major government efforts to combat poverty have faltered).

low funding that leads to below-norm payment rates for providers.⁵⁶ Low reimbursement rates have a signaling effect, hinting that states view these patients as not warranting health care providers' full efforts. Low payment in Medicaid is, like other welfare programs, a remnant of the Elizabethan fear of prolonged dependence and permanent pauperism. It also reflected fear southern states expressed in the passage of the Social Security Act and subsequent related programs that poor African-Americans would rely on states for support and that the federal money supporting them would expedite desegregation.⁵⁷ For these and other reasons, welfare programs have long been underfunded in the United States, and that underfunding has contributed to Medicaid's stigma.⁵⁸

Fast forward to the ACA, in which Congress created a universal insurance coverage architecture that expanded Medicaid eligibility and promised states generous funding for the newly eligible population's entry into Medicaid.⁵⁹ More specifically, the ACA mandated expansion of Medicaid eligibility to all adults under age sixty-five with incomes up to 133% of the federal poverty level ("FPL").⁶⁰ For the first time, the expansion includes non-disabled, non-elderly, childless adults in Medicaid. The federal government

⁵⁶ Nicole Huberfeld, *The Supreme Court Ruling That Blocked Providers from Seeking Higher Medicaid Payments Also Undercut the Entire Program*, 34 HEALTH AFF. 1156, 1157 (2015) (discussing Medicaid's historic low payment and its potential effect on the success of expansion).

⁵⁷ EDWIN E. WITTE, *THE DEVELOPMENT OF THE SOCIAL SECURITY ACT* 143-44 (1962). Witte wrote:

Title I of the original bill was very bitterly attacked, particularly by Senator Byrd, on the score that it vested in a federal department the power to dictate to the states to whom pensions should be paid and how much. In this position, Senator Byrd was supported by nearly all of the southern members of both committees, it being very evident that at least some southern senators feared that this measure might serve as an entering wedge for federal interference with the handling of the Negro question in the South. The southern members did not want to give authority to anyone in Washington to deny aid to any state because it discriminated against Negroes in the administration of old age assistance.

Id.

⁵⁸ See generally DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY 1965-2007* (2008) (highlighting historical biases, legislation, and policies that contribute to Medicaid's stigma, as expressed in underfunding and other programmatic weaknesses).

⁵⁹ Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of U.S.C. tits. 18, 20-21, 25-26, 28-31, 35, 42 (2012)). Congress amended the ACA immediately by the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of U.S.C. tits. 20, 26, 42 (2012)). This Article refers to the two Acts collectively as the ACA.

⁶⁰ ACA § 2001, 124 Stat. at 271. As modified by the HCERA, the Medicaid expansion includes individuals earning up to 138% of the FPL due to a 5% income disregard. HCERA § 1004(e), 124 Stat. at 1036. This Article accounts for this adjustment by referring to the expansion level as 138% of the FPL.

completely funds the expansion through 2017, gradually decreasing the federal match to 90% by 2020 (the “supermatch”). Even when reduced in 2020, the supermatch is greater than the Medicaid funding states have received historically, which is tied to per capita income and ranges from no less than 50% to approximately 78% federal funding on the state dollar.

Nearly one in four Americans will have medical care and costs covered by the Medicaid program when it has been fully expanded pursuant to the ACA.⁶¹ The Medicaid expansion responded to America’s high levels of uninsurance (more than one-fifth of the population when the ACA was passed) as well as the fact that most of the uninsured were low-income working poor who either were not offered health insurance as an employment benefit or were offered health insurance that is unaffordable. As with past Medicaid amendments, this expansion responded to state inability (or unwillingness) to cover low-income citizens who needed consistent access to health care.

The promise of full federal funding for the newly eligible population enticed some states to expand their Medicaid programs; however, half of the states challenged the constitutionality of the Medicaid expansion, resulting in the Supreme Court’s decision in *NFIB*.⁶² That judgment gave states the power to ignore the ACA’s mandated Medicaid expansion without other penalties, effectively rendering the Medicaid expansion optional by limiting the Federal Department of Health and Human Services’ (“HHS”) ability to enforce its own statute. To date, thirty states and the District of Columbia have decided to participate in expansion. The remaining states are more slowly negotiating their expansions internally and through the waiver process with HHS.

The ACA rejected Medicaid’s exclusionary approach to health care coverage, but *NFIB*-empowered states are resisting the principle of universality in their discussions with HHS.⁶³ State politicians have displayed reticence to opt into Medicaid expansion based on bias against those historically deemed unworthy of governmental assistance, mainly the “able-bodied” poor. Some examples of this bias have included: “It was never designed to

⁶¹ See CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024, at 58 (2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf [<https://perma.cc/R4PZ-35EK>] (projecting enrollment of eighty-nine million individuals in Medicaid by 2024).

⁶² 132 S. Ct. at 2580, 2581, 2606–07. Twenty-six states challenged the Affordable Care Act. *Id.* at 2580. These challengers specifically questioned the Medicaid expansion. *Id.* at 2581. Eventually the Court’s decision severely limited the power of the Medicaid expansion. *See id.* at 2606–07.

⁶³ Huberfeld, *supra* note 9, at 85.

be there for able-bodied adults.”⁶⁴ “[Medicaid] creates a new welfare entitlement system for able-bodied working adults.”⁶⁵ “I’d rather find a way, particularly for able-bodied adults without children, . . . to get them into the workforce.”⁶⁶ And, most recently, regarding failed legislation in Florida, “Opponents objected to the bill because it relied too much on federal funds and would expand coverage to what they called ‘single, able-bodied adults.’”⁶⁷

Additionally, state politicians have expressed concern that Medicaid expansion will lead to “dependency” (ostensibly rather than working). Politicians have stated, for example: “We can break the cycle of poverty, but not with programs that drag our communities and our people into the downward spiral of dependence,”⁶⁸ and, “Imagine what we could do if we took a good chunk of that money and put it toward job training.”⁶⁹ Part II demonstrates that this perception of low-income Americans who need health insurance as non-workers is measurably false, but these statements still matter. Although on the surface they appear to be political theater in the name of American individualism,⁷⁰ this viewpoint is being incorporated into Republican proposals for variations on the Medicaid expansion. Some red states have tried to include work requirements in their expansion negotiations and plans. HHS cannot approve the incorporation of work requirements into a § 1115 waiver for Medicaid expansion because it is unrelated to the Medicaid Act’s

⁶⁴ Greg Richter, *Bobby Jindal: Medicaid Expansion Robs People of Private Insurance*, NEWSMAX (Nov. 16, 2014, 11:30 AM), <http://www.newsmax.com/Newsfront/bobby-jindal-medicaid-insurance-private/2014/11/16/id/607634> [<https://perma.cc/5UPG-QJCF>] (reporting remarks of Governor Bobby Jindal of Louisiana on “Meet the Press”).

⁶⁵ Laura Vozzella, *Va. House GOP Budget Plan to Include Health Funds for Mentally Ill, Poor*, WASH. POST (Feb. 5, 2015), https://www.washingtonpost.com/local/virginia-politics/va-house-gop-budget-plan-to-include-health-funds-for-mentally-ill-poor/2015/02/05/84d14a0a-ad62-11e4-9c91-e9d2f9fde644_story.html [<https://perma.cc/MW76-43EQ>] (quoting remarks of Steve Landes, Vice Chairman of Appropriations Committee of Virginia House of Delegates).

⁶⁶ Sarah Ferris, *Gov. Walker Faces Growing Pressure Over Medicaid Expansion*, THE HILL (Feb. 17, 2015, 12:54 PM), <http://thehill.com/policy/healthcare/232962-new-medicaid-cost-estimates-add-pressure-to-scott-walker> [<https://perma.cc/NK2D-LFXH>] (reporting remarks by Governor Scott Walker of Wisconsin).

⁶⁷ Rohrer, *supra* note 20 (quoting multiple legislative opponents of a bill that would have accepted the Medicaid expansion).

⁶⁸ Robert Bentley, Governor of Ala., State of the State Address (Jan. 14, 2014), <http://governor.alabama.gov/newsroom/2014/01/governor-bentleys-2014-state-state-address> [<https://perma.cc/346P-DN34>].

⁶⁹ *Medicaid Redesign Proposal Stalls*, UNICAMERAL UPDATE (Apr. 9, 2015), <http://update.legislature.ne.gov/?p=17048> [<https://perma.cc/KY5W-K6HG>] (quoting State Senator Beau McCoy in the Nebraska legislative session).

⁷⁰ See David W. Johnson & Nancy M. Kane, *The U.S. Healthcare System: A Product of American History and Values*, in *THE FRAGMENTATION OF U.S. HEALTH CARE* 323 (Einer R. Elhauge ed., 2010) (discussing the role of American individualism in the health care system as a whole).

provision of “medical assistance,” yet some states are still considering their own side-along work requirements for the newly eligible Medicaid population.⁷¹

Even though Medicaid was decoupled from welfare in 1996, the expansion’s universality is being distorted into a return to castigatory welfare-style requirements. The work and dependency rhetoric draw heavily on the myth of self-reliance, as discussed in Part II. Although the ACA rejected the notion that only some individuals are worthy of assistance in its universalism, states are reintroducing that narrative thanks to *NFIB*.⁷² This trend stands in sharp contrast to the indirectly funded, employer-based, private health insurance system, discussed next in section B.

B. Hidden Government Assistance

Unlike the disdain for the visible assistance described above, private insurance coverage has carried an air of belonging and acceptance; people with private health insurance most often obtain it through their employers, an arrangement encouraged through longstanding federal tax subsidies to both employers and employees. In many ways, private insurance connotes playing by the rules, while public insurance (except for Medicare) connotes shirking.

Although programs like Medicare and Medicaid appear to be paradigmatic government-assisted health insurance, federal tax policy has enabled broad access to health insurance coverage for decades, and for a large portion of the population, albeit indirectly through employer-based health insurance benefits. The hidden nature of tax benefits, in addition to the narrative that people who purchase private insurance are self-reliant, has rendered this form of subsidy for private health insurance less politically charged.

But the economic reality of tax subsidization of private health insurance is masked. In part, this indirect source of federal assistance is hidden because the annual federal accounting of “National Health Expenditures”

⁷¹ See Drew Altman, *Behind the Split Over Linking Medicaid Coverage to Work Requirements*, WALL STREET J.: WASH. WIRE (May 11, 2015, 9:55 AM), <http://blogs.wsj.com/washwire/2015/05/11/behind-the-split-over-linking-medicaid-coverage-to-work-requirements> [<https://perma.cc/PUF4-7JQ7>] (discussing various states’ proposals or work requirements for the newly eligible Medicaid expansion population).

⁷² KAISER COMM’N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., ARE UNINSURED ADULTS WHO COULD GAIN MEDICAID COVERAGE WORKING? 1–2 (2015), <http://files.kff.org/attachment/fact-sheet-are-uninsured-adults-who-could-gain-medicaid-coverage-working> [<https://perma.cc/S8T4-VFQG>] [hereinafter UNINSURED ADULTS] (discussing the red state drive for work requirements in implementing Medicaid eligibility expansion under the ACA and the demographics of the uninsured population relative to work status).

published by the Centers for Medicare and Medicaid Services does not include tax incentives in its tally.⁷³ Instead, the report examines household, federal government, state and local government, and private business spending on health care.⁷⁴ Additionally, most private health insurance is obtained as an employment benefit, and employees notoriously do not notice how much they and their employer contribute to their private insurance, let alone how much the federal government subsidizes that insurance through tax breaks.⁷⁵ In a 2002 Harvard study, researchers determined that the federal government accounts for nearly sixty percent of health spending when tax incentives are counted in federal government spending, rather than just “who wrote the last check.”⁷⁶ Thus, this Article calls private insurance subsidies—whether they pre-date or post-date the ACA—“hidden government assistance.” This section considers, briefly, the history and nature of hidden government assistance for private health insurance as well as the ACA’s reliance on this preexisting system of subsidies.

Since the early 1900s, cash-payment medical care has been too expensive for low- and middle-income Americans.⁷⁷ Presidents since Theodore Roosevelt have attempted to address the problem of high medical costs, recognizing that low-income families were suffering due to costly hospital and physician bills.⁷⁸ Franklin D. Roosevelt attempted to address health insurance in the social insurance manner that European nations were offering it, and Harry Truman took up the health insurance fight during his presidency.⁷⁹ At the key moment after World War II when other nations were establishing national health care systems, national health insurance in the United States was

⁷³ See, e.g., *National Health Expenditures 2013 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf> [<https://perma.cc/F842-NARR>].

⁷⁴ *Id.*

⁷⁵ To make this information more transparent, the ACA required that W-2 forms include the value of health insurance as a specific line item. See *Form W-2 Reporting of Employer-Sponsored Health Coverage*, INTERNAL REVENUE SERV., <http://www.irs.gov/Affordable-Care-Act/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage> [<https://perma.cc/EGU7-GKLN>]; see also Robert Pear, *To Open Eyes, W-2s List Cost of Providing a Health Plan*, N.Y. TIMES (Jan. 29, 2013), <http://www.nytimes.com/2013/01/30/health/to-open-eyes-w-2s-list-cost-of-health-plans.html> [<https://perma.cc/Z3BE-LDKN>] (reporting on the new W-2 information designed to enlighten employees as to the value of their health insurance).

⁷⁶ Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, 21 HEALTH AFF. 88, 88 (2002).

⁷⁷ See STARR, *supra* note 31, at 36–37; PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235–89 (1982) [hereinafter STARR, THE SOCIAL TRANSFORMATION] (examining political and sociological factors that defeated efforts for a national health insurance program in the early to mid-1900s).

⁷⁸ See STARR, THE SOCIAL TRANSFORMATION, *supra* note 77, at 243 (discussing Theodore Roosevelt’s interest).

⁷⁹ See STARR, *supra* note 31, at 39–40.

defeated by a variety of factors, including political and ideological barriers, public ambivalence about appropriate methods for addressing medical expenses, and the American Medical Association's "socialized medicine" bugaboo.⁸⁰

Instead, health insurance as an employment benefit became an American phenomenon, wherein the federal government encourages employers to offer health insurance benefits by deeming them a business expense that is excluded from taxable income.⁸¹ Simultaneously, employees are encouraged to accept this benefit because the value of the health insurance coverage is excluded from taxable income.⁸² This subsidy system has been successful from the perspective that a majority of Americans obtain health insurance through their employers (53.9% of the population as of 2013).⁸³ But this percentage has been decreasing through the last decade or more, in part giving rise to the high levels of uninsurance that precipitated the ACA's enactment.⁸⁴

The Congressional Budget Office ("CBO") has called tax subsidies for employment-based health insurance the "largest single tax expenditure by the federal government."⁸⁵ As of 2013, the CBO valued this tax subsidy at \$248 billion, not including the tax deduction taken by self-employed individuals (valued at about \$6 billion).⁸⁶ Though rarely discussed as such, this tax subsidy is concrete financial support for access to health care through subsidized private health insurance. Yet when it is raised as part of health reform or other political conversations, rather than expressing concern regarding dependency or entitlement, the tax subsidy tends to be critiqued in terms of moral hazard (insurance overuse), unequal cost burdens (less af-

⁸⁰ See *id.* This is a too-pithy summary of a long history; for an extensive historical and sociological account, see generally STARR, *THE SOCIAL TRANSFORMATION*, *supra* note 77.

⁸¹ See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 *YALE J. HEALTH POL'Y L. & ETHICS* 23, 25–26 (2001) (explaining the history of employer-based health insurance).

⁸² See I.R.C. § 106(a) (2012) ("[G]ross income of an employee does not include employer-provided coverage under an accident or health plan.").

⁸³ JESSICA C. SMITH & CARLA MEDALIA, U.S. CENSUS BUREAU, *HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2013*, at 2 (2014), <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf> [<https://perma.cc/KPX2-P7RX>].

⁸⁴ See, e.g., NAT'L INST. FOR HEALTH CARE MGMT., *EMPLOYER-SPONSORED HEALTH INSURANCE: RECENT TRENDS AND FUTURE DIRECTIONS 2* (2013), <http://www.nihcm.org/images/pdf/Employer-Sponsored-Health-Insurance-v2-data-brief.pdf> [<https://perma.cc/8K9Z-C28R>] (documenting the decline in employer-sponsored health insurance coverage, from 69.3% in 2000 to 58.4% in 2011).

⁸⁵ CONG. BUDGET OFFICE, *OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023*, at 244 (2013), <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf> [<https://perma.cc/3XXG-QEJH>].

⁸⁶ *Id.*

fordable for lower wage earners), or fostering inefficiency (employers have no special expertise as health care intermediaries).⁸⁷

The ACA builds on the employment-based private health insurance system in a number of ways in an effort to achieve universal insurance coverage.⁸⁸ For example, large employers (already highly likely to provide health insurance as an employment benefit) must pay a penalty if they do not offer health insurance at all or if the insurance they offer is unaffordable, and their employees purchase tax-subsidized insurance on an exchange.⁸⁹ The ACA further fortifies employment-based insurance, especially for small employers (those with fewer than fifty employees, which are much less likely to offer health insurance benefits),⁹⁰ by creating special mechanisms for small businesses to offer affordable health insurance benefits to their employees in small groups, which have historically had to pay higher premiums.⁹¹ These legislative provisions entrenched reliance on the employer-based, private insurance model by requiring certain employment benefits, which was historically deemed voluntary on the part of the employer. Further, the “individual mandate” facilitates this entrenchment by increasing the likelihood that an employee will accept the offered benefit rather than attempt to pocket additional salary.⁹²

⁸⁷ See, e.g., ROBERT E. MOFFIT & NINA OWCHARENKO, HERITAGE FOUND., THE MCCAIN HEALTH CARE PLAN: MORE POWER TO FAMILIES 4–6 (2008), http://s3.amazonaws.com/thf_media/2008/pdf/bg2198.pdf [<https://perma.cc/EE58-PQ87>] (discussing presidential candidate John McCain’s plan for eliminating federal tax subsidies for health insurance); see also TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 185–86 (2003) (summarizing critiques of federal tax policy related to private, employer-based health insurance); Nicholas Drew, Note, *Two Federally Subsidized Health Insurance Programs Are One Too Many: Reconsidering the Federal Income Tax Exclusion for Employer-Provided Health Insurance in Light of the Patient Protection and Affordable Care Act*, 54 B.C. L. REV. 2047, 2086–87 (2013) (presenting possible reforms to the federal tax subsidies for employer-provided health insurance).

⁸⁸ See generally Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885 (2011) (predicting and evaluating the ACA’s impact on employer-sponsored insurance).

⁸⁹ See ACA § 1513(a), 124 Stat. at 253 (enacting the penalty); *State Health Facts, Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size*, KAISER FAMILY FOUND. (2013), <http://kff.org/other/state-indicator/firms-offering-coverage-by-size> [<http://perma.cc/7HSS-F5PV>] [hereinafter *State Health Facts*] (showing that 95.7% of employers with more than fifty employees offer health insurance as a benefit).

⁹⁰ *State Health Facts*, *supra* note 89 (34.8% of employers with fewer than fifty employees offer health insurance as a benefit).

⁹¹ For example, small employers receive a tax credit for offering health insurance. See ACA § 1421(a), 124 Stat. at 237, *amended by* HCERA § 10105(e)(1)–(2), 124 Stat. at 906.

⁹² ACA § 1501(b), 124 Stat. at 244, *amended by* HCERA § 10106(b), 124 Stat. at 909; HCERA § 1002, 124 Stat. at 1032. An additional critique of the employer-based health insurance model is that it depresses wages. Employers tend to stifle wage growth when providing generous

The ACA also invigorated private health insurance markets by unifying the rules for individual and small group insurance unrelated to employer benefits.⁹³ Before the ACA, individual health insurance plans were largely unattainable because insurers demanded very high premiums for such plans and the offered benefits were highly variable.⁹⁴ The ACA increased access to a private insurance market that was elusive for most Americans by enabling access to individual insurance through health insurance exchanges, which standardize the minimum allowable benefits for Qualified Health Plans.⁹⁵ The ACA also leveled the playing field by eliminating common exclusionary practices such as pre-existing condition clauses.⁹⁶

But leveling the playing field would not be enough to facilitate universal coverage without some kind of financial adjustment, as the individual and small group markets historically have been prohibitively expensive for low- and middle-income Americans. Consequently, the ACA created federal tax subsidies for insurance premiums to everyone earning 100% to 400% of the FPL, or \$11,770 to \$47,080 for a one-person household.⁹⁷ These new tax subsidies for health insurance are estimated to cost \$45 billion in 2015 and are projected to increase to \$91 billion by 2017 as implementation of the ACA gains momentum through upcoming open enrollment periods.⁹⁸ These expenses further expand the hidden government assistance for private health insurance.

The private insurance tax subsidies were challenged in *King v. Burwell*.⁹⁹ In *King*, the U.S. Supreme Court upheld the IRS regulations that provide tax subsidies to qualifying purchasers in federally run exchanges as

benefits, and employees tend not to perceive the true cost in gross income that the benefit demands. See JOST, *supra* note 87, at 186.

⁹³ See generally ACA §§ 1002–1004, 2711–2719 (Title I, Part A: Individual and Group Market Reforms).

⁹⁴ See, e.g., KAISER FAMILY FOUND. & EHEALTHINSURANCE, UPDATE ON INDIVIDUAL HEALTH INSURANCE 4–5 & tbls.4 & 5 (2004), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/update-on-individual-health-insurance.pdf> [<https://perma.cc/5BG7-9RPG>]; cf. Larry Levitt et al., *Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act?*, KAISER FAMILY FOUND., <http://kff.org/private-insurance/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/> [<https://perma.cc/72JJ-VTTZ>] (last updated May 12, 2015).

⁹⁵ ACA § 1301, 124 Stat. at 162 (defining Qualified Health Plans); *id.* § 1302, 124 Stat. at 163 (establishing essential health benefits).

⁹⁶ ACA § 2704, 124 Stat. at 323.

⁹⁷ ACA § 1401(a), 124 Stat. at 213, *amended by* HCERA § 10105(a)–(c), 124 Stat. at 906; see also HCERA § 1001, 124 Stat. at 1030 (further amending I.R.C. § 36B).

⁹⁸ Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to John Boehner, Speaker, U.S. House of Representatives 5 tbl.2 (July 24, 2012), <http://www.cbo.gov/publication/43471> [<https://perma.cc/ZSB4-NFKM>].

⁹⁹ *King*, 135 S. Ct. at 2488.

a matter of statutory interpretation.¹⁰⁰ This willingness to preserve Congress's intended role for the subsidies stands in contrast to the Court's unwillingness to defer to Congress on the Medicaid expansion in *NFIB*.¹⁰¹ Even though the Court undermined Medicaid expansion in *NFIB*, calling the expansion an impermissibly coercive new program, it displayed a nuanced and deferential understanding of the importance of tax subsidies in the exchanges in *King*.¹⁰² Arguably, in *King*, the Court not only demonstrated a better understanding of the ACA¹⁰³ but also reflected the politically preferred status of indirect benefits in private insurance, as compared to direct public insurance benefits.

Although the continued reliance on (employment-based) private health insurance is consistent with the narrative of American individualism, Congress expressed through the ACA implicit recognition that most low-to-middle income Americans simply cannot afford health insurance, even with the equalizing rules that the ACA imposes on private health insurers. Very few Americans can afford to purchase private health insurance on the open market, and the current subsidy numbers underline this fact. Reports indicate that approximately 86% of individuals who purchased health insurance through exchanges in the 2015 open enrollment period qualified for tax subsidies, and more than half of them were earning less than 250% of the FPL.¹⁰⁴ Despite the common public narrative that private health insurance is consistent with American self-reliance, in reality almost everyone purchasing health insurance, whether individually or through an employer, is receiving some kind of federal government subsidy to be able to afford it.

In sum, the American government provides assistance obtaining health insurance coverage in two different ways: through highly visible direct benefits and through hidden tax subsidies. Despite the substantial similarities between the two models, particularly with respect to low-income populations, one has been stigmatized and attacked politically in a way the other has not. With respect to the poor and near-poor, this differentiation has created two perceived classes of individuals: undesirable dependents who rely on Medicaid and workers who deserve assistance in participating in the American dream. The following Part takes a closer look at the self-reliance

¹⁰⁰ See *id.* at 2495–96.

¹⁰¹ *NFIB*, 132 S. Ct. at 2608.

¹⁰² *King*, 135 S. Ct. at 2485–87; see *NFIB*, 132 S. Ct. at 2606–07 (noting that “wherever that line [where persuasion gives way to coercion] may be,” the Medicaid expansion “is surely beyond it”).

¹⁰³ See Nicole Huberfeld, *Heed Not the Umpire (Justice Ginsburg Called NFIB)*, 15 U. PA. J. CONST. L. HEIGHTENED SCRUTINY 43, 44–49 (2013), <https://www.law.upenn.edu/live/files/1657-huberfeld15upajconstlheightscrutiny432013pdf> [<https://perma.cc/7A7G-VURE>] (exploring the argued misunderstanding of the ACA by the *NFIB* Court).

¹⁰⁴ Pear, *supra* note 13.

narrative underlying this classification and reveals that the dichotomy between dependents and workers in the context of government assistance in health insurance is a false one.

II. DEBUNKING THE MYTH OF SELF-RELIANCE

As explored in Part I, politicians have condemned expanding Medicaid as fostering a culture of dependence, while the recipients of the low-income subsidies have faced no comparable opposition. This Part demonstrates that these differing reactions are rooted in the American ideal of self-reliance and the corollary construction of individuals in need of support as undesirable dependents. According to this narrative, recipients of visible government assistance are lazy and rely on the government as an alternative to being personally responsible and independent, whereas recipients of hidden government assistance are responsible, wage-earning citizens. These beliefs generate a series of either-or dyads: people are either workers or paupers, independent or dependent, good citizens or bad. Through the use of vulnerability theory and demographic data, this Part demonstrates that self-reliance is a myth and exposes this bifurcated view as a false dichotomy. Specifically, this Part asserts that the distinction between visible and hidden government assistance is an unprincipled dividing line, as the very same individuals will find themselves qualifying for either form of assistance at any given moment and moving between them, a phenomenon called “churn.” In establishing this reality, it becomes clear that having two systems for helping the low-income population access health care is a needlessly complex and unprincipled means for financing health care.

A. The American Myth of Self-Reliance and Its Dichotomies

Self-reliance is a long-standing American ideal.¹⁰⁵ The United States has been cast as the land of opportunity, where anyone from anywhere in the world can come to create a fortune and participate in “American Excep-

¹⁰⁵ See, e.g., DECLARATION OF INDEPENDENCE para. 2 (1776) (referencing in its title the American independence ideal); BARLOW, *supra* note 21, at 115 (discussing Benjamin Franklin’s writings on individual success and “success literature” generally); RALPH WALDO EMERSON, *Self-Reliance*, in ESSAYS: FIRST SERIES (1841), <http://www.emersoncentral.com/selfreliance.htm> [<https://perma.cc/E659-Z4L2>]; THE FEDERALIST NO. 1, at 3 (Alexander Hamilton) (Charles R. Kressler ed., 2003); HERBERT HOOVER, AMERICAN INDIVIDUALISM 8–9 (1922) (citing the Declaration of Independence as evidence of the primacy of liberty and self-sufficiency in American culture); HERBERT HOOVER, THE CHALLENGE TO LIBERTY 18–21 (1934) (same).

tionalism.”¹⁰⁶ The narrative of the self-made man, pulled up by his bootstraps, is a familiar trope, often expressed as “individualism,” meaning that the individual makes his or her own fortune, good or bad.¹⁰⁷ The converse of self-reliance is, of course, dependence. Because of the high value placed on (particularly financial) independence, state assistance has been stigmatized and devalued.¹⁰⁸

The concept of self-reliance, as a principle in modern American social and political discourse, is a myth. Yet, contrary to popular use, the word myth does not connote something that is completely false. One author describes this use of the word myth as “a complex of profoundly held attitudes and values which condition the way men view the world and understand their experience.”¹⁰⁹ In her work on vulnerability, Martha Albertson Fineman defines myth as “a legendary story that invokes gods and heroes and explains a cultural practice or phenomenon.”¹¹⁰ From this perspective, myths are ideological, not factual.¹¹¹ They represent beliefs about the world, not empirical realities.¹¹² But, though a myth cannot be disproved, it can be studied for its influence on policy, politics, law, and its other societal effects.¹¹³

All societies have myths,¹¹⁴ which serve a variety of important functions. They define our national identity (both domestically and in relation to other countries), they provide historical context by giving nations origin stories, they explain social roles and disparities, and they tell us what it means to

¹⁰⁶ See Alberto Alesina et al., *Why Doesn't the United States Have a European-Style Welfare State?*, 2001 BROOKINGS PAPERS ON ECON. ACTIVITY 187, 223–24 (discussing this “equality of opportunity” as a factor in avoiding the sharp class divides of Europe).

¹⁰⁷ This idea may have been coined by Alexis de Tocqueville when describing what makes America unusual among European colonial nations. See ARTHUR E. SUTHERLAND, *THE LAW AND ONE MAN AMONG MANY* 4 (1956) (citing 2 ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 119 (1840)). Individualism can have many meanings, and Sutherland suggested two strains of individualism, rugged individualism and individual freedom individualism; he argued that rugged individualism disappeared in the 1930s. See *id.* at 17.

¹⁰⁸ See Alesina et al., *supra* note 106, at 239–40 (discussing that American culture rejects offering government benefits to the poor because they are perceived as lazy rather than unfortunate).

¹⁰⁹ RICHARD WEISS, *THE AMERICAN MYTH OF SUCCESS: FROM HORATIO ALGER TO NORMAN VINCENT PEALE* 3–4 (1988).

¹¹⁰ MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* 11 (2004).

¹¹¹ See *id.* at 13.

¹¹² See *id.* at 25 (discussing myths as abstractions).

¹¹³ *Id.* at 15 (“Unlike a program or a prediction, a myth cannot be refuted.” (quoting HENRY TUDOR, *POLITICAL MYTH* 15–16 (1972))); see also WEISS, *supra* note 109, at 4 (recognizing the value and pervasiveness of understanding the self-reliance myth even while refuting it).

¹¹⁴ FINEMAN, *supra* note 110, at 11.

be good citizens.¹¹⁵ Thus, myths are also aspirational: They not only communicate people's beliefs about how the world is, but they also communicate beliefs about how people think the world should be.¹¹⁶ The myths of our own culture tend to be accepted as natural, fundamental truths without much critical thought.¹¹⁷ Hence, myths shape cultural worldview and bias individual perceptions.¹¹⁸ Moreover, myths tend to support the status quo.¹¹⁹ Consequently, challenging a nation's underlying myths to enact social reform can be particularly fraught.¹²⁰

In the United States—a country whose origin story involves a revolution against a tyrannical monarchy¹²¹—self-reliance and independence are among our most-cherished ideals.¹²² The American myth of self-reliance is tied up with the American dream.¹²³ According to our country's mythos, with enough effort and perseverance, anyone can create the life they want.¹²⁴ Survey data indicate that the American people believe that self-determination and hard work result in success.¹²⁵ This belief also leads Americans to overestimate their personal accomplishments and to underestimate the contributions of others.¹²⁶ This perspective mirrors the United States' origin story as a land of plenty, built from nothing.¹²⁷ The idea that hard work leads to success and that anyone can become self-reliant likewise reflects this nation's capitalist

¹¹⁵ *Id.* at 11–12; ROBERT WUTHNOW, AMERICAN MYTHOS: WHY OUR BEST EFFORTS TO BE A BETTER NATION FALL SHORT 3 (2006).

¹¹⁶ WUTHNOW, *supra* note 115, at 3.

¹¹⁷ *Id.* at 1, 109.

¹¹⁸ *See id.* at 1; Nancy Fraser & Linda Gordon, *A Genealogy of Dependency: Tracing a Keyword of the U.S. Welfare State*, 19 SIGNS 309, 310 (1994) (noting the power of certain expressions to “carry unspoken assumptions and connotations that can powerfully influence the discourses they permeate”).

¹¹⁹ FINEMAN, *supra* note 110, at 16.

¹²⁰ *Id.* at 15–16.

¹²¹ *Id.* at 17.

¹²² STEPHANIE COONTZ, THE WAY WE NEVER WERE: AMERICAN FAMILIES AND THE NOSTALGIA TRAP 69 (2000) (“Self-reliance is one of the most cherished American values.”); Knut Halvorsen, *Symbolic Purposes and Factual Consequences of the Concepts “Self-Reliance” and “Dependency” in Contemporary Discourses on Welfare*, 7 SCANDINAVIAN J. SOC. WELFARE 56, 56 (1998) (“To be self-reliant has been a dominant norm in Western societies since early Christianity.”); *id.* (“The term ‘self-reliance’ is probably the most dominant term in shaping American social policy.”); *id.* at 58 (“Western-oriented capitalistic countries are based on the traditional American virtue of self-reliance.”); Jennifer A. Sandlin, “It’s All Up to You”: How Welfare-to-Work Educational Programs Construct Workforce Success, 54 ADULT EDUC. Q. 89, 89 (2004) (“There is perhaps no more enduring myth in the United States than the myth of success.”).

¹²³ *See* Alesina et al., *supra* note 106, at 223.

¹²⁴ WEISS, *supra* note 109, at 3; Sandlin, *supra* note 122, at 89.

¹²⁵ *See* WUTHNOW, *supra* note 115, at 118 (citing numerous surveys showing similar conclusions); Alesina et al., *supra* note 106.

¹²⁶ COONTZ, *supra* note 122, at 70.

¹²⁷ *Id.*

ideals.¹²⁸ The American dream is, therefore, a dream of individual achievement.¹²⁹ This achievement can then be translated into independence.¹³⁰ Beliefs about the importance—and attainability of—“individual independence, autonomy, and self-sufficiency” are foundational American myths,¹³¹ championed by both liberals and conservatives.¹³²

The myth of self-reliance has a longstanding history. Ancient Greek philosophers first defined self-sufficiency, and Aristotle queried whether self-reliance is a desirable goal.¹³³ These ideals came early to the United States. Seventeenth-century Puritanism advocated hard work and a moral life as the pathway to success.¹³⁴ The primary characters in classic stories of American self-reliance were the self-made man,¹³⁵ individually, and the self-sufficient family,¹³⁶ collectively. For example, these archetypes made regular appearances in *McGuffey* readers and the writings of Horatio Alger.¹³⁷ Even today, these paradigmatic figures persist. Their legacy can be readily identified in the beloved children’s book *The Little Engine That Could*, the story of a self-made protagonist who succeeded through the power of positive thinking,¹³⁸ and in the countless books of the ever-popular self-help industry.¹³⁹ Of course, as myths, the notions surrounding autonomy, independence, and self-reliance are simply widely held beliefs about how the world operates and do not reflect the realities of social mobility in the United States.¹⁴⁰ Nevertheless, several important observations about the American psyche and how it shapes the political sphere flow from analyzing these ideologies.

First, the American ideal of self-reliance takes a simplified and primarily economic view of personhood.¹⁴¹ Economic self-sufficiency becomes both a proxy and a precondition for other versions of autonomy and inde-

¹²⁸ See *id.* at 56 (exploring capitalism as an outgrowth of a one’s ability, and therefore one’s duty, to provide for one’s family).

¹²⁹ Halvorsen, *supra* note 122, at 58.

¹³⁰ *Id.*

¹³¹ Martha Albertson Fineman, *Cracking the Foundational Myths: Independence, Autonomy, and Self-Sufficiency*, 8 AM. U. J. GENDER SOC. POL’Y & L. 13, 14 (1999).

¹³² Halvorsen, *supra* note 122, at 58–59.

¹³³ Robert H. Daugherty & Gerard M. Barber, *Self-Sufficiency, Ecology of Work, and Welfare Reform*, 75 SOC. SERV. REV. 662, 663 (2001).

¹³⁴ Sandlin, *supra* note 122, at 89–90.

¹³⁵ WUTHNOW, *supra* note 115, at 104–05.

¹³⁶ COONTZ, *supra* note 122, at 73; FINEMAN, *supra* note 110, at 21.

¹³⁷ WUTHNOW, *supra* note 115, at 105.

¹³⁸ *Id.* at 121.

¹³⁹ Sandlin, *supra* note 122, at 90.

¹⁴⁰ WEISS, *supra* note 109, at 3; Sandlin, *supra* note 122, at 89.

¹⁴¹ See Daugherty & Barber, *supra* note 133, at 662–63 (challenging such an economic view of personhood).

pendence.¹⁴² Because myths have strong moral components, being financially independent is also associated with virtue and good moral character. Both the Puritan and the greater Protestant traditions equated material success with grace and financial ruin with sin.¹⁴³ Consequently, self-reliance is a highly valued trait and characteristic of the ideal American citizen.¹⁴⁴ American notions of self-worth, therefore, are constructed in largely economic terms.¹⁴⁵ In other words, financial worth becomes self-worth.

Second, the moral underpinnings and highly desirable social status of self-reliance renders economic self-sufficiency a condition of being a good citizen. Some have argued that “self-sufficiency” is “a precondition for being a member of society in good standing” and “an intrinsic obligation of healthy adults.”¹⁴⁶ But, given that very few Americans can achieve economic independence without working for someone else, paid labor occupies a central role in the myth of self-reliance.¹⁴⁷ The myth therefore transforms into the social obligation to work for compensation.¹⁴⁸ Paid work is thus the currency of good, moral citizenship in the United States.

Conversely, to not be self-sufficient is to be labeled a failure. In a society that venerates self-reliance, people who are not economically independent are not “fully human participants in society.”¹⁴⁹ The appropriate social reaction to such individuals is either condemnation, at worst, or pity, at best.¹⁵⁰ Dependency, though—not simply poverty¹⁵¹—is the nemesis of self-reliance.¹⁵² Poverty is an objective state that may at times have certain virtues, whereas dependency as a condition implies that the individual is not a

¹⁴² FINEMAN, *supra* note 110, at 22.

¹⁴³ WEISS, *supra* note 109, at 5, 7; Halvorsen, *supra* note 122, at 58; Sandlin, *supra* note 122, at 89–90.

¹⁴⁴ FINEMAN, *supra* note 110, at 22; Halvorsen, *supra* note 122, at 59.

¹⁴⁵ Halvorsen, *supra* note 122, at 57.

¹⁴⁶ *Id.* at 58 (quoting Charles Murray, *LOSING GROUND* 140 (1984)).

¹⁴⁷ FINEMAN, *supra* note 110, at 9, 22.

¹⁴⁸ Daugherty & Barber, *supra* 133, at 664. As described elsewhere,

If there is indeed a categorical imperative for modern American society, it is the deeply held belief in the value and universality of work. Americans typically hold that everyone who is physically and mentally able to work should absolutely do so; they treat this economic-based self-sufficiency as a moral ontological reality and obligation.

Id. (citations omitted).

¹⁴⁹ *Id.* at 666.

¹⁵⁰ FINEMAN, *supra* note 110, at 34.

¹⁵¹ Poverty was not always negative. Various religions elevate poverty in their dogma; for example, poverty was venerated by the Catholic Church, but it has become “both a negative personal and social phenomenon.” Daugherty & Barber, *supra* note 133, at 665.

¹⁵² *Cf. id.* at 662 (referring to dependency and self-sufficiency as “sister concept[s]”).

fully developed human being.¹⁵³ Just as being self-sufficient signals the virtue and good moral character of the ideal citizen, being dependent in the United States implies a defect in character that brings with it inferior social status.¹⁵⁴ Self-reliance and dependency are understood as inherently incompatible states and thereby dichotomous terms.¹⁵⁵ Yet like its counterpart self-reliance, dependency has specific meanings and cultural contexts. To start, dependency also has predominantly economic associations.¹⁵⁶ It means to be dependent on the state for monetary support.¹⁵⁷ Dependency is therefore synonymous with welfare dependency.¹⁵⁸ This use of the word is relatively new, however.

In their work on dependency, Nancy Fraser and Linda Gordon identify “three principal icons of [post-industrial] dependency,” which function in contrast to the white male worker, who is seen as the ideal citizen: the pauper, the colonial native or slave, and the housewife.¹⁵⁹ The archetypal figure of most relevance to this Article is the pauper “who lived not on wages but on poor relief”:

In the strenuous new culture of emergent capitalism, the figure of the pauper was like a bad double of the upstanding workingman, threatening the latter should he lag. . . . Paupers were not simply poor but degraded, their character corrupted and their will sapped through reliance on charity. . . . While nineteenth-century charity experts acknowledged that poverty could contribute to pauperization, they also held that character defects could cause poverty. Toward the end of the century, as hereditarian (eugenic) thought

¹⁵³ Fraser & Gordon, *supra* note 118, at 309. As Nancy Fraser and Linda Gordon explained,

[T]he issue of welfare is the issue of dependency. It is different from poverty. To be poor is an objective condition; to be dependent, a subjective one as well Being poor is often associated with considerable personal qualities; being dependent rarely so. [Dependency] is an incomplete state in life: normal in the child, abnormal in the adult. In a world where completed men and women stand on their own feet, persons who are dependent—as the buried imagery of the word denotes—hang.

Id. (citing DANIEL P. MOYNIHAN, *THE POLITICS OF A GUARANTEED INCOME: THE NIXON ADMINISTRATION AND THE FAMILY ASSISTANCE PLAN* 17 (1973)).

¹⁵⁴ Daugherty & Barber, *supra* note 133, at 663; Fraser & Gordon, *supra* note 118, at 320, 332.

¹⁵⁵ Fineman, *supra* note 131, at 17; Halvorsen, *supra* note 122, at 57.

¹⁵⁶ Halvorsen, *supra* note 122, at 57.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ Fraser & Gordon, *supra* note 118, at 316.

caught on, the pauper's character defects were given a basis in biology.¹⁶⁰

Casting dependents as socially and morally defective secured the independent worker's superior standing. To achieve full membership in society, then, one must distinguish oneself from the undesirable classes of dependents.¹⁶¹

Perhaps the most significant change to come out of the evolving concept of dependency is its relationship to paid work. Whereas wage laborers were the paradigmatic dependents of the pre-industrial age, the current construction of dependency situates paid work as its juxtapositional opposite. As a result, individuals who work for money are encouraged to believe they are achieving self-reliance and therefore superior to individuals who receive government benefits.¹⁶² The corollary that accompanies the idealization of paid labor is the devaluation of welfare relief, rendering a person who depends on government benefits a pauper or a parasite. Welfare recipients in America are regarded as undeserving, second-class citizens who shirk their responsibility to engage in paid labor.¹⁶³

Despite the reality that many government aid recipients also work for pay,¹⁶⁴ working and receiving government benefits are portrayed as either-or propositions.¹⁶⁵ According to this construction, each individual person then chooses between two equally available sources of income, work or welfare.¹⁶⁶ Put differently, dependency (receiving government benefits) is construed as fundamentally incompatible with paid work. Thus, if a person receives welfare benefits, it is presumed that person does not also work.¹⁶⁷ Given that a substantial portion of the American population has jobs that do

¹⁶⁰ *Id.* at 316–17 (citations omitted).

¹⁶¹ *Id.* at 318. In more recent times, the stigmatized status of the word “dependency” is clear from its pathological associations in medicine and psychology, e.g., drug dependency, which then bled into other notions of dependency, such as the assumption that welfare recipients are also drug addicts. *Id.* at 325.

¹⁶² Halvorsen, *supra* note 122, at 59.

¹⁶³ Alesina et al., *supra* note 106; Fraser & Gordon, *supra* note 118, at 315, 329; Halvorsen, *supra* note 122, at 59.

¹⁶⁴ See *infra* notes 188–269 and accompanying text (exploring false assumptions that those who receive government assistance do not engage in work).

¹⁶⁵ See Fraser & Gordon, *supra* note 118, at 328.

¹⁶⁶ *Id.*

¹⁶⁷ Fineman, *supra* note 131, at 17. Moreover, the notion that so-called welfare mothers do not “work” presumes child-rearing does not count as labor. Fraser & Gordon, *supra* note 118, at 329. Of course, when upper-class women stay home with their children, they are praised as good parents. See *id.* (discussing a “class double standard” of expectations and perceptions of work between wealthy mothers and poor mothers).

not pay a living wage, leading workers to also rely on government assistance, this conclusion epitomizes the myth of self-reliance.¹⁶⁸

The American myth of self-reliance can be summarized as follows:

Figure 1: Premises and Conclusions of Self-Reliance

- P1: Americans have social and moral duties to work to maintain self-sufficiency and to avoid dependency.
 C1: Therefore, if people depend on government assistance, then they are social and moral failures.
 P2: Paid workers are not dependents.
 C2: Therefore, if people receive government benefits, then they do not work for pay.
 C3: Therefore, people who receive government benefits are social and moral failures who do not work.

The premises and conclusions above in turn lead to the following dichotomies:

Figure 2: Self-Reliance/Dependency Dichotomies

Self-Reliance	Dependency
Paid work	Government assistance
Active	Passive
Self-sustaining	Parasitic
Independent	Dependent
Worker	Pauper
Producer	Consumer

¹⁶⁸ Fifteen percent of the U.S. population lived at or below the FPL as of 2013, *Distribution of the Total Population by Federal Poverty Level (Above and Below 100% FPL)*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/population-up-to-139-fpl> [https://perma.cc/M27D-3RGF], and 34% of the population lived at or below 200% of the FPL, *Distribution of the Total Population by Federal Poverty Level (Above and Below 200% FPL)*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/population-up-to-200-fpl> [https://perma.cc/Z84B-Q6L2]. See also BARBARA EHRENREICH, NICKEL AND DIMED: ON (NOT) GETTING BY IN AMERICA 4–6 (2001) (reporting the impossibility of living on minimum wage in various geographic regions with different types of jobs); Lauren Eyster, *How Do We Grow Our Economy When Most of the Jobs Are Low Wage and Low Skill?*, URBAN INST. (Jan. 10, 2014), <http://www.urban.org/urban-wire/how-do-we-grow-our-economy-when-most-jobs-are-low-wage-and-low-skill> [https://perma.cc/4V4D-MD9F] (discussing the concentration of below-federal poverty level jobs in the post-recession job market). Living wage should be distinguished from minimum wage. See Jared Bernstein, *Minimum Wage: Who Makes It?*, N.Y. TIMES: THE UPSHOT (June 9, 2014), <http://www.nytimes.com/2014/06/10/upshot/minimum-wage.html> [https://perma.cc/RR7X-23MP] (discussing demographic data of those who earn minimum wage); Ben Casselman, *When Living Wage Is Minimum Wage*, FIVETHIRTYEIGHT (Mar. 18, 2014, 6:25 AM), <http://fivethirtyeight.com/features/when-living-wage-is-minimum-wage> [https://perma.cc/Z85B-H3WF] (explaining why studying minimum wage must include studying both minimum wage earners and those who earn slightly more to get a full picture of a living wage).

Good citizen

Bad citizen

These myths and their corresponding beliefs affect our laws and social policies. Social myths, like the myth of self-reliance, are powerful narratives because they are legitimizing. They provide the relevant backdrop for the current state of our culture and society and they reinforce the notion that our long-standing social structures are fair and just. The self-reliance myth tells us that our accomplishments are earned through hard work and virtuous choices.¹⁶⁹ As one author stated, “We simply feel better about ourselves and our society if we believe our successes in life are not the result of some random or unjust forces—which means that stories about self-made men and women fit well with how we believe, and we want to believe, the world works.”¹⁷⁰ It also tells us that those failing to meet the ideal of self-reliance—those who are dependent—have likewise earned their lot in life and deserve their current predicament because of their laziness or their moral shortcomings.¹⁷¹ As a result, acting with self-interest is not self-centered or greedy but rather an act of personal responsibility.¹⁷²

Although there may not be a strong sense of collective responsibility in the United States, poverty nonetheless constitutes a well-recognized social and political problem. Yet the response has been to help only those deemed deserving of aid. Consequently, lawmakers and policymakers have divided the poor into distinct groups: unfortunates who merit assistance, and parasites who warrant begrudging and limited help.¹⁷³ Those individuals who deserve assistance will be familiar to many as the “deserving poor”: the elderly, children, widows, the disabled—those society has deemed blameless in their poverty.¹⁷⁴

By contrast, the undeserving poor do not merit governmental support because they are deemed poor by choice.¹⁷⁵ According to this construction, dependency is in an individual character defect or pathology.¹⁷⁶ The need for help is not a product of misfortune or circumstances but rather the result of personal failings. It follows that the undeserving poor are by definition unworthy of assistance.¹⁷⁷ After all, why should the government help those

¹⁶⁹ WUTHNOW, *supra* note 115, at 110; Daugherty & Barber, *supra* 133, at 664.

¹⁷⁰ WUTHNOW, *supra* note 115, at 125.

¹⁷¹ *Id.* at 119; Fraser & Gordon, *supra* note 118, at 325; Sandlin, *supra* note 122, at 99.

¹⁷² FINEMAN, *supra* note 110, at 32.

¹⁷³ STEVENS & STEVENS, *supra* note 44, at 5.

¹⁷⁴ *Id.* at 6; Daugherty & Barber, *supra* note 133, at 665–66; Fraser & Gordon, *supra* note 118, at 320. Fineman calls these populations “inevitably dependent” persons. Fineman, *supra* note 22, at 264.

¹⁷⁵ Daugherty & Barber, *supra* note 133, at 666.

¹⁷⁶ Fraser & Gordon, *supra* note 118, at 320, 323.

¹⁷⁷ *Id.* at 320.

who do not help themselves? The government need not intervene; their station is a personal—not a societal—failure.¹⁷⁸ Hence, the myth of self-reliance serves to maintain the status quo by assuring potential reformers that there is no need for widespread social, legal, or political change: the wealthy and powerful deserve their successes and the impoverished and disempowered deserve their struggles.¹⁷⁹ In this view, the goal of good social policy is to differentiate the deserving poor from the undeserving paupers.

The opposition to government assistance has created a corresponding preference for privatization.¹⁸⁰ Because popular wisdom holds that the private market thrives with less legal and regulatory oversight, deregulation and small government have now become popular public policy goals.¹⁸¹ The backlash against government benefits and the push toward privatization offer another set of useful dichotomies for analyzing the post-ACA health care system: private/public, work/welfare, free market/government, and personal/collective responsibility.

Among the visible and hidden forms of government assistance described in Part I, only the one strongly associated with dependency—Medicaid—has been stigmatized. The program has faced such stigma that even individuals in great need have been hesitant to accept assistance. Moreover, ongoing hostility toward public benefits generally—and Medicaid specifically—is evident from the opposition to the ACA's Medicaid expansion, described above.¹⁸² As discussed, excepting *King*, no such animosity accompanies the low-income subsidies. Revisiting the myth-enforcing dichotomies above helps to explain this divided approach to health care financing.

Consider first Medicaid recipients. Because they rely on the government for health care benefits, they are presumed to be social and moral failures, as demonstrated by the stigma associated with the program. Next, regardless of whether Medicaid recipients are actually working, it is assumed they do not have jobs. People on Medicaid are presumed to be parasitic dependents, the undertone of which is that they are bad Americans. It is no surprise, then, that proposals to reform Medicaid have included employment initiatives designed to spur recipients into self-reliance, and recent gubernatorial efforts to bend the ACA to the right have included work-

¹⁷⁸ WUTHNOW, *supra* note 115, at 127.

¹⁷⁹ COONTZ, *supra* note 122, at 69; FINEMAN, *supra* note 110, at 32; WEISS, *supra* note 109, at 7; Fineman, *supra* note 131, at 16; Fraser & Gordon, *supra* note 118, at 311; Halvorsen, *supra* note 122, at 56, 63.

¹⁸⁰ FINEMAN, *supra* note 110, at xv (“Privatization is increasingly seen as the solution to complicated social problems reflecting persistent inequality and poverty.”).

¹⁸¹ *Id.* at xiii, xxii, 20, 270.

¹⁸² See *supra* notes 37–104 and accompanying text (examining public attitudes toward Medicaid and the ACA's Medicaid expansion).

search proposals.¹⁸³ For example, Arizona Governor Doug Ducey recently approved restrictions on his state's existing Medicaid expansion that would require the newly eligible to be employed in order to continue to qualify and would terminate their benefits after five years (presumably to prevent "dependency").¹⁸⁴

The persistent employer-provided benefits system, despite substantial hidden government subsidies,¹⁸⁵ can also be viewed through the lens of self-reliance. Workers are understood as personally responsible, self-sustaining, and independent—ideal Americans—because they “earn” access to health insurance via their employment. Health insurance and meaningful health care access is then something primarily reserved for the “good” working population. Thus, the dichotomy of “good” workers and “bad” dependents is an American myth that applies with equal force to the health care sphere as in other questions of government assistance.

Moreover, the political preference for privatization as a means for addressing inequalities was clearly part of the ACA's architecture,¹⁸⁶ which relied on employer-provided benefits and distinctly favored the private sector. Further, with respect to benefits to the poor, the low-income subsidies—which can be used to purchase health insurance on the *private* market—have created far less friction than the ACA's attempt at a *public* option, Medicaid expansion. Consequently, the ACA expressed a preference for purchasing private health insurance—even if highly subsidized—over government-provided benefits. This preference for private markets flies in the face of long-standing evidence that the administrative costs for private health insurers are higher than those for Medicare or Medicaid.¹⁸⁷ One can

¹⁸³ HHS has yet to approve any of these proposals because it has no authority to approve work-related Medicaid enrollment requirements. *See, e.g.*, Associated Press, *Feds: Utah Will Not Get Medicaid Work Requirement*, MODERN HEALTHCARE (Jan. 8, 2015), <http://www.modernhealthcare.com/article/20150108/NEWS/301089955> [<https://perma.cc/28CW-43B2>] (quoting HHS representative as saying “work initiatives are not the purpose of the Medicaid program and cannot be a condition of Medicaid eligibility”).

¹⁸⁴ Tara Culp-Ressler, *Arizona Governor Calls Plan to Kick 500,000 Low-Income People Off of Medicaid 'Responsible'*, THINKPROGRESS (Mar. 9, 2015, 11:35 AM), <http://thinkprogress.org/health/2015/03/09/3631297/arizona-medicaid-reforms> [<https://perma.cc/5YTC-5TMK>].

¹⁸⁵ *See supra* notes 73–104 and accompanying text (exploring the hidden government assistance of subsidies for private health insurance).

¹⁸⁶ *See, e.g.*, Robert Pear, *As Medicare and Medicaid Turn 50, Use of Private Health Plans Surges*, N.Y. TIMES (July 30, 2015), http://www.nytimes.com/2015/07/30/us/as-medicare-and-medicaid-turn-50-use-of-private-health-plans-surges.html?_r=0 [<https://perma.cc/H6TH-ZNL2>] (discussing how the ACA relies on the private sector to provide insurance).

¹⁸⁷ *See, e.g.*, Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768 (2003) (discussing the administrative costs of private and public insurance); Drew Altman, *Public vs. Private Health Insurance on Controlling Spending*, WALL STREET J.: WASH. WIRE (Apr. 16, 2015, 7:05 AM), <http://blogs.wsj.com/wash>

therefore see the public versus private dichotomy played out in health care with the preference for the low-income subsidies, despite the questionable economics of this private market structure.

The dependency versus self-reliance narrative in health care is problematic for at least two reasons. First, it stigmatizes recipients of government assistance so significantly that they may choose not to reap the benefits of those initiatives. Individuals who qualify for Medicaid may reject the only available gateway to needed health care out of the fear of being stigmatized. Second, it provides politicians with a very powerful discourse for not supporting the ACA's legislative principle of universality, which capitalizes on the well-worn rhetoric of American self-reliance and the construction of dependency as a social harm. Professor Fineman's vulnerability theory, however, reveals that self-reliance is a myth and all humans are constantly vulnerable to becoming dependent.

B. Debunking the Dividing Line

The American myth of self-reliance valorizes self-sufficiency and independence and positions dependency in conflict with paid labor. Its theoretical roots lie in the ideals of free will and personal responsibility for fortunes and misfortunes. These myths and belief systems have infiltrated the debates surrounding health care reform and are readily discernible in both the hostility to the Medicaid expansion and the support for the low-income subsidy. A closer examination of these beliefs reveals that they are both theoretically and practically unsound.

wire/2015/04/16/public-vs-private-health-insurance-on-controlling-spending [https://perma.cc/7XS2-HH9P] (stating public programs are better at controlling costs); Diane Archer, *Medicare Is More Efficient Than Private Insurance*, HEALTH AFF.: BLOG (Sept. 20, 2011, 9:08 AM), <http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance> [https://perma.cc/XVW8-RN6F] (discussing reports from the CBO and Centers for Medicare and Medicaid Services ("CMS") that Medicare and Medicaid are more administratively efficient than private insurance); Austin Frakt, *Medicare and Facts*, INCIDENTAL ECONOMIST (Aug. 9, 2011, 4:00 PM), <http://theincidentaleconomist.com/wordpress/medicare-and-facts> [https://perma.cc/9WB4-NQMA]; David Himmelstein & Steffie Woolhandler, *The Post-Launch Problem: The Affordable Care Act's Persistently High Administrative Costs*, HEALTH AFF.: BLOG (May 27, 2015, 10:22 AM), <http://healthaffairs.org/blog/2015/05/27/the-post-launch-problem-the-affordable-care-acts-persistently-high-administrative-costs> (discussing how subcontracting with private entities increases the administrative costs of public programs); Paul Krugman, Opinion, *It's the Health Care Costs, Stupid*, N.Y. TIMES: CONSCIENCE LIBERAL (June 12, 2011, 9:32 AM), <http://krugman.blogs.nytimes.com/2011/06/12/its-the-health-care-costs-stupid> [https://perma.cc/D9BC-LKKG] (discussing Medicare's lower administrative costs).

1. Dividing Line as Theoretically Unprincipled

For a theoretical excavation of the myth of self-reliance, this subsection looks to Professor Fineman's work on universal vulnerability. Her work takes aim at the centrality of autonomy in American life and culture, as well as the accompanying trend away from collective responsibility and toward privatization, deregulation, and reliance on the free market as the proper methods of social reform.

According to Fineman, the myths described above have had a negative impact on American society. She explains that American beliefs surrounding the desirability and attainability of self-sufficiency have affected the way in which we understand equality, as well as the role of the state.¹⁸⁸ As discussed above, the myth of self-reliance holds that, through enough hard work and discipline, independence is available to everyone. This particular conception of autonomy is incompatible with vulnerability and dependence; it assumes that decisionmakers are independent actors capable of making their own unconstrained choices. Society equates failure with personal shortcomings and blames dependency on the very government programs designed to help those in need, thereby avoiding important issues of social justice.¹⁸⁹ The move away from government aid privatizes issues of dependency by situating them as problems for individual families and not for society as a whole.¹⁹⁰ Blaming others (and their families) for their dependency allows the state to avoid taking collective action to remedy social inequality.¹⁹¹

By valuing autonomy over substantive equality, Americans have developed a preference for formal equality (treating people the same) and for a limited role of the state.¹⁹² The current American legal construction of equality, particularly in the context of equal protection, is, therefore, narrow, identity-based, and "takes only a limited view of what should constitute governmental responsibility in regard to social justice issues."¹⁹³ Pursuant to this kind of thinking, government benefits are undesirable because they single out certain groups for assistance—thereby violating formal equality—and because they require an expanded role for the government. The back-

¹⁸⁸ FINEMAN, *supra* note 110, at xiii.

¹⁸⁹ *Id.* at 9; WEISS, *supra* note 109, at 7.

¹⁹⁰ Fineman, *supra* note 131, at 16.

¹⁹¹ FINEMAN, *supra* note 110, at xvi; Fineman, *supra* note 131, at 24; Halvorsen, *supra* note 122, at 62.

¹⁹² Fineman, *supra* note 22, 258 ("A state whose primary obligation is to guarantee autonomy is less interventionist than one that privileges equality in assessing what state action is warranted.")

¹⁹³ *Id.* at 254.

lash against government intervention within the past thirty years has been socially damaging, as the programs being attacked and rolled back had tangible benefits for the disadvantaged.¹⁹⁴ The result of the backlash has been an unresponsive government that is unwilling to address the structural barriers that perpetuate existing disparities.¹⁹⁵ Thus, for Americans to achieve meaningful reform, we must be willing to rethink our foundational myths.¹⁹⁶ In particular, Fineman urges us to reconsider the current relationships between autonomy, dependency, and equality.¹⁹⁷

Vulnerability theory provides a tool for reassessing the myth of self-reliance. Fineman argues that the proper construction of equality is equal opportunity, not formal equal treatment.¹⁹⁸ She contends that the current construction of autonomy is a fiction because of humanity's shared vulnerability. She therefore challenges many of the established ideological dichotomies underlying the myth of self-reliance (described earlier in this Part).¹⁹⁹ By advocating a theory that presents dependency as both inevitable and universal, Fineman argues in favor of a heightened sense of collective responsibility and a state that is responsive to the needs of its citizenry because no human being is—or can be—truly independent.²⁰⁰

Dependency does not exist in a single metric: it is a complex concept with varying axes and degrees.²⁰¹ For the purposes of this discussion of health care, biological and economic dependency are most relevant. The inevitability of biological dependency is perhaps the easiest to understand because all have experienced it firsthand. As Fineman explains, “Far from being pathological, avoidable, and the result of individual failings, a state of dependency is a natural part of the human condition and is developmental in nature.”²⁰² We were all dependent as children and we may well become dependent again through old age or disability. Hence, dependency is simply part of being human.²⁰³ Moreover, because everyone is vulnerable to injury, disease, aging, and disability, we could all find ourselves dependent at a moment's notice.²⁰⁴

¹⁹⁴ See COONTZ, *supra* note 122, at 81 (noting that poverty grew in that time among groups whose subsidies and interventions declined).

¹⁹⁵ See Fineman, *supra* note 22, at 257.

¹⁹⁶ FINEMAN, *supra* note 110, at 33–34.

¹⁹⁷ *Id.* at xvii, 9.

¹⁹⁸ *Id.* at 261.

¹⁹⁹ *Id.* at xvi; see *supra* notes 105–187 (explaining the ideological dichotomies).

²⁰⁰ FINEMAN, *supra* note 110, at xvii.

²⁰¹ *Id.* at 35.

²⁰² *Id.* at 34–35; see also Fineman, *supra* note 131, at 18 (discussing the “inevitab[ility]” of dependence).

²⁰³ Fineman, *supra* note 131, at 18.

²⁰⁴ Fineman, *supra* note 174, at 267 (“Human vulnerability arises from our embodiment, which carries with it the imminent or ever present possibility of harm, injury, and misfortune.”).

Yet although we are all universally vulnerable, depending on our bodily and environmental conditions, we are all at varying degrees of that vulnerability.²⁰⁵ Although the ubiquity of biological dependency is hard to refute, the inevitability of other kinds of dependency, like economic dependency, is not generally recognized.²⁰⁶

Yet economic dependency is almost as universal as biological dependency. Despite the United States' relative affluence and opportunity, one in six adult Americans and one in five American children live in poverty.²⁰⁷ Moreover, almost all Americans depend on some kind of financial support outside of their immediate family to survive.²⁰⁸ By objective measures, people who work for pay are not inherently independent or self-reliant.²⁰⁹ The choice for the vast majority of Americans is, therefore, not between dependency or self-reliance but rather between being dependent on the state or being dependent on employment.²¹⁰ Moreover, Fineman points out that even the highest-level CEO's success still depends on the labor of secretaries and truck drivers.²¹¹ Because we are all interdependent, we can never assume that any one person is completely self-sufficient.²¹² As another author explains, "The problem is not dependency *per se*, but society's labeling of some groups of people in particular circumstances as dependent."²¹³

Furthermore, despite the dichotomies described previously in section A, paid work and dependence on government benefits are not mutually exclusive. Particularly, many people in the United States either do not have access to paid work or do not have access to a living wage.²¹⁴ When the number of jobs that are available goes down, individuals who would prefer to be working must join the ranks of the unemployed. As of 2014, there

²⁰⁵ *Id.* at 268–69 (“While all human beings stand in a position of constant vulnerability, we are individually positioned differently.”).

²⁰⁶ FINEMAN, *supra* note 110, at 37.

²⁰⁷ CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2013, at 13 tbl.3 (2014), <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf> [<https://perma.cc/XK3G-FZG8>]; *Income and Poverty in the United States: 2013—Highlights*, U.S. CENSUS BUREAU, <https://www.census.gov/hhes/www/poverty/data/incpovhlth/2013/highlights.html> [<https://perma.cc/4L2W-HRME>] [hereinafter *Income and Poverty in the United States*].

²⁰⁸ COONTZ, *supra* note 122, at 69.

²⁰⁹ Fineman, *supra* note 131, at 27.

²¹⁰ Halvorsen, *supra* note 122, at 61.

²¹¹ FINEMAN, *supra* note 110, at 289.

²¹² Halvorsen, *supra* note 122, at 63.

²¹³ *Id.* at 61.

²¹⁴ See *supra* note 168 and accompanying text (discussing how many Americans do not earn a living wage).

were approximately two job seekers for every available job.²¹⁵ Put another way, at least half of the population who wanted to work could not; or, the only available jobs were low-pay, low-skill, hourly-wage jobs that often do not offer benefits at all, or not at affordable cost.²¹⁶ Government assistance is crucial for those people. And for every percentage increase in the rate of unemployment, the number of Medicaid enrollees goes up by one million people.²¹⁷ The political position described in Part I, that Medicaid is therefore inappropriate for able-bodied, single adults, rings especially hollow. Furthermore, low-paying jobs do little to remove families from poverty.²¹⁸ To put it bluntly, working for pay does not guarantee self-reliance.²¹⁹

Based on these realities, self-reliance, at least as constructed in the American ethos, is a myth. It is a myth both in the sense that it provides a socio-cultural backdrop for many of our laws and social policies (as described in section A of Part II) and in the sense that it is untrue (as described directly above). The promise of self-reliance that permeates American cultural life is both impossible—because of the universality of dependency and vulnerability—and undesirable—because such a worldview excludes anyone who is not a fully functioning, unencumbered adult.²²⁰

As discussed earlier, assuming that all individuals are autonomous stagnates reform because people are assumed to get what they deserve.²²¹ This assumption constrains political power because any effort to change the status quo appears to either limit freedom or engage in redistribution.²²² Alternatively, construing autonomy as a goal for public policy favors efforts to create equal opportunities for all Americans.²²³ According to the latter view, independence occurs when a person has access to basic resources allowing

²¹⁵ Heidi Shierholz, *Hires and Quits Were Flat in April, While Job Openings Rose*, ECON. POLICY INST. (June 10, 2014), <http://www.epi.org/publication/hires-quits-flat-april-job-openings-rose> [https://perma.cc/NH7D-69XY].

²¹⁶ Annie Lowrey, *Recovery Has Created Far More Low-Wage Jobs Than Better-Paid Ones*, N.Y. TIMES (Apr. 27, 2014), http://www.nytimes.com/2014/04/28/business/economy/recovery-has-created-far-more-low-wage-jobs-than-better-paid-ones.html?_r=0 [https://perma.cc/BMA7-UFQU].

²¹⁷ KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., MEDICAID: A PRIMER 1, 4 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf> [https://perma.cc/NF8S-46J7].

²¹⁸ Halvorsen, *supra* note 122, at 61.

²¹⁹ *Id.*

²²⁰ FINEMAN, *supra* note 110, at 28, 272–73.

²²¹ See WEISS, *supra* note 109, at 7.

²²² Fineman notes that “[o]n a political level, autonomy restrains the state from acting in any way that can be characterized as either a constraint on freedom of action or some form of wealth or power redistribution.” Fineman, *supra* note 174, at 259.

²²³ WEISS, *supra* note 109, at 7.

participation in both society's benefits and burdens.²²⁴ Lacking necessities, like food, shelter, and clothing, constrains the choices available to an individual.²²⁵ Pursuant to this framework, autonomy is not an assumed state of the human condition but rather an aspiration.

Additionally, much like dependency and vulnerability, subsidy is also universal. Because dependency at varying points and to varying extents in our lives is inevitable, reliance on the government for support is likewise inevitable.²²⁶ Fineman's theory of universal vulnerability, therefore, also captures the notion of universal subsidy.²²⁷ Frequently subsidies are understood as direct economic or monetary assistance, yet subsidies can come in many different forms and from many different sources.²²⁸ Thus, subsidies include both visible government wealth transfers, as in Medicare and Medicaid, as well as hidden wealth transfers, such as tax benefits.²²⁹

From this perspective, no one in modern society is truly economically or socially self-sufficient.²³⁰ Fineman puts it bluntly: "[W]e all live subsidized lives."²³¹ Yet not all subsidies are stigmatized or linked with dependency.²³² Insofar as various subsidies have been associated with visible government assistance, as in the case of the Medicaid program, they have been linked to socially undesirable dependency and construed as antithetical to self-reliance.²³³ By contrast, subsidies that tend to perpetuate wealth and privilege are rarely labeled as such.²³⁴ Both politicians and the American public tend to apply different standards of self-reliance to different situations. In particular, Fineman points out that assistance for disaster relief or for corporate failures is not met with the same kinds of resistance as government aid to the poor.²³⁵ The real puzzle then lies in why some subsidies face significant stigma while others remain insulated from public scrutiny.²³⁶

²²⁴ Fineman, *supra* note 131, at 25–26, 29.

²²⁵ Fineman explains that "the concept [of autonomy] only has meaning in situations in which individual choices are not made impossible, constrained by inequalities, particularly those inequalities that arise from poverty." FINEMAN, *supra* note 110, at 30.

²²⁶ *Id.* at xvii.

²²⁷ *Id.*

²²⁸ *Id.* at 49–50; Fineman, *supra* note 131, at 22. According to Fineman, "[A] subsidy is nothing more than the process of allocating collective resources to some persons or endeavors rather than other persons or endeavors, because a social judgment is made that they are in some way 'entitled' or the subsidy is justified." FINEMAN, *supra* note 110, at 49.

²²⁹ FINEMAN, *supra* note 110, at xvii, 49–50; Fineman, *supra* note 131, at 22.

²³⁰ FINEMAN, *supra* note 110, at 50; Fineman, *supra* note 131, at 22–23.

²³¹ FINEMAN, *supra* note 110, at xvii, 50; Fineman, *supra* note 131, at 22–23.

²³² FINEMAN, *supra* note 110, at xvii.

²³³ Fineman, *supra* note 131, at 22.

²³⁴ FINEMAN, *supra* note 110, at 273.

²³⁵ *Id.* at 32–33.

²³⁶ *Id.* at 51; *accord* Fineman, *supra* note 131, at 23.

Consequently, autonomy as a central governing principle envisions a particular role for the state. The issue for reformers is not to eradicate dependency or subsidies but rather to provide for the citizenry.²³⁷ Fineman makes a claim for collective responsibility.²³⁸ She therefore argues for substantive, as opposed to formal, equality. This notion of equality seeks to eliminate disparities and to minimize oppression and exploitation.²³⁹ It sets a floor of basic resources and dignity under which individual citizens cannot drop.²⁴⁰ Ensuring this brand of equality requires the active involvement of the state.²⁴¹ True equality of opportunity, therefore, obligates the government to provide access to social goods, such as wealth, health, employment, or security, and to ensure that the opportunities are evenly distributed so that no person or groups of persons are unduly privileged while others have few or no opportunities.²⁴² Replacing formal equal treatment by the state with equality of opportunity, Fineman posits, can actually enhance liberty and freedom by providing individuals who are limited under the current regime with more meaningful choices.²⁴³

In sum, vulnerability theory is a particularly powerful tool to advocate for social justice for the poor, who lack status before the Supreme Court and Congress as an independent antidiscrimination category, and who lack political power in general.²⁴⁴ The theory applies particularly well to issues of health care access for lower income Americans, because it is exactly the kind of social good that would be included in a meaningful construction of substantive equality. Moreover, health care access intersects with dependency in a number of important ways. People with limited access to medical treatment experience heightened levels of vulnerability. Because of their limited resources, they may wait until a condition has progressed relatively far before obtaining health care or may go without treatment altogether. Thus, people whose economic status restricts their health care access are also more likely to find themselves sick or disabled. That is, they are more likely to end up in states of biological dependency.

²³⁷ FINEMAN, *supra* note 110, at xxi.

²³⁸ *Id.* at xiii, 16, 20, 38, 48; Fineman, *supra* note 174, at 255–56.

²³⁹ Fineman, *supra* note 174, at 274.

²⁴⁰ FINEMAN, *supra* note 110, at 10.

²⁴¹ Fineman, *supra* note 174, at 271.

²⁴² *Id.* at 256–57.

²⁴³ *Id.* at 260 (explaining “[autonomy] cannot be attained without an underlying provision of substantial assistance, subsidy, and support from society and its institutions, which give individuals the resources they need to create options and make choices”).

²⁴⁴ See *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973) (holding that wealth status does not receive heightened scrutiny under the Equal Protection Clause).

This lens reveals that the ACA's attempt to provide universal health insurance coverage is not merely a contentious partisan issue but rather an essential element to recognizing and responding to the inherent vulnerability of all Americans.²⁴⁵ Understanding health care reform through vulnerability theory emphasizes the law's equalizing and social justice effects, which are possible when the myth of self-reliance is unveiled so that policy can move toward a more just and responsive state. Post-ACA, poorer individuals have access to two different avenues of government assistance: the expanded Medicaid program and the low-income subsidy for private insurance—initiatives that can be understood as examples of the state responding to the concerns of its vulnerable citizens.

These programs also powerfully demonstrate that no bright line exists between work and welfare. First, two-thirds of the uninsured have at least one full-time or part-time worker in their household.²⁴⁶ Work no longer equates to health care benefits. Second, the ACA's expansion will render Medicaid the primary health insurance provider for the working poor. As expanded, Medicaid will cover non-elderly, non-disabled adults regardless of their work status.²⁴⁷ Many of the working poor do not receive employer-provided benefits, or are offered benefits that are too expensive,²⁴⁸ rendering Medicaid's public insurance benefit a foundational benefit for the health care access of Americans under the age of sixty-five.²⁴⁹ Third, one study found that, if the Supreme Court had ruled against the government in its 2015 *King v. Burwell* decision, of the individuals who would have lost their subsidies, 46% work full-time and 35% work part-time.²⁵⁰ A substantial portion

²⁴⁵ As noted above, one in six Americans and one in five children live in poverty, which is an inherently vulnerable status. See DENAVAS-WALT & PROCTOR, *supra* note 207, at 13 tbl.3; *Income and Poverty in the United States*, *supra* note 207.

²⁴⁶ KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., THE UNINSURED: A PRIMER, 4 figs.2 & 5 (2015), <http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer> [https://perma.cc/ANB4-9VMB].

²⁴⁷ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 547–48; Huberfeld & Roberts, *Great Society*, *supra* note 10, at 3–4.

²⁴⁸ MATTHEW BUETTGENS ET AL., URBAN INST., CHURNING UNDER THE ACA AND STATE POLICY OPTIONS FOR MITIGATION 2 (2012), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF> [https://perma.cc/R7DQ-TYRZ] (highlighting that many earning between 138–400% of the FPL must turn down employer-sponsored insurance because it is too expensive—32% of the uninsured are offered employer-sponsored insurance by their calculation).

²⁴⁹ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 556.

²⁵⁰ LINDA J. BLUMBERG ET AL., URBAN INST., CHARACTERISTICS OF THOSE AFFECTED BY A SUPREME COURT FINDING FOR THE PLAINTIFF IN *KING V. BURWELL* 1 (2015), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000078-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf> [https://perma.cc/M6GR-AJC4]; see also *King v. Burwell*, 135 S. Ct. 2480, 2492–93 (2015) (rejecting petitioners' interpretation of the statute).

of working Americans must depend on government supports, visible and hidden, to access private health care, especially given that employer-sponsored insurance has been decreasing over the last eight years.²⁵¹ Fourth, the phenomenon called “churn,” discussed in subsection 2, shows that public or private insurance status is a false indicator of “self-reliance.”

2. Dividing Line as Empirically Unprincipled

On one dimension, the ACA’s statutory drive for universality demonstrates the responsive state addressing inevitable human vulnerability, regardless of work status. But, on a different dimension, the statute’s perpetuation of the divided public versus private, dependent versus worker system extends the dichotomies explored earlier in this Part. These dyads do not reflect reality, as many Americans simultaneously work and rely on public benefits. More pointedly, contrary to the “able-bodied” rhetoric, most individuals who are newly eligible for Medicaid are also employed or in a household with a worker.²⁵² Although expansion-resistant politicians have cast Medicaid recipients as undesirable dependents who do not deserve governmental assistance,²⁵³ individuals receiving the low-income subsidy have been immune from such labels. This discrepancy is attributable to the differing views surrounding visible and hidden government benefits. This subsection shows that the dividing line between individuals on Medicaid and individuals receiving the low-income subsidy breaks down both on the theoretical and the data-driven, applied level.

²⁵¹ See Jessica Vistnes et al., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, MEDICAL EXPENDITURE PANEL SURVEY INSURANCE COMPONENT CHARTBOOK 2014, at vii (2015), http://meps.ahrq.gov/mepsweb/survey_comp/MEPSICChartbook.pdf [<https://perma.cc/BF4T-UUMV>]. One survey found:

Continuing a trend that began in 2008, the percentage of employees working in an establishment where insurance was offered fell from 84.9 percent in 2013 to 83.2 percent in 2014, a decline of 1.7 percentage points. Between 2003 and 2013, the percentage of employees at firms of all sizes who worked for employers that offered health insurance declined from 86.8 percent to 84.9 percent, with all the decline occurring between 2008 and 2012.

Id.

²⁵² KEY FACTS ABOUT THE UNINSURED, *supra* note 26, at 5 fig.4. In fact,

Most of the uninsured are in low-income working families. In 2013, nearly 8 in 10 [of the uninsured] were in a family with a worker, and nearly 6 in 10 have family income below 200% of poverty. Reflecting the more limited availability of public coverage, adults have been more likely to be uninsured than children.

Id. at 1.

²⁵³ See *supra* notes 64–67 and accompanying text (providing statements from politicians regarding the worthiness of Medicaid recipients).

The ACA's benefits for lower-income Americans provide a real-time case study for the arbitrary line drawn between socially acceptable and socially stigmatized government subsidies. Because the expanded Medicaid program provides visible government assistance and has been historically associated with welfare, which signals dependency, it has faced political opposition. But because the low-income subsidy is hidden assistance that facilitates purchasing health insurance on the private market, it has escaped self-reliance scrutiny. Even an individual subsidized completely—having all health insurance costs paid by the government—does not experience the stigma and political rhetoric of self-reliance scrutiny like the person who receives Medicaid benefits.

The artificial dividing line between people enrolled in Medicaid and people receiving low-income subsidies is not just theoretically false, it is quantifiably erroneous. Recall that Medicaid, as expanded, provides benefits to any non-elderly individual who earns up to 138% of the FPL and that the low-income subsidies are available, on a sliding scale, to individuals making 100% to 400% of the FPL. Because income and employment (with its attendant benefits) are variable, especially for hourly and low-wage workers, individuals bounce back and forth between the two vectors of health insurance, a phenomenon called “churn.”²⁵⁴ Before the ACA, low-income Americans were more likely to churn in and out of Medicaid, with no other affordable insurance mechanism existing to assist them when Medicaid eligibility ceased. Now, churn will occur between Medicaid and subsidized private insurance plans on the exchanges in states that have expanded Medicaid eligibility, which is less harmful to the insured.²⁵⁵ Churn is estimated to affect 50% of the newly insured Medicaid population.²⁵⁶

Churn is not a new problem; in 2003, one prominent article identified seven different patterns of insurance coverage instability.²⁵⁷ The problem of churn and its economic and medical effects was well known when the ACA was enacted. But churn has been exacerbated by the divided structure of

²⁵⁴ Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 228 (2011).

²⁵⁵ Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. 700, 705 (2014).

²⁵⁶ See Sommers & Rosenbaum, *supra* note 254, at 232; see also BUETTGENS ET AL., *supra* note 248 (reiterating the numbers involved in churn from the Sommers and Rosenbaum 2011 study); Sommers et al., *supra* note 255, at 704 (reporting year-long continuous coverage rates of approximately 50%, implying churn rates of a similar percentage).

²⁵⁷ See generally Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 HEALTH AFF. 244 (2003) (discussing the different patterns of insurance coverage instability then present).

universal health insurance coverage under the ACA.²⁵⁸ In the past few years, studies first predicted and then documented the phenomenon of churn in the era of the ACA, which is (counterintuitively) worse in richer states because they have more people living near or just above the FPL.²⁵⁹ Poorer states have more people living below the poverty level, so their coverage is less likely to change with small gains or losses in income.²⁶⁰

Whether an individual receives public or private insurance under the ACA's design is dependent on income, which appears a reasonable metric on the surface. But consider how churn highlights the illogical line between public and private insurance, with all of their underlying implications: a person who earns 140% of the FPL obtains private insurance on an exchange and is given generous subsidies for insurance premiums and any cost-sharing, but a person who earns 138% of the FPL qualifies for Medicaid and is receiving generous governmental insurance coverage (that largely forbids cost-sharing without a special waiver). At least one of these two people will, in any twelve-month period, move between Medicaid and subsidized private insurance. In non-expansion states, the person earning 138% of FPL will fall into the "penultimate poor" category, meaning no Medicaid expansion coverage exists once he or she churns out of private insurance.

Further, consider the income difference (or lack thereof). In 2015, the FPL was \$11,770 in income per year for a single individual,²⁶¹ so 138% of the FPL was \$16,242.60. That individual earns \$1353.55 per month, or \$338.38 per week, or \$67.67 per day in a five-day workweek (slightly more than a person earning minimum wage). By comparison, 140% of the FPL is \$16,478 in annual income, or \$1373.16 per month, or \$343.29 per week, or \$68.65 per day in a five-day workweek. In other words, the difference between the low-income subsidy and Medicaid is only several hundred dollars per year, the equivalent of a few days' pay. The person earning 140% of the FPL will then move from being deemed a self-reliant private insurance purchaser to a dependent Medicaid beneficiary after missing only a few days of work.

Studies have shown that individuals earning at the level of the FPL are the most likely to experience fluctuations in income and employment that result in churn.²⁶² Indeed, for someone earning 100% of the FPL, one day's

²⁵⁸ Sommers et al., *supra* note 255, at 705.

²⁵⁹ *See id.* at 704; *see also* BUETTGENS ET AL., *supra* note 248, at 5 ("To place churning's total magnitude in perspective, the 29.4 million people who will change coverage systems from year to year equal 31 percent of the estimated 95.9 million who will receive either Medicaid or exchange subsidies during any given year.")

²⁶⁰ *See* Sommers et al., *supra* note 255, at 704–05.

²⁶¹ 80 Fed. Reg. 3236 (Jan. 22, 2015).

²⁶² Sommers et al., *supra* note 255, at 704.

work is all it would take to lose private insurance and either enroll in Medicaid or lose coverage, depending on the state. To wit: a person earning the 2015 FPL of \$11,770 per year, or \$980.33 per month, or \$245 per week, or \$49.04 per day (in a five-day workweek) will lose subsidized coverage by missing just one day of work, given that an individual earning minimum wage would gross \$58 in one day. By this admittedly simplistic calculation, one day's work is the difference between insurance and non-insurance in non-expansion states, and three-and-a-half days' work is the difference in expansion states.

This distinction between self-reliance and dependence is completely arbitrary, yet very real given that people move—predictably—in and out of the safety net due to job status and other circumstances often beyond individual control. The difference between 140% and 138% of the FPL is not one between self-reliance and dependence. Missing work because of a brief illness or a family obligation could easily result in churn from the private to the public system. Somewhat ironically, the penultimate poor in non-expansion states are like Medicaid beneficiaries, who historically have cycled between Medicaid and non-insurance. Now, people enrolled in subsidized qualified health plans on the exchanges will also cycle between insurance and non-insurance in non-expansion states, even though the ACA intended Medicaid to catch all who churn off of public insurance to facilitate universality.

Furthermore, many Americans who are not currently in need of visible government assistance in obtaining health care could find themselves enrolled in Medicaid as the result of circumstances such as pregnancy and childbirth, disability, or old age. One aspect of Medicaid that renders its safety net effective is continual open enrollment, unlike the private insurance on the exchanges. Even prior to the ACA, Medicaid provided medical assistance to substantial numbers of pregnant women, funding half of the births in the United States and two-thirds of unplanned pregnancies (half of pregnancies are unplanned in the United States).²⁶³ The program also covered over one-third of American children as of 2012.²⁶⁴ As expanded, Medicaid will also cover many non-elderly, non-disabled adults regardless of their work status.²⁶⁵ Finally, as the primary funder of long-term care and mental health care in the United States, Medicaid plays a significant role in

²⁶³ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 551; Huberfeld & Roberts, *Great Society*, *supra* note 10, at 4.

²⁶⁴ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 551–52; Huberfeld & Roberts, *Great Society*, *supra* note 10, at 4.

²⁶⁵ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 546; Huberfeld & Roberts, *Great Society*, *supra* note 10, at 3–4.

the event of disability and at the end of life.²⁶⁶ Thus, Medicaid is the primary provider of health care for inevitably, though unforeseeably, dependent persons. Even an economically stable person who currently relies on the private market could also land in the public system as the result of a life event causing either temporary or permanent dependence.

Not only is the dividing line between visible and hidden government assistance empirically unprincipled, it is also harmful.²⁶⁷ Maintaining two completely distinct, complex programs for effectively the same population generates complications and efficiency costs as those individuals bounce between the different systems. Just when an individual has obtained one type of benefit and become acquainted with its rules and intricacies, that individual may be forced to seek a different type of benefit from a different source because of a one-day change in income. Churn is administratively inefficient and costly for the government and for insurance enrollees.²⁶⁸ Churn also causes insurance loss and provider change when moving between plans, leading to less efficient and less effective medical care if not total loss of care.²⁶⁹ And, churn exposes the insured to financial risk when health care must be obtained without insurance coverage. But churn is a symptom of the larger problem, which is the need to overcome the myth of self-reliance in policymaking, especially in the health care sphere.

As explained in the above sections, the myth of self-reliance permeates American culture, including the health insurance system, perpetuating false dichotomies. Individuals who receive government benefits through Medicaid are undesirable “dependents,” whereas those who obtain private health insurance—even if heavily subsidized—are good workers and productive citizens. This division proves false both theoretically and through demographic data. All human beings are potentially vulnerable and dependency

²⁶⁶ Huberfeld & Roberts, *Empirical*, *supra* note 10, at 552–53; Huberfeld & Roberts, *Great Society*, *supra* note 10, at 4–5.

²⁶⁷ Sara Rosenbaum, *Clash of the Titans: Medicaid Meets Private Health Insurance*, 15 *YALE J. HEALTH POL'Y L. & ETHICS* 197, 203 (2015). As one scholar explained,

The great advance of the ACA is that, as with Massachusetts, the law has the potential to dramatically reduce periods without coverage. But the bifurcation of the affordable insurance system means that breaks are essentially baked into the design of the program unless effective mitigation strategies can be developed. And coverage breaks are a major cause for concern—not only because of their implications for the continuity and quality of coverage and care but also because of their impact on risk estimates. As people cycle on and off coverage, the risk also increases that they will delay necessary health care until insurance is subsequently regained, a danger to their health and an added element of financial risk for the private insurance market.

Id.

²⁶⁸ See BUETTGENS ET AL., *supra* note 248, at 2, 7–8.

²⁶⁹ See Sommers & Rosenbaum, *supra* note 254, at 232.

is universal. Moreover, individuals who benefit from Medicaid and the subsidies are largely the same populations, with low-income Americans moving from one system to the other and back again. Yet on one side of the line there is political and social support, and on the other there has been vitriolic opposition and self-reliance scrutiny. Not only is the current distinction between visible and hidden assistance for the poor unprincipled, it is also socially damaging, as time and resources are wasted and medical care is missed when individuals move between the two systems. Hence, health care is not an opportunity to be seized by the self-reliant individualist but rather a public good that will be needed by all, as underlined by the ACA's universality. To that end, the following Part proposes erasing this false dividing line.

III. MOVING BEYOND MYTHS: TOWARD A UNIFIED SYSTEM

Having established that self-reliance in health care is a myth and that, by consequence, the dividing line between visible and hidden government assistance is unprincipled and perhaps even harmful to patients, this Article now turns to addressing this seemingly intractable and uniquely American problem. This Part proposes that Congress should abandon the bifurcated insurance system continued by the ACA for low-income Americans and adopt a unified structure that reflects the intended universality of the ACA.

This Part therefore explores the benefits and drawbacks of a single program of government assistance for health insurance, either based in the ACA's tax subsidies or in Medicaid, to facilitate a simpler, more effective, and perhaps even less stigmatized, system of support for the poor. This proposal works with the structure of the ACA because it appears to be on solid legal ground in the post-*NFIB* and post-*King* era.²⁷⁰ The authors recognize, however, that the ACA may be itself an interim step toward a more radically revised health care system, perhaps one less path-dependent and complex. This exploration is deliberately limited in light of the political realities of the current Congress, which seems hopelessly deadlocked on most matters health care-related.

A. Subsidy-Based Unified System

One possibility for a unified health insurance system, given the current structure of health insurance under the ACA, would be to eliminate the historically contentious Medicaid program entirely and to instead provide access to health insurance exclusively through tax subsidies. Such an ap-

²⁷⁰ See *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 123 S. Ct. 2566, 2608 (2012).

proach has positive and negative ramifications from a variety of viewpoints, including personal and programmatic stigma perpetuation, access to care, administrative matters, and cost control implications.

Within the context of this Article's exploration of the myth of self-reliance, a subsidy-based unified program would likely thwart a significant amount of dependency rhetoric and its attendant imposed stigma. Under such a system, anyone who needed government assistance to pay for health insurance would receive the more politically accepted hidden government assistance of tax subsidies. As a result, no one would be labeled an underserving able-bodied dependent on the basis of need for government assistance when obtaining health insurance.²⁷¹

The absence of personal stigma could in turn have a positive effect on health care access by stimulating enrollment by those already eligible. As noted, eligible individuals may avoid enrolling in Medicaid because they do not want to be classified as socially undesirable dependents.²⁷² The absence of comparable animosity toward the hidden subsidy indicates that more people may be willing to accept such benefits when they qualify. In fact, the ACA contains a provision that combats Medicaid's stigma by facilitating enrollment through "no wrong door" policies, meaning a person who applies through an exchange but who qualifies for Medicaid will be directed appropriately to Medicaid, and vice versa. This unified enrollment mechanism is administratively efficient, but it also hides the Medicaid application, creating an equalizing and less stigmatizing effect that encourages enrollment.²⁷³ Thus, government assistance through hidden benefits could capture more individuals in need than visible government assistance.

In addition, private insurance historically offers a wider network of health care providers to policyholders than Medicaid. In part, this phenomenon is related to private insurance paying providers more than both Medicare and Medicaid on average. In part, the wider network is related to the stigma that Medicaid beneficiaries and the program itself face in physicians' offices, where they are often labeled as noncompliant and difficult, among

²⁷¹ Proponents of the earned income tax credit ("EITC") have made similar arguments. See Anne Alstott, *The Earned Income Tax Credit and the Limitations of Tax-Based Welfare Reform*, 108 HARV. L. REV. 533, 565 (1995) ("[A]dvocates claim[] tax-based transfers can reduce the stigma and social isolation associated with welfare.").

²⁷² Empirical data indicate that stigma can have a negative effect on Medicaid enrollment. See Jennifer Stuber & Karl Kronebusch, *Stigma and Other Determinants of Participation in TANF and Medicaid*, 23 J. POL'Y ANALYSIS & MGMT. 509, 526 (2004) ("Identity stigma—concerns about being labeled by welfare stereotypes—decreased participation . . . in Medicaid.").

²⁷³ See Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289–91 (2010) (codified in scattered sections of U.S.C. tits. 18, 20–21, 25–26, 28–31, 35, 42 (2012)) (enacting such policies).

other epithets. Health care providers often perceive Medicaid as more administratively difficult than private insurance, as states can be very slow to pay in addition to paying lower rates than other forms of health insurance.²⁷⁴ Accordingly, having low-income populations in private insurance plans could increase their access to health care providers in meaningful ways because they would bypass the Medicaid stigma both personally and programmatically. But this anti-stigma effect on access could be defeated by the post-ACA trend toward narrow networks, in which insurers engage fewer health care providers in an effort to control costs.²⁷⁵

Yet, although an all-subsidy system may avoid the personal and programmatic stigma of dependency and positively impact access, it leaves the beliefs and dichotomies of the self-reliance myth intact. Though Medicaid recipients' stigma would be alleviated, the beneficiaries of other visible benefits programs (namely welfare programs) would still find themselves subject to self-reliance scrutiny. A subsidy-based unified system might thereby destigmatize government aid for health insurance but not for other kinds of visible government assistance.

Eliminating Medicaid and replacing it with an all-subsidy private insurance model could have administrative implications. For example, the current subsidy operates as a tax credit.²⁷⁶ Individuals can receive their support in one of two ways: either (1) as a direct payment to an insurer on the marketplace to lower the recipient's costs or (2) as an adjustment on the person's tax return.²⁷⁷ Recipients can decide how much of their credit they would like to apply toward their monthly premiums and how much they would like to receive at tax time.²⁷⁸ Advocates of tax-based welfare initiatives have also asserted that hidden benefits are more administratively efficient than their more visible counterparts because most people already file annual tax returns. For example, proponents of the earned income tax credit

²⁷⁴ See generally Huberfeld, *supra* note 56 (discussing the importance of payment rates in physicians' decisions of whether to see Medicaid patients).

²⁷⁵ See generally SABRINA CORLETTE ET AL., GEORGETOWN UNIV. HEALTH POLICY INST. & URBAN INST., NARROW PROVIDER NETWORKS IN NEW HEALTH PLANS: BALANCING AFFORDABILITY WITH ACCESS TO QUALITY CARE (2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643 [<https://perma.cc/G66V-EUPU>] (discussing the phenomenon of narrow networks).

²⁷⁶ KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 4 (2014), <http://files.kff.org/attachment/explaining-health-care-reform-questions-about-health-insurance-subsidies-issue-brief> [<https://perma.cc/7JQT-3PZK>] [hereinafter EXPLAINING HEALTH CARE REFORM].

²⁷⁷ *Id.* at 5.

²⁷⁸ *Id.*

and other programs argue that such programs could reduce the role of complex and costly bureaucracy.²⁷⁹

In terms of economic benefits, an all-subsidy program may hold potential for more economic flexibility, and perhaps cost savings, than Medicaid. Although states may vary in terms of the benefits they provide recipients above the federally required mandatory floor, once enrolled, Medicaid beneficiaries for the most part have free access to their state's program.²⁸⁰ In other words, a person who is at 138% of the FPL and a person at 38% of the FPL will have access to the same set of benefits at the same cost if they live in the same place. Conversely, the low-income subsidy provides tax credits on a sliding scale, according to income level. Unlike Medicaid's equalizing uniformity, the low-income subsidy's structure allows the government to tailor the level of assistance to each individual's economic need. This level of specificity could make the unified subsidy option more economically efficient because it could reduce the chances that a person might receive more of a benefit than what is actually required, and only individuals with the greatest need would get policies that are fully funded by the government. This flexibility might be politically palatable on both sides of the aisle.

Although tax credits have generally gained popularity as a "pro-work" alternative to direct assistance,²⁸¹ they face certain administrative limits as a welfare-policy vehicle. To start, not everyone must file a tax return. Specifically, the poor are not typically required to file, unless they are seeking a tax credit.²⁸² Thus, one drawback of an all-subsidy system is that those who are in need of government assistance with health insurance may not regularly file tax returns. Requiring government assistance to turn on filing a tax return—when the person would not otherwise be obligated to do so and perhaps cannot afford to do so—could therefore inadvertently exclude a signif-

²⁷⁹ Alstott, *supra* note 271, at 564–65.

²⁸⁰ Some states have been requiring cost-sharing as part of their § 1115 waivers to expand Medicaid under the ACA. MARYBETH MUSMECI & ROBIN RUDOWITZ, KAISER FAMILY FOUND., THE ACA AND MEDICAID EXPANSION WAIVERS 8–9 (2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers> [<https://perma.cc/3MS6-PY2P>]. And the Deficit Reduction Act of 2005 as well as the ACA allowed states to engage in some cost-sharing experiments, especially with the newly eligible population (under the ACA). Paradise, *supra* note 40, at 5; see also *infra* note 309 (discussing the Deficit Reduction Act).

²⁸¹ Alstott, *supra* note 271, at 539 n.22 (quoting 139 CONG. REC. H5532 (daily ed. July 30, 1993) (statement of Rep. Richardson)) (explaining that advocates of the EITC described the tax credit as "pro-work because, unlike other forms of assistance to the poor, only those who work and have earnings can receive benefits").

²⁸² *Id.* at 585.

icant portion of government beneficiaries, thereby undermining the goal of the program.²⁸³

Even assuming that eligible individuals file tax returns, the subsidy still faces other administrative challenges as a vehicle of government assistance for the poor. One scholar explains that a tax-based welfare program must inevitably confront the issue of how to measure income, as defining income for tax purposes and defining income for benefits purposes serve two different sets of objectives.²⁸⁴ “Income” in the benefits context is more rightly understood as a proxy for “economic resources.”²⁸⁵ Hence, in assessing income, tax-based welfare programs are attempting to assess need. Taxable income is such a flawed measure of need, though, that another scholar has opined:

Taxable income as defined for the federal income tax is so poor a definition of need that to use it as the base for negative income tax payments would be a travesty of common sense and good justice. Society does not want to pay benefits to people with low taxable income but with ample resources—wealth, tax-exempt interest, capital gains, pensions, social security stipends, college fellowships, large itemized deductions, gift receipts, and so on.²⁸⁶

Thus, although a subsidy system could offer a finer calibration of need because it operates on a sliding scale, using taxable income as a baseline could result in an allocation of benefits that does not correspond to actual resources.²⁸⁷

In addition, scholars point out that there is a lag between changes in income and the responsiveness of the tax system. Depending on the given tax structure and its associated accounting periods, a tax credit may either favor or harm individuals with fluctuating or with steady incomes.²⁸⁸ Because incomes fluctuate, the associated benefit will also shift—going back to the problem of churn, discussed above. The HealthCare.gov website explains that, “If your income changes, or if you add or lose members of your

²⁸³ Anne Alstott makes a similar observation regarding the EITC. *See id.* (“Ironically, the traditional tax policy goal of exempting the poor from income taxation tends to undermine automatic EITC participation.”).

²⁸⁴ *Id.* at 566–69.

²⁸⁵ *Id.* at 571.

²⁸⁶ *Id.* at 573 (quoting James Tobin, *Raising the Incomes of the Poor*, in *AGENDA FOR THE NATION* 113 (Kermit Gordon ed., 1968)).

²⁸⁷ *Id.* at 576–79.

²⁸⁸ *Id.* at 579–83.

household, your premium tax credit will probably change too.”²⁸⁹ Specifically, it explains that if an individual actually makes more than originally anticipated, he or she might have to pay back some—even all—of the premium tax credit received.²⁹⁰ A person with an unstable income who needs a subsidy may not be able to afford the cost of the full premium up front. The website also cautions individuals that they must immediately report any life changes that could affect their subsidy amount or they could end up owing money to the government.²⁹¹ In 2015, by at least one estimate, two-thirds of subsidy recipients ended up owing the government some amount of money at tax time.²⁹² That said, it is also possible that a Medicaid recipient might end up owing the government money. If a person’s income increases past the eligibility point while on benefits, the government may require reimbursement for services received before the change in status officially took effect. On the other hand, for a program offering a single level of support, eligibility is an up-or-down determination. A person cannot be partially eligible.

Finally, private insurance is, by most accounts, more expensive, administratively and in terms of the cost of care, than public insurance.²⁹³ Researchers have consistently found that private insurance is more costly than public insurance.²⁹⁴ This may in part be due to the fact that we invite the mid-

²⁸⁹ *How to Save on Your Monthly Insurance Bill with a Premium Tax Credit*, HEALTH CARE.GOV, <https://www.healthcare.gov/lower-costs/save-on-monthly-premiums> [<https://perma.cc/C9LJ-A3QV>] [hereinafter *How to Save*]; see also *Premium Tax Credits*, OBAMACARE FACTS, <http://obamacarefacts.com/insurance-exchange/premium-tax-credits/> [<https://perma.cc/9B27-HS5R>] (explaining “[i]f your income changes slightly, then the exact amount of assistance you get will too”).

²⁹⁰ *How to Save*, *supra* note 289; see also *Premium Tax Credits*, *supra* note 289 (advising subsidy recipients who are unsure of their exact amount of income not to take any of the credit in advance and to just wait for the benefit until tax time).

²⁹¹ *How to Save*, *supra* note 289 (“It’s very important to report income and household changes to the Marketplace as soon as possible.”); see also *Premium Tax Credits*, *supra* note 289 (stressing the importance of reporting life changes to the marketplace).

²⁹² Tom Howell, Jr., *No Free Ride: Two-Thirds of Obamacare Recipients Had to Repay Subsidies to IRS*, WASH. TIMES (Apr. 27, 2015), <http://www.washingtontimes.com/news/2015/apr/27/66-pct-obamacare-customers-paid-back-subsidies-irs> [<https://perma.cc/G98G-XA87>].

²⁹³ E.g., Jack Hadley & John Holahan, *Is Health Care Spending Higher Under Medicaid or Private Insurance?*, 40 INQUIRY 323, 333 (2003).

²⁹⁴ CMS recently issued a report showing that qualified health plans in the exchanges are more costly than public plans. CTRS. FOR MEDICARE & MEDICAID SERVS., CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS 3 (2015), <http://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf> [<https://perma.cc/WAU6-8ZB7>] (finding that the Children’s Health Insurance Program, which is tied to Medicaid in many states, offers more comprehensive insurance coverage at lower out of pocket cost than qualified health plans in any state). See generally Leighton Ku & Matthew Broaddus, *Public and Private Health Insurance: Stacking Up the Costs*, 27 HEALTH AFF. w318 (2008), <http://content.healthaffairs.org/content/27/4/w318.full.pdf+html> [<https://perma.cc/ETV6-VWFK>] (reporting higher costs for private insurance than Medicaid

dleman of employers into private insurance, and because Medicaid simply pays providers less than private insurance; but it is also due to private-insurance-specific factors, such as high pay for executives, marketing costs, concerns about shareholder profits, and administrative costs and waste in refusing and delaying payment. Thus, pushing all low-income Americans into private insurance could result in higher health care costs due to an extension of the higher costs of private insurance.

B. Medicaid-Based Unified System

Building on the universality embraced by the ACA, Medicaid could cover everyone up to 250% of the FPL, with no other qualifying characteristics. Like the all-subsidy approach, this model contains positive and negative implications from a variety of viewpoints, including possible influence on health care fragmentation, personal and programmatic stigma, access to care, administrative matters, cost control, and implications for universality.

From a theoretical perspective, an all-Medicaid system would avoid self-reliance scrutiny and destigmatize recipients of government assistance. The ACA adopted a principle of universality,²⁹⁵ a key change for a previously exclusionary system.²⁹⁶ This effort is arguably most evident in Medicaid.²⁹⁷ Because the ACA's principle of universality rendered Medicaid a social insurance program, rather than a welfare program, this section briefly considers the statutory implications of the ACA as enacted (rather than as judicially interpreted). If the ACA were implemented as enacted, every state would cover all of the nation's poor earning up to 138% of the FPL, regardless of work status, parenting status, or other proxy for self-reliance. As enacted, the ACA ensured that the poor would not be excluded from health insurance because they could not afford it, whether or not they are currently working. As enacted, the ACA rejected states' path dependence in welfare policies—

and CHIP); Letter from Douglas Elmendorf, Dir., Cong. Budget Office, to Honorable Charles B. Rangel, Chairman, House Comm. on Ways & Means (Oct. 29, 2009), <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/hr3962rangel0.pdf> [<https://perma.cc/7R75-XHQ3>] (analyzing the proposed public health insurance option as administratively cheaper than private insurance, but not necessarily cheaper than private insurance overall depending on whether the payment rates compete with private insurance).

²⁹⁵ See generally Roberts & Huberfeld, *Empirical*, *supra* note 10 (exploring the principle of universality in Medicaid); Roberts & Huberfeld, *Great Society*, *supra* note 10 (same).

²⁹⁶ See generally Huberfeld, *supra* note 9 (exploring the principle of universality in Medicaid).

²⁹⁷ See *supra* notes 37–72 and accompanying text (examining self-reliance scrutiny and stigma against Medicaid recipients under current scheme). See generally Roberts & Huberfeld, *Empirical*, *supra* note 10 (exploring the principle of universality in Medicaid); Roberts & Huberfeld, *Great Society*, *supra* note 10 (same).

policies which have often been punitive in nature and have facilitated exclusion in health care access in many states. As enacted, the ACA strengthened Medicaid's universality by increasing payments to primary care physicians for 2013–14, which was designed to encourage better physician uptake of the newly eligible population.²⁹⁸ And, as enacted, the Medicaid population would already be one quarter of the U.S. population at any given moment, further facilitating the ACA's destigmatizing effects through the principle of universality.

Instead, *NFIB* continues to thwart low-income Americans intended to be protected by the principle of universality from being fully de-stigmatized. Though *King* would have been disastrous for people relying on tax subsidies if the Court had held for the law's challengers, *NFIB* has done more than frustrate unified implementation of the Medicaid expansion—it has allowed states to reintroduce self-reliance scrutiny into Medicaid. The Obama Administration is negotiating with states in a conciliatory fashion to ensure that expansion and enrollment occur; their current goal is policy entrenchment. As these expansion negotiations continue, *NFIB* has made it so that the myth of self-reliance can be reintroduced into health care through enforceable cost-sharing requirements, job training, work search,²⁹⁹ and related “self-reliance” requirements.³⁰⁰ HHS rejects such state-imposed self-reliance myths, as they are unrelated to the Medicaid Act's goal of providing “medical assistance,” but state legislators have been finding ways to link state-based work search requirements to state-run welfare programs as side-along requirements for Medicaid expansion.³⁰¹

²⁹⁸ Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, § 1202, 124 Stat. 1029 (codified in scattered sections of U.S.C. tits. 20, 26, 42 (2012)).

²⁹⁹ See, e.g., Eric Whitney, *Wittich Suspicious of Montana Medicaid Expansion Waiver Application*, MONT. PUB. RADIO (Aug. 17, 2015), <http://mtrp.org/post/wittich-suspicious-montana-medicaid-expansion-waiver-application> [https://perma.cc/9ZVA-UYP4] (discussing Montana's waiver application). The article conveys, regarding Montana's Medicaid expansion waiver negotiations:

Representative Art Wittich, a Belgrade Republican, says the state's draft waiver application appears to leave out provisions requiring some recipients to work or look for work to continue receiving benefits if they fail to pay premiums for Medicaid coverage. “That language was not in this waiver application,” Wittich said, “and I want to make sure that CMS has that so that there isn't a misunderstanding down the road when the state wants to enforce it.”

Id.

³⁰⁰ Though HHS cannot approve work-related requirements, some states are contemplating state-based work-search requirements that could interfere with other welfare benefits if not fulfilled. See UNINSURED ADULTS, *supra* note 72, at 2.

³⁰¹ See Corey Davis, *Medicaid Expansion Work Requirements*, NAT'L HEALTH L. PROGRAM (Oct. 4, 2013), <http://www.healthlaw.org/publications/search-publications/Medicaid-expansion->

If Medicaid covered everyone up to 250% of the FPL, these non-health care related requirements would be revealed as ideology rather than meaningful health policy. As discussed above, people falling into the category of the penultimate poor who qualify for Medicaid but cannot enroll because they live in non-expansion states are largely workers.³⁰² And those uninsured before the ACA was enacted were primarily workers.³⁰³ Work requirements would be meaningless for people already working and would be revealed as political grandstanding if Medicaid eligibility increased to earnings of 250% of the FPL.

Moreover, just by covering low-income families at up to 138% of the FPL, which in 2015 was about \$16,245 per year for a single person, Medicaid is estimated to cover 25% of the U.S. population upon full implementation of Medicaid expansion.³⁰⁴ A program that commonplace, through pure numbers, could defeat the stigma traditionally associated with it on both personal and programmatic dimensions—especially if 138% were raised to 250% of the FPL.³⁰⁵ In fact, some managed-care companies that serve Medicaid beneficiaries are already using marketing language like “treat yourself” to Medicaid, a signal that universality makes the program more desirable.³⁰⁶ Additionally, from a personal stigma perspective, Medicaid beneficiaries would no longer be “other”—the status of using Medicaid for health insurance would be the norm, rather than relegated to maternity wards, nursing homes, and a limited range of other health care providers.³⁰⁷ This personal destigmatization could strengthen programmatic reputation, as Medicaid

work [<https://perma.cc/CW9C-7JWW>] (explaining why states will be unable to impose such work requirements).

³⁰² See *supra* notes 188–269 and accompanying text (examining and dismissing popular notions that those receiving public assistance do not engage in work).

³⁰³ See Sara Rosenbaum, *Medicaid and National Health Care Reform*, 361 *NEW ENG. J. MED.* 2009, 2010 (2009).

³⁰⁴ CONG. BUDGET OFFICE, *supra* note 61, at 58 (“By 2024, about 89 million people will be enrolled in Medicaid at some time during the year.”). Medicaid already covers 22% of the population. *Total Monthly Medicaid and CHIP Enrollment*, KAISER FAMILY FOUND. (2015), <http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment> [<https://perma.cc/5W49-8Z58>].

³⁰⁵ See generally Heidi Allen et al., *The Role of Stigma in Access to Health Care for the Poor*, 92 *MILBANK Q.* 289 (2014) (studying and discussing the role of stigma for low-income patients).

³⁰⁶ For example, Passport Health Plan in Kentucky used this language in newspaper and billboard advertisements to encourage enrollment when Kentucky expanded Medicaid eligibility. See *Advertisement for Passport Health Plan*, FLOYD COUNTY TIMES (Nov. 19, 2014), <http://ads.floydcountytimes.com/prestonburg-ky/communication/newspaper/the-floyd-county-times/2014-11-19-1383772-treat-yourself-to-a-medicaid-plan-that-cares-if-you-ve-had-trouble-getting-health-care-coverage-call-passport-we-ll-take-the-time-to-listen-and-understand-your-needs-call-us-at-1-800-578-0603-to-make-passport-your-medicaid-plan-we-take-t> [<https://perma.cc/MA4W-HGXE>].

³⁰⁷ See Huberfeld, *supra* note 9, at 69 (discussing value of expanding Medicaid beyond certain persons and illnesses).

beneficiaries would be in every part of the health care system, forcing the program itself to stop behaving like Medicare's stunted sibling. This universality would underline Medicaid's new role as social insurance rather than welfare medicine, which in turn could have a halo effect on other welfare-related programs and populations.

Beyond the potential to destigmatize, raising the eligibility level to earnings of 250% of the FPL would be prudent policy for a number of reasons. Current data regarding purchasers of health insurance through state and federal exchanges indicate that the 250% line would capture most families that receive substantial tax subsidies and assistance with cost-sharing.³⁰⁸ Moving enrollment from hidden to visible government assistance would place low-income individuals and families in a public program that has fewer out-of-pocket expenses.³⁰⁹

³⁰⁸ In 2015, about 11.7 million people "selected" qualified health plans, and 10.2 million effectuated that selection by paying premiums for private health insurance on the federal and state exchanges. *March 31, 2015 Effectuated Enrollment Snapshot*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html> [<https://perma.cc/BU45-KE2C>]. Of the 10.2 million who purchased private insurance, about 85% (8.7 million) qualified for subsidies, and nearly 58% of all enrollees also qualified received cost-sharing assistance (5.9 million). *Id.* Cost-sharing assistance is available on a sliding scale to those earning 100–400% of the FPL, but the greatest cost-sharing benefits go to those earning 100–250% of the FPL due to the ACA's complex algorithm for cost-sharing assistance. *See* ACA § 1402, 124 Stat. at 202. Additionally,

People who are eligible to receive a premium tax credit and have household incomes from 100% to 250% of poverty are eligible for cost-sharing subsidies. (The cost-sharing subsidies are available only to the lowest income Marketplace enrollees who meet all of the other criteria for receiving the premium tax credit). . . . [T]he eligible individual or family must purchase a silver level plan in order to receive the cost-sharing subsidy.

EXPLAINING HEALTH CARE REFORM, *supra* note 276, at 5.

³⁰⁹ As enacted in 1965, Medicaid contained no premiums and no co-payments, and studies have consistently shown that such expenses (premiums and co-payments) prevent Medicaid beneficiaries and other patients from obtaining care. *See, e.g.,* Niteesh K. Choudhry et al., *Eliminating Medication Copayments Reduces Disparities in Cardiovascular Care*, 33 HEALTH AFF. 863, 863 (2014) (finding co-payments are a barrier to appropriate care for non-white patients after a cardiovascular event); LEIGHTON KU & VICTORIA WACHINO, CTR. ON BUDGET & POLICY PRIORITIES, THE EFFECT OF INCREASED COST-SHARING IN MEDICAID 1–2 (2005), <http://www.cbpp.org/sites/default/files/atoms/files/5-31-05health2.pdf> [<https://www.perma.cc/2ATU-S8RW>] (asserting that co-payments and premiums in Medicaid are barriers to enrolling in insurance and to accessing care). Nevertheless, through waivers and some measures implemented by recent statutory amendments such as the Deficit Reduction Act of 2005, as well as the ACA, some cost-sharing occurs in Medicaid, though historically it is non-enforceable, meaning care cannot be denied for inability to pay. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-71, 120 Stat. 4 (codified in scattered sections of U.S.C. tits. 7, 12, 16, 20, 28–29, 42, 47); Ctrs. for Medicare & Medicaid Servs., *Cost Sharing*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html> [<https://perma.cc/ZU5Y-V356>]. The premiums and cost-sharing in private insurance, and thus in the exchanges, are notably higher than what is permitted in Medi-

Raising the eligibility level could also unite families that have disparate policies, which complicates health care access and cost. The following situation, for example, is not uncommon for low-income families: the mother is on Medicaid when she's pregnant, her spouse is receiving subsidies to purchase an individual policy on an exchange, and their child is enrolled in the Children's Health Insurance Program. Such families experience individual fragmentation within our already highly fragmented health care system.³¹⁰ Fragmentation encompasses disconnection along the vectors of both access to and continuity of care. When each family member has a different type of insurance with different types of accompanying benefits, accessing the health care system becomes even more complex and daunting.³¹¹ Unification through raising Medicaid eligibility to 250% of the FPL could combat both individual and systemic fragmentation, improving care and simplifying families' financial and health care needs.³¹²

In terms of administrative simplification, Medicaid eligibility up to 250% of FPL could create a floor of federal standards that is less state-deferential than the rules for qualified health plans in the exchanges. Though states have flexibility in creating benchmark equivalent coverage for the newly eligible Medicaid population under the ACA, the benchmark coverage arguably is more consistent from state to state than the private insurance available on the exchanges.³¹³ Further, staffing could be streamlined, eliminating the need for navigators and others who facilitate insurance enrollment through exchanges. More generous open enrollment and more consistent enrollment and payment policy for Medicaid could simplify not only administration of health insurance generally, but also such common individual life events as moving to another state for a job or adding a family member.

On the other hand, despite federally uniform standards, Medicaid has fifty-six different versions; each state, territory, and the District of Columbia can exercise options available in the Medicaid Act, which complicates the administration of Medicaid as compared to a totally federal program like Medi-

caid. See Ku & Broaddus, *supra* note 294, at w322–25 (comparing Medicaid to private insurance costs and finding that Medicaid has significantly lower out-of-pocket costs and costs less per insured).

³¹⁰ See generally THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 70 (exploring the fragmented nature of the health care system in the United States).

³¹¹ Organizations like Texas-based Community Health Choice attempt to provide an ad hoc solution for this fragmentation for low-income families by offering plan management across the various programs. See *About Us*, CMTY. HEALTH CHOICE, <https://www.communitycares.com/en-us/About-Us> [<https://perma.cc/S47E-MT2R>].

³¹² See generally Huberfeld, *supra* note 9 (discussing the de-fragmenting effect universality should have on health care generally).

³¹³ See ACA § 2001, 124 Stat. at 271–79 (regarding benchmark coverage for the newly eligible Medicaid population).

care. This federal-state partnership can encourage experimentation that spurs improved enrollment or better care, but the argument for “innovation” is overshadowed by the fact that no clearinghouse exists for processing or analyzing state experimentation and its results. Though the federalism relationships in Medicaid may be confounding, Medicaid’s various state-based incarnations are no more complicated than tax subsidies that are dependent on the federal tax system combined with state-based models.

In terms of economic implications, Medicaid historically has been inexpensive—by American health care standards—on a per capita basis as well as in administrative costs.³¹⁴ This may seem counterintuitive given the large share of state budgets that Medicaid occupies (typically the second-largest budget item, behind education). Medicaid’s relatively low costs stem from various factors, including a small administrative agency staff relative to the size of the program, sharing costs with states, and paying participating providers less than private insurance or Medicare.³¹⁵ The low payment of health care providers in Medicaid has been the subject of much litigation, recently shut down by the Supreme Court.³¹⁶ One of the authors has written elsewhere about the Supreme Court’s 2015 decision in *Armstrong v. Exceptional Child Center, Inc.* and next steps for ensuring sufficient payment for Medicaid providers.³¹⁷ Fair payment in Medicaid certainly factors into provider willingness to see Medicaid patients, and states have proven that their need to balance budgets on the back of Medicaid providers makes HHS’s role in overseeing payment rates crucial. But, although some states have been slow to pay in times of budget crises, Medicaid generally does not engage in the same slow-pay or no-pay games that private insurers have used. Further, Medicaid carries neither the executive compensation nor marketing expenses that private insurers claim are essential to their operations.³¹⁸

Unifying insurance coverage through Medicaid for everyone earning up to 250% FPL could also reduce churn, as people earning less than 250% of FPL are the most likely to experience income fluctuation and thus discontinuity of insurance coverage.³¹⁹ Health policy experts have suggested

³¹⁴ See Ku & Broaddus, *supra* note 294, at w323; Rosenbaum, *supra* note 303, at 2010–11.

³¹⁵ See Huberfeld, *supra* note 56, at 1157 (discussing Medicaid’s low payment rates from an empirical perspective).

³¹⁶ *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1383 (2015) (deciding that the Supremacy Clause does not provide a private right of action for health care providers seeking to force states to pay sufficient rates in the Medicaid program).

³¹⁷ See Huberfeld, *supra* note 56, at 1159–60.

³¹⁸ See Rosenbaum, *supra* note 303, at 2011 (noting Medicaid’s lower administrative costs relative to commercial insurers).

³¹⁹ See BUETTGENS ET AL., *supra* note 248, at 4 (finding that churn is most prevalent for those earning 200% of the FPL or less).

other measures to help reduce churn, such as data collection regarding disenrollment and other enrollment-related information; twelve-month eligibility rather than monthly determinations in Medicaid; use of premium assistance to help Medicaid beneficiaries purchase private insurance in exchanges so they can stay in one plan regardless of the source of payment; and use of the ACA's Basic Health Program option.³²⁰ Although these measures are likely to mitigate churn in the context of the existing statutory structure, raising Medicaid eligibility could have even greater impact in reducing interruptions in care and coverage that now occur because of churn.

In summary, this Part demonstrates that a unified system of government assistance for the poor has both theoretical and real-world benefits. An all-subsidy government program for the poor could avoid the dependency stigma and self-reliance scrutiny frequently attached to visible government benefits like Medicaid, facilitating greater enrollment and perhaps greater access to health care providers than Medicaid beneficiaries typically experience. From a cost perspective, a subsidy-based system that operates on a sliding scale also may offer some economic nimbleness, ideally ensuring that people in need receive the right amount of support from the government while avoiding waste. Although the low-income subsidy avoids the pitfalls of self-reliance scrutiny, it does nothing to nullify the underlying beliefs. Consequently, aid recipients might escape negative stereotyping in the health insurance context but still be subject to dependency stigma in other areas. Further, tax subsidies are a clunky mechanism for redistributing wealth for health insurance coverage, and private insurance has been shown to be more administratively costly than public insurance.

On the other hand, an all-Medicaid program that raises eligibility to 250% of FPL reduces health care fragmentation for both families and the system as a whole. The sheer number of people covered and their ubiquity in the health care system, in contrast to their current limited visibility, would reduce personal and programmatic stigmatization. Further, all-Medicaid would likely simplify administrative matters, and relatedly would likely result in lower costs of care, as Medicaid is historically a less expensive mechanism for

³²⁰ See, e.g., SARA ROSENBAUM ET AL., THE COMMONWEALTH FUND, MITIGATING THE EFFECTS OF CHURNING UNDER THE AFFORDABLE CARE ACT: LESSONS FROM MEDICAID 3–4 (2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1754_rosenbaum_mitigating_effects_churning_aca_rb_v2.pdf [<https://perma.cc/EJS2-J9TH>]; Sommers et al., *supra* note 255, at 705–06; Katherine Swartz et al., *Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year Is Most Effective*, 34 HEALTH AFF. 1180, 1181, 1184 (2015) (analyzing potential impact of four possible churn-reduction proposals); *Key Implementation Issues: Retention and Churn*, NAT'L ACADEMY FOR STATE HEALTH POL'Y, <http://www.nashp.org/retention-and-churn> [<https://perma.cc/8WJH-GKVX>].

providing medical care. Finally, the principle of universality is better fulfilled, in all of its dimensions, through this approach.

CONCLUSION

In the United States, government assistance in health insurance takes two primary forms: visible direct benefits and hidden tax subsidies. When Congress enacted the ACA, it perpetuated this divided system by creating bifurcated support for poorer Americans through (1) the low-income subsidy and (2) the expanded Medicaid program. Yet, although the low-income subsidy survived its legal challenge in June 2015, the Supreme Court effectively gutted the Medicaid expansion in an earlier decision. Likewise, politicians have expressed disdain and reluctance for visible benefits for low-income Americans, while remaining relatively silent on this issue of hidden ones.

The disparate treatment of these two substantively similar programs mirrors the self-reliance versus dependency and private versus public dichotomies that are so entrenched in American mythos. Medicaid recipients are subject to self-reliance scrutiny, with society labeling them as undesirable dependents. Self-reliance, though, is a myth, both in general and in the context of health care. This Article reveals that the line between visible and hidden government assistance is unprincipled and incurs financial and administrative costs. This Article therefore explores dismantling the current divided system in favor of a unified program designed to provide a more unified mechanism of health insurance to low-income individuals and families.

The authors hope that this proposal will have meaningful social and practical impact. By attacking the American myth of self-reliance, this Article demonstrates that society is not divided between lazy dependents and good citizens, but rather that all Americans could at some point find themselves in need of government assistance. Whereas for its first forty-nine years, Medicaid only covered roughly 40% of the poor, the program now touches nearly every American life.³²¹ Due to the ACA, an estimated 25% of the population will benefit from Medicaid's health care coverage.³²² Thus, if an individual is not on Medicaid, chances are a friend, family member, co-worker, or employee is. Likewise, the low-income subsidy is an essential aspect of health care reform, helping at least ten million individuals pur-

³²¹ See Huberfeld & Roberts, *Great Society*, *supra* note 10, at 1.

³²² *Id.*

chase coverage to obtain policies on the state exchanges in 2014.³²³ The subsidy redistributes income via health insurance policies funded with tax credits to individuals in financial need.³²⁴ Revealing that the dividing line between Medicaid and the low-income subsidies is theoretically unprincipled calls into question the bifurcated government assistance that reflects it. After all, missing just one day's work is enough to bounce a person from visible to hidden government assistance.

Moreover, by arguing for a unified system, we hope to streamline health insurance for lower-income Americans, making government assistance both simpler and less costly. As people bounce back and forth between Medicaid and subsidized private insurance, it costs both those individuals and the government time and money. A single system, whether based in Medicaid or on subsidies, would therefore be more efficient.

Given the fraught legal battles surrounding the ACA for the past five years, Congress may not revisit the issue of providing health insurance to the poor in the near future. Nevertheless, when it does, lawmakers should consider dismantling the falsely divisive private versus public system of government assistance in favor of a more inclusive and more efficient unified program.

³²³ Kevin Quealy & Margo Sanger-Katz, *Obama's Health Law: Who Was Helped Most*, N.Y. TIMES: UPSHOT (Oct. 29, 2014), <http://www.nytimes.com/interactive/2014/10/29/upshot/obama-care-who-was-helped-most.html> [<https://perma.cc/W3LM-FA8R>].

³²⁴ *Id.*