Counterproductive Consequences of a Conservative Ideology: Medicaid Expansion and Personal Responsibility Requirements

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Medicaid expansion, a key part of the Affordable Care Act, has been opposed by conservative politicians despite its fiscal and public health benefits. In response, some Republican-led states have expanded Medicaid with new reforms, including requirements for cost sharing and behavioral incentives, that promote conservative political values tied to an ideology of personal responsibility. We examine this trend using Michigan's Medicaid expansion as a case example. We explore the origins, evidence base, and possible consequences of these reforms. We argue that these reforms prioritize ideology over sound public health knowledge, deflecting attention away from the social, economic, and structural factors that influence the health of the poor, and may ultimately contribute to counterproductive public health and fiscal outcomes. (*Am J Public Health*. 2016;106:1181–1187. doi:10.2105/AJPH.2016.303192)

A key element of the 2010 Affordable Care Act (ACA) was to expand Medicaid to cover approximately 17 million more Americans.[1] Although this may make good fiscal sense, conservative politicians have vigorously opposed this provision. In many Republican-led states, Medicaid expansion has been outright rejected. In others, it has gone forward with the addition of reforms designed to promote market-based principles and an ethos of personal responsibility. Such policies introduce new models of cost sharing and behavioral incentives, which are rooted in conservative principles of self-reliance and accountability. Incorporating such principles into Medicaid policy may have made Medicaid expansion politically viable in conservative states. However, these reforms also redefine the problem of caring for our nation's poorest citizens in terms that may, in effect, work counter to public health goals.

We examine the recent trend of states expanding Medicaid with program reforms that emphasize cost sharing and behavioral incentives. Using Michigan's Medicaid expansion as a case example, we explore the origins, evidence base, and possible consequences of such reforms. We argue that these policies both reflect and reinforce a narrow understanding of the problems of Medicaid and its beneficiaries, deflecting attention away from the well-known influence of social, economic, and structural factors, and may ultimately contribute to counterproductive public health and fiscal outcomes.

MEDICAID EXPANSION AND SECTION 1115 WAIVERS

Prior to the ACA, federal law required states to provide Medicaid only to specific categories of low-income people such as pregnant women, individuals with disabilities, and some children and parents. In 2014, the ACA expanded Medicaid eligibility to most people younger than 65 years with household income under 138% of the federal poverty level, with the federal government covering at least 90% of the cost of expansion.[2] Despite being mostly federally funded, this expansion has been highly politically divisive, with many conservatives balking at the growth of a government program they have long seen as dysfunctional and costly. As Sommers and Epstein have noted,

> Medicaid makes a convenient target for conservative governors and legislators because it represents many of the ideological right's lightning rods for outrage: federal control, major government spending, a means-tested program that can be seen as rewarding poverty, and now a manifestation of health care reform.[3(p101)]

Soon after the ACA was passed, its constitutionality was challenged in numerous state-led court cases, culminating in the 2012 Supreme Court decision that made Medicaid expansion optional for states.

States opting not to expand Medicaid face obvious costs in not only leaving vast numbers of people uninsured, but also forgoing substantial federal funding—an estimated $166 million to $9.2 billion, depending on the state.[4] Nonetheless, Medicaid expansion remains highly unpopular among political conservatives. Decisions regarding expansion have fallen largely along party lines, with most Democratic-led states moving quickly in support of expansion and most Republican-led states rejecting expansion or delaying a decision.[2] Republican leaders opposing Medicaid expansion represent it as a "broken program" that has negative budgetary impacts, expands federal control, and encourages dependence on the state.[5(p498)]

Although some Republican-led states have expanded Medicaid, a few have done so

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only after adding new requirements for participants under federally approved Section 1115 waivers, allowing modification of Medicaid rules. As of January 2016, 7 states—Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, and Pennsylvania—had obtained approval of such waivers.[6] (Under a newly elected Democratic governor, Pennsylvania has replaced its waiver plan with standard Medicaid expansion.)

Although each state's Medicaid expansion waiver is distinct, most share 2 features that Wishner et al.[7] term "personal responsibility requirements": cost sharing and incentives for healthy behavior. The term "cost sharing" in Medicaid refers to the charges beneficiaries must pay, such as copays, deductibles, and premiums. Healthy behavior incentives are rewards or punishments, typically financial in nature, meant to encourage specific targeted behaviors.

These personal responsibility requirements, adapted from the private health insurance market, build on past efforts to integrate market-based concepts into Medicaid, such as Medicaid managed care and other versions of Medicaid cost sharing. The current set of waivers introduce more extensive market-based strategies, charging premiums to individuals otherwise not subject to them and implementing financial incentives for healthy behaviors.[8]

Those promoting this approach to Medicaid expansion argue that it is a practical compromise between liberal and conservative ideals, advancing universal health care coverage while promoting market principles and addressing program costs.[9] However, critics are concerned that increased cost sharing will be financially burdensome and discourage use of needed services by poor families,[8] and that the systems for implementation will increase the costs and bureaucratic complexity of the program.[10] Michigan's Medicaid expansion plan, as a case example, provides context for considering these issues.

THE HEALTHY MICHIGAN PLAN

Michigan's plan for Medicaid expansion emerged out of a conservative political climate at a time of substantial need and financial incentive. If the state chose to expand Medicaid, more than a half million uninsured adults would become eligible for coverage, and the state would see an estimated $1 billion in net savings in 10 years.[11] Governor Rick Snyder, a moderate Republican, announced his support for Medicaid expansion in February 2013, touting its economic benefits and the potential to reduce strain on hospital emergency departments.[12] After first rejecting the idea of Medicaid expansion, in August 2013, the Republican-controlled legislature passed a contentiously debated bill to expand Medicaid, contingent on adding program requirements such as expanded cost sharing (with copays and premiums paid into health savings accounts) and financial incentives for healthy behaviors. Representative Joe Haveman expressed the ambivalence shared by many conservative legislators toward this approach:

> This was the toughest vote of my career, as no Republican wants to appear to support Obamacare, and none of us believed that it is ultimately sustainable. But, for now, the federal government is desperate to implement its health care plan and expand Medicaid coverage to more people, which gave us a unique opportunity to negotiate for key reforms.[13]

Governor Snyder soon signed it into law, and the federal government approved the waiver expanding Medicaid under the name "the Healthy Michigan Plan." Enrollment began in April 2014, and 605 000 people were signed up within the first year.[14] Key elements of the Healthy Michigan Plan, including its cost sharing and behavioral incentives, are summarized in the box on the next page.

The prominence of the ideologies of market principles and personal responsibility in the Healthy Michigan Plan was highlighted by Governor Snyder in an August 2013 statement:

> The Healthy Michigan Plan emphasizes personal responsibility. Those covered by the plan will be required to share in the costs through premiums. There also will be incentives for them to take responsibility for their lifestyle choices and to maintain or improve their health.[18]

This ideological framing, as a political strategy to expand Medicaid "without losing political face,"[19(p439)] appears to have made Medicaid expansion more acceptable to reluctant conservative legislators and has been promoted as a model for Medicaid expansion under Republican leadership.[9] However, before the Healthy Michigan Plan and plans like it are used as models, their implications and effects ought to be examined carefully beyond their ideological acceptability. In the following sections, we critically consider some conceptual and practical issues with these reforms.

MICHIGAN'S FOCUS ON PERSONAL RESPONSIBILITY

The ideological framing of the Healthy Michigan Plan was clearly a central aspect of its very inception. In its federal waiver request, the state of Michigan presented the issue of personal responsibility as a key problem the Healthy Michigan Plan would address, arguing that its reforms would improve Medicaid costs and quality by shaping beneficiaries into informed and engaged consumers of health care. Consider the waiver request's description of the health savings accounts to be used to implement cost sharing and healthy behavior incentives:

> These accounts will be a component of health care reform that will assist in the reduction of the growth of health care costs and increase the efficiency of the health care system. . . . This account is intended to be a tool to encourage beneficiaries to become more active consumers of their health care, to save for future health care expenses and become more aware of the cost of the services they receive. By encouraging and fostering consumer engagement, Michigan believes that beneficiaries will become more involved and accountable with making health care decisions that will improve health outcomes.[20(p8)]

Another important aspect of the Healthy Michigan Plan that reflects an ideological framing is the plan's incentivized health behavior: the completion of a health risk assessment. The Healthy Michigan Plan's health risk assessment is a 4-page questionnaire that gathers information on an individual's health behaviors, health measurements, and health risks, designed to assess "unhealthy characteristics" such as obesity, insufficient immunizations, and tobacco, alcohol, and substance use.[20(p12)] To receive the healthy behavior incentive, beneficiaries must attend an appointment with a primary care provider, where their health risk assessment is completed, and agree to try to change a specific behavior (unless there are significant barriers to doing so) or to maintain healthy behaviors if no change is needed.[15] The plan protocol says that the intention

KEY COMPONENTS OF THE HEALTHY MICHIGAN PLAN

Eligibility
• Michigan residents aged 19–64 y
• Income ≤ 138% of the FPL[a]
• Not qualified for Medicare or other Medicaid programs
Benefits
• ACA Essential Health Benefits
• Some additional services (e.g., family planning and dental care)
Cost Sharing

• Most beneficiaries pay copays[b]
  • $1–$3 for clinical visits and prescriptions; $50 for inpatient hospital stays
  • Beneficiaries pay an average monthly copay based on prior health services utilization

• Beneficiaries at 100%–138% of FPL pay monthly premiums, called "contributions," equal to 2% of income
• Total cost sharing is capped at 5% of income
Health Savings Accounts
• Cost sharing is tracked and paid through the beneficiary's MI Health Account
• A summary of the beneficiary's cost sharing, service utilization, and healthy behavior incentives is included in quarterly account statements
• Accounts are administered by a third-party vendor
Healthy Behavior Incentives

• To be eligible for incentives, beneficiaries must:
  • Meet with a primary care provider
  • Complete a health risk assessment
  • Agree to change or maintain a health behavior, or agree that behaviors need to be changed but there are substantial barriers to doing so

• Financial incentives include:
  • 50% reduction of monthly contributions
  • $50 gift card, for beneficiaries not subject to contributions
  • Reduction of copays, if the beneficiary has paid 2% of income in copays

Note. ACA = Affordable Care Act; FPL = federal poverty level.

Source. Michigan Department of Community Health.[15–17] (The protocol documents are no longer available on the Healthy Michigan Plan Web site but may be accessed through archived links, as cited in the reference list.)

[a]Although federal eligibility rules sometimes describe the upper limit as 133% of FPL, the rules include a 5% "disregard" that means the actual upper limit is 138% of FPL.

[b]These copay amounts are the same as those in Michigan's standard Medicaid state plan. Select beneficiary groups and health services are exempt from copay requirements.

is "to reward Healthy Michigan Plan Managed Care members for their conscientious use of services," and that they earn incentives "on the basis of their active, appropriate participation in the health care delivery system."[15(p1)]

Together, these policy reforms portray beneficiaries' irresponsible behaviors and flawed sense of personal accountability as the root of the problem that Michigan's Medicaid expansion needs to address. In this framing, the Medicaid beneficiaries themselves are the problem, needing to be dissuaded from imprudent use of health services and from unhealthy lifestyles. When the problem is understood in this light, to limit the costs and enhance the health impacts of Medicaid programs, reforms must be enacted to foster personal responsibility. This theme recurs with remarkable persistence throughout recent policy reforms in the United States, a context we will now consider in more depth.

PROBLEM REPRESENTATIONS OF PERSONAL RESPONSIBILITY

Bacchi suggests that any given policy is based on a particular understanding of an issue—a "problem representation."[21(pxii)] Policies are created in historical and cultural context, and their problem representations incorporate the values and assumptions of the environments in which they are produced. By identifying a solution to a problem, policy indicates certain factors as at fault, while leaving others unaddressed and thereby "unproblematic."[21(p14)] In this way, policies do not simply respond to problems; they define them. Examining problem representations is important, Bacchi argues, because these constructions have real material and experiential effects on groups of people

targeted through policy. Problem representations also shape public understanding of issues, limiting how they may be thought about and, consequently, how they may be addressed through interventions.[21] Drawing on Bacchi's approach, we will first review the context in which problem representations focused on personal responsibility have developed in Medicaid policy and then consider their possible ramifications.

The traditional value of individualism has long been influential in American views concerning social and public health policy and the role of personal responsibility.[22] The American Dream is defined by economic individualism: the idea that anyone willing to work hard has equal opportunity to be financially prosperous. This belief and its inverse—that the poor must not have worked hard enough—are reflected in historical notions of which groups "deserve" social welfare benefits, such as public health care. In contrasting the rhetoric associated with Medicare versus Medicaid legislation and implementation, Piatak[23] argues that the 2 plans are structured in radically different and inequitable ways, with Medicare "beneficiaries" represented as deserving, having worked and contributed taxes, and Medicaid "recipients" viewed as inherently undeserving, having failed in their responsibility to do so.

Traditional ideals valuing individualism provided fertile ground for the rise of neoliberal political thought in the United States and the increasing emphasis on personal responsibility in US policy. Neoliberalism, as defined by Harvey,[24(p2)] is a political–economic orientation that promotes "individual entrepreneurial freedoms and skills" through free markets, free trade, and privatization, and views the state as responsible for ensuring conditions that allow those principles to unfold while otherwise interfering minimally. Concern about personal responsibility is a natural outgrowth of these concepts, as the state takes a hands-off approach and responsibility shifts from the collective to the individual. Reaganomics in the 1980s and welfare reform in the 1990s are some of the best-known illustrations of neoliberalism at work in the United States. As Olson observes, these ideas continue to guide today's conservative lawmakers, who aim to "dismantle social programs and replace them with privatized alternatives and social benefits that conform to the demands and logic of the market."[25(p295)] In US health policy, which has long been characterized by a fragmented and market-driven health care system, the advance of neoliberal principles coincided with a host of other factors encouraging a shift toward personal responsibility beginning in the 1970s. As Minkler explains, these include recognition of the limitations of clinical medicine, increased attention to modifiable health behaviors, and a need to control the costs of health care.[26] Public health policy rooted in neoliberalism burgeoned in the 1980s and 1990s, and these principles continue to define more recent health policy and discourse —most visibly in the ACA, with its principally market-based approach to health care coverage and reform.

A market-based, personal responsibility approach to health is not just economic and political, however. It is also cultural, shaping which behaviors are ascribed to being a responsible citizen (e.g., purchasing health insurance, having preventative checkups, and practicing a healthy lifestyle).[27] Conservative politicians' success in promoting their agendas in recent years may be attributable, in part, to skillful message framing in terms of such deeply held cultural beliefs—including self-reliance, discipline, and supremacy of the market—which Lakoff calls the conservative "Strict Father" morality.[28]

In summary, the problem representation inherent in current Medicaid reforms has grown out of a complex historical, political, and cultural context, with its focus on personal responsibility rooted in the American ideal of individualism. Responsibility for health, particularly the health of the "undeserving" poor, has long been shirked by neoliberal social policies and instead placed on the individual. Building on this understanding, we argue that the emphasis on personal responsibility in recent Medicaid expansion programs not only represents the self-reliance and accountability of beneficiaries as problematic and needing reform, but also encourages neglect of the "unproblematic" factors not central to the problem representation being invoked. This permits and reinforces inattention to key social, economic, and structural factors well known to constitute crucial health challenges for the poor and fosters a blind spot toward the institutional and systemic factors that importantly affect Medicaid costs.

ASSESSING THE VALUE OF THESE MEDICAID REFORMS

We have argued that the current social and political environment is one in which the moral vocabulary of market-based principles and personal responsibility is widely embraced and the "problem" to be addressed by Medicaid reforms is defined in terms of individual accountability, obscuring potential flaws of such policies. We now turn our attention to some concerns with common features of Medicaid expansion waivers, which have yet to be incorporated into public assessment of their value.

First, there is little evidence to indicate that these Medicaid reforms will actually reduce program costs, suggesting that market-based strategies may not translate directly to Medicaid. Past experiments with Medicaid cost sharing, such as copays, have failed to consistently produce expected improvements in health care expenditures and service utilization.[29] Current waiver plans introduce premiums, small sums often charged to just a fraction of beneficiaries, producing relatively little revenue. Although it is difficult to locate specific figures, it seems that the funds that waiver programs generate through cost sharing do not begin to cover their administrative expenses. Such has been the case in past Medicaid cost-sharing initiatives.[30] Elements likely to contribute to waiver program costs were captured by Wishner et al.,[7] whose respondents noted that for the Healthy Michigan Plan, the costs of managing accounts, producing and mailing quarterly statements, keeping income and claims information up to date, documenting compliance with healthy behavior incentives, and processing payments will far exceed the funds beneficiaries will ever contribute to the system. The continued replication of programs like these, despite their apparent financial inefficiency, suggests that ideology—such as the misguided belief that Medicaid beneficiaries need "skin in the game"—may trump logic in at least the short-term enthusiasm for these policies.

Although some evidence suggests that financial incentives may encourage healthy behaviors, a number of concerns with these findings lead us to question their applicability to Medicaid expansion waiver plans. Studies have found incentive programs to be effective for simple, short-term behaviors, but their long-term effectiveness in modifying sustained "lifestyle choices" is less clear.[31] Furthermore, studies of incentives for complex lifestyle changes have been conducted primarily in workplace settings or among middle-class participants, groups likely vastly different from Medicaid beneficiaries. One of the few published reviews of incentive programs specific to Medicaid, focusing on Florida, Idaho, and West Virginia, found generally mixed results, with some success promoting simple behaviors but not complex behaviors.[32] The study suggested that beneficiaries had limited understanding of programs and that incentives were too small or delayed to be effective.

Some programs, for example Iowa's and Michigan's, incentivize completion of a health risk assessment as a key element of the program. Research finds insufficient evidence for the effectiveness of health risk assessments, without additional intervention, in improving health behaviors or outcomes.[33] Most research on their effectiveness has been conducted within workplace initiatives and not Medicaid programs, whose beneficiaries face unique challenges to behavioral change. Because health risk assessments in Medicaid plans like these are administered during primary care visits, they may be further constrained by providers' limited time and capacity to promote behavioral change.[34]

Overall, research on behavioral incentives in Medicaid is scant, suggesting that programs have been initiated in expansion waivers without clear evidence of their effect. It may be prudent to postpone widespread inclusion of such incentive programs in expansion policy until more data about what is effective for this population become available. Such research should be forthcoming. As part of an ACA-authorized initiative, the Medicaid Incentives for the Prevention of Chronic Diseases model, studies are under way in 10 states to evaluate the effectiveness of incentive programs that promote weight loss, encourage smoking cessation, and address other chronic-illness risk factors.[35]

There is also reason to be concerned that the changes introduced in Medicaid expansion waivers place substantial burdens on beneficiaries, health care providers, and the Medicaid system, which may be counterproductive. With their complicated cost sharing and behavioral incentive schemes, these Medicaid programs may be both confusing and difficult for beneficiaries to afford.[8,10] Under the Healthy Michigan Plan, a single individual with an annual income of $12 000 could be asked to pay as much as $600 per year in premiums and copays. Critics note that requiring such costs may decrease utilization of important health services and medications and lower program enrollment.[8] Furthermore, requiring providers to help beneficiaries qualify for incentive programs increases their work burden and may discourage acceptance of Medicaid patients. For the Medicaid system more broadly, implementing these changes is likely to add administrative and bureaucratic burdens.[10] Indeed, in Iowa, bureaucratic challenges in securing a third-party vendor have resulted in the behavioral incentive program not being fully implemented.[36]

Finally, we wish to consider what the problem representation in Medicaid waiver reforms leaves out. This is what Bacchi[21(p2)] calls the "silences" of the policy—that which is not addressed and therefore not deemed problematic. By putting forth market-based solutions meant to foster personal responsibility, Medicaid expansion waivers represent individual accountability as the root of the problem, discouraging consideration of other influences on the health and health care costs of the poor. They neglect the hard realities of poverty and the role of social determinants, such as income inequality, neighborhood factors, and issues with accessing quality care and other needed resources, which are well known to have a central impact on health and utilization of services. This problem representation also disregards factors within the US health care system that make it costly and difficult to afford, outside of individual beneficiaries' health services consumption. Lastly, by reforming Medicaid programs to look more and more like private health insurance, these policies distract from Medicaid's purpose—to provide a social safety net program that supports equitable health care access.

RECONSIDERING PERSONAL RESPONSIBILITY IN MEDICAID

Bacchi directs policy analysts

> to pay attention both to the means through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful.[21(p19)]

An emphasis on personal responsibility is not new to US social policy or to general public perceptions about health. However, when this problem representation is put forth in the context of Medicaid, it is given institutional authority and particular prominence in public and political discourse. It shapes how the issues of Medicaid and the health of the poor are discussed and understood, and it restricts the forms of intervention that may be considered. In this way, Medicaid reforms founded on an ethic of personal responsibility may be damaging to public health goals.

To be clear, we do not wish to reject the role of personal responsibility in health. Individual behavior does have direct effects on health and, to some extent, the costs of health care. However, it is well understood that factors affecting health exist on numerous ecological levels. Among the poor, given all that is known about the severe limitations on daily health decision-making presented by their socioeconomic status, to assume that encouraging personal responsibility is the key to health promotion would seem both naïve and misplaced.

We also do not wish to minimize the public health achievement of expanding Medicaid coverage to large numbers of low-income adults. Building personal responsibility requirements into Medicaid policy may have been an effective political strategy for expanding the program in conservative states. However, it is imperative that these policies be examined carefully as they unfold. A critical discussion of the concerns we raise is important as upcoming Medicaid reforms replicate and build on programs of this sort. Similar programs are already rapidly

proliferating throughout the country, systematically chipping away at the boundaries of federal Medicaid law. Arizona, Kentucky, and Ohio are moving to incorporate personal responsibility requirements into their existing Medicaid expansion plans.[37–39] Arkansas is seeking an additional waiver to add more stringent requirements, such as mandated work training.[40] And in December 2015, the Centers for Medicare & Medicaid Services approved a second waiver for Michigan, making participation in the healthy behavior program a requirement for Healthy Michigan Plan beneficiaries above the federal poverty level.[41] Although outcomes are difficult to assess with certitude in this early phase of Medicaid expansion reforms, the trend clearly seems to be to expand the ideologically based aspects of the program in the absence of systematic evidence demonstrating their actual value.

CONCLUSIONS

Recent Medicaid expansions enacted through Section 1115 waivers are designed to promote conservative political values of personal responsibility and accountability, fostered through market-based principles. The Healthy Michigan Plan exemplifies this trend, with cost sharing and incentives for healthy behaviors. Drawing on Bacchi's approach to policy analysis, we have explored the problem representation upon which such policies are premised and critiqued their evidence base and potential outcomes. We have argued that rather than being based in a convincing body of evidence, these policies are rooted in ideology that favors personal responsibility over society's responsibility in caring for the public's health. They are more political than logical, serving to make Medicaid expansion more palatable in conservative states by imposing reforms on the oft-reviled Obamacare.

We argue that the challenge for the public health community is to be vigilant in monitoring these policies, the ways in which they evolve, and their impacts and unintended consequences. More broadly, we have shown that the trend in Medicaid reforms is grounded more in ideology than in soundly reasoned fiscal or health policy. If, as Lakoff writes, "frames trump facts,"[28(p115)] calling attention to the pervasiveness of this ideology and the ways it is communicated may be just as important as gathering data to scrutinize its logic. Lastly, we maintain that it is critical to remember, amid incessant political rhetoric, that these issues are not simply politics. They have meaningful impacts on this country's most vulnerable citizens and the safety net systems on which they rely. AJPH

CONTRIBUTORS

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