The “Undeserving Poor,” Racial Bias, and Medicaid Coverage of African Americans

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Abstract

The Affordable Care Act’s Medicaid expansion increased coverage especially for the “undeserving poor”—non-disabled, nonelderly adults, who disproportionately are African American. However, African Americans benefited comparably less than other groups from Medicaid expansion because they disproportionately reside in states that rejected Medicaid expansion. Psychological and other social science research establishes that disapproval of providing “welfare” to “undeserving poor” is closely aligned with racial bias, and that these sentiments partly motivate public disapproval of policies such as Medicaid for non-disabled, non-elderly adults. It is important to clarify and acknowledge this barrier for a realistic perspective on obstacles to keeping and expanding Medicaid coverage.

*Keywords*: African Americans’ health insurance coverage, Affordable Care Act, African Americans’ poverty, explicit and implicit bias
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Under the Affordable Care Act’s (ACA; Emanuel, 2014) Medicaid expansion, African Americans experienced significant, if less-than-maximum coverage gains. They would have benefited even more from full Medicaid expansion, but African Americans are overrepresented in states that declined expansion. In view of the generous terms of the federal offer to states, this rejection reflects deep reservations about Medicaid and Medicaid recipients. Critics seek restrictions on coverage for non-elderly, non-disabled adults, partly because Medicaid is viewed as a kind of “welfare” that should be withheld from the “undeserving poor.” Unlike children, the elderly, pregnant women and persons with disabilities (the “deserving poor”), and despite the fact that most nondisabled, nonelderly Medicaid recipients work, these undeserving poor are characterized as able-bodied adults who must be encouraged to work and to be self-sufficient (Applebaum, 2001; Gans, 1996).

Conservative political views and associated party affiliations, and commitments to individualism and independence explain some of the resistance to insurance coverage for the “undeserving” poor. But rigorous psychological and other social science research points to a significant, independent role of intermingled anti-African American and “non-deserving poor” stereotypes and biases. These stereotypes and biases serve to disproportionately deny African Americans opportunities for much needed treatment for behavioral health and physical health problems.

By reckoning with anti-African American biases as they affect political views and policy choices in Medicaid decision-making, this paper opens a window on the wider world of often-overlooked structural determinants of African Americans’ physical and psychological
well-being. It invites psychologists to bring both science expertise and theoretical insights as they consider political and policy forces shaping African Americans’ lives.

Medicaid and African Americans’ Access to Effective Healthcare

Nonelderly Whites outnumber nonelderly African Americans on Medicaid by about 2.5 times, and 85% of African American non-elderly adults are not Medicaid covered (The Henry J. Kaiser Family Foundation, 2018a). But African Americans rely on Medicaid disproportionately because the African American poverty rate is about three times the White poverty rate (DeNavas-Walt, Proctor, & Smith, 2013) and because African Americans’ poverty spells last longer than those of Whites (Edwards, 2014). The cumulative effect is that African Americans’ lifetime chances of experiencing poverty are considerably greater than those of Whites (Rank & Hirschl, 2001). Insurance coverage is linked to better access and receipt of care, and to health outcomes, to mortality, and to financial security (Sommer, Gawande, & Baicker, 2017). African Americans’ lower coverage rates contribute to well-documented health care access disparities, and they contribute also to disparities in untreated and inadequately treated illness and greater disease burden (Artiga, Ubri, Foutz, & Damico, 2016; Fiscella & Sanders, 2016; Franks, Muennig, Lubetkin, & Jia; National Center for Health Statistics, 2016; Nelson, Stith, & Smedley, 2002).

African Americans’ Health Insurance Coverage in Non-Medicaid Expansion States

With the passage of the Affordable Care Act (ACA; 2014), Medicaid eligibility was expanded from a handful of selected groups—mostly children, pregnant women, and those with disabilities (the “deserving poor”)—to all adults with incomes below 138% of the Federal Poverty Level (FPL). Under this legislation, the federal government pays 100% of the costs for new Medicaid enrollees initially, with states paying 10% after 2020 (Emanuel, 2014). Medicaid
expansion affords an opportunity to expand coverage at relatively low cost to states due to the very low state contribution for newly enrolled recipients who, when urgent care was unavoidable, were treated without compensation by safety net providers. According to one estimate, between 2015 and 2023, uninsured people in states not expanding Medicaid would consume $266 billion in uncompensated care under current Medicaid policy decisions. Were these states to expand Medicaid, the amount of uncompensated care over this period would fall to $185 billion (Buettgens, Holahan, Blumberg, & Recht, 2015). Yet 19 states declined to accept Medicaid expansion initially (The Henry J. Kaiser Foundation, 2016a), and only a few have subsequently accepted.

Medicaid expansion increased African Americans’ Medicaid coverage. Among non-elderly adults and children in 2013, the year before the passage of the Affordable Care Act, African Americans’ Medicaid coverage rate was 31% while Whites’ was only 13%. African Americans’ coverage rates rose to 32% versus 16% for Whites in both 2014 and 2015 (The Henry J.Kaiser Family Foundation, 2017). Controlled analysis confirmed that African American coverage gains persisted after adjusting for differences in income, education, gender, age, health status, occupation, region, ACA health insurance marketplace and other state characteristics (Chen et al., 2016; Courtemanche et al., 2016). Yet African Americans’ coverage rate gains did not surpass gains for Whites and therefore African American-White disparities were unaffected. Between 2013 and 2015, racial/ethnic minority-White disparities decreased statistically significantly for Latinos and they were eliminated for Asian Americans. However, disparities remained unchanged for African Americans (Artiga, Ubri, Foutz, & Damico, 2016).

States acceptance of the ACA, and of Medicaid expansion in particular, appear to have played a role in limiting African Americans’ coverage gains. In states that declined Medicaid
expansion, many adults fell into a coverage gap: they remained uninsured after Medicaid expansion because they were ineligible for Medicaid under non-expansion rules, and had incomes below 100% of the FPL—which is too low to qualify for subsidies for individually-purchased coverage on the healthcare exchanges.

The coverage gap was responsible for 20% of adult African Americans who remained uninsured in 2016. Coverage gap rates were 10% of uninsured Whites and only 5% of Latinos and 3% of Asian Americans (Artiga et al., 2016). The greater African American-White disparity reflects African Americans’ disproportionate residence in states that declined expanded Medicaid (Artiga, Damico, & Garfield, 2015). Counting the District of Columbia, in the top quartile of 13 states accounting for 48% of the African American population, only 4 states accepted Medicaid expansion in 2014 (Buettgens & Kenney, 2016). Grogin and Park (2017) predicted states’ acceptance of Medicaid expansion based on states’ African American racial representation and Whites’ willingness to accept Medicaid expansion. They reported that where Whites’ willingness to accept expansion was low, increasing Black population size was associated with a lesser likelihood of states’ acceptance of expanded Medicaid. Why policy makers and citizens in African American high-representation states were disinclined to accept expanded Medicaid and how race might be implicated are important questions to answer.

**Disapproval of Medicaid Coverage as “Welfare”**

Many Americans disapprove of “welfare” (Cook & Barrett, 1992; Gilens, 1991; Moffitt, 2015), including Medicaid and other means-tested programs (those restricted to individuals meeting specific low-income requirements) such as the following: Temporary Assistance for Needy Families (TANF), formerly Aid to Families with Dependent Children (AFDC), a cash assistance government program for families; the Supplemental Nutrition Assistance Program
(SNAP; “food stamps”); and Section 8 vouchers and other housing assistance programs. Disapproval stems from preferences for limited government size and spending.

Anti-welfare sentiments also stem from beliefs about the character and values of welfare recipients, and how such people respond to incentives created by welfare. From this perspective, welfare recipients lack individual initiative and perseverance and a strong enough work ethic to succeed. Without a sense of personal responsibility to attain economic independence, welfare recipients are lulled into a state of dependency on government support (Applebaum, 2001; Gans, 1996). As will be shown, welfare and African American stereotypes have become intertwined as these very qualities are also attributed to most African Americans.

Though Medicaid is restricted to low income people, but not all Medicaid benefits are considered welfare. Medicaid is now acceptable for “deserving poor,” as Medicaid has come to play a dominant role in financing long-term care for the elderly and disabled (Inglehart & Sommers, 2015), and as Medicaid is now a leading source of financing of children’s healthcare (Henry Kaiser Family Foundation, 2018b). Medicaid’s acceptability for children is such that many non-poor adults actually seek Medicaid funding under various specialized Medicaid expansion programs to fund additional home and community-based care for their disabled children (Graaf & Snowden, 2017). Declining stigma for some Medicaid populations might stem from Medicaid’s significant penetration into the US population. Half of the public is covered by Medicaid or knows someone who is, and 60% view Medicaid as equivalent to any other health insurance program (Inglehart & Sommers, 2015).

However, for “non-deserving” poor populations, critics contend that these non-elderly and non-disabled adults should be able to work for employer-sponsored health coverage or otherwise pay for their own healthcare expenses. Yet the statistics counter this position. About
60% of non-disabled, nonelderly adults on Medicaid already work full or part time, and 32% do not work because of illness, school attendance, or caregiving (Muscumeci, Garfield, & 2018; Garfield, Rudowitz, & Damico 2017). Furthermore, health insurance coverage is not available for 73% of working adults in any case (The Henry J. Kaiser Foundation, 2016). Despite these facts, concerns over idleness and dependency continue to drive the belief that health insurance coverage should be earned. This belief shapes Medicaid policy: Kentucky, Indiana, and Arkansas Medicaid programs have adopted a work requirement and several other states have federal applications pending to include such requirements in their Medicaid programs (Musumeci, Garfield, & Rudowitz, 2018; Musumeci, Rudowitz, Hinton, Antonisse, & Hall, 2018).

**Racial Bias, Ideas of Deservingness, and Approval of Safety Net Programs**

Like acceptance of Medicaid expansion, states’ discretionary Medicaid spending is sensitive to state populations’ proportion of African Americans (Kousser, 2002). Several factors explain these correlations between race and support for Medicaid. Along with conservatism and its opposition to excessive federal government size and spending, as well as personal commitments to personal independence and responsibility, anti-welfare and anti-African American stereotypes and biases—which overlap and are mutually reinforced—appear to help explain differential acceptance of Medicaid as “welfare.” Studies demonstrating these connections include surveys of large, representative samples and randomized studies using surveys or laboratory experiments.

Working from survey data, Gilens (1999) empirically identified four sources of opposition to welfare spending. One, there is a preference for individual initiative and personal responsibility. Two, there is a belief that welfare recipients prefer welfare to work. Three, wealthier persons have had little first-hand experience with welfare recipients affording them
little first-hand experience with recipients’ struggles. And four, there are the negative attitudes toward Blacks--specifically, that Blacks are not hardworking and that Blacks are lazy. After controlling for party identification, Liberal/Conservative political philosophy, and region of residence, and demographic factors in a nationally representative sample, Gilens (1999) found that both considering welfare recipients as undeserving and Blacks as lazy were more than twice as important as other factors in predicting an unfavorable view of welfare (Model $R^2 = 0.20$).

In an experimental manipulation on a second nationally representative sample, Gilens (1999) predicted opposition to welfare spending by asking randomly assigned respondents identical questions about welfare recipients, describing them as either Black or White. In controlled analysis, negative views of African Americans were more than twice as influential when the recipient was described as Black as opposed to White (Black welfare recipient Model $R^2 = 0.21$, White welfare recipient Model $R^2 = 0.23$).

Going beyond written responses on questionnaires, Brown-Iannuzzi, Dotsch, Cooley, and Payne (2017) conducted laboratory studies using a perceptual task for constructing pictorial images of a “typical welfare recipient” and a “typical non-recipient.” Participants selected facial features from pairs presented over successive rounds as they worked to crystalize images from racially ambiguous starting images. Later studies with new samples rated the images as to whether they were Black or White and how much participants approved of this “person” receiving welfare. “Compared with the average non-welfare-recipient image, the average welfare-recipient image was perceived (by a separate sample) as more African American and more representative of stereotypes associated with welfare recipients and African Americans” (Brown-Iannuzzi et al., p. 1). Furthermore, as the typical welfare recipient was perceived more as
Black than white, they considered that person less deserving of welfare ($r=.25$) and were less supportive of giving welfare ($r=.20$).

**Identification with President Obama and Disapproval of the Health Policies**

In a series of studies, Tesler (2016) demonstrated that President Obama’s election sensitized the public to the salience of race such that racial attitudes influenced policy preferences that previously were insensitive to racial attitudes. He linked respondents’ “racial resentment,” combining African American’s supposed low levels of individualism, self-reliance, work ethic, and alleged overreliance on safety net programs, to disapproval of policy proposals in several areas, including health insurance and healthcare.

After party identification, liberal/conservative ideology, preference for limited government, and concern about medical costs were controlled, studies on nationally representative samples showed that racial resentment significantly predicted opposition to “government health insurance”: “moving from least to most racially resentful decreased white support for government involvement in health insurance by about 9 percent of the scales range in March 2009”. (Tesler, 2016, p.101) Further studies have demonstrated that racial resentment came to be even more strongly associated with disapproval of government health insurance over a 6-month span during which the health care reform debate intensified and was increasingly identified with President Obama. From March 2009 to September 2009: “The same change in racial resentment, however, nearly doubled to a 17% change in opposition to government health insurance in September 2009—a highly significant difference in over-time effect sizes ($p = .03$)”(Tesler, 2016,p.101). Another survey’s findings corroborated Tesler’s; during the years of ACA debate, Henderson and Hillygus (2011) documented strong increases in racial resentment’s
connection to approval of the ACA’s principal objective—attainment of universal health coverage.

To strengthen inferences of causality, in another Tesler study, survey respondents were randomly assigned to being asked about proposed government health plans “guaranteeing health care coverage for all Americans,” framed as “President Obama’s proposal”, or “President Clinton’s proposal” (Tesler, 2016). Respondents were more likely angered, indicating stronger racial resentment, when the proposal was framed as Obama’s: about 35% of whites were angered by a proposal presented as “Obama’s plan”, and 28% of whites were angered by the same plan presented as “Clinton’s plan”.

**Implicit and Explicit Bias and Medicaid Spending**

An emerging body of psychological research associates levels of conscious, overt “explicit bias,” and hard-to-control ascription of positive and negative qualities to Blacks and Whites, or “implicit bias,” with higher rates of African Americans’ illness and mortality (Blair & Brondolo, 2017). This research documents the existence of effects where units of analysis are counties, states, or other geographical units. Using Project Implicit, a multiyear national database containing almost 1.5 million assessments of explicit and implicit bias, Leitner and colleagues (2016a) connected Whites’ bias levels with higher Black death rates from circulatory diseases. Orchard and Price (2017) reported that pre-term birth disparities were higher where Whites’ bias levels were higher.

Leiter, Heiman, and Snowden (2018) extended bias research on geographically defined aggregates to understanding variation among state Medicaid programs in per-capita expenditures for disabled Medicaid beneficiaries. Whites’ explicit and implicit biases were associated with lower expenditures after controlling for state’s conservatism and Blacks’ and Whites’ income
levels. Furthermore, significant interactions between income and bias were such that bias’s effect was especially great where Whites’ state income was low and Blacks’ income was high. Income disparities may have triggered fairness concerns, ultimately expressed in voting patterns transmitting disapproving of Medicaid spending. The predictive models were highly successful (Model $R^2 = .69$ for explicit bias, $R^2 = .70$ for implicit bias).

Theorists conclude that in implicit and explicit bias research, effects for anti-Black bias measured in neighborhoods, regions, or states are stronger and more stable than effects for the anti-Black bias measured in individual people: that is, when the unit of analysis for bias is a place rather than a person. This is because aggregate effects incorporate contexts of shared cues for bias elicitation and networks for bias-reinforcing social interaction (Payne, Vuletich, & Lundberg, 2017). Support for or against “welfare,” amid discussions of safety net size and spending and the prospect of voting, frame a potentially potent political context.

Bias activation in a real-world political context could occur as follows: A prospective voter might, when evaluating candidates, think about and discuss government support for purportedly expansive “welfare” programs in the United States. These conversations would most likely take place with like-minded others. If this person holds negative views of African Americans, he or she might come to focus on how “welfare” facilitates African American’s alleged idleness and judge candidates as they favor or oppose “welfare”. Thus, political reflection, discussion, and decision-making might serve to elicit and reinforce this person’s anti-Black bias.

**Conclusions**

Rejection of Medicaid expansion, a key feature of the ACA may have been inspired—at least in part—by opposition to increased coverage for the “undeserving poor.” Because idleness
is a considered a hallmark of the “undeserving” poor, the fact that states are seeking Medicaid
waivers that allow for states to include work requirements in future Medicaid expansions
supports this interpretation. Concern about the “undeserving poor,” in many minds, evokes
the concept of “racial resentment” fully integrating anti-African American and anti-“welfare”
bases. Racial resentment unites lower levels of individualism, lesser self-reliance, work ethic,
and discipline as supposed characteristics of African Americans’ with African Americans’
alleged overreliance on safety net programs.

Medicaid expansion is a core feature of the Affordable Care Act, and the Affordable Care
Act is so intimately identified with President Obama as to be nicknamed “Obamacare”.
Concerning Obama’s race and racial resentment, Tesler (2016) has written the following:

…health care’s strong association with President Obama both effectively racialized
public opinion about this especially important policy and contributed to the unusual anger
exhibited toward the President’s proposals during the bitter 2009-2010 healthcare debate
(p. 98).

The economic case for accepting Medicaid expansion is compelling because Medicaid
expansion absorbs costs of uncompensated care. When governors prod legislators to consider
expanding Medicaid, economic and financial considerations dominate their messaging (Rozier &
Singer, 2016). In expansion-rejecting states, however, along with acknowledged political and
values-based concerns, racial resentment may outweigh economic considerations in determining
health care financing—which disproportionately affects African Americans. Along with
conservatism, individualism, fiscal concerns, and other commitments, biases and stereotypes
associating African Americans with welfare dependence appear to drive Medicaid expansion
rejection. These sources of disapproval must be recognized as genuine barriers to wider acceptance of Medicaid expansion, which promotes the physical and behavioral healthcare of disproportionate numbers of African Americans with unmet treatment need.

For psychologists seeking to promote greater acceptance of Medicaid expansion and a wider scope of African American’s Medicaid coverage, several opportunities beckon. Researchers can continue to document the impact of Medicaid coverage on physical and behavioral health, as they strengthen the body of knowledge demonstrating the necessity of increased coverage and refining our understanding of how bias impedes progress toward meeting this objective. Advocates can press public officials to accept Medicaid expansion, drawing encouragement from successful referenda calling for Medicaid expansion in several states and by acceptance of Medicaid expansion since implementation of the ACA in two states with large African American populations—Louisiana and Virginia. They can point to bias’ illegitimate role as a barrier to expansion as they underscore the health-related and cost-related benefits from expansion—benefiting both African Americans in particular, and society at large. Medicaid-financed health care is often delivered by managed care organizations (Ndumele, Schpero, & Trivedi, 2018), and managers and practitioners can help such organizations formulate plans to ensure that African Americans have ready access to care through culturally sensitive programming. Through these and other measures, great potential gains will be realized which improve the health and well-being of African Americans nationwide.
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