Work Requirements and Perceived Deservingness of Medicaid

Jennifer D. Wu

Yale University

September 10, 2021

Abstract

Does an individual's effort to find work affect whether they are deserving of health insurance? Much of the current literature that examines the deservingness of federally funded health insurance focuses on an individual's responsibility in becoming ill. However, logic from the welfare literature would suggest the willingness to work for one's welfare, or reciprocity, is an important determinant of deservingness. The relevance of employment seeking in Medicaid deservingness comes at a crucial time given recent attempts by state governments to implement work requirements as a part of Medicaid eligibility. Using a series of survey experiments, I compare the importance of responsibility versus reciprocity and find that responsibility, what one does to become ill, is the primary driver of judgments of deservingness. What one does to earn their Medicaid plays a negligible role in driving attitudes. These findings have implications for how we understand the determinants of support for Medicaid policy.

Keywords: public opinion; policy attitudes; deservinginess; Medicaid; work requirements

Work Requirements and Perceived Deservingness of Medicaid

What makes someone deserving of federally-funded health insurance? Logic from the welfare literature would suggest that deservingness is partly a function of how much a person has done to earn their aid (Cook & Barrett, 1992). This is often referred to as *reciprocity*. However, much of the work that has been done looking at the deservingness of health insurance focuses on what an individual has done to incur their health-related illness such that they need to access the health care system in the first place; often referred to as *responsibility*. One issue encountered in the health insurance deservingness literature is that studies often conflate deservingness of health *insurance* with deservingness of health *care*. While the concept of responsibility applies cleanly to provision of health care, this is less true when we consider provision of health *insurance*. This paper argues that both dimensions of *responsibility* and *reciprocity* need to be considered when examining perceptions of deservingness of federally-funded health insurance.

Understanding attitudes towards provision of health insurance using logic from the welfare literature is of particular importance given the current discourse around the American healthcare system. Healthcare in the United States has continually differentiated itself from the rest of the developed world in its means of provision. The United States provides government-funded health insurance through two main programs, Medicare and Medicaid. Though the two programs have similar objectives in providing insurance to the otherwise uninsured, they service relatively different recipient populations. While Medicare provides coverage for the elderly, Medicaid provides coverage for low-income individuals. It is not surprising, then, that when respondents are polled for their support for a Medicare-For-All type expansion of government provision, polling results score relatively high (e.g. see Kirzinger, Wu, & Brodie, 2018). This is concerning because while Medicare-for-All, a point on which many primary candidates have campaigned on in the 2020 election cycle, finds broad support, its support is nonetheless generated on the basis of attitudes towards a different population group than Medicaid. It would thus be erroneous to extrapolate attitudes based on Medicare to predicted attitudes of nationalized healthcare. Framed differently, how would these polls look if instead of a "Medicare-for-all" plan, respondents were presented with a "Medicaid-for-all" plan? Medicaid and Medicare cover relatively different populations and attitudes may not be consistent across recipient populations. If we were to extend health insurance to the currently uninsured, the population pool would look more like the Medicaid population (i.e. low-income individuals).

The uninsured population tend to be low-income white men who have a high school educa-

tion or lower and live primarily in Southern states. Are these individuals perceived as deserving of some form of federal assistance? If they are, then we can expect support for a nationalized health plan to be driven by a respondent's perception of their own involvement in supporting the system; whether people support a nationalized health plan becomes a question of "how much do I pay into this thing and is it fair"? On the other hand, if the average uninsured person is not perceived as deserving of federal assistance, then we can link support for nationalized health care back to a respondent's attitudes towards the uninsured population; support then becomes a question of "do I like the people in this program"? Understanding what drives support for government-sponsored insurance, and expansion of government insurance, thus needs to acknowledge that judgement of a recipient is based on both what the recipient is doing to incur their need for the policy as well as what they are doing in return for the help.

This paper operationalizes these two dimensions by focusing on the concepts of *reciprocity*, what a policy beneficiary does to earn or payback federal assistance, and *responsibility*, how much control a policy beneficiary had in incurring the need for assistance in the first place. Specifically, I focus on the role of work requirements in affecting an individual's perceived deservingness of federally funded health insurance. "Community engagement" requirements, as they are officially described, have been introduced in the discussion of restructuring Medicaid eligibility. As of this year, Arizona, Indiana, Michigan, Ohio, Utah, and Wisconsin have successfully waived regulations against having work requirements as part of Medicaid eligibility. At least seven more states have filed similar waiver requests (Kaiser Family Foundation, 2019). The State Medicaid Director Letter issued to describe the potential introduction of community engagement requirements stipulates that individuals subjected to the work/community engagement requirements are those who are "eligible for Medicaid on a basis other than disability" (CMS, 2019). The range of applicable activities that would satisfy the requirements include career planning, job training, volunteering, and so on. However, these descriptions rely on the premise that a majority of current Medicaid recipients are not already involved in such endeavors, which is empirically not the case. Data from the Kaiser Family Foundation show that in 2016, approximately 60% of Medicaid recipients are working either full time or part-time. Among the remaining 40% of recipients who are not working, only 7-8% are not working for reasons related to disability, illness, caregiving, or school attendance. In other words, it is to this 7-8% of individuals that work requirements would be targeting. The consequence of augmenting eligibility guidelines to target a relatively small portion of recipients is that current

individuals who are on Medicaid for any of the other reasons may find themselves ineligible, should they not meet the new work requirements (Garfield, Rudowitz, & Orgera, 2019).

In order to test the relevance of work requirements (i.e. reciprocity) as a means of evaluating an individual's deservingness of federally funded health insurance, I employ a series of survey experiments which ask respondents to evaluate a hypothetical individual who is uninsured and needs health insurance. In addition to varying the individual's level of reciprocity, I also randomize his level of responsibility. The results from the survey experiment suggest that an individual's level of responsibility is far more salient in informing people's judgements of his deservingness, more so than reciprocity. In a second set of survey experiments, I confirm that respondents' attitudes are driven more by learning what type of person is a recipient, rather than by attitudes towards the program itself. In the following, I describe extant work that has been done on the issues of deservingness and policy program support, both in the general policy arena as well as health policy. I then present the research question and describe the experimental designs implemented to test the relevant hypotheses. I conclude with a discussion of the implications of these results on Medicaid programming and design.

Background

Deservingness and Program Support

Support for social programs can be broken down to two dimensions: program effectiveness and attitudes towards the recipient population. Whether a program is effective in addressing the policy issue it was meant to address and whether it is efficiently implemented naturally has an effect on whether there is support for it. It could be the case that while people support the intention of a policy, they do not support the means by which it is implemented or the agents in charge of its implementation. The converse also holds. This paper sets aside consideration about program effectiveness and institutional efficiency to focus on how attitudes towards recipient populations affect policy support.

Much of the work that studies attitudes towards health policies is framed in the context of racialization of policy, looking at the relevance of the racial background of the recipient population. Health care in the U.S. has a long history of being heavily racialized. Targeted insurance programs that used the guise of appropriate employment to exclude agricultural labor - jobs that were mainly held by minorities at the time - from employer-sponsored care contributed

to the health disparities between racial groups we see today (Gordon, 2003). Unsurprisingly, this had spillover effects in individual-level attitudes. Rigby, Soss, Brooske, Rohan, and Robert (2009) show that respondents were found to be less supportive of government intervention in improving health disparities if they thought those disparities were driven by factors specific to racial groups (i.e. genetics). Gollust and Lynch (2011) additionally find that, when asked to select explanations for mortality disparities between different types of groups (e.g. whites vs. blacks, low vs. high income, etc.), non-white respondents were more likely to attribute group differences to systematic factors, like failure of the economic or health care systems. On the other hand, conservatives were more likely to attribute group differences to differences in personal behavior, suggesting a lack of awareness of causes in health disparities between different groups, as well as a projection of group-based stereotypes on health outcomes that are either driven by genuine beliefs about biological group differences or by outgroup animus. Race becomes a salient factor when these projections and stereotypes are used in the racialization (when racial attitudes influence political preferences), of attitudes towards federally funded healthcare, particularly with respect to expectations of individuals in acquiring coverage. For example, Tesler (2012) provides an in depth analysis of the racialization of support for health policy, depending on whether the policy is framed as being Obama's policy versus Clinton's policy. Knowles, Lowery, and Schaumberg (2010) provide similar results, showing that implicit prejudice was prognostic of less favorable views of Obama and his policies compared to Clinton. More generally, Bobo and Kluegel (1993) establish that race-targeted policies elicit stronger (negative) reactions against support than non-race targeted (e.g. income-targeted) policies.

While race is an undeniably important factor in thinking about how attitudes about program recipients affects program support, many empirical results fail to distinguish whether attitudes are measured solely on the basis of the treatment or mediator or if they also capture racial attitudes. If race is important in motivating attitudes about health provision, it must be identified independently of other factors such as ideology or stereotype. How race is included in an experiment may elicit racial attitudes that are correlated with (conservative) ideology, which makes it difficult to distinguish between whether a change in outcome measures comes from racial animus or ideologically driven views about individual agency (Feldman & Huddy, 2005a, 2009b). This is not to say that the conflation of multiple factors, i.e. that racial stereotypes are projected in otherwise non-racial areas, is not important to acknowledge, but rather that being specific about what we are identifying is crucial, given the potential impact on policy that this

type of research often has. To that end, the experimental designs described in later sections, will attempt to control for racial stereotyping by specifying upfront individual demographics.

More broadly, deservingness itself has enjoyed a thorough treatment in the extant literature and is generally accepted as an important factor in explaining preferences towards social insurance programs. The literature offers the following as factors of one's deservingness: source of need and how much control and responsibility one has over their need, individual agency and will to be independent, and gratefulness and reciprocity (Cook, 1979; Cook & Barrett, 1992). For example, Gilens' *Why Americans Hate Welfare* extensively examines what drives opposition to welfare assistance. Because the delivered good is a form of income (i.e. cash assistance, food stamps), a recipient's perceived deservingness is intrinsically tied to employment. Indeed, Gilens shows that unemployment confirms perceptions of black Americans as being lazy and thus undeserving of any additional government help.

The relevance of work requirements as mentioned in the introduction cannot be understated here with respect to its role in evaluating deservingness of policy benefits. Previous research looking at attitudes for government provision of healthcare have mainly focused on perceptions of *responsibility* and specifically on behavioral reasons for bad health. Gollust and Lynch (2011) find that support for government provision of health care is much lower when an individual's ill health is brought on by unhealthy behaviors (such as having a bad diet). An additional line of research in this area suggests that part of what drives support or lack of support for government provision is prior expectations of access to care. For example, Republicans systematically underestimated difficulty of access and comparability of quality of care between the uninsured and insured, which lead to variation in support for government health insurance (Lynch & Gollust, 2010). Democrats are also more likely than Republicans to believe that the uninsured have difficulty gaining access to care. Even if they are made aware of the difficulty of gaining access, Republicans are less likely to support health care reform (Oakman, Blandon, Campbell, Zaslavsky, & Benson, 2010). It would perhaps be reasonable then, that for an individual who thinks that everyone has equal access to both health provision and quality care, if people incur health problems (perhaps due to the lack of quality care) or are unable to access provision, it must be due to personal behaviors and/or a lack of individual effort in earning the necessary coverage.

Notably, perceived recipient deservingness varies between social insurance programs and welfare programs. These differences have important implications for how we expect perceptions

of deservingness to differ based on how federally funded health care programs are viewed. While federally-funded health care is technically a form of welfare, a welfare-based conception of deservingness is not totally sufficient in the context of health insurance. First, health coverage has an added consideration of risk. Jensen and Petersen (2017) show that perceptions of deservingness are higher in the matters of health insurance assistance because individuals are less likely to have control over their illnesses. Second, social insurance in the form of health coverage is complicated by the fact that there are two dimensions of consideration: health status and insurance status. While work in this area has focused on individuals' personal behaviors that lead to ill health, little has been done to examine the deservingness of insurance status itself, specifically when we consider what it means to earn one's insurance.

Reciprocity versus Responsibility: Work Requirements in Medicaid

As described above, the concept of deservingness is well-established in the welfare literature. Notably, what I take from the welfare literature for the purposes of this paper is the notion of reciprocity, the idea that a recipient has earned their aid or will give back to the greater good after having received federal assistance. This notion of reciprocity is distinct from responsibility. It is well-established in the literature that an individual's responsibility in incurring the need for assistance plays a great role in their perceived deservingness of assistance. The less control an individual has over their situation or the more vulnerable they are (for similar reasons related to control, i.e. the elderly, children, etc.), the more deserving they are perceived to be.

Medicaid locates at the intersection between welfare and health insurance. While the both of the relationships between welfare and deservingness and between health risk and deservingness is relatively well-understood, the combination of the two is less so. While the former is understood through the context of reciprocity and responsibility, the latter has until now been studied through the lens of responsibility. Framed differently, what does it mean to earn one's health care? Focusing the study on the two main factors of reciprocity and responsibility will allow us to differentiate between the two effects. In the experimental design, I operationalize reciprocity in the form of employment: does an individual's employment status have any bearing on their deservingness of federal health insurance? This implicitly assumes that employment status is an appropriate proxy for earning one's health care, but the recent focus of some states on embedding work requirements into Medicaid eligibility suggests that this assumption is not unreasonable. Additionally, grounding Medicaid reciprocity in the context of work will allow

theoretical connections to the welfare literature itself.

Methodology

This study relies primarily on two survey experiments. The main design (Experiment 1) tests the effects of an individual's responsibility and reciprocity on his perceived deservingness of federal insurance. Survey respondents are presented with a description of a hypothetical individual named Joe who is sick and needs health insurance to help cover the costs of treatment. Joe's responsibility is captured by manipulating why he has become sick; he is diagnosed with either Type I diabetes as a result of bad genes (i.e. he is less responsible) or Type II diabetes as a result of an unhealthy lifestyle (i.e. he is more responsible). Joe's reciprocity is captured by manipulating his employment status as it relates to his lack of insurance; he is uninsured either because he is working full time at a job that does not offer insurance, because he has been laid off, or because he has been fired. After reading the description of Joe, respondents are then presented with a series of questions related to their beliefs about how culpable Joe is for being both sick and uninsured (i.e. a manipulation check) and about how deserving Joe is of receiving federally funded health insurance to address his lack of insurance.

A second experiment (Experiment 2) is run to address a concern in Experiment 1 about attitude bundling. An issue that arises in Experiment 1 is that I measure respondents' perceptions of Joe's Medicaid deservingness by asking if they believe Joe should be eligible for Medicaid. However, the outcome measure captures both attitudes towards Medicaid and attitudes towards Joe as a potential recipient on Medicaid. There is reason to be concerned about whether the responses to Joe's deservingness of Medicaid is due to the treatment (learning about a "type" of recipient) or due to respondents' latent attitudes towards Medicaid and federally funded health insurance. Experiment 2 differentiates between respondent attitudes as they are moved by a treatment in which they learn about a hypothetical individual Joe who is on federally funded health insurance and respondent attitudes that are due to prior attitudes to the program itself.

Experiment 1: Identifying Between Responsibility and Reciprocity

There are two main questions Experiment 1 attempts to address. The first is whether an individual's employment status actually affects respondent's perceptions of their deservingess. The second is whether this effect is greater than the effect from the individual's level of respon-

sibility for being sick. If the concept of work requirements has any traction in public opinion, we would expect that respondents to be more supportive of an individual if they are working for their health insurance (in this case, by being be employed). If the individual is sick but has tried to obtain health insurance through employment, would respondents still fault him for not being insured? Framed differently, I aim to disentangle considerations of responsibility for being sick with responsibility for being unable to actually afford health care (i.e. reciprocity).

Experiment 1 consists of two surveys. The main survey, which I will refer to as "Employment-Health", aims to address the first question about reciprocity. Respondents will be presented a vignette about a hypothetical individual named Joe. Joe has recently been diagnosed with diabetes (whether it is Type 1 or Type 2 is specified) and will eventually incur costs due to treatment. Unfortunately for Joe, he is also uninsured, which makes paying those costs financially burdensome. The main manipulation of interest is the Employment treatment (presented below), in which Joe has varying degrees of responsibility for not having insurance through employment. Additionally, to degree to which Joe is responsible for being diagnosed with diabetes is manipulated through the Health Treatment (also presented below). Combined, there are 6 possible treatment conditions a respondent can be assigned to. The vignette takes the following form:

> Joe is a thirty-year-old man who is married and has two kids (a five-year-old daughter and a six-year-old-son). He [**Health Treatment**]. He [**Employment Treatment**]. While Joe would like to have coverage, he cannot afford to purchase health insurance for himself to cover the cost of treatment because the costs are too expensive in his state. Additionally, Joe lives in a state with strict eligibility requirements and would not qualify for Medicaid.
>
> **Health Treatments:**
>
> 1. **At Fault:** has an unhealthy diet, consisting mainly of fast food and processed snacks and was recently diagnosed with Type II diabetes
> 2. **Not at Fault:** has a family history of Type I diabetes and was recently diagnosed with Type II diabetes
>
> **Employment Treatments:**
>
> 1. **Employed:** works full-time (earning about $32,000 a year), but his employer

recently eliminated health insurance benefits. As a result, Joe no longer has health insurance.

2. **Laid Off:** is recently unemployed (he was earning about $32,000 a year), having been let go after his company relocated out of state. As a result, he has also lost his employer-sponsored health coverage
3. **Fired:** is recently unemployed (he was earning about $32,000 a year), having been fired from his job. As a result, he has also lost his employer-sponsored health coverage

The contribution to existing literature lies with the Employment Treatment, which explicitly tests whether employment status affects Joe's perceived deservingness and blame for his situation. Since previous research has focused on health-specific reasons for needing health support, the inclusion of the Health Treatment will allow me to compare the saliency of the employment effect benchmarked against health-behavior factors. Additionally, pre-treatment questions will be asked to determine respondents' employment status, insurance status, and familiarity with and attitudes towards social insurance programs. Partisanship and ideology are asked post treatment, so as to avoid political priming.

The second survey, which I refer to as "Employment-Only", aims to address the second question by comparing the results from the Employment-Health to a simplified experiment which holds constant Joe's health responsibility and randomizes his employment status. Respondents will be presented a similar vignette about Joe but will not be a description about his responsibility in incurring diabetes. Comparing the results from Employment-Health to Employment-Only will give us a sense of how much more of the respondents' attitudes are driven by Joe's health status, compared to just his employment status. The vignette shown in "Employment-Only" follows:

> Joe is a married, thirty-year-old white man and has two kids (a five-year-old daughter and a six-year-old son). [**Employment Treatment**]. While Joe would like to have health insurance coverage, he cannot afford to purchase health insurance for himself because it is too expensive in his state. Additionally, Joe lives in a state with strict eligibility requirements and would not qualify for Medicaid.

After seeing the vignette, respondents are questioned on five main outcome variables. The first two outcomes (Blame of Illness, Blame of Insurance) measure how much Joe is to blame

for being sick and for being uninsured. While not explicit manipulation checks, the resulting blame measures (at least Blame of Illness) should generally comport with expectations from the relevant treatment condition. For example, when Joe is At Fault, we would generally expect respondents to assign blame only when they are asked health-related questions, regardless of his employment condition. Conversely, when Joe is less reciprocal in the employment conditions, we would expect respondents to react accordingly when asked insurance-related questions, regardless of his health condition. If there are spillovers, e.g. respondents blame Joe for not having insurance because he is at fault, even though he is reciprocal, it would suggest that respondents are using unrelated characteristics as cues for determining judgment in domains we would not expect. This would have important implications for how would we subsequently understand the foundations of policy attitudes. These expectations are formalized in the following hypotheses:

H1. *Joe will be perceived as more to blame for being sick if he is at fault for his diagnosis.*

H2. *Joe will be perceived as more to blame for being uninsured if he is unemployed. Additionally, he will be more to blame if he is fired than if he is laid off.*

The second set of measures (Deserving: Federal, Medicaid), and of primary interest, includes two questions related to Joe's perceived deservingness of federal assistance with paying his health costs. Respondents are asked how deserving they think Joe is of receiving federal support for health insurance and then specifically, how deserving Joe is of being on Medicaid. The final outcome measure (Burden of Costs) asks respondents who bears more burden for paying Joe's health care costs. While this measure exists in a similar vein as the deservingness questions, it specifies that citizens of a society, rather than the federal government or federal program), are the ones who are paying into Joe's health care support. The hypotheses generated from this intuition are:

H3. *Respondents will perceive Joe as being more deserving if he is employed. If Joe is unemployed, he will be perceived as more deserving if his unemployment status was due to being laid off rather than being fired.*

H4. *Respondents will perceive Joe as being more deserving if he is not at fault for his illness.*

Results. Data were collected from a sample 2,448 respondents on Lucid. Of these, 1,650 respondents were randomized into the Employment-Health survey. The remaining 798 were allocated

to the Employment-Only survey. Discussion will be focused primarily on the Employment-Health, while the results from the Employment-Only experiment will provide a sense of how much of the main effects are driven additionally by the presence of the Health conditions. A breakdown of the demographics of the sample is provided in Appendix Table 1.

The initial analysis of the data includes three main OLS specifications which are provided in **??**. The first specification (Model 1) compares being At Fault (Joe has Type 2 diabetes) to being Not at Fault (Joe has Type 1 diabetes); i.e. the pooled effect of the health treatment. I marginalize over the Employment conditions to get a general sense of how being responsible (At Fault) for his own illness affects attitudes towards Joe. Similarly, the second specification (Model 2) marginalizes over the Health conditions and compares Joe being Fired or Laid Off to being Employed; i.e. the pooled effect of the Employment treatment. This specification will provide intuition for what the Employment conditions are generally doing. For example, I expect that if Joe is laid off or fired, then respondents will be more likely to blame him for being uninsured.

Finally, the third specification (Model 3) compares the effect of each treatment condition to being Not at Fault and Employed. This specification will identify whether considerations of reciprocity are greater than those of responsibility when it comes to perceived deservingness. If the results show that Joe is less deserving when he is At Fault, regardless of what his employment status is, then that would suggest that deservingness of health insurance, and not just health care, is a function of one's health-related behaviors. If the results show that Joe's deservingness tracks with his level of reciprocity (e.g. least deserving when he is Fired), and these are comparable across Health conditions, then that suggests that respondents can appropriately differentiate between the domains in which to evaluate Joe's deservingness of insurance receipt. Finally, if the results show something in between the two, e.g. deservingness of insurance tracks with reciprocity but Joe is less deserving when he is At Fault than Not at Fault, then we can infer some interaction between the reciprocity and responsibility dimensions in how people think about one's deservingness.

[TABLE **??** HERE]

Table **??** reports results for the overall effect of Joe either being at fault for his diabetes diagnosis (having bad health behaviors) or not being at fault (being genetically predisposed to

diabetes). First and most intuitive is looking at how much respondents blame Joe for being diagnosed with diabetes. Unsurprisingly, Column 1 suggests that being at fault for his diagnosis near doubles the amount of blame respondents put on Joe. The more interesting result comes from looking at how much blame respondents put on Joe for lacking insurance, which is presented in Column 2. Theoretically, we would expect that Joe's lack of insurance is attributed to characteristics related to his attempt to procure insurance, i.e. employment, and not necessarily related to health-specific behaviors. This suggests that health-related behaviors themselves have a significant effect on blame attribution. While the effect is half of that for blame attribution of illness, that health-related behaviors can move respondents to blame Joe for non-health related circumstances is in itself interesting. While it is difficult to identify is exactly what explains this effect strictly from the data. An intuitive explanation is that Joe's unhealthy behaviors lead respondents to update about other facets of his character, such that he is nevertheless to blame for any unfortunate state he finds himself in.

Columns 3 and 4 capture Joe's perceived deservingness of federal help with paying for his health costs. When asked whether Joe is deserving of federal assistance, either in general or specifically through the Medicaid program, respondents report Joe as being more deserving when he is not at fault for his illness. In particular, while Joe is generally more deserving when he is not at fault, it is not necessarily the case that he should be insured through Medicaid. While both estimates are highly precise and in the same direction, it is unclear whether the difference in magnitude, while slight, motivates any meaningful further interpretation. Column 5 reports results for the outcome measure asking who bears the burden of paying for Joe's medical care. This outcome differs from the two deservingness measures in specifically framing the provider of the costs for medical care as a choice between Joe on his own or citizens in society. The ambiguity of what it means for the federal government to provide support (i.e. through citizens' taxes) is excluded. While respondents are less inclined to put the burden of costs on society, the effect size from Joe being at fault for his illness is nevertheless approximate to that in either of the deservingness measures. Overall, it would appear that respondents react strongly to whether Joe is personally at fault for his diabetes diagnoses.

[TABLE **??** HERE]

I conduct a similar analysis of the employment treatments, the results of which are presented

in Table **??**. First looking at whether respondents blame Joe for his illness (Column 1), we see that Joe is blamed for being sick primarily when he is fired. This suggests some level of spillover from his responsibility, i.e. respondents are potentially making inferences about who Joe is on the basis that he was fired. This is less so the case when Joe is laid off. Column 2 reports results for the measure of how much respondents blame Joe for lacking insurance. While the results here are intuitive - Joe is more to blame for being uninsured if he is fired - it is worth noting that the baseline mean is 2.8 on a scale from 1 to 7. This suggests that respondents are generally not overly inclined to ascribe blame for being uninsured. Additionally, I cannot yet identify from this data what the underlying mechanism is, whether Joe is blameful because respondents believe his being fired is what led him to be in a state of not having insurance or if Joe being fired signals some unfavorable characteristic that makes him inherently more blameful for being uninsured.

Column 3 to 5 report the measures for Joe's deservingness of federal or societal assistance in paying for his health costs. There are no significant effects across the three treatment conditions. This is interesting in that it suggests that respondents are not necessarily updating negatively about Joe's character (in as far as he should be helped by society and the government) based on whether he was fired or laid off from his job.

[TABLE **??** HERE]

Comparing the specific treatment conditions, i.e. the interaction between the pooled health and employment treatments, allows us to understand what is driving the effects from the individual treatments. For example, the effects in the employment treatment could be entirely driven by Joe being At Fault, rather than the actual employment condition itself. Indeed, the first three rows in Table **??** suggest that much of the effects we saw in the Table **??** were driven by Joe's being at fault for his diabetes diagnosis. In Column (2), we see that respondents are more likely to rate Joe as being more to blame for not having insurance when he is both Fired and At Fault than when he is just Fired (and Not at Fault). In Column (1), we still see that respondents blame Joe for his illness when he is fired, even though he is not a fault for his illness. This supports the previous conjecture that respondents are using Joe's negative characteristics to make judgments against him, regardless of the domain in which those judgments are meant to take place.

In Columns 3-5, we see that respondents view Joe as less deserving and more on the hook for his costs when he is At Fault, regardless of his employment status (the first three coefficients in each column are negative and precisely estimated compared to the bottom three). An interesting result is that Joe is still undeservingness when he is employed, but nonetheless at fault for his illness (given by the negative coefficients in the third row of Columns 3 and 4). While the coefficient is slightly more positive than the other two employment conditions, the difference is marginal. At risk of over interpreting the results, one could posit that if Joe is At Fault and Fired then he is definitely to blame for his situation, so he should be paying his own costs. However, if Joe is At Fault and Employed, then he is still to blame for incurring health costs, but he is also in a position of earning income with which he can allocate towards his health costs; so, Joe is still undeserving of federal health insurance. The underlying mechanism in this case cannot be identified without further testing.

More generally, one way to interpret the negative coefficients in the At Fault conditions is that Joe's level of responsibility is doing most of the work in how respondents' attitudes are generated. Respondents do not care so much about what Joe is doing to earn his health insurance, but rather, what Joe has done to incur the need for health care in the first place. While receipt of health insurance and of health care are technically different considerations, this seems to be less so the case in the court of public opinion.

[TABLE **??** HERE]

Comparison to Employment-Only survey. How much work is the Health treatment doing in moving respondent attitudes? It is obvious from the preceding analysis that responsibility (i.e. how much Joe is at fault for his illness) plays a more salient role in moving respondents' attitudes than does reciprocity. But, we may worry that much of that effect is coming from Type II diabetes having a highly stigamatizing effect, thus overpowering variation we would otherwise hope to see from within the two responsibility conditions. Respondents could be updating about Joe's type (as a person) based on him being responsible in a way that informs their responses on the other insurance-specific measures.

To provide some intuition, I run a pared down version of the Employment-Health survey where respondents are shown a similar vignette that randomizes Joe's employment status only. The results from this survey are presented in Table **??** and are somewhat comparable (at least

in magnitude and direction) to those in Table **??** and the bottom half of Table **??**. Looking at the treatment arm from Employment-Health in which Joe has Type I rather than Type II diabetes (i.e. Not at Fault) is also a useful benchmark for how to think about the effect sizes in Table **??**, since one could think of Type I as a less stigmatizing illness than Type II. The results in **??** shows that respondents are most likely to attribute blame for lacking insurance to Joe when he has been fired from his job. Moreover, we no longer see precise estimation of blame for illness (Column 1) when Joe is fired, as we did in the Employment-Health survey. We also no longer see precise estimation of the deservingness measures. Comparing these results to those from the full design suggests that much of the negative judgement of Joe is being driven by his health-related responsibilty, more so than what Joe is doing to reciprocate getting health insurance.

This supports the previous results that Joe's responsibility for incurring illness plays a much greater role in informing attitudes about his deservingness than does his effort in working for his insurance. Ultimately what these experiment suggest is that reciprocity, to the extent that it is captured by Joe earning insurance through employer-sponsorship, does not matter all that much in people's evaluations of how deserving he is of federal health insurance. Two intuitions follow: 1) People generally do not care about reciprocity efforts when it comes to welfare in the form of health insurance, and/or 2) People consider the question of whether someone deserves health care and the question of whether someone deserves health insurance as relatively similar issues.

[TABLE **??** HERE]

Limitations. One main limitation of the current analysis is its ability to speak to underlying mechanisms. While conclusions can be drawn about whether Joe is more to blame or more deserving as a result of any one of the six treatments, I cannot identify *why* respondents react in the way they do. Whether Joe is less deserving of Medicaid when he is at fault could be because respondents want to punish Joe for bad health behaviors and lifestyle. It could also be due to concerns about how burdensome Joe, who is unhealthy, will be on Medicaid, which is funded by taxpayer dollars. If Joe is going to access Medicaid more because he is demonstrably unhealthy (and perhaps, consequently, unlikely to change his behaviors), his deservingness to be on Medicaid has less to do with his responsibility for his predicament and more about

respondents' concerns about how Medicaid is run.

To this end, I run a second experiment (Experiment 2) which aims to capture baseline attitudes towards the Medicaid program itself. While the results from this design cannot address all of the mechanism bundling described, it nonetheless sheds some light as to how respondents differentiate between 1) the policy learning how works/who it services and 2) recipients on the policy.

Experiment 2: Identifying Sources of Program Attitudes

Experiment 2 addresses the issue in Experiment 1 that respondents' attitudes are bundled and we cannot distinguish between baseline affect towards the recipient from affect towards Medicaid as a result of learning about a potential recipient on the program. Framed differently, respondents may view Joe as undeserving of Medicaid either because they dislike Joe or because they dislike Joe (e.g. because he is irresponsible and nonreciprocating) and they just learned that Medicaid is a program that provides benefits to people like Joe. Experiment 2 is designed to measure the effects of learning about program recipients on program attitudes.

There are two main randomizations that occur in Experiment 2. The first is what policy respondents are being asked questions about ("Policy Treatment"). The two main programs that are described are Medicaid and Medicare. While the Medicaid treatments are the main focus of this project, exposing respondents to descriptions about Medicare will provide a useful benchmark to better understand the Medicaid results. Within the Policy Treatment, I also randomize how much information a respondent receives about either program. The intent behind this manipulation is to address the question of why respondents may have negative attitudes towards a program; is it because of the program itself (i.e. in name only) or because of how the program actually works (i.e. eligibility criteria and funding sources, both which touch on expectations of deservingness)? In total, the Policy Treatment contains four treatment arms.

The second randomization is on the recipient type ("Recipient Treatment"). To be consistent with Experiment 1, if respondents learn about a program recipient, they are given a profile of Joe, who has either Type I or Type II diabetes. If respondents do not learn about a program recipient, then they only learn about the program itself via the Policy Treatments. The main question this randomization is addressing is whether respondents will update (negatively) about Medicare or Medicaid when they learn about a person who is receiving benefits from it. The main vignette is organized such that respondents first see the text presented in the Policy

Treatment and then text presented in the Recipient Treatment, with randomizations occurring where noted:

Policy Treatment The United State is one of the few developed countries without guaranteed federally funded health care. [POLICY]

1. **Medicare:** As a result, some American rely on Medicare, which is a federally funded health insurance program that generally covers individuals 65 years and older. Around 17% of Americans currently get their insurance through Medicare.
2. **Medicare+Info:** As a result, some American rely on Medicare, which is a federally funded health insurance program that generally covers individuals 65 years and older. Individuals are eligible for Medicare if they are 65 or older and US citizens, and they or their spouse has paid Medicare taxes for at least 10 years. Around 17% of Americans currently get their insurance through Medicare.
3. **Medicaid:** As a result, some Americans rely on Medicaid, which is a jointly state and federal funded health insurance program that generally covers low-income individuals. Around 19% of Americans currently get their insurance through Medicaid.
4. **Medicaid+Info:** As a result, some Americans rely on Medicaid, which is a jointly state and federal funded health insurance program that generally covers low-income individuals. Individuals and their families are eligible for Medicaid if they are US citizens earning less than 133% of the federal poverty level. Around 19% of Americans currently get their insurance through Medicaid

Recipient Treatment

1. **Irresponsible:** Recall that X% of Americans rely on [POLICY] for their health insurance. We will now describe an individual who falls into that X% and ask some questions about your attitudes toward him.

   Joe is a single, white man who works a full time job and has a high school diploma. He has an unhealthy diet, consisting mainly of fast food and pro-

cessed snacks and has been diagnosed with Type II diabetes. In order to cover the costs of treatment, Joe relies on [POLICY].

For reference, Type I diabetes (also called juvenile-onset or insulin-dependent diabetes) is an autoimmune disease that an individual is typically born with, as a result of genes. Type II diabetes (also called adult-onset or non-insulin-dependent diabetes) can develop at any age and is often a result of unhealthy behaviors. While individuals can be genetically predisposed to Type II diabetes, it is most frequently caused by lifestyle factors, like obesity and inactivity.

2. **Responsible:** Recall that X% of Americans rely on [POLICY] for their health insurance. We will now describe an individual who falls into that X% and ask some questions about your attitudes toward him.

   Joe is a single, white man who works a full time job and has a high school diploma. He has a family history of Type I diabetes and has been diagnosed with Type I. In order to cover the costs of treatment, Joe relies on [POLICY].

   For reference, Type I diabetes (also called juvenile-onset or insulin-dependent diabetes) is an autoimmune disease that an individual is typically born with, as a result of genes. Type II diabetes (also called adult-onset or non-insulin-dependent diabetes) can develop at any age and is often a result of unhealthy behaviors. While individuals can be genetically predisposed to Type II diabetes, it is most frequently caused by lifestyle factors, like obesity and inactivity.

3. **No Joe:** *(no text)*

There are two main predictions that are tested in this design. First, respondents will have more negative attitudes towards the program after learning about Joe (more so if he has Type 2 than Type 1) being a recipient. Negative attitudes here are measured as support for expanding program benefits to people currently uninsured and willingness to pay slightly more in taxes. Second, respondents will be less supportive of Medicaid when they learn more about how Med-

icaid is funded and its eligibility requirements than otherwise. I am agnostic about how this manifests in the Medicare condition, but I suspect there is a weak increase in support because of programmatic differences between the two programs.

Additionally, while comparisons across policies are difficult to make (i.e. Medicaid and Medicare are such fundamentally different programs that the treatment conditions themselves may prime things that I cannot control for), I would suspect that the magnitude of the attitude change will be smaller in the Medicare conditions than in the Medicaid conditions. This stems primarily from the fact that Medicare is generally viewed more positively than is Medicaid.

The main outcomes of interest are concerned with policy support. Policy support is captured by three measures that capture different aspects of support: 1) support for expansion, 2) support for the program itself, and 3) willingness to pay more in taxes. As the results will show, the type of support plays a nontrivial role. Respondents may be generally supportive of policy, but what that support looks like, i.e. program expansion versus general support versus paying more in taxes, will itself vary.

If respondents are randomized into one of the two Medicaid conditions, they are also asked about their attitudes toward work requirements. If they are in these conditions, respondents will be shown the following text prior to the question:

> "One recent development in Medicaid is the implementation of community engagement requirements (often referred to as work requirements) as a condition of eligibility. According to a memo by the Department of Health and Human Services, these work requirements are "designed to help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program."

These measures were included to capture how respondents felt about work requirements specifically in the context of Medicaid eligibility, which was not done in Experiment 1, primarily due to concerns about priming effects.

Results. Data were collected from a sample of 1,075 respondents from a survey run on Amazon's Mechanical Turk. The assignment mechanism allocated each respondent into one of the 12 treatment conditions with equal probability.

In general, the results from Experiment 2 suggest that programmatic support is contingent on both how the policy works (i.e. eligibility requirements and how its funded) as well as

who is benefiting from the program. That said, there is a lack of evidence that this support would translate into policy expansion to currently unemployed individuals. The first set of tables (Tables **??** and **??**) looks at the effect of learning about a type of recipient on the policy attitude. The analysis is broken down by the Policy Treatment (i.e. I do not pool the Medicaid and Medicaid+Info results together even though they both focus on Medicaid) to address concerns about differential treatments within a policy program.

If we first focus on attitudes towards Medicaid (Table **??**), there is suggestive evidence that learning about an irresponsible recipient on Medicaid negatively effects attitudes towards Medicaid. In the Medicaid with no additional info treatment (the left half of **??**), learning about an irresponsible Joe decreases respondents' average attitude against work requirements (i.e. they do not think work requirements are as much of a burden if they are presented with an irresponsible Joe). In the Medicaid+Info treatment, general support for Medicaid decreases by about half a point if they learn about an irresponsible Joe. Table **??** suggest that the effect is reversed if we look at the Medicare treatments. Respondents were more willing to pay more in taxes to fund Medicare if they learn that a responsible Joe was a recipient of program benefits, more so than if they were just told about Medicare in general. Framed differently, it is not just that respondents like Medicare as a program itself, but also that they like Medicare more when they learn about "good" recipients on the program.

Tables **??** and **??** estimates the interaction of the policy information treatment with the recipient treatment to address the question of how much of program attitudes are driven by programmatic features, i.e. who is eligible and how it is funded. It could be that support for Medicaid is more of an issue knowing (or not knowing) how the program works rather than one of distaste for the program or recipient. Framed differently, if respondents are dissatisfied with how Medicaid operates and not with the targeted recipient population, then being primed about programmatic features of Medicaid should not vary expressed support. On the other hand, we might expect that learning about how Medicaid actually works would decrease support (especially compared to Medicare) because of its similarity to other welfare programs (i.e. you don't pay into Medicaid whereas you do pay into Medicare). Appendix Tables **??** and **??** run a pooled comparison of policy with and without additional information. We see that respondents are more likely to view work requirements as less burdensome when they are more informed about how Medicaid is run. That is to say, learning about eligibility requirements for Medicaid makes respondents view work requirements as marginally more appropriate for eligibility.

More specifically, Tables **??** and **??** present a full analysis of the interactive effect of learning about a recipient type and learning about how a policy works. Table **??** shows that support for Medicaid decreases when respondents learn that an irresponsible type is receiving benefits from Medicaid, particularly when they are primed to think about how Medicaid is run. While we cannot reject the argument that people take no issue with the programmatic features of Medicaid (i.e. we cannot accept null that there's no effect of learning additional information), the results suggests that learning about recipients on Medicaid plays a salient role in informing attitudes towards Medicaid. Comparing these results to what we see in the Medicare conditions (Table **??**), the direction of the effect at minimum suggest some variation in how respondents view the two programs. Overall, these results suggest that learning about potential recipients of a policy program is important for program evaluation, beyond the baseline attitudes toward the program itself.

[TABLE **??** HERE]

[TABLE **??** HERE]

It is worth connecting the work requirement results (from Tables **??** and **??**) to the results from Experiment 1, where the notion of work requirements is operationalized through Joe's employment status. We see in the results for Experiment 2, respondents react to an irresponsible Joe by being more supportive of work requirements; this seemingly runs counter to the results from Experiment 1 which suggest that respondents do not care that much about Joe' reciprocity. One way to interpret these results is that Experiment 2 directly asks respondents about their attitudes to work requirements while Experiment 1 asks respondents about the underlying intent of work requirements (i.e. the *notion* of reciprocity). Work requirements are generally discussed as a means for states to assess Medicaid recipients and much of the rhetoric around them is an issue of framing. However, as discussed in previous sections, this does not actually comport with the empirical reality of the non-working Medicaid population nor necessarily with how people understand the role of work requirements once we strip away some of the framing rhetoric.

[TABLE **??** HERE]

[TABLE ?? HERE]

Conclusion

Whether an individual deserves federally-funded health insurance is based on a number of considerations.While extant work has established the importance of health-related behaviors in changing perceptions of deservingness, something that is unclear is whether individuals can differentiate between desert of health care and desert of health insurance. This distinction is important given what we know about program deservingness from the literature on welfare. While reciprocity, what one does to earn or return program benefits is an important factor in welfare recipiency, most of the work on deservingness of health insurance has focused on an alternative factor, responsibility. This focus is not unwarranted, since what an individual does to incur need of health care should indeed affect how we evaluate their deservingness of said health care. However, there is a difference between provision of health *care* and health *insurance*. By conflating these two goods, we cannot tell from extant research whether attitudes towards provision of health insurance (e.g. in the form of Medicaid) are driven by health-related considerations (i.e. what they did to become sick) or by work-related considerations, which would align more with the work on attitudes towards welfare.

This paper addresses this by distinguishing between the role of individual responsibility for one's health condition and one's state of being uninsured. Specifically, I run a series of survey experiments in which one's responsibility is operationalized through either being at fault or not at fault for a form of diabetes and one's reciprocity is operationalized through employment status. To summarize the main results, I find that people rely on health-related behaviors in evaluating recipients of Medicaid, more so than on behaviors related to whether one has earned their health insurance. This suggests that respondents either do not care much about an individual's reciprocity when it comes to health insurance receipt or that the questions of deservingness of health care and of health insurance are in fact the same question. Additionally, a supplementary experiment confirms that it is indeed the profile of the recipient that matters in driving these attitudes, and that the results are not due to respondents updating about the programmatic features of Medicaid itself.

What is a real-world relevance of reciprocity in federally-funded health insurance? States are currently engaging in efforts to waive Obama-era restrictions against using work require-

ments as part of Medicaid eligibility. Not only are a majority of Medicaid recipients either already employed or unable to work (due to chronic illness, schooling, etc.), but the implementation of work requirements may make current Medicaid recipients newly ineligible. The idea of work requirements speaks to an age old American tradition of earning ones keep. What does it mean for someone to deserve to be or to earn health insurance, and why is work and employment a good way to measure deservingness? In the case of the experimental designs, I ask whether has Joe earned Medicaid or federal support to fix his state of being uninsured. While work requirements work (in theory) for a number of policy dimension (i.e. most prominently, welfare), their relevance in the health sphere seems to be relatively negligible. The data suggest that, if anything, the more relevant factor is how individuals are perceived to be utilizing health insurance. Joe is perceived more favorable when he is responsible for his diagnosis and, consequently, his need to access the health care system which incurs health costs. These results complicate the introduction and relevance of work requirements in Medicaid eligibility. If there is no relevance of reciprocity in public opinion, then the relevance of work requirements as part of Medicaid eligibility requires further questioning.

Perhaps the most important takeaway is that attitudes towards policy programming are heavily influenced by the recipient population. This aligns with what we know about the relevance of target populations in policy design (e.g. Schneider and Ingram, 1993). Given the focus on Medicare-for-All's viability as a solution to the health care crisis, one point worth bringing into the discussion is how the recipient population of whatever the new health care policy will be will affect its support. We can generally agree that most people want some improvement to the current health care system, but we have yet to really consider what will happen when the discussion shifts to asking *who* benefits from these improvements. Identifying the role of individual responsibility, independent of the role of reciprocity, in driving attitudes toward programmatic support will help researchers and policymakers better understand the contours of health policy design.

References

Center for Medicare & Medicaid Services. (2018, January 11). RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

Cook, F.L. (1979). *Who Should Be Helped? Public Support for Social Services.* Beverly Hills: Sage Publications.

Cook, F.L. & Edith J. Barrett. (1992). *Support for the American Welfare State.* Columbia University Press.

Bobo, L. & J.R. Kluegel. (1993). Opposition to Race-Targeting: Self-Interest, Stratification Ideology, or Racial Attitudes? *American Sociological Review*, 58(4), 443-464.

Feldman, S. & L. Huddy. (2005). Racial Resentment and White Opposition to Race-Conscious Programs: Principles or Prejudice *American Journal of Political Science*, 49(1), 168-183.

Gallup Historical Trends. (2019). Healthcare system. Retrieved from http://news.gallup.com/poll/4708/healthcare-system.aspx.

Garfield, R., R. Rudowitz, & K. Orgera. (2019, August 8). Understanding the Intersection of Medicaid and Work: What Does the Data Say? Retrieved from https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/.

Gilens, M. (2000). *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy.* University of Chicago Press.

Gollust, S. & J. Lynch. (2011). Who Deserves Health Care? The Effects of Causal Attributions and Group Cues on Public Attitudes about Responsibility for Health Care Costs. *Journal of Health Politics, Policy and Law*, 36, 1061-1095.

Gordon, C. (2003). *Dead on Arrival: The Politics of Health Care in Twentieth-Century America. Princeton University Press.*

Huddy, L. & S. Feldman. (2009). On Assessing the Political Effects of Racial Prejudice. *Annual Review of Political Science*, 12, 423-47.

Jensen, C. & M. Bang Petersen. (2017). The Deservingness Heuristic and the Politics of Health Care. *American Journal of Political Science*, 61(1), 68-83.

Kaiser Family Foundation. (2019, August 21). Medicaid Waiver Tracker: Approved and Pending Section 115 Waivers by State. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

Kirzinger, A., B. Wu, & M. Brodie. (2018, March 23). Kaiser Health Tracking Poll - March 2018: Views on Prescription Drug Pricing and Medicare-for-all Proposals. Retrieved from https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-march-2018-prescription-drug-pricing-medicare-for-all-proposals

Knowles, E., B.S. Lowery, & R.L. Schaumberg. (2010). Racial prejudice predicts opposition to Obama and his health care reform plan. *Journal of Experimental Social Psychology*, 46, 420-423.

Oakman, T.S., R.J. Blandon, A.L. Campbell, A.M. Zaslavsky, & J.M. Benson. (2010). A Partisan Divide on the Uninsured. *Health Affairs*, 29(4), 706-711.

Lynch, J. & S.E. Gollust. (2010). Policy Preferences in the United States. *Journal of Health Politics, Policy, and Law.* 35(6): 849-887.

"Public support for 'single payer' health coverage grows, driven by Democrats." Pew Research Center, Washington, D.C. (June 23, 2017). http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats

Rigby, E., J. Soss, B.C. Brooske, A. Rohan, & S.A. Robert. (2009). Public Responses to Health Disparities: How Group Cues Influence Support for Government Intervention. *Social Science Quarterly*, 90(5), 1322-1340.

Schneider, A. and H. Ingram. (1993). Social Construction of Target Populations: Implications for Politics and Policy. *American Political Science Review*, 87(2), 334-347.

Tesler, M. (2012). The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race. *American Journal of Political Science*, 56(3), 690-704.

Tables

Table 1: Model Specifications

Model Number	**Regression Equation**
(1) Health	$Y_i = \alpha_{1i} + \beta_1 \text{At Fault}_i + \epsilon_{1i}$
(2) Employment	$Y_i = \alpha_{2i} + \beta_2 \text{Laid Off}_i + \beta_3 \text{Fired}_i + \epsilon_{2i}$
(3) Interaction	$Y_i = \alpha_{3i} + \beta_4 \text{At Fault}_i + \beta_5 \text{Laid Off}_i + \beta_6 \text{Fired}_i$ $+\beta_7(\text{At Fault x Employed})_i + \beta_8(\text{At Fault x Laid Off})_i$ $+\beta_9(\text{At Fault x Fired})_i + \epsilon_{3i}$

Notes: Y_i is any one of the outcome measures described in the appendix. At Fault is equal to 1 if Joe was presented as having Type 2 diabetes. Fired and Laid Off are equal 1 if Joe was fired or laid off, respectively, from his job. The baseline in (1) is Joe being Not at Fault (he has Type 1). The baseline in (2) is Joe being Employed but without health benefits. The baseline in (3) is Joe being Not at Fault and Employed.

Table 2: Effect of Responsibility on Deservingness (Pooled)

	Outcome Measures				
Health Treatments	Blame: Illness (1)	Blame: Insurance (2)	Deserving: Federal (3)	Deserving: Medicaid (4)	Burden of Costs (5)
At Fault	1.781***	0.881***	-0.414***	-0.508***	-0.339***
	(0.082)	(0.083)	(0.081)	(0.083)	(0.075)
Constant	2.567***	2.829***	5.118***	5.201***	4.237***
	(0.060)	(0.058)	(0.056)	(0.058)	(0.052)
N	1,650	1,650	1,650	1,650	1,650

Notes: Robust standard errors in parentheses: *** p<0.01, ** p<0.05, * p<0.1. The constant reports the mean value of the outcome measure under the Not at Fault condition.

Table 3: Effect of Reciprocity (Pooled)

	Outcome Measures				
Employment Treatments	Blame: Illness (1)	Blame: Insurance (2)	Deserving: Federal (3)	Deserving: Medicaid (4)	Burden of Costs (5)
Fired	0.236**	0.689***	-0.082	-0.061	0.038
	(0.113)	(0.103)	(0.099)	(0.103)	(0.092)
Laid Off	0.162	0.219**	-0.152	-0.072	-0.037
	(0.113)	(0.104)	(0.098)	(0.101)	(0.091)
Constant	3.319***	2.963***	4.989***	4.993***	4.068***
	(0.078)	(0.072)	(0.067)	(0.070)	(0.062)
N	1,650	1,650	1,650	1,650	1,650

Notes: Robust standard errors in parentheses: *** p<0.01, ** p<0.05, * p<0.1. The constant reports the mean value of the outcome measure under the Employed condition.

Table 4: Effect of Responsibility and Reciprocity

	Deservingness of Coverage				
All Treatments	Blame: Illness (1)	Blame: Insurance (2)	Deserving: Federal (3)	Deserving: Medicaid (4)	Burden of Costs (5)
At Fault x Fired	2.042***	1.637***	-0.520***	-0.551***	-0.286**
	(0.142)	(0.141)	(0.146)	(0.150)	(0.135)
At Fault x Laid Off	1.937***	1.079***	-0.507***	-0.572***	-0.346***
	(0.140)	(0.145)	(0.143)	(0.147)	(0.132)
At Fault x Employed	1.745***	0.915**	-0.327**	-0.434***	-0.235*
	(0.138)	(0.140)	(0.134)	(0.139)	(0.125)
Fired	0.242*	0.690***	0.009	-0.023	0.112
	(0.145)	(0.140)	(0.137)	(0.143)	(0.126)
Laid Off	0.127	0.272*	-0.123	-0.005	0.039
	(0.145)	(0.140)	(0.136)	(0.141)	(0.127)
Constant	2.443***	2.504***	5.154***	5.211***	4.186***
	(0.101)	(0.099)	(0.098)	(0.102)	(0.090)
N	1,650	1,650	1,650	1,650	1,650

Notes: Robust standard errors in parentheses: *** p<0.01, ** p<0.05, * p<0.1. The constant reports the mean value of the outcome measure under the Not at Fault x Employed condition.

Table 5: Effect of Reciprocity (Employment-Only)

	Outcome Measures				
Employment Treatments	Blame: Illness (1)	Blame: Insurance (2)	Deserving: Federal (3)	Deserving: Medicaid (4)	Burden of Costs (5)
Fired	0.226	0.494***	-0.073	0.104	-0.041
	(0.140)	(0.147)	(0.138)	(0.142)	(0.130)
Laid Off	0.066	0.087	-0.074	0.128	0.243*
	(0.145)	(0.153)	(0.144)	(0.150)	(0.129)
Constant	2.516***	2.553***	5.179***	5.070***	4.094***
	(0.101)	(0.108)	(0.100)	(0.106)	(0.093)
N	798	797	796	797	796

Notes: Robust standard errors in parentheses: *** p<0.01, ** p<0.05, * p<0.1. The constant reports the mean value of the outcome measure under the Employed condition.

Table 6: Effect of Recipient Type on Medicaid Attitudes

	Medicaid					Medicaid+Info				
Recipient Treatments	Support for Expansion (1)	Support for Medicaid (2)	Willing to Pay More in Tax (3)	Support Work Reqs (4)	Burden of Work Reqs (5)	Support for Expansion (6)	Support for Medicaid (7)	Willing to Pay More in Tax (8)	Support Work Reqs (9)	Burden of Work Reqs (10)
Irresponsible	-0.300	-0.307	-0.367	0.022	-0.584*	-0.392	-0.417*	-0.162	0.031	-0.204
	(0.239)	(0.209)	(0.283)	(0.282)	(0.305)	(0.239)	(0.219)	(0.300)	(0.316)	(0.319)
Responsible	0.030	-0.100	0.089	0.044	-0.052	-0.062	0.084	0.502	0.291	0.482
	(0.223)	(0.195)	(0.273)	(0.275)	(0.294)	(0.239)	(0.209)	(0.313)	(0.343)	(0.343)
Constant	5.800***	6.000***	5.000***	4.456***	4.719***	5.845***	5.964***	4.643***	4.131***	4.012***
(No Joe)	(0.162)	(0.140)	(0.189)	(0.192)	(0.201)	(0.161)	(0.147)	(0.223)	(0.245)	(0.245)
N	268	268	270	270	268	273	272	273	272	270

Notes: $^{***}p < 0.01, ^{**}p < 0.05, ^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Joe condition. N varies across columns due to lack of response from respondents for those questions.

Table 7: Effect of Recipient Type on Medicare Attitudes

	Outcome Measures			Outcome Measures		
Info Treatments	Support for Expansion (1)	Support for Medicare (2)	Willing to Pay More in Tax (3)	Support for Expansion (4)	Support for Medicare (5)	Willing to Pay More in Tax (6)
Irresponsible Joe	0.196	0.072	0.181	0.048	0.205	0.098
	(0.270)	(0.196)	(0.315)	(0.284)	(0.212)	(0.321)
Responsible Joe	0.193	-0.178	0.553*	0.103	0.127	0.178
	(0.269)	(0.200)	(0.291)	(0.295)	(0.214)	(0.334)
Constant (No Joe)	5.227***	5.888***	4.357***	5.342***	5.848***	4.481***
	(0.200)	(0.141)	(0.223)	(0.210)	(0.154)	(0.235)
N	275	273	276	275	273	276

Notes: $^{***}p < 0.01,^{**}p < 0.05,^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Joe condition. N varies across columns due to lack of response from respondents for those questions.

Table 8: Effect of Additional Medicaid Info on Attitudes Toward Medicaid, by Recipient Type

	Outcome Measures				
Info x Recipient Treatments	Support for Expansion	Support for Medicaid	Willing to Pay More in Tax	Support Work Reqs	Burden of Work Reqs
	(1)	(2)	(3)	(4)	(5)
Additional Info x	-0.347	-0.453**	-0.519*	-0.294	-0.911***
Irresponsible	(0.240)	(0.215)	(0.276)	(0.277)	(0.286)
No Info x	-0.300	-0.307	-0.367	0.022	-0.584*
Irresponsible	(0.239)	(0.209)	(0.283)	(0.282)	(0.305)
Additional Info x	-0.017	0.049	0.145	-0.034	-0.225
Responsible	(0.240)	(0.204)	(0.290)	(0.308)	(0.314)
No Info x	0.030	-0.100	0.089	0.044	-0.052
Responsible	(0.223)	(0.195)	(0.273)	(0.275)	(0.294)
Additional Info x	0.045	-0.036	-0.357	-0.325	-0.707**
No Joe	(0.228)	(0.203)	(0.292)	(0.311)	(0.317)
Constant	5.800***	6.000***	5.000***	4.456***	4.719***
(No Info x No Joe)	(0.162)	(0.140)	(0.189)	(0.192)	(0.201)
N	541	540	543	542	538

Notes: $^{***}p < 0.01, ^{**}p < 0.05, ^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Info x No Joe condition. N varies across columns due to lack of response from respondents for those questions.

Table 9: Effect of Additional Medicare Info on Attitudes Toward Medicare, by Recipient Type

	Outcome Measures		
Info x Recipient Treatments	Support for Expansion	Support for Medicare	Willing to Pay More in Tax
	(1)	(2)	(3)
Additional Info x Irresponsible	0.163	0.165	0.222
	(0.277)	(0.203)	(0.312)
No Info x Irresponsible	0.196	0.072	0.181
	(0.271)	(0.196)	(0.315)
Additional Info x Responsible	0.218	0.088	0.301
	(0.288)	(0.204)	(0.326)
No Info x Responsible	0.193	-0.178	0.553*
	(0.269)	(0.200)	(0.291)
Additional Info x No Joe	0.115	-0.040	0.124
	(0.290)	(0.208)	(0.324)
Constant (No Info x No Joe)	5.227***	5.888***	4.357***
	(0.200)	(0.141)	(0.223)
N	530	528	532

Notes: $^{***}p < 0.01, ^{**}p < 0.05, ^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Info x No Joe condition. N varies across columns due to lack of response from respondents for those questions.

Appendix

Experiment 1 Outcomes

Blame of Insurance Status: Based on this limited information, some people might guess that Joe is completely to blame for not being insured. Others might guess that he is not to blame at all. Where would you place yourself on this scale?
Scale: 1 to 7, 1 = Joe completely to blame, 7 = Joe not at all to blame

Blame of Illness: Based on this limited information, some people might guess that Joe is completely to blame his own illness. Others might guess that he is not to blame at all. Where would you place yourself on this scale?
Scale: 1 to 7, 1 = Joe completely to blame, 7 = Joe not at all to blame

Responsibility of Provision: In your opinion, who should be responsible for providing health care coverage for Joe? Check all that apply.
Options: The federal government; His state government; Joe, by finding a job that provides health benefits; Joe, by buying insurance through private markets; Other

Support for the Unemployed: How much would you support expanding Medicaid to who are unemployed?
Scale: 1 to 7, 1 = Completely opposed, 7 = Totally support

Support for the Employed: How much would you support expanding Medicaid to who are employed (working at least part-time)?
Scale: 1 to 7, 1 = Completely opposed, 7 = Totally support

Deservingness of Government Support: How much do you think Joe deserves to receive health coverage from the government?
Scale: 1 to 7, 1 = Not deserving at all, 7 = Very deserving

Burden of Costs: Some people think that in a fair society, Joe should be the one to pay for all the costs of his medical care. Others think that citizens should cover all the costs of Joe's medical care through their taxes or insurance premiums. Where would you place yourself on this scale?
Scale: 1 to 7, 1 = Joe should pay all costs, 7 = Citizens in society should pay all costs

Representativeness: Medicaid offers federally-funded health insurance to over 74.4 million individuals. In your mind, how representative would you say Joe is of the average Medicaid recipient?

Scale: 1 to 7, 1 = Not at all representative, 7 = Completely representative

Experiment 2 Outcomes

1. **Support for Expansion:** How much would you support expanding [Medicaid/Medicare] coverage to provide health insurance to people who are currently uninsured and who cannot afford private insurance? (Scale: 1 to 7, 1 = Completely opposed, 7 = Totally support)

2. **Support for Program:** In general, how much would you say you support [Medicare/Medicaid]? (Scale: 1 to 7, 1 = Completely opposed, 7 = Totally support)

3. **Willing to Pay More in Tax:** [Medicare/Medicaid] is funded by federal and state taxes. How willing would you be to pay more in taxes so that people who are currently ineligible for [Medicare/Medicaid] would be eligible for [Medicare/Medicaid]? (Scale: 1 to 7, 1 = Completely unwilling, 7 = Totally willing)

4. **Support Work Reqs:** How much would you say you support implementing work requirements as a part of Medicaid eligibility? (Scale: 1 to 7, 1 = Strongly oppose, 7 = Strongly support)

5. **Burden of Work Reqs:** To what extent do you agree or disagree with the following statement: Implementing work requirements as part of Medicaid eligibility would place undue burden on individuals who depend on Medicaid for health insurance. (Scale: 1 to 7, 1 = Totally disagree, 7 = Totally agree)

Appendix Tables

Table A1: Respondent Demographics

	Experiment 1 (Lucid Sample)	Experiment 2 (mTurk Sample)
Age	46.35	38.61
% Female	0.52	0.50
% Male	0.48	0.49
Partisanship		
% Republican	038	0.30
% Democrat	0.45	0.56
% Independent	0.17	0.14
Employment Status		
% Employed	0.48	0.81
% Unemployed	0.25	0.19
Insurance Status		
Insured	0.89	0.88
Insured - by employer	0.35	0.54
Insured - federally	0.41	0.21
Not Insured	0.11	0.12
N	1,650	1,075

Notes: The Lucid sample for Experiment 1 was collected in May 2018. The mTurk sample for a pilot of Experiment 2 was collected in March 2019.

Table A2: Effect of Additional Policy Info on Medicaid Attitudes

	Outcome Measures				
Info Treatments	Support for Expansion (1)	Support for Medicaid (2)	Willing to Pay More in Tax (3)	Support Work Reqs (4)	Burden of Work Reqs (5)
Additional Info	-0.035	-0.038	-0.175	-0.246	-0.426**
	(0.138)	(0.123)	(0.169)	(0.173)	(0.182)
Constant (No Info)	5.709***	5.866***	4.907***	4.478***	4.507***
	(0.095)	(0.083)	(0.115)	(0.114)	(0.125)
N	541	540	543	542	538

Notes: $^{***}p < 0.01, ^{**}p < 0.05, ^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Info condition. N varies across columns due to lack of response from respondents for those questions.

Table A3: Effect of Additional Policy Info on Medicare Attitudes

	Outcome Measures		
Info Treatments	Support for Expansion	Support for Medicare	Willing to Pay More in Tax
	(1)	(2)	(3)
Additional Info	0.039	0.122	-0.034
	(0.160)	(0.119)	(0.180)
Constant (No Info)	5.353***	5.842***	4.609***
	(0.109)	(0.082)	(0.122)
N	530	528	532

Notes: $^{***}p < 0.01, ^{**}p < 0.05, ^{*}p < 0.10$. Robust standard errors are in parentheses. The constant reports the mean value of the outcome measure under the No Info condition. N varies across columns due to lack of response from respondents for those questions.