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Blake, Valarie K.

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The Social Costs of Health Care

Valarie K. Blake*

Imagine you had to choose between your health and your freedom. Many Americans do. Choices to work, marry, retire, move, cohabitate—all are influenced by health care finance laws. Access to health insurance is not guaranteed, and eligibility comes with social costs. For the publicly insured, recipients forgo work, marriage, and security in old age to meet strict income and asset tests. People with disabilities, their medical needs pigeon-holed into public programs, are denied equal opportunity in this way. Employer-sponsored insurance presents its own costs, limiting the range of jobs people take, when they can retire, and whether to marry and divorce. Medicaid expansion and premium tax credits mitigate these harms by degrees but are diminished under the current presidential administration.

Research is conclusive that social conditions shape our health. The inverse is also true, that the health care system shapes social conditions. This undermines goals of a health care system to make people healthier, insulate them financially, and enable them to live meaningful lives. It breeds social inequality.

This Article names and defines this problem, with an effort to center it in the health reform work of scholars, lawmakers, and judges. The Article offers minor and major policy reforms to address the problem. It contributes to scholarly discourse and policymaking on health and welfare reform at state and federal levels.

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INTRODUCTION

The lives of most Americans are getting worse. Congress recently passed and President Trump signed into law the One Big Beautiful Bill Act,[1] which chips away at Medicaid,[2] while Republicans have refused to extend Biden-era enhanced subsidies for the purchase of individual insurance.[3] Obviously, reducing access to health benefits makes health care costlier and harder to come by.[4] Less pronounced,

1. One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025).

2. Aliza Rosen, *How New Federal Legislation Will Affect Health Care Costs and Access for Americans*, JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH (July 30, 2025), https://publichealth.jhu.edu/2025/the-changes-coming-to-the-aca-medicaid-and-medicare [perma.cc/LS9C-7DW2].

3. Katie Keith, *Senate Republicans Pass Budget Reconciliation Legislation: What's New in the Coverage Provisions?*, HEALTH AFFS. (July 2, 2025), https://www.healthaffairs.org/content/forefront/senate-republicans-pass-budget-reconciliation-legislation-s-new-coverage-provisions [web.archive.org/web/20250708043420/https://www.healthaffairs.org/content/forefront/senate-republicans-pass-budget-reconciliation-legislation-s-new-coverage-provisions]; Cynthia Cox, *What Trump's 2024 Victory Means for the Affordable Care Act*, KAISER FAM. FOUND.: QUICK TAKES (Nov. 6, 2024), https://www.kff.org/quick-take/what-trumps-2024-victory-means-for-the-affordable-care-act/ [perma.cc/CQ3S-F9VM] (describing the conservative political agenda regarding premium tax credits).

4. Sara Rosenbaum, *Medicaid and a Second Trump Administration*, MILBANK MEM'L FUND: MILBANK Q. (Dec. 11, 2024), https://www.milbank.org/quarterly/opinions/medicaid-and-a-second-trump-administration/ [perma.cc/4NQ3-MN5Y] (describing harms of projected Medicaid cuts on individual access and state economies); Berkeley Lovelace, *Millions at Risk of Losing Health Insurance After Trump's Victory*, NBC NEWS: HEALTH NEWS (Nov. 7, 2024), https://www.nbcnews.com/health

these policy changes will make it harder for people to work, marry, grow their wealth, and support their families.

This is because our health insurance system in its current form is inextricably linked to these and other social opportunities.[5] The Medicaid expansion and enhanced premium tax credits made some progress toward reducing social tradeoffs,[6] but now they are under threat. These and other reforms are necessary for a health care system that supports social equality.[7]

Over 100 million Americans depend on a means-tested benefit program,[8] and these programs most significantly restrict opportunity.[9] Medicaid, Children's Health Insurance Program (CHIP), and premium tax credits have greatly improved morbidity and mortality and reduced medical debt,[10] but they also impose income and sometimes asset tests on individuals and their families.[11] Frequently these individuals and their families are marginalized people, including people of color,[12] people with disabilities,[13] and low income individuals.[14] To remain financially needy, some people abstain from work, limit hours or pay, or self-employ.[15] Means-

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/health-news/millions-risk-losing-health-insurance-trumps-victory-rcna179146 [perma.cc/6E2S-Z6N5] (describing threats of uninsurance and rising health care costs with erosions of premium tax credits).

5. *See* discussion *infra* Parts I & II.

6. Carmen M. Gutierrez, *The Institutional Determinants of Health Insurance: Moving Away from Labor Market, Marriage, and Family Attachments Under the ACA*, 83 AM. SOCIO. REV. 1144, 1161 (2018) (establishing, through the use of data, that ACA reforms detached insurance from work and marriage).

7. *See* discussion *infra* Part IV.

8. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., AUGUST 2024: MEDICAID AND CHIP ELIGIBILITY OPERATIONS AND ENROLLMENT SNAPSHOT 6 (2024), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-august2024.pdf [perma.cc/MBB2-HA6Q]; CONG. BUDGET OFFICE, THE PREMIUM TAX CREDIT AND RELATED SPENDING (2024), https://www.cbo.gov/system/files/2024-07/60523-2024-07-premium-tax-credit.pdf [perma.cc/M5LM-2Z8H].

9. This Article focuses only on means-tested public benefits programs. Universal public programs like Medicare are not means tested and do not raise the same freedom problems, as will be discussed in Part IV.

10. Melissa McInerney, Ruth Winecoff, Padmaja Ayyagari, Kosali Simon & M. Kate Bundorf, *ACA Medicaid Expansion Associated with Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence from the Health and Retirement Study*, 57 INQUIRY: THE J. OF HEALTH CARE ORG., PROVISION, & FIN. July 28, 2020, at 1, 1; *but see* Katherine Baicker, Sarah L. Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider, Bill J. Wright, Alan M. Zaslavsky & Amy N. Finkelstein, *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*, 368 NEJM 1713, 1713 (2013) (describing Medicaid as having minimal to no effect on certain health measures but having eliminated catastrophic medical debt).

11. *See* discussion *infra* Section I.A.

12. *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, KAISER FAM. FOUND.: STATE HEALTH FACTS, https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/ [perma.cc/GF2Y-N74H] (last visited Sep. 16, 2025).

13. Elizabeth Williams & MaryBeth Musumeci, *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access*, KAISER FAM. FOUND.: MEDICAID (Oct. 4, 2021), https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/ [perma.cc/7WVG-93HA]; Jae Kennedy, Elizabeth Geneva Wood & Lex Frieden, *Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults*, 54 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN., November 22, 2017, at 1, 1.

14. *Medicaid Coverage Rates or the Nonelderly Federal Poverty Level (FPL)*, KAISER FAM. FOUND.: STATE HEALTH FACTS, https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-federal-poverty-level-fpl/ [perma.cc/82PH-KBQ5] (last visited Sep. 16, 2025).

15. *See* discussion *infra* Section I.B.1.

testing thus can make accumulating wealth and savings for retirement incredibly difficult, if not impossible.[16] Some avoid marriage or cohabitation, or even "medically divorce," unless their romantic partners are impoverished enough not to impact eligibility.[17] Even place of residency can be influenced by eligibility criteria.[18] These issues are most pronounced for people with disabilities, whose health needs are sometimes only met by Medicaid.[19] Medicaid and other means-tested health care programs save lives but hamper their beneficiaries in their the ability to live fully and equally. Medicaid expansion improved social and economic opportunity[20] but still forces some limits on work and home life.[21]

Over half of the population receives benefits through employer-sponsored insurance (ESI), either as a worker, spouse, or dependent.[22] These comparatively wealthier, privately-insured individuals too face limits on opportunity, though to lesser degrees than those relying on poverty programs. ESI creates job lock, or the phenomenon where people make work decisions based on benefits.[23] Some workers may stay in unsuitable jobs, or be prevented from self-employing, starting businesses, or taking leave to care for children and ailing loved ones.[24] The need to maintain ESI may prevent early retirements, or even timely ones, if a spouse or adult child still depends on the family plan at the time the worker ages into Medicare.[25] Couples may be incentivized to marry when they otherwise might not, while others may be unable to divorce if one partner is dependent on the other for benefits.[26] The premium tax credits therefore provide an important alternative to ESI by uncoupling access to private insurance from work. They also provide an option for

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16. *See* discussion *infra* Section I.B.1.

17. *See* discussion *infra* Section I.B.2.

18. Particularly, the federalist nature of the Medicaid program enables expansive differences in eligibility and benefit coverage across state lines. *See* Margot Jackson, Chinyere Agbai & Emily Rauscher, *The Effects of State-Level Medicaid Coverage on Family Wealth*, 7 RUSSEL SAGE FOUND. J. SOC. SCIS. 216, 216 (2021) (describing how variations of state approaches to Medicaid influence wealth); Ramin Mojtabai, Kenneth A. Feder, Marc Kealhofer, Noa Krawczyk, Carla Storr, Kayla N. Tormohlen, Andrea S. Young, Mark Olfson & Rosa M. Crum, *State Variations in Medicaid Enrollment and Utilization of Substance Use Services: Results from a National Longitudinal Study*, 89 J. SUBSTANCE ABUSE TREATMENT 75, 75 (2018) (detailing how state variations in Medicaid affect access to substance use services).

19. MARY CROSSLEY, EMBODIED JUSTICE 128–29 (2022); MaryBeth Musumeci & Kendal Orgera, *People with Disabilities are at Risk of Losing Medicaid Without the ACA Expansion*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (Nov. 2, 2020), https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/ [perma.cc/5KTF-8GZZ] (explaining different pathways to Medicaid and why each is critical for people with disabilities).

20. Gutierrez, *supra* note 6.

21. *See* discussion *infra* Part I.

22. *See* Katherine Keisler-Starkey, Lisa N. Bunch & Rachel A. Lindstrom, *Health Insurance Coverage in the United States: 2022*, U.S. CENSUS BUREAU: LIBR. PUBL'NS (Sep. 12, 2023), https://www.census.gov/library/publications/2023/demo/p60-281.html [perma.cc/5KTF-8GZZ] (reporting that 54.5 percent of the population received ESI).

23. *See* discussion *infra* Section II.B.1; see DEAN BAKER, JOB LOCK AND EMPLOYER-PROVIDED HEALTH INSURANCE: EVIDENCE FROM THE LITERATURE 1 (2015), https://www.aarp.org/content/dam/aarp/ppi/2015-03/JobLock-Report.pdf [perma.cc/J797-LCR6], for a comprehensive overview of research on job lock.

24. BAKER, *supra* note 23.

25. *See* discussion *infra* Section II.B.1.

26. *See* discussion *infra* Section II.B.2.

people who earn too much to continuously qualify for Medicaid.[27] Especially during the credits' temporary increased availability due to the Inflation Reduction Act,[28] the premium tax credits were one of the best methods for reducing the social costs of insurance.

These opportunity costs are placed in sharper relief when one considers what we get in return from our health care system. A 2024 Commonwealth Fund report ranked the United States last among ten high-income countries in the performance of its health care system, lower than any others in access to care, equity, administrative efficiency, and health care outcomes.[29] The United States ranks lower in these metrics despite spending more gross domestic product than any other of these nations on health care.[30]

A health care system that compromises economic and social opportunity, and drives many into poverty, fails at many practical and theoretical goals. Foremost, we expect a health care system to help us stay healthy.[31] The current system undermines people's access to social determinants of health by compromising their economic and social opportunity and mandating poverty.[32] Second, most agree a health care system ought to insulate us from economic risk and spread economic cost fairly across the population.[33] The current system denies people equal economic opportunity, and while it reduces the risk of out-of-pocket health care costs for some individuals, it simultaneously places them in a position with broader financial insecurity.[34] Third, many scholars argue that health care ought serve as a means to support human flourishing and functioning in society.[35] A system that denies us a chance to live our lives fully and meaningfully, and burdens people unequally in this regard, does not achieve this aim.[36]

While we live in an unequal society, there is no health policy rationale for why the health care system must compound that inequality. It is a policy choice and one that can be undone by thoughtful health reform. First, we must learn from and safeguard progress.[37] Expanded Medicaid benefits and premium tax credits freed people to obtain insurance without demonstrating significant poverty or

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27. Natasha Murphy & Sarah Millender, *How States Can Build Bridges by Smoothing Medicaid-to-Marketplace Coverage Transitions*, CTR. AM. PROGRESS (Feb. 14, 2023), https://www.americanprogress.org/article/how-states-can-build-bridges-by-smoothing-medicaid-to-marketplace-coverage-transitions/ [web.archive.org/web/20250620095425/https://www.americanprogress.org/article/how-states-can-build-bridges-by-smoothing-medicaid-to-marketplace-coverage-transitions/] (describing the relationship between Medicaid and tax credits).

28. *See infra* notes 123–128.

29. David Blumenthal, Evan Gumas, Arnav Shah, Munira Gunja & Reginald Williams II, *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System*, COMMONWEALTH FUND (Sep. 19, 2024), https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024 [web.archive.org/web/20251101024541/https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024] (describing the admirable performance of the United States on one domain, care process, due to citizens' strong access to preventive care and a system that meets patients' care preferences).

30. *Id.*

31. *See* discussion *infra* Section III.A.

32. *See* discussion *infra* Section III.A.

33. *See* discussion *infra* Section III.B.

34. *See* discussion *infra* Section III.B.

35. *See* discussion *infra* Section III.C.

36. *See* discussion *infra* Section III.C.

37. *See* discussion *infra* Section IV.A.

maintaining employment.[38] New federal legislation reduces Medicaid access and fails to maintain enhanced premium tax credits. The social and economic consequences of such repeal, not to mention the harms posed to access to health care, support the need for lawmakers to reconsider recent health policy reforms.[39] Second, many incremental reforms can achieve progress in the future, especially reforms at the state level.[40] Third, universal health care is offered as a more complete, though less politically viable, remedy.[41]

This Article makes several novel contributions. One, it is the first to comprehensively describe the social costs of the health care finance system and why this system ought to be a focus in health reform. Two, it contributes original research for illustration[42] Three, it integrates scholarship across disparate disciplines of welfare law, employment law, disability law, family law, and health law to create a cohesive novel criticism of the health care system. Lastly, it introduces a new lens to evaluate health and social welfare policies, with immediate application to the policy aims of the new presidency.

Part I describes the social and economic tradeoffs experienced by recipients of means-tested benefits. This Part briefly outlines means-tested income and asset tests of major public programs. It then considers ways these programs harm economic and social interests around work, savings, retirement, marriage, and cohabitation.

Part II describes eligibility criteria for ESI and how people on ESI experience job lock, limitations on retirement, and pressures to marry and not divorce.

Part III incorporates into the Article practical and theoretical scholarship on the purposes of health care systems. It offers criticisms of the social and economic costs of the current system, arguing the system fails to safeguard health and financial security, and compromises people's ability to live meaningful lives.

Lastly, Part IV offers three levels of remedy. At its most fundamental, this Article argues that a robust Medicaid program and premium tax credits, which is in direct opposition to the enacted policies by the new Congress and presidential administration, are necessary to maintain ground. Additionally, state-level reforms that offer some progress are discussed. Lastly, universal health care is presented as a fulsome, though long-term, strategy.

I. SOCIAL AND ECONOMIC COSTS OF MEANS-TESTED HEALTH CARE

Nearly one hundred million people, or approximately 28 percent of the U.S. population, relied on a means-tested program to obtain health insurance coverage in 2024, and a majority was enrolled in Medicaid, the program for low-income

38. *See* discussion *infra* Section IV.A.
39. Rosen, *supra* note 2; Keith, *supra* note 3.
40. *See* discussion *infra* Section IV.B.
41. *See* discussion *infra* Section IV.C.
42. Informal interviews were conducted with people enrolled in Medicaid with high health care expenses, defined as having an estimated annual medical cost of $100,000 or more. Interview participants are anonymized given that information shared concerns medical privacy interests and actual or perceived security of health and income benefits. To preserve anonymity further, a state or region, rather than city, is given for a location of an interview. Designation of "exempt" was received from the institutional review board for not meeting the definition of human subject research.

individuals and people with disabilities.[43] Others were enrolled in the CHIP,[44] the program for low-income children and pregnant women. Still, others obtained premium tax credits through the Affordable Care Act (ACA) to purchase private insurance on the state and federal insurance exchanges.[45]

People of color,[46] people with disabilities,[47] low-wage workers,[48] those who work for small employers or part-time,[49] minority children,[50] children from low-income households,[51] and low-income elderly individuals[52] all disproportionately rely on Medicaid and other means-tested programs because they are routinely excluded from the dominant, private ESI system.

Means-tested programs offer low or no cost health care, providing critical life-saving access to care to millions[53] who might otherwise be uninsured.[54] For some

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43. AUGUST 2024: MEDICAID AND CHIP ELIGIBILITY OPERATIONS AND ENROLLMENT SNAPSHOT, *supra* note 8.

44. *Id.* at 22 (reporting that 7,152,133 people were enrolled in CHIP in August 2024).

45. THE PREMIUM TAX CREDIT AND RELATED SPENDING, *supra* note 8. The Congressional Budget Office projects that 20.1 million people will receive premium tax credits to purchase insurance on the exchanges in 2024. *Id.*

46. Latoya Hill, Nambi Ndugga, Samantha Artiga & Anthony Damico, *Health Coverage by Race & Ethnicity, 2010-2023*, KAISER FAM. FOUND.: RACIAL EQUITY & HEALTH POL'Y (Feb. 13, 2025), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/ [perma.cc/G3PW-Z5XZ].

47. MaryBeth Musumeci, Priya Chidambaram & Molly O'Malley Watts, *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey*, KAISER FAM. FOUND.: MEDICAID (June 14, 2019), https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/ [perma.cc/F6GM-JYC8]. Around ten million Medicaid enrollees qualified for the program based on their disability in 2020. Kimberly Proctor, *CMS Releases Data Briefs That Provide Key Medicaid Demographic Data for the First Time*, CTRS. MEDICARE & MEDICAID SERVS.: NEWSROOM (July 25, 2023), https://www.cms.gov/blog/cms-releases-data-briefs-provide-key-medicaid-demographic-data-first-time [perma.cc/9Q3F-ZX7C].

48. Elizabeth Hinton & Robin Rudowitz, *5 Key Facts About Medicaid Work Requirements*, KAISER FAM. FOUND.: MEDICAID (Feb. 18, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/ [perma.cc/2CCZ-NQHC].

49. *Id.*

50. CTRS. FOR MEDICARE & MEDICAID SERVS., RACE AND ETHNICITY OF THE NATIONAL MEDICAID AND CHIP POPULATION IN 2020 2 (2021), https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/2020-race-etncity-data-brf.pdf [perma.cc/PVF9-AXWH] (detailing that 61 percent of children on Medicaid and CHIP come from racial and ethnic minority backgrounds).

51. Williams & Musumeci, *supra* note 13 (explaining CHIP and Medicaid are particularly critical for children with special health care needs).

52. MEDPAC, DUAL ELIGIBLE BENEFICIARIES: AN OVERVIEW 72 (2004), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/June04_ch3.pdf [perma.cc/L8YU-6XBE] (explaining some low-income elderly and people with disabilities who receive Medicare benefits are "dual eligibles" who also receive Medicaid to cover Medicare's costly out-of-pocket expenses).

53. Sarah Miller, Norman Johnson & Laura R. Wherry, *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data* 3, 23 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26081, 2019) (projecting that states implementing the Medicaid expansion have saved 19,000 lives over the first four years after the expansion, while other states' failure to expand has contributed to 15,000 premature deaths).

54. Alice Burns, Elizabeth Hinton, Robin Rudowitz & Maiss Mohamed, *10 Things to Know About Medicaid*, KAISER FAM. FOUND. (Feb. 18, 2025), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/ [perma.cc/Q36G-D95E] (observing that Medicaid is an especially important source of access to care for people of color, people with disabilities, residents in nursing home populations, people transitioning out of carceral environments, and people who are homeless).

individuals, including those with disabilities, programs like Medicaid are the *only* insurance to cover particular services that these individuals need to survive and function. For example, Medicaid covers nursing home care and home- and community-based services, including attendant care, that enable people to live and work independently.[55]

Part I begins with a description of the eligibility pathways for the primary means-tested health care programs. Some programs, like traditional Medicaid, have income and asset limits below poverty.[56] Other programs, like Medicaid expansion and CHIP, eliminate asset restrictions but still require incomes not far above poverty.[57]

Following this discussion, the remainder of this Part reveals an alarming irony of means-tested health care. Intended to serve the poor, these programs force many to *stay* poor and some to *become* poor in order to access them. The need to maintain poverty shapes peoples' lives dramatically in their ability to work, to save and age with dignity and security, and to marry and cohabitate.

A. Eligibility Pathways for Means-Tested Benefits

Eligibility for means-tested health care is determined in two manners: (1) Supplemental Security Income (SSI)-eligibility determinations, which apply to the categorically- and medically-needy Medicaid program; and (2) modified adjusted gross income (MAGI)-eligibility determinations, which apply to Medicaid expansion, CHIP, and premium tax credits. The former is relatively stricter, but both modes limit opportunity.

1. SSI-Eligibility Pathways

Those who rely on traditional Medicaid, including both categorically- and medically-needy pathways, must meet standards for SSI eligibility.[58] Despite carrying the most restrictive means tests,[59] Medicaid remains the only pathway to health care access for some, despite many reforms aimed at liberalizing access.

The earliest versions of Medicaid, passed in 1965, were tied to SSI eligibility,[60] the cash payment for people for whom disability, age, or other circumstances

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55. *Home- and Community-Based Services*, CTRS. MEDICARE & MEDICAID SERVS.: TRAINING & EDUCATION, https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services [perma.cc/QTJ4-PE6T] (last visited Sep. 21, 2025) (describing community-based and home-based services as services that enable individuals to live in their communities as opposed to in institutions, and personal care or attendant care as care in the home for activities of daily living like bathing, dressing, using the restroom, cooking, and cleaning) For more on the special importance of Medicaid to the chronically ill and people with disabilities, see Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, 9 YALE J. HEALTH POL'Y L. & ETHICS 453 (2009).

56. *See* discussion *infra* Section I.A.1.

57. *See* discussion *infra* Section I.A.2.

58. MaryBeth Musumeci & Kendal Orgera, *Supplemental Security Income for People with Disabilities: Implications for Medicaid*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (June 23, 2021), https://www.kff.org/medicaid/issue-brief/supplemental-security-income-for-people-with-disabilities-implications-for-medicaid/ [perma.cc/4JJZ-PTL2].

59. *Id.*

60. 42 U.S.C. § 1396-1 ("For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish [] medical assistance on behalf of families with dependent children

rendered them unable to work.[61] Implicit was the idea that those on Medicaid must be unable to work.[62] Originally, the program was limited to the "deserving poor," or "families with dependent children [or] aged, blind, or disabled individuals, whose income and resources [were] insufficient to meet the costs of necessary medical services . . . ."[63] In other words, those demographics that merited social assistance beyond the mere poor and uninsured.[64] States early on had the option to cover the "medically needy," wealthier members of the "deserving poor" who were functionally poor once one accounted for money spent on medical expenses.[65] In the 1980s, the class of "deserving poor" was extended to cover some poor children and pregnant women.[66]

Even at the time of Medicaid's passage, the linkage between poverty and health care was criticized.[67] Why should the need for health care be conditioned upon impoverishment?[68] Critics feared the system would lock out workers who might need care, and only serve those who were expected not to take part in the labor market.[69] Of course, this was quite intentional, to exclude the able-bodied who were deemed undeserving and not in need of government assistance and who lawmakers feared would be deterred from labor if given benefits.[70] It also carried some forms of biases against certain populations: Dependency on government presumed a person was unable to work because of their age or disability.[71] Tying Medicaid to welfare also enhanced the social stigma of the program and even today influences people's willingness to be covered by Medicaid.[72]

Even if a person is willing to be covered by Medicaid, SSI eligibility has income and asset tests.[73] Income limits for 2025 dictate that individuals earn no more than

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and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . .").

61. *Supplemental Security Income (SSI)*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi?gad_source=1&gclid=CjwKCAiApY-7BhBjEiwAQMrrEYJ4j0FNz8I8zdIHbSXdRVYasxwljgEcfR_3-JCZX9YxXmGi2Sp0fhoClosQAvD_BwE [perma.cc/PQF9-V9TG] (last visited June 12, 2025).

62. *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 439 n.31 (2011) (describing a path dependence in Medicaid that links it to frailty).

63. 42 U.S.C. § 1396-1 (alteration in original).

64. Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 12 (2016) ("The deserving poor were not deemed to be culpable for their inability to care for themselves and, consequently, were 'deserving' of government assistance.").

65. 42 U.S.C. §§ 1396a(a)(10)(C), 1396d(a)(iii)–(v). This group can still be covered under Medicaid (but not SSI) if members either (1) make less than the state's income limit for medically-needy people (which is typically higher than categorically-needy people), or (2) income qualify after subtracting out their regular medical care and long-term care costs from their incomes. Musumeci et al., *supra* note 47.

66. Christie Provost & Paul Hughes, *Medicaid: 35 Years of Service*, 22 HEALTH CARE FIN. REV. 141, 142 (2000) (describing a legislative history of Medicaid).

67. Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FIN. REV. 45, 45 (2005).

68. *Id.* at 48 ("Some said the Medicaid legislation did not go far enough and disliked the vestiges of welfare, such as means and assets tests.").

69. *Id.*

70. Huberfeld & Roberts, *supra* note 64, at 13–15.

71. Huberfeld & Roberts, *supra* note 64, at 28.

72. Huberfeld & Roberts, *supra* note 64, at 31 (observing how stigma affects Medicaid enrollment).

73. SOC. SEC. ADMIN., ANNUAL REPORT OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM 9 (2021), https://www.ssa.gov/oact/ssir/SSI21/ssi2021.pdf [perma.cc/3YWJ-HXWA].

$967 per month or $11,604.53 annually,[74] with couples capped at $1,450 monthly and $17,404.87 annually.[75] Individuals or couples who earn income above this threshold may lose Medicaid.[76] Assets are limited to $2,000 in countable assets for individuals and $3,000 for married couples.[77] Countable assets do not include one car, one family home, household goods, and modest burial and life insurance funds.[78]

Given these thresholds, income and assets limits are more restrictive for married couples than single people. Two single people could earn a collective $23,209.06 compared to $17,404.87 annually for a married couple in 2025.[79] Likewise, two individuals may collectively maintain $4,000 in assets compared to the $3,000 limit for a married couple.[80] Cohabitation can also be penalized under SSI-style programs. Married people's assets and incomes count towards the total,[81] but so do people whom SSI officials deem as "holding out" as married.[82] Regulators consider parties who cohabitate and are members of the opposite sex as "holding out" as married if the couple leads people to believe they are husband and wife.[83]

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74. *SSI Federal Payment Amounts for 2025*, SOC. SEC. ADMIN., https://www.ssa.gov/oact/cola/SSI.html [perma.cc/6X29-SDA7] (last visited June 12, 2025).

75. *Id.* (detailing that where only one spouse is eligible for SSI, the government may count or "deem" some of the non-eligible spouse's income in determining eligibility); 20 C.F.R. § 416.1163 (2025).

76. *Continued Medicaid Eligibility (1619(B))*, SOC. SEC. ADMIN.: DISABILITY RSCH., https://www.ssa.gov/disabilityresearch/wi/1619b.htm [perma.cc/LA5C-EJ9Y] (last visited June 12, 2025).

77. *Spotlight on Resources — 2025 Edition*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi/spotlights/spot-resources.htm [perma.cc/ESE5-34DB] (describing that for married couples, administrators consider both parties' assets) (last visited June 12, 2025).

78. *Id.*

79. *See SSI Federal Payment Amounts for 2025*, *supra* note 74.

80. *See Spotlight on Resources — 2025 Edition*, *supra* note 77.

81. 20 C.F.R. § 416.1806 (2025) ("We will consider someone to be your spouse (and therefore consider you to be married) for SSI purposes if—(1) You are legally married under the laws of the State where your and his or her permanent home is (or was when you lived together); . . .").

82. *Id.* ("We will consider someone to be your spouse (and therefore consider you to be married) for SSI purposes if— . . . (3) You and an unrelated person of the opposite sex are living together in the same household at or after the time you apply for SSI benefits, and you both lead people to believe that you are husband and wife.").

83. The *Code of Federal Regulations* states the following:

> (a) *General rule: Proof is unnecessary*. If you do not live with an unrelated person of the opposite sex and you say that you are not married, we will generally accept your statement unless we have information to the contrary. . . . .
>
> (c) *Exception: If you are living with an unrelated person of the opposite sex*. (1) If you are living with an unrelated person of the opposite sex, you and the person you are living with must explain to us what your relationship is and answer questions such as the following:
>
> (i) What names are the two of you known by?
>
> (ii) Do you introduce yourselves as husband and wife? If not, how are you introduced?
>
> (iii) What names are used on mail for each of you?
>
> (iv) Who owns or rents the place where you live?
>
> (v) Do any deeds, leases, time payment papers, tax papers, or any other papers show you as husband and wife?
>
> (2) We will consider you married to the person you live with unless the information we have, including the answers to the questions in paragraph (c)(1) of this section, all considered together, show that the two of you do not lead people to believe that you are each other's husband and wife.

20 C.F.R. § 416.1826 (2025).

Some states offer more generous income and asset caps towards SSI and Medicaid eligibility, with the poorest states tending to implement stricter income and asset testing.[84] Income has increased since the passage of Medicaid and is annually adjusted based on cost-of-living adjustments (COLA).[85] Asset limits have remained the same for decades, without variance for inflation or cost-of-living.[86]

More economically forgiving pathways to Medicaid (and other programs), described in the following Section, are not available to all. One pathway is through the Medicaid expansion, which eliminated the need for individuals to fall into a category of "deserving poor" to be eligible by increasing the income eligibility threshold and eliminating an asset test.[87] Yet, ten states have failed to adopt the expansion[88] nearly fifteen years after the passage of the ACA. In those states, categorical and medical need through SSI determinations remains the pathway to Medicaid.[89] Also, some important services are optional and not mandatory under Medicaid,[90] giving states latitude regarding eligibility. For example, nearly all states offer home- and community-based services (HCBS) through a waiver program for people who would otherwise receive care in institutions.[91] States use SSI determination for this waiver program, though states have the option to raise income and asset limits above SSI, and many states do, especially with respect to income.[92] Another pathway to Medicaid is by qualifying as a dual-eligible. Dual-eligibles are traditionally eligible for Medicaid by SSI determination and is comprised of individuals who qualify for Medicare and are also poor enough to qualify for Medicaid as a supplemental insurance.[93] And of course, some people elect the SSI-pathway because they need SSI cash payments, in addition to Medicaid.

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84. Musumeci et al., *supra* note 47.

85. *Cost-of-Living Adjustment (COLA) Information for 2025*, SOC. SEC. ADMIN., https://www.ssa.gov/cola/ [perma.cc/B9L3-RDN4] (last visited June 12, 2025).

86. *Policy Basics: Supplemental Security Income*, CTR. ON BUDGET & POL'Y PRIORITIES (Mar. 20, 2024), https://www.cbpp.org/research/social-security/supplemental-security-income [web.archive.org/web/20250930190415/https://www.cbpp.org/research/social-security/supplemental-security-income].

87. *See supra* notes 73–76.

88. *Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND.: MEDICAID (Sep. 12, 2025), https://www.kff.org/status-of-state-medicaid-expansion-decisions/ [perma.cc/U7NK-ZKJW] (observing holdout states include Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming).

89. *Id.*

90. *Mandatory & Optional Medicaid Benefits*, MEDICAID.GOV: BENEFITS, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html [perma.cc/78P9-FY2X] (last visited June 12, 2025).

91. *Home & Community-Based Services 1915(c)*, MEDICAID.GOV: HOME & CMTY. BASED SERVS., https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html [perma.cc/9YH6-ZJY4] (last visited June 12, 2025).

92. Molly O'Malley Watts, MaryBeth Musumeci & Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, KAISER FAM. FOUND. (Mar. 4, 2022), https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/ [perma.cc/SX7A-XVKH] (explaining that states have the option to increase eligibility to up to 300 percent of SSI, and to raise or even forgo an asset test).

93. CTRS. OF MEDICARE & MEDICAID SERVS., BENEFICIARIES DUALLY ELIGIBLE FOR MEDICARE & MEDICAID 3 (2024), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf [perma.cc/B7WN-NUM6].

2. MAGI-Eligibility Pathways

Subsequent means-tested health care programs have been progressively more generous, eliminating asset tests and raising income limits. These modern adaptations utilize MAGI methods to determine eligibility, rather than SSI determinations.[94] Medicaid expansion, some state-optional Medicaid programs, CHIP, and the premium tax credits all use MAGI to determine eligibility.[95]

The ACA's Medicaid expansion was a sea of change, permitting states to expand Medicaid to people solely based on income.[96] Eligibility now encompasses the working poor, as well as the "deserving poor."[97] Expansion populations can earn up to 138 percent of the federal poverty level (FPL) and do not face any asset limits.[98] While the expansion was originally mandatory under the ACA, the U.S. Supreme Court rendered it optional in *National Federation of Independent Business v. Sebelius*.[99] States have the option to offer an "alternative benefit plan" (ABP), modeled after popular commercial insurance products, which does not typically cover the services many people with disabilities require.[100] Some individuals, including some with disabilities, thus may elect to receive Medicaid through this pathway, enabling these individuals to earn higher incomes and purchase assets without limits.[101]

In addition, states have options to cover higher-earning, categorically-needy individuals in their Medicaid program, and these programs typically apply MAGI eligibility.[102] Under this pathway, individuals can no longer qualify for SSI but still retain Medicaid.[103] States may also use waivers to increase income and asset restrictions, particularly for working individuals with disabilities.[104] A type of

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94. *Eligibility Policy*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility-policy/index.html [perma.cc/MC6A-2PQ4] (last visited June 12, 2024).

95. *Id.*

96. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII).

97. Huberfeld & Roberts, *supra* note 64.

98. U.S. DEP'T OF HEALTH & HUM. SERVS., 2024 POVERTY GUIDELINES: 48 CONTIGUOUS STATES (ALL STATES EXCEPT ALASKA AND HAWAII) (2024), https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailed-guidelines-2024.pdf [perma.cc/VXK3-XZFE].

99. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

100. EVELYNE P. BAUMRUCKER, CONG. RSCH. SERV., R45412, MEDICAID ALTERNATIVE BENEFIT PLAN COVERAGE: FREQUENTLY ASKED QUESTIONS 2 (2018), https://sgp.fas.org/crs/misc/R45412.pdf [perma.cc/42ST-MJ9V].

101. MaryBeth Musumeci, Priya Chidambaram & Molly O'Malley Watts, *Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (June 26, 2019), https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/ [perma.cc/CNE2-QSDP]. The law has a frailty exception which allows states to supply more traditional benefits to those designated as medically frail. *Id.*

102. 42 U.S.C. § 1396a(a)(10)(A)(ii). Optional categorically needy individuals can include lower income families, elderly, people with disabilities, and pregnant women, all who may have higher incomes than would otherwise qualify for mandatory benefits. Under this pathway, income is calculated using MAGI, instead of SSI standards. Assets are not considered for eligibility. Musumeci et al., *supra* note 47.

103. Musumeci et al., *supra* note 47.

104. *Medicaid Eligibility Through Buy-In Programs for Working People with Disabilities*, KAISER FAM. FOUND.: STATE HEALTH FACTS, https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/ [perma.cc/5Y8J-CGVC] (analyzing a fifty-state survey of Medicaid buy-ins for workers with disabilities using data reported for 2025) (last visited Sep. 21, 2025).

Medicaid buy-in, individuals pay a premium but receive benefits they otherwise would not.[105] Most states, though not all, adopt this program and raise income and asset limits to varying degrees.[106]

The One Big Beautiful Bill Act is estimated to cut federal Medicaid expenditures to the tune of $911 billion.[107] The Act does not repeal any of the Medicaid programs. However, it imposes work requirement on many Medicaid enrollees. Most Medicaid participants could in theory satisfy such requirements. A study looking at similar state reforms in Arkansas suggested as many as 95 percent of enrollees were exempted, either because they were working or were part of a class of people exempted from work requirements.[108] However, experts expect the added administrative burden from the work requirements will simply disqualify many from coverage, even if they ought to remain qualified in name.[109]

The Act also reduces provider taxes that are given to states, revises the limit for state-directed payments, and ends Biden-era reforms that made it easier to enroll.[110] All of these reforms mean tighter budgets for states, incentivizing them to cut benefits and minimize enrollees. Estimates indicate that 7.8 million people will be uninsured due to these various Medicaid cuts.[111]

CHIP is another MAGI-style health benefits program that is designed for uninsured children of families that make too much to qualify for Medicaid.[112] About half of all children with special health needs are on CHIP.[113] Some pregnant women may also receive CHIP or Medicaid benefits in some states.[114] Families and pregnant women pay premiums for CHIP benefits, typically five percent of the

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105. *Id.*

106. *Id.* (observing the average monthly income for individuals is 250 percent of the FPL and many states eliminate the asset cap or raise it significantly).

107. Rhiannon Euhus, Elizabeth Williams, Alice Burns & Robin Rudowitz, *Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package*, KAISER FAM. FOUND.: MEDICAID (July 23, 2025), https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/ [perma.cc/43K6-UVG4].

108. Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, John Orav & Arnold M. Epstein, *Medicaid Work Requirements — Results from the First Year in Arkansas*, 381 NEJM 1073, 1079 (2019).

109. *Id.* ("[I]mplementation of the first-ever work requirements in Medicaid in 2018 was associated with significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment. Lack of awareness and confusion about the reporting requirements were common, which may explain why thousands of persons lost coverage even though more than 95% of the target population appeared to meet the requirements or qualify for an exemption.").

110. Euhus et al., *supra* note 107.

111. Jared Ortaliza, Matt McGough, Cynthia Cox, Kaye Pestaina, Robin Rudowitz & Alice Burns, *How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (June 18, 2025), https://www.kff.org/policy-watch/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/ [perma.cc/5JAE-RZN2].

112. *Children's Health Insurance Program (CHIP)*, CTRS. FOR MEDICARE & MEDICAID SERVS.: TRAINING & EDUCATION, https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/chip [perma.cc/E647-DG7K] (last visited June 12, 2025).

113. Musumeci et al., *supra* note 47.

114. *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level*, KAISER FAM. FOUND.: STATE HEALTH FACTS, https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/ [perma.cc/LP3Y-EDRS] (last visited Sep. 21, 2025).

family's income.[115] Income eligibility varies by state and by age of the child, and there are no asset restrictions.[116]

Lastly, the ACA's premium tax credits are the latest means-tested benefit innovation. Part of the ACA, the premium tax credits support the private, regulated insurance market for individual purchase of insurance.[117] The individual insurance market was notoriously stingy, a market of last resort for those who lacked coverage by another means.[118] This market became markedly available after the ACA subsidized access and imposed consumer protections,[119] most notably, the prohibition against discrimination for people with preexisting conditions.[120] Originally, premium tax credits were available to individuals making between 100 and 400 percent of the federal poverty level to assist with purchasing insurance on federal- and state-based insurance marketplaces.[121] The amount of tax credits was on a sliding scale, decreasing as one's earnings increased.[122] The tax credits are not a set sum, but instead a maximum percentage of income paid towards health benefits before the tax credits kicks in.[123] Individuals or families making between 100 and 250 percent of the FPL also qualify for cost-sharing assistance (copays and deductibles, for instance).[124] The tax credits reflect a relative affluence, with a person making as high as 400 percent of the FPL being eligible, when compared to Medicaid pathways which restrict the income eligibility range to between 75 and 138

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115. *The Children's Health Insurance Program (CHIP)*, HEALTHCARE.GOV: MEDICAID & CHIP, https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/ [perma.cc/CN7V-X634] (last visited June 12, 2025).

116. *Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html [perma.cc/K28G-QL5A] (last visited June 12, 2025).

117. 42 U.S.C. § 18031 (providing standards for the regulated insurance exchanges under the ACA).

118. Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt & Karen Pollitz, *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/ [perma.cc/94TD-BEX6] (characterizing the discriminatory nature of the individual insurance market pre-ACA).

119. *See generally* LINDA J. BLUMBERG & JOHN HOLAHAN, THE ACA'S TRANSFORMATION OF PRIVATE HEALTH INSURANCE (2024) https://www.urban.org/sites/default/files/2024-05/The%20ACAs%20Transformation%20of%20Private%20Health%20Insurance.pdf [perma.cc/HM9W-CHUC] (describing various market reforms to the individual market imposed by the ACA and their effects on that market).

120. 42 U.S.C. § 300gg-3(a) ("A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.").

121. 42 U.S.C. § 18071(b). Though these are private benefits, not public benefits, they are included in this section because they function as a means-tested program for health care coverage.

122. 42 U.S.C. § 18071(c).

123. 42 U.S.C. § 18071(b). The premium tax credit is tied to the cost of a "silver" plan, or a plan in which the insurer pays about 70 percent of health care expenses. Gideon Lukens and Elizabeth Zhang, A*dministration's ACA Marketplace Rule Will Raise Health Care Costs for Millions of Families*, CTR. BUDGET & POL'Y PRIORITIES (Aug. 1, 2025), https://www.cbpp.org/research/health/administrations-aca-marketplace-rule-will-raise-health-care-costs-for-millions-of#_ftn14 [web.archive.org/web/20251001155916/https://www.cbpp.org/research/health/administrations-aca-marketplace-rule-will-raise-health-care-costs-for-millions-of#_ftn14%20].

124. 42 U.S.C. § 18071(c).

percent of the FPL.[125] However, at higher incomes, the tax credit covers some, not all, of the premiums and none of the cost-sharing.[126] Insurance may be out of reach for many at those price points, especially for older adults (whom the ACA permits insurers to charge higher premiums) and people residing in states or locales with costly premiums.[127]

The Inflation Reduction Act (IRA) made important changes to premium tax credits to make them more generous,[128] though these changes expired at the end of 2025. The One Big Beautiful Bill Act specifically fails to renew the more generous premium tax credits. Prior to the IRA, the premium tax credits had been criticized for their sharp "cliff," with people making 401 percent of the federal poverty level no longer being eligible for assistance.[129] The IRA eliminated the cliff, making the tax credit available to everyone.[130] The tax credits apply to everyone purchasing insurance on the exchanges and guarantee that their premiums do not cost more than 8.5 percent of their income.[131] A higher earner in a costly insurance market thus can benefit from the tax credit now, when prior to the IRA they would not have. These tax credit reforms saved the average person $700 in premiums in 2024,[132] and enrollment in the individual market has nearly doubled since 2020, before the IRA reforms.[133] However, the new federal Act does not renew these credits. Estimates suggest that premiums for individual insurance will climb by an average of 75 percent,[134] and 4.2 million people will become uninsured due to those cuts.[135]

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125. 42 U.S.C. § 18071(b).

126. 42 U.S.C. § 18071(c) (observing the sliding-scale model).

127. Katherine Hempstead & Matt Valeta, *Marketplace Pulse: What's at Stake for Enrollees Over 400% FPL if Enhanced Premium Tax Credits Expire?*, ROBERT WOOD JOHNSON FOUND. (Oct. 17, 2024), https://www.rwjf.org/en/insights/our-research/2024/10/marketplace-pulse-whats-at-stake-for-enrollees-over-400-fpl-if-enhanced-ptc-expire.html [perma.cc/8XTM-ELCR].

128. Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818 (building off the original policy from the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4, and reforming the premium tax credits for 2021-2022).

129. Jason Levitis, Sabrina Corlette & Clair O'Brien, *Delays in Extending Enhanced Marketplace Subsidies Would Raise Premiums and Reduce Coverage*, HEALTH AFFS.: FOREFRONT (Sep. 6, 2024), https://www.healthaffairs.org/content/forefront/delays-extending-enhanced-marketplace-subsidies-would-raise-premiums-and-reduce#:~:text=The%20PTC%20as%20originally%20enacted,leaving%20some%20middle%2Dincome%20people [web.archive.org/web/20250725224537/https://www.healthaffairs.org/content/forefront/delays-extending-enhanced-marketplace-subsidies-would-raise-premiums-and-reduce#:~:text=The%20PTC%20as%20originally%20enacted,leaving%20some%20middle%2Dincome%20people] (criticizing the cliff that would leave some middle-income people without assistance).

130. Inflation Reduction Act of 2022, *supra* note 128.

131. *Id.*

132. CTRS. FOR MEDICARE & MEDICAID SERVS, HEALTH INSURANCE MARKETPLACES 2024 OPEN ENROLLMENT REPORT 21 (2024), https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf [perma.cc/6642-6ZU7] (estimating the average consumer saved $700 in premiums in 2024).

133. Cynthia Cox & Jared Ortaliza, *Where ACA Marketplace Enrollment is Growing the Fastest, and Why*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (May 16, 2024), https://www.kff.org/policy-watch/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/ [perma.cc/UQ6G-BZG7] (observing that enrollment has risen from eleven million people enrolled in 2020 to twenty-one million in 2024).

134. Rosen, *supra* note 2.

135. Ortaliza et al., *supra* note 111.

MAGI is calculated by assessing adjusted gross income, with the inclusion of some specialty taxes.[136] Qualification for MAGI-style programs is then determined based on one's MAGI and the federal poverty level. For instance, under the Medicaid expansion, everyone whose MAGI places them at or below 138 percent of the FPL qualifies for Medicaid.[137] In 2024, 138 percent of the FPL was $20,782.80 annually for a family of one and $28,207.20 for a family of two.[138]

MAGI programs are more generous than SSI programs in three ways. One, MAGI programs have much higher income limits. While they are means-tested programs, they are not tied to a poverty cash benefit.[139] In 2024, a person could earn $20,782.80 and still qualify for expansion Medicaid.[140] To qualify for SSI Medicaid, that same person can only earn $11,604.53 in 2025.[141] SSI determinations allow individuals to deduct some income from the total income determination,[142] but the income limit is still lower. MAGI determinations consider tax deductions, and the income permitted is higher.[143]

Two, SSI determinations limit assets while MAGI programs do not. SSI-style Medicaid requires the individual to have no more than $2,000 in assets and couples to have no more than $3,000 in assets, and no similar restriction is in place for Medicaid expansion, CHIP, or tax credits.[144]

Three, whether spouses' and live-in partners' income is included in the calculations varies across SSI and MAGI. In SSI, recipients are penalized for marriage, and cohabitation if deemed holding out as married, as the calculation looks at both incomes and assets in the determination.[145] A higher earning spouse could skew the couple away from eligibility even if one individual needs the benefits. And being deemed married or cohabitating simply means less money on an already tight budget; in 2025 a qualifying couple could only earn $17,404.87, compared to a qualifying individual who could earn $11,604.53.[146] Likewise, the couple could only have $3,000 in assets compared to the $2,000 assets cap for the individual.[147]

Under MAGI determinations, marriage is disincentivized but cohabitation, at least, is not. For Medicaid expansion and CHIP, married people count as two persons so long as they cohabitate, regardless of tax filing status. For tax credits, married people count as two persons if they file their taxes jointly (and, with few

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136. *Count Income & Household Size*, HEALTHCARE.GOV, https://www.healthcare.gov/income-and-household-information/income/#magi [perma.cc/6YNE-TMFM] (last visited June 12, 2024). Income also includes any untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. *Id.*

137. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII).

138. *See* 2024 POVERTY GUIDELINES: 48 CONTIGUOUS STATES (ALL STATES EXCEPT ALASKA AND HAWAII), *supra* note 98.

139. *See* discussion *supra* Section I.A.1.

140. *See* 2024 POVERTY GUIDELINES: 48 CONTIGUOUS STATES (ALL STATES EXCEPT ALASKA AND HAWAII), *supra* note 98.

141. *See SSI Federal Payment Amounts for 2025*, *supra* note 74.

142. *Income Exclusions for SSI Program*, SOC. SEC. ADMIN., https://www.ssa.gov/oact/cola/incomexcluded.html [perma.cc/6XZY-WABC] (last visited June 12, 2025).

143. *See supra* notes 136–137.

144. *See Spotlight on Resources — 2025 Edition*, *supra* note 77.

145. *See supra* notes 799–83.

146. *See SSI Federal Payment Amounts for 2025*, *supra* note 74.

147. *See Spotlight on Resources — 2025 Edition*, *supra* note 77.

exceptions, are required to do so to be eligible).[148] Married people thus count as two persons so long as they cohabitate and typically regardless of tax filing status, but they may have an out if they elect not to cohabitate. Unmarried people who cohabitate may count as individuals if they do not file their partner as a dependent.[149] Under Medicaid expansion, this distinction can make an enormous difference: a married couple could only earn $28,207.20, compared to a cohabitating couple that could earn $41,565.60.

	Income Limit	Asset Limit	MAGI/ SSI
Medicaid-Categorical Need	√	√	SSI
Medicaid-Medical Need	√	√	SSI
Medicaid-Expansion	√		MAGI
CHIP	√		MAGI
Premium Tax Credit	√		MAGI

Table 1: Income and Asset Limits for Means-Tested Health Programs in the United States.

B. Economic and Social Harms of Means-Testing

1. Work, Savings, and Aging

Means-tested health programs limit peoples' ability to work, save, and be economically secure in retirement. These issues affect individuals, their families, and the broader economy. MAGI-style programs present challenges, though limitations are far greater for those in SSI-determinative programs.

Strict means-testing can force people out of work, or into less than full-time work or lower-wage positions. Work "literally doesn't pay," according to one young woman.[150] Couple A both have disabilities that require them to use attendant care in their home. They depend on SSI and categorically-needy Medicaid.[151] One is severely disabled and unable to work, and the cash benefit is helpful. The other would much prefer to work but if she took paid work, she could not accumulate much wealth and earnings before she would disqualify them both from Medicaid, something she cannot risk with her partner's survival in the balance.[152] Medicaid expansion might be an option but the increased earnings are not enough to justify the loss of housing and income support she receives at a lower income.[153] She elects unpaid, volunteer work instead, taking an hour-long bus ride each way.[154] She dreams of a career in social work but does not see the point of getting an education

148. CTRS. FOR MEDICARE & MEDICAID SERVS, INCOME ELIGIBILITY USING MAGI RULES 12 (2021), https://www.cms.gov/marketplace/technical-assistance-resources/income-eligibility-using-magi-rules.pdf [perma.cc/QW2B-H8CZ].

149. *Determining Household Size Medicaid and the Children's Health Insurance Program*, CTR. BUDGET & POL'Y PRIORITIES: BEYOND THE BASICS (Sep. 2024), https://www.healthreformbeyondthebasics.org/key-facts-determining-household-size-for-medicaid-and-chip/ [perma.cc/G3MG-U4VK].

150. Interview with Anonymous, in Pa. (Nov. 10, 2020).

151. *Id.*

152. *Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions*, *supra* note 100 (suggesting that Expansion Medicaid is not an option because the Alternative Benefit Plan coverage does not cover the services they need to remain independent).

153. Interview with Anonymous, in Pa. (Nov. 10, 2020).

154. *Id.*

and accruing debt when her earnings will forever be limited.[155] She is an example that "far and away the most significant barrier to employment for people with disabilities is the current structure of our health insurance system."[156]

A potential higher earner faces a different challenge. Person A is a middle-aged woman with muscular dystrophy, and she pays a premium for a Medicaid buy-in program for workers with disabilities that allows for higher earnings but retains the asset cap.[157] She has a doctoral degree and years of experience.[158] Most jobs would pay her six figures, too high for even the Medicaid buy-in and far too low to afford services out-of-pocket.[159] She self-employs, paying herself below the market rate, with no benefits, sick days, holidays, or other employment benefits.[160]

Person B is a young mother living with a hereditary autoimmune disorder that qualifies her for insurance through the Medicaid expansion.[161] She turned down a new job because the pay was too high and would consequently cause her to lose benefits for her and her young son, who has the same condition.[162] She is locked into low-wage work, with the constant need to stay within the bounds of mean-testing robbing her of financial opportunities.[163] The risk of losing benefits because of minor financial gains, or churn, is costly for individuals, causing them unexpected costs and barriers to care; it is also administratively costly to the programs.[164]

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155. *Id.* Professor Doron Dorfman reveals a similar trend in his work with people with disabilities. In one study he interviewed a person who postponed entering the workforce and continued his education so that he could earn enough to handle his medical expenses: "[I]n a sense [I] had to continue a career in academia, postponing my entry to the labor market until my human capital was sufficiently high to generate the income that would allow me to cover the costs of my disability." Doron Dorfman, *Re-Claiming Disability: Identity, Procedural Justice, and the Disability Determination Process*, 42 LAW & SOC. INQUIRY 195, 221 (2017). As Dorfman aptly elaborates in the article: "The system puts benefits claimants in a quandary: on the one hand, they would love to work and contribute to society, but on the other, they feel that without the [SSI] benefits and the medical insurance, it would be hard to support themselves and cover the expenses that go along with living with disabilities." *Id.*

156. Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 26 (2004); *see* NATIONAL COUNCIL ON DISABILITY, 2020 PROGRESS REPORT ON NATIONAL DISABILITY POLICY: INCREASING DISABILITY EMPLOYMENT 2 (2020), https://www.ncd.gov/assets/uploads/docs/ncd-progress-report-508-0.pdf [web.archive.org/web/20250918164024/https://www.ncd.gov/assets/uploads/docs/ncd-progress-report-508-0.pdf] (identifying as one of four critical aims "the need to dismantle disincentives to work present in the Social Security Act and the Medicaid Act").

157. At the time of the interview and in her state of residence, workers with qualifying disabilities could receive Medicaid while earning annually up to $63,800; traditional asset caps remained. Recipients paid 5 percent of their income in the form of premiums. *Medical Assistance Benefits for Workers with Disabilities*, COMMONWEALTH PA.: DEP'T HUM. SERV., https://www.pa.gov/Services/Assistance/Pages/MA-for-Disabled-Workers.aspx [perma.cc/84GA-WC67] (last visited Sep. 21, 2025). The state of Pennsylvania has since raised income, eliminated assets, and increased premiums. Tobacco Settlement Act, 2021 Pa. Laws.

158. Interview with Anonymous, in Pa. (Nov. 4, 2020).

159. *Id.*

160. Another writer describes a protest in the 1980s where a disability rights activist, Dr. Paul Longmore, burned the book he had written in front of the city's social security office. Longmore's need for SSI and Medicaid meant he could not earn royalties on his work. Longmore successfully lobbied for changes to social security policies pertaining to book royalties. Ari Ne'eman, *A 'Safety Net' That's a Kafkaesque Mess*, N.Y. TIMES: OPINION (July 25, 2020), https://www.nytimes.com/2020/07/25/opinion/a-safety-net-thats-a-kafkaesque-mess.html [perma.cc/JJ7Z-8GZR].

161. Interview with Anonymous, in Va. (Oct. 15, 2020).

162. *Id.*

163. *Id.*

164. Bradley Corallo, Rachel Garfield, Jennifer Tolbert & Robin Rudowitz, *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, KAISER FAM. FOUND.: MEDICAID (Dec. 14,

Person B also passed on another job out of state because the state had not expanded Medicaid,[165] an example of how means-testing locks people into geographic locations.[166] Medicaid and CHIP are state-federal partnerships that vary across states in regards to eligibility and benefit designs; for instance, after *Sebelius*, states vary in whether they expanded Medicaid,[167] in income and asset levels,[168] and in whether they cover children and pregnant women at certain income ranges.[169] This flexibility can be a positive if one lives in a more generous state, but it functionally "locks" people into living in states with more favorable benefit policies, even if they have good reasons to move.

Means-tested health programs compromise financial security in retirement and savings, as well. Financial security for workers as they age is important not only for individual dignity and well-being,[170] but also for our broader economy since older workers who retire open up opportunities for younger people's job growth.[171] Means-tested benefits restrict the ability to save for retirement and other major financial goals like home ownership or education.[172] Income restrictions promote part-time or lower wage work, which means a lower likelihood of receiving

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2021), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/ [perma.cc/E5T7-UGVX].

165. Interview with Anonymous, in Va. (Oct. 15, 2020).

166. The ability to move to a different geographic location is an important economic and social right that is "associated with the highest values of American democracy: liberty, autonomy, and upward mobility." Naomi Schoenbaum, *Mobility Measures*, 2012 BYU L. REV. 1165, 1167 (2012); *see generally* David Schleicher, *Stuck! The Law and Economics of Residential Stagnation*, 127 YALE L.J. 78 (2018) (describing reduced rates of interstate mobility and their macro-economic significance).

167. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

168. *Medicaid & CHIP Eligibility Limits*, KAISER FAM. FOUND.: MEDICAID & CHIP, https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/ [perma.cc/6C87-PJG8] (last visited Sep. 21, 2025).

169. *See generally* MAGGIE CLARK, MEDICAID AND CHIP COVERAGE FOR PREGNANT WOMEN: FEDERAL REQUIREMENTS, STATE OPTIONS (2020), https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf [perma.cc/JC96-UCNW].

170. The rise of pensions in the early 1900s was a way to provide some dignity and security to the older workers and to honor the many years of labor they gave to their employer. WORKPLACE FLEXIBILITY 2010, GEO. UNIV. L. CTR., A TIMELINE OF THE EVOLUTION OF RETIREMENT IN THE UNITED STATES 1 (2010), https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1049&context=legal [perma.cc/KUQ4-7FCN]. Later, the Depression Era prompted the need for a public system of old age assistance for those left out of the private one. *See* James A. Wooten, *"A The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 683–86 (2001).

171. One actuarial specialist on retirement used the following as an example: "If 4 percent of your population is retirement eligible and half of those people choose to delay retirement, the effect could be that 10 percent of your employees experience promotion blockage. . . . This means 1,000 employees would experience promotion delays in a 10,000-employee firm." Stephen Miller, *When Workers Won't Retire, Workforce Challenges Arise*, SOC'Y HUM. RES. MGMT.: WORKPLACE NEWS & TRENDS (Dec. 19, 2014), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/workers-not-retiring.aspx [perma.cc/Z4PD-6P85].

172. Means-tested benefits restrict the ability to save because of their low income and asset caps. *See supra* notes 74–77. The PhD-educated interviewee indicated that full-time, regular employment would offer lesser benefit to her, as she could not obtain the benefit of a 401(k). Interview with Anonymous, in Pa. (Nov. 4, 2020).

employer-matching retirement accounts,[173] and less income to save for retirement or to receive the full benefits of employer matching.[174]

Categorically- and medically-needy Medicaid recipients face the added barrier of asset tests. Traditional retirement savings funds count as wealth, as do savings accounts.[175] The lowest down payment for a home is traditionally 3 percent, which means a couple under one of these programs could only afford a $100,000 home, well below the mean price of a home in the United States in 2022.[176] And while regulations allow individuals to preserve some wealth from asset limits (like a family home or a car),[177] this does little good for those who lack these assets and are trying to save to purchase them.

Lawmakers have created an end-run around the asset cap for people with disabilities through the Achieving a Better Life Experience Act, which established "ABLE accounts."[178] ABLE accounts allow individuals who became disabled before the age of twenty-six to save up to $200,000 for retirement (saving at maximum $15,000 per year) without losing eligibility for SSI.[179] Thus, a person can save even more and still retain Medicaid.[180] Still, ABLE accounts have significant limitations that have prevented their widespread adoption and make them an unviable choice for some.[181] The total amount of savings permitted does not vary by severity of the disability, for instance, and people disabled later in life are not eligible for the program.[182]

Medicaid is also the only insurer to cover nursing home or long-term care.[183] Those who cannot afford to pay out of pocket for a bed in a nursing home (averaging $127,750 annually in 2024)[184] must meet the same asset tests as the

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173. Historically, part-time workers were excluded from retirement plans. A recent law, the Securing a Strong Retirement Act of 2022, requires companies to consider long-term part-time workers in employee retirement plans. H.R. 2954, 117th Cong. § 116 (2022).

174. Stephen Miller, *One in Four Workers Miss Out on Full 401(k) Match*, SOC'Y HUM. RES. MGMT.: WORKPLACE NEWS & TRENDS (May 22, 2015), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/missing-out-on—match.aspx.

175. *Supplemental Security Income (SSI) Resources*, SOC. SEC. ADMIN.: SUPPLEMENT SEC. INCOME, https://www.ssa.gov/ssi/text-resources-ussi.htm [perma.cc/XM5V-DAYD].

176. *Average Prices for U.S. Homes Hits Record High in May Despite Rise in Interest Rates*, GUARDIAN: HOUSING (June 21, 2022), https://www.theguardian.com/society/2022/jun/21/us-home-average-price-record-high-may [perma.cc/REH3-6FWC].

177. *See Spotlight on Resources — 2025 Edition*, *supra* note 777.

178. Achieving a Better Life Experience (ABLE) Act of 2014, H.R. 647, 113th Cong. (2014); 26 U.S.C. § 529A.

179. ABLE NAT'L RES. CTR., FIVE THINGS YOU NEED TO KNOW ABOUT ABLE ACCOUNTS 1 (2018), https://www.ablenrc.org/wp-content/uploads/2019/07/ANRC-5-Things-to-Know-about-ABLE-2018.pdf [perma.cc/NRH2-7CGW]. Funds can be used for any "qualified disability-related expenses" that maintain the person with disability's health and independence, including "expenses related to education, housing, transportation, employment training and support, assistive technology, personal support services, health care expenses, financial management and administrative services and other expenses." *Id.*

180. *Id.*

181. Stephanie R. Hoffer, *Making the Law More ABLE: Reforming Medicaid for Disability*, 76 OHIO ST. L.J. 1255, 1260–61 (2015) (describing limits of ABLE and special needs trust accounts).

182. *Id.*

183. *See Mandatory & Optional Medicaid Benefits*, *supra* note 90.

184. The price is slightly lower for a shared room at $111,325 annually. *2024 Nursing Home Costs by State and Region*, AM. COUNS. AGING (June 9, 2025), https://www.medicaidplanningassistance.org/nursing-home-costs/ [perma.cc/8QAA-R5PL].

categorically needy to qualify for Medicaid. Medicaid regulators employ a five-year look-back period, potentially counting transfers, gifts, or the sale of items less than market value against the applicant's eligibility.[185] Recipients must also meet a monthly income cap, which may be less than the individual's social security checks and other sources of income.[186] Individuals must spend excess income on health-related expenses, like medicine and assisted devices, or the government may take back income exceeding the monthly cap.[187]

Hard-won retirement funds, like 401(k)s and IRAs, may be at stake in a spend down, or where an individual must give back part of their social security disability insurance (SSDI) income each month to qualify for Medicaid.[188] Community spouses (those not living in the nursing home) can preserve some income and assets.[189] Excess money beyond a set amount of income and assets is given to the nursing home or long-term care facility before Medicaid payments kick in. The community spouse may still lose income and assets to a degree that changes their usual standard of living.[190] Unmarried couples face serious disadvantages, with the community partner unable to claim assets in the same way as a married community partner could.[191] Finally, even for people who fairly qualify for Medicaid, officials can still recoup expenses from the person's estate once they have died, a matter of importance for all remaining family members.[192]

Recent legislative initiatives, rather than trying to resolve this problem, have sought to impose "work requirements" on Medicaid recipients.[193] These work mandates ignore that most people who are on Medicaid do work; a majority of those

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185. *See* 42 U.S.C. § 1396p(c). Regulators scrutinize transfers that were made with an intent to qualify for Medicaid. Routine gift giving to family is not likely to cause any problems, but regulators may penalize an individual if the size of the gifts climbs or for large one-off gifts. Applicants can best avoid this issue by transferring assets prior to the look back period, but few can predict timing. *Id.* This is considered a more generous law, coming after a short-lived and controversial law, colloquially referred to as "Granny Goes to Jail," that criminalized certain asset transfers that were conducted to become eligible for Medicaid. For more on Medicaid planning and its various legal reforms, see John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 13 CORN. J.L. & PUB. POL'Y 81, 81–82 (2003).

186. 42 U.S.C. § 1396p(c).

187. *Id.*

188. Retirement funds are counted, as income if they have been cashed out (meaning the recipient is receiving monthly payments), or assets if they have not been cashed out. *Id.*

189. This amounts to roughly $3,948 a month in income or $157,920 in assets, and the community spouse pays taxes on these sums. *Medicaid Eligibility: 2025 Income, Asset & Care Requirements for Nursing Homes & Long-Term Care*, AM. COUNS. AGING, https://www.medicaidplanningassistance.org/medicaid-eligibility/ [perma.cc/LR46-4NXJ] (last visited Sep. 21, 2025).

190. Heidi L. Brady & Robin Fretwell Wilson, *The Precarious Status of Domestic Partnerships for the Elderly in a Post-Obergefell World*, 24 ELDER L.J. 49, 82–83 (2016).

191. As an example, see Karin Price Mueller, *My Partner Needs Medicaid. What About Our House with a Reverse Mortgage?*, NJ.COM (Dec. 7, 2021), https://www.nj.com/news/2021/12/my-partner-needs-medicaid-what-about-our-house-with-a-reverse-mortgage.html [perma.cc/9P6Z-43TZ], for a discussion of a never-married couple where the community partner may lose their home, after a reverse mortgage.

192. *Estate Recovery*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/estate-recovery/index.html [perma.cc/CN5L-2SLY] (last visited Sep. 21, 2025).

193. One Big Beautiful Bill Act, *supra* note 1; Madeline Guth & MaryBeth Musumeci, *An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?*, KAISER FAM. FOUND.: MEDICAID (May 3, 2022), https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/ [perma.cc/6E9P-9Y9C]; Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 NEJM 788, 788 (2018).

who do not work report either taking care of children or loved ones or being too sick or disabled to work.[194] Moreover, for many people who would choose to and could work, the law operates as a structural barrier to working.[195] That we have long denied people with disabilities the opportunity work is at least partly rooted in harmful stereotypes that the law underscores, specifically that people with disabilities cannot be meaningful contributors to the workforce.[196]

2. Marriage, Cohabitation, and Divorce

Little attention has been paid to the "marriage penalty," or the way means-testing limits the ability to marry and cohabitate or, in some cases, necessitates "medical divorce."[197] People who depend on these programs are forced into untenable choices between irrational financial decisions or forgoing legal and social relationships.[198] Professor Rabia Belt has coined this phenomenon the "last marriage equality frontier."[199] Distinct from the battle for same-sex marriage where states outright denied access to the institution based on sex,[200] in the case of the marriage penalty for people with disabilities, the U.S. Supreme Court has previously held that SSI policies penalizing marriage do not implicate due process protections.[201] These programs, just like with work, presume people with disabilities are dependents, stuck in a perpetual adolescence, and unable to live independently nor marry.[202]

The marriage penalty falls hardest on those who depend on means-tested benefits. Categorically-needy Medicaid recipients can lose access to Medicaid even for cohabitating, let alone marrying, and face harsh income and asset tests if they do marry.[203] Other programs, like the Disabled Adult Children program, simply

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194. Ivette Gomez, Jennifer Tolbert, Sammy Cervantes & Usha Ranji, *Medicaid Work Requirements: Implications for Low Income Women's Coverage*, KAISER FAM. FOUND.: WOMEN'S HEALTH POL'Y (Mar. 4, 2021), https://www.kff.org/womens-health-policy/issue-brief/medicaid-work-requirements-implications-for-low-income-womens-coverage/ [perma.cc/WQ73-HLR8]; *see also* Madeline Guth, Patrick Drake, Robin Rudowitz & Maiss Mohamed, *Understanding the Intersection of Medicaid & Work: A Look at What the Data Say*, KAISER FAM. FOUND.: MEDICAID (Apr. 24, 2023), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/ [perma.cc/HLW2-GF8M].

195. Bagenstos, *supra* note 156, at 26.

196. Huberfeld & Roberts, *supra* note 64 (describing a path dependence in Medicaid that links it to frailty)*; see also* Dorfman, *supra* note 155, at 202 ("Research indicates that there is a stereotypical expectation of people with disabilities to 'just sit home, out of society's sight, and collect the check' given to them as a paternalistic gesture of governmental assistance." (citing Deborah L. Little, *"Sit Home and Collect the Check": Race, Class and the Social Construction of Disability Identity*, in DISABILITY AS A FLUID STATE 183–202, 193 (Sharon N. Barnartt ed., 2010))).

197. Rabia Belt, *Disability: The Last Marriage Equality Frontier* 1–8 (Stan. L. Sch. Pub. L. Working Paper, Paper No. 2653117, 2022).

198. *Id.*

199. *Id.*

200. Obergefell v. Hodges, 576 U.S. 644, 675 (2015).

201. Califano v. Jobst, 434 U.S. 47, 48–49 (1977).

202. Dorfman, *supra* note 155, at 202; *see also* Bagenstos, *supra* note 156, at 72–73.

203. *See* 20 C.F.R. § 416.1826 (2025). For a historical background on the purposes of these laws, see generally Kerry Abrams, *Marriage Fraud*, 100 CALIF. L. REV. 1 (2012) (describing laws on marriage fraud which evolved in the 20th century that view marriage during public benefits as a public fraud).

strip benefits upon marriage.[204] Married CHIP, Medicaid expansion, and tax credit recipients also must earn less per person than unmarried counterparts to qualify.[205]

Person A, the self-employed PhD recipient, has not been married to her partner for over a decade.[206] Her partner has great ESI benefits but they do not cover her needs, and his income and assets (though not exorbitant) are enough to disqualify her from Medicaid (even the more generous Medicaid buy-in).[207] The inability to marry has affected their ability to start a family.[208] While they desire to adopt, several agencies have ranked them lower priority because they are not legally married.[209]

Couple A, on categorically-needy Medicaid, was fearful to divulge that they had held a secret commitment ceremony.[210] They described a certain terror at being deemed by regulators as "holding out" as married.[211] Marriage is especially important for them because one of the individuals has dramatically outlived his life expectancy.[212] Both feel as though they are living in sin because they cannot be married in the eyes of the church or law.[213]

For people with disabilities, marriage is also inextricably laced with caregiver and other family responsibilities. Marriage, if it means losing Medicaid, may mean shifting a spouse or other loved one into that daily attendant care role.[214] Parents of

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204. This is a program for people who were disabled before age twenty-two and who may become eligible to receive Medicare and parental SSDI benefits after their parents die. *Disability Benefits: How Does Someone Become Eligible?*, SOC. SEC. ADMIN.: BENEFITS, https://www.ssa.gov/benefits/disability/qualify.html#:~:text=The%20Disabled%20Adult%20Child%20(DAC,definition%20of%20disability%20for%20adults [perma.cc/F9A2-7FJH] (last visited Sep. 21, 2025).

205. CTRS. FOR MEDICARE & MEDICAID SERVS., MAGI-BASED HOUSEHOLD INCOME ELIGIBILITY TRAINING MANUAL (2020), https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/household-composition-and-income-training.pdf [perma.cc/36RS-VM2K]. This is true so long as individuals do not claim one another as dependents for tax purposes. *Id.*

206. Interview with Anonymous, in Pa. (Nov. 4, 2020).

207. *Id.*

208. *Id.*

209. *Id.*; Fulton v. City of Phila., 593 U.S. 522, 542 (2021) (holding that a private Christian adoption agency is protected under religious freedom when it denies adoption services to same sex couples or unmarried couples regardless of their sexual orientation).

210. Interview with Anonymous, in Pa. (Nov. 10, 2020).

211. *Id.*

212. *Id.*; One lawyer describes holding out determination as heavily subjective and considering the reporting of friends, neighbors, and coworkers about whether the couple treats themselves like a married couple. He also notes that the marriage penalty for holding out is enforced even in states that lack common law marriage. Carly Stern, *Forced to Divorce: Americans with Disabilities Must Pick Marriage or Health Care*, OZY (Apr. 25, 2019), https://authory.com/CarlyStern/Forced-to-Divorce-Americans-With-Disabilities-Must-Pick-Marriage-or-Health-Care-a8915957e02c1469ba328f0d7d5eaa526 [perma.cc/36N8-7VLB].

213. *Id.* Echoing religious concerns, a young Muslim woman with cerebral palsy reported she would forgo Medicaid and SSI benefits before living in sin. Stern, *supra* note 212.

214. Julian J. Z. Polaris, *Personal Networks: Health Coverage Status and the Invisible Burden on Family and Friends*, 39 HARV. J.L. & GENDER 115, 142–43 (2016); Gabriella Garbero, *Rights Not Fundamental: Disability and the Right to Marry*, 14 ST. LOUIS U. J. HEALTH L. & POL'Y 587, 612 (2021) ("Another option that would encourage healthy marriages and discourage Medicaid divorces is to eliminate policies that shift the burden of caregiving responsibilities to family members. This burden creates stressful family dynamics and puts unnecessary pressure on relationships.").

children with disabilities also have a different calculus when it comes to marriage.[215] As explained by one mother:

> I have not gotten married because of health care. . . . I have had my daughter on Washington State health care since she was born. If I were to get married to the guy that I have been with for the past ten years, then our combined income would disqualify my daughter for her coverage.[216]

For the currently single, Medicaid is an unwelcomed complexity in their love lives. Some I spoke with said they knew marriage would be impossible, except with another person who is low-income or has a disability.[217] Others, not yet on Medicaid and not yet married, were contemplating hypothetical future divorces if their conditions worsened and Medicaid became necessary.[218]

Means-testing even forces happy marriages to end. "Medical divorces" occur when couples divorce to meet income or asset tests.[219] The topic is understudied in health policy[220] but anecdotes of the practice abound and a Google search turns up pages of law firms offering advice on the topic.[221] Courts have stated that Medicaid divorce is against public policy,[222] but this ignores the very real financial and other pressures facing some couples.

Couple B, a couple in their fifties who have been married for twenty years and are raising a daughter together, both receive SSDI.[223] SSDI recipients are eligible for Medicare after a two-year waiting period.[224] When the husband was diagnosed with cancer, growing out-of-pockets costs necessitated he switch to Medicaid.[225] With two long work histories, the couple earns too much SSDI income to qualify for Medicaid so they "spend down," or give back part of their SSDI income each month.[226] If the couple divorced, they would need to give back less, amounting to

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215. "*I Married for Health Insurance*", ABC NEWS (July 15, 2008), https://abcnews.go.com/Business/CareerManagement/story?id=5379923&page [perma.cc/QMB6-RYWR].

216. *Id.*

217. Interview with Anonymous, in Pa. (Nov. 10, 2020).

218. Interview with Anonymous, in Pa. (Oct. 31, 2020).

219. Matthew B. Lawrence, *The Social Consequences Problem in Health Insurance and How to Solve It*, 13 HARV. L. & POL'Y REV. 593, 607 (2019).

220. *Id. See also* Garance Franke-Ruta, *The Hidden Marriage Penalty in Obamacare*, THE ATLANTIC: POLITICS (Nov. 5, 2013), https://www.theatlantic.com/politics/archive/2013/11/the-hidden-marriage-penalty-in-obamacare/280890/ [perma.cc/2R86-EQB7] ("While statistical studies about the size of this phenomenon do not exist, the observable amount of anecdotal evidence—from court cases, legal guides for lawyers on how to handle such divorces, and newspaper articles—testifies that this is not a marginal occurrence.").

221. *Getting Divorced to Avoid Mandatory Medicaid Spend Down: A Good Idea or Not?*, HANLON, NIEMANN & WRIGHT, https://www.hnwlaw.com/elder-law/new-jersey-medicaid-attorney/getting-divorced-to-avoid-medicaid-a-good-idea/ [perma.cc/6LKF-P2Z9] (last visited Sep. 21, 2025); *Medicaid Divorce*, WEINBERGER DIVORCE & FAM. L. GRP., https://www.weinbergerlawgroup.com/divorce/medicaid/ [perma.cc/UKV8-YWPG] (last visited Sep. 21, 2025); *The Medicaid Divorce: Critical Considerations*, FIELDS & DENNIS LLP, https://www.fieldsdennis.com/the-medicaid-divorce-critical-considerations [perma.cc/3Q3Q-N3HV] (last visited Sep. 21, 2025).

222. H.K. v. Div. of Med. Assistance & Health Servs., 878 A.2d 16, 19 (N.J. Super. Ct. App. Div. 2005) ("Using a divorce proceeding to accelerate Medicaid . . . violates public policy in general and the underlying policy of the Medicaid Act.").

223. Interview with Anonymous, in Ill. (Mar. 12, 2021).

224. 42 U.S.C. § 1395c (1965).

225. Interview with Anonymous, in Ill. (Mar. 12, 2021).

226. *Id.*

a savings of $1,000 per month.[227] Divorce makes clear economic sense, but both are children of divorce and hope to give their daughter a model of a healthy marriage.[228] They also believe divorce "goes against God's wishes after being legally married in the church."[229] And, depending on their state of residence and the pathways to Medicaid, cohabitation may not even be an option for the couple.[230]

Happily married parents of two daughters contemplated divorce after their youngest daughter was born with a rare genetic disorder demanding around-the-clock care.[231] The husband's employer benefits do not cover many of the child's medical expenses, with the couple paying $15,000 per year in out-of-pocket expenses.[232] With $40,000 per year in annual income, they make too much to qualify for Medicaid or CHIP and too little to tolerate the ongoing out-of-pocket costs.[233] A state benefit program is an option, but it has a 60,000-person waitlist.[234] If the couple divorce, the wife will be a single mother with little or no income, and she and her daughters will easily qualify for benefits.[235] Again, they may not be able to cohabitate.

The tax credits, while a major policy improvement, too may encourage divorce. A married couple in Brooklyn looked to purchase benefits on the exchange after losing benefits with a job lay-off.[236] Ironically, the couple had tied the knot several years prior so that one could enroll in the other's employer plan.[237] Now, marriage had become a penalty.[238] They could make far more money if they were not married and cohabitating, than if they stayed married.[239]

Older people not yet eligible for Medicare may be especially vulnerable to Medicaid and tax credit divorce, given that the ACA permits insurers to charge older people as much as three times the premiums of younger people.[240] Anecdotally, stories have been shared with the Author of people divorcing before cancer treatments, heart surgeries, and amputations.

II. SOCIAL AND ECONOMIC COSTS OF EMPLOYER-SPONSORED INSURANCE

Over half of the population receives their health benefits through their employers.[241] Typically, these benefits are confined to full-time workers for large employers. ESI is a family affair, with many people depending on a spouse or parent

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227. *Id.*
228. *Id.*
229. *Id.*
230. *See supra* notes 74–77.
231. Eun Kyung Kim, *Happily Married Couple Considers Divorce to Pay for Daughter's Health Care Costs*, TODAY: HEALTH (July 11, 2018), https://www.today.com/health/happily-married-couple-considers-divorce-pay-daughter-s-health-care-t132915 [perma.cc/H7L2-9JWD].
232. *Id.*
233. *Id.*
234. *Id.*
235. *Id.*
236. Franke-Ruta, *supra* note 220.
237. *Id.*
238. *Id.*
239. *Id.*
240. 42 U.S.C. § 300gg.
241. Keisler-Starkey et al., *supra* note 22.

to provide these benefits.[242] Though ESI is typically thought of as the benefit system for wealthier and more privileged individuals, it too limits people's opportunities.

The incentives of ESI generally run in the reverse of those associated with means-tested health care programs: pressure to work instead of pressure not to, pressure to stay working even when retirement better suits, and pressure to marry and stay married. Still, as this Part describes, ESI exerts substantial control over people in how they conduct their personal and economic dealings.

A. Eligibility Pathways for Employer-Sponsored Insurance

Eligibility criteria for ESI is substantially simpler than those for means-tested benefits. One must work for an employer that offers benefits.

Yet, only about half of employers in the private sector provides benefits to employees,[243] while state and federal governments provide their own forms of ESI.[244] Employers who offer benefits typically only extend them to full-time workers.[245] Only thirty-four percent of employers offered benefits to their part-time workers in 2020.[246] An even smaller portion, seven percent, offered benefits to temporary workers.[247]

Employers are not mandated to insure their workers but penalties and incentives encourage employers to offer benefits. Employers do not pay taxes on their portion of employer health insurance, in the way they do for payroll.[248] Under the ACA, small employers receive subsidies to offset the costs of furnishing ESI to their employees.[249] The ACA penalizes large employers (with more than fifty employees) who do not provide their employees with affordable health insurance.[250] The ACA's employer shared responsibility penalty, however, only penalizes

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242. *See 2019 Employer Health Benefits Survey*, KAISER FAM. FOUND.: HEALTH COSTS (Sep. 25, 2019), https://www.kff.org/report-section/ehbs-2019-section-2-health-benefits-offer-rates/ [perma.cc/7MXW-W76Z].

243. *Percent of Private Sector Establishments That Offer Health Insurance to Employees*, KAISER FAM. FOUND.: STATE HEALTH FACTS, https://www.kff.org/other/state-indicator/percent-of-firms-offering-coverage/ [perma.cc/L7Z7-32C9] (last visited Sep. 21, 2025).

244. Details on the Federal Employee Health Benefits program can be found here: *Healthcare*, U.S. OFF. PERS. MGMT.: HEALTHCARE INS., https://www.opm.gov/healthcare-insurance/healthcare/ [perma.cc/LFR3-SWS6] (last visited Sep. 21, 2025). Details on TRICARE, health benefits for active military, are available here: TRICARE, https://www.tricare.mil/ [web.archive.org/web/20251012040404/https://www.tricare.mil/]. The National Conference of State Legislatures provides a summary of state employee benefits here: *State Employee Health Benefits, Insurance and Costs*, NAT'L CONF. STATE LEGIS. (May 1, 2020), https://www.ncsl.org/health/state-employee-health-benefits-insurance-and-costs [perma.cc/L8HR-NJ32].

245. *2020 Employer Health Benefits Survey*, KAISER FAM. FOUND.: HEALTH COSTS (Oct. 8, 2020), https://www.kff.org/report-section/ehbs-2020-summary-of-findings/#fn1 [perma.cc/CLA5-Y23B].

246. *Id.*

247. *2019 Employer Health Benefits Survey*, *supra* note 242.

248. ESI began during WWII when employers faced a wage freeze and worker shortages and subsequently turned to other incentives like health benefits and pensions to attract new hires. Tax incentives have become ingrained as the most common form of insurance, with large employers lobbying to keep these advantages. For a summary of the history behind ESI, see Thomas C. Buchmueller & Alan C. Monheit, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform*, 46 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN. 187 (2009).

249. Regulations for the Small Business Tax Credit are found at 26 C.F.R. § 1 (2025).

250. 26 U.S.C. § 4980H; 26 C.F.R. §§ 1, 54, 301 (2025).

employers not offering benefits to workers who work on average thirty or more hours per week.[251]

Importantly, some people gain entry to the ESI system through a family connection. The ACA requires employer plans to offer benefits to employees' dependent children up to age twenty-six, though they need not subsidize these benefits.[252] The employer penalty does not apply to spouses,[253] but about 95 percent of employers extend benefits to spouses.[254] Employers are not obligated to cover domestic partners and less than half of employers do so.[255] Professors Naomi Cahn and June Carbone criticize this "family wage model" (the dependency of family benefits on a single wage earner who are historically male) as impractical and out of step with modern living.[256] Romantic relationships and employment enjoy far less stability across the course of a person's life than they once did, resulting in far less stability in insurance.[257]

B. Economic and Social Harms of Employer-Sponsored Insurance

ESI, just like in mean-tested programs, influences opportunities to work, save, retire, marry, and divorce.

1. Work, Savings, and Aging

"Job lock" is the most well-studied and regulated of all the topics discussed in this Article. Job lock describes the phenomenon where employees base their employment decisions on health benefits, rather than other interests like safety, suitability, wages, or professional growth potential.[258] Job lock may affect job selection, job mobility, self-employment, entrepreneurship, or the ability to reduce hours or take leave to care for children and ailing loved ones.[259]

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251. 26 C.F.R. § 54.4980H-1(a)(22) (2025).

252. *Id.* (providing that children under age twenty-six are dependents that must be covered under plans).

253. 26 C.F.R. § 54.4980H-1(a)(12) (2025) (providing that spouses are not dependents that must be covered under plans).

254. *2020 Employer Health Benefits Survey*, *supra* note 245. Fewer plans, about 88 percent, cover the spouse if the spouse has accessed another form of insurance, such as ESI offered through the spouse's own employer. Some employers charge spouses a surcharge to be on the ESI family plan if the spouse has benefits available through the spouse's own employer. Kerry Hannon, *Employers Penalizing Spouses for Health Insurance*, FORBES (Apr. 25, 2013), https://www.forbes.com/sites/nextavenue/2013/04/25/employers-penalizing-spouses-for-health-insurance/?sh=703106d950bd [perma.cc/W8VU-ZBRY].

255. In 2019, about 34 percent of employers covered opposite-sex domestic partners, while 43 percent covered same-sex domestic partners. *2019 Employer Health Benefits Survey*, *supra* note 242.

256. Naomi Cahn & June Carbone, *Uncoupling*, 53 ARIZ. ST. L.J. 1 (2021).

257. *Id.*

258. For a comprehensive overview of research on job lock, see BAKER, *supra* note 23. Other research includes, but certainly is not limited to, David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23 (2001) (exploring advantages of an employer- based market); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 373 (1997) (describing the need for job lock reform); Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006) (describing options to reform job lock).

259. BAKER, *supra* note 23. Ironically, job lock may prevent some people from leaving work to care for disabled loved ones, further aggravating the problems detailed in Part I.

It is logical that people would want to retain ESI, when the alternatives are to have no insurance or to deal with the structures of means-tested health care. Job lock is especially prevalent among individuals or families who have reason to fear future health issues.[260] One-third of cancer survivors report job lock for themselves or their partners,[261] while 23 percent of childhood survivors of cancer report job lock when they reach adulthood.[262] Extreme variation in the costs of benefits and covered benefits across employers can also explain job lock.[263]

Job lock is harmful to both the economy and workers,[264] though the extent of the problem is debated.[265] In one study, 88 percent of respondents indicated that they would give heavy or some consideration to a lower wage job with better health benefits versus a higher wage job with weaker ones.[266] The study looked at a variety of benefits that could sway employment decisions and found health, dental, and vision benefits received the greatest priority.[267]

Nearly half of Americans report selecting their current job in part because of the health benefits, with 9 percent saying health insurance was the decisive factor in selecting their current job.[268] The other half of Americans report that health insurance impacts to some degree their decision to *stay* in their current job.[269] And as many as one in six workers report currently being in a job they would leave but for health benefits.[270] Job lock is higher for Black workers and people who make less than $48,000 annually.[271]

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260. Erin E. Kent, Janet S. de Moor & Jingxuan Zhao, *Staying at One's Job to Maintain Employer-Based Health Insurance Among Cancer Survivors and Their Spouses/Partners*, 6 JAMA ONCOLOGY 929, 929–32 (2020).

261. *Id.*

262. Anne C. Kirchhoff, Ryan Nipp & Echo L. Warner, *"Job Lock" Among Long-Term Survivors of Childhood Cancer: A Report from the Childhood Cancer Survivor Study*, 4 JAMA ONCOLOGY 707, 707–11 (2018).

263. *New Poll: Strong Majority of Americans Satisfied with Employer-Provided Health Coverage*, AM.'S HEALTH INS. PLANS (Nov. 13, 2024), https://www.ahip.org/news/articles/new-poll-strong-majority-of-americans-satisfied-with-employer-provided-health-coverage [perma.cc/NKD5-RVZQ].

264. BAKER, *supra* note 23; U.S. GOV'T ACCOUNTABILITY OFF., GAO-12-166R, HEALTH CARE COVERAGE: JOB LOCK AND THE POTENTIAL IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Dec. 15, 2011), https://www.gao.gov/products/gao-12-166r [perma.cc/7YN8-T53Y].

265. *See* Tim Bersak, *Identification of Job Lock and Inefficient Labor Market Mobility*, 86 S. ECON. J. 530, 530–47 (2019).

266. Gareth Olds, *Entrepreneurship and Public Health Insurance* (Harv. Bus. Sch., Working Paper No. 16-144, 2016), https://www.hbs.edu/ris/Publication%20Files/16-144_d9ce8326-eeaa-4650-a8af-6ff03c3f7e77.pdf [perma.cc/3JNH-MGFQ].

267. *Id.*

268. *New Poll: Strong Majority of Americans Satisfied with Employer-Provided Health Coverage*, AM.'S HEALTH INS. PLANS (Nov. 13, 2024), https://www.ahip.org/news/articles/new-poll-strong-majority-of-americans-satisfied-with-employer-provided-health-coverage [perma.cc/H4QZ-GLQ3]. 49 percent reported they selected their job at least in part because of health benefits. *Id.*

269. *Id.*

270. Dan Witters, *1 in 6 U.S. Workers Stay in Unwanted Jobs for Health Benefits*, GALLUP (May 6, 2021), https://news.gallup.com/poll/349094/workers-stay-unwanted-job-health-benefits.aspx [web.archive.org/web/20250929185938/https://news.gallup.com/poll/349094/workers-stay-unwanted-job-health-benefits.aspx].

271. *Id.*

The COVID-19 pandemic further illustrated job lock. In one survey, 61 percent of respondents said that either they or their spouse settled for a lower paying job during the pandemic so that they could receive ESI.[272]

While most would describe job lock as harmful and an unnecessary barrier to working, job lock might be seen as a net good if it keeps people in the labor market.[273] But job lock is not a simple binary of work versus no work. Many who depend on work for health benefits, if given the freedom, would still choose to work, just in different positions or different hours, or would only leave the market temporarily until they fulfilled their other obligations. The benefits of working are also limited where the job provides low security, is high stress, or involves harmful working conditions.[274] ESI and means-tested benefits may lock people into bad jobs and, in doing so, perhaps decrease the motivation of employers to make improvements. Job lock is associated with job dissatisfaction and a lack of emotional well-being.[275] Job lock has been the target of multiple laws, in effort to stem harms it poses to individuals and the economy,[276] though these did not fully resolve the problem.[277]

The need to maintain employer benefits for a whole career can be demanding and limiting. Take the example of Couple C. The husband, a business owner, spent the better part of his adult life self-employed.[278] He depended on his wife's job for benefits.[279] When she was diagnosed with multiple sclerosis, she was unable to work, but became eligible for SSDI, and subsequently Medicare after a waiting period.[280] But the state they reside in did not require insurers to sell Medigap policies to individuals under the age of sixty-five.[281] Fearing bankruptcy if there was a health

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272. *One of Four Couples Married During COVID Did It for the Health Insurance*, AFFORDABLE HEALTH INS., https://www.affordablehealthinsurance.com/one-out-of-four-couples-married-during-covid-did-it-for-the-health-insurance/ [perma.cc/MP2X-H6T3] (last visited Sep. 18, 2025).

273. Yevgeniy Feyman, *Health Care's Labor Problem*, MANHATTAN INST. (July 24, 2013), https://manhattan.institute/article/health-cares-labor-problem [perma.cc/YK6W-LPR5] ("For all the negative impacts of employer-sponsored health insurance, the "job lock" phenomenon does have one positive effect—it keeps people in the labor force and working.").

274. Jerome M. Adams, *Improving Individual and Community Health Through Better Employment Opportunities*, HEALTH AFFS. (May 8, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180507.274276/full/ [perma.cc/832Y-4WJH].

275. Gwenith G. Fisher, Lindsay H. Ryan, Amanda Sonnega & Megan N. Naudé, *Job Lock, Work, and Psychological Well-Being in the United States*, 2 WORK AGING RETIRE 345, 345 (2016).

276. Katherine Elizabeth Ulrich, *You Can't Take It with You: An Examination Employee Benefit Portability and its Relationship to Job Lock and the New Psychological Contract*, 19 HOFSTRA LAB. & EMP. L.J. 173 (2002) (describing market aspects of employer insurance that necessitated legal reforms). Passed in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) gives people an affordable insurance option for periods between employment. Consolidated Omnibus Budget Reconciliation Act of 1985, H.R. 3128, 99th Cong. (1985); 29 U.S.C. § 1161. The Health Insurance Portability and Accountability Act (HIPAA) permits employees to change jobs and not face discrimination based on preexisting conditions, so long as their lapses of insurance are not for an extended time period. Health Insurance Portability and Accountability Act of 1996, H.R. 3103, 104th Cong. (1996).

277. Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885 (2011) (describing reasons why COBRA and HIPAA failed to fully resolve job lock).

278. Interview with Anonymous, in Neb. (Jan. 20, 2021).

279. *Id.*

280. *Id. 2020 Employer Health Benefits Survey*, *supra* note 245.

281. About 80 percent of Medicare beneficiaries have some form of supplemental insurance to cover out-of-pocket costs. Jeannie Fuglesten Biniek, Nancy Ochieng, Juliette Cubanski & Tricia

crisis, the husband shuttered his business and sought any jobs with health benefits that would take a man in his sixties.[282] Eventually, he took a job eight hours away.[283] The two spent years apart, too far to reliably travel for birthdays and holidays, and managed the costs of two separate households until both were too unhealthy to manage the costs alone.[284] The wife soon after aged into Medicare and became eligible for Medigap (for which plans must be sold to individuals aged sixty-five or older), and the husband was able to come back home, though his business was gone forever.[285]

For Person C, a young graduate student just about to embark on her career, health benefits have controlled the type of work she does.[286] She has always dreamed of working in the public sector but may take the private sector job she does not want because its benefits will cover the insulin pump she needs to better manage her Type 1 diabetes.[287]

Similar to means-testing, the design of ESI also influences aging and financial planning. Individuals may have many reasons to seek early retirement or to shift to part-time.[288] Health is commonly cited, along with job layoffs and taking care of a sick loved one or a grandchild.[289] But early retirement or loss of full-time work can mean loss of health benefits for the worker and their families.

Medicare is not available until age sixty-five (except in the case of qualifying disabilities).[290] Of large employers who offered ESI in 2020, less than a third offered retirees health benefits.[291] Rates of retirees' benefits diminish the smaller the employer.[292] Many employers who offer retiree benefits pay less or no premium for retirees, leaving retirees to bear a higher cost of insurance than when they were working, all while adapting to less income.[293] Additionally, individual purchase of insurance on exchanges can be costlier for older people, with insurers free to charge

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Neuman, *Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, KAISER FAM. FOUND. (June 25, 2021), https://www.kff.org/medicare/issue-brief/cost-related-problems-are-less-common-among-beneficiaries-in-traditional-medicare-than-in-medicare-advantage-mainly-due-to-supplemental-coverage/ [perma.cc/8D8C-R546].

282. Interview with Anonymous, in Neb. (Jan. 20, 2021).

283. *Id.*

284. *Id.*

285. *Id.*

286. Interview with Anonymous, in W. Va. (July 21, 2020).

287. *Id.*

288. Alicia H. Munnell, Geoffrey T. Sanzenbacher & Matthew S. Rutledge, *What Causes Workers to Retire Before They Plan?*, CTR. RET. RSCH. B.C. (Sep. 23, 2015), https://crr.bc.edu/working-papers/what-causes-workers-to-retire-before-they-plan/ [perma.cc/U9RZ-LJLH].

289. *Id.*

290. 42 U.S.C. § 426(c).

291. In 2020, 52 percent of employers with 5,000+ employees offered retiree benefits, 37 percent of employers with 1,000–4,999 workers offered retiree benefits, and 27 percent of workers with 200-999 workers offered retiree benefits. *2020 Employer Health Benefits Survey*, *supra* note 245.

292. In one survey, 5 percent of employers with 3–199 workers offered benefits. Frank McArdle, Tricia Neuman & Jennifer Huang, *Retiree Health Benefits at a Crossroads*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (Apr. 14, 2014), https://www.kff.org/report-section/retiree-health-benefits-at-the-crossroads-emerging-strategies-for-employers-offering-retiree-health-coverage/ [perma.cc/S4U2-HV25].

293. Retirees paid the full premium, with no employer support, in 39 percent of large employer plans. *Id.*

three times the premiums they charge younger individuals.[294] In one study of Americans nearing retirement age, almost 50 percent expressed concerns about being able to afford insurance post-retirement and 11 percent reported delaying retirement to retain ESI.[295]

Medicare is an individual benefit with no family option. This may delay retirements of workers who are married to a spouse not yet old enough for Medicare and without his or her own source of insurance.[296] Throughout the interviews, numerous people had described how they or a spouse have delayed retirement until both parties aged onto Medicare.

Children may also be a factor. The proportion of people between the ages of forty and forty-four who are having children has doubled between 1987 and 2007.[297] This group ages into Medicare while their children are still in their teens or early twenties and likely dependent on the family for insurance.[298] The ACA permits children up to age twenty-six to remain on family plans,[299] because young adults are less likely to have another source of insurance.[300] Some parents are forced to choose—put off retirement, pay out of pocket for benefits that may be too costly for them or their children to afford, or let their children go uninsured. A young graduate student with a chronic condition described her father putting his retirement on hold until she finished school and found a job.[301]

Grandparents increasingly raise grandchildren, the pandemic[302] and the opioid crisis[303] being two among other contributing factors to this trend. About 7.8 million children live with a caregiving grandparent.[304] If the family does not qualify for

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294. 42 U.S.C. § 300gg.

295. Renuka Tipirneni, Erica Solway & Preeti Malani, *Health Insurance Affordability Concerns and Health Care Avoidance Among US Adults Approaching Retirement*, 3 JAMA 1, 1 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760437 [web.archive.org/web/20250129044959/https://jamanetwork.com/web/20250129044959/https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760437].

296. *General Enrollment Information: My Husband and I Are Retired*, KAISER FAM. FOUND.: FAQS (Sep. 18, 2025), https://www.kff.org/faqs/medicare-open-enrollment-faqs/my-husband-and-i-are-retired-he-just-turned-65-and-is-now-covered-by-medicare-but-i-am-62-and-i-dont-have-health-insurance-as-the-spouse-of-a-medicare-beneficiary-can-i-enroll-in-medicare/ [perma.cc/88ES-99CM].

297. Michelle Andrews, *Retirees Can Find Insuring Young Adult Children Difficult*, KAISER HEALTH NEWS (Nov. 23, 2010), https://khn.org/news/michelle-andrews-on-medicare-and-adult-children/ [perma.cc/8CCD-4EZ2].

298. *Id.*

299. 42 U.S.C. § 300gg-14.

300. *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses*, CTRS. MEDICARE & MEDICAID SERVS. (Sep. 10, 2024), https://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet [perma.cc/2X23-WDGG].

301. Interview with Anonymous, in W. Va. (July 21, 2020); *see also* Andrews, *supra* note 297.

302. GENERATIONS UNITED, FACING A PANDEMIC: GRANDFAMILIES LIVING TOGETHER DURING COVID-19 AND THRIVING BEYOND 7 (2020), https://www.gu.org/app/uploads/2020/10/2020-Grandfamilies-Report-Web.pdf [perma.cc/D62F-E7ZJ] ("With this pandemic and its resulting deaths, COVID-19 is not only heightening challenges for existing grandfamilies but creating new ones.") (describing anecdotal data on death of one or both parents in households from COVID-19).

303. Lydia Anderson, *States with High Opioid Prescribing Rates Have Higher Rates of Grandparents Responsible for Grandchildren*, U.S. CENSUS BUREAU (Apr. 22, 2019), https://www.census.gov/library/stories/2019/04/opioid-crisis-grandparents-raising-grandchildren.html [perma.cc/9VND-Z8PL].

304. *Grandfamilies*, GENERATIONS UNITED, https://www.gu.org/explore-our-topics/grandfamilies/ [perma.cc/H89Y-LCUZ] (last visited Sep. 18, 2025).

Medicaid or CHIP because of their income, families must pay for private insurance on the exchange, or forgo retirement to provide ESI to grandchildren.[305] One study of caregiving grandparents reports that up to 25 percent delayed retirements, and 7 percent of those returning to the workforce are prompted by health care and financial needs of caring for grandchildren.[306] The circumstances by which children end up living with their grandparents may also mean a greater need for medical services.[307]

2. Marriage, Cohabitation, and Divorce

Employers typically offer benefits to employees' spouses, less so to live-in partners.[308] This creates both an incentive to marry and a penalty for divorce.

A study from Kaiser Family Foundation reports that as many as 7 percent of couples decide to get married because of health benefits.[309] This number rose in the COVID-19 pandemic to as high as 25 percent.[310] There is an impact on the economic well-being of singles, too.[311] Women are less likely to have insurance through their employer, and far likelier to obtain it as a dependent spouse.[312] One study estimates that an unmarried woman who makes $40,000 can expect to pay $500,000 more in her lifetime than a married woman, with health care being one component of the difference.[313]

Health benefits incentivize marriage for couples who would otherwise cohabitate. Or it might simply alter the timing of marriage, for instance, a nurse who moved up her wedding date and married her uninsured fiancée at the justice of the

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305. Robin Marantz Henig, *The Age of Grandparents is Made of Many Tragedies*, ATLANTIC (June 1, 2018), https://www.theatlantic.com/family/archive/2018/06/this-is-the-age-of-grandparents/561527/ [perma.cc/RYN4-WZSF] (discussing how grandfamilies often experience poverty, poor health, and few resources to raise their grandchildren).

306. *Grandparents Raising Grandchildren Face Daunting Financial and Social Challenges Altarum Survey Shows*, ALTARUM (Dec. 12, 2018), https://altarum.org/news/grandparents-raising-grandchildren-face-daunting-financial-and-social-challenges-altarum-survey [perma.cc/94W3-YZWS].

307. *Id.*

308. *2020 Employer Health Benefits Survey*, *supra* note 245.

309. The decision may be even more critical for young people who statistically are underrepresented in the kinds of jobs that offer health benefit. Francesca Fontana, *I Married Him for Love—and So He Could Be on My Health Insurance*, WALL ST. J. (Oct. 16, 2020), https://www.wsj.com/articles/i-married-him-for-loveand-so-he-could-be-on-my-health-insurance-11602861266 [perma.cc/B4VV-6FT2].

310. This figure was slightly higher in lower-income households, at 28 percent. *One of Four Couples Married During COVID Did It for the Health Insurance*, *supra* note 272.

311. Anne Helen Petersen, *The Escalating Costs of Being Single in America*, VOX (Dec. 2, 2021), https://www.vox.com/the-goods/22788620/single-living-alone-cost [perma.cc/S2LR-UBNZ].

312. Kaiser Family Foundation reports that 38 percent of women have ESI, compared to 46 percent of men. Twenty-three percent of women are covered as a dependent, compared to only 16 percent of men. While women are less likely to be uninsured than men, this is a consequence of Medicaid, which comes with its own limitations, as discussed later in this Article. *Women's Health Insurance Coverage*, KAISER FAM. FOUND.: WOMEN'S HEALTH POL'Y (Nov. 8, 2021), https://www.kff.org/other/fact-sheet/womens-health-insurance-coverage/ [perma.cc/SU3C-BNYG].

313. Lisa Arnold & Christina Campbell, *The High Price of Being Single in America*, ATLANTIC (Jan. 14, 2013), https://www.theatlantic.com/sexes/archive/2013/01/the-high-price-of-being-single-in-america/267043/ [perma.cc/8UFG-RBT9] (describing that the figure was double when a woman made $80,000 per year).

peace, so he could get on her dental insurance after he broke seventeen teeth in a work accident.[314]

Spouses who depend on the other for health benefits are also less likely to divorce.[315] Couples may be 70 percent less likely to divorce when they lack access to insurance independent of one another.[316] Women, facing a lack of alternative insurance, are less likely to divorce than men.[317]

The need for women to rely on a romantic partner for health benefits, and the possibility that this may trap some women into marriage, has long been a cause for concern among feminist scholars.[318] As one woman put it, while battling breast cancer and deciding whether to stay on Medicaid or marry her boyfriend for ESI, it forces women to "[p]ick [their] dependency—the state, or a partner."[319] Health expert Deb Gordon details a tragic story of a woman who remained in an abusive marriage for over thirty years so she could stay on her partner's health plan.[320] The woman worked during that period but not in jobs that provided health benefits.[321] She depended on her partner's health plan for treatment for her various mental health conditions.[322] The woman was only able to break free from the marriage when she finally got her own job with benefits, at which point she finally divorced and remarried.[323] In another example, a writer describes two health events that landed her in emergency rooms: the first time left her with medical bills totaling half of her annual salary that took her years to repay and the second costing thirty dollars.[324] The difference? The freelance writer was uninsured on the first visit and married with her partner's benefits on the second.[325] Now, with her chronic

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314. Kevin Sack, *Health Benefits Inspire Rush to Marry, or Divorce*, N.Y. TIMES (Aug. 12, 2008), https://www.nytimes.com/2008/08/13/us/13marriage.html [perma.cc/23QN-UUZJ] ("'They come in and say, 'We were going to get married anyway, but right now we really need the insurance,' said Mr. Hoffman. 'There may be an unplanned pregnancy, or there is an illness, or they've lost their job and can't get insurance.'").

315. Heeju Sohn, *Health Insurance and Risk of Divorce: Does Having Your Own Insurance Matter?*, 77 J. MARRIAGE FAM. 982, 982 (2015).

316. *Id.*

317. *Id.*

318. Professor Suzanne Kahn shows that, ironically, rising divorce rates led to policies that strengthened the use of marriage to determine eligibility for benefits. SUZANNE KAHN, DIVORCE, AMERICAN STYLE: FIGHTING FOR WOMEN'S ECONOMIC CITIZENSHIP IN THE NEOLIBERAL ERA 109–14 (2021)*; see also* MELINDA COOPER, FAMILY VALUES: BETWEEN NEOLIBERALISM AND THE NEW SOCIAL CONSERVATISM (2019) (exploring various ways policies have placed responsibility for risk and well-being on family units, rather than robust social safety nets).

319. Danielle Paquette, *A Cancer Sufferer's Agonizing Choice: Marriage or Medicaid*, WASH. POST (July 21, 2014), https://www.washingtonpost.com/news/storyline/wp/2014/07/17/marriage-or-medicaid/ [web.archive.org/web/20220120204922/https://www.washingtonpost.com/news/storyline/wp/2014/07/17/marriage-or-medicaid/].

320. Deb Gordon, *Health Care on the Line: What Americans Will Do for Health Insurance*, USC ANNENBERG CTR. HEALTH JOURNALISM (Nov. 12, 2020), https://centerforhealthjournalism.org/2020/11/11/health-care-line-what-americans-will-do-health-insurance [perma.cc/U2YL-H7ZA].

321. *Id.*

322. *Id.*

323. *Id.*

324. Jessa Crispin, *Like Millions of Americans, I Can Never Leave My Spouse. I'll Lose My Healthcare*, GUARDIAN (July 23, 2021), https://www.theguardian.com/commentisfree/2021/jul/23/americans-healthcare-insurance-spouse [perma.cc/JVX5-UAWH].

325. *Id.*

condition under better control, she acknowledges that she can never leave her husband, even if she wants to, because her very health is at stake.[326]

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The U.S. health care system influences the work, finances, aging, and romantic relationships of more than half the population and without any clear health policy justification. The next Part considers why this contributes to the overall failure of the system in being able to achieve its broader aims.

III. SOCIAL AND ECONOMICS TRADEOFFS OF THE HEALTH CARE SYSTEM UNDERMINE ITS PURPOSE

The health care finance system in its current form forces people to trade opportunity for access to health care. This Part explores three aims of a health care system: health promotion, insulation from financial risk, and human flourishing. It demonstrates how each aim is undercut by the social costs of the present system.

A. Health Justice and Health Promotion Goals

A commonly advanced goal of a successful health care finance system is that it ought to promote good health.[327] As one team of scholars aptly put it, "The defining goal for the health system is to improve the health of the population. If health systems did not contribute to improved health we would choose not to have them."[328]

Of course, the notion of how a system contributes to health is complicated and changes over time. A growing chorus of scholars are centering a health justice mission within health law and policy scholarship, focusing on how laws and policies can address "root causes of poor health," redress health disparities, eliminate health inequity, and promote broader social justice.[329] This literature engages deeply with the need to address social determinants of health (SDOH), or the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[330] The health justice movement asks us to look beyond the health care system as the locus for health outcomes, to broader societal conditions.[331] Put simply, this viewpoint stresses that "[t]here is

326. *Id.*

327. Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1875–79 (2011) (identifying three aims of a health care financing system: to promote health, to provide financial security, and to redress brute luck).

328. Christopher J.L. Murray & Julio Frenk, *A Framework for Assessing the Performance of Health Systems*, 78 BULL. WORLD HEALTH ORG. 717, 719 (2000).

329. Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORN. J.L. & PUB. POL'Y 47, 96 (2014); Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275 (2015); Medha D. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680 (2020); Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758 (2020).

330. *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 [perma.cc/V3SV-6WKR] (last visited Sep. 18, 2025).

331. Benfer, *supra* note 329.

more to health than health care."[332] Economic and social opportunities, living and working conditions, medical care, and personal behaviors all shape health outcomes (and personal behaviors are of course shaped by these elements).[333] Wealth and income, educational attainment, intergenerational transfer of wealth and health, stress, race and racism, neighborhood, and working conditions have all been particular sources of study.[334] Healthy People 2030, a government initiative to reduce health disparities, defines SDOH in five distinct buckets: economic stability, educational access and quality, neighborhood and built environment, social and community context, and health care access and quality.[335]

If a goal of the health care finance system is to promote health and SDOH are critical to health, then we should challenge a system that unequally burdens people with poverty, economic instability, and compromised social relationships.

Work generally means higher income, which generally means greater access to the social determinants of good health.[336] Work is associated with better mental and physical health,[337] and improved health is documented when people begin work after a period of unemployment.[338] And while ESI operates to lock some into the job market, the benefits of work are limited where the job provides low security, is high stress, or involves harmful working conditions.[339] The health benefits of retirement are more mixed, with some studies suggesting that retirement contributes to poorer health and other studies suggesting the opposite.[340] To the degree the system limits retirement options for some, at minimum it may be forcing some individuals to work when they suffer poor health. And for those in means-tested programs, the inability to retire with a secure income may be harmful to their health to the extent wealth equates with better health.[341]

The current system also prevents many from growing assets, especially if the Medicaid expansion were repealed.[342] This and income caps can compromise generational wealth.

SDOH literature also underscores the importance of social relationships to our health. Research demonstrates that marriage can be beneficial to an individual's health. Married people tend to live longer and have fewer strokes and heart attacks,

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332. Risa Lavizzo-Mourey & David R. Williams, *Strong Medicine for a Healthier America: Introduction*, 40 AM. J. PREVENTIVE MED. S1, S1 (2011).

333. Paula Braveman, Susan Egerter & David R. Williams, *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 385–88 (2011).

334. *Id.*

335. *Social Determinants of Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION: HEALTHY PEOPLE 2030, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health [perma.cc/GWK9-TMW7] (last visited Sep. 18, 2025).

336. Jerome M. Adams, *Improving Individual and Community Health Through Better Employment Opportunities*, HEALTH AFFS.: FOREFRONT (May 8, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180507.274276/full/ [perma.cc/QXJ4-4GNV].

337. *Id.*; Tyler J. VanderWeele, *On the Promotion of Human Flourishing*, 114 PNAS 8148, 8152 (2017).

338. VanderWeele, *supra* note 3377.

339. Adams, *supra* note 3366.

340. Ranu Sewdas, Astrid de Wind, Sari Stenholm, Pieter Coenen, Ilse Louwerse, Cécile Boot & Allard van der Beek, *Association Between Retirement and Mortality: Working Longer, Living Longer? A Systematic Review and Meta-Analysis*, 74 J. EPIDEMIOLOGY & CMTY. HEALTH 473, 476–77 (2020).

341. Braveman et al., *supra* note 333.

342. *See Spotlight on Resources — 2025 Edition*, *supra* note 77.

better mental health, better cancer outcomes, and better outcomes after surgery.[343] One explanation for this marital health benefit may be lower levels of cortisol.[344] Divorce is associated with poor mental and physical health, a problem which incentivizes some to medically divorce to maintain health benefits.[345] And while the system can sometimes discourage divorce,[346] it is hard to imagine those forced to stay in unhappy or unsafe marriages are healthier for it.

B. Insulation from Financial Disaster

Another primary aim of the health care financing system is to insulate people from the financial destruction of disease.[347] Relatedly, some posit that the cost of illness ought to be borne fairly across populations.[348] To this latter point, scholars argue people need not become impoverished in order to obtain care.[349]

When Medicare passed into law in 1965, President Lyndon Johnson celebrated the meaning of the law for many impoverished elderly: "There are those fearing the terrible darkness of despairing poverty—despite their long years of labor and expectation—who will now look up to see the light of hope and realization."[350] This celebrated aspect of Medicare is precisely one of the limitations of Medicaid, passed on that very same day.

Certainly, Medicaid and other means-tested programs operate to pay for health care services, thus helping to insulate people from medical-related bankruptcies or unmanageable out of pocket expenses.[351] Yet, means-tested health care puts people who need public benefits at obvious economic disadvantage, and even financial precarity.[352] As one scholar described, "The income and asset limits that define eligibility impose financial precariousness on the very recipients they are supposedly helping."[353] The Bureau of Labor Statistics shows that, irrespective of education, people with disabilities are more likely to be unemployed, to work part-time, or to be self-employed than their nondisabled counterparts, and for many, their employment status is not out of preference or ability.[354] Medicaid and SSI policy

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343. VanderWeele, *supra* note 3377.

344. Brian Chin, Michael L.M. Murphy, Denise Janicki-Deverts & Sheldon Cohen, *Marital Status as a Predictor of Diurnal Salivary Cortisol Levels and Slopes in a Community Sample of Healthy Adults*, 78 PSYCHONEUROENDOCRINOLOGY 68, 68 (2017).

345. VanderWeele, *supra* note 337.

346. *See* discussion *infra* Section II.B.

347. Professor Allison Hoffman argues a health care financing system may have several distinct aims: to promote health, to provide financial security, and to redress brute luck. Hoffman, *supra* note 327.

348. Murray & Frenk, *supra* note 328, at 720.

349. *Id.*

350. CTRS. OF MEDICARE & MEDICAID SERVS., CMS HISTORY PROJECT PRESIDENT'S SPEECHES: PRESIDENT LYNDON B. JOHNSON'S REMARKS WITH PRESIDENT TRUMAN AT THE SIGNING IN INDEPENDENCE OF THE MEDICARE BILL JULY 30, 1965 18 (2012), https://www.cms.gov/About-CMS/Agency-Information/History/downloads/CMSPresidentsSpeeches.pdf [perma.cc/D2PU-WJP7].

351. Baicker et al., *supra* note 10.

352. *See* discussion *infra* Section I.A.

353. Andrea Louise Campbell, *Reassessing the Conventional Wisdom: Entitlements from the Inside*, 13 FORUM 105, 108 (2015).

354. U.S. BUREAU OF LAB. STAT., PERSONS WITH DISABILITY, 2019: CURRENT POPULATION SURVEY (CPS) 8 (2020), https://www.dol.gov/sites/dolgov/files/odep/pdf/dol-odep-2019-briefing-appended-submission.pdf [perma.cc/7CY6-9HXK].

partly explain why. The ability to stop working, and to be financially secure in old age are also important economic and social interests.[355] The health care system compromises this interest, for some by forcing them to work beyond when they would retire even when they have the financial security to do so. For others, the system forces them to spend down this money to qualify for government benefits, and still others by preventing them from meaningfully saving for retirement in the first instance.[356]

Marriage and divorce have enormous economic implications.[357] Married couples enjoy the greatest wealth of any family structure.[358] Barriers to marriage may influence financial security including into older age, since unmarried cohabitants are not eligible for one another's social security benefits when they die.[359] Marriage also has legal and financial implications for couples' offspring.[360] A higher proportion of low-income families cohabitate than marry[361] and means-tested benefits is one determinative factor. Among couples whose joint income would otherwise place them outside of Medicaid eligibility, their likelihood of marriage would be two to four percentage points less were they to face a marriage penalty in Medicaid eligibility or food stamps.[362] One-third of Americans aged eighteen through sixty personally know at least one person who has chosen not to marry for fear of losing means-tested benefits.[363] People with disabilities have lower rates of marriage.[364]

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355. Wooten, *supra* note 170.

356. *See* discussion *infra* Sections I.B.1 & II.B.1.

357. *For Many Americans, 'Marriage Is an Economic Decision,' Sociologist Says*, NPR (Sep. 29, 2010), www.npr.org/templates/transcript/transcript.php?storyId=130218357 (interviewing Andrew J. Cherlin, who said that "marriage is an economic decision").

358. Erez Aloni, *The Marital Wealth Gap*, 93 WASH. L. REV. 1, 2 (2018). Economy of scale and federal and state laws that privilege the institution are just two reasons why married people fare better financially than their single counterparts. There are economic and tax advantages of ESI family plans, including favorable tax filing statuses and deductions, capital gains tax exclusions for sale of a principal home that largely favor married couples over single people, laws that safeguard inheritance when estate planning occurs between married couples, social security benefits that accrue to spouses, financial advantages of IRAs and other retirement plans for couples, among many other examples. *See* Spencer Rand, *The Real Marriage Penalty: How Welfare Law Discourages Marriage Despite Public Policy Statements to the Contrary - and What Can Be Done About It*, 18 UDC/DCSL L. REV. 93, 115–22 (2015).

359. Lynn Marie Kohm, *Why Marriage is Still the Best Default in Estate Planning Conflicts*, 117 PENN. ST. L. REV. 1219, 1246 (2013) (describing a host of financial benefits not eligible to unmarried cohabitants at the time of a partner's death).

360. *See* Maynard v. Hill, 125 U.S. 190, 203 (1888) ("When once formed, a relation is created between the parties which they cannot change, and the rights and obligations of which depend not upon their agreement, but upon the law, statutory or common. It is an institution of society, regulated and controlled by public authority.").

361. Richard Fry & D'Vera Cohn, *Living Together: The Economics of Cohabitation*, PEW RSCH. CTR. (June 27, 2011), https://www.pewresearch.org/social-trends/2011/06/27/living-together-the-economics-of-cohabitation/ [perma.cc/KM8R-RE5E].

362. This was among a group whose income was between $24,000 and $79,000. Brad Wilcox, *Marriage Penalized: Does Social-Welfare Policy Affect Family Formation?*, AM. ENTER. INST. (July 26, 2016), https://www.aei.org/research-products/report/marriage-penalized-does-social-welfare-policy-affect-family-formation/ [web.archive.org/web/20250827174646/https://www.aei.org/research-products/report/marriage-penalized-does-social-welfare-policy-affect-family-formation/].

363. *Id.*

364. *People With Disabilities Less Likely to Get Married*, MD. POPULATION RSCH. CTR., https://www.popcenter.umd.edu/news/news_1483634158302 [perma.cc/P4K9-FV28]. *See generally* Robert E. Rains, *Disability and Family Relationship: Marriage Penalties and Support Anomalies*, 22 GA. ST. U. L. REV. 561 (2006) (summarizing ways that disability harms opportunities for marriage).

This denial of opportunity seems insidious when one considers the government spends billions annually on promoting the institution of marriage for some but not others.[365]

C. Human Flourishing, Participation

Scholars frequently emphasize that health care is special for its ability to enable people to engage meaningfully in society, to be equal members of society, and to enjoy economic security.[366] Others advocate similarly for viewing health care as a positive right, a human right, or something necessary for human flourishing.[367] The capabilities approach contemplates health as one of an important number of capabilities that policies should support for all as a means of promoting human dignity.[368] Under such a framework, the value of health care can be understood in part by its ability to enable people to engage in a variety of other capabilities, or vital goals.[369] Importantly, many of these theories, like the capabilities approach, emphasize that human dignity and rights should be measured not according to whether someone has a formal right to a thing but rather whether they have the ingredients to enjoy the right or interest.[370]

If an aim of health care financing is to improve quality of life and promote human flourishing, then the current system as-is runs contrary to this aim. Yes, individuals are gaining access to needed health care, but at the cost to opportunity. Few examples in this Article show outright prohibitions on personal freedoms. For instance, Medicaid laws do not prohibit a recipient from marrying while on Medicaid (if they did, we may have constitutional remedies).[371] But standards of eligibility practically mean that marriage comes at a cost to access to life-saving care.[372] Thus, the formal right to marriage may remain, but not the ends to marry.

This Article adds to these many varied arguments that health care is important to individuals' capabilities and opportunities. But it asks an important question: If health care is of value because it enables us to live out our lives and capabilities,

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365. Erez Aloni, *Deprivative Recognition*, 61 UCLA L. REV. 1276, 1282–83 (2014) (arguing that means-testing is a form of social control by policymakers to penalize what they believe are socially undesirable activities like cohabitating after divorce or using welfare benefits).

366. Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 3 (2001); Daniel Callahan, *Ends and Means: the Goals of Health Care*, *in* ETHICAL DIMENSIONS OF HEALTH POL'Y 3, 4 (Marion Danis, Carolyn Clancy & Larry R. Churchill eds., 2002).

367. Jennifer Prah Ruger, *Governing Health*, 121 HARV. L. REV. F. 43, 44 (2008).

368. AMARTYA SEN, EQUALITY OF WHAT? 215 (1979), https://www.ophi.org.uk/wp-content/uploads/Sen-1979_Equality-of-What.pdf [perma.cc/8WRD-L992]; MARTHA C. NUSSBAUM, WOMEN AND HUMAN DEVELOPMENT: THE CAPABILITIES APPROACH 77–78 (2000); Martha C. Nussbaum, *Capabilities as Fundamental Entitlements: Sen and Social Justice*, 9 FEMINIST ECON. 33, 40–41 (2003).

369. LENNART NORDENFELT, ON THE NATURE OF HEALTH: AN ACTION-THEORETIC APPROACH (1995) (arguing that the value of health care can be understood in part by its ability to enable people to engage in a variety of other capabilities, or vital goals as he terms them); Sridhar Venkatapuram, *Health, Vital Goals, and Central Human Capabilities*, 27 BIOETHICS 271, 271 (2013) (arguing that good health means the ability of people to achieve "a cluster of basic human activities . . . [based from] what constitutes a minimal conception of a human life with equal human dignity in the modern world").

370. SEN, *supra* note 368; Nussbaum, *Capabilities as Fundamental Entitlements*, *supra* note 368.

371. *See supra* notes 200–201.

372. *See* discussion *supra* Section I.B.2.

then what value is a system that provides us health care at a cost to those lived experiences?

IV. OPTIONS FOR REFORM

The social costs of the health care system are not inevitable but a policy choice, a direct result of the way we finance health care. Progress can be made, but models of health and social welfare reforms must be designed or reformed with these issues in mind. Otherwise, we risk crafting fixes that exacerbate the problem. This Part offers three policy agendas. First, Medicaid expansion and credits are two ACA innovations that have mitigated the problem, and both are compromised under the new presidential administration. Second, this Part offers incremental forms that can improve the issue for many, though not all. Lastly, universal health care is proposed as a more comprehensive, and politically challenging, solution.

A. Maintaining Ground: Preserving Medicaid Expansion and Premium Tax Credits

Perhaps no recent legislation has offset the social and economic harms of health insurance better than the ACA. The law gave people more viable pathways to insurance with fewer tradeoffs through two primary mechanisms.[373] One, the Medicaid expansion allowed more people access to benefits, with no asset tests and more generous income tests.[374] It also eliminated the need to be a part of the "deserving poor."[375] Two, it made individual insurance affordable by offering premium[376] and cost-sharing tax credits,[377] and available by eliminating persistent strains of discrimination in this market against those with preexisting conditions.[378] These reforms gave people meaningful access to the private system uncoupled from work, and access to the public system with more generous means-testing. Both reforms proved critical access points in the unemployment crisis stemming from the COVID-19 pandemic.[379]

The Congressional Budget Office projects that the ACA enabled 2.5 million people over a period of ten years to stop working at their jobs.[380] Another study estimates the ACA decreased the attachments to the labor market by 61 percent.[381]

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373. *See* Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 2022–26 (2013) (noting the particular benefit the ACA holds for people with disabilities).

374. 42 U.S.C. § 1396(b)(2)(A)(iii).

375. *See* discussion *infra* Section I.A.1.

376. 42 U.S.C. § 18071(b).

377. 42 U.S.C. § 18071(c).

378. 42 U.S.C. § 300gg-3.

379. Madeline Guth, Bradley Corallo, Robin Rudowitz & Rachel Garfield, *Medicaid Expansion Enrollment and Spending Leading Up to the COVID-19 Pandemic*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (Jan. 12, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-expansion-enrollment-and-spending-leading-up-to-the-covid-19-pandemic/ [perma.cc/XF3C-Q8ZR] (reporting an enrollment expansion of five million people during the pandemic in the months between February 2020 and August 2020).

380. David Orentlicher, *Employer-Based Health Care Insurance: Not So Exceptional After All*, 36 U. ARK. LITTLE ROCK L. REV. 541, 544 (2014).

381. Guttierez, *supra* note 6; *but see* James Bailey, Gregory Colman & Dhaval Dave, *The Evolution of Job Lock in the U.S.: Evidence from the Affordable Care Act*, 15 J. RISK & FIN. MGMT. 296, 296 (2022) (concluding the ACA did not mitigate job lock and speculating that ESI is more desirable with rising premiums on exchanges and penalties for noninsurance originally imposed by the ACA).

Post-ACA, people are more likely to self-employ.[382] The law decreased attachments to marriage and family on health insurance by 78 percent and 45 percent, respectively.[383] The greatest reduction in marriage rates have been in people with preexisting conditions when comparing people with spouses with preexisting conditions and people without preexisting conditions.[384] At the same time, the ACA reduced the rates of birth outside of marriage by 2 percent.[385] Medicaid expansion reduced medical divorce in older populations.[386] Studies estimate that the security of access to benefits, especially for older workers and those with preexisting conditions, can increase the probability of retirement as great as 80 percent.[387]

Many of these studies precede the more generous premium tax credits of the IRA.[388] This law, which eliminated the cliff, only improved matters. More people could access premium tax credits, especially older people who the ACA permits to charge higher premiums than the young.[389] This progress is achieved despite the failure of ten states to expand Medicaid.[390] There is even more opportunity for progress, then, if other states expand.

Unfortunately, much of this progress may be undone in the second Trump administration. Its policies are expected to increase costs of health and reduce access. Rightful recipients of Medicaid are expected to be disenrolled because of administrative burdens.[391] The Medicaid expansion, with their more generous income limits, may be harder to access, forcing people to remain on traditional Medicaid with its attendant income and asset burdens.[392]

The premium tax credits that eliminated the fiscal cliff ended in 2025 with no successful effort yet by Congress to renew them.[393] This makes it far harder for

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382. Sayeh S. Nikpay, *Entrepreneurship and Job Lock: The Interaction Between Tax Subsidies and Health Insurance Regulations*, 38 CONTEMP. ECON. POL'Y 30, 30 (2020).

383. Guttierez, *supra* note 6. Another study estimates that Medicaid expansion decreased new marriages by women by as much as 11.6 percent, suggesting that some women may avoid marriage if they have an alternative pathway to benefits other than marital dependency. Chandrayee Chatterjee, *Impact of the Affordable Care Act Medicaid Expansions on Marriage and Divorce Decisions* 4 (The Ctr. for Growth & Opportunity and Utah State Univ., Working Paper, 2021), https://www.thecgo.org/wp-content/uploads/2021/02/Impact-of-the-Affordable-Care-Act-Medicaid-Expansions-on-Marriage-and-Divorce-Decisions.pdf [perma.cc/LW88-8UCR].

384. Matt Hampton & Otto Lenhart, *The Effect of the Affordable Care Act Preexisting Conditions Provision on Marriage*, 28 HEALTH ECONS. 1345 (2019).

385. Scott Barkowski & Joanne Song McLaughlin, *In Sickness and in Health: Interaction Effects of State and Federal Health Insurance Coverage Mandates on Marriage of Young Adults*, 57 J. HUM. RES. 637, 637 (2022).

386. David Slusky & Donna Ginther, *Did Medicaid Expansion Reduce Medical Divorce?* 4 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23139, 2020), https://www.nber.org/papers/w23139.pdf [perma.cc/X9NJ-4SQU] (concluding Medicaid expansion reduced medical divorces among adults aged fifty to sixty-four with a college degree).

387. Fisher et al., *supra* note 275*; see also* Kevin Wood, *Health Insurance Reform and Retirement: Evidence from the Affordable Care Act*, 28 HEALTH ECONS. 1462, 1462 (2019) ("Research results indicate a 2% and 8% decrease in labor force participation resulting from the premium subsidies and Medicaid expansions, respectively.").

388. *See supra* notes 128–135.

389. Hempstead & Valeta, *supra* note 127.

390. *Status of State Medicaid Expansion Decisions*, *supra* note 88.

391. Sommers et al., *supra* note 108.

392. *Id.*

393. Ortaliza et al., *supra* note 111.

people to access the individual insurance market, the market that often gave people more social and economic flexibility.

A policy priority is to restore the more generous premium tax credits, and a more robust and funded Medicaid. This Article highlights the critical nature of these reforms to people's and the nation's economic mobility and well-being, along with health. Notably, many of the interests raised in this Article have across-the-aisle support. Support for marriage and having children within wedlock,[394] the ability of people to live religious values,[395] and the ability of people to work all enjoy conservative support. The Congressional balance is quite tight, and voters across both parties have a vested interest in keeping ACA provisions intact for health care access interest, as well as financial and social ones.[396]

States also have a role to play and interests at stake. Whether red or blue states, ACA policies help to make citizens in the state more economically self-sufficient. Absent federal financial support, states are free to maintain Medicaid expansion and premium tax credits.[397] Medicaid expansion is generally budget neutral for most states, offsetting other state expenditures, though inevitably the costs will rise if there is reduced or no federal support.[398]

B. Incremental Reforms, Focused on States

This Part contemplates pathways to incremental progress. The social and economic tradeoffs in the system are a collection of various smaller problems, and so differing types of reforms could alleviate these tradeoffs. For example, maintaining an IRA is one of the better alternatives to enrolling in employer benefits.[399]

In the means-tested space, the most promising state remedy is for more states to take advantage of robust Medicaid buy-ins. The Ticket to Work law, passed in 1999, permits states to raise their Medicaid income and asset tests for workers with disabilities.[400]

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394. For instance, the first item on the 2024 Republican Party Platform was to "promote a Culture that values the Sanctity of Marriage, the blessings of childhood, the foundational role of families . . . ." *2024 GOP Platform: Make America Great Again!*, THE AM. PRESIDENCY PROJECT (July 8, 2024), https://www.presidency.ucsb.edu/documents/2024-republican-party-platform.

395. A number of GOP platform goals address religious freedom. *Id.*

396. Ashley Kirzinger, Isabelle Valdes, Alex Montero, Liz Hamel & Mollyann Brodie, *5 Charts About Public Opinion on the Affordable Care Act*, KAISER FAM. FOUND.: AFFORDABLE CARE ACT (May 15, 2024), https://www.kff.org/affordable-care-act/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act/ [perma.cc/UE49-8SRK].

397. Louise Norris, *Which States Offer Their Own Health Insurance Subsidies*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/faqs/which-states-offer-their-own-health-insurance-subsidies/ [perma.cc/ZR4E-JZD7] (last visited Sep. 21, 2025).

398. Jonathan Gruber & Benjamin D. Sommers, *Paying for Medicaid—State Budgets and the Case for Expansion in the time of Coronavirus*, 382 NEJM 2280, 2280 (2020)("[C]ase studies from several states showing that they have used federal dollars from the Medicaid expansion to offset other areas of state spending, such as direct subsidies to public hospitals and mental health centers, health care costs for people involved with the justice system, and a more generous match rate for optional groups previously covered by many state Medicaid programs.").

399. *See supra* notes 380–387.

400. Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-70, 113 Stat. 1860. The law also guarantees SSDI recipients Medicare benefits for ninety-three consecutive months after a return to work. The law was prompted by a U.S. Government Accountability Office study showing that SSDI and SSI benefits lost health benefits upon returning to work. U.S. GOV'T

Forty-six states have implemented some program that permits higher income and sometimes assets for workers with disabilities.[401] The average income limit in these programs is 250 percent of the FPL (compared to the roughly 75 percent of the FPL required to qualify as categorically need).[402] The average asset limit is $10,000.[403] Eight states have no asset limits in such programs and a majority require payment of some premium.[404]

These programs have room to grow. Some states have failed to adopt them.[405] Some states could be far more generous in these programs.[406] And, notably, even the most generous states still impose limits on earning potential and sometimes savings for these classes of people.[407]

Moreover, the federal government appears to be stilting these state-level initiatives. For example, in May 2024, Tennessee passed into law its first-ever Medicaid buy-in for people with disabilities.[408] The law was set to go into effect on January 1, 2025. However, news reporting suggests the law has yet to be enforced, as sign off at the federal level has been stalled since August 2024.[409] This may suggest that the federal government is standing in the way of such state efforts. If so, a critical state policy maneuver to improve economic and social opportunity for people with disabilities is currently under threat.

Other proposals would provide credits to married couples to offset their earnings[410] or prevent the marriage penalty for Disabled Adult Children.[411] One proposed bill in the U.S. House of Representatives, H.R. 7138, would require income and asset limits to increase with inflation and would overall raise the asset limit to $10,000 for individuals and $20,000 for couples.[412]

ACCOUNTABILITY OFF., GAO/HEHS-96-62, SSA DISABILITY: PROGRAM REDESIGN NECESSARY TO ENCOURAGE RETURN TO WORK (Apr. 1996), https://www.gao.gov/products/hehs-96-62.

401. *Medicaid Eligibility Through Buy-In Programs*, *supra* note 104. Non-adopters include Alabama, Minnesota, Tennessee, and Washington (though some states may have alternative policies to achieve similar benefits). Tennessee has had recent bills introduced to generate such a program. Elizabeth Fite, *Sen. Bo Watson Sponsoring Bill for Working Tennesseans with Disabilities to Buy Into Medicaid*, CHATTANOOGA TIMES FREE PRESS (Feb. 24, 2024), https://www.timesfreepress.com/news/2024/feb/24/sen-bo-watson-sponsoring-bill-for-working-tennesseans-with-disabilities-to-buy-into-medicaid/. Massachusetts appears to have adopted some similar program through a 1115 waiver. *MassHealth Section 1115 Demonstration Waiver*, MASS.GOV, https://www.mass.gov/info-details/masshealth-section-1115-demonstration-waiver [perma.cc/7647-Q4CL] (last visited Sep. 24, 2025).

402. *Medicaid Eligibility Through Buy-In Programs*, *supra* note 104.

403. *Id.*

404. *Id.*

405. *Id.*

406. *Id.*

407. *Id.*

408. TennCare for Working Individuals with Disabilities Act, 2024 Tenn. Pub. Acts 1002.

409. Braden Ross, *'I'm Being Blocked from the American Dream': Law Creating TennCare Buy-in Program for People with Disabilities is Stalled in Federal Medicaid Office*, WSMV4 (July 22, 2025), https://www.wsmv.com/2025/07/23/im-being-blocked-american-dream-law-creating-tenncare-buy-in-program-people-with-disabilities-is-stalled-federal-medicaid-office/ [perma.cc/786E-HSL9].

410. Wilcox et al., *supra* note 362.

411. Marriage Equality for Disabled Adults Act, H.R. 6640, 118th Cong. (2023).

412. Supplemental Security Income Restoration Act of 2024, H.R. 7138, 118th Cong.; Garbero, *supra* note 214 (noting that versions of this bill have been introduced in the House of Representatives since 2013).

C. Universal Health Care

While sufficient incremental reforms at the state level can alleviate the opportunity costs of health insurance, a system that affords universal care is still another option and is one that most economically developed nations adopt. Many scholars support some version of universal health care for economic,[413] equity,[414] health outcome,[415] innovation,[416] and disability rights reasons.[417] This Article offers another justification for the role universal health care could play in mitigating social costs of health care.

Universal programs cover anybody who meets a pre-determined, universal criterion like citizenship or residency.[418] One receives benefits on an individual basis whether the person has enjoyed a long work history or none, is married or single, or is rich or poor.[419] Under such a model, people also generally receive the same benefits for the same price, regardless of whether they are able-bodied or disabled, or young or old.[420] Medicare, one of the only universal-like programs for

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413. Scholars analyzing the relationship between universal healthcare and economics stated the following:

> A survey of other countries' healthcare systems compared with their relative levels of economic vitality suggests that providing universal care is more likely to foster economic growth than inhibit it. . . . This report will illustrate that the United States economy is currently hampered in numerous ways by having an inefficient, inequitable healthcare system.

David Sterret, Ashley Bender & David Palmer, *A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All*, 8 HEALTH L. & POL'Y BRIEF 41, 43–44 (2014); *see also* Walter McClure, Alain C. Enthoven & Tim McDonald, *Universal Health Coverage? Why?*, HEALTH AFFS. (July 25, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20170725.061210/ [web.archive.org/web/20250506124728/https://www.healthaffairs.org/content/forefront/universal-health-coverage-why] (describing how universal health care can improve health outcomes but requires cost containments).

414. Harris & Pamukcu, *supra* note 329.

415. Eric C. Schneider, Arnav Shah, Michelle M. Doty, Roosa Tikkanen, Katharine Fields & Reginald D. Williams II, *Mirror, Mirror 2021: Reflecting Poorly*, COMMONWEALTH FUND (Aug. 4, 2021), https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly [web.archive.org/web/20251007085212/https://www.commonwealthfund.org/web/20251007085212/https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly].

416. William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of "Medicare-for-All" in Post-Pandemic Health Reform*, 20 YALE J. HEALTH POL'Y L. & ETHICS 68, 68 (2021) (arguing that Medicare-for-All could prompt transformation and innovation in health care and medical practice).

417. Sharona Hoffman, *Settling the Matter: Does Title I of the ADA Work?*, 59 ALA. L. REV. 305, 332 (2008) (arguing for universal health care as a mechanism to resolve barriers to work for people with disabilities); Ani B. Satz, *Overcoming Fragmentation in Disability and Health Law*, 60 EMORY L.J. 277 (2010) (arguing for universality in health benefits given that antidiscrimination laws are too fragmented to fully help people with disabilities); Mark C. Weber, *Disability Rights, Welfare Law*, 32 CARDOZO L. REV. 2483, 2505–06, 2514–15 (2011) (arguing for the adoption of universal health care to address barriers to work for people with disabilities).

418. *How Does Universal Health Coverage Work?*, COMMONWEALTH FUND, https://www.commonwealthfund.org/international-health-policy-center/system-features/how-does-universal-health-coverage-work [web.archive.org/web/20250924022210/https://www.commonwealthfund.org/International-health-policy-center/system-features/how-does-universal-health-coverage-work] (describing various countries' universal care programs) (last visited Sep. 18, 2025).

419. *Id.*

420. *Id.*

health care in America, provides a useful example, albeit an imperfect one.[421] Any citizen (or permanent resident of five years) qualifies once they reach age sixty-five.[422] Medicare enjoys a large amount of political insulation, in part because it is a universal benefit.[423] Medicare is not dependent on work status; one can enroll if still working, or even absent a work history, though a person in the latter case may pay higher premiums.[424] Individuals have the freedom to come and go from jobs at will, work or not, self-employ, open a business, take a break and care for a loved one, all without fear of losing health benefits.[425] Medicare is also not relational, as one qualifies solely based on their own status.[426] One can be married or not, divorced or not, childless or with a large family, and none of these characteristics affects coverage.[427] People who age into Medicare may still need to work to provide benefits for loved ones, but this is due to defects in other health benefits systems, not Medicare. The program is not means-tested; billionaires are just as able to benefit from the program as a person who has never made more than minimum wage.[428]

Of course, a universal program improperly designed could merely perpetuate the harms described in this Article. The benefits program would need to include services critical to the health and well-being of people with disabilities, like home health and attendant care, long-term care, and nursing home services—those services historically siloed in Medicaid.[429] A failure to cover these services could stagnate, or even worsen, the health and well-being of people with disabilities if supplemental markets were prohibited or too costly because they mainly served higher risk individuals. The cost concerns associated with generous benefits could prove the juggernaut in any real debate about universal eligibility. It is thus no accident that the ACA stopped short of requiring insurers to cover some services,

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421. Other universal plans, like Veteran Affairs (VA) benefits or Indian Health Services, only cover individuals with specific demographics such that only certain subsets of Americans qualify. *Eligibility for VA Health Care*, U.S. DEP'T VETERANS AFFS.: HEALTH CARE, https://www.va.gov/health-care/eligibility/ [perma.cc/H4WM-WPJN] (last visited Sep, 24, 2025); *Chapter 1 – Eligibility for Services*, U.S. DEP'T HEALTH & HUM. SERVS.: INDIAN HEALTH SERV., https://www.ihs.gov/ihm/pc/part-2/chapter-1-eligibility-for-services/#:~:text=2%2D1.2%20PERSONS%20ELIGIBLE%20FOR,Children [perma.cc/2CZG-7G8G] (last visited Sep, 24, 2025).

422. Medicare also covers people with disabilities if they have a qualifying work history, people who have end stage renal disease (ESRD), and people with amyotrophic lateral sclerosis (ALS). 42 U.S.C. § 1395(c).

423. Mira Norton, Bianca DiJulio & Mollyann Brodie, *Medicare and Medicaid at 50*, KAISER FAM. FOUND.: MEDICARE (Apr. 17, 2015), https://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/ ("Among people ages 65 and older, virtually all of whom are covered by Medicare, support is broad across party lines, with 85 percent of Republicans, 89 percent of independents, and 92 percent of Democrats saying the program is very important.").

424. *Who is Eligible for Medicare?*, U.S. DEP'T HEALTH & HUM. SERVS.: MEDICARE & MEDICAID, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html [perma.cc/6GHU-Q4AL] (last visited Sep. 18, 2025).

425. Because Medicare co-exists alongside ESI, there are some complexities for older workers in deciding when to enroll in Medicare or retain ESI, a decision which can come with enrollment penalties. *Avoid Late Enrollment Penalties*, MEDICARE.GOV, https://www.medicare.gov/basics/costs/medicare-costs/avoid-penalties [perma.cc/R835-VHRP] (last visited Sep. 16, 2025).

426. *Who is Eligible for Medicare?*, *supra* note 424.

427. *Id.*

428. *Id.*

429. For more on theoretical considerations regarding benefit design in universal health care, see Gabrielle Scheffler, *Equality and Sufficiency in Health Care Reform*, 81 MD. L. REV. 144 (2021).

instead leaving them to be covered by Medicaid.[430] The Medicaid expansion, too, represented a concession as the expansion allowed states to provide benefits packages to expansion populations that differ from those provided to the categorically needy.[431] In spite of arguments for more generous benefits running up against arguments about heightened costs, it is equally true that the American public as taxpayers already subsidize these costly services through Medicaid, in largely inefficient ways, and in ways that inhibit some people with disabilities from giving back by way of contributing to the workforce.

This Article does not take a position on what model of universal eligibility would be most ideal. Models abound around the globe.[432] Notably, universal eligibility might be achieved through a traditional, single-payer government model, or some type of government and private hybrid model.[433] State-based approaches to universal care could also be a viable, more politically feasible option.[434] Public option models,[435] allowing members of the public to purchase into government plans, could also be designed to reduce harmful social tradeoffs.[436]

Even universal health care would not fully resolve all aspects of the problem. People who require supplemental income might still face restrictions on work, marriage, and retirement if SSI and SSDI benefits systems are not reformed.[437] It would, however, resolve the problem for a subset of people who are on SSI for health care needs rather than for income assistance. Many family law scholars have proposed reforms to resolve the marriage penalty in SSI and SSDI benefits systems.[438]

Inducements and penalties to marry, work, and retire will always exist,[439] even if we correct the freedom flaw in health care. The important thing is that our health care system *need not impose these tradeoffs to be a successful health care system*.

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430. Allison K. Hoffman, *Risk and Reform of Long-Term Care*, HEALTH AFFS. (Nov. 14, 2014), https://www.healthaffairs.org/content/forefront/risk-and-reform-long-term-care [perma.cc/9TKT-4TPZ] (describing initial efforts and failures of ACA to address the long-term care crisis).

431. Musumeci et al., *supra* note 101 (describing specific ways the ABP must address those with most significant medical needs).

432. Schneider et al., *supra* note 415.

433. *See* Brendan S. Maher, *The Private Option*, 2020 MICH. ST. L. REV. 1043 (2021) (offering a compelling case of important roles private insurers play in health care markets).

434. Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 389–90 (2020); Erin C. Fuse Brown & Armeet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 NEJM 5, 7 (2018).

435. Some models allow individuals to buy in if the individual lacks access to another affordable plans, while others allow people to use the money they get from their employers to choose between an employer plan or the public option. Christine Monahan & Kevin Lucia, *Congressional Proposals for a Federal Public Health Insurance Option*, COMMONWEALTH FUND (Nov. 3, 2022), https://www.commonwealthfund.org/blog/2022/congressional-proposals-federal-public-health-insurance-option [web.archive.org/web/20250711222533/https://www.commonwealthfund.org/blog/2022/congressional-proposals-federal-public-health-insurance-option].

436. For example, the Choose Medicare Act would give everyone a pathway to purchase into Medicare, and for some, a pathway to purchase subsidies. OFFICE OF SEN. CHRIS MURPHY, CHOOSE MEDICARE ACT 1, https://www.murphy.senate.gov/imo/media/doc/CM_One%20Pager.pdf [perma.cc/PDJ8-FJHJ].

437. Rand, *supra* note 358; Aloni, *supra* note 358.

438. Rand, *supra* note 358; Aloni, *supra* note 358.

439. Michael Christl, Silvia De Poli & Viginta Ivaškaitė-Tamošiūnė, *Does It Pay to Say "I Do"? Marriage Bonuses and Penalties Across the EU*, 33 J. EUR. SOC. POL'Y 317 (2023) (describing tax advantages and other policy gains or losses of marriage in different EU countries).

Universal health care might create different incentives and these are worth exploring further in future research, pressures to obtain citizenship being one example.[440] Still these pressures can be found in any universal health care system, and they do not go to the fundamental social interests like marriage and the ability to work.

CONCLUSION

Burdens of illness and disease are felt unfairly, robbing some of social and economic opportunities. Our health care system need not amplify this unfairness. Those on means-tested benefits bear opportunity costs throughout their lives, because their medical needs are not met by private markets. The privately insured face lesser but still very real limits on their own economic and romantic potential. The encroachment of health care into the personal is harmful to both individuals and society. It undermines the broader value of a health care system. Many reforms are possible, minor and major. Health reform proposals, whatever model, should be scrutinized for their bearing on social freedoms, with an aim towards minimizing or avoiding these harms in the future.

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440. Hannah Bradby, Adele Lebano, Sarah Hamed, Alejandro Gil-Salmerón, Estrella Durá-Ferrandis, Jorge Garcés-Ferrer, William Sherlaw, Iva Christova, Pania Karnaki, Dina Zota & Elena Riza, *Policy Makers', NGO, and Healthcare Workers' Accounts of Migrants' and Refugees' Healthcare Access Across Europe—Human Rights and Citizenship Based Claims*, 5 FRONTIER SOCIO. 1, 8 (2020); Wendy E. Parmet, *The Worst of Health: Law and Policy at the Intersection of Health & Immigration*, 16 IND. HEALTH L. REV. 211, 232–33 (2019).