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Original Investigation

The Politics of Medicaid: Most Americans Are Connected to the Program, Support Its Expansion, and Do Not View It as Stigmatizing

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Policy Points:

- More than half of Americans are connected to the Medicaid program—either through their own coverage or that of a family member or close friend—and are significantly more likely to view Medicaid as important and to support increases in spending, even among conservatives. This finding helps explain why Affordable Care Act repeal efforts faced (and will continue to face) strong public backlash.
- Policymakers should be aware that although renaming programs within Medicaid may have increased enrollment take-up, this destigmatization effort might have also increased program confusion and reduced support for Medicaid even among enrollees who say the program is important to them.

Context: Since the 1980s, Medicaid enrollment has expanded so dramatically that by 2015 two-thirds of Americans had some connection to the program in which either they themselves, a family member, or a close friend is currently or was previously enrolled.

Methods: Utilizing a nationally representative survey—the Kaiser Family Foundation Poll: Medicare and Medicaid at 50 (n = 1,849)—and employing ordinal and logistic regression analyses, our study examines 3 questions: (1) are individuals with a connection to Medicaid more likely to view the program as important, (2) are they more likely to support an increase in Medicaid spending, and (3) are they more likely to support adoption of the Medicaid expansion offered under the Affordable Care Act? For each of these questions

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we examine whether partisanship and views of stigma also impact support for Medicaid and, if so, whether these factors overwhelm the impact of connection to the program.

Findings: Controlling for the strong effect of partisanship, people with any connection to the Medicaid program are more likely to view the program as important than those with no connection. However, when it comes to increasing spending or expanding the program, the type of connection to the program matters. In particular, adults with current and previous Medicaid coverage and those with a family member or close friend with Medicaid coverage are more likely to support increases in spending and the Medicaid expansion; but, those connected to Medicaid only through coverage of a child are no more likely to support Medicaid than those with no connection.

Conclusions: Future research should probe more deeply into whether people with different types of connection to Medicaid view the program differently, and, if so, how and why. Moreover, future research should also explore whether state-level attempts to destigmatize Medicaid by renaming the program also serves to reduce knowledge and support for Medicaid.

Keywords: Medicaid, stigma, public opinion, partisanship, policy feedback effects.

How is it that Medicaid—America's health care program for the poor—has become a major point of contention during the intensive effort by Republican leaders in Congress, with strong support from the White House, to "repeal and replace" the Affordable Care Act (ACA)? Access to Medicaid when it was enacted in 1965 was primarily obtained through one's eligibility for highly stigmatizing cash assistance programs determined by the states and designated for poor, single-headed families with children, as well as the elderly, blind, and disabled. Because Medicaid was passed alongside Medicare—our federal social insurance program for the elderly that provides universal access regardless of income, health status, or one's personal circumstances—Medicaid has long been considered Medicare's poor stepchild with little political support.[1] It was "long considered" that is, until the 1980s, when the program began to expand. By the early 2000s, after numerous incremental coverage expansions and the creation of the State Children's Health Insurance Program (SCHIP)—administered through state Medicaid agencies—that helped to delink Medicaid from cash welfare programs, descriptions of Medicaid changed to reflect a much larger, more complex program that grew in ways no one would have predicted in 1965.[2]

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Indeed, many recent studies of Medicaid's policy evolution over time note its surprising resilience to retrenchment.[2-6] The surprise of course is based on its origins and the fact that most means-tested programs in the United States are stigmatizing and, as a result, are less resilient to retrenchment efforts than universal entitlements.[7-11] However, the *continued* surprise might also be due to the reality that although Medicaid has grown tremendously and withstood major attempts to retrench, it is nevertheless ensnared in partisan politics and ends up repeatedly on the Republican chopping block. The most extreme example is states' reaction to the Medicaid expansion under the ACA, where all Democrat-controlled states adopted expansion and all 19 nonexpansion states are controlled by Republicans.[12-15]

Yet, even the recent attempts to pass an ACA repeal bill (ie, the American Health Care Act [AHCA] of 2017, HR 1628; and the Better Care Reconciliation Act [BCRA] in the Senate) under the Trump administration, where Medicaid retrenchment—lightly disguised as changes in funding policy—was a central component of the bill, is just the most recent example in a long line of efforts at the federal level to seriously retrench the program. Starting with Ronald Reagan in 1981, and continuing with Newt Gingrich's leadership in 1995, the Bush administration in 2003, and Paul Ryan as House majority leader under the Obama administration, Republican politicians have attempted to block-grant Medicaid, which under each proposed bill would have resulted in a significant reduction in funding.[2,5,16] In response to these Republican attempts to retrench Medicaid, Democratic leaders often appealed to Medicaid recipients, and the advocacy groups representing them, to mobilize opposition—typically highlighting how much the program has expanded to "nonpoor" working families who need coverage for their children or long-term care services for their elderly parents.[4,5] Because none of these block-grant attempts have been successful, many conclude that Medicaid has grown enough that political leaders and interest groups are able to mobilize sympathetic constituencies, making rescinding Medicaid benefits too difficult politically.[17]

Especially in light of the growing number of Americans who report a connection to the program, which was nearly two-thirds in 2015, one might expect that the importance of Medicaid benefits would have produced a constituency against retrenchment. That is the focal question of this paper: Controlling for the effect of partisanship, are people connected to the Medicaid program more likely to view the program

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as important and support expansions? This is a crucial question to help determine whether Medicaid has pivoted closer to politics resembling a "middle-class" entitlement program. With a unique nationally representative survey conducted in 2015 by the Kaiser Family Foundation, we are able to examine this question by analyzing not only whether connection to Medicaid matters but also whether the *proximity* of connection matters. That is, are those currently covered by Medicaid more supportive of the program than those who don't have Medicaid but have had a family member or close friend on the program?

We find that both those with self-coverage and those with other family and close friends covered by Medicaid are more likely to believe the program is important and support increasing spending and adoption of the Medicaid expansion compared to those with no connection. However, those who are connected to the program only through coverage for their children are no more likely to support expansions than those with no connection. Before detailing our methodological approach and presenting our findings, we review the arguments for and against why connection would influence support for expansions. We conclude by exploring possible explanations for these findings and by considering the implications of our findings for Medicaid politics going forward.

Medicaid Growth: Positive or Negative Feedback Effects?

A central idea behind the argument that connection to the Medicaid program should influence public support for the program is the concept of "policy feedbacks."[18-20] The concept posits that public opinion not only affects the creation of public policies but is also shaped by policies once passed. The classic US examples of positive feedback effects are Social Security and Medicare. The structure of these programs—namely, that they are federally administered, federally financed out of payroll tax and put into a designated trust fund, and universal—helped create this positive policy feedback. This policy design creates a strong sense of deservingness for the beneficiaries of these programs for 3 main reasons: (1) all Americans—regardless of income, race, or family status—receive benefits once they reach age 65 and no one group is singled out as undeserving; (2) the federal structure creates uniformity so major benefit policies do not vary by place; and (3) the payroll tax is presented as a

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"pay-as-you-go" tax so that Social Security and Medicare are perceived as "earned benefits."[18,19] As a result of these mechanisms, support for these universal programs is resilient across partisan differences and has largely persisted despite growing political polarization.[21]

In contrast, means-tested, target programs are known to produce negative policy feedbacks. The classic example of this is the Temporary Assistance for Needy Families (TANF) program, which provides cash assistance to very poor families. This program is administered by the states and, therefore, generosity varies dramatically by state; strict eligibility rules determine who is deserving of benefits; and, because it relies on general appropriations, it has no protected financing structure.[22] As a result, the program is highly stigmatizing and lacks political support. Studies further show that beneficiaries' participation in the program actually reduces political participation.[20,23] Most noteworthy is that public support for means-tested programs tends to be strongly partisan.[20,23]

While the policy feedback effects of these programs on the opposite ends of the targeting-universalism spectrum are clear, the feedback effects for Medicaid remain unclear. On the one hand, the program has expanded dramatically. In addition to low-income families, Medicaid also expanded in significant ways for people with disabilities—and not just for those with physical disabilities, but for those with diagnoses of mental illness and, more recently under the ACA, for those with substance use disorders.[24] The program has also long been important for the elderly in need of long-term care services. Although the program remains means-tested for the elderly (as it does for all groups), over the years states have passed a number of reforms to allow families (eg, spouses and children) to maintain assets and savings while their elderly loved one resided in a nursing home covered by Medicaid.[2,3,25,26]

Taken together, these policy changes mean that broad constituencies of Americans rely on Medicaid for coverage: from very poor to low- and even middle-income families who rely on Medicaid for their own coverage and/or coverage for their children or elderly parents in need of long-term care services. And, the extension of coverage to these constituencies—if the benefits are valuable—explains why Medicaid could produce positive feedback effects, under which Medicaid constituents—and their allies—would fight against retrenchment to protect their benefits.

On the other hand, there are 2 factors that could produce negative feedback effects: (1) Medicaid stigma and (2) partisan politics. We discuss these two mechanisms in turn.

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Medicaid Stigma

Although Medicaid was initially a targeted program with strict categorical eligibility rules, these rules have gradually been shed to the point that in states that have adopted the Medicaid expansion they have been eliminated altogether. Even before the ACA, incremental legislation over time gradually delinked eligibility for Medicaid from the cash assistance program so that the majority of people on Medicaid today do not receive cash assistance (or what is commonly referred to as "welfare").[4,27]

Indeed, SCHIP, which was enacted in 1997, was purposefully intended to cover uninsured children in low-income working families who did not have access to employer-based health insurance and for which private insurance was too expensive. While several studies show how TANF and other programs targeted at the poor are intentionally designed to stigmatize its recipients,[28,29] when states adopted SCHIP they implemented many policies to destigmatize Medicaid.[30] States were very concerned that because Medicaid's historical attachment to welfare cash assistance (then called Aid to Families with Dependent Children) had stigmatized the program, low-income working families would not sign up. As a result, many states streamlined the eligibility process by allowing people to mail in applications or sign up online or in places more accepting and welcoming than welfare offices, such as community centers or health care facilities. States also adopted 12-month continuous eligibility in order to eliminate the stigmatizing process of month-to-month redeterminations and to increase continuity of care. Finally, almost all states changed the name of their Medicaid program, especially for programs associated with SCHIP, to "user-friendly" names, such as Denali KidCare in Alaska, AllKids in Illinois, HUSKY in Connecticut, and BadgerCare in Wisconsin.[31] The new names intentionally hid the connection to Medicaid and presented a new frame that eligible recipients are deserving.

Some qualitative studies show that these rebranding efforts helped SCHIP beneficiaries carry less social stigma and perceive better treatment compared to their previous experience with Medicaid.[32] Herd, DeLeire, Harvey, and Moynihan[33] also show that Medicaid take-up increased after enrollment streamlining policies were put in place. Moreover, in response to a story about Medicaid's resilience against repeal, Mollyann Brodie, who oversees polling for the Kaiser Family Foundation, recently said: "The conventional wisdom that there's a great deal of

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stigma attached to this program does not bear out in the public opinion data."[17]

Yet, despite attempts to destigmatize and the reported positive take-up rates, other studies suggest that Medicaid is still associated with stigma in a variety of ways.[34] There are 2 potential forms of stigma associated with public programs: "experienced" and "internalized" welfare stigma.[34,35] Experienced stigma in the health care setting is grounded in a person's direct interactions with providers or the health care system itself. For example, if a Medicaid recipient experiences (or perceives) discrimination in the health care setting, this may be categorized as experiential Medicaid stigma. Such stigma has been found to discourage recipients from taking part in the health care process and results in declining access and lower health outcomes.[35]

Internalized stigma is associated with the experience of being in need of public assistance.[36] As mentioned, it has long been the case that official policy—either through legislation or bureaucratic behavior—is deliberately designed to create a sense of shame and moral inferiority on the part of those who seek assistance.[7,8,29,37] Shame has long been used to discourage people from applying for assistance in the first place and to encourage them to get off programs as soon as possible.[7,8,29,37] In addition to official policy, media portrayals of and political discourse about welfare recipients often reinforce a view of their moral failing, problems with "personal responsibility," and "illegitimacy."[38,39] Moreover, these welfare frames are so heavily biased by race, gender, and social class that welfare recipients are disproportionately portrayed as single female parents and people of color.[11,28,29,40,41]

Both types of stigma, of course, can occur in the Medicaid program. A recent study by Allen and colleagues[34] of Medicaid recipients in Oregon found evidence of experienced stigma that happened most often in provider-patient interactions, which recipients described as demeaning. Yet, while Allen and colleagues found no sense of shame associated with receiving public insurance, Stuber and Kronebusch[42] found in a 1999 survey of Medicaid recipients in community health centers across 10 states that stereotypes associated with welfare stigma reduced Medicaid enrollment. The difference between the findings in these 2 studies might be attributable to explicit changes to destigmatize Medicaid over time. However, Campbell[43] argues, based on her more recent case study in California, that Medicaid policy is designed in such a way that it still stigmatizes beneficiaries and maintains a weak constituency base.

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Focusing on Medicaid's benefits for the disabled population, she argues that its fastidious application process and requirements visibly highlight the government's surveillance role over enrollees' benefits and reminds recipients' of their inability to stay insured on their own accord.[43] Michener[44] takes the analysis of stigma one step further to examine if Medicaid reduces recipients' political action. Utilizing national data and controlling for a number of factors, she finds evidence of reduced political participation in geographic areas where Medicaid density is high.

In sum, the above findings suggest that despite the extension of coverage to a broad constituency group, stigma associated with Medicaid persists and remains strong enough for the program to produce negative feedback effects.[44] If societal notions of Medicaid deservingness are indeed negative and widespread, with these intimidating and degrading experiences and social/cultural accusations over welfare recipients not paying their dues, Medicaid recipients may feel that reliance on Medicaid is bad and should only happen as a last resort, and they may not support expanding coverage or increasing spending on Medicaid.

Partisan Politics

Another indication that Medicaid may still be subject to negative feedback effects is the influence of partisanship on public support for the program. It is noteworthy that Social Security and Medicare are off the table for budget cuts even in 2017 when the Republican party controls both the legislative and the executive branches. For example, Medicare was not part of the budget proposal put forth by the Trump administration nor was it in the House (ie, AHCA or HR 1628) or Senate versions of the repeal bills (ie, BCRA). As mentioned, the common explanation for this is positive policy feedback effects, which argues that universal programs create a widespread middle-class constituency that is mobilized politically to protect its benefits, which cuts across partisan politics.[9,10,18] As such, because of this engaged constituency, Social Security and Medicare are considered sacrosanct programs that even conservatives—despite their ideological opposition to entitlements—are reluctant to cut for fear of political retribution. Although Medicare has suffered retrenchment over time,[45-47] these retrenchment policies have had to occur in more hidden ways as a type of "subterranean politics."[48]

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In contrast, while Medicaid has survived numerous attempts to significantly retrench the program, it is also repeatedly attacked and several conservative states have recently succeeded in passing Medicaid policy regulations with the intent to create more "personal responsibility"—a classic welfare trope—and explicit rhetoric to keep Medicaid as (or turn it back into) a welfare program for the "truly needy."[14]

While the influence of party control on Medicaid policymaking is not new, the growth in political polarization may have important effects on Medicaid policy.[12,13,49] A number of studies confirm growing partisan polarization in Congress and across American state legislatures over the last several decades,[50-52] as well as growing partisan divisions among the American electorate.[21] A poll conducted in 2016 by Pew Research Center found that Republicans and Democrats have more negative views of the opposing party than at any point in nearly a quarter century.[53] This partisan divide was particularly acute when it came to views about the ACA. Another poll conducted just 2 weeks prior to the presidential election in November 2016 found that the vast majority of Democrats (82%) said they approved of the law, while 91% of Republicans disapproved of it.[54] Partisans have been divided on the ACA since the bill was passed in 2010; however, they grew even farther apart during the election campaign in 2016. As reported by Pew, 94% of registered voters who supported Trump disapproved of the ACA, whereas 82% of supporters of Democratic candidate Hillary Clinton approved of the ACA.[54] As concluded by John Gramlich of the Pew Research Center, "This represents one of the biggest areas of disagreement between supporters of the two candidates."

Yet, despite this strong divide in November, by January 2017 the polls reported a shift in public opinion. For the first time since 2010, more Americans reported feeling favorable about the ACA than unfavorable.[55] More importantly, although there remains a partisan divide in response to the replacement bills, the divide is narrowing and there was much less support among Republicans in the summer of 2017 than the polls in November 2016 might have suggested. In particular, according to a June 2017 poll, only 56% of Republicans supported the replacement plan.[55] While the replacement plan proposed to repeal the ACA health insurance exchanges, the reforms to Medicaid were at the forefront of the opposition against the bill.[17] Most relevant to this paper, while three-fourths of the general public (74%) hold a favorable view of Medicaid, 61% of Republicans also hold a favorable view.[56]

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Given the strong partisan divide among Americans, what explains this Republican support for Medicaid? We argue that if Medicaid stigma has been sufficiently reduced, Republicans who benefit from Medicaid coverage—whether directly or indirectly through coverage of family and close friends—will be more likely to support the program than those with no connection to the program despite political party opposition. This paper provides a test of that argument. In particular, using public opinion data from 2015 we examine 3 questions: (1) are individuals with a connection to Medicaid more likely to view the program as important for themselves or their family, (2) are they more likely to support an increase in Medicaid spending, and (3) are they more likely to support adoption of the ACA Medicaid expansion? For each of these questions we examine whether views of stigma and partisan affiliations impact views about Medicaid and, if so, does it overwhelm the impact of connection to the program?

Methods

To explore these questions we utilize the Kaiser Family Foundation Poll: Medicare and Medicaid at 50 survey (n = 1,849) conducted in April-May 2015.[57] This survey is ideal for addressing these questions because it asked detailed questions about how the respondent is connected to the Medicaid program, opinions about the Medicaid program, perceptions of Medicaid stigma, party affiliation, and a battery of demographic questions known to impact public opinion. The survey data and documents are available through the Roper Center Public Opinion Archives. After generating the key variables described next, we applied ordinal or logistic regression analyses based on the nature of the dependent variables. Survey weights were employed throughout the analyses.

Three dependent variables are drawn from the dataset: (1) importance of Medicaid program, (2) support for Medicaid spending, and (3) support for Medicaid expansion. The survey asked: "How important is Medicaid for you and your family? Is it very important for you and your family, somewhat important, not too important, or not at all important?" We generated an ordinal variable with 4 categories, from "not at all important (1)" to "very important (4)."

The second dependent variable is based on the following survey question asked to all respondents: "As you know, there are many competing

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spending priorities facing the president and Congress. Thinking about the federal budget, do you want to see the president and Congress increase spending on Medicaid, decrease spending, or keep it about the same?" An ordinal variable is drawn from the response.

The third dependent variable is measured among the respondents residing in the states that had not expanded Medicaid at the time the survey was conducted (n = 747). The poll asked, "For states that expand their Medicaid program to cover more low-income uninsured adults, the federal government initially pays the entire cost of this expansion, and after several years, states will pay 10% and the federal government will pay 90%. Do you think your state should (keep Medicaid as it is today) or (expand Medicaid to cover more low-income uninsured people)?" A bivariate variable is created based on the response.

Medicaid connection is our main independent variable. The survey asked about the multiple ways respondents, their children (if relevant), and other family or close friends are connected to the program: Do you currently or have you ever "received health insurance through the Medicaid program (which may also be known in your state as [state-specific Medicaid program name])"; "received (pregnancy-related care), home health care, or nursing home care that was paid for in part by Medicaid"; or "gotten help from Medicaid to pay your Medicare premiums." Based on this information, we generated 2 ordinal variables. The first connection variable has 4 categories: currently directly connected (either self or child), previously directly connected (either self or child), indirectly connected (other family or close friend), and not connected. The variable is ordinal because we conceptualize current connection as most strongly connected, followed by previous connection, indirect connection, and no connection. If there is overlap—for example, directly and indirectly connected—we use the strongest noted connection.

The second connection variable provides even more detail on the type of connection. It is an ordinal variable with 6 categories. The indirectly connected and those who had no connections remain the same; however, we separated out the directly connected into 4 ordered groups according to the paths and timing of the connection. The currently directly connected group is divided into current self-connection and current child-connection categories; and the previously directly connected were similarly split into previous self-connection and previous child-connection.

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The second key independent variable of interest is stigma; that is, whether the respondent views the Medicaid program as stigmatizing. The survey asked customized questions on stigma based on the respondents' relationship to the Medicaid program, which allowed us to capture both internalized and experienced stigma. In particular, for those who were not currently covered by Medicaid, we captured their view of internalized stigma through the following question: "If you were uninsured, needed health care, and qualified for Medicaid, would you enroll in the Medicaid program or not?" and "(If you had an uninsured child/If your child was uninsured) and you were told he or she was eligible for Medicaid, would you enroll your child in the Medicaid program, or not?" Respondents are coded as "not stigmatized" when they answered "yes" to both questions. For those who responded "no" to both questions they are coded as "stigmatized." The remaining respondents, who answered "yes" to one question and "no" to the other, are coded as "somewhat stigmatized."

For respondents with current Medicaid coverage, we captured their view of experienced stigma through a set of questions regarding difficulties they had with the program, such as "problems finding a doctor or health care provider willing to accept your health insurance" and "problems getting a referral or an appointment to see a specialist, such as a cardiologist or orthopedist." Respondents who expressed difficulties in answers to all these experiential questions are coded as "stigmatized," whereas respondents with no such difficulties are coded as "not stigmatized." The individuals with mixed responses are coded as "somewhat stigmatized."

The third key independent variable is party affiliation. We used the following survey question to capture respondents' affiliation: "In politics today, do you consider yourself a {Republican, Democrat or Democrat, Republican}, an Independent, or what?" where the order of "Republican" and "Democrat" was rotated to limit primacy advantage. Respondents are coded as "Republican" or "Democrat" when they answered so. Those who do not consider themselves as Republican or Democrat are coded as "Independent."

We also include 2 insurance status variables: whether the respondent is uninsured or insured through individual commercial insurance, including the ACA exchange plans. These variables are included for 2 reasons: first, all else equal, a person who is currently uninsured might logically favor expansion in Medicaid coverage since she or he has a high

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probability of gaining coverage; second, all else equal, a person who is currently paying for coverage (either on the exchange or through a private commercial plan) might feel resentment toward Medicaid recipients who pay much less and therefore might be against any further expansions in Medicaid coverage. Both of these ideas are presented in news stories about why some Americans favor expansion in Medicaid coverage, while others resent recipients receiving Medicaid coverage. For example, a person who purchased an ACA plan on the marketplace was quoted as saying: "I really think Medicaid is good, but I'm really having a problem with the people that don't want to work. Us middle-class people are really, really upset about having to work constantly, and then these people are not responsible." While this person was negative about expanding Medicaid, others who were uninsured said they wanted a more robust Medicaid program so that they could also gain coverage.[58] By using a nationally representative survey, we are able to test whether insurance status is statistically related to opinions about Medicaid.

Finally, we also include a set of demographic variables—education level, age, race/ethnicity, gender, and income level—known to influence public opinion. A regional variable is also included as a proxy to control for the variation in political culture across the states.

Findings

In 2015, two-thirds (64%) of Americans reported a connection at some point in their lives to the Medicaid program, a 12% growth from 2011 (Figure 1).[59] A third (34%) of the US population reported having Medicaid coverage for themselves or their child, either currently or at some time in the past. This represents an 8% increase from 2011 (22%) to 2015. Another third (30%) have close friends or other family members who have received coverage. This is an increase of 5% since 2011. The remaining 36% reported "no connection" to the Medicaid program, a 12% decrease from 2011.

The majority of respondents feel favorable toward the Medicaid program on multiple dimensions (see Table 1, column 1). First, the majority (52%) say that Medicaid is very important (35%) or somewhat important (17%) to them. Second, the vast majority (87%) are against cutting spending on Medicaid: 38% favor increasing spending and 49%

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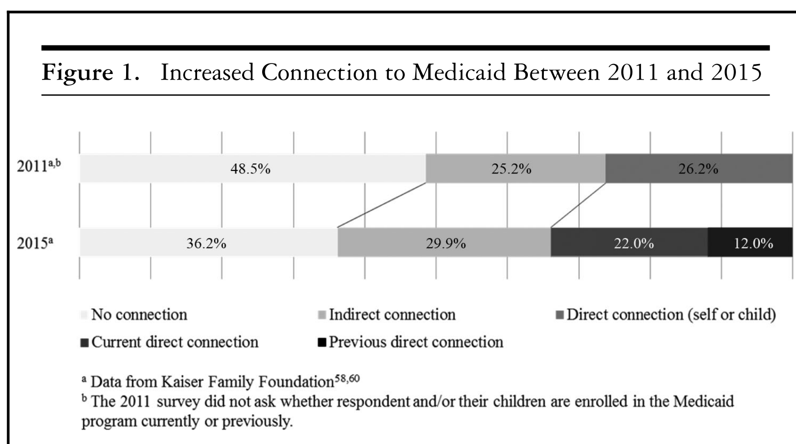

Figure 1. Increased Connection to Medicaid Between 2011 and 2015

[a] Data from Kaiser Family Foundation[58,60]
[b] The 2011 survey did not ask whether respondent and/or their children are enrolled in the Medicaid program currently or previously.

favor keeping current spending the same. Finally, 66% of respondents in nonexpansion states favor adopting the Medicaid expansion.

Also noteworthy is that a large majority (79%) of respondents reported no perceived stigma associated with the Medicaid program. Although 30% of those currently covered by Medicaid reported some experience with stigma, 70% reported no experienced stigma. Even among those with no connection to the Medicaid program, nearly three-fourths said they would sign up for Medicaid if they needed it—a strong indicator that for the majority of Americans there is no internalized stigma associated with the program.

Turning to the multivariate analyses, we find, as hypothesized, that connection to the Medicaid program is strongly associated with views about the program's importance (Table 2). Those currently covered have a very high odds ratio: they are 17 times as likely as those with no connection to say the program is very or somewhat important. Even those previously covered by Medicaid and indirectly connected to Medicaid are significantly more likely to view the program as important.

As expected, stigma and partisanship are significant in the hypothesized direction. Views of Medicaid stigma are significantly related to views about whether the program is important: those who view the program as stigmatizing in some way are more likely to not view the program as important. And Republicans are less likely than Democrats to view the program as important. Moreover, while uninsured status is significant—the uninsured are more likely to view the program as

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Table 1. Descriptive Statistics by Connection Type

	Overall Sample (100%)	No Connection (36.2%)	Indirect Connection (29.9%)	Previous Direct Connection: Overall (12.0%)	Previous Direct Connection: Child-Connection (2.2%)	Previous Direct Connection: Self-Connection (9.8%)	Current Direct Connection: Overall (22.0%)	Current Direct Connection: Child-Connection (8.0%)	Current Direct Connection: Self-Connection (13.9%)
Medicaid importance									
Not at all important	32.9	51.9	34.2	27.9	36.5	25.9	3.4	4.4	2.8
Not too much important	14.9	18.8	20.4	11.9	21.9	9.5	3.1	3.7	2.8
Somewhat important	16.6	13.9	21.5	21.2	5.7	24.8	11.9	10.7	12.6
Very important	35.5	15.5	23.9	39.0	35.9	39.7	81.6	81.3	81.8
Medicaid spending support									
Decrease spending	13.0	18.9	12.6	11.1	22.5	8.6	5.4	6.9	4.6
Keep it the same	48.7	51.6	46.3	44.5	56.9	41.7	49.7	50.3	49.4
Increase spending	38.2	29.4	41.2	44.4	20.6	49.8	44.8	42.9	46.0
Medicaid expansion support[a]									
Keep Medicaid as it is	34.5	44.8	29.0	38.6	50.9	33.1	21.0	22.5	19.8
Expand Medicaid	65.5	55.2	71.0	61.4	49.1	66.9	79.0	77.5	80.2
Stigma									
No stigma	79.3	73.7	87.9	90.9	89.5	91.2	70.4	76.5	67.0
Some stigma	14.1	16.2	7.5	7.9	9.5	7.5	23.3	15.5	27.8
Full stigma	6.5	10.1	4.6	1.2	1.0	1.3	6.3	8.0	5.3
Insurance status									
Uninsured	13.1	10.0	11.4	22.5	22.6	22.5	15.6	42.6	0.0
Marketplace	14.1	14.4	13.9	15.4	14.6	15.5	13.4	22.9	10.1

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Table 1. *Continued*

	Overall Sample (100%)	No Connection (36.2%)	Indirect Connection (29.9%)	Previous Direct Connection: Overall (12.0%)	Previous Direct Connection: Child-Connection (2.2%)	Previous Direct Connection: Self-Connection (9.8%)	Current Direct Connection: Overall (22.0%)	Current Direct Connection: Child-Connection (8.0%)	Current Direct Connection: Self-Connection (13.9%)
Political ideology									
Republican	24.1	29.8	27.4	17.2	32.4	13.7	14.1	15.7	13.2
Independent	42.6	43.6	38.9	43.0	48.8	41.7	45.8	47.8	44.6
Democrat	33.3	26.6	33.8	39.8	18.8	44.6	40.1	36.5	42.2
Education									
Less than high school	11.5	5.6	6.9	15.7	19.7	14.8	25.1	21.9	26.9
High school graduate	31.9	27.5	33.1	29.8	19.7	32.1	38.3	41.1	36.8
Some college	26.5	25.5	24.5	34.6	32.9	35.0	26.3	25.1	27.1
College graduate+	30.2	41.3	35.5	19.9	27.7	18.1	10.2	11.9	9.3
Age									
18-29	21.1	15.4	21.4	26.5	1.1	32.2	27.2	27.5	27.0
30-49	32.3	28.6	33.1	37.6	40.0	31.8	34.4	46.9	27.2
50-64	27.9	29.1	30.4	25.4	30.7	24.5	23.8	19.7	26.2
65+	18.6	26.8	15.1	10.4	9.1	11.5	14.6	5.9	19.6
Race/ethnicity									
White	66.6	74.0	74.2	55.1	57.8	54.5	50.5	42.9	54.9
Black	11.5	9.7	7.3	16.0	10.1	17.4	17.4	14.0	19.3
Hispanic	14.4	8.4	11.8	17.8	26.8	15.8	25.7	36.4	19.6
Other	7.6	7.9	6.8	11.0	5.3	12.3	6.5	6.7	6.3

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Table 1. *Continued*

	Overall Sample (100%)	No Connection (36.2%)	Indirect Connection (29.9%)	Previous Direct Connection: Overall (12.0%)	Previous Direct Connection: Child-Connection (2.2%)	Previous Direct Connection: Self-Connection (9.8%)	Current Direct Connection: Overall (22.0%)	Current Direct Connection: Child-Connection (8.0%)	Current Direct Connection: Self-Connection (13.9%)
Gender									
Male	48.5	54.2	49.9	47.0	58.4	44.5	38.2	37.2	38.7
Female	51.5	45.8	50.1	53.0	41.6	55.5	61.9	62.8	61.3
Income									
<$15K	16.0	8.1	10.4	10.8	0.0	13.4	38.2	16.3	50.4
$15K-$30K	21.2	14.6	16.7	27.8	29.4	27.4	33.4	41.6	28.9
$30K-$50K	18.8	20.5	16.9	25.7	19.2	27.2	15.0	21.6	11.3
$50K-$75K	12.7	15.0	13.5	13.5	22.8	11.3	7.6	14.8	3.7
$75K-$100K	12.3	13.0	17.7	13.0	17.3	12.0	2.5	5.4	2.4
$100K+	19.1	28.8	24.8	9.2	11.3	8.7	2.3	0.3	3.5
Region									
Northeast	18.5	20.3	14.9	14.7	14.1	14.9	22.8	16.8	26.2
Midwest	21.3	22.7	22.4	19.8	12.5	21.4	18.1	18.7	17.7
South	36.8	37.2	35.8	41.1	56.8	37.6	35.4	41.0	32.2
West	22.4	19.8	27.0	24.4	16.6	26.2	23.8	23.5	23.9

[a]Respondents in nonexpansion states only ($n = 747$).

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Table 2. Results (Odds Ratio) of Ordered Logistic Regression Analysis on Medicaid Importance

	(1)	(2)
Connection to Medicaid (ref. not connected)		
Indirectly connected	1.73***	1.74***
Previously directly connected	2.16**	
Previous child-connection		1.52
Previous self-connection		2.37***
Currently directly connected	17.05***	
Current child-connection		17.61***
Current self-connection		16.88***
Stigma (ref. no stigma)		
Some stigma	0.52***	0.52***
Full stigma	0.27***	0.27***
Uninsured	1.73*	1.73*
Marketplace insured	1.19	1.19
Political party (ref. Democrat)		
Republican	0.68*	0.69*
Independent and lean Republican/Democrat	0.77	0.77
Education (ref. less than high school)		
High school graduate	0.64	0.64
Some college	0.43**	0.43**
College graduate+	0.54*	0.53*
Age (ref. 18-29)		
30-49	1.01	1.03
50-64	1.12	1.14
65+	0.86	0.87
Race/ethnicity (ref. white)		
Black	1.86*	1.85*
Hispanic	1.89**	1.91**
Other	2.16**	2.13**
Female	1.24	1.23
Income (ref. <$15K)		
$15K-$30K	0.63*	0.63
$30K-$50K	0.44**	0.44**
$50K-$75K	0.35***	0.35***
$75K-$100K	0.32***	0.31***
$100K+	0.21***	0.21***
Region (ref. South)		
Northeast	0.78	0.77
Midwest	0.72	0.72
West	0.91	0.91
F (n = 1,539)	14.73***	13.81***

$^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$

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important compared to the insured—those with nongroup private insurance (including the marketplace) are no more likely to view the program as important than those with other insurance status.

The overall model is significant and most of the control variables are significant in the predicted direction: those with higher educational attainment, higher income, and whites compared to nonwhites are less likely to view the program as important. When we detail connection status further to include whether the respondent is connected through coverage for self or child, the model findings largely hold; though, importantly, those previously connected to Medicaid through coverage of a child are no more likely to view Medicaid as important than those with no connection.

While connection to Medicaid is strongly associated with views of the program's importance, the findings change slightly when we consider views about Medicaid spending. Those who are currently covered by the program and those with an indirect connection (family and close friends) are more likely to support increases in Medicaid spending than those with no connection to the program. However, those who previously received Medicaid coverage are no more likely than those with no connection to the program to support increases in Medicaid spending (Table 3, model 1).

Stigma and partisanship are still significant, but many of the other control variables lose their significance when analyzing Medicaid spending, including those who are uninsured. Because political party affiliation is much more strongly significant in relation to views about Medicaid spending, we interacted the partisanship variable with previous connection and uninsured status to explore whether partisanship was masking the effect of these variables. With the interactions in the model, previous connection becomes weakly significant ($p < .06$), the uninsured are more likely to favor increases in spending compared to the insured, and uninsured Republicans are less likely to favor increases compared to uninsured Democrats (see Table 3, model 2).

Although previous coverage becomes weakly significant with the interaction terms in the model, breaking down connection type further to self- and child-coverage reveals that while adults covered by Medicaid either currently or previously are more likely to support increases in spending, those connected only through coverage of their children (current or previous) are no more likely to support increases in spending than those with no connection (see Table 3, model 3).

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Table 3. Results (Odds Ratio) of Ordered Logistic Regression Analysis on Medicaid Spending Support

	(1)	(2)	(3)
Connection to Medicaid (ref. not connected)			
Indirectly connected	1.52*	1.54**	1.55**
Previously directly connected	1.26	1.87#	
Previous child-connection			0.63
Previous self-connection			2.08*
Currently directly connected	1.65*	1.74**	
Current child-connection			1.46
Current self-connection			1.99**
Stigma (ref. no stigma)			
Some stigma	0.61*	0.61*	0.61*
Full stigma	0.26***	0.24***	0.24***
Uninsured	1.36	2.13**	2.38**
Marketplace insured	0.95	0.94	0.96
Political party (ref. Democrat)			
Republican	0.32***	0.40***	0.39***
Independent and lean Republican/Democrat	0.48***	0.55***	0.55***
Previous connection* Republican		0.45	0.69
Previous connection* Independent and lean Republican/Democrat		0.55	0.63
Uninsured Republican		0.22***	0.22***
Education (ref. less than high school)			
High school graduate	0.84	0.84	0.83
Some college	0.74	0.77	0.76
College graduate+	0.89	0.90	0.89
Age (ref. 18–29)			
30-49	0.90	0.92	0.98
50-64	1.10	1.16	1.20
65+	0.86	0.90	0.92
Race/ethnicity (ref. white)			
Black	1.83**	1.77**	1.73**
Hispanic	1.30	1.28	1.31
Other	1.47	1.52	1.47
Female	1.01	1.02	1.01
Income (ref. <15K)			
$15K-$30K	1.23	1.23	1.33
$30K-$50K	1.04	1.05	1.13
$50K-$75K	0.76	0.76	0.84
$75K-$100K	1.05	1.05	1.14
$100K+	0.72	0.72	0.77

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Table 3. *Continued*

	(1)	(2)	(3)
Region (ref. South)			
Northeast	0.83	0.81	0.79
Midwest	1.06	1.07	1.04
West	0.94	0.95	0.92
F (n = 1,525)	5.71***	5.53***	5.42***

$^{\#}p < 0.06$, $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$

Analyzing support for the Medicaid expansion reveals a slightly different dynamic. This question was only asked of respondents living in states that had not adopted the Medicaid expansion by 2015. In these states, perceived stigma and partisanship are strongly significant in all the models. However, controlling for stigma and partisanship, those with current Medicaid coverage and indirect coverage through family and close friends are still more likely to support the Medicaid expansion than those with no connection (Table 4, model 1). However, when we add the partisanship and uninsured status interaction terms, only current self-connection and those indirectly connected (through family and friends) are significant. Again, those connected through child coverage (current or previous) are no more likely to support the Medicaid expansion than those with no connection (see Table 4, models 2 and 3). Finally, uninsured status is only weakly significant ($p < .06$), which is somewhat surprising because the Medicaid expansion would most advantage a large proportion of the currently uninsured in these states.

Discussion

Several important findings emerge from this research. First, people currently and previously covered (24%) and those with an indirect connection (30%) are more likely than those with no connection to the Medicaid program to say the program is important, support spending increases in Medicaid coverage, and support state adoption of the Medicaid expansion. These findings suggest that for people with these types

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Table 4. Results (Odds Ratio) of Logistic Regression Analysis on Medicaid Expansion Support

	(1)	(2)	(3)
Connection to Medicaid (ref. not connected)			
Indirectly connected	1.98**	1.97*	1.98*
Previously directly connected	0.78	0.79	
Previous child-connection			0.77
Previous self-connection			0.77
Currently directly connected	2.44*	2.42*	
Current child-connection			1.37
Current self-connection			4.08**
Stigma (ref. no stigma)			
Some stigma	0.44*	0.44*	0.42**
Full stigma	0.16***	0.16***	0.15***
Uninsured	3.02*	2.56	3.18#
Marketplace insured	0.94	0.94	0.98
Political party (ref. Democrat)			
Republican	0.34**	0.33**	0.33***
Independent and lean Republican/Democrat	0.86	0.85	0.86
Uninsured* Republican		1.50	1.53
Education (ref. less than high school)			
High school graduate	1.30	1.29	1.38
Some college	2.00	1.97	2.07
College graduate+	2.41	2.38	2.54
Age (ref. 18–29)			
30-49	0.51	0.51	0.49#
50-64	0.37**	0.37**	0.35**
65+	0.66	0.66	0.62
Race/ethnicity (ref. white)			
Black	2.11#	2.14*	2.14#
Hispanic	1.34	1.35	1.39
Other	1.26	1.23	1.29
Female	1.07	1.07	1.07
Income (ref. <15K)			
$15K-$30K	1.47	1.48	1.70
$30K-$50K	0.60	0.59	0.72
$50K-$75K	0.60	0.60	0.71
$75K-$100K	0.60	0.60	0.70
$100K+	0.70	0.70	0.82
F (n = 596)	3.18***	3.08***	3.04***

#$p < 0.06$, *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

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of connections, the Medicaid program is creating a positive feedback effect, even controlling for partisanship and stigma. This is important because 54% of respondents from a nationally representative survey fell into these categories.

We cannot predict whether this support would translate into political mobilization. Indeed, one study suggests that in places where there is a high density of Medicaid coverage, political participation decreases.[44] However, this study only considered current Medicaid coverage. Our findings reveal that those with an indirect connection to Medicaid are similar to those currently covered by the program in their view of program importance and support for spending increases and coverage expansion.

We also do not claim that public opinion will directly affect policy outcomes. The process that produces policy outcomes is complex, and multiple factors always impact the development and crafting of public policy.[60-62] For example, there are other key factors reinforcing Medicaid, such as strong support from various health care providers and many state governors and legislators. Meanwhile, the rise of the conservative network, which has pushed Republican policymakers even further to the right of their core partisan followers, has acted as an important threat to Medicaid in conservative states.[63] Nonetheless, numerous studies confirm the importance of public opinion in shaping policy, especially when the policy is politically salient.[13,64,65] Most important for this study is to distinguish between the influence of public opinion and constituent opinion—the latter is the policy feedback effect we discussed previously. We focus specifically on opinions of Medicaid constituents (ie, those connected in various ways to the Medicaid program). Studies suggest that it is under times of retrenchment that the threat of losing benefits mobilizes constituents in support of benefits to action.[18,47,66]

Medicaid retrenchment was at the center of the debates over the repeal and replace bills during the summer of 2017. Several key Republican governors who passed the Medicaid expansion suggested they were keeping a close watch on the opinions of their constituency and especially those constituents who have Medicaid coverage.[67-69] Three Republican senators—Susan Collins (ME), Lisa Murkowski (AK), and John McCain (AZ)—broke with their party to vote down BCRA. As the *Bangor Daily News* in Maine reported, "What actually happened shows how much citizens mattered in the health care fight. . . . On health care, Collins did not start where she ended and she shifted after considerable grassroots

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action."[70] Moreover, preliminary research (C. Bersamira, A. Abraham, C. Grogan, H. Pollack, and B. Smith, unpublished data, 2017) suggests that many state actors involved in Medicaid reforms are proceeding as if repeal and replace efforts will not succeed.

Second, perceptions of Medicaid stigma remain strongly associated with support for the Medicaid program. Although the percent who view Medicaid as stigmatizing is small (about 20% overall), they are more likely to say the program is not important and to reject increases in Medicaid spending and adoption of the Medicaid expansion. Thus, although Medicaid has expanded dramatically, and this expanded constituency connected to the program is much more supportive of it, beliefs about Medicaid stigma persist and these beliefs influence support for the program. Thus, there is some evidence of Medicaid facing a persistent but unequal conflict between a relatively small group who view Medicaid as a stigmatizing welfare program and a much larger group who view Medicaid as an important nonstigmatizing entitlement.

Third, people who received Medicaid coverage for their children (currently or in the past) are no more likely to support spending increases or expansion than those with no connection. And those with previous coverage for their children are no more likely to view Medicaid as important. This finding is puzzling especially in light of the significance of those indirectly connected. Why would those with an indirect connection be more likely than those with a child connection to support spending and expansion? We offer 3 possible explanations.

First, it might be that state efforts to destigmatize Medicaid by changing the name of the program, especially for SCHIP (now just CHIP)—which creates the connection only through children—and Medicaid expansion programs may have been so successful that the people enrolled in these programs do not actually know they are (or were) on Medicaid. The survey questions used for this study were worded in such a way that this could be true. When asking about whether a respondent's child was covered under Medicaid, the question was worded: "Does any child under the age of 19 in your household currently have health insurance through Medicaid, also known in your state as [insert state name], or not?"

However, when respondents were asked about changes in Medicaid spending, the question only used the term "Medicaid"; that is, they did not follow with "also known in your state as [insert state name]." Because states made a concerted effort to distance their SCHIP/CHIP coverage

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from the Medicaid program, it is conceivable that people receiving this coverage for their children do not actually view it as Medicaid coverage. If this is the case, it is not surprising that their view about Medicaid spending and the Medicaid expansion is, all else equal, similar to those with no connection to Medicaid.

Second, another important policy change occurred alongside the adoption of SCHIP. Starting in the early 1990s, a number of states began reforming their Medicaid programs to contract out with Medicaid managed care organizations (MCOs) to provide services primarily to nonelderly and nondisabled adults enrolled in Medicaid. Today, almost all US states contract with MCOs; 77% of Medicaid enrollees were enrolled in an MCO as of July 2014.[71] The use of MCOs is (and has been) especially prominent for those enrolled in CHIP (with coverage only for their child[ren]). Thus, not only do people sign up for Healthy Michigan, but they must also enroll in a health plan, such as a "Blue Cross Complete" plan, allowing another layer of confusion as to whether they are enrolled in Medicaid. It is quite possible that many enrollees believe they are privately insured through their private MCO plan and have lost awareness of their status as Medicaid enrollees.

Third, it could be that people connected to Medicaid only through their children do have a more restrictive view of whom the program should be for and what its purpose should be. Perhaps because these respondents are working and only their children are eligible for coverage (by program design) and because many states often require them to pay premiums and some cost-sharing, they might feel resentment toward people on "regular" Medicaid. This view is well illustrated by an interview detailed by VOX news reporter Sarah Kliff[58]:

> "[Kathy] had enrolled on Medicaid for a few months, right before she started this job. She was taking some time off to care for her husband, who has cancer and was in chemotherapy treatment. [The reporter] asked how she felt about enrolling in a program she sometimes criticizes.
> 'Oh, no,' [Kathy] said quickly. 'I worked my whole life, so I know I paid into it. I just felt like it was a time that I needed it. That's what the system is set up for.'"

Notice that Kathy is the same person quoted earlier in this article as saying, "I really think Medicaid is good, but I'm really having a problem with the people that don't want to work. Us middle-class people are really, really upset about having to work constantly, and then these

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people are not responsible." Kathy seems to view Medicaid as appropriate for those in need, but only temporarily, if they can work. Because respondents currently connected to Medicaid only through children are also more likely to say Medicaid is very or somewhat important to them than those with no connection, but don't believe spending should be increased or eligibility expanded, their view seems to align with Kathy's that Medicaid is appropriate as a last resort for the "truly needy." Such respondents further agree with Kathy's view that while she (and others like her) have earned it—90% of those who were on CHIP say they would sign up for Medicaid if they or their children were eligible—others on "regular Medicaid" may not be as deserving. Other studies reveal similar views about deservingness among low-income working Americans about other people on means-tested public assistance programs.[72,73]

Unfortunately, the survey data used for this research do not allow us to explore these possible explanations. Future research should probe more deeply into whether people with different types of connection to Medicaid view the program differently, and, if so, how and why. Moreover, future research should also explore more thoroughly whether state-level attempts to destigmatize and increase take-up into public programs also hide the role of the state so much so that constituents do not realize the true source of their benefits.

Mettler shows that hiding the role of government in various subsidized programs is part of a broader phenomenon in the American welfare state.[48] Public subsidies received through tax exemptions, such as employer-based health insurance, are so well hidden from view that many people who benefit from such programs do not believe they have ever received a public subsidy, which influences their view of government in general and hence of public programs. Her study reveals an implicit process of submerging the role of the state, especially for certain groups of people, through the design of public policies.

In the case of American health care policy, the process might be more explicit. Perhaps taking a cue from the SCHIP experience, states similarly attempted to delink their state-run marketplaces and their state Medicaid expansion programs from the ACA, or the more politically contentious "Obamacare." Kentucky, for example, calls its marketplace "Kynect" and has sought to disassociate it from the ACA. The enrollment outreach workers actively hide the connection: "When we're approaching people about getting signed up on health care, one of the first questions

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they have is, 'Is this Obamacare?' So we would tell them, 'No, this is not Obamacare. This is a state-run plan.'"[58]

Stories like this suggest that if CHIP enrollees are subject to similar outreach efforts for AllKids in Illinois and PeachCare in Georgia, for example, it may be that they are sufficiently unclear whether Medicaid is indeed the program they benefit from. They are logically confused because Medicaid is no longer referred to as "Medicaid." Instead, because states have also intentionally created multiple types of Medicaid programs, each with a different name and set of rules for who is eligible, it may be that constituents feel connected to their particular program but not to Medicaid as a whole. Do people who, for example, are indirectly connected to Medicaid through their elderly parents in a nursing home fight against Medicaid retrenchment for low-income families, or just against retrenchment to the long-term care side of Medicaid?

Policy Implications

For policymakers concerned about creating a more politically stable and sustainable policy environment for Medicaid, they might want to reconsider 2 common practices of framing and describing the Medicaid program. First, as discussed above, the common effort to destigmatize particular programs within Medicaid by rebranding what it is called and explicitly marketing the program as "not Medicaid" may have produced program stability costs and an unintended effect of increasing perceived stigma of those who remain on "regular Medicaid." It is a more nuanced form of stigma that the survey used herein could not capture.

Second, and somewhat similar, Medicaid has often been described and administered as 3 separate programs: (1) long-term care for the elderly, (2) long-term care for the disabled, and (3) acute health care for poor and low-income families. Because states have shaped their programs in different ways for these groups, another unintended consequence might be that each program shapes a set of policy views and political preferences unique to that particular program.[74]

Given this, a key policy recommendation would be to embrace the "Medicaid" name, rather than hide it, with the intent to increase knowledge and familiarity about the program's broad-based constituency. The American public and Medicaid recipients in particular deserve a clear

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and honest depiction of the largest health care program in the United States—its purpose, who it is intended to serve, and what is common across all of Medicaid's constituent groups.

Conclusion

This research finds that people with a connection to the Medicaid program—now over 60% of Americans—are more likely to view the program as important than are those with no connection. However, when it comes to increasing spending or expanding the program, the type of connection to the program matters. In particular, adults with current and previous Medicaid coverage and those with a family member or close friend with Medicaid coverage—54% of Americans—are more likely to support increases in spending. This is true even controlling for the impact of partisanship and perceived stigma on support for Medicaid. Yet, those connected to Medicaid through a child are no more likely to support increases in spending than are those with no connection.

Connection type matters for views about adopting the Medicaid expansion as well. The same patterns emerge, however, even among those with previous self-coverage; they are no more likely to support Medicaid expansion than those with no connection. As predicted, in the case of support for the Medicaid expansion, partisanship plays a stronger role. Nonetheless, particularly important about these findings is that 80%-90% of respondents from these groups report no hesitation about signing up for Medicaid if they need it, suggesting that their lack of support is not related to views about welfare stigma, at least in the traditional sense. Members of such groups may believe that they themselves are deserving of benefits and, at the same time, believe that other groups on the program are not deserving.

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