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# Administrative Burdens in Health Policy

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## Abstract

The US healthcare system is enormously complex, begetting a seemingly endless array of bureaucratic obstacles that make it both costly and difficult to navigate for users. We apply the administrative burden framework to three particular aspects of health policy: the Affordable Care Act (ACA), Medicaid, and Medicare. The applications are more illustrative than definitive, intended to demonstrate that administrative burdens play a key and underappreciated role in how policies are implemented, sometimes deliberately so. The following claims arise from our framework. First, burdens are consequential – they make a difference in our lives, most obviously in terms of access to healthcare. Second, administrative burdens are distributive: some groups, like the poor, are more burdened than others. Third, burdens are a function of political and administrative choices, constructed via processes of both policy design and implementation.

**Keywords:** Administrative burdens, Medicaid, Medicare, Affordable Care Act

## Points for Practitioners

- Administrative burdens are barriers that making accessing services onerous; they are frictions that can be categorized as learning, compliance, and psychological costs.
- Administrative burdens are not mere administrative details. They shape how individuals experience government, and are often the difference between whether people do or do not receive critical services.
- Policymakers and administrators construct administrative burdens through policy design and implementation. In some cases they may not understand the negative impact of burdens. In recent years, however, burdens have become a primary policymaking tool in contemporary health policy, used to undermine fundamental goals of policies like Medicaid.
- Burdens can exacerbate inequality when they are targeted at more vulnerable groups.

## Introduction: What are Administrative Burdens?

Administrative burdens are the frictions of interacting with government, the experience of policy implementation as onerous (Burden, Canon, Mayer, & Moynihan, 2012) and arise via three primary mechanisms: the costs that people encounter when they search for information about public services (learning costs), respond to rules and requirements (compliance costs), and experience the stresses, loss of autonomy, frustrations or stigma that come from such encounters (psychological costs) (Herd & Moynihan, 2018). Table 1 provides more detail.

**Table 1.** The Components of Administrative Burden

Learning costs	Time and effort expended to learn about the program or service, ascertaining eligibility status, the nature of benefits, conditions that must be
Compliance costs	Provision of information and documentation to demonstrate standing; financial costs to access services (such as fees, legal representation, travel costs); avoiding or responding to discretionary demands made by
Psychological costs	Stigma arising from applying for and participating in an unpopular program; loss of autonomy that comes from intrusive administrative supervision; frustration at dealing with learning and compliance costs, unjust or unnecessary procedures; stresses that arise from uncertainty about whether citizen can negotiate processes and compliance costs.

*Adapted from:* Herd and Moynihan 2018

Cumulatively, these burdens color our experience and perception of government, and more specifically as we describe here, the health care system. They are, to some degree, inevitable, but they are often deployed unnecessarily. We make three basic claims to demonstrate why burdens are relevant to public policies. First, burdens are consequential – they make a difference in our lives. Second, administrative burdens are distributive, some groups, like the poor, are more burdened than others. Third, burdens are a function of political and administrative choices.

To our first point, that burdens are consequential: they have large effects on whether people are able to gain access to publicly supported health insurance. Estimates of Medicaid take-up rates – that is, the percentage of eligible individual claimants who actually access a service – vary a good deal, but typically find that anywhere from 30 to 50 percent of eligible beneficiaries do not access Medicaid (Herd & Moynihan, 2018). Among the non-elderly eligible for Medicaid and not receiving other health insurance, seven out of ten participate in the Medicaid program. Take-up rates vary significantly across states, ranging from 48 percent in Texas to 96 percent in the District of Columbia (Kenney, Haley, Pan, Lynch, & Buettgens, 2016). This variance in take-up cannot be alone explained by variance in the nature of the people living in these states, or the benefits on offer, but also differences in the costs citizens face in seeking to access the benefit, an observation best illustrated by changes in such costs in short periods of time, such as efforts by state governments to dramatically increase or reduce take-up by managing learning, compliance and psychological costs (Herd, DeLeire, Harvey, & Moynihan, 2013).

Second, administrative burdens are distributive. They affect some groups more than others, and in doing so, tend to reinforce inequalities in society. Administrative burdens play a central role in determining who receives publicly supported health insurance, as well as when, how, and where (Michener, 2018). If burdens are the product of governmental rules and procedures, do they help or hurt some groups more than others? If so, who are the winners and losers?

Those who are least advantaged tend to more systematically face burdens, even as they have fewer resources to manage and overcome them. In general, those who lack political power or who are seen as undeserving tend to be less successful in winning benefits from the policy process (Schneider & Ingram, 1997), and the same insight applies to administrative burdens: those who are powerless or are categorized as undeserving are more likely to be targeted with burdens. Using Schneider and Ingram's framework, Medicaid beneficiaries traditionally fall into the category of "contenders" – sympathetic but with limited political power. This means they may be more subject to burdens, especially if politicians can shift the framing of beneficiaries from being contenders to "deviants" i.e. those viewed unsympathetically and with little political power. For example, the recent attempts impose work requirements for Medicaid beneficiaries assumes that beneficiaries are so likely to shirk societal responsibilities that they must routinely document their work history.

And while we are largely focused on government sponsored health insurance and health care here, it is critical to understand that for many Americans, especially poor Americans targeted for Medicaid, the experience of government is predominantly the experience of burdens. Individuals applying for Medicaid are also likely applying for other means tested programs like the Supplemental Nutrition Assistance Program, what is colloquially known as food stamps. These same individuals are also less likely to have IDs or live in neighborhoods that provide sufficient polling places, making it harder to access the right to vote. Poor women are disproportionately more likely to have unplanned pregnancies and also to need access to abortion services—which many states are making more difficult to access; shuttered clinics, due to unreasonable and unnecessary regulations, and mandatory waiting periods all increase the already high costs of getting an abortion, further ensuring it is an out of reach for poor women (Herd & Moynihan, 2018). In short, it is not just that policies targeted at the poor are more burdensome; it is that the poor are more likely to experience government as routinely burdensome.

Third, burdens, like public policies themselves, are constructed via administrative and political choices, and therefore central to policymaking and politics. In some cases, burdens may arise inadvertently, through history, accident, limited administrative capacity, or lack of foresight. In other cases, burdens serve legitimate purposes, such as program integrity. But political ideology or policy preferences also lead politicians to use burdens to make government a source of hindrance rather than help. Policymakers sometimes deliberately construct administrative burdens – as a complement or alternative to traditional forms of policymaking – to achieve their policy goals.

Fights over burdens are fights about political values, such as access or program integrity or the deservingness of recipients. The venues for these fights are often within and between bureaucracies, such as waiver applications in Medicaid, where values are converted into bureaucratic logics. As far back as the Nixon administration, distributive programs have been designed to ensure there are no mistaken payments to ineligible beneficiaries, rather than ensuring that eligible beneficiaries receive needed benefits (Brodkin, 1987). Federal quality control guidelines offered states stronger incentives to avoid overpayment rather than to enroll eligible participants (Hanratty, 2006). During the George W. Bush

administration, the White House used this technique to curb state efforts to expand Medicaid, pressuring state governments to reduce take-up error rates in Medicaid – and consequently increase administrative burden (Thompson, 2012). Ultimately, the Obama administration withdrew the policy, amidst threats of litigation from states over the failure of the Bush administration to follow the rulemaking process for this relatively dramatic reinterpretation of law.

### **Learning Costs in the Affordable Care Act**

The ACA, like the U.S. health care system, is complex. The sustained publicity stemming from the political opposition to Obamacare might be expected to help to reduce learning costs. But general awareness of the program, and even targeted outreach efforts, did not eliminate significant learning costs that come from determining individual eligibility and benefits for a new and complex program, or sorting through the suitability of competing plans. A Commonwealth Fund (Collins, Gunja, Doty, & Beutel, 2016) survey found that nearly half of those uninsured were simply unaware of the Medicaid expansion or financial subsidies for private Marketplace plans. A 2017 poll found that one-third of individuals did not know that Obamacare and the ACA were the same policy, with the highest confusion among those with lower incomes (Dropp & Nyhan, 2017).

To address this problem the Obama administration used an extensive outreach campaign to explain the program, show people how they could benefit from it, and help them enroll for health insurance. It also funded “navigators” who could further reduce learning and compliance costs by helping people to enroll in the program.

Providing help to potential applicants mattered to enrollment. A 2014 Urban Institute survey found that among previously uninsured adults, those who had benefited from application assistance were more likely to have enrolled through the marketplace – more than half of enrollees had used assistance, compared to less than a third of non-enrollees (Dorn, 2014). A 2016 survey found that among individuals whose were income-eligible and ultimately enrolled, and accounting for demographic differences, 77 percent had received assistance, compared to 60 percent of those who received no personal assistance (Collins, Gunja, Doty, & Beutel, 2016). Administrative data obtained from the Center for Medicare and Medicaid Services (CMS) also found that among those uninsured who visited the marketplace, the biggest difference between those who enrolled and those who did not was in whether they had received personal assistance (Dorn, 2014). Outreach and messaging therefore had a positive effect on giving citizens access to a product that could significantly improve their quality of life.

Those ideologically opposed to the ACA saw undermining outreach as a way to hobble Obamacare. The Insurance Commissioner in Georgia spelled out this approach: “Let me tell you what we're doing. Everything in our power to be an obstructionist. We have passed a law that says that a Navigator, which is a position in that exchange, has to be licensed by our Department of Insurance. The Obamacare law says that we cannot require them to be an insurance agent, so we said fine, we'll just require them to be a licensed Navigator. So, we're going to make up the test, and basically you take the insurance agent

test, you erase the name, you write 'Navigator test' on it" (Herd & Moynihan, 2018, p. 109).

Republican governors restricted navigators seeking to help people enroll in the ACA (Herd & Moynihan, 2018). Thirteen states adopted regulations that hindered assisters, such as additional fees, residency requirements, and background checks including fingerprinting, training and examinations and evidence of financial responsibility. Ten of those states had Republican legislative control, while two others had split-party legislative control but with Republican Governors. While the ACA prohibited requiring navigators to carry malpractice coverage, some states asked navigators to show financial capacity to protect themselves against liability. Eleven states limited what navigators could discuss with clients, including advice regarding the benefits, terms, and features of the health insurance plans, or making comparisons between plans, which heightened client learning costs.

The Trump administration, too, adopted actions that would increase learning and compliance costs. Trump's first secretary of the Department of Health and Human Services (HHS), Tom Price, outlined an early blueprint to undermine the ACA if legislative efforts to repeal failed, in large part by increasing administrative burdens on participants. He suggested shortening the period when people could enroll for the ACA, tightening grace periods for individuals to pay late premiums, and requiring more documentation to enroll during special enrollment periods. HHS implemented some of these proposals, such as shortening the enrollment period from 3 months to 45 days. It also made Healthcare.gov less accessible via more frequent shutdowns, and largely eliminated advertising of the program during the enrollment period and slashed the navigator budget from \$63 million to \$10 million (Brooks 2018).

The lack of outreach has increased learning costs and hurt enrollment. A Kaiser Family Foundation poll found that only one in four people who buy their own insurance knew the application deadline for 2019. Enrollment dropped 4 percent in 2019, with a 15 percent drop in first-time enrollees (Goldstein, 2018).

### **Medicaid Work Requirements: The Case of Arkansas**

Along with the expansion of Medicaid eligibility in the ACA, the legislation also attempted to reduce administrative burdens in the Medicaid program. Indeed, in the years following its enactment states made enrollment processes easier through a range of mechanisms, such as expanding enrollment options to include internet, phone, and mail, by drawing on existing administrative data to verify eligibility rather than requiring participants to chase down documentation, as well generally reducing documentation requirements (Weiss & Sheedy, 2015). But just as the Trump Administration increased burdens in the ACA by exacerbating learning costs, they also looked for ways to expand burdens in the Medicaid Program.

Perhaps the best example of the Trump administration's deployment of administrative burdens is the use of work requirements. The Trump administration released an executive order on April 10, 2018 that directed agencies to deploy "work requirements when legally permissible" in means-tested social programs. But even before that order, CMS

Administrator Seema Verma had already telegraphed her desire to impose work requirements into Medicaid. In late 2017, she told state policymakers: “The thought that a program designed for our most vulnerable citizens should be used as a vehicle to serve working age, able-bodied adults does not make sense...These are individuals who are physically capable of being actively engaged in their communities, whether it be through working, volunteering, going to school or obtaining job training. Let me be clear to everyone in this room, we will approve proposals that promote community engagement activities” (Pear, 2017, p. A19). Ten states, all led by Republican Governors, quickly sought waivers from the Trump administration to impose work requirements. The nature of the work requirements varied, though all are required to exempt people with disabilities, pregnant women, and the elderly. However, individuals exempt from these requirements will need to document and prove those exemptions, itself a form of administrative burden.

The issue of work requirements is a fascinating example of the slippery nature of espoused political values in justifying burdens, and the role of evidence in rebutting political claims. The primary justification for work requirements is economic: to increase employment by moving people from welfare (that is, health insurance) to work. While increased labor force participation is a valid political goal, the statutory goal of Medicaid is not to increase employment, but to improve access to healthcare. The Medicaid Act seeks to enable each state “to furnish medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” The law specifies that waivers are only to be provided to the extent that they facilitate the objectives of the Medicaid Act.

The addition of work requirements faced legal challenges because, plaintiffs argued, CMS used the waiver process to undermine the statutory intent of Medicaid. This posed a problem for the Trump administration. And so, they claimed that the work requirements did not just enhance the economy, they would also improve health outcomes because those who are working tend to enjoy better health. This argument, however, ignores that many people enroll in Medicaid precisely because they are in poor health. Moreover, there is no evidence to suggest that removing health coverage, or other types of welfare, from those who are not working improves health. Instead, the opposite is closer to the truth. A randomized control trial of a Florida program that made benefits conditional on workforce participation found that participants had a 16 percent higher mortality rate 18 years later relative to a control group not subject to such conditionality (Muennig, Rosen, & Wilde, 2013). Another study found that welfare reform programs that emphasized quick entry into the workforce contributes to depressive symptoms among parents with pre-school age children (Morris, 2008). Workfare thus appears to worsen, rather than improve, health outcomes. The Trump administration also ignored heterogenous effects in the relationship between work and health. Those working in low-wage jobs are especially likely to have health problems, many of which start in childhood, (see, e.g., Marmot et al., 1991). As the US labor market has shifted from jobs with stable hours to more precarious forms of employment, the type of low-wage jobs with uncertain schedules on offer for Medicaid

beneficiaries are also associated with psychological distress and poor sleep quality (Schneider & Harknett, 2019).

A closer look at the logic behind work requirements illustrates why these burdens create costs with little gain. Almost all non-disabled working-age Medicaid-eligible individuals are already working (Silvestri, Holland, & Ross, 2018). This means there is not a large population of unemployed claimants ready to move into the workforce. Work requirements therefore cannot solve a problem – low labor-force participation among Medicaid beneficiaries – that does not exist. On the other hand, if most are already working, what is the problem with the requirements? To answer this question means that to understand the effects of work requirements in Medicaid we need to properly understand them as *work-reporting requirements*, since it is the reporting part that causes people to lose health insurance.

Reporting work means documenting work activity or exemption from the requirement because of a disability, a pregnancy, or another status. For many working in informal low-income, self-employed or service jobs, work documentation may not be straightforward. Work-reporting requirements assume stable work patterns. Arkansas, which at time of writing is the only state that has implemented the requirements, required people to work 80 hours per month. But low-income workers in the service industry have unstable hours, where they may be called in to work for 40 hours one month, and 120 hours the next (Schneider & Harknett, 2019), meaning they may be locked out of the program because of the shifting commodification of work by employers. The work-reporting requirements also assume it is easy to document work, which is less likely to be the case for more informal work, or self-employed workers.

Work-reporting requirements may pose a difficulty for people because of learning costs. With any new program it takes a great deal of effort and communication to make the public aware. For example, with the creation of Social Security, the federal government undertook a huge informational campaign solely focused on communications and outreach, including an entire organization that directed promotional films (Herd & Moynihan, 2018). The probability that the public will be closely attuned to *administrative changes* in an existing policy is much lower, especially if those changes are poorly advertised. People generally assume that existing policies will continue to work as they have. A qualitative study of Arkansas Medicaid recipients found that two-thirds had not heard about the change (Greene, 2018): “First time I’ve ever heard anything [about it],” a 31-year old man, who had started a vocational training program the day we spoke, said. “You’d think it’d be on the news or something. I ain’t seen it on the news, and I watch Channel 8 news every night.” Others echoed his surprise: “I’ve never even heard of it” and “I can’t believe I ain’t heard something about it on the news.” (Greene 2018).

The compliance costs of documentation create a new demand on all recipients, but will be especially intense for those with low administrative literacy. In the case of Arkansas, reporting was online-only. But 30 percent of Medicaid adults report they never use a computer, 28 percent say they do not use the internet, and 41 percent do not use email. It is unrealistic to expect that such a population will possess the

technological literacy to navigate online documentation processes (Garfield, Rudowitz, Musucemi, & Damico, 2018).

The evidence from Arkansas was discouraging. Almost 17,000 people have lost health insurance coverage in just four months. The state did not track these individuals, so it was possible that they had found insurance in the private sector with new jobs. But this proved not to be the case. An analysis in the *New England Journal of Medicine* tracked the effects on 6,000 Medicaid recipients, focusing on 30-49 year-old recipients in Arkansas, but using recipients in Kentucky, Texas and Louisiana as controls (Sommers, Goldman, Blendon, Orav, & Epstein, 2019). The results demonstrated that work requirements did not increase labor market participation, and those who lost insurance had largely not found new coverage.

At the same time, the results validated concerns about significant loss in Medicaid take-up because of reporting requirements. Coverage of low-income adults declined from 70.5 percent to 63.7 percent, even though 95 percent of those who lost benefits were actually completing the required work or should have qualified for an exemption. The problem was that they could not overcome the onerous reporting processes. Learning costs played a significant role. One-third of those affected had not heard about the new requirements, and 44 percent were unsure if they applied to them. Compliance costs also played a role: one-third of adult Medicaid recipients in Arkansas lack access to the internet, making the online-only reporting process a major barrier. In short, a policy justified as increasing work not only failed in that goal, but instead caused large numbers of low-income beneficiaries to lose health insurance, for which they were eligible, because of administrative burdens.

### **Lost in The Medicare Maze**

Thus far we have focused on the ACA and Medicaid, because, in general, burdens are more likely to occur in means-tested programs – where individuals must routinely document their eligibility (Herd & Moynihan, 2018). However, Medicare illustrates how learning, compliance and psychological costs can arise in what is nominally a universal program for older adults. In the case of Medicare, the partial privatization of the program, specifically the inclusion of private health insurers, is amplifying burdens. Over one-third of current Medicare beneficiaries are exclusively covered by private insurers through Medicare Advantage, and a majority of the remainder have supplemental private coverage. Calls for Medicare-for-All are at least partly based on the assumption that Medicare is a ‘single payer’ system (or could be made so). In reality, Medicare is a mixed public and private system. The third-party actors embedded in Medicare profit from increased administrative burdens, making efforts to reduce burdens less likely to arise or succeed.

Starting in the 1980s, Medicare allowed a larger role for non-public actors, specifically private health insurers. Beneficiaries could enroll in an array of private health insurance plans, in addition to traditional Medicare. While debates over private insurers were contentious, little attention was paid to their implications for administrative burdens. Today, more than one-third of Medicare beneficiaries are covered by private insurers, in

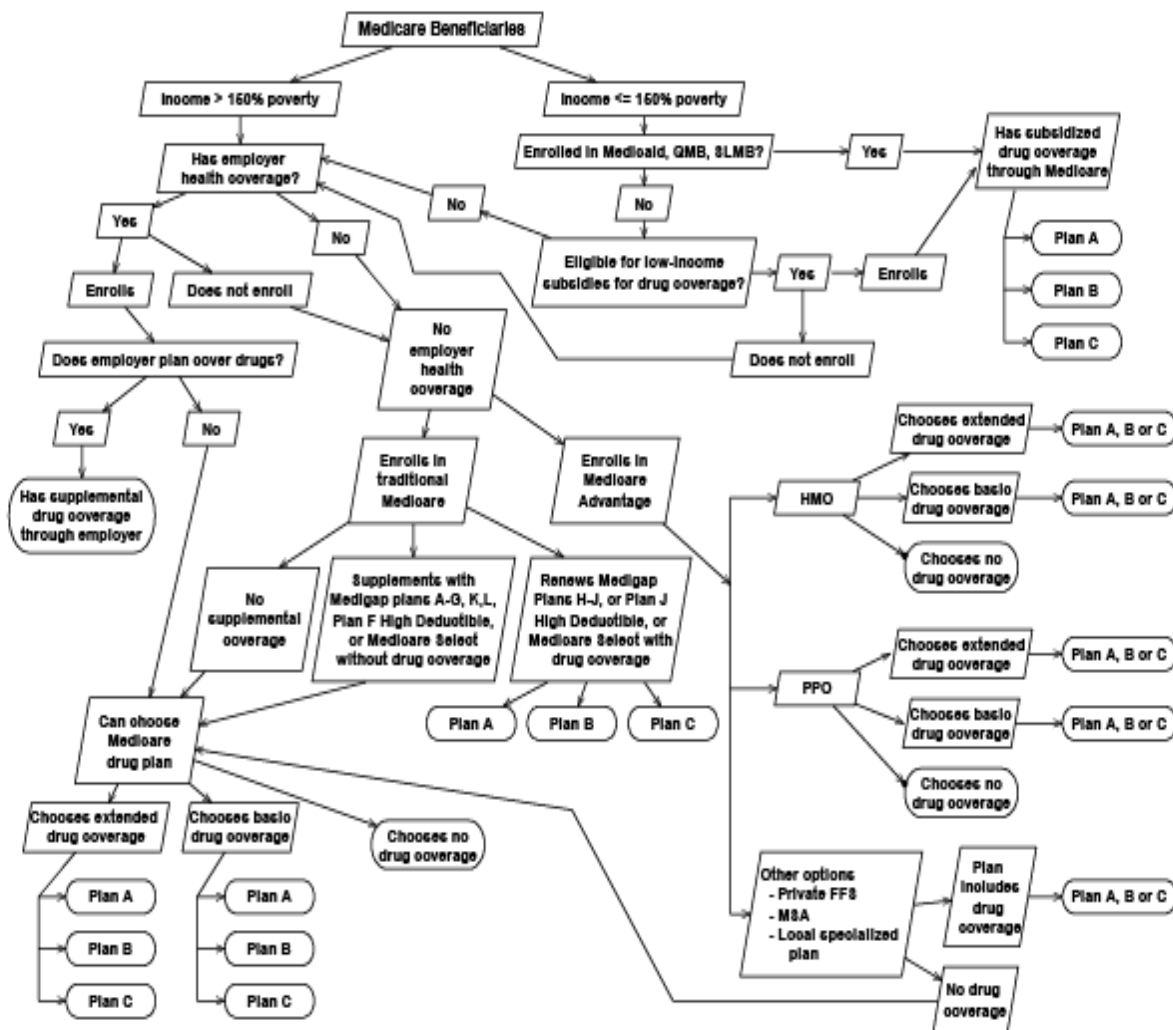


what is known as the Medicare Advantage program (Jacobsen, Damico, & Nuemann, 2018). Many of the remaining beneficiaries have private insurance coverage, through Medigap and Medicare Part D prescription drug coverage or their former employers, to help offset the health care costs not covered by Medicare Parts A and B, which amount to almost half of the overall cost of their care (De Nardi, French, Jones, & McCauley, 2016). In fact, 44 percent of Medicare dollars goes through private insurance plans and a majority of Medicare beneficiaries must interact with private insurers.

Signing-up for private-plan options is enormously complicated, and it is not a one-off process – it is a decision revisited annually, during an open enrollment period. An individual must choose between traditional Medicare or Medicare Advantage; and a variety of Medigap and Prescription Drug plans that change annually. Figure 1 illustrates the complexity of the process. Though there is a base benefit package, there are also many and varied options, ranging from which prescription drugs are covered to the amount of premiums, co-payments and deductibles.

Figuring out the right insurance is difficult, given that both individual health needs and the plans on offer vary every year. Choice overload theory proposes that people presented with more and more options become less motivated to choose and make poorer decisions, with empirical evidence appearing to support this point in the context of health insurance (see, e.g., Jilke, Van Ryzin, & Van de Walle, 2016). Greater choice has led to greater confusion and learning costs, resulting in poorer decisions and outcomes in healthcare programs (e.g., McWilliams, Afendulis, McGuire, & Landon, 2011). The risks of poorer outcomes can be expected to become greater as older adults experience cognitive decline and reduced executive function (Christensen, Aarøe, Baekgaard, Herd, & Moynihan, 2020). Studies find that older adults are overwhelmed and frustrated, being asked to complete complex demands as they face cognitive declines. As one recipient noted, “There are days when I look at a plan, or look at my plan, and I think about the possibility of making a change...I’ve reached the age of 78 and I’m saying to myself, ‘I’m too goddamn tired to investigate this’” (Jacobsen, Swoope, Perry, & Slosar 2014, p. 14).

Getting the best coverage for the lowest costs requires switching plans nearly every year but overwhelmed by the choices, most stick with the status quo (Zhou and Zhang 2012). As the mechanisms for competition between insurers are defused, individuals make suboptimal choices and face higher health costs, and the Medicare program fails to see the promised cost-saving. One study found that only 5 percent of Medicare beneficiaries choose the prescription drug plan that will cover their costs for the lowest price (Zhou & Zhang, 2012). Providing personalized information about which plans best match with healthcare needs increases switching (Kling, Mullainathan, Shafir, Vermeulen, & Wrobel, 2012), but private insurers stand to benefit from such consumers not shopping around, giving them little incentive to reduce learning costs.



**Health Insurance Decisions Facing Medicare Beneficiaries**

Source: Hanoch and Rice (2006)

**Conclusion**

American health policy is riddled with administrative burdens that impact not just whether people can have health insurance, but ultimately whether they can access care. The types of burdens, however, vary across policy. While Medicaid is characterized by learning and compliance costs that influence whether people can get, and keep, any health insurance. In contrast, Medicare’s administrative burdens are largely learning costs that influence the quality and cost of beneficiary coverage.

In addition, the examples point to some broad conclusions. First, the generally opaque nature of administrative burdens makes them valuable as a form a “policymaking by

other means.” Where overt changes are unpopular (such as reducing benefits), administrative burdens offer a low-profile alternative. For example, directly changing Medicaid benefits requires legislative battles. By contrast, constructing complex, confusing, and time-consuming application procedures is a less visible form of policymaking that can effectively thwart an individual from accessing benefits, even if they are eligible by law. In short, burdens are one of the tactics of contemporary political warfare that have profoundly shaped American’s access to key public health insurance programs, including the ACA and Medicaid.

An administrative burden framework also highlights some of the risks that come with an approach to healthcare that presents itself as consumer-driven, giving people more choice. Such an approach assumes an ability to overcome learning costs in the face an excess of choices, each involving a complex set of decisions. But having lots of information about lots of choices does not necessarily result in people making better decisions. A consumer-based approach stumbles if people are not rational actors making good choices, but are, instead, regular people who have a limited capacity to manage a dizzying array of complex information.

The burdens inherent in Medicare are important to understand given calls new policy reforms such as Medicare for All. The incrementalist history of health policy reform in the United States suggests that an expansion of the current Medicare program is the most probable outcome if Medicare for All is going to emerge. And yet the sizable role private insurers already play in Medicare is largely overlooked, even as they cause substantial administrative burdens for beneficiaries. It is not just Medicare. Nearly all coverage expansions over the last 20 years have relied on private insurers. Subsidizing private health insurance coverage formed the basis of the ACA. Private health insurers play a larger role in Medicaid as the program has grown. Expansions in coverage have left intact the Sisyphean task of dealing with the private health insurance bureaucracy. If Medicare For All merely puts the frustrations that people experience in the existing system under a public brand, it will be a magnet for attack.

There are ways to make the process easier using a mixture of regulation and government guidance. Regulatory approaches could more seamlessly standardize plan options so that it is easier to compare what people are “buying.” For example, the ACA categorizes plans – based on the distribution of costs between insurers and the individual – into four broad and intuitive buckets ranging from Bronze to Platinum. Another option is to limit the number of choices to ensure there is not a flock of essentially identical plans that add little more than confusion. Government can do more to help people enroll and ensure they receive the benefits to which they are entitled, applying the type of help that was offered, initially at least, with the Affordable Care Act.

More broadly, scholars and policymakers should understand the administrative burdens inherent in how health services are designed and delivered. The simple set of categories we offer – learning, compliance, and psychological costs – offer an intuitive way to understanding the individual’s experience of these policies as onerous or otherwise. Understanding these experiences is a first step towards understanding the costs of burdens, and weighing those costs against whatever proposed benefits they are expected to deliver.

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