HEALTH POLICY BRIEF

CULTURE OF HEALTH

How Administrative Burdens Can Harm Health

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Health-promoting social welfare programs, such as unemployment insurance, food stamps, and Medicaid, are critical in a major recession. However, administrative burdens that block access to these benefits and create stress may undermine health.

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KEY POINTS:

- **Administrative burdens can negatively affect health by blocking people from accessing health-promoting social welfare programs such as food stamps and income supports, and may also have more direct health impacts via the**

psychological and stress mechanisms that come from navigating burdensome bureaucracies.

- **Administrative burdens include learning costs, such as finding out whether one is eligible for a program; compliance costs, such as burdensome paperwork and documentation; and psychological costs, such as the stress and stigma that people feel when interacting with government programs.**
- **We know relatively little about the downstream health implications of negative encounters with bureaucracies. Documenting the health effects of burdens is a compelling research opportunity that population health researchers are uniquely situated to address. To fulfill that opportunity, researchers need to pay just as much attention to the administration of social and economic policies as they do to their design.**
- **Administrative burdens associated with social welfare policies and programs may be just as important determinants of health as the policies themselves. Public officials should look to minimize burdens.**

The coronavirus disease 2019 (COVID-19) pandemic created an economic tsunami. Massive unemployment, income loss, and lost access to employer-provided health insurance have obvious negative effects on health beyond the virus. A social safety net should buffer such economic distress and its long-term health impacts, but many who need and are entitled to benefits do not receive them. Among those eligible for targeted social welfare supports, approximately 30–80 percent actually receive them versus almost 100 percent for a more universal program such as Social Security.

The COVID-19 pandemic and ensuing recession are exposing profound gaps in our social welfare system, including the byzantine bureaucracies that those seeking help must negotiate. As nearly fifty million Americans sought unemployment benefits, they encountered crashing websites, overloaded telephone lines, and confusing forms. As one Floridian commented, “It’s very obvious that this is a weaponized system to keep you from using your benefits.”

These problems are not exclusive to unemployment insurance. Other social welfare programs that soften the economic blow from recessions, including food stamps, the Earned Income Tax Credit, and Medicaid, are also laden with administrative burdens such as complicated eligibility rules, confusing forms, multiple requests for the same information, and demands for in-person visits that ignore the transportation and work schedules of low-income beneficiaries. Social welfare program design often seems more focused on excluding the ineligible than on including the eligible.

In this brief, we detail how administrative burdens in our largest targeted social welfare

policies may undermine health. First, we document the role of these social welfare policies in protecting health. We then define and conceptualize administrative burdens and detail how they limit access to these health-protective social welfare supports, all of which are critical in a major recession. Finally, we propose a research agenda to address the health implications of social welfare policy administration, especially the psychological and stress-related health impacts that may result from cumulative exposure to multiple administrative burdens.

Evidence: Social Policies Influence Health

Existing social welfare supports help offset the large downstream health costs of economic insecurity, especially during an economic crisis. Indeed, income supplements such as unemployment insurance and the Earned Income Tax Credit, income substitutes such as food stamps (the Supplemental Nutrition Assistance Program, or SNAP), and access to health insurance via Medicaid have all been shown to improve health. Unemployment insurance, via its role in softening income losses from unemployment, reduces the negative impact of job loss on health and even increases the probability of smoking cessation. The Earned Income Tax Credit, an income supplement for the working poor, improves infant and child health, as well as maternal physical and mental health. Income substitutes, which meet basic nutrition and health care needs, also help. The implementation of food stamps in the 1960s reduced infant mortality and increased birth weights, with long-term implications for better health later in life. In addition, access to public health insurance, including Medicaid for low-income populations, has substantially improved infant, child, and adult health outcomes, including for mental health.

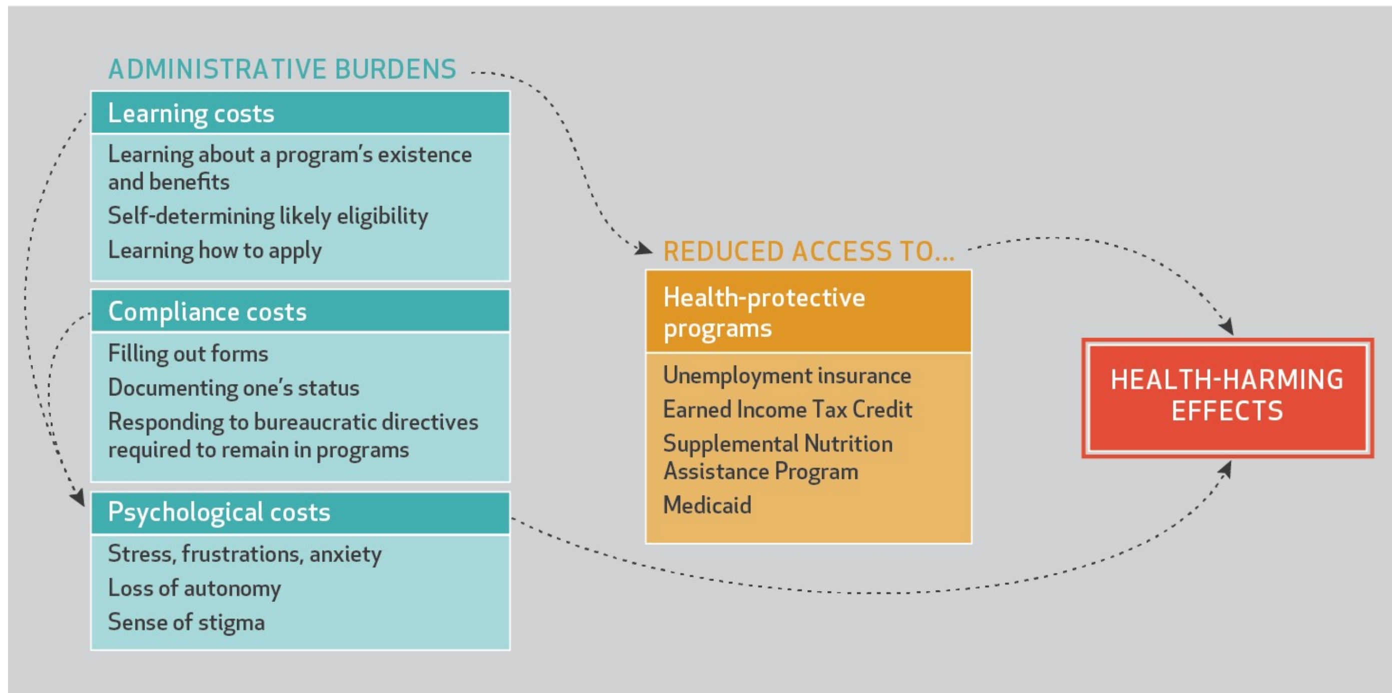
Evidence: Administrative Burdens Limit Access

The health benefits of social policies, however, are dependent on people accessing them. The coronavirus-induced economic turmoil highlighted how hard it can be to access our largest social welfare programs. We provide a conceptual framework to understand people's experience of this kind of onerous policy administration. Administrative burdens emerge in three subcategories: the learning costs of finding out about a program's existence and benefits, determining whether one is eligible for the program and what benefits one might receive, and understanding how to apply for and stay on programs; the compliance costs of filling out forms, documenting one's status, or responding to bureaucratic directives; and the psychological costs, including stress, frustrations, anxiety, loss of autonomy, or sense of stigma, that arise from interacting with these programs.

Exhibit 1 delineates the connections between administrative burdens and health. The health-harming effects of all three burden subcategories are mediated through reduced access to health protective programs, thereby indirectly undermining health. One category of burden —psychological costs (for example, increased stress)—likely also has a more direct negative

effect on health, as we describe later in the brief.

EXHIBIT 1 How administrative burden could harm health



Source: Authors' analysis

Burdens often have political origins and significant distributional impacts. Many are deployed as "policy by other means" to achieve aims that politicians otherwise struggle to acknowledge or enact, including rationing of benefits and services. Although most people are familiar with cumbersome bureaucratic processes, it is easy to miss the scale, systemic nature, and intensity of the effects these processes can have. Moreover, they are often targeted at certain groups, including female, Black, poor, and disabled Americans.

These burdens become magnified during major economic downturns, such as the COVID-19 pandemic-
induced recession. Here, we detail health-harming burdens in our largest targeted social welfare programs, which also constitute crucial protections for those hit hardest by a recession.

UNEMPLOYMENT INSURANCE

The most visible social welfare policy in the COVID-19 pandemic-induced recession was unemployment insurance. In March 2020, the unemployment rate skyrocketed, with 40 percent of low-income workers laid off and with Black women hit especially hard. The Coronavirus Aid, Relief, and Economic Security Act largely funneled economic relief for individual Americans through unemployment insurance by increasing benefits and expanding

eligibility. The intense demand for unemployment insurance benefits after the pandemic hit highlighted the long-standing administrative burdens associated with the program. When tens of millions of people lost employment in March 2020, states paid out only 14 percent of all claims by the end of March and 47 percent of all claims by the end of April. Although it is unclear how many people were stymied by eligibility requirements versus burdens, recent data suggest there were large compliance costs, with almost 40 percent of beneficiaries in June waiting more than a month between their initial claim and benefit receipt. Months-long delays in benefit receipt likely led to increased housing and food insecurity.

The dysfunction of unemployment insurance was not just the result of an unusual surge in applications. Even in "normal" times, only about three-quarters of those eligible for unemployment insurance actually receive benefits, with many jobless people deemed ineligible. The fraction of unemployed people receiving benefits ranges from about 10 percent in North Carolina to 57 percent in New Jersey. Notably, there are large race differences. For example, during the Great Recession of 2007–09, 23.8 percent of Black unemployed people received unemployment insurance versus 33.2 percent of White unemployed people. In part, states with higher proportions of Black people also tend to have stingier unemployment insurance benefits, but learning costs also contribute to low take-up of benefits across all racial groups. In addition, benefit eligibility varies across states in terms of job classifications, wage requirements, and reasons for leaving a job, meaning many unemployed workers are unaware of their eligibility status.

Challenges accessing unemployment insurance during the current recession reflect prior policy choices made, especially after the Great Recession, to narrow eligibility and broaden burdens. The cumulative effect was to reduce the overall fraction of unemployed workers receiving benefits from around 31 percent between 2004 and 2007 to 23 percent between 2012 and 2016. Compliance costs played a key role in this decrease. States such as Florida and North Carolina confounded the application process with burdens to reduce unemployment insurance spending. Across states, new programs to facilitate employment, such as job counseling and required documentation of job-seeking activities, led to people getting kicked off unemployment insurance for failing to meet administrative requirements, rather than leading to increased employment.

EARNED INCOME TAX CREDIT

The Earned Income Tax Credit is the largest income support for low-income families. Its benefits will likely grow in importance as the recession deepens. Unlike unemployment insurance, the Earned Income Tax Credit is received annually, so it does not offset immediate financial losses. It, too, is hampered by administrative burdens. Learning and compliance costs are the largest problems. For the one in four eligible people not claiming the credit, the average benefit loss is $1,096, equivalent to a month of earnings.

The Earned Income Tax Credit is delivered as a tax refund, but many of those who are eligible earn so little that they do not file tax returns, and are therefore unlikely to know that they are eligible to receive the credit. There are also compliance costs to completing a tax return, such as collecting W-2 forms from one or more employers. Tax preparers help reduce compliance costs and ensure people receive a benefit, but in doing so, they consume about 5 percent of the benefit. Moreover, audits increase compliance costs dramatically. About 500,000 Earned Income Tax Credit audits take place each year, primarily by mail, with approximately four of five benefit disallowances a result of undelivered mail, nonresponse, or insufficient response, rather than evidence of wrongdoing. The long-term cost is that 30–40 percent of those audited do not claim the benefit in later years, despite their eligibility.

SNAP

The COVID-19 pandemic-induced recession has increased demand for SNAP, the largest federal nutrition assistance program. But longstanding compliance costs, such as lengthy applications, documentation requirements, in-person interviews, and the need to recertify or reapply to maintain benefits, undermine its ability to address increased food insecurity. For example, a Michigan study found that half of SNAP recipients lost their benefits during recertification, even though most were still eligible. On average, 85 percent of those eligible received benefits in 2018, although the take-up rate has varied considerably over time.

States have attempted to minimize these burdens. For example, shifting from paper food stamps to electronic benefit payment (EBT) cards made it easier for participants to receive and use their benefits. A recent study found that the shift to EBT in California increased SNAP participation by 19 percent. Importantly, this is one of the only studies that directly linked reduced burdens to improved infant health, via increased program participation.

During the COVID-19 pandemic, burdens related to food support have been mixed. On one hand, states were allowed to eliminate in-person visits and delay recertification for SNAP, although not all states reduced these burdens. On the other hand, Congress, rather than increasing SNAP benefits for the COVID-19 pandemic, created a new program to reduce food insecurity: Pandemic EBT. After three months, however, just twelve states had started Pandemic EBT programs, and only 15 percent of eligible children had received benefits. In retrospect, asking states to build new administrative machinery in the midst of a pandemic rather than expanding an imperfect but existing means of delivering benefits was unwise.

MEDICAID

Medicaid is critical, especially during a recession, but burdens limit access to it. Approximately twenty-seven million Americans lost employer-based health insurance between March 1 and May 3, 2020, and may therefore need to sign up for Medicaid coverage.

Even before the COVID-19 pandemic, nearly 40 percent of children were covered by Medicaid. However, Medicaid take-up is often quite low. Reflecting variance in administrative burdens, Medicaid take-up rates among eligible parents range from 50 percent in Texas to 96 percent in Massachusetts. And there is evidence that burdens may be increasing. One change backed by the Trump administration, but mired in lawsuits, allowed states to institute work requirements for Medicaid eligibility. When Arkansas instituted such requirements, nearly 17,000 people lost coverage in just four months. One survey found that 95 percent of those who lost coverage worked enough to meet requirements or should have been exempted; much of the coverage loss was a result of high learning and compliance costs. One-third of the target population had never heard of the policy change, and 44 percent were unsure whether it applied to them. The reporting method was online-only, but one-third of beneficiaries did not have internet access.

Additional state policy changes have increased Medicaid learning and compliance costs. In 2018 alone, Tennessee dropped approximately 10 percent of Medicaid-enrolled children from the program via an onerous recertification process. Renewal occurred only by mail. Mail-in forms often do not reach target populations, mostly because poorer families move frequently. Those families that failed to complete the forty-seven-page form, returned it late, or made errors lost benefits. Of 319,000 forms mailed out, more than 200,000 were never returned and about 20,000 more were incomplete or late. In Missouri, 60,000 eligible children lost coverage when their parents lost coverage because the state did not communicate that the children remained eligible, placing the learning costs on parents.

Research Agenda: Direct Effects Of Burdens On Health

The previous section outlines how burdens may undermine health indirectly by reducing access to health protective programs. This section speculates about direct ways that burdens may influence health, as suggested in exhibit 1, pointing to a potential research agenda.

We know little about how learning and compliance costs affect psychological costs—including stress, frustration, anxiety, and loss of autonomy—as well as the downstream health behavior and health impacts that might manifest as a result of these costs. One laboratory-based experiment showed that paperwork and confusing directions increased physiological responses, including electrodermal activity and heart rates. Experimental work is a promising route to test directly how compliance costs cause psychological and physiological harms. Given robust evidence that stress increases health behavior risks such as smoking and a wide array of health problems, these experiences may have long-term consequences.

We also know little about the cumulative consequences of these interactions. Most evidence points to chronic, rather than acute, stress as having a greater influence on health. Study designs that capture cumulative stress resulting from navigating learning and

compliance costs will be critical. Policy research typically focuses on the health effects of stand-alone policies, in part because of methodological challenges. But to fully understand how compliance and learning costs influence psychological and physiological outcomes, we must capture the accumulation of burdens across programs and over time. Those people who rely on social welfare programs simply spend more of their lives navigating complicated bureaucracies to meet their basic needs than do those with more resources. Moreover, the stakes are high for those failing to navigate these burdens. Worrying that one cannot feed one's children or access critical medical care further heightens stress. As a consequence, even successful applicants may experience deleterious health impacts through physiological and behavioral pathways.

Finally, although learning and compliance costs may affect psychological and physiological outcomes, how people are treated while they try to receive and keep benefits also likely matters. Psychological costs from stigma and discriminatory or belittling treatment may have long-term health consequences. Given evidence directly linking the experience of racial discrimination to poor health, it seems plausible that people who experience patterns of discrimination and negative bureaucratic encounters might also have worse downstream health. There is a need for more work examining the health implications of negative encounters with bureaucracies, many of which are patterned by race.

Conclusion

The COVID-19 pandemic made starkly visible not just the holes in the safety net that result from policy design but also those that result from policy administration. Ample evidence demonstrates that reducing learning and compliance costs substantially increases access to critical benefits. Americans must pressure policy makers to turn coverage of all eligible people into a policy goal. Most federal enforcement effort is focused more on keeping the ineligible out of programs than on ensuring the eligible get in. As a result, in a program like SNAP, it is far more likely that a person will not receive benefits they should than it is that a person will receive benefits they should not.

Documenting the health effects of administrative burdens is a compelling research opportunity that population health researchers are uniquely situated to address. To fulfill that opportunity, researchers and policy makers should pay just as much attention to the administration of social and economic policies as they do to their design. If the way in which a program is administered limits access to health-promoting policies, it undermines health. The administrative state may be just as important a determinant of health as the policies themselves.