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MEDICAID ELIGIBILITY POLICY IN THE STATES

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of the requirements for the
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I Introduction

Beginning in 1965, the United States has been providing health insurance through Medicaid to certain low-income groups. The program was created by the federal government, and the federal government is responsible for setting some general regulations and provides most of the funding. Yet, from the beginning, it has been the states who have administered Medicaid, and they have had a great deal of discretion in setting its rules. Besides the question whether a state should have a Medicaid program in the first place, states have been allowed to cover or not cover optional services, use Managed Care, and set reimbursement rates for physicians and hospitals. Most notably, the states have been allowed to determine, within some restrictions, the key question of who should be made eligible for the program and who should not. Initially, the program focused on targeted groups that were widely held to be vulnerable: the elderly, the disabled, and recipients of certain public assistance programs — in particular, single mothers and their children. Over time, however, the Medicaid program has been expanded considerably and now covers groups that were not previously recognized as in need of public assistance. Since so much of the action has occurred on the state level, one cannot understand the dynamics of change in Medicaid without directing one's attention towards the states.

This paper contributes to a better understanding of the implications of the devolution of authority to the states by studying the political processes in the states through which they make decisions about Medicaid parameters within federal guidelines — specifically, which individuals should be eligible. Ultimately, this knowledge will inform whether or not this delegation of authority to the states is equitable and efficient. One can imagine a variety of arguments made on this point. Pro-

ponents of delegation might argue, for example, that residents of different states have different preferences regarding the generosity of the welfare state. In this view, delegation allows state governments to tailor the welfare state more specifically to their populations than a one-size-fits-all welfare regime imposed by the federal government could do. Similarly, some claim that state governments simply have better information about local conditions than the federal government would and could therefore deliver services more cost efficiently than the federal government would be able to (Bovbjerg, Wiener and Housman 2003). However, others are worried that states with the largest populations of the poor might also be the governments with the fewest resources available to assist, and so the states that need Medicaid the most might end up with the least generous programs. The federal government's Medicaid financing scheme was designed to address this concern by supplying poorer states with higher matching grants, but this may not have been sufficient to offset the inequalities entirely. Taking this point further, some see health care as a right which should be accessible to everyone, independent of the state they reside in, and so oppose delegation on this point. Furthermore, unlike the federal government, most states have rules in place that require them to balance their operating budget. Thus, one might be concerned that during a recession, precisely at the time when low-income individuals depend most heavily on the government's safety net, state governments might have to make cuts in response to falling tax revenues, whereas the federal government could simply run a deficit. Moreover, the argument has been made that states are undercutting each other's standards so as not to be more generous than their neighbors and avoid "welfare migration" (Peterson and Rom 1990). A last danger to equitable access to health insurance is racism. In some states, a larger share of the poor are of color than in others. If whites hold racial prejudices towards Medicaid recipients, then racist voters or policymakers might

push for more generous programs in states with a small minority share of the poor, and for less generous programs in states with a large minority share of the poor. Presumably, through the imposition of uniform national standards, this problem could be ameliorated if program design were left to the federal government.

To address any of these concerns, it is important to study how Medicaid policy is formulated. In particular, I will construct a model of policymaking that stresses the importance of ideology, facts, pressure from other actors, and attention to the process of defining eligibility thresholds. I will then test this model empirically to determine which important factors influence the levels of state eligibility standards, and whether incremental changes in these standards differ systematically from non-incremental ones. My findings reveal that Democratic control of the legislature and a liberal public are associated with more expansive eligibility standards, but that this difference is more pronounced in rules for adults than for children. Contrary to what one might expect, states do not cut down on Medicaid eligibility during recessions. However, states find a clandestine way to reduce Medicaid caseloads in bad economic times by raising bureaucratic barriers to enrollment, a process that, due to its incremental nature, largely escapes public notice. Lastly, I find some evidence of states trying to undercut each other's eligibility standards, but no evidence of racism. The results indicate that policymakers shape their policies to conform to their constituents' ideological beliefs, but also respond to the state's fiscal outlook, and that more could be done to prevent hidden Medicaid cutbacks during recessions.

2 Medicaid and its Evolution¹

Medicaid was established as part of the 1965 Social Security Amendment as a joint effort by the federal government and the states to provide health insurance to certain needy populations that would not be able to afford medical care otherwise. Each state develops its own program subject to federal regulations and approval by the federal government and receives matching dollars from the federal government in return. In particular, states design their programs along three crucial dimensions: they decide who is eligible, which barriers applicants have to overcome to sign up for the program, and, to some extent, which medical services are covered under the program at which reimbursement rates. Moreover, Medicaid is administered by the state governments through their Departments of Health and Human Services (DHHS). Thus, this is a program shaped to a large extent by the actions of the states.

Yet, the federal government retains a non-negligible amount of control over the program as well. The federal government has imposed a number of regulations on the services that must, may, or may not be covered under the program. Similarly, the federal government has repeatedly defined certain populations that must be covered by all states with a Medicaid program. It has also greatly restricted the scope for cost-sharing through copayments or deductibles. Exceptions to some of these restrictions are possible: states can apply for waivers from some of the rules, for instance through the use of managed care, which have to be approved by the Centers for Medicare and Medicaid Services (CMS), a federal agency. In exchange for this control over the states' programs, the federal government contributes to the financing by matching each dollar spent by the states with at least one dollar out

¹Much of the following discussion is informed by Gruber (2003).

of the federal budget. The matching rate varies by the states' economic conditions: the federal government contributes 50% of total expenditures in richer states, and the rate rises to 82% for the poorest states.

Since the creation of Medicaid in 1965, its target population has been altered considerably. From the beginning, Medicaid was aimed at four different populations, which is why it has been characterized as “four public insurance programs in one” (Gruber 2003, 15). The first three are certain elderly who need access to some medical services not covered by Medicare, the low-income disabled, and institutionalized elderly. While these make up only 25% of enrollees, they account for two thirds of the costs, mostly due to the high costs of services for the disabled and in nursing homes. However, the largest share of enrollees consists of low-income, non-elderly families. Here, the understanding of what exactly it means to have an income “low enough” to qualify for Medicaid has changed over time. At the outset, Medicaid eligibility for this group was linked to receipt of other transfer programs, most notably Aid to Families with Dependent Children (AFDC). The presumption was that health insurance should be provided through the workplace, and that it was therefore necessary to provide public health insurance only to persons on the welfare rolls who were not expected to work.

With time, this understanding eroded for a number of reasons. First, by tying itself to a narrow definition of the eligible population that consisted mainly of single women with children, Medicaid invited criticism from liberals who contended that the “merely” poor and uninsured were equally deserving of assistance (Tallon and Brown 1998). Second, employers can no longer be counted on to provide comprehensive health insurance, especially for low-wage workers. Private health insurance coverage dropped after covering 79% of the population in 1968 to 67% in 2007 (Cohen et al. 2009). This erosion of the system of private health care coverage meant

that calls for government to reduce the number of uninsured gained traction. Third, starting in the 1980s, novel arguments based on cost-effectiveness were being made for a Medicaid expansion for pregnant women and children (Grogan and Patashnik 2005). Analysts argued that pregnant women and children were relatively cheap to insure, yet their health outcomes would be crucial for determining children's health outcomes in the future. Therefore, insuring them now would prove a sound investment that would prevent higher future costs. Fourth, the characteristics of welfare recipients themselves, and with it their perception in the general public, has changed (Moffitt 2003). When AFDC was set up in the 1930s as part of the New Deal, women receiving public assistance were generally not expected to work outside the home. Since this precluded them from obtaining health insurance through an employer, it seemed sensible to provide these women with public health insurance. However, over time, the expectation that women on welfare ought to work became much more widespread, and policymakers sought ways to better integrate these women into the labor market. Medicaid expansions served this purpose, because granting health insurance to low-wage workers meant that women who moved off the welfare rolls into employment did not have to fear losing their health insurance. Furthermore, the 1996 welfare reform pushed many recipients off the welfare rolls. With uninsurance still a serious problem, however, supporters of Medicaid argued that Medicaid should be expanded beyond the welfare rolls to cover all, or at least most, of the poor who needed health insurance (Smith and Moore 2008).

In fact, such an expansion had gradually begun a decade earlier. Alarmed by a loss of health insurance for many families with an unemployed bread-winner during the 1981-1982 recession, as well as numbers showing an infant mortality rate that far surpassed that of other developed nations, Congress first allowed and then mandated states to expand eligibility for Medicaid beyond the traditional welfare

population. The expansions were targeted at pregnant mothers and infants and appealed to a wide range of groups, including liberals concerned about assistance for the vulnerable, pro-life groups trying to curb abortion, and Southern politicians worried about their region's high uninsurance and infant mortality rates (Smith and Moore 2008). In the following years, states continued to modify eligibility rules, leading to a great diversity in program regulations across states. By the time welfare reform was enacted, the tight link between AFDC and Medicaid had already been severed.

Interestingly, Grogan and Patashnik (2005) note that the expansions set in motion a dynamic that fortified the program's place in the American political landscape. By expanding eligibility beyond the welfare population, the Medicaid program was decreasingly associated with a stigmatized constituency and became increasingly amenable to support from the middle class. Grogan and Patashnik show that in 1995 when Republicans called for Medicaid cutbacks, President Clinton forcefully defended the program by pointing out that much of Medicaid spending goes to non-poor elderly in nursing homes, effectively linking the program to the middle class. This strategy helped preserve the program against political attacks and set the stage for the single biggest implemented expansion yet.

In 1997, Congress created the Children's Health Insurance Program (CHIP), an attempt to expand public health insurance coverage for children and infants living in families with incomes substantially above the poverty line. Like Medicaid, this program is a joint undertaking of federal and state governments with federal support in the form of matching grants. States have a bit more flexibility in defining the benefits package in a separate CHIP program than they do in traditional Medicaid, and states may make use of premiums and copayments, which is not the case in Medicaid. Unlike Medicaid, CHIP is not an entitlement program, and states can

cap enrollment or place applicants on waiting lists. The matching rate for CHIP is enhanced, meaning that a larger share of the costs are borne by the federal government. Overall, however, the parallels between CHIP and Medicaid are considerable, reflected in the fact that states were given the option to integrate CHIP into their existing Medicaid programs; many chose to do so. This is why, from here on, I will use “Medicaid” to refer to both Medicaid and CHIP, unless otherwise noted.

In addition to expansions of the Medicaid and CHIP programs, some states also covered additional groups through entirely state-funded initiatives. Although such programs received no funding from the federal government, they nevertheless seemed attractive to some states because they were not bound to federal regulations in the design of the program. Accordingly, they were free to expand eligibility to groups that Medicaid could not cover, but also to include premiums, copayments, deductibles or more limited benefit packages than what would have been allowed under Medicaid. Yet, these programs are still usually more attractive than insurance sold on the market, and they have played an important role offering publicly funded health insurance to low- and middle-income families whose income is too high to qualify for Medicaid.

In sum, Medicaid has evolved from a relatively limited entitlement program strongly linked to welfare receipt to a broader program that covers many individuals below, and increasingly even above, the poverty line. This process was marked by ongoing discussions about just how expansive the program should be, who should be made eligible and who should not. In these discussions, Republicans have tended to favor more restrictive eligibility, often citing the fiscal strain Medicaid puts on the federal and state governments as a reason to be wary of large expansions in eligibility. In this view, Medicaid takes away resources from other important government priorities or necessitates tax hikes that harm taxpayers and the economy (Hacker

and Skocpol 1997). Another worry is crowd-out, the phenomenon that individuals drop private coverage in order to enroll in Medicaid. Although there are problems for Medicaid enrollees because some doctors refuse to see them as a result of low reimbursement rates, the expansive coverage of benefits and the absence of premiums and cost-sharing mechanisms make Medicaid a quite attractive option. There is some empirical support for the hypothesis that Medicaid expansions, especially the ones that make higher-income individuals eligible, induce crowd-out (Gruber and Simon 2008). In the presence of crowd-out, the government covers households who do not need Medicaid to obtain health insurance coverage, which reduces the effectiveness of Medicaid as a means to cover the uninsured. Democrats, by contrast, have usually been associated with expansions of the program, arguing the points raised above: that the growing population of the uninsured is vulnerable and in need of public assistance and that spending on health care, especially for pregnant women and infants, represents an investment in future health that will pay off for all of society. More generally, their support for a relatively generous program seems driven by a more sympathetic attitude towards government support for low-income households (Cook and Barrett 1992).

3 Review of Earlier Scholarship

There is a long tradition of scholarship examining interstate differences in anti-poverty policies. AFDC, as the older welfare program, was the one that attracted attention first; it was only when Medicaid eligibility was decoupled from AFDC eligibility in the 1980s that researchers could identify effects of Medicaid that were independent from effects of AFDC, and so Medicaid could be studied separately. The earliest studies of interstate differences in generosity for welfare policies (e.g., Dawson and Robinson 1963, Hofferbert 1966, Jennings 1979) focus on differences in welfare expenditure as a function of socioeconomic characteristics of the state population and interparty competition. They test a hypothesis derived from Key (1949) according to which in those states where interparty competition is greater, parties have to pay greater attention to the poor to win over their votes, resulting in more generous welfare policies. Neither author finds support for their hypotheses, concluding that socioeconomic factors, rather than political ones, drive the differences. However, their studies suffer from serious methodological deficiencies (Dye 1984), including poorly defined measures of welfare policy, a measure of interparty competition that lumps Republican-controlled and Democratic-controlled legislatures together, and the reliance on rank-order correlations, which assumes that any two consecutively ranked states are equally far apart in the distribution, an assumption that is almost certainly false. Moreover, it is of course logically incoherent to conclude that no political forces factor into a policy decision, just because the one selected variable, interparty competition, does not.

Dye (1984) criticizes these earlier papers and makes several improvements in his own study, such as differentiating between Republican- and Democratic-controlled legislatures, controlling for per capita income and dispensing with rank-order cor-

relations. He concludes that welfare expenditure is linked to Democratic control of the legislature in twenty states. Hanson (1984) is the first scholar to consider Medicaid independently, and also delivers a forceful argument against using total expenditure as a dependent variable because knowing about total expenditure still does not permit inferences about the content of the program. He argues that it is much more informative to look at the program characteristics that produce these expenditures, and that using expenditure represents an unjustified confusion of the process and the outcome of policy. However, his own analysis of determinants of Medicaid caseloads contains only a few explanatory variables, and his main findings are, unsurprisingly, that a large population size and high unemployment are associated with high caseloads.

Barrilleaux and Miller (1988), studying a cross-section of states, provide the first analysis that takes interest groups into account, and find that in states where the density of medical providers is high, Medicaid expenditures are also. However, their analysis of Medicaid expenditures suffers from the deficiencies noted by Hanson. Furthermore, they include few other explanatory variables; notably, as Kousser (2002) remarks, a measure of party control of the state legislature is conspicuously absent.

Since then, three articles have treated Medicaid with more theoretical sophistication, and my work is most similar in spirit to these three. Each article builds on the previous one, so I will treat the three in turn, and discuss their results as well as their limitations.

Grogan's (1994, 1996) paper greatly improves upon the theoretically lacking earlier articles. She recognizes that Medicaid expenditures are the results of several distinct political processes, each of them being shaped in different degrees by different actors. Grogan divides Medicaid into the dimensions of financial eligibility (eligi-

bility tied to AFDC receipt), categorical eligibility (several groups of persons states can cover optionally) and benefit coverage. She then proceeds to posit different hypotheses regarding the political processes that govern each dimension, considering, among other things, party control, political culture, interest group pressure, demographics and several measures of economic prosperity. Regarding eligibility, she finds that political culture, strength of interest groups, per capita income, a measure of the population's health, the matching rate and the average wage from the lowest-paying industry enter significantly. However, party control, the unemployment rate, and the size of the minority population are notably insignificant.

Although Grogan's article marks a great improvement over previous work, it has still left considerable room for improvement. As Kousser (2002) points out, she uses a timewise autoregressive model described in Kmenta (1986) that has been shown to be unreliable for panel data (Beck and Katz 1995). Furthermore, Grogan fails to take several factors into account, and uses questionable methods to measure others. Curiously, she does not include a measure of the severity of the political problem Medicaid should address, such as the number of uninsured, in her model. She also ignores the role of the governor. Her measure of financial eligibility is based on a state's AFDC standards, which may have had some validity for the time period she considers in her study (the 1980s), but would be inappropriate to use now that the link between AFDC and Medicaid has been weakened considerably. Grogan's measure of interest group strength is based on the work by Hrebennar and Thomas (1987, 1992, 1993a, 1993b), which is cross-sectional in nature and does not take into account changes over time. This is problematic, because health care-related interest groups have grown considerably in strength since 1980 (Thomas and Hrebennar 2004). Finally, her measure of political culture is rather dated and does not allow for variation over time: she uses Sharkansky's (1969) index of states, who assigns

states scores that place them on a continuum from moralistic via individualistic to traditionalistic, a categorization based on Elazar (1966). It is worth noting that even Sharkansky himself had reservations about the meaningfulness of this classification, calling it “of questionable reliability” (Sharkansky 1969, 83).

The next attempt to explain variation in Medicaid eligibility policy comes from Kousser (2002). His work is based on expenditure, although he disregards spending the federal government mandates state governments to undertake and focuses only on discretionary spending. This allows him to find that legislative party control does matter — states with legislatures controlled by Democrats choose to spend more on Medicaid. Moreover, wealthier states, states with more female-headed households, states with a larger medical lobby, and states with smaller minority populations choose to spend more on Medicaid. However, it appears that public opinion and the governor’s party affiliation do not influence Medicaid expenditures.

Kousser’s work is valuable for the breadth of independent variables considered, and it suffers from fewer methodological shortcomings than Grogan’s. One important weakness, however, remains: Kousser’s measure of discretionary expenditure is in large part driven by expenditures for the “medically needy,” non-poor individuals who have high medical bills they cannot afford. A large part of those eligible under this section of the program are elderly who have high nursing home expenditures. Since the elderly have a very different standing in the American political landscape than low-income families, it appears likely that the political forces shaping rules for the “medically needy” could be quite different from those shaping eligibility rules for poor families. Therefore, it is unclear whether Kousser’s findings still hold once attention is restricted to low-income families.

The third major study, Baughman and Milyo (2008), represents the only paper to date that uses “simulated eligibility” as the dependent variable. Simulated eligi-

bility, originally introduced by Currie and Gruber (1996), uses a randomly drawn national sample of the population and applies each state's eligibility rules to this sample as though it actually reflected the state's population. It thus imputes what percentage of the population would be eligible if the state's population had the demographic and economic characteristics of the national average. Unlike the actual share of the population eligible, this measure manages to isolate the effects of the legislative environment from the general demographic and economic conditions of the state. The authors' main findings are that the share of Democrats in the legislature and per capita income are positively related to eligibility levels, and that the federal matching rate and fiscal capacity (a measure of states' revenues if they all had the same tax structure) are negatively related to eligibility. The former two estimates are unsurprising, and the findings regarding the matching rate confirm results from Grogan (1994, 1996) and Kousser (2002). Higher matching rates are granted to poorer states, and the negative coefficients seem to indicate that wealthier states can afford more generous programs despite facing lower matching rates. The counterintuitive findings on fiscal capacity are likely a result of a misapplication of the measure of fiscal capacity employed, an index compiled by Tannenwald (1999, 2002), Tannenwald and Turner (2006) and Yilmaz et al. (2006). These indices, in addition to covering only a few years (Baughman and Milyo have to interpolate for years not covered), are scaled so that the mean state always has score 100; thus, if each state's fiscal capacity improved from one year to the next, the index would be unable to pick up the change. This makes the index's use in a longitudinal dataset questionable, to say the least.

The paper has several more shortcomings. It fails to account for public opinion, party control of the governorship and interest groups, and instead includes several measures of "good governance" (term limits, contribution limits and public election

funding). The latter is particularly puzzling since the authors themselves admit that there is no good scientific basis why they should be important; not surprisingly, they turn up insignificant. Similarly, it should not come as a surprise that the inclusion of voter turnout as a variable produces no significant results: while Baughman and Milyo cite some scholarship purporting to show that higher turnout is associated with larger welfare spending (Husted and Kenny 1997, Lott and Kenny 1999), this research is actually geared towards the much more specific question of the effect of expanding suffrage to women and minorities on the size of government.

In addition to this research specifically directed towards Medicaid eligibility, there are a few other studies that are of interest here. First, there is the idea of a “race to the bottom,” which was first suggested by Peterson and Rom (1990) and has subsequently been taken up by a number of authors (see Rom, Peterson and Scheve 1998, Mooney 2001, Berry, Fording and Hanson 2003, Bailey and Rom 2004). It concerns the question of “welfare magnets,” states with such generous welfare standards that welfare recipients migrate from surrounding states to take advantage of the welfare program. Even if such migration were rare in practice, the fear of becoming a “welfare magnet” could prompt legislators to lower its welfare benefits, setting in motion a “race to the bottom”. Both Grogan (1994, 1996) and Baughman and Milyo (2008) claim to find support for the “race to the bottom” thesis as they are able to show that, controlling for socioeconomic characteristics, a state’s eligibility criteria are correlated with the benefit level of its surrounding states. This mirrors findings that AFDC benefits in neighboring states are correlated (Rom, Peterson and Scheve 1998). However, Bailey and Rom (2004) have clarified the theory by differentiating between mere convergence (neighboring states adopt similar welfare levels) and competition (states will not mind spending less than their neighbors, but will be reluctant to spend more). By separating the two effects that other re-

searchers, including ones studying Medicaid, have treated as one, the authors are able to test more sharply for the existence of a "race to the bottom". They find evidence of a "race to the bottom" for AFDC and Medicaid expenditure, but not for Medicaid eligibility levels. Overall, the authors note wryly that "the race appears to be one of turtles, not of hares" (Bailey and Rom 2004, 339), since the estimated effects are not particularly large for any program.

Second, since the earlier literature cited above was so preoccupied with electoral competition and produced such unsatisfactory results, the more recent studies have largely ignored the concept, and neither Grogan nor Kousser or Baughman and Milyo take it up. Yet, a few advances have been made in the literature. Most notably, Barrilleaux, Holbrook and Langer (2002), in a study of interstate differences in AFDC expenditure, propose a more sophisticated theory of interparty competition. They argue that the core constituency of the Democratic Party cares greatly about welfare, whereas the core constituency of the Republican Party does not. Moreover, they propose, in tight election campaigns, each party tries to appeal to its core with a variety of promises. Therefore, one would expect Democratic party control to translate frequently into more generous welfare policies in very competitive states, and less so in less competitive states. The authors indeed find empirical support for their hypothesis, and it will be interesting to see whether it can be substantiated in the context of Medicaid policy as well.

Third, there has been some interesting scholarship showing gender to be of some interest in relation to social policy. Lott and Kenny (1999) show that women used their newly attained suffrage rights to push for increases in the size of government. Cook and Barrett (1992) note that female survey respondents tend to express more support for welfare programs than male ones. And Poggione (2004) reports that female legislators are significantly more supportive of welfare programs than

their male counterparts. With this in mind, incorporating the gender of legislators and the governor as a potential determinant of Medicaid generosity might be a worthwhile addition to the existing literature.

In addition to incorporating these strands of the literature into the study of Medicaid eligibility, I believe that the existing studies have a few more weaknesses in common that I can improve on. For one, each of the three major studies uses a dichotomous variable to indicate party control over the legislature² noting that, in a polarized legislature, a majority of seats is crucial to pass bills and obtain chairmanship of important committees. However, such a variable neglects the likelihood that a majority party with a 60% majority enjoys greater political power than one with only a 51% majority. This is especially true in light of Wright and Osborn's (2002) finding that party affiliation is less important to roll call voting patterns in some state legislatures than in Congress. With party discipline sometimes less stringent than on the federal level, a continuous measure of the seats held by the Democratic Party would have been the better choice. Failure to include it might explain why neither Grogan nor Baughman and Milyo obtain significant results for party control.

Second, all three studies in question do not adequately include a variable that indicates the severity of the problem — lack of access to insurance — that Medicaid is supposed to address. Presumably, when access to insurance is difficult, policymakers would see a greater need to expand access to Medicaid. Yet, only Baughman and Milyo use such a variable: the percentage of children without health insurance. As the authors themselves realize, the inclusion of this variable presents endogeneity

²As a matter of fact, Baughman and Milyo include both a dichotomous variable and the share of Democrats in the legislature, and the latter is significant with the expected sign. However, they interpret only the former as an indicator of legislative control and the latter as a proxy for the population's ideology — a disputable proposition, since ideology does not directly and smoothly translate into election outcomes.

problems, because states should be able to lower their uninsurance rate with generous Medicaid programs. Baughman and Milyo try to address the problem by using all of their other explanatory variables in neighboring states as instrumental variables. However, it is far from clear that variables of neighboring states should have sufficient predictive power, and the authors do not present the results from the first-stage regression. I suspect that the explanatory power of the instruments in the first stage may have been low, and that this is the reason why uninsurance rates turn out insignificant. In sum, neither article pays sufficient attention to this factor. I will propose another instrument, namely the share of employers that offers pension plans, which I believe to be, if not perfect, at least a marked improvement.

Third, the existing literature has had great difficulties finding appropriate measures for interest group strength. Baughman and Milyo (2008) neglect this factor outright; Grogan (1994, 1996) and Kousser (2002) both rely on the Hrebentar-Thomas measure which does not vary over time. The measure consists merely of a list of influential interest groups in a state, which was compiled in a somewhat subjective manner. This makes it a very rough indicator of interest group strength that should be taken with a grain of salt when used to make cross-state comparisons. I plan to take a new look at the problem by using campaign contributions as the measure of interest group strength, which has the advantage of being available in comparable units at every election cycle and thus much better suited to panel data analysis.

Fourth, all articles focus exclusively on income cutoffs as the defining barrier to Medicaid enrollment. Yet, many who are eligible do not take up insurance, and take-up rates have decreased relative to earlier expansions (Card and Shore-Sheppard 2004), presumably because Medicaid has been expanded to populations who are more likely to have insurance already, or are unaware that they might be eligible

because they have never been eligible for a welfare program. However, another explanation has also found empirical support recently. Two studies have found that bureaucratic barriers to enrollment can reduce take-up rates (Wolfe and Scrivner 2005, Bansak and Raphael 2006), and states vary with respect to the extent that they have these barriers to enrollment in place. This indicates that there might exist another fruitful avenue of research, the study of the determinants of enrollment barriers, that has not been explored by previous research.

In sum, the literature has produced some noteworthy results. It seems clear that Democratic control of the legislature produces more generous eligibility rules, that a stronger medical lobby is associated with larger Medicaid expenditures, and that wealthier states, despite lower matching rates, have larger Medicaid programs. Beyond that, however, much is unclear. Using tools developed in other strands of the literature, such as better “race to the bottom” measures, a better understanding of interparty competition, and consideration for gender-specific attitudes towards the welfare state, in addition to making some methodological advances, I believe that my study improves the existing literature.

4 Model

As discussed in section 2, states can shape their Medicaid policy primarily through three channels. They define who is eligible for Medicaid receipt, which administrative hurdles eligible individuals have to overcome to enroll in the program, and which services are covered under the program at which reimbursement rates. Among these three, it has been the question of eligibility that has seen the most substantial reforms in the last years, and it thus provides an interesting opportunity to study how states operate the program. I therefore focus on the key policy dimension of income thresholds and administrative hurdles shaping who among the poor, near-poor, and increasingly the middle class will be eligible to receive Medicaid coverage. Because these decisions are formulated at the legislative level, state legislatures will be my object of study.

Thus, in my model, state legislatures make three decisions: decisions defining income cutoffs for adult eligibility, decisions defining income cutoffs for child eligibility, and decisions regarding administrative hurdles to Medicaid enrollment. Further, their decisions are defined by four dimensions: the legislators' own ideology, facts, the influence of other actors, and attention. Their ideology dictates how amenable legislators will be towards addressing a perceived problem — low-income households unable to obtain health insurance — through Medicaid expansions. Regardless of their ideology, legislators are also confronted with certain facts that inform them about the necessity and possibility of political action. Some of these facts are directly related to the political problem (how many households would need access to health insurance but cannot afford it), others relate more generally to the objective circumstances the state finds itself in (such as demographics or the state of the economy). Additionally, other actors seek to push the legislators to-

wards action, or to refrain from it. Much of the previous literature on Medicaid policy has essentially been an exercise in trying to identify the relative importance of certain facts, the influence of other actors, and the legislators' ideology.

To these factors, while important, I would like to add another dimension, namely attention. Political scientists have recognized that while politicians face a multitude of problems worth addressing, they can only focus on a few at any given time (Baumgartner and Jones 1993). This is due not only to limited human cognitive abilities and limited information about the world, but more importantly, also to the nature of policymaking itself. Once a proposal for reform has been formulated, it is not immediately passed and then replaced by the next item on the agenda. Rather, it has to undergo a period of discussion, negotiation and adjustment. The proponents discuss the proposal with possible supporters to persuade them of its merits; they negotiate with opponents to identify ways to reach an acceptable compromise; and they adjust the proposal to meet the demands of parties whose support is deemed crucial. In the case of far-reaching reform proposals, this process can take a long time and command much of the legislators' attention, attention which then cannot be expended to other issues. As a result, issues will be showered with attention at some times when they have been put on the political agenda, only to then be neglected for extended periods of time. Applied to Medicaid, this concept implies that far-reaching overhauls of Medicaid rules will be possible only in those years when attention paid to these rules is sufficiently large. As will be shown later on, especially for the somewhat more technical and obscure realm of administrative hurdles, this is not the case in most years.

Yet this does not mean that Medicaid rules stay entirely unchanged during those years when they are not reformed extensively. Rather, incremental changes at the margin can still occur in the absence of much attention expended to the issue.

Baumgartner and Jones (1993) argue that during these stretches of time of limited attention, formulation of policy is left to a rather small circle of experts and interested parties who are familiar with the intricacies of the issue. The result is a “policy monopoly,” a small circle of experts who share a certain interpretation of the political issue and the preferred way of addressing it. In the case of Medicaid policy, the issue is the affordability of medical care, the preferred policy is a Medicaid program with certain basic characteristics, and the actors consist of select lawmakers with a particular interest in the topic (perhaps the members of the health committee), a few lobbyists of interested parties, and senior Department of Health and Human Services officials. Although they might have some private misgivings about Medicaid, these actors have accepted a common interpretation of the goals and the scope of the program and display no interest in radical change. Indeed, they have a strong incentive not to propose radical reform, for such a debate would attract the attention of many other parties and the general public, thereby endangering the expert circle’s privileged position. Incremental changes, on the other hand, are quite feasible. The advantage of incremental change is that it allows for a process of experimentation, evaluation and adjustment without taking overly large risks of unexpected outcomes, a large advantage in a world where information is limited and costly to obtain, and consequences of proposed action are uncertain (Braybrooke and Lindblom 1960). Moreover, a small change can often be implemented without inviting the attention (and opposition) of potential opponents of the policy, as they are busy paying attention to other issues higher on the agenda. Therefore, the process of discussion, negotiation and adjustment is truncated considerably.

If the proposed model holds, then attention is an important factor in the formulation of Medicaid policy, for the obvious reason that incremental and non-incremental policies are formulated by two different sets of actors. In the non-

incremental case, it is the full legislature that is deciding on the policy, whereas incremental reform is formulated by a smaller circle of legislators intimately involved with the subject matter. Moreover, there are reasons to believe that the degree of attention might be related to the interplay of ideology and other factors in important ways. That is, some of them might be of greater relevance in explaining non-incremental change in high-attention settings, while others could be better suited to account for incremental change in low-attention settings. In particular, since incrementalism restricts the terms and the number of actors involved in the process of discussion, negotiation and adjustment, factors that are tied to this process are presumably less relevant for explaining incremental change. I will discuss later which factors can be hypothesized to be of which kind. First, I will introduce ideology, facts, and the other actors contained in my model and why they are potentially important.

Ideology. Decisions regarding Medicaid eligibility fall into the realm of the contested issue of the appropriate scope of government intervention through the welfare state. Some see broader access to Medicaid as much-needed assistance to the needy who lack access to a service essential to human well-being; others regard it as an intrusion into a functioning market and an inappropriate extension of government power.

Party affiliation. Ideology plays out both in the legislative and the executive branch, and party affiliation is important in both cases to structure ideological positions. In general, liberals have generally been associated with support for a larger Medicaid program, while conservatives have tended to argue for a more restricted scope of the program. In the legislature, scholarship indicates that legislators align along party lines in state legislatures in ways similar to Congress, with Democrats taking liberal, Republicans taking conservative positions (Wright and

Osborn 2002). The governor can bring his ideology to bear because he enjoys some form of veto power in all states. In addition, he can shape policy through a number of more indirect tools, such as the drafting of the governor's budget (which usually serves as a blueprint for the final budget passed by the legislature), his power to convene the legislature to special sessions, and his strong public presence that allows him to shape the agenda. For either branch of the government, one can expect control by Democrats to improve the prospects of a possible Medicaid expansion.

Gender. Since women tend to express more support for a larger welfare state (Cook and Barrett 1992, Poggione 2004), we would expect a larger share of women in the state legislature or the presence of a female governor to improve the prospects of a Medicaid expansion.

Directly problem-related facts. The more they perceive the market is unable to provide affordable health insurance to low-income households, the more legislators or the governor will feel the need to act, and an expansion of Medicaid is the most straightforward way to make health insurance accessible to more people. Thus, high rates of involuntary uninsurance will be more likely to spur legislators or the governor into action.

Lack of private Insurance. Medicaid is meant to provide public health insurance to those who are unable to obtain it through the open market. Low levels of private insurance coverage will increase the pressure on state legislatures to act to mitigate the problem.

The number of poor. Whether or not someone is covered by private insurance does not tell us whether the lack of insurance is involuntary. Some Americans have access to health insurance but decide not to buy it. To account for this possibility, it is necessary to include some measure of involuntary uninsurance, and the share of the population living below the poverty line can serve this purpose. Health insur-

ance is usually provided through the employer, where each worker is part of a rather favorable risk pool (able-bodied adults under 65) and can thus purchase insurance more cheaply than he could on his own. Low-paying jobs, however, are less likely to offer it. Consequentially, poor individuals with no work or with only a low-paying job are less likely to have access to private health insurance. States with a larger poor population, then, are likely to have a greater involuntary uninsurance rate.

General facts. Different states operate in different economic and demographic environments, and state legislatures will take these into account when making eligibility decisions. Some states have a stronger economic standing, enabling state governments to extract higher taxes and expand eligibility further than others. Yet other states have demographic characteristics that make it relatively more expensive to expand Medicaid than others.

Gross State Product. All other things equal, wealthier states should be able to afford more generous welfare programs, including eligibility rules.

Tax revenue. Where gross state product measures the general state of the economy, tax revenue is a more specific measure of the extent of financial leeway available to a state government in a given year. Less revenue translates into a tighter constraint on program generosity.

The Federal Matching Rate. To assist economically weaker states, the federal government provides a variable federal matching rate: for each dollar the state spends on Medicaid, the federal government matches it with at least another dollar, and often more. The matching rate is designed so as to match payments of poorer states with more federal dollars than of richer states. A high federal matching rate makes it relatively cheaper for a state to reap benefits for its population, and so represents a relatively stronger pressure on legislators to expand eligibility. It will be interesting to see whether the matching rate can effectively counteract the more

dire economic circumstances of the poorer states.

The demographic share of children. In states where children make up a larger share of the population, extending Medicaid to higher income strata will imply larger numbers of children on the roll, and thus higher costs. On the other hand, holding economic conditions constant, more children will translate into more children who lack access to health insurance, and this might contribute to the impression that the state needed to get active. It is unclear, then, whether states with many children should have more or less generous eligibility cutoffs.

The demographic share of the elderly. Senior citizens, while making up only a small fraction of Medicaid recipients, account for a disproportionate amount of expenses due to high costs of nursing-home care. Therefore, large numbers of elderly citizens should be associated with large costs to the Medicaid program, and by extension, less financial leeway to extend the program to non-elderly populations.

Minorities. Minorities are disproportionately affected by poverty, and hence also more likely to receive Medicaid. To the extent that white voters are racist and seek to prevent welfare state expenditures that will go to minority populations, a large minority population will invite more hostility to Medicaid eligibility expansions by white racist voters.

Other actors. Legislators do not operate in a vacuum — they are only some of a number of actors trying to influence the legislative outcome. Also involved in the legislative process are interest groups, and, at least in some cases, the public at large.

Interest group pressure. Through their lobbying efforts, interest groups can affect the outcome of the legislative process. Although there are, to my knowledge, no strong organized interest groups representing the poor on the state level, there are other relevant interest groups to take into account: the insurance industry, labor unions, hospitals, and physicians. Since an expansion of Medicaid can theoretically

lead to some crowd-out of private insurance, I would expect a strong presence of the insurance industry to be associated with less generous eligibility rules. On the other end of the political spectrum, labor unions will usually lobby for Medicaid expansions in order to score gains for their working-class constituency. The expectations for hospitals and physicians are more mixed. On the one hand, to the extent that Medicaid expansions cover the previously uninsured, these two groups will support more generous eligibility rules as it increases the number of paying clients. This is especially true for hospitals, who might otherwise have to provide emergency inpatient services to the uninsured for which they would never get reimbursed, though this is mitigated in many states by uncompensated care funds (Grogan 1994). On the other hand, to the extent that Medicaid crowds out private insurance, these two groups will be opposed to Medicaid expansions as reimbursement rates for Medicaid are usually far lower than for private insurance companies. Ex ante, it is not clear which of the two effects should be stronger.

Public opinion. Although the public does not control policymaking directly, I would nevertheless expect forward-looking legislators who wish to win reelection to take public opinion into account when making a decision at least some of the time. In general, one would expect more liberal populations to support more generous Medicaid programs.

Interparty competition. Barrilleaux, Holbrook and Langer (2002) hypothesize that, whenever races are tightly contested, candidates try to secure victory by appealing to their party base. In the case of Democrats, the base tends to be more liberal, and thus in favor of more generous eligibility rules. Therefore, Democrats in tightly contested states might feel more compelled to expand eligibility.

Other states. Some scholars believe that states engage in a “race to the bottom,” reducing generosity to prevent populations from surrounding states from moving

in so as to take advantage of the more generous rules. Even if migration does not actually happen, the mere concern that it might can spur politicians into action. If states which are relatively generous with their eligibility rules compared to their neighbors systematically reduced their generosity, it would provide support for the “race to the bottom” thesis.

How would these factors play out differently in settings where a policy monopoly is intact (and thus any change, if at all, will be incremental) versus settings where a policy monopoly does not exist (which opens the door to non-incremental change)? What is clear is that, while a policy monopoly is firmly entrenched, an issue will not be subject to much public discussion, and thus will attract little attention from the public, including the Democratic party base. Therefore, one can expect public opinion and interparty competition to play less of a role. Beyond that, however, it is not obvious how a functioning policy monopoly would make a difference. Whether or not a policy monopoly exists, a shift of power that changes the ideological composition of either the circle of experts or, more broadly, the legislature and/or the executive branch, should result in change in the same direction. Similarly, interest groups will have their say whether a policy monopoly exists or not. And facts can always be taken into account by decision-makers, whether they form part of a policy monopoly or not. Thus, except for public opinion and interparty competition, I cannot formulate any hypotheses as to which other forces should be relatively more important in bringing about either incremental or non-incremental change. A distinct possibility, however, is that, because a policy monopoly consists of only a few actors, a change could easily come about simply due to idiosyncratic factors that only involve the members of the policy monopoly (e.g., a few members become preoccupied with other issues, someone retires or becomes sick, etc.). Such an event might change the dynamics of the policy monopoly and lead to change

without a change in any of the systemic factors examined here.

Finally, I would expect states that have generous eligibility rules along one dimension to also be generous along the other two. It is interesting to think of reasons why this might not be the case. One reason could be that policies on the different dimensions are crafted at different times by different actors, and the outcome differs for that reason. Another explanation could be that one might value one dimension more highly than others: some consider children more deserving than adults, and are thus willing to tolerate low eligibility thresholds for adults while pushing for generous policies for children. Others would prefer relatively generous eligibility standards for poor adults, even if this takes resources away from the children. A third scenario, perhaps somewhat cynical, is that some politicians would like their Medicaid to appear more generous than they actually are, to capture votes while meeting the budget. One way to do this would be to grant generous income thresholds while at the same time making the application process very odious. These possibilities notwithstanding, I would broadly expect the same forces to be at work pushing for expansion or contraction along all three dimensions, and generosity should be roughly similar.

5 Empirical Strategy & Data

My strategy to test the model is to construct a panel of 47 states — all 48 contiguous states minus Nebraska³ — across a 14-year time frame from 1997 to 2010.⁴ The timeframe is chosen because since the federal government created CHIP in 1997, no new major federal legislation has mandated changes in eligibility standards in Medicaid. Thus, changes in the eligibility standards during this time can be solely attributed to the states. I will use measures of children’s eligibility, adult’s eligibility, and administrative barriers to enrollment as my dependent variables, and run separate regressions for each of them, using state- and year-fixed effects to focus on within-state, over-time variation. My baseline regression equation is:

$$\begin{aligned} \textit{Generosity} = & \beta_0 + \beta_1 \% \textit{ Democratic Seats} + \beta_2 \textit{ Democratic Governor} \\ & + \beta_3 \% \textit{ Female Legislators} + \beta_4 \textit{ Female Governor} \\ & + \beta_5 \textit{ Private Insurance Coverage} + \beta_6 \textit{ Poverty Rate} \\ & + \beta_7 \textit{ Campaign Spending} + \beta_8 \textit{ Public Opinion} \\ & + \beta_9 \textit{ Relative GSP} + \beta_{10} \textit{ GSP Growth} + \beta_{11} \textit{ FMAP} \\ & + \beta_{12} \textit{ Tax Revenue} + \beta_{13} (\% \textit{ 18-}) + \beta_{14} (\% \textit{ 65+}) \\ & + \beta_{15} \% \textit{ Hispanics} + \beta_{16} \% \textit{ Black} + \beta_{17} \textit{ Interparty Competition} \\ & + \beta_{18} \textit{ Competition x Democratic Seats} + \gamma \textit{ State} + \delta \textit{ Year} + \epsilon \end{aligned}$$

Generosity refers to a measure of the state’s generosity regarding Medicaid eligibility. For children’s eligibility, I follow Baughman and Milyo (2008) and use “simulated eligibility,” which is created via an imputation of the percentage of children

³Nebraska has to be excluded because of its nonpartisan legislature, whose members are not officially affiliated with either party. Thus, there is no way to code the state for the “% Democratic Seats” variable.

⁴The year 2010 presents a problem because not all data are yet available for this most recent year. Data on the demographic composition of the state populations and public opinion have not yet been released. For these variables, I have to extrapolate values for 2010. Comparisons with regressions where I have dropped the year 2010 entirely indicate that this makes very little difference, and the results are essentially the same.

eligible for Medicaid in a given state and year if that state's children had the demographic and economic characteristics of the national average. Included are children eligible for Medicaid, CHIP and state-funded programs, provided these programs provide a complete benefit package. I use this variable because it has two highly desirable properties. First, in many states, income eligibility cutoffs vary by the children's age; the simulated eligibility variable collapses a complex set of rules into a single index that represents overall eligibility of all children. Any income threshold would only apply to a given age group of children, and thus fail to represent the entirety of rules for different age groups. Second, the simulated instrument depends only on the legislative environment and not on the general economic climate in a given year. Therefore, if a recession sets in that affects the number of children eligible by pushing more people's incomes below the income threshold, this variable does not change. This is a key difference from the number of children actually eligible each year, which fluctuates not only with changes in legislation but also with the economic environment. My variable is based upon a 1996 sample drawn from the Current Population Survey (CPS) and is based on the imputation algorithm of Cutler and Gruber (1996), Shore-Sheppard (2008) and Watson (2010).

Table 5.1 presents some summary statistics of the simulated variable. Overall, states have moved towards more comprehensive coverage for children, and by 2010, the average share of children eligible has reached 53%, up from 37% in 1997.⁵ A phase of expansion from 1997 to 2002 was followed by a phase of stagnation until 2006, and there has been renewed expansion since then. The fact that the average moved up is not just a product of a few outliers increasing eligibility standards while everyone else stayed put. All states except Rhode Island increased eligibility at least

⁵It should be noted that these are state averages, not national averages. A small state like North Dakota and a large state like California receive equal weight in the calculation of these statistics.

Table 5.1: Summary Statistics: % of Children Eligible in a Given Year (Simulated)

Year	Average	St. Dev.	Range
1997	37.19	6.82	29.4-57.4
1998	38.89	8.48	29.4-74.9
1999	43.26	9.72	29.4-74.9
2000	44.72	10.12	29.4-74.9
2001	46	9.36	29.4-74.9
2002	46.77	9.66	29.4-74.9
2003	46.17	8.67	29.4-70.2
2004	46.46	8.31	31.1-70.2
2005	46.62	8.12	31.1-70.2
2006	47.14	8.35	31.1-70.2
2007	49.22	11.64	31.1-100
2008	49.84	11.34	33.2-100
2009	50.69	11.87	33.2-100
2010	53.12	11.99	35.2-100

once, and no state had lower eligibility standards in 2010 than in 1997. In 1997, there were 15 states which granted eligibility to less than 30% of children; by 2010, there were none. Since 2006, Illinois stands out as the only state to cover all children through its state-funded AllKids program. What is also remarkable is that there is no prima facie evidence of an adverse impact of the 2001 recession and the recent financial crisis on eligibility standards. Both recessions occurred during a period of expansion of the program, and neither has adversely impacted eligibility rules. In the case of the 2008-2010 recession, this might have been an effect of the stimulus package, which stipulated that states which received federal funds were not allowed to reduce eligibility standards below what they were in July 2008.⁶ Nevertheless, some states even increased eligibility standards during this difficult time for state budgets.

Unfortunately, the simulated variable has only been created for children, and it

⁶As the next section will show, eligibility standards for adults decreased slightly since 2008. This is mostly due to standards being eroded by inflation and states' closing enrollment for some extra programs that had been created under a waiver from CMS. Apparently, waiver programs were unaffected by the stimulus rules.

Table 5.2: Summary Statistics: Income Eligibility Thresholds for Working Parents, in % of the Federal Poverty Line

Year	Average	St. Dev.	Range
1997	65.32	34.06	23-193
1998	69.79	34.51	22-193
1999	73.85	39.97	22-193
2000	78.19	42.64	22-193
2001	85.04	53.70	21-275
2002	84.96	54.69	20-275
2003	84.89	54.11	20-275
2004	83.54	54.79	19-275
2005	84.80	57.67	19-275
2006	86.42	59.12	18-275
2007	87.22	60.46	18-275
2008	90.74	62.51	17-275
2009	86.08	61.58	17-275
2010	86.56	58.85	17-275

would have been too time-intensive to create one for adults as well. Therefore, my variable for adult eligibility will be the maximum income threshold as a percent of the poverty line for heads of 3-person families, after accounting for any earnings disregards. The data come from Hamersma and Kim (2009), Cohen-Ross et al. (various years) and Heberlein et al. (2011).⁷

As Table 5.2 shows, eligibility for parents became significantly more generous on the whole between 1997 and 2001 before leveling off during the following decade. At the same time, the standard deviation continued to increase, an indication that divergence in the extent to which different states decided to cover adults increased during the period. By 2009, the variation had become quite remarkable. In 2009,

⁷The data provided by Hamersma and Kim (2009) cover 1996-2003; data from Cohen-Ross et al. have been consistently available since 2003. To make the data compatible, I have to make several modifications to Hamersma and Kim's data. First, their data are monthly, so I use July as the reference month to convert them into annual data. Second, they report income thresholds as referring to someone who has been on Medicaid for 12 months, whereas Cohen-Ross et al. use thresholds for new applicants. Third, they exclude all programs for which enrollees have to pay a premium, whereas Cohen-Ross et al. include these. If there are discrepancies between the two sources, I adjust Hamersma and Kim's data to fit Cohen-Ross et al.'s. Overall, I believe that these are minor technicalities that should not greatly influence my results.

Table 5.3: Bureaucratic Barriers to Medicaid Enrollment

Description	Included in Weighted Index?	Weight
Separate Medicaid and CHIP program	Yes	9.7
Separate applications for Medicaid and CHIP	No, not included in Bansak and Raphael (2006)	N/A
No presumptive eligibility	No, wrong sign in BR	N/A
Required proof of income	Yes	1
Loss of eligibility if income changes during the year	Yes	5.7
Separate renewal forms for Medicaid and CHIP	Yes	7.6
Required minimum time of uninsurance before eligibility	Yes	6
Separate applications for different family members	No, wrong sign in BR	N/A
Renewal more frequent than annual (children)	No, not included in BR	N/A
Face-to-face interview at renewal (children)	Yes	0.2
Face-to-face interview at application (children)	Yes	3.5
Asset test (children)	Yes	17.1
Express Lane Eligibility ⁸ not yet implemented	No, not included in BR	N/A
Face-to-face interview at Application (adults)	No, not included in BR	N/A
Asset test (adults)	No, not included in BR	N/A
Renewal more frequent than annual (adults)	No, not included in BR	N/A
Face-to-face interview at renewal (adults)	No, not included in BR	N/A

the most stringent states, Alabama, Arkansas, Idaho, Louisiana, Missouri and Texas, only offered insurance to parents with an income of less than 30% of the poverty line. By contrast, Maine, Minnesota, New Jersey and Wisconsin all offered public health insurance to parents with an income up to 200% of the poverty line; Minnesota even went as far as 275%.

My third variable is a measure of the barriers to enrollment Medicaid applicants face, which constitute an indirect way for states to affect the number of people on the program by making these barriers more or less onerous. The barriers, listed in Table 5.3, can take on a number of forms, and data on them are available in the form of a series of dichotomous variables.⁹ Most, but not all, refer to the appli-

⁸This is a new feature that allows states to use data from other means-tested programs to determine eligibility, thereby speeding up the application process.

⁹One drawback of the indices is that while they contain many important barriers, they do not take into account on-line applications. Unfortunately, data on the availability of on-line applications have not been collected throughout the years, yet this is where states have been quite active in the most recent years (Heberlein et al. 2011). As a result, the index probably understates the amount

Table 5.4: Summary Statistics: Indices of Bureaucratic Barriers to Medicaid Enrollment

	Year	2002	2003	2004	2005	2006	2007	2008	2009	2010
Unweighted Index	Average	10.33	10.24	10.18	10.24	10.40	10.06	10.80	11.03	11.24
	Standard Deviation	2.22	1.90	2.02	2.11	1.93	2.07	2.06	2.00	2.02
Weighted Index	Average	17.59	16.93	15.97	16.15	15.86	15.92	15.76	16.29	16.76
	Standard Deviation	9.39	9.92	10.24	9.43	8.74	8.52	8.56	9.30	9.38

cation process for children, while some concern the application process for adults. To collapse all enrollment barriers into one variable, I have constructed two indices, one unweighted and one weighted. In the unweighted index, each state is awarded one point for each measure it has undertaken to ease the application. If the state has separate CHIP and Medicaid programs, the removal of a barrier for only one program but not the other results in half a point. The weighted index uses as weights the estimated effect of the barriers on take-up rates, according to Bansak and Raphael (2006). The weighted index has the obvious advantage that it assigns more weight to those barriers that have been found to be more important; however, some barriers were not investigated in the study by Bansak and Raphael, and for two, the estimates had the wrong sign. I dropped these from the dataset. Cohen-Ross et al. (various years) and Heberlein et al. (2011) provide data on eligibility barriers; unfortunately, the data have only been collected since 2002. Table 5.4 contains some summary statistics of the indices. During the time period for which the data are available, neither index shows any discernible trend regarding either its average or its standard deviation. Thus, neither did states tighten or loosen bureaucratic restrictions overall, nor did they converge to a certain level of “tightness”.

Next, there are a series of independent variables, summary statistics of which of change that has occurred in the most recent years. More generally, there is doubtlessly some measurement error contained in this variable, because occasionally, the rules are too complex to be expressed in a simple yes/no scheme, and some judgment calls have to be made in these cases.

are presented in Table 5.5. *% Democratic Seats* is the average share of seats held by the Democratic Party in the two state legislatures. This variable is why Nebraska has to be excluded from the dataset: its legislature is nonpartisan. The remaining variables regarding government ideology, *Democratic Governor*, *% Female Legislators*, and *Female Governor*, indicate whether the governor is Democratic, the percentage of the legislatures made up by women, and whether the governor is a woman, respectively. The variables relating to the legislatures are percentages, and thus range from 0 to 100, while the variables on governors are dummy variables, and are thus 0 or 1 for each observation. This information comes from the National Conference of State Legislatures and from the Center for American Women and Politics.

Private Insurance and *Poverty Rate* are the percentage of the state's population that has private health insurance coverage and the percentage with incomes below the federal poverty line, respectively. *Private Insurance* includes military and veteran's insurance, and I have two separate variables for children and for the general non-elderly population. The latter is used in the regression on adult eligibility rules, while I choose the former for all other regressions. On average, the percentages for both variables are around 70, while the percentage of the population below the poverty line ranges from about 5 to 25. Insurance coverage presents a special problem that needs to be addressed. Because a generous Medicaid program can lead to crowd-out of private health insurance (Gruber and Simon 2008), the equation as stated above could suffer from reverse causality, causing bias in the coefficients. One way to handle this problem is to find an instrumental variable that is correlated with private health insurance coverage but does not affect Medicaid coverage through any channel other than its effect on health insurance coverage. However, finding such a variable is difficult. In my view, the variable that comes closest to meeting these criteria is the share of employees whose employer offers a

Table 5.5: Summary Statistics: Independent Variables

Variable Name	Description	Mean	SD	Range
% Democratic Seats	Average share of seats in both chambers that are held by Democrats	51.56	14.50	14-89.5
Democratic Governor	1 if Governor is a Democrat, 0 otherwise	0.45	0.50	0-1
% Female Legislators	Average share of female legislators in both chambers	22.74	7.34	4.3-40.8
Female Governor	1 if Governor is female, 0 otherwise	0.11	0.31	0-1
Private Insurance, Children	% of the population under 18 with private health insurance	71.80	8.01	46.9-89.9
Private Insurance, Adults	% of the population under 65 with private health insurance	70.70	6.77	52.3-87.8
Poverty Rate	% of the population with income below the Federal Poverty Line	12.13	3.24	4.5-25.5
Campaign Spending, Physicians	Campaign contributions by groups representing health professionals, averaged over two years, in per capita dollars	0.17	0.14	0-1.28
Campaign Spending, Hospitals	Campaign contributions by groups representing hospitals, averaged over two years, in per capita dollars	0.059	0.139	0-1.07
Campaign Spending, Insurance	Campaign contributions by groups representing accident & health insurance, averaged over two years, in per capita dollars	0.036	0.055	0-0.41
Campaign Spending, Unions	Campaign contributions by unions, averaged over two years, in per capita dollars	0.46	0.63	0-5.52
Campaign Spending, Senior Citizens	Campaign contributions by groups representing senior citizens, averaged over two years, in per capita dollars	0.093	0.146	0-1.20
Public Opinion	Share of survey respondents that identifies as liberal minus share that identifies as conservative	-14.71	10.69	-46.4-13.9
Relative GSP	GSP per capita divided by average GSP per capita of all states in the sample	1.00	0.18	0.69-1.63
GSP Growth	Real GSP growth from previous year	2.39	2.62	-6.39-10.75
Tax Revenue	Change from previous fiscal year's total per capita tax revenue	65.23	139.0	-539-795
FMAP	Federal Matching Percentage	60.52	8.44	50-78.1
% 18-	% of the population under 18 years old	24.91	1.86	19.9-33
% 65+	% of the population over 65 years old	12.81	1.59	8.5-18.2
% Hispanics	% of the population who identifies as Hispanic	8.86	9.57	0.5-46
% Black	% of the population who identifies as Black and not Hispanic	10.67	9.58	0.3-37.4
Interparty Competition	Square root of average margin of victory in state legislature elections	6.78	1.26	1.9-8.84
Competition x Democratic Seats	Product of Interparty Competition and Democratic Seats	341.75	119.48	51.4-710
Race to the Bottom	Difference between the average child eligibility level of a state's neighboring states and the state itself	-0.44	10.51	-53.85-19

pension plan. It is certainly correlated with health insurance coverage — employers who have set up a pension plan for their employees are also likely to offer other fringe benefits, such as health insurance. A univariate regression of children's private insurance coverage on the share of employees with a pension plan is highly significant with the expected positive sign (t-statistic: 22.9). As for the second criterion, the instrument should be able to address the crowd-out problem (a change in Medicaid policy should not change an employer's willingness to offer a pension plan), but I cannot be entirely sure that it is not correlated with Medicaid policy in a state through a channel that is unaccounted for in the regression. I have tried to account for the two factors I see as the most likely to affect both Medicaid policy and pension plan coverage — gross state product and the strength of unions (see below). However, there are still other channels through which bias could be introduced into the equation. For example, a state might choose an expensive Medicaid program and raise income taxes to finance it, and employers might react by paying employees less in income and more in the form of fringe benefits. These difficulties notwithstanding, I still believe that using the instrument is preferable to going without it, because at least it manages to eliminate bias resulting from crowd-out. The reader should be aware of the difficulties and treat the resulting estimates with some caution. Both insurance coverage and poverty rate data come from the Current Population Survey.

Campaign Spending is a vector indicating the strength of various interest groups in the states. My measure of interest group strength is per capita campaign contributions in state gubernatorial, congressional, court and ballot races. The five different categories of interest groups considered here are groups representing health professionals, hospital associations, accident and health insurance companies, labor unions, and senior citizens. One drawback of this measure is that regular elections

in states occur only once every two years. Therefore, I group the years into pairs and assign each year the average of spending for the pair, starting with 1997-1998. Union spending, at 46 cents of spending per inhabitant of a typical state in a given year, is far higher than any of the other groups, with only doctors (average spending of 17 cents per inhabitant) making campaign contributions that are anywhere close to what unions spend. Equally noticeable is the large variation in spending, as the standard deviation is larger than the mean in nearly every category. Data on campaign spending come from the nonpartisan activist group National Institute on Money in State Politics.

Public Opinion is a measure of voter ideology following Erikson, Wright and McIver (1992). It is based on regular CBS/New York Times polls in which respondents are asked to identify themselves as liberal, moderate or conservative. The measure consists of the difference between the percentage that identifies as liberal and the percentage that identifies as conservative; if there are more conservatives than liberals, it will be negative. Theoretically, this measure could range from -100 (everyone identifies as conservative) to 100 (everyone identifies as liberal); in practice, the variable ranges from -46 to 14. The single largest disadvantage of this measure is that sample sizes are too small to allow ideology scores for each year and each state. In two states (Wyoming and North Dakota), annual sample sizes are as small as 60 in most years. This problem can be somewhat mitigated by using moving averages, taking into account not just the current year but also previous and future years. I have decided to use this approach, adding the previous and the coming year whenever necessary to increase the combined sample size to over 600,¹⁰ up to a maximum of four years in either direction. To give the most weight to observations

¹⁰Setting it to at least 600 implies that the margin of error will be smaller than 4%, which seem to strike an appropriate balance between precise estimates and few years.

Table 5.6: Average Sample Sizes in Public Opinion Data

Sample Size	Moving Average	States
Over 600	none	CA, FL, IL, MI, NY, NC, OH, PA, TX
200-600	3-year	AL, AZ, AR, CO, CT, GA, IN, IA, KS, KY, LA, MD, MA, MN, MS, MO, NJ, OK, OR, SC, TN, VA, WA, WI
120-200	5-year	ME, NH, UT, WV
80-120	7-year	ID, MT, NV, NM, VT
Under 80	9-year	DE, ND, RI, SD, WY

from the current year, a weighted moving average is used, where the current year receives weight n , the adjacent years receive weight $n-1$, then $n-2$, and so forth, all the way to the years furthest removed from the current year, which receive weight 1. Table 5.6 shows state-by-state comparisons of how much pooling is necessary. For most states, a three-year moving average (consisting of the current, the coming and the previous year) appears sufficient. Five states, however, have such small samples that I need to use four future and past years to bring the sample size up. While using ideology from a total of nine years might seem troubling, the problem is not overly severe in light of McIver, Erikson and Wright's (2001) finding that differences in ideology across states remain very stable over time.¹¹

The remaining variables address economic and demographic circumstances of the states. *GSP* is real per capita gross state product, a measure of the overall prosperity of the state. To tease out two slightly different effects, I have included two separate variables. One is *GSP relative to average GSP* across all states in a given year, and it should measure whether relatively poor states have more stringent eligibility rules than relatively rich ones. On average, this variable is, of course, 1. The other, *GSP Growth*, is the GSP growth rate relative to the previous year, and

¹¹At the end of the sample, there are no future years to consider, so the average is over at most five years.

it should measure whether periods of economic expansion or recession affect the Medicaid program. Over the course of the period studied, average GSP growth was 2.39%. The reason these two might be different is *FMAP*, the federal matching rate for Medicaid. The matching rate, ranging from 50 to 78, is higher for relatively poorer states and thus somewhat offsets the effects of being a relatively poor state, but not the effects of having lower growth than other states in a given year. *Tax Revenue* is the annual change in the total amount of per capita state tax collections over the previous fiscal year. Because tax revenues generally increase over time due to economic growth and inflation, I use changes from the previous year as a detrended measure to capture deviations from the general upward trend. On average, per capita tax revenue increase by 65 dollars, but there are significant deviations in either direction.

% 18- gives the proportion of the population under 18 (mean: 24.9), *% 65+* is the proportion of the population over 65 (mean: 12.8). *% Hispanics* (mean: 8.9) and *% Black* (mean: 10.6) identify the share of the population that is Hispanic and black but non-Hispanic, respectively. As could be expected, the ethnic variation by state is far higher than the variation by age group. All economic and demographic information is taken from the Census Bureau and the U.S. Department of Health and Human Services.

Next, *Interparty Competition* is a measure of interparty competition inspired by Barrilleaux, Holbrook and Langer (2002), defined as the average of the square root of each candidate's margin of victory in statewide electoral races. The square root is chosen to penalize uncontested races, where the margin of victory is by definition 100%; without the square root, a handful of uncontested races in an otherwise competitive state might skew the results relative to one where all races are contested. Theoretically, then, this variable could range from 0 (all races are

ties) to 10 (all races are uncontested), while it actually ranges from 1.9 to 8.8. Data on statewide election races come from Carsey et al. (2008) and suffer from one serious deficiency: the dataset has been discontinued after 2003, and to my knowledge, no other comparable dataset exists. Therefore, each regression has to be run twice, once with the interparty competition variable included, one without it to capture the years since 2003. Since Barrilleaux, Holbrook and Langer argue that increased interparty competition leads to more liberal policies in states controlled by Democrats (but not to more conservative policies in states controlled by Republicans), I have also constructed the variable *Interparty Competition x Democratic Seats* as the product of the two variables. It should measure whether increased interparty competition leads to more generous eligibility policies if Democrats are relatively more powerful in the legislature.

Finally, *State* and *Year* add the state- and year-fixed effects, the inclusion of which warrants some discussion. On the one hand, it is tempting to include these effects because I am dealing with a panel of states, and there may be unobserved attributes to the states or to particular years that are not captured in the other variables. Hence, the inclusion of the fixed effects could be useful to eliminate omitted variable bias. On the other hand, it is important to keep in mind that eligibility rules are not reformulated in every state during each year in the sample, yet inaction constitutes also useful information that should not be suppressed. As a hypothetical example, consider a liberal state with Democratic control of the legislature throughout the observed period, which has instituted relatively generous policies before the observation began and has not changed them since. Without the fixed effects, such a state would provide support for the hypotheses that Democratic party control of the legislature and liberal ideology is conducive to generous eligibility policies. Yet, upon the inclusion of state-fixed effects, the state would no longer contribute

to the identification of the effect of Democratic party control, because including state-fixed effects is algebraically equivalent to taking differences from the mean across years, and these differences are zero for all years in our example. Therefore, the decision whether or not to include the fixed effects involves a trade-off between allowing for some omitted variable bias and removing some informative variation. I will therefore run the regressions both with and without these effects.

While the baseline regression allows a great deal of inference about variables affecting Medicaid eligibility, it is unable to account for different political processes leading to incremental or non-incremental change. A second step will allow me to test my model more thoroughly. First, I isolate all instances of change in a state's eligibility policy, and then group them according to whether or not the change is incremental. Such a distinction can be made only approximately, because I have no way of observing whether or not a policy monopoly is intact at any given time; to do so would require a more detailed case study of a state. Thus, I am left having to define a certain cutoff between incremental and non-incremental change, and there is no precisely "correct" way of going about it. In addition to my baseline cutoffs described here, I also try several other cutoffs to test robustness. Regarding children, I set incremental change to be any change that results in three percent or fewer of all children gaining or losing eligibility. For parent eligibility, I define as incremental any change that adjusts the income threshold by five to twenty percent of the federal poverty line. Changes smaller than five percent are not considered changes at all, for a simple reason. While the federal poverty line is adjusted every year to account for inflation, some states define their income thresholds in dollar terms and do not adjust them for inflation. In these states, the threshold will decline by one to three percent from one year to the next when it is expressed in percent of the poverty line, even though the underlying legislation has not changed. While

Table 5.7: Number of Incremental and Non-Incremental Changes

	Incremental Change		Non-Incremental Change		Total
	+	-	+	-	
Children's Eligibility	29	0	53	1	83
Adults' Eligibility	37	12	38	11	98
Barriers to Enrollment	98	77	7	1	183
Total	164	89	98	13	

the legislators are likely aware of this erosion of the thresholds' real value, being inactive in stopping the erosion should not be mistaken for actively lowering income eligibility levels. Therefore, I ignore all changes smaller than five percent. For enrollment barriers, I consider a change non-incremental if the unweighted index changes by more than two units; all other changes are considered incremental. The idea is that a state pursues incremental change if it changes one or two enrollment policies in a year, but is pursuing a broader overhaul if it enacts more changes than that.

Table 5.7 provides an overview over legislative changes from 1997 to 2010. Columns with a plus sign denote an expansion in eligibility, a minus is a reduction. Two features are noteworthy. First, the vast majority of changes to enrollment barriers are incremental. Evidently, broad overhauls of these rules are far less common than small adjustments of one or two rules at a time. This makes sense since rules regarding enrollment barriers seldom grab the spotlight of public attention, and their discussion is thus more likely to be confined to a smaller circle of experts. As discussed in section 4, such circles are more likely to settle for incremental change. Second, most changes to adult eligibility and all but one change to children's eligibility have expanded eligibility. This is consistent with the earlier tables 5.1 and 5.2, which show a gradual expansion of eligibility since 1997.

With so few instances of eligibility reductions in income eligibility on the one

hand and non-incremental changes in enrollment barriers on the other hand, I cannot test statistically for each type of change separately. Instead, I group them into three categories: instances of incremental expansions, instances of non-incremental expansions, and instances of reductions. Ideally, I would have liked to distinguish between incremental and non-incremental eligibility reductions as well, but the limited number of reductions does not allow that. For each of the three categories, I form a dummy variable indicating for each state-year observation whether such a change has taken place, and then run regressions using linear probability models. These models are suitable for my purposes because they produce easily interpretable coefficients, which indicate the change in probability of the legislative change occurring associated with a one-unit change in the explanatory variable. Furthermore, they allow me to keep the state- and year-fixed effects, which more sophisticated methods such as logistic regression do not.

In addition, the linear probability regressions allow for a test for a “race to the bottom” through the inclusion of an additional variable which measures the percentage difference in generosity between the average of each state’s neighbors and the state itself. For instance, if a state has policies that grant Medicaid eligibility to 50% of children, and all its neighbors have 25% of children eligible, this variable would be -25. A negative coefficient on this variable in the regression with eligibility reductions indicates the presence of a race to the bottom: states that have more generous standards than their neighbors are more likely to reduce eligibility. Thus, not only will these regressions allow me to identify systematic differences between the processes that produce incremental and non-incremental change, I also hope they will shed new light on the question of whether states could be engaging in a race to the bottom in Medicaid policy.

Finally, a few general econometric issues need to be addressed. One is the prob-

lem of possible multicollinearity. Several of the economic variables in particular measure things that are closely related — states with high relative GSP will tend to be those that have a low poverty rate and also those with a low FMAP, while states with high GSP growth in a given year will typically also see a large increase in tax revenue that year. Under these circumstances, neither variable might enter significantly in the regressions, even though they are jointly significant. To test for this possibility, I conduct an F-test after every regression, which reports the probability that neither independent variable affects the dependent variable. I also conduct several other F-tests to check for joint significance of variables that belong together, even though I do not suspect a terrible multicollinearity problem. These are the two gender variables (female governor and % female legislators), the five interest group variables, and the four demographic variables. If these turn out insignificant, then I can make the broader claim that a whole class of variables, rather than just each variable individually, cannot be shown to matter for a certain Medicaid eligibility decision.

Second, there is the issue of timing. It is unclear whether, in making their decisions, legislators operate on the basis of the current or the previous year. On the one hand, most state legislatures are in session during the first half of the year, and many figures for the year have not yet been released at that point, especially the economic numbers (tax revenue, GSP, poverty rate). On the other hand, legislators constantly get information on current trends in more informal ways, through the media or interaction with citizens, for example. Thus, a good case can be made either for using information from the current or the previous year. A similar issue arises for information from the Current Population Survey on pensions and health insurance coverage. Survey respondents are interviewed in march of each year, but the question asks for pension and insurance status during the previous calendar

year. Yet, it is often suspected that the respondents answer the question as if it was asking for their current insurance status, or at least the insurance status of the last few months (Shore-Sheppard 2008). Given these uncertainties, I use contemporaneous information for the regressions from the upcoming section, but re-run every regression with tax revenue, GSP, poverty rate, FMAP, private insurance rate and pension coverage all lagged by one year as a robustness check.

6 Results

Table 6.1 presents the result from my baseline regression, beginning with child and adult eligibility as the dependent variables. This and the following regression tables are lengthy and contain lots of information, so I will only point out some of the most noteworthy features of the results.

First, there is the expected positive effect of Democratic party control of the legislature on eligibility rules. The estimates are about equally large whether or not fixed effects are employed, though some estimates are less precise than others. On average, a 10-point gain in the share of Democrats in both legislatures translates into an expected increase of the share of children eligible by about 1.5 percent, and is associated with an income threshold for adults that is about 4.5-6% of the poverty line higher. By contrast, the results for Democratic control of the Governor's office are more ambiguous, with a mix of positive and negative estimates. This mirrors findings by Baughman and Milyo (2008), who also identify a strong independent effect of Democratic control of the legislature but not the governor's office on Medicaid eligibility levels.

Second, the coefficients on the public opinion variable provide useful insights. They are significant for both adult and child eligibility in the regressions without the state-fixed effects. Once the state-fixed effects are included, the effect becomes much smaller, which is what one would expect given McIver, Wright and Erikson's (2001) finding that differences across states in public opinion are quite stable over time. Take two states, one of which has a proportion of respondents who identify themselves as liberal that is 10 percentage points higher than the other (while the share of conservatives is the same). On average, the former state will raise the share of children eligible by 3.2%, and the income threshold for adults by a striking 23%

Table 6.1: Results of the Baseline 2SLS Regression on Child and Adult Eligibility

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Child Eligibility			Adult Eligibility		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
% Democratic Seats	0.1559*** (0.0597)	0.1896*** (0.0615)	0.1691 (0.1096)	0.4931 (0.4673)	0.5961 (0.4700)	0.5405* (0.2938)
Democratic Governor	1.4514 (1.4895)	1.6319 (1.3265)	-0.1679 (1.3221)	-6.7012 (7.9495)	-6.3284 (7.1049)	12.9724*** (3.9162)
% Female Legislators	-1.0191 (1.7083)	-2.1336 (1.7765)	-3.4953*** (1.2773)	-1.7004 (14.2853)	-6.0550 (13.8202)	-1.0363 (7.2203)
Female Governor	0.0775 (0.1396)	-0.0118 (0.1407)	0.0715 (0.1248)	0.9691 (0.8135)	0.8163 (0.7862)	0.3309 (0.8463)
Private Insurance	0.0977 (0.3219)	0.3166 (0.4003)	0.6707 (0.6197)	-0.4305 (1.7121)	0.2845 (2.0274)	-4.3019 (3.6485)
Poverty Rate	-0.1303 (0.3318)	0.0914 (0.3080)	-0.0337 (0.1168)	-0.6566 (1.1083)	0.0274 (1.2453)	-0.6766 (0.6366)
Campaign Spending, Physicians	-2.8357 (3.3651)	-2.0601 (2.9083)	-2.6191 (3.4591)	-12.4543 (21.3113)	-22.9621 (21.8107)	-10.6896 (9.9168)
Campaign Spending, Hospitals	4.7228 (4.6436)	4.2453 (5.1634)	2.8584* (1.6956)	-4.2829 (22.5428)	-7.7593 (23.4825)	5.8734 (10.4886)
Campaign Spending, Insurance	25.0838** (10.1586)	9.8388 (11.0240)	10.9777 (10.1676)	25.4771 (47.5698)	32.0536 (64.7093)	-26.0174 (39.1605)
Campaign Spending, Unions	-0.9149 (0.6942)	-1.9549*** (0.6751)	-0.1836 (0.4367)	-1.0947 (4.4508)	-4.8046 (4.3874)	-1.0626 (2.0522)
Campaign Spending, Senior Citizens	-5.2021** (2.5572)	-2.9084 (3.3327)	0.5235 (1.9981)	20.3488 (23.7482)	29.0102 (24.7707)	0.5657 (8.3868)
Public Opinion	0.1396 (0.1188)	0.3241*** (0.1214)	0.0291 (0.1149)	1.8630*** (0.6225)	2.2679*** (0.6281)	0.6473 (0.4027)

Table 6.1: Results of the Baseline 2SLS Regression on Child and Adult Eligibility

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Child Eligibility			Adult Eligibility		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
Relative GSP	-8.4779 (7.0438)	-12.9266** (6.3121)	-20.5661 (17.4780)	21.5680 (28.1594)	18.8723 (29.7430)	55.5310 (47.2220)
GSP Growth	-0.7763*** (0.1843)	-0.1061 (0.1683)	0.1872 (0.1802)	-2.0187 (1.2674)	-0.7151 (0.8831)	-1.3846 (0.9699)
FMAP	-0.3078 (0.2388)	-0.3327 (0.2793)	-0.0368 (0.3157)	-0.1910 (1.3195)	-0.1816 (1.2797)	-1.0068 (1.5096)
Tax Revenue	0.0035* (0.0020)	0.0084** (0.0034)	0.0057*** (0.0022)	0.0101 (0.0097)	0.0088 (0.0155)	-0.0105 (0.0143)
% 18-	-0.5760 (0.8607)	1.2848 (1.0285)	-0.6597 (1.8798)	0.2959 (5.3446)	4.9564 (5.3445)	8.7065 (6.5290)
% 65+	-0.5381 (0.7587)	0.5028 (0.8083)	-7.0049* (3.5801)	2.2493 (4.3826)	5.1125 (4.3993)	10.1162 (9.0772)
% Hispanics	0.0973 (0.1504)	0.0858 (0.1949)	-1.0570 (0.7732)	-0.5077 (0.9705)	-0.5315 (0.9745)	-0.7785 (4.1844)
% Black	0.0515 (0.0960)	0.1096 (0.1159)	-3.3846 (2.8037)	-0.8669 (0.6881)	-0.7851 (0.7328)	5.5156 (11.5669)
Constant	81.2145* (45.3031)	14.9828 (57.0406)	130.4901 (104.2288)	75.6083 (179.3503)	-125.9162 (245.1124)	3.3846 (358.0633)
Observations	658	658	658	655	655	655
R-Squared	0.3280	0.4076	0.6833	0.3789	0.4026	0.7935

*** p<0.01, ** p<0.05, * p<0.1

Note: Results come from panel 2SLS regressions with Private Insurance instrumented for. Standard errors are clustered by state. Observations span years 1997-2010.

of the poverty line, relative to the latter. I believe this pattern is not a coincidence, but reflects different attitudes by liberals and conservatives about the appropriate scope of the Medicaid program. Both liberal and conservative populations share a concern for the health of children, and thus there is but moderate disagreement regarding efforts to reduce the number of uninsured children in a state. Opinions diverge, however, when it comes to the treatment of adults, and liberals tend to be far more approving of extending public health insurance coverage to adults than conservatives. Hence, while having a liberal population is not a necessary precondition for a state to create extensive coverage for children, only a relatively liberal public will approve of similar measures for adults.

Third, it is interesting to consider the coefficients on GSP growth. There are negative coefficients on GSP growth in the child eligibility regression, but once year-fixed effects are included, the effects become much smaller and are no longer significant. Abstracting from these results, they could mean one of two things. Either states experience certain shocks to GSP growth at the same time (such as a nationwide recession), and then they change their Medicaid policy, but states do not make such adjustments if they are growing more or less rapidly than the national average. Or the regression without the year-fixed effects captures time trends unrelated to the question at hand. Specifically, we know that eligibility levels are higher today than they were in 1997, while GSP growth has likely seen an overall downward trajectory over this time period, so there might be a spurious correlation. To check for this possibility, I repeat the regression using a linear time trend instead of year-fixed effects (not shown). If the regression with no fixed effects is merely picking up a constant trend over my sample period, then this effect should disappear with the inclusion of a linear time trend, and indeed, this is what I find. Thus, despite the statistically significant effect in the regression without fixed effects, there is in-

sufficient evidence to conclude that the business cycle affects Medicaid eligibility policy.

By contrast, the coefficients on tax revenue are strongly significant, at least for children. How can this be reconciled with the finding that business cycle fluctuations do not affect eligibility? My best interpretation is to point to a possible lag between the business cycle and tax revenue. Indeed, univariate regressions of current and past GSP growth on changes in tax revenue (not shown) indicate this strongly: current GSP can only explain 2% in the variation of current tax revenue, but last year's GSP can explain 17% and the GSP of two years ago still a considerable 6%. Thus, it might be that, as a recession hits, fiscal pressures are mild, whereas concern for the increased number of people who need government support, as well as pressure from the federal government not to reduce eligibility, are at a maximum. As the recession wanes, the perceived urgency of the problem of uninsured children is reduced, while budgetary pressures mount, increasing the pressure to restrict the scope of the Medicaid program. This appears to be happening in the United States right now: although the recession is officially over, the fiscal outlook of the states continues to worsen, and there is talk in some states talk about cutting Medicaid.

Finally, a number of variables produce notably contradictory or even counterintuitive results. No clear trend is apparent for the two variables on gender, with a widely varying mix of positive and negative estimates, especially for control of the governor's office. This impression is corroborated by F-tests for joint significance (not shown), all but one of which are insignificant. Thus, the hypothesis that more women in political positions of power translates into different eligibility levels cannot be corroborated here. Another set of variables, the ones on interest groups, fare no better: estimates vary widely and, curiously, frequently run counter to expectations. For example, a stronger presence of unions seems to be, if anything,

associated with less generous Medicaid standards, which does not square with the expectation that unions should represent the working class. These curiosities, coupled with the fact that the F-tests are insignificant for most regressions, lead me to conclude that what associations we observe are likely spurious.

Table 6.2: Results of the Baseline 2SLS Regression with Electoral Competition

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Child Eligibility			Adult Eligibility		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
% Democratic Seats	-0.2453*	-0.2201	0.1332	-0.4427	-0.3597	-1.7071**
	(0.1490)	(0.1474)	(0.2032)	(0.7435)	(0.7099)	(0.8524)
Democratic Governor	0.2501	1.2306	-1.2488	-6.2336	-3.1975	10.9585**
	(2.0968)	(2.0477)	(1.3006)	(6.1781)	(5.3950)	(5.5748)
% Female Legislators	-0.0552	-0.0726	0.2723*	0.7727	0.7539	-2.1435**
	(0.1427)	(0.1507)	(0.1632)	(0.4974)	(0.5141)	(0.9462)
Female Governor	3.3373	1.6077	-4.3889**	-3.9719	-11.2166	-8.6907
	(2.3760)	(2.4740)	(1.7359)	(19.0528)	(16.7560)	(7.4976)
Private Insurance	0.5017***	0.3391	0.3075	0.9145	0.6047	-0.1112
	(0.1908)	(0.2099)	(0.3729)	(2.0073)	(1.8581)	(5.5302)
Poverty Rate	-0.2985	-0.1320	0.0086	-2.4253*	-1.7821	0.0369
	(0.1972)	(0.1800)	(0.1214)	(1.3330)	(1.2434)	(0.7202)
Campaign Spending, Physicians	3.9514	-1.8172	0.1875	-22.3493	-42.6976	-36.6445**
	(4.9720)	(3.7774)	(2.0736)	(24.0807)	(27.0122)	(18.0646)
Campaign Spending, Hospitals	-8.7544**	-5.7332	0.7516	19.5049	29.5952	27.3671
	(4.2567)	(3.8440)	(2.7772)	(24.3005)	(24.9949)	(20.4740)
Campaign Spending, Insurance	11.2239	8.1130	9.8682	-92.9995	-127.5061	-207.4219*
	(29.2404)	(23.6284)	(20.6019)	(120.8252)	(117.4263)	(119.2500)

Table 6.2: Results of the Baseline 2SLS Regression with Electoral Competition

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Child Eligibility			Adult Eligibility		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
Campaign Spending, Unions	-1.2581 (2.6724)	-3.8283 (2.6647)	0.1746 (1.5992)	14.3446 (11.9722)	4.4726 (11.3194)	2.7809 (11.5967)
Campaign Spending, Senior Citizens	2.1221 (4.0849)	1.6015 (4.1491)	0.4947 (2.3759)	12.9842 (19.2822)	14.6822 (18.6574)	7.9899 (9.0146)
Public Opinion	0.2355 (0.1999)	0.2236 (0.1820)	0.1155 (0.1576)	2.1568*** (0.7589)	2.2474*** (0.7267)	-0.4706 (0.7052)
Relative GSP	-14.5439*** (5.0929)	-15.5287*** (4.8384)	-15.4950 (16.5167)	2.2874 (28.3122)	-2.9446 (28.5275)	127.1711 (83.8693)
GSP Growth	-0.5678*** (0.1704)	-0.1378 (0.1452)	0.1185 (0.1705)	-1.5280 (1.2536)	0.5367 (0.9547)	-2.1464* (1.2217)
FMAP	-0.2639 (0.1727)	-0.4871** (0.1913)	-0.3877 (0.5369)	0.6402 (1.3403)	0.0176 (1.2022)	-2.2844 (3.0119)
Tax Revenue	-0.0025 (0.0038)	0.0046 (0.0038)	0.0042* (0.0025)	-0.0209 (0.0208)	0.0135 (0.0165)	-0.0141 (0.0185)
% 18-	-0.2367 (1.1323)	0.9051 (1.1861)	0.6559 (2.0794)	-0.9897 (4.7196)	3.3806 (4.1108)	12.0489 (15.4941)
% 65+	-0.0865 (0.8094)	0.7511 (0.8263)	-1.0593 (3.4931)	3.2226 (3.5555)	6.5275* (3.4765)	8.2115 (12.3867)
% Hispanics	0.3076** (0.1233)	0.1694 (0.1491)	-0.5908 (0.8227)	-0.0618 (1.1524)	-0.4380 (1.0046)	-2.1678 (10.9196)
% Black	0.1351 (0.1011)	0.0723 (0.1137)	-0.2361 (2.7473)	-0.5553 (0.7014)	-0.6160 (0.6971)	18.9993 (27.8945)
Interparty Competition	-2.7064*** (0.7269)	-2.3907*** (0.7541)	-1.3411* (0.7099)	-0.4902 (4.0894)	1.1712 (3.7804)	-3.0431 (3.0655)

Table 6.2: Results of the Baseline 2SLS Regression with Electoral Competition

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Child Eligibility			Adult Eligibility		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
Competition x Democratic Seats	0.0287*** (0.0091)	0.0276*** (0.0086)	0.0065 (0.0065)	0.0566* (0.0328)	0.0551* (0.0319)	0.0412 (0.0331)
Constant	70.8200 (58.0414)	56.1379 (59.9954)	53.8355 (126.5970)	14.6434 (206.7548)	-109.0056 (236.7538)	-258.0502 (424.4997)
Observations	319	319	319	316	316	316
R-Squared	0.3904	0.4784	0.8445	0.3746	0.4152	0.7855

*** p<0.01, ** p<0.05, * p<0.1

Note: Results come from panel 2SLS regressions with Private Insurance instrumented for. Standard errors are clustered by state. Observations span years 1997-2003.

Next, I test for effects from electoral competition, which necessitates an additional set of regressions because data on election outcomes are available only until 2003. Therefore, I have to re-run the regression on a restricted sample ranging only from 1997 to 2003, with two additional variables included that measure interparty competition and interparty competition interacted with democratic control of the state legislature. As can be seen from the results in Table 6.2, there is some evidence of a systematic effect of electoral competition on Medicaid policy both for children and adults, though it is less precisely estimated for adults. The second variable, which combines interparty competition with democratic control of the state legislature, is positive and significant. This conforms to the findings of Barrilleaux, Holbrook and Langer (2002), who argue that Democrats react to tight competition by appealing to their liberal base. The effect disappears upon the inclusion

of state-fixed effects, which is likely due to lack of interstate variation in electoral competition; while some states are known swing states with tightly contested races, others have electorates with clearly defined ideological preferences, which reduces competitiveness. This, again, ties back to the relative stability in states' ideological positions over time.

Having discussed the baseline regressions with child and adult eligibility levels as the dependent variables, I now move on to the indices of eligibility barriers as the dependent variables. Methodologically, the regressions mirror the baseline regressions from Table 6.1, and results are presented in table 6.3. No tests of the effect of interparty competition are possible because the interparty competition dataset has been discontinued in 2003, while eligibility barrier data have only been collected since 2002.

Table 6.3: Results of the Baseline 2SLS Regression on Enrollment Barriers

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Unweighted Enrollment Barrier Index			Weighted Enrollment Barrier Index		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
% Democratic Seats	0.0003 (0.0191)	0.0017 (0.0204)	0.0152 (0.0179)	0.2136** (0.1007)	0.2216** (0.1048)	0.1390* (0.0844)
Democratic Governor	0.4235 (0.3525)	0.3866 (0.3545)	0.4241 (0.2761)	3.0379* (1.5737)	2.9987* (1.5938)	1.0832 (1.9637)
% Female Legislators	0.0546 (0.0375)	0.0434 (0.0381)	-0.0002 (0.0408)	0.2378 (0.1818)	0.2483 (0.1846)	0.2870 (0.2945)
Female Governor	0.0414 (0.4436)	0.1258 (0.4566)	-0.2732 (0.3556)	-2.3521 (2.2696)	-2.2817 (2.3532)	0.1469 (2.2951)

Table 6.3: Results of the Baseline 2SLS Regression on Enrollment Barriers

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Unweighted Enrollment Barrier Index			Weighted Enrollment Barrier Index		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
Private Insurance	0.0713 (0.1249)	0.1182 (0.1535)	-0.1226 (0.1827)	0.6968 (0.6562)	0.7481 (0.8283)	1.1867 (1.3903)
Poverty Rate	-0.0241 (0.0902)	-0.0216 (0.0955)	-0.0357 (0.0394)	0.5510 (0.3694)	0.5732 (0.4421)	0.3142 (0.2577)
Campaign Spending, Physicians	-0.7755 (1.2673)	0.0890 (1.4075)	0.1565 (0.8547)	9.3765 (5.8530)	9.4571 (7.3415)	6.0082 (4.9491)
Campaign Spending, Hospitals	0.9363 (1.0681)	1.0133 (1.1739)	0.9222*** (0.3532)	-7.2386 (4.4865)	-7.1325 (4.6435)	1.7594 (3.6651)
Campaign Spending, Insurance	1.8609 (2.3180)	-0.7390 (2.8039)	-1.1932 (2.0695)	-5.8167 (12.3462)	-5.6808 (11.5861)	-7.6800 (10.0910)
Campaign Spending, Unions	0.1341 (0.2470)	0.1625 (0.2497)	0.1929 (0.1189)	-0.5678 (1.0120)	-0.4158 (1.0402)	0.6710 (0.5958)
Campaign Spending, Senior Citizens	0.9323 (0.9733)	1.1876 (0.9481)	0.1565 (0.4886)	-2.5696 (5.8411)	-2.3838 (5.8644)	-3.6466 (2.9786)
Public Opinion	0.0222 (0.0289)	0.0390 (0.0301)	-0.0082 (0.0193)	-0.0600 (0.1168)	-0.0717 (0.1235)	-0.0551 (0.1035)
Relative GSP	5.6014*** (1.9579)	4.7260** (1.8598)	6.6686* (3.7548)	2.0424 (7.2699)	0.7467 (7.7165)	12.4735 (22.6107)
GSP Growth	-0.1333*** (0.0410)	-0.0876* (0.0492)	-0.0285 (0.0343)	-0.2503 (0.2100)	-0.3667 (0.2431)	-0.1150 (0.2324)
FMAP	0.1343 (0.0830)	0.1516 (0.0937)	0.0659 (0.0590)	0.4298 (0.4219)	0.4303 (0.4819)	0.5847 (0.4307)
Tax Revenue	0.0000 (0.0005)	0.0012 (0.0009)	-0.0007 (0.0005)	0.0022 (0.0018)	0.0071* (0.0039)	0.0013 (0.0028)

Table 6.3: Results of the Baseline 2SLS Regression on Enrollment Barriers

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Unweighted Enrollment Barrier Index			Weighted Enrollment Barrier Index		
	No fixed effects	Year-fixed effects	State- and year-fixed effects	No fixed effects	Year-fixed effects	State- and year-fixed effects
% 18-	-0.1123 (0.3015)	-0.0430 (0.3242)	-0.0528 (0.5236)	0.2439 (1.6666)	0.2804 (1.6778)	-1.5613 (2.6373)
% 65+	0.1980 (0.2668)	0.2113 (0.2730)	-0.2230 (0.7147)	1.5487* (0.9225)	1.6070* (0.9228)	-3.7389 (5.3983)
% Hispanics	0.0246 (0.0722)	0.0424 (0.0821)	0.2515 (0.3093)	0.1636 (0.3846)	0.1900 (0.4364)	1.6401 (1.2630)
% Black	0.0319 (0.0333)	0.0450 (0.0389)	0.0182 (0.6196)	0.2474 (0.2018)	0.2623 (0.2274)	6.9057** (3.2846)
Constant	-9.3530 (15.0271)	-14.3614 (18.8188)	11.5308 (17.8356)	-117.7152* (64.7956)	-124.8179 (84.8874)	-76.9642 (76.3460)
Observations	423	423	423	423	423	423
R-Squared	0.2265	0.2285	0.7955	0.1277	0.1251	0.7341

*** p<0.01, ** p<0.05, * p<0.1

Note: Results come from panel 2SLS regressions with Private Insurance instrumented for. Standard errors are clustered by state. Observations span years 2002-2010.

In general, some caution appears warranted in the interpretation of the enrollment barrier regressions. Although the two indices are based on the same information about state Medicaid programs, the regression coefficients frequently do not agree, making the regressions rather uninformative. Only two results stands out: first, a high relative GSP appears to be positively associated with points on my enrollment barrier index, meaning the barriers are lower. Thus, it seems that richer states seem more willing to accommodate applicants, perhaps because they

can better afford to admit persons into the program who should not be eligible. Second, GSP growth is negatively associated with the unweighted eligibility barriers index, and this time, the effect does not disappear if the year-fixed effects are replaced with a linear trend (not shown). Indeed, the results, while significant only at the 90% level with year-fixed effects and not at all significant with both state- and year-fixed effects, are significant at the 95% level with a linear time trend and at the 90% level with state-fixed effects and a linear time trend. Therefore, there seems to be sufficient evidence to conclude that bureaucratic eligibility barriers are higher during bad economic times than they are during good ones. Beyond these two findings, much is unclear, and this should perhaps not be overly surprising. For one, as noted before, I have only a few years of observations for the eligibility barriers. For another, there is undoubtedly some measurement error contained in the variable, as certain enrollment barrier characteristics could not always be cleanly translated into a yes/no variable and others, such as on-line applications, have simply not been recorded. In addition to these technical issues, the reason may also be substantive. Since eligibility barriers constitute a somewhat more arcane issue with fewer political ramifications, they may be more conducive to being regulated by a policy monopoly. Such a policy monopoly, being a rather small group, might produce change simply because of idiosyncratic changes affecting only the members of the group, without a change in systemic variables. If this is the case, then even a larger sample or better measurement would be no help, and the determination of enrollment barriers could simply not be pinned down with this type of statistical analysis.

To better distinguish between incremental and non-incremental change, I move on to my second set of regressions, which test linear probability models. The three dependent variables are dummy variables indicating whether or not eligibility has

been incrementally expanded, non-incrementally expanded, or reduced. I run two sets of regressions: one without fixed effects, and one with year-fixed effects. I could include additional state-fixed effects as well, but this presents me with an acute bias-precision tradeoff. On the one hand, it is conceivable that just as some states have constantly different *levels* of Medicaid eligibility, some would be inherently prone to make *changes* to their policy more often. For example, the legislature could be more activist or more professionally organized, or the state's media might be very vigilant and spurs lots of political discussion, etc. On the other hand, as Table 5.6 reported earlier, there is not a huge number of changes that occurred over the period studied, anyway. Including state-level effects could take away the variation necessary to statistically identify any effects, especially given the large number of independent variables in my study. Indeed, when state-fixed effects are included, there are no individually significant effects, and only one jointly significant result, which I address below. For this reason, I do not report results with state-fixed effects, while results from the other regressions are presented in Table 6.4.

The first column reveals that almost all variables enter insignificantly when incremental change is used as the dependent variable. One exception is the variable on Democratic control of the governor's office, which increases the odds of incremental change by an estimated 6%. However, this estimate is barely statistically significant, and only in the regression without fixed effects, where standard errors are smaller. With that noted, the estimate is not entirely implausible, because it might be that the governor enjoys a greater deal of power when a policy monopoly is intact, either because he himself is part of it, or because the policy monopoly contains actors who pursue his interests, such as the governor-appointed head of the Department of Health of Human Services. The other rather surprising significant effect is that of spending by hospital associations, which is positive and significant,

though not very large. A spending increase by 10 cent per capita (recall that the mean was 6 and the standard deviation 14 cent) is associated with an increase in the probability of an incremental change by roughly 3 percent. Because the variable does not enter significantly in the following regressions, and the other interest group variables show such little movement, I am unconvinced that this observed effect is more than just statistical noise.

Otherwise, the regression does not offer much explanation, and the factors thought to be influencing the decision-making cannot be shown to have any effect on the policy outcome. As explained in Section 4, such a result should not come as a surprise. If incremental change is indeed the product of a functioning policy monopoly containing only few actors, then any change may well be the product of idiosyncratic dynamics that concern only the members of the policy monopoly. If this is indeed the primary explanation for incremental change, then one would expect a regression such as the one in the first column to produce no significant results.

Table 6.4: Results from Linear Probability Regressions

Dependent Variable	(1)		(2)		(3)		(4)		(5)		(6)	
	Increm. Expansion		Non-Increm. Expansion		Reduction		Reduction		Reduction		Reduction	
	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects
% Democratic Seats	-0.0016 (0.0015)	-0.0013 (0.0014)	0.0025 (0.0016)	-0.0000 (0.0007)	-0.0011 (0.0012)	0.0001 (0.0011)						
Democratic Governor	0.0584* (0.0343)	0.0513 (0.0319)	0.0155 (0.0553)	0.0236 (0.0220)	-0.0005 (0.0370)	0.0015 (0.0330)						
% Female Legislators	-0.0004 (0.0027)	-0.0017 (0.0025)	-0.0026 (0.0049)	0.0009 (0.0017)	0.0007 (0.0025)	0.0008 (0.0023)						

Table 6.4: Results from Linear Probability Regressions

Dependent Variable	(1)	(2)	(3)	(4)	(5)	(6)
	Increm. Expansion		Non-Increm. Expansion		Reduction	
	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects
Female Governor	-0.0131 (0.0510)	-0.0160 (0.0425)	-0.1620** (0.0806)	-0.0379 (0.0333)	0.0066 (0.0355)	-0.0330 (0.0433)
Private Insurance	-0.0003 (0.0094)	0.0048 (0.0111)	0.0352*** (0.0095)	-0.0072 (0.0055)	-0.0028 (0.0077)	0.0087 (0.0099)
Poverty Rate	0.0005 (0.0079)	0.0007 (0.0080)	0.0222*** (0.0060)	0.0005 (0.0042)	-0.0012 (0.0069)	0.0091 (0.0073)
Campaign Spending, Physicians	-0.1254 (0.1498)	-0.0300 (0.1735)	-0.0931 (0.1836)	0.1250 (0.1214)	0.2777 (0.1753)	0.1426 (0.1768)
Campaign Spending, Hospitals	0.3266** (0.1631)	0.3297** (0.1601)	-0.1815 (0.1474)	-0.0538 (0.1193)	-0.0939 (0.1631)	-0.1778 (0.1503)
Campaign Spending, Insurance	0.5814 (0.3586)	0.3875 (0.3705)	-0.4314 (0.4201)	0.0953 (0.2887)	-0.2842 (0.3068)	0.1199 (0.3465)
Campaign Spending, Unions	0.0567* (0.0331)	0.0427 (0.0317)	-0.0635*** (0.0219)	-0.0103 (0.0172)	0.0397 (0.0313)	0.0036 (0.0317)
Campaign Spending, Senior Citizens	0.0374 (0.1307)	0.1028 (0.1196)	0.3670*** (0.1229)	-0.0687 (0.0667)	-0.1410 (0.0930)	-0.0292 (0.0920)
Public Opinion	-0.0030 (0.0029)	-0.0004 (0.0030)	0.0133*** (0.0030)	-0.0001 (0.0022)	-0.0034* (0.0020)	-0.0008 (0.0021)
Relative GSP	0.0716 (0.1464)	0.0418 (0.1308)	0.0399 (0.1632)	0.1930*** (0.0694)	-0.0617 (0.1408)	-0.0033 (0.0897)
GSP Growth	-0.0074 (0.0061)	-0.0038 (0.0070)	0.0207*** (0.0056)	-0.0020 (0.0044)	-0.0133** (0.0052)	-0.0118* (0.0062)
FMAP	-0.0004 (0.0064)	0.0020 (0.0078)	0.0093 (0.0069)	-0.0002 (0.0035)	-0.0009 (0.0057)	0.0037 (0.0059)

Table 6.4: Results from Linear Probability Regressions

Dependent Variable	(1) (2)		(3) (4)		(5) (6)	
	Increm. Expansion		Non-Increm. Expansion		Reduction	
	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects	No fixed effects	Year-fixed effects
Tax Revenue	-0.0001 (0.0001)	-0.0001 (0.0001)	0.0000 (0.0001)	0.0000 (0.0001)	-0.0000 (0.0001)	-0.0001 (0.0001)
% 18-	-0.0377** (0.0188)	-0.0259 (0.0222)	0.1271*** (0.0363)	0.0112 (0.0111)	-0.0312** (0.0156)	-0.0101 (0.0160)
% 65+	0.0025 (0.0097)	0.0044 (0.0096)	0.0718*** (0.0243)	0.0031 (0.0099)	-0.0154 (0.0152)	0.0020 (0.0151)
% Hispanics	0.0038 (0.0047)	0.0053 (0.0055)	0.0046 (0.0057)	-0.0043** (0.0020)	0.0034 (0.0032)	0.0070* (0.0041)
% Black	0.0009 (0.0022)	0.0020 (0.0026)	0.0047 (0.0042)	-0.0019 (0.0014)	0.0003 (0.0023)	0.0025 (0.0024)
Race to the Bottom	-0.0009 (0.0016)	-0.0003 (0.0019)	0.0006 (0.0025)	-0.0034*** (0.0012)	-0.0034** (0.0017)	-0.0032** (0.0015)
Constant	1.0534 (0.9805)	0.3414 (1.1201)	-6.9290*** (1.0012)	0.0458 (0.7342)	1.4071 (0.8707)	-0.6501 (0.9448)
Observations	658	658	658	658	658	658
R-Squared	0.0798	0.1170	0.4126	0.8024	0.0764	0.1481

*** p<0.01, ** p<0.05, * p<0.1

Note: Results come from panel zSLS linear probability regressions with Private Insurance instrumented for. Standard errors are clustered by state. Observations span years 1997-2010.

The second column contains the results from the regression with non-incremental change as the dependent variable. Here, there are a number of statistically significant results, only to see virtually all of them disappear upon the inclusion of year-fixed effects. The only variables that remain are relative GSP, indicating that

richer states have been responsible for a greater share of the non-incremental expansions, and the variable for a race to the bottom, which signals that states that already have higher eligibility standards than their neighbors (as indicated by a negative value for this variable) are more likely to expand again. This would result in rising divergence across states over time, which is indeed what Tables 5.1 and 5.2 showed earlier. As for the variables that become insignificant when year-fixed effects are added, the question is whether this is merely an effect of capturing long-run trends in the variables that are not related. Replacing the year-fixed effects with linear time trends indicates that this is indeed so, as all of these variables become statistically insignificant, even jointly (not shown).

The third column, which has eligibility reductions as the dependent variable, allows for two more interesting observations. First, there is some evidence suggestive of a race to the bottom. The variable indicates that a state which makes 10% more children eligible than its neighbors has an increased probability of lowering its standards by 3.2%. To be sure, this is not a large effect, but it might not be entirely irrelevant, either. Second, the coefficients on GSP growth are negative and significant at at least the 90% level, even after controlling for year-fixed effects. In addition, when state-fixed effects are included as well (not shown), the two variables related to business cycles, tax revenue and GSP growth, are jointly significant. The finding that higher GSP growth is associate with a lower probability of eligibility reductions fits in very nicely with the previous results, once one takes into account which changes belong to which policy dimension. The reader may recall from Tables 6.1 and 6.3 that GSP growth cannot be shown to be associated with eligibility expansions for children or adults, but that higher GSP growth appears related to lower eligibility barriers. Moreover, Table 5.6 explains that eligibility expansions have come in the form of either higher income thresholds for adults and children

or new enrollment barriers, whereas the vast majority of eligibility reductions has come in the form of new enrollment barriers. Taking all of this information together, we would expect to find GSP growth not to be associated with eligibility expansions, but we would think that higher growth would decrease the odds of reductions, and that is exactly why Table 6.4 shows. In short, while this regression provides no evidence that states reduce their eligibility standards for children in response to a poor economic climate, there does appear to be a response in the form of new eligibility barriers. On average, each percentage point of growth lost translates into a 1.2% increase in the odds of new enrollment barriers being erected.

To finish my empirical analysis, I conduct a series of robustness checks that are not reported because they generally make very little difference. First, I use one-year lags for GSP, tax revenue, pensions, private insurance coverage, and the poverty rate, to check if policymakers might be operating, or survey respondents might be answering, on the basis of information from the previous rather than the current year. The estimates are almost the same as the ones reported here, with tax revenue being the sole exception; its coefficients are consistently larger, and even statistically significant for the regressions on incremental change. This supports the idea that policymakers base this year's decisions in part on last year's tax revenue. As a second robustness check, I change the definition of the public opinion variable to a three-year average for every state, independent of its population. This affects the estimates only marginally. Finally, I use several different cutoffs for incremental change, both lower (2 instead of 3% for child eligibility, 15 instead of 20% for adults, 1 instead of 2 for eligibility barriers), and higher (5, 30 and 3, respectively) than the original. Once again, the differences are negligible.

7 Conclusion

Medicaid has gradually expanded from a relatively limited program aimed mostly at recipients of other cash assistance programs to a program that covers many low-income families and especially their children. With much of the authority of the program delegated, this expansion has been driven to a large extent by the states. With Medicaid set to be expanded once again by the recent health care reform act, it is increasingly important to understand how states are formulating decisions over who should be eligible for the program and who should not.

The empirical analysis in this paper has yielded four principal results. First, a liberal electorate and democratic control of the legislature has the expected impact of resulting in a more generous Medicaid program. Second, a liberal public seems to have a greater effect on eligibility rules for adults than for children. This, coupled with the fact that most eligibility expansions in the past have focused on children, suggests that, while liberals and conservatives can agree on insuring children from low-income families, views diverge more sharply on whether adults should be made eligible, as well. Third, states do not react to tough economic times by changing Medicaid eligibility standards, at least in the short run. I speculate that this happens due to a combination of factors, including heightened concern for low-income populations in bad economic times, intervention by the federal government, and the fact that recessions do not immediately impact the coffers of state governments. However, there is some evidence that what the states do find a clandestine method to reduce Medicaid caseloads: in reaction to difficult times, they increase barriers to enrollment in order to lower take-up and bring down program costs. Since most of the changes to enrollment barriers are incremental and somewhat technical in kind, this generally escapes public attention. Fourth, the factors investigated here

appear much more relevant to explaining non-incremental than incremental Medicaid expansion. With the exception of party control of the Governor's office, I have not been able to detect any noteworthy factors correlated with incremental change, suggesting that, while policy monopolies are intact, idiosyncratic factors largely determine whether or not incremental change will occur.

In all, I believe that these findings warrant ending this paper on an mixed note. Medicaid eligibility rules seem to be responsive to public opinion in the states, which backs up the claim that delegation to the states allows them to adjust the rules to take into account their constituencies' beliefs about the appropriate scope of the program. Moreover, some of the possible concerns about equity could not be substantiated: I do not find evidence of racially motivated efforts to exclude minorities from Medicaid receipt. However, the tentative evidence of a race to the bottom warrants some concern, as does the finding of states raising eligibility barriers in response to a poor economic climate. It seems that, despite promises to the contrary made to the federal government, the states find clandestine ways to reduce Medicaid enrollment during recessions after all. With its rule in the stimulus package stipulating that states do not reduce their eligibility standards, the federal government has already signaled it is concerned about Medicaid cuts during a recession. In the next recession, it should consider extending the "no cutbacks" rule to bureaucratic barriers, as well.

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