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Medicaid Expansion in the United States: A State Comparative Study Examining Factors that Influence State Decision Making

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MEDICAID EXPANSION IN THE UNITED STATES: A STATE COMPARATIVE STUDY EXAMINING FACTORS THAT INFLUENCE STATE DECISION MAKING

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ABSTRACT

MEDICAID EXPANSION IN THE UNITED STATES: A STATE COMPARATIVE STUDY EXAMINING FACTORS THAT INFLUENCE STATE DECISION-MAKING

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Old Dominion University, 2016
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Since the passage of the Patient Protection and Affordable Care Act (ACA) and a Supreme Court ruling that the federal government cannot compel states to expand Medicaid, a policy window has opened for states to change Medicaid policy. States are now faced with the option to expand Medicaid. Although the literature on Medicaid expansion indicates that politics plays a determining role on states' decisions on Medicaid expansion, comprehensive analyses of dominant factors that affect these decisions on Medicaid is lacking in the field of Medicaid policy. This study will explore the decision making process of state level policies and the effect of relevant state characteristics on Medicaid expansion.

This dissertation examines prominent factors that influence state decisions on Medicaid expansion. Although the literature on Medicaid expansion post the ACA is limited in scope, this study is informed by a range of other disciplines, such as education, political science, intergovernmental management, and economics. A conceptual framework is developed based on the interdisciplinary nature of the literature and five models are created: political, economic, needs-based, state capacity, and state innovation and diffusion. A state comparative cross-sectional research design is utilized to test the five models and a combined model of state decision making on Medicaid expansion using multinomial logistic regression analysis and descriptive statistics.

The results of this study reveal that when all of the models are combined, state needs-based factors are more influential than political, economic, state capacity, and state innovation and diffusion factors. However, the political model has the most explanatory power when the individual models are tested separately. This research demonstrates that the five models utilized in this study play a significant role in the decision making process of states on Medicaid expansion. In addition, this research addresses a gap in the literature that elucidates influential factors that affect the decisions of states on not only Medicaid policy, but also general state policies.

DEDICATION

First and foremost, I thank God, and my Lord and Savior Jesus Christ, for directing my steps and keeping me encouraged during the midnight hour. Lord, I owe everything to you and I will praise, honor and glorify your name for the rest of my life.

I dedicate this dissertation to my parents, Jackie and Evelyn Henley, who always believed in me and told me that I could do anything that I want as long as I have faith, work hard, persevere in times of adversity, and stay true to myself and the values they instilled in me.

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CHAPTER 1

INTRODUCTION

The expansion of Medicaid is a topic that is worthy of study for the 21st century in America. While states are charged with overseeing this program, the advent of healthcare reform is forcing states to make policy-related health care decisions that will have long-standing impacts on residents, state funding and budgets, intergovernmental relationships, and state resources. With a system marked by great latitude in state discretion, wide variations in the delivery and care of patients, and rising health care costs, the opportunity to examine the effects or factors influencing state decision making on the adoption of Medicaid expansion has arisen. In effect, a policy window has opened with the passage of the Patient Protection and Affordable Care Act (ACA) and changed the landscape of health care in the United States (U.S.) by allowing states to expand Medicaid eligibility to additional adult beneficiaries. Moreover, federal funding at 100% for expansion is provided for the first 3 years starting with the year 2014; thereafter 90% of Medicaid expansion costs are covered by 2020 (Medicaid.gov, 2015). With increasing federal oversight and less state control of the U.S. health care system (Sparer, France, & Clinton, 2011), there are multifarious implications affecting the delivery, administration, and implementation of health care services.

The factors influencing states to adopt Medicaid expansion under the auspices of the ACA is the focus of this study. The choice to adopt or expand a policy from a state perspective is fraught with many competing thoughts, theories, and changes in administration over time. Beginning with the Constitution, the prevailing governance arrangement or structure for public policies in the U.S. is a system of dual sovereignty between the federal government and state

governments. Under this system, policy decisions, choices, and questions are handled at the state-level unless the federal government can establish that a policy is within its scope or jurisdiction for action at the national level (Adler, 2011). While the roles of the states and federal government are clearly defined, the factors that influence state decisions and actions concerning policy problems are varied. The literature on state policy choices primarily focus on state-level internal determinants such as social, political, and economic factors; and external determinants involving federal pressure, state competition, and emulation in regards to policy adoption or state action (see Berry & Berry, 2007; Gray, 1973; Olive, Gunasekara, & Raymond, 2012; Koski, 2007; Rom, Peterson, & Scheve, 1998; Soss, Schram, Vartanian, & O'Brien, 2001; Walker, 1969).

In the arena of health care policy on Medicaid, the explanations for why states make health-related policy decisions are largely ignored, misunderstood, or shown as irrelevant. An earlier generation of scholars examining health care policy (Key, 1949; Lockard, 1959) found that the provision of welfare services was largely influenced by political dynamics. However, later studies revealed the results as premature and inconclusive (Kousser, 2002). The next generation of scholars (Dye, 1966; Hofferbert, 1966; Dawson & Robinson, 1963; Winters, 1976) presumed that demographic and economic circumstances dictated policy decisions on state-level spending for health care expenditures. Later studies found mixed results on the effect of political parties (Kousser, 2002). The current literature on state policy choices, while limited, considers the expertise of states, levels of conflict and cooperation, and alignment of goals with joint federal welfare programs (Esterling, 2009, Gormley, 2006; Zimmerman, 2001).

Problem Statement

For many decades, health care in the United States has been progressively shifting towards an unsustainable state as the result of rising health care costs, an aging population, and the advancement of medical technology (Porter, 2009). In 2009, the U.S. Social Security Advisory Board reported that the rising cost of health care expenditures would affect the well-being and economic security of retirees and workers due to high rates of out-of-pocket costs affecting personal income (Schieber, Bilyeu, Hardy, Katz, Kennelly, & Warshawsky, 2009). Moreover, rising health care costs have led to reductions in health care coverage and access to health services (Chernew, Hirth, & Cutler, 2003). The enactment of the Patient Protection and Affordable Care Act of 2010 addresses several of these issues that plague the delivery of health care services. The problems affecting the health care system include a high proportion of uninsured adults and children, expensive health care plans, barriers associated with pre-existing conditions and loss of health insurance coverage for individuals with a serious illness, and inaccessibility to health care services for select populations such as U.S. born children of immigrants and underprivileged individuals (Rich, Cheung, & Lurvey, 2013).

The major aims of the ACA include universal coverage for U.S. citizens, affordable health care coverage, quality-based care, access to health care services with special emphasis on preventative and primary care, and strategic investments through the expansion of health care services to strengthen the health of the public (Rosenbaum, 2011). With the major aims of the ACA in mind and the problems affecting the health care system, this study seeks to examine why states are choosing to adopt Medicaid expansion and to identify the explanatory factors that are driving state responses to expand Medicaid.

The expansion of Medicaid is an important phenomenon of study because it is a large-scale program that affects many stakeholders including states, citizens, physicians, hospitals, etc., and the cost of expanding Medicaid accounts for 45% of expenditures in overall costs relating to the ACA (Jacobs & Skocpol, 2010). Medicaid is jointly funded by the federal government and each state within the U.S., and states are tasked with the responsibility to administer health care services for Medicaid recipients (Landers & Leeman, 2011). Medicaid expansion would provide health insurance coverage to individuals below or up to 133% of the federal poverty level (Sommers, Tomasi, Swartz, & Epstein, 2012). A 2014 report by the Council of Economic Advisors commissioned by the Executive Office of the President states that 5.7 million individuals are affected by states choosing to opt-out of Medicaid expansion. Furthermore, the report declares that states choosing to opt-out will also lose billions of dollars in federal funds that could otherwise boost their economy (The Council of Economic Advisors, 2014). Out of 50 states, 30 have chosen to adopt Medicaid expansion, and despite additional funding from the federal government to expand Medicaid, 20 states have chosen to either delay expansion or refuse to adopt Medicaid expansion (Kaiser Family Foundation, 2015; The Council of Economic Advisors, 2014).

While there is much speculation as to the reasons why a state may choose to adopt or decline expanding Medicaid such as politics or the cost of expanding services, scholarly research is lacking in regards to the consequences, implications, and explanation of such decisions in the health care arena. Moreover, the choice to expand Medicaid is an on-going issue that states are still considering even though there are available appropriations for expansion (Perkins, 2013). This research is important because it will test various factors that have been studied and shown to influence state actions. Moreover, we will test five models derived from a body of literature that

spans a multitude of disciplines with special emphasis on state policy choices and decisions, and ultimately offer a model that predicts drivers of state decisions for Medicaid expansion under the ACA.

Research Questions

The research objectives of this study are to examine the factors that influence the decision making process of states in the expansion of Medicaid. As implementation efforts of the ACA unfold, there will be a plethora of opportunities for states to participate in initiatives that could revolutionize the provision and delivery of health care services. Every decision or non-decision, choice or non-choice, and action or non-action has a consequence. An examination and understanding of factors that influence state decision making will allow states, policymakers, and researchers make informed decisions.

The research question that will guide this study is: *What are the factors that influence states to adopt Medicaid Expansion?* Corollary questions include the following: (a) *Do economic factors influence the decision of states to adopt Medicaid?* (b) *Do political factors influence the decision of states to adopt Medicaid?* (c) *Do state population needs influence the decision of states to adopt Medicaid expansion?* (d) *Does state capacity influence the decision of states to adopt Medicaid expansion?* (e) *Do innovation and diffusion influence the decision of states to adopt Medicaid expansion?*

This study will test five models derived from the literature on state policy choices and decision making. The first model is the political model. The proposition with this model is that a state's legislative composition and party competition affect the adoption of new programs (Walker, 1969). The economic model suggests that the fiscal health of a state influences the

adoption of a new program (Lowry, 2005). The needs-based model presupposes that new approaches to an existing problem may stimulate the adoption of a new program (Nice, 1994). The state capacity model presumes that states have the capacity to "(1) respond effectively to change, (2) to make decisions efficiently, effectively, and responsively, (3) to manage conflict" through institutional arrangements (Bowman & Kearney, 1988, p. 343). Last, the state innovation and diffusion model assumes that policy choices are influenced by both internal and external factors. Moreover, the policy choices of states are driven by tendencies to gravitate toward innovation, which is demonstrated through state actions (Berry & Berry, 2007; Gray, 1973; Soss, Schram, Vartanian, & O'Brien, 2001).

Methodology

This study uses a state comparative cross-sectional research design to test five models using multinomial logistic regression analysis. The five models consist of established variables known to influence the decisions of states in policy research. The corollary questions are indicative of the proposed models: the economic model, the political model, needs-based model, state capacity model, and the innovation and diffusion model. The unit of analysis for this research is states and each model will be tested to determine the relationship between the factors within each model and the decision to adopt the expansion of Medicaid using statistical analysis mechanisms.

Significance of this Study

The passage of the ACA in 2010 has transformed the U.S. health care system on many levels. In accordance with the law, individuals are mandated to purchase health insurance, the

insurance industry is required to follow state and federal guidelines for the provision of health care services, medical providers are tasked with following a number of regulations specified by the ACA, and states are given the option to expand Medicaid (Manchikanti, Caraway, Parr, Fellows, & Hirsch, 2011). The choice given to states to expand Medicaid was not a part of the original health care plan; however, a Supreme Court ruling determined that "it was unduly coercive to require states to expand coverage as a condition of continuing to participate in the federal Medicaid program" (Brecher & Rose, 2013, p. s62). This controversial ruling has upended the intended aims of the ACA and has created an additional financial burden to millions of low-income individuals. As a result, states must decide to either opt-in or opt-out of Medicaid expansion while considering a myriad of policy alternatives, consequences, and opportunities.

This research is important for several reasons. First, one area of particular concern is the effect of state policy decisions on health disparities and inequality amongst low- income individuals. Since the enactment of the ACA in 2010, 30 states and the District of Columbia have chosen to adopt Medicaid expansion (Kaiser Family Foundation, 2015). It is estimated that 5.7 million uninsured individuals who would meet the eligibility requirements under Medicaid Expansion are affected by states that have not opted to expand Medicaid (Kaiser Family Foundation, 2014; The Council of Economic Advisors, 2014). The decision to opt out of Medicaid expansion creates a considerable gap in health care coverage for low-income and permanent residents (Crowley & Golden, 2014). Hypothesis testing of the Needs-Based Model may shed light on certain characteristics that may lead a state to adopt Medicaid expansion based on the composition of the total population of the state, because the Needs-Based Model includes demographic variables.

Second, this study is important because the extant research is limited in the areas of Medicaid expansion and state decision making pertaining to policy adoption. Two studies that were conducted prior to the ACA explored certain aspects of Medicaid expansion and policy adoption, diffusion, and innovation. One study analyzed the Children's Health Insurance Program (CHIP) and examined the diffusion path of similar states using a dyad-year event history analysis (Volden, 2006). The other study analyzed the probability of states adopting managed care programs through Medicaid also using an event history analysis (Satterthwaite, 2002). The last two relevant studies pertaining to this research were conducted after the ACA. One study focused on the variation of states implementing Medicaid expansion and real-time decision making of states adopting Medicaid expansion with the creation of a measure that assessed Medicaid Expansion based on state legislative documents (Jacobs & Callaghan, 2013). The other study, conducted by Barrilleaux and Rainey (2014), examined the decisions of governors in opposition of Medicaid expansion and theorized that the needs of citizens and politics affected gubernatorial decisions. This research is different from the studies mentioned above because there will be an examination of factors that influence the policy adoption of Medicaid expansion by testing established explanators found in the literature on state policy adoption and health care.

This study is pertinent to the fields of health care, public policy, and public administration because it examines the interaction of many factors influencing policy adoption and it allows the researcher to compare the proposed models explaining the adoption of Medicaid expansion. Moreover, a multinomial logistic regression will be utilized for this study and an analysis of summary statistics will be employed to observe the likelihood that a state will adopt Medicaid in accordance with the independent variables.

This research is important because it adds understanding to what drives states to make a decision to adopt a policy when given the choice. Understanding the factors that influence states to expand Medicaid could have several implications. (1) The crafting of policies could be geared toward state preferences instead of perceived needs or issues. The alignment of evidence-based research and state preferences will allow researchers and policymakers to make decisions that are customized towards actualized state needs. (2) Competition among state concerns could be sorted based on an understanding of the drivers of state responses to policy adoption. (3) The ability to predict factors that may influence the adoption of Medicaid expansion may assist policymakers recast or re-frame policies or policy objectives in order to achieve purposeful optimal outcomes.

Plan of this Dissertation

This dissertation explores the expansion of Medicaid and the influence of state decision making. Chapter 1 provides an overview of Medicaid and the policy window that has opened due to the passage of the Patient Protection and Affordable Care Act. Research questions and the significance of this study are also outlined in this chapter. Chapter 2 provides a detailed review of the Medicaid program and the ACA, and develops the five models employed in the study. Chapter 3 details the methods used to conduct this study and offers a comprehensive description of the variables, statistical tests used, and data sources. Chapter 4 provides an analytical discussion of the results of the study. Chapter 5 concludes with insights from this study, limitations and delimitations, and implications for future scholarly research

CHAPTER 2

LITERATURE REVIEW AND THEORY

The implementation of Medicaid expansion is at a standstill. Presently, 30 states have adopted Medicaid expansion, 17 states have chosen to decline expansion, and 3 states are undecided (Kaiser Family Foundation, 2015). While the Patient Protection and Affordable Care Act (ACA) was formulated with an expectation of participation from the states; political conflicts, court proceedings, and changes in governmental leaders across all levels of government have contributed to disjointed portions of the law and variations in the adoption of Medicaid expansion among states (Jones, Bradley, & Oberlander, 2014; Jost & Rosenbaum, 2012; Leonard, 2012. This chapter seeks to understand what factors influence states to adopt Medicaid expansion by reviewing the literature on Medicaid expansion in addition to relevant studies on the adoption of Medicaid policies and programs by states.

This chapter begins with a brief discussion of the research approach to the literature review and a historical account of Medicaid and the ACA in order to understand the circumstances surrounding and leading up to Medicaid expansion and the role of states. A discussion is presented on state policy choices and decisions to explain certain components of the decision making process and pressures facing states on public policies. A conceptual framework of the process of state decision making is introduced to depict the inner workings of state policy decisions on Medicaid expansion. A review of the literature is analyzed and summarized with remarks and inferences on the influencers of state decisions on Medicaid expansion and previous policies and programs followed by a summary of the chapter.

Approach to Research

The literature on Medicaid expansion in the 21st century is limited in scope and detail due to the enactment of the ACA in 2010, challenges to health care reform, and changes in political leaders at the state-level. As a result, this research is informed by other disciplines such as education, intergovernmental management, political science, economics, and welfare policy. The conceptual framework of state decision making on Medicaid is borne out of an analysis of relevant state characteristics and Medicaid policy.

The search criteria for this research focused on topics such as *Medicaid expansion*, *Medicaid policy*, *state decision making*, *state policy choices*, and *adoption of state policies*. The following databases were used: Google Scholar, Academic Search Complete, JSTOR, ScienceDirect, and ProQuest. Theoretical and empirical articles were analyzed to guide the literature review. For the empirical articles spanning multiple disciplines, a chart was made for personal use detailing the operationalization of variables used to explain the state adoption of a particular policy of interest. An examination of the chart revealed the common indicators of state policy adoptions, which were then categorized and selected to represent the five proposed models in this study after an iterative process of reviewing the literature (political model, economic model, needs-based model, and state capacity model, and state innovation and diffusion model).

Historical Overview of Medicaid

The Road to Medicaid

Preceding the enactment of Medicaid in 1965, the provision of medical care for disadvantaged individuals was sporadic, ad hoc, or nonexistent (Stevens & Stevens, 1974). The depression era of the late 1920s served as an impetus for what some call the American Welfare State with the passing of the Social Security Act in 1935. By means of this Act, individuals were given financial assistance from the government during times of hardship (Weikel & Leamond, 1976). As a mechanism for income protection, the Social Security Act shielded the elderly, disabled, widowed, and children from financial ruin by adopting and codifying into law state eligibility guidelines for deserving, low-income individuals (Huberfeld, 2011).

The Social Security Act of 1935 established two types of social programs: Social insurance for working individuals such as worker's compensation and pension plans, and unemployment insurance and financial assistance from the states for those deemed needy (Weikel & Leamond, 1976). The determination of need was not defined just by professional standards of care according to medical practice, but included socially defined needs based on cultural norms and economic considerations (Kronebusch, 1997). Due to the conceptions of the policymakers following the Social Security Act of 1935, the benefactors of financial assistance were one-parent families, the elderly, and disabled individuals. Although medical insurance was not provided to recipients meeting eligibility requirements, allotted monthly payments took into consideration medical expenses. State participation was optional, but the federal government provided matching funds (Weikel & Leamond, 1976).

After the passage of the Social Security Act, several amendments were passed to expand the scope of the program with special emphasis on providing sufficient benefits to individuals and families rather than financial independence and equitable distribution (Kollmann, 2000). However, the most historic amendment serving as a catalyst for the establishment for Medicaid came in the form of the Kerr-Mills legislation in 1960 (Smith & Moore, 2008). States received federal funding for impoverished individuals aged 65 and older for medical expenditures under Kerr-Mills through the Medical Assistance to the Aged (MAA) program (Moore & Smith, 2004).

Following the implementation of Kerr-Mills, proposals for a comprehensive bill on Medicare was gaining attention at the national level and was supported by the public. In 1964, the President-elect, Lyndon Johnson, welcomed extended benefits for the elderly because it complimented his agenda on developing a Great Society. Wilbur Mills crafted the legislation that included care for inpatient hospital stays and nursing home services under Medicare Part A and outpatient services under Medicare Part B. In 1965, these provisions were amended to the Social Security Act Title XX (Olson, 2010). The services under Title XX centered on life-sustaining and self-maintenance care. As a result, Title XX benefits provided basic supportive services for the elderly (Nelson, 1982). In 1975, a federal block grant was authorized to allow states to determine their own benefits based on state-specific priorities (Schram & Hurley, 1977). The design of the new amendments to Medicare was carefully planned and it appealed to many stakeholders including opponents of changes to the MAA program because it focused on an insurance plan rather than a collectivist approach to managing health care (Olson, 2010).

Medicaid on the hand was, "the third piece of what Mills labeled a 'three-layer cake,' Medicaid (Title X1X of the 1965 Social Security Act) was more hastily devised, emerging after only minimal debate" (Olson, 2010, p. 25). The bill created by Mills and other members of the

House Ways and Means committee included three separate and competing proposals or layers, which became known as Medicare Part A, Medicare Part B, and Medicaid (Stevens & Stevens, 1974). While most of the congressional debates focused on Medicare, the formulation of Medicaid lacked clear goals, a projection of current and future program costs, and the insight to handle programmatic problems (Weikel & Leamond, 1976). The enactment and implementation of Medicaid were further overshadowed by major events such as the Civil Rights movement, the Vietnam War, and Watergate (Smith & Moore, 2008).

Although Medicaid was conceived as an afterthought, many states implemented the program within the first few years of enactment, eventually leading to full participation of all states within the U.S. (Huberfeld, 2011). Currently, Medicaid is a program that services low-income Americans through a joint partnership between the states and the federal government. States are given a great deal of discretion to consider or make administrative policy choices and decisions (Kronebusch, 1997). There are basic statutory guidelines established by the federal government that each state must adhere to in order to ensure essential health services and access to Medicaid and services, irrespective of "the state's ability to pay for the medical assistance" (Huberfeld, 2011). Members meeting the requirements of a deserving group included poor mothers and children or families, pregnant women, the elderly, the disabled, and the blind with incomes below state poverty levels. However, individuals seeking such benefits had to meet eligibility at the state poverty level and be deemed a member of a deserving group (Tanenbaum, 1995).

Since the inception of Medicaid, there has been a multitude of amendments to the Medicaid Act. The major changes included the following. In the 1960s, Medicaid was governed by the Social Rehabilitation Administration and costs were curbed by setting eligibility

requirements through asset and income determinations. Other changes included providing coverage for certain populations such as the blind, disabled, and families with dependent children (Kaiser Family Foundation, 2008; Moore & Smith, 2004). Additionally, states were limited by federal rules in implementing Medicaid (Ferguson & Leddy, 1999). In the 1970s, states were allowed to reduce spending on Medicaid with the abolishment of the "maintenance of effort" (Kaiser Family Foundation, 2008). As health expenditures increased, many states responded by imposing strict eligibility requirements and cutting benefits (Brown & Sparer, 2003)

In the 1980s, the Omnibus Reconciliation Act allowed for a reduction in federal matching funds to states (Kaiser Family Foundation, 2008). Federal reductions in aid, a depressed economy, and changing views on providing cash assistance to the needy contributed to the diminution of poverty level thresholds (Brecher & Rose, 2013). Additionally, many states contracted with private insurance companies to provide managed care to use state resources efficiently (Oberg & Polich, 1988). In the 1990s, the Clinton administration encouraged state expansion of Medicaid using section 1115 waivers, which allowed states to experiment with new programs and policies with exemption from federal Medicaid requirements (Kaiser Family Foundation, 2008; Schneider, 1997). During this era, the Personal Responsibility and Work Opportunity Act of 1996 was enacted, which replaced the Aid to Families with Dependent Children cash assistance program with a block grant program under Temporary Assistance for Needy Families (Kaiser Family Foundation, 2008). Modifications to federal law in regards to Medicaid expanded state discretion and allowed great flexibility in implementing Medicaid policies (Cantor, Thompson, & Farnham, 2013). In the 2000s, regulations were put in place to crack down on upper payment limits and the Bush administration supported the use of section

1115 waivers (Kaiser Family Foundation, 2008). As changes in Medicaid occurred over time, the next transformation in Medicaid transpired with the passage of the ACA.

The History of the Patient Protection and Affordable Care Act

The Current State of Health Care in the United States

Prior to the enactment of the ACA, the United States experienced a recession with a national unemployment rate of 5% in 2007, ending at 10% in 2009 (U.S. Bureau of Labor Statistics, 2012). A Kaiser Family Foundation poll, assessing the attitudes of Americans, found that 54% of the population considered health care a priority and 50% indicated rising health care costs contributed to postponing care for a medical need (Kaiser Family Foundation, 2009). Although previous presidential administrations have advocated for health care reform, endeavors were met with much resistance to change by opposing political parties and constituent groups. Nonetheless, extreme rhetoric, steadfastness, cooperation, tremendous organizational efforts, and voting along party lines changed the course of health care in the United States, thus leading to the enactment of the Patient Protection and Affordable Care Act (Beaussier, 2012).

The formulation of the ACA was riddled with many hindrances and differences of opinion in how the current health care system should be restructured. Three proposals were drafted with the perception that the process was occurring in a transparent and open manner to influence the public and stakeholders in supporting universal health insurance (Frakes, 2012). The first proposal was led by senators through a bipartisan partnership. The plan included subsidies to economically disadvantaged citizens, an individual mandate, and decreased spending in Medicare (Hayes, 2011; Jacobs & Skocpol, 2010). The senators in the bipartisan partnership disbanded over ideological differences and party conflicts, and the proposal was disregarded

(Jacobs & Skocpol, 2010). The second proposal was created by the House of Representatives and revised to maintain party support (Beaussier, 2012). The proposal consisted of a public option, an employer mandate for corporations with 50 employees or more, a national health insurance exchange, and subsidies for both middle and low-income individuals for the purchase of health insurance (Jacobs & Skocpol, 2010). The third proposal was developed by the Senate and passed with support from both Republicans and Democrats; it included an individual mandate and state-based health insurance exchanges (Hayes, 2011; Jacobs & Skocpol, 2010).

During the merger of both the Senate and the House of Representative proposals, the Democratic Party lost a Senate seat and a filibuster-proof majority due to the death of Senator Ted Kennedy (Flint, 2014; Hayes, 2011). A bipartisan summit was instituted to settle differences and to garner an agreement on the finalized proposal for health care reform. The call for cooperation through the summit reached an impasse with refusals to reach common ground on the legislation (Jacobs & Skocpol, 2010). Although there was much opposition in passing the ACA, the Senate bill was approved without the vote of the new republican Senator Scott Brown (Farley, 2010). Two days later, President Obama signed PPACA on March 23, 2010 (Quadagno, 2014).

The Current State of Medicaid in the United States

Many factors contributed to the passage of the ACA: politics, interest groups, and policy entrepreneurs. Opponents of the ACA objected to many aspects of the bill, and some parts of the law were challenged. Republican leaders and governors called for the repeal of the ACA (Jones, Bradley, & Oberlander, 2014). Commentators suggested that opponents appealed to political theatrics, antics from the Tea Party, and midterm election gamesmanship (Leonard, 2011).

Proponents argued that the ACA would improve the provision and delivery of health care services and supply necessary services to millions of uninsured Americans (Manchikanti, Caraway, Parr, Fellows, & Hirsch, 2011).

In the case of Medicaid, the states challenged Medicaid expansion and the mandate that required all individuals to buy health insurance (Leonard, 2012). The state of Florida filed a lawsuit in conjunction with 25 additional states that challenged the constitutionality of Medicaid expansion under the Spending Clause (Cohen & Blumstein, 2012). The Spending Clause is a doctrine that is established under the U.S. Constitution. In the Supreme Court ruling; *United States v. Butler*[1], the Court determined that "Congress is free…to condition the receipt of federal funds upon compliance with federal statutes and administrative directives" (Binder, 2001, p. 150). In further support of the Spending Clause, in *South Dakota v. Dole*[2], the Supreme Court ruled that "Congress could condition the receipt of federal highway funds upon states raising the minimum drinking age to twenty-one" (Binder, 2001, p. 150). In sum, the Spending Clause gives the federal government authorization to compel states to adhere to conditional grants to ensure accountability while providing for the general welfare of the public (Bagenstos, 2012). Although Congress has the ability to attach conditions to federal programs through funding mechanisms, the court has recognized and accepted this form of exchange between the states and the federal government (Jost & Rosenbaum, 2012). However, the challenge to Medicaid expansion highlighted an inherent issue within the law that violated the Constitution:

> Federal conditions must be unambiguous, ensuring that states are given clear notice of their obligations when they accept federal funds so that they can knowingly exercise their

[1] 297 U.S. 1 (1936)
[2] 483 U.S. 203 (1987)

> choice (which is protected under the Constitution) about whether to participate; and the federal government may not employ the spending power in such a way as to 'coerce the states into compliance with federal objectives.' (Cohen & Blumstein, 2012, p. 104)

The states that opposed the expansion claimed that the ACA crossed the line through coercion to participate in Medicaid expansion (Perkins, 2013). The Supreme Court heard the case and decided that the "coercion doctrine is fundamental to federalism and that brandishing federal funding to coerce states to participate in federal programs threatens the states' independent sovereignty" (Jost & Rosenbaum, 2012). The Court made a distinction between Medicaid expansion and the existing Medicaid program and determined that Medicaid expansion was a new program (Hall, 2012). This ruling eliminated the possible threat of losing federal funding for existing Medicaid programs for failure to adopt Medicaid expansion (Jost & Rosenbaum, 2012). As a result, the mandate was rendered unenforceable, but states were given the option to adopt Medicaid expansion with a munificent amount of federal funding (Hall, 2012; Jost & Rosenbaum, 2012).

The Supreme Court decision marked a historical moment in time for Medicaid policy and public policy, because it limited the power of the federal government in garnering the compliance of states and the ability of Congress to impose monetary constraints on joint federal-state programs based on state actions or choices (Rosenbaum & Westmoreland, 2012). As a result, states were given the choice to refuse Medicaid expansion without fear of losing federal funding or face penalization. Conversely, states that had made the choice to adopt Medicaid expansion were able to take advantage of the federal funding that is available, which included 100% of expansion costs until the year of 2016 and gradual reductions thereafter (Perkins, 2013).

Understanding State Policy Choices

The partnership between the states and the federal government in Medicaid policy encompasses two major components. The first component involves federal matching funds, which first encouraged states to establish Medicaid and now incentivizes states to maintain Medicaid coverage (Rossi, 2014; Schneider, 1997). The second component includes general guidelines set forth by the federal government, which serves as an overarching umbrella that allows states the freedom and flexibility to operate a Medicaid program in accordance with the needs and capabilities of each state (Schneider, 1997). In the realm of health care, states are responsible for financing, delivering, and coordinating health care services (Adler, 2011; Huberfeld, 2011; Kronebusch, 1997). More specifically, they must control health care costs, regulate medical providers and the sale of health insurance, set health care rates, determine benefits, define eligibility standards, and provide licensing services (Kronebusch & Elbel, 2004; Weissert, 2004).

The management of Medicaid involves many choices. The choice to expand Medicaid or adopt any new changes is limited by a variety of "pressures and realities in the environment" (Bachman, Altman, & Beatrice, 1988, p. 248). Furthermore, limitations create a range of available policy choices, thus affecting the selection of proposed policy changes (Bachman, Altman, & Beatrice, 1988). Policy choices in the arena of Medicaid policy are most affected by state regulations, policy instruments, and barriers and perceptions.

Regulatory policy choices at the state-level typically follow a consistent pattern or policy direction (McGinnis, 2002). This type of policy controls private and market behavior and is often technically inclined (Gerber & Teske, 2000). Health insurance coverage for low-income individuals is heavily impacted by state choices. Regulatory choices faced by states considering

Medicaid policy changes include decisions on determining eligibility requirements, premiums, cost-sharing mechanisms, accepting federal funds with attached strings, and managing third party insurers (Cromwell, Hurdle, & Schurman, 1987; Holahan, Uccello, Feder, & Kim, 2000). While policies are the product of regulation, policymakers can choose to use regulation as a tool to mitigate market failure, deliver a service, or finance a program such as Medicaid (McGinnis, 2002).

Policy instruments are tools such as regulations, grants, certifications, and contracts used by the government to implement public policies (Howlett, 1991). State-based policies on Medicaid use tools that are redistributive in nature and allow states to have an active role in determining program features (Barrilleaux & Brace, 2007). States may pursue policy instruments that offer flexibility and autonomy, such as block grants and waivers. As Kronbusch (1997) noted, states have enjoyed greater flexibility and discretion over Medicaid using waivers to expand program services. On the other hand, a market-based approach to managing Medicaid may focus on minimizing moral hazard and increasing economic development (Barrilleaux & Brace, 2007). With market-based policies, states may seek contractual agreements with managed care organizations. The selection or non-selection of policy instruments depends upon state preferences and choices that in turn affect the administration and implementation of Medicaid (Ewalt & Jennings, 2004). While policy instruments provide a means to obtain policy objectives, their outcomes differ and states are given the opportunity to choose their instrument of choice, which might not serve a large population of low-income and/or uninsured individuals.

Multiple barriers and perceptions also affect state policy choices. The cost of Medicaid reform is highly expensive and states must dedicate staff, time, and resources to a program that has sometimes produced uncertain and undesirable results. Action at the state-level for Medicaid

reform will often require a real or perceived crisis (Bachman, Altman, & Beatrice, 1988). Perceptions of Medicaid needs may differ among policymakers. Medicaid considers both medical and social needs, but some needs are believed to be more important than others (Kronebusch, 1997). Last, barriers such as financial, political, legal, and managerial issues limit the ability of states to tackle problems effectively while serving the Medicaid population (Barrilleaux & Brace, 2007). Perceptions and barriers can place constraints on state policy choices and thus affect state decisions. State policy choices are an important component of decision making because they serve as an antecedent to the adoption of public policies. While states are responsible for the welfare of its residents, they must decide on complex issues and also be a good steward of their finances and resources while operating within their defined jurisdiction.

Rationalization of State Decision Making

The role of states in Medicaid policy is important because they decide how to control health care costs, improve quality, and increase efficiency and access while attending to a multitude of functions in the management of Medicaid (Miller, Wang, Feng, & Mor, 2012). Decisions at the state-level are influenced by competing institutional and environmental circumstances. Political pressures from state leaders, political parties, interest groups, and industries infiltrate the policy making process thus impacting state decisions. Economic constraints force states to prioritize their objectives and determine the best method for allocating resources (Kronebusch, 1997). As states consider the expansion of Medicaid, deliberations concerning adoption are contextualized to state-specific issues, such as the population of low-income uninsured adults and children, state resources and budgeted expenses, industries that will

be affected by the adoption or nonadoption of Medicaid expansion, the will of the people they serve, and impending state elections (Frakt & Carroll, 2013). Other considerations that affect the decision making process of states include state priorities, the amount of discretion afforded by federal and state policies, and the ability to respond to a problem (Barrilleaux & Brace, 2007; Kronebusch, 1997; Leider, Resnick, Kass, Sellers, Young, Bernet, & Jarris, 2014).

The delivery of health care services is very expensive and states are burdened with balancing their budgets and making determinations as to how much they will spend on Medicaid relative to their overall expenses (Greipp, 2002). Just on health care spending, states are making resource allocation decisions based on priorities. State agencies have found that while public needs and adhering to mandates are top priorities; political interests and scarce resources can be challenging (Leider, Resnick, Kass, Sellers, Young, Bernet, & Jarris, 2014). As federal policy changes have occurred over time, allowing states to have more discretion and flexibility in operating Medicaid, state priorities have shifted. States are able to select their own social services programs, redefine mandated programs, reduce program benefits, and eliminate administrative personnel all of which are actions reflective of state priorities (Agranoff & Pattakos, 1984).

As states have gained more control over Medicaid policy, state discretion has increased, leading to a more flexible Medicaid program, but also wide variations in the delivery, financing, and coverage of health care services across states (Schneider, 1998). State discretion has its strengths and weaknesses. For instance, states could utilize discretion to create innovative programs with the aim to decrease health disparities and inequities. In contrast, decreased federal oversight and direction may lead to an unbalanced use of state discretion spurring negative consequences, such as funding cuts and unmet health care needs (Budetti, Butler, &

McManus, 1982). In principle, increased state discretion and authority allows states to adopt policies, but to avoid the mistakes of previous welfare reforms, states must move beyond proscribed federal guidelines and punitive consequences in order to be responsive to the needs of Medicaid beneficiaries (Lee, 2009; Soss, Schram, Vartanian, & O'Brien, 2001).

State responsiveness can occur through "policy liberalism," in which policymakers determine program features and guidelines or actions taken by state agency administrators in implementing enacted laws (Fossett & Thompson, 2006). Through policy liberalism, some of the factors that have compelled states to respond to Medicaid expansion include financial inducements and public and industry support. On the other hand, countervailing forces include economic constraints, political resistance, and limited administrative and infrastructure capacity (Brecher & Rose, 2013).

Since state representatives lack the resources and expertise to implement complex public policies, policy making authority is delegated to government agencies. Depending upon the severity of the public problem (whether real or perceived), the delegation of authority can be expansive or limited. As a result, there can be situations where state representatives set policy directions, government agencies such as state Medicaid agencies that operate with a great amount of autonomy, or circumstances where there is a struggle between political control and agency command (Potoski, 2002). In the case of Medicaid expansion, the refusal by state officials to adopt expansion has overridden enticements such as a generous federal funding scheme and programmatic latitude (Callaghan & Jacobs, 2014). Nonetheless, state participation is voluntary and states have a great amount of leverage in deciding upon the adoption of Medicaid expansion (Dinan, 2014).

The Utilization of Medicaid Expansion: Serving as the Dependent Variable

The full impact of health care reform cannot be realized if all states do not participate or believe in the objectives of the ACA. As decreed by the ACA, access to health care services for millions of Americans is mostly dependent upon two programs: Health insurance exchanges and Medicaid expansion (Callaghan & Jacobs, 2014). However, there are differences that exist that involve governance. Although States can decide whether to operate an exchange, the implementation of the ACA is not affected by the state's refusal to manage an exchange because the federal government provides a federally operated health insurance exchange. The fallback system in place for state-based exchanges does not extend to Medicaid.

State participation in the expansion of Medicaid is voluntary. Prior to the ACA, states had the flexibility and discretion to tailor Medicaid to fit their needs and budgets. With the ACA, directives to increase eligibility to 138% of the federal poverty level for all individuals under the age of 65 regardless of whether they have a disability or children did not fare very well with all of the states (Sullivan & Gershon, 2014). Many states refused Medicaid expansion based on the grounds that expansion would be too costly due to the new eligibility standards (Landers & Leeman, 2011). However, recent scholarship on the progress of Medicaid expansion for states that have chosen to expand show that states are projecting budget savings in Medicaid for the next decade. Additionally, the majority of states are optimistic about the benefits that will be gained by the beneficiaries in regards to better health, financial protection, and access to health care services (Sommers, Gordon, Somers, Ingram, & Epstein, 2014).

State decisions concerning the adoption of Medicaid expansion have many implications. The same problems that have persisted across states such as variability in Medicaid policies,

rates of uninsured individuals, health disparities, and spending will still remain with almost half of the states refusing to expand Medicaid. Moreover, these state differences and coverage gaps will widen as implementation of Medicaid expansion and the ACA progresses (Richardson & Yilmazer, 2013). For these reasons and more, Medicaid expansion is the dependent variable of significance. This variable is measured by analyzing the decisions of states for the year 2012 and grouping state decisions in the following categories: Adopt Medicaid expansion, support Medicaid expansion, undecided, and decline Medicaid expansion. The year 2012 is used in this study as the cross-sectional year because states are given the option to expand Medicaid as the result of the Supreme Court decision, *National Federation of Independent Business (NFIB) v. Sebelius*[3] in 2012.

This study will examine the factors that drive states to expand Medicaid. The forces driving states to adopt Medicaid expansion will be analyzed through five models as follows: The political model, the economic model, the needs-based model, the state capacity model, and the state innovation and diffusion model. The literature review of the models is centered on studies that discuss the adoption of Medicaid policies by states. The assumptions of each model are explicitly stated at the beginning of each model and hypotheses are provided based on the success or promising theories of prior studies. The full model of state decision making in Medicaid expansion can be seen in Figure 2.1 below.

[3] 132 S. Ct. 2566 (2012)

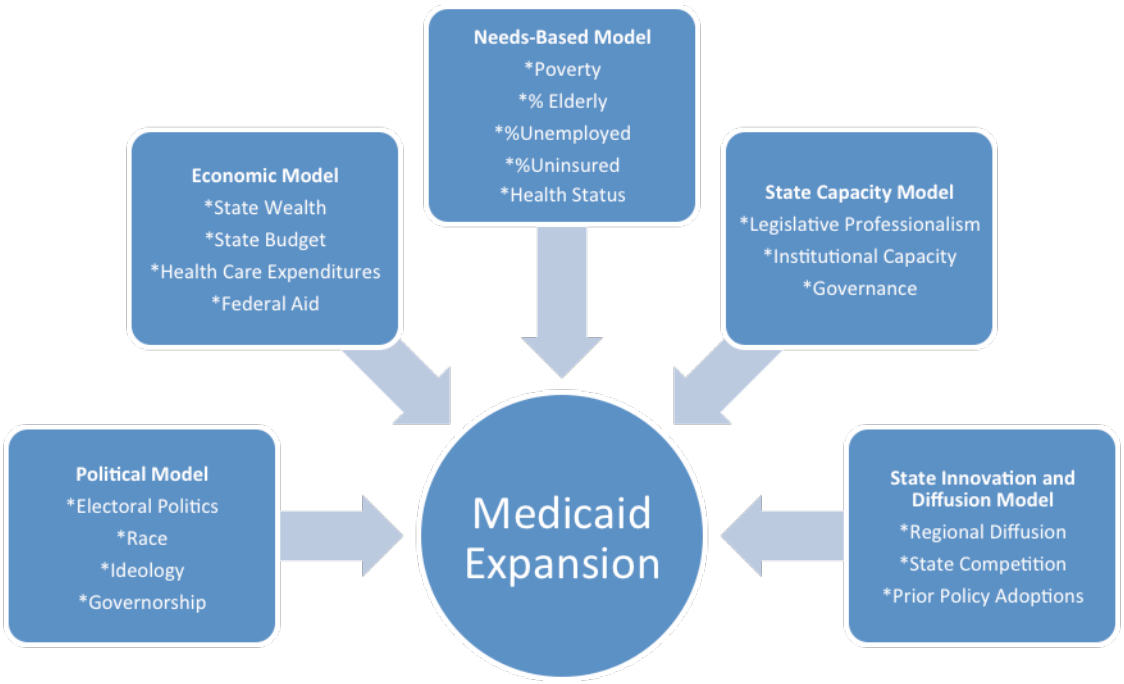


Figure 2.1. A Model of State Decision Making in Medicaid Expansion

Political Model

Political explanators permeate the literature on state decision making and Medicaid policy. While a political model is not established within the literature on Medicaid policy, this research proposes a model that is based on established exegetic variables. The political model assumes that the composition of the state's legislative body and the competition of major parties influence the adoption of new initiatives or programs (Walker, 1969). Moreover, this model assumes that state legislators consider the concerns of its constituents; however, the degree of consideration depends upon the responsiveness and actions of voters and interest groups (Grogan, 1999). The Political model comprises variables that demonstrate an effectual change in state decision making. The agents of change include electoral politics, race, ideology, and governorship. Figure 2.2 depicts the Political model below.

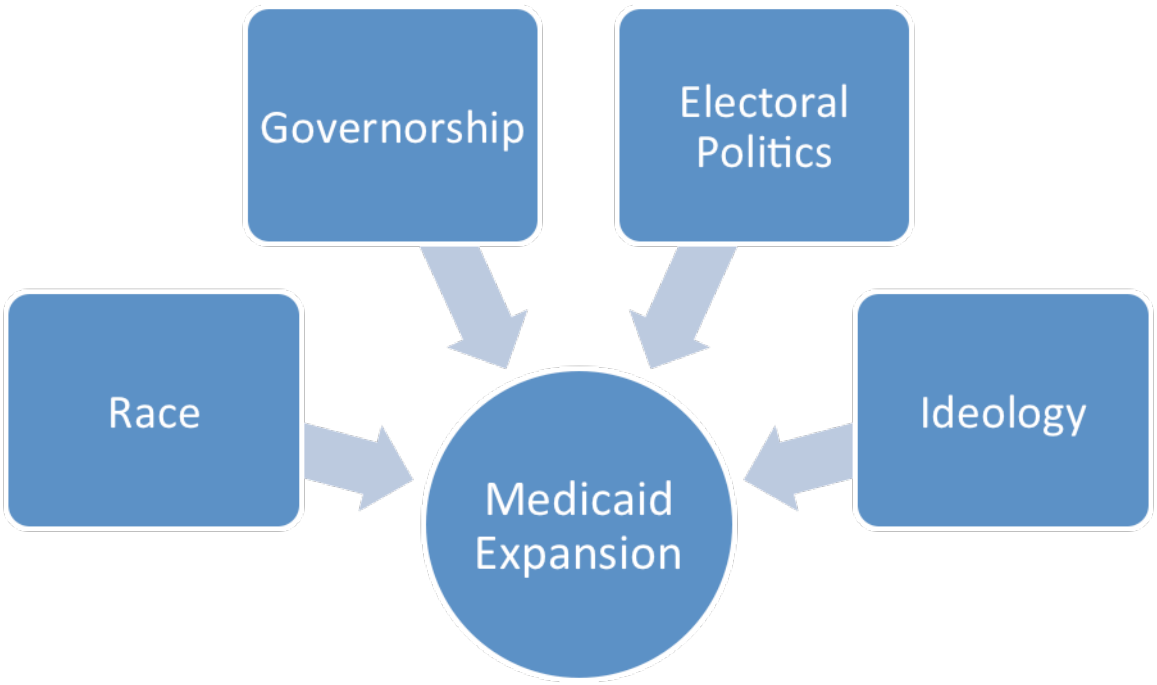


Figure 2.2. Political Model

Electoral Politics

Major parties represent the political will of states shaping the scope of policy designs and "structuring the control of implementation" (Koski, 2007, p. 414). Previous studies involving welfare policy postulated that political factors were secondary to socioeconomic factors in policy making (Kousser, 2002, Key, 1949, Lockard, 1959, Fenton, 1966; Hanson, 2004). Dawson and Robinson (1963) analyze the relationship between the adoption of state welfare policies and political processes and determine that state wealth and socioeconomic forces play more of a role in shaping public welfare policies than politics. Furthermore, they conclude that inter-party competition is not a significant factor in determining the scope and nature of public policies concerning welfare. In a study analyzing the redistributive impact of the Aid to Families with Dependent Children (AFDC) welfare program, Plotnick and Winters (1985) find that there is not a link between liberal party control and redistribution policies. They conclude that party control

may serve as an indirect factor or an interaction variable when there is party competition or a change in party control. Buchanan, Cappelleri, and Ohsfeldt (1991) find that state Medicaid spending levels are heavily influenced by social factors as opposed to political forces. The authors conclude that one of two possible explanations could account for their findings. The first explanation consists of the idea that the measure used to assess political underpinnings did not encapsulate the ideology of politicians. The second explanation suggests that state spending on Medicaid is unaffected by politics.

Due to further research and refined instruments, scholars have established a link between politics and welfare benefits. Scholarship on the power of the major parties has shown that the influence of Republican control is linked to reductions in welfare benefits and restrictive welfare policies (Kim & Jennings, 2012; Rom, Peterson, Scheve, 1998). However, Grogan's (1999) examination of the effect of party control on AFDC benefits shows mixed results. Democratic control supports the expansion of financial eligibility as expected. On the other hand, Republican control did not appear significant for policies on benefits and coverage for those considered medically needy. Nonetheless, Grogan's (1999) study did find a negative association between Republican control and payment policies. This difference in support for Medicaid policies suggests that context and degrees of support for different policies within a singular program should be considered. As Grogan (1999) mentioned, "this finding supports that Republican control does not lead to retrenchment in welfare benefits due to pressure put on the party not to appear mean-spirited" (p. 28). Brown's (1995) analysis on the impact of political parties on state policy reveals that party control is a significant factor in influencing state welfare efforts when examined in context and partisan divisions exist.

While studying state variations on Medicaid spending, Kousser (2002) tests the theory that party control is a driver of health policy. He mentions that, "controlling more than 50 percent of legislative seats is the 'magic number' for Medicaid policy making" (Kousser, 2002, p. 650). Through testing the strength of a party and party control, Kousser (2002) discovers that there is evidence to support the notion that party control shapes policy, especially when specific policies such as spending, are isolated to control for rival causal explanations. In a study analyzing the influence of party control on Medicaid programs and the uninsured based on state population, Cummins' (2011) is surprised to find that there is an association between unified Republican control and a reduction in the uninsured population for average sized states. On the other hand, for average-sized states, Cummins also finds that a majority control of Democratic legislative seats led to an increase in an uninsured population. Cummins (2011) suggests that Republicans may be more effective in reducing the uninsured rate due to the adoption of more policy reforms and implementation of established and successful programs than Democrats. However, Cummins (2011) warns that the policy reforms that were analyzed for the purposes of his study were adopted during times of a divided government.

Shifting to current studies, Kim and Jennings (2012) analyze state variations in Medicaid managed care and conclude that states with a unified Democratic Party tend to have more extensive primary care case management programs. They also have fewer managed care programs based on risk. In contrast, Kim and Jennings (2012) did not find a statistically significant relationship with a unified Republican party in regards to either managing care programs (risk-based models or primary care case management models). Jacobs and Callaghan (2013) also find that there is a strong correlation between Medicaid expansion and party control while examining variations in Medicaid expansion. In states with Republican control, the

expansion of Medicaid is rejected or involves a slow process of implementation. In contrast, for states under Democratic control, Medicaid expansion is implemented very quickly. Jacobs and Callaghan (2013) point out that the opposition or support for the ACA among party lines crosses over to Medicaid expansion, which in turn affects state adoption and implementation decisions.

Interparty competition is also an important component of electoral systems within each state (Soss et al., 2001). The pluralist view of party competition holds that in states with electoral competition, officials that are elected are more responsive to median voters (Jenkins, Leicht, & Wendt, 2006). In describing V.O. Key's (1949) analysis on southern politics and interparty politics, Soss et al. (2001) note that "the policy process is more likely to respond to the needs of the disadvantaged when political parties are more evenly matched and, hence, forced to contend with one another by mobilizing and swaying voters" (p. 383). While analyzing the differences between state and market strategies for health reform in the 1990s, Barrilleaux and Brace (2007) characterize electoral competition as "the closeness of races in terms of votes" (p. 668), versus the dissemination of legislature seats among parties. They conclude that more health reform policies are adopted when there is a high degree of electoral competition, health insurance coverage issues, high resident incomes, and a history of policy adoptions.

Bernick (2001) tested the notion of partisan competition while examining policy diversity and state variation for managed care programs using a measure developed by Holbrook and Van Dunk (1993). The measure includes several factors at the legislative district level such as the proportion of popular votes, margins of victory, contested elections, and the safety of legislative seats occupied by a major party (Bernick, 2011; Holbrook & Van Dunk, 1993). Bernick (2011) finds that states with a greater degree of partisan competition tend to have more liberal policies.

Additionally, Bernick (2011) suggests that noncompetitive states are those that know what they want or need politically from policies in relation to managed care in welfare reform.

The influence of party control could be linked to a school of thought that suggests Medicaid policies are reflective of the values of the controlling party in office. This reasoning stems from a decisional aspect of policy making where Medicaid policies are typically made by fiscal and health committees, and members of the committees are appointed by an elected official of a controlling party (Kousser, 2002). This line of thought presumes that the party in control has longevity and very little competition. Traditional measures of party control do not take into account interparty competition. Many studies analyze party control using a dichotomous measure and evidence that demonstrates a link between a particular policy and the dominant political party under study (Barrilleaux & Rainey, 2014; Kim & Jennings, 2012; Kousser, 2002; Satterthwaite, 2002; Volden, 2006). Other studies utilize additive scales to measure party control employing a continuum from republican to democrat or vice versa (Callaghan & Jacobs, 2014; Jacobs & Callaghan, 2013). While there are a variety of methods to measure party control, the environment surrounding health care reform requires a system of measurement that takes into account the contentious nature of Medicaid expansion. Thus, in relation to the dominant two-party political system in the U.S., we will investigate the influence of interparty competition on Medicaid expansion.

Interparty competition is a subject of debate among scholars of American politics because of its potential to influence policy outputs (Holbrook & Van Dunk, 1993). The prevailing thought raised, by Key (1949) is that competition among political parties produces liberal policies versus conservative policies enacted by noncompetitive systems of government. Although Ranney (1976) developed an index to measure interparty competition, the index

focuses on measuring the influential power of the Democratic Party. Building on Ranney's index, Holbrook and Van Dunk (1993) create an index that measures the competitiveness of state legislative elections at the district level using the following components: the victor's percentage of popular votes, margin of victory, "whether or not the seat is safe," and whether the race was contested (p. 956). Shufeldt and Flavin (2011) analyze both the Ranney index and the Holbrook and Van Dunk measure of interparty competition from 1970-2003 and find that Holbrook and Van Dunk's measure is more stable over time because electoral competition does not vary much across state elections. Due to the stability of Holbrook and Van Dunk's interparty competition measure, we will test the following hypothesis:

> H_1: States with a high degree of interparty competition are more likely to adopt Medicaid expansion.

Race

Redistributive policies, such as, welfare can be thought of as a pulley system in the context of a politicized process. In this sense, public policies are pushed and pulled in a multitude of directions. Political parties compete for votes by appealing to the interests of constituents, whether they are poor or rich. Promises are made and money or benefits are extracted from the uninformed or wealthy (Downs, 1957; Plotnick & Winters, 1985; Schumpeter, 1947). While there are limits to this process, many factors influence the development and progression of public policies. Brown (1995) finds that the population of African-American residents impacts state welfare efforts. Brown's (1995) empirical analysis reveals that as the proportion of African-Americans multiplied, welfare efforts decreased. Kim and Jennings (2012) also test the impact of race on state Medicaid policy making, because

previous studies have demonstrated that African-Americans are negatively affected by welfare policies (see Grogan, 1994; Soss et al., 2001). However, Kim and Jennings (2012) realize that racial politics is insignificant in relation to implemented policies on the receipt of cash assistance.

The findings of many studies demonstrate that Medicaid politics are shaped by race (Brown, 1995, Kim & Jennings, 2012; Soss et al. 2001). Additionally, scholarship on this topic repeatedly reveals a consistent link between the proportion of American Americans on Medicaid and welfare generosity (Soss, 2001). To measure the effect of race on Medicaid expansion, we use the percentage of African-American voters as a proxy. Prior research suggests that states with a high population of African-Americans are more likely to provide minimal welfare benefits (Howard, 1999; Soss et al, 2010). We assume that African-American voters represent the interests of minorities and that states' responses to welfare policies are predicated on community engagement. Therefore, we expect states to decline Medicaid expansion when there are a low proportion of African-American voters.

H_2: States with a low proportion of African-American voters are more likely to reject Medicaid Expansion.

Ideology

The motivations driving legislators to adopt certain policies coincide with ingrained ideologies. Republicans tend to favor policies that reduce uncompensated health care and decrease health expenditures. On the other hand, Democrats support policies that increase access, improve continuity and quality of care, and curtail stigmas on welfare recipients (Pracht, 2007). Moreover, states with a liberal ideology have provided strong fiscal support for welfare programs

(Barrilleaux & Miller, 1988; Miller, Harrington, Ramsland, & Goldstein, 2002; Schneider, 1993, 1997). Political philosophies are infused in public policies because the policy making process is not easily translated and enacted based on the interests of advocacy groups and the electorate (Grogan, 1999).

There is a plethora of research that demonstrates that ideology influences public policy and health policy. Soss et al. (2001) find that conservative governments are more likely to enact restrictive Temporary Assistance for Needy Families (TANF) policies. Volden (2006) discovers that government ideology is significant among all different types of policy changes tested in relation to eligibility requirements, types of programs, premiums, waiting periods, and co-pay benefits for the Children's Health Insurance Program (CHIP). Bernick (2011) finds that liberal states have diverse Medicaid managed care programs, but moderate states have the most diverse Medicaid programs. Mayer, Kenter, and Morris (2015) determine that state decisions in regards to public policies are not fueled by policy needs, but instead by ingrained ideological beliefs.

Ideology has been considered a significant determinant in the shaping of public and health policies (Berry, Fording, Ringquist, Hanson, & Klarner, 2010; Coggburn & Schneider, 2003; Fossett & Thompson, 2006). When examining ideology and the consideration of the adoption of a policy by states, Grossback et al. (2004) point out that there is an assumption that,

> the policy can be described along some dimension (which we refer to as liberal-conservative, although it need not be) and that the preference of the government can be described as a point on this continuum. The implication is that if ideology were all that mattered to the state government, a state would adopt a policy if its placement on this continuum were closer to the state's ideal point than the status quo. (p. 524)

Following the logic of this basic assumption, we will examine the influence of state government ideology on Medicaid expansion.

> H_3: State governments with a conservative ideology are more likely to oppose Medicaid expansion.

Governorship

Governors are considered key actors in promoting policy change and influencing Medicaid policy (Soumerai, Ross-Degnan, Fortress & Walser, 1997). Barrilleaux and Rainey (2014) examine the decisions of governors in support or opposition of Medicaid expansion and find that Republican governors are more liable to resist Medicaid expansion than Democrats. Moreover, there is a strong indication that Republican control of state legislatures is associated with opposition to Medicaid expansion. This finding supports Barrilleaux and Rainey's (2014) hypothesis that "governors should be more likely to oppose the funds when they can expect their decision to oppose expansion to be supported by the state legislature" (p. 443). Although there is evidence that demonstrates that the decisions of governors in supporting or opposing Medicaid expansion are influenced by the support of state legislatures (Barrilleaux & Rainey, 2014), the constitutional power of state governors is worthy of examination.

The role of governors in state decision making and policy making is dependent upon state constitutional powers and policy arenas (Randall & Parente, 2012). Woods (2004) posits that governors utilize their formal powers to influence policy. Institutional power varies by state; some governors are able to exercise their power through appointments and line-item vetoes. Alternatively, other governors are constricted by constitutional strongholds (McLendon, Heller, & Young, 2005). Kousser (2002) mentions that the power to veto items is granted to some

governors to reduce wasteful spending. Kousser (2002) adds that following this logic; the power to veto items leads to a diminution of Medicaid expenditures. Therefore, we expect states to decline Medicaid expansion when governors have high institutional powers.

H_4: Governors with a high level of institutional powers are more likely to oppose Medicaid expansion.

Economic Model

The Economic model assumes that the wealth of a state impacts the adoption of new programs as a result of the availability and accessibility of resources (Walker, 1969; Gray, 1973). Additionally, the model presupposes that larger states with greater financial freedom are able to adopt new programs faster than smaller states or financially burdened states with less capital. Moreover, the choices states make are dependent upon state resources (Goggin, 1999).

Hanson (1984) argues that economic factors constrain the behavior of policymakers and place limitations on policy options. While this model analyzes economic forces, the other models in this study observe a variety of internal and external forces that influence the decision making process. Consequently, this model will examine state wealth, tax effort, state budgets, health care expenditures, and federal aid. Figure 2.3 represents the economic model below.

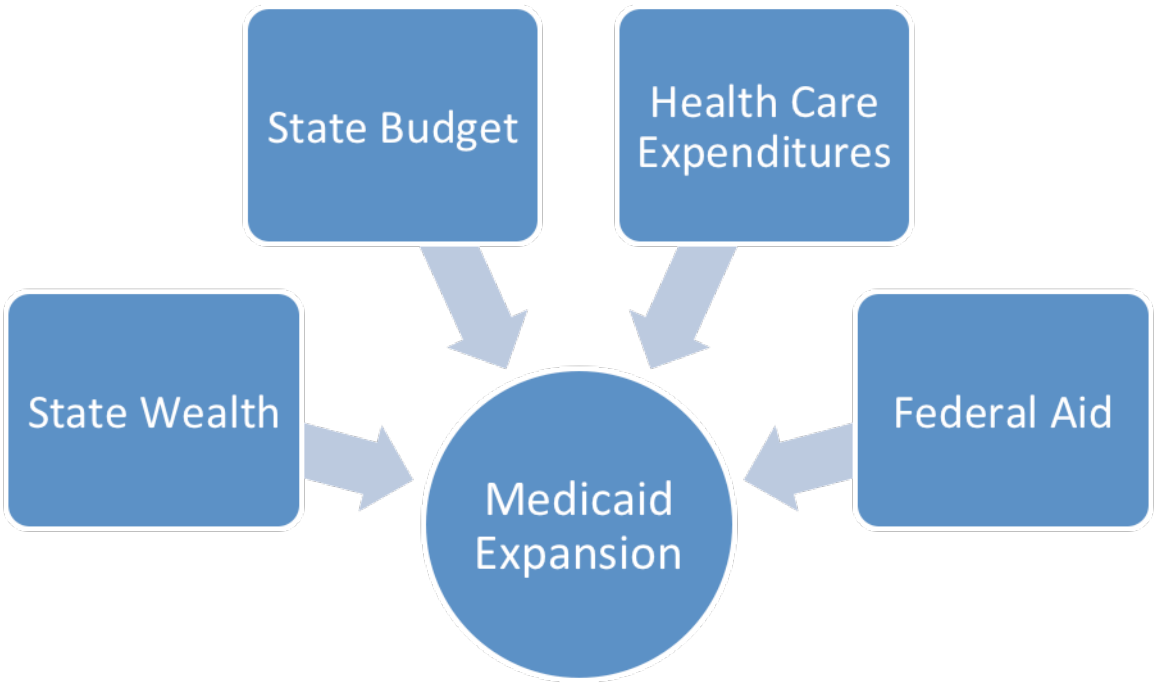


Figure 2.3. Economic Model

State Wealth

Wealth is an important criterion that affects the actions of decision makers. The availability of resources and relative wealth are considered determinants of innovation, which represents the willingness of decision makers to adopt new policies (Walker, 1969). There is a notion that progressive states, also known as liberal states, have generous welfare benefits and tend to be richer states with great economic wealth (Gray, 1973). However, it should also be noted that wealthier states also have the ability to pay for Medicaid services (Buchanan, Cappelleri, & Ohsfeldt, 1991).

Walker (1969) measures state wealth as per capita personal income and finds that wealthier states are more likely to adopt an array of policies. Tropman and Gordon (1978) investigate the relationship between state demographics and public welfare activity and ascertain

that per capita income, serving as a proxy for state wealth, explains 60% of the variance in their model. The model reveals that there is a link between the wealth of a state and the number of individuals who are covered by Medicaid services, and wealthier states tend to provide more state welfare coverage. Buchanan, Cappelleri, and Ohsfeldt (1991) also use per capita personal income as a measure for state wealth and find that economic factors are more significant than political forces when examining state spending levels on Medicaid. Grogan and Rigby (2009) study the effect of partisan conflict on the enactment of the State Children's Health Insurance Program (SCHIP) and report that per capita income is significant when predicting the design of the SCHIP program, but it is not important when predicting SCHIP program eligibility. Other measures of state wealth, such as, the cost of living are associated with higher eligibility levels. Grogan and Rigby's (2009) findings provide mixed results with partisan factors being more prevalent than state resources, benefits, and costs in eligibility setting, but not important in regards to choice of program design.

For this study, we will examine state wealth using two indicators that are popular within the literature on Medicaid policy. First, we will analyze per capita income as a measure of state wealth. Then, we will assess the effect of tax effort on Medicaid expansion. Per capita income is used in many studies and research on state wealth demonstrates a consistent link between the adoption of a policy and the wealth of a state (Grogan & Rigby, 2009; Satterthwaite, 2002; Tropman & Gordon, 1978; Volden, 2006; Walker, 1969). Based on previous research, we expect to see a positive relationship between states with high per capita income and the expansion of Medicaid.

H_5: States with a high level of per capita income are more likely to expand Medicaid.

While the literature on state wealth mainly uses per capita income as a measure, more studies are using tax effort or tax capacity as an indicator of state wealth. The importance of tax effort is evident when considering the function of taxation. When state revenues are low, states must choose to either limit state spending or raise taxes (Grogan, 1999). In the context of Medicaid, state dollars for Medicaid are drawn from the total revenue of state budgets and even if the tax base is reduced, states must account for rising medical costs (Grogan, 1999). Satterthwaite (2002) notes, "wealthier states…have a greater capacity to deal with fiscal stress because of their ability to generate new revenue through taxation" (p.199). In a study examining inequalities across state-level welfare policies on U.S. immigrants, Graefe, De Jong, Hall, Sturgeon, and Van Eerden (2008) find that smaller states with reduced tax capacity have stringent eligibility rules.

Many scholars utilize either tax effort or tax capacity to assess state-level policy decisions or choices. Tax capacity measures the amount of income a state could generate through taxation; while tax effort measures the "extent to which [state governments] utilizes its tax capacity" (Berry & Fording, 1997, p. 158). More specifically, tax effort represents the amount of taxes that states collect from residents. We are particularly interested in tax effort because it captures the actual revenue of state governments derived from common state tax collections. Tax capacity is not a desirable measure for this study because the decision to expand Medicaid by states is optional and the federal government covers 100% of expansion costs for the first 3 years from 2014-2016. Then federal funds for Medicaid expansion slowly decrease over the next few years, but by the year 2020 and after, the government covers 90% of program costs related to Medicaid expansion (Angeles, 2012). Due to the financial federal scheme of Medicaid expansion, tax capacity is not as important as tax effort. When states have a sufficient

amount of funds and resources through the collection of taxes, they are able to experiment and take risks with slack resources (Satterthwaite, 2002). An accurate account of available state funds enables states to make action-oriented policy decisions when making the decision to expand Medicaid. We expect to observe states opting to expand Medicaid when tax efforts are high.

H_6: As tax efforts increase, states are more likely to expand Medicaid.

State Budget

State governments are responsible for balancing their budgets. As budgets become constrained, state legislators will often cut Medicaid benefits and fees to providers (Olson, 2012). Budgetary considerations for Medicaid reveal differences in benefits, prices, fiscal capacity, political ideology, and reimbursement policy leading to wide variations across states (Boyd, 2003). In a study analyzing the decision making process of state budget cuts and Medicaid programs, Hoadley, Cunningham, and McHugh (2004) find that states contain costs by reducing provider payments, imposing cost-sharing plans, limiting or eliminating eligibility for some recipient groups, and choosing to indefinitely cancel plans to expand Medicaid services. Additionally, some states reduce enrollment by reducing outreach efforts, putting a freeze on enrollment, and instituting administrative barriers. While analyzing the ACA's impact on Medicaid participation rates, Sonier, Boudreaux, and Blewett (2013) find that states with a low baseline participation rate could experience a large woodwork effect (meaning a sizeable influx of new enrollees) with the expansion of Medicaid thus negatively affecting state budgets.

This study will use state budget shortfalls to assess the likelihood of Medicaid expansion among states. Budget shortfalls represent "the extent to which states' revenues fall[s] short of

the cost of providing services" (Oliff, Mai, & Palacios, 2012, p. 2). This measure provides a realistic depiction of the financial health of states because the size of the budget shortfall is an indicator of how well states are managing their financial resources. Therefore, we expect states to decline Medicaid expansion when state budget shortfalls are copious.

H_7: The larger a state's budget shortfall, the less likely they are to expand Medicaid.

Health Care Expenditures

Medicaid expenditures account for a large portion of state expenditures and policymakers respond to rising costs through adjusting Medicaid policies and benefits (Lukens, 2014). As Grannemann and Pauly (2010) note, analyzing health care expenditures is a reflection of "the overall level of resources a state devotes annually to meeting the needs of a typical low-income person" (p. 55). Colby, Lipson, and Turchin (2012) declare that Medicaid spending on children is a predictor of health insurance adequacy, where adequacy represents access to health care, covered benefits, and preventative services. For the most part, these authors find that states with high Medicaid expenditures provide children with better insurance adequacy. However, there are six states with lower than average health care expenditures that provided adequate health insurance: Alabama, Georgia, Hawaii, Indiana, South Carolina, and Tennessee (Colby, Lipson, & Turchin, 2012). Although these states are outliers, the relative growth of health care expenditures affects states negatively in a multitude of ways.

Patrick and Freed (2012) investigate the relative growth of Medicaid health care expenditures in adults and children from 1991 to 2005 and discover that, although disabled individuals make up a small fraction of Medicaid recipients, Medicaid spending for this population accounts for 43% of total Medicaid expenditures. The next largest group of high

utilizers of medical care is long-term care patients with expenses accruing up to 31% of Medicaid costs. Patrick and Freed (2012) argue that the cost of Medicaid programs is straining states and opportunities to institute cost-saving strategies. States are struggling to implement case management programs, control fraud and abuse, reduce long-term care payments, and Medicaid benefits are becoming scarce or limited. In a similar study on state Medicaid spending trends from 1992 to 2009, Cantor, Thompson, and Farnham (2013) find that Medicaid expenditures have increased annually at a rate of 3%. They suggest that countervailing factors such as fiscal stress, political forces, and Medicaid spending that interfere with other investments (e.g., education) may contribute to the reluctance of state policymakers to expand Medicaid.

The cost of health care services is a real concern for many states. When making decisions in regards to Medicaid policies, states consider the cost of the program, the benefits of the program, and the population of people who will receive the benefits (Kim & Jennings, 2012). These considerations are based on the projected cost of Medicaid expenditures. State budgets are negatively affected when Medicaid expenditures are high, thus leading to less monetary funds for other investments (Cantor, Thompson, & Farnham, 2013). Therefore, we expect to observe a positive effect on Medicaid expansion with the presence of low Medicaid expenditures.

H_8: States with a low level of Medicaid expenditures are more likely to expand Medicaid.

Federal Aid

Federal governments influence policy by requiring states to implement national initiatives or by enticing states to establish programs with financial incentives (Adler, 2011). In a study examining state variation and the expansion of Medicaid, Jacobs and Callaghan (2013) contend

that federal funding may persuade states to adopt new Medicaid programs when states are facing economic uncertainty, thus suggesting that less affluent states will opt to receive federal matching funds to expand Medicaid. Satterthwaite (2002) also analyzed the effect of federal contributions on Medicaid using the federal medical assistance percentage (FMAP), which is the federal share of monetary assistance given to states to expand and/or operate Medicaid. Satterthwaite's (2002) results reveal that states with a low FMAP rate are less likely to adopt new Medicaid programs. Conversely, states with high FMAP rates are more likely to adopt new innovations.

The FMAP is a formula-based schema that governs the federal portion of funds dedicated to Medicaid state programs. The federal government covers 50% or more of Medicaid costs depending on the established FMAP rate for each state (Kaiser Commission on Medicaid and the Uninsured, 2012). The dissemination of federal funds is more inclined to benefit states experiencing economic hardship in addition to states that dedicate additional efforts to provide more services for Medicaid (Dinan & Gamkhar, 2009). Therefore, we expect states with a high FMAP rate to expand Medicaid.

H_9: States with high Federal Medical Assistance Percentage (FMAP) rates are more likely to expand Medicaid.

Needs-Based Model

The needs-based model assumes that policy action at the state-level is more likely to occur following the presence or the severity of a problem. In a problem environment, there is usually the existence of a gap between expectations and actual conditions (Nice, 1994). Research has shown that the existence of a problem influences the decisions of policymakers

(Anakwenze & Zuberi, 2013; Nice, 1994; Routhe, Jones, & Feldman, 2005; Shaxon, 2009). Problems may become worse over time or current programs or policies may no longer be effective (Nice, 1994). The severity of a problem serves as an impetus for change (Sapat, 2004). As an explanation of state policy choice and decision making, the common thought is that as problems become more severe, state policymakers will most likely respond to resolve the issue(s) (Olive, Gunasekara, Raymond, 2012). Through the passing of new legislation, the needs of states are expressed (Satterthwaite, 2002). States expressions are assessed through the needs-based model, which includes variables that states monitor to ascertain the needs of its population. The variables are poverty rates, the percentage of the elderly in states, unemployment rates, uninsured rates, and health status. Figure 2.4 illustrates the needs-based model below.

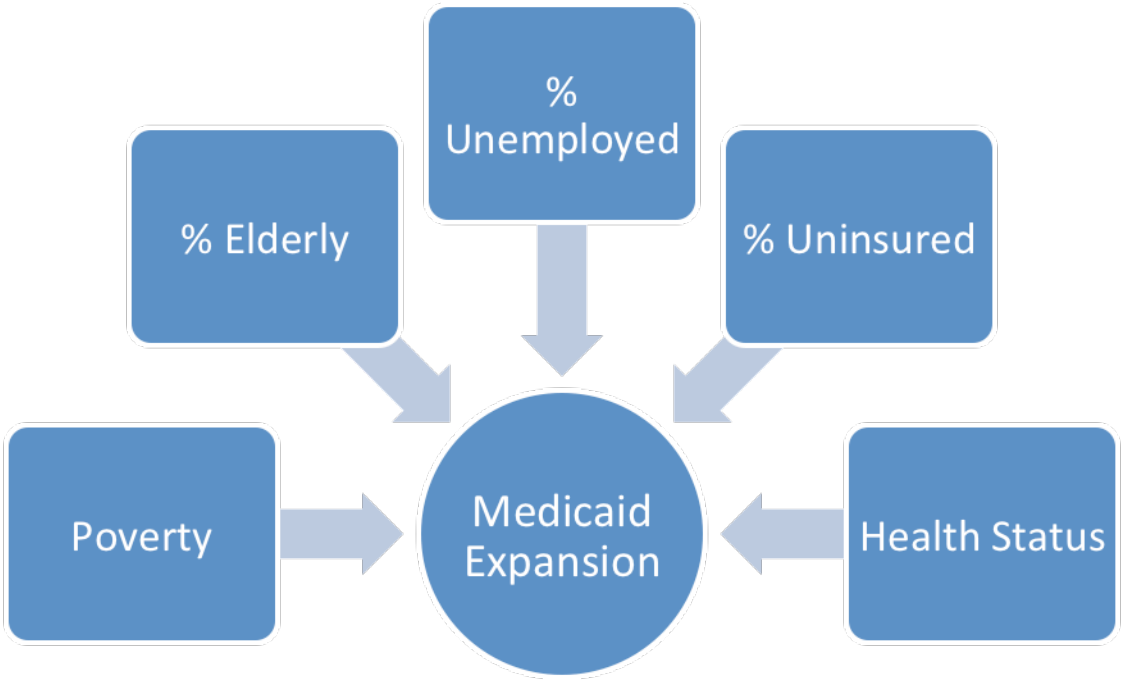


Figure 2.4. Needs-Based Model

Poverty Rate

With a large proportion of individuals living in poverty, there is a need for an expanded system of Medicaid (Kousser, 2002). Poverty is an indicator that signifies a demand for Medicaid services (Miller, Harrington, Ramsland, & Goldstein, 2002). The decision to decline Medicaid expansion by states places additional burdens on many individuals living in poverty (Antos, 2013). Frakt and Carroll note, "it is the poorest of the poor--- those with incomes below 100 percent of the FPL [Federal Poverty Level] ---whose access to affordable insurance is most at risk" (p. 173).

Rom et al.'s (1998) research on welfare policy and interstate competition confirms previous research that demonstrates a correlation between low benefit levels and high poverty rates. However, Rom et al. (1998) note that interactions between per capita income and the proportion of African-Americans in a state —in addition to poverty rates— may have obscured the effects of each individual variable. Although Kousser (2002) views poverty rate as a demographic variable, the author asserts that there is a need for expanded Medicaid systems when states have a high proportion of poor people. Moreover, while examining state discretionary spending, Kousser (2002) discovers that poverty is a driver of program size and total Medicaid expenditures per capita.

In a study analyzing the effect of Medicaid on poverty, Sommers and Oellerich (2013) find that Medicaid reduces poverty rates by 2.2% for disabled individuals and 1.0% for children. The authors conclude that Medicaid has kept 2.1 million adults, children, disabled, and elderly persons out of poverty. Furthermore, Sommers and Oellerich (2013) suggest that Medicaid cuts and the elimination of benefits may result in further health care issues and an increase in poverty

rates. In fact, Richardson and Yilmazer (2013) explore the impact of health care reform on states and find that in states opting out of Medicaid expansion, 4-10% of adults living in poverty will not have insurance. Richardson and Yilmazer's (2013) model also demonstrates that states with generous benefits will encounter a small growth in added Medicaid beneficiaries with Medicaid expansion. On the other hand, states with high poverty rates will experience elevated levels of new Medicaid enrollees.

Although there is a line of thought that presumes that state policymakers respond to the needs of its citizens, research demonstrates that states with high poverty rates offer limited Medicaid benefits and are more likely to opt out of Medicaid expansion (Barrilleaux & Rainey, 2014; Peterson & Rom, 1989; Peltzman, 1980; Rom et al. 1998). Prior research on poverty rates uses the official poverty measure as a unit of measurement; however, for this study, we will analyze the effect of poverty using the Census Bureau's supplemental poverty measure (SPM) as opposed to the official poverty measure. The official measure of poverty "consists of a set of thresholds for families of different sizes and compositions that are compared with before-tax income to determine a family's poverty status" (Bridges & Gesumaria, 2013, p. 49). On the other hand, the SPM consists of "thresholds [that] are based on a broad measure of necessary expenditures (food, clothing, shelter, and utilities" (Bridges & Gesumaria, 2013, p.50). Additionally, the SPM takes into account cash income, government benefits, and geographical variations in relation to the cost of living (Bridges & Gesumaria, 2013). We believe that the SPM provides a more accurate portrayal of poverty and we expect states to expand Medicaid when they have high rates of poverty using the SPM.

H_{10}: States with higher supplemental poverty measure (SPM) rates are more likely to expand Medicaid.

The Elderly

Ailments are a multifaceted burden affecting many elderly persons. Additionally, chronic illnesses, which are more prevalent among the elderly, require increased use of medical services and ongoing health care expenditures. The elderly are eligible for Medicaid services if they are categorically eligible or medically eligible (Rowland & Lyons, 1996). In 2009, Medicaid services were provided to 70% of nursing home seniors and total Medicaid expenditures on the elderly equaled $75 billion in 2008 (De Nardi, French, Jones, Gooptu, 2012). While Medicaid financially protects low-income persons who are elderly, the scope of available services is limited. Although each state determines eligibility standards, the amount and type of health care services, reimbursement rates, and the scope of services, some elderly persons aged 65 and older qualify for Medicaid coverage. Moreover, under Medicaid, dual eligible and Medicare advantage beneficiaries are eligible to receive home health care services, outpatient care, durable medical equipment, physician services, and preventative care (Centers for Medicare and Medicaid Services, 2016). The problems faced by the elderly include complex enrollment issues, negative social stigmas associated with welfare programs, and lack of understanding and awareness of Medicaid services (Rowland & Lyons, 1996).

While examining the effects of state policy on elderly Medicaid beneficiaries, Pezzin and Kasper (2002) also find that almost 50% of elderly persons meeting federal poverty levels at or below 100% are not enrolled in Medicaid. Moreover, they find that states with generous home- and community-based services have more Medicaid enrollees versus states with less generous Medicaid policies. The authors suggest that not only do state policies influence participation in Medicaid; they may also shed light on the success or failure of Medicaid programs and whether the intended purposes are served. In a similar albeit qualitative study exploring expanded

coverage for low-income elderly persons, Lamphere and Rosenbach (2000) acknowledge that the cost of medical care is a problem for individuals aged 65 and over and the low-income elderly account for a large proportion of state populations. They note that a common problem that exists between the states and the federal government involves joint responsibility such as financial conflicts and confusion regarding mandated policies for the elderly with low-incomes. Moreover, Lamphere and Rosenbach (2000) argue that rising health care costs have "left federal and state policy makers wary of actions that commit the public sector to further underwriting health entitlements" (p. 216). Furthermore, Kousser (2002) contends that policymakers must decide on a trade-off between serving the needs of the state or supply funds for the health care of many seniors with exacerbated health care costs.

As medical technology advances and citizens live longer, the population of elderly persons on Medicaid will be a topic of central concern in Medicaid policy. While Medicare provides medical care to individuals age 65 and older, Medicaid acts as a safety net for low-income and disabled elderly adults (Kaiser Commission on Medicaid Facts, 2010). As of 2011, adults aged 65 and older account for 9% of the total Medicaid population (68 million) and 21% of Medicaid expenditures while overall Medicaid expenses total $397.6 billion (Paradise, 2015). Even though the elderly population is very small in comparison to other groups (children, adults, and the disabled), this population is a high consumer of medical services. Moreover, the elderly have Medicare coverage, and knowledge of this fact could give states the impression that expanded services under Medicaid are not a necessity. Therefore, we expect states with a large population of individuals age 65 and older to reject the expansion of Medicaid.

H_{11}: States with a high proportion of elderly persons are less likely to expand Medicaid.

The Unemployed

State action in relation to Medicaid policies can be influenced by fluctuations in the rate of unemployment. For instance, Grogan (1999) hypothesizes that as the rate of unemployment rises, the number of eligible persons for Medicaid increases along with program costs, which serves as a catalyst for states to respond by reducing Medicaid benefits. However, Grogan's (1999) research produces mixed results, revealing that an increase in unemployment leads to stricter state eligibility policies, but also unexpectedly leads to a positive effect on benefit policies. Soss et al. (2001) also study the effect of the unemployed while recognizing that welfare systems and policies function to meet the societal needs of states under a labor-market hypothesis. The authors predict that, "states with lower unemployment rates will adopt more restrictive TANF policies" (p. 383). They find that the chances that a state will adopt work requirements increases when unemployment rates decrease. Soss et al. (2001) conclude that lawmakers use work requirements as a way of controlling the poor instead of outright denying benefits.

The rate of unemployment can reflect a greater issue that is present in state economies. High unemployment rates signal higher incidences of poverty, divorce, physical and mental health issues, and long-term earnings loss and instability (Schmitt & Jones, 2012). On the other hand, low unemployment rates tend to be associated with reduced poverty rates, an expanded labor force, and reductions in welfare caseloads (Blank, 2000; Schoeni & Blank, 2000). Previous research demonstrates that high rates of unemployment are associated with a plethora of problems and states respond to this policy problem with restrictive welfare benefits (Grogan, 1999; Schmitt & Jones, 2012; Soss, Schram, Vartanian, & O'Brien, 2001). Since most private and public organizations offer insurance to their employees, we expect states to expand Medicaid

when the unemployment rate is low because the gainfully employed are less likely to sign up or meet eligibility standards for Medicaid.

H_{12}: States with low unemployment rates are more likely to expand Medicaid.

The Uninsured

Many individuals lack health insurance and this can be problematic for several reasons: (a) Health status and outcomes are typically poor for this population; (b) there are financial implications for both states and the uninsured when health services are needed due to the rising costs of health care; and (c) hospitals are burdened with uncompensated care because they treat individuals without health insurance (Frakt & Carroll, 2013). The barriers to care affecting the uninsured are getting and maintaining health insurance, meeting restrictive requirements to obtain Medicaid services, and finding providers that will accept Medicaid (DeVoe, Baez, Angier, Krois, Edlund, & Carney, 2007). As DeVoe et al. (2007) note, unmet health needs have contributed to high medical expenditures, which are not affordable for the uninsured.

Just as there are individual barriers to health care for the uninsured, there are barriers that limit the ability of states to address the problem which are political, financial, and legal in nature. States may not have the support of the public on policies aimed at reducing the uninsured rate; the cost of insuring the uninsured may not be conducive to state budgets; and federal mandates may coincide with proposed health reforms at the state-level to reduce the number of uninsured individuals (Barrilleaux & Brace, 2007; Skocpol, 1993). While analyzing state policy strategies to reduce the proportion of uninsured persons, Barrilleaux and Brace (2007) find that as the rate of the uninsured rises, the adoption of state policies aimed at reducing the uninsured decreases. The authors suggest that “heightened demand for relief may have the perverse effect of leading

state governments to enact policies that attempt to shift the problem to the market place" (Barrilleaux & Brace, 2007, p. 673).

In a study analyzing the decisions of governors and Medicaid expansion, Barrilleaux and Rainey (2014) argued that there was an expectation from policy makers that states would adopt Medicaid expansion because many states had mission statements and strategic plans to reduce the rate of uninsurance. With the expansion of Medicaid, many parties would benefit from expansion: managed care organizations, hospitals, clinics, pharmacies, low-income individuals, physicians, and health care suppliers. This, in turn, would benefit states by addressing a public need. Although Barrilleaux and Rainey (2014) hypothesized that, "governors are less likely to oppose the federal Medicaid expansion funds as the percent of uninsured in their state increases" (p. 444), their results indicated otherwise. They found that regardless of need or the political party of the governor, as the level of uninsurance increases, the level of opposition also rises. We will test Barrilleaux and Rainey's finding to determine if the results can be reproduced.

H_{13}: States with high uninsurance rates are more likely to oppose Medicaid expansion.

Health Status

The health status of states can signal whether a need exists among state populations. With the provision of health care services and early treatment, major illnesses or chronic diseases can be prevented. Moreover, early treatment can also reduce expensive health care costs that could arise later in life (Copeland & Meier, 1987). Hill, Abdus, Hudson, and Selden (2014) suggest that states expanding Medicaid may not have to deal with issues of adverse selection with new enrollees meeting the federal eligibility requirements because they are healthier than the typical Medicaid population. They tested several health indicators, such as mental health, physical

health, and chronic diseases. The authors conducted sensitivity tests to determine the differences between pre-ACA enrollees and post-ACA Medicaid beneficiaries.

Grogan (1999) utilizes an index variable to measure the health status of states, which includes a state's violent crime rate, death rate, frequency of smoking, and total number of accidental deaths. While Grogan (1999) assumes that states respond to increasing health service needs by reducing benefits, the author finds that states respond positively to recognized medical and health needs. Many scholars utilize infant mortality as an indicator of health, which is what Satterthwaite (2002) uses in the study examining Medicaid managed care programs. However, Satterthwaite does not find a statistically significant relationship and concludes that the need for better health care services does not affect a state's determination to adopt managed care for Medicaid.

Barrilleaux and Rainey (2014) measure the health status of states by analyzing low birth weight, heart disease, death rate, and life expectancy. They discover that all of the health measures, with the exception of life expectancy, had "little to no effect on governors' decisions to support or oppose expansion" (Barrilleaux & Rainey, 2014). Regardless of the level of need, their analyses reveal that there are other factors, such as politics, that influence governors to oppose Medicaid expansion (Barrilleaux & Rainey, 2014).

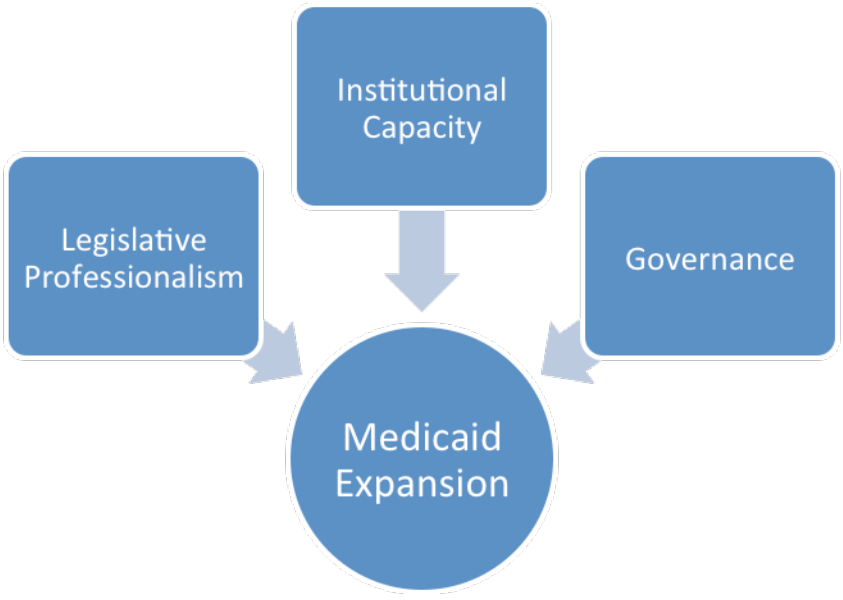
Although states spend a significant amount of money on health care services, a major concern confronting states, and the nation as a whole, is that the level of spending on health does not equate to better health outcomes or a qualified health care system. Because of this mismatch between spending on health and health outcomes, states have opportunities to invest in prevention programs and to maximize their dollars spent on health care (Wold, 2010).

Furthermore, knowledge of the health needs and overall health of state residents' helps states in determining health-related services and prospective costs when making decisions to expand Medicaid (Hill, Abdus, Hudson, & Selten, 2014). To measure the health of state residents, we examine perceptions of overall health status, mental health, and low birth weight. We choose to measure mental health because there is a growing trend of increased services and expenditures for this population of Medicaid utilizers that indicates a need for expanded services (Soni, 2015). We also include overall perceptions of health because we believe that understanding the perceived health needs of residents can help states develop interventions to address systems and health-related deficiencies in Medicaid (The Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, 2014b). Last, we examine low birth weight because this measure signifies the health and survival of infants. When infants weigh less than 5 pounds 8 ounces, they are more likely to suffer from chronic illnesses or some form of disability than babies within average weight limits. States that invest in maternal health and comprehensive prenatal services can reduce the incidence of low-birth weight babies (The Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, 2014b). To capture a cumulative measure of health status we develop an index to test the influence of health status on Medicaid expansion. We choose indicators relevant to the decision making process of Medicaid policies, and thus expect to observe states expand Medicaid when its residents are in good health.

H_{14}: States with a high level of residents with good health statuses are more likely to expand Medicaid.

State Capacity Model

The state capacity model is based on Bowman and Kearney's (1988) conception of state government capability and assumes that states have the capability to respond effectively, efficiently and responsibly to change, decisions, and conflicts. More specifically, Bowman and Kearney define state government capability as "three activities that are most salient for state government: (1) to respond effectively to change; (2) to make decisions efficiently, effectively (i.e., rationally) and responsively; and (3) to manage conflict" (p. 343). By means of capacity building, states are able to implement a broad array of initiatives through the selection and establishment of institutional arrangements, which allows them to be more responsive to the public (Bowman & Kearney, 1988). The constructs that will represent this model include legislative professionalism, institutional capacity, and governance. Figure 2.5 presents the state capacity model



below.

Figure 2.5. State Capacity Model

Legislative Professionalism

State legislatures have undergone many reforms over the years to increase their capacity to respond to pressing problems, implement many programs and deliver services (Bowman & Kearney, 1988). While administrative professionalism within government agencies is recognized as an indicator affecting performance and decisions, the importance of professionalism can be difficult to assess at the state level (Sapat, 2004). The Citizens Conference on State Legislatures (CCSL), which concentrates on the concepts of independence, representativeness, accountability, functionality, and informedness, created the first evaluative measure of state legislatures. These concepts are examined in-depth by examining committee structure, leadership, staffing, rules and procedures, time, facilities, ethics, and size (Bowman & Kearney, 1988; Citizens Conference on State Legislatures, 1971).

Since the CCSL's evaluative measure of state legislatures was published, many scholars have expanded upon the concepts. Grumm (1971) created a professional index with five indicator variables for legislative professionalism. The measures include length of session, a legislative service score based on the CCSL report, the number of bills introduced, and legislative compensation (Bowman & Kearney, 1988). Morehouse (1973) updated Grumm's index and substituted the measure on the number of bills introduced with "the average population per house seat" (Bowman & Kearney, 1988, p. 344).

Over the years, state legislatures became more professional and the development of administrative capacity led to more responsibilities in a wide range of policy areas, such as environmental, economic, and social programs (Jenkins, Leicht, & Wendt, 2006). In an article analyzing the circumstances in which health policy reforms are adopted, Carter and LaPlant

(1997) explore the effect of legislative professionalism. The basis for studying legislative professionalism came out of a concern for criticisms of state governments being repressive and deficient in professionalism. They assume that the more professional a state legislature became, the more likely state legislatures were able to manage complex policy problems and adopt health policy reforms. However, Carter and LaPlant's (1997) study reveals inconsistent results. They discover that there is a statistically significant relationship between highly professionalized legislatures and the adoption of pre-existing condition policies. On the other hand, less professionalized legislatures are more likely to adopt riskier reforms with less state involvement (i.e., contracted services with third parties), which could be the result of poor fiscal health. Barrilleaux and Brace (2007) also study state capacity and the ability of state governments to address complex problems through policy making in the Medicaid arena. They contend that "more capable state governments should produce more state center policy solutions, as the strength of governing institutions is an important determinant of both what polities do and how they do it" (Barrilleaux & Brace, 2007, p. 668). They analyze the strength of state legislatures using the following indicators: salaries of public personnel, publications authored by public employees, staff education, the size of staff, and the proportion of protected civil service employees. These authors find that increased state capacity led to few policy adoptions, more reliance on state-based policies, and less dependence on market-based strategies. The authors' findings are unique because prior scholarship on state capacity associated highly professionalized legislatures with heightened government activity. Although Barrilleaux and Brace (2007) refer to legislative professionalism as institutional capacity, they admit in their study that their measure is based on Bowman and Kearney's (1988) legislative professionalism construct.

The reformation of state legislatures over the years has led to improvements in addressing complex policy problems, the administration and delivery of state services, and conflict resolution skills (Bowman & Kearney, 1988; Jones, 1994). Professional state legislatures are known to have long-term appointments, high salaries, and adequate support staff. They also tend to support progressive policies (Brace & Ward, 1999; Finegold & Skocpol, 1995; Jenkins, Leicht, Wendt, 2006). Thus, we expect states with a high level of professionalism to expand Medicaid.

H_{15}: States with a high degree of legislative professionalism are more likely to adopt Medicaid expansion.

Institutional Capacity

Institutional capacity refers to organizational structures and processes, which give state legislatures the ability to carry out a wide range of activities. This definition of institutional capacity is quite different from legislative professionalism, which focuses on societal traits of the legislative body culturally accepted as professional (Bowman & Kearney, 1988). In reference to the distinction between professional and institutional capacity, LeLoup (1978) states that "professionalism appears to be something that the wealthier states can afford, but many reforms, structures, and procedures that make legislatures more capable are not bound by high monetary costs… [which] suggest[s] that professionalism and capability are empirically distinguishable" (p. 618). With this distinction in mind, this research will focus on organizational and administrative traits to assess institutional capacity.

Prior studies exploring institutional capacity in Medicaid programs focus on identifying administrative issues. Gold, Sparer, and Chu (1996) realize that states need to concentrate on

oversight and observe the following: There is a lack of policies and procedures guiding health plans; administrative tasks are fragmented and decentralized causing increased administrative costs; there is a shortage of resources and staff, and states are lacking in information technology to track and monitor Medicaid trends and patterns. Gold et al. (1996) suggest that while states need to tailor their methods of managing Medicaid, they should also consider the following: (a) investing in administrative infrastructure that allows states to meet program demands, (b) design policies that are comprehendible for their servicing population, (c) develop strategic plans that allow program growth and are compatible with existing plans, and (d) dedicate an adequate amount of time and resources to implement new systems and programs. While examining the experiences of states and Medicaid managed care, Holahan, Zuckerman, Evans, and Rangarajan (1998) also find that complex administrative issues affect many facets of service. Many states engage in negotiations, competitive bidding, and rate setting, which require a certain level of capacity building to ensure low risks, the protection of state funds and Medicaid beneficiaries, and mutually satisfying contracts between providers and states.

More recent studies have analyzed and operationalized institutional capacity at the state-level. Through the devolution of services and programs created at the national level, states are compelled to manage many government programs, which require the development and succession of administrative capacity (Bowling & Wright, 1998). To assess institutional capacity, many scholars have used the Government Performance Project which was created in 1996 to better understand the functions of state governments in respect to management and performance (Barrett & Greene, 2008). Coggburn and Schneider (2003) analyze state managerial capacity using data from the Maxwell School's Government Performance Project (GPP), which provides letter grades in the areas of human resources management, capacity

management, information technology, managing for results, and financial management. These components are converted to a grade point average scale and serve as a proxy to measure managerial capacity. Coggburn and Schneider (2003) find that management capacity not only influences state priorities but also shapes the outcomes of programs. They conclude that states with a high level of management capacity make decisions or choose policy alternatives that benefit the majority.

Fossett and Thompson (2006) also use the GPP to measure administrative capacity with the inclusion of other indicators (i.e., performance, information technology) known to affect the adoption of administrative orientations. However, they do not find administrative capacity predictive of best practices related to administrative responsiveness to the disadvantaged (ARD). While they admit that half of the variance of their study is not explained, they suggest that certain characteristics of "administrative agents" may not have been captured in their study (Fossett & Thompson, 2006). However, their qualitative analysis reveals that there is concern among administrators in regards to the high rates of enrollment and having the administrative capacity to deal with new enrollees for the State Children's Health Insurance Program (SCHIP) program (Fossett & Thompson, 2006). In a study analyzing the impact of internal state characteristics on the extensiveness of managed Medicaid programs, Kim and Jennings (2012) also use the GPP to measure management capacity. They use data from 2001 and 1998 and average the scores from the areas of financial management, human resource management, information technology, capital management, and management for results. While they expected a positive relationship between the adoption of risk-based program enrollment and management capacity and a negative relationship between the adoption of primary care case management and

management capacity, the results of their analysis was not statistically significant (Kim & Jennings, 2012).

With inconsistent and inadequate measures of administrative capacity, the most recent scholarship on administrative capacity focuses on the development of a new measure to assess this construct. Jacobs and Callaghan (2013) develop a composite measure that includes insurance oversight, the prevention of fraud, and expanding high-risk pools to eligible persons. They find that there is a great deal of variation among the states, and states with a lower level of administrative capacity are slower to adopt or establish health care reforms. In a later study, Callaghan and Jacobs (2014) use the same measure for administrative capacity with slight modifications to study the progress of implementation of Medicaid expansion. Their findings are insignificant and they suggest that financial incentives and institutional resources, which are drivers of vertical federalism, could be at odds with administrative capacity.

Although some studies on institutional capacity produce insignificant results, we suspect that there is a connection between the expansion of state programs and the ability of states to implement such services (Callaghan & Jacobs, 2014; Fossett & Thompson, 2006; Kim & Jennings, 2012). As scholars experiment and test new measures, there is always the chance that a variable does not measure the intended concept or construct. These issues may be indicative of measurement validity such as content validity, face validity, or perhaps construct validity. To test the influence of institutional capacity on Medicaid expansion, we will use Coggburn and Schneider's (2003) grade point average scoring system to assess institutional capacity. We expect states to support Medicaid expansion when they have a high level of institutional capacity.

H_{16}: States with a high level of institutional capacity will be more likely to expand Medicaid.

Governance

Governance arrangements have yet to be studied in Medicaid policy. Much of the literature on governance focuses on the role of states, governments, agencies, providers, and individuals (Freeman, 2000; Kettl, 2000; Morgan & Campbell, 2011; Rowland & Tallon, 2003). However, there is one article by Plein (2004) that examines the role of administrative structures for SCHIP programs. This study explores administrative arrangements by assessing SCHIP programs by determining whether the program is a stand-alone entity, combined, subsists within an existing Medicaid bureaucracy, or exists aside from an existing Medicaid agency. While this study captures certain elements of governance within one aspect of Medicaid policy, it would be difficult to measure this administrative typology because the study is specific to the SCHIP population. Additionally, this dissertation is different because it is focuses on Medicaid expansion as a whole rather than on a single program.

While there is a lack of scholarly research on governance structures focusing on Medicaid, there is a wealth of literature on this subject within the area of postsecondary education (Delaney & Doyle, 2011; Hearn & Holdsworth, 2002; Mokher & McLendon, 2009; Tandberg, 2010). McGuinness (1988, 1994) developed a classification system of state structures that describes how states govern public entities. There are three types of state structures: (a) consolidated governing boards, where a single entity develops and implements policy, coordinates responsibilities, allocates resources, and appoints personnel, and governs other institutions within its own jurisdiction; (b) coordinating boards, which are decentralized and act

with the authority to serve either as a regulatory entity or an advisory bureau; and (c) planning agencies, which do not have much authority, but facilitate planning and implementation functions between selected sectors and institutions (McGuinness, 1994). The state structures differ in strength. The consolidating and coordinating/regulatory boards are strong in nature, while the coordinating/advisory and planning boards are weak (McLendon, Heller, & Young, 2005). Although McGuiness' research focuses on postsecondary education governing boards, Hearn and Griswold (1994) note that state governing arrangements have been around since the 1950s. However, with the growth of government and the demand for expertise, evaluations, and the recognition of institutional needs, states have developed governing arrangements to fit their needs. This research will apply this method of reasoning to Medicaid agencies. Every state has a Medicaid agency and a corresponding governing board. As a result, we will test McGuinness' governance typology to determine if the arrangements of Medicaid agencies impact the decision making process of states.

While McGuiness' governance typology is based on the governance arrangement of postsecondary state boards of education, some studies suggest that there is a relationship between welfare and education programs and that the support and/or expansion of both programs are indicative of state policy preferences (Hega & Hokenmaier, 2002). While research on higher education demonstrates a link between consolidated governing boards and expanded educational programs (McLendon, Hearn, & Mokher, 2009), we expect states to expand Medicaid when a consolidated governing board governs Medicaid agencies. Following the same line of reasoning in accordance with research on higher educational governance boards, we also assume that advisory and planning boards are limited in decisional authority (Callan, 1975; Hearn & Griswold, 1994; McLendon, Heller, & Young, 2005).

H_{17}: States with centralized Medicaid governing boards will most likely expand Medicaid.

State Innovation and Diffusion Model

The state innovation and diffusion model assumes that internal and external dynamics drive policy adoptions (Berry & Berry, 2007). State actions are the result of policy choices affected by propensities to innovate (Gray, 1973; Soss et al., 2001). This model accepts Walker's (1969) definition of innovation, which is "a program or policy which is new to the states adopting it, no matter how old the program may be or how many states have adopted it" (p. 881). Complimentary to Walker's definition, Roger's (1983) description of diffusion also guides this model, which is, "the process by which an innovation is communicated through certain channels over time among the members of a social system" (p. 5). Internal determinants are state specific factors and include social, political, and economic characteristics (Berry & Berry, 2007; Olive, Gunasekara, & Raymond, 2012). For the purposes of this study, internal determinants will focus on state actions, which are the result of decisions that encompass social, political and economic characteristics. External determinants are elements that facilitate the diffusion of policies, such as the emulation of initiatives from other states, and competition amongst states (Olive, Gunasekara, & Raymond, 2012). This model will analyze the impact of neighboring states, state competition, and prior policy adoptions on the expansion of Medicaid. Figure 2.6 embodies the State Innovation and Diffusion model below.

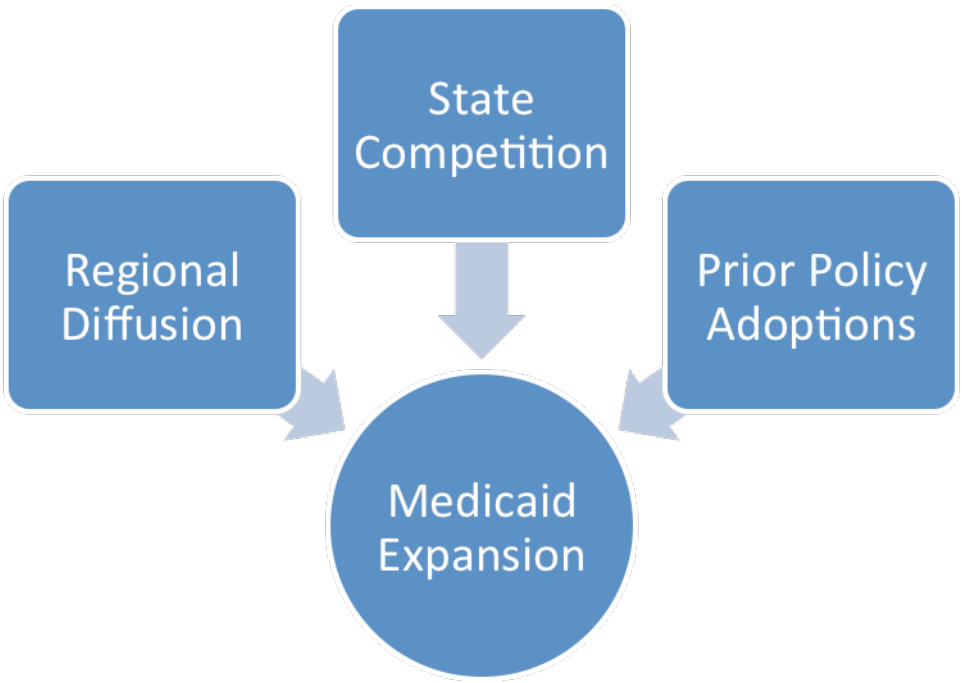


Figure 2.6. State Innovation and Diffusion Model

Regional Diffusion

The diffusion of a policy can occur through convergence. Policy convergence is "the tendency of societies to grow more alike, to develop similarities in structures, processes and performances" (Kerr, 1983, p. 3). Moreover, policy convergence occurs through emulation, networking from influential leaders in an effort to standardize the implementation of a policy or to address pressures from interest groups and external actors (Bennett, 1991). Through empirical testing, scholars in a variety of disciplines have found that neighboring states are influenced by the policies of their counterparts, thus increasing their motivation to innovate (Berry & Berry, 1990; Dye, 1966; Glick & Hays, 1991; Mintrom, 1997; Satterthwaite, 2002, Volden, 2006).

In the realm of Medicaid policy, scholarly research is emerging on the influence of neighboring states on policy adoptions. Carter and LaPlant (1997) study regional influences under the premise that, "policy adoptions in a nearby state can make it easier for politicians to justify similar adoptions to voters in their own state" (p. 22). They analyze three regions (i.e., Northeast, West, South) and use the North Central region as a reference point to test their premise. They find that while there is some evidence that supports the influence of regional diffusion, their findings are inconsistent and dependent upon the nature of specific policies. The authors conclude that their study lacks sufficient evidence to establish a pattern of regional diffusion in the innovation of health care policies. In a similar study, Kousser (2002) tests the policy convergence theory noting that state officials make decisions based on shared circumstances. Kousser (2002) examines subregions (i.e., New England, Mid-Atlantic, Midwest) using the Statistical Abstract of the United States operating under the assumption that the New England, Mid-Atlantic, and Midwest regions share a common trait which is high spending, while Pacific, Southern, and Mountain regions are frugal. Satterthwaite (2002) also references the policy convergence theory and claims that states seek policy direction from each other. She finds that the more neighboring states adopt Medicaid managed care, the more likely it became that a state would adopt the same or similar policy. However, Sattherwaite (2002) cautions that although regional diffusion occurs, the likelihood of diffusion is dependent upon certain conditions and/or when other factors such as state wealth are present.

Volden (2006) also examines the effect of state similarities on diffusion and policy learning and finds that while the relationship is positive, there is not a statistically significant relationship. Volden (2006) concludes that "an alternative hypothesis to the emulation of policies of similar states is simply that similar states adopt similar policies, without necessarily relying on

any learning from other states" (p. 304). Similarly, Kim and Jennings (2012) sought to distinguish internal learning from external learning by examining state characteristics on diffusion and program extensiveness of Medicaid managed care. They also presume that states seek policy directions from each other to assess policy success. However, in contrast to Volden (2006), Kim and Jennings (2012) find that neighboring states do learn from each other and that states with extensive Medicaid managed care programs contribute to the adoption of extensive programs by neighboring states.

The process of diffusion involves an assumption that, when state decision-makers are confronted with complex policy alternatives, they will take cues from their neighbors to decide on a course of action (Satterthwaite, 2002; Simon, 1957; Walker, 1969). In relation to Medicaid, states are more likely to emulate their neighbor by pursuing similar policies. We will gravitate to previous research that leads us to expect states to emulate their geographic neighbors in the adoption of Medicaid. This will indicate whether geographic neighbors will emulate each other based on similar policies.

> H_{18}: States are more likely to emulate their geographic neighbors in choosing to adopt Medicaid expansion.

State Competition

State competition is a construct that differs greatly from regional diffusion. While regional diffusion assesses the process of diffusion through similar state characteristics, another school of thought is that the adoption of policies spread through state competition. Dating back to 1956, Tiebout suggests that states compete for citizens through the provision of public policies, tax breaks, and program spending. There are two different thought patterns that drive

state competition. The first pattern suggests that states seek to innovate, emulate each other, diversify, and experiment to better serve their constituencies (Bailey & Rom, 2004; Dye, 1966; Lowery, Konda, & Garand 1984). The second thought pattern implies that states manipulate welfare benefits and policies based on the actions of other states to prevent the occurrence of becoming a welfare state magnet (Bailey & Rom, 2004; Grogan, 1999; Peterson, 1995). Rom, Peterson, and Scheve (1998) explains state competition as follows:

> The competitive model of interstate relationships…implies that states compete with one another, that states may pay a penalty if they do not attend to the decisions taken by their neighbor, and that more than just information is at work. The competitive model also implies that states, when making decisions, may not be deciding autonomously whether or not to adopt policies enacted elsewhere. On the contrary, the fact that these policies have been adopted elsewhere compels the state's attention. The competitive model also has more general application than diffusion theory. It applies not just to new proposals but to any policies pursued by other states, whether these are marginal changes in existing laws or breathtaking new adventures. (p. 20)

While testing this theory of interstate competition, Rom et al. (1998) find that competition between states influence welfare policies even when other phenomena such as political, economic, and demographic factors are controlled.

Similar to the concept of interstate competition and the second school of thought on state competition, Grogan (1999) hypothesizes that welfare migration takes place when Medicaid beneficiaries migrate to other states due to a reduction in AFDC payments. This action leads to higher program costs for the migrated state, which in turn triggers states to lower their welfare

benefits. This suggests that while states may not compete to provide the best welfare programs, they could be in competition with each other to lower benefits. Berry and Baybeck (2005) also examine welfare migration and interstate competition using geographic information systems to study the propensity of poor individuals relocating to another state for better health benefits. The authors assume that governors and state legislatures determine welfare policy, and the adoption of a policy is influenced by state officials' concerns in regards to the behaviors of state citizens (i.e., relocating to another state for generous welfare benefits). Berry and Baybeck (2005) find that states do not compete with each other over welfare benefits, but rather set reasonable benefit levels according to the benchmarks of neighboring states through policy learning. While Berry and Baybeck (2005) do not find interstate competition to be a concern for states, they mention that their research applies to Aid to Families with Dependent Children (AFDC) benefits and that tight federal control of the program may account for the lack of competition amongst the states. On the other hand, the authors also note that the block program under Temporary Assistance for Needy Families (TANF) which allows for greater state autonomy and discretion may result in different findings due to the structure of the TANF block program (Berry & Baybeck, 2005).

Bailey and Rom (2004) analyze the effect of interstate competition on welfare generosity, and find that there is competition amongst all welfare programs (except Medicare) as a result of state control over welfare programs. They also find that competition is strongest in AFDC benefits, providing access to services, regulating Medicaid costs, and determining benefits. Bailey and Rom (2004) measure state competition by determining whether states are more or less generous than their peers. De Jong, Graefe, and St. Pierre (2005) take a different approach to analyzing welfare policy by modeling interstate migration and focusing on migratory behaviors

of families and the roles of states. They discover that states' stringent eligibility and expectations in modifying behavior through policies drive families to move to other states.

Although there are alternative methods to examining state interstate competition, we will direct our attention to Bailey and Rom's (2004) measures of state competition because they are more representative of state-level actions. We will analyze the effect of neighbors, which is "the percent difference between states' generosity and its neighbors' generosity" (Bailey & Rom, 2004, p. 333). This measure assesses the extent states are influenced by the generosity of other states. Then we will utilize the data derived from the effect of neighbors to determine if states are competitive with each other based on whether they are more or less generous than their neighbors. If the thought that states will manipulate benefits and policies to avoid becoming welfare magnets remains supported, then we expect to observe states opt out of Medicaid expansion when they have less generous Medicaid policies than their competitive neighbors (competitive neighbors are also known as contiguous neighbor states).

> H_{19}: States with less generous Medicaid policies than their competitive neighbors are less likely to expand Medicaid.

Prior Policy Adoptions

Policy history is an important component of the diffusion process because the history of previous policies can constrain or facilitate the policy making process, which in turn, affects the development and/or implementation of future policies (Kronebusch, 1997). Cowart (1969) suggests that welfare policies are incremental and new programs are influenced by previous policies. Additionally, Pierson (2005) notes the following in regards to policy history:

> Studying the present as a 'snapshot' of a moment of time can distort what we see and how we understand it in profound ways. Shifting to a developmental perspective presses us, even when we are focusing on the present, to pay more attention to the long-term sources of policy change, to address the central issue of policy sustainability, to consider the possibilities that in the long run 'small' outcomes may end up being very big, while 'big' ones end up being small, and to adapt our analyses to the reality of ubiquitous unintended consequences (p. 48).

Comparative studies on policy history provide insight on the evolving nature of policies and how problems are addressed through statutory tools. Welfare policies, in particular, are well documented and they display differences among state policies and divergent methods of tackling a problem (Baldwin, 2005).

While studying the innovation and diffusion of Medicaid managed care programs, Satterthwaite (2002) also analyzes the effect of previous policies. To assess policy history she uses the number of years a health maintenance organization (HMO) has been present in a state and whether a state has received a Section 1915 trial waiver as proxies to measure policy history. Section 1915 waivers enable states to require Medicaid beneficiaries to enroll in state-approved health plans, such as managed care organizations (MCO) and primary care case management programs (Maglione & Ridgely, 2006; Satterthwaite, 2002). Satterthwaite (2002) finds that increases in both measures contribute to the adoption of managed care. In a more recent study, Callaghan and Jacobs (2014) create a policy trajectory measure that takes into account established SCHIP and Medicaid policies to evaluate policy history. The measure focuses on program generosity and their study reveals an association between the adoption of Medicaid expansion under the ACA and previous policy decisions that offer generous welfare benefits.

Policy history plays a significant role in the adoption of any policy (Kronebusch, 1997; Satterthwaite, 2002). Welfare policies signify the intentions of state policymakers and provide material/textual evidence by which to evaluate state Medicaid policies and rules (De Jong, Graefe, Irving, Pierre, 2006). To observe the influence of policy history on Medicaid expansion, we will utilize the Urban Institute's Welfare Rules Database to assess Medicaid policies on a lenient to stringent continuum (De Jong, Graefe, Irving, & Pierre, 2006). We believe that the assessment of documented Medicaid policies is an appropriate measure of policy history because of its comprehensive nature. Previous studies analyze policy history by focusing on generous policies or prior Medicaid regulations (Callaghan & Jacobs, 2014; Jacobs & Callaghan, 2013; Satterthwaite, 2002). Since many studies have found a correlation between liberal Medicaid policies and the adoption of new programs, we expect states to expand Medicaid when they have adopted liberal policies in the past.

H_{20}: States that have adopted generous Medicaid policies in the past are more likely adopt Medicaid expansion.

Chapter Summary

The objectives of this chapter are to shed light on the current state of Medicaid expansion and to review the extant literature on the adoption of Medicaid policies by states in an effort to understand what drives states to adopt Medicaid expansion. An exploration of the literature reveals established explanators of state policy decisions which are then analyzed and fashioned into five models: the political model, the economic model, the needs-based model, the state capacity model, and the state innovation and diffusion model. Much of the research that is presented in each of the models is based on the adoption of previous Medicaid policies, such as

the SCHIP program, eligibility requirements, and managed care programs by states. While there is a lack of research overall on the drivers of state decisions on Medicaid expansion, a few empirical articles have tested some of the factors influencing state decisions in the expansion of Medicaid (Barrilleaux & Rainey, 2014; Callaghan & Jacobs, 2014; Jacobs & Callaghan, 2013). These articles conclude that politics trumps some of the drivers raised by this study including citizen needs, but they lack an all-inclusive set of factors that influence state decisions. This study is unique because it draws mostly on explanatory factors of prior Medicaid policies and the current studies on Medicaid expansion to provide a comprehensive picture of the adoption of Medicaid expansion by states. See Figure 2.7 below.

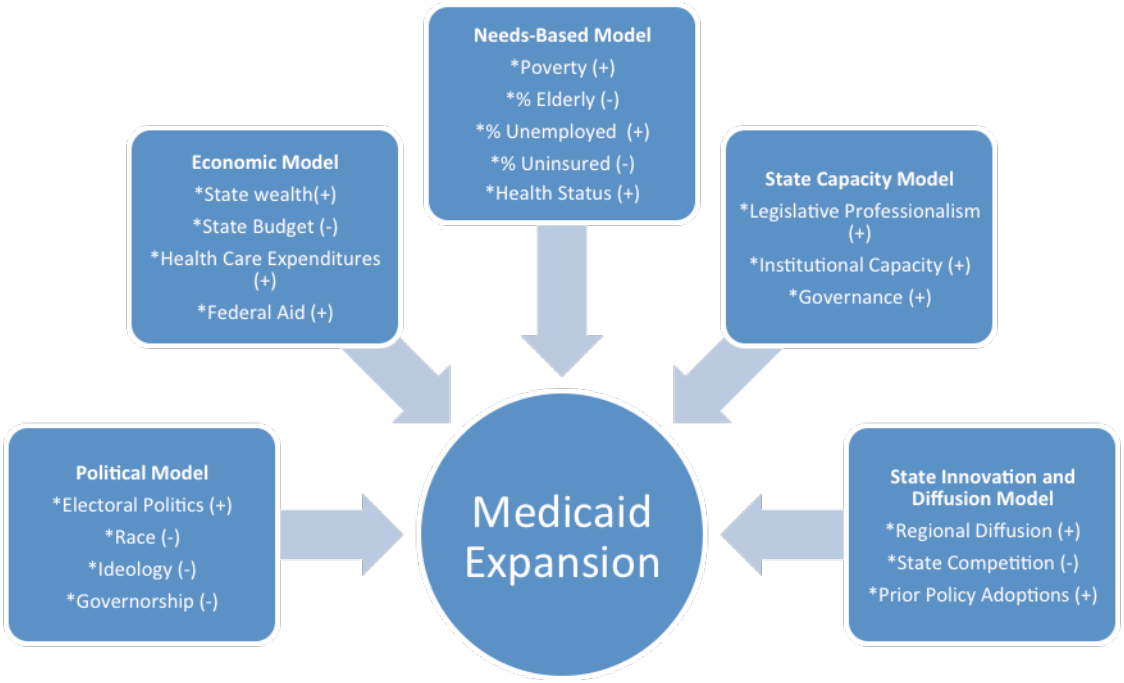


Figure 2.7. A Model of State Decision making in Medicaid Expansion

A recap of the hypotheses in this study is provided below.

H_1: States with a high degree of interparty competition are more likely to adopt Medicaid expansion.

H_2: States with a low proportion of African-American voters are more likely to reject Medicaid Expansion.

H_3: State governments with a conservative ideology are more likely to oppose Medicaid expansion.

H_4: Governors with a high level of institutional powers are more likely to oppose Medicaid expansion.

H_5: States with a high level of per capita income are more likely to expand Medicaid.

H_6: As tax efforts increase, states are more likely to expand Medicaid.

H_7: The larger a state's budget shortfall, the less likely they are to expand Medicaid.

H_8: States with a low level of Medicaid expenditures are more likely to expand Medicaid.

H_9: States with high Federal Medical Assistance Percentage (FMAP) rates are more likely to expand Medicaid.

H_{10}: States with higher supplemental poverty measure (SPM) rates are more likely to expand Medicaid.

H_{11}: States with a high proportion of elderly persons are less likely to expand Medicaid.

H_{12}: States with low unemployment rates are more likely to expand Medicaid.

H_{13}: States with high uninsurance rates are more likely to oppose Medicaid expansion.

H_{14}: States with a high level of residents with good health statuses are more likely to expand Medicaid.

H_{15}: States with a high degree of legislative professionalism are more likely to adopt Medicaid expansion.

H_{16}: States with a high level of institutional capacity will be more likely to expand Medicaid.

H_{17}: States with centralized Medicaid governing boards will most likely expand Medicaid.

H_{18}: States are more likely to emulate their geographic neighbors in choosing to adopt Medicaid expansion.

H_{19}: States with less generous Medicaid policies than their competitive neighbors are less likely to expand Medicaid.

H_{20}: States that have adopted generous Medicaid policies in the past are more likely adopt Medicaid expansion.

CHAPTER 3

METHODOLOGY

Chapter 1 introduced the Patient Protection and Affordable Care Act (ACA) and the issue of Medicaid expansion. An explanation as to the significance and purpose of this study is offered, which is to examine the influence of multiple factors that affect the adoption of Medicaid expansion. Chapter 2 provided a review of past research on the adoption of Medicaid policies and presented a model of state decision making in the adoption of Medicaid expansion using five models as explanators of state adoption. This chapter will offer an explanation of this dissertation's methodology.

This chapter commences with a discussion of the research questions along with the research design and approach. Then, the variables of interest are defined and displayed in table form. Subsequently, the method of data analysis is described and limitations are presented. Last, a summary of this chapter is provided to recapitulate the aims of this research.

Research Questions

The research question underlying this study is as follows: *What are the factors that influence states to adopt Medicaid expansion?* The other research questions derived from the proposed models suggested in this study, include the following: (a) *Do political factors influence the decision of states to adopt Medicaid expansion?* (b) *Do economic factors influence the decision of states to adopt Medicaid expansion?* (c) *Do state population needs influence the decision of states to adopt Medicaid expansion?* (d) *Does state capacity influence the decision of states to adopt Medicaid expansion?* (e) *Do innovation and diffusion influence the decision of*

states to adopt Medicaid expansion? The examination of these research questions will contribute to the body of knowledge on health policy and public policy by exploring influential factors at the decision making stage of policy making. As the implementation of the ACA continues and the lines of authority between states and the federal government become blurred in the field of health care, the actions of states are of critical importance as states choose whether to implement certain aspects of the ACA. While this study focuses on Medicaid expansion, one aspect of this research agenda is to develop a model that can be replicated in future studies on Medicaid expansion and adapted to other aspects of health policy making at the state-level.

Research Design and Approach

This study utilizes a state comparative cross-sectional research design to examine the influence of political, economic, needs-based, state capacity, and innovation and diffusion factors on Medicaid expansion. We primarily focus on the year 2012 because in the Supreme Court ruling *National Federation of Independent Business (NFIB) v. Sebelius,* the federal mandate to expand Medicaid was found unconstitutional and states were given the choice to expand Medicaid. Therefore, the year 2012 represents a turning point for states as they decide whether to adopt Medicaid expansion. This design is appropriate because there is a wealth of information at the state level on the factors that play an influential role on Medicaid policy decisions. The availability of state-wide data and the research design of this dissertation provide a platform to examine and analyze the research questions in this study. Additionally, a cross-sectional design allows for the comparison of a geographically dispersed population and the collection of data at one point in time. Although changes cannot be measured over time and causal inferences cannot be deduced, a cross-sectional design enables the researcher to analyze

multiple outcomes and expose intended and unintended relationships among variables (O'Sullivan, Rassel, & Berner, 2003; Mann, 2003).

A comparative analysis at the state-level is utilized as a methodological strategy to inform this research. Comparing and contrasting phenomena with similar and dissimilar attributes contributes to the interpretation and application of knowledge to complex processes (Azarian, 2011). Comparative analysis is useful because it can reveal the policy practices of states and provides insight into how states learn and borrow from each other (May, 2011, p. 249). This type of analysis helps to understand, explore, and explain divergences across similar cases (Azarian, 2011). Also, comparative analyses "help us to make sense of the observed variations and capture the principles of both similarities and differences (Azarian, 2011, p. 118).

Although many studies have utilized a comparative analysis approach to study health care policies at the state, national, and global level, scholars have questioned the validity of comparative studies due to observed inconsistencies in regards to the operationalization of variables (Wenzelburger, Zohlnhöfer, & Wolf, 2013). This dissertation primarily relies on secondary data collected at the state-level and reported by federal agencies or reputable Foundations such as the U.S. Census Bureau, U.S. Bureau of Economic Analysis, U.S. Bureau of Labor Statistics, the Federal Register, the Kaiser Family Foundation, or the Pew Research Center. Considerations for the measurement and selection of every variable are assessed according to the history of success of established variables, common criticisms associated with the selection of a variable, and the promising nature of variables. Therefore, we examine variables that consistently demonstrate an effect on Medicaid policies. We also evaluate contentious variables and determine the selection of a variable using the literature as a guide and the availability of data. Last, we examine new concepts in an effort to provide an innovative

contribution to the body of health and public policy. To ensure transparency and validity, a description of every variable is provided in this chapter.

Unit of Analysis

States serve as the unit of analysis for this study, and the collection of data are drawn from a multitude of databases with state-level data. According to Neuman (2002), "the units of analysis determine how a researcher measures variables or themes. They also correspond loosely to the level of analysis in an explanation" (p. 156). All of the data for this study correspond to state-specific characteristics and themes; conclusions will be contextualized accordingly. Moreover, this study examines the influencers of the adoption of Medicaid expansion at the macro-level because all 50 states are included in the study.

Dependent Variable

Although some may argue that the U.S. health care system is broken, fragmented, or unsustainable, there is a lack of consensus on how to remedy the health care problems faced by American citizens and states (Berwick, Nolan, Whittington, 2008; Chernew, Baicker, & Hsu, 2010). Although the original intention of the Patient Protection and Affordable Care Act (ACA) was to provide affordable health insurance for all U.S. citizens, the decision to expand Medicaid became a choice for states that is riddled with competing philosophies. To tease out these competing philosophies, five models are tested (political, economic, needs-based, state capacity, and state innovation and diffusion) in order to assess the influence of state-level factors on the adoption of Medicaid expansion. The dependent variable of interest in this study is Medicaid expansion, more specifically, the actions taken by states in deciding to adopt Medicaid

expansion. This measure is coded as 0 for states that have chosen to decline Medicaid expansion, 1 for states that are undecided, 2 for states that have supported Medicaid expansion, and 3 for states that have decided to adopt Medicaid expansion. Data for this variable is collected from several sources for the year 2012. To determine whether states declined, supported, adopted or are undecided about Medicaid expansion, we examine state legislation. The criteria for demarcating the decisions of states follows: (1) If a state passed a House and Senate bill in favor of Medicaid expansion and the Governor signed the bill or a Governor issued an executive order expanding Medicaid, then we count that state as adopting Medicaid expansion. (2) If a state passed a House and/or Senate bill in favor of Medicaid expansion, then we count that state as supporting Medicaid expansion. (3) If a state proposed a study to evaluate Medicaid expansion or a House or Senate bill is tabled or died without a decision being made by the legislature, then we count that state as undecided. (4) If a state passed a House and/or Senate bill in opposition of Medicaid expansion, then we count that state as declining Medicaid expansion. (5) If there is not a bill on file in regards to Medicaid expansion, then we direct our attention to states that challenged the constitutionality of Medicaid expansion (coded as "decline Medicaid expansion"), filed amicus briefs in support of Medicaid expansion (coded as "support Medicaid expansion"), or did not take a legal or formal position on Medicaid expansion (coded as "undecided") in the U.S. Supreme Court case *National Federation of Independent Business (NFIB) v. Sebelius* to determine the status of state decisions on Medicaid expansion. This information is reported by the Kaiser Family Foundation for the year 2012. Data for this variable is displayed in Table 3.1.

Table 3.1

State Decision Status of Medicaid Expansion

State	State Decision	Value	Data Source
Alabama	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Alaska	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Arizona	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Arkansas	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
California	Adopt Medicaid Expansion	3	State Legislation SB 853
Colorado	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Connecticut	Adopt Medicaid Expansion	3	State Legislation SB 1240
Delaware	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Florida	Decline Medicaid Expansion	0	Kaiser Family Foundation Filed lawsuit Challenging the constitutionality of Medicaid Expansion

Georgia	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Hawaii	Support Medicaid Expansion	2	State Legislation SB 420 Kaiser Family Foundation Filed Amicus Brief
Idaho	Decline Medicaid Expansion	0	State Legislation H 555 Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Illinois	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Indiana	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Iowa	Undecided	1	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion Filed Amicus Brief
Kansas	Decline Medicaid Expansion	0	State Legislation HR 6011
Kentucky	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Louisiana	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion

Maine	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Maryland	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Massachusetts	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Michigan	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Minnesota	Adopt Medicaid Expansion	3	Executive Order 11-01
Mississippi	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Missouri	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Montana	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Nebraska	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Nevada	Undecided	1	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
New Hampshire	Undecided	1	Kaiser Family Foundation Did not take a formal or legal position on Medicaid Expansion

New Jersey	Adopt Medicaid Expansion	3	State Legislation P.L.2010, CHAPTER 74
New Mexico	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
New York	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
North Carolina	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
North Dakota	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Ohio	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Oklahoma	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Oregon	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Pennsylvania	Undecided	1	State Legislation H.R. No. 884 Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Rhode Island	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
South Carolina	Undecided	1	State Legislation H 3167

South Dakota	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Tennessee	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Texas	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Utah	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Vermont	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Virginia	Decline Medicaid Expansion	0	State Legislation HB 345
Washington	Adopt Medicaid Expansion	3	State Legislation SB5596
West Virginia	Undecided	1	State Legislation SCR No. 80
Wisconsin	Decline Medicaid Expansion	0	Kaiser Family Foundation Filed lawsuit challenging the constitutionality of Medicaid Expansion
Wyoming	Undecided	1	State Legislation SF No. 0034

Independent Variables

Political Model

Political factors permeate the decision making process of Medicaid policies. State decision makers affect policies through the identification of problems and facilitation of health interventions via governmental action (Oliver, 2006). The political model in this study includes four variables: interparty competition, governor institutional power, African-American voter, and state government ideology. These variables measure the strength of political parties, the impact of gubernatorial formal powers, the influence of race, and the ideological leanings of state governments. A summary of the political variables is provided in Table 3.2.

Interparty Competition. Interparty competition is defined as the degree of competition amongst elected officials in state legislative elections. This study utilizes Holbrook and Van Dunk's index to capture interparty competition with updated data collected from Shufeldt and Flavin with the aggregated years 1990-1999. Although data for this variable are not available for the year 2012, Holbrook and Van Dunk's measure has produced stable results over the last 30 years (Shufeldt & Flavin, 2003).

Governor Institutional Power. Governor institutional power is defined as "powers given to the governor by the state constitution, state statutes, and the voters when they vote on constitutions and referenda" (Ferguson, 2013, p. 220). This study uses the index score for each state for the year 2010 because data for the year 2012 are not available. Data for this variable are collected from Ferguson (2013) from the *Book of States* and the election results for the year 2011 (Source: *Book of States*. [2010, 2011]. Lexington, KY: Council of State Governments).

African-American Voter. African-American voter is defined as the percentage of African-American voters for each state. In an effort to measure the influence of race on Medicaid expansion, this study utilizes data collected from the U.S. Census Bureau: Current Population Survey for the year 2012.

Ideology. State government ideology is defined as "the ideological 'center of gravity' of a state's elected governmental institutions on a liberal-conservative continuum" (Berry, Fording, Ringquist, Hanson, & Klarner, 2010 p. 1). This study utilizes the state government ideology score reported for each state for the year 2012. Data for this variable are collected from the "Updated Citizen and Government Ideology Data, 1960-2013" data file (Fording, 2015).

Table 3.2

Political Model

Variable	**Operationalization**	**Data Source**	**Level of Measurement**
Inter-party Competition	Index Range: (22.22-66.08)	Shufeldt & Flavin, 2012	Interval
African-American Voter	Percentage of African-American voters in each state	U.S. Census Bureau: Current Population Survey	Ratio
Ideology	Index Range: (2.58-91.63)	Berry et al. 2015	Interval
Governor Institutional Power	Index Range: (1.75-5.00)	Ferguson, 2013	Interval

Economic Model

Economic factors play a critical role in determining the feasibility of adopting a health policy. Although states consider the cost of operating Medicaid expansion, states also rely on assumptions of present and future fiscal conditions (Sommers & Epstein, 2010). The economic model includes five variables: per capita income, tax effort, state budget shortfalls, health care expenditures, and the federal medical assistance percentage (FMAP) rate. These variables measure the fiscal condition of states, expenditures incurred by Medicaid beneficiaries, and federal assistance given to states to operate Medicaid programs. A summary of the economic variables is provided in Table 3.3.

Per Capita income. Per capita income is defined as the average earned income of residents for each state. Data for this variable are measured in thousands of dollars for each state. This information is collected from the U.S. Department of Commerce: Bureau of Economic Analysis for the year 2012.

Tax Effort. Tax effort is characterized as the amount of taxes paid to states per capita. This information is measured in dollars for each state. Data for this variable are collected from the 2012 Annual Survey of State Government Tax Collections and the U.S. Census Bureau Population Estimates. This information is obtained by a computation method utilized by the Kaiser Family Foundation, which calculates state totals for income taxes, property taxes, license taxes, sales and gross receipts taxes, and unclassified state taxes marked as other for the year 2012.

State Budget Shortfalls. According to the Center on Budget and Policy Priorities, budget shortfalls are defined as “the extent to which states’ revenues fall short of the cost of providing

services" (Oliff, Mai, & Palacios, 2012, p. 2). Data for this variable are collected from the Center on Budget and Policy Priorities using state estimates of budget shortfalls for the year 2012.

Health Care Expenditures. Health care expenditures are defined as spending on health care by states. This information is collected from the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation (2014a) for the year 2012. The data contains aggregated estimates of state-level spending on health care by services rendered to Medicaid beneficiaries, administrative costs, disproportionate share hospital payments, and local funding for Medicaid services.

FMAP Rate. The Federal Medical Assistance Percentage (FMAP) is classified as the percentage of medical costs paid by the Federal government for each state for Medicaid programs (Truffer, Klemm, Wolfe, Rennie, & Shuff, 2012). Data for this variable are collected from the Federal Register for the year 2012 and reported in percentages.

Table 3.3

Economic Model

Variable	**Operationalization**	**Data Source**	**Level of Measurement**
Per Capita Income	Per capita income is defined as the average earned income of residents for each state	U.S. Department of Commerce: Bureau of Economic Analysis	Interval
Tax Effort	Total amount of taxes paid to states per capita	U.S. Census Bureau: 2012 Annual Survey of State Government Tax Collections	Interval
State Budget Shortfall	Total budget shortfall reported for each state	Center on Budget and Policy Priorities	Interval
Health Care Expenditures	Total amount of state-funded Medicaid spending in each state	The Pew Charitable Trusts and the John D. and Catherine T. MacArthur foundation	Interval
FMAP Rate	Percentage of Medical costs paid by the federal government for Medicaid Services	U.S. Department of Health and Human Services: Federal Register	Ratio

Needs-Based Model

Needs-based factors are an integral component of state decision making. State health policy priorities are based on the needs of the population. The needs-based model includes five variables: poverty, the percentage of elderly, the percentage of the unemployed, the percentage of the uninsured, and health status. These variables measure the prevalence of social conditions that contribute to poor standards of living and impact of health indicators. A summary of the needs-based variables is provided in Table 3.4.

Poverty. This variable is defined as the percentage of people living in poverty during a given calendar year. Data for this variable are collected from the United States Census Bureau's supplemental poverty measure (SPM) for the year 2012. The SPM takes into account cash resources, noncash benefits, and also subtracts essential expenses such as childcare, health care, and taxes (United States Census, 2014).

The Elderly. This variable is defined as the percentage of elderly persons aged 65 and older living in each state. Data for this variable are collected from the U.S. Department of Health and Human Services: Administration on Aging for the year 2012.

Unemployed. This variable is defined as the percentage of the labor force that is unemployed by state. Data for this variable are collected from the Bureau of Labor Statistics for the year 2012.

The Uninsured. The uninsured is defined as the percentage of individuals who did not have health insurance by state for the year 2012. Data for this variable are collected from the U.S. Department of Commerce and the U.S. Census Bureau and the by means of the Annual Social and Economic Supplement and derived from the Current Population Survey.

Health Status/Health Indicators. Health indicators play an important role in the management of health care services. Klazinga, Stronks, Delnoij, and Verhoeff (2001) state that "the link between indicators and public health lies in the extent that indicators measure for management purposes… aimed at preventing disease, prolonging life and promoting health. Thus, indicators are management tools for health care services and health systems" (p. 433). In the past, common health indicators, such as life expectancy, infant mortality, and cause-related mortality have directed population health priorities and assessments of health status (Robine,

Romieu, & Cambois, 1999). Such indicators do not capture a holistic view of public health needs. Currently, there is an acknowledgment amongst the healthcare community that measures of health status should include physical, psychological, and social features of health in addition to perceptions of well-being (Hennessy, Moriarty, Zack, Scheer, & Backbill, 1994). While there are some health status measures that include an integrated assessment of health, there is no measure of health status that is amendable to the Medicaid population. As a result, we create a health status index that includes health perceptions, the mentally ill, and low birth weight. We combine the percentages reported for each health indicator and divide the total score by three and perform an inverse transformation to create a range from low (poor health status) to high (fair or good health status). This calculation and transformation produces an index score for each state and treats all indicators equally.

Health Perception. Health perception is defined as the percentage of state residents who reported an overall health status as either fair or poor. Data for this variable are collected from the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation Tracking Key Health Indicators (2014b) report for the year 2010 because data for the year 2012 are not available.

Mentally Ill. Mentally ill is defined as the percentage of persons who have been diagnosed as having a mental, emotional, or behavioral disorder by state. Data for this variable are collected from the Substance Abuse and Mental Health Services Administration using the National Surveys on Drug Use and Health for the combined years 2009-2010, because data for the year 2012 are not available.

Low-birth weight. Low-birth weight is defined as the percentage of babies born in each state that weigh less than 2,500 grams. Data for this variable are collected from National Vital Statistics Reports for the year 2010. Although data are available for the year 2012, we will compile information on this variable for the year 2010 to establish a consistent measure of health status by collecting data across all of the health indicators for the same year.

Table 3.4

Needs-Based Model

Variable	**Operationalization**	**Data Source**	**Level of Measurement**
Poverty	Percentage of state residents living in poverty	U.S. Census Bureau Supplemental poverty measure	Ratio
Elderly	Percentage of individuals aged 65 and older	U.S. Department of Health and Human Services: Administration on Aging	Ratio
Unemployed	Percentage of unemployed state residents	U.S. Bureau of Labor Statistics	Ratio
Uninsured	Percentage of uninsured state residents	U.S. Department of Commerce and Census Bureau: Current Population Reports	Ratio
Health Status	Index 1) Health Perception Percentage of state residents reporting an overall health status of poor or fair 2) Mentally Ill Percentage of state residents diagnosed with a mental, emotional, or behavioral disorder 3) Low Birth Weight Percentage of babies born in each state that weigh less than 2,500 grams	 Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation Substance Abuse and Mental Health Services Administration; National Surveys on Drug Use and Health National Vital Statistics Reports	Interval

State Capacity Model

State capacity factors are an essential element of the decision making process of Medicaid policies. States assess their ability to execute the stated objectives of Medicaid policies and consider the expertise of individuals in charge of handling complex health policies (Bowen & Zei, 2005). The variables in the state capacity model include three variables: Legislative professionalism, institutional capacity, and governance. A summary of these variables is provided in Table 3.5.

Legislative Professionalism. This variable is defined as state legislative characteristics that enable states to respond to problems and deliver services. Data for this variable are collected from Squire's (2012) state legislative professionalization index for the year 2009 because data for the year 2012 are not available.

Institutional Capacity. Institutional capacity is defined as organizational structures and processes that give state legislatures the ability to carry out a wide range of activities. Institutional capacity is measured using data from the Government Performance Project on financial management, human resources management, infrastructure, and performance management for each state. Data for this variable are collected for the year 2008 because data for the year 2012 are not available. We adopt Coggburn and Schneider's (2003) method of measurement by converting the assigned letter grades for each category to a 4.0 grade point average scale for each state. We also create an index variable by using the average score for each dimension of institutional capacity (financial management, human resources management, infrastructure, and performance management) and dividing the total score by four. This

calculation produces an index score for each state that treats each dimension of institutional capacity equally.

Governance. Governance is defined as the governance structure (centralized, shared, decentralized, and mixed) states utilize to manage Medicaid programs. We adopt the 2014 Association of State and Territorial Health Officials (ASTHO) categorization of governance systems and assign a numerical value to each governing board based on ASTHO's assessment of strength. We utilize an ordinal scale with the highest value of 4 representing a consolidated board (the most powerful arrangement) to the lowest value of 1 representing a planning board (the weakest arrangement). Data for this variable are collected from the Centers for Disease Control and Prevention (CDC, 2016).

Table 3.5

State Capacity Model

Variable	**Operationalization**	**Data Source**	**Level of Measurement**
Legislative Professionalism	Index Range: (.031-.606)	Squire, 2012	Interval
Institutional Capacity	Grade point average of the following: 1) Financial Management 2) Human Resources 3) Infrastructure 4) Performance Management Range: (1.00-4.00)	The Pew Center on the States' Government Performance Project	Interval
Governance	Centralized Governance Arrangement=4; Shared Governance Arrangement=3 Decentralized Governance Arrangement=2 Mixed Governance Arrangement=1	Centers for Disease Control and Prevention, 2016	Ordinal

State Innovation and Diffusion Model

State innovation and diffusion factors play an important role in the decision making process of Medicaid policies through emulation. State decision makers approach policy problems by considering the actions or decisions of other states. The state innovation and diffusion model includes four variables: geographic neighbor, neighbor effect, state competition, and policy history. These variables measure the impact of geographic neighbors on Medicaid

expansion and previous Medicaid policies enacted by states. A summary of each variable is provided in Table 3.6.

Geographic Neighbor. Geographic neighbor is described as the proportion of a state's bordering neighbors that have expanded Medicaid. Data on this variable are collected from state legislation on Medicaid expansion and the Kaiser Family Foundation (2015) for the year 2012.

Neighbor Effect. Using Bailey and Rom's (2004) definition of neighbor effect, this variable is defined as "the percent difference between a states' generosity and its neighbor's generosity" (p. 333). Data for this variable are collected from the Kaiser Family Foundation using the amount of money a state spends per recipient annually on Medicaid for the year 2011. This variable is lagged based on the assumption that "a state's generosity in a given year is influenced by its peers' generosity in the previous year" (Bailey & Rom, 2004, p. 334). For the purposes of this study, we will analyze the differences in state generosity for the year 2011. Additionally, states are weighted according to the size of their population using the United States Statistical Abstract. Although we do not directly test the neighbor effect variable in our study, we created this variable to test the influence of state competition on Medicaid expansion.

State Competition. State competition is defined as whether a state is competitive with its contiguous states based on generosity. This variable utilizes the neighbor effect variable to determine the generosity of a state to generate a dichotomous variable using Bailey and Rom's (2004) operationalization of "compete," where a state is assigned a value of 1 if it is more generous than its contiguous states and 0 if it spends less money on Medicaid enrollees. Data for this variable are collected from the Kaiser Family Foundation for the year 2011. This variable is lagged for the same reasons as the neighbor effect variable.

Policy History. Policy history is defined as previous welfare rules that have been enacted by states. To measure this variable we develop a coding scheme that assigns a value of 1 if a state adopted a guideline and 0 if a state had restrictions or did not adopt a guideline. Then a total count of the adopted guidelines is reported. High scores for this variable indicate that a state has liberal welfare policies, while low scores signify stringent state policies. Our coding scheme is loosely based on De Jong et al.'s (2006) welfare policy measure. De Jong et al. (2006) utilize a lenient-to-stringent coding schema and determine the stringency/leniency of welfare policies through dichotomous and ordinal measures. Since we are more interested in the factors that influence states to adopt Medicaid expansion, we assign a value of 1 to states that adopt state welfare guidelines to observe the prevalence of liberal policies. We also do not utilize the ordinal component of De Jong et al.'s (2006) policy measure, because our study is not concerned with multiple levels of stringency and leniency. Thus, we institute a continuous measure to assess state welfare policies. Data for this variable are collected from the Urban Institute's Rules Database for the year 2012.

Table 3.6

State Innovation and Diffusion Model

Variable	**Operationalization**	**Data Source**	**Level of Measurement**
Geographic State	Proportion of a state's bordering neighbors that have adopted Medicaid expansion	State Legislatures; Kaiser Family Foundation	Interval
Neighbor Effect	Difference in generosity between a state and it's neighbors	Kaiser Family Foundation; United States Statistical Abstract	Interval
State Competition	Competitive=1; Non-competitive=0	Kaiser Family Foundation; United States Statistical Abstract	Nominal
Policy History	Total number of adopted welfare guidelines	Urban Institute's Welfare Rules Database	Interval

Data Analysis

This research seeks to recognize, categorize, and apply meaning to the factors that influence states to expand Medicaid. We test five research questions proposed by this study and utilize multinomial logistic regression to analyze each model using the statistical software program STATA. This method of analysis is appropriate for this study because the dependent variable is categorical. Moreover, multinomial logistic regression is suitable for our study because the predictor variables are continuous, categorical, or a combination (Lee & Pradhan, 2007). Our study respects the general assumptions of multinomial logistic regression and includes the following: (a) the relationship among the variables is not normally distributed, (b)

Outliers are absent from the model, and (c) there is full model specification (Berman & Wang, 2012).

In addition to multinomial logistic regression and predicted probabilities, descriptive statistics and cross tabulations will be performed to assure full model specification. We will also clean the data, check the data for outliers, and create new variables from existing databases to fit the parameters of our study. Additionally, we will assess the goodness of fit for each model, and the log likelihood value to evaluate the entire model. Moreover, the Cox & Snell R^2 and Nagelkerke R^2 will be analyzed to explain the variance of the model, and the Hosmer and Lemeshow statistic will be evaluated to analyze how close the observed frequencies and predicted frequencies match (Bayaga, 2010; Berman & Wang, 2012; Hosmer, Hosmer, Le Cessie, & Lemeshow, 1997). Each model will be analyzed using this process and then a comprehensive model will be formed based on the significant factors that influence Medicaid expansion.

Limitations

Although every effort is made to design this study carefully and methodically, there are some limitations. This study utilizes a cross-sectional research design, but some of the data that are used in this study are not available for the year 2012. As a result, we use data in preceding or latter years to measure certain variables. To avoid using outdated data, we investigate the stability of the measures over time through literature searches.

Another limitation involves the generalizability of this study. This study is limited to the United States and the policy issues and propositions that are contained in this study may not be applicable to other countries. However, this study could be useful to other policy domains

within the United States. The models comprise factors that affect the decision making process of states and are derived from a multitude of disciplines.

Summary

This chapter provides an explanatory approach to the research methodology of this study. A description of the dependent and independent variables were presented along with the data sources used to collect the information. This study will utilize multinomial logistic regression to analyze five models (political, economic, needs-based, state capacity, and state innovation and diffusion) and a resultant comprehensive model of state decision making in the expansion of Medicaid. This research seeks to understand the factors that influence states to expand Medicaid and contribute to the academic body of knowledge by offering explanations on dominant state characteristics and prominent factors influencing Medicaid policy. Chapter 4 presents the findings of this study in addition to descriptive statistics and the data analyses derived from each model.

CHAPTER 4

RESULTS AND ANALYSIS

This chapter presents the descriptive statistics for the data used in this study and the results of the multinomial regression analysis for each model. The software program utilized to perform statistical analysis is Stata/IC 12.1. The results are represented in tabular displays and organized by each model and research question. The chapter commences with a discussion of the dependent variable and follows with analytic descriptions and analysis of the data and findings.

Dependent Variable

Descriptive Statistics

The dependent variable is comprised of decisions made by states measured by analyzing state actions in adopting Medicaid expansion. As discussed in Chapter 3, a coding scheme is developed to assess and measure the actions of states. The measure is coded as 0 for states that have chosen to decline Medicaid expansion, 1 for states that are undecided, 2 for states that have supported Medicaid expansion, and 3 for states that have decided to adopt Medicaid expansion. The dependent variable is positively skewed to the right and leptokurtic. Table 4.1 represents the descriptive statistics for Medicaid expansion for all 50 states. Table 4.2 provides the decisions of states on Medicaid expansion.

Table 4.1

Descriptive Statistics for Medicaid Expansion for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Medicaid Expansion	1	1.01	0	3	2.2	3

Table 4.2

State Decision Status of Medicaid Expansion

State	State Decision	Value	Data Source
Alabama	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Alaska	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Arizona	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Arkansas	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
California	Adopt Medicaid Expansion	3	State Legislation SB 853
Colorado	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Connecticut	Adopt Medicaid Expansion	3	State Legislation SB 1240

Delaware	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Florida	Decline Medicaid Expansion	0	Kaiser Family Foundation Filed lawsuit Challenging the constitutionality of Medicaid Expansion
Georgia	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Hawaii	Support Medicaid Expansion	2	State Legislation SB 420 Kaiser Family Foundation Filed Amicus Brief
Idaho	Decline Medicaid Expansion	0	State Legislation H 555 Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Illinois	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Indiana	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Iowa	Undecided	1	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion Filed Amicus Brief
Kansas	Decline Medicaid Expansion	0	State Legislation HR 6011

Kentucky	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Louisiana	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Maine	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Maryland	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Massachusetts	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Michigan	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Minnesota	Adopt Medicaid Expansion	3	Executive Order 11-01
Mississippi	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Missouri	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Montana	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion

Nebraska	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Nevada	Undecided	1	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
New Hampshire	Undecided	1	Kaiser Family Foundation Did not take a formal or legal position on Medicaid Expansion
New Jersey	Adopt Medicaid Expansion	3	State Legislation P.L.2010, Chapter 74
New Mexico	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
New York	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
North Carolina	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
North Dakota	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Ohio	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Oklahoma	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion

Oregon	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Pennsylvania	Undecided	1	State Legislation H.R. No. 884 Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Rhode Island	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
South Carolina	Undecided	1	State Legislation H 3167
South Dakota	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Tennessee	Undecided	1	Kaiser Family Foundation Did not take a legal or formal position on Medicaid Expansion
Texas	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Utah	Decline Medicaid Expansion	0	Kaiser Family Foundation Challenged the constitutionality of Medicaid Expansion
Vermont	Support Medicaid Expansion	2	Kaiser Family Foundation Filed Amicus Brief
Virginia	Decline Medicaid Expansion	0	State Legislation HB 345
Washington	Adopt Medicaid Expansion	3	State Legislation SB5596

West Virginia	Undecided	1	State Legislation SCR No. 80
Wisconsin	Decline Medicaid Expansion	0	Kaiser Family Foundation Filed lawsuit challenging the constitutionality of Medicaid Expansion
Wyoming	Undecided	1	State Legislation SF No. 0034

Political Model

Descriptive Statistics

The political model consists of four variables; interparty competition, African-American voter, ideology, and governor institutional power. Table 4.3 depicts the descriptive statistics for all 50 states. The variables interparty competition and African-American voter are negatively skewed, but interparty competition is leptokurtic while African-American voter is platykurtic. The variable ideology is positively skewed and leptokurtic. The variable governor institutional power is positively skewed and bimodal which indicates that two peaks are far apart (Knapp, 2007). An analysis of the descriptive statistics reveals that the data are not normally distributed; however, multinomial logistic regression does not require nor assume normality, linearity, or homogeneity for independent variables (Bayaga, 2010; Berman & Wang, 2012). For this reason, natural log transformations were not performed to normalize the data.

Table 4.3

Political Model Descriptive Statistics for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Inter-Party Competition	44.40	10.84	22.22	66.08	2.31	43.86
African-American Voter	39.83	29.77	0	82	-.49	82
Ideology	41.48	30.32	2.58	91.63	1.58	89.05
Governor Institutional Power	3.26	.48	2.3	4.3	2.34	2

Correlation Analysis

An examination of correlations between the independent and dependent variables is performed. Table 4.4 illustrates the results for the political model. According to Guilford's guidelines for interpreting Pearson *r* values (Sprinthall, 2012), there is a low negative correlation between interparty competition and African-American voter ($r = -.34$, $p < .05$). Although there is an assumption that diversity leads to an increase in interparty competition (Hero & Tolbert, 1996), the results of this study can reflect changes in voting patterns and diversity of political party representation amongst African-American voters (Griffin & Keane, 2006). Moreover, there is a low positive association between Medicaid expansion and interparty competition ($r = .30$, $p < .05$). This correlation supports the literature that demonstrates that states are more likely to adopt Medicaid expansion when there is interparty competition (Barrilleaux & Brace, 2007; Bernick, 2011; Soss et al. 2001). Last, there is a moderate positive correlation between Medicaid expansion and ideology ($r = .69$, $p < .001$). Again, the literature shows that liberal states are more likely to increase Medicaid expansion (Barrilleaux & Miller, 1988; Pracht, 2007; Schneider, 1993, 1997; Volden, 2006).

Since interparty competition and African-Americans is negatively correlated and multinomial logistic regression assumes that multicollinearity is not present, further investigation is warranted. For linear regression, the variance inflation factor (VIF) is used to assess multicollinearity. However, the VIF test is not an available function for multinomial regression. As an alternative method for analyzing multicollinearity, linear regression is performed due to the composition of the dependent variable to generate VIF values. The mean VIF value for all of the variables is 1.13, which indicates that multicollinearity is not an issue for the political model because the threshold for collinearity is 10 and higher (Hair et al., 2010; Institute for Digital Research and Education, 2016). As a result of the VIF test, all of the variables will remain in the political model.

Table 4.4

Political Model Correlations for Dependent and Independent Variables

	Inter-Party Competition	**African-American Voter**	**Ideology**	**Governor Institutional Power**	**Medicaid Expansion**
Inter-Party Competition	1.00				
African-American Voter	-.34*	1.00			
Ideology	.27	-.11	1.00		
Governor Institutional Power	.16	.06	.16	1.00	
Medicaid Expansion	.30*	.07	.69***	.13	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level, ***Correlation is significant at .001 level.

Data Analysis

Multinomial logistic regression is utilized to analyze the political model and to address the following question: *Do political factors influence the decision of states to adopt Medicaid*

expansion? The model is significant with a likelihood ratio chi-square of 56.74 and a p-value of .0001. Statistical tests to assess goodness of fit are performed and are presented in Table 4.5. The Hosmer-Lemeshow goodness of fit test is not an available function with the software program Stata, however, an alternative test is used that produces the same results (Fagerland & Hosmer, 2012). Although the Hosmer-Lemshow statistics are reported in the model summary, it should be noted that this test has limitations and one cannot conclude that the model is poorly fitted based on the results of one goodness-of-fit test (Fagerland & Hosmer, 2012). The political model summary results indicate that 73.5% of the variance in state decisions in Medicaid expansion is explained by the model.

Table 4.5

Political Model Summary

Model/ Significance	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow/ Significance**
56.74 (.000)	.443	.678	.735	14.623 (.931)

The results from the multinomial regression analysis for the political model are displayed in Table 4.6. For the purpose of interpretation, the relative risk ratio is utilized instead of the coefficients to lend understanding to the variables of interest. Relative risk ratios provide meaningful applications to public health affairs because calculations are based on a proportional scale versus an absolute scale (Schechtman, 2002).

Table 4.6

Political Model Multinomial Regression Analysis

(Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Inter-Party Competition	.04	1.04	.05
African-American Voter	.01	1.01	.02
Ideology	-.04*	.96	.02
Governor Institutional Power	2.30*	10.01	11.26
Constant	-7.70	.00	.00
Support			
Inter-Party Competition	.04	1.05	.07
African-American Voter	.00	1.00	.02
Ideology	.06*	1.06	.03
Governor Institutional Power	3.57*	35.37	54.17
Constant	-17.01	4.11	2.66
Adopt			
Inter-Party Competition	.28	1.33	.20
African-American Voter	.05	1.06	.04
Ideology	.07	1.08	.05
Governor Institutional Power	3.30	27.21	53.09
Constant	-32.88	5.26	6.56

Note: *Correlation is significant at .05 level.

There is a wealth of literature that demonstrates that political factors influence Medicaid policies (Brown, 1995; Kim & Jennings, 2012; Rom, Peterson, & Scheve, 1998). However, for the political model, only two variables are statistically significant. Hypothesis 1 predicts that states with a high degree of interparty competition are more likely to adopt Medicaid expansion. Surprisingly, interparty competition did not have any effect on the decisions of states to expand Medicaid. Although there is a positive relationship between ideology and Medicaid as expected, the results are insignificant. An important factor that deserves consideration is the scale of measurement used to determine interparty competition. The literature on political factors assessing interparty competition and party control is inundated with multiple scales of

measurement (Barrilleaux & Rainey, 2014; Callaghan & Jacobs, 2014; Satterwaithe, 2002). Although the most consistent measure of interparty competition is used in this study, there may be another measure that appropriately captures the influence of interparty competition on Medicaid expansion or perhaps Medicaid expansion is an issue that is nonpartisan. The other variable that does not have an effect on Medicaid expansion is race.

Hypothesis 2 approximates that states with a low proportion of African-American voters are more likely to reject Medicaid expansion. Research on the influence of racial politics focuses primarily on welfare benefits (Howard, 1999; Soss, Schram, Vartanian, & O'Brien, 2001). However, there is a distinct difference between the actions of states on limiting benefits and implementing a large-scale program. The findings indicate that racial politics in terms of voter participation does not affect the decisions of states on Medicaid expansion. This finding could reflect a false notion that "as the number of African-Americans who vote increases, one would expect government to treat them more favorably" (Filer, Kenny, & Morton, 1991, p. 393). On the other hand, the results could suggest a difference of representation among African-American voters. Griffin and Keane's (2006) study on the composition of African-American voters and voter turnout reveal that the policy preferences of conservative African-American voters are considered more than the policy preferences of moderate or liberal African-Americans by European American members of Congress.

Although interparty competition and race do not have an effect on Medicaid expansion, ideology and governor institutional power are statistically significant. Hypothesis 3 is supported by the findings and suggests that state governments with a conservative ideology are more likely to oppose Medicaid expansion. A one-way table of summary statistics (See Appendix A) reveals that states that opt to decline Medicaid expansion have an average state government ideology

score of 19.65. According to Berry et al.'s (1998) measure of state government ideology, low values on the continuum of state ideology represent conservative governments. Conversely, ideology is also statistically significant for states that support Medicaid expansion. The ideological mean score of state governments that support Medicaid expansion is 71.67. This mean score falls on the high end of the continuum thus indicating that liberal states support Medicaid expansion. While the findings confirm that conservative governments are declining Medicaid expansion, we also see that liberal state governments support Medicaid expansion.

Hypothesis 4 proposes that governors with a high level of institutional powers are more likely to oppose Medicaid expansion. An increase in governor institutional power of one standard deviation is associated with a 910% greater relative risk of states deciding to decline Medicaid expansion ($RRR = 10.01$, $p < .01$). This finding is consistent with other studies that find that gubernatorial institutional powers influence policy (Barrilleaux & Rainey, 2014; Kousser, 2002; Woods, 2004). Unexpectedly, governor institutional capacity is also positively statistically significant for states that support Medicaid expansion ($RRR = 35.37$, $p < .05$). This finding leads one to suspect that conservative governors with a high level of institutional powers are more likely to take an affirmative stance on Medicaid expansion than liberal governors with high levels of institutional power.

A comparison of state decisions using a one-way stable of summary statistics (see Appendix A) and using the mean score of each variable on Medicaid expansion reveals that states with a high degree of interparty competition choose to adopt Medicaid expansion versus decline, support, or are undecided on Medicaid expansion. States that choose to support Medicaid expansion have a moderate degree of interparty competition. States that decline or are undecided on Medicaid expansion have a low degree of interparty competition. These findings

support the literature on interparty competition, which demonstrates a link between the adoption of Medicaid policies when states have a high degree of interparty competition and the non-adoption of Medicaid policies when states have a low degree of interparty competition (Barrilleaux & Brace, 2007; Bernick, 2011).

An analysis of state decisions on the effect of African American voters on Medicaid expansion shows that states that choose to adopt Medicaid expansion have a higher percentage of African-American voters than states that choose to decline, support, or are undecided on Medicaid expansion. For states that choose to decline Medicaid expansion, there are a moderate percentage of African-American voters. There is not much of a difference between states that support or are undecided in regards to the influence of African-American voters on Medicaid expansion. The states are similar in terms of the average population of African-American voters. This finding indicates that states with a lower population of African-American voters are more likely to support or are undecided on Medicaid expansion.

For ideology, an examination of state decisions on Medicaid expansion demonstrates that conservative states are more likely to decline Medicaid expansion. Conversely, liberal states are more likely to support and adopt Medicaid expansion. This finding indicates that the defining characteristic that leads states to adopt or support Medicaid expansion is liberalism. On the conservative to liberal continuum, states that are undecided fall in the middle. This outcome provides additional evidence that Medicaid expansion may be nonpartisan.

A review of the effect of governor institutional power on state decisions on Medicaid expansion discloses that governors with higher than average institutional powers are more likely to support and adopt Medicaid expansion. On the other hand, governors with slightly higher

than average institutional powers are more likely to decline Medicaid expansion. These findings suggest that governors with high institutional powers exercise their rights to make affirmative decisions. For states that are undecided on Medicaid expansion, the findings reveal that governors have low institutional powers. This result alludes to the fact that states are slower to act on a decision when governors have a low degree of institutional power.

The decisions of states on Medicaid expansion in relation to political factors are varied, with the exception of governor institutional power. The adoption of Medicaid expansion is associated with high percentages of African-Americans and high levels of governor institutional power, state government, and interparty competition. However, for states that decide to decline, support, or are undecided on Medicaid expansion, the political factors do not display a pattern amongst each dimension. Figure 4.1 represents the influence of political factors on Medicaid expansion in graphical form.

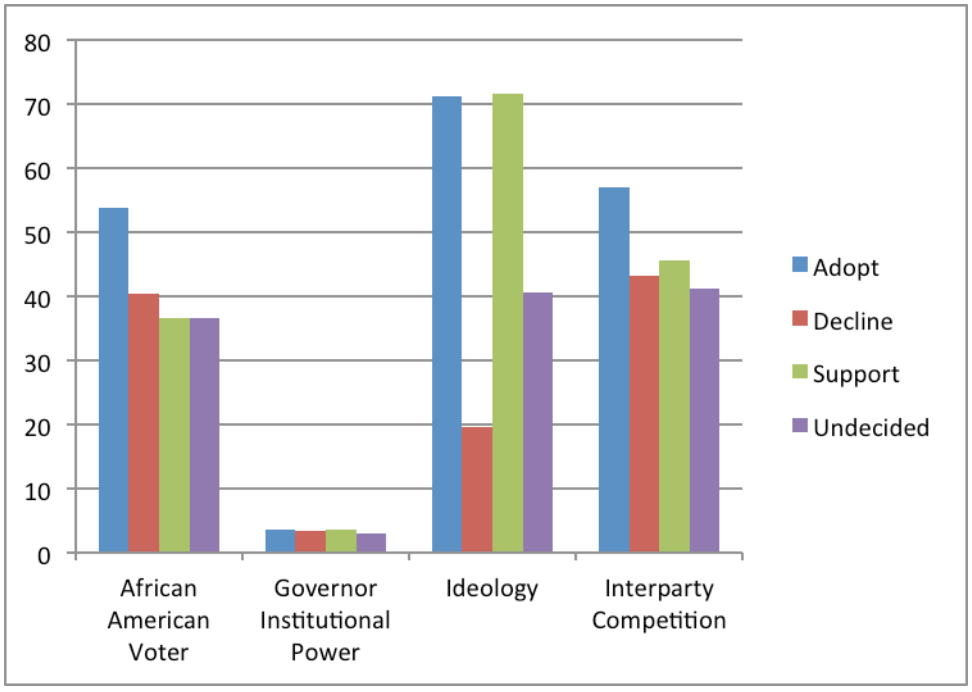


Figure 4.1. Pivot table displaying the effect of political factors on Medicaid expansion using mean values of the variables African-American voter, governor institutional power, ideology, and interparty competition in relation to the decision of states on Medicaid expansion.

Economic Model

Descriptive Statistics

The economic model consists of five variables; per capita income, tax effort, state budget shortfall, health care experiences, and federal medical assistance percentage (FMAP) rates. Table 4.7 illustrates the descriptive statistics for all 50 states. All of the variables are skewed to the right and leptokurtic. The numerical value of the variables per capita income, tax effort, state budget shortfall, and health care expenditures are reduced for interpretational purposes. The reduction of the data partially reflects the schema of government data reports. For example, 1.5 billion represents a value of 1.5; 700 million denotes 0.7; 115 million signifies 0.115; 11 million

indicates 0.011; 6 million conveys .006; and 62 thousand refers to .000062. This study focuses on the relative size of each variable.

Table 4.7

Economic Model Descriptive Statistics for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Per Capita Income	0.0000432	6.72	0.000033	0.000062	2.95	0.000029
Tax Effort	0.01592	0.02	0.002	0.115	15.75	0.113
State Budget Shortfall	2.14	4.03	0	23.9	18.71	23.9
Healthcare Expenditures	3.616	5.28	0.3	26.3	13.85	26
FMAP Rate	59.42	7.96	50.00	74.18	13.85	24.18

Correlation Analysis

Correlations between the dependent and independent variables are performed. Table 4.8 depicts the results for the economic model. Using Guilford's guidelines for interpreting Pearson *r* values (Sprinthall, 2012), there is a low positive correlation between per capita income and state budget shortfall ($r = .29$, $p < .05$). This is consistent with the findings of other studies that show that states with great wealth have greater government expenditures (Baqir, 2002; Buchanan, Cappelleri, & Ohsfeldt, 1991; Gray, 1973). Additionally, there is a negative high correlation between per capita income and FMAP rates ($r = -.87$, $p < .0001$) and a positive moderate correlation between per capita income and Medicaid expansion ($r = .42$, $p < .01$). The negative correlation between per capita income and FMAP rates is due to the financing structure of the Medicaid program in which the federal government contributes less monetary funds to states with high per capita income (Hoffman, Klees, & Curtis, 2000). The correlation between per capita income and Medicaid expansion is also indicative of the literature, which shows that

states with great wealth have a propensity to adopt Medicaid expansion (Grogan & Rigby, 2009; Satterthwaite, 2002; Walker, 1969).

Tax effort is significantly correlated with four variables. The results indicate that there is a very high positive correlation between tax effort and health expenditures ($r = .94$, $p < .0001$), a negative low correlation between tax effort and FMAP rates ($r = -.31$, $p < .05$), a very high positive correlation between tax effort and state budget shortfalls ($r = .96$, $p < .0001$), and a positive low correlation between tax effort and Medicaid expansion ($r = .34$, $p < .05$). The positive correlations between tax effort and health care expenditures, state budget shortfalls, and Medicaid expansion represent the "economic reach of governments" and the capacity of state governments (Arbetman-Rabinowitz & Johnson, 2007, p. 2). When states draw dollars from state government taxes, they can spend more money on health care, government expenditures, and expanded Medicaid programs. The negative correlation between tax effort and FMAP rates is also indicative of the financing scheme of the Medicaid program (Hoffman, Klees, & Curtis, 2000). States that receive fewer funds in taxes from state residents are most likely to have a low level of per capita income. In such a case, a state thus qualifies for a high FMAP rate.

State budget shortfalls and health care expenditures are also significantly correlated with multiple variables. The correlation analysis indicates that there is a positive high correlation between state budget shortfall and health care expenditures ($r = .87$, $p < .0001$), a negative low correlation between state budget shortfall and FMAP rates ($r = -.36$, $p < .05$), and a positive moderate correlation between state budget shortfall and Medicaid expansion ($r = .42$, $p < .01$). The correlation between state budget shortfall and health expenditures is most likely due to the cost of health care and its effect on state government budgets, such as creating large deficits (Bodenheimer, 2005). The association between state budget shortfall and Medicaid expansion

might signify that states need to expand Medicaid because of large state government expenditures.

Since many of the variables in the economic model are correlated, a VIF test is utilized to assess multicollinearity. The mean value for all of the variables is 13.93, thus signaling an issue of multicollinearity. As a result, the variables tax effort and state budget shortfalls are excluded from the multinomial regression analysis. Since governments have reactive tendencies (Haveman, 1994), we assume that states are more likely to make policy decisions in relation to Medicaid based on rising health care costs than tax effort and state budget shortfalls. Health care expenditures have contributed significantly to state government deficits and many states are reluctant to increase taxes for state residents during times of economic uncertainty (Osborne, 1993). Moreover, health care expenditures remain in the economic model because the literature on indicators that impact Medicaid policies is slanted more towards the influence of health care expenditures rather than state budget shortfalls and tax effort.

Table 4.8

Economic Model Correlations for Dependent and Independent Variables

	Per Capita Income	**Tax Effort**	**State Budget Shortfall**	**Health Care Expenditures**	**FMAP Rate**	**Medicaid Expansion**
Per Capita Income	1.00					
Tax Effort	.23	1.00				
State Budget Shortfall	.29*	.94***	1.00			
Health Care Expenditures	.27***	.96***	.87***	1.00		
FMAP Rate	-.87***	-.31*	-.36**	-.32*	1.00	
Medicaid Expansion	.42**	.34*	.42**	.33*	-.42**	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level, ***Correlation is significant at .001 level.

Data Analysis

Multinomial logistic regression is utilized to address the following question: *Do economic factors influence the decision of states to adopt Medicaid expansion?* The economic model in this study failed to achieve convergence. To identify and address issues of convergence, Long (1997) suggests the following: (a) Data should be checked for incorrect variables, (b) convergence problems can occur when the proportion of observations in relation to the number of variables is large, (c) large differences in regards to the standard deviation among the variables can contribute to convergence failures, and (d) the distribution of the outcome variable and the number of cases that fall within each category can produce convergence problems. An assessment of each suggestion offered by Long (1997) reveals that the economic model does not violate the common issues associated with convergence failure. As a result, we utilize Allison's (2008) approach for dealing with convergence failures; we report the results and notate the offending variables with an infinity sign. Allison (2008) argues that, "if one leaves the offending variables in the model, the coefficients, standards errors, and test statistics for the remaining variables are still valid maximum likelihood estimates" (p. 8).

The model summary is presented in Table 4.9. Statistical tests are performed to assess goodness of fit; however, an error message occurred that indicates that convergence is not achieved. The model is significant, with a likelihood ratio chi-square of 22.12 and a p-value of .01. The Hosmer-Lemeshow statistic is not reported for this model because it could not be estimated with the alternative test offered by Fagerland, Hosmer, and Bofin (Fagerland & Hosmer, 2012). The results from the economic model summary suggest that 38.7% of the variance in state decisions in Medicaid expansion is explained by the model.

Table 4.9

Economic Model Summary

Model/ Significance	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow/ Significance**
22.12(.003)	.173	.357	.387	n/a

The results from the multinomial regression analysis for the economic model are displayed in Table 4.10. Relative risk ratios are reported for interpretation purposes. Again, the model did not achieve convergence and the infinity sign symbolizes offending variables and missing maximum likelihood estimates.

Table 4.10

Economic Multinomial Regression Analysis

(Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Per Capita Income	-20568.93	0.00	0.00
Health Care Expenditure	.08	1.09	0.16
FMAP Rate	-.03	0.97	.10
Constant	2.56	12.90	138.72
Support			
Per Capita Income	-4378.52	0.00	0.00
Health Care Expenditure	.17	1.19	0.18
FMAP Rate	-.10	.91	0.10
Constant	5.14	171.33	2028.99
Adopt			
Per Capita Income	754.97	∞	∞
Health Care Expenditure	.17	1.19	0.19
FMAP Rate	-22.79***	1.27	2.06
Constant	∞	∞	∞

Note: ***Correlation is significant at .001 level.
∞: Maximum likelihood estimates do not exist.

For the economic model, one variable out of three is statistically significant. Hypothesis 5 specifies that states with a high level of per capita income are more likely to expand Medicaid. Although many studies find that per capita income has an effect on the adoption of Medicaid policies (Grogan & Ribgy, 2009; Satterthwaite, 2002; Volden, 2006), per capita income is not statistically significant in this study. Hypotheses 6 and 7 are omitted from the analysis due to issues of multicollinearity. Nor are health care expenditures statistically significant. Hypothesis 8 suggests that states with a low level of Medicaid expenditures are more likely to expand Medicaid. Surprisingly, health care expenditures did not have an effect on the adoption of Medicaid expansion. Again, the results of the economic model are affected by convergence failure.

The only significant variable in the economic model is FMAP rate. Hypothesis 9 proposes that states with high FMAP rates are more likely to expand Medicaid. The findings indicate that a one standard deviation in FMAP rate is associated with a 27% greater relative risk of states adopting Medicaid expansion. Unexpectedly, the results indicate that although this variable is significant, it is significant in the opposite direction. This finding runs counter to Satterthwaite's (2002) study in which the results demonstrate that states with low FMAP rates are more likely to forgo new Medicaid programs while states with high FMAP rates were more likely to adopt innovative Medicaid programs. This counterintuitive finding could result from changing economic conditions. In 2002 many states were facing budget deficits and FMAP rates were declining because the formula was based on data from times of economic prosperity. As states were struggling to pay for Medicaid programs with fewer federal funds, the Greater Access to Pharmaceutical Act was passed to provide an increase in matching funds for a temporary period of time (Ku, Ross, & Nathanson, 2002).

A comparison of state decisions using a one-way stable of summary statistics (see Appendix B) and using the mean score of each variable on the influence of per capita income on Medicaid expansion reveals that states that choose to decline or are undecided on Medicaid expansion have lower than average per capita income. This finding could signal that states are unwilling to expand Medicaid when they cannot draw a substantial amount of tax dollars from per capita income. On the other hand, states that choose to support or adopt Medicaid expansion have higher than average per capita income. This finding confirms the notion that states that have great wealth are more likely to experiment or adopt new programs (Gray, 1973, Satterthwaite, 2002; Walker, 1969).

An analysis of states decisions on the effect of health care expenditures on Medicaid expansion shows that states that support or adopt Medicaid expansion have higher than average health care expenditures. This finding indicates that these states have a vested interest in expanding Medicaid due to the amount of state dollars that are spent on health care expenditures for Medicaid recipients. Conversely, states that choose to decline or are undecided on expanding Medicaid have lower than average health care expenditures. This discovery contradicts the proposed hypothesis, H_8, that states with a low level of health care expenditures are more likely to expand Medicaid. Although states assess their Medicaid programs and make policy decisions as a result of program expenditures (Kim & Jennings, 2012; Cantor, Thompson & Farnham, 2013), the findings suggest that states are risk-averse.

An examination of FMAP rates in relation to the decisions of states in Medicaid expansion demonstrates that states that chose to decline or are undecided on Medicaid expansion have higher than average FMAP rates. This finding indicates that these states are receiving a substantial amount of funding from the federal government based on the federal guidelines

formula for matching funds (Kaiser Commission on Medicaid and the Uninsured, 2012). Moreover, the results of this study indicates that there is little incentive for these states to expand Medicaid because they have low health care expenditures and the government subsidies a substantial portion of the Medicaid program. In contrast, states that choose to adopt or support Medicaid expansion have low FMAP rates. Again, the results demonstrate that states have a vested interest in expanding Medicaid because they are receiving fewer funds from the federal government to operate the current Medicaid program.

Overall, the economic model shows diverse patterns amongst the states in regards to their decisions on Medicaid expansion. However, the difference between states that adopt and decline Medicaid expansion is conversely related. States that opt to adopt Medicaid expansion have low FMAP rates, high health care expenditures, and high per capita income, while states that decide to decline Medicaid expansion have high FMAP rates, low health care expenditures, and low per capita income. Figure 4.2 represents the influence of economic factors on Medicaid expansion in graphical form. The variables health care expenditures and per capita income are transformed to reflect whole numbers.

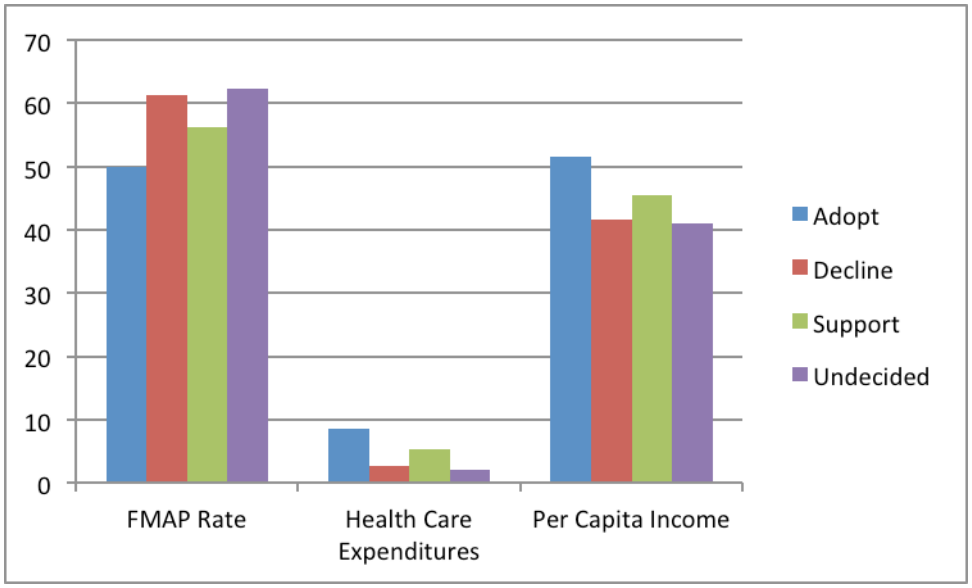


Figure 4.2. Pivot table displaying the effect of economic factors on Medicaid expansion using mean values of the variables FMAP rate, health care expenditures, and per capita income in relation to the decision of states on Medicaid expansion.

Needs-Based Model

Descriptive Statistics

The needs-based model consists of five variables; poverty, the percentage of the elderly, the percentage of the unemployed, the percentage of the uninsured, and health status. Table 4.11 depicts the descriptive statistics for all 50 states. The variables poverty and the percentage of uninsured are positively skewed and leptokurtic. Alternatively, the variables percentage of the elderly, percentage of the unemployed, and health status are negatively skewed and leptokurtic.

Table 4.11

Needs-Based Model Descriptive Statistics for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Poverty	13.87	3.15	8.6	23.8	3.60	15.2
% Elderly	14.03	1.68	8.5	18.2	5.22	9.7
% Unemployed	7.34	1.71	3.1	11.2	2.81	8.1
% Uninsured	13.61	4.14	3.9	22.5	2.59	18.6
Health Status	.07	.01	.06	.09	2.63	0.03

Correlation Analysis

Correlations are performed between the dependent and independent variables. Table 4.12 depicts the results for the needs-based model. The percentage of uninsured is correlated with all of the other variables at a significant level. Moreover, there is a low negative correlation between Medicaid expansion and the percentage of uninsured (r = -.33, p <.05). This correlation demonstrates that states are not expanding Medicaid when they have a high proportion of uninsured individuals. There is also a moderate positive correlation between poverty and the percentage of the uninsured (r = .52, p < .001). This association may be the result of increases in part-time employees and minimum wage positions (Wilensky, 1988). A moderate negative correlation between health status and poverty (r = -.45, p < .01), implies that people who have poor health also live in poverty.

Since many of the variables in the needs-based model are moderately correlated, a VIF test is utilized to assess multicollinearity. The mean VIF value for all of the variables is 1.82. The VIF test did not signal a need to account for an issue of multicollinearity, because the

threshold for collinearity does not exceed a mean value of 10. As a result, all of the variables remain in the needs-based model.

Table 4.12

Needs-Based Model Correlations for Dependent and Independent Variables

	Poverty	**%Elderly**	**%Unemployed**	**%Uninsured**	**Health Status**	**Medicaid Expansion**
Poverty	1.00					
%Elderly	-.10	1.00				
%Unemployed	.69***	-.01	1.00			
%Uninsured	.52***	-.37**	.37**	1.00		
Health Status	-.45**	-.48**	-.48**	-.50**	1.00	
Medicaid Expansion	.12	.24	.24	-.33*	.15	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level, ***Correlation is significant at .001 level.

Data Analysis

To analyze the needs-based model, multinomial logistic regression is utilized to address the following question: *Do state population needs influence the decision of states to adopt Medicaid expansion?* The model is significant with a likelihood ratio chi-square of 49.90 and a p-value of .0001. Table 4.13 provides the results of the statistical tests used to examine goodness of fit. The results indicate that 68.4% of the variance in state decisions on Medicaid expansion is explained by the model.

Table 4.13

Needs-Based Model Summary

Model/ Significance	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow/ Significance**
49.90(.000)	.390	.631	.684	37.56(.038)

The findings from the multinomial regression analysis for the needs-based model are displayed in Table 4.14. Four variables are significant. The relative risk ratio for health status is not reported due to estimation limitations, but the multinomial regression analysis reveals that health status is statistically significant.

Table 4.14

Needs-Based Multinomial Regression Analysis

(Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Poverty	.67*	1.96	.63
%Elderly	-.69*	.50	.17
%Unemployed	-.58	.56	.22
%Uninsured	-.22	.81	.16
Health Status	121.28	4.68	3.48
Constant	-.40	.67	5.55
Support			
Poverty	1.13**	3.11	1.30
%Elderly	-.58	.56	.27
%Unemployed	-.10	.91	.47
%Uninsured	-.83**	.43	.13
Health Status	168.20	1.12	1.33
Constant	-8.10	.00	.00
Adopt			
Poverty	.95*	2.59	1.16
%Elderly	-1.05	.35	.23
%Unemployed	1.53	4.63	4.55
%Uninsured	-.72*	.49	.17
Health Status	741.62*	∞	0
Constant	-58.01	6.43	2.28

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level.
∞: Maximum likelihood estimate do not exist.

For the needs-based model, four variables out of five are statistically significant. Hypothesis 10 suggests that states with higher supplemental poverty measure rates are more likely to expand Medicaid. Although the findings produce mixed results, the findings suggest

that states are responsive to actualized needs and they are more apt to support (*RRR* = 1.96, $p <$ .01) or adopt (*RRR* = 3.11, $p < .05$) Medicaid expansion rather than decline (*RRR* = 2.59, $p < .05$) Medicaid expansion. The percentage of the elderly population is also significant in the expected direction. Hypothesis 11 postulates that states with a high proportion of elderly persons are less likely to expand Medicaid expansion. A one standard deviation increase in the percentage of the elderly is associated with a 50% lower relative risk that states will decline Medicaid expansion relative to the undecided referent group (*RRR* = .50, $p < .05$). This finding supports the literature that states are less inclined to expand Medicaid services when there are a high proportion of elderly residents (Kousser, 2000; Lamphere & Rosenbach, 2000).

The only variable that is not statistically significant in the needs-based model is the percentage of the unemployed. Hypothesis 12 proposes that states with low unemployment rates are more likely to expand Medicaid expansion. Although prior research demonstrates a link between the rate of unemployment and restrictive welfare benefits, mixed results have been reported on the effect of unemployment rates on different types of Medicaid policies (Grogan, 1999; Soss et al. 2001). This model also produces mixed results on the effect of unemployment rates on Medicaid expansion. The results indicate that states are more likely to adopt Medicaid expansion when unemployment rates are high. However, there is a negative relationship between states that support and decline Medicaid expansion and the percentage of unemployed individuals. Although there is no clear explanation to account for the mixed results, possible reasons could be the cost of expanding Medicaid or political opposition.

While the percentage of the unemployed does not have an effect on Medicaid expansion, the last two variables (percentage of uninsured and health status) in the needs-based model are positively significant. Hypothesis 13 estimates that states with high uninsurance rates are more

likely to oppose Medicaid expansion. Contrary to the hypothesized direction for the percentage of the uninsured, states are more inclined to support (*RRR* = .43, $p < .01$) or adopt (*RRR* = .49, $p < .05$) Medicaid expansion when the uninsured rate increases. This finding implies that states are more apt to adopt Medicaid expansion when there is a real need as suggested for the case on poverty.

Hypothesis 14 postulates that states with a high level of residents with good health are more likely to expand Medicaid. Although the relative risk ratio for health status is not estimated, the findings support Hypothesis 14 with a significance level of $p < .05$. This finding supports Grogan's (1999) conclusion that states respond positively to recognized medical and health needs. Moreover, the results from this study on health status also lend support to Hill et al.'s (2014) arguments that knowledge of overall state health needs aid states in determining prospective costs and expanding Medicaid.

A comparison of state decisions using a one-way table of summary statistics (see Appendix C), and using the mean score of each variable on the effect of poverty on Medicaid expansion reveals, that states that choose to adopt or support Medicaid expansion have higher than average state residents living in poverty. This finding is surprising because these states also have higher than average per capita income. On the other hand, states that chose to decline or are undecided on Medicaid expansion have a lower than average proportion of state residents living in poverty. These results speak to the issues of income disparities and economic inequalities throughout the United States. A study examining economic inequality trends in industrialized countries found that "a low-income American at the 10^{th} percentile in 2000 had an income that is only 39 percent of median income, whereas a high-income American in the 90^{th} percentile had an income that is 210 percent of the median" (Smeeding, 2005, p. 959).

An analysis of the influence of the percentage of the elderly population on state decisions on Medicaid expansion demonstrates that states that choose to support or are undecided on Medicaid expansion have a higher than average population of elderly persons. On the contrary, states that choose to decline or adopt Medicaid expansion have a lower than average elderly population. For states that decline Medicaid expansion, these findings show that expanding Medicaid would not be as expensive compared to other states with a high population of elderly persons.

An evaluation of the impact of the percentage of unemployed persons on Medicaid expansion reveals that states that choose to adopt, support or are undecided on Medicaid expansion have a higher than average population of unemployed individuals. This finding suggests that the employment status of state residents is a motivational force in state decisions on expanding Medicaid. Alternatively, states that chose to decline Medicaid expansion have a lower population of state residents who are unemployed.

An investigation of the effect of health status on state decisions on Medicaid expansion shows that states that choose to decline, support, or adopt Medicaid expansion have state residents with good health statuses. This finding indicates that while states are more inclined to adopt or support Medicaid expansion when they have healthy residents; some states do not consider the overall health status of state residents to be a driving force in expanding Medicaid.

An examination of the influence of the percentage of uninsured of state decisions on Medicaid expansion reveals that states that choose to decline or are undecided on Medicaid expansion have a higher than average percentage of uninsured individuals. This finding suggests these states are risk-averse to expanding Medicaid. On the other hand, states that adopt or

support Medicaid expansion have a lower than average population of uninsured individuals. This result implies that these states are more inclined to expand Medicaid because there are fewer people to insure.

The decisions of states on Medicaid expansion in relation to need-based factors show marginal differences amongst the states with the exception of the uninsured. The variable health status is transformed to reflect a whole number. Figure 4.3 illustrates the impact of needs-based factors on Medicaid expansion in graphical form.

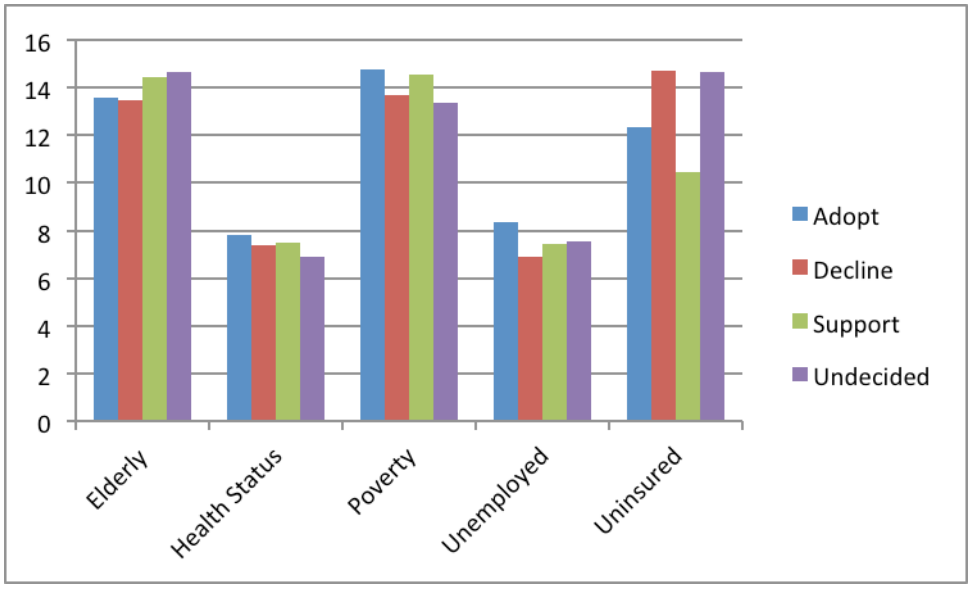


Figure 4.3. Pivot table displaying the effect of needs-based factors on Medicaid expansion using mean values of the variables percentage of the elderly, health status, poverty, the percentage of the unemployed, and the percentage of the uninsured in relation to the decision of states on Medicaid expansion.

State Capacity Model

Descriptive Statistics

The state capacity model consists of three variables: legislative professionalism, institutional capacity, and governance. Table 4.15 illustrates the descriptive statistics for all 50 states. All of the variables are positively skewed and leptokurtic.

Table 4.15

State Capacity Model Descriptive Statistics for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Legislative Professionalism	.19	.12	0.031	0.606	6.30	0.575
Institutional Capacity	2.60	.53	1.325	3.825	2.95	2.5
Governance	2.48	1.01	1	4	1.96	3

Correlation Analysis

An examination of correlations between the dependent and independent variables is performed. Using Guilford's guidelines for assessing Pearson *r* values (Sprinthall, 2012), the correlation analysis indicates that there is a low negative correlation between governance and legislative professionalism ($r = -.29$, $p < .05$). This relationship may result from differences in legislative values and institutional objectives when formulating and implementing public service initiatives. Issues of contention revolve around power constraints, representation, leadership, responsiveness, efficiency and effectiveness, and autonomy (Bourdeaux & Chiukoto, 2008). Moreover, there is a positive low correlation between Medicaid expansion and legislative professionalism ($r = .35$, $p < .05$). This association supports the literature that professional legislatures are more likely to shape and adopt public policies (Boushey & McGrath, 2015;

Brace & Ward, 1999; Finegold & Skocpol, 1995; Jenkins, Leicht, & Wendt, 2006). A VIF test is performed to examine and identify issues relating to multicollinearity. The mean VIF value for all of the variables is 1.06, thus signifying that multicollinarity is not a problem for the state capacity model. Table 4.16 depicts the results for the state capacity model.

Table 4.16

State Capacity Model Correlations for Dependent and Independent Variables

	Legislative Professionalism	**Institutional Capacity**	**Governance**	**Medicaid Expansion**
Legislative Professionalism	1.00			
Institutional Capacity	.01	1.00		
Governance	-.29*	-.05	1.00	
Medicaid Expansion	.35**	-.11	-.02**	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level.

Data Analysis

Multinomial logistic regression is utilized to analyze the state capacity model and to address the following question: *Does state capacity influence the decision of states to adopt Medicaid expansion?* The model is significant with a likelihood ratio chi-square of 17.60 and a p-value of .05. The statistical tests utilized to evaluate goodness of fit are presented in Table 4.17. The results indicate that 32.2% of the variance in state decisions is explained by the model.

Table 4.17

State Capacity Model Summary

Model/ Significance	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow/ Significance**
17.60(.040)	.138	.297	.322	19.159(.743)

The results from the multinomial regression analysis for the state capacity model are displayed in Table 4.18. Two variables have an effect on Medicaid expansion: legislative professionalism and governance. Relative risk ratios are reported for purposes of interpretation.

Table 4.18

State Capacity Multinomial Regression Analysis

(Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Legislative Professionalism	1.21	3.36	16.00
Institutional Capacity	1.03	2.81	1.99
Governance	.22	1.25	.46
Constant	-3.11	.04	.10
Support			
Legislative Professionalism	12.50*	268141.3	1437493
Institutional Capacity	.40	1.49	1.33
Governance	1.22*	3.39	1.86
Constant	-7.14	.00	.00
Adopt			
Legislative Professionalism	9.27	10666.63	56817.92
Institutional Capacity	.74	2.10	2.35
Governance	-.15	.86	.62
Constant	-4.53	.01	.04

Note: *Correlation is significant at .05 level.

For the state capacity model, the relationship between legislative professionalism and Medicaid expansion indicates that states are more likely to support Medicaid expansion as the degree of legislative professionalism increases relative to the referent group, undecided (*RRR* = 268141.3, $p < .05$). The findings demonstrate that Hypothesis 15 is not supported, which postulates that states with a high degree of legislative professionalism are more likely to adopt Medicaid expansion. This finding should be understood in the environmental context of Medicaid expansion. In June of 2012, the Supreme Court ruled that compelling states to expand Medicaid is unconstitutional (Jost & Rosenbaum, 2012). As a result, many states did not formally adopt Medicaid expansion until the following year or years after. Although many states did not formally adopt Medicaid expansion, the results demonstrate that there is a positive relationship between highly professionalized legislatures and Medicaid expansion in the expected direction, but the results do not reach a significant level. Consequently, there is reason to believe that legislative professionalism will have more predictive power in analyses conducted for future years to come.

Institutional capacity also did not have an effect on Medicaid expansion. Hypothesis 16 estimates that states with a high level of institutional capacity will be more likely to expand Medicaid. The insignificant results for institutional capacity could be due to a number of problems. First, the data used to measure institutional capacity is collected from the year 2008. Although this information is outdated, there is research that suggests that state characteristics do not vary much over time (Milward & Provan, 2000; Weaver & Rockman, 1993; West, 2004). The other issue is that prior studies have measured institutional capacity using multiple methods (Fossett & Thompson, 2006; Jacobs & Callaghan, 2013; Kim & Jennings, 2012). The insignificant results could suggest that the method selected for this study may not be the

appropriate measure to assess institutional capacity. However, the institutional capacity measure used in this study is comprehensive and has been in existence for 14 years (Barrett & Greene, 2008). Moreover, many studies have reported significant findings using data from the government performance project (Fossett & Thompson, 2006; Hou, Moynihan, & Ingramham, 2003; King, Zeckhauser, & Kim, 2004), on which this study draws for the institutional capacity measure.

Surprisingly, the findings indicate that states are more likely to support Medicaid expansion when Medicaid governance arrangements are centralized (*RRR* = 3.39, $p < .05$). Hypothesis 17 posits that states with centralized Medicaid governing boards will most likely expand Medicaid and it is unsupported. In contrast, the findings demonstrate that states that adopt Medicaid expansion are more likely to have a decentralized governance arrangement. Again, since many states did not formally adopt Medicaid expansion in 2012, there is reason to believe that governance will have a larger effect on Medicaid expansion in future years. Nonetheless, the influence of state governance arrangement on Medicaid expansion may vary in future years because mixed and shared governance arrangements are gaining prominence in fostering and establishing collaborative partnerships to improve public health initiatives (Beitsch, Brooks, Grigg, Menachemi, 2006).

A comparison of state decisions using a one-way stable of summary statistics (see Appendix D) along with using the mean score of each variable on Medicaid expansion reveals that states that choose to support or adopt Medicaid expansion have higher than average legislative professionals. This finding supports the literature, which indicates that professional state legislators support progressive policies (Brace & Ward, 1999; Finegold & Skocpol, 1995; Jenkins, Leicht, & Wendt, 2006). On the other hand, states that choose to decline or are

undecided on Medicaid expansion have lower than average legislative professionals. This finding could indicate that these states do not have the knowledge and skills to effectively manage an expanded Medicaid program.

An analysis of the effect of institutional capacity of state decisions on Medicaid expansion reveals that states that choose to decline or adopt Medicaid expansion have higher than average levels of institutional capacity. This finding demonstrates that although states have the institutional capacity to expand Medicaid, some states are making the choice to decline expansion. States that choose to support or are undecided on Medicaid expansion have lower than average institutional capacity. This outcome suggests that a lack of institutional capacity may be hindering states from fully adopting Medicaid expansion.

For governance, a chi-square analysis and summary of statistics table (see Appendix D) shows that there is no difference between a states' decision to adopt, support, decline or remain undecided on Medicaid and the governance structure of state Medicaid agencies. The decentralized governance structure comprises 54% of state Medicaid governance structures. The findings indicate that most states adopt a decentralized approach to handle the health and welfare of state residents, but such an approach creates wide variations in health services and outcomes. Wallis and Oates (1988) maintain that,

> the decentralized provision of public services provides a means to increase the level of economic welfare by differentiating levels of public outputs according to the demands of local constituencies. The magnitude of the potential gains from such decentralization depends upon the variation in the optimal levels of public outputs across jurisdictions. (p. 12)

The negative consequences of decentralization include inequality amongst communities and regions and dominance of public policies by the political elite (Fauget, 2004). The results of this study offer a glimpse of disproportionate effects, such as health outcomes and institutional capacity, which could stem from a decentralized approach to handling Medicaid policies.

Overall, the state capacity model shows similar patterns amongst the states in regards to their decisions on Medicaid expansion for governance and institutional capacity. However, the differences between states that adopt and support Medicaid expansion are more pronounced than states that decline or are undecided on Medicaid expansion. Figure 4.4 represents the influence of state capacity factors on Medicaid expansion in graphical form.

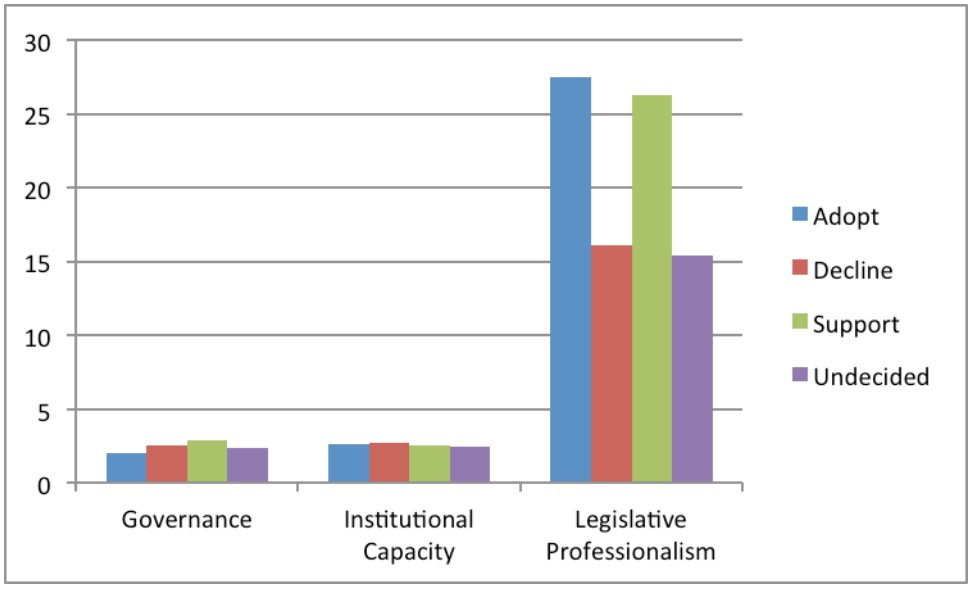


Figure 4.4. Pivot table displaying the effect of state capacity factors on Medicaid expansion using mean values of the variables governance, institutional capacity, and legislative professionalism in relation to the decision of states on Medicaid expansion.

State Innovation and Diffusion

Descriptive Statistics

The state innovation and diffusion model consists of three variables: geographic state, state competition, and policy history. Table 4.19 depicts the descriptive statistics for all 50 states. The variables, geographic state and state competition assumes that all of the states share a border with another state and that a state is influenced by its border states. Hawaii and Alaska are the only states that do not share a border with another state. We included these states in our analysis and assigned them a value of 0 based on the assumption that since they do not share a border state, they are not influenced by the actions of other states. The policy history variable is negatively skewed and leptokurtic. On the other hand, the geographic state variable and the state competition variable are positively skewed and leptokurtic.

Table 4.19

State Innovation and Diffusion Model Descriptive Statistics for all 50 States

Variable	Mean	Std. Dev.	Min	Max	Kurtosis	Range
Geographic State	.08	.12	0	0.4	2.69	0.4
State Competition	.42	.50	0	1	1.11	1
Policy History	20.70	3.57	8	27	4.75	19

Correlation Analysis

Correlations between the dependent and independent variables are performed. Table 4.20 provides the results of the state innovation and diffusion model. Guildford's guidelines for interpreting Pearson *r*-values are utilized to assess each correlation (Sprinthall, 2012). The correlation analysis reveals that there is a positive moderate correlation between geographic state

and Medicaid expansion ($r = .46$, $p < .001$). This correlation corroborates the findings of other studies that demonstrate a positive correlation between geographic neighbors and the adoption of Medicaid or public policies (Berry & Berry, 1990; Satterthwaite, 2002; Volden, 2006). Moreover, there is a low positive correlation between geographic state and policy history ($r = .39$, $p < .01$). This correlation suggests that states are influenced by their neighbors and share a history of adopting similar Medicaid policies from past years. Last, there is a low positive correlation between policy history and Medicaid expansion ($r = .35$, $p < .05$). Again, this association supports prior studies, which show that states are more likely to adopt Medicaid expansion when they have a history of adopting previous Medicaid policies (Callaghan & Jacobs, 2014; Jacobs & Callaghan, 2013; Satterthwaite, 2002). A VIF test produces a mean VIF value of 1.14, thus indicating that multicollinearity is not an issue for the needs-based model.

Table 4.20

State Innovation and Diffusion Correlations for Dependent and Independent Variables

	Geographic State	**State Competition**	**Policy History**	**Medicaid Expansion**
Geographic State	1.00			
State Competition	.14	1.00		
Policy History	.39**	-.01	1.00	
Medicaid Expansion	.46***	.00	.35**	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level, ***Correlation is significant at .001 level.

Data Analysis

Multinomial logistic regression is utilized to examine the state innovation and diffusion model to address the following question: *Do innovation and diffusion influence the decision of states to adopt Medicaid expansion?* The model is significant with a likelihood ratio chi-square of 17.86 and a p-value of .05. Statistical tests to assess goodness of fit are performed and are

presented in Table 4.21. The state innovation and diffusion model summary results indicate that 32.6% of the variance in state decisions in Medicaid expansion is explained by the model.

Table 4.21

State Innovation and Diffusion Model Summary

Model/ Significance	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow/ Significance**
17.86(.037)	.140	.300	.326	11.588(.984)

The results from the multinomial regression analysis for the state innovation and diffusion model are displayed in Table 4.22. Of the three variables included in this model, geographic state is statistically significant. The reporting of relative risks is reported to lend additional understanding to the variable of interest.

Table 4.22

State Innovation and Diffusion Multinomial Regression Analysis

(Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Geographic State	-.37	.69	2.60
State Competition	-.26	.77	.55
Policy History	.00	1.01	.10
Constant	.32	1.37	2.90
Support			
Geographic State	3.48	32.34	128.46
State Competition	-.38	.69	.61
Policy History	.18	1.20	.18
Constant	-4.34	.01	.04
Adopt			
Geographic State	13.35*	626374.8	4035010
State Competition	-1.17	.31	.42
Policy History	.46	1.58	.46
Constant	-13.04	2.17	.00

Note: *Correlation is significant at .05 level.

For the state innovation and diffusion model, there is only one variable that is statistically significant; the others were surprisingly insignificant. The influence of geographic neighbors on Medicaid expansion is positively and statistically significant (*RRR* = 626374, $p < .05$) and supports Hypothesis 18, which postulates that states are more likely to emulate their geographic neighbors in choosing to adopt Medicaid expansion. This finding confirms prior research, which

theorizes that states are influenced by their neighbors and pursue similar policies (Berry & Berry, 1990; Satterthwaite, 2002; Walker, 1969).

State competition and policy history did not have an effect on Medicaid expansion. Hypothesis 19 predicts that states with less generous Medicaid policies than their competitive neighbors are less likely to expand Medicaid. While the findings follow in the expected direction, the influence of state competition on Medicaid expansion is not powerful. Countervailing factors that could affect this finding include other policy priorities, such as education and transportation. The prevalence of other policy priorities could hinder or stall the expansion of Medicaid (Hoadley, Cunningham, & McHugh, 2004). Hypothesis 20 posits that states that have adopted generous Medicaid policies in the past are more likely to adopt Medicaid expansion. Again, the findings follow in the expected direction, but the results are insignificant. These findings suggest that states are more inclined to learn from each other by pursuing similar policies than to compete (Berry & Baybeck 2005; Kim & Jennings, 2012). Moreover, the findings also suggest that prior Medicaid policies have no bearing on the future of welfare policies.

A comparison of state decisions using a one-way stable of summary statistics (see Appendix E) and using the mean score of each variable on Medicaid expansion reveals that states that support or adopt Medicaid expansion are more likely to emulate their neighbor than states that decline or are undecided on Medicaid expansion. This indicates that policy convergence is occurring, but only amongst 30% of the states. For states that choose to decline or are undecided on Medicaid expansion, failure to innovate and diffuse could be the result of a lack of understanding concerning the impact of expanding Medicaid, incomplete or inaccurate information, or ingrained beliefs (Jaffe, Newell, & Stavins, 2005).

An examination of the impact of state competition on state decisions on Medicaid expansion reveals that states that choose to decline, support, and adopt Medicaid expansion have lower than average scores for state competition. This indicates that there is not much of a difference on states decisions for state competition on Medicaid expansion. However, for states that are undecided on Medicaid expansion, there is a higher than average score on state competition. This suggests that there is some form of competition going on within undecided states and it is most likely associated with declining Medicaid expansion since there is a negative relationship between state competition and Medicaid expansion.

An analysis of state decisions reveals that states that choose to decline or are undecided on Medicaid expansion adopt fewer prior policies than states that support or adopt Medicaid expansion. States that decline and are undecided on Medicaid expansion are very similar in terms of the policies they support and adopt. The findings demonstrate that there is clear line between states that have liberal Medicaid policies and states that have conservative Medicaid policies.

In general, the state innovation and diffusion model shows distinct differences amongst the states in regards to their decisions on Medicaid expansion with the exception of state competition. Again, for state competition, the findings demonstrate that there is not much a difference between the states for this variable in relation to Medicaid expansion. Figure 4.5 represents the influence of state innovation and diffusion factors on Medicaid expansion in graphical form.

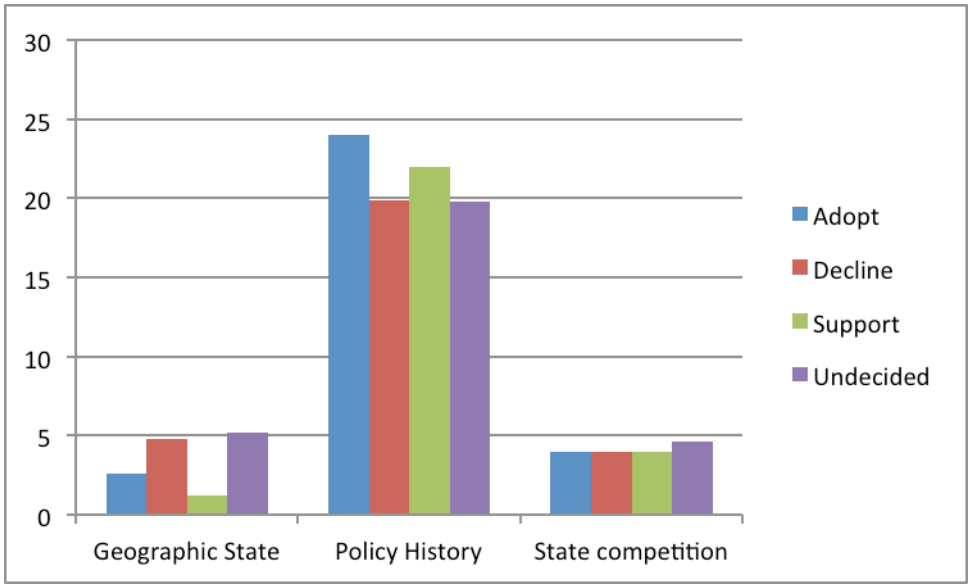


Figure 4.5. Pivot table displaying the effect of state innovation and diffusion on Medicaid expansion using mean values of the variables geographic state, policy history, and state competition in relation to the decision of states on Medicaid expansion.

The Model of State Decision Making in Medicaid Expansion

As discussed in Chapter 3, all of the variables that are significant in each model are included for analysis in a full model of state decision making in Medicaid expansion. The model consists of ten variables: ideology, governor institutional power, FMAP rate, poverty, percentage of elderly, percentage of uninsured, health status, legislative professionalism, governance, and geographic state. Additionally, the model provides results on cross tabulations, goodness of fit measures, and multinomial regression analysis.

Correlation Analysis

Correlations are performed between the dependent variable and the independent variables. Table 4.23 depicts the results for the full model of state decision making in Medicaid

expansion. In view of the fact that many of the variables are correlated, a VIF is utilized to assess multicollinearity. The mean value of all of the variables is 2.26, thus indicating the VIF scores are well below 10, which signifies that multicollinearity is not an issue (Hair et al., 2010). As a result, all of the variables are included in the model

Table 23

Full Model of State Decision Making in Medicaid Expansion Correlations for Dependent and Independent Variables

	Ideology	**Governor Instit. Power**	**FMAP Rate**	**Poverty**	**Elderly**	**Health Status**	**Legislative Profess.**	**Governance**	**Geographic State**	**Uninsured**	**Medicaid Expansion**
Ideology	1.00										
Governor Institutional Power	.16	1.00									
FMAP Rate	-.44***	-.29**	1.00								
Poverty	.09	-.19	.06	1.00							
% Elderly	.16	-.08	.14	-.10	1.00						
Health Status	.15	.33	-.64	-.45	-.04	1.00					
Legislative Professionalism	.20	.23	-.29	.45	-.02	.01	1.00				
Governance	.14	-.10	.11	.18	.17	-.10	-.29**	1.00			
%Uninsured	-.38**	-.38**	.35**	.52***	-.37**	-.50***	-.10	-.09	-.26	1.00	
Medicaid Expansion	.69***	.21	-.42**	.12	.13	.15	.36**	-.02	.46***	-.33*	1.00

Note: *Correlation is significant at .05 level, **Correlation is significant at .01 level, ***Correlation is significant at .001 level.

Data Analysis

Multinomial regression is utilized to answer the overarching question of this study: *What are the factors that influence states to adopt Medicaid expansion?* The model is significant with a likelihood ratio chi-square of 107.02 and a p-value of .001. The statistical tests used to assess goodness of fit are presented in Table 4.24. The Hosmer-Lemeshow statistic did not produce a chi-squared statistic or a p-value. However, it should be noted that an alternative test is utilized to generate the Hosmer-Lemeshow statistic and this test is not recommended for model-building purposes (Fagerland & Hosmer, 2012). The results from the other goodness of fit statistics for the full model of state decision making indicate; 95.6% of the variance of state decisions is explained by the model. Governor institutional power, poverty, the elderly population, and health status significantly contribute to explaining the variance in Medicaid expansion. As a result of the literature on Medicaid policies and state public policies, the full model sheds light on the positive and negative effects of influential factors on Medicaid expansion. Overall, the model shows strong results for factors that influence states to decline Medicaid expansion.

Table 4.24

Full Model of State Decision Making in Medicaid Expansion Summary

Model	**McFadden R^2**	**Cox and Snell R^2**	**NagelKerke R^2**	**Hosmer-Lemeshow**
107.02(.000)	.836	.882	.956	n/a

The results from the multinomial regression analysis for the state decision making model are displayed in Table 4.25. The variables health status and percentage of elderly are statistically

significant at the $p = .05$ level. Other variables that are significant at the $p = .10$ level are poverty and governor institutional power.

Table 4.25

Full Model of State Decision making in Medicaid Expansion Multinomial Regression Analysis (Base Outcome Group: Undecided)

	β	**RRR**	**S.E.**
Decline			
Ideology	-.04	.96	.03
Governor Institutional Power	5.97*	392.75	3.37
FMAP Rate	.21	1.24	.16
Poverty	1.02*	2.76	.53
%Elderly	-.98**	.38	.50
Health Status	364.95**	3.10	184.42
Legislative Professionalism	-7.0	.00	8.93
Governance	.01	1.01	.65
Geographic State	-7.40	.00	8.70
%Uninsured	-.41	.66	.31
Constant	-48.51	8.59	27.06
Support			
Ideology	4.28	72.57	1684.61
Governor Institutional Power	110.50	9.80	51322.42
FMAP Rate	14.10	1333149	11070.48
Poverty	.51	1.66	45714.8
%Elderly	-8.37	.00	24369.93
Health Status	11929.87	∞	9517423
Legislative Professionalism	882.43	∞	676444.1

Governance	28.94	3.71	79209.46
Geographic State	188.78	9.64	202969.4
%Uninsured	7.60	2004.38	25578.99
Constant	-2591.71	0	1389524
Adopt			
Ideology	.43	1.53	5285.44
Governor Institutional Power	36.60	7.82	96720.09
FMAP Rate	-6.09	.00	14988.62
Poverty	25.30	9.68	27882.14
%Elderly	-20.07	1.92	125306.3
Health Status	6330.32	∞	2.98
Legislative Professionalism	201.06	2.09	413092.7
Governance	-25.69	6.94	87878.68
Geographic State	661.85	2.70	940983.2
%Uninsured	-8.69	.00	57359.77
Constant	-367.64	2.20	4311921

Note: *Correlation is significant at .10 level, **Correlation is significant at .05 level.

∞: Maximum likelihood estimate do not exist.

This study assumes that states make decisions based on political, economic, needs-based, state capacity, and state innovation and diffusion factors. Again, the overarching research question driving this research is "*What are the factors that influence states to adopt Medicaid*?" The results from the full model of state decision making demonstrate that, as a whole, most of the factors do not have a significant effect on states decisions on adopting Medicaid expansion, but rather declining Medicaid expansion. However, the model sheds light on an unexpected

result. There are two variables that are statistically significant and they are the percentage of elderly (*RRR* = .38, $p < .05$) and health status (*RRR* = 3.1, $p < .05$). A one standard deviation increase in the percentage of elderly is associated with a 62% lower relative risk of states declining Medicaid expansion. However, a one-way table of summary statistics (See Appendix F) reveals that the percentage of elderly mean score of states that chose to decline Medicaid expansion is 13.45. This indicates that the majority of states that are declining Medicaid expansion have a moderate population of elderly persons.

The results from the full model of state decision making took a surprising turn for the variable of health status. The individual model on state health needs shows that states are more likely to adopt Medicaid expansion when state residents have good health status. However, a one standard increase in health status is associated with a 210% greater relative risk of states declining Medicaid expansion. Moreover, a one-way table of summary statistics (See Appendix F) reveals a health status mean score of .07 for states that chose to decline Medicaid expansion. This statistic also indicates that states are choosing to decline Medicaid expansion even when state residents have good health status. Overall, contrary to the literature on Medicaid expansion and the overriding influence of political factors (Barrilleaux & Rainey, 2014; Brown, 1995; Kousser, 2002; Jacobs & Callaghan, 2013), the findings from this study reveal that state health needs trumps politics.

Chapter Summary

This chapter provides descriptive statistics, cross tabulations, model summaries, and regression analyses of the following models: political, economic, needs-based, state capacity, and state innovation and diffusion. Multinomial regression analysis is used to analyze each

model. A resultant model, the state decision making in Medicaid expansion, is developed based on the significant indicators that have an impact on Medicaid expansion.

The overall results of this study indicate that state health needs are more influential than politics, economics, state capacity, and state innovation and diffusion. Of the individual models, politics has the most explanatory power. The factors, ideology and governor institutional power, have a considerable effect on Medicaid expansion. Although the economic model fails to reach convergence, the findings reveal that states with a low federal medical percentage rate (FMAP) are more likely to adopt Medicaid expansion. The findings also reveal that the needs-based model has the most variables that have a significant effect on Medicaid expansion. The state capacity model does not have a large effect on Medicaid expansion, but there is reason to believe that changes over time in Medicaid expansion will produce different results. Similarly, the state innovation and diffusion model does not have a large effect on Medicaid expansion. In sum, the findings indicate that states do not compete with each other and past policies do not affect state decisions in Medicaid expansion.

The variance in the full model explains 95.6% of state decisions on Medicaid expansion. Such a large variance provides robust explanatory power for the full model of state decision making in Medicaid expansion and aligns with the literature on state health and public policies. Moreover, the results of this study demonstrate the utility and predictive power of each variable on Medicaid expansion. Furthermore, this study provides insight into the complexities of Medicaid expansion and explains the differences between states when deciding to adopt, decline, support, or are undecided on expanding Medicaid.

This study engages in hypothesis testing. Twenty hypotheses are derived from the literature and examined using multinomial regression. However, due to issues of multicollinearity, only 18 hypotheses are tested. Figure 4.6 displays the expected direction of each concept in relation to each hypothesis.

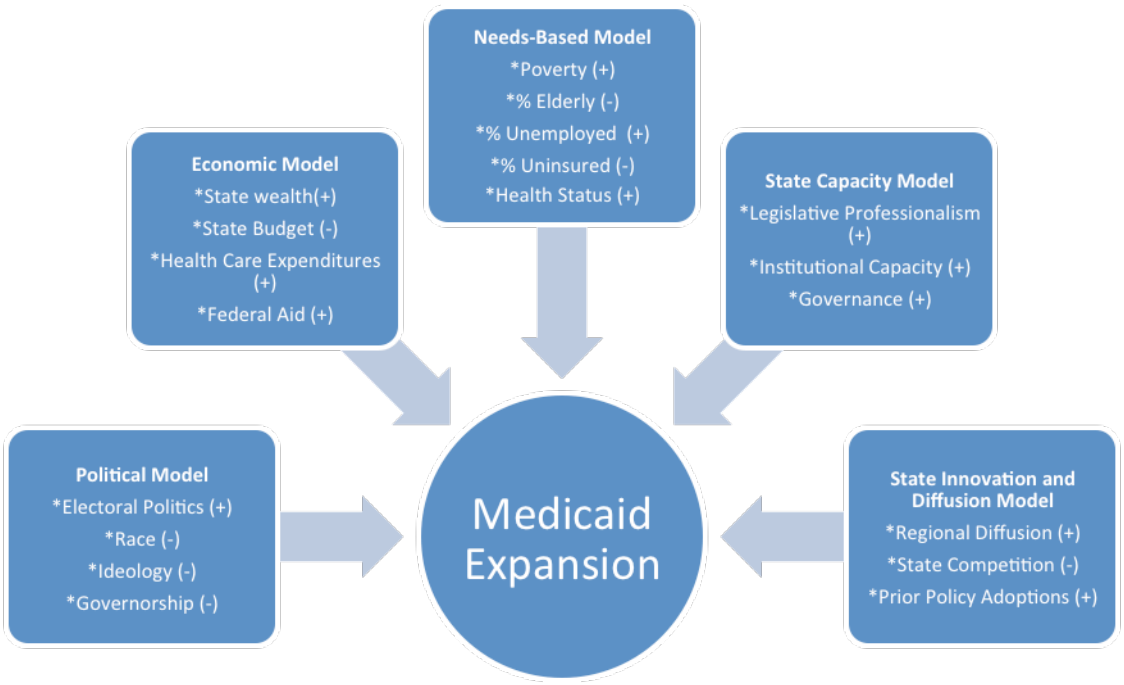


Figure 4.6. A Model of State Decision Making in Medicaid Expansion

Of the hypotheses tested for the full model of state decisions on Medicaid expansion, this study confirms the influence and effect of ideology, governorship, poverty, percentage of the elderly, the percentage of the uninsured, health status, and regional diffusion on Medicaid expansion. The findings on FMAP rates runs counter to the literature on governance structures and the adoption of state policies is not supported by this study. Figure 4.7 provides the end results of this study.

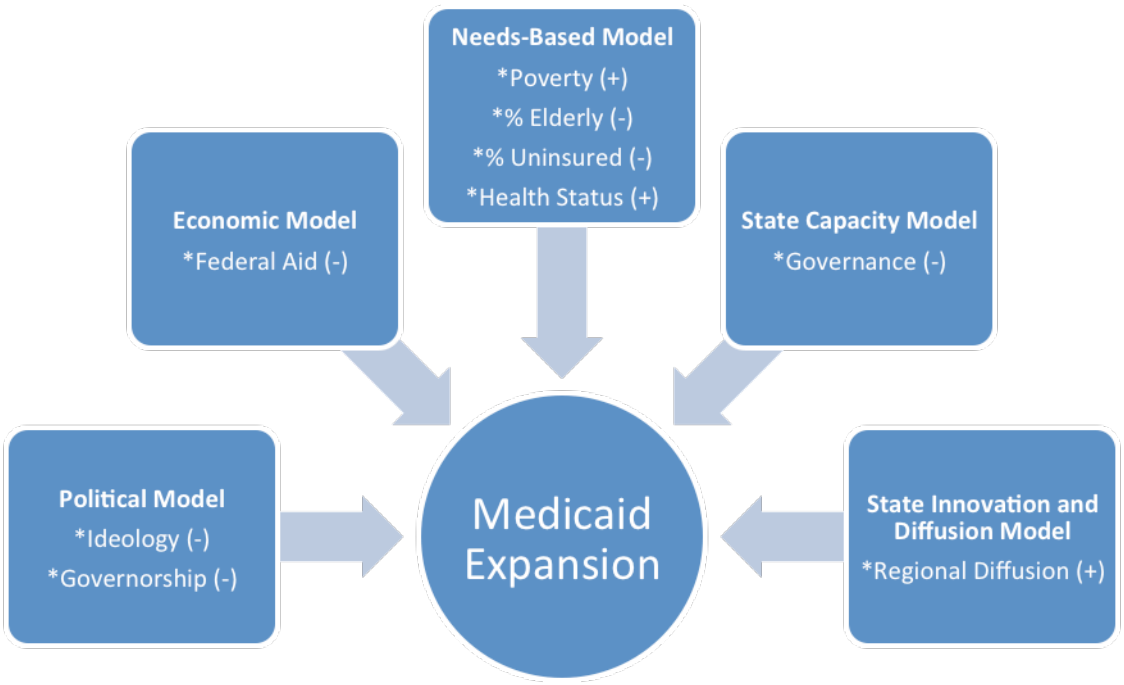


Figure 4.7. A Model of Best Fit of State Decision Making in Medicaid Expansion

Each model offers substantial insight into the prominent factors that affect the decisions of states in Medicaid policy. This study demonstrates that political, economic, needs-based, state capacity, and state innovation and diffusion factors play an important role in the adoption of Medicaid policies. Moreover, the full model of state decision making in Medicaid expansion uncovers an essential set of needs-based factors that play a large role in the decision making process of states that is often neglected in the literature on Medicaid expansion.

CHAPTER 5

IMPLICATIONS AND CONCLUSIONS

This chapter recapitulates the findings from this study as set forth in Chapters 3 and 4. Then, the theoretical and policy contributions and implications are discussed. Next, study limitations and delimitations are offered to address the flaws inherent in this research. Finally, areas of future research and a concluding section are presented to explicate the utility of this study.

Summary of the Research

The purpose of this study is to explore instrumental factors that influence states to adopt Medicaid expansion. This research is informed by a vast array of literature from multiple disciplines; five models that drive policy decisions at the state-level are identified and tested. This study is important because there is a gap in scholarly research on state-level decision making indicators that influence policy adoptions. Moreover, this study fills the gap by introducing a comprehensive model of state decision making in Medicaid expansion that can be adapted and modified to apply to other policy arenas.

A state comparative cross-sectional research design governs this study; the relationship between Medicaid expansion and the influence of political, economic, needs-based, state capacity, and innovation and diffusion factors is examined. The primary research question that guides this study is "*What are the factors that influence states to adopt Medicaid expansion*?" Secondary data are collected at the state level and multinomial regression is utilized to analyze the five models identified from the literature review and the comprehensive model of state

decision making in Medicaid expansion. The results from this study are summarized and organized by research question in the proceeding section.

Research Questions

The first research question pertains to the political model and asks the question: *"Do political factors influence the decision of states to adopt Medicaid?"* The significant factors in the political model are state government ideology and governor institutional power. The data analysis supports Hypotheses 3 and 4 that conservative state governments and governors with high institutional powers are more likely to decline Medicaid expansion. The results of the analysis also reveal that liberal state governments and governors with high institutional powers are more likely to support Medicaid expansion. The insignificant variables are African-American voters and interparty competition. None of the variables have an effect on the decisions of states to adopt Medicaid expansion. This finding supports the literature on Medicaid expansion, which demonstrates that political factors have an overwhelming influence on the decisions of states to decline Medicaid expansion (Barrilleaux & Rainey, 2014; Jacobs & Callaghan, 2013). In contrast, the results of this study in terms of the comprehensive model reveal that the decisions of states to adopt Medicaid expansion are not influenced by political factors. However, the support of Medicaid expansion by states is influenced by ideology and gubernatorial institutional powers. Likewise, the declination of Medicaid expansion by states is also influenced by gubernatorial institutional powers and ideology.

The second research question is related to the economic model and asks: *"Do economic factors influence the decision of states to adopt Medicaid expansion?"* This model failed to reach convergence and some of the variables were omitted because they were highly correlated.

The federal medical assistance percentage rate (FMAP) appears to be a significant factor that affects the decisions of states to adopt Medicaid expansion. This finding runs contrary to the hypothesized direction, but the results indicate that states are more likely to adopt Medicaid expansion when FMAP rates are low. The other variables (per capita income and health care expenditures) do not have an effect on the decision of states to expand Medicaid. Although per capita income and health care expenditures do not have an effect on the decisions of states to adopt, support, or decline Medicaid expansion, this study demonstrates that FMAP rates have considerable influence on state decisions to adopt Medicaid. However, it should be noted that the results of this model should be interpreted with caution due to convergence failure.

The third research question is connected to the needs-based model and follows: *"Do state population needs influence the decision of states to adopt Medicaid expansion?"* All of the variables with the exception of the percentage of employed are statistically significant. The poverty variable produced mixed results. The results reveal that states with a moderate population of people living in poverty are opting to decline and support Medicaid expansion. The findings also show that states are more apt to decline Medicaid expansion when there is a moderate population of elderly persons. This could suggest that states are not willing invest in Medicaid expansion when they know that a certain population of high utilizers of health care services will increase health care costs and decrease state resources in relation to the provision of health care services.

Unpredictably, the results reveal that states with a moderate level of uninsured persons are more likely to adopt Medicaid expansion. Moreover, Hypothesis 14 is supported by the analysis and states with residents that have good health statuses are more likely to adopt Medicaid expansion. This model suggests that states are responsive to some state population

needs. In response to the third research question, the results indicate that poverty, the percentage of the uninsured, and health status influence states to adopt Medicaid expansion. In contrast, the decision to decline Medicaid expansion by states is affected by poverty and high populations of elderly persons. Last, states that support Medicaid expansion are influenced by poverty and high populations of uninsured individuals.

The fourth research question concerns the state capacity model and reads: *"Does state capacity influence the decision of states to adopt Medicaid expansion?"* Legislative professionalism is a statistically significant variable in the state capacity model and the results indicate that states with a high degree of legislative professionalism are more likely to support rather than decline or adopt Medicaid expansion. Governance is the other statistically significant variable and this variable does not have an effect on the decisions of states to adopt Medicaid expansion as hypothesized, but instead is significant for the decisions of states in supporting Medicaid expansion. Institutional capacity did not have an effect at all on the decisions of states to expand Medicaid. The findings from the state capacity model suggest that the variables will have more predictive power in the future because states did not formally decide to take a position on Medicaid expansion until after the year 2012. In conclusion, state capacity factors do not influence states to adopt Medicaid expansion. Moreover, these factors do not have an effect on the decisions of states that decline Medicaid expansion as well. However, the results indicate that states that support Medicaid expansion are influenced by legislative professionalism and governance arrangements.

The fifth research question involves the state innovation and diffusion model: *"Do innovation and diffusion influence the decision of states to adopt Medicaid expansion?"* The variable geographic state is significant and supports Hypothesis 18, which indicates that states

are more likely to emulate their geographic neighbors in choosing to adopt Medicaid expansion. The other variables (state competition and policy history) are insignificant and do not have an effect on the decisions of states to expand Medicaid. This model suggests that states are not influenced by past policy preferences and states are not competing with each other on any level in relation to Medicaid expansion. In accordance with Question 5, the results indicate that states are influenced by their geographic neighbor. The others factors that comprise the state innovation and diffusion model do not wield a significant amount of influence on state decisions to adopt Medicaid expansion. For states that decline or support Medicaid expansion, the findings reveal that geographic neighbors, policy history and state competition do not influence state decisions.

Last, we revisit the overarching question guiding this study that relates to the full model of state decision making in Medicaid expansion: *"What are the factors that influence states to adopt Medicaid expansion?"* Although 10 variables are included in the model, only 2 variables are statistically significant with a p-value of .05. The two variables are the percentage of elderly and health status. Poverty and governor institutional power are also significant with a p-value of .10. The findings indicate that states are more likely to decline Medicaid expansion when they have a moderate population of elderly persons. Additionally, the results reveal that states are also more likely to decline Medicaid expansion when residents have good health statuses. The other variables in the model do not have a significant effect on Medicaid expansion. Moreover, of the variables that comprise the full model of state decision making in Medicaid expansion, none of them show influential power in states choosing to adopt Medicaid expansion. Surprisingly, this model suggests that in relation to Medicaid expansion state population needs are more influential than political factors.

Theoretical Contributions and Implications

The literature on Medicaid expansion and Medicaid policy does not acknowledge the different dimensions of influential factors that affect the decision making process of states, which in turn affect public health policies. There is a gap in the literature that fails to connect why states make decisions and the implications that follow when states choose to adopt or refuse to adopt a given policy. The empirical findings from this study demonstrate that each model of prominent factors that influence state decisions in Medicaid expansion are important as they stand alone, but they also interact differently when combined.

The development of a comprehensive model for state decision making in Medicaid expansion is the first major contribution to this study. The variance of this model explains 95.6% of state decisions in Medicaid expansion. Although high values for the coefficient of determination (r^2) is uncommon in the field of social sciences, the full model is based on an interdisciplinary literature search that focuses on state-level factors that influence state decisions in public policy. The drivers of state decision making fall under the following individual models; political, economic, needs-based, state capacity, and state innovation and diffusion. These factors comprise essential elements of the policy adoption stage of state decision making in public policies.

The model of state decision making in Medicaid expansion can assist theorists in building knowledge and addressing additional gaps in research and practice. Replication studies and model modifications can advance the field of public policy and health policy over time by lending consistency and reliability in the measures used to analyze the model. Furthermore, the model can assist theorists in improving the decision making process of states by identifying problem areas through quantitative and analytical processes to inform practice on state policy

directives and management practices. State-level policy directives and management practices include, but are not limited to, factors involving resource management, issue management, and financial management.

The second major contribution of this study involves revelatory insight. Corley and Gioia (2011) maintain that a significant theoretical contribution "rests in the idea that contribution arises when theory reveals what we otherwise had not seen, known, or conceived" (p. 17). This study identifies and illuminates the driving factors of state responses to policy adoption. Until this study, research on state decision making in any arena does not encompass a wide-ranging model of influential factors that affect policy adoptions. Moreover, this study reveals that state needs are just as important as politics, and this discovery is largely ignored or not fully explored in the literature on Medicaid expansion since the passage of the Patient Protection and Affordable Care Act (Barrilleaux & Rainey, 2014; Brown, 1995; Jacobs & Callaghan, 2013). This finding suggests that there should to be more emphasis on understanding issue definition in the context of Medicaid expansion. Issue definition relates to the process by which the initial stage of policy development shapes policy deliberations, and certain interests are deemed important for policy decisions (Burgess, 2005). Moreover, Mooney (1999) acknowledges that "issue definition is central to determining the politics of the policy making process. Even a small change in this definition can affect the extent to which the process is driven" (p. 678). When issue definition is understood, decision-makers can adequately assess constraints, examine alternatives, and direct and implement judicial decisions and agency policy directives (Stankey, Hendee, & Clark, 1975). This study demonstrates how state concerns can be sorted based on an understanding of the drivers of state decisions.

Policy Contributions and Implications

States play an important role in the adoption and implementation of Medicaid policy. A review of the literature (see Chapter 2) reveals that political, economic, needs-based, state capacity, and innovation and diffusion influences the adoption of state policies. The results of this study indicate that policy adoption at the state level is influenced by a multitude of competing factors, but when all of the factors are combined, states are more inclined to respond negatively to state needs. Although Medicaid expansion provides an opportunity to improve the health status of state residents, eliminate gaps in coverage, and control variations in health outcomes across states (Crowley & Golden, 2014; Jacobs & Callaghan, 2013; Richardson & Yilmazer, 2013), the far-reaching benefits of implementing Medicaid expansion are null if states do not adopt Medicaid expansion. This research contributes to the fields of health policy and public policy in four ways.

First, an understanding of the factors that influence state policies and the problem that governs Medicaid expansion can provide a starting point for meaningful and factual discourse. Understanding the issues that affect Medicaid expansion can assist policymakers and policy advocates with demystifying inaccurate claims and personal biases by reframing policy problems. Schon and Rein (1994) refer to reframing as a deliberative process that is based on evidence and policy debates that encourage participants to seriously reflect and adjust their original framing of the policy issue. This process involves a paradigm shift of the policy problem. In addition to recasting and reframing policy issues, rhetoric could also induce policy change. To reorient policy problems through rhetoric, Gottweis (2007) suggests "conceptualiz[ing] these elements [emotions, virtue, trust, ethos, and feelings] in policy making not as expressions of irrationality but as inseparable from the operation of reason" (p. 248).

A simplistic form of using rhetoric in relation to this study would be to appeal to the public and lawmakers using reason and emotion to persuade states to adopt Medicaid expansion. A case could be presented where a healthy person who does not have health insurance lives in a state that is declining Medicaid expansion and cannot access affordable care. A situation occurs where the healthy person neglects getting care and ends up in the hospital and costs the state thousands of dollars in uncompensated care. Then, research into the cause of illness reveals that the illness could have been prevented by one trip to a primary care physician and medication that costs less than $25 with health insurance. Soon after, a study is conducted using the model of state decision making in Medicaid expansion and the results of this study is confirmed and states are still declining Medicaid expansion when they have a high population of healthy residents. Further analyses of economic factors and forecasting reveal that states will save money if they expand Medicaid. This case represents how lawmakers, researchers, policy entrepreneurs, interest groups, and public health advocates can use rhetoric and reason to influence policy adoption.

Second, history demonstrates that states respond to financial inducements (Brecher & Rose, 2013; Pollack, 2013). The findings from this study show that states are more likely to expand Medicaid when FMAP rates are low. This suggests that states that are receiving more financial assistance are declining Medicaid expansion. Although the federal government will fund Medicaid expansion at 100% from 2014 to 2016 and 90% thereafter, there is speculation that states are declining Medicaid expansion because they are afraid that future changes in the law or administration will shift the burden from the federal government to the states (Angeles, 2012; Antos, 2013). This highlights a need to understand and research the interplay between trust in government and the adoption of Medicaid policies as well as public health and public

policies. The influence of financial inducements or federal aid should be examined in more depth through qualitative inquiry.

Third, the exploration of trend analysis can lend additional understanding to policy adoption in Medicaid expansion. This study serves as a baseline design for decision making at the state level and can assist analysts in predicting what will happen in the future with Medicaid expansion. Moreover, researchers and practitioners can use trend analysis as a strategic tool to identify common trends and pattern changes over time. Additionally, the impact of Medicaid expansion and policy shifts can be evaluated. Furthermore, targeted studies can assess and compare the relationship between Medicaid expansion and the predictor variables according to geographic areas and ideological stances over time.

Fourth, practical application of this study may be guided through evidence-informed policy, which involves gathering contextual based evidence from a variety of sources. Then, the evidence should be continuously assessed and research should be understood by the way the problem is framed, the interpretation of the research is analyzed, and the application is prioritized and effective. Last, capacity should be assessed and determined to implement policies based on evidence (Bowen & Zwi, 2005). Gambrill (2006) suggests that in order to employ an evidence-informed approach to policy, practitioners should acquire information science skills, incorporate feedback in decisions, and have access to decisional tools, resources, and training to improve the quality of health care decisions. However, Bowen and Zwi (2005) note that "the starting point for navigating the use of evidence in policy and practice is understanding diffusion (how ideas spread throughout systems), how decisions are made, how policy is developed, and how capacity is required to effectively use evidence in this process" (p. e166). By examining Medicaid expansion through an evidence-informed approach, researchers and practitioners can better

understand state factors on a contextual level and determine the appropriate strategy to adopt and implement Medicaid expansion.

The implications of this study are far-reaching. States can use the model of state decision making in Medicaid expansion to assess political support for new and expanded programs and evaluate economic conditions that can impact the implementation of new initiatives. States can also examine the needs of its constituents and provide services or expand programs that serve the welfare of the public. Moreover, states can assess their capacity to implement new programs and learn from each other through innovation and diffusion.

Practitioners can utilize the findings from this study by understanding the factors that affect state decisions in Medicaid expansion and assisting with the development of new policies to remedy policy problems. Practitioners can also serve as health policy advocates and provide evidence-based research on the impact of health care policies on vulnerable populations. Likewise, policymakers can use the results of this study to champion new or expanded services. This study provides statistics for each state and policymakers can use the data from this study to identify problems and suggest a course of action. Through active engagement and evidence-informed policy, policymakers, practitioners, and states have the power to transform the delivery and service of health care.

Study Limitations and Delimitations

There are several limitations pertaining to this study. First, this research provides a foundational model that allows researchers to evaluate and test prominent factors at the state level that affect state decisions on Medicaid expansion. Some of the factors are context specific and generalizations may not extend to others areas of Medicaid policy or other policy arenas.

This limitation can be managed by understanding the rationalization of state decision making and comprehending the context for each model and variable. Furthermore, it should be noted that Medicaid expansion and the ACA is evolving and this study examines initial state policy choices and early-stage adoption in Medicaid expansion. As implementation of the ACA continues, additional studies will need to be conducted to account for changes in state and federal laws as well as changes in state characteristics.

The second limitation involves data limitations and data choices. The selection of data for this study is based on literature reviews and cross comparisons from other fields. This study utilizes a cross-sectional research design for the year 2012, but some of the data are unavailable for various reasons. As result, this study uses data for prior years or proceeding years for variables that could not be obtained for the year 2012.

The third limitation concerns multiple methods of measurement. The literature on some of the variables in this study utilizes different measures to analyze various phenomena, such as party control and interparty competition (Barrilleaux & Rainey, 2014; Jacobs & Callaghan, 2013; Shufeldt & Flavin, 2011). To mitigate this limitation, this study uses consistent or time-tested measures and also acknowledges that state characteristics do not vary a great deal over time (Weaver & Rockman, 1993; West, 2004). Moreover, the selection of each variable is based on the availability of the data and prior research that demonstrates a consistent effect on the state decision making process.

The fourth litigation relates to model estimation errors. The economic model failed to achieve convergence and goodness of fit measures could not be estimated. To address these limitations, a literature review search on multinomial regression from experts in the field guided

the process on how to deal with model estimation errors and data reporting (Allison, 2008; Fagerland, Hosmer, & Bofin, 2008; Long, 1997).

Future Research

This research examines dominant factors that influence the decisions of states to adopt Medicaid expansion. Data from all 50 states for the cross-sectional year 2012 are utilized to inform the study on which factors have an effect on Medicaid expansion. Now that a model of state decision making on Medicaid expansion is created and time has passed and more data will be accessible, the opportunity to examine this study through a time series analysis can offer insight on changes over time and also future trends can be forecasted (O'Sullivan, Rassel, & Berner, 2003).

Another line of future research is employing a multiple case study approach. An understanding of state decisions among states with similar characteristics may provide insightful information on significant factors that influence the decision making process. A mixed methods study may also add value to this line of research by gaining a deeper understanding of not only the influential factors used in this study, but other factors that may be revealed such as the influence of interest groups. The influence of interest groups is difficult to measure, but a mixed methods study may uncover an important factor that has an effect on Medicaid expansion.

The most important line of research involves improving upon the model of state decision making in Medicaid expansion. The findings indicate that the economic model needs to be revisited and modified. Once the model is reevaluated, replication studies can be conducted for other cross-sectional years and different policy arenas. Additionally, the data limitations will also need to be revisited. As implementation of the ACA moves along, data on state factors that

comprise the full model will become available and readily accessible for future studies. Moreover, the issues involving multiple methods of measurement will need to be addressed via statistical methods such as factor analysis or an in-depth meta-analysis. Although the limitations will need to be remedied, researchers from other policy arenas can and should modify some of the variables in each model to substantiate the phenomenon of interest.

Conclusion

This study explores and examines the effect of political, economic, needs-based, state capacity, and state innovation and diffusion factors at the state level on Medicaid expansion. A number of hypotheses are tested using multinomial regression and state decisions on Medicaid expansion are analyzed in accordance with the influential factors of policy making and policy adoption. This research is important because it addresses a gap in the literature and offers a model of state decision making in Medicaid expansion by which researchers can explain policy decisions and apply to other policy settings.

The results of this study indicate that when all significant factors of state decision making are considered, state needs are more influential than politics— contrary to the literature on Medicaid expansion post the ACA (Barrilleaux & Rainey, 2014; Jacobs & Callaghan, 2013). The results also offer an explanation for why states decline Medicaid expansion more so than adopt Medicaid expansion. However, when the individual models are analyzed separately we see more variation in state decisions and the findings indicate that states are more inclined to support Medicaid expansion rather than adopt expansion. Moreover, the overall findings of this study should be understood in the context of (a) the time period in which the data are collected and (b) the circumstances surrounding the enactment of the ACA (see Chapter 2).

The utility of this research are manifest. This study provides a foundational path for researchers to explore the adoption of health and public policies at the state level. This study also investigates an unexplored phenomenon and that is the effect of governance structures in health policy. While the findings indicate that there is an association between governance arrangements and states supporting Medicaid expansion, further research will need to be conducted to evaluate the true impact of governance structures on Medicaid expansion decisions in future years. Last, this research has the potential to transform policy making in the area of adoption at the theoretical and policy level. An understanding of drivers of state decisions at the theoretical level will help inform policy and practice. This study identifies state concerns and policy preferences; knowledge of why states make decisions gives researchers and lawmakers the ability to strategically address policy issues and facilitate policy adoption.

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APPENDIX A: POLITICAL MODEL SUMMARY OF STATISTICS

```
. tabulate med_expan, summarize (interparty)
```

Medicaid Expansion	Summary of Inter-party Competition Mean	Std. Dev.	Freq.
Decline	43.124	11.010167	20
Undecided	41.166	9.5834124	15
Support	45.571	10.912816	10
Adopt	56.912	5.3883049	5
Total	44.4048	10.84481	50

```
. summarize interparty
```

Variable	Obs	Mean	Std. Dev.	Min	Max
interparty	50	44.4048	10.84481	22.22	66.08

```
. tabulate med_expan, summarize (aa_voter)
```

Medicaid Expansion	Summary of African-American Voter Mean	Std. Dev.	Freq.
Decline	40.31	31.528849	20
Undecided	36.653333	31.676712	15
Support	36.66	31.750562	10
Adopt	53.78	6.7072347	5
Total	39.83	29.766919	50

```
. summarize aa_voter
```

Variable	Obs	Mean	Std. Dev.	Min	Max
aa_voter	50	39.83	29.76692	0	82

```
. tabulate med_expan, summarize (aa_voter)
```

Medicaid Expansion	Summary of African-American Voter Mean	Std. Dev.	Freq.
Decline	40.31	31.528849	20
Undecided	36.653333	31.676712	15
Support	36.66	31.750562	10
Adopt	53.78	6.7072347	5
Total	39.83	29.766919	50

```
. summarize aa_voter
```

Variable	Obs	Mean	Std. Dev.	Min	Max
aa_voter	50	39.83	29.76692	0	82

```
. tabulate med_expan, summarize (ideology)
```

Medicaid Expansion	Summary of State Ideology Mean	Std. Dev.	Freq.
Decline	19.649185	17.129344	20
Undecided	40.514875	25.511333	15
Support	71.673152	26.026073	10
Adopt	71.284386	17.102958	5
Total	41.477206	30.323478	50

```
. summarize ideology
```

Variable	Obs	Mean	Std. Dev.	Min	Max
ideology	50	41.47721	30.32348	2.580879	91.6323

```
. tabulate med_expan, summarize (governor_powr)
```

Medicaid Expansion	Summary of Governor Institutional Power		
	Mean	Std. Dev.	Freq.
Decline	3.2975	.32463543	20
Undecided	2.9233334	.38446006	15
Support	3.57	.61291656	10
Adopt	3.5400001	.46690465	5
Total	3.264	.48245123	50

```
. summarize governor_powr
```

Variable	Obs	Mean	Std. Dev.	Min	Max
governor_p~r	50	3.264	.4824512	2.3	4.3

APPENDIX B: ECONOMIC MODEL SUMMARY OF STATISTICS

```
. tabulate med_exp, summarize (per_capita)
```

Medicaid Expansion	Summary of Per Capita Income Mean	Std. Dev.	Freq.
Decline	41588.6	5899.0079	20
Undecided	41065.867	5262.57	15
Support	45441.9	6973.8434	10
Adopt	51815.4	6774.7803	5
Total	43225.12	6718.538	50

```
. summarize per_capita
```

Variable	Obs	Mean	Std. Dev.	Min	Max
per_capita	50	43225.12	6718.538	32982	62347

```
. tabulate med_exp, summarize (tax_eff)
```

Medicaid Expansion	Summary of Tax Effort Mean	Std. Dev.	Freq.
Decline	.01295	.01150503	20
Undecided	.00953333	.00839104	15
Support	.0198	.02137912	10
Adopt	.0392	.04260517	5
Total	.01592	.0194431	50

```
. summarize tax_eff
```

Variable	Obs	Mean	Std. Dev.	Min	Max
tax_eff	50	.01592	.0194431	.002	.115

```
. tabulate med_exp, summarize (sb_sf)
```

Medicaid Expansion	Summary of State Budget Shortfall		
	Mean	Std. Dev.	Freq.
Decline	1.41275	2.0701835	20
Undecided	.71493335	1.0501407	15
Support	2.3633	3.3742734	10
Adopt	8.9199999	9.0325521	5
Total	2.14424	4.0331938	50

```
. summarize sb_sf
```

Variable	Obs	Mean	Std. Dev.	Min	Max
sb_sf	50	2.14424	4.033194	0	23.9

```
. tabulate med_exp, summarize (hlt_exp)
```

Medicaid Expansion	Summary of Health Expenditures		
	Mean	Std. Dev.	Freq.
Decline	2.67	2.9558328	20
Undecided	2.1	2.3685439	15
Support	5.2999999	7.7625881	10
Adopt	8.5799999	9.6574838	5
Total	3.616	5.275796	50

```
. summarize hlt_exp
```

Variable	Obs	Mean	Std. Dev.	Min	Max
hlt_exp	50	3.616	5.275796	.3	26.3

```
. tabulate med_exp, summarize (fmap)
```

Medicaid Expansion	Summary of FMAP Rate		
	Mean	Std. Dev.	Freq.
Decline	61.291001	7.2480215	20
Undecided	62.262	7.8423269	15
Support	56.114	7.4795503	10
Adopt	50	0	5
Total	59.4178	7.9626812	50

```
. summarize fmap
```

Variable	Obs	Mean	Std. Dev.	Min	Max
fmap	50	59.4178	7.962681	50	74.18

APPENDIX C: NEEDS-BASED MODEL SUMMARY OF STATISTICS

```
. tabulate med_exp, summarize (spm_pov)
```

Medicaid Expansion	Summary of Supplemental Poverty Rate		
	Mean	Std. Dev.	Freq.
Decline	13.71	3.1748849	20
Undecided	13.36	2.8776974	15
Support	14.53	2.2759857	10
Adopt	14.74	5.4665343	5
Total	13.872	3.1498648	50

```
. summarize spm_pov
```

Variable	Obs	Mean	Std. Dev.	Min	Max
spm_pov	50	13.872	3.149865	8.6	23.8

```
. tabulate med_exp, summarize (elderly)
```

Medicaid Expansion	Summary of Percentage of Elderly		
	Mean	Std. Dev.	Freq.
Decline	13.445	2.2621544	20
Undecided	14.68	1.030395	15
Support	14.44	.87203466	10
Adopt	13.56	1.0114346	5
Total	14.026	1.6842379	50

```
. summarize elderly
```

Variable	Obs	Mean	Std. Dev.	Min	Max
elderly	50	14.026	1.684238	8.5	18.2

```
. tabulate med_exp, summarize (unemployed)
```

Medicaid Expansion	Summary of Percentage of Unemployed		
	Mean	Std. Dev.	Freq.
Decline	6.89	1.6732886	20
Undecided	7.54	1.9093004	15
Support	7.44	1.3785662	10
Adopt	8.3400001	1.7840963	5
Total	7.34	1.7132139	50

```
. summarize unemployed
```

Variable	Obs	Mean	Std. Dev.	Min	Max
unemployed	50	7.34	1.713214	3.1	11.2

```
. tabulate med_exp, summarize (uninsured)
```

Medicaid Expansion	Summary of Percentage of Uninsured		
	Mean	Std. Dev.	Freq.
Decline	14.73	3.8139771	20
Undecided	14.633333	3.6665801	15
Support	10.48	4.2619243	10
Adopt	12.32	3.9625747	5
Total	13.61	4.135375	50

```
. summarize uninsured
```

Variable	Obs	Mean	Std. Dev.	Min	Max
uninsured	50	13.61	4.135375	3.9	22.5

```
. tabulate med_exp, summarize (hlt_stat)
```

Medicaid Expansion	Summary of Health Status		
	Mean	Std. Dev.	Freq.
Decline	.07405	.00858686	20
Undecided	.06906667	.00673442	15
Support	.0756	.00414193	10
Adopt	.078	.00524404	5
Total	.07326	.0074828	50

```
. summarize hlt_stat
```

Variable	Obs	Mean	Std. Dev.	Min	Max
hlt_stat	50	.07326	.0074828	.057	.089

APPENDIX D: STATE CAPACITY SUMMARY OF STATISTICS

```
. tabulate med_exp, summarize (leg_pro)
```

Medicaid Expansion	Summary of Legislative Professionalism		
	Mean	Std. Dev.	Freq.
Decline	.1608	.08089148	20
Undecided	.15413333	.10116667	15
Support	.263	.15946369	10
Adopt	.27439999	.17286496	5
Total	.1906	.12299295	50

```
. summarize leg_pro
```

Variable	Obs	Mean	Std. Dev.	Min	Max
leg_pro	50	.1906	.1229929	.031	.606

```
. tabulate med_exp, summarize (inst_cap)
```

Medicaid Expansion	Summary of Institutional Capacity		
	Mean	Std. Dev.	Freq.
Decline	2.725	.5364356	20
Undecided	2.4516667	.51888159	15
Support	2.53	.48229776	10
Adopt	2.64	.67235594	5
Total	2.5955	.53140386	50

```
. summarize inst_cap
```

Variable	Obs	Mean	Std. Dev.	Min	Max
inst_cap	50	2.5955	.5314039	1.325	3.825

```
. tabulate med_exp, summarize (gov)
```

Medicaid Expansion	Summary of Governance Mean	Std. Dev.	Freq.
Decline	2.5	1	20
Undecided	2.3333333	1.1751393	15
Support	2.9	.99442893	10
Adopt	2	0	5
Total	2.48	1.0149897	50

```
. summarize gov
```

Variable	Obs	Mean	Std. Dev.	Min	Max
gov	50	2.48	1.01499	1	4

```
. tabulate med_exp gov, chi2
```

Medicaid Expansion	Governance Mixed	Decentral	Shared	Centraliz	Total
Decline	2	11	2	5	20
Undecided	4	6	1	4	15
Support	0	5	1	4	10
Adopt	0	5	0	0	5
Total	6	27	4	13	50

Pearson chi2(9) = 9.7400 Pr = 0.372

APPENDIX E: STATE INNOVATION AND DIFFUSION SUMMARY OF STATISTICS

```
. tabulate med_exp, summarize (geo_st)
```

Medicaid Expansion	Summary of Geographic State Mean	Std. Dev.	Freq.
Decline	.04765	.0883702	20
Undecided	.0524	.09945911	15
Support	.115	.1595229	10
Adopt	.2566	.04788319	5
Total	.08344	.12164001	50

```
. summarize geo_st
```

Variable	Obs	Mean	Std. Dev.	Min	Max
geo_st	50	.08344	.12164	0	.4

```
. tabulate med_exp, summarize (st_comp)
```

Medicaid Expansion	Summary of State Competition Mean	Std. Dev.	Freq.
Decline	.4	.50262469	20
Undecided	.46666667	.51639778	15
Support	.4	.51639778	10
Adopt	.4	.54772256	5
Total	.42	.49856938	50

```
. summarize st_comp
```

Variable	Obs	Mean	Std. Dev.	Min	Max
st_comp	50	.42	.4985694	0	1

```
. tabulate med_exp, summarize (p_hist)
```

Medicaid Expansion	Summary of Policy History		
	Mean	Std. Dev.	Freq.
Decline	19.9	4.2040081	20
Undecided	19.8	3.4058773	15
Support	22	1.490712	10
Adopt	24	1.5811388	5
Total	20.7	3.5699997	50

```
. summarize p_hist
```

Variable	Obs	Mean	Std. Dev.	Min	Max
p_hist	50	20.7	3.57	8	27

Tiffany Henley

Curriculum Vitae

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EDUCATION

Old Dominion University Norfolk, VA
Ph.D. in Public Administration and Urban Policy August, 2016
Concentration: Public Policy
Cognate Area: Health Policy
Dissertation Title: *Medicaid Expansion in the United States: A State Comparative Study Examining Factors that Influence State Decision-Making.* Chair: Dr. John C. Morris. (Expected date of graduation, August 2016).

Regent University Virginia Beach, VA
Master's Degree of Arts in Government May, 2011
Concentration: Public Administration
American Government
Certificate: Law and Public Policy

University of Rhode Island Kingston, RI
Bachelor of Arts and Sciences (Cum Laude) May, 2006
Major: Psychology

CURRENT AREAS OF RESEARCH INTEREST

Public Policy
Health Policy
Organizational Theory
Collaboration

RESEARCH EXPERIENCE

Old Dominion University, Norfolk, VA August 2015-Present

Graduate Research Assistant

- Create and maintain data and documentation as needed for academic affairs.
- Develop methodologies for using data analytics tools and manage reporting, visualizations, and statistical graphs to illustrate findings.
- Collaborate with teams and committees to prepare internal reports for the Southern Association of Colleges and Schools Commission on Colleges accreditation requirements.
- Arrange meetings with faculty to understand data opportunities and needs to drive data quality improvement.

- Analyze financial information and report discrepancies to assist in effective business decisions.

Old Dominion University, Norfolk, VA September 2011-May 2015

Graduate Research Assistant

- Edited manuscripts for conferences and publication purposes.
- Conducted literature reviews on corruption and state capture and other research-related activities.
- Assisted advisor on teacher-related duties.
- Prepared handouts and provided supplemental reading material for a doctoral level course PAUP 803 Multivariate Quantitative Analysis for Public Administration.
- Trained students on analyzing, performing, and interpreting statistical techniques using Stata software.

TEACHING EXPERIENCE

Old Dominion University, Norfolk, VA October 2012-December 2014

Guest Lecturer

- Provided a lecture on administrative reform detailing various strategies that the United States has implemented over time.
- Lectured on accountability in nonprofits and engaged the students in an activity that allowed them to evaluate mission statements, fiscal duties, and operating budgets among other items to determine if nonprofits were meeting established best practices.
- Prepared and presented two lectures on public administration theories, public trust, ethics, and the future of public administration.

Old Dominion University, Norfolk, VA January 2013- May 2013

Instructor

- Taught an intermediate-level course on ethics, governance, and accountability online.
- Integrated case studies, wiki assignments, blogs, discussion board posts, and video presentations.
- Effectively encouraged growth and improvement through providing thorough feedback to students (Average enrollment=30).

Old Dominion University, Norfolk, VA September 2012- December 2014

Graduate Teaching Assistant

- Assisted in developing PAS 301: Ethics, governance, and accountability by recording lectures, creating deadlines for assignments, and inputting information in Blackboard.
- Contributed to the development of PAS 410 Public and Nonprofit Organization by creating PowerPoint slides, developing test questions, course objectives, and homework assignments.
- Collaboratively worked with professors to develop and assist in teaching a Masters level online course for PADM 734 Negotiation and Dispute Resolution by organizing and entering the course content in Blackboard and Personal Learning Environment (PLE) and facilitating online interactions with students.

PROFESSIONAL EXPERIENCE

Amerigroup Corporation, Virginia Beach, VA March 2007-August 2011

Care Services Technician II

- Performed telephonic outreach efforts related to the Medicaid population
- Worked closely with members, providers, and community agencies to proactively coordinate and resolve issues involving access to health care services.
- Coordinated, authorized, fulfilled, monitored, and tracked health care services
- Worked collaboratively with departments within the health plans; which include but are not limited to, utilization management and case management.

Virginia Beach Psychiatric Center, Virginia Beach, VA July 2006 – March 2007

Mental Health Counselor

- Provided counseling to adults and children's with serious mental illness.
- Performed technical nursing assignments; taking vital signs, weights, and laboratory specimens.
- Facilitated and monitored therapeutic groups.
- Trained and educated new hires on various policies and procedures on selected units.

Rhode Island Department of Corrections, Cranston, RI September 2005-December 2005

Therapeutic Assistant (Volunteer)

- Co-facilitated therapeutic and education sessions/ groups
- Monitored female offenders while they nurtured their children
- Coordinated meetings, conferences, and morale related events

Perspectives Corporation, Youth and Family Services, Wakefield, RI March 2005– June 2005

Behavioral Specialist

- Worked individually with children on developmental issues and anger management techniques.
- Arranged daily activity schedules for children.
- Monitored behavior and activity by maintaining thorough records and worksheets.
- Independently supervised and taught social skills to youth.

CONFERENCE PRESENTATIONS

Henley, T. (October, 2013). *Citizen Perceptions: Do they Influence the Economic Condition?* Paper presented at the annual conference of the Southeastern Conference for Public Administration (SECoPA), Coral Springs, FL.

Henley, T., & Miller-Stevens, K. (November, 2013). *The Massachusetts Health Connector: A Trailblazer in the Transformation of Healthcare Reform.* Paper presented at the annual conference of the Northeastern Political Science Association (NPSA), Philadelphia, PA.

Henley, T. (April, 2014). *An Exploration and Emancipation for Workplace Complexity: Delving in the Lives of Nonprofit Employees.* Paper presented at the annual conference of the Midwest Political Science Association (MPSA), Chicago, IL.

Henley, T. (October, 2014). *Value-Based Services: Is it Achievable, Operational, or Practical.* Paper presented at the annual conference Southeastern Conference for Public Administration (SECoPA), Atlanta, GA.

Henley, T. (October, 2015). *Health Care Policy from a Public Administration Perspective.* Poster presented at Commonwealth Graduate Education Day, Richmond, VA.

Henley, T. (April, 2016). *Health Care Policy from a Public Administration Perspective.* Invited poster presentation at Old Dominion University Graduate Research Achievement Day, Norfolk, VA.

PUBLISHED WORKS

Book Chapter

Miller-Stevens, K., Henley, T.*, & Diaz-Kope, L.* (2015). A new model of collaborative federalism through a governance perspective. In J.C. Morris & K. Miller-Stevens (Eds.) *Advancing collaboration theory: New models and typologies*. London, UK: Routledge Publishing.

Peer-Reviewed Publication

Henley, T., & Boshier, M. (2015). The future of health care services for Native Americans in the United States: An analysis of policy options using a multiple streams approach. *Journal of Health Economics, Policy and Law*, available on CJO2016. Doi: 10.1017/S1744133116000141.

ACKNOWLEDGMENT

Morris, J.C., & Miller-Stevens, K. (2015). *Advancing collaboration theory: New models and typologies*. (Eds.). London, UK: Routledge Publishing.

RESEARCH AND MANUSCRIPTS IN PROGRESS

Henley, T. *Value-based services: Is it achievable, operational, or practical*.

Henley, T. & De Leo, G. *Early-stage prostate cancer: Proceed with caution*.

Henley, T. *Collaboration meets accountable care organizations: Developing a framework for mental health collaboratives*.

Henley, T & Miller-Stevens, K. *An exploration and emancipation of workplace complexity: Delving into the lives of nonprofit employees*.

GRANT AWARDED

Co-Principal Investigators: Gordon, SB., Klinger, R., Henley, T., Cotterrell, P, Mengistu, M. (September 2015). *Stakeholder Perspectives of the Needed and Actual Competencies, Values,*

and Attitudes of City and County Government Procurement Officials. Funded by NIGP, $20,000.

CERTIFICATES

Foundational Strategies for Effective Online Teaching, 2014
Preparing Future Faculty, On-going

HONORS/ACTIVITIES

- Member, Phi Kappa Phi Honor Society, Present
- Member, Pi Alpha Alpha Honor Society, Present
- Member, Political Science Association
- Member, American Society for Public Administration
- Member, Onyx Senior Honor Society, Present
- Faculty Summer Institute Workshop on Diversity, 2016
- Panelist, Commonwealth Graduate Education Day, 2015
- Faculty Summer Institute Workshop on Teaching and Learning, 2013
- President, Public Administration and Urban Policy Ph.D. Student Organization, 2012-2013
- Panelist, New Graduate Student Orientation, 2012
- Vice President, Public Administration and Urban Policy Ph.D. Student Organization, 2011
- Student Alumni Ambassador, 2011
- Volunteer, Amerigroup Real Caring Volunteers, 2007-2011
- Volunteer, Women Helping Women, Present
- Dean's Marshall, 2010
- Bachelor of Arts, Cum Laude, 2006
- Education Chair, National Association for the Advancement of Colored People, 2006
- Recipient, Academic Achievement Award, American International College, 2003