The Politics of Discretionary Medicaid Spending, 1980-1993

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Abstract Why do some states choose to spend more than four times as much as others to provide health care to the disadvantaged? Political scientists who have traditionally explored this question by analyzing trends in overall Medicaid expenditures lumped states' discretionary spending in with other money that states are mandated to spend. Analyses of total expenditures found that socioeconomic factors drove spending but that party control of state legislatures made no difference in health policy making.

By isolating discretionary state Medicaid expenditues from total spending figures, I reexamine the influences of political as well as economic and demographic factors. The often-doubted importance of party control becomes clear. This study investigates spending patterns in the discretionary portions of state Medicaid programs in forty-six states from 1980 to 1993 and analyzes both incremental program changes and absolute differences in state spending. To discover how greatly the researcher's choice of dependent variables can affect results, optional spending is separated from total spending levels and the variation is modeled in both.

Focusing not on the spending that the federal government requires of state officials but on the policies that state officials actually choose allows a balanced exploration of both political and economic effects on welfare expenditures. This research also provides new insights about which forces will shape policy decisions if more and more control of the public health care system is devolved to the states.

How do political factors and socioeconomic conditions combine to influence state Medicaid spending decisions? Intuitively, it seems quite likely that parties, interest groups, and legislative regulations would play a pri-

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mary role in setting expenditures for the nation's largest welfare program.[1] Many early state policy scholars (Key 1949; Lockard 1959; Fenton 1966) attributed great importance to political factors—especially party structures—in determining levels of social service provision. Those who are directly involved in the Medicaid policy-making process, such as state representative Phil Pankey (R-COL), testify that "there is no question that it is 100 percent partisan."[2] However, when political scientists first began using quantitative tools in the 1960s to analyze patterns in Aid to Families with Dependent Children (AFDC) and Medicaid outlays, their new methods yielded a counterintuitive result.

In their examinations of welfare expenditures, Richard Dawson and James Robinson (1963), Thomas Dye (1966), Richard Hofferbert (1966), and Richard Winters (1976) each concluded that the economic and demographic conditions present in a state determine its level of spending and that party control has little effect. Under this view, state officials act as politically neutral bureaucrats in their administration of social service programs. Except for Colleen Grogan (1994, 1996), all of the more recent efforts to model variation in Medicaid expenditures (Barrilleaux and Miller 1988; Schneider 1988; Kronebusch 1993; and Camobreco 1996) likewise found no significant effects for party control.

What can explain this inconsistency between commonsense theorizing and empirical evidence? Are the observations of experienced state policy makers mistaken, or are the quantitative investigations flawed? This study argues that political scientists have trained their statistical lenses on an object that state officials might not entirely recognize: an amalgam of federally mandated and state chosen expenditures. Recent attempts to model patterns in Medicaid spending missed out on some of the strongest effects of political factors because they analyzed a dependent variable over which state politicians have incomplete control. Most of the previous scholarship has not differentiated between the portion of state expenditures that is mandated by the federal government and that which is authorized by state politicians themselves. No distinction, in other words, is made between mandatory and optional Medicaid payments.[3]

1. While the sums of money involved in the Medicare and Social Security programs are larger, yearly Medicaid expenditures are far greater than spending for the programs usually described as "welfare" (AFDC, food stamps, unemployment insurance, and public housing). For spending comparisons over the period of this study, see U.S. Bureau of the Census (1995: 375).

2. Phil Pankey, Republican caucus chair and former chair of the Health, Education, Welfare and Institutions Committee, interview by author, tape recording, Denver, 15 August 1995.

3. Grogan (1994) presents models of estimated discretionary spending. Yet because of the possible flaws in her analysis (discussed below in note 8), there remains a need for properly computed regressions on actual discretionary spending to confirm the influence of party control on Medicaid policy.

This article presents a model of variation in each state's *discretionary* spending. Using data from forty-six states in the years 1980–1993,[4] I separate optional payments from the outlays that states are forced to make. I compute regressions of both optional and total spending to show that the factors that drive generous discretionary spending differ from those that affect the overall program size figures generally studied by previous scholars. Analysis of this new dependent variable leads to three main conclusions that sharpen the findings of other quantitative works:

Analyzing Discretionary Rather Than Total Spending Focuses Studies on the Decisions of State Officials. The scholar's choice of dependent variables when studying federal and state programs has great importance. In the models presented here, political effects are masked when patterns in mandatory and discretionary spending are analyzed together. Yet in regressions computed with optional expenditures as the dependent variable, the impacts of political variables and especially party control can be seen. Students of state policy must consciously decide whether they wish to explain decisions made in state capitols or spending directions coming from Washington, D.C., and choose their dependent variables accordingly.[5]

State Politics Matters in Medicaid. At the state level, spending decisions are not made solely by bureaucrats responding to federal mandates but also by elected officials who are given considerable freedom to craft their own policies. Throughout the 1980s, Congress[6] granted the states more and more options in deciding who to cover and what services to offer in their Medicaid programs. Consequently, there is great variation among states, much of which can be explained by political factors. A comparison of the effects of economic, demographic, and political vari-

4. For different reasons, I have chosen to exclude four states from my study. Arizona did not have a Medicaid program until 1982, and since then its system has operated under a federal waiver for its unique capitated payment system. Hawaii's universal health care network distorts its Medicaid spending figures. Nebraska's unicameral, nonpartisan legislature makes measuring political conditions there difficult, and Alaska's disproportionately youthful and male population makes it a demographic anomaly.

5. Similarly, Camobreco (1996) illustrates the importance of dependent variable choice in his analysis of the role of interest groups in Medicaid spending. He shows that when total expenditures are disaggregated into outlays for Medicaid recipients who live primarily in nursing homes and spending on those served by physicians, the effects of different types of interest groups can be examined.

6. Because Democratic-controlled Congresses in the 1980s gave states the opportunity to expand their Medicaid programs, and because Lyndon Johnson's 1965 Congress established a "matching rate" system (see independent variables section) that encouraged greater discretionary spending, there exist national-level party control effects in addition to the state-level effects that I find here. It is beyond the scope of this article to quantitatively model the national effects.

ables reveals that political factors play an important role in explaining state spending variation.

Party Control Strongly Influences Levels of State Optional Expenditures. States with Democratic-controlled legislatures tend to fund their programs more generously than those with Republicans in charge. Because party control of the governorship exerts little influence in my models, divided state governments do not appear to differ greatly from unified ones in their Medicaid policies. The effects of party control are statistically significant across the country, regardless of the "partisan cleavage type" that may split the parties (Brown 1995).

This article begins with a brief survey of the relevant literature on state AFDC and Medicaid provision, followed by a more complete description of my generosity measure. I then introduce the independent variables that I used in my regressions—classified as economic, demographic, or political factors—and set forth hypotheses about their affects and the theories behind these expectations. The fourth section outlines the two basic models and explains the statistical methods employed. Next come the results from a pair of panel regressions on forty-six states through fourteen years as well as cross-sectional regressions that seek to explain optional and total spending levels during 1992. After examining these results in some depth, I consider their implications for academic models of state policy making as well as the policy implications for future health care initiatives.

Context

In such fields as fiscal policy (Hibbs 1987) and civil rights (Carmines and Stimson 1989), the impact of party control has been clearly demonstrated. Yet the effect of parties on state social service programs, especially Medicaid, is not so uniformly accepted. In their 1951 discussion of education, welfare, and health policies, William Anderson and Edward Weidner wrote that "it should be obvious that public policy in these areas is not automatically formulated in the legislature and coldly and impartially administered in various state and local agencies. Social policy is formulated by public opinion, pressure groups, legislative bodies, administrative agencies, and clientele groups, to mention only a few." Many other early scholars also observed the impact of such political variables on social service provision. V. O. Key (1949) and Duane Lockard (1959) linked higher levels of interparty competition to greater welfare spend-

ing, with John Fenton (1966) later using statistical evidence to defend their plausible claims.

However, the first sophisticated empirical studies of welfare policy argued that socioeconomic environments, rather than political factors, determine spending levels. These studies analyzed variation in total program sizes or support levels in each state. Generally, they did not separate the portions of programs over which state officials exercised discretion from spending mandated by the federal government. This was a critical measurement choice because in many program areas changes in such demographic factors as poverty rates, the number of female-headed households, and the age of the population automatically swelled mandatory expenditures. The size of discretionary spending, by contrast, could be driven by political choices in addition to demographic trends. Once state officials chose to cover a new group of recipients or provide a higher level of support, socioeconomic shifts influenced the costs of these actions. In their initial decisions, however, state policy makers were not bounded by demographics. The importance of the political factors that may have driven their decisions was lost in studies that lumped together discretionary and mandatory spending.

Using rank order correlations to analyze welfare orientation, Richard Hofferbert (1966) found "no significant relationship" between "the party in power and public policy." This claim is by no means radical compared to those made in other contemporary works. Dye (1966: 293) concluded that "Differences in the policy choices of states with different types of political systems turn out to be largely a product of differing socioeconomic levels rather than a direct product of political variables." Winters (1976: 629) argued that, in state governments, party control makes "little or no difference" in explaining how tax burdens and spending benefits are distributed.

More recent studies of welfare policy making have offered quantitative refinements that illustrate the strong impact of legislative party control on welfare outlays. Robert Brown (1995) groups states by the type of partisan cleavages over which parties compete (New Deal, post-New Deal, or southern) to show where party control can affect state spending. Mark Smith (1997) uses a continuous measure of party control to show that Democratic Party strength leads to expansive cash assistance programs. Debate over the role of parties in state social service policy making, however, is far from resolved. While Robert Erikson, Gerald Wright, and John McIver (1993) and Charles Barrilleaux (1997) find significant

effects of party control on an index of state policy liberalism, Democratic legislative strength paradoxically leads to less liberal policy outputs.

Though efforts at modeling the variation in Medicaid spending have taken both a political and an economic approach, they have not credited parties with great influence. Russell Hanson (1984) found no significant effects of party control on the scope of Medicaid programs. Democratic control of the governorship or of either house has no statistically significant impact on the number of total recipients or payments per recipient in the work of Karl Kronebusch (1993), although party control did appear to affect coverage of adults receiving AFDC.[7] Robert Plotnick and Richard Winters found an insignificant positive coefficient for liberal party control in their often-cited 1985 study of welfare guarantees. Their 1990 model, in contrast, yields significant negative effects for Democratic control of state senates. Such surprising findings suggesting that Democratic politicians prefer lower social spending levels most likely reflect the conservatism of southern Democrats.

So discounted has been the role of party in Medicaid decision making that neither Barrilleaux and Mark Miller (1988) nor Saundra Schneider (1988) includes any measure of party control in their analyses of program expenditures. They do, however, look at other political factors, such as interest group power, state ideology, and the level of government (state or county) that administers the program. Marian Lief Palley (1997) credits interest groups with maintaining the federal government's regulatory role in health policy, and Camobreco (1996) shows that these groups are powerful and act independently of one another. By contrast, only Grogan (1994, 1996) finds significant effects of party control variables, which explain variation only in estimates of benefit coverage (but not in recipient coverage). This article builds on her approach, using a dependent variable built from actual spending figures to offer more reliable and generalizable findings.[8]

7. This study breaks down the Medicaid program by many demographic groups. I am grateful to Professor Kronebusch for providing me with 1980–1990 data on state incomes; federal matching rates; minority, elderly, and young population percentages; numbers of female-headed households; gross national product; and the item veto.

8. Although her study makes a significant improvement on the existing Medicaid literature, it does not represent the final word on the subject for a number of reasons. The coefficient of Grogan's party control variable on service generosity is 1.7 times its standard error, an effect that is statistically significant only when a one-tailed test is employed. More important, Grogan's estimates of service generosity and spending on optional programs are extrapolations from Minnesota data. Because Minnesota devotes most of its optional expenditures to its medically needy program, the figures on how much it spends for other optional groups appear to be too small and unreliable to be used in making national estimates. Also, Grogan uses the timewise autoregressive model suggested by Kmenta (1986) to compute her regressions. Beck and Katz (1995) show

Disaggregating Mandatory and Discretionary Spending

Some state programs are large because demographic conditions compel them to be; others are big because politicians want them to be. The central claim of this research is that the effects of party control are revealed when the discretionary component of state spending is separated from the mandatory component. The approach used here, then, is to analyze Medicaid spending on optional recipients rather than the raw policy output of total spending.

Patterns of discretionary expenditures for optional recipients can differ greatly from those for total outlays. In fact, there are two ways in which states could have more generous[9] discretionary Medicaid spending: by expanding their pool of recipients or by offering more services to each enrollee. This article explores why states broaden eligibility. Although an examination of what causes policy makers to offer extra services is equally important, finding a reliable measure of service generosity proves quite difficult. States report only the number of optional services that they offer, not the dollars that they spend on these program enhancements. Since some services have a price tag many times greater than that of others,[10] a simple count of how many of the thirty-three optional services a state chooses to cover is a poor measure of generosity. Russell Hanson (1984) and Thad Kousser (1996) both attempt to analyze discretionary service provision, but the focus here is on the cost of covering extra recipients.

Since the inception of the Medicaid program in 1965, the federal gov-

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that this method very often underestimates standard errors, thus giving researchers too much confidence in the significance of their coefficients. Because some of the coefficients that Grogan reports are as much as twenty times the size of their standard errors, we should view her findings on the influence of party control with caution. For further discussion, see Kmenta (1986) and Beck and Katz (1995).

9. *Generous* is a value-laden word, and its usage here is not meant to imply that greater Medicaid generosity is better public policy. Using terms like *fiscally irresponsible* and *liberal* would be no less contestable. A more generous state, as the term is used here, is one that chooses to devote more of its scarce funds toward providing Medicaid coverage beyond what the federal government mandates.

10. The cost of the most expensive services, like transportation and dental care, dwarf the expense of providing ones like TB-related care and Christian Science nurses. A variable that weighs all of these services equally, then, can distort patterns in state spending. I created (but do not report here) an index of estimated costs by using the relative prices of the services that California provided in 1994. Perhaps because California does not cover certain key services, this index appeared unreliable and models of its variation yielded significant coefficients for only four independent variables.

ernment has mandated that all states provide benefits to certain categories of individuals. Over the period of this study, states were required to cover all citizens who qualified for AFDC.[11] States must also cover citizen recipients of Supplemental Security Income (SSI: aged, blind, and disabled citizens) as well as pregnant women and children up to age six in families earning less than 133 1/3 percent of the federal poverty line. All children under nineteen born into families below the poverty line are scheduled to be covered by 2002 (HCFA 1995b: 3). Even though states can soften the fiscal blow of these mandates by paying low reimbursement rates to providers or by keeping their AFDC programs as small as possible, the federal requirements impose significant costs. Altogether, spending on mandatory recipients averaged 52.2 percent of state Medicaid outlays a year in the period 1980–1993.

Beyond this basic set of recipients, state officials have been able to choose to cover individuals in a number of other groups. They can include pregnant women and infants in families making between 133.3 percent and 185 percent of the federal poverty line, institutionalized individuals, adopted children with special medical needs, disabled children, and others (HCFA 1993: 43). They can also cover the "medically needy": people who qualify for the program because their health care bills use up so much of their income. By 1993, thirty-six states accepted federal matching funds to take on this costly option.

Table 1 breaks down spending figures from the Health Care Financing Administration's (HCFA) form 2082 from fiscal years 1979 to 1993.[12] In the early 1980s, just over half of state and federal outlays went to

11. Since the 1996 federal welfare reform enacted in H.R. 3734, states have been required to cover anyone who would have qualified for AFDC under the state's welfare program as of July 1996.

12. The HCFA tables used to generate this information, HCFA 2082 Table 7 until 1988 and HCFA 2082 Table 9 thereafter, list Medicaid medical vendor payments by maintenance assistance status and by region and state. The figure for mandatory recipients comes from the column of "categorically needy" recipients receiving cash payment plus those covered by post-1988 congressional mandates. Thus, it slightly underestimates mandatory spending because it does not include outlays for pregnant women and children who meet the state's AFDC financial requirements, have incomes below 133 percent of the federal poverty line, but do not receive cash payments. It also misses persons who lose welfare payments due to increased earnings but keep Medicaid benefits for a limited time. The measure of expenditures for the medically needy comes from a column in the table of the same name. Spending on other optional recipients is the sum of vendor payments for categorically needy recipients not receiving cash payments and individuals given other coverage allowed by laws passed by Congress before 1988. I am grateful to George Ghilani at the HCFA regional office in Boston and to Anthony Parker of the Information Processing Branch at HCFA's Baltimore offices for helping me to locate these statistics.

Table 1 Spending on Optional and Mandatory Recipients over Time

Time Period	Percentage Spent on Mandatory Recipients	Percentage Spent on Optional Recipients	
		Medically Needy	Other Optionals
1979–1984	53.3	28.1	18.6
1985–1989	50.8	26.8	22.4
1990–1993	52.1	20.0	28.0

cover mandatory recipients. The bulk of dollars going to care for optional recipients at this time went to the medically needy, expensive patients who are often cared for in nursing homes. As Congress began to offer states more and more opportunities to cover poor women and children during the late 1980s, the balance of optional spending switched to favor these groups. The percentage spent on mandatory recipients also slipped toward 50 percent in the early 1990s.

One flaw, though probably not a fatal one, that is present in the use of payments on optional recipients is the variable's inability to reflect the relative generosity of state AFDC programs. States required to provide Medicaid to all of their AFDC recipients can trim the mandatory portion of their Medicaid rolls by trimming their welfare rolls. In this sense, they exert some discretion over the spending category that is labeled here as mandatory. Brown (1995) and Smith (1997) demonstrate that political variables drive AFDC eligibility. Yet even though the mandatory spending figures employed here may be "polluted" by other discretionary policy choices, this will not bias my analysis of optional Medicaid spending. Regressions indicating that political variables explain variation in optional expenditures show that state politics affects Medicaid spending over and above its impact on AFDC eligibility.

Consequently, I use data from each state and each year that retain the mandatory/optional distinction in Table 1. Dividing by the total state population, I transformed all of these values into per capita spending levels that reflect Medicaid effort independent of a state's size. Also, to make them comparable from year to year and from state to state, I have converted the numbers into 1982–1984 dollars and deflated them by an index of the regional consumer price index.[13] I use this deflator instead of

13. Because the purchasing power of a dollar varies significantly between the Northeast, Midwest, South, and West, I have adjusted all variables in my model that take dollar values by the overall consumer price index in these four regions. Although the deflating rate for medical consumer price index was also available, I chose not to use this rate because of the political

a medical price index because the focus of this study is on state budgeting choices rather than how much medical care states are able to provide (U.S. Bureau of the Census 1994: Table 750). Considerable variation exists even in these standardized figures. Optional expenditures in 1992 for New York, the most generous state, were six times as high as those in frugal Colorado (a ratio 50 percent larger than the four-to-one difference in total outlays between New York and Utah).

Why might patterns in optional expenditures differ systematically from trends in the amount of money that a state is required to spend on Medicaid? The number of mandatory recipients who must be covered increases when welfare and SSI rolls swell. This means that in states with disproportionately large numbers of poor families, female-headed households, and children or senior citizens demographic conditions automatically boost mandatory expenditures. Once states have elected to cover groups of optional recipients, socioeconomic trends will affect their discretionary spending levels (unless they retrench). But in their initial decisions about how far to extend their Medicaid programs, state politicians are not bound by demographics. They are free to let the efforts of lobbyists, public sentiment, and their own ideologies affect optional expenditures.

Consequently, the hypothesis presented below is that political variables will play a critical role in predicting state discretionary spending levels. Economic and demographic conditions will also be significant causal factors, since state policy cannot be made in a vacuum. However, they will not overwhelm the impact of political variables here as they have in the total spending models prevalent in the literature.

The period of this study traces the growth in spending on optional recipients from $9.2 billion a year (44.9 percent of the total budget) to a level of generosity that cost the states and the federal government $47.2 billion annually (46.3 percent) (HCFA 1993). It also covers great variation in the fiscal conditions and intergovernmental contexts that state policy makers faced. During the early 1980s, Congress gave states the flexibility to control skyrocketing Medicaid costs (that grew an average of

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focus of this study. I did not wish to measure how many medical services a state buys with its expenditures but how much money it takes out of its budget. Policy makers must focus on the trade-off between, for example, one dollar of spending on health and one dollar of spending on schools. Because budget writers compare the financial needs of Medicaid with those of other state programs, expenditure levels in all sectors should be deflated by the overall consumer price index. For a more complete discussion, see Alt and Chrystal (1983: 188).

17.3 percent a year over the 1970s), allowing states to reduce spending growth to an annual 7.2 percent from 1982 to 1984 (Congressional Research Service 1993). Declining inflation aided the cause greatly. With the costs of this entitlement somewhat contained, state leaders had more freedom to reveal their true spending priorities through their budgets. They could choose to be generous with the optional portions of their Medicaid programs or choose to spend discretionary funds on other programs or on tax cuts.

Later in the decade, however, Medicaid growth again climbed into double digits not merely through economic forces but because of federal mandates: Congress added services and/or enlarged eligibility every year from 1984 to 1991 (Congressional Research Service 1993; Coughlin, Ku, and Holahan 1994). Medicaid was termed the Pac-Man of state budgets and compared by Governor Zell Miller to Georgia's quick-spreading kudzu plant (Weissert 1992). At the same time that it helped health care costs eat up state budgets, federal legislation offered matching grants to states electing to expand their coverage to poor women and children who did not receive AFDC. The new recipient categories created by Omnibus Budget Reconciliation Acts in 1986, 1987, 1989, and 1990 eroded the link between Medicaid and other welfare programs. States had more freedom than ever to adopt generous health care plans, but the costs of such expansions would be higher than ever.

Over the first portion of this study, states saw the costs of health care provision stabilize, but their options for expanding coverage were limited by federal law. When Congress began to open up greater opportunities for generosity in the second half of the period, inflating program costs brought by federal mandates made these expansions politically expensive. Of course, the two recessions that plagued the United States over this period also dictated higher Medicaid spending as unemployment shot up in 1982 and 1991. Overall, the economic and demographic trends from 1980 to 1993, combined with changes in intergovernmental incentives, make these excellent years to test the effects of such variables on Medicaid generosity. I did not model optional spending after 1993 because the expansion of Medicaid to a much broader population through managed care plans in many states,[14] federal welfare reform in 1996, and the State

14. By 1995, federal waivers had allowed twenty-four states to force some of their Medicaid recipients into managed care plans. Since these moves lowered per-recipients costs in nearly half the states, my measure of spending on optional recipients becomes a less accurate index of comparative generosity in the mid-1990s. Fourteen of these states also expanded their coverage to the working poor, who often had to pay sliding-scale premiums, transforming Medicaid from

Children's Health Insurance Program have changed the program's financing and politics drastically.

Independent Variables

In order to introduce the variables used in this analysis, this section groups them into three categories: political, economic, and demographic. Table 2 provides descriptive statistics about each potential explanatory factor along with predictions about how they might affect both optional and total spending.

Political Variables

Party control. I use a dichotomous variable to capture party control of the legislative branch. The theory behind this approach is that because so much of Medicaid policy is made in various health and fiscal committees, it is critical to know which party has more than 50 percent of the seats in a house and thus control of committee appointments. Although the power of committee chairs and the extent to which these bodies are dominated by the majority party vary across states, I hypothesize that committees are important enough to give the party that controls them control over Medicaid policy.

Several works on welfare liberalism have examined a slightly different concept. Winters (1976); Plotnick and Winters (1985); and Erikson, Wright, and McIver (1989, 1993) analyze party strength—a continuous measure of the percentage of legislative seats held. Mark Smith (1997) shows that party strength exerts a stronger effect on variation in cash assistance per capita than does a dichotomous party control variable. In the relatively narrow health policy realm, however, I hypothesize that party control will drive policy. To test my theory that controlling more than 50 percent of legislative seats is the "magic number" for Medicaid policy making, I computed models with the measures of party control and strength used by Smith (1997). A dichotomous measure of party control, in fact, had the most significant effects.

Consequently, in the models presented below, "Republican control of

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a narrow social service benefit to a wider state-sponsored insurance program. Beamer (1999) describes managed care Medicaid politics as a move from providing a particular benefit to a production of public goods, while Kousser (1996) argues that political parties produced different types of managed care transitions to reach their differing policy goals.

Table 2 Independent Variables and Their Predicted Effects

			Regressions on Optional Payments		Regressions on Total Payments	
Variable Name (or Type)	Mean	Standard Deviation	Sign	Strength	Sign	Strength
Economic						
Income ($1000s)	$12.456	$2.120	+	strong	+	moderate
Federal match	60.57 %	8.77%	+	strong	+	weak
Demographic						
Female head of household	3.895	0.741	+	moderate	+	strong
Poverty rate	13.86%	4.17%	+	weak	+	strong
Young	26.94%	2.53%	+	moderate	+	moderate
Elderly	12.10%	1.87%	+	weak	+	moderate
Minority	14.74%	11.02%	–	strong	–	moderate
Political						
Rep. control of legislature	0.20	0.40	–	strong	–	weak
Rep. governor	0.42	0.49	–	strong	–	moderate
State ideology	0.151	0.084	–	weak	–	weak
Tax effort ($1000s)	0.757	0.242	+	strong	+	moderate
Item veto	0.848	0.359	–	strong	–	moderate
Doctors' lobby	0.804	0.825	+	moderate	+	weak
Medical lobby	0.522	0.745	+	moderate	+	weak
AARP members	0.0805	0.0136	+	moderate	+	weak
AHA members	0.000027	0.000014	+	moderate	+	weak
Control						
National wealth ($1000s)	$18.349	$4.025	+	strong	+	moderate
Northeast	0.43	0.50	+	strong	+	strong
(ln) lagged optional $s	4.16	0.63	+	very strong	n/a	n/a
(ln) lagged total $s	4.90	0.45	n/a	n/a	+	very strong

the legislature" registers a 1 when the Republican Party holds a majority in both the lower and upper houses and 0 otherwise. I also look at control of the executive branch with a similarly constructed variable, "Republican control of the governorship." Including separate measures of executive and legislative party control allows independent tests of each branch's impact on Medicaid policy. Their relative influence can be compared. Possible gridlock effects of divided government will also become clear if the governor's party affiliation matters, holding party control of the legislature constant (and vice versa).

I expect Republican control of each branch to hold down Medicaid spending, controlling for other factors. According to interviews with more than forty elected officials, legislative staff members, bureaucrats, and lobbyists involved in Medicaid policy making,[15] Democratic politicians in western states seek to expand health care programs for the poor because of their ideological beliefs and because such expansions benefit their core constituencies. This trend may vary with the region, however. Specifically, conservative Democrats in the South may be no more liberal than Republican leaders in other states.[16] I investigate this possibility in my regressions below by including a regional control variable that will counteract this effect. Regardless, the effects of party control should be seen most clearly in the regressions on optional payments, although they may be obscured in the analysis of total program size as they have been in the past.

Tax effort. To measure each state's overall level of taxation, I include state general fund revenues (reported in per capita 1982–1984 dollars and deflated by the regional consumer price index). Because my regressions also include state income levels, this variable captures the amount of money that a state has collected from its citizens, holding their wealth constant. Tax effort, then, measures the size of the budgetary "pie" that

15. These interviews were conducted by the author in California, Arizona, New Mexico, and Colorado during July and August 1995. States were sampled to create maximum variation in the party control of legislative and executive branches, and interview participants were selected using a snowball sampling scheme.

16. Studies of congressional voting from an earlier era provide mixed evidence on whether conservative Democrats in the South are likely to be conservative on providing health care for the indigent. In their analysis of roll call votes from 1933 to 1950, Ira Katznelson, Kim Geiger, and Daniel Kryder (1993) find that southern Democrats defect from their party colleagues on civil rights and labor issues but not on welfare and economic redistribution votes. Barbara Sinclair (1978) finds that southern Democrats were highly supportive of an activist federal government until 1945–1946, when their support for social welfare programs collapsed into massive defection.

elected officials give themselves to allocate, and party control influences the size of the slice of this pie that they choose to spend on Medicaid.

Public ideology. Independent of partisan control, the opinions of voters on political issues may influence health care policy. Politicians concerned about their chances for reelection or those genuinely striving to represent the "voice of the people," the traditional theory goes, will react to public ideology regardless of their party affiliation. An ideal measure of ideology would poll public opinion specifically on health care provision to the poor. Unfortunately, no such measure is available across all states. To gauge state-level ideology, then, I use the weighted estimate reported by Wright, Erikson, and McIver (1985), which ranks states on a scale of 0 (extremely liberal) to 0.4 (extremely conservative).

I strongly doubt, however, that public opinion plays a large role in the making of state health policy, controlling for overall state spending. Medicaid is not the type of high-profile political issue that will make or break elections, and indeed few American voters are even aware of which optional eligibility groups or services their state governments fund. The sector of the public most likely to be knowledgeable about Medicaid—the recipients themselves—are by definition poor and thus in a demographic group that votes at relatively low rates (Rosenstone and Wolfinger 1980: 34). Policy makers will not, therefore, be able to alter their electoral fortunes by taking a certain position on Medicaid, and the Wright, Erickson, and McIver measure should have only a weak effect.

Item veto. State constitutions that grant their governors the power of the item veto do so primarily to allow the executive to line out wasteful portions of spending programs written in by legislators. From this logic, it follows that the presence of an item veto should lead to lower Medicaid expenditures as thrifty governors cut the "fat" out of health programs. Beth Capell of the California Nurses Association contends that "the item veto means that we have no iron triangles in this town. A legislative committee can't do a sweet deal with the bureaucracy and jack up their budget and survive an item veto."[17] Though the costs of expanding Medicaid make it an unlikely candidate for sweet deals, some of this logic may be at work here. The effects of an item veto on optional spending can provide a partial test of Capell's claim. Because an item veto is an effec-

17. Beth Capell, director of government relations, California Nurses Association, interview by author, tape recording, Sacramento, CA, 14 July 1995.

tive tool for trimming discretionary state spending, I expect its presence to have a strong negative effect on Medicaid generosity. While only seven of the forty-six states in this study lack an item veto, constraining variation in this factor, its effects may still be significant.

Interest group power. While the general public may not be particularly well informed or concerned about Medicaid policy, there are many organized groups that care greatly about it. A lobbyist's power is derived from both a reputation as an honest and informed adviser and the strength of the organization that is represented. This suggests that I use two separate variables to capture the strength of a particular interest group. The best available proxy for reputation and personal relationships is a classification of state lobbying organizations on the basis of their effectiveness, found in Ronald Hrebenar and Clive Thomas's work (1987, 1992, 1993a, 1993b). These works report the most influential lobbying groups in each state and list major interest groups whose power is waxing or waning. Since lobbyists must compete with one another for the ear of policy makers, these *relative* rankings provide a reliable basis for a cross-state comparison of the *absolute* strength of interest groups.

I focused on groups representing doctors, senior citizens or medical industry companies and created three categories, "0, 1, 2." If one of these organizations showed up as one of the most influential groups in a state, I coded it as a "2." I assigned a "1" to the group if its power was moderate (categorized as increasing or decreasing), and a "0" if it did not appear on the list.[18] Because seniors, doctors, and the medical industry all benefit from more generous Medicaid programs,[19] each of these variables should have a positive coefficient. To capture the boost in a lobbyist's power supplied by a strong grassroots network, I include three separate variables. I expect increases in the number of members of the American Association of Retired Persons, the American Medical Asso-

18. Because Hrebenar and Thomas base their classifications on demonstrations of lobbyist influence that occurred only in the early years of my dataset, I am not particularly concerned that this variable is in some cases a measure of what I am attempting to test (the effect of interest group influence on policy).

19. It is quite possible that interest groups advocate only types of spending that specifically benefit them. Analysis of estimates of each state's generosity in providing optional services (Kousser 1996) shows that states with the most hospitals per capita provide fewer services, ceteris paribus. The explanation for this striking result, which suggests that hospitals oppose service expansion, seems straightforward. The coverage of services like prescription drugs, prosthetic devices, dental care, medical transportation, and case management by Medicaid brings no money into the coffers of hospitals. In fact, these services may replace those offered in hospitals or use up scarce resources in a program's operating budget. Consequently, it may be in the interests of hospital association lobbyists to oppose expansion of services.

ciation, and the American Hospital Association members per capita each to bring a rise in optional Medicaid expenditures.

Economic Variables

Per capita income. States in which residents make higher salaries have more funds to devote to social programs than do states with poorer citizens, even if their tax structures are identical. To capture this effect, I use per capita incomes adjusted by the regional consumer price index and stated in 1982–1984 dollars (U.S. Bureau of the Census 1994). I hypothesize that increases in adjusted per capita incomes will lead to significantly higher levels of spending on optional Medicaid recipients and services, holding constant the size of the state's budget. Because state officials have little control over spending on mandatory recipients, however, total payments will not respond as much to income variation. Although two related measures, poverty rates and tax revenues, are also included in my models, each captures a conceptually and empirically distinct factor.[20]

Federal matching rate. States receive federal money to match the funds that they spend on health care for the indigent, with lower-income states receiving a higher matching rate.[21] In 1993, for instance, relatively prosperous Colorado took in 54.42 cents of federal funds for every dollar of state money spent by its program, while less affluent New Mexico received a match of 73.85 percent. During that year, twelve states had incomes so high that they were given the minimum amount of federal assistance, fifty cents on the dollar (HCFA 1995a: 131). The higher match makes the dollars that less wealthy states spend stretch farther, giving them an economic incentive to devote more resources to Medicaid. This graduated payment structure, in place since the program's inception, has been one of the federal government's most important tools for influencing state

20. Including three measures of state wealth raises the specter of multicollinearity. These variables measures three fundamentally different factors, however, and their respective correlations are either moderate or weak. Because state tax revenues represent tax rates when per capita income is held constant, these two variables differ as much as state tax policies differ. Incomes and poverty rates are also distinct phenomena as evidenced by the fact that the United States consistently has one of the worst poverty rates of industrialized nations even though its per capita income is among the highest.

21. With the stipulation that the match be no less than fifty cents of every state dollar spent and no more than eighty-three cents, the rate is determined by the following formula: federal share = 1 – 0.45 (squared state income/squared mean state income) (Grogan 1994: 600).

policy. I hypothesize that the matching rate will have its intended effect of increasing generosity.[22]

Demographic Variables

Female head of households (per 100 state residents). Since poor families headed by a single female parent or guardian received AFDC and were thus automatically eligible for Medicaid during the period studied, this factor will almost certainly drive spending on mandatory recipients. Also, in states with many single-parent households, there may be a greater perceived need for or increased political pressure to extend optional coverage to pregnant mothers and their infant children. Yet because "moms and babies" tend to cost considerably less to care for than other recipients, the number of female-headed households should have only a moderate effect on optional expenditures.

Poverty rates. Quite simply, states with more poor people have a greater need for large Medicaid systems. I measure this population characteristic by the percentage of residents in each state living in families with incomes below the federal poverty line as reported in the *Statistical Abstract of the United States*.[23] States with higher poverty rates should spend more on the mandatory portions of their Medicaid programs. It is uncertain how high poverty rates should influence discretionary spending, because policy makers may be pressured to cut optional costs when mandatory expenditures skyrocket.

Young population. States with more residents under eighteen can be expected to contain more poor children. Their AFDC programs must be relatively large to meet this need, which consequently fills up their mandatory Medicaid rolls no matter what ideological positions state

22. Because there is a fairly close inverse correlation between the match and state income (–0.73), the positive effects of income might may manifest themselves as a negative effect for the matching rates. Grogan (1994) finds such a negative influence on financial eligibility standards. More frequently, the effects of the federal subsidy are drowned out by income effects. The matching rate has generally weak coefficients in Kronebusch (1993). But because my models explain variation only in state discretionary spending and hold income constant, the federal match should have a strong positive effect.

23. While a 1987 change in the accounting method gives rates after that year a slightly different meaning than previous figures, these are the best numbers available and suitable for the purposes of this analysis. By "purposes of this analysis" I mean the cross-sectionally dominated nature of my dataset. Since comparisons are being made primarily between states rather than between years, the fact that pre- and post-1987 poverty rates are not perfectly comparable should not be viewed as a tremendous setback.

politicians hold. States with more children also presumably have more children just above the poverty line who could be granted eligibility at the option of legislators and officials. Politicians in states with youthful populations probably respond by casting the safety net a bit wider to cover low-income children.

Elderly population. Even controlling for the political clout of seniors as an interest group, the percentage of state residents age sixty-five and over should have a positive influence on Medicaid expenditures. Toward the end of this study's time span, state Medicaid programs were required to pay Medicare premiums, co-payments, and deductibles for seniors whose incomes are below the federal poverty line (HCFA 1994a: 4). Even though nearly 2 million eligible seniors did not take advantage of this program (Associated Press 1993), mandatory spending will still be closely linked to the size of a state's elderly population. States have the option of taking on the even larger burden of providing care for the medically needy, most of whom are elderly citizens. Consequently, the thirty-six states that elected to have medically needy programs in 1993 assumed responsibility for funding long-term care and spent a combined $18.9 billion on it that year (HCFA 1994b: 63). Because this care is so costly, policy makers in a state with many seniors must trade off the increased needs of their population with the skyrocketing costs of providing nursing home care for so many citizens. Because of these countervailing considerations, a state's elderly population should have only a weak effect on optional spending.

Minority population. Numerous studies (Grogan 1994; Kronebusch 1993; Plotnick and Winters 1985) have found that the larger a state's nonwhite population is, the less money its leaders tend to devote to welfare programs that disproportionately benefit minorities. The standard conclusion here is that politicians act in a discriminatory manner. Another possibility is that because race is a more politicized issue in states with higher nonwhite populations (Key 1949), leaders there cut back on social service spending in an attempt to appeal to their polarized white constituents. In this explanation, leaders are motivated more by electoral incentives than by personal racism. Regardless, I expect the percentage of residents in a state who identify themselves as black or Hispanic to have a considerable negative effect on discretionary Medicaid spending but not on the mandatory spending over which state leaders have little power.

Control Variables

National wealth. I include this variable to eliminate the shared trends of national economic growth and rising affluence in the individual states, thus allowing the state per capita income variable to display its independent effect.[24]

Region. Recent studies have found that geographical groups of states are likely to pursue similar Medicaid policies for a number of possible reasons. Perhaps policy makers feel that they must take care to keep their Medicaid programs in step with those of their neighbors lest they become "welfare magnets" (Peterson and Rom 1990). An alternative explanation is that there is much policy convergence within regions because officials of states in these groupings are reacting to shared circumstances not picked up by other variables in my model. Previous works as well as my preliminary findings indicate that states in the New England, Mid-Atlantic, and Midwest subregions, as defined by the *Statistical Abstract of the United States*, form one high-spending group while Southern, Mountain, and Pacific states share a common frugality. For the sake of parsimony, then, I combine the first three subregions into a single northeastern category and designate the latter three as southwestern. To test the hypothesis that there are distinct Medicaid regions, I will include northeast dichotomous variables in my regressions and leave out the southwest to serve as an intercept. The coefficients on northeast, then, can be interpreted as the effects of shifting from a southern, mountain, or Pacific state to one in New England, the Mid-Atlantic, or the Midwest, *ceteris paribus*. I expect to find a significant positive effect for this regional difference.

Lagged dependent variable. By including the previous year's value of spending on optional or total recipients as an independent variable in my time-series, cross-section regressions, I am in effect modeling year-to-year changes in spending rather than the variation in absolute levels of Medicaid generosity in these models. The theory behind this approach is that state officials do not design their eligibility criteria anew every year

24. Regressing on this variable presents another specification difficulty as rises in the GNP closely mirror the progression of the years during the time series that I am examining. The high degree of collinearity (0.98) between GNP and an interval variable for the year prevents the growth in national wealth and the time trend from being tested independently. Consequently, I include only the per capita GNP in my regressions and do not attempt to interpret its coefficient as a causal effect.

but in fact make incremental changes. According to David Maxwell-Jolly, consultant for the California Assembly's Appropriations Committee, legislators "really only look at the marginal changes in the Medicaid program. There is a base that is unquestioned."[25] Aaron Wildavsky (1964: 13–16) finds evidence of incremental budgeting in his classic work. Because of the policy continuity in this area, I expect Medicaid generosity in year n-1 to have a strong positive coefficient that makes it the single best predictor of spending.

Interactions. One of the assumptions I make in running time-series, cross-sectional regressions rather than fourteen separate cross-sectional regressions is that coefficients are similar across years and can thus be pooled together. To test this assumption, I will interact dummy variables for the fourteen years in my study with every explanatory variable that I use in my restricted models, leaving out 1980 as the intercept case. A significant interaction coefficient indicates that one of my variables has an effect on Medicaid generosity in a given year that is demonstrably different from its effect in 1980. I will include any significant interactions in my final models.

Description of the Model

The models presented in Table 3 compare the effects that the independent variables discussed above have on both total Medicaid program expenditures and spending on optional recipients. I estimate a pair of panel regressions, models that explore both the time-series and cross-sectional variation in each dependent variable. By including lagged expenditure figures as independent variables, these models examine the ways in which economic, demographic, and political factors brought incremental alterations in Medicaid eligibility policies from 1980 to 1993 in forty-six states. By presenting models of total and optional spending side by side, I highlight the differences between analyses of the dependent variable used in the existing literature and of a new measure.

In Table 4, I present a pair of cross-sectional regressions that take a snapshot of Medicaid programs in 1992.[26] Table 4 allows for a different

25. David Maxwell-Jolly, California Assembly Appropriations Committee consultant, interview by author, tape recording, Sacramento, CA, 12 July 1995.

26. I selected 1992 because it offers the best recent comparison between the models of optional and total expenditures (both models performed well until 1992 but explained less of the variance in 1993 spending levels).

comparison of dependent variables, optional versus mandatory spending, to contrast the explanatory factors for these two components of total expenditures. Because these models do not control for lagged expenditures, they show which variables explain absolute differences in spending across the states. Each approach, panel and cross section, essentially analyzes a different dependent variable to answer a different, and equally important, research question.

In the panel equations, I first computed an unrestricted model that examined the effects of every potential explanatory factor listed above. I then settled on a more parsimonious restricted model. My motivation for taking this approach was to test my hypotheses that many of these variables have insignificant effects on Medicaid generosity. Checking to see that their influences are indeed weak also gives me confidence that the significant coefficients in the restricted models are not affected by omitted variable bias. To come up with more parsimonious models, I dropped the clearly insignificant variables one at a time, checking both the robustness of the other estimates to these changes and possible collinearity between pairs of seemingly insignificant variables. I excluded from the panel regressions those variables with coefficients half the size of their standard errors in a pooled model and that small in at least ten of the fourteen years (as gauged by interactions between the variables and dummy variables for each year). Lacking this criterion in the 1992 cross-sectional equations, I retained all independent variables.

Previous research has found an exponential, rather than linear, relationship between independent variables and levels of Medicaid spending. I tested both types of models by running ordinary least squares regressions on each dependent variable as well as its natural log,[27] and found a larger R-squared for the exponential models. Though I have no prior theoretical reason to expect the independent variables positively related with Medicaid spending to have increasing rather than constant or decreasing effects, some plausible post hoc explanations come to mind. Slight alterations in economic conditions or demographic characteristics may go unnoticed, but policy makers will have to pay attention when these swings are extreme. The effects of partisanship, interest group power, or public opinion may be greatest when one party is clearly in control, when a single lobbying faction is dominant, or when the populace is united behind a policy. Whatever its cause, the exponential relationship between exoge-

27. The results yielded by this method, however, are equivalent to those obtained in a maximum likelihood estimation with a systematic component of $y = e^{xb}$.

nous variables and Medicaid spending is supported by past research and empirical evidence.

Many difficulties emerge when a standard OLS procedure is employed in the analysis of time-series, cross-section data.[28] Consequently, I follow Nathaniel Beck and Jonathan Katz's (1995) prescription of estimating an OLS model with panel-corrected standard errors.[29] The 1992 cross-sectional models are OLS regressions using the transformed (logged) dependent variables.

Results

Table 3 presents the results of a pair of panel regressions investigating patterns in total expenditures (the figure most often analyzed in the past) and spending on optional recipients (a new measure of generosity). The findings differ in expected ways. Although party control of a legislature has no clear effect on total outlays, it does have a large impact on state discretionary spending. By presenting these two models side by side, I show that this novel result appears not because of a new model specification, a fresh set of control factors, or a different period of study but because optional spending is isolated. Table 4 presents the results of a cross-sectional analysis of program sizes in 1992. Since the general findings here are similar—party control affects discretionary but not total expenditures—this section explores only the panel results in depth.

Political Variables

In the model of optional spending, the effect of party control is statistically clear, substantively strong, and in the expected direction. Republican legislators choose to spend $13.71 per capita less a year on optional recipient groups than their Democratic counterparts, compared with an

28. "Contemporaneous correlation" of errors is quite likely. For example, if a model poorly predicts expenditures in Massachusetts in 1983, there is a good chance that its predictions of spending in Michigan during that year will also be far off. This relationship between the variances across units violates one of classical regression's four basic assumptions and makes the standard errors of coefficient estimates inaccurate. In most cases, standard errors are underestimated, giving researchers false confidence in the significance of their coefficients. Beck and Katz (1995) illustrate this problem and introduce a method for computing the correct standard errors. They show that while OLS coefficients are consistent, they tend to be inefficient. The authors propose alternative formulas that take contemporaneous correlation into account when computing standard errors.

29. To compute panel-corrected standard errors, I wrote a Gauss program that called a procedure written by Rob Franzese. An identical procedure is now incorporated into STATA 6.0.

Table 3 1980–1993 Panel Regressions on Logged Spending Per Capita

	Optional Recipient Spending Per Capita		Total Recipient Spending Per Capita	
Variable Name (or Type)	Estimate	Standard Error	Estimate	Standard Error
Economic				
Income ($1000s)	**0.04**	0.01	0.006	0.0049
Federal match	**0.0072**	0.0022	**0.0025**	0.00088
Demographic				
Female head of household	**0.049**	0.024	0.0084	0.01
Poverty rate	0.0038	0.0037	**0.0031**	0.0015
Minority %	**–0.0067**	0.0015	**–0.0012**	0.0006
Elderly %	0.017	0.0087	–0.0029	0.035
Young %	**0.017**	0.0082	–0.0038	0.0033
Political				
Rep. control of legislature	**–0.073**	0.027	0.0063	0.01
Tax effort ($1000s)	**0.15**	0.04	**0.054**	0.02
Item veto	**–0.069**	0.028	-0.0055	0.01
Medical lobby	0.02	0.013	**0.01**	0.005
Control				
National wealth ($1000s)	**0.018**	0.0046	**0.012**	0.002
Northeast	**0.092**	0.025	**0.024**	0.011
(ln) lagged dependent	**0.72**	0.021	**0.91**	0.014
Minority* 1990–1992	**0.0057**	0.0012	**0.0028**	0.00047
Elderly* 1980–1983	**0.0082**	0.0026	**0.0037**	0.001
Intercept	**–0.96**	0.38	0.075	0.15
	Adjusted *R*-square: 0.897		Adjusted *R*-square: 0.970	
	Std. Err. of Reg: 0.2 ($1.22)		Std. Err. of Reg: 0.08 ($1.08)	
	Mean y: 4.24 ($69.41)		Mean y: 4.965 ($143.31)	
	Number of cases: 644		Number of cases: 644	

Note: Panel-corrected standard errors are reported, with coefficients more than 1.96 times the size of their standard errors in bold.

average expenditure of $69.41 over the 1980–1993 period.[30] This effect is robust, holding up across the country and in states where the parties battle over different political cleavages. In Robert Brown's (1995) analy-

30. The substantive effects of coefficients in this model of the natural log of spending are derived by holding all other independent variables at their means, obtaining a predicted level of logged spending, increasing this prediction by the value of the coefficient in question, and then taking the inverse natural log of this figure. This method must be used because a logarithmic model assumes that the marginal effects on spending increase at higher absolute levels of spending.

Table 4 1992 Cross-Sectional Regressions on Logged Spending Per Capita

	Optional Recipient Spending Per Capita		Total Recipient Spending Per Capita	
Variable Name (or Type)	Estimate	Standard Error	Estimate	Standard Error
Economic				
Income ($1000s)	**0.12**	0.05	−0.13	0.08
Federal match	0.006	0.02	−0.003	0.02
Demographic				
Female head of household	**0.31**	0.14	0.25	0.23
Poverty rate	0.01	0.02	0.002	0.04
Minority %	**−0.02**	0.01	−0.007	0.01
Elderly %	0.09	0.05	−0.01	0.08
Young %	**0.16**	0.04	−0.05	0.07
Political				
Rep. control of legislature	**−0.51**	0.16	0.02	0.26
Rep. governor	−0.03	0.09	0.02	0.15
State ideology	0.05	0.69	**−2.38**	1.11
Tax effort ($1000s)	0.04	0.02	0.02	0.04
Item veto	**−0.57**	0.16	0.27	0.26
Seniors' lobby	−0.20	0.11	0.11	0.17
Medical lobby	0.05	0.07	−0.06	0.12
Doctors' lobby	0.02	0.06	0.08	0.09
AARP members	3.85	5.36	−5.05	8.65
AHA members	**5563**	1842	**5860**	2972
AMA members	74.7	211.6	−80.6	341.4
Control				
Northeast	0.23	0.16	0.28	0.25
Intercept	−4.29	2.46	**8.33**	3.97
	Adjusted *R*-square: 0.68		Adjusted *R*-square: 0.29	
	Std. Err. of Reg: 0.25 ($45.21)		Std. Err. of Reg: 0.40 ($83.96)	
	Mean y: 5.07 ($175.19)		Mean y: 5.14 ($192.73)	
	Number of cases: 46		Number of cases: 46	

Note: Coefficients more than 1.96 times the size of their standard errors are reported in bold.

sis of AFDC effort, he finds that legislative party control affects state effort levels only when a "New Deal" political cleavage issue divides the party. Using Brown's cleavage classifications and regression method,[31] I analyzed Medicaid generosity and found that party control retains its effect in the presence of every cleavage type.

The impact of a state's tax effort and the presence of an item veto are both strong and in their hypothesized directions. States that tax their citizens at higher rates are more generous, and governors are able to control Medicaid costs (an average of $4.87 annually per capita) with their veto pens. All of these effects easily pass conventional tests of statistical significance. Though not clearly significant at the 0.05 confidence level, the power of the medical industry's lobbyists in each state also appears to increase optional expenditures. A shift in all of these political variables from their twenty-fifth to seventy-fifth percentile levels brings a predicted 23 percent increase in optional payments. Such a change appears to increase total program size by only 3.8 percent, though. Interest group strength and tax effort have positive impacts on total outlays, but the effects of party control and the item veto are obscured when optional payments are grouped together with spending on mandatory recipients. Partisan battles and executive powers do affect social service policy, it seems, but only through the policy choices that states control.

The reported models are notable for what they do not include. Party controls of the governorship and a measure of public opinion have been dropped from these refined models. Their coefficients did not approach substantive or statistical significance, and the effects of other variables appeared robust to their exclusion. The absence of an executive party control effect may not be as surprising as it first appears. In making incremental changes to a program that must be altered through legislation, perhaps the governor is at a disadvantage. The noneffect also implies that divided and unified state governments do not differ greatly in their Medicaid generosity, a finding that agrees with David Mayhew's (1991) study of national legislation and Morris Fiorina's (1992) survey of the literature.

A standard index of state public opinion also shows no links with Medicaid generosity. The coefficient for Wright, Erickson, and McIver's (1985) index of state ideology in a model including all independent vari-

31. The results, not reported here, show that interactions between party cleavage types and party control are substantively weak and not statistically significant. The strong negative effect of Republican party control on optional spending does not vary significantly with the type of political context measured by Brown.

ables, –0.0007, was only 0.26 the size of its standard error. Even when I estimated models omitting tax effort and legislative party control (through which citizen ideology might be working), the coefficient was only 0.13 times the size of its standard error. This indicates that I might find a larger effect by chance alone in more than nine cases out of ten, if citizen ideology has no true effect.

Economic Conditions

Economic conditions clearly affect a state's optional spending levels but have a weaker impact upon total spending. A shift from the 1993 income level of Connecticut—the nation's wealthiest state—to the per capita income of impoverished Mississippi would bring a predicted drop in discretionary spending of $34.74 per capita, all other things being equal. This income effect is partially offset by the impact of federal matching rates, which give poorer states a higher funding rate. Holding other variables at their means, a state that receives Mississippi's 79 percent match should spend about $14.98 (22 percent of the average payment) more on its optional program for every resident than a state paying fifty cents on the dollar such as Connecticut. It is possible that the apparent effects of this matching rate, which is calculated by formula including state income squared, simply represents a second-order income effect. Regardless, the effects of both of these variables on overall Medicaid budgets (the sum of optional and mandatory spending) are not as strong. This makes sense because state officials simply have no freedom to alter the mandatory portions of their programs in reaction to financial conditions and intergovernmental incentives.

Demographic Variables

As a group, these exert some influence on both dependent variables. However, the individual variables that account for the most variation differ between equations. Having more female-headed households increases predicted optional spending, although (contrary to my expectations) it has no significant effect on total expenditures. Still, the apparent responsiveness of state policy makers to the needs of single mothers, which appears to be consistent over time, is a striking finding. Also conspicuous is the impact of minority populations, which fits with earlier findings of discriminatory social service policy making. Optional spending tends to decline by $8.18 per capita when the minority percentage of a population

increases from its twenty-fifth to its seventy-fifth percentile level. The effect of race is weaker on overall program size, which is driven more by poverty rates. Finally, the numbers of children and seniors in a state seem to influence the Medicaid policies that are set at the state level, though there is little evidence of their positive effects on total payments.

The regressions using cross-sectional data from 1992 in Table 4 provide even stronger evidence that discretionary state Medicaid spending is responsive to political changes (perhaps because Congress increased state discretion throughout the 1980s at the same time that it added mandates). In the model of optional spending, party control of the legislature and the number of hospitals in a state work along with economic and demographic variables to explain absolute levels of generosity. The power of the seniors' lobby exerts an effect that borders on significance.

Comparing these results with a model of mandatory spending suggests that different causal processes are at work. States with more conservative ideologies appear to have lower mandatory expenditures. As expected, party control of a state legislature or executive branch has no discernable impact on spending mandated by Congress. If mandatory and optional spending had been lumped together into a single dependent variable, the effect of party control on discretionary policy would have been obscured. Put together, Tables 3 and 4 have a strong message. Political variables affect both incremental shifts in generosity and differences in absolute levels, demonstrating the powerful role of politics in Medicaid policy over the course of this study.

Conclusions

The findings reported in this article have implications for both the academic study of state politics and for current policy debates. The most important result, undiscovered in the previous literature, is that the party controlling a state legislature can shape the breadth of a Medicaid program to fit its partisan goals. This effect becomes clear only when optional spending is isolated. If we want to model the decision processes of state policy makers, we must choose measures of the spending over which they have control. Past studies that explain variation in total program size miss out on the crucial impact of party and other political variables because they fail to recognize this fundamental point.

For students of state legislatures, this finding confirms the suspicions of early scholars (Key 1949; Lockard 1959; Fenton 1966) that political parties play a strong role in shaping social service policy. Over the 1980–

1993 period of this study, politics mattered in Medicaid generosity. In the cross-sectional analysis of 1992 generosity, interest groups seem to be important as well. The analysis presented here also indicates that one notable political variable, public opinion, has little impact on Medicaid generosity. It appears that state politicians' decisions on this health care program are determined by their party affiliations and by the demands of lobbyists, while citizen preferences that are not filtered through party and interest group activities are ignored.

Together, these results pose new academic questions. Why does the party of the governor appear irrelevant while legislative party control is important? If the legislative branch has an advantage in making incremental changes to the health care budget, perhaps the executive is more important in constructing social programs when power is devolved to states. A good test of this proposition could be made by examining the relative power of each branch in shaping Temporary Assistance for Needy Families (TANF) programs after the 1996 welfare reform act or in building the new State Children's Health Insurance Programs.

The effect of legislative party control on generosity is obvious, but it is less clear what political forces drive this relationship. Is a legislator's party affiliation merely a proxy for the policy positions of his or her district's median voter, as many formal models assume? If this is true, shifts in party control reflect shifts in public opinion and bring about the level of social service provision that a state legislature's median constituent prefers. Do the parties differ on Medicaid policy because they represent groups that face different benefits/tax ratios from the program, as Glenn Beamer (1999) proposes? If so, shifts in optional health spending fit policy to the economic interests of political victors. Is party a marker for the beliefs of legislators, who are free to pursue their ideological ends in this low-profile policy arena? If this is the case, state spending decisions reflect the values of leaders who are relatively unchecked by their electoral connections. Further investigation is needed to decode the link between party and spending.

Yet this historical study of Medicaid generosity—defined as high spending that policy makers control—holds definite lessons for what might happen if state officials are granted more authority over health care provision in the future. Many plans to incrementally widen coverage of children and the working poor, including proposals made during the 2000 presidential race, work through matching grants to the states. Should states be granted wide latitude in determining the scope of this expansion?

While state-to-state variation in health policy is not necessarily bad—and may be "the price we pay for federalism" (Leichter 1997)—it is still crucial to know what produces this variation. Allow state politicians more control, someone informed by past empirical findings might argue. If governors and legislators acted as neutral translators of socioeconomic realities into appropriate policies, giving them more discretion really would bring this welfare policy "closer to people's homes and communities," as Republican congressional leaders have asserted (*New Republic* 1995). This study shows, however, that state policy makers are not neutral; political factors combine with socioeconomic concerns to shape state decisions. Partisan battles, along with community needs, dictate the direction of health policy when states are given discretion. A devolution of power designed to bring the policy "closer to the people" would in effect bring control over health care for the uninsured closer to legislators who are lobbied by interest groups, constrained by tight budgets, and possessed of ideological goals.

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