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Political Research Quarterly 1994; 47; 589
DOI: 10.1177/106591299404700303

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A political-economic theory is developed to explain the formation of public policy in the American states; here, I focus specifically on states' Medicaid policy decisions. I analyze three dimensions of Medicaid policy—financial eligibility, categorical eligibility, and benefit coverage—and argue that each dimension represents a different political process. My theory assumes that state politicians maximize their political utility by attempting to satisfy the preferences of voters, interest groups and their own ideology, while at the same time they minimize their political disutility by attempting to keep the political costs of their actions as low as possible. However, I postulate further that the political process varies according to the degree to which constituents are interested in the policy, the strength of interest groups, and politicians' political ideology. To test this theory, I use a heteroskedastic, timewise autoregressive model for panel data. My theory is fairly well supported by the empirical results: the Medicaid policy dimensions do represent different political processes, and politicians must trade off the utility gained from increasing spending with the utility lost from increasing public expenditures. However, contrary to my theory, politicians' political ideology plays a significant role in all the Medicaid policy decisions.

During the 1960s and 1970s, political scientists studying public policy in the American states tended to focus on the relative importance of political system variables versus economic development variables in explaining the variation in state policies (Dawson and Robinson 1963; Hofferbert 1966; Sharkansky and Hofferbert 1969; Gray 1974; Jennings 1979; Dye 1966; 1970; 1984; Hanson 1983; 1984). At the same time, researchers from the subdiscipline public choice focused on either the effects of voter demands on public policy or the effects of political behavior on public policy, rather than presenting an integrated model of the political marketplace (Downs 1957; Buchanan and Tullock 1962; Arrow 1963; Niskanen 1971; Orr 1976). Recently researchers have developed broader models to encompass both political and economic variables (Plotnick and Winters 1985; Barrilleaux and Miller 1988; Reutzel 1989; Peterson and Rom

NOTE: The author wishes to acknowledge the helpful comments of Roger Feldman, Virginia Gray, Jon Christianson, Ira Moscovice, and three anonymous reviewers for this journal.

1990). However, a full theoretical model that considers the relationship between demanders (i.e., voters, interest groups) and suppliers (i.e., politicians) of public policy has not been sufficiently developed. In addition, how the economic and political dimensions interrelate, if at all, is not clear. One result of treating the two approaches (economic and political) as separate is that several models (Plotnick and Winters 1985; Barrilleaux and Miller 1988; Reutzel 1989) make the unrealistic assumption that voter demands have a direct effect on public policy regardless of the political process.

I argue that the political process affects the degree to which individuals' collective demand is translated into the public goods supplied. Moreover, the political process will change depending on the public policy of interest. For example, a redistributional policy, such as income tax rates, fits the rational-activist model because it is a high-profile policy receiving a significant amount of media attention that affects every voter. The pressure group model, on the other hand, provides a better explanation of distributive policies, such as physician or hospital payment issues, where the interests of health provider groups are intense, but the interests of the general citizenry are diffuse. Thus, the practice of using the same global state determinants in several diverse state policy studies, such as interparty competition or state median income, obscures the reality that the factors affecting policy decisions vary according to the specific policies confronted.

I deviate from previous research by specifying a different policy process for each dimension of one major social welfare program—Medicaid.

Theoretical Model of State Medicaid Policy

Politicians are concerned about their constituents' interests when they decide on public policy; however, the degree to which constituents are interested in the politicians' decisions varies according to the policy under consideration. The desires of constituents can be conceived of as boundaries beyond which politicians dare not step without hindering their reelection possibilities. These boundaries are wide on certain political issues and narrow on others. If the constituents are interested and aware, their desires are the most important factor in the politician's decision-making process. However, when the constituency is not very interested in a policy the politician has more decision latitude and other factors, such as interest group lobbying, have greater opportunity for influence (Milbrath 1970).

State legislators maximize a political utility function of the following form:

$$V_m = \sum_{i=1}^{3} [\Phi_i U_i^p + \gamma_i U_i^x + \alpha_i U_i^I] - K \qquad \text{[Eq. 1]}$$

where,

$$\Phi_i = f(\gamma_i, \alpha_i) \qquad \text{[Eq. 2]}$$

The following definitions are used:

V_m = state legislators' political utility from Medicaid policy;
U^P_i = the utility obtained by state legislators philosophically interested in policy i;
U^c_i = the utility obtained by the constituents (or voters) interested in policy i;
U^I_i = the utility obtained by interest groups due to policy i;
Φ_i = the degree to which state legislators' political ideology/culture is not constrained;
γ_i = the width of the constituent boundary for policy i;
α_i = the political power of the interest groups concerned about policy i;
K = state legislators' political cost; and
i = dimensions of Medicaid policy, where i = 1, 2 or 3, and 1 = financial eligibility, 2 = categorical eligibility, 3 = benefit coverage.

State legislators[1] maximize their political utility by attempting to satisfy the preferences of voters, interest groups, and their own ideology, while at the same time minimize their political disutility by attempting to keep the political costs of their actions as low as possible. Most gubernatorial defeats in recent years have been publicly linked to tax increases, and a recent study suggests that about 20 percent of gubernatorial defeats in the past 30 years were due to tax increases (Hansen 1990; Beyle 1990). Therefore, state politicians fear that support for a new tax or tax increase will result in political destruction (Hansen 1990). Yet, with the onslaught of "New Federalism" in the 1980s, states are also forced to assume greater responsibility for social services. This tension between pressures to increase spending and the political costs associated with increased spending is depicted in the above model.

I also incorporate the notion of a constituent boundary in the model. State legislators experience varying degrees of pressure from voters (γ), interest groups (α) and their own political ideology (Φ). The degree to which state legislators can rely on their own political ideology depends on the width of the constituent boundary and the political power of interest groups (as depicted in Eq. 2). For example, when state legislators face a wide constituency boundary and a low degree of political interest group power, Φ increases meaning that state politicians have more freedom to pursue their own politicial beliefs.

[1] The terms legislators and politicians are used as synonyms in the text.

Three dimensions of Medicaid policy are of interest: financial eligibility (at what income level is a person or family eligible for Medicaid?), categorical eligibility (what types of persons or families are eligible?), and benefit coverage (what optional medical services are reimbursed under the state's Medicaid policy?). Each Medicaid policy dimension represents a different political process due to varying degrees of γ and α. An explanation of the political process for each of the Medicaid policy dimensions–financial eligibility, categorical eligibility, and benefit coverage–and the political cost function is provided below.

1. *Financial Eligibility: Narrow Constituency Boundary/Limited Interest Group Pressure*

Medicaid eligibility policies are very complicated. In general, Medicaid eligibility is linked to a person's eligibility for AFDC and to the Supplemental Security Income (SSI) program for the aged, blind, and disabled. States are required under federal law to cover all AFDC and SSI recipients. Because the SSI program has fairly uniform federal eligibility criteria, I focus on AFDC Medicaid recipients since this group represents the greatest source of variation in program policy among the states. Therefore, financial eligibility policy is defined[2] as the state's decision about AFDC payment levels.[3]

Because AFDC payments are provided directly to the program's beneficiaries, there are no economic interest groups with concentrated interests in the financial eligibility policy of the Medicaid program. While there are certainly interest groups that act as advocates for the poor, they usually do not enjoy the same degree of power as business (or economic-related) groups; when interest groups for the poor do yield political power it tends to surface at the federal level rather than in the states (Hrebenar and Thomas 1987). Voters, on the other hand, are very concerned about AFDC payment levels. Therefore, Medicaid financial eligibility policy represents a fairly tight constituent boundary with limited interest group pressure. I expand on this argument below by discussing the factors that affect voters' determination of appropriate AFDC payment levels.

Low-Income Wage Rate. State welfare programs base their level of assistance on some concept of what is minimally necessary. Several studies have shown that a person's sense of well-being depends on how (s)he compares with others in the relevant social group; however, individuals also have *relative* perceptions of other persons' needs (Lane 1978; Easterlin 1973; Bradburn and Caplovitz 1965). Rainwater (1974) analyzed Gallup Poll survey responses, from 1946 to 1969, to the following question, "What is the smallest amount of money a family

[2] Further discussion of this definition is provided in the Measurement section below.

[3] The terms–Medicaid financial eligibility policy and state welfare policy–are used interchangeably.

of four needs to get along in this community?" The average amount that individuals (from national samples) regarded as adequate was just above the take-home pay for a worker in a private nonagricultural industry. In addition, persons in rural areas tended to have a different perception of an adequate minimum budget (a lower income level) than those in urban areas. These findings support the notion that people judge need according to the relative social norms in their community.

Opinions about deservingness in American society are also strongly tied to one's ability to work (Marmor et al. 1990). U.S. voters prefer to limit welfare benefits to individuals who cannot be expected to earn wages. With the pronounced changes in women's labor force status in the last twenty years, the belief that female-headed families are exempt from the work force has begun to erode (Burtless 1990). Because Americans question whether AFDC families should be exempt from the work force, state politicians are very concerned about how the payment level will affect AFDC recipients' incentive to work. States try to set payment levels which reinforce incentives to find work and, hence, to leave welfare. The key word here is *try*—neither state politicians nor citizens know which level of assistance is so low that families are not adequately taken care of and do not receive the *opportunity* to help themselves out of poverty, or which level is so high that a disincentive to working is created (and may also be considered unfair to working families). In their search for an appropriate level of assistance, politicians translate voter preferences for a "fair" AFDC payment level by setting the level in accordance with the "lower-income social norm." Therefore, I hypothesize that the state's average wage rate in the lowest paying, nonunion industry is positively related to the state's Medicaid financial eligibility policy.

Perceived Incentive for Welfare Migration. Not only do social norms within the state affect its determination of AFDC payment levels, but regional norms will affect a state's perception of need as well. The reason a state is affected by AFDC policies in surrounding states has to do with voter concern about welfare migration. The popular view is that AFDC beneficiaries migrate to states with relatively high benefits. For example, when 1,107 adults were asked in a 1969 nationwide survey whether they agreed with the statement, "A lot of people are moving to this state from other states just to get welfare money here," 41 percent agreed, 31 percent disagreed and 28 percent were uncertain (Feagin 1972).[4] Although this survey is dated, press coverage and social science research on welfare migration continue. For example, in the mid-1980s, Wisconsin newspaper headlines such as "State's generous welfare creating border-

[4] Cited by the Wisconsin Expenditure Commission, *Report of the Welfare Magnet Study Committee* (December 1986).

hopping problem," "AFDC cases in state are up 20 percent," and in the Chicago *Tribune* "Wisconsin welfare bounty a lure" were common appearances (Voss et al. 1986).

Politicians are affected by these views, as evidenced by Wisconsin Governor Anthony Earl's suggestions, in 1986, for broad welfare reform aimed at getting people off relief roles.[5] Empirical studies also support this theory that states are affected by regional AFDC payment norms. Two separate studies—Gramlich (1982) and Peterson and Rom (1990)—reported that the migration term in regressions predicting AFDC benefit levels was highly significant. In a later study Gramlich and Laren (1984) also concluded that the "perception that this (welfare) migration is important does seem to have a significant influence on states in their setting of AFDC benefits . . . (State legislatures) appear to be very much conditioned by what other states are doing when they set AFDC benefits."[6] Thus, the financial eligibility level in contiguous states (the measure of potential welfare migration) is positively related to the state's Medicaid financial eligibility policy.

Racism. Some empirical studies have found that specific demographic characteristics of AFDC recipients also affect voters' perceptions of the appropriate AFDC payment level (Orr 1976; Plotnick and Winters 1985). These studies report a significant positive relationship between the proportion of white AFDC recipients in a state and the state AFDC payment level. Such findings suggest that racial prejudices influence voters' utility for social welfare policy. Specifically, I hypothesize that AFDC recipient race (the proportion of non-white AFDC recipients) is negatively related to the state's Medicaid financial eligibility policy.

By applying the above discussion to Equation 2 of the theoretical model, I hypothesize the following: the constituency boundary (γ_1) weight is high, and the interest group strength (α_1) weight is low; therefore the state legislators' political ideology (Φ_1) weight is low.

2. *Categorical Eligibility: Wide Constituency Boundary/Moderate Interest Group Pressure*

I postulate that categorical eligibility policy represents a wide constituency boundary and moderate interest group pressure. In the 1980s, states had the option to extend AFDC coverage (and therefore Medicaid) to two categorical groups called, AFDC-UP (families with unemployed parents) and students up to 19 years of age. In addition, states can provide Medicaid only coverage (non-cash aid) to the following six groups: (1) financially eligible persons under age

[5] Drayna, J. "Earl calling for welfare reform," *Green Bay News-Chronicle*, June 26, 1986, p. A-5.

[6] Quoted in Wisconsin Expenditure Commission, *Report of the Welfare Magnet Study Committee*, (December 1986): 8.

21; (2) persons eligible for but not receiving cash; (3) persons who would be eligible except for institutional status; (4) persons who would be eligible if the state plan were as broad as the social security act allows; (5) persons who would be eligibleif child care costs were paid from earnings; and (6) the Medically Needy. Because these categorical group definitions are so specific and not often publicized, the general citizenry is neither aware nor particularly concerned about which groups are included in the state's Medicaid program. Therefore, politicians enjoy a wide constituency boundary when deciding which categorical optional groups to include in the program. However, as explained below, politicians face some interest group pressure due to the importance of the Medically Needy program.

Interest Groups. While the persons who fall into these categorical groups are clearly interested in gaining Medicaid coverage, they are not a homogeneous group and are not organized as a group to affect public policy. One exception is the Medically Needy program. The medically needy are "those who meet criteria for categorically needy assistance (AFDC or SSI) except for income and/or resources and who have incurred large medical expenses" (DHHS 1990: 69). In 1989, thirty-six states offered coverage for the medically needy. As mentioned, states electing this option must establish income and resource standards; these standards can be higher than the categorically needy standards, but not higher than 133 percent of the AFDC payment standard. Medically needy applicants are allowed to deduct certain medical expenses from the amount of countable income for eligibility determination. This is known as the medically needy spend-down provision and is especially important for granting Medicaid eligibility to the institutionalized who incur very large medical expenses. The elderly are the primary beneficiaries of the Medically Needy program. They are substantially more likely than the other eligibility groups to receive medically needy coverage: 47 percent of the aged (65 or over) Medicaid recipients receive non-cash medical assistance, compared to 22 percent of the disabled and 23 percent of the AFDC recipients (DHHS 1990). Senior citizen groups are usually active lobbyists for issues related to the medicaid program, particularly advocating for the Medically Needy program because it provides important coverage for the elderly in nursing homes. Thomas and Hrebenar's (1990) study of interest groups in the American states found that senior citizen groups are present in over forty states and particularly influential in twelve states.

Health care providers are very interested in Medicaid benefit policy (as will be discussed in the following section), but most are not concerned (any more than the rest of the citizenry) about which specific "poor" groups attain Medicaid coverage in their state. The reason for this is related to Medicaid fees. In most states, Medicaid fees for physician services are lower than Medicare and private pay fees. At least one study found that low Medicaid reimbursement

rates are related to low physician participation rates in the Medicaid program (Held et al. 1982). In addition, other Medicaid program factors were found to affect adversely participation rates such as the inability to prescribe drugs or other treatments as desired due to program restrictions, heavy paperwork, and slow payment (ibid.). At least among physicians, the concern is over benefit coverage and reimbursement rates for the patients they do take care of, not increasing their Medicaid caseload. In addition, public hospitals, the primary acute care provider for Medicaid patients, have experienced severe financial problems under the Medicaid program. Therefore, hospitals are less apt to lobby for an increase in Medicaid patients and more likely to focus on increasing reimbursement rates. Moreover, many states have uncompensated care funds to reimburse hospitals for bad debt acquired from uninsured patients.

Nursing homes, however, are one exception to the scenario described above. Nursing homes receive 50 percent of their payments from state Medicaid programs. Many elderly must "spend down" to the Medicaid financial eligibility level before their nursing home services will be covered by the state. To the extent that the elderly would go to a nursing home sooner if the Medicaid eligibility level is raised (which is essentially what the Medically Needy program does for the elderly) nursing homes support the Medically Needy program and advocate for its passage in the state.

The degree to which senior/nursing home interest groups will affect politicians' decisions regarding categorical eligibility depends of the strength of these interest groups (Hrebenar and Thomas 1987), but I hypothesize that the strength is positively related to the state's Medicaid categorical eligibility policy.

Political Culture. Because state politicans enjoy a relatively wide constituent boundary when deciding on Medicaid categorical eligibility and only receive pressure from senior citizen and nursing home groups when considering the Medically Needy program, they are allowed a fairly high degree of latitude to determine categorical eligibility policy in accordance with their political philosophy. Of course, state reactions will vary according to their political ideology or culture.

Elazar (1984) developed a theory and classification of American political culture. He suggests that this culture is a combination of three political subcultures termed moralistic, individualistic, and traditionalistic. Each of the three political subcultures embodies a different perspective about the role of government, the citizens' role in government, and the process of politics. Because those in moralistic states tend to veiw political activity as a way to improve societal conditions, state legislators in a predominantly moralistic political culture are most likely to support Medicaid eligibility for the various categorical groups. In contrast, politicians in predominantly traditionalistic states are least likely to support Medicaid categorical eligibility groups, because they tend to view political activity

as limited to secure the existing order. Politicians in individualistic states occupy a middle position between the moralistic and traditionalistic states. Individualistic cultures tend to support government intervention if such political activity is viewed as maintaining the order of the marketplace. Therefore, government action with regard to certain categorical groups may be perceived as a necessary investment in the state's future prosperity and productivity. Based on Elazar's theory, I hypothesize that state political culture (measured on a continuum[7]) from moralist (rated low) to traditionalist (rated high) is negatively related to the state's Medicaid categorical eligibility policy.

Party Control. Findings from a study eliciting opinions from the U.S. public and members of Congress on social welfare policy reveal that self-proclaimed Democrats and Democratic Congress members are much more likely to support increases in Medicaid benefit levels than their Republican counterparts (Cook et al. 1988). Among committee leaders, 83 percent of Democrats support increasing benefit levels for Medicaid compared to 20 percent of Republicans; and among Congress members at large 52 percent of Democrats supported compared to 28 percent of Republicans. If federal Congress members are reflective of state legislators, we may expect to find similar ideological differences among political parties in the states with regard to Medicaid policy. On the other hand, some studies have shown that party labels are not always accurate indicators of party idology (Jennings 1977; 1979). A southern Democrat is often as ideologically conservative on welfare issues as a northern Republican. However, by controlling for political culture, the appropriate effect of party control on Medicaid categorical eligibility policy will be revealed. I hypothesize that state party control (measured as a 1 if the state is controlled by the Democratic party,[8] 2 if mixed control and 3 if Republican control) is negatively related to categorical eligibility policy.

Again, by applying this discussion about the political process of categorical eligibility to Equation 2 of the theoretical model, I hypothesize the following: the constituency boundary (γ_1) weight is low, and the interest group strength (α_1) weight is moderate; therefore the state legislators' political ideology (Φ_1) weight is high.

3. Benefit Coverage: Wide Constituency Boundary/High Interest Group Pressure

In keeping with my overall theoretical proposition, I argue that benefit policies are affected by a different political process than either financial or categorical eligibility policy decisions. Namely, a pressure group model best explains

[7] I use Sharkansky's (1969) political culture index measure.

[8] Control is defined as upper and lower house and executive branch being controlled by the same political party.

Medicaid benefit policy. This policy represents a situation in which constituents are not very interested or aware of Medicaid benefits; therefore, politicians enjoy a wide constituency boundary. In contrast, health provider groups are very interested and aware of the optional Medicaid benefits provided in their state. However, the degree to which provider interest groups affect benefit coverage policy depends on the level of interest group *strength*; and this strength or political influence, will clearly vary among the states.

Interest Groups. Lobbyists representing a variety of interests are present in any state capital during the legislative session (Zeigler 1983). In Zeigler's analysis of the types and strength of interest groups in the American states he found that "in many states the number of registered lobbyists exceeds the number of elected representatives by a margin of two to one." The range of active state organizations is quite broad–bankers, undertakers, optometrists, and civil rights activists to name just a few. While the range of interest groups active in the states is quite broad, the influential, long-term groups tend to be from business or professional associations (Zeigler 1983). Many researchers have classified the American Medical Association (AMA) as one of the most powerful and influential interest groups (Milbrath 1970; Starr 1982; Marmor 1983). At the state level, provider specialty groups tend to have significant influence on occupational regulation policy (Begun, Crowe and Feldman 1981).

I postulate that Medicaid benefit policies represent a situation in which voters are not very interested or aware of Medicaid benefits; whereas health provider groups are very interested and aware. Stigler's (1972) theory of regulation provides a rationale for this political dynamic. The limited involvement of the voting public in benefit policy is due to low levels of public knowledge of such policies. Because the perceived benefits fail to outweigh the costs of taking action (becoming more knowledgeable), voters do not mobilize. Health provider interest groups, on the other hand, perceive significant potential gains (i.e., increased coverage of medical services) through their involvement in politics (ibid.; Begun et al. 1981).[9] Thus, I hypothesize specifically first, that the strength of health provider interest groups is positively related to the state's Medicaid benefit coverage policy, and more broadly the following: the constituency boundary (γ_1) weight is low, and the interest group strength (α_1) weight is high; therefore the state legislators' political ideology (Φ_1) weight is low.

[9] Although Medicaid recipients are interested in all three of the dimensions of Medicaid policy, they are not politically powerful and have no discernable influence on state political decision making. Cook et al.'s (1988) study found that most Congress members head very little, if at all, from poor people on the policies that affected poor people most. Because interest group strength is not determined purely by size, benefit policy decision are not affected by the poor's interests, even in very poor states.

Although in reality these key variables—constituent boundary, interest group strength, and political ideology—are present in each of the Medicaid policy dimensions, the relative effects of, for example, interest groups compared to voter preferences on financial eligibility or voter preference compared to interest groups on benefit coverage, are assumed to be quite small. Therefore, to simplify without grossly distorting reality, we assume the following values of γ, α and Φ: (1) under financial eligibility, $\alpha_1 = 0$, $\Phi_1 = 0$); (2) under categorical eligibility, $\gamma_2 = 0$; and (3) under benefit coverage, $\gamma_3 = 0$, and $\Phi_3 = 0$. Under these assumptions, state legislators' political utility function for Medicaid reduces to the following equation:

$$V_m = \{\gamma_1 U_1^c\} + \{\Phi_2 U_2^p + \alpha_2 U_2^l\} + \{\alpha_3 U_3^l\} - K \qquad \text{[Eq. 3]}$$

4. Political Cost Function

Due to the tremendous political awareness of tax increases and the political pressure (and in some states constitutional rulings) on state governments to balance their budgets, state legislators face a zero sum situation: increases in political utility are not acquired without commensurate increases in political costs. Below is a discussion of the factors that affect the political cost function (K).

State income affects the cost function due to its effect on the state tax base (i.e., a decrease in state income decreases the state tax base from which to raise revenues). Under a reduced tax base, states must either reduce their current level of spending or increase taxes. Similarly, an increase in the cost of the Medicaid program increases political disutility because the state now requires more of its total revenue dollars for the same level of Medicaid policy. Therefore, I hypothesize that state income is positively related to the state's Medicaid policy dimensions.

The cost of the Medicaid program, or the Medicaid budget is equal to the quantity of medical goods consumed multiplied by unit prices. Quantity is analogous to the Medicaid utilization rate, and price is the Medicaid provider reimbursement rate. Medicaid utilization depends on the number of recipients and the types of services covered which in turn depend on the three policy dimensions—financial and categorical eligibility and benefit coverage. Therefore, the state government influences the Medicaid budget by manipulating the policy dimensions of the Medicaid program.[10]

[10] The fourth policy dimension, Medicaid reimbursement levels, is implicitly included in the theory through the third policy dimension because the factors affecting benefit coverage policy (namely, health provider interest groups, α_3) have the same effect on reimbursement policy. Because reimbursement policy enters the model in the same way

Other variables that also affect the Medicaid budget include: the federal matching rate for Medicaid, the state's unemployment rate, average wage rate of lowest paying industry in the state, welfare migration, and potential health service needs. Each variable is discussed in turn below.

The federal matching rate formula is 1 - state share:

$$State\ Share_i = \frac{Y_i^2}{\bar{Y}^2} * .45$$

The formula sets lower rates of federal matching (down to a minimum of 50 percent) for states with relatively high per capita incomes, and sets higher federal matching rates (up to a maximum of 83 percent) for states with relatively low per capita incomes. For states receiving a federal matching rate above the minimum of 50 percent, there is a combined income and price effect when state per capita income changes. As mentioned, when a state's income increases, an increase in Medicaid benefits is expected; however, at the same time the state realizes an increase in the price of Medicaid (because the federal matching rate decreases) which induces the state to decrease Medicaid. However, for states receiving the minimum federal matching rate, an increase in income does not change the price of Medicaid to the state; therefore, a change in income only results in an income effect. The federal Medicaid matching rate is hypothesized to be positively related to the state's Medicaid policy dimensions, though the combined (income/price) effect is indeterminant.

Several empirical studies have shown that economic variables such as unemployment and wage rates affect Medicaid enrollments (Albin and Stein 1977; Bluestone and Sumrall 1977; Peden and Brooks 1981; Cromwell et al. 1986). An unemployed individual is clearly restricted in her ability to obtain a wage above the welfare payment standard; therefore, a negative relationship to the state's Medicaid policy dimensions is hypothesized. In addition, while wages earned from full-time or part-time work may be higher than the welfare cash payment levels, they may be lower than the entire welfare benefit package. Because individuals consider in-kind benefits as well as cash payments when determining the overall welfare package, a decrease in wages among those in low-paying jobs will induce some families to leave (or not to enter) the labor force and seek welfare.[11]

that the benefit coverage policy does, both policies can be represented by β_3 (as shown above) and the reduced form equations are unaffected by the explicit exclusion of reimbursement policy from the model. For simplicity, β_3 is defined only as benefit coverage; however, it is implied that reimbursement policy could also be estimated with this model.

[11] There are other unmeasurable sociological factors which also affect welfare enrollment such as a societal shame, pride, work ethic, etc.

Welfare migration also affects the cost of the Medicaid program. While most studies have shown that welfare recipients migrate for reasons similar to the rest of the population (family, friends, and quality of life factors), some studies have shown that welfare benefit levels play at least a minor role in recipients' decisions to migrate (Southwick 1981; Blank 1985; Voss et al. 1986). Therefore, to account for all of the possible effects of welfare migration on Medicaid policy, the perceived welfare migration variable is also included in the cost side of the model.

Health service needs in a state affect the Medicaid budget through the utilization of services. States with less healthy populations (higher mortality, accident rates and smoking prevalence rates) and greater social disorganizaton (higher violent crime rates) will utilize more medical services overall, and therefore have higher Medicaid expenditures per capita. Several studies have shown that health (illness-morbidity characteristics) affects the utilization of medical services (Aday and Andersen 1974, 1981; Mechanic 1979). Thus, I hypothesize that the health of the state's population is positively related to the state's Medicaid policy dimensions (as health[12] improves, the Medicaid policy dimensions will increase).

The discussion presented in the sections above suggest the following relationships:

$$U_1^c = f(\beta_1, W, M, R)$$
$$U_2^p = f(\beta_2, PC, PT)$$
$$U_2^I = f(\beta_2)$$
$$U_3^I = f(\beta_3)$$
$$K = f(I, \beta_m)$$

where

$$\beta_m = \lambda\ [f\ (\beta_1,\ \beta_2,\ \beta_3,\ UE,\ W,\ M,\ H)]$$
$$\lambda = \lambda(I)$$

Therefore, by substitution, the theoretical model can be written as follows:

$$V_m = \gamma_x\ U_1^c\ (\beta_1,\ W,M,R) + \Phi_2\ U_2^p\ (\beta_2,\ PC,\ PT) + \alpha_2\ U_2^I\ (\beta_2)$$
$$+ \alpha_3\ U_3^I\ (\beta_3) - \kappa\ [I,\ \lambda f(\beta_1,\ \beta_2,\ \beta_3,\ UE,\ W,\ M,\ H)] \qquad \text{[Eq. 4]}$$

[12] This is a composite measure based on the state's death rate, prevlanece of smoking, violent crime rate, and total accident deaths. For more detail about this measure see Grogan (1991).

The following definitions are used,

W = low-income social norm in a state;
M = perceived incentive for welfare migration;
R = AFDC recipients' race;
PC = state political culture;
PT = political party control;
I = state income;
λ = federal matching rate;
UE = state unemployment rate;
H = potential health needs in a state;
γ_i = the width of the constituent boundary for the financial eligibility policy;
Φ_2 = the degree to which state legislators' political ideology concerning categorical eligibility is not constrained;
α_2 = the political power of interest groups concerned about categorical eligibility policy; and
α_3 = the political power of the interest groups concerned about benefit coverage and reimbursement policy.

My model (Eq. 4) summarizes two important aspects of state Medicaid policymaking: first, each policy dimension represents a different political process; and second, the tension among state legislators to increase spending for the various Medicaid policy dimensions (either to please voters or the pressure groups associated with the policy or their own ideological beliefs) on the one hand, and the political pressures to keep spending down on the other. Although the theory postulates that a different political process affects each of the Medicaid policy dimensions, the policy dimensions are tied together through the political cost function. That is, an increase in one of the policy dimensions, all other things equal, must result in a decrease in one or both of the other policy dimensions in order for the model to attain an equilibrium state; or in more practical terms, politicians must often make trade-offs between the various Medicaid policy dimensions in order for the state to attain a balanced budget thereby minimizing its political cost function.[13]

Because an increase in the categorical eligibility policy increases the cost of the Medicaid program, politicians gain both political utility and political disutility. In an attempt to minimize their political disutility, politicians (controlling

[13] Hypotheses for the effect of wages and migration on categorical eligibility and benefit coverage are indeterminant due to their additional direct effects (through the financial eligibility policy dimension) on costs.

for all other factors) will decrease the other two policy dimensions. Thus, in the reduced form, all the variables affect the three policy dimensions either directly (as specified in the theory) or through the political cost function. For example, political party control not only affects categorical eligibility, as discussed, but also affects financial eligibility and benefit coverage policies in the opposite direction through the political cost function.

Methodology

Estimation

A pooled cross-sectional time series data base (also called panel data) is an effective method of utilizing a limited number of observations, and can also provide a clear picture (relative to separate cross-sectional or time series data) of the sources of variation in the dependent variable (Hsiao 1986). This research includes 49 cross-sectional observations—49 states[14] and six time-series observations (1979, 1981, 1983, 1985, 1987, and 1989), each two years apart, to yield a complete set of 294 observations.[15]

I chose the 1979–89 time period because it represents a time when states were better able to determine the costs and benefits of the Medicaid program after roughly fourteen years in existence. Moreover, studying this time period will provide some insight into the actions states have taken under the "New Federalism" of the 1980s in which states were given greater control in designing Medicaid policy under increased fiscal constraints. In addition, the two-year spread between time periods allows for more variation in the dependent variables of interest. This is a particular concern because many states do not change their benefit levels from year to year.

In specifying a pooled regression model, it is assumed that the regression coefficients are the same across subsets of the data (i.e., structural consistency in the cross-sections over time). To test the null hypothesis that the pooled data has no subsample effects, ordinary least squares (OLS) regression estimates from each of the separate six cross-sections (four cross-sections for categorical eligibility) are compared to the pooled estimates. The Chow Test allows one to determine whether the exogenous variables in the pooled data set should be interacted with time dummy variables. The test results indicate a failure to reject the null hypothesis of structural consistency for all three dependent variables (financial eligibility, categorical eligibility and benefit coverage here

[14] The District of Columbia is not included because the political characteristic variables—political culture and party control—are unattainable for the district. Arizona is also excluded because it does not have a traditional Medicaid program.

[15] Data for years 1987 and 1989 are unavailable for categorical eligibility policy, therefore, the total number of observations is lower (N=196).

after referred to as FE, CE and BC respectively) (test results are shown in Appendix A). These findings suggest first that pooling the data is appropriate, and second that consistent estimates can be obtained without interacting time with the other exogenous variables in the model.

The reduced-form equation (for each policy dimension)[16] is:

$$\beta_{ijt} = f(W_{it}, M_{it}, R_{it}, PC_{it}, PT_{it}, \alpha_{2it}, \alpha_{3it}, UE_{it}, H_{it}, I_{it}, \lambda_{it})$$

where,

β = Medicaid policy dimension;
j = Medicaid policy dimensions, where j = 1, 2, or 3, and 1 = financial eligibility, 2 = categorical eligibility and 3 = benefit coverage;
i = 49 states (excluding Arizona); and
t = time period, where t = 1, 2, 3, 4, 5 and 6, and 1 = 1979, 2 = 1981, 3 = 1983, 4 = 1985, 5 = 1987, and 6 = 1989.

There are a number of specific estimation models that could be applied to panel data. A model that is commonly used when dealing with pooled cross-section and time-series observations is the so-called fixed effects or covariance model. The notion behind this model is that each cross-sectional unit and each time period are characterized by their own unique intercept. Many of these differential state and time effects are unmeasurable, but can be incorporated into the regression equation by the use of dummy variables. Some methodologists criticize the fixed effects model because there is no theoretical rationale for the state and year dummy variables – they argue that these effects should be treated as errors in the equation (see Mundlak 1978; Inverarity and Tedrow 1988). The random effects approach indentifies the systematic state and time components in the errors, and explicitly incorporates this error distribution in the model. For some time the debate over fixed or random effects focused on the issue of whether the nature of the effects should be thought of as random or constant (see ibid. and Maddala 1971). However, Mundlak (1978: 70) argues that to focus the debate on "the nature of the effect, whether it is random or fixed, is both arbitrary and unnecessary." It is arbitrary because researchers can clearly

[16] As the theoretical model postulates, each Medicaid policy equation is related to the others; therefore, an additional problem of correlation among the residuals from the three different equations is likely. When this is the case, Zellner's GLS estimator, referred to as SURE (seemingly unrelated regression equations), is more efficient than the OLS estimator. However, the GLS (SURE) estimator reduces to OLS if the regressors in each equation are identical (Johnston 1984). Indeed, in this study the explanatory variables are identical across the three policy equations. Therefore, although the equations are clearly related, the GLS SURE estimator is not needed because no efficiency is gained by using SURE.

come up with arguments for both constant and random effects (though Mundlak argues that cross-sectional effects can always be considered random since the effects cannot be known or estimated until after the sample has been drawn). More importantly, however, the debate is unnecessary because the real issue is whether the individual cross-sectional effects are correlated with the other regressors in the model. If correlation exists, the random effects model suffers from inconsistency due to omitted variables (Mundlak 1978; Kmenta 1986; Greene 1990). In essence, the decision to use random or fixed effects may be a choice between consistent or efficient estimators.[17]

Hausman (1978) developed a specification test to determine the orthogonality of the random effects and the regressors. The test is based on the idea that under the hypothesis of no correlation, both the OLS estimates under fixed effects and the GLS estimates under random effects are consistent, but OLS estimates are inefficient. The alternative hypothesis postulates that OLS is consistent and GLS is inconsistent (Greene 1990). The Hausman specification test was conducted for each of the policy equations to determine whether the random effects model has inconsistent estimators. The chi-square for all three equations is very low (roughly .00001) indicating that the random effects model is appropriate.

Within the random effects approach, there are several ways to specify the behavior of the disturbances. These various approaches have been classified under two main model headings—error components model and cross-sectionally heteroskedastic (or cross-sectionally correlated) timewise autoregressive model (CCAR) (for a review see Kmenta 1986). Of the two models, the error component model is more commonly used because it is easier computationally. The disadvantage of this model, and the reason it will not be used in this research, is that its assumptions are very restrictive in relation to the CCAR model. Therefore, the cross-sectionally heteroskedastic (or cross-sectionally correlated) timewise autoregressive model (CCAR) is used in this study because it allows for the following realistic assumptions: heteroskedasticity, mutual correlation, and autocorrelation.[18] All estimates were obtained using version 6.1 of SHAZAM (White 1978).

[17] Mundlak (1978) in fact claims that there is only one estimator because the correlation between the cross-sectional dummies and the regressors unifies the two approaches in the sense that the resulting GLS estimator is identical to the fixed effects estimator. Hsiao (1986), however, suggests that this argument is too strong because the assumption depends on the effects being correlated with every explanatory variable in the regression.

[18] The heteroskedasticity assumption means that the variances among states are not constant; a realistic assumption because it is likely that the New York state error is different from the Alabama state error. Cross-sectional (mutual) correlation is likely to exist when the cross-sectional units are geographical regions with arbitrarily drawn boundaries, such

Measurement

The data were drawn from numerous secondary sources, including federal government publications. The measurement procedures for the three dependent variables are provided in this section; because measurement for interest group strength is sufficiently complex it is explained in more detail in Appendix B.

Financial eligibility policy (β_1). After 1990, Medicaid eligibility loosened considerably to include most children and pregnant women below the federal poverty line; however, prior to 1990, which is the time period in this study (1979 to 1989) Medicaid eligibility was strongly tied to AFDC income eligibility requirements (especially for states that chose not to offer the Medically Needy program).[19] Of course, mandatory AFDC recipients must meet the states' income and asset tests to be eligible for Medicaid. Actually, all states must set two AFCD income levels: a need standard and a payment level. According to a Supreme Court Ruling (*Rosado* v. *Wyman*, 397 U.S. 397, 1970) the need standard is supposed to be an objective measure reflecting the state's true determination of need and the payment level is that which the state can realistically afford to offer. While the need standard does play some role in determining initial AFCD eligibility status,[20] only families eligible for AFDC *payments* are eligible

as states. It is likely that Minnesota is highly correlated with Wisconsin, and Alabama with Mississippi. While this assumption is theoretically desirable, it is very difficult to apply computationally when the cross-section is rather large such as 49 states. Because the correlations for every possible cross-sectional pair must be computed, the variance matrix is usually inestimable when using most computer packages. An alternative method to control for cross-sectional correlation among the states is to include regional dummy variables in the model because the highest correlations are likely to occur among states within regions. The variable used to measure the "incentive or fear of welfare migration" (to be discussed in the following section) essentially acts as regional dummy variables would. It is measured as the regional financial eligibility norm so that each state within a census region receives the same score. In addition, this score changes over time which is consistent with the specification of the second equation for mutual correlation above. The final assumption allows the correlation of the disturbances to change over time and the distribution of this correlation over time to differ among the states. There is no reason to believe that all states will have the same level of serial autocorrelation; depending on the type of "time shock" in each state, states' reaction to such a shock will likely differ. Therefore, a "rho" matrix is estimated in which each state has its own estimated serial correlation value (P_i). Because there is a small number of time periods in this dataset, it is difficult to accurately estimate rho (P_i) (for details on the sensitivity analysis for estimates of rho see Grogan 1991).

[19] As mentioned, because the SSI program has fairly uniform federal eligibility criteria, I focus on AFDC Medicaid recipients under the financial eligibility policy.

[20] To be eligible for AFDC, a family must first pass two income tests related to the need standard: first, the applicant's countable income must be less than the need standard; second, an applicant's gross income must be less than 185 percent of the state's need

for Medicaid.[21] Over half the states (33 in 1989) have payment levels that are less than the need standard. Therefore, financial eligibility is measured as a continuous variable defined as the monthly AFDC payment level with no countable income.

Each state must set a payment level (and need standard) for each possible family size. AFDC payment and need standard data are collected and published for two-, three-, and four-person families (one adult with either one, two, or three children). While previous studies have devoted little attention to the issue of which family size is the appropriate measure of a state's AFDC payment levels, most simply use the payment level for a four-person family. Yet, the majority of AFDC recipient come from two-person family units (DHHS 1989). Due to different beliefs about the relationship between income level increases by family size and incentives to have more children, states vary in how they increase the payment level for different family sizes. For example, in 1989 Alabama provided a monthly incremental increase of $30.64 between a two- and three-person family unit, and $28.90 additional between a three- and four-person family. Wisconsin increased the monthly payment level $78.93 from a two-to three-person family and $100.16 from a three- to four-person family. Notice that Alabama decreases the incremental amount as a family size increases from two to four, whereas Wisconsin increases its incremental amount. Therefore, to account for the variation in states' incremental increases in family size and the proportional cost of different family sizes to the state, I measure the state's AFDC monthly payment for an individual.[22] In particular, the AFDC monthly payment with no countable income for a family of two is divided by two; the payment for a family of three is divided by three; and so on. Financial

standard (Ruther et al. 1990).

[21] If the state chose the categorically optional program that covers "individuals who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A of the Social Security Act (42 CFR 435.223)," then families whose countable income is below the state's need standard but above the payment standard would be eligible for Medicaid (Ruther et al. 1990). Very few states chose this option: the highest number was 15 states in 1980. In addition, for most of these states (10 in 1980) the option is meaningless because their payment level equals the need standard. Therefore, it is not surprising that when I used the need standard as the appropriate measure for states that chose this option the findings were the same as those presented in Table 1 for financial eligibility.

[22] I estimated the model using the separate measures for a family size of three and four respectively to determine if there would be any differences in the findings. The findings were largely consistent with those reported in Table 1 for financial eligibility with the exception of IG2 and UMEMP—the signs are the same, but differ in significance levels (both are insignificant in the three-person family equation, but significant for the four person family).

eligibility is measured by the weighted average of these three individual level payments with the weights being the proportion of recipients in each assistance unit (1 adult and 1 child, 1 adult and 2 children, or 1 adult and 3 or more children) by state.[23]

For states that choose to include the Medically Needy (MN) program, the Medically Needy income level (for the most part)[24] determines Medicaid eligibility. However, even for these states, the AFDC payment level is still a relevant policy decision because the MN income level is tied to the AFDC payment level: the MN income level can be no higher than 133 percent of the AFDC payment standard. Therefore, while the MN income level is important, it is a separate policy decision and is theorized to be determined under a different political process—the categorical eligibility policy dimension.

Categorical Eligibility Policy (β_2). States have the option to include a number of categorical groups in their Medicaid program. Optional AFDC groups include: unemployed parents with children (termed AFDC-UP), independent children under the ages 21, 20, 19, or 18 (depending on the state), persons regularly attending school, and pregnant women (Cromwell et al. 1986; Federal Register 1987). States also have the option to extend Medicaid coverage, but *not* cash assistance, to five "AFDC-related" categorically needy groups. Another optional categorical group includes individuals who meet the categorical eligibility requirements of the cash assistance programs but who have income and resources that exceed allowable financial eligibility levels (Federal Register 1987). This group is termed the "medically needy (MN)."

A weighted sum—weighing each optional program by its relative cost to the state—was used to measure the categorical eligibility policy as one variable while also incorporating the varying financial importance of each optional program to the state. Due to data limitations in determining the cost weight for each optional program, I conducted a simulation analysis and also measured categorical eligibility according to a simple additive index.[25]

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[23] The source for these data (both the proportion of recipients by family size and their respective payment levels): Department of Health and Human Services, Family Support Administration, Office of Family Assistance, *Characteristics and Financial Circumstances of AFDC Recipients* for Fiscal Years 1979, 1981, 1983, 1985, 1987, and 1989.

[24] If a state chooses the MN option, it must offer coverage to children under age 18 and pregnant women, but it can choose which other groups to include; it may choose to include the aged and disabled but not parents of dependent children, for example.

[25] Due to a lack of data on the specific costs of each categorical program to the states, a weighted sum measurement in which each optional program has a specific weight is unattainable. Payment data for some optional groups, however, are collected by the state of Minnesota. Assuming that the *relative* cost of the categorical optional group is similar across states, the proportional costs of these optional groups can be applied as the weights for

As mentioned, the Medically Needy (MN) program is unique because if states elect to offer the program they must also determine its financial eligibility level. Therefore, under the categorical eligibility policy dimension, I also estimate the MN income level. Due to the reasons discussed above for the AFDC payment level, I also measure the MN income level for individuals by averaging across amounts by family size. In the estimation equation I include all states that offered the MN program from 1979 to 1989 (there were 27 states over six years for a total of 162).

Benefit coverage policy (β_3). Benefit coverage policy is treated in a fashion similar to categorical eligibility policy: a weighted sum is calculated to account for the relative cost of each optional medical benefit to the state (see Table B-1 in Appendix B for the list of services). Again, due to data limitations (having to extrapolate from Minnesota data) I also measured benefit coverage policy using a simple additive index.

Results

Constituency Boundary and Interest Group Pressure

My theory predicts a different political process for each of the Medicaid policy dimensions. For the most part, the findings support this proposition (see Table 1). Financial eligibility policy is hypothesized to have a narrow constituency boundary and limited interest group pressure: the factors affecting voters' determination of the AFDC payment level—the low-income wage rate, potential for welfare migration, and recipient race—are all significant and in the hypothesized direction. Also, as predicted, there is evidence of interest group pressure, for categorical eligibility policy (both the number of optional programs and the MN income levels) and benefit coverage policy: interest group variables—IG2 and IG3—are significantly positive in their respective equations.

Political Ideology

In the theoretical model I argued that the degree to which politicians can pursue their political ideological beliefs is constrained by the width of the constituency

all states. This assumption with regard to the Medically Needy (MN) program is problematic. The MN program represents about 30 percent of total Medicaid costs for the state of Minnesota, while the proportional cost of the other eight optional programs ranges from .01 percent to 2.3 percent. States that offer the MN program can set the income eligibility level up to 133 percent of their AFDC income level. Because Minnesota has a high AFDC payment level to begin with (6th highest of the fifty states) *and* offers the maximum percentage (133 percent), it is likely that the proportional cost of the MN program in Minnesota is higher than in most other states offering the MN program. One way to address this problem is to conduct a sensitivity analysis using varying assumptions about the cost of the MN program for states. The sensitivity analysis results are discussed in the 'results' section of this article.

Table 1

FACTORS AFFECTING THE MEDICAID POLICY DIMENSIONS

	Financial Eligibility			Categorical Eligibility						Benefit Coverage		
				Optional Programs			Medically Needy Income					
Variable Name	Est. Coef.	St. Error	T-Ratio 278 df	Est. Coef.	St. Error	T-Ratio 180 df	Est. Coef.	St. Error	T-Ratio 145 df	Est. Coef.	St. Error	T-Ratio 278 df
WAGE	.304***	.0523	5.81	.0004	.0004	1.08	−.620***	.1226	−5.057	−.0003	.0002	−1.805
MIG	.645***	.0313	20.59	−.0008**	.0002	−3.28	.438***	.0573	7.844	.0001	.0001	1.554
RACE	−0.192***	.0539	−3.57	−.0001	.0003	−0.42	.016	.0923	0.172	.0008***	.0002	4.807
PC	−1.358**	.5382	−2.52	−.0142**	.0045	−3.18	−8.970***	1.151	−7.791	−.0083***	.0018	−4.722
PTY	−4.786**	1.454	−3.29	−.0591***	.0093	−6.36	−16.85***	2.436	−6.908	−.0069*	.0040	−1.699
IG2	−0.226*	.1117	−2.03	.0047***	.0009	4.95	.649*	.3248	1.999	−.0004	.0003	−1.067
IG3	.001	.0007	0.83	−.0000	.0000	−1.23	−0.004***	.0011	−4.008	.00001***	.0000	3.459
UMEMP	−0.026	.4457	−0.06	.0027	.0026	1.03	−0.903	.7197	−1.254	.0103***	.0013	8.269
HEALTH	−0.115***	.0145	−7.98	−.0009***	.0001	−5.94	.021	.0325	0.640	−.0002***	.0001	−3.541
INCOME	.002***	.0004	4.77	.00001**	.0000	2.44	−.002**	.0007	2.981	.00001***	.0000	3.723
FMD	−0.001***	.0002	−7.06	.00001**	.0000	2.90	.0004	.0004	1.075	.0000	.0000	.1278
CONSTANT	−8.136	17.41	−0.47	.2718	.1419	1.92	−33.540	41.53	−0.808	.5256	.0499	10.54
Main Effects:												
SENIOR	19.331	6.204	3.116	−.2337	.0474	−4.06	−28.57	18.60	−1.536	.0240	.0198	1.213
NURSB	.438	.1480	2.963	−.0067	.0013	−5.16	−0.644	.3974	−1.620	.0005	.0005	1.179
PROV	.037	.0235	1.578	.0022	.0003	8.36	−.164	.0357	4.594	−.0001	.0001	−.2949
HLTHP	.636	.6152	1.034	.0071	.0038	1.84	5.274	1.043	5.055	.0035	.0017	1.995
HINFL	−1.519	1.706	−.890	.0061	.0155	0.39	10.08	2.936	3.434	−.0139	.0051	−2.749
Buse R^2			.9148			.7213			.8926			.5939
Buse Raw-M. R^2			.9922			.9192			.9939			.9957
F-test			185.87			28.96			75.33			5.32

* $p < .05$
** $p < .01$
*** $p < .001$

where,

FE = financial eligibility policy;
CE = categorical eligibility policy;
BC = benefit coverage policy;
WAGE = average wage from lowest paying, non-union industry;
MIG = migration incentive;
RACE = AFDC recipient race;
PC = political culture;
PTY = party control;
IG2 = interest groups for categorical eligibility policy dimension;
SENIOR = political influence of senior citizens;
NURSB = nrusing home beds per 1,000 persons aged 65 or over;
IG3 = interest groups for benefit coverage policy dimension;
PROV = size of medical provider group (physicians, dentists, and hospital beds);
HLTHP = proportion of political lobbying groups that are health related;
HINFL = political influence of medical providers;
UNEMP = unemployment rate;
HEALTH = health of the state's population;
FMD = federal matching rate; and
INC = state per capita income.

boundary and the degree of interest group pressure. The findings do not support this conjecture. While political culture and political party control were significantly negative for categorical eligibility (both optional programs and the MN income level), as predicted, these variables were also significantly negative for financial elegibility (under a narrow constituency boundary) and benefit coverage (under strong interest group pressure). These results suggest that state politicians have some leeway to consider their own political ideology on all three policy dimensions. Therefore, the theoretical model should be revised to allow political ideology to be independent (not to depend on the constituency boundary and interest group strength) and, thus, to play a role in the determination of each policy dimension.

Political Cost Function

I theorized that the policy dimensions are tied together through the political cost function. I postulate that an increase in one of the policy dimensions, all other things equal, will result in a decrease in one or both of the other policy dimensions due to the Medicaid budget constraint. Therefore, in the reduced form, all the variables affect the three policy dimensions either directly (as already discussed above) or through the political cost function.

The findings provide some support for this integrated theory: variables that affect one of the policy dimensions directly and the other two through the political cost function are either consistant with the theory or insignificant.[26] Notice that senior and nursing home interest group strength (IG2) is negatively related to financial eligibility suggesting that these groups tend to elicit categorical optional benefits at the cost of more generous financial eligibility levels for AFDC recipients.

Other variables that only enter the model through the political cost function include the state's unemployment rate, potential health service needs, state income and the federal matching rate. Each variable is discussed in turn below.

I hypothesized that the unemployment rate is negatively related to the Medicaid policy dimensions because an increase in the unemployment rate would increase AFDC caseloads, which would increase the cost of the Medicaid program. However, the empirical findings are unsupportive: the unemployment rate is insignificant in explaining either financial eligibility or categorical eligibility policy, and has a significant positive effect on benefit coverage policy (though

[26] Two exceptions are wages and migration which are indeterminant due to their opposing effects on the spending and cost sides of the model. In addition, as explained in footnote 15, the migration variable is also acting as a regional dummy variable to control for mutual correlation among the states making an accurate interpretation of its effect on the categorical eligibility or benefit coverage policies impossible.

its elasticity is quite low—a 1 percent change in the unemployment rate results in only a 12th of a percent change in benefit coverage).

A plausible explanation for these findings is that changes in AFDC caseloads have a minimal effect on Medicaid costs. While only one-third of the Medicaid caseload consists of nursing home and institutionalized recipients, over two-thirds of the Medicaid budget is devoted to these long-term care costs suggesting that changes in the AFDC caseload would result in minor changes in Medicaid costs. Thus, while unemployment likely affects AFDC Medicaid caseloads, changes in AFDC Medicaid caseloads due to changes in unemployment have a minimal effect on total Medicaid costs. This conjecture is supported by several studies reporting a positive relationship between AFDC caseloads and the unemployment rate (Albion and Stein 1977; Bluestone and Sumrall 1977; Peden and Brooks 1981; Cromwell et al. 1986).

As expected, the potential health needs of a state's population have a significant negative effect on three of the four policy variables. As health needs increase the use of health services increases, and the cost of the state's Medicaid program increases. This puts pressure on state politicians to reduce Medicaid eligibility and benefit coverage levels. The one anomaly to this finding is the significant relationship with the medically needy income level. This finding, however, is not surprising in light of the purpose of the Medically Needy program: to help those who have become impoverished due to large medical expenses.

In an effort to discover the separate income and price effects, the federal matching rate was replaced by an interaction term (labeled FMD in Table 1) of state per capita income multiplied by a dummy variable for "poor" states (states above the federal matching rate minimum). This interaction variable represents the price of Medicaid because the federal matching rate in relatively poor states is a formula determined by state income (as well as the average per capita income among the states).

The income and price effects for financial eligibility are significantly positive and negative, respectively. For Medically Needy and benefit coverage policy, income is significantly positive, while price is not significantly different from zero. However, if we measure benefit coverage as a simple additive index (omitting the proportional cost weights as discussed), income is significantly positive and price significantly negative as hypothesized (see Table 2).[27] The combined effect is determined by summing the coefficients from income (INC) and price (FMD): financial eligibility is .0007, Medically Needy income is .0016, and benefit coverage is .00001 (or .0004 for results in Table 2). These findings indicate

[27] The coefficients for the other variables in the model are consistent with those presented in Table 1 for benefit coverage.

that the total effect is positive even for relatively poor states; the fall in the federal matching rate does not overcome the income effect.

The income and price coefficients for categorical eligibility optional programs are significantly positive; these results are the same when this variable is measured as a simple additive index (see Table 2). Sensitivity analysis results for the optional programs policy reveal that the model is robust under a wide variation of assumptions about the proportional cost of the Medically Needy program. Under lower MN proportional cost assumptions, income is consistently insignificant. Again, although price is significantly positive under all of the assumptions employed, the price elasticities are very low–ranging from .08 to .15 of 1 percent (see Table 2). Therefore, while the price coefficient is unexpectedly positive, the effect appears to be minimal suggesting that decisions related to the MN program are relatively price insensitive.

When the MN program is not included in the categorical eligibility measure, the estimation results also support the notion of MN price insensitivity (consistent with the findings for the MN income level policy variable): income is significantly positive and price is significantly negative, as hypothesized (see Table 2). This price insensitivity may be due to the nature of the MN program–adding the group to the Medicaid rolls is a rather large commitment for a state; once this groups is added it can be costly and yet is very difficult to rescind the offer.

Conclusion

In this article I have presented a new approach to explaining social welfare policy in the American states. The strength of the theoretical model in explaining state Medicaid policy lends credence to my argument that an explanation for the determinants of state policy must focus on the discretionary choices available to states in designing their social programs. In other words, the practice of observing global state determinants, such as state political structure and state economic resources, for all state policies, obscures the reality that the factors affecting policy decisions will vary according to the specific policies confronted. Thus, while the basic assumptions of my theoretical model can be generalized to other state policies, the factors influencing policies such as education or transportation will be different from the factors affecting state Medicaid policy because the constituency boundary and interest group strength vary among policies. Clearly, the state political process depends on the policy under consideration.

My empirical findings support the notion that the following three factors determine the political process of state public policies: (1) the width of the constituent boundary (whether voters are vitally interested in the policy): (2) the political power of interest groups concerned about the policy; and (3) state political ideology. As these variables change, the political process changes. The

Table 2

Effects of Varying Levels of Medically Needy (MN) Program Cost on Categorical Eligibility Optional Programs Variable and Additive Index Variables for Categorical Optional Programs and Benefit Coverage Variables

	Simulation Analysis for Optional Programs Variable					Additive Indexes	
	Proportional Cost Assumptions						
Variable Name	MN Not Included	MN = .05	MN=.10	MN=.15	MN=.20	Optional Programs	Benefit Coverage
WAGE	−0.0000	0.0002**	0.0003**	0.0004*	0.0005*	−0.0007	−0.0434***
MIG	0.0000	−0.0001	0.0002**	0.0003	0.0005**	0.0025	0.0345***
RACE	−0.0000	−0.0001	−0.0001	−0.0001	−0.0001	0.0061	0.0250**
PC	−0.0020***	−0.0039***	−0.0056***	−0.0074**	−0.0093**	−0.3264***	−.07272***
PTY	−0.109***	−0.0197***	−0.0276***	−0.0351***	−0.0427***	−0.9666***	−0.2577
IG2	0.0004***	0.0010***	0.0018***	0.0024***	0.0031***	0.0377***	− 0.0234
IG3	−0.0000	−0.0000	−0.0000	−0.0000	−0.0000	−0.0001	0.0005***
UNEMP	0.0007**	0.0007	0.0006	0.0010	0.0015	−0.173	0.3160***
HEALTH	−0.0001***	−0.0002***	−0.0004***	−0.0005***	−0.0006***	−0.0072***	−0.0067*
INC	0.0000*	0.0000	0.0000	0.0000	0.0000	0.0001**	0.0005***
FMD	−0.0000*	0.0000**	0.0000**	0.0000**	0.0000**	0.0000*	−0.0001**
CONSTANT	0.0488	0.0727	0.1033	0.1328	0.1646	5.446	17.25
Main Effects							
SENIOR	−0.0140**	−0.0487***	−0.0862***	−0.1177***	−0.1536***	−1.4860**	1.0690
NURSB	−0.0006***	−0.0015***	−0.0025***	−0.0033***	−0.0043***	−0.0736***	0.0101
PROV	0.0002***	0.0006***	0.0009***	0.0012***	0.0015***	0.0284***	−0.0051
HLTHP	0.0006	0.0024**	0.0044**	0.0052**	0.0059**	−0.9242	0.0584
HINFL	−0.0006	0.0011	0.0033	0.0047	0.0057	−0.0733	−0.9082**
Buse R^2	.8315	.8201	.7803	.7453	.7220	.8018	.7065
Raw-M R^2	.9609	.9541	.9393	.9281	.9207	.9821	.9649
F-Statistic	55.20	51.01	39.72	32.74	29.06	45.25	41.68

factors hypothesized to affect the voters' utility for financial eligibility policy were significant in the financial eligibility equation; similarly, the strength of provider interest groups was significant in the categorical eligibility and benefit coverage equations. However, the findings also reveal that legislators rely heavily on their own political beliefs. Moreover, the extent to which they rely on their own political beliefs does not depend on either the constituency boundary or interest group strength. Indeed, this study found that political ideology influence all three dimensions of Medicaid policy. Thus, my theoretical model should be respecified to include the politicians' political ideology (Φ) utility weight for each of the policy dimensions.

Another key concept in my theoretical model is that when state politicians maximize their political utility, they, at the same time, minimize their political disutility by attempting to keep the political costs of their actions as low as possible. Specifically, I theorized that the Medicaid policy dimensions are linked through the political cost function so that an increase in one policy dimension, all other things being equal, results in a decrease in one or both of the other policy dimensions due to the Medicaid budget constraint. The findings provide some support for this integrated theory, indicating that politicians make policy decisions based on the trade-offs between pressures to increase spending and the political costs associated with increased spending.

Appendix A: Chow Test

The following are the Chow Test specifications for the appropriateness of pooling subsamples (Greene 1990):

Q_0 = sum of squared residuals (SSE) under the null hypothesis of pooling (no separate subsample effects);
Q_i = SSE for the ith subsample under alternative hypothesis;
m = number of subsamples (or cross-sections);
n_i = number of observations in ith subsample; and
k = number of parameters in each of the subsample regressions.

$$F_a = \frac{(Q_0 - \Sigma Q_i)/(m-1)(k-1)}{\Sigma Q_i/(\Sigma n_i - mk)}$$

The null hypothesis of structural consistency is rejected if $F_a >$ critical F with df = $[(m-1)(k-1), (\Sigma n_i - mk)]$. Table A-1 presents the residual sum of squares from each subsample and pooled OLS estimations and the Chow Test statistic. With the addition of 5 time trend dummy variables in the pooled model, there are 15 parameters in the subsample and 20 in the pooled estimation. By adding the time trend dummy variables, time, measured in years, is allowed to have a different intercept effect in the pooled as well as the restricted model.

Table A-1:
CHOW TEST FOR STRUCTURAL CHANGE

	FE	CE	BC
Q_i	119595	628	174002
ΣQ_i	99558	540	149953
F_a	.587	.522	.467
$F(\alpha = .01)$	1.0	1.57	1.00

APPENDIX B: VARIABLE MEASUREMENT

The width of the constituency boundary (γ_1) and the degree to which politicians' political ideology is not constrained (Φ_2) are not measured because they are theorized to be constant. All income related variables—financial eligibility, wages, and the migration incentive—are adjusted for inflation using 1982–84 dollars.

Table B-1: OPTIONAL MEDICAL SERVICES

Podiatrist Service	Dentures
Optometric Service	Prosthetic Devices
Chiropractic Service	Eyeglasses
Other Practitioner Services	Diagnostic Services
Nursing Services	Screening Services
Clinic Serivces	Preventive Services
Dental Services	Rehabilitative Services
Physical Therapy	Inpatient Psychiatric < 21
Occupational Therapy	Emergency Hospital Services
Speech Therapy/Audiologist	Prescribed Drugs

Source: Minnesota Medical Assistance Department, Report #00-00239.

Interest Group Strength for Categorical Eligibility (α_2) and for Benefit Coverage (α_3). Hrebenar-Thomas (1987) categorized interest groups in each of the 50 states according to two categories: the most influential groups in the state; and groups that are either increasing or decreasing in influential power. These findings were used to measure interest group strength.

Senior citizen influence was coded 2 if a senior citizen group appeared in a state's first category of Hrebenar and Thomas's list; coded 1 if it appeared in the second category, and coded 0 if it did not appear at all. I also measure interest group size as another indicator of strength: the proportion of the number of nursing home beds per 1,000 elderly population (65 years of age or older).

The interest group variable (α_2) is measured as an interaction term between the senior citizen influence and nursing beds per senior population.

The health provider interest groups were measured by four dimensions. The first dimension is the influence variable from the Hrebenar-Thomas study measured as described above. Because some states have more than one influential health provider group; the second dimension measures the number of health groups in Hrebenar-Thomas' categories 1 or 2 for a state. Dimension three measures the number of health groups that have lobbyists in the state.[28] The fourth dimension includes provider variables that act as proxies for interest group size. The following equation is used to measure provider interest group strength.

$$\left[\left(\frac{P_i}{\overline{P}}*100\right) + \left(\frac{D_i}{\overline{D}}*100\right) + \left(\frac{H_i}{\overline{H}}*100\right)\right]*HLTHP*HINFL$$

where,

Pi = number of physicians per 100,000 population in the state;
Di = number of dentists per 100,000 population in the state;
Hi = number of acute care hospital beds per 100,000 population in the state; and
HLTHP = the proportion of registered lobbyists that are health related.

$$HINFL = (HLTHI*HLTHG)$$

where,

HLTHI = 1 if health groups in the state have no influence; = 2 if a least one health group has some influence in the state; and = 3 if at least one health group has significant influence in the state; HLTHG = number of influential health groups in the state (ranges from 1 to 3).

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[28] The data for this variable comes from research conducted by V. Gray at the University of Minnesota Political Science Department. For more details of the study see Grogan 1991.

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Received: December 14, 1992

Accepted for Publication: September 10, 1993

Political Research Quarterly, Vol. 47, No. 3 (September 1994) pp. 589–622