Fragmented Democracy

Medicaid is the single largest public health insurer in the United States, covering upward of 70 million Americans. Crucially, Medicaid is also an intergovernmental program that yokes poverty to federalism: the federal government determines its broad contours, while states have tremendous discretion over how it is designed and implemented. Where some locales are generous and openhanded, others are tightfisted and punitive. In Fragmented Democracy, Jamila Michener demonstrates the consequences of such disparities for democratic citizenship. Unpacking how federalism transforms Medicaid beneficiaries' interpretations of government and structures their participation in politics, this book examines American democracy from the vantage point(s) of those who are living in or near poverty, (disproportionately) black or Latino, and reliant on a federated government for vital resources.

Jamila Michener is Assistant Professor of Government at Cornell University. She is a faculty affiliate of the Center for the Study of Inequality, the American Studies Program, and the Africana Studies Department. She studies poverty, racial inequality, politics, and public policy in the United States. Her work has been supported by the Russell Sage Foundation, the National Science Foundation, the Robert Wood Johnson Foundation, and the Ford Foundation. Her research appears in numerous journals including Political Behavior, the Journal of Health Politics, Policy and Law, the Journal of Poverty and Public Policy, and The Forum: A Journal of Applied Research in Contemporary Politics. She received her PhD in political science from the University of Chicago and completed a postdoctoral fellowship as a Health Policy Scholar at the University of Michigan.
Fragmented Democracy

Medicaid, Federalism, and Unequal Politics

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To Jace and Jax – my sweet, beautiful boys. I hope that you will always uphold the cause of the poor and the oppressed (Psalm 82:3)
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Properly acknowledging all of the people who contributed to this book over the years is impossible. My sincere apologies to whomever I may omit.

I started on the road toward this project haphazardly. In the course of talking to unemployed, economically marginal people of color on the south and west sides of Chicago, I stumbled upon the subject of Medicaid. I knew little about it and I was afraid to delve in. But I could not ignore what the people I interviewed told me, so I reluctantly included one chapter on Medicaid in my dissertation. As it turned out, it was the only chapter that I even remotely liked. Serendipitously, I soon landed the best possible gig given my burgeoning interest: a two-year postdoc as a health policy scholar with the Robert Wood Johnson Foundation (RWJF). I am deeply appreciative of RWJF. As a postdoc at the University of Michigan, I had the time, resources, and intellectual community necessary to learn more about Medicaid than I could have ever hoped to otherwise. I am tremendously grateful for the knowledge I gained from the many people I engaged with via RWJF, including Christopher Bail, C. Daniel Meyers, Graeme Boushey, Alice Goffman, Seth Freedman, Rachel Best, Sarah Miller, Francisco Pedraza, Edward Norton, Rick Hall, Helen Levy, Daniel Lee, Rob Mickey, Vince Hutchings, Tiffany Josephs, Dan Gillion, and Jake Haselswerdt.

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that it is possible for a person – a woman of color in particular – to do this work well, and remain true to her convictions. That example has meant so much to me.

Along with Cathy, I had the indefatigable support of some of the most brilliant teachers the University of Chicago could offer, most notably Michael Dawson, John Brehm, Mario Small, and the late Iris Young. I often still find myself passing on knowledge that I learned from them, and I am struck by how profoundly my thinking has been shaped by their interventions into my scholarly life.

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I would be remiss to forget my parents, Naldine and Anthony Celestine. Thank you for the sacrifices you made so that I might have opportunities. You came to this country, faced tremendous obstacles, and worked hard to give your children the chance at a better life. I am ever grateful.

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it is because of him. To the extent that my life is filled with more light and love than I ever imagined possible – you get the idea.

Finally and most importantly, I offer my deepest gratitude to the Medicaid beneficiaries across the country who shared their stories with me and relayed their experiences compellingly and incisively, sometimes to the point of tears. My hope is to put them front and center – notwithstanding a world that too often relegates them to the margins.
Medicaid, Political Life, and Fragmented Democracy

“No one can travel the length and breadth of the United States without the conviction of its inexpugnable variety. East and West, South and North, its regions are real and different, and each has problems real and different too. The temptation is profound to insist that here, if ever, is the classic place for a federal experiment ... This kind of argument is familiar in a hundred forms. I believe that, more than any other philosophic pattern, it is responsible for the malaise of American democracy.”

– Harold Laski, 1939

“I’ve worked in Ohio, I’ve worked in California, I’ve worked in Washington and as a single parent I have always had Medicaid. Now here in Georgia in 2012 they cut me off because I have a part-time job ... This is the only state that has ever cut me off Medicaid because I have a job, a part-time job that does not allow me to afford insurance. Why cut off someone for that? You know I have to be healthy to work right? You want me to be a functioning, self-sufficient adult. So why take away the very thing that keeps me functioning, self-sufficient, and able to provide?”

– Terrie, 2012

One warm August day I sat in a burger joint on the outskirts of Atlanta and spoke with Terrie, a middle-aged black woman. I treated Terrie to a banana milkshake and she gave me the scoop on Medicaid. Because of her limited income, Terrie had been on and off Medicaid for more than seventeen years. Over this period of time she lived in Ohio, California, Washington, Illinois, and Georgia. Of everything she divulged about her experiences, Terrie’s most emphatic observation was that Medicaid varied dramatically from place to place. Before we sat down to talk, I told her that the purpose of my research was to understand what it
was like to be insured through Medicaid. Then, I began with a very open question: “Tell me a little about yourself?” In response, Terrie portentously broached the core issue that she would dwell on throughout our conversation:

My name is [Terrie] and I have a sixteen-year-old son; he’ll be seventeen soon. I have traveled a lot so the difference between state to state with Medicaid and what it offers and the programs and how consistent they are; I have a lot of experience with that. Being in [Medicaid] seventeen years, you know, it has just been a whirlwind with keeping [my son] safe and healthy.

I was struck by the prominence of geographic variation in Terrie’s first words. Her emphasis on this proved persistent and pointed. She soon offered details about the merits of various state Medicaid programs: “Ohio is the easiest, they do care about their people.” “California, their process is probably faster, but there are so many people and it’s so rapid that it is out of control.” “In Georgia, there are limitations in everything that they offer … you either can get this and can’t have that, or you can have this and can’t get that … you can only go to this doctor on this day at this time.”

Foremost on Terrie’s mind was how the intergovernmental design of Medicaid affected interstate travel. She shared this:

When I knew I was going to meet you, I got upset a little bit thinking about it, because I’ve got a lot to say about Medicaid. Like, for instance, my grandmother was here from Chicago just this past week. She went to the doctor and to the hospital. We got some prescriptions we needed to fill for her. So we go to the pharmacy and we can’t fill this prescription because Medicaid is non-transferable state to state … and her prescription was $190, so we really had to find $190 for her prescription. That was amazing … and for something that’s provided by the government … you’re limiting the use of something meant to make people better.

As our conversation progressed, Terrie elaborated on the (state-specific) political lessons that she drew from such geographic discontinuities:

If it was about helping people, you would say yes, let my state be more productive and healthy so that we do not have people losing their lives [and] so that they can be productive citizens … These types of people are here serving you food when you go out … wouldn’t you like to know that they are healthy? These are the people that you want to give Medicaid, the very people who are serving your food … you do not want to insure the very people that are serving you food? (emphasis added)
Toward the end of the interview, I asked Terrie whether politics might be an avenue for changing some of the things we had talked about. She stared at me in what seemed like disbelief and sardonically uttered, “white noise.” I looked back at her, confused. Again, she reiterated, “white noise.” After a few seconds of awkward silence, I asked her what she meant. She explained by saying,

White noise is the people that choose to say well, if they give it to me, they give it to me, if they don’t, they don’t … white noise also means that you feel like in your world, you have no say, no say in the process if you don’t agree with what is going on in Medicaid. It’s demeaning, you know, the process. So when you want to, you can’t get through that door and you are wondering how can you possibly get through the magic door to get people to understand … I have never seen anyone really stand up about Medicaid. We fight a little bit … politically we fight a little over welfare reform and Medicaid reform and all that, but in general as people, I don’t know why we don’t fight (emphasis mine).

Terrie was among those who did not fight. Most of her time was spent working grueling low-wage jobs while taking care of her son, and she simply did not believe Georgia was a place where one could make a difference on issues like Medicaid. Throughout our conversation, she would recount some feature of how Georgia’s Medicaid program operated, compare it to another place she had lived (often Ohio), sigh audibly, and say, “that’s Georgia.”

Terrie recognized that Georgia was not the only “headache when it comes to Medicaid.” She named other culprits, like Louisiana, a state that “doesn’t give a toss about Medicaid whatsoever.” She thought this was an injustice, reasoning that “Everyone in America needs to be covered so America is covered.” Still, Terrie saw little hope for change. She was mostly resigned to a life of second-class citizenship. She even admitted being “amazed” that I cared enough to talk to her, much less write an entire book about people on Medicaid.

Terrie’s contextually inflected experiences with Medicaid were accompanied by feelings of political inefficacy and powerlessness, “white noise” as she dubbed it. She was not exceptional in this regard. Though the details differed in rich and revealing ways, nearly all of the Medicaid beneficiaries I interviewed for this book described program experiences that varied across states, counties, and even neighborhoods – critically shaping political life along the way. John, Fiona, and Daphne provide additional examples. Before I proffer a single word about academic literature or scholarship, I present their stories. I lead with the voices of
Medicaid beneficiaries because their experiences paint a compelling and multitone portrait of the largely veiled operations of federalism in the everyday lives of economically and (disproportionately) racially marginal Americans. The ensuing narratives exemplify the profound implications of federalism for democratic citizenship and provide a springboard for the scholarly inquiry taken up in this book.

JOHN: “MARRIED” TO MICHIGAN MEDICAID

John is a white man from Michigan who was diagnosed with a life-threatening chronic illness in early childhood. He expressed gratitude for Medicaid, but he also admitted feeling as though he was “married to Michigan” medically, without “the option of really going other places.” Like Terrie, John described an out-of-state trip gone wrong: “I actually hurt my leg and I got like a patch of gout down in my ankle and [Michigan] refused the bill and I got a whopping bill in the mail that I am still paying.” Further underscoring his weddedness to Michigan, John discussed his dashed hopes of relocating to Arizona to start a new life. After speaking to caseworkers and friends in Arizona, John learned that the Arizona Healthcare Cost Containment System (that is the name of the state Medicaid agency) had meager home health care provisions that would not cover the services he required. “I got some other friends [who] live down [in Arizona] who have the same disease I do and … they’re stuck over there with what they got and it just kind of becomes a struggle.” Reluctant to jeopardize his life-sustaining benefits, John decided not to move. He explained that “beggars can’t be choosers,” and declared that he would “live on Mars” if he had to. John also pointed out that if the government “just did like a federal insurance and everybody had their insurance card regardless of who we are, where you are, I think it would solve a lot of problems for people, but I don’t think that’s going to happen.” Incredulous about the possibility of change, John noted that Medicaid beneficiaries were politically lackluster because “it does kind of feel like you just reach a fork in the road where you just give up, you just lose.” Throughout our conversation, he continually referenced his thwarted aspirations: “I wanted to venture off and go try to do something different for myself … seeing other family and friends and they’re able to move on … it is tough.” When I finally asked him what he thought about “politics,” he assured me that he was not the least bit “interested in that.” I return to John in
subsequent chapters because it turns out that when mobilized by a cause proximate to his life, health, and community, he cares quite a bit about “politics” (which, as I make clear throughout this book, extends far beyond voting and elections). Still, separate from the concrete political outcomes I detail later on, the snapshot of John offered here speaks to how profoundly a federal political system conditions life for those who find themselves in need of assistance from the government to secure vital resources.

FIONA: “MEDICAID SAVED MY BABY’S LIFE” (BUT ALMOST DIDN’T)

Fiona’s story was more heartening, but the challenges she encountered are nonetheless instructive. Fiona was unexpectedly thrust into the world of health care policy when her son Jack was born with a potentially fatal tumor on his leg. With her partner in school, the family lost health coverage when she quit her job to care for Jack. Sympathetic and supportive hospital employees in North Carolina helped to sign Jack up for Medicaid. The program paid for everything and even covered expenses retroactively from a period before he was enrolled. Fiona had great things to say about Medicaid because it met her family’s most dire need during a perilous time. Nonetheless, she recounted a disconcerting problem. After about a year, the treatment that Jack’s physicians in North Carolina were providing stopped working. Fiona sought care from experts in Boston who were more knowledgeable about the rare condition that Jack suffered from. But North Carolina’s Medicaid program refused to cover that care, cautioning Fiona that if she pursued treatment in Massachusetts, she would have to do so on her own dime. At a devastating loss, Fiona waited and hoped. She soon noticed that Jack’s tumor was shrinking. Doctors said that the treatment he received in North Carolina had kept him alive long enough for his body to mount its own defense against the illness. Fiona avowed, “Medicaid saved my son’s life!” I relished in her happy ending, but wondered what would have happened if Jack’s body had not taken over. Fiona rightly spent little time pondering this. Instead, her experience with Medicaid motivated a new career: she now works for a grassroots organization advocating “health care for all.” In this role, Fiona coordinates with activists in Florida, Texas, and North Carolina to spearhead the fight for Medicaid expansion in the states that have refused it.
DAPHNE: MEDICAID AS THE BURGER KING OF THE HOOD

At the time we initially spoke, Daphne – a young black woman in her early twenties – had been insured through Medicaid for her entire life. She grew up in a high-poverty, high-crime, hyper-segregated neighborhood in Syracuse, New York. She was living at home, attending community college, and desperately trying to “get out of the hood.” Her life had been so deeply defined by where she lived, that when I asked her about Medicaid, the overbearing power of place lurked in the subtext of nearly all that she relayed to me. For Daphne, Medicaid meant the scary clinic downtown where only the most indigent beneficiaries ventured. It meant being treated in “ridiculous” ways by health care practitioners who surely would not do the same to (white) people from nicer neighborhoods like “Fayetteville or Cicero or North Syracuse.” Medicaid meant missing out on high-quality care, not (only) because the program itself was inadequate, but because the places where poor people utilized the benefits were lacking. As far as the practical application of Medicaid services, Daphne told me that “it is different in different places … [like] say if you’re at an Olive Garden or you go to a Burger King, they treat you really different.” Daphne and those who lived in communities like hers were relegated to the medical equivalent of the cheapest junk food.

Daphne was savvy enough to know that this was politically meaningful. Her politics – like most politics, perhaps – were local.3 No matter the direction our conversation veered, the specter of the neighborhood loomed. What’s more: Daphne mapped the local to places beyond it, and she developed her ideas about policy and politics accordingly. For example, when I raised the topic of Medicaid expansion, Daphne confessed that she was glad New York had expanded the program, but deeply uncomfortable with that decision being left in the hands of any particular state: I don’t really like the state choosing things … I don’t really trust the state … I just think everybody having the same access and it being the same everywhere … would be more helpful instead of having all these rules and here and there … I wish it was just nationwide … I just wish it was the same nationwide and not just the state, because I don’t think the state could be trusted, honestly. We can’t even trust our police force (emphasis added).

At the root of Daphne’s mistrust of the state, there was something more proximate: her mistrust of local police. Extrapolating from one level/
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institution (neighborhood/polic) to another (state/Medicaid), Daphne deduced that policy decisions should be uniform across the nation. In doing so, she unknowingly foreshadowed her own struggles.

A few months after our initial interview I caught up with Daphne and learned that she had come to experience the consequences of federalism more acutely than she ever wanted to. Her long-held dream had come true: she was accepted to a college in North Carolina and given sufficient financial aid to actually go. Exultantly, she had made it out of “the hood.” Distressingly, her Medicaid could not go with her. Since North Carolina had stricter eligibility criteria, Daphne could not qualify and had to remain signed up for Medicaid in New York. Her plan was to visit her doctors when she came home over breaks. So when she tore a major muscle in an accident, she could not immediately see a doctor in North Carolina. Instead, she aggravated her injury by waiting until she could arrange travel home for treatment. As Daphne finished her first year in a bachelors degree program, her move south represented her purest aspirations for upward mobility, but it imperiled her health.

Political Life: Participation and Citizenship

The political lives of Terrie, John, Fiona, and Daphne bear the imprint of Medicaid’s federated structure. By invoking political “life” in this way, I am being intentionally capacious. I mean for this to include “political behavior” as traditionally understood by political scientists (which encapsulates activities such as voting, contacting an official, and protesting). Going further, political life also involves more mundane actions taken by denizens seeking resources, redress, or protection from national, state, or municipal governments (such as filing a complaint within a local bureaucracy or requesting a fair hearing). Extending beyond the realm of participatory action, political life is also about how a person experiences democratic citizenship. Citizenship includes the “rights, duties and obligations imposed by government, as well as citizens’ responses to them” (Mettler and SoRelle 2014: 156).

Folks who cannot recall participating in any political activity at all nonetheless have political lives worth recognizing. Some of the people featured in this book exemplify that. They returned only blank stares when I asked them how, if at all, they “participated” in politics. But when I probed their experiences with Medicaid, they surprised themselves by having more to say than they had thought possible. And despite their disconnection from “politics” in the formal sense, they captivatingly articulated
how they were actually living politics off the record. This is what Terrie, John, Fiona, and Daphne voice to us. While I will demonstrate why and how people like them take political action, I will also describe how they live in and make sense of a polity that is fragmented by the powerful force of federalism.

This book thus illuminates a pressing question: how do Americans understand and respond to a political system that confers (or withholds) access to resources for the most indigent – not on the basis of needs or rights – but on the basis of geographic location? To tackle this inquiry, I investigate whether, how, and under what conditions Medicaid influences political life. I find that it has varied effects across states, counties, and neighborhoods. In this way, federalism produces geographically differentiated political capacity across its population of beneficiaries and federalist social policy is a key purveyor of political inequality.

Why Medicaid?

The design of Medicaid is one reason for its central place in this book. The intergovernmental configuration of the program allows for wide discretion across state and local levels, which facilitates the policy fragmentation that I seek to understand. Still, Medicaid is not merely a useful case for investigating larger questions; it is substantively important in its own right.

Medicaid is the largest source of public health insurance in the United States and the primary mechanism for providing health coverage to low-income Americans. It is the third most costly domestic program in the federal budget (following Social Security and Medicare) and the biggest source of federal revenue in state budgets, accounting for one out of every six dollars spent on health care (Paradise 2015; Snyder and Rudowitz 2015). Recognizing Medicaid’s immense significance, scholars have studied it carefully. Among other things, they have found that Medicaid has (positive) effects on mortality, mental health, financial security, and educational outcomes (Baicker et al. 2013; Cohodes et al. 2016; Finkelstein et al. 2012; Sommers, Baicker, and Epstein 2012a). In this book, I assess its effects on democratic citizenship and political participation.

With growing ensemble of academics, pundits, and ordinary people stridently pronouncing (and denouncing) the economic stratification of political life in America, tracing the conduits of political inequality remains a first-order task. Given that charge, Medicaid is especially
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significant. Its beneficiaries are overwhelmingly poor, disproportionately people of color, and unduly prone to health troubles. As such, Medicaid policy brings government directly into the lives of the most marginal citizens (Hernández-Cancio, Bailey, and Mahan 2011; Manchanda 2011).

Foremost among such persons are the economically marginal. Income is the chief criterion of Medicaid eligibility, especially for able-bodied adult beneficiaries. In the wake of the 2010 Patient Protection and Affordable Care Act (commonly called the Affordable Care Act, or the ACA), non-elderly adults became eligible for Medicaid in states that implemented expansion so long as their income fell below 138 percent of the federal poverty line (FPL). In Wisconsin (a state that did not expand Medicaid) the cutoff is 100 percent of the FPL. The remaining (non-expansion) states have varied income requirements that mostly exclude non-disabled adults; when parents with dependent children qualify, they must fall (on average) below 44 percent of the FPL (see Figure 1.1).

The larger point is this: though Medicaid plays many important roles in our health care system, the overall picture suggests that it is a primary resource for those who are living in or near poverty. In 2015, more than 90 percent of non-elderly beneficiaries were either poor or low-income: 54 percent were officially below the FPL (accounting for

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**Figure 1.1** Income eligibility limits for adults in non-expansion states (2016)

Data from Henry J. Kaiser Family Foundation, 2016

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36 percent of all Americans in poverty), while an additional 38 percent hovered between 100 percent and 199 percent of the FPL (comprising roughly 30 percent of all low-income Americans). The tethering of class to race in the United States means that the penury of beneficiaries has racial repercussions. People of color are disproportionately represented in Medicaid: 32 percent of African-Americans and 34 percent of Latinos were enrolled in 2015 compared to only 16 percent of whites. Though blacks and Latinos (combined) composed 30 percent of the U.S. population in 2015, they accounted for 50 percent of Medicaid enrollees.

Not surprisingly, given well-documented racial and economic health disparities, Medicaid beneficiaries are also more likely to suffer from illnesses like diabetes, asthma, obesity, high cholesterol, and high blood pressure (Mendes 2013). Figure 1.2 contrasts people insured through Medicaid to those with employer-sponsored insurance. The ailments of beneficiaries are particularly worrisome in light of mounting evidence that health can affect both electoral participation and democratic representation (Gollust and Rahn 2013; Pacheco 2013; Pacheco and Fletcher 2015; Pacheco and Ojeda 2015; Schur et al. 2002).

The trifecta of race, class, and health puts Medicaid beneficiaries among the most politically vulnerable persons in the country. Discerning the democratic corollaries of Medicaid is therefore essential for an accurate picture of political (in)equality in the United States. Relatedly, comprehending the political consequences of Medicaid policy requires attentiveness to its defining institutional facilitator: federalism (more on that in Chapter 2).
What’s Democracy Got to Do with It?

You may have noticed that I just shifted from describing the demographic profile of Medicaid beneficiaries (race, class, health) to asserting its importance for democracy. One reason for this jump is that demographic realities signal political vulnerability. When those most affected by a policy are also most marginal in the polity, it is worth stopping to think about how policy and polity interact (Schneider and Ingram 1993). Even more crucially, turning to democracy is unavoidable as we move away from the hard numbers of Medicaid and toward the people behind them. As of 2017, more than 70 million Americans had health coverage through Medicaid. Fifteen percent of those beneficiaries were disabled, 9 percent were elderly, 48 percent were low-income children, and 27 percent were low-income adults. These statistics are useful, but incomplete unless we relate them to the very real human beings who rely on Medicaid to meet their most pressing needs: the jobless mother who is too proud to apply for food stamps but humbled enough by debilitating back pain to embrace Medicaid; the minimum wage-earning father who was kicked off the Medicaid rolls despite his epilepsy and eventually had a seizure that caused him to bite off a portion of his own tongue; the homeless man who insisted that “Government totally sucks. They can determine when you can live and how you can live. They give you that assistance and it determines your lifestyle … your weight and your health and all those things.” These examples are drawn from the accounts of Medicaid beneficiaries I interviewed for this research. Before talking to them, I could have opined on the “politics of Medicaid” without once mentioning or thinking of an actual person. Afterward, I can do no such thing.

Though Medicaid beneficiaries are key stakeholders in the American health care system, many of them hardly make a blip on anyone’s political radar. Certainly, some groups of beneficiaries – like the elderly and the disabled – are better positioned politically. But overall, most remain disempowered in the face of polarized, pivotal public debates that may literally determine whether they live or die. They are the numbers behind the statistics in these debates, but where are their voices? They are the people who will be most deeply affected by the policy that politics creates, but what of their political lives?

This is where democracy comes in. The relative quiescence of Medicaid beneficiaries is not an inevitable or inflexible outcome. For example, in September 2011, numerous “My Medicaid Matters” rallies were held throughout the country and thousands of people showed up to oppose
program cuts. The flow of protests continued thereafter. In 2012, demonstrators in Texas held rallies challenging the state’s defunding of a women’s Medicaid program and warned Governor Rick Perry not to “mess with Texas women.” In 2013, activists in Philadelphia demanded that then Governor Tom Corbett expand Medicaid, holding up signs with the query, “Medicaid or Millionaires, what will it be?” In 2014, two dozen people converged on Topeka’s copper-domed state house, waving American flags and urging Kansas Governor Sam Brownback to implement Medicaid expansion. In 2015, hundreds of protesters descended upon the Missouri state capital with the goal of letting “the legislature and senators know that … there are many people in the state of Missouri [who] are dying that have no means to go to a doctor and to get assistance.” On Valentine’s Day in 2017, hundreds of activists in North Carolina called for lawmakers to “have a heart,” delivering thousands of individually signed “Valentines” to two Republican senators asking them to expand Medicaid and protect the ACA.

Just over a month later, on March 21, 2017, Rise and Resist, a direct-action political group, organized a rally in New York City around the theme “Medicaid Block Grants Kill.” Roughly 300 demonstrators gathered in front of Federal Plaza at the intersection of Broadway and Worth, holding signs that read, “Medicaid Block Grants Kill,” “Medicaid Cuts Kill,” “We Need Medicaid,” and “TrumpCare Makes Us Sick.” (Some of these protestors are pictured on the front cover of this book.) Medicaid beneficiaries in attendance shared about why they needed the program; they expressed their disdain for President Trump and they literally pleaded for their lives. Foremost among their concerns was the prospect that Medicaid budgets would be slashed and thousands of lives sacrificed at the altar of “state flexibility.” Ironically, on the same day as the rally in New York City, Congressman Bruce Westerman (R-AR K) published an op-ed explaining how “Medicaid Block Grants Give States More Freedom” and arguing in favor of them. The divergence between Westerman’s sentiments and those of the Medicaid beneficiaries fighting for their lives on the streets of New York City bespoke a gaping chasm between the elites making decisions about Medicaid policy and the everyday Americans affected by those decisions.

Since the passage of the ACA, hundreds of rallies about Medicaid have taken place, attended by anywhere from 25 to 8,000 people (at a single event). Though scattered and sporadic, such activity hints at the life that is coursing through the veins of our body politic. It insinuates the potential for Medicaid beneficiaries (and would-be beneficiaries) to play an
active role in American democracy. However, the political capacity of this population and the quality of their democratic citizenship depend upon processes that are structured by the institution of federalism (Mettler 1998; Soss, Fording, and Schram 2011). In the next chapter, I take a closer look at federalism: what is it and why is it so important? But first, I provide a brief mapping of this book, say a bit about my methodological approach, and clarify the political stakes of this work.

Outline of Book

Since federalism is a foundational American institution that dynamically structures politics at multiple levels of governance, across various repertoires of action, and with dramatic material and ideational consequence, this book covers a broad scope. After conceptualizing federalism in more detail, Chapter 2 situates this book in a broader literature and poses a framework for understanding my contribution to scholarship on political participation, policy feedback, and contextual effects.

Chapter 3 then pans out, with a historical perspective on the profound implications of federalism for U.S. social welfare policy – most especially health policy and Medicaid. It has always been the case that what it means to live in poverty in Maine is very different from what it means in Michigan; that Cook County (IL) offers a markedly different array of services than Cuyahoga County (OH); and that teetering at the economic brink in Seattle is quite unlike doing so in Syracuse. I show how such incongruences have been buttressed and amplified by federalism. Medicaid is an especially arresting case, epitomizing how federalism generates inequity by creating geographic variation in access to vital resources.

After recounting this historically, I present a contemporary sketch of Medicaid to demonstrate how federalism enables systematic disparities among economically and racially marginalized Americans. This is not because federalism is inherently bad. Federated political systems have a host of well-noted advantages and disadvantages, so coarse characterizations will not do (Zimmerman 2008). Nor is Medicaid the problem; it is a program that saves thousands of lives every year and provides tens of millions of Americans with the security of health insurance (Sommers, Baicker, and Epstein 2012a). Chapter 3 emphasizes that inequities among Medicaid beneficiaries (and between beneficiaries and non-beneficiaries) are the product of policy choices made possible (but not necessitated)
by federalism. Not only do such policy alternatives underwrite material inequities that diminish the social citizenship of marginal Americans; they also contribute to political inequities (Marshall 1950).

Chapter 4 represents the first step in making an empirical case for the latter claim. Here, I examine the participatory effects of state-level Medicaid policy variation. After establishing that disparities exist in political participation between Medicaid beneficiaries and similarly situated non-beneficiaries, I dig deeper to make sense of heterogeneous political outcomes among beneficiaries. I find that Medicaid has the potential to be either a boon or a bust for political engagement. The outcome realized depends in large part on how state contexts shape beneficiaries’ experiences of policy. Beneficiaries living in states offering a wide scope of services, fiscally equipped bureaucracies, and expanding Medicaid programs are significantly more likely to participate in politics. In this way, the geographic inequalities induced by Medicaid’s federalist design have tangible consequences for the political health of low-income populations.

Having found a critical role for state-level policy design, Chapter 5 concentrates on the counties that implement policy. To study how county administration shapes politics among Medicaid beneficiaries, I highlight the political resistance that unfolds as they push back against the perceived injustices they face at the hands of local bureaucracies. Examining county-level records on fair hearings in combination with interview data, I investigate the processes that lead beneficiaries to take oppositional action. Despite counties’ oft-lamented lack of control over Medicaid spending, federalism positions them to exercise substantial discretion in overseeing beneficiary disputes with Medicaid agencies. Consequently, counties shape political resistance in ways that are consequential both for continued access to health resources and for democratic engagement.

Chapter 6 turns to a frontier that few scholars recognize as relevant to either federalism or Medicaid: the American city. After explaining the links between federalism and urban politics, I assess how cities influence the political reach of Medicaid. I find striking variation in Medicaid’s participatory effects across Chicago neighborhoods, with strong and negative effects limited to highly disorderly neighborhoods. The upshot of this is that the urban geography of race and class, together with the contemporary trajectory of federalism, makes antipoverty policy (like Medicaid) especially demobilizing for disadvantaged people when they live in destitute places.

Chapter 7 switches gears to look at Medicaid policy advocacy. Drawing on qualitative interviews, I chart the varied responses of
activist beneficiaries to changing policy landscapes. Confirming and broadening the findings from earlier chapters, I specify the numerous limits that federalism places on beneficiaries who are advocating for their own interests (as well as those faced by external advocates acting on beneficiaries’ behalf). At the same time, I demonstrate possibilities that federalism creates for particular advocacy strategies and repertoires of action. Political entrepreneurs sometimes adroitly exploit those possibilities, but they often confront steep challenges and disconcerting democratic deficits.

In the final chapter, I consider what we have learned about Medicaid, federalism, and democratic citizenship. The lessons imparted are not about federalism being either good or bad. Instead, I follow Simeon (2006: 18) in asserting that “federalism is not a value in itself. Like any other set of institutions, it must be evaluated in terms of its consequences for other, more fundamental values and principles.” In this light, federalism is a multivalent, dynamic institution that sometimes works at cross-purposes with the principles of democratic self-governance and other times strengthens them. Cultivating the latter outcome requires a focus on securing the well-being of those who are most vulnerable, ensuring geographic equity, reviving struggling communities, and valuing state and local flexibility contingently, only to the extent that they serve higher ideals.

**Methodological Approach: On Centering the Voices of Medicaid Beneficiaries**

I take a bottom-up approach to investigating these inquiries. I foreground the experiences of low-income policy beneficiaries (like those whose stories anchor this chapter) instead of accentuating intergovernmental jockeying among political elites. I consider where federalism emerges in the lives of those who are economically and racially marginal, how it affects their understanding of politics, when it prompts (or suppresses) political participation, and how it transforms their citizenship (social and political). To study all of this, I rely on a mixed-methods empirical design. Mario Small (2011) quite rightly asserts that the designation of “mixed methods” is hardly straightforward. Scholars can mix several different things (data types, data collection methods, and data analysis techniques) in different ways. In this book, I draw primarily on three types of data: 1) interviews with Medicaid beneficiaries and those who advocate on their behalf; 2) state administrative records; 3) large-sample surveys. The latter
two require “quantitative” analyses while the former involve “qualitative” analyses.\footnote{Citation}

The methods I employ are a function of the questions that motivate the research and the answers that unfold as the research progresses. Sometimes, I rely on the interview data to generate hypotheses and then leverage the large-sample or administrative data to test them (as in Chapters 4, 5, and 6). Other times, the interviews stand alone, revealing things that the other data do not speak to directly (as in Chapter 7). The data are never the point; the arguments are (though the two are closely related).

The methodological appendix offers lots of information, and it is a vital addendum to the main text. Still, I must stress two related points up front. First, my overarching methodological approach is pragmatic rather than dogmatic. The questions detailed in this chapter drive my research – not fidelity to a particular method. I am devoted to getting the most correct answers possible to the questions I pose, given (inevitable) practical limits. At times, my search for the best answers leads me to quantitative data. As appropriate, I use a range of techniques to get a better handle on whether observed correlations indicate possible causation (controlling for confounders, attempting alternative model specifications, matching, multilevel models, fixed-effects models). Still, many of the questions that I ask do not lend themselves to experimentation, nor do I always find it possible or optimal to employ the latest, most sophisticated techniques for making quantitative causal inferences. My strategy is to bring strong and varied evidence to bear on important (and at times complex) inquiries. Though I cannot promise dispositive certainties, I offer thoughtful, compelling, and empirically corroborated arguments.

As further foreshadowing of the overarching approach on offer here, my second disclosure is that the voices of Medicaid beneficiaries figure prominently in this book. Beneficiaries provide this book’s core insights. Perhaps most illustratively, federalism was not a topic that I naturally found interesting. As I started talking to people involved with Medicaid, they kept mentioning the relevance of where they lived. I took notice. Even then, I imagined that further investigation would reveal the significance of “contexts” as this was a framing that resonated naturally with me. Yet, as the research progressed, a contextual focus proved inadequate on its own. Yes, contexts shaped how Medicaid beneficiaries engaged politically, but those contexts were themselves political phenomena deeply tied to larger institutional forces like federalism. I would not have
drawn such conclusions in the absence of in-depth conversations with beneficiaries themselves (Mosley 2013; Soss 2006).

This research exposes troubling political inequities undergirded by a federated political system that too frequently mutes the voices of economically and racially marginal populations. It is no small thing then, that in order to produce the findings, those very voices had to be heard. In that sense, the methodological foundations of this work gesture toward the shift that must occur in American politics if we are to strengthen and preserve the democratic process.

The Political Stakes of this Research

I cannot move on without directly articulating the stakes of this work. In the wake of the ACA, health care became even more of a political lightening rod than it had long been. The election of Donald Trump intensified this state of affairs. After dozens of futile votes to repeal the ACA while Obama was still in office, the dawn of 2017 ushered in a political moment when repeal was finally possible. The U.S. House tried (but failed) to make good on this new opportunity in March 2017 by proposing the American Healthcare Act (AHCA; H.R. 1628). In June and September of that year (respectively), the U.S. Senate made two attempts at repeal: the Better Care Reconciliation Act (BCRA) and the Graham-Cassidy bill. The AHCA, BCRA, and Graham-Cassidy all promised to roll back the ACA’s expansion of Medicaid and to radically restructure the program so that federal funding is capped (through block grants or on a per capita basis). Such changes would have given states even more power to determine the contours of Medicaid. Moreover, these policies would have led to tens of millions of additional people being uninsured (Jost 2017).

Given the gravity of such policy developments, I must be straightforward about this book’s implications. The broadest strokes are as follows: I bring to the fore an often neglected aspect of Medicaid policy – how it affects citizenship and democratic participation. I show how and why state variation in policy design and local variation in policy implementation – while not inherently or necessarily detrimental – often pose substantial dangers to democracy. All of this (and more) will become clear in the pages to follow. But before delving into the deep end, allow me to make a critical clarification: no honest interpretation of this book can or should be used to crudely impugn Medicaid or to justify its retrenchment. Program cuts accomplish little and risk setting
off a different sequence of politically demobilizing processes than those I describe here. Keep in mind that though I focus on some of the negative democratic upshots of Medicaid, I trace them to specific policy and administrative choices. The pathway to improving Medicaid (and social policy more broadly) lies in elaborating and addressing the (sometimes unrecognized) consequences of such choices. That is what I aim to do.

Medicaid provides vital benefits to tens of millions of Americans. As the people highlighted in this book relay, it is literally “a lifesaver.” That fact notwithstanding, many Medicaid beneficiaries live in states and localities that design and implement the program in ways that weaken their connections to political life and erode their citizenship. I aver that the provision of life-sustaining health care benefits need not conflict with the safeguarding of democracy. In fact, these tasks should reinforce one another. That they do not is because of the political decisions our nation has long made, and those we continue to make now. This book is meant to bring such matters to the fore of policy discourse, to enrich the academic literature, and to inform the public. Above all, however, it is meant to advance an agenda: not a particular partisan plan, but an agenda that centers on the material and political well-being of economically and racially marginal groups and that pushes for public policy and political institutions to cultivate, incorporate, and respond to the needs of those who too often fallen through the cracks of our fragmented democracy.
Democratic Citizenship and Contextualized Policy Feedback

As democratic citizens, how do Medicaid beneficiaries experience, understand, and respond to federalism – a political system in which their access to health resources is closely linked to their geographic location? Many moving parts underlie this question: federalism, democratic citizenship, policy feedback, political participation, and contextual theories. To intelligibly grapple with this motley crew of ideas, some theoretical housekeeping is in order. I’m not mixing academic flavors in the vain hope of coming up with something tasty; these components are connected. In this chapter, I elaborate on them and coherently link them.

A LEGACY OF DUAL CITIZENSHIP

The federal structure of the American political system has long raised tough questions about the jurisdiction of U.S. citizenship. For instance, take the prominent Supreme Court case of Barron v. Baltimore.¹ In the early 1830s, the City of Baltimore inadvertently ruined John Barron’s wharf² while completing street construction. Barron sued, seeking compensation for his losses. After a defeat in state appellate court, he appealed to the Supreme Court on the basis of the Fifth Amendment.³ In a seminal decision, Chief Justice John Marshall ruled against Barron, insisting that “the Fifth Amendment must be understood as restraining the power of the General Government, not as applicable to the States.” Essentially, Marshall claimed that the Fifth Amendment regulated the actions of the federal government, but did not pertain to the states. Had a federal construction project damaged Barron’s wharf, he would have been vindicated; but since the constitution of Maryland did not
offer protections analogous to those of the U.S. Constitution, Barron was not granted relief by the Supreme Court. This case established the doctrine of “dual citizenship” by confirming that Americans were separately and simultaneously citizens of the national government and of their respective state governments – with different rules applying to each domain.

More than thirty years later, the Fourteenth Amendment provided a potential corrective to Barron, forbidding states from making or enforcing laws that “abridge the privileges or immunities of citizens of the United States.” Still, it would be nearly a century before the Supreme Court extended the entire Bill of Rights to citizens, irrespective of their state of residence (Lowi et al. 2017). Over the long period of time during which the precedent set by Barron held sway, the courts openly adjudicated an enduringly difficult question: what are the bounds of citizenship in a federal polity where multiple levels of government share distinct powers? Today, from a formal constitutional perspective, that question is largely settled. However, as a political and ethical inquiry, it remains very much alive and is central to this book. To understand why, we must interrogate federalism: what is it, what has it been, and why does it matter for democratic citizenship?

WHAT IT IS: A BRIEF PRIMER ON FEDERALISM

Federalism is a nebulous and contested notion for which “there is no accepted theory … Nor agreement on what, exactly, [it] is” (Duchachek 1987: 189). I will not get snagged in the conceptual or definitional “tangled mess” that awaits those who seek a comprehensive theoretical mapping of federalism (Landau 1973: 173). Nevertheless, to pursue questions about how it shapes citizenship and democracy, I need a working description. To that end, I define federalism as a “set of institutional arrangements and decision rules” that divides government authority into constituent parts, each of which maintains substantive autonomy within its respective realm (Obinger, Castles, and Leibfried 2005: 9; Scott 2011). I emphasize a particular “species” of federalism characterized by a national polity with multiple levels that are “territorially defined” and divided between central and subnational governmental entities (Gibson 2004: 5). While federalism looks quite different across polities, a major distinguishing aspect of all federations is that they have “an architecture of government … driven by a process of bargaining between a number of constituent units and a center” (Beramendi 2009: 754).
In the United States, the specific content of this general form is reflected in the constitutional division of power between the states and the national government. The national government has powers that are directly enumerated in the Constitution (e.g., the power to collect taxes, borrow money, or declare war), as well as “implied” powers that are not so straightforwardly expressed but are deemed necessary in order to execute those that are. Perhaps most strikingly, the “supremacy clause” of the Constitution makes national law the “supreme law of the land.”

Notwithstanding this marked centralization of power, the U.S. national government does not reign unilaterally, by far. The Tenth Amendment dictates that states retain all powers not otherwise delegated. This encompasses an astounding array. Consider just a few laid out by Lowi and colleagues (2017: 77) in their classic textbook:

The power to develop and enforce criminal codes, administer health and safety rules, and regulate the family via marriage and divorce laws. The states have the power to regulate individuals’ livelihoods ... to define private property ... the state may seize your property for anything it deems to be a public purpose.

As this demarcation of powers elucidates, under the U.S. system of federalism, both the national government and the states have substantial autonomy; each is granted power to affect a wide variety of political and material outcomes.

Though such authority is established constitutionally, the U.S. Constitution does not exclusively determine the contours of federalism. For example, the Constitution does not delegate any powers to local governments. Yet not a single state in the country reserves all of its power for itself (Richardson, Gough, and Puentes 2003). Instead, states endow local governments (municipal, county, city) with varying degrees of autonomy and often do so via institutional mechanisms that are enabled by the U.S. Constitution (like state constitutions). So, despite common depictions of American federalism as two-tiered (state and national), the practice of federalism incorporates local entities, and has since its inception. This is not simply decentralization or devolution for the purpose of conducting bureaucratic or administrative affairs. Federalism extends “all the way down” in substantive and pervasive ways (Anton 1989; Gerken 2010). Cities, counties, and municipalities are granted official institutional power, they operate autonomously to a significant degree (even if interpedently), and they are central to the practice of democracy (Anton 1989; Zimmerman 2008). Despite their formal absence from the Constitution, local governments are knit into the very fabric of federalism.
WHAT IT HAS BEEN: THE DEVELOPMENT OF FEDERALISM

It is impossible to give a brief synopsis of the history of federalism without being painfully reductive. In Chapter 3, I look at federalism historically through the specific lens of social welfare policy and health policy. For a broader historical view than that, I necessarily direct the reader to texts more suited for the task (Conlan 2010; LaCroix 2010; Robertson 2012). Nevertheless, it is crucial to say something about the development of federalism – what it has been – because doing so situates this work in a wider intellectual and political landscape.

In the United States, federalism has played a role in “every major political conflict in American history” (Robertson 2012: 9). Some of the most divisive and enduring political battles animated by federalism have been fought over issues concerning the maintenance of white supremacy – such as slavery, Jim Crow, and civil rights (Katzenelson 2005; Lieberman 2005; Lowndes, Novkov, and Warren 2008; Robertson 2012). Another (and often related) pivotal set of struggles has been waged around matters related to capitalism and economic development – like unionization, tariffs, and antitrust laws (Bensel 2000; Ritter 1999; Robertson 2012; Scheiber 1975). These two arenas (race and economic development) are critical, yet they only scratch the surface of the many ways that federalism has figured into American political development (Robertson 2012, 2014). There is scarcely a policy domain one can envision without invoking federalism in some way (think: education, marriage equality, environmental protections, mass incarceration, and so on).

Despite the undeniable influence of federalism in U.S. history, understanding its effects remains an elusive quest, made all the more difficult by the broad transformations it has undergone over many years. Before the 1930s, the American political system was characterized by “dual federalism,” an arrangement by which the national government had a relatively distinct and limited role, while states and localities did most of the governing (Corwin 1950; Kincaid 1996). The 1930s ushered in an era of cooperative federalism (Conlan 2006; Kincaid 1990, 1996). During this time, the role of the national government expanded significantly, but relations between the federal government and states remained largely collaborative. As the 1970s came around, the grand national policies of cooperative federalism that were aimed at building the Great Society, waging the War on Poverty, and providing civil rights protections gave way to a “new” more “coercive” or “regulated” federalism marked by
heightened anxieties over “big government,” deepening tensions between national and subnational sovereigns, reduced federal funding for states and localities, and the beginning of historic devolution in social welfare policies (Béland, Rocco and Waddan 2016; Kincaid 1990, 1996; Peterson 1995; Soss et al. 2011; Weber and Brace 1999). Contemporarily, federalism continues to be defined and redefined in relation to changing political contexts. For instance, scholars have become increasingly attentive to the possibilities of “progressive federalism” or “federalism as the new nationalism” (Gerken 2012, 2014; Rogers and Freeman 2007). Given an intensely polarized political system, progressive federalism posits federalism as a mechanism for transcending political gridlock, cultivating democratic discourse, setting the national agenda, and catalyzing productive policy conflicts.

I have sketched these assorted (and still unfolding) iterations of federalism in order to clarify a crucial point: federalism is a dynamic institution. Grasping its effects is a challenging endeavor. I thus proceed with care and assert the bounds of my evidence and arguments as precisely as possible. The empirical chapters in this book are oriented toward the contemporary moment, so the findings cannot be blithely applied to the past, nor can they be assumed applicable indefinitely. Thoughtful consideration of federalism requires continued assessment and attentiveness, which necessitates engagement with the ideas offered here, but goes beyond any single text.

WHY IT MATTERS: FEDERALISM AND DEMOCRACY

In light of both the history and the prospects of federalism, scholars have devoted substantial energy to deciphering its role in shaping public policies. They have considered how the institution of federalism affects (or is affected by) racial and gender inequality, labor relations, social welfare, social citizenship, health, and crime (Banting 2006; Brown 2003; Doonan 2013; Freeman and Rogers 2007; Johnson 2006; Lieberman 1998 Mettler 1998; Miller 2008; Nathan 2005; Soss et al. 2011). Notwithstanding this impressive corpus, little empirical research directly assesses the consequences of federalism for political participation. More than seventy-five years after Harold Laski’s audacious insinuation (noted in the epigraph of the first chapter) that federalism was “the malaise of American democracy,” we remain underequipped to scrutinize his claim.

Many stylized and normative accounts of federalism suggest that it buttresses democracy (Andre 2014; Anton 1989; Stephen 1999; Tushnet
1998). The purported reasons for this are myriad. In the roughest sense, federalism was designed to prevent the concentration of political power (*Federalist* No. 51). It multiplies the potential points of citizen influence, which presumably expands opportunities for political engagement (Anton 1989; Ostrom, Tiebout, and Warren 1961; Riker 1975; Trench 2006). It also invests power in the hands of political officials at different levels of government who can then craft policy specific to their constituencies and this generates proximate incentives for those constituencies to become involved in politics (Anton 1989; Arnold and Holahan 2014; Tushnet 1998). Furthermore, federalism disciplines local government by giving citizens choices and allowing those who are mobile to wield power by voting with their feet (Greve 1999; Hirschman 1970; Tiebout 1956).

Juxtaposed to such reasoning, numerous descriptions of federalism highlight its antidemocratic bent. For example, scholars of comparative politics have asserted that federalism contributes to low levels of citizen participation and is generally incompatible with democracy (Cameron and Simeon 2000; Smiley 1979; Warhurst 1987).

Scholars of American political development (ADP) have offered multiple, diverging narratives about federalism and democracy. On the one hand, APD research demonstrates how federalism has facilitated the diffusion of progressive policy arrangements and radical political movements (Skocpol 1992; Valelly 1989). On the other hand, APD perspectives highlight how federalism has begotten fragmented political parties, weak labor unions, and overly dispersed interest groups – all while empowering corporations (Robertson 2014). Perhaps most damning, ample research has confirmed that federalism bolsters one of the most antidemocratic forces in the American polity: racism (Brown 2003; Lieberman 2005; Lieberman and Lapinski 2001; Miller 2008; Riker 1964; Soss et al. 2011; Soss et al. 2004; Strolovitch, Warren, and Frymer 2006; Ward 2009).

While claims about the virtues or inadequacies of federalism abound, they often lack sufficient “empirical analysis of how federalism actually structures political activity on the ground, whether it produces the ends it is alleged to encourage, or even whether those ends are, in fact, essential to the advancement of democratic values” (Miller 2013: 267). As a result, federalism’s “democratic credentials” remain unclear and contested (Smith 2004: 8). So much so, that when a leading scholar of American politics recently identified a handful of “crucial questions that offer fertile topics for future research,” he included an inquiry about whether “federalism facilitate[s] democracy” (Robertson 2014: 10). This book sheds light on that subject.
To do so, it relies on the rich intellectual underpinnings of scholars who have produced seminal research about public policy, federalism, and democracy (Campbell 2014; Mettler 1998; Miller 2008, 2013; Soss et al. 2011). These authors provide invaluable antecedents to the questions that I raise here. Perhaps most aptly, in Dividing Citizens (1998), Suzanne Mettler persuasively argues that the configuration of federalist social policy during the New Deal era “facilitated a gendered division of Americans as social citizens” (19). As a result, “the incorporation of citizens in the context of American federalism has tended to undercut possibilities for full inclusion ... curtailing more complete opportunities for participation in public life” (12). In advancing such claims, Mettler lays the groundwork for scholarly scrutiny of the relationships between federalism, policy, and democratic citizenship.

Expanding on this foundation, Lisa Miller delineates The Perils of Federalism, highlighting its “significant implications for political representation and accountability.” Miller shows how federalism can splinter democratic participation “in ways that strengthen existing power differentials” by consigning interest groups advocating for marginal constituencies to local legislative settings, while shutting them out of more powerful state and national venues (2008: 10, 20, 27).

By establishing how federalism “functions as a political institution that structures power relations,” Mettler and Miller provide a point of departure for my work (Miller 2013: 268). While Mettler’s tack was historical and elite-oriented, I concentrate on the contemporary bottom-up operations of federalism in the political lives of policy beneficiaries. Mettler accentuated citizenship “divided” between the states and the national government; I consider the many subdivides embedded in these arrangements, and the resulting possibilities for proliferating inequities. Similarly, where Miller highlights interest group activity across levels of government, I look primarily to the political actions of ordinary people and the pedestrian politics that emerge when they encounter federalist government. Tens of millions of Americans do so each year. A robust scholarly literature avers that their experiences with government often matter for political behavior (Campbell 2003, 2012; Mettler 2005; Mettler and Soss 2004; Soss 2000). Yet federalism seldom factors explicitly into the story. For example, the word federalism did not appear in Andrea Campbell’s now classic review of the policy feedback literature (2012). The absence of federalism was not due to Campbell’s neglect of the literature, it was due to the literature’s neglect of federalism.
Filling this lacuna means heeding the admonition that “the capacity of public policies to remake politics is contingent, conditional and contested” (Patashnik and Zelizer 2013: 1072). I examine a crucial condition that determines how policy is designed, implemented, and experienced: geographic context. In the United States, the institutional force of such context principally derives from the dictates of federalism. So my task is to understand how federalism shapes the political effects of Medicaid policy. Along the way, I advance a synoptic account of how people like Terrie, John, Fiona, and Daphne (introduced in Chapter 1) experience American democracy amid the conspicuous geographic discontinuities that characterize much of American social policy.

Previous research has touched on such discontinuities. Joe Soss, Richard Fording, and Sanford Schram (2011) dedicate their extensive analytical wherewithal to a sweeping analysis of the ways that racially inflected policy devolution – powered by federalism – shapes contemporary poverty governance. In a book that offers an incisive descriptive portrait of Medicaid, Andrea Campbell devotes a chapter to discussing state-level program differences (2014). Notwithstanding such scholarship, no one has yet pulled federalism, social policy, and political behavior into a single orbit to assess how the subnational heterogeneity of public policy bears upon democratic citizenship and one of its key components – political participation. That is the distinct contribution I make here.

A CONTEXTUALIZED FEEDBACK MODEL OF POLITICAL PARTICIPATION

To illuminate the extent and value of that contribution, I develop a contextualized feedback (CF) model of political participation. This stylized rendering (graphically depicted in Figure 2.1) maps the questions interrogated in this book onto a broader schema incorporating three (usually distinct) approaches to political behavior: traditional, feedback, and contextual. The CF model seeks to “integrate both individual and contextual factors into a common frame of analysis” by coalescing dominant approaches to the study of political participation while keeping political institutions in clear view (Soss and Jacobs 2009: 105).

Panel A represents traditional models. For example, Steven Rosenstone and John Mark Hansen (1993: 6) offer a decisive take on the foundations of political participation: “citizens participate in elections and government both because they go to politics and because politics comes...
to them.” The authors subsequently explore two sets of mechanisms propelling the participatory process: 1) individual characteristics that motivate people to “go to politics”; 2) institutional elements of the political system that draw ordinary folks into politics. Panel A reflects Rosenstone and Hansen’s theory as well as insights from a range of other scholars, including Verba, Schlozman, and Brady (1995), who highlight similar dynamics; Campbell, Converse, Miller, and Stokes (1960), who emphasize partisan attachments; and a host of other political scientists who demonstrate the effects of individual characteristics and meso-level institutions like interest groups, organizations, places of worship, and media (Garcia-Rios and Barretto 2016; Hahn 2009, 2014; Jamal 2005; Schlozman et al. 2012).
Panel B highlights an important addition to such theories, the policy feedback model. The imperative intervention of the feedback literature has been to view public policy as an especially significant institution that is not only an output of the participatory process but a vital input as well (Easton 1957). Scholars in this literature have gone a long way in showing how “policies create politics” (Campbell 2003, 2012; Mettler 2005; Mettler and Soss 2004; Pierson 1993; Schattschneider 1935; Soss 1999, 2002; Weaver and Lerman 2014). Policy feedback models do not replace traditional models; they extend and supplement them (hence the plus sign in the diagram).

Next, Panel C incorporates research that highlights the role of context. A substantial body of work has confirmed the political relevance of states, cities, neighborhoods and even counties (Alex-Assensoh 1998; Books and Prysby 1988; Cohen and Dawson 1993; Gay 2012; Huckfeldt 1979; Michener 2013, 2017a). Economically marginal persons are especially vulnerable to contextual influence because those with the fewest resources are more concentrated and less insulated from negative externalities (Jargowsky 1997; Massey, Gross, and Eggers 1991; Sharkey 2013; Wilson 1987). Moreover, interconnected, cascading disadvantages amplify the potential impact of overlapping adverse contexts (Harris and Lin 2008). For these reasons, economic, political, and social settings play a key role in conditioning politics in under-resourced groups.

Finally, Panel D brings together all three models. Though traditional, feedback, and contextual approaches to studying participation are complementary, they have developed largely independently from one another, especially the latter two. As a result, scholars of participation and policy feedback have paid inadequate attention to three things: 1) that the design, implementation, and constraints of public policy are contingent upon state, county, and even neighborhood contexts; 2) that macro-institutions structure those contexts; 3) that such institutionally embedded contexts affect individuals’ experiences with policies, shaping their political capacity and thereby influencing a wide range of participatory actions. Points 1 and 2 are not novel, but the advantage of the CF model lies in more fully integrating them into theories of participation. Doing so implicates point 3, which is a core claim of this book. Let’s consider each point in turn.

First, the design, implementation, and constraints of public policy are often contingent upon state, county, and even neighborhood contexts, most especially for means-tested benefits (Mettler 1998; Soss et al. 2011; Soss and Jacobs 2009). This gives us reason to suspect that the political
effects of such programs could be geographically heterogeneous across states (which have some discretion over design), counties (which often handle administration), and more proximate localities (which impose concrete constraints on things like the safety of communities in which policies are implemented). While scholars have separately considered the effect of state policy differences on political participation (Bruch, Ferree, and Soss 2010) and the impact of county policy administration on material outcomes (Soss et al. 2011), they have not cohesively examined the multilevel political effects of geographic policy variation.

Second, macro-institutions structure the aforementioned contexts. State and local contexts are important, but they are embedded in a larger set of social, economic, and political arrangements that dictate how and when they matter. In this book I focus on how one vital macro-institution (federalism) affects political participation through its influence on a paramount policy (Medicaid). The CF model can be applied more generally across policy domains and macro-institutions (though its applicability will vary based on the specifics). For example, we might consider a different macro-institution (civil law) and its influence on how citizens experience one or more related policies (e.g., eviction and/or child custody policies). A CF approach would be distinguished by attentiveness to the multilevel contextual conditions created by the civil legal system (e.g., the structures and practices of city, state, and county housing/family courts) and investigation into the implications of those conditions for the political capacity of those who come into contact with such institutions.

The latter point relates to the third and most crucial aspect of the CF model: institutionally embedded contexts affect individuals’ experiences with policies, which can in turn affect their political capacity and shape a wide range of participatory actions. In the dotted path of Figure 2.1 (Panel D) federalism frames the settings in which policy is designed, implemented, and constrained. Then, policy (through the differential experiences of beneficiaries) affects political capacity. Note the shift of the intermediary mechanism here from “political engagement” (models A–C) to “political capacity” (model D). Capacity is engagement in context. It encompasses the factors that bear upon citizens’ willingness to take political action (efficacy, knowledge, attitudes, resources), but recognizes that institutionally rooted contexts structure those factors via public policy.

Finally, by referencing a range of political actions, point 3 underscores that an institution-driven, multilevel, contextual approach requires a capacious understanding of participation. That is why the number of activities included in the participation box multiplies as we progress
from model A to model D. When we add public policy to the panorama of relevant institutions (model B), we must consider the political action that occurs within implementing bureaucracies (as I do in Chapter 5), and we must recognize the policy advocacy of beneficiaries (Chapter 7). Similarly, when we incorporate contexts as a central feature of the analysis (model C), we must then think about how citizens engage in relation to their local communities (Chapter 6).

**AN ILLUSTRATION OF THE CF MODEL**

The CF model is a framework connecting the research questions motivating this book to relevant academic ideas and literatures. For those familiar with one or more of those literatures, the CF approach should prove useful; for the uninitiated reader, it may seem like a confusing enigma. To clarify and concretely elucidate the CF model, let’s briefly consider the experiences of Lucy, a woman I interviewed just outside of Atlanta, Georgia. For now, I emphasize the particulars of her life that most directly relate to the CF model. (Lucy will also emerge at several other points later in this book.)

As a first step in understanding Lucy’s political life, traditional models of participation (Figure 2.1, Panel A) would point us to her individual characteristics (she is an African-American single mother with a very low income, her elderly parents live in poverty and were never highly educated) and to her thin connections with meso-level political institutions (she is neither religious nor involved in civic organizations and her partisan attachments are weak). To be sure, predicting the behavior of a single individual this way is not possible. Still, for the purposes of expounding the CF approach, we might surmise that, per traditional models of participation, Lucy is unlikely to take part in political activities such as voting, contributing to a campaign, and other conventional forms of action.

Layered on top of such prospects, the policy feedback model (Panel B) stresses additional factors. Lucy has lived in poverty her entire life and along the way she has utilized public assistance via the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid. Though Lucy views Medicaid as distinct in numerous ways, her overarching assessment of these policies was negative – she readily recounted the challenges that she faced with them and she connected those experiences to her deep cynicism toward “dirty” politics and “bad” government. In this way, the policy feedback model
and traditional participation models are unified in suggesting dim prospects for Lucy’s political activity.

One apparent missed opportunity for catalyzing Lucy’s political life was via military service (Ellison 1992; Leal 1999; Parker 2009). Lucy enlisted with the hope of gaining upward mobility and making money to care for her family. Had that happened, perhaps she would have seen government more positively (interpretive feedback effects) or gained additional material wherewithal and civic skills (resource-based feedback effects). However, Lucy prematurely withdrew from the army in order to care for her ailing parents. As a result, she received fewer of the benefits she thought she would from her military career. In fact, she was astonished at how badly she fared given that she was a veteran who served for four years. Her military background only reinforced the negative messages conveyed by other experiences with government and she was decidedly uninterested in engaging the government that had burned her so badly in so many ways (literally, Lucy relayed an experience of suffering through an untreated third-degree burn because she was ineligible for Medicaid).

An important exception to this general pattern was Lucy’s experiences with the bureaucratic policy implementation. Lucy recounted initiating an administrative fair hearing when she felt that Medicaid had made an unfair decision about her benefits. In this way, exploring her “political [life] within welfare institutions” reveals a wider array of participatory outcomes than are ordinarily included in traditional models of participation (Soss 2000: 3).

By now, we may be tempted to think that we understand a lot about Lucy’s political world: we have considered both her political apathy (with respect to voting) and her political action (with respect to resisting bureaucratic authorities). But we would be misguided in stopping here. As contextual models of participation suggest, Lucy’s political experiences have been marked by her attachments to particular places and those places have shaped her participatory inclinations. Lucy was born in Mississippi and lived there through young adulthood, but she did not stay put. She moved to Texas and eventually settled in Georgia. She observed stark Medicaid policy differences across these states. Furthermore, Lucy recounted the varied experiences of living in rural versus urban counties, particularly with reference to the composition of her social networks. She had a deeper social network of fellow beneficiaries in the urban county where she lived when we spoke (because Medicaid density was higher there), but she had a wider
social network of *non-beneficiaries* in the rural county from which she hailed (where bureaucrats and beneficiaries shared the same small town). These contexts had political implications. Wide rural networks engendered smoother bureaucratic interactions. Lucy had grown up alongside some of the bureaucrats who worked in the rural Medicaid office and knew them personally. As such, relations with bureaucratic authority remained informal and did not occur through administrative hearings or any official processes. Lucy personally experienced the rural South as deeply racist and parochial – a fact that drew her to the big city – but when she arrived in Atlanta, she suddenly felt like “just another number” as far as Medicaid was concerned. When problems with the program arose, she could not make a personal appeal to her local neighborhood bureaucrat; she had to fight formally to get what her family needed. Moreover, the contextual constraints of the city were not limited to problems posed by Medicaid bureaucrats. For example, Lucy’s children went to an elementary school that did not allow students to enroll without immunization shots – even when delays in getting those shots were on account of stumbling blocks imposed through Medicaid rules. The overburdened school had neither the time nor the inclination to contact the Medicaid office – and the fact that the two refused to interact made Lucy critical of both, forcing her to engage in extended battles on two fronts. In the poor, mostly black, urban neighborhoods where Lucy now resided, constraints and conflict were abundant.

Accounting for context sheds a different light on Lucy’s experiences and on her political behavior. Lucy’s story is not just about political apathy, as traditional participation theories might have us believe; it is also about how local constraints (elaborated in contextual theories), state policies (emphasized by policy feedback theories), and individual factors (at the core of traditional theories) work in distinct but interrelated ways to structure political life and shape a range of political actions. Not only does the CF model merge these theoretical perspectives, it also extends them by recognizing the macro-institutions that sit outside of the observational purview of Lucy’s immediate experiences. Lucy does not explicitly identify federalism as an element of her political experiences, but the contextualized feedback approach sensitizes us to the ways that federalism structures the multilevel arenas that affect Lucy’s social and political citizenship.
Federalism, Health Care, and Inequity

“Were there to be a change in values toward equality of condition, the political culture that undergirds federalism would fall apart ... you cannot have a belief in equality of results ... and still have a federal system ... There is no escape from a compelling truth: federalism and equality of result cannot coexist.”

– Aaron Wildavsky (1984: 68)

This epigraph is a gauntlet thrown down by a prominent political scientist. Among those who have taken it up, some have corroborated Wildavsky’s assertion about the inequitable consequences of federalism (Lieberman 2005; Robertson 2014; Soss, Fording and Schram 2011). Others have maintained that federalism also has the power to do good (Finegold 2005; Freeman and Rogers 2007; Gerken 2012). All things considered, the relationship between federalism and equality cannot be determined out of context. Only focused attention to historical realities and policy specificities can shed light on its variegated effects (Cashin 1999; Robertson 2014). To that end, this chapter examines overlapping policy arenas that underscore the relationship between federalism and inequality (antipoverty policy and health policy). My objective is to set the stage for grappling with the democratic implications of the “compelling truth” that Wildavsky articulates. Federalism is anything but a “dusty constitutional issue largely disconnected from normal politics and policy,” as I admittedly once viewed it (Johnson 2007: 9). At every juncture in our nation’s history, it has shaped the trajectory of public policy. This has been most true for policy aimed at people living in poverty and those seeking health care. By charting the path of federalism
in these realms, I frame the context undergirding the larger narrative of this book.

FEDERALISM AND POLICY RESPONSES TO POVERTY

A study of the history of poverty in the United States shows that there is no escaping the enduring distinction between the “deserving” and the “underserving” (Katz 1983, 1986, 2013; Patterson 1981; Pimpare 2008; Trattner 1999). The inclination to classify people living in poverty according to desert is the most critical component of American poverty governance. Federalism follows as a less salient yet still decisive influence on the politics of poverty in the United States (Tani 2016). As far back as 1536, England’s Henrician Poor Law identified local government as the appropriate source of aid to the needy (Kunze 1971; Trattner 1999: 9). By 1601, when the legendary Elizabethan Poor Law was passed, the idea that “poor relief” should be locally financed and administered was already well established (Trattner 1999). These statutes represent a policy lineage that predated the emergence of U.S. federalism, but prefigured the basic outlines of social welfare practices in the United States. The practices they promulgated eventually developed alongside federalism and were continually reinforced by it.

Relying on the blueprint supplied by the Elizabethan Poor Law, the earliest colonial governments emphasized “the doctrine of local care,” which left responsibility for the indigent in the hands of the smallest unit of government. In New England this was the town, and in the South it was the parish (Trattner 1999). To avoid being overwhelmed by the needs of the impoverished, localities set up strict residency requirements that enabled them to circumvent the burden of caring for those outside of the immediate community (Jones 1975; Kelso 1922; Trattner 1999). Still, nearly everyone accepted the responsibility of caring for those within the community, with the marked exception of blacks and indigenous peoples, who were blatantly excluded from this ethic of care.

While the overarching rule of local control dominated at the dawn of American politics, even then it was peppered with exceptions. Most notably, community-based systems of care foundered in times of trouble: when refugees from beleaguered frontier settlements drifted into town or when impoverished immigrants flooded seaport cities. As early as 1675,
municipalities began to rely on aid from the colonial treasury to reimburse funds spent on the “unsettled” poor (Kelso 1922; Trattner 1999).

This was the inception of a persistent pattern. When towns, parishes, counties, or states could not adequately meet the needs of those within their borders, they would seek help from a higher level of government (Patterson 1981; Trattner 1999). This happened in the aftermath of the American Revolution, before federalism had even taken form (Trattner 1999). By the time the federated colonies were constitutionally established as a polity (circa 1788), localism had a stronghold in American political culture, but its limits were also quite apparent. Thereafter, the need for a strong central government was periodically salient, especially during times of crisis: in the wake of the social and economic dislocations prompted by industrialization, in the devastated South after the Civil War (Patterson 1981; Skocpol 1992; Trattner 1999). Essentially, poverty alleviation was always an intergovernmental affair (though to an extent that varied across time and geographic space).

Notwithstanding this fact, there is no denying that a default preference for localism has been a robust reality in the United States. Contrastingly, the widespread acceptance of a strong federal role in helping people living in poverty has been spotty and begrudging (Tani 2016). Civil War pensions, the broad-based federal assistance program for men who had served in the Civil War (and their dependents), proved temporary and pyrrhic, as they later became political fodder for those who (successfully) sought to eliminate social assistance programs for adult men in the post–Civil War generation (Skocpol 1992). Policy victories after this point were often more limited (such as those that applied only to preferred subgroups like white children and widows) and much less centralized (like those achieved in particular localities or states). Fleeting Civil War pensions were an exception to a general rule that prevailed prior to the 1930s: minimal federal funds to directly support people living in poverty. As late as 1929, the federal government did not spend money on poverty relief except for its expenditures on well-defined and carefully delimited groups like “Indian” wards and war veterans (Patterson 1981). To be sure, the tightfistedness of the federal government in the pre–New Deal era was partly because national coffers were smaller. Even more crucial was that widely held, fiercely protected, racially suffused political commitments to states’ rights and localism (especially, though not exclusively among Southern elites) were a powerful force constraining federal intervention (Lowndes 2008).
With the task of poverty alleviation largely left in the hands of states and localities, geographic disparities were nothing short of wild. In 1929 the average monthly grant for assisting single (white) mothers “ranged from $4.33 in Arkansas to $69.31 in Massachusetts” (Patterson 1981: 27). At this point in American history, eight states placed legal limits on the maximum amount that local governments could spend on the poor, and countless localities squabbled in the courts over who was responsible for particular “unsettled paupers” rather than risk taking responsibility for anyone whom they were not unequivocally obligated to (Patterson 1981: 28). Southern states were especially stingy and capricious, both because bureaucrats discriminated against African-Americans and because powerful officials actively discouraged welfare generosity in order to create more favorable labor conditions for economic elites (Fox 2012; Lieberman 1998; Mettler 1998). Southwestern states made life especially hard for indigent Mexican immigrants, whom they opted to deport rather than support (Fox 2012). In general, the political uses of federalism were perennially tied to efforts to exclude racial and ethnic “others” from the welfare state (Brown 1999; Fox 2012; Lieberman 1998; Lowndes 2008; Mettler 1998).

Though the Great Depression shook the foundations of localism, expansive national policies remained difficult to achieve. The broadest and boldest policy to emerge from the Depression was Old Age Insurance (OAI), now known simply as Social Security. OAI was originally designed to disproportionately help the most well-regarded segments of the American populace: working white men. On the opposite end of the policy spectrum lay targeted, state-level programs like Aid to Dependent Children (ADC) and Unemployment Insurance (both a product of the same legislation that created OAI). ADC in particular was aimed at less powerful groups like (white) mothers living in poverty. Even in the midst of economic desperation, political elites insisted that states and localities maintain control over the boundaries of social policy where marginal or stigmatized citizens were concerned (Mettler 1998b). In the context of U.S. federalism, such preferences were widely accepted and led to the creation of policies like ADC. The long-term repercussion of this has been the development of a two-tiered social policy system with a national/local overlay. Under such arrangements, people of color, women, and people living in poverty have most heavily populated the localized track. Their access to policy benefits has been less generous, more variable, and highly discriminatory (Fox 2012; Lieberman 1998; Mettler 1998). Instructively, similar patterns exist in the arena of health (Engel 2006).
Historically, the politics of health care in the United States parallels the politics of antipoverty policy in many ways. The colonial approach to caring for the sick was parochial. Some town governments appointed physicians who were primarily tasked with indigent care (Hoffman 2012). Individual physicians also recognized their obligations to those in need and often donated their services to fellow community members. On the whole, health care remained a provincial responsibility. However, because of the acute needs of particular groups, health care sometimes required multilevel government intervention.

In the prewar era, the federal government took an active role in health care only where specially favored populations were concerned. Veterans were one example. As early as 1798, Congress approved a hospital insurance program for men in the U.S. Navy. Sailors paid a tax of twenty cents per month and received access to hospitals in return. By the 1860s, the government had used these funds to build two dozen hospitals and insure 10,000 mariners (Hoffman 2012). For a well-delimited, popular, and relatively homogenous group like veterans, federal provisions of health benefits was both financially feasible and politically palatable.

The historical role of states in health care has similarly been to provide for specific subgroups, especially if their needs stretched the capacity of localities. The mentally ill were a prototypical case. Care for the “insane” was widely viewed as a responsibility of the states (Hoffman 2012). As early as 1752, Pennsylvania dedicated space in a state hospital to the mentally ill. By 1890, every state had built one or more public mental facilities, and by the mid-twentieth century, these institutions housed more than half a million patients (National Library of Medicine).

The key point is this: even before the advent of employer-sponsored health insurance (1940s), the availability of limited coverage for low-income elderly people (1960), and the passage of Medicare and Medicaid (1965), federal and state governments contingently intervened in the ostensibly local realm of health care. The paradigm of local care could never withstand the reality of severe need that sometimes surpassed what communities could independently manage. Furthermore, private practitioners (through powerful organizations like the American Medical Association [AMA]) were adroit at exploiting federalism. On the one hand, they marshaled great political force to guarantee that government did not subsidize insurance for anyone who could afford to pay (Hoffman 2012). At the same time, they lobbied for national, state,
county, and city dollars to finance care for notoriously unprofitable populations (Hoffman 2012; Olson 2010). In this way, the permanent existence of sizable and glaring subsets of the populace for whom an entirely privatized health care system was infeasible prevented the veneration of localism from fully taking hold in the domain of health care. Where it concerned health, the “local first” model of caring for economically disadvantaged people was strained even during good times. It took neither a war nor a depression for Americans to be mentally ill, chronically sick, or catastrophically injured. Any health care system worth its salt had to address these inevitable occurrences and an exclusively local or even state model has never sufficed.

Given this, federalism has provided a mechanism for the national government to fill vital gaps in the health care system, while allowing states and localities to retain as much control as possible. But it has always been a contested mechanism, both because private interests struggled to achieve the precise configuration of governmental intervention that was most amenable to profiteering, and because political elites rarely relented from their reverence for localism (Engel 2006; Hoffman 2012; Olson 2010). Medicaid policy conveys this history and points us to the vast present-day implications of federalism.

**BATTLES FOR PUBLIC HEALTH INSURANCE AND INTERGOVERNMENTAL DYNAMICS**

Medicaid yields vital insights into the policy challenges of caring for the impoverished in a federalist regime. Federalism has historically conferred an abundance of policy options and the choices made in the face of those possibilities have bred deep spatial inequalities. Even a rudimentary understanding of how and why this has happened elucidates some of the most durable conflicts of our nation’s history.

Political battles for a universal or near-universal health insurance system have been as recurrent as they have been unsuccessful. Peterson (2005: 207) fittingly declares that “when it comes to national proposals for comprehensive health care reform ... Congress has been an unrelenting graveyard.” Prior to the progressive era, there was limited organized demand for government to intervene in the realm of health care. Then, in 1915, the American Association of Labor Legislation (AALL) drafted a bill in support of compulsory health insurance and lobbied state legislatures across the country in an effort that initially went quite well (Chasse 1994). Though the coverage that
AALL proposed would be available only to the (white) working class, it was a radical option at the time. Ultimately, stymied by the disruption of World War I and flanked by staunch opposition from private insurance companies and the American Federation of Labor, the AALL bill was killed by 1920.

In the 1930s there was again serious hope for a large national health program. But as the Great Depression deepened, unemployment and social security were more pressing issues for President Franklin D. Roosevelt and health care was dropped from the Social Security Legislation for fear that it would doom the bill (Gordon 2004; Hoffman 2012). Another attempt during Roosevelt’s tenure, the 1943 Wagner-Murray-Dingell bill, sought to establish a national medical care fund for employed persons and their families. The bill was backed by organized labor and farm organizations but forcefully rejected by physicians and other powerful groups. It was labeled socialist medicine and never even came to a vote in Congress (AHA 2013; Quadagno 2006).

Ever more vigorous efforts followed in the mid-1940s when President Harry Truman ardently took up the cause of health care. In 1945, 75 percent of Americans supported the idea of national health insurance (Quadagno 2006). That year, President Truman supported the introduction of a revised Wagner-Murray-Dingell bill. The measure failed again, but Truman pressed on, addressing health care during his campaign tour in 1948 and going before Congress to ask for health legislation in 1949. Eventually, divisions from outside (e.g., the highly organized and well-funded AMA) and from within his own party (i.e., Southern Democrats who feared that national insurance would provide the federal government with leverage to undermine segregation) won out and Truman dropped the issue. The tide of public opinion also turned: by 1949 only 21 percent of Americans supported national health insurance (Hoffman 2012; Quadagno 2006).

Though the history of health care reads like a series of dead ends, these failures served to orient health care policy toward a model of federalist fragmentation (Engel 2006). For opponents of a federally subsidized universal health care system, one key to keeping victory out of the hands of their adversaries was to offer viable but more limited alternatives (Engel 2006; Hoffman 2012; Sparer 1996). At the same time, in the wake of losses, those most keen on universal coverage became willing to negotiate. The struggle for health care thus generated compromises: the Sheppard-Towner Act of the 1920s, the Hill Burton Hospital Construction Act of the 1940s, and the amendments to the Social Security Act of 1950. These...
policies shared a common denominator: they afforded states and localities tremendous power and resources.

The controversial Sheppard-Towner Act of 1921 provided federal matching funds to incentivize states to develop programs that supported the health of mothers and babies. This funding was precariously contingent upon state legislatures officially setting up their own Sheppard-Towner programs (Lemons 1969; Skocpol 1992). Connecticut, Illinois, and Massachusetts never did so, while Maine and Kentucky delayed until 1927, just two years before Sheppard-Towner was repealed (Lemons 1969). Even among the states that complied, program design varied substantially (Lemons 1969).

Similar geographic disparities emerged as a consequence of the Hill Burton Hospital Survey and Construction Act of 1946. By disseminating health resources through (unevenly distributed and inequitably funded) medical institutions tethered to particular geographic areas, this Act ensured that power remained solidly in the hands of state and local economic elites (Fox 1986).

Finally, the Social Security Act of 1950 was intended to “broaden and liberalize Federal grants to the States” and it became the first federal program to provide funds to states who were willing to pay health care providers for the care of welfare beneficiaries (Cohen and Myers 1950; Sparer 1996).

Sheppard-Towner, Hill-Burton, and the 1950 Social Security Amendments all laid the foundation upon which Medicaid was built. A preference for localism buttressed by the institution of federalism made state and local power sacred political assets that any viable health care legislation had to abide in order to secure backing.

THE GENESIS AND DEVELOPMENT OF MEDICAID

In 1957, Rep. Aime Forand (D-RI) introduced a plan for health insurance that did not sufficiently conform to this requirement: it promised to provide sixty days of hospitalization coverage and sixty days of nursing home coverage to all Americans over sixty-five who qualified for Social Security. Southern Democrats blocked the bill in committee, but Forand reintroduced it in 1960, this time with more political support. Roused by the growing strength of Forand’s coalition, the AMA mobilized the opposition and presented an alternative: Senators Robert Kerr (D-OK) and Wilbur Mills (D-AK) sponsored the Kerr-Mills bill. This legislation provided matching grants to states for assisting very low-income elderly

Unlike the (Forand) legislation that it was designed as an antidote to, Kerr-Mills did not apply to everyone eligible for Social Security, only to the very poor. And like its forbearers, it was largely the prerogative of the states. As the most proximate precursor to Medicaid, Kerr-Mills foreshadowed the implications of such a structure for geographic equity. By 1962, forty-three states had expanded their coverage of the elderly poor and more were on the path to doing so. Though all of them were tapping into the same newly available funds, they were using those resources to develop “fifty separate programs ... with only mild similarities” (Engel 2006: 37). Eligibility standards, family contribution levels, deductibles, co-payments, payment ceilings, and provider reimbursement rates all varied widely. In 1961, spending per beneficiary ranged from $16 in Maryland to $353 in Pennsylvania (Engel 2006: 37). By 1963, just five states accounted for 90 percent of the Kerr-Mills money and less than 1 percent of the elderly received benefits (Zelizer 2015).

In light of the many inadequacies of Kerr-Mills, liberals in Congress continued to push for the passage of major health care legislation to help senior citizens. In 1962, President Kennedy attended a rally in Madison Square Garden with more than 17,000 people and made a speech to a national television audience of 20 million in defense of health care expansion. Congressional conservatives were not swayed and Wilbur Mills, a fiscally conservative Democrat from Arkansas and the powerful longtime chair of the House Ways and Means Committee, refused to allow health care legislation to come up for a vote (Zelizer 2015). A stalemate over the issue continued until the landslide defeat of Republican presidential nominee Barry Goldwater at the hands of Lyndon Johnson in 1964. Goldwater had aligned himself with the AMA and staunchly opposed Medicare. Meanwhile, not a single incumbent who had supported Medicare (from either party) was voted out of office in that election. Observers concluded that opposition to Medicare was not politically palatable (Zelizer 2015).

Perhaps even more consequentially, the 1964 election ushered in an 89th Congress with Democratic supermajorities in both chambers, emboldening liberal Democrats who were intent on passing Medicare and sobering Republicans who had previously opposed such a policy. Before long, the once formidable opponent of Medicare, Wilbur Mills, was working alongside health policy wonk Wilbur J. Cohen to plan a comprehensive policy that would provide medical aid to the needy. Mills
is credited with combining several legislative proposals that were floating around at the time to devise the now famous “three layer cake” structure of Medicare: Part A provided insurance for hospitalization, Part B for doctor’s visits, and Part C was an expansion of Kerr-Mills (Zelizer 2015). Part C was ultimately called Medicaid.

When Title IX of the Social Security Act of 1964 created Medicaid, it met little fanfare (Oberlander 2003; Olson 2010). Kerr-Mills had been insignificant enough that there was no precedent to suggest that Medicaid would be an important program (Olson 2010; Zelizer 2015). Initially, Medicaid committed federal matching funds to states to create a medical program for low-income Aid to Families with Dependent Children (AFDC) beneficiaries. The program was thus built directly on the two-tiered foundation established during the New Deal era and positioned firmly in the lower tier, among policies that were targeted and state centered. By linking Medicaid eligibility to AFDC, the federal government left most decision-making power vested in the hands of states (given that states largely determined AFDC eligibility). The states set the terms of entry into Medicaid, allowing them to select the benefits that would be offered, decree how much health care providers would be compensated, and (discriminatorily) determine which groups would be covered (Cohen et al. 2015).

Despite initial rallying cries against Medicaid and some significant foot dragging, states eventually realized how much they stood to gain (see Figure 3.1).4 By 1967, twenty-six states were on board with Medicaid. In the following two years, fifteen more states were added. Alaska held out until 1972 and Arizona fought the change until 1982. This state-by-state rollout meant that beneficiaries’ ability to access health care was largely dependent on where they lived. If an eligible person got sick in the wrong state during the wrong year, the consequences of policy fragmentation could be life altering.

In the more than fifty years that have passed since Medicaid’s enactment, it has become an “iconic [part] of the American social insurance system” (Cohen et al. 2015: xii). Along the way, it has weathered a multitude of storms: popular ambivalence toward its aims, hostile presidential administrations, sinking economic conditions, ballooning health care costs, massive welfare retrenchment, and more. Crucially, these tempests have been navigated in the waters of federalism, setting Medicaid on a trajectory of increasing heterogeneity and inequity (Grannemann and Pauly 2010; Sparer 1996). To be sure, Medicaid has continually expanded and consistently helped millions upon millions of Americans. It represents a groundbreaking step forward in our national commitment to health care.
But the American health care story is not a simple, linear, or unequivocally progressive tale. Even while recognizing the path-breaking value of Medicaid, we must concede that it has taken constant political struggle to keep the program alive. The political compromises spawned by that struggle have paved the way for geographic inequities.

Other scholars have already done the pivotal work of unearthing Medicaid’s rich policy history, so I will not repeat their efforts (Cohen et al. 2015; Engel 2006; Olson 2010; Smith 2008; Sparer 1996; Thompson 2012). I will, however, briefly track the program through the lens of federalism to show how the seeds for place-based inequality were sown from the start, watered plentifully, and cultivated intently, even as Medicaid did much good in the lives of Americans (see Table 3.1). The democratic implications of this are like the proverbial pink elephant in a small room: highly visible but scarcely acknowledged.

The political history of Medicaid encompasses four distinct policy eras (Sparer 1996; Thompson 2012). The first spanned from the program’s beginning in 1965 to 1980. This was a time of relatively unhampered state discretion. States controlled AFDC eligibility and could therefore hold sway over Medicaid. AFDC had always exhibited massive variation across states so Medicaid followed suit. In the early days of the program, interstate variation proliferated in virtually every arena, from benefits to reimbursement. Even attempts to impose uniformity via broad federal mandates were weak. For example, all states were required to provide inpatient hospital services (a uniform standard), but they were free to
### Table 3.1 Medicaid Expansions in the 1980s

<table>
<thead>
<tr>
<th>Act</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Enactment in 1965</td>
<td>Medicaid covers beneficiaries of Aid to Families with Dependent Children; states have discretion over coverage of additional groups.</td>
</tr>
<tr>
<td>Social Security Amendments of 1972</td>
<td>States must now cover Supplemental Security Income (SSI) beneficiaries (elderly, people with disabilities).</td>
</tr>
<tr>
<td>Omnibus Reconciliation Act of 1981</td>
<td>Repealed requirement that states pay Medicare hospital payment rates, but allowed states to make additional payments to disproportionate share hospitals (DSH) serving a disproportionate share of Medicaid and low-income patients.</td>
</tr>
<tr>
<td></td>
<td>Allowed states to pursue a Section 1915(c) HCBS waiver, which enabled them to cover home- and community-based long-term care services for the elderly and individuals with disabilities at risk of institutional care.</td>
</tr>
<tr>
<td></td>
<td>Allows states to impose nominal cost sharing on some beneficiaries.</td>
</tr>
<tr>
<td></td>
<td>States must now cover AFDC-eligible first-time pregnant women and pregnant women in two-parent unemployed families.</td>
</tr>
<tr>
<td>The Consolidated Omnibus Budget Reconciliation Act of 1985</td>
<td>States must now cover all AFDC-eligible pregnant women.</td>
</tr>
<tr>
<td>Omnibus Reconciliation Act of 1986</td>
<td>Option for states to cover all pregnant women and children up to age five with incomes at or below 100 percent FPL.</td>
</tr>
<tr>
<td>Omnibus Reconciliation Act of 1987</td>
<td>Option for states to cover all pregnant women and infants with incomes at or below 185 percent FPL.</td>
</tr>
<tr>
<td>Medicare Catastrophic Coverage Act of 1988</td>
<td>Option for states to cover children up to age eight with incomes below 100 percent FPL.</td>
</tr>
<tr>
<td></td>
<td>States must now phase in coverage of pregnant women and infants with incomes up to 100 percent FPL.</td>
</tr>
</tbody>
</table>

(continued)
limit how often beneficiaries could utilize those services: in Louisiana, the cap was fifteen days per calendar year and in Florida, it was forty-five days (Sparer 1996: 38). The variation that existed with respect to optional services like dental, vision, and podiatry was even starker. States developed essentially different programs under the banner of a single federal funding source. Medicaid was *ex uno plures*. The most notable departure from this in the pre-1980s period was the requirement included in the 1972 Social Security Amendments that states provide Supplemental Security Income (SSI) beneficiaries with Medicaid coverage. Still, the specific benefits that SSI beneficiaries received was decided by the states.

The second era of Medicaid policy making was between the early 1980s and 1992. These years were marked by increased federal intervention. President Ronald Reagan was determined to cut and redesign Medicaid in ways that were an anathema to the states. Though Reagan failed to a large degree (his 1981 bid to convert Medicaid to a capped block grant was a flop), his tenure put state governors and legislators on high alert. During this very same time, a string of national eligibility expansion options deftly coordinated by Congressman Henry Waxman (D-CA) pushed states to cover more pregnant women and children (see Table 3.1). By the late 1980s and early 1990s, many of those options became mandatory. During this era, legislative and executive interventions (or attempted interventions) from the national government served to mobilize state political elites, who neither wanted to lose Medicaid funding nor desired to be mandated to cover more people than they saw fit. In the next (longer) stage of Medicaid’s political development, embattled state legislators and governors had learned important lessons and they emerged as much more formidable actors in Medicaid politics.

| Omnibus Budget Reconciliation Act of 1989 | • States must now cover pregnant women and children up to age six with incomes at or below 133 percent FPL  
| | • States must now cover services offered at Federally Qualified Health Centers. |
| Omnibus Budget Reconciliation Act of 1990 | • States must now phase in coverage of children ages six through eighteen with incomes at or below 100 percent FPL |

*Sources: Kaiser Commission on Medicaid and the Uninsured: “A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage” and “Medicaid: a Timeline of Key Developments”*
The third stage of Medicaid politics, stretching from 1992 to 2008, was marked by the phenomenon of growing state power and heightened intergovernmental contention. By the mid-1990s, a more active federal government coupled with steadily rising health care costs caused states to agitate for more flexibility in Medicaid policy design. The apogee of this struggle was when Republican governors and congressman came together and resolved to convert Medicaid from an entitlement (for which the federal government’s financial obligation had no cap) to a block grant (with capped federal contributions and drastically loosened federal oversight). The Republican-conceived Balanced Budget Act of 1995 (H.R. 2491) mandated a Medicaid block grant that threatened severe program cuts (Smith 2002). Insisting on “federalism not paternalism,” advocates of this legislation sought to confer unprecedented authority over Medicaid to the states (Havemann and Goldstein 1995; Thompson 2012). Their efforts failed, in part because they were coupled with attempts to cut Medicare. Despite controlling both the House and the Senate, Republicans could not overcome the veto of President William Jefferson Clinton. Though Clinton was a “New Democrat” with centrist orientations toward social welfare policies, he could not abide the scale of retrenchment promised by H.R. 2491. Republicans proved unable to force his hand. The attempt to do so by shutting down the government backfired when the tide of public opinion turned against Newt Gingrich.

Most crucially, this episode set the stage for contentious struggles over the locus of power in Medicaid design and implementation. While block grants failed to pass muster, they were one weapon in an armory aimed at expanding state control. Some of those efforts won out. Most notably, Medicaid waivers became a key channel through which states wrestled for, in President Clinton’s words, “relief from a cumbersome process by which federal government had micromanaged the health care system affecting poor Americans” (Friedman 1993; Thompson 2012: 134, 2015). From a state-centered perspective, waivers were the equivalent of having your cake and eating it too: expanded power over the design of state programs without sacrificing an uncapped funding commitment from the federal government (Thompson 2012). Beginning in the mid-1990s, states increasingly used waivers for a variety of purposes: to expand eligibility, implement managed care, attempt private market initiatives, provide emergency response relief, expand family planning, and even make broad-based reforms to state health care systems (Schneider 1997; Thompson 2012). There is no single story about these waivers; sometimes they meant that Medicaid beneficiaries would be getting more,

The final stage of Medicaid development covers the presidency of Barack Obama, from 2009 to 2017. Obama’s signature legislation, the Patient Protection and Affordable Care Act (ACA), instituted a wide range of reforms meant to move the country toward universal health coverage (Jacobs and Skocpol 2015). As expressed in Vice President Joe Biden’s infamous gaffe (which included more colorful language than I will use here), the ACA was a “big ... deal.” Recall the history recounted in this chapter. Comprehensive health care provision in the United States has always been a steep, uphill climb. When Barack Obama took office in 2009, he proceeded with laser-sharp focus in efforts to scale the mountain of opposition that blocked his path to the goal of health care reform. He had many of the necessary tools to do so: Democratic majorities in both chambers, a public expecting to see significant change, and a health care system that was in dire straits – and getting worse by the day (Jacobs and Skocpol 2015). Still, in a highly polarized political environment (and with the futile hope of attaining bipartisan cooperation), Obama and the Democrats made many concessions. Most notably, the so-called public option – to offer a government insurance plan that would directly compete with private options for health insurance coverage – was dropped from the ACA, despite Obama’s initial support for it (Halpin and Harbage 2010; Jacobs and Skocpol 2015).

In order to gain support for the ACA and achieve the policy outcomes that they imagined, Democrats came to believe that Medicaid was a central conduit for expanding the number of Americans with health insurance. Accordingly, Medicaid expansion was a key component of the ACA. But in 2012, the U.S. Supreme Court threw a wrench in the plan. In a landmark decision, National Federation of Independent Business v. Sebelius, the court maintained that states could not be forced to accept the ACA’s Medicaid expansion. Framing the expansion as significant enough to constitute a new program altogether, Chief Justice Roberts reasoned that it was beyond the purview of the federal government to coerce states into adopting one policy (Medicaid expansion) by threatening to defund another (traditional Medicaid). The court ultimately espoused the logic that “the shift in Medicaid policy was so enormous, and potential sanction of the loss of all federal funding for failure to comply with a new mandate was so onerous” that requiring expansion was unconstitutional (Rosenbaum and Westmoreland 2012: 1666).
The *Sebelius* decision fueled intergovernmental jostling. As the Obama administration pressed for a uniform expansion of coverage to all people below 138 percent of the FPL, the high court equipped states with the legal power to resist this move. Given the additional leverage for bargaining, Medicaid waivers became even more prominent and state Medicaid programs grew as variable as they have ever been. A relatively simple and logical perspective on waivers is that they’re practically useful: they create pathways for reform where none would otherwise exist. Whether and how waivers achieve the goals of health care reform remains to be seen, and given the alternative of no expansion at all, it is likely that Medicaid beneficiaries in states that negotiated waivers are better off (though they are not necessarily better off than they would have been under traditional expansion).

Looking beyond the general valence of waivers, scholars have broadly considered their larger implications: whether they erode checks and balances by giving the executive branch primary gatekeeping power, whether they threaten the solvency of Medicaid as a single government program, and more (Bolton 2003; Gais and Fossett 2005; Thompson and Burke 2007). On the whole, however, the democratic consequences of proliferating geographic disparities encouraged by waivers remain unclear. As a further step in understanding this and related questions, I next consider the striking geographic differences that Medicaid beneficiaries now confront as a result of the long legacy of federalism.

**CONTEMPORARY MEDICAID AND GEOGRAPHIC INEQUALITY**

Given the historical policy development that I have described thus far, it should be no surprise that Medicaid – though a vital and invaluable program – is presently a fragmented labyrinth that underwrites a dizzying array of disparate services. This has come to pass despite the concerns about geographic inequity that have existed since the inception of the program and steps taken to address them. From the beginning, states were given differing levels of assistance from the federal government such that poorer states got more money. This continues today. Figure 3.2 shows the range of these disproportions. New York State’s Medicaid costs are matched at a rate of 50 percent whereas Mississippi has nearly 75 percent of its costs federally subsidized. This compensatory funding scheme speaks to policy makers’ recognition that states have distinct needs. Differential federal medical assistance percentage (FMAP) match
rates are designed to minimize geographic divergences. However, they have proven an inadequate tool in that regard, and the extent of policy-based dissimilarities in health resources has grown wide across a number of metrics.

Medicaid in the States: From the Cradle to the Grave

Medicaid policies shape the resources that citizens have access to at every stage: from birth, throughout life, and right down to death. This endows Medicaid with an ethical force that speaks to the very nature of our polity. As Vice President Hubert Humphrey powerfully articulated, “The moral test of a government is how that government treats those who are in the dawn of life – the children; the twilight of life – the elderly; and the shadows of life – the sick, the needy, and the handicapped.” Medicaid brings this formulation into sharp relief because beneficiary subgroups roughly map onto Humphrey’s stages, and states vary in their investment across such groups. For example, some states spend much more than the national average on child enrollees, exhibiting noticeable generosity toward children. Other states spend comparatively little on children (and
more on other categories of enrollees). Figure 3.3 shows the top five and bottom five states in terms of the percent of all Medicaid funds that are expended for child enrollees. At the top, New Mexico spent 47 percent of all Medicaid funds on children (with 31 percent of children in the state living in poverty). At the bottom, New York spent 11 percent of Medicaid funds for children (with 23 percent of children living in poverty). Of course, the reasons for these patterns are complex, so we cannot draw strong conclusions from such descriptive data. Still, no matter the reasons, it is clear that states prioritize enrollee populations differently. The variation illustrated in Figure 3.3 exists whether we highlight children, adults, the elderly, or disabled people, and it does not always covary with poverty rates. As a result, beneficiaries’ likelihood of being eligible, their ease of signing up, and their access to services are all tightly linked to their stage in life. Surveying Medicaid from a life course perspective, with an emphasis on federalism and inequality, reveals persistent and distinct disparities.

On a tour through the life of a Medicaid beneficiary, we begin with birth. On average, 45 percent of all births in the United States are financed by Medicaid. Childbearing is thus a major avenue through which pregnant women and young mothers (especially women of color) experience government (Bridges 2008). Yet this average conceals significant subnational disparities (see Figure 3.4). For example, in 2010, Massachusetts fell well below average, with only 26 percent of births financed by Medicaid, while Louisiana came in at a whopping 69 percent. It is beyond the scope

![Figure 3.3 Medicaid dollars spent on child enrollees (2011)]
Figure 3.4  Percent of births financed by Medicaid (2010)
of this chapter to assay the reasons for this, but suffice it to say that the incidence of pregnant women relying on Medicaid for health care varies dramatically by place. To the extent that Medicaid coverage during pregnancy affects the experience of democratic citizenship, mothers in Louisiana may be disadvantaged relative to mothers in Massachusetts for reasons that do not reflect the core principles on which our polity is (or at the least, should be) grounded.

Pregnancy is hardly the only time in life when Medicaid proves crucial. One thing that my conversations with beneficiaries made clear is that when there is an important medical need to be met, Medicaid shows its true colors. Four health arenas offer key examples: dental, vision, hearing aids, and physical therapy. I have not cherry-picked these services because they show unique variation befitting this narrative. To the contrary, they illustrate patterns common to many services. Still, I select these areas because they involve health resources that are crucial for coping with everyday life and with the difficulties that affect low-income people in especially devastating ways. In what follows, I provide very specific details on state variation in each of these domains, not with the intention of inundating the reader with minutiae, but in hopes of conveying the concrete realities of federalism. From the perspective of a low-income adult with decaying teeth, cataracts, loss of hearing, or a bum leg, these are not irrelevant particulars. They are the stuff of daily life and for our purposes here, the tangible evidence of the failings or successes of state policies and the larger macro-institutions (like federalism) that enable them. As we will see in Chapter 4, optional services like dental and vision prove especially important because they are highly visible to Medicaid beneficiaries and can therefore influence their evaluations of policy and politics.

**Dental**

Alabama, South Carolina, Delaware, and Tennessee offer no dental coverage to adults. All other states provide some services to adults, but to an assorted degree. In Arizona, dental coverage is limited to emergency treatment by physicians for relief of pain and infection. The same is true for Florida, Illinois, Kansas, Mississippi, New Hampshire, and many others. At one pace ahead of their peers, North Carolina, North Dakota, Ohio, Vermont, Wisconsin, and Wyoming additionally offer dental exams and/or cleanings (but the precise number of exams covered per year varies). More flexibly, some states put a yearly cap on spending: $500 in Arkansas, $1,000 in Nebraska, $1,150 in Alaska, $1,800 in California,
and so on. Perhaps most notably, in addition to giving, states are also taking: twenty-two states require co-payments for adult dental services, ranging from 50¢ in Georgia to $7 in New Mexico and as much as 5 percent of procedural costs in Florida.

Vision

A similar battery of differences exists for adult vision coverage. Nominally, every state covers ophthalmology services. Yet ten states do not include routine eye care in those services, only emergency medical procedures. Some states offer eye exams, but all states limit the number of such exams a beneficiary can have: one every two years in Rhode Island, two per year in Pennsylvania, etc. Again, twenty-nine states require co-payments. Beneficiaries must pay co-pays ranging from $2 (Florida) to $3 (North Carolina) and $7 (New Mexico) per visit. Idaho will allow such expenses to run as high as 5 percent of a beneficiary’s total yearly income.

Hearing

Thirty-four states offer adult coverage for hearing aids. Alabama, Arizona, Arkansas, Colorado, Delaware, Maine, and Pennsylvania are among those that do not. Yet, even for those that do, the terms of support look quite different from place to place. In Indiana, you are only covered for one hearing aid every five years, though no such limitation exists if you move across the border to Illinois. New Jersey will spend no more than $4,000 on your hearing aids, but a drive across the George Washington Bridge or through the Holland Tunnel takes you to a state (New York) that imposes no such limit. South Carolina will provide beneficiaries with hearing aids only if they have diagnosed intellectual disabilities. Utah will only do so if you’re a pregnant woman.

Physical Therapy

The landscape is similarly spattered for adults living in poverty who might require physical therapy (PT). Seventeen states do not offer it at all. Among those that do, limits abound: in Missouri, no PT unless you’re pregnant or blind. In New Hampshire, any beneficiary can have eighty PT sessions per year, though only in fifteen-minute increments. In states like Minnesota, Oregon, and Tennessee, what you get depends on which beneficiary group you belong to (pregnant women, childless adults, etc.).
End of Life Care

Even at the very end of life, Medicaid does not equalize its treatment across place. While nearly all states fund hospice care for elderly people who are dually eligible for Medicaid and Medicare, for non-elderly adults who are dying, only forty-two states support such services. Even among that large number, access depends upon whether beneficiaries can afford a co-payment (in Florida, Missouri, Montana, and Oklahoma, for example), whether they suffer from an illness on a particular “priority list” (Oregon), or whether they have qualifying emergency conditions (Utah). Since hospice is generally something that families coordinate, this is one phase of life when the quality of access to care can reach beyond the immediate beneficiary to impact the ways that their loved ones vicariously experience government (Campbell 2015; Levitsky 2014; Michener 2017a).

Proliferating Inequality

As I have made clear, Medicaid provides uneven and inconsistent access to policy benefits across geographic space. The purpose of this book is to examine the politics produced by such an institutional backdrop, particularly with respect to the ideas and actions of policy beneficiaries themselves. What I find (and relay in the proceeding pages) is that by dint of federalism, Medicaid policy produces unequal politics and deepens already yawning racial, class, and geographic disparities in the United States. This is not an inherent, inevitable, or invariable outcome; it is a systematic upshot of the institutional arrangements and social forces that prevail in American politics.

The continuing saga of Medicaid expansion offers an apt prima facie example. For many adults living in or near poverty, the battle for access to health care continued after passage of the ACA. Though the law dramatically reduced the number of uninsured Americans and allowed many previously ineligible adults to benefit from Medicaid, it was fiercely contested. By early 2017, nineteen states continued to reject the expansion of Medicaid (see Figure 3.5). As a result, millions of low-income adults fell into a “coverage gap”: not poor enough to qualify for Medicaid, but too poor to take advantage of the ACA’s market subsidies. Represented among the states that were unwilling to implement Medicaid expansion were eight of the top eleven states with the largest share of the nation’s African-American population: Alabama, Florida,
Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. As a result, 56 percent of non-elderly uninsured adults who fell into the coverage gap were either black or Latino (Artiga, Stephens, and Damico 2015). Also represented among states that refused to expand were eight of the top eleven states with the highest poverty rates: Alabama, Florida, Georgia, Mississippi, North Carolina, Oklahoma, Tennessee, and Texas. Because of federalism, the geographic constellation of access to Medicaid tethers health policy even more deeply to race and poverty.

Also crucial is that post-ACA Medicaid expansion has opened up space for even more geographic fragmentation. To induce states to expand, the federal government has granted several 1115 Waivers allowing them to significantly alter the program requirements. Waiver-based expansions have occurred in Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire. In these states, expansion has taken very distinct forms: Medicaid coverage can happen via subsidies for private insurance, it may require co-pays or premiums, it can entail incentives for healthy behaviors, and it might deny beneficiaries (previously standard) retroactive coverage.

Table 3.2 provides information on the initial group of such waivers, but it is quite likely that more are coming down the pipeline. On November 8, 2016, Donald J. Trump was elected the forty-fifth president of the United States. Across the political spectrum, his election raised many questions about the future of Medicaid. In a postelection interview with Jake Tapper on CNN, Mike Pence, vice president-elect of the
United States at the time, foreshadowed what the new administration was planning:

I would anticipate that a part of what we will do is what the President Elect has called for during the course of the campaign, and that is ... we’re going to develop a plan to block grant Medicaid back to the states so that the states can do exactly what Indiana9 was able to do ... states can innovate in Medicaid and it’s going to be part and parcel of our plan to replace Obamacare.

Presidents have significant leverage for institutionalizing state heterogeneity and inequality in Medicaid policy. States are not blind to this fact. Not long after President Trump’s election, states began considering policies like drug testing Medicaid beneficiaries (Wisconsin), imposing limits on the length of time beneficiaries can be enrolled in Medicaid throughout their lives (Arizona), and requiring work or volunteer service for “able-bodied” adult beneficiaries (Kentucky). In June 2016, Wisconsin submitted a waiver request that included drug-screening/testing and work requirements.10 If such policies are implemented, geographic disparities in the experiences of Medicaid beneficiaries and the resources that they have access to will grow even wider.

### POLICY INEQUITIES, SOCIAL CITIZENSHIP, AND POLITICAL CAPACITY

The policy-based geographic health care inequities described earlier should prompt us to contemplate the democratic repercussions of federalism in two respects. First, we should think in terms of social citizenship

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### TABLE 3.2 State Medicaid 1115 Waivers

<table>
<thead>
<tr>
<th>State</th>
<th>Premium Assistance for Private Insurance</th>
<th>Cost Sharing</th>
<th>Healthy Behavior Incentives</th>
<th>Premiums</th>
<th>No Retroactive Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td></td>
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<td></td>
<td>✓</td>
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<td>New Hampshireere</td>
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<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Sources: Hinton et al. (2017)
Federalism, Health Care, and Inequity

(Marshall 1950). This dimension of citizenship is about access to the material resources necessary to be a full and productive member of the polity. Dahl (2003: 152) expresses the logic of social citizenship quite aptly, asserting that “In order to exercise the fundamental rights to which citizens in a democratic order are entitled – to vote, speak, publish, protest, assemble, organize, among others – citizens must also possess the minimal resources that are necessary in order to take advantage of the opportunities and to exercise their rights.” Unequal access to the resources necessary to remain healthy is a reflection of differentiated social citizenship. The disparities relayed earlier in this chapter illustrate the contours of that differentiation in the realm of health care and are thus democratically consequential in their own right.

To go further, these inequities also directly implicate the political dimensions of citizenship because they affect political attitudes and behavior. Among numerous processes that are explained in the pages that follow, a primary mechanism by which the distribution of Medicaid benefits is linked to political participation is through the experiences of beneficiaries themselves. Medicaid beneficiaries recognize many of the unequal patterns that I have outlined. They are residentially mobile, they have friends and family who live in other states, they travel, and they perceive policy changes both within states (over time/across the life cycle) and across states and localities. Moreover, their experiences provide knowledge that has political meaning. Medicaid beneficiaries can spot politics at work; they can appreciate the ways their fate is intertwined with state power and policies. Alice Wong, a disability rights activist in her forties who has been a Medicaid beneficiary since she turned eighteen, captured this in an op-ed she penned for the New York Times:

When you are disabled and rely on public services and programs, you face vulnerability every day. This vulnerability is felt in my bones and in my relationship with the state. Fluctuations in the economy and politics determine whether my attendants will receive a living wage and whether I’ll have enough services to subsist rather than thrive. The fragility and weakness of my body, I can handle. The fragility of the safety net is something I fear and worry about constantly. 11

Of course, as a former presidential appointee to the National Council on Disability, Alice Wong is well attuned to political dynamics. Nevertheless, her sentiments are not singular. Indeed, most of the beneficiaries I interviewed for this research confessed similar impressions. Even those who admitted having little interest in politics experienced the tangible
consequences of Medicaid policy and discerned that their health care access (or lack thereof) was a result of politics. This means that federalism, as it is experienced on the ground, is relevant to democratic engagement and political participation.

The chapters to follow demonstrate more specifically that Medicaid beneficiaries’ political capacity is influenced by salient policy experiences enabled via federalism. These experiences affect views of government and they are often (though not always) politically demobilizing. Federalism thus generates geographically differentiated political capacities across beneficiary populations. Recall that I define political capacity as citizens’ ability or willingness to take political action relative to their positioning within the polity (political engagement in context). Political action includes voting, protesting, local activism, particularistic demands upon government, and more. Capacity concerns the relational field in which such action occurs and thus links political behavior to one’s place in a political structure (Soss and Jacobs 2009). Capacity captures how institutional contexts shape micro-political relations. This goes beyond the traditional contextual effects literature to consider how pivotal political forces like federalism affect the bonds between place and politics.

The trouble with federalism as identified here is not simply that it subsidizes geographic inequality. It is part and parcel of politics that some groups benefit from certain institutional arrangements, while others are disadvantaged. That is neither unusual nor (necessarily) unsettling. The dilemma arises when institutions systematically and consistently encumber particular groups (e.g., people living in poverty, African-Americans, residents of certain states or regions). When that happens, as is often the case with federalism, then policy makers and ordinary Americans should consider what such institutional arrangements mean for citizenship and democracy. Though legal scholars have contemplated these matters and pointed out the possibilities that federalism holds for empowering those who are marginalized, careful empirical study of political participation in the context of federalist distributional inequalities is not yet part of the scholarly record (Gerken 2012). I take on precisely that task with the hope of spurring a discourse focused on hard, but critical questions. For policy makers,
this might mean explicitly considering how block granting, state policy waivers, and similar strategies bear upon democratic inclusion. For everyday people, it means asking how closely yoked geography and access to vital economic/political resources should be, and whether a strong nexus between the two comports with the national ideals many Americans purport to hold dear.
In January 2015, Mike Pence, then the governor of Indiana, announced that his state would extend Medicaid to everyone living below 138 percent of the federal poverty line. Following the prescriptions of the ACA, the Healthy Indiana Plan pledged to insure an additional 350,000 low-income people, but there were a few caveats. As a Republican eager to distance himself from “Obamacare,” Pence proudly touted the modifications that Indiana would make to the program. Beneficiaries would be required to pay monthly premiums amounting to 2 percent of their household income. Those unable or unwilling to pay would only be eligible for downgraded coverage (which excluded dental and vision and required co-payments up to $75). Moreover, benefits could be suspended for up to six months as a penalty for nonpayment. In Governor Pence’s sanguine view, this reform would prompt people to “take greater ownership of their health care.”

Looking beyond Indiana, critics decried a more worrisome outcome: a “many-headed Medicaid” marked by different standards in different states and spawning increasing inequality across the nation (Sanger-Katz 2015). In Chapter 3, I sketched a portrait of precisely such a landscape (historically and contemporarily). In this chapter, I investigate the democratic consequences of Medicaid policy fragmentation by examining how state policy disparities bear upon beneficiaries’ political behavior.

MEDICAID, FEDERALISM, AND POLICY FEEDBACK
For more than two decades, scholars have marshaled robust evidence that policies affect citizens’ political behavior (Bruch, Ferree, and Soss 2010; Campbell 2003, 2012; Mettler 2005; Pierson 1993; Soss 1999,
Such research has shown that the structure and design of government programs can influence civic and political participation by channeling resources, generating interests, and shaping interpretive schemas (Béland 2010; Campbell 2012; Mettler and Soss 2004; Pierson 1993; Schneider and Ingram 1993). Though impressive in range and depth, most studies of policy feedback have paid little attention to subnational differences in policies.

More generally, theories of policy feedback provide useful but indeterminate guidance about the micro-political effects of Medicaid. Much of the literature implies that as a means-tested program, Medicaid is likely to depress the political participation of those who enroll (Campbell 2012; Mettler 2002; Mettler and Stonecash 2008; Soss 1999). However, Medicaid has fared well in the court of public opinion and years of research confirm that it is less stigmatized than other means-tested programs (Campbell 2015; Cook and Barrett 1992; Grogan and Patashnik 2003; Howard 2006; Stuber and Kronebusch 2004). Moreover, burgeoning scholarship examining the short-term aggregate participatory effects of recent Medicaid expansions has found an increased likelihood of districtwide and countywide voting in the wake of coverage expansions (Clinton and Sances 2017; Haselswerdt 2017). However, though the immediate positive effects of coverage expansion may indicate an electorate that is responsive to major policy changes, such effects do not speak to the more enduring consequences of the experiences that emerge from actually using Medicaid. In short, coverage effects are quite distinct from the experiential effects of policy utilization. To date, political scientists have only probed the former. Altogether, the research record does not offer a clear and comprehensive view of the effect of Medicaid on individual-level political participation.

Perhaps paradoxically, I seek to further complicate this literature by suggesting that uncovering Medicaid’s broad political effects is a less pressing task than understanding how those effects are geographically distributed. There is no uniform Medicaid program. Each state runs its own program and (as I detailed in Chapter 3) they vary substantially. We should therefore approach overly expansive assessments of Medicaid’s policy feedback processes with some trepidation.

MEDICAID AND POLITICAL PARTICIPATION:
THEORIZING BEYOND THE GENERAL

I began this research with a very general question: how do experiences with Medicaid affect political behavior? I then embarked on a series of
in-depth interviews with beneficiaries. At that point, I knew enough to
deduce that since Medicaid was a federal-state program, I should inter-
view beneficiaries in a range of places. This was a commonsense intuition
about case selection, but I originally put little theoretical emphasis on
geography. Instead, I was searching for a general theory of the Medicaid-
to-politics link. Then I began talking to people. One of the first benefi-
ciaries I spoke to was John, whom I introduced in Chapter 1. John perceived
stigma in relying on Medicaid and sometimes had negative bureaucratic
interactions. Though he had a chronic debilitating illness, John was a
young (in his thirties) white man who at times appeared healthy, and he
believed that this aroused suspicions among bureaucrats:

I’ve had a few instances where they [caseworkers], I know I was just looked at
differently because I am a male and I think it was more or less the women, you
know; I hate to say that, but dealing with what I’ve dealt with, like when an older
woman if I’m assigned to her [as a caseworker] she just looks me up and down
and I kind of, I kind of look better [health wise] than I am you know.

This subtle invocation of stigma was not surprising given that Medicaid is a
means-tested public program (Mettler 2002; Mettler and Stonecash 2008).
In addition, John mentioned administrative burdens and negative evaluations
of caseworkers (Burden et al. 2012; Moynihan, Herd, and Harvey 2014):

As far as like the caseworkers and the paperwork ... all the caseworkers quit all
the time and they’re sick of dealing with everybody, and everybody hates each
other; it’s been just like a circus, like a zoo ... the paperwork is fill this out, come
here, and then you know, home inspections, they come to my house and I have to
have my doctors fill this out, and it’s yeah, it’s been getting pretty rough.

Near the end of the interview, John noted that he did not believe Medicaid
beneficiaries have much power: “No, I don’t think that we are going to
change anything as patients.” He also admitted that he made little invest-
ment in electoral politics:

I have listened to a few speeches or whatever on TV and I honestly can’t tell you
anything about what they support or if they are Democrat or Republican ... I am
not involved and I know I probably should be.

Coming early in the research process, my conversation with John sig-
naled some of what I surmised dampened Medicaid beneficiaries’ politi-
cal participation: stigma and negative interactions with state government.
However, John’s narrative also contained elements that I had not antic-
ipated: a declaration that he was “married” to Michigan medically and
an account of an attempt to move to Arizona that was foiled by the
impossibility of getting equivalent Medicaid benefits there. I was especially struck by how profoundly this cross-state limitation seemed to drive John’s sense of his life prospects:

I guess that’s pretty much the boat I’m in now. I’m just, I’m not where I want to be, but you know, I guess beggars can’t be choosers, and I try to tell myself, you know, I’ll also live on Mars the second I have to and you’re just going to do what you got to do and it’s just not very fun, but okay unless something changes you know … if they did like a federal insurance and everybody had their insurance card regardless of who we are, where you are, I think it would solve a lot of problems for people, but I don’t think that’s going to happen … being a man, you know and being older and being like, just knowing that you’re never going to better yourself … in that sense it’s been hard … seeing other family and friends and they’re able to move on … you know it is tough. You know, it’s hard to, I mean I’ve accepted it a long time ago because it is what it is and I’ve always known that you know, that’s just how it is.

After talking to John, I had a hunch that Medicaid’s policy feedback process was in some ways akin to that of other means-tested programs, but I was not clear about the role of geography. I kept this in the back of my mind, but did not yet perceive it as central.

Going forward, my qualitative research took me to Florida, Georgia, Idaho, New York, and more. Across all of these places, Medicaid beneficiaries continued to describe their experiences in terms of stigma and negative bureaucratic interactions. In Table 4.1, I offer just a few illustrations. Enumerating everything relevant that came up in the interviews would take too many pages, but these examples are reflective of the kinds of statements that generally emerged in my conversations with beneficiaries.

Given the proliferation of such attitudes, I developed the general hypothesis (which I provide quantitative evidence for later in this chapter) that the individual-level relationship between Medicaid enrollment and political participation would be negative (H1). Comparing beneficiaries to similarly situated non-beneficiaries, I expected that the former would be less likely to participate in politics because of their stigmatized identities as policy beneficiaries and their negative interactions with government bureaucrats.

By the conclusion of my interviews, however, I was not as interested in this general hypothesis as I was intrigued by the stark surfacing of something that I did not expect: vast geographic heterogeneity in the policy experiences Medicaid beneficiaries recounted. It was the observation of such discrepancies that led me to contemplate the relevance of
federalism and to theorize beyond a general Medicaid-to-politics link. Instead, I redirected my focus to the reasons why Medicaid beneficiaries’ interpretations of government and politics seemed especially dependent on where they lived. In making this theoretical shift, I heeded the encouragement of Mettler and Soss (2004: 64), who suggested that scholars could enrich the study of policy feedback by recognizing that “policy-based resources may have very different political effects ... clients in a single public program, for example, may draw different lessons from their encounters.” In what follows, I demonstrate that state context is one avenue through which divergent lessons can be conveyed to beneficiaries in the same program.

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<th>Stigma</th>
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<td><strong>Terrie:</strong> “It’s demeaning, you know; the process is extra-extensive, long.”</td>
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<td><strong>Louisa:</strong> “You feel embarrassed.”</td>
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<td><strong>Ahmad:</strong> “They treat us like we are stupid animals; we don’t know anything ... This is what I feel ... I feel like shit. I feel like I’m nothing, because when you are in Medicaid, they do whatever. You have to be on their rules.”</td>
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<td><strong>Daphne:</strong> “I think it does come with a negative stigma. Like they talk about it at school in economics and stuff, just in my business classes, and just hearing my classmates talk about it.”</td>
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<th>Administrative Burden/Negative Bureaucratic Interactions</th>
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<td><strong>Roxy:</strong> “It’s a lot of paperwork. You have to have a physical, you have to have proof of your pregnancy ... You have to have proof of your income. You have to have your bills, how much you spend per your paycheck.”</td>
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<td><strong>Dani:</strong> “It’s a lot of work. They make it a lot of work. They want to see everything. They want to make sure that you really qualify for what they’re offering. So it’s a lot of work.”</td>
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<td><strong>Kay:</strong> “I distinctly remember taking the binder ... they gave us a binder and said, ‘Start working on this.’ And it was the Medicaid application, and it was so complex and there were so many pages, and I was like, it can’t be this difficult.”</td>
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<td><strong>Nessa:</strong> “And they[‘re] so rude and nasty; that’s why I try not to come up to them ‘cause they are rude and they’re nasty ... I just hate it and so I try not to go up there.”</td>
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<td><strong>Katrina:</strong> “The people [who] are working in these offices ... there’s sometimes a respect issue, and there’s sometimes just a – I don’t know. When I say it felt like they were stupid, part of that is coming from a place of real frustration, and part of it is just the way they talked, which was irritating to me because it felt like the future of my health is in your hands right now, so don’t talk to me like this.”</td>
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**Table 4.1 Qualitative Descriptions of Stigma and Bureaucratic Interactions**
I begin with qualitative underpinnings for my arguments. The case study data used in this book are based on sixty-one in-depth interviews with forty-five Medicaid beneficiaries and sixteen key stakeholders. To someone who is unfamiliar with qualitative methods, a quick reaction to these numbers may be to think, “What can you really learn from talking to 61 people?” The answer is that you can learn a lot. The value of these interviews was not in the number of cases. The goal of the qualitative component of this work was depth, not breadth. Neither achieving representativeness nor obtaining a massive “sample” were my focus. Instead, I engaged in close, detailed conversation with beneficiaries in an effort to acquire a more rich understanding of their experiences and interpretations of Medicaid policy. Those conversations yielded vital insights and are especially significant given the glaring absence of Medicaid beneficiaries’ voices from much of the research attempting to explain outcomes in their lives.

The interview cases were purposively selected with the goal of achieving a range on the basis of race, gender, and geography (Yin 2003). Among the beneficiaries I interviewed, 82 percent were women, 42 percent were African-American, and 16 percent were Latino. They hailed from thirteen states and represented a variety of regions within those states (urban, rural, and suburban). The interviews were audio recorded, transcribed, and thematically coded. Analyses of the resulting transcripts uncovered the ideas that ground my understanding of the heterogeneity of Medicaid’s micro-political effects. In light of a dearth of knowledge about the experiences of Medicaid beneficiaries, and given research indicating that perceptions are an important mechanism through which geographic context affects political participation, it was fitting to center the views of beneficiaries as a starting point (Michener 2013). Still, I resist making strong causal claims based solely on the interviews. Instead, I leverage the qualitative data as one form of important evidence to gain clarity on the processes that shape Medicaid beneficiaries’ political lives and to develop focused quantitative models (Auerbach and Silverstein 2003; Small 2011).

The interview data corroborate and extend the political learning approach advanced by Joe Soss (1999, 2000). In explaining the relationship between welfare receipt and political involvement, Soss’ framework emphasizes the actual experience of receiving benefits. The core logic is that salient interactions with the government convey important political
lessons. Critically, policy experiences and their corresponding lessons differ by design. Soss (1999, 2000) first focuses on the broad distinction between means-tested and non-means-tested designs, arguing that the former teach welfare beneficiaries to view government in ways that undermine external political efficacy and thereby dampen participation. In later work, Bruch, Ferree, and Soss (2010) look beyond the means-testing dichotomy to differentiate between paternalistic (cash assistance), bureaucratic (public housing), and incorporating (Head Start) means-tested policy designs.

Building on these insights, I consider heterogeneity within a single means-tested program (Medicaid) based on variation across states. I argue that 1) the adequacy; and 2) the capriciousness of material benefits are crucial purveyors of differential policy-based learning. More specifically, beneficiaries consistently highlighted two imperative political lessons: that government lacked the resources to meet even basic needs (inadequacy), and that government could not reliably provide benefits (capriciousness). Having become sensitized to these shortcomings, Medicaid beneficiaries were generally unenthusiastic about the primary means of influencing government: politics. Most crucially, since the adequacy and capriciousness of Medicaid resources vary by state, these political learning mechanisms produce geographically differentiated effects.

A View from Policy Beneficiaries: Learning Government Inadequacy and Capriciousness

Nearly every interviewee I spoke to initially said positive things about Medicaid, echoing a recent Gallup poll showing that 76 percent of Medicaid beneficiaries are “satisfied” with how the health care system is working for them (Searing 2014). They described Medicaid as “awesome,” “great,” “a lifesaver,” and so on. Willy, a man in his late thirties who had had a heart attack when he was twenty-five and had been on Medicaid ever since, illustrates beneficiaries’ most general evaluations: “I have been poor my whole life, and without Medicaid I would be sick, homeless, and dead probably … so I would just say that I think Medicaid is great.” Similarly, Christy, a fifty-year-old mother of eight, declared, “I am blessed to have Medicaid … I am satisfied to the utmost.” Willy, Christy, and many others might have given Medicaid eight, nine, or even ten points on a ten-point scale. But at the slightest probing, more thorough descriptions of the program often pivoted to perceptions of inadequacy and capriciousness. Take Willy, for example; despite his overall
satisfaction, he struggled with getting transportation to and from the local Medicaid office and did not understand why Michigan could not cover transportation services. Likewise, though Christy stressed her blessings, she later explained that with Medicaid:

> There are some things you can get [and] some things you can’t, like glasses; I can’t see. You know they say go to the dollar store and get some reading glasses ... but now my eyes are getting worse and worse. Medicaid told me that I can get a free eye examination, but not glasses.

Accounts like this were common. Efrain’s experience underscores as much. In 2011, Efrain enrolled in Florida’s Medicaid program. The coverage he was given proved a godsend. He was finally able to see doctors and was eventually diagnosed with diabetes. As a result, his “opinion of Medicaid [was] very positive.” He explained that “the access in many cases is very good ... so I haven’t had a problem ... everyone is very nice.” Despite these positive assurances, before long Efrain mentioned his disappointment that in recent years Florida had cut back on dental coverage: “I miss the Medicaid when there is none, like in the case of the dental program, which is very reduced – they never give you anything, basically.” Efrain also discussed program changes that happened in 2013. Around that time, making appointments with specialists (like his urologist) became much more difficult and filling prescriptions became a burdensome task. Efrain recalled that for the first time at that point, Medicaid would not cover his prescription costs. His pharmacist realized that a medication was being refused because the program had recently stopped covering treatments for ear problems. To circumvent this, the pharmacist gave Efrain the precise same prescription – but for his eyes. It turned out that the same drugs could be used to treat either eyes or ears. So the pharmacist put in a prescription for eye care, but instructed Efrain to use it for his ears. While Efrain appreciated the ingenious solution, he was struck by Florida’s seemingly arbitrary coverage parameters.

This kind of epiphany was par for the course among Medicaid beneficiaries. Kay – a mother of four whose youngest son, Brian, was born prematurely and with severe disabilities – relayed an especially arresting story. At the time we spoke, Kay was the director of nursing at a health care facility and her husband was also a working professional. When Brian was born, Kay and her family had private health insurance and Brian was covered under it. But his health care expenses began skyrocketing immediately. Kay noted that his “NICU8 stay, just the bed alone, not counting any of the doctors’ visits or surgeries or medications or
anything, just for the bed, was $532,000.” When Brian’s numerous health
conditions were diagnosed, his nurses immediately encouraged Kay to
sign him up for Medicaid. Had Brian not qualified, Kay and her hus-
band’s middle-class income would not have been sufficient to pay for the
many medical needs not covered by their private insurer. Not only did
Kay know this, she was acutely aware of the seemingly arbitrary terms
of Brian’s eligibility:

We filled out all of that paperwork and then Brian was in the neonatal intensive
care unit for four months. So what we then learned was there were different kinds
of technicalities for a child to automatically qualify for Medicaid if they’re born
prematurely, so born at thirty-one weeks or less and weighing two pounds, ten
ounces or less automatically qualified. So Brian was born at thirty-one weeks and
he weighed two pounds, ten ounces. So by the grace of God, he automatically
qualified for that, which ended up being – he ends up costing about a million
dollars a year in health care costs. Yeah, he averages about a million dollars a
year (emphasis mine).

In Kay’s view, it was only by the grace of God that her family dodged the
bullet of being saddled with impossible health care costs. When I asked
her what would have happened had Brian been born at thirty-two weeks
or weighed two pounds, eleven ounces, she noted that “there are a lot
of parents who fall into that gap and end up paying – have to pay that
off, because their private insurance doesn’t cover it.” Only “grace” had
allowed her family to avoid this disastrous policy gap. Still, she was
exceedingly grateful because Medicaid saved Brian’s life.

Ultimately, the simple story of high “consumer satisfaction” proved
misleadingly superficial. Beneficiaries were appreciative for what
Medicaid provided, and such gratitude was apparent in their general
evaluations of the program. At the same time, they were painfully aware
of what Medicaid did not provide and perceptively mindful of the arbi-
trary and shifting boundary lines between provision and non-provision.

Note that lessons about adequacy and capriciousness did not emerge
from the sheer weight of poverty (i.e., I am poor, therefore I just do not
think the government is doing enough for me), but were instead connected
to specific (usually geographically rooted) policy experiences. Attesting to
this, beneficiaries from a wide range of backgrounds expressed similar
and consistent sentiments. Approximately 30 percent of the people I inter-
viewed were, like Kay, from otherwise middle-class backgrounds. They
relied on Medicaid for a variety of reasons (a chronic illness, a recent job
loss), but they lived in middle-class neighborhoods, grew up with parents
who were professionals (and/or were professionals themselves), and had
little experience with traditional welfare. Nonetheless, when these beneficiares found themselves navigating Medicaid, they were still attuned to a lack of resources and dependability. Altogether, Medicaid beneficiares across a range of race, class, and gender categories regularly expressed that government was inadequate and capricious (though to different effect, which I discuss in subsequent chapters).

Perhaps most vitally, beneficiares shrewdly related these cognitions to politics. Angie, for example, spent much of our interview detailing all of the difficulties she had with Medicaid in Michigan. When I asked her if those experiences had anything to do with politics, she quickly declared, “Yes, it has a lot to do with politics … I don’t think the average everyday working person really can influence politics much … I don’t do politics.”

Will was resigned to the fact that “if they are going to make cuts, there is not much that people [can] do about it but accept it.” Darius lamented his intermittent ineligibility for Medicaid and chalked it up to “politics,” which he then described as “like a double-edged sword. I mean it helps and then it is also dangerous too … it requires a lot.” Likewise, Efrain thought that politics was “very important … because it changes things,” but he suspected that Medicaid beneficiares had “very little influence” in politics. When I asked Kay about how her experiences with Medicaid shaped her views of politics, she conveyed a deep sense of cynicism:

ME: Do you think your experiences with Medicaid have changed anything in terms of the way you view politics … has it shaped your thoughts about politics, your feelings?
KAY: It has brought to light the dirty side of it and that it’s corrupt, and that this battle in Iowa, when it comes down to it, isn’t about what is best for Iowans; it’s a political game. That’s all it is. This is an election year, and the political game is disgusting, it’s filthy, it’s unethical. It’s *House of Cards* dirty. That’s what makes me sick, is that if people only knew that the intentions are not pure, what’s driving this is greed in politics. It’s dirty. And that is just disgusting.

Again and again beneficiares proffered perspectives on the connections between politics and Medicaid, linking the program’s capriciousness and inadequacy to perceptions of political disempowerment. While a small handful reacted to such perceptions by delving more deeply into policy advocacy (like Kay, whose advocacy I discuss in Chapter 7), most responded with distrust and disengagement. Even the engaged beneficiares viewed themselves as exceptions rather than the rule. Instructively, when Kay “changed hats” in our conversation, shifting from centering on her experiences as the mother of a beneficiaery to her role as a nurse, she acknowledged that “if you put it on my nurse hat … managing
people and caring for [beneficiaries] … I don’t see people advocating for themselves or even taking politics seriously.”

MEDICAID AND POLITICAL PARTICIPATION: A QUALITATIVE VIEW OF STATE HETEROGENEITY

Even as beneficiaries stressed capriciousness and inadequacy, geographic positioning was central to their narratives. Remember Terrie from the first chapter? I began my interview of her with the open-ended question: “Tell me a little about yourself.” In response, she noted “the difference between state to state with Medicaid and what it offers and the programs and how consistent they are.” Like Terrie, nearly every beneficiary referred to Medicaid in state or local terms, and many enumerated specific aspects of state programs. Lucy, describing her former state of residence, insisted that “in Mississippi, they’re still behind time … it’s who you know; it’s not what you need.” Lydia relayed that “in New York, assistance is easier to get than out here in Georgia.” Riley contemplated moving away from Iowa to get better mental health services. Frank too confessed that only his penury kept him in Florida where Medicaid was paltry. Again, Kay was an uncommon but important example: her family actually did move from Iowa to Minnesota, leaving behind middle-class jobs and a home they owned in order to access the superior Medicaid benefits Minnesota promised to offer Brian. Kay more generally connected this move with another life-altering experience of Medicaid’s geographic variation:

You know, after our son was born, we looked at moving to Tennessee because my parents live there and we would have had a home to live in that we wouldn’t have had to pay for, just so that they were close by to help us. But they [Tennessee] don’t have a waiver program, so the only way our son would have been able to get Medicaid was if we lived under the poverty line, so then we wouldn’t work. Well then if I didn’t work, I wouldn’t be in homecare, and it was like, that makes no sense. And so I kept going around and around and basically learned there was no winning there. So we couldn’t move there for our family to help us [but] we’re actually going to be moving to Minnesota here in another month because … their Medicaid is set up and designed and run better, so when this MCO thing came to light [in Iowa] … it became a very easy decision to go. I don’t have to fight anymore. Screw it, let’s go. And so we’re moving.

Kay was made painfully aware of which states had “waiver programs” that would allow disabled children in middle-class families to qualify for Medicaid. The lack of such a program in Tennessee prevented her from moving there to live near her parents during a time of dire need. But even
in Iowa, where Brian benefited from a waiver policy, there was a new “MCO thing.” MCO is an acronym for “Managed Care Organization.” Iowa had recently decided to transition from a state-run Medicaid program to a managed-care model that would put the administration of Medicaid in the hands of private entities contracted by the state. The privatization of Medicaid was a problem for Kay largely because of the unpredictability of the upcoming transition to managed care: it was unclear what changes there would be to coverage, whether Brian’s doctors would be included in coverage networks, and whether he would have to get special authorizations before he could receive care. Kay found this capriciousness unbearable and it was eventually the final straw that led her family to migrate to Minnesota.

While Kay’s case is unique, I found that even when beneficiaries had not moved much from state to state, they had friends, family, and social contacts who enabled them to compare experiences. Brianna, for example, lived in upstate New York for most of her life, but her two sisters and mother were also on Medicaid. Brianna’s mother recently migrated southward to Kentucky and managed to enroll in Medicaid there. She subsequently told Brianna all about how much less generous Medicaid benefits were in Kentucky. When Brianna and her mother contrasted the specifics of their state Medicaid programs, both women gained an entry point for understanding cross-state policy differences. Many of the other beneficiaries I spoke to described a similar dynamic. When asked how they thought Medicaid differed across states, nearly all of them offered details based either on their own experiences or on those of someone they were close to.

States are the teachers that draft the curriculum on which policy beneficiaries’ political learning is based. People learn experientially about the inadequacy and capriciousness of their states’ Medicaid policy. In particular, beneficiaries’ narratives frequently highlighted four issues: 1) benefit expansions; 2) benefit contractions; 3) the scope of services offered; 4) administrative capacity. Accordingly, these are the variables that I expect to be associated with political behavior among beneficiaries. In what follows, I draw on examples from interviews to delineate hypotheses related to each factor.

Benefit Contraction or Expansion

Changes in the benefits covered by Medicaid make a strong impression on people who rely on the program. Trajectory is especially important
because the status quo becomes more visible once it is altered. When people who were once unable to visit the doctor are now able to do so, they are more liable to develop positive views of government even if they previously felt negatively, and vice versa. Shana, a young woman from Michigan, ardently maintained that “I love Medicaid because … it helps low-income families that can’t afford insurance.” She then followed up that sentiment with an observation that “the policy is changing … making it hard for anyone to pretty much go to a doctor, just to get a general pap exam or any kind of exam.” Across several years, she could chart a process of retrenchment, recalling a downward trend that worried her. Most vitally, she directly implicated politics, declaring that “politics is what matters the most … if you need services that you can’t afford, like Medicaid.” Likewise, John observed:

Over the past few years, it’s kind of becoming more of a struggle, you know. I think the state, they’re cutting back on a lot of benefits for people and they’re trying to make it harder and harder to where you just give up and you just feel like, well, I don’t want to do that or it’s not worth it to me, and they, you know, they figure if we can eliminate 10 people out of 100 that applied, you know, there’s savings for the state and all that. I understand that, that there is no money and there’s no, it’s not a lot of help … again the past couple of years, I kind of don’t know what changed; it’s probably just like a budget issue, but I’ve run into a problem … I’ve got a feeding tube and they don’t want to pay for the formula anymore, they don’t want to pay … And the dietician is even fighting like tooth and nail and the doctor is saying, “he needs so many calories, you know, he’s underweight, he’s sick, he’s blah, blah, blah,” but they just have this category in their head.

John connected benefit retractions to the state he lived in (Michigan) and identified inadequate resources (i.e., the budget) as the culprit. Moreover, the loss of benefits was capricious insofar as it did not correspond to changing needs. Nothing about John’s health had changed over the past few years, but he nonetheless could no longer rely on the state to provide a vital need. Beneficiaries frequently exhibited this kind of knowledge of changes and assigned responsibility to the state for such shifts. When programs retract, they view state government as both capricious and inadequate. As such, I hypothesize (H2) that beneficiaries living in states that have recently retracted Medicaid benefits will be less likely to participate in politics (relative to beneficiaries living in states that have not retracted benefits). Alternatively, when programs expand, beneficiaries view government through a lens of adequacy. Given this, I hypothesize (H3) that beneficiaries living in states on an expansionary trajectory will be more
likely to participate in politics (relative to those living in states that have not expanded benefits).

Scope of Services Offered

As is typical in the U.S. federal system, there are many optional benefits that the national government does not mandate, but that states can nonetheless choose to provide. Some of these make a major difference in the lives of beneficiaries. Dani, a young mother from Michigan, said she was treated fairly and respectfully during the three years she was on Medicaid, but later told me, “I kind of wished they offered a few more services.” When I asked what kinds of services, she promptly answered:

Like vision. They don’t do any eye care … unless you have low vision … I think contacts are a luxury, so to speak, but I just feel like glasses are not. That’s definitely something that I think is needed to work. I can’t see. I couldn’t drive, no way. I can’t see; things are blurry to me twenty feet in front of me, ten feet in front of me. I’m not considered low vision because low vision is like almost next to blind, so I don’t get that.

Dani easily saw the political dimensions of this:

It’s the Democrats representing the people [who] need social services. You know what I mean, but they’re not Democrats [who] ever have even been in need of social services. I don’t know; for some reason, it’s like that population of people [who] are utilizing the services just – they don’t even have a voice.

Many beneficiaries mentioned dental and vision services. Terrie emblematically explained the benefits and disadvantages of her particular health plan, saying, “With Well Care I pay for 30 percent dental and vision is free. We have bad eyes, so I'll take free vision and pay 30 percent dental ‘cause we have great teeth. You see what I’m saying?” Echoing this, Kyra told me, “I need braces because I grind my teeth, but they don’t pay for it. Both my kids need braces and they don’t pay for it … Medicaid needs to … you know, get people … where their teeth are healthy.” Brianna and Maggie were especially bothered by Medicaid’s refusal to cover root canals (in New York and Michigan, respectively). This was memorable for both of them because it was a painful dental episode for which they had limited recourse to relief. Maggie recalled that “they don’t pay for root canals; you can only get them pulled, that’s it … and eventually get dentures once you are approved.” Brianna believed that Medicaid did not pay for root canals because it was “cheaper to just take it out” rather than
try to “save the tooth.” Brianna had an entire row of teeth removed as a result of this. Maggie mentioned dental issues numerous times throughout our hour-long interview. She was openly perplexed over Medicaid’s refusal to acknowledge the importance of oral health.

The scope of services that beneficiaries were aware of did not stop at dental and vision. Maggie told of a skin condition: “I have vitiligo, which causes my skin to lose its color pigmentation. They consider that a cosmetic issue, so they won’t cover the cream I need for it.” Greg could not get inpatient expenses covered for his ankle surgery. Lucy even noticed limits on the amount of ice cream and juice that Georgia’s Medicaid would cover after her seven-year-old daughter got a tonsillectomy. It seemed as though there was no end to the nuances of optional services. Beneficiaries were cognizant of every nook and cranny and keen on the stakes for their families. Moreover, they identified states as the locus of Medicaid policies. When asked whether Medicaid was about national, local, or state politics, Maggie, Brianna, Lucy, and Greg each pointed to states. But in the face of miserly state resources, they often felt little power, echoing Maggie: “there is nothing you can do … politicians have the control … not beneficiaries.” Considering this state of affairs, I hypothesize that when non-mandatory benefits are narrow in scope, beneficiaries view the state through a lens of inadequacy and will be less likely to participate in politics (H4).

Administrative Capacity

Interviewees frequently relayed the extent to which Medicaid was overburdened. There were too many “clients” and too few “workers.” This state of affairs made the caseworkers hardened and unresponsive. To my surprise, beneficiaries did not usually blame street-level bureaucrats (even when they described negative interactions with them). Instead, they expressed a modicum of sympathy for bureaucrats. Maggie, for example, noted that “[caseworkers] have a hard job with a lot of clients … I can only imagine how difficult their job must be trying to deal with so many individuals and remember so many different cases.” Similarly, when I asked Dani about her caseworker, she told me, “I mean you can tell that she is just busy and boggled down by caseloads up to the ceiling, you know what I mean, just like hundreds and hundreds of people that she is taking care of.” In beneficiaries’ view, caseworkers were trying to make lemonade with the sour lemons given to them by the “powers that be” (as Angie described it). Having little to work with, street-level bureaucrats
cannot help but succumb to the stresses of the job. As Lucy explained, the issue was fundamentally one of capacity: “It’s not enough caseworkers … You have six, seven caseworkers to all these people, but instead of trying to break it down or hire more caseworkers, they get to you when they can get to you. You just better hope you have everything ready to go when they call you. If not, there’s another ten to twelve days.”

These kinds of observations convinced beneficiaries of the inadequacies of the government, over and above the failings of its individual employees. Illustratively, Shana, the Michigan woman I mentioned previously, praised the geniality of her interactions with Medicaid bureaucrats, saying, “I always have a good experience.” But as she later recounted the difficulty of reaching anyone from the Medicaid office on the phone, she drew larger conclusions about the limits of government, noting that with the government, “you can’t have your cake and eat it too” because “they can only do so much.” Human resource scarcity dampens beneficiaries’ views of government adequacy. As such, I expect that beneficiaries living in states with a low ratio of public welfare workers to people living in poverty will be less likely to participate in politics (H₅).

QUANTITATIVE EVIDENCE OF THE MEDICAID-TO-PARTICIPATION LINK

To quantitatively test my five hypotheses, I use data from the third wave (2001/2004) of the Fragile Families and Child Well-Being Study (FFS).¹⁰ This survey follows a cohort of nearly 5,000 children born in U.S. cities, interviewing both mothers and fathers around the time of their child’s birth and at various intervals subsequently. Since the sample was composed to reflect nonmarital births in large U.S. cities, it is not nationally representative in the traditional sense. However, the emphasis on “fragile families” means that FFS contains an unusually large number of persons living in poverty and just under 4,000 Medicaid beneficiaries (53 percent of the sample).¹¹ In using this sample, I follow other scholars who have sought to understand the political behavior of disadvantaged Americans (Bruch et al. 2010; Weaver and Lerman 2010). Importantly, however, Medicaid beneficiaries in the FFS sample are not reflective of the (adult) Medicaid population nationally. FFS beneficiaries are younger, healthier, more likely to be male, and less likely to live below the poverty line. Since these are the characteristics of the beneficiaries who have recently joined Medicaid as a result of the expansion spurred on by the ACA, the patterns observed among FFS respondents are indicative of what we might
expect from expansion-based beneficiaries. To address concerns about this unique sample, I reproduced the initial findings using an alternative source of data (the National Longitudinal Study of Adolescent Health). Doing so generated comparable results.

In the absence of an experimental intervention that randomly distributes Medicaid benefits to some eligible individuals while withholding them from others, it is not possible to make an unequivocal case for Medicaid’s political effects. Still, working with available data, I take numerous steps to conduct robust analyses. After examining an initial set of regression models, I expand them to include pivotal but often overlooked factors that are principally relevant to low-income people. Next, I use a quasi-experimental matching technique to control for the confounding influence of factors causally unrelated to the primary independent variable. Finally, I use seemingly unrelated regression to mitigate concerns about who selects into the Medicaid program.

**Measuring Political Participation**

The models I present here estimate voter turnout, voter registration, and a more extensive index of political participation. Though I selected these dependent measures because of availability, it is also worth noting their substantive implications. Registering to vote and voting are central components of democratic citizenship, and they signal the most formal engagement with the political system. It is vital for scholars to understand the conditions that cultivate formal engagement among people on the economic and racial margins of American society (as many Medicaid beneficiaries are). The participation index additionally accounts for membership in a political group and taking part in a political rally. These are less conventional forms of involvement; both incorporate political action that extends beyond the bounds of electoral politics. Among groups who are politically disaffected, the inclusion of non-electoral participatory channels is imperative (Michener and Wong 2018). Of course, the measures of participation available via the FFS data are not exhaustive. In later chapters I examine other forms of political behavior including resistance to bureaucratic authority, local community activism, and policy advocacy.

**Accounting for Other Factors**

The main predictor of interest is a dichotomous measure of Medicaid enrollment. Additional controls reflect classic insights from the political
participation literature (Rosenstone and Hansen 1993; Verba, Schlozman, and Brady 1995) by focusing on key individual characteristics (age, education, employment, income, sex, race, nativity, cash welfare receipt, and civic attitudes), as well as mobilizing factors (church attendance). I also include controls for personal health and child health.

**Some Initial Results**

I begin with H1 and the general question of the Medicaid-to-politics link. This is not my main focus, but it is useful to evince that there is a correlation between Medicaid enrollment and political participation and, as per my qualitative indications, that it is negative. To do so, I predict each political outcome as a function of Medicaid enrollment plus the controls. The vote and registration models were estimated via probit and the participation model via ordinary least squares. As shown in Table 4.2, compared to the rest of the FFS sample, respondents who indicated being Medicaid beneficiaries are significantly less likely to vote, register, and participate more generally. A simple regression (column 1) confirms H1, indicating that Medicaid enrollment corresponds to a five-percentage-point decrease in the probability of voting, a five-percentage-point decrease in the probability of registering, and a six-percentage-point decrease in the probability of participation.

To bolster our confidence in these results, I conduct three robustness checks. First, following Bruch, Soss and Ferree (2010), I expand the models to incorporate factors often omitted from traditional studies of political behavior but known to have strong bearing on the lives of disadvantaged persons. These included drug and alcohol dependence, depression, incarceration, the number of kids in a household, and marital status. Though many of these prove significant (especially the measure for incarceration), adding them did not attenuate the significance of Medicaid (see Table 4.2, column 2).

Next, I present the results after using coarsened exact matching (Iacus, King, and Porro 2012). Matching attempts to address the confounding influence of factors causally prior to the primary independent variable by better aligning the distributions of observed covariates in the treatment group (Medicaid beneficiaries) with those in the control group (non-beneficiaries). As shown in Table 4.2 (column 3), statistical models using matched data indicate that the earlier findings hold. This means that compared to non-beneficiaries who are similarly situated in terms of age, sex, receipt of cash assistance, education, race, marital status, and
income, Medicaid beneficiaries are still significantly less likely to participate. There are a host of reasons why demographically similar survey respondents may not be enrolled in Medicaid: they may not have encountered an institution that encourages them to enroll (many beneficiaries join through hospitals or clinics), they may not know that they are eligible (many eligible people fail to enroll; see Sommers et al. 2012b), they may view Medicaid as stigmatizing and thus decline to enroll (Levinson and Rahardja 2004), or they may not be able to navigate sometimes complex enrollment procedures (Stuber and Kronebusch 2004). Instructively, most of the factors that explain non-enrollment among a group that is demographically similar to Medicaid beneficiaries point to such a group being in a *weaker* position vis-à-vis political engagement (e.g., out of contact with community institutions and social networks, vulnerable to feeling stigmatized, having limited knowledge of bureaucratic processes).

In other words, unless Medicaid itself is affecting political behavior, we should expect a group of people who are demographically similar to Medicaid beneficiaries but not enrolled in the program to be *less* politically active. That means that the bar for finding a negative relationship (in the empirical context of a matched sample) was high, which makes the results even more compelling.

Finally, in the vein of considering barriers to enrollment, I offer a set of Seemingly Unrelated Regression (SUR) models aimed at addressing the possibility that unobserved factors influence *both* the decision to get Medicaid and the decision to vote. If it turns out that, contrary to

### Table 4.2: Estimated Effects of Medicaid on Political Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Simple Regression (1)</th>
<th>Expanded Models (2)</th>
<th>Coarsened Exact Matching (3)</th>
<th>Seemingly Unrelated (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vote</td>
<td>−0.10*</td>
<td>−0.12*</td>
<td>−0.07*</td>
<td>−0.37*</td>
</tr>
<tr>
<td>Register</td>
<td>−0.12*</td>
<td>−0.17*</td>
<td>−0.09*</td>
<td>−0.34*</td>
</tr>
<tr>
<td>Participation</td>
<td>−0.06*</td>
<td>−0.07*</td>
<td>−0.03*</td>
<td>−0.39*</td>
</tr>
<tr>
<td>N</td>
<td>5,033 (Vote)</td>
<td>4,935 (Vote)</td>
<td>5,925 (Vote)</td>
<td>3,299 (Vote)</td>
</tr>
<tr>
<td></td>
<td>7,079 (Register)</td>
<td>6,915 (Register)</td>
<td>5,543 (Register)</td>
<td>4,663 (Register)</td>
</tr>
<tr>
<td></td>
<td>7,113 (Participate)</td>
<td>6,948 (Participate)</td>
<td>6,563 (Participate)</td>
<td>4,426 (Participate)</td>
</tr>
</tbody>
</table>

Cells report coefficients from Medicaid variable, with standard errors in parentheses. Asterisks denote point estimates that were statistically significant at the p < 0.10 level (two-tailed tests). All models include full array of controls described in text.
what I suggested earlier, people who decide to enroll in Medicaid somehow share an unmeasured trait that makes them less likely to vote, then the SUR models should capture this. As shown in Table 4.2 (column 4), estimating the models via SUR does not change the findings: Medicaid remains a significant and strong predictor of political behavior.

MEDICAID AND STATE POLICY CONTEXTS

The empirical support I provide for H1 is not incontrovertible, but it is strong evidence that Medicaid enrollment has an overall negative individual-level correlation with political participation. Recall, however, that my qualitative work led me to question the geographic patterns underlying this overarching relationship. Closer scrutiny confirms the validity of this line of inquiry. For example, separate (matched) regression models for each of the fifteen core states represented in the Fragile Families data indicate that the relationship between Medicaid and political participation exhibits wide geographic variation (see Figure 4.1). There is a negative and significant association in New York, California, and Virginia, a positive relationship in Wisconsin, and no significant association in Texas, Michigan, New Jersey, and others. Note that Medicaid can be a boon to participation. Though the examples offered earlier stress beneficiaries’ adverse experiences with the program, it is worth noting that such outcomes are not inevitable. If we are to grasp how to avoid the negative gradient, it is crucial to identify the policy factors that contribute to it. Guided by the themes identified through the in-depth interviews, I turn to the quantitative data to do so.

The Political Effects of State Policy Heterogeneity

Recall that the political learning approach outlined earlier focuses on the lessons that beneficiaries are taught about the adequacy and capriciousness of state Medicaid policies. In particular, I hypothesized that four factors would prove especially educational for beneficiaries: 1) benefit expansions; 2) benefit retractions; 3) the scope of services offered; 4) administrative capacity. Benefit reductions implicate the capriciousness of the government, while benefit expansions, a limited scope of services, and human resource scarcity each implicate the adequacy of government (albeit in distinct ways).

In the models that follow, I explore the associations between these factors and the political participation of Medicaid beneficiaries. Note my
transition from employing models that compare beneficiaries and (similarly situated) non-beneficiaries, to examining models limited to only beneficiaries. The political learning explanation posits that the political influence of state policies depends upon the experience of Medicaid policy and the lessons it confers. As such, I expect that only Medicaid beneficiaries’ political participation will vary based on the specific kinds of policy heterogeneity emphasized here. Since some of these factors may also affect participation among disadvantaged non-beneficiaries, I keep a comparative eye on equivalent models among that group as well. This is a placebo test. To the extent that the expectations outlined earlier are borne out more so among beneficiaries than among their matched counterparts, it is evidence of the ways that states help turn policy into politics by distinctively shaping the experiences (and therefore interpretive lenses) of policy beneficiaries.

In the quantitative models of state policy heterogeneity, the outcome variables and basic controls are the same as those presented earlier. I also control for the proportion of Medicaid enrollees who were black and the degree of within-state geographic health disparities. The predictors of interest are measures that reflect the following state-level features: 1)
whether a state had expanded the Medicaid benefits offered in the past year; 2) whether a state has retracted any benefits; 3) how a state Medicaid program ranks in terms of provision of optional health services; 4) the density of state welfare bureaucrats. The models are limited to the fifteen core states contained in the Fragile Families data. Figure 4.2 illustrates the main findings.

As shown, state policy arrangements can boost or dampen political action among Medicaid beneficiaries. Beneficiaries living in states that expanded benefits in the previous year are significantly more likely to register and participate more generally; those living in states with a higher density of welfare employees are substantially more likely to register; those in states offering a wider scope of optional services are more likely to vote; and those living in states that have recently reduced benefits are significantly less likely to participate, vote, and register.

The effect of benefit reductions was the largest and most consistent. To provide a sense of magnitude, Figure 4.3 displays three graphs showing the marginal effects of Medicaid policy reductions on each political outcome. As shown, compared to beneficiaries living in states that did not reduce benefits, beneficiaries living in states that had made
the most reductions were between four and nine percentage points less likely to vote, register, or participate.

These results are substantively strong and consistent with expectations. They are also robust to many additional controls, including states’ ideological leanings, a measure of state welfare paternalism, the size of the Medicaid population, the partisan composition of state legislatures, the proportion of noncitizens in a state, the degree of within-state income inequality, contextual demographics at the census tract level, and even the organizational structure of state Medicaid programs (i.e., whether they are linked to or separate from state public health, mental health, and human services departments). Crucially, most of the state policy variables highlighted in the models are insignificant when the models are run for similarly situated (i.e., matched) non-beneficiaries. This suggests that the political behavior of beneficiaries is especially responsive to state policy factors that shape their experience of the program.

Of course, these findings are not dispositive. The Fragile Families Survey provides access to a uniquely large but nonetheless idiosyncratic group of Medicaid beneficiaries. Though similar analyses conducted using a very different sample showed equivalent results (not shown), caution is still warranted when generalizing beyond the sampled populations. In addition, while the empirical models cover much ground, they do not eliminate the possibility of inferential biases.
Finally, note that the quantitative models do not explain the general Medicaid-to-politics link (though they establish it as best as possible). While I aver, based on qualitative observations, that stigma and negative bureaucratic interactions are part of the reason for this link, most of my emphasis was on grasping the contours of state variation. Moreover, adding the state-level factors based on H2–H5 to the original (full sample) models (which estimated the general relationship between Medicaid and participation) does not render the indicator for Medicaid enrollment insignificant. If it did, then I would have evidence that state factors explain the general Medicaid-to-politics link. But that is not the case. Instead, accounting for state policy factors primarily helps us to understand the distributional patterning of Medicaid’s relationship to political behavior.

The multi-method evidence presented in this chapter indicates that Medicaid’s democratic reverberations are tethered to the federal political system. Federalism gives states the discretion to design policy (to expand benefits or to reduce them, to offer a broad or narrow scope of services) and to implement it (hiring enough workers to meet demand or failing to do so). This produces heterogeneity in Medicaid beneficiaries’ experiences of policy, teaching pointed and differential lessons about the inadequacy and capriciousness of government in the face of need. Qualitative evidence indicates that this education (or miseducation) has political upshots, shaping the way that Medicaid beneficiaries view government and politics. Quantitative evidence supports this, revealing that the Medicaid-to-politics relationship varies across states based on policy configurations.

Political scientists have long argued that “policy makes politics.” I demonstrate some of the conditions under which state policies make particular kinds of politics. But federalism is not “just a system that allows states to pursue different strategies; it is also a relationship between levels of government” (Soss et al. 2011: 93). With this broader view in my sights, I turn to the counties that operate within states to consider their implications for Medicaid beneficiaries’ political lives.
Particularistic Resistance in County Contexts

“Where there is power, there is resistance.”
– Michel Foucault, 1978

I met Shana in the spring of 2012. She was a mother of two in her early thirties and a lifelong “Michigander” who excitedly shared that she had just begun nursing school. Her husband, Tim, worked a low-wage job and suffered from severe epilepsy. Their young son had a serious kidney disease. For much of the previous decade, Shana and her family were enrolled in Medicaid. When I asked her about their experiences with the program, she told me that she “loved” it. Medicaid had made it possible for her to have “one happy, poor family.” About forty-five minutes into our conversation, Shana rather nonchalantly divulged that Tim’s benefits had recently been “cut off.” Someone “at the agency” told him that due to policy changes, he now had to “spend down $440 a month” to retain his health coverage. Given their family’s limited income, the financial impossibility of this cost was exceeded only by the price of Tim’s medicine. So Tim stopped filling his expensive prescription. Soon afterward, he had an epileptic seizure and nearly bit off his own tongue. Shana “cobbled together” the money to pay for his ER visit because “you can’t go around with your tongue hanging off of your mouth.” When I asked what they could do to avoid this happening again, Shana echoed my query: “What can we do?” Then she replied, “nothing really.” When I questioned whether she knew how to appeal the decision, Shana proved familiar with the process. Once, when she was assigned an apathetic caseworker, she complained, initiated a fair hearing, and eventually got a new caseworker. Now, only
a few years later, she was convinced that “nothing” could be done to reinstate Tim’s coverage and prevent his dangerous epileptic seizures. This perplexed me. It was not about casting a ballot in an election – an activity that could very well seem futile from the vantage point of beneficiaries whose experiences with Medicaid sometimes reinforced the government’s inadequacy and capriciousness. Instead, this was about obtaining benefits that were critical to survival. By what logic did people like Shana and Tim acquiesce in such circumstances? Under what conditions would they push back?

In pursuing these inquiries, this chapter focuses on the role of county-level institutional contexts. As clarified in Chapter 2, though local governments like counties are formally excluded from the constitutional architecture of federalism, they are deeply integrated into the practice of federalism (Anton 1989). Shana and Tim are not unattached individual “claimants.” They are citizens embedded in local political environments (in this case, counties) that influence their decisions about whether to fight against or capitulate to the bureaucracies that hold sway in their lives. Even such relatively pedestrian political choices about how to respond to unfavorable bureaucratic decisions are tied to the practices of federalist institutions.

PARSING PARTICIPATION: THE SIGNIFICANCE OF PARTICULARISTIC RESISTANCE

When policy beneficiaries take oppositional action in response to administrative decisions that threaten their access to valuable resources, I call it particularistic resistance (PR). PR can include contacting supervisors about problems with lower-level bureaucrats, lodging formal or informal administrative complaints, requesting administrative “fair” hearings, and even initiating external legal proceedings against an agency. The common thread underlying each of these is an aim to challenge, reverse, or amend decisions made by agents of state welfare bureaucracies. Put simply, to resist them.

Though it is an essential facet of human behavior, resistance is a contested concept that has eluded conclusive definition (Hollander and Einwohner 2004; McCann and March 1996; Rubin 1996; Scott 1985, 1990). As a result, social scientists locate resistance across an extensive gamut of acts ranging from rallies and protests to hairstyle choices, artistic performances, and deviant deeds (Cohen 2004; Hollander and Einwohner 2004; Silva 1997; Weitz 2001). Frequent and sometimes
Uncritical deployment of the concept has allowed “some scholars to see it almost everywhere and others almost nowhere” (Weitz 2001: 669).

Notwithstanding these complexities, there are two straightforward criteria for identifying resistance: 1) action on the part of the resister; 2) opposition to something the resister views unfavorably (Hollander and Einwohner 2004). Policy beneficiaries meet these criteria when they take steps to contest bureaucratic outcomes (action) that they perceive as adverse to their well-being (opposition). I designate such resistance as particularistic because it is focused on the needs and interests of specific individuals. PR is not part of an intentional mass strategy to impel government action, as was the case during the welfare rights movement (Piven and Cloward 1966). Neither is it “contentious politics” involving “interactions in which actors make claims bearing on other actors’ interests, leading to coordinated efforts on behalf of shared interests” (Tilly and Tarrow 2015: 7). Though PR certainly entails contention as Tilly and Tarrow define it (“making claims that bear on someone else’s interests”) and it counts as politics (as I soon explain), it generally does not involve coordinated efforts and thus does not meet their criteria for contentious politics. Moreover, while the conceptual frames of “intrapolitics” or “everyday politics” are related, PR does not fit neatly into these molds because it is neither hidden nor subversive, it occurs openly in formal political spaces, and it relies on codified rights protected by the state (Scott 1985, 1990; Tani 2016; White 1990). Particularistic resistance thus falls in the conceptual cracks between several more prominent notions. This makes it less perceptible, obscuring a potentially important political arena from scholarly view.

In their 1972 classic, Participation in America: Political Democracy and Social Equality, Verba and Nie highlight a close conceptual counterpart to PR: the third of four categories of participation: 1) voting; 2) campaign activity; 3) citizen-initiated contact; 4) group organizational activity. Like PR, citizen-initiated contact (CIC) occurs in “those instances in which individuals with particular concerns initiate contacts with government officials” (46–47). Verba and Nie assert that the four modes of participation they identify are distinct along four axes: “the type of influence exerted over leaders by the political act, the scope of the outcome that can be expected from the act, the amount of conflict in which such act involves the participant, and the amount of initiative needed to engage in the act” (47). In relation to these axes, CIC stacks up as follows: it exerts a narrow influence, has a limited scope, involves little conflict, and requires a fair amount of initiative. Verba andNie claim
that the scope of the outcome is the most idiosyncratic element of CIC because “only this mode of participation can reasonably be expected to result in a particularized benefit” (52).

Though CIC may sound like PR, there are notable contrasts. For example, Verba and Nie say that for a given (male) citizen who contacts a government official: “he determines the timing, substance and the act of participation” (47, emphasis theirs). This logic holds if one has in mind a neighborhood resident deciding whether to contact his or her local alderwoman about a broken streetlight or an annoying pothole. But when a citizen is responding to a perceived failing on the part of the government to provide a well-defined material resource, such first-mover privilege is less assured than Verba and Nie suggest. Take Brianna, for example, for whom Medicaid covered the removal of an entire row of teeth. Once her teeth were removed, she was in the precarious position of hoping that Medicaid would then also approve replacement dentures. Fortunately, her dentures were permitted, but had they not been, Brianna would not have freely “determined” the timing and substance of the contact she initiated. She would have been hard pressed, for rather tangible reasons, to act swiftly and in whatever ways bureaucrats would respond most favorably. Barbara Nelson (1980) captured this when detailing the unique nature of the “contact” that occurs within welfare bureaucracies, observing that “particularistic contacts, such as making a complaint about litter removal ... are not equivalent to applying for public social benefits or services.” The latter, Nelson points out, is a form of “help-seeking” that acts to “confer a durable status on the grievant” and for which the outcome of the interaction can “appreciably and fairly immediately alter the opportunities individuals have in society” (177). This is why the invocation of resistance is consequential. Most low-income policy beneficiaries who “initiate contact” with government are doing so from a position that affords them limited control over the terms of the interaction. Given an array of forces working against their active engagement, such political action is not only particularistic (aimed at securing benefits directly for themselves) but also oppositional (aimed at resisting some decision or outcome that will negatively affect them).

Several other assumptions that Verba and Nie make about CIC also do not fit with PR. For example, counter to their expectations for CIC, PR can occasion substantial conflict because beneficiaries and bureaucrats have interests and incentives that sometimes put them at odds with one another. In addition, since PR takes multiple forms, the level of initiative it requires ranges widely. Sometimes all it consists of is asking your
caseworker if you can speak to a manager (as Dani and others recount in what follows). Other times beneficiaries must go further by requesting administrative “fair hearings” (as Shana did when her caseworker was not sufficiently responsive). Still yet, some people do even more by leaning on outside advocates for help. Finally, depending upon its form, PR can have both scope and influence. In Chapter 7, I describe how uncoordinated individual beneficiaries approaching public benefits lawyers en masse can (unintentionally) alert policy advocates to problems in the system and cause them to look for broader solutions. In Pennsylvania in 2011, when a fraction of disgruntled beneficiaries who had been unfairly kicked off the Medicaid rolls individually made their way to local legal services attorneys, it was enough to get advocates asking questions and demanding information. Ultimately, this led to nearly 200,000 people having their benefits reinstated.

While PR clearly has similarities to CIC as Verba and Nie conceptualize it, it does not align with their assessments of scope, influence, conflict, and initiative. Juxtaposing CIC with PR is useful for orienting the latter (less familiar) outcome vis-à-vis a more traditional schema of political behavior. But PR is a distinctive outcome that merits inclusion in an appraisal of Medicaid (and other policy) beneficiaries’ political lives.

**MEDICAID, RESISTANCE, AND THE SECOND FACE OF THE STATE**

Medicaid bureaucracies have many of the ingredients necessary to generate PR. Though the program’s provisions for the elderly and disabled make it relevant to the middle class, the fact remains that it primarily serves populations associated with America’s “traditional” poor: very low-income adults and their children (Grogan and Patashnik 2003b; Quadagno 2015). As politically vulnerable target populations (Schneider and Ingram 1993), these groups contend with an intergovernmental program that leaves much discretion in the hands of local bureaucrats who are granted asymmetric power and gatekeeping authority over vital resources (Soss, Fording, and Schram 2011).

In addition, beneficiaries must confront a program that is extraordinarily complex. Both anecdotal and scholarly evidence underscore the bureaucratic labyrinth that Medicaid has become (Campbell 2014; Moynihan, Herd, and Harvey 2014; Moynihan, Herd, and Rigby 2016). The prevalence of red tape and administrative burden means that there
are many possible points of contention and correspondingly, many choices about whether and how to resist adverse bureaucratic decisions.

Importantly, escaping the burden of the Medicaid bureaucracy is often not an option. For low-income Americans, health insurance coverage is difficult to obtain through other means. Even middle-income Americans who qualify due to expensive or debilitating health circumstances have few alternatives. As Terrie noted: “[Medicaid is] number one to me, you know, you have ... other programs that will help me get food if there is need be, but your child going to see a doctor on a regular basis, it’s just so much more necessary.” This suggests that there is some incentive for those who rely on Medicaid to push back against reductions or cancellations. But how is such an inducement tempered by the social and institutional contexts of counties?

To date, political scientists have limited insights on this question because the kind of resistance that occurs in response to local Medicaid agencies has not often been a subject of inquiry. Such an oversight is exacerbated by the theoretical distinction often made between politics and administration (Moynihan and Soss 2014; Soss and Keiser 2006). As Soss and Keiser (2006: 133) point out, claims on the state made within welfare institutions:

provide citizens with a relatively accessible and targeted mechanism for influencing the allocation of public resources. Such claims have obvious importance for the applicant’s personal security and well-being; they also have considerable significance for the broader polity. Although welfare claims generally lack coordination and explicit political intent, they add up to a potent form of mass action that shapes the societal distribution of resources, capacities, and rights.

Especially for people living in poverty and/or people of color, negotiations with the government pervade life through multiple avenues and with striking intensity: through the criminal justice system, child support enforcement, public assistance agencies, and much more. Exchanges with these government entities are more than a one-shot deal of going into a government agency to apply for benefits or going into a court to contest a charge and so forth. Instead, they are multisided (often) iterative interactions that can reinforce class identities, engender alienation from government and/or create avenues for participation (Michener 2017; Soss 2000). This is part of a larger political process that is the underside of the more widely vaunted “liberal democratic” or “first” face of the state (Soss and Weaver 2016: 74). This “second face” of the American state comprises the “activities of governing institutions and officials that
exercise social control and encompass various modes of coercion, containment, repression, surveillance, regulation, predation, discipline and violence” (Soss and Weaver 2016: 74). I conceive of particularistic resistance as Medicaid beneficiaries’ response to the incursions of the second face of the state into a vital aspect of life. While mass protest is one particularly salient political reaction to government practices that make life difficult for “race-class subjugated communities,” activities like particularistic resistance are less prominent. In fact, means-tested policies and the bureaucracies that administer them are “seldom analyzed as ... a site where citizens exercise important forms of political agency, or an arena for direct political experiences with modes of social control that have lasting consequences for political consciousness and action” (Soss and Weaver 2016: 86). Examining PR thus advances the project of understanding “how policies fit into ongoing political transactions and construct objects and subjects of governance” (Moynihan and Soss 2014: 322).

Admittedly, PR is mundane compared to other kinds of politics. Its tactics are less broad based (i.e., small-scale individual acts versus larger collective organizing), its goals are more modest (i.e., particularistic gains versus far-reaching policy change), and its salience is muted (fair hearings do not make for good headlines). Nonetheless, PR is quintessentially political. For scholars who view politics as the generalized process of determining “who gets what, when, and how” PR entails actions aimed at influencing the distribution of highly coveted resources (Lasswell 1936). For those who more narrowly see politics as practices associated with the formal operations of government (Verba, Schlozman, and Brady 1995: 38), PR highlights relations that occur between denizens and the state. Finally, for scholars who broadly conceive of politics as the struggle over power (Goodin and Klingemann 1996), PR involves individuals struggling for a critical kind of power: that which permits access to vital services.

COUNTY BOUND: THE CONTEXTS OF RESISTANCE

To better understand particularistic resistance and to grasp the conditions under which Medicaid beneficiaries make claims against the state, I turn to legal scholarship about processes of dispute formation. One seminal legal framework depicts a “dispute pyramid” that highlights the progressive steps of naming, blaming, and claiming (Albiston, Edelman and Milligan 2014; Felstiner et al. 1980-81; Miller and Sarat 1980-81).
Naming involves recognizing that a wrong has been committed against you. Blaming entails attributing that harm to the responsible party or social entity. Claiming consists of communicating the harm done and asking for a response or remedy (Felstiner et al. 1980–1981: 635–636). This rendering of the dispute process has been enduring and influential; it has motivated a shift from viewing disputes as “found objects in the world” to recognizing them as “social constructs” (Albitson et al. 2014: 106). At the same time, a weakness of this perspective is its individualist orientation toward “narrow precipitating events … rather than the fundamental structural features of society or the long-term social processes” (Albiston, Edelman and Milligan 2014: 107).

Per the insights and criticisms of this dispute framework, we might view the particularistic claims of Medicaid beneficiaries as social constructs with both individual and systemic precursors (Levitsky 2014). Emphasizing the latter, I highlight beneficiaries’ positioning in a federal political structure that empowers counties. Counties can have tremendous sway over the contexts of claiming, but scholars ask relatively little about their influence (Soss et al. 2011 are a noteworthy exception). For example, in a seminal article, Felstiner and colleagues (1980–1981: 633) invite us to “Assume a population living down-wind from a nuclear test site” and offer a logic to help explain why some of the individuals in this population might make claims in response to perceived wrongs, while others might not. This thought experiment obscures the role of context. If instead, we assume multiple institutionally embedded communities, we can ask why some people, in some places, at some times produce different patterns of claiming than other people, in other places, at other times.

Local administrative contexts are especially critical in this regard. In Chapter 3, I described the historical genesis of Medicaid’s intergovernmental design and the contemporary heterogeneity it spawns in access to health resources. There, I focused mostly on variation across states. However, federalism also implicates subnational governing entities that have the power to influence policy via administrative channels (Anton 1989; Rich 1993; Soss et al. 2011). While this complicates the assessment of federalism’s participatory effects, it enriches our knowledge of how federalism functions in policy beneficiaries’ daily lives. I thus follow Hills (1999) in asserting the necessity of “dissecting the state”:

In discussions of American politics it is common to speak of a “state government” as if it were a black box, an individual speaking with a single voice. State governments are, of course, no such thing. Rather, a state actually incorporates a bundle of different subdivisions, branches and agencies. (1201)
Counties are one such subdivision, and a particularly important one at that (Benton 2002; Soss et al. 2011). As a hub for the negotiation of disputes over Medicaid’s procedural aspects, counties are proximate sites at which Medicaid policy is administered. Few scholars have made the case for the significance of administrative/bureaucratic implementation as lucidly as Moynihan and Soss (2014: 322), so I will echo them:

Policy implementation can reorganize power relations in a society, redefine terms of political conflict, mobilize or pacify constituencies, and convey cues about group deservingness … Bureaucratic encounters can teach citizens lessons about the state, mark them in politically consequential ways, alter their political capacities, and reposition them in relation to other citizens and dominant institutions. Through these and other processes, bureaucracies shape their own political environments and alter the broader organization and functioning of the polity.

For Medicaid beneficiaries, bureaucracies’ administrative decisions can affect life in profound ways. Recall Tim and Shana: their lives were severely altered after Tim’s benefits were cut. As such, their decision not to fight against the bureaucratic outcome that deemed Tim ineligible was consequential. If they had instead decided to resist, their only option would have been to do so on the front lines where county administrative judges and local bureaucrats exercise sizeable discretion.

As an artifact of federalism, the devolution of responsibility for Medicaid from the states to the counties varies markedly across the nation. Such heterogeneous intergovernmental dynamics mean that counties are more central to the provision (and regulation) of social welfare services in some states than others (Benton 2002). Connecticut and Rhode Island do not have functional county systems; counties are only minimally relevant in Maine, Vermont, and Massachusetts; they are influential in states like California and New York; they also are quite imperative in many Southern states (where they are sometimes called parishes).

In New York and Florida in particular, counties have a historically significant responsibility for administering Medicaid and bearing its costs. The analyses that follow show that in these states, patterns of particularistic resistance are reflective of county-level social, political, and institutional characteristics. Since it is not immediately obvious how counties influence particularistic resistance, I begin with insights from in-depth interviews that illuminate the relevant features of counties. While beneficiaries often do not speak in terms of counties, as a researcher, I know: 1) that many of the factors they describe when recounting decisions about whether to resist vary significantly across counties; 2) that
the administrative processes mitigating resistance are housed at the county level. I thus infer that counties are a pertinent incubator of action related to resistance based on knowledge of how the Medicaid bureaucracy operates. However, I rely on beneficiaries’ accounts of their experiences to explicate the key aspects of counties that matter for PR. The qualitative work then provides theoretical guidance for statistical models of county-level variation in a quantifiable manifestation of PR: the initiation of administrative fair hearings.

Given this approach, I am cautious in making unequivocal inferences: the ecological fallacy dictates that quantitative aggregate analyses of county-level data do not provide sufficient leverage for making inferences about the political behavior of individuals (and vice versa). Nevertheless, the qualitative and quantitative data presented here offer distinct and complementary indications that the factors at play in Medicaid beneficiaries’ decisions about particularistic resistance vary significantly across counties and in ways that are connected to the action (or inaction) of the state.

**PARTICULARISTIC RESISTANCE FROM THE BENEFICIARIES’ PERSPECTIVE**

When I asked Medicaid beneficiaries if they had encountered a problem in dealing with the program, the answer was nearly always yes. I then asked about the specific nature of the problem. In response, detailed conversations usually ensued. Finally, I followed up by inquiring about whether beneficiaries had done anything in response to any of the problems they faced. Though nearly all of the interviewees felt wronged by the program, only some of them recalled taking informal oppositional action and fewer still took formal action (for example, by requesting a fair hearing). Analysis of the interview data reveals that three factors were especially germane to such decisions: 1) perceptions of socioeconomic status; 2) perceptions of race; 3) perceptions of institutional responsiveness. We might view these as the usual suspects, but they are nonetheless enlightening. Indeed, beneficiaries’ perspectives on how their racialized and class-laden positions structured oppositional engagement with (sometimes) unresponsive local bureaucracies provide an imperative window into the second face of the American state. In highlighting these accounts, I cover the very terrain that Soss and Weaver (2016: 83) argue is under-traveled by political scientists:
Mainstream scholarship offers little about why, when, and how various actions by state authorities *construct race-class positions* or how organized governmental practices of social control are guided and rationalized through the coordinates of race and class. The political lives of RCS [race-class subjugated] communities, in fact, are not defined simply by their lack of integration into the political processes of representative government. To the contrary, people in RCS communities routinely interact with state institutions and officials and ... On a regular basis, people in RCS communities actively seek out governmental authorities (e.g., police and welfare officials) to address the problems they confront – often to control and regulate others on their behalf. In large numbers, they have direct, personal experiences with state officials who have the authority to alter their lives in profoundly damaging or beneficial ways ... They claim and receive public resources that allow them to feed their children or perhaps have this lifeline severed when they are deemed to have violated government rules. In RCS communities, these types of events are central to the lived experience of citizenship. They raise fundamental questions of governmental responsiveness and state power, and they are frequently at the heart of grievances that generate political demands.

As I show in what follows, Medicaid beneficiaries consistently assert the role of class, race, and local institutional responsiveness in motivating (or undermining) such particularized political demands.

**Perceptions of Socioeconomic Status**

Medicaid beneficiaries often articulated ideas about their socioeconomic status/social class as an explanation for decisions related to PR. They were highly conscious of such status and its implications for the possibilities of resistance. Angie, an African-American Detroit native and working mother of three, had a very clear notion of where she stood relative to others, and this delimited what she would do in terms of resisting. Early on, Angie clarified her thoughts about the standing of Medicaid beneficiaries:

> It’s like you are *uneducated* and you just want to get these free services and somehow *you are inferior* to other people if you receive those benefits ... Once they hear Medicaid its oh, one of those people ... if you have Medicaid you are certainly looked down upon, you are certainly *placed in some classification* (emphasis mine).

Mindfulness of her “classification” permeated Angie’s choices about resistance. For one thing, it convinced her that she had to push hard in order to be heard: “You’re lost in the wind unless you’re really adamant.” Since Angie believed that she was widely perceived as “a nobody,” resistance was necessary to obtain redress for agency wrongdoings. So when
she was sent a notice saying that she had been “cut off” for not turning in a review form and that Michigan Medicaid was now “too full” to reinstate her, she “raised enough sin” that she was put back on. Here is how Angie describes it:

I called the supervisor and I guess I didn’t turn in the review letter on time so my entire case was shut, you know what I’m saying ... So, when I got the letter that said I was cut off, I called up there and I said, “I didn’t receive the six-month review letter because I had moved so a lot of my mail was still going to a different address and I didn’t receive it, you know. You have to give me some type of, you know, leeway here because I didn’t receive it,” and they were like well, the case has been closed, there is nothing we can do. I’m like, “no, there is always something you can do.” So I just requested a formal hearing and I guess that in itself was enough for them to just review and change their decision because I got a letter, instead of, you know an appointment to come in for the hearing, I got a letter stating that I had been reinstated to Medicaid [laugh].

This and other experiences convinced Angie that when nobody really cares about you, it is essential that you “make a lot of noise to the right people.” Furthermore, Angie viewed the entire ordeal as “a game.” Though she was confident that no one cared, the rules of the game dictated that they had to pretend to care. This created opportunities for resistance, which Angie took advantage of when she saw fit:

You know, in anything, the poor are always who suffer the most and you know the saying, he who has the gold makes the rules, it’s most certainly true because they don’t care ... you know the people who make these rules and these guidelines they don’t know anyone on Medicaid they don’t have any poor people in their family, you know, they don’t care. That is why they are willing to chop so many services for the poor. That is why they are willing to make all these horrible mandates and cut services to people who really need them because they don’t care and they have no vested interest in caring. [But] you know, politics goes into it, they have to pacify certain people, they have to put out the front that they do care but in reality they don’t, so it’s all a game, it really is just a game (emphasis mine).

Angie laughed when she told me about times she had pushed back and gotten the agency to budge. This underscored her notion of the process being like a game that she relished winning whenever possible.

Angie exemplified how perceptions of socioeconomic status were both constraining and enabling. On the one hand, they compelled her to act, because she knew no one was concerned enough to act on her behalf. On the other hand, they placed a ceiling on her sense of the possibilities. Though she was willing to fight for minor, procedural, or incremental gains, Angie would not do so over “higher issues” because her position as
a “nobody” sensitized her to limits. The cat-and-mouse games she played with her caseworkers and their supervisors could only go so far because “on certain issues the powers that be are willing to bend a little bit; you may have some influence if you make a lot of noise, but other issues and maybe higher than that, I don’t think so.” So, while awareness of socio-economic standing could prompt beneficiaries to fight for themselves, such perceptions also constricted resistance, especially for more serious issues.

Shana, the woman whose story I opened this chapter with, is an example of this. Once, when Shana found it impossible to reach her caseworker, she knew that there was something she could do about it. She recognized that her “worker” had a position within the Medicaid hierarchy and in sensing her caseworker’s relatively low status, Shana was emboldened. Although her caseworker was “above” her, she was not too high up to be taken to task for neglecting her job. Shana requested a hearing, told “her side” of the story, and was eventually assigned a new caseworker. Yet, some time later when Shana and her husband were unexpectedly cut from the program, they did nothing about it. Shana’s explanation for this: “you can’t have your cake and eat it too.” She was happy that her kids were still on Medicaid and felt there was little point in complaining about her situation. The idea of fighting to have her benefits reinstated did not cross her mind because given “where she was at in life,” she reasoned that she shouldn’t expect “a handout.” Here is the takeaway: when the going really got tough and resistance required action against the state in a broad sense (rather than against a specific caseworker whom Shana viewed as relatively close to her on the socioeconomic ladder), the stigma of dependency pushed Shana away from her prior assertiveness and toward quiescence. This was common among the low-income beneficiaries I spoke with. Kyra, for example, noted early in our interview: “Being on Medicaid is for poor people. That’s what I think it is … and I don’t want to be labeled as poor but I am.” As the interview progressed, she noted several problems that she and her family had encountered with the program, but when I asked what she had done in response, again and again she expressed reluctance to resist. She finally summed it up by saying, “its Medicaid – you can’t complain about it.”

But not every Medicaid beneficiary shared this view. Those who had a higher socioeconomic status (and more advantageous racial status) made for a striking contrast. John, Dani, and Kay are examples. Recall that John was a white man in his mid-thirties with a genetic disease. Though his illness had impoverished him, he was from a middle-class family.
Moreover, because he attributed his reliance on Medicaid to his incapacitating health condition, he saw himself as having equal social standing with caseworkers (even while he acknowledged their stigmatized view of him). That is why, though John did not vote, and despite his expressions of deep cynicism about government and political change (“No, I don’t think we are going to change anything as patients”), he nonetheless did engage in particularistic ways. For example, when his vital home health services were threatened by proposed cuts in the state of Michigan, he noted that “eventually a union got involved and they kind of fought for workers’ rights and to try to keep people [working] in their homes and I can remember I went to a ton of meetings and we actually went down to Lansing [Michigan] and they went down right in front of the state capital and they eventually got it approved … some things are worth fighting for.” John resisted when he thought it was valuable to him (and when mobilized by a union). Quite crucially, John’s repertoire of actions was wider than beneficiaries who viewed themselves as poor, uneducated, and/or racialized subjects.

Dani was another example of this. As an Indian immigrant who had lived in the United States since she was five, Dani considered herself accomplished. Just minutes into our conversation she mentioned having a bachelor’s degree from a Big 10 school. She then explained that she was doing very well until she became pregnant with her son. At that point, she moved in with her parents and stopped working full time. She needed health care so she turned to Medicaid, but she prided herself on not being “your typical person that’s on Medicaid.” She assumed that caseworkers noticed this about her too: “I think even though they see that I’m on Medicaid, the fact is that I can speak clearly and I’m literate and all those things that they’re not used to seeing, so … I think they more so judge me as a person rather than that I’m on Medicaid.” Dani knew that one could be judged “as a person” or as someone “on Medicaid” and she sensed that the former was the case for her. For Dani, perceptions of her socioeconomic status buttressed resistance. When she ran into trouble with Medicaid, she did not back down. She explained one situation this way:

I needed a medication … I remember it because I was pregnant … Medicaid hadn’t kicked in yet; there was a lapse in coverage … I remember it was summer; it was so hot. I remember just being so frustrated … it’s already hot, I’m pregnant, I’m sweating, what the heck … I was on the phone for hours trying to get this medication because it was so expensive I couldn’t afford it out of pocket … It was an inhaler … and I have really bad asthma … I just talked to the supervisor. I’d
tell the supervisor, you’re not giving me the answer I want, I want to talk to your supervisor. You’re not giving me the answer I want, I’ll talk to your supervisor … finally I ended up getting somebody that could immediately get me what I needed. 

Dani expected that Medicaid would meet her needs and she acted accordingly. Her sense of socioeconomic standing undergirded such expectations to the extent that she resisted on the basis of seeking coverage for something that Medicaid, as per her own knowledge, had justifiably denied. Dani did not care about the technicalities of coverage and she did not hew to the rules. Instead, her socioeconomic positioning empowered her to go after whatever she needed. 

Kay, the mother who featured prominently in Chapter 4, is a remarkable example of how socioeconomically advantaged beneficiaries engage in needs-based particularistic resistance. As an educated, middle-class (white) woman who directed a nursing facility, Kay was accustomed to being heard and she knew how to make things happen. When Medicaid denied a claim for a $5,000 compression device that Brian needed for his lungs, Kay pushed to figure out what Medicaid would cover and learned that “they would cover a vest system that’s $20,000. And so I thought that was backwards … now we have a $20,000 machine that he uses twice a day.” An especially frustrating battle that Kay recounted was over diapers. She did not think that the diapers Medicaid offered were of sufficiently high quality. Though that is not the kind of criticism that local agencies are normally responsive to, this was Kay’s experience:

We have gone round and round about diapers at DHS [Department of Health Services]. After age three, they provide diapers, and so the company we get them from – they’re really poor quality. And so finally, after a year going back and forth with [DHS], their employee said, “I’ve been told to just get you whatever it is that you want” (emphasis mine).

How did Kay manage to wrest Medicaid’s concession to give her whatever she wanted? I asked about that. Our exchange was as follows:

ME: “So when you say a year of going back and forth, are you calling different people? Are you sending letters? I mean, what could you be doing for a year?”

KAY: “Calling and emailing, yes.”

ME: “And you just kind of keep going until somebody – whoever gives first …”

KAY: “Yes. I will basically knock down any door that needs to be knocked down to get whatever our son needs. See, I just tell them at this point, ‘The words that need to come out of your mouth are, ‘As you wish,’ because I’m not going to let up until you get him what it is he needs to survive, and I shouldn’t have to fight for every single thing he needs to survive.’”

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Particularistic Resistance in County Contexts

ME: “What kinds of responses do you get [to that]?”

KAY: Sometimes it’s just general incompetence. Other times, it’s—I feel like we are getting the runaround. I just forewarn people in the beginning that I am that mother. I am the one that will take it to the Nth degree to get what my son needs because, one, I am a nurse and I know the system, and two, I’m not willing to risk my son’s life. So you’re going to do what he needs [you] to do. And for the most part, once people realize I don’t ask for anything unreasonable, I will not call unless he absolutely needs it, I am not the boy [who] cried wolf. I am educated, I’m willing to take on the battle, and I will not back down at all. Once people understand and get that, then we get along great and we do fine. Until that point, then I’m the bitch in the room, and I don’t care (emphasis mine).

This level of engagement was exceptional relative to the experiences that low-income beneficiaries recounted. Remember that Shana did not respond this way even after Tim bit off part of his tongue. Among economically and racially marginalized beneficiaries, unless they were certain of some form of error on the part of the agency, they were generally unwilling to resist, almost irrespective of need. Folks with perceptions of low socioeconomic status did not engage in needs-based resistance. Recall Angie’s fair hearing: she did not initiate it on the basis of her own need but because of a technicality: she had moved and did not receive the mail the agency sent. The only beneficiaries who spoke about resisting in order to get things that were beyond the bounds of what Medicaid actually offered were those who were both middle class and non-black. On the alternative end of the spectrum were beneficiaries who indicated that they would not resist under any circumstances. Maggie, for example, was a white woman in her forties who worked as a school janitor before seriously injuring her leg and signing up for Medicaid. She insisted that she would “never complain” about “anything” Medicaid did because “it’s Medicaid and I’m poor.” She saw herself as having no basis for taking issue with the program.

In sum, though perceptions of low socioeconomic status did prompt PR at times (when beneficiaries felt they had to fight for themselves because no one else cared), beneficiaries more often indicated that such views undercut resistance by truncating the range of things they were willing to go after.

Race

In addition to conceiving of social status on the basis of a stigmatized designation as “poor” or “uneducated,” there was also a racial component
to positional perceptions (Blumer 1958). Without any prompting from me, African-American interviewees consistently noted race as an explanation for their treatment at the hands of caseworkers. Despite the fact that many caseworkers were also black, African-Americans believed that they “got it the worst.” Lucy was a black woman who lived in Georgia at the time of our interview. Her children had Medicaid, but she did not. She noted that when she walked in the Medicaid office, the assumption of bureaucrats was, “oh okay she black she just want the free assistance.” She went on to say this:

I mean you can have white people [who] are on assistance but to them it’s not assistance; [its] like, “I just need a little help right now.” Whereas, they look at us and be like, “oh that’s all you all want.” ... They still look at you in a different way because you have the Medicaid. I got burned last year, third degree. I could not get Medicaid. And I only make seven fifty an hour, but that was too much for them and I have four kids. I was out of work for almost two months. I had to fend for me and my kids.

From her vantage point in Michigan, Angie offered a similar assessment:

The color factor too that goes into that, you know, because they like to, you know propagandize that, you know the face of poverty is African-American. When in reality, there are more Caucasians and other races on Medicaid and food stamps and everything else than African-Americans by far. But you know it’s like, if you’re white and you have Medicaid ... then you are looked upon with more sympathy. You know, “she’s going through a hard time right now ... Everybody goes through that rough patch.” That’s the attitude they’re aware of. If it’s us, you know African-Americans, then we’re looking for a handout and you know we must be uneducated and we, this is just a life we like to live and we are treated as such that way.

Further still, black beneficiaries’ racial reference points were both white and Latino beneficiaries. Nessa, a black woman from Georgia, insisted that “in that [Medicaid] office, we’re in the bottom. Whites, then Mexicans, then us all the way down there. If a Mexican girl come in there with her ten kids, then I gotta wait until they talk to her first.” Lucy reiterated this, gesturing toward the non-responsiveness of her caseworker. “I still haven’t got no phone call, I still haven’t got no letter. I don’t even know who my caseworker is, whereas another nationality where it comes from Mexicans, they get approved more quick[ly].” Black beneficiaries brought this up consistently and across states. For them, race saliently manifested in ordinary administrative interactions and in observations of other beneficiaries’ treatment. Even some white beneficiaries believed that they were treated more favorably because of
their race. When I asked Roxy, a young white mother of three from rural upstate New York, whether she was treated differently due to her status as a Medicaid beneficiary, I did not invoke race at all (although perhaps my very presence as black woman invokes it). Nonetheless, Roxy told me, “I don’t think they really judge [me] at all. They may judge some people based on their skin color. They might.”

These racial dynamics are connected to decisions about whether and how to resist, but not in a straightforward way. African-American Medicaid beneficiaries expressed hesitance about resisting, citing fear of retaliation. They also expressed concerns about seeming like troublemakers. Zolene, for example, pointed out that “it is in our culture to fight back, but not in other ethnicities.” This was an attribute that she believed “could work against us” given anti-blackness and the hierarchical Medicaid bureaucracy. Such hesitance militated against resistance among black people.

At the same time, African-Americans most often noted having adversarial relationships with the Medicaid agency, and perceptions of racial discrimination only amplified that. Three of the four interviewees who initiated a fair hearing were black women (Shana, Lucy, and Angie). Moreover, large cuts to the Medicaid program disproportionately affect African-Americans (Franklin 2017), so their presence in a state or county is likely correlated with more occasions for resistance. Altogether, while the qualitative evidence points to the importance of race, it offers a complex, multifaceted picture of the precise influence of race on decisions about PR.

Institutional Responsiveness

Perceptions of institutional responsiveness were the third factor that came to the fore in an analysis of the qualitative data. By this I mean the degree to which beneficiaries believed that the Medicaid bureaucracy was responsive to their needs. Beneficiaries viewed bureaucrats as largely unresponsive due to being overburdened and because of a larger organizational culture of voicelessness. In a people processing agency like Medicaid, bureaucrats were focused on establishing eligibility and managing recertification, listening to beneficiaries was simply not part of the job (Barnes and Michener 2017; Hasenfeld 1972; Vinter 1963).

Interviewees frequently noted that the administrative strain of caseworkers did not bode well for the chances of successful resistance. Recall that in Chapter 4 I made the connection between administrative capacity
(a marker of the adequacy of state resources) and traditional forms of political participation. I now extend the relevance of that factor to the county level, both because there is distinct variation in levels of administrative capacity across counties and because Medicaid beneficiaries viewed bureaucratic non-responsiveness as a signal of an environment that was inhospitable to resistance.

Beneficiaries believed that local agencies were slow and indifferent because there were too many “clients” and too few “workers.” Lucy said, “it’s so big and it has so many cases so it gets to the point where they don’t care.” Nessa felt similarly:

I’ve never spoken to my caseworker and I’ve left messages trying to get in contact with her … she doesn’t call back; I guess they don’t check their voicemail. It’s … hectic trying to get in touch with a caseworker.

Many beneficiaries were convinced that bureaucrats saddled with enormous workloads became too hardened and intractable to respond to their needs. Beneficiaries believed that workers viewed them as “just another number” and were apt to retaliate for any semblance of opposition. When you made bureaucrats’ lives harder, they returned the favor. Kim, a young mother from Chicago, described her situation:

Right after I had [the baby] there was one [social worker] lady right down the street on Western. My son had been living with me all his life, but there was a young boy in Iowa with the same last name, same first name, same birth date – it was amazing. And the [social worker] lady kept telling me that my son don’t stay with me and that he live in Iowa, and so I took him to the office with me and I was like, that’s [him]. So that went on like that for two years, every time I went in to renew, we had the same problem. Um, then … I had my youngest daughter; she’s five now. I had her and I went in there and she told me I should get up and get a job. Oh, she was real nasty with me.

When I asked Kim if she ever considered doing anything about the way she was treated, she said this:

Yeah, but it would prolong it. It would take longer putting my paperwork in. They’ll push it to the back. So it’s just best to keep your mouth closed. It’s just best to lay low in there. It’s kind of sad that people would treat people that way. It makes you not want to go get the help that you need and there are a lot of people who ha[ve] issues with pride and they don’t even want to be bothered with it, so they just suffer.

The notion that resisting would only make things more difficult was widespread. Terrie insisted that “they don’t make it easy … fight [against] the system and they will lead you and charge you in paperwork …
appointments [until you’re] red, blue, and black in the face. And you get frustrated and you say, ‘Well eff it, I don’t need it.’ ”

Layered on top of caseworker recalcitrance, Medicaid beneficiaries discerned a more general culture of non-responsiveness and muting of their voices. By their accounting, the Medicaid bureaucracy was a heavily tiered system with little indication that anyone cared to involve them in the processes affecting their lives. Terrie noted:

There’s no opinion box in the Medicaid office, there is no “tell us how we’re doing” box in the Medicaid office, there is no supervisor like, “I don’t like what my caseworker is doing.” [If you] need to talk to a supervisor, you would probably never reach that person; they’re always running in an office, in a meeting, too busy, and they’re not returning that phone call.

Noting the importance of the county context, Terrie also explained that:

There is no interacting with people anymore in Cobb County … Our cases have actually been moved to another county, Cherokee County. So now what? If you’re on a bus as a parent, you are not getting there. If you’re in a car, maybe, but it’s not even a place we can go and make contact with them … You can go to the office and apply on one of those computer screens or fill out the paperwork. If you need to see someone, it would take three to four hours and if they have time allotted, I mean you may see them that day, but they don’t really have answers for you except we’ll contact you, we’ll mail you something when we get some new information.

Sentiments like this were communicated repeatedly. Maggie literally laughed when I asked her if there was any way she could influence what happened with her Medicaid case, then she followed up this skeptical chuckle with a simple, “no, no one listens.” Like many beneficiaries, Maggie had grown accustomed to a nonresponsive Medicaid bureaucracy focused on processing people, not on interacting with them in more substantive ways (Barnes and Michener 2017; Hasenfeld 1972; Vinter 1963).

Perceptions of socioeconomic status, race, and institutional responsiveness shape particularistic resistance in complex (and sometimes countervailing) ways. None of these factors is deterministic, but beneficiaries’ accounts broadly skew toward viewing resistance as a restricted and dubious option. While the qualitative work cannot provide neat, variable-based assessments of what shapes PR, it does suggest that socioeconomic status, race, and institutional responsiveness underlie decisions about whether to resist. With these things in mind, I turn to a quantitative evaluation of the role that county contexts play in shaping an important manifestation of PR: the initiation of administrative fair hearings.
TAking IT Up the Chain: Initiating Medicaid Administrative Fair Hearings

Only a handful of the beneficiaries I interviewed (four out of forty-five) had direct experiences with administrative fair hearings. Others acknowledged the possibility of a hearing, only to explain precisely why they would not bother. Non-initiation was often connected to ideas about responsiveness. Terrie knew that if you had a problem with something, “you can schedule a hearing.” But despite encountering a host of serious problems, she hadn’t done so because “that takes thirty days to schedule the hearing. Thirty days until you have an appearance; by then you’re so far down the line living life again, it doesn’t matter.” Lucy expressed similar sentiments:

You can do a hearing, but the hearing takes so long ... the process is too long. I am actually looking for help for the well-being of me and my family and you’re telling me to wait thirty to sixty days? I mean, I have a problem now.

The responsiveness of the hearing process was not only cast in terms of time, it was also viewed as a calculus of the likelihood of being heard. A leading official responsible for overseeing Medicaid fair hearings in Illinois admitted that “one big concern” that her agency has is that “people know about [the appeals process], but they just – they don’t think it’s going to be worth their time ... [they] assume it’s a rubber stamp process and they just don’t feel they’re going to be heard.” By all indications from the vantage point of the beneficiaries I spoke to, this is indeed the prevailing sentiment. Lucy expressed it most clearly:

When you walk into a hearing ... you have to ask yourself, do they already have their mind made up? And they just have to give you this hearing by law. But in their mind quite naturally it’s already made up. And the decision is already made, but because they have to give you that hearing, they will ... you have to go in there asking yourself, is this hearing really working? Or the next time you have a review [are] they going to make it harder?

Notably, Lucy still decided to initiate a fair hearing. Part of what enabled her to move past her reservations was a unique aspect of her social positioning: recall from Chapter 2 that though Lucy was a black single mother living in poverty, she was also a veteran. She had joined the military and gone on several tours, all in the name of providing for her family. The narrative she offered about herself in our interview centered on her willingness to do “whatever” she had to do for her family, even when it
was hard. Being a veteran was the ultimate reflection of that willingness and by a similar logic, Lucy initiated a hearing despite her misgivings:

At the end of the day I have to ask myself, “Are you concerned about what these people are going to think, or are you concerned about the health of your child, and which comes first?” So they can think what they want or have their minds made up to whatever extent they want, but at the end of the day, even if the hearing [doesn’t] do well, I’m still going higher because everybody has a boss and you’re going to eventually get to the top and find that one person [who is] going to really listen.

Lucy was cynical about administrative fair hearings, but her familiarity with hierarchy enabled her to view them as an avenue for being heard. Most of the beneficiaries I spoke to shared her cynicism, but were not inclined to push past it; they did not initiate hearings even when they thought there was cause to do so. Before I examine the county-level contextual factors that shape such decisions, a brief elucidation of the administrative appeals process is in order.

**FAIR HEARINGS: THE PROCESS OF APPEALING STATE ACTIONS**

Fair hearings are part of Medicaid’s administrative appeals procedure. Appealing (i.e., initiating a hearing) is an option available to Medicaid beneficiaries (or applicants) whenever the state, its agents, or its contractors take an action (or fail to take prompt action) regarding eligibility or benefits. Such actions can include denial, termination, or suspension of Medicaid eligibility and/or denial or reduction of particular medical services. Inaction generally involves the failure to process applications or requests in a timely manner. Beneficiaries have the same rights to a hearing whether the dispute is about eligibility or about medical services, and such rights hold whether benefits are administered through the fee-for-service system or a managed care organization (Musumeci 2012).\(^4\)

Though beneficiaries can initiate a hearing at any time, in interviews they noted doing so (or considering it) in response to receiving a notice about state decisions related to reductions, cancellations, or refusals of benefits. States are legally obligated to send notice of impending action that concerns eligibility or services, and when they do so, they must include information about beneficiaries’ options for appealing. State notices stipulate the legally prescribed time frames for appealing and the process by which to do so. For example, in New York State, beneficiaries
must request a hearing within sixty days of receiving a notice. They can do so by completing a fair hearing request form available online and in local social services offices. Figure 5.1 provides an example of the (blank) New York State form.

Once beneficiaries (or applicants) request a hearing, the state must respond either by offering a local evidentiary hearing or by scheduling
an administrative fair hearing. The former may provide more immediate relief, but if evidentiary hearings result in a denial, then beneficiaries can still request an administrative fair hearing. The right to an administrative hearing is guaranteed (via Goldberg v. Kelly, a landmark decision of the U.S. Supreme Court). Once a decision is rendered concerning the fair hearing, beneficiaries can technically appeal further in state court, but this requires resources, knowledge, and time that most people do not have. In practice then, fair hearings are a key and (often) final mechanism for beneficiaries to obtain access when vital health benefits have been denied.

PARTICULARISTIC RESISTANCE IN CONTEXT: COUNTY CHARACTERISTICS AND FAIR HEARINGS

Since the late 1960s, public administration scholars have studied the use of fair hearings (not for Medicaid, but for other public assistance programs) as an instrument for contesting government action (Bell and Norvell 1967; Hammer and Hartley 1978; Handler 1969, 1986; Lens 2005, 2007a, 2007b, 2009, 2011; Lens and Vorsanger 2005; Perales 1990). These researchers have recognized administrative hearings as the “only formal mechanism by which clients can challenge agency decisions” (Lens 2005: 431) and the “most effective way to determine facts accurately and to maintain a sense of fairness and equality in governmental action” (Hammer and Hartley 1978: 146). Welfare beneficiaries of all stripes use hearings in various capacities: as a tactical tool, as a way of resisting laws perceived as unjust, and as a space for explaining the realities of their lived experiences to those who have the power to intervene (Lens 2007b). Even when officials rule that “clients” have not been wronged, fair hearings still ensure that “those whose assistance has been correctly denied or discontinued ... are given the opportunity to state their cases. They too are afforded the dignity of being listened to, of being taken seriously” (Perales 1990: 892). Finally, hearings act as a check, though limited, on the arbitrary use of government’s discretionary power in the lives of the poor. They can function as a corrective to agency error and help to reveal organizational failings (Lens 2009; Perales 1990).

Scholarship on fair hearings has generally focused either on overarching administrative patterns or on individual experiences with the appeals process (Bell and Norvell 1967; Hammer and Hartley 1978; Handler
Such studies have shown that it is relatively uncommon for social policy beneficiaries to utilize the appeals system. Initiating a hearing is a rare occurrence (Baum 1974; Bell and Norvell 1967; Hammer and Hartley 1978; Handler 1969; Lens and Vorsanger 2005). In states like Texas, Wisconsin, and New York (those that studies to date have concentrated on), appeals occur in response to less than 1 percent of state actions (but this rate may be as high as 10 percent in some places). Although most scholars focus on a single state at a single point in time, cumulative findings indicate marked variation across time and place (Lens and Vorsanger 2005). To date, we have a limited understanding of how institutional contexts influence such heterogeneity.

Though appeals are rare events, they represent the opportunity to be heard concerning issues of crucial importance to beneficiaries. When the second face of the state exerts its power over resources in ways that beneficiaries view as harmful, initiating a fair hearing is one way to resist. But none of this happens in a vacuum. The models that follow put the individualized particularistic action of appealing into broader context to consider how counties (as subnational entities that form part of the structure of federalism) determine appeal frequency.

### Analyzing Fair Hearings

Utilizing data on fair hearings obtained through Freedom of Information Requests (FOIA), I analyze county variation in New York and Florida, the second and fourth largest Medicaid programs in the country (respectively). These states are home to more than 8 million Medicaid beneficiaries. Both are known for delegating significant financial and administrative responsibility for Medicaid down to counties. As such, they represent “most likely” cases for observing whether patterns of resistance are shaped by county characteristics. At the same time, they offer contrasts in terms of region, demographics, and political context.

The empirical models explain the frequency (count) with which fair hearings (appeals) were initiated in counties across New York and Florida between 2004 and 2011. There were 39,794 Medicaid-related hearings initiated in Florida during this time period and 95,289 in New York. These hearings were unevenly and differentially distributed across years (see Figure 5.2). In both states, overall appeal rates were very low. Over
the time period in question, only 86 out of every 100,000 beneficiaries from New York initiated a hearing, and in Florida the comparable number was 26.7

To examine the determinants of appeal frequency, I consider county-level variables related to the three factors highlighted in the qualitative work: socioeconomic status (SES), race, and institutional responsiveness. Since the qualitative work reveals that these factors have important but at times countervailing connections to resistance, I cannot specify the expected direction of relationships. One purpose of the analysis is to uncover that.

To measure SES, I include the percentage of county residents with a high school education.8 To account for race, I add the black percentage of county population.9 Finally, to gauge institutional responsiveness, I include the density of welfare bureaucracy (measured as the number of public welfare employees per person in poverty) and the mean time to resolution (this is the mean time between the formal initiation of a hearing and the issuance of a resolution).

I estimate negative binomial regression models with fixed effects. Negative binomial models are appropriate for over-dispersed count data of the sort I use here.10 Similarly, fixed effects partial out the many time-invariant county characteristics that can easily confound findings.11 While this limits us in some ways (fixed effects can only illuminate the determinants of changes in appeal frequency within counties over time), it also frees us from some (certainly not all) of the entanglements of endogeneity that accompany observational studies.
Table 5.1 displays the findings. The second column presents estimates for Florida and the third column contains those for New York. As shown, counties shape resistance differently in Florida than they do in New York.

In Florida, government employee density and race are not significant factors. On the other hand, county education levels and mean time to resolution are both positively correlated with appealing. Substantively, this means that as the percent of county residents with a high school education increases by one unit over time (from one year to the next), there is a corresponding 3 percent increase in the number of appeals. Furthermore, as the mean resolution time increases by one unit over time (from one year to the next), there is a 0.4 percent increase in the number of appeals. This latter number seems trivial, but note that a unit for mean time to resolution variable represents one day. Across Florida counties, the standard deviation for the mean time to resolution variable was thirty-seven (days). If a county increased its mean time to resolution (from one year to the next) by just under half of a standard deviation (eighteen days), this would be associated with a nearly 7.2 percent increase in the number of appeals. Of course, the magnitude of such an increase would depend on the base number of appeals from which the increase occurred.

Turning to New York (Table 5.1, column 2), we see very different patterns: more educated county populations are not associated with increases in the frequency of appeals. On the other hand, higher percentages of African-Americans and increased administrative capacity (ratio of welfare bureaucrats to people in poverty) are both positively and significantly correlated with the number of appeals, while mean time to resolution is negatively correlated with appeal frequency.
Substantively, in New York State, a one-unit (percentage) increase in the number of African-American residents (from one year to the next) is associated with a 10 percent increase in the number of appeals. Furthermore, as the mean resolution time increases by one unit (from one year to the next), there is a 0.01 percent decrease in the number of appeals. Finally, since the ratio of government employees to people living in poverty is small and its interpretation is not intuitive, I graphically depict the magnitude of the effect in Figure 5.3. As shown, an increase from the minimum ratio observed in the data (0.001) to the mean ratio across all New York counties (0.01) is associated with an increase from roughly twenty-eight to forty appeals.

The reasons for the divergence between Florida and New York are not immediately clear, and it is not feasible to attempt a comprehensive explanation here. Still, knowledge about the particularities of the states in question points toward potential explanations. For example, education may be more consequential to the processes unfolding in Florida because there are starker educational inequalities there. Residents of New York State are substantially more likely to have a high school diploma, a college diploma, and an advanced degree than residents of Florida. In a state environment with a lower density of people who are well educated, increased education at the county level may prove a weighty advantage.
in prompting PR. Alternatively, having a populace that is generally more educated may cultivate a statewide culture of claiming among both the educated and the uneducated (hence, higher rates of appealing in New York), dampening the discernable (over time) effect of education in the models.

Analogously, differences in the role of race may be traced back to state specificities. African-Americans in New York have long had more protections, rights, and power than their counterparts in Florida. As a result, the presence of African-Americans in a particular county may not be as politically stigmatizing or demobilizing in New York compared to Florida.

Welfare employee density and mean resolution time have effects that go in opposite directions across these two states. Again, the reasons are likely state specific. For example, welfare bureaucrats may be quite different in each state. If bureaucrats in New York are more liberal (which is plausible) and there are enough of them that they can pay sufficient attention to their clients, then perhaps those bureaucrats will be more able and willing to inform beneficiaries of their right to appeal and less inclined to respond harshly to them when they do so. This would account for the positive association between employee density and appealing in New York. If, on the other hand, bureaucrats in Florida are more conservative, then having more of them could easily exert the opposite effect. A caseworker who pays close attention in Florida would recognize and perhaps retaliate against a beneficiary who appeals. Of course, I do not know enough about bureaucrats in New York and Florida for this to be any more than informed speculation. For my purposes here, it is not the content of the suppositions that matters as much as the takeaway point: the very same county-level factors may play a different role across states depending on the larger demographics and culture of the states. Similar logic applies to resolution time. In New York, increased time to resolution may not exert as much of a negative effect on appeal frequency if beneficiaries believe that the time is being spent fairly adjudicating their case (or in some other justifiable way). How beneficiaries make sense of time to resolution may vary across states. None of the data I use in this chapter (even the qualitative data) is parsed finely enough to detect such nuance. Still, these findings open up an important set of questions related to contextual variation in the democratic effects of policy administration.

The precise reasons for the differences between Florida and New York may be unclear, but the differences themselves are not surprising. Counties are nested in state contexts, which I have already
established vary dramatically (in large part as a result of federalism). That the processes that shape PR differ across counties and states, underscores my broader argument about considering the role of multilevel federalist contexts when studying public policy and political participation.

WHAT MATTERS ABOUT PARTICULARISTIC RESISTANCE?

I began this chapter by situating the concept of particularistic resistance and detailing why it is especially important for Medicaid beneficiaries. Then, I connected it to the broader county contexts in which beneficiaries are embedded, and explained how counties fit into the landscape of federalism. I opened with this extended exposition of PR because it is not an outcome that political scientists generally study. Given the qualitative and quantitative evidence that I subsequently presented about the ways that race, class, and institutional responsiveness bear upon beneficiaries’ decisions about resistance, what insights can we glean?

In all honesty, this chapter raises many questions. But fostering inquiry is a crucial mechanism for generating knowledge, so the indeterminacies that emerged are valuable. Why do Florida and New York exhibit such divergent determinants of appeal frequency? How should we interpret some of the countervailing patterns that came to light in the interviews (e.g., African-Americans feeling more stigmatized and self-conscious about appealing, but also seeming more willing to appeal under the right circumstances)? I provide a springboard for considering these more specific inquiries, but do not resolve them.

Particularistic resistance offers Medicaid beneficiaries an avenue for checking the power of local welfare institutions and delivers a proximate opportunity for exercising political voice. But counties are an essential and often overlooked part of the federalist arrangements that structure the possibilities for PR. Though the dynamics within counties that affect PR are complex, it is clear that race, class, and institutional responsiveness are imperative factors. Only by confronting the dilemmas revealed by these axes of inequity can we begin to work toward equipping Medicaid beneficiaries with the power to have a say in the processes that govern their access to vital health resources.
People, Places, and Social Policy in the City

Tasha is a twenty-five-year-old Orlando native raising a small child on her own while working part-time and going to college full-time. When I met her in early 2013, she had been on Medicaid for nearly her entire life: first as a child, then as a teenager, then as a new mother. When I asked Tasha what struck her most about using Medicaid for all of those years, she quickly declared: “the clinics.” I probed and she explained this:

On Medicaid … you are assigned to a certain clinic. So, it’s like you have to be in there with all of these people and I don’t like that … I remember in high school getting my tooth pulled and I had to go to this clinic where I’d see bums and stuff outside and I was like [oh] man!

Tasha’s comments focused more on the local context where she received Medicaid benefits as on the services themselves. Living in high-poverty parts of the city meant that she had to go to clinics in downtrodden areas, and this made her experience of Medicaid uncomfortable. Darius, a middle-aged man from Chicago, offered a complementary account by describing the differences in the way Medicaid offices operate on the North and South sides of the city:

On the North Side you go in and basically you talk to somebody and they will get you on the computer, get you the stuff and get you out of there … and somebody sits down with you and [they] tell you what your benefits are and everything … Well now, over here [on the South Side], it seems like so many people, there [is a] backlog … they get tired with so many people coming in … On the North Side I have never had to stand in line … I went in there and got out real fast.

Melissa, a woman from Florida, similarly suggested that at Medicaid offices in West Orlando, “you’re treated differently.” And Zolene, a
Detroit expat living in Ypsilanti, Michigan informed me that one reason she was glad to be out of Detroit was because with “Detroit Medicaid 99.9 percent of the time you have to go outside of your community to see a good doctor.” These beneficiaries were all African-Americans from poor, racially isolated neighborhoods. When I asked them to talk about their experiences with Medicaid, their responses were refracted through the prism of urban inequality. Such observations point toward a question that has been neither asked nor answered about the relationship between federalism and social policy in cities: how do intracity disparities influence policy feedback processes?

**FEDERALISM GOES TO THE CITY**

Since it is not obvious why a book about Medicaid and federalism should focus on cities, it is worth taking a moment to explain. The arms of federalism are far-reaching: they go “all the way down” through states and into assorted substate entities (Frug and Barron 2008; Gerken 2010; Hills 1999; Peterson 1993; Rich 1993). These entities do not have the same degree of autonomy as states, and they do not have as much leverage for making constitutional claims to sovereignty (Gerken 2010), but they nonetheless enter the fray of intergovernmental power sharing via (at least) three avenues. First, cities (or other kinds of municipalities) can be granted power by states (for a variety of reasons, including political commitments to localism and any other state prerogatives that incentivize decentralization). Second, cities can wrest power from states. For example, in places where city delegates are well represented in state government (e.g., Chicago) or where the state government is run from the city center (e.g., Atlanta, Denver), cities do not have complete autonomy, but they do (at times) have the power to override state-level decisions (Frug and Barron 2008). Finally (and relatively rarely), cities can be given power by the federal government that is separate from that of the states. For example, the Community Development Block Grant program (CDBG), a policy descendent of Lyndon Johnson’s Model Cities program, was enacted under Richard Nixon in 1974. Approximately 80 percent of CDBG funds were allocated to metropolitan areas and provided directly to localities, bypassing state authorities. CDBG was thus designed as a largely federal-local program (Wong and Peterson 1986).

Given the range of ways that cities are implicated in multilevel struggles for state power, they are part and parcel of assessing federalism, especially with regards to social policy. The economic, social, and political
security of urban areas hinges on intergovernmental decisions that influence the flow of social policy benefits into cities. Such decisions, in turn, depend on the dynamic relationships between the national center and its periphery, as well as those between subnational units (e.g., states and cities). This web of connections is defined by federalism and it has consequences for the economic and political life of cities.

Since the 1970s, there has been extensive disinvestment from cities on the part of both federal and state governments. This has left cities with a relative dearth of place-based resources (i.e., resources specifically delineated to places as opposed to people), and that deficit contributes to the deterioration of the most needy parts of cities. Put simply: macro-institutional forces of federalism have played a part in generating urban deprivation (Frug and Barron 2008; Warren 1974). This is germane to the extent that urban conditions structure the relationship between social policy and political capacity. Recall the contextualized feedback (CF) model offered in Chapter 2. Key to the CF model is that federalism configures contexts and sets the stage for the design, implementation, and constraints of public policy. Neighborhood environments may act as formidable constraints. Residents’ immediate surroundings can cultivate or amplify the political influence of state and federal policies. It is for this reason that the urban fortunes (or misfortunes) engendered by federalism implicate policy feedback processes.

THE LIMITED CITY AND PEOPLE-BASED POLICY

Cities are major actors that are at times conspicuously absent from the mainstream discourse on federalism. The circumstances of metropoles have ebbed and flowed in tandem with the transformations of federalism over the past fifty years. In 1969, Daniel Patrick Moynihan asserted that “there is hardly a department or agency of the national government whose programs do not in some way have important consequences for the life of cities, and those who live in them” (Moynihan 1969: 11). Within ten years of this declaration, the tide began to turn. For several decades, both federal and state support for cities has waned (Bissinger 1997; Eisinger 1998; Kincaid 1999, 2001; O’Connor 1999; Weir 1996). With a strong emphasis on local control and fiscal belt-tightening, President Ronald Reagan spearheaded the dramatic shift of national antipoverty policy away from place-based policies that tackled the unique challenges of indigent locales and toward people-based policies that provided individuals with relief from penury (Katz 1995; Kincaid 1999, 2001, 2011;
The once “hidden, virtuous intersection of people-oriented and place-oriented policies” evolved into a widening gulf (Katz and Bradley 2013: 173). As shown in Figure 6.1, federal grants-in-aid to state and local governments for resources distributed directly to people (such as Medicaid) have increased markedly since the mid-1970s, while outlays for programs aimed at places have plummeted.

Despite often contentious relationships between national, state, and city governments, cities still receive large infusions of resources from national and state governments, but in the form of assistance for people-based programs, with little commitment to places. In 1978, roughly 15 percent of city revenues came from federal aid; today that number is in the range of 1 percent to 3 percent (Kincaid 1999). Between 1980 and 1990, the Reagan and Bush administrations slashed grants to cities by 46 percent (Katz 1995). Funds for low-income housing dried up, Community Development Block Grants were cut by 25 percent, urban jobs programs disappeared, and general revenue sharing – which had formerly provided cities with flexible funding – was eliminated (Katz 1995; Kincaid 2011). As suburban politicians began dominating state legislatures, similar declines occurred in state aid to cities (Katz 1995; Weir 1996). With their well-noted fiscal constraints, cities were not equipped to step in and take on the redistributive role of higher governments (Peterson 1981). Moreover, though local grassroots organizations

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Figure 6.1 Federal grants-in-aid to state and local governments for persons and places

Percent to persons for social welfare

Percent to place for state and local capital investment and general government

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sometimes rallied to fill the gaps, they proved even more limited than city governments and too frequently accommodated or exacerbated the preexisting boundaries of inequality (Garrow 2015).

Importantly, there is no evidence that this change in the direction of funding was because place matters less for life outcomes. Indeed, the best available evidence demonstrates that place is as important as ever for economic security and mobility (Chetty and Hendren 2015). As national funding for place-based programs decreased, urban poverty and residential segregation—two of our nation’s most enduring place-based challenges—were also on the rise (Bischoff and Reardon 2014). The turn away from place-based federal assistance was not a product of changing needs, it was the upshot of shifting political terrain. A confluence of forces soured the national political standing of cities: white flight, tumbling urban populations, federally subsidized suburbanization, and tough fiscal crises all contributed (Katz 1995). As these developments unfolded, the power of urban electorates was eroded, and both the national government and the states devoted fewer resources to cities (Eisinger 1998; Katz 1995).

What are the implications of these developments for policy feedback processes? There is evidence that place-based resources uniquely affect the material conditions of cities (Neumark and Simpson 2014; Partridge and Rickman 2006). So, to the degree that federalism has a corrosive influence on such resources, it plays a role in structuring the urban landscape. That landscape then bears on the micro-political effects of social policy, connecting federalism to urban processes of contextualized feedback.

**MEDICAID BENEFICIARIES ROLLING DEEP IN THE CITY**

Medicaid is an especially worthwhile lens through which to consider how such processes operate. Cities contain outsized shares of the nation’s poorest populations and are common sites for major medical institutions. Medicaid beneficiaries are thus disproportionately likely to live in urban centers. To put it quite colloquially, Medicaid beneficiaries roll deep in cities. Table 6.1 shows the percentage of various urban populations that are insured via Medicaid. The percentages for adults and children are separate since they vary so widely. The average numbers for each state are provided for reference. As shown, cities like Los Angeles, Philadelphia, and especially New York (the data are broken down by the four largest boroughs in New York City) have a high density of Medicaid
beneficiaries. For example, in Queens, New York (where I grew up!), nearly 50 percent of children and 20 percent of adults receive health coverage through Medicaid. And that pales in comparison to the Bronx, where nearly 63 percent of children and 33 percent of adults are enrolled in Medicaid. The people represented by those statistics are spread across neighborhoods. As they navigate their surroundings, they encounter conditions that shape how they experience Medicaid. If this leads to differential policy feedback, then the disadvantages of urban inequality intersect with social policy in democratically significant ways.

### Neighborhoods Matter (And Federalism Does Too)

As the national government and states make major funding decisions concerning Medicaid, cities must contend with the needs of their denizens in the face of unpredictably shifting policy trajectories. To boot, the powerful forces of economic deprivation and racial segregation generate a difficult quandary: the communities with the highest density of Medicaid beneficiaries are often the places where racial and economic marginality intersect most perniciously. As the attestations of the folks quoted at the opening of this chapter suggest, this can lead to distinct policy experiences for beneficiaries within the city, producing political effects that are differentiated by place.

### Table 6.1 Medicaid Density in Urban Centers

<table>
<thead>
<tr>
<th>State or City</th>
<th>Average (child)</th>
<th>Average (Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>45.6</td>
<td>22.8</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>50.0</td>
<td>26.0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>34.3</td>
<td>12.2</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>53.3</td>
<td>20.6</td>
</tr>
<tr>
<td>Illinois</td>
<td>37.8</td>
<td>14.6</td>
</tr>
<tr>
<td>Chicago</td>
<td>42.2</td>
<td>10.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>30.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Denver</td>
<td>39.9</td>
<td>11.0</td>
</tr>
<tr>
<td>New York</td>
<td>30.5</td>
<td>14.9</td>
</tr>
<tr>
<td>Bronx</td>
<td>62.6</td>
<td>32.5</td>
</tr>
<tr>
<td>Queens</td>
<td>46.4</td>
<td>19.8</td>
</tr>
<tr>
<td>Kings (Brooklyn)</td>
<td>50.1</td>
<td>26.0</td>
</tr>
<tr>
<td>New York (Manhattan)</td>
<td>40.1</td>
<td>15.8</td>
</tr>
</tbody>
</table>
Though little research directly explores this, tangential scholarly knowledge substantiates its pertinence. Social scientists spanning several disciplines have consistently demonstrated that cities are bastions of inequality and that neighborhoods exert tremendous social and economic influence (Chetty and Hendren 2015; Chetty, Hendren, and Katz 2015; Dreier, Mollenkopf, and Swanstrom 2004; Jargowsky 1997; Massey and Denton 1993; Sampson 2013; Sharkey 2013; Wilson 1987). Building on this, political scientists have established the significance of neighborhoods for political participation (Alex-Assensoh 1998; Cohen and Dawson 1993; Gay 2012; Huckfeldt 1979; Huckfeldt and Sprague 1993; Michener 2013). Economists have also shown that local contexts shape the effectiveness of antipoverty policy (Blank 2005; Partridge and Rickman 2006). In sum, neighborhoods matter for people, politics, and policy – and federalism matters for neighborhoods (Keating and Krumholz 1999; Warren 1974).

With this in view, I inquire about how urban contexts shape denizens’ experiences of Medicaid. Drawing on in-depth interviews, I develop hypotheses about how neighborhoods structure the Medicaid-to-politics link. I then examine survey data to test those hypotheses.

**MEDICAID AND URBAN INEQUALITY: MAPPING THE PATHWAYS OF INFLUENCE**

It is not patently evident how local context is related to Medicaid policy. Fortunately, the beneficiaries I spoke to elaborated on how neighborhood-level processes of political learning occurred. Foremost in these descriptions were references to the maze of institutions that Medicaid entangled beneficiaries in: hospitals, community health centers, social service departments, nonprofits, and schools. Since many of these organizations were located in the neighborhoods where beneficiaries lived, whatever occurred within them simultaneously reflected the realities of place and policy – a distinction that beneficiaries rarely made. That is why when Tasha considered Medicaid she thought of “clinics” and the frightening people who loiter near them, Kim remembered the “nasty” lady at the welfare office “down on Western Ave.,” and Lucy recalled the neighborhood school that would not enroll her children unless they got the very immunization shots that Medicaid was refusing to pay for (she wondered: “Couldn’t the school talk to the Medicaid people?”).

These beneficiaries conveyed narratives that prominently featured local institutions and they readily supplied commentary on the significance of
neighborhoods in relation to their experience of Medicaid. Such observations did not surface among middle-class beneficiaries who resided in more advantaged places. Instead, neighborhoods mattered most for those upon whom they conferred the most disadvantage: African Americans living in poverty. And they mattered enough that beneficiaries consistently referenced neighborhoods with no prompting on my part. In fact, at the time I was conducting the interviews, I did not fully grasp the relevance of neighborhoods, so I did not ask directly about them. Nevertheless, many beneficiaries independently underlined this aspect of their lives because it was part and parcel of their thinking about Medicaid.

Specifically, interviewees noted two facets of local context that sensitized them to policy dynamics in politically relevant ways: 1) neighborhood disorder; 2) neighborhood social cohesion. Beneficiaries living in places they perceived as disorderly and socially dislocated recounted negative and disempowering experiences with Medicaid. Let’s consider the significance of each factor from the viewpoint of beneficiaries.

**Disorder from Daphne’s Perspective**

I follow Skogan (2012: 174) in characterizing disorder as “unsettling or potentially threatening and perhaps unlawful public behaviors” and “overt signs of negligence or unchecked decay as well as the visible consequences of malevolent misconduct.” Indicators of disorder include public drinking or drug use, visible litter or paraphernalia, vandalism, graffiti, drug sales, street fights, and more. Hospitals, clinics, and Medicaid offices located in neighborhoods plagued by disorder bring difficult contextual realities to the fore at inopportune times: during medical emergencies, when a child is sick, or when a tooth is aching. Visceral reactions to potentially “dangerous” people loitering outside of a place to which you must go in order to secure health services does not cultivate confidence in Medicaid or the government that subsidizes it.

To illustrate the complex and multivalent ways that place matters in this regard, I highlight Daphne, the young black woman from Syracuse introduced in Chapter 1. Remember that Daphne has been on Medicaid for her entire life, and her “whole family” was enrolled as well (including her mother, grandmother, aunt, and brother). Though Medicaid was all Daphne had known, she realized that it was different from private insurance. For much of her life, Daphne’s mother took care of the details of enrollment and recertification. But as soon as she turned eighteen, she
was required to apply on her own. This was her first indication of something distinct about Medicaid. She observed that:

Some of my friends, they stay on their parents’ until they’re like twenty-four, twenty-five or six. Yeah, so they stay until they’re twenty-six and I just thought that was interesting that they could stay until they’re twenty-six and then they have to get their own policy, but when you’re on Medicaid, when you’re eighteen you have to get your own and you have to apply.

Though the application process itself was rather smooth, Daphne faced some of the challenges that I have discussed in previous chapters regarding staffing, agency responsiveness, and overcrowding. Crucially, many of these difficulties were associated with a specific health center that had special significance for Daphne:

*I really don’t like going to the health center. It’s an older building. It’s a lot of people. A lot of people, they’re there, they’re kind of upset, the waiting rooms are always filled. You’ve got to go in – people be waiting hours, and some people have kids and they’ve got jobs they’ve got to get to, so they get annoyed or they start getting irritated and start raising their voices or being impatient, like just frustrated. I don’t know if they even have air condition[ing] in there. I don’t even like going … But yeah, it’s just a long process and then I feel like the people in the back [who] work there, I feel like they’re understaffed and people are frustrated with them so they just are not the most pleasant people to speak to (emphasis mine).*

Before long, Daphne extended her observations to the neighborhood surrounding the clinic:

It’s kind of like downtown … I mean, like right there you have the shelter. And then a lot of people who go to the Salvation Army shelter, a lot of them are on drugs and stuff … I would hear about people being robbed over there, being robbed early in the morning. It’s just, you’ve got to be careful. There’s a lot of sketchy people over there. And it’s definitely downtown. There’s a lot of sketchy people downtown. A lot of people don’t go downtown. A lot of the wealthier people go to Armory Square, but you wouldn’t see the wealthy people downtown. You’d see them in the nicer part of downtown like the Armory Square. You wouldn’t really see black people over there [in Armory Square]. But *I wouldn’t say* [the clinic] is in a good neighborhood. It’s kind of going toward the hood. *It’s like right down the street [from the hood] (emphasis mine).*

Later in the interview, Daphne reiterated, “I just don’t like going to the health center. I do try to avoid it.” But she could not avoid it because her aunt has “special needs” and had to be taken to appointments at the health center. Daphne even noted memories of going to the center as a child. When she thought of Medicaid, she had years of experiences
linking the program with a particular place and that place represented disorder: robbery, open drug use, homeless shelters, and people loitering.

Interestingly, when the conversation turned to politics and power, Daphne’s views continued to be filtered through a prism of place. Take this exchange, for example:

**ME:** Do you think if people who were on Medicaid wanted to do anything to change the program or change Medicaid policy, do you think they have any power? Do you think they would be able to do that?

**DAPHNE:** I don’t know how they can. I don’t know if they do have any power to change it, but I believe they would like to change things and how everything works. Because it’s ridiculous how you get treated and how you [can] be in the office for hours. *I bet that doesn’t go on in Fayetteville or Cicero or North Syracuse.* That’s just unheard of. People are in and they’re out when they have appointments … I feel like it is different in different places … [like] say if you’re at an Olive Garden or you go to a Burger King, they treat you really different.

**ME:** Okay, so do you think that those experiences that you just described, do you think they have anything to do with the political system?

**DAPHNE:** Yeah, I think everything has to do with politics, just there’s like winners or losers. I can’t really describe. I think everything has to do with politics. They don’t care about the poor unless they want the black vote. I know Hillary Clinton was visiting upstate New York and New York [City]. *The hoods and stuff like that, you never see her in there.* And I just heard her say, like people have videos of her saying different things and contradicting herself, and yeah, I just feel like everything has to do with politics.

**ME:** So … what do you think the main barriers are that prevent Medicaid beneficiaries from being able to have an influence?

**DAPHNE:** Well, I just think a lot of Medicaid people … I feel like sometimes I don’t really think they understand politics, and a lot of them are not really well educated. So sometimes it’s kind of frustrating to sit and listen when you don’t really know what they’re talking about, or just hear terms and you just don’t really know the basic economics. I kind of know more because I go to college and I talk to people about it. I definitely had to learn certain things, because I didn’t really know what it meant … I just think a lot of people, when the polls are open, if people have jobs, like low-income jobs that they’re working, some people work like two to three jobs just to make ends meet, so I don’t even think they have time to go to the polls to vote. And I just think a lot of people have trouble with the law. I don’t even think they can vote, if you have like a felony or something. Like I know our population deal[s] with mass incarceration, so even that too. So I feel like sometimes the system, it’s made for us to stay down and to stay on Medicaid … it’s hard to get out of it, to climb out.

As a young black woman from a rough neighborhood, Daphne proved impressively familiar with the many barriers to political participation facing people in her community. She suspected that political elites like Hilary Clinton avoided communities like hers (“the hoods and stuff like
that”) and she sensed that outcomes would be different for people who lived elsewhere (“Fayetteville or Cicero or North Syracuse”). All of this created a wellspring of mistrust that flowed into her outlook on policy. For example, when I asked Daphne her thoughts on “Medicaid expansion,” she keenly homed in on the fact that the expansion had not happened uniformly across states:

I don’t really like the state choosing things. Yeah, I don’t really trust the state and the politicians. I don’t know. I just think everybody having the same access and it being the same everywhere, I think that would be more helpful instead of having all these rules and here and there, and you’ve got to apply for insurance. I wish it was just nationwide, like you’re just not insured if you’re insured in New York State but if you move somewhere else you have to reapply. I know a lot of jobs moved, like Chrysler was big in upstate New York and then they moved to Detroit, and people had to move with their jobs and you probably discouraged them from moving because they probably wouldn’t qualify for insurance there and they’d have to stay here and loss of a job they had out of high school making good money. I don’t know. Like I just wish it was the same nationwide and not just the state, because I don’t think the state could be trusted, honestly. We can’t even trust our police force.

Throughout her life, Daphne had traumatic experiences with the police in Syracuse. She told me that police targeted neighborhoods like hers and the people living in them. Because of this, she did not trust the police and by extension, she did not trust New York State. Such localized perspectives came to define her attitudes toward Medicaid policy (“I wish it was the same nationwide”).

Like Daphne, many of the African-American beneficiaries I spoke with described the physical conditions of neighborhoods in the course of explaining their experiences with Medicaid. Mabel, an African-American woman in her early sixties who lived on the South Side of Chicago, explained the difference between applying for Medicaid on the South Side and doing so when she had lived in “middle-class” suburbs. On the South Side, the building was “nasty” and the line was out of the door. Mabel was so turned off by the environment that she did not even stay long enough to apply. Though she was a diabetic and needed health coverage, she chose to go home rather than to wait in the place where had gone to apply. Alternatively, during a brief stint living in the suburbs, she experienced something very different:

When I was in the suburbs you didn’t see the welfare office because I lived in a part of the suburbs, middle class or whatever. They didn’t have any welfare office, you know what they have? … the welfare office is in the bank building and I went
in there to get a medical card and I was out in like ten minutes. They are very kind and very nice and very helpful, but you couldn’t do that here [on the South Side]... there’s a difference.

Mabel eventually had to move from the suburbs back to the city for “financial reasons.” By the time of our interview, her Medicaid enrollment had lapsed, but she was reluctant to go to the local office to reenroll. Instead, she had been making do by going to a health clinic. Recent news that Cook County would be closing some of its clinics was causing her major stress, enough that she contemplated applying for Medicaid again.

I’m afraid that when they do [close the clinics], if this goes any further, then I’m going to be broke. And I can’t still afford to pay my insurance or my medical bills, I can’t afford to pay ... I do need to go and stand in somebody’s line to get some medical help.

Soon after discussing her medical situation, I asked Mabel what, if anything, people like her could do to change such situations and what role the government should play. Her response betrayed a dim view of politics:

I don’t know what, but I’m sure there is something that we can do. You know, like vote. It’s supposed to be making a difference if you vote ... and it did make a difference in November [2008], but we vote for everything else and we don’t get it ... that is why you ask me about government, I’ll be saying I do not know what’s going on there.

Mabel had a vague sense that people should be able to do something and that voting might be related; she viewed the election of Barack Obama as a signal that voting sometimes worked, but when it came to the specifics of her life, she was hard-pressed to see how the government had been very helpful. Things like the deteriorated conditions of the building where the Medicaid office was located were very proximate signals of disorder that directly shaped her experiences with public policy.

Social scientists across a range of disciplines have accumulated evidence of the multifaceted effects of disorder on social, economic, psychological, and political outcomes (Casciano and Massey 2011; Christie-Mizell and Erickson 2007; Hill et al. 2005; Michener 2013). This growing literature confirms that disorder works mainly by shaping the lenses through which residents view their communities and their experiences within them (Hwang and Sampson 2014; Michener 2013; Murphy 2012; Sampson and Raudenbush 2004; Wallace, Louton, and Fornango 2015). Daphne’s narrative demonstrates something else about neighborhood disorder: it structures people’s experiences with social policy in ways that reflect
badly upon government. Given this, I hypothesize that there will be a stronger negative association between Medicaid and political participation in neighborhoods perceived as disorderly (H1).

Neighborhood Social Cohesion: Making It Through Together

As a key aspect of urban life, social cohesion is the network of relationships, values and norms of residents in a neighborhood (Friedkin 2004; Rios, Aiken and Zatura 2012). Cohesion facilitates access to concrete goods and services; without it, people must navigate neighborhood minefields alone. That means not having people who can tell you about the high quality clinics or nursing homes to go to, the right doctors to see, or the best social service organizations to get you signed up for Medicaid. Though not as prominent in my conversations as disorder, networks were often invoked by the beneficiaries I spoke with. In particular, they described how social connections equipped them with the knowledge necessary to adeptly traverse local terrain. Frankly, even (relatively) economically advantaged beneficiaries needed such knowledge to avoid ending up in places that are detrimental vis-à-vis Medicaid. Take Kay, for example. She made an effort to ensure that her family’s move from Iowa to Minnesota would land them in just the right part of Minnesota: near the children’s hospital of their choice and in a neighborhood with the best services. She explains it this way:

We talked to Brian’s neurosurgeon … and said, “Tell us what you know” … And so he said there’s a few social workers in the organization he really trusts and then he said, “Let me see if one of them appears today.” … So they pulled a social worker in, and so she explained to us how the counties manage the Medicaid, and so she said, versus if you go to a more heavily populated county, there’s more people pulling for those dollars. She said, “You know, it’s supposed to be divided up per capita, but if you imagine a lot of people needing those dollars, the kids with special needs may not get as much as they could in a less populated area.” So then knowing that, then we began the search of which school district has the best services for children with special needs and then we talked to several doctors, several families, I talked to parents, and then figured out where that was, and then homed into that county, that school district, here is a neighborhood that we can buy in.

As a middle-class, well-educated person, Kay forged connections that went beyond her neighborhood. Her family had the resources to select into the place that would best meet her son’s needs. Most low-income beneficiaries do not have such networks, nor can they freely choose the best place to live. What they can do is leverage local ties to more successfully
navigate community institutions and service providers. Lucy gave several examples of how she uses her familiarity with the community to help when she sees her “friends struggling.” For instance, she noted that “some of my friends, they go to a doctor’s office. There are predominately white doctors … but I go to a doctor’s office where it’s Indian doctors who are already a minority … so I do not get treated [in] any different way [there].” By passing such information onto her friends, Lucy helps them avoid instances of racial discrimination that many beneficiaries described having. Similarly, Terrie remarked that she and a friend who is also on Medicaid have been “helping each other out with [Medicaid] since we met.” Most arresting, Louisa told me of learning about which local hospital should be avoided at all costs because of an experience that her friend, a fellow beneficiary, had told her about. Louisa described the hospital’s treatment of her friend in horrid specificity saying:

She was on Medicaid when she had her baby [and] they actually left a piece of her placenta in there, in her stomach. So you know … when you are pregnant you stay at the hospital maybe two days, then they release you; she went home [and] started having real high fevers and … she had to go to the emergency room. She’s been in and out the emergency room for a while because of the placenta, piece of her placenta being left.

Indeed, when I used snowball techniques to recruit interviewees, some beneficiaries could easily point me to friends who were in the program. Others however, drew total blanks and said that they did not know any other Medicaid beneficiaries. Such social linkages (or lack thereof) may bear upon beneficiaries’ ability to cope with (or avoid) Medicaid’s place-specific challenges, and thus affect how they experience the program. If so, Medicaid should have a stronger negative effect on local political engagement among those who view their neighborhoods as socially disconnected (H2).

MEDICAID IN AN URBAN CONTEXT: A QUANTITATIVE ASSESSMENT

To test these hypotheses, I use data from the Chicago Community Adult Health Study (CCAHS). This survey included a household probability sample of 3,105 adults stratified by 343 neighborhood clusters (Morenoff et al. 2007). CCAHS was administered between May 2001 and March 2003 and generated a response rate of nearly 72 percent. To date, it is the only study of a large U.S. city to comprehensively sample all local
neighborhoods. While the CCAHS’ singular emphasis on Chicago limits its breadth, it offers unparalleled depth. First, it covers a much wider range of variables than the traditional data sets that political scientists rely on. Second, Chicago contains widely recognized neighborhoods that closely match the CCAHS neighborhood clusters. This ensures that the geographic level of analysis that demarcates neighborhoods accurately represents local residents’ experiences of neighborhood spaces. Third, Chicago is a preeminent urban center that, while not representative in a strict sense, is a strong basis for asserting the relevance of a particular urban phenomenon. If Chicago neighborhoods shape the way Medicaid policy effects political participation, then there is good reason for inquiring about whether the same holds true in other places.

I base the analyses on a composite measure of participation that captures a wide range of nonvoting political activities, many of which are directly or indirectly linked to the local environment. This index of political activities combines information about whether respondents have engaged in the following activities over the past twelve months: (1) signing a petition; (2) attending a political meeting or rally; (3) working on a community project; (4) participating in demonstrations, protests, or boycotts; (5) participating in a group that took local action for reform; (6) participating in an ethnic, nationality, or civil rights organization; (7) participating in a labor union.

The control variables are standard for models of political participation: age, sex, education, income, race (indicators for African-American and Latino, respectively), nativity (whether the respondent was born in the United States), and health. I also control for neighborhood characteristics: the local rate of family poverty and the proportion of African-American residents.

The key independent variable is a measure based on respondents’ report of their source of health insurance. Approximately 8 percent of the CCAHS sample was enrolled in Medicaid.

Given the use of observational data and its accompanying limitations, these analyses aim to explore the relationships between Medicaid, political behavior, and neighborhood context, but cannot support unequivocal causal arguments about those relationships. Though I do not to claim dispositive certainties, I present important evidence that the relationship between Medicaid and political engagement is contingent upon neighborhood context.

I address the nested structure of the data (some of the variables are measured at the level of the neighborhood) via multilevel modeling.
Multilevel regression is an approach well suited to questions that involve hierarchical data (Raudenbush and Bryk 2002; Steenbergen and Jones 2002). I begin by using the CCAHS data to duplicate the findings from Chapter 4 (which were based on the Fragile Families Survey). This baseline model (see Appendix B, Table B8) estimates a multilevel regression with the political participation index as the outcome, Medicaid receipt as the key independent variable, and all of the individual-level control variables. It also includes the two contextual variables (neighborhood race and neighborhood poverty). The results confirm a significant negative relationship between Medicaid and political participation, even after controlling for local contextual factors.

Next, I move on to the more nuanced analysis suggested by the hypotheses developed in this chapter. Extending the baseline model, I add a variable for *perceptions of neighborhood disorder* and one for *perceptions of social cohesion*. Since prior research indicates that perceptions of disorder can display a curvilinear relationship with participation, I also include a quadratic term to account for potential nonlinearity (Michener 2013). Finally, since the hypotheses point to interactive effects (i.e., the relationship between Medicaid and participation will vary based on perceptions of disorder [H1] and cohesion [H2]), I add interactions between Medicaid and the perceptions variables. For simplicity, these continuous scales are converted into categorical variables indicating whether perceptions of disorder and cohesion were low, moderate, or high.

The results show that perceptions of cohesion and disorder are significantly and positively associated with political engagement. Individuals who score high on the neighborhood cohesion scale are more likely to participate (see Appendix B, Table B9). Disorder is also positively correlated with participation, which may seem counterintuitive, but since the quadratic disorder term is negative and significant, this denotes that the relationship is curvilinear. Participation rises along with negative perceptions of disorder, but at a decreasing rate. So those with moderate perceptions of disorder are most likely to participate, while those at the extremes (either most or least aware of disorder) are less likely to take political action.

The key findings for our purposes concern the interaction terms. How do perceptions of disorder and cohesion moderate the link between Medicaid and participation? First, the results reveal a significant association between participation and the interactive disorder term. Since interactions can be difficult to interpret, I display this correlation graphically in...
Figure 6.2. The figure highlights patterns among Medicaid beneficiaries, showing that beneficiaries who perceive very little disorder in their neighborhoods are most likely to participate, while those who perceive the most disorder are least likely to do so (unlike the direct effect of perceptions of disorder, the interactive effect is linear). Since the standard deviation of the participation index was 1.3, the decrease shown represents a little less than one-third of a standard deviation.

Unlike disorder, there was no significant interactive association between Medicaid and neighborhood social cohesion. This does not prove such a relationship is nonexistent, but it means the analyses do not corroborate its existence. Keeping in mind that the number of Medicaid beneficiaries in the sample was relatively small and the interactive variables were highly correlated (0.70), it is possible that the CCAHS data are not best suited for detecting an interactive association between Medicaid and cohesion. It is also possible that cohesion is not enough of a driving factor to exert an effect over and above disorder. Disorder certainly loomed larger in the qualitative accounts than cohesion did. While cohesive networks are useful for navigating the challenges of Medicaid, they do not mark its very infrastructure. By comparison, disorder is more profound.
and harder to ignore. Robberies and drug addicts near the biggest clinic in town, long lines of beneficiaries stretching down the litter-filled and dangerous block outside the Medicaid office—these experiences trigger a memorable and visceral reaction and they forge a link between the harsh realities of urban inequity and the limited capacity of the very state that is providing health benefits.

Such possibilities aside, I do not offer the final word on whether the non-significance of the cohesion interaction indicates that it has no effect, or whether the data and analysis utilized here simply cannot detect such an effect. These relationships are important enough that the analyses offered here should not be considered the final word, but the opening salvo.

Perhaps most incisively, the non-significance of the social cohesion interaction suggests that the significant interaction between perceptions of disorder and Medicaid is not simply reflective of a nonspecific pattern that will emerge anytime one interacts a proxy for neighborhood disadvantage with Medicaid enrollment status. This is not simply a case of people who live in “bad” neighborhoods participating in politics less because they are poor (and thus more likely to be Medicaid beneficiaries) or because they experience negative environmental externalities. The intervention I make is more pointed: particular kinds of neighborhood conditions (i.e., those that connect disorder to the local institutions that supply Medicaid services) bear upon the experiences of Medicaid beneficiaries and thus shape the program’s individual-level political effects. The crux is this: though Medicaid beneficiaries take political action less frequently in general, those beneficiaries who face certain kinds of contextual challenges (specifically, high levels of perceived disorder) participate even less (after accounting for individual socioeconomic factors, neighborhood poverty, neighborhood racial composition, and more).

CITIES MATTER

I submit multipronged evidence that the places in which policies are enacted shape their political consequences. As intimated by the contextualized feedback framework, I build on the tradition of policy feedback, with an added focus on how contextual conditions shape the interpretive effects of social policy. Bridging the tacit divide separating research on social contexts from studies of policy feedback, I illuminate a neglected nexus between policy and place. Productively merging meso- emphases on social policy with micro-orientations toward concrete urban environments, I find that experience with Medicaid dampens the proclivity for
local political activism among beneficiaries who perceive disorder in their neighborhoods more than it does for beneficiaries who are not as cognizant of disorder.

Policy feedback processes do not unfold apart from larger contexts of inequality. To the degree that urban inequality leads to divergent perceptions of phenomena like neighborhood disorder, it can also amplify disempowering feedback cycles. In this light, investments in people-based policies like Medicaid are perhaps best complemented by initiatives to improve the places where beneficiaries live (Blank 2005; Partridge and Rickman 2006). However, when intergovernmental conflicts pit national or state authorities against cities, wide scale support for place-based policy dwindles. Take for example, President Trump’s threat to rescind federal funds from immigrant-friendly “sanctuary cities.” A battle between cities and the federal government over the proper jurisdiction of their powers is possible only because of the federated structure of our political system. Yet, if such a scuffle leads to decreased federal funding for cities, then place-based urban policies will suffer and urban denizens’ primary form of federal support will be through people-based policies like Medicaid. The evidence I present in this chapter highlights one (additional) reason why that is problematic. People and places are closely intertwined, so implementing people-based policies in places marked by deprivation can undermine the democratic life of those very communities.

In a milieu of contentious federalism marked by urban retrenchment, policies that are exclusively people-based may exacerbate the deep inequalities that presently plague American cities. To be clear, the problem is not federalism. Nor is it people-based policies. Both can be leveraged for the good of marginalized populations. The challenge lies in harmonizing people- and place-based policies in ways that draw on the strengths of each, while mitigating their weaknesses. What does this look like in practice? Ultimately, policy makers (and the citizens who empower them) must decide the details. My primary purpose is to signal that we should take great pause when policies are designed to serve floating people without recognizing their attachment to places. A well-functioning institution of federalism should emphasize the prerogatives of both. Katz and Bradley (2013) give us a glimpse of what they think that this implies for federalism:

The federalism that best serves the cities and metros that drive economic development in the 21st century is not the traditional “dual sovereignty” that splits power between federal and state governments according to subject matter – but a form of collaborative federalism in the service of cities and metros that set priorities
and lead implementation. This requires a re-sorting of the roles and responsibilities of government that focuses on how the constitutional sovereigns – the state and federal governments – interact with their city and metro partners across the private and public sectors to co-produce the public good.

House Representative James E Clyburn (D-SC) has for years advanced his own, more concrete vision of what place-sensitive federal policy should look like. Clyburn has repeatedly advocated for the 10–20–30 initiative, a proposal requiring that at least 10 percent of federal funds for a given economic project be devoted to counties that have had at least 20 percent poverty rates for more than thirty years. (These places are called persistent-poverty counties.) When Clyburn was able to get a 10–20–30 provision applied to the 2009 Recovery Act, it prompted $1.7 billion worth of economic development projects in low-income urban and rural communities across the nation. This policy tool only dictates how funds that have already been appropriated are distributed (10 percent goes to persistently poor counties); it does not introduce any additional costs. In addition, the 10–20–30 plan benefits both rural and urban counties, both Democratic and Republican constituencies. For this reason, Clyburn offers it as a bipartisan strategy for addressing place-based poverty.

I do not introduce Clyburn’s idea as a solution to the now decades-long neglect of the unique problems faced by poor communities in the United States. That would be premature. Further still, truly transformative political strategies to balancing place-based and people-based needs will necessarily involve infusing resources, not only reshuffling them. Nevertheless, I bring up 10–20–30 to illustrate a policy possibility: it is an alternative approach to poverty alleviation that incorporates states, counties, and cities with a focus on the economic and political incorporation of marginal groups. The findings offered in this chapter suggest that an investment in policies that prioritize such imperatives doubles as an investment in American democracy.
Policy Advocacy across a Fragmented Polity

When studying how a macro-institution (like federalism) affects micro-actors (like Medicaid beneficiaries), it is tempting to tacitly view the latter as haplessly tossed about by forces that they lack any power to substantively influence. While many scholars embrace the notion that “some agency is always there,” they also easily neglect to shoulder the work of discerning “under what conditions it is viable, robust, animating an active society; and under what conditions it is weak, fragile, sustaining a passive society” (Sztompka 1991: 132). With an eye toward charting the political agency of Medicaid beneficiaries, I now turn to an assessment of policy advocacy. Research examining policy processes too often overlooks the influence (or attempted influence) of policy beneficiaries, especially when those beneficiaries are not politically dominant. Nonetheless, Medicaid beneficiaries do sometimes endeavor to sway the policy process (or are brought into it by those attempting to do so on their behalf). Federalism structures both how such efforts unfold and what they achieve. Even though the advocacy of beneficiaries quite often fails to secure change, it nevertheless reveals the problems and possibilities of exercising political voice in a fragmented polity.

Federalism can be advantageous for beneficiaries involved in policy advocacy. As widely theorized, it provides models for comparison, rousing the political imagination of activists (à la Justice Brandeis’ now seminal depiction of states as “laboratories of democracy”¹). Federalism also affords multiple points of political entry, permitting advocates to strategically select venues and enabling them to capitalize on place-based expertise (Baumgartner and Jones 1993; Grodzins and Wildavsky 1967; Smith 2004). At the same time, federalism can significantly weaken the
efforts of policy advocates: it fragments potential coalitions, splinters networks of activists, stifles the energies of those living in politically unresponsive places, and allows politicians to avoid constituent pressures by shifting responsibilities to different levels of government (Jordan 2008; Miller 2008; Obinger, Castles, and Leibfried 2005; Robertson 2014). Tracing the individual and organizational contours of Medicaid policy advocacy brings the gains and losses of federalism into more clear and concrete view.

WHY POLICY ADVOCACY?

Many studies of political behavior do not incorporate policy advocacy into the universe of outcomes that they consider. In part, this is because scholars who study policy and those who study participation often inhabit different disciplines or divergent corners of the same discipline, with insufficient overlap. Further still, advocacy is often assessed on an organizational or institutional level, not with respect to individual advocates or activists. This focus obscures advocacy as a mode of political behavior. Most generally, sociologists and political scientists pose too few questions about the interactions between advocacy and political institutions, and this omission undermines our ability “to answer core questions about democracy” (Andrews and Edwards 2004: 501). Among such questions are the two taken up in this chapter: how do policy beneficiaries engage in policy advocacy, and how does federalism affect their actions?

To start, I define policy advocacy as action individuals or organizations initiate in an effort to change, preserve, or create specific policies. Advocacy is more diffuse than voting in the sense that it pragmatically incorporates an array of actors (including bureaucrats, political appointees, and elected officials at several levels of government) and actions (including coordinated voting activities, contacting legislators, and lobbying). At the same time, advocacy is more focused than voting because it is directed at changing or protecting specific policies. Though advocacy is often the prerogative of organizations, it also encompasses action taken by individuals.

Policy advocacy is rare. Only a handful (five out of forty-five) of the beneficiaries I interviewed reported engaging in activity that could be defined as advocacy. Despite being uncommon, there are four reasons why these beneficiaries’ advocacy efforts are an important political outcome. First, successful advocacy can affect hundreds or thousands of beneficiaries, so even if it is infrequent, it holds immense practical
promise. Second, beneficiaries who are advocates are outliers. It is thus instructive to chart the paths that go from receiving the benefits of policy to actively trying to shape that policy. Mapping such terrain and making sense of why it is so seldom traveled tends insights about the prospects for mobilizing beneficiaries. Beneficiary advocates are often well connected to other beneficiaries and to the political system more broadly, so understanding the channels through which they mobilize offers a view of how political capacity can be cultivated. Finally, policy advocacy also involves those who act on behalf of beneficiaries. External (non-beneficiary) advocates sometimes prove a source of indirect or mediated advocacy. Registering these efforts and the constraints on them is therefore important.

Medicaid Beneficiaries Taking on Policy

Though evidence in the previous chapters shows that on average, Medicaid enrollment depresses political participation, it is worth noting that in some (less common) instances experiences with Medicaid can spark political activism. While interviewing beneficiaries for this book, I was struck by the narratives of activist beneficiaries. They told me of times when they directly appealed to legislators, the media, high-level bureaucrats, and anyone who might listen. In the absence of a survey that asks a random sample of beneficiaries about advocacy related to Medicaid, it is difficult to tell how common this is (or how it varies geographically). Yet, though it is probably atypical, such advocacy warrants our attention. Of the forty-five beneficiaries I interviewed, the five who took up the work of advocacy were the most engaged one could expect any ordinary citizen to be. In that light, it is educative to observe the challenges they faced. Comprehending how even the most motivated and active beneficiaries struggled with the strictures put in place by federalism (and less frequently, benefited from its advantages) gives us a sense of the scope of federalism’s role in the lives of Medicaid beneficiaries. To clarify these points, I highlight the activism of three advocates: Riley, Kay, and Frank. I also discuss the efforts of several advocacy organizations that work on behalf of beneficiaries. I quote more heavily and directly from the interviewees than in previous chapters because advocates were exceptionally good at telling their own stories and describing their own actions. Since their words uncovered relevant aspects of federalism, to the extent that is legible, I let them speak.
RILEY: MEDICAID FORGES A LEADER

Riley’s initial experience with Medicaid was as the parent of an ill child. In those early days, when only her daughter Mary was a beneficiary, Riley did not focus on advocacy – even when the program caused her grief. She instead trained her energies on navigating “the system.” She had to be Mary’s “full time caseworker” or else nothing got done. It was a taxing but necessary job, and Mary’s well-being was hanging in the balance. Riley was grateful to be college educated and adroit at negotiating bureaucratic tangles. She “managed [Mary’s] case” through years of near disenrollment, medication refusals, and program mishaps. She became an expert at making noise until she got what she needed. She knew the system was flawed, but her young child was her first priority.

By 2014, everything was different. Mary was an adult and though Riley still helped with her Medicaid case, that responsibility was less pressing. Not so for other areas of life. After a series of health challenges, Riley had to be hospitalized. When she was released earlier than she should have been and not given proper follow-up care, she nearly died. After that, helpful hospital administrators got her signed up for Medicaid. Now she was dealing with “the system” from an entirely different vantage point – and with her own well-being at stake. Just as Riley’s medical situation stabilized, the policy landscape in Iowa began to shift under her feet. State officials were taking steps to delegate the administration of the program to private corporations (otherwise called a transition to Medicaid “managed care”). Notwithstanding the seriousness of such a change, beneficiaries were kept in the dark about the details. There was little communication from above and the information they did receive was vague and confusing. Unsure of what would happen if the state implemented an ill-conceived privatization scheme, some beneficiaries became anxious.

Riley and a friend pondered moving because their benefits were too critical to risk. At the same time, the very reason they relied on Medicaid was because of limited financial resources. Moving was fiscally infeasible. Losing Medicaid was flat out unthinkable. Riley saw only one option: to fight. She began contacting the beneficiaries she knew, attending state hearings at the capital, reaching out to political officials, and enlisting the help of former coworkers. As it turned out, her contacts were deep and wide. She had connections from her professional life in her younger years and she knew quite a few Medicaid bureaucrats because of her many experiences helping Mary. She was able to find sponsors to fund bus trips so that groups of beneficiaries (who otherwise could not...
afford transportation) could travel to the statehouse for hearings related to Medicaid. She trained beneficiaries on how to contact the Center for Medicaid and Medicare Services (CMS), she taught them how to effectively communicate with their local representatives, and she helped them to demand more information about the private companies bidding to administer Medicaid.

In our first conversation, Riley told me about a Facebook group she organized for Medicaid beneficiaries in Iowa, their family members, and those advocating for them. This began with a few dozen active beneficiaries, but before long there were thousands of members. The demand was so significant that Riley had to set up a separate group for Medicaid service providers, who were also clamoring to talk about the issues they faced as the policy landscape in Iowa was transformed. The original Facebook group now has more than 2,400 members (and counting). The group page acts as a clearinghouse for advice, Medicaid horror stories, announcements of local political events related to Medicaid, and the expression of political sentiments about Medicaid. The Medicaid beneficiaries (and often parents or relatives of beneficiaries) who log on daily span the ideological gamut but exhibit unity in supporting Medicaid, opposing privatization, and wanting their voices to be a prominent part of the debate. Riley was the central player in this network. In the one and a half years that I was part of the Facebook group, Riley posted online nearly every day and her posts generated many responses. Even state political representatives took notice: they began posting on the page to inform beneficiaries of political meetings, town halls, or conference calls related to Medicaid. Quite uniquely, Riley’s experiences with Medicaid forged a political leader.

The political perspectives of Riley and her fellow beneficiaries were decidedly influenced by firsthand knowledge of federalism as it relates to Medicaid. For example, Riley insisted that:

There have to be alternatives in between what we have now and the [Managed Care Organizations]. So, thirty-plus other states have done it ... as I always told my kids ... if another kid jumped off a cliff, would you? We don’t have to jump off the cliff that thirty-plus other states have been hurt by. There is middle ground. We were just never given the opportunity to find it!

In the Facebook group that Riley administered, commentary like this was par for the course. On a recurring basis, posters shared articles about Medicaid horror stories in other states preceded by the phrase “not Iowa, but.” The idea was to draw on the mistakes other states were making as
evidence of the appropriate (or inappropriate) policy direction in Iowa. In other cases, posters shared stories from states that were considered important models, preceded by statements like “look at what is possible.” These tactics were meant to inform, motivate, and mobilize beneficiaries (Skocpol 1992). In fact, what happened in other states was so important to Riley’s organizing and mobilizing strategy that she asked on multiple occasions if I could help her find research about the consequences of Medicaid programs in states that had taken a policy path she hoped Iowa could avoid (Kansas and Kentucky especially). Riley was in contact with advocates in Kansas and exchanged ideas with them about how to keep Iowa from going down a route she viewed as extreme and careless privatization.

It is important to note that though Facebook was not the exclusive locus of Riley’s advocacy activities, it was a key component of her advocacy that reinforced the others. Riley’s large online following facilitated access to elected representatives, positioned her as an indispensable arbiter of information, and provided her with opportunities for organizing political events in “real life” (including bus trips to the capital, letter/e-mail writing campaigns to targeted political representatives about their votes on specific legislation, attendance at local town hall meetings to advance issues relevant to Medicaid beneficiaries, and much more). Given the tangible leverage that Riley’s online advocacy provided, the discussions in the Facebook group she managed proved informative.

To this end, I did a simple content analysis of posts to the page over a nine-month period (January 1, 2016 to September 9, 2016). Keep in mind that as of the end of 2015, there were fewer than 239,000 adult Medicaid beneficiaries in Iowa – roughly 13 percent of the state population.2 Medicaid expansion in the state began on January 1, 2016, so that number grew in the following year, but overall, Iowa is a small state (ranked thirty-third out of fifty-one states, including Washington, DC, in terms of the size of its Medicaid enrollment).3 Given this, the level of activity on the Facebook group that Riley administers is substantial. The group has more than 2,400 members. Not all group members are beneficiaries, but since Riley set up a different page entirely for providers (who were commandeering the discussions that beneficiaries were attempting to have initially), many of the people who post are either beneficiaries or their close relatives (as per my reading of their statements on the page). Moreover, most of the group members appeared to be from Iowa (though this was hard to systematically count since not everyone divulged their state of residence).
Figure 7.1 shows the distribution of topics that people posted about on the page. Over the nine-month period that I examined, there were 1,782 posts on the group page. Though there were certainly serial posters (Riley among them), this activity was not driven by a handful of people. As shown, a combined 61 percent of the posts fit into four categories: 1) requesting for help in dealing with Medicaid administrators or local political officials; 2) sharing an opinion article relevant to Medicaid; 3) discussing a personal experience with Medicaid; 4) political organizing/mobilizing. In addition, the “other/admin” category consists mostly of posts from Riley periodically reminding people of what is not allowed on the page (advertisements, job postings, heated political discussions that do not involve Medicaid, and other such issues). “Other/admin” also includes instances of venting: people complaining about Medicaid in nondescript terms that did not reference specific personal experiences. Importantly, “other/admin” did not include miscellaneous posts unrelated to Medicaid because as moderator, Riley systematically deleted those (and often scolded those who posted them).

The categories most germane to the ideas presented in this chapter are political “organizing/mobilization” and “federalism.” Though the latter category is infrequent relative to the others, it is more common than posts about the governor, policy statements, or state politics. Culling the
comments of Riley and those I observed in her immediate circle of online interlocutors (many of whom also engaged in “offline” advocacy), I will paint the broad contours of how political organizing and federalism fit into the bigger picture of Riley’s advocacy.

Riley led the way in using Facebook as a tool for political organizing and mobilization. I could hardly recount all of her posts in this regard as they were profuse and varied. Riley talked about town hall meetings, calling political officials, speeches at the capital, and so much more. Along the way, she was not simply relaying her own experiences; instead, she was nearly always encouraging others to participate, both at the polls and beyond. The following text from one of her posts is an exemplary instance of her mobilization efforts. I relay the post at length because it is broadly reflective of Riley’s online “identity” and because she herself marks it as intentionally educative (all of the caps and asterisks are hers; I edit in order to cut length and include ellipses at points where I have cut text):

ELECTION EDUCATION POST … we – Medicaid beneficiaries, family members, and providers – have not made Iowa’s Medicaid Managed Care a partisan issue. However, throughout the 2016 Legislative Session it became clear quite quickly that the Democrats were fighting for us and Republicans were blindly following Governor Branstad’s Medicaid Managed Care plan. Also for months, we’ve been saying guns, abortion, and the presidential candidates are not appropriate topics in this group because they don’t relate to Iowa Medicaid … Well, guns just stepped into the Medicaid battle directly. If you read the following blog post [link to post] you will see the National Rifle Association is targeting Iowa’s Democratic-controlled Senate.****Why is this important to Medicaid beneficiaries, family members, and providers? Iowa’s Senate is made up of 50 seats. The Democrats control the Senate by having a 26–24 majority. That is a RAZOR thin majority. To get anything accomplished, a tie of 25–25 Democrats to Republicans must not occur under normal circumstances. It would be a great deal of nothing getting accomplished and legislators largely voting along party lines … the NRA is targeting the Senate to flip the majority to a Republican advantage so it will be more gun friendly. Personally, I have nothing against guns. However, I am adamant that I am FOR people … Soooo, as we’ve been saying all year, YOUR VOTE MATTERS! Well, now it matters EVEN MORE! We MUST turn out in large numbers to vote our hearts and minds around Medicaid, which will overwhelmingly be for Democrats given how the Democratic legislators have tried to fight FOR the Medicaid population. I HATE, HATE, HATE party politics!! … As a leader of this group, I have to talk in realities and the reality is in Iowa there are two political parties – Democrats and Republicans. They’re either for us or against us. Therefore, I BEG EVERY MEMBER of this group to search your soul as we head into November’s election when you go to vote. And, GO VOTE!! Your
ONE vote matters! Ultimately, all these campaign donations can impact how some legislators vote once they’re in office. But, only WE THE PEOPLE CAN BY ONE VOTE AT A TIME can put a legislator in office! ... WE NEED TO USE EVERY MEANS NECESSARY TO MAKE SURE WE DO ****NOT**** PUT LEGISLATORS IN OFFICE THAT WILL BLINDLY FOLLOW THE GOVERNOR’S LEAD ON MEDICAID!! I CAN’T stress that enough! If you think things are bad now and WE aren’t being heard by legislators in Des Moines … trust me, it isn’t going to be an improvement to add more Republicans … If ANYONE doesn’t understand how their ONE vote can make a difference, PLEASE ask rather than choosing NOT to vote in November!

Impassioned and lucid, Riley is exhorting citizens to use every means possible. Even after the election is over, these kinds of posts do not let up. Riley just switches gears toward contacting and pressuring federal, state, and local political representatives. It is in this capacity that the federalism emerges as an issue. For example, a particular thorn in Riley’s side has to do with the way that federal officials abdicate responsibility; she laments that when she contacts congressional representatives about Medicaid (caps hers):

Most of them are saying it is a STATE issue. However, that is not true because Medicaid is funded by state and federal dollars. The only federal legislator NOT saying that is Dave Loebsack. It is NOT a coincidence that all the federal level legislators saying this is something they can’t help with are Republicans and Loebsack is a Democrat.

This is broadly reflective of comments that I categorized as about “federalism.” For example, in a separate post, a fellow advocate who often engages Riley said:

Legislators punting: I have contacted all three of my *federal* congressional representatives (I am in Iowa’s first district) regarding many issues and have received nothing but one form email from Blum.

Again and again, advocates observed that they were thwarted (by political elites) in their attempts to leverage all levels of government to work in their favor.

This was not the only way that federalism came up. As I suggested earlier, federalism gave activist beneficiaries a vision for strategizing, a framework for understanding partisan machinations, and a basis for mobilization. For instance, Roy, a beneficiary who advocates for Medicaid policy on- and offline, also saw Medicaid through the lens of intergovernmental relations:

We have thirty-one states with GOP governors, twenty-two states with GOP governors and legislatures, and nine states with GOP majorities in the legislatures.
What the GOP is doing, by privatizing Medicaid state by state is getting its overall agenda on privatizing ALL of Medicaid done through fifty back doors ... Once enough states are accustomed to this, Congress might be able to privatize Medicaid for the whole country. We have to stop it and provide the example for others in other states to stop it ... We need to know who our reps and senators are, who is challenging them, and select accordingly. This is in our and our families' better interest.

Despite not using the word “federalism,” beneficiaries were savvy enough to detect that it mattered and to peg their political strategies accordingly.

Riley was in many ways a singular case. She was a force to be reckoned with in Iowa, she was invited to take formal part in state hearings and other legislative activity, and she maintained vast networks of connections to beneficiaries and their families. Though idiosyncratic, her case was instructive. Her efforts showed the classic ways that advocates try to exploit federalism: using the mistakes and models found in other states and leveraging multiple points of access (Anton 1989; Ostrom, Tiebout, and Warren 1961; Riker 1975). At the same time, Riley’s story highlights some of the limitations of federalism: it creates opportunities for evasion by both beneficiaries (Riley fought in Iowa only because she had to; she would have voted with her feet if she was able to; see Hirschman 1970; Tiebout 1956) and political elites (federal legislators point to the states, state legislators claim that they are handicapped by the feds, and so on).

In addition, federalism makes Medicaid beneficiaries especially vulnerable to the effects of local partisan squabbles because so much discretion is in the hands of (often) extremely polarized state legislatures. This necessitates that advocates strategize around state partisan battle lines, even when they would prefer not to. While having all decision-making power sit at the federal level would only shift this struggle to different terrain, the crucial point is that in a federated polity, advocates must consider both sets of partisan cleavages and they must contend with substantial loss when these (sometimes) conflicting arenas take turns undermining their efforts to protect and reform Medicaid.

**KAY: THE PERSONAL IS POLITICAL**

By now, you are familiar with Kay, the woman whose experiences with her son Brian have come up in previous chapters. Kay’s twofold status as the mother of a severely disabled child and a nurse at a long-term care facility eventually pushed her to engage in advocacy. In particular, the overarching lesson that Kay took from her personal experiences securing Brian’s care was that “You have to fight for absolutely everything.” At the
nursing home where she worked, Kay saw all too often what happened otherwise:

They just roll over and take it, they end up getting lost in the system, they end up living further in poverty and thinking that whatever they are told is the truth and they have to accept it. They lose out on care ... they die ... It’s disgusting the horrible care that goes on if someone is not there advocating for people ... People get lost in the system and if you don’t stand up and advocate for people, they die ... people just take it ... if you look at people who are living in poverty if they don’t have opportunity for education or access to somebody that is willing to stand up for them, they’re screwed.

Kay was convinced that Brian was alive only because of her passion, energy, knowledge, and skills – and she decided to use those to fight for broader systemic transformation.

I've always been a staunch Democrat, I've always been assertive, I've always been the one that will stand up for what needs to be done and I will make it happen. So yes, I've been a leader in my group of nursing in that side of it, but not one that has had a cause that needed to go to that point. Had there been a cause, I would have done it, but there wasn’t one that presented.

When Brian was enrolled in Medicaid, Kay unwittingly found the “cause” that took her “to that point” from conventional electoral participation to full-throttle advocacy. As part of the same social network as Riley, Kay marshaled her limited time and energy to push against the move toward privatization in Iowa. One problem she had with privatization was the proposed authorization requirements of Managed Care Organizations (MCOs):

So if we needed a medication, it would have to be okayed through that. Well, that’s a three-to-five day process is what we’re being told at this point, so if he needed a chest x-ray, which I would not wait more than fifteen minutes for – if I thought he needed it right now, I would go kick down whatever door I needed to kick down to make it happen – waiting three to five days is not acceptable. He could be dead in that time.

Kay viewed this requirement as directly contradicting the mandate to serve beneficiaries’ best interests and she would not stand for it. Her response was to take action:

I went and spoke to the legislators ... I was the only person that got over three minutes, and I made one of them cry. And the other one took my posters and has them in her office, one of the senators, she said that she would use it for the greater good to make the point ... I asked them how many people have died. I’m not willing to risk my son’s life. I don’t think it’s fair that we should risk people’s
lives. If you want to save money, you should pull it back out of your pockets. That’s what you’re lining it with. That’s not realistic. And what you’re doing is morally and ethically wrong. How can you live with yourself? And one of them looked me straight in the eye at the end and he said, “These MCOs will happen.” And I so wanted to walk up to him and say, “I am a nurse … and if you dropped over, I would not start CPR.” I didn’t [say it], but I wanted to.

When I asked Kay how she ended up before the legislators, she described a process that was unique and self-propelled:

I am an insomniac because of Brian and because of who I am, so I’m up all the time researching, trying to find what would make his life better, what’s going on. And I found that this legislative forum was going to happen, and there was an opportunity for the public to speak but they have to request ahead of time. So at like 11:30 at night, I read that and I emailed, and the cutoff was like the next morning. And I emailed and said, “Please, may I speak? Here’s why.” And at 6:30 in the morning, I got a response saying, “Yes, you may speak,” and I was one of the last people … and got the opportunity to.

Later, Kay described her experience speaking to the legislature in more detail, laying out the way that she prepared for it and the interactions that she had. It was clear that she was not only a mother worried for her child, she was a powerful and effective advocate:

I went to Staples and had these posters made with Brian’s pictures on it so that he was front and center. It’s visual. I researched every single person on that committee, where they were from, if they were Republican or Democrat, if they were parents, what their education was, and then I studied them and watched them all day long. And WellCare was one of the MCOs in the beginning that was part of this group, and during the presentation, all of the MCOs were there, but halfway through, the WellCare woman who was all, “Oh, we’re here for our people we’re supporting. We want to know their stories,” she got up and left. And I thought she was going to go to the restroom and come back, but she never came back. But I used it to my advantage and said if she really cared about her people, she would be sitting right there. And I pointed to her empty chair. It all just worked out.

Then afterward, Senator Mathis came up and gave me a hug and said, “Thank you so much.” And she said, “You know, I would love to get a picture of Brian’s posters here,” and I said, “Here you go. They’re yours. You can have them.” And she said, “Really?” I said, “If you’re going to use them for the greater good, use them. If they’re going to motivate you to make a better change, you can have them. They’re yours.” So she took them and is keeping them for that.

Kay and Riley knew each other and were connected; they worked together, yet independently. Their advocacy was a combination of self-motivated action and collective organizing. Riley was at the event that Kay describes, among a handful of other beneficiaries. They each used
their own methods to advance the cause of anti-privatization. Kay drew on the strength of her sympathetic story; Riley culled her massive social network and talent for mobilizing. Kay describes it this way:

There were thirty-six people [who] were allowed to speak, and I would say a third of them were providers, a third of them were people that the MCOs had brought in to do the dog-and-pony show … I know more people asked to speak, but there wasn’t enough. They only have so much time. But the room was completely packed, and then inside the Capitol there’s the rotunda area, which is like the lobby, and that was completely full. So we were on the inside, and I got in there and stood. There were no chairs and I said, “I’m not moving. I will stand here all day long. I don’t care. You’re going to look at me.” And I held his [Brian’s] posters up. They’re like two-feet-by-three-feet posters … It was standing room only and the rotunda was packed. *Riley had organized groups to come in by chartered bus* (emphasis mine).

Though Riley’s relative strength was in bringing people together, Kay was a core member of the advocacy network. In particular, her primary function was in forging relationships with the parents of child Medicaid beneficiaries. Kay was optimally positioned to appeal to members of this more middle-class-leaning group and to bring them into the larger fold of beneficiaries that included Iowans who were more poor and less well educated.

As a mother of four, a working professional, and an advocate, Kay made a herculean commitment to Medicaid. But her experiences demonstrate the limits of relying too heavily on already strained populations to make such intense efforts – especially in the context of federalism. Kay ultimately moved from Iowa to Minnesota. She did not move because she liked the houses or neighborhoods or schools in Minnesota better. Her family had a lovely home in Iowa. She had a good job in Iowa. She moved because she could not stand the strictures of Medicaid in Iowa anymore. The move was decidedly political and directly related to perceived cross-state differences in the kinds of services she could access from Medicaid. For example, Kay reasoned that Minnesota was a “more liberal state. Their intentions are to serve their people, and then also it’s illegal in Minnesota for a hospital to operate on a for-profit nature. In Iowa, it’s not.”

For Kay, the personal (her experiences with Medicaid) was political in two contrasting ways: 1) it motivated her fervent advocacy for a “cause”; 2) it was the basis for endless bureaucratic battles that she feared would one day cause Brian’s death (Hanisch [1969] 2000). In the final calculus, the latter prompted her exit from the state of Iowa.
As per traditional participation models, Kay is in many ways the kind of person we expect to vote or to contribute to a campaign (relatively well resourced, equipped with civic skills, deeply socialized into political activity, linked to networks, etc.). Before Brian was born (and even as a mother of three), she was in fact a consistent voter. But Brian’s birth brought her out of the realm of the traditional, not only by exposing her to the feedback effects of particular policy experiences, but by virtue of the fact that those effects were contextualized. Kay experienced policy in a federal polity and the very same traits that made her apt to participate also provided her with the wherewithal to devise an exit strategy. One might view this as an advantage of federalism (after all, thank goodness Kay had options) or as a disadvantage (the advocacy network in Iowa lost a key actor and many beneficiaries do not have the options Kay did).

**FRANK: THE UPHILL CLIMB OF ADVOCACY**

Lest one think that all of the advocacy action is happening among a very distinct group of women in Iowa, it is worth exploring another case. Frank is a forty-six-year-old Floridian. He is very different from either Kay or Riley. Not only is he from Florida, but he is single, unemployed, has lifelong disabilities, and is not very well connected to advocacy networks. Despite a long history of being uninsured, he did not begin advocating for health care until he realized that Florida was refusing to expand Medicaid under the Affordable Care Act.

Frank is the son of two working-class and disabled parents. He was born in New Jersey but raised in Florida. He had developmental disabilities and severe asthma starting very early in life. At the age of sixteen, he experienced an asthma attack that brought him to the emergency room. It was there that he learned he had been dropped from his parents’ insurance because of his preexisting conditions. That is where his health care saga began. As Frank expressed:

I will turn forty-six in March. For the past thirty years, I’ve never had health care, never had it in my adult lifetime. So I get to my twenties, I graduated from community college and a four-year college, moved to New Jersey, got a BA in communications, but I have problems driving a car, which at that time hindered my employment … So basically, for years I’d struggle and I’d take care of my dad, who was disabled for a long time. I got a few jobs, two or three different ones, but I had to quit them and take care of him, and basically I’ve been uninsured for most of that.
Despite not actually being a Medicaid beneficiary, Frank was always on the cusp. He pursued Medicaid coverage for decades; he applied and hoped that one day he could secure it. He viewed himself as a future beneficiary, and fought to become one. But the stars never seemed to align in his favor. Instead, Frank was “stuck without a doctor, without a hospital, and without insurance.” When the Affordable Care Act passed in 2010, he was elated. He thought his health care woes would finally be over. But Governor Rick Scott refused to expand Medicaid. This is when Frank reached his wits’ end:

Governor Scott didn’t expand Medicaid. I was stuck and I was tired of waiting. So I had been learning Twitter and Facebook, basically for something to do because I had a proper disability and I couldn’t work anymore. So basically I became an activist slowly but surely ... But the only form of political involvement I ever did before that was ... I wrote three letters to the editor. That was it. So basically, I created the ... accounts on Twitter, and eventually the [website] ... I also created the Facebook page ... I [also] started the petition on MoveOn. The petition was not successful, but it opened a lot of doors for me, where normally I wouldn’t have one ... eventually I partnered with some other people. That didn’t work out ... but surely I became an activist.

Before engaging in these online activities, Frank had voted and written letters to editors, but he was not an activist. In part, this was because of his disability. He had “transportation issues” and “other issues” that prevented him from doing physically taxing work. His discovery of social media, catalyzed by his anger over Florida’s refusal to expand Medicaid, changed all of that. Interestingly, because of his background and the path he took to advocacy, Frank was not especially well networked. When I asked him about his networks, he described them this way:

I’m trying to, but it’s a very loose, hodgepodge connection. My goal when I founded this was to be the top organization for lobbying, and unfortunately with funding and access to more stuff, we can’t quite do that. We’re still big on social media, but we’re not where we need to be. And other organizations support it, but they umbrella it to other causes. And in my opinion, we really do need like what “Moms Demand Action” does for gun control and “Everytown” does. You need a pure Medicaid expansion advocacy group, which I’m trying to do but it can’t quite get off the ground, and make it a national movement.

Frank had national aspirations, but thin networks and strong ideas about advocacy strategies. His collaborators could not even agree on what to call their effort:

We met this weekend with a couple advocacy groups to see if we can form a coalition, but the thing is, I’d like “Expand Medicaid Now” to be the primary
name, because it stresses the urgency of the situation, and then they’re going with other language. You know, we’re having little technical issues when we need to be on the same page. See, I feel “Expand Medicaid Now” is the best way to say it because it shows the urgency. They feel like “Close the Gap” does, but it’s like, I’m trying to tell them, “Close the Gap” doesn’t tell what gap. Okay, you start the conversation, but people don’t want a conversation a lot of times. I went to college for communication, and we’re such a simple, sound-bite-we-get-bored-easy world, that if you just see “Expand Medicaid Now” on the screen or whatever, that’s going to register. You’re not going to have to research it.

As Florida is a bigger, more diverse state than Iowa, it was a challenge for advocates in Florida to work together effectively. Many organizations engaged in health care advocacy, but they did not coordinate as seamlessly as Riley and Kay (who were not even part of any official or formal organization). Moreover, they were more divided by race, which was an issue that less frequently emerged in (largely white) Iowa. For example, Frank observed that a lot of organizing energy in Florida was being devoted to the cause of Black Lives Matter (BLM). He was “supportive” of BLM, but confessed that he did not (and would not) work with the group. He believed that Medicaid advocates should be out in large numbers filling up malls. But he wanted the issue to be Medicaid, not anything else. Moreover, he was clear in saying that he did not want to “shut down” the malls like BLM; he only wanted to fill them with advocates and activists.

As a consequence of the fractured organizational landscape in Florida, Frank noted that “real-life” political action was especially hard.

We just brought a ballot initiative to get it on the ballot, but unfortunately, they started too slow and they weren’t effectively organized enough to get the signatures yet, so we don’t even know if we can put it on the ballot … the whole thing is you have this activist group working here, you have this – I’ll put it this way. You’ve got A, B, C, D, and E activist group working on it, okay? Instead of working as one unified part, this activist group wants to do their thing, their thing. And then they sometimes don’t do it full-time; they do it part-time and move on to another issue.

Layered on top of the difficulties posed by the patchwork organizational field within the state of Florida, Frank was also cognizant of barriers erected as a consequence of the national fragmentation of advocacy networks. His organizing strategy was built around a commitment to rectify this latter problem (in essence, to circumvent the downsides of federalism). He explained it this way:

Some of the Facebook groups and some of the pages are just statewide. They’ll say expand Medicaid … in Florida, Georgia, Tennessee. I made mine
an American organization, because I decided it wouldn’t be right for me as a Floridian and an American to get my insurance and then leave other people hanging. So it’s not right. That’s why I made mine a national organization. I understand we need to go coalition on this. We cannot just sit here and go state by state, passport by passport. The civil rights movement did not historically work that way. Each state worked together, the NAACP chapters. They worked together and they got it done. It took them a long time, but they got it done.

Of course, Frank understood that state residence mattered. He was informed about the particularities of Florida’s political environment:

In Florida … our health care plan (that failed) to expand Medicaid was a partnership of the Republicans, the Democrats, the chamber of commerce, and the hospitals. This thing had State Senate support, 100 percent, Democrats and Republicans, but it failed in the House because the House was bought and paid for … And Rick Scott himself – and this is where I get controversial with this – stole from you, me, my parents, my grandparents, everyone else in Medicare and Medicaid when he was running Hospital Corporation of America. He pleaded the fifth, walked away a billionaire, and unfortunately became governor and ruined our state.

Florida’s politics was one of the main sources of frustration for Frank. He acknowledged that if he moved back to New Jersey (where he had attended college), he would solve a lot of his own problems, because he could qualify for Medicaid there. Frank would move back if he could. But he was not in a financial position to do so.

The whole thing is the expense. See, we’re from New Jersey … rents are just too much money. Plus, my dad being in a wheelchair, when we get a blizzard, he’s going to be stuck inside. The only time we’re stuck inside in Florida is when we get rain. We can go to the store and function as long as it doesn’t rain. A blizzard, the ice and snow, means he’s stuck in a wheelchair because he has a bad leg. It’s terrible for him. So that’s one drawback, plus the cost of heating and rent, et cetera, up there, it’s just, it can’t be feasible.

The differences and similarities between Frank and Kay (and between Florida and Iowa) are informative. On an individual level, Frank’s disability, limited mobility, and status as the sole caregiver for an ailing parent made online advocacy his primary option. Kay also cared for an ill dependent, but she had a spouse and a supportive family. Moreover, she was not herself physically restricted. Traveling to the capital to testify before the legislature was simply not as feasible for Frank. As a result, the Internet was his forte and it was generally not a springboard for other political activities. This meant that Frank was less connected to state
politics and more nationally focused. Riley and Kay talked much more in terms of states and understood the minutiae of Iowa politics. They had to do so in order to target their local political activity. Since Frank worked mostly online, he focused less on which local political representatives to go after and more on getting the attention of the national media.

A central difference between Frank, on the one hand, and Riley and Kay on the other, was their organizational networks. Frank was at a disadvantage, in part, because he was not formally a Medicaid beneficiary. He wanted to be, he anticipated being, and he readily advocated for beneficiaries against any policy that he perceived as limiting benefits, but he did not have a history with the program. He did not know fellow beneficiaries with whom he could make common cause. Consequently, he was actually not deeply ensconced in Medicaid politics. He knew that he wanted expansion, but paid less attention to the other particulars of the program. In part, this was just a difference in policy focus (Frank was advocating for Medicaid expansion; Kay was advocating against Medicaid privatization). But that difference came with a distinction. Kay and Riley were able to connect with providers, fellow beneficiaries, even bureaucrats who were already invested in Medicaid and thus incentivized to support their cause. Frank was an outsider and his closest allies were also outsiders. Furthermore, his outside status was cemented by his refusal to focus on place. Riley and Kay capitalized on the specificity of place, they mobilized Iowans qua Iowans, and leveraged state identity as part of their political cause. Posts on Riley’s page would often say things about what other states were doing and then follow up with phrases like “this is not Iowa.” The significance of place in Kay and Riley’s narratives allowed them to take advantage of federalism. They used cross-state comparisons as political fodder, and they drew inspiration from other places that had implemented localized political strategies to launch successful advocacy initiatives. They also invested deeply in learning about and navigating Iowa politics, because they knew that was an unavoidable (though not singular) factor in their battle. Frank generally eschewed such tactics. He even took pride in his national focus. But in many ways, the geographic diffuseness of Frank’s approach hindered him. For example, despite his formidable online presence (on Facebook, Twitter, and even his own personal blog), Frank’s Facebook group had only 487 followers (compared to Riley’s 2,400). To be fair, Frank had more than 4,000 followers on Twitter. However, the differences in these platforms mattered. Since Riley’s Facebook group consisted mostly of Iowans, group members from across the state could be called on to attend
local political events, contact local political representatives, and take very specific actions in their spheres of influence. And they did. Riley would often advertise an event only to have folks later post updates on how the event turned out, how many fellow group members they saw there, etc. Riley’s group was a catalyst for local political action. Frank, on the other hand, posted articles to Twitter and Facebook about Medicaid horror stories or the politics of expansion across the nation. Most of the postings came from Frank. The members of the Facebook group – and to an even greater extent his Twitter followers – were passive observers rather than active participants.

This points to the role of federalism in structuring advocacy. Riley and Kay embraced federalism and organized in response to their awareness of cross-state differences and multilevel governance. Federalism factored into their advocacy strategies. Frank had higher ideals (that Kay and Riley likely shared in principle) dictating that health care was a national issue and a human right. He frowned on state-oriented organizing tactics and thus did not tap into the local constituencies that may have joined his cause. Of course, on top of this he operated in a much more fragmented, diverse advocacy network and he had an array of personal limitations. Taken together, these issues undermined Frank’s ability to advocate with optimal effectiveness.

**Mediated Advocacy and the Power of Place**

Thus far, I have focused on Medicaid beneficiaries and would-be beneficiaries. However, Medicaid policy advocacy most often depends upon the interventions of professional employees of nonprofit organizations tasked with representing the interests of Medicaid beneficiaries. I call this mediated advocacy. To understand it, I interviewed fifteen professional policy advocates from organizations in Missouri, New Jersey, New York, North Carolina, and Pennsylvania. I selected organizations/policy advocates with the objective of getting variation in state contexts as well as organizational mission, structure, and resources. For example, the budgets of the organizations I picked varied from thousands of dollars to nearly $60 million. Their sizes ranged from only a single employee (with several volunteers) to hundreds of employees. Their structure was heterogeneous as well: a few were local subsidiaries of a larger network of nonprofits, but most were independent state or local entities. I promised these interviewees anonymity in exchange for their honesty, so I hold back details here (states, cities, names of organizations) that could pinpoint
specific organizations or people. Moreover, I am not a scholar of organizations and do not seek to make an intervention into the literature about how organizations operate. Instead, given the aims of this book, I train my lens on the extent to which mediated advocacy is a channel through which beneficiaries are incorporated into politics and investigate how federalism shapes those efforts.

Across the swath of organizational professionals that I interviewed, there was near consensus about the role of actual beneficiaries in shaping the advocacy of professional organizations: it was woefully limited. Lainey, the head of a small nonprofit that focuses exclusively on advocating for Medicaid beneficiaries in a single state, expressed the general sentiment quite well in this exchange:

**ME:** To what extent do beneficiaries themselves actually play any kind of role in your organization? I’m just wondering, from your perspective, where the beneficiaries themselves fit in, in terms of how they directly can impact the work that your organization is doing.

**LAINLEY:** That’s an excellent question, and we have grappled with that ourselves over the years. I tell people this all the time, because there is sometimes some confusion or some assumptions made that I work directly with consumers and I do not … many [advocacy organizations] do not do that at all either because they themselves are statewide organizations or statewide associations that also sit in offices … and do not work on the ground with people. We do not have regular involvement of actual Medicaid consumers, but we have on occasion over the years engaged people directly by bringing people to … legislative visits and including people in other policy discussions in that way. For a lot of people, including myself, it is kind of an internal conflict that we deal with all the time, because we want to make sure that we adequately and appropriately address consumer interests, but we don’t say that we speak for consumers; we say that we speak on behalf of people – I’m going to bungle it myself. We say that we speak on behalf of the interests of people in the program; not on behalf of people. A lot of that has to do with the fact that … the work involved in engaging people would be a whole different animal that would be very, very valuable in many ways but would be an entirely different component of our work. We have had the opportunity to facilitate people being involved in different ways. For instance, a few years ago the Medicaid director … wanted to engage consumers directly, so we were involved in finding organizations that could find volunteers from within their service networks to go and sit with the Medicaid director and have a meeting with him directly … so we were able to provide the resource of linking people, but we don’t directly do that work ourselves.

Lainey was one of the first organizational leaders I interviewed, so I wondered whether this was happening elsewhere. Over the year that followed, as I tracked down other (busy and time-crunched) advocates (who were doing thankless work and making less than they would have
otherwise), I always asked them the same question: how much do the beneficiaries that you are advocating on behalf of take part in what you are doing? I usually got responses that mirrored Lainey’s: apologetic explanations of why it would be really great to include beneficiaries, but it was simply not feasible.

A few organizations noted making more of an effort to bring beneficiaries into the fold. Lenora, a policy director at a health care advocacy organization in the South, explained that her nonprofit included beneficiaries by putting their “stories” in policy reports that go directly to legislators and training them about how “to tell their own stories in front of legislators.” Lenora explicitly articulated the goal of giving beneficiaries “some empowerment … to be able to give them the choice is really exciting and hopefully helpful to them.” All the same, this was an almost infinitesimal part of the work that her organization did and it could not be much more because:

Oh my God, there are so many hard parts of [engaging the consumer]. So number one is, a lot of the consumers … are managing really overwhelming life circumstances so they’re managing multiple chronic diseases, they are working multiple jobs, or they’re taking care of family members or a combination of all these things. So their time is limited and we don’t want to overburden them with lots of requests like we’d like to spend an hour with you to coach you on your story, and also we’d like you to spend an hour with this reporter, and then we want you to go talk to legislators. So we don’t want to tax them with too much; we don’t want to ask them too much. Additionally, that takes a lot of time from our staff too … there is only so much we can do, so it’s a matter of what’s going to have the most impact.

Besides constrained resources, a key rationale that organizations gave for their limited inclusion of actual policy beneficiaries had to do with geographic variation. National organizations expressed the desire to incorporate Medicaid “consumers” but wondered, *which ones?* Different beneficiaries in different states would have very distinct experiences. Whose experiences should be highlighted? To address this dilemma, nationally based advocates often passed the baton to their state-based coalitional partners. However, state organizations faced the same difficulty: beneficiaries in different parts of the state had such dissimilar experiences, how could they get all of the perspectives they would need to fairly represent *all* beneficiaries? As I spoke to more advocates, I was struck by the predicament that geographic heterogeneity presented in terms of incorporating the voices of beneficiaries into advocacy work. Lainey captures this well:
We have a wealth of membership from the city, which is not surprising, obviously, because that’s where most of the state’s population is, and it’s where most of the state’s Medicaid population is, though we do have strong representation in [the capital], mostly because there are several statewide associations and organizations based there. And we do have representation from different areas around the state that are not necessarily based on the number of people or the particular need in any given area … people are served in different and disparate ways, and that all contributes to them not having as strong representation in the advocacy community … that all definitely does come into play and it is an ongoing challenge for us … I think part of that is our own fault for not making sure that our advocacy efforts are as balanced as possible.

Many of the organizational advocates I interviewed echoed this. Often, it was a specter hanging over their heads as a source of guilt. But sometimes, it was a matter they took on directly. Importantly, when organizations straightforwardly confronted the reality of geographic fragmentation, they often pivoted toward a more incorporating kind of mediated advocacy. In other words, embracing geographic heterogeneity paired well with listening to and communicating the unique experiences of people across place. For example, Jackie, the leader of a (single-state) health care advocacy organization in the Midwest that had multiple chapters across the state, explained her organization’s recent efforts to expand to rural areas:

Jackie: And our grassroots organizing, it’s very kind of local organizing. We chose a select number of geographic regions to get started, so have kind of stuck with that model as we just keep growing the number of regions. But one of the things that we’re really proud of is that we’re one of the few organizations in [our state] actually doing organizing in rural communities. There’s a lot of groups that call themselves statewide, but they’re really based in [the major cities], which are important, but frankly, there’s a lot more of the state that’s rural and a lot more legislators who are rural. So to really move things, we’ve been doing work in the rural communities. We’ve got organizers in multiple communities throughout the state, not just in one or two urban offices.

Me: Can you give me a sense of what that looks like on the ground? So the people who are trying to develop this grassroots base to push for the different policy goals that you might have, how do they do that? What happens on the ground?

Jackie: We do a lot of what we call story-making. It’s one of our biggest initiatives. So we collect personal health care stories of [state residents] who are impacted by these issues we’re working on, and so those folks are very involved in the community, so they’ve helped connect us to people who are willing to be interviewed by us. They’ve done media things, so when the King v. Burwell decision came out last spring, they held a local press conference … Legislator work [too], so we do in-district meetings. I think actually one of our most impactful things is where you meet locally with the legislator with a group of
constituents to talk in depth about issues. So they’ve met with their state senator and their state representative. We’ll be trying to do that again here. And then they also have come to the capital for our lobbying, to meet with legislators there. So they deal with kind of a little bit of everything.

The most striking feature of all of the “little bits of everything” that Jackie’s organization does is that much of it involves mobilizing beneficiaries (or would-be beneficiaries who fall into the “coverage gap” in states that have not expanded Medicaid) on a very local level. Organizations like this use state and local differences as a resource instead of viewing them as a barrier to representation. Importantly, Jackie believed that this strategy was effective. She noticed that legislators responded differently when faced by groups of people in their own districts and she reported that though her red state had rejected Medicaid expansion, a few local representatives had begun to signal openness to discussing it – especially those from the poor, rural districts where they had focused their mobilization energies.

Mediated Advocacy that Makes an Impact

A very different group of non-beneficiary advocates that I interviewed consisted of public benefits attorneys at legal aid organizations. Perhaps these are not the people who come to mind when we consider advocacy, especially since federally funded legal aid attorneys are barred from bringing class action suits and limited to providing case-by-case representation. However, after hearing several beneficiaries refer to such lawyers as advocates, I decided to interview a few of them. What I found was that public assistance attorneys are overlooked advocates for Medicaid beneficiaries – and not only on an individual scale.

Public assistance attorneys view themselves as advocates for entire communities of poor people who would remain locked out of the civil legal system without legal representation. Renee, an attorney and director of a legal services office in a poor and densely populated city in New Jersey, explained that:

In general trying to advocate on your own, to even get a fair hearing, it very difficult at times, very difficult. Clients will go over here to the local welfare office to request a hearing and it never leaves that office … it never happens. Our office is a very important resource for the community here because we get very involved (emphasis mine).

Echoing this, Renee’s coworker and fellow attorney Robert insisted that “even filing for an appeal, for a fair hearing with Medicaid, without
having legal aid available, I can’t imagine them doing that successfully, and we know from experience that many times they can’t.”

Given this state of affairs, legal aid attorneys spend a tremendous amount of time and effort on public assistance cases, many of which involve Medicaid. In Renee’s crowded office:

Wedgesdays and Thursdays are benefit days here ... We open at 8:30 and people will start waiting out there at 7:30, that’s how many come in here for these kinds of cases. Here in this area benefits are number one, that is the area we see the most client need. No question.

As many cases as Renee’s office takes on, she estimated that probably only 10 percent of public assistance beneficiaries ever utilize legal services. Given the rarity of this particularistic behavior, what broader policy consequences could it possibly have? Initially, I assumed not much at all. I began to reconsider that after an interview with several attorneys who worked almost exclusively on Medicaid benefits cases in New York City. When I asked about whether the representation of individual Medicaid beneficiaries had any broader systemic implications, one lawyer offered a “typical” recent example of a woman who was inadvertently disenrolled from Medicaid and about to lose her life-sustaining homecare. The woman was no longer (mentally) capable of making her own decisions, so her husband needed to get power of attorney in order to sort out the mistake with her Medicaid case. The attorney explained the rest this way:

He was calling around trying to get help ... that is how the case came to us ... I walked the case over to our director and said “What do we do? Isn’t this what you are working on, on a policy level?” So our director was able to contact people at the state who were in charge ... and say, “here is an actual example and here is all the client’s information. One, you need to make sure that this client has homecare tomorrow, and two, let’s figure out how to have a policy that addresses this for other clients.” ... We have had ongoing cases with this exact fact pattern and sometimes they are even more devastating ... We have been meeting with the state and a group of advocates for months to get them to actually have a policy that streamlines the enrollment of people into a plan to ensure that it is a seamless transition without losing services. But it is such a good example of how the cases that come in demonstrate where the holes are in the system and we let the state know about it ... We continually bring cases to their attention so they can see, “hey, we’re not making this up; this actually truly affects people lives” (emphasis mine).

As I conducted more interviews, I realized that all of the legal services attorneys I spoke to believed their representation of individual Medicaid beneficiaries had a larger impact beyond specific claimants. This did not
appear to be wishful thinking or effort justification on the part of over-worked and underpaid legal services lawyers as they readily offered a litany of compelling illustrations. Ronald, for example, had been a public benefits attorney in Pennsylvania for decades, representing countless Medicaid beneficiaries. He explained that when he noticed something problematic among the beneficiaries coming into his offices, he responded on multiple fronts. First, he took advantage of his “close relationships” with “everybody” in the welfare bureaucracy. Sometimes, by simply picking up a phone, calling someone with influence, and telling them that there was a problem, he could convince Pennsylvania benefit agencies to make administrative changes. For example, his office successfully spearheaded an effort to “make sure that the welfare department gave receipts” so that beneficiaries had proof of their transactions with caseworkers.

When reasoning with bureaucratic elites proved ineffective, Ronald admitted that benefits attorneys “fed” reporters from major newspapers “a lot of stuff.” Shining a public light on the challenges that beneficiaries faced was a less direct but useful strategy for pushing wide-scale change. Other tactics included convincing well-resourced law firms to take on potentially impactful cases pro bono (“we got some lawyers from [prominent private firm] to help us”) and reaching out to federal officials (“we brought in CMS”). Most importantly, Ronald stressed he had seen policy achievements grow directly “out of what we were seeing and what we were hearing from the clients.” He offered a recent example of a stunning victory from just a few years ago:

Pennsylvania had a new welfare director [who] claimed that the state was inadvertently paying for dead Medicaid beneficiaries. He issued a dictate saying that he wanted everyone who had not been re-determined in six months to be re-determined in the coming month. One of my colleagues called it “log-jammed July” because it was just total chaos, and we kept hearing the same story over and over again, I mean like literally scores of people … everybody and their uncle was coming in and saying that they’re being cut off.

In response, Ronald began poking around and soon discovered a host of problems ranging from technical issues with scanning software to a paperwork backlog so massive that “it was blocking the aisles … the auditors found that there were 474 boxes of unfiled paperwork.” It turned out that even people who had done everything correctly were being cut off because their redetermination files had not been processed. As a result, at least 89,000 children had been booted from the program and when adults were added, the number climbed into the hundreds of
thousands. Despite this massive upheaval, “the higher ups in Harrisburg were heavily into denial ... they did not think that there was a problem.” Ronald and his team got the media involved, talked to “the Feds,” and threatened the “higher ups” to the point of “drawing up all the papers” necessary for a lawsuit. Through all this, a key goal was to bring the stories of beneficiaries to the forefront. After a while, Ronald said, “we convinced them, it’s like, look, we’re not making this stuff up.” Then “they settled on an agreement where they automatically reinstated a bunch of people and then gave other people the right to get reinstated immediately, about 200,000 people.”

I could fill several more pages with examples like this. Undoubtedly, indirect policy representation via legal advocates is an imperfect medium for political voice. It conceals the actual role of beneficiaries, who likely have no idea that they helped to shape the policies that later affect them. Moreover, lawyers are not unbiased policy advocates. Most of the attorneys I spoke to appeared more apt to take action when elderly people and children were involved; some noted as much explicitly. This means that certain populations with certain kinds of issues might be systematically neglected when policy representation depends upon a legal middleman.

Notwithstanding these drawbacks, the observations of legal advocates shine an imperative light on mediated advocacy (and, recalling Chapter 5, on a different kind of particularistic resistance). Most pertinent is that this legal advocacy raises critical questions about federalism. Since there is no federal constitutional right to counsel in civil cases, many states provide very little support for it. Paltry investments from the national government (that fluctuate quite widely across presidential administrations) make for under-resourced legal assistance agencies that cannot meet demand (Legal Services Corporation 2009). Moreover, variable support from state governments makes for significant heterogeneity in access to representation (National Center for Access to Justice 2016). Figure 7.2 shows the geographic distribution of civil legal aid attorneys in the United States. As you can see, New York and Washington, DC lead the way in the provision of such support, while Mississippi, Alabama, and South Carolina fare the worst. The point is this: despite the potential for legal advocates to represent the interests of Medicaid beneficiaries, their ability to do so is tightly tied to geographic discontinuities. Because the legal domain parallels the realm of social policy in its fragmentation, there is no way around this for Medicaid beneficiaries.
Medicaid, Advocacy, and Federalism

The advocates described in this chapter are not representative of Medicaid beneficiaries more broadly. To the contrary, the qualitative approach taken here is based on an explicit turn toward outliers for several reasons. First, even a handful of advocates can make a difference for Medicaid policy, shifting the discourse and altering the political landscape in the places where they live. This is what women like Riley and Kay achieve, it is what organizations that mobilize grassroots rural constituencies work toward, and it is what legal advocates who take particularistic claims to the larger political arena accomplish. Advocates need not be plentiful to be impactful.

Second, the outliers often do not stand alone. Instead, they are connected and well positioned to influence others. Riley and Kay demonstrate this. They may each be idiosyncratic, but their actions radiate out; they are tied to other beneficiaries and committed to using those connections for the purposes of political mobilization that advances the cause of Medicaid access and administration.

Third, beneficiary advocates somehow traversed the unlikely path from being a recipient of government benefits to being an advocate for themselves and others. Illuminating the contours of their journeys points to strategies for mobilizing. For example, though Riley was politically active throughout her life, the primary catalyst for her full political blossoming
was her role in administering a popular Facebook group. Importantly, Riley would not have been able to do this without the help of others, because for a while, she could not even afford to pay for Internet services. When a wealthy supporter of her cause stepped up and offered to cover those charges, she was propelled on her trajectory as a political leader. Kay and Frank are also very active online. This suggests that access to social media and the Internet may be a vital tool for mobilizing disadvantaged constituencies. Admittedly, this is not what I expected to find when I began studying activists and beneficiaries. I assumed that the Internet would just not be how such folks connected with one another. That proved untrue and is an avenue that is worthy of further exploration.

Finally, my central rationale for studying policy advocacy is because it elucidates the way that federalism affects participatory outcomes – even among advocates who are the most motivated to engage politically. The pros of federalism include providing examples (good and bad) of policy alternatives that activists use as fodder for mobilization, providing different points of access (local, state, and federal) for targeting advocacy efforts, and facilitating the development of policy communities and networks. The downsides of federalism included affording a basis for political elites to shirk their responsibilities by pointing to other levels of government, creating exit routes through which effective advocates retreat from states that are less hospitable, undermining the efforts of advocacy organizations to represent the “interests” of beneficiaries (given that those interests vary so widely across place), and fragmenting the civil legal infrastructure that provides beneficiaries with an additional institutional path for redress when they have been wronged. Understanding the democratic force of federalism requires attentiveness to both sides of this ledger. Further still, advancing democracy requires contending with the downsides of federalism in the realm of advocacy (and beyond).
Federalism and Political Inequality

“The relation of the states to the federal government is the cardinal question of our constitutional system. [It cannot be settled by] one generation, because it is a question of growth, and every successive stage of our political and economic development gives it a new aspect, makes it a new question.”

– Woodrow Wilson

“American federalism … is a highly protean form, subject to constant reinterpretation. It is long on change and confusion and very low on fixed, generally accepted principles.”

– Martha Derthick

The challenges of governing a federal polity have always been central to American politics. The “founding fathers” grappled with this and the Constitution reflected the compromises that emerged from their negotiations. But that document – though accepted as the preeminent law of the land – could not resolve the profound and ongoing dilemmas posed by federalism. As Woodrow Wilson intimated, the central difficulties of that institution are always outstanding and must be taken up again and again as we traverse new stages of political and economic change. Likewise, as political scientist Martha Derthick noted, federalism is subject to “constant reinterpretation” because there are few (if any) axiomatic truths we can fall back on to inform our perspectives on it (Derthick 2001: 153). Instead, as Derthick insisted, “American federalism was born in ambiguity, it institutionalizes ambiguity in our form of government, and changes in it tend to be ambiguous too” (154). It is precisely because of how equivocal federalism is that we must periodically shed new light on it given contemporary challenges.
Today, under the specters of unprecedented economic inequality and persisting poverty, the question of “the relation of the states to the federal government” begs deeper engagement. It beckons with a special urgency because of the present political context. Extreme ideological and political polarization is now the norm. Congressional gridlock is a standard expectation. Americans are cynical about the intentions of their elected officials and about the possibilities for political consensus on vital issues like climate change, gun control, immigration, and health care. Far-reaching policy shifts at the national level are sporadic, hard-earned, and sometimes pyrrhic victories. In this milieu, activists, policy makers, and advocates are turning to subnational governments in attempts to make policy inroads. Many are openly wondering what one *New York Times* writer also asked: “If Congress won’t focus on a new policy idea, and if state legislatures are indifferent or hostile, why not skip them both and start at the city level?” Federalism is being touted as a potential solution to problems of governing by those on both the ideological left and the right. It is thus an important phenomenon to understand. Yet astonishingly, policy makers, pundits, and scholars often overlook its consequences for democratic citizenship.

The Affordable Care Act is an example par excellence. As noted at previous points, contentious national politics led to litigation in the courts, which left Medicaid expansion as the prerogative of the states. Now, the services to which beneficiaries have access and the means through which they gain that access are more variable than ever. Increasing numbers of states are applying for and receiving waivers that allow them to mold Medicaid as they see fit. In Arkansas, the trend is toward privatization. Indiana bends in a punitive direction. Vermont is notably openhanded. Some onlookers point out how problematic this is (Sanger-Katz 2015). Medicaid’s fragmented policy structure generates preposterous situations: cross the state line and you can get treated for your cancer; otherwise, you’re out of luck. Few people think this is ethical, sensible or preferable. Fewer still think about what it means for the nature and quality of American democracy.

On the day that Donald J. Trump was sworn in as president of the United States, he issued an Executive Order on the Affordable Care Act. This order prominently announced his intention to “afford the states more flexibility and control.” President Trump could send no clearer signal of his determination to further proliferate geographic differences in access to health care. While it behooves us to closely interrogate what this means for the social and economic equality of Americans who do
not happen to live in more generous states, we must also confront what it portends for their political equality and for the democratic aspirations of the nation.

Scholars and political elites often emphasize federalism in relation to cherished American ideals like freedom and states’ rights, while occluding its consequences for equality. Scholars have only intermittently acknowledged the potential for federalism to spawn inequality, much less grappled with the depth of this dilemma (Peterson 1981, 1995; Riker 1964; Wildavsky 1985). The most worrisome object of neglect has been political inequality. This book remedies that oversight by connecting the inequities of federalism to the prospects for a robust democracy.

Through the lens of Medicaid and with an eye toward the political incorporation of vulnerable populations, I have explored federalism’s implications for democratic participation. The empirical analyses in Chapters 4 through 7 tackle distinct facets of this phenomenon, but share the overarching purpose of revealing the manifold ways that federalism is connected to the political capacity of social policy beneficiaries. With the contextualized feedback model as a starting point, I theorize a threefold process: 1) the macro-institution of federalism structures state, county, and city contexts; 2) through public policy – a primary mechanism by which federalism operates – such contexts shape the experiences of policy beneficiaries; 3) contextually contingent policy experiences (enabled by federalism) influence the political attitudes and actions of policy beneficiaries. Of particular note is that the modes of political action in question span the gamut from the traditional (voting) to the unconventional (particularistic resistance) to the uncommon (policy advocacy). Because I conceive of federalism as encompassing intergovernmental interactions across all levels, the scope for political maneuvering is varied and the forms of political engagement that emerge are motley.

Charting the processes of the contextualized feedback model does not uncover a simple story of federalism as a “national neurosis” that is straightforwardly bad for vulnerable social policy beneficiaries (Rubin and Feely 1993). Some states (sometimes) make policy choices that are a boon for Medicaid beneficiaries’ political participation; some counties (sometimes) run efficiently and fairly, making it more likely that beneficiaries will obtain redress in the face of unfair administrative decisions; some federal policies (sometimes) allocate crucial resources to cities, helping to make them more equitable and forefending against disproportionately negative feedback between policy and polity for struggling neighborhoods; some states (sometimes) foster healthier advocacy
networks than others. In the main, however, the findings lean toward the negative sides of these outcomes, raising concerns about the democratic ramifications of federalist policy fragmentation.

By directing us to those trepidations, I do not wish to unproductively denigrate federalism or fruitlessly highlight its downsides. After all:

Federal institutions exist as an integral part of the political landscape; they are not going to go away ... Political actors in search of social justice must work within and through these institutions. This means that in each of them, there is a vital reform agenda: for any given system we must ask: how can it be rendered more just? (Simeon 2006: 43)

With this broad inquiry in view, I follow Smith (2004: 8) in submitting that “federalism is a structure with the potential to enhance democracy or to diminish it. Which way federalism leans depends a great deal on the way that political and bureaucratic actors, and citizens, use the structure.” Assessing the “democratic credentials” of federalism thus requires analysis. Even when a Supreme Court justice declares that federalism “increases opportunity for citizen involvement in democratic processes,” or “makes government more responsive,” these statements should be viewed as conditional conjecture rather than as inherent truth.

Arguments in favor of federalism are sometimes compelling (see Derthick 2001, for example), but they tend to pay insufficient attention to the positioning of Americans situated at the margins of the polity. That is not the kind of indifference we can afford to suffer any longer. Notably, Richard Freeman and Joel Rogers (2007) penned a persuasive essay that makes a case for “progressive federalism” built on nationally determined “floors” for social and economic policy, fiscal redistribution that funds the mandates imposed by such floors, and a more thorough approach to evaluating the benefits of state policy innovations and promoting those that prove effective. These are sound ideas, but Freeman and Rogers give short shrift to the problems that federalism poses for equality. They admit that federalism naturally leads to disparities in outcomes, but they suggest that this does not compromise “equalities of opportunities” (221). By such logic, any inequalities federalism produces stem either from geographic differences in political preferences or from dissimilarities in the development of policy. Ostensibly, these are both things that we should expect and probably embrace. Still, Freeman and Rogers never tell us what inequalities in “outcomes” look like or why they should be so easily elided. The core problem here is not uniquely theirs; it is based on a common (but I would argue conceptually unsustainable) assumption that
persisting inequality in outcomes is compatible with the goal of equality in opportunities. In a world where this is true, states can perpetually provoke vastly divergent outcomes in many policy arenas with little consequence for “opportunity.” In the actual world, this is not conceivable.

For example, when some states (perhaps because of preexisting political preferences and a willingness to innovate) implemented harsher criminal justice policies with significant implications for the racial and geographic composition of incarcerated populations, there were innumerable costs for young black and brown men and women, for the families who lost them to prisons that increasingly peppered rural hinterlands and for the racially segregated urban communities from which many of them hailed (Burch 2013; Lerman and Weaver 2014). For these populations, shifting outcomes in the domain of criminal justice policy dictated profoundly altered trajectories of opportunity.

Of course, this was not singularly the fault of federalism. As Lisa Miller (2008) points out, federalism is a flexible institution that can be used for both good and ill in nearly any policy arena. As if to prove Miller right, in recent years the tide has turned and federalism has enabled some states to loosen the strictures of excessive incarceration and its concomitant collateral damage. Still, what I mean to highlight is that such a turnabout may begin to change some things relatively quickly, but will only slowly adjust the opportunities that have been ravaged on account of decades of destructive state and local practices underwritten by federalism. Even as states begin to release more low-level, nonviolent drug offenders from confinement, they can hardly grasp at restoring the emotional, economic, social, and political bonds that have been broken by federalism run amok in the arena of incarceration (Lerman and Weaver 2014). Most importantly, federalism means that such brokenness will have a particular geography that maps onto the broader national contours of race and poverty. Far from shaping outcomes with no ramifications for opportunities, federalism is a primary channel through which the geography of opportunity is shaped in America. Most distressingly, when federalism structures the contours of democratic voice (as I have shown that it sometimes does), the landscape that it etches is marked by tremendous inertia.

I take seriously Freeman and Rogers’ assertion that all of the disadvantages of federalism could ostensibly be turned into advantages. States, counties, and even neighborhoods can make choices that mobilize their most vulnerable residents; they can shape policies in ways that enliven the citizenry and when they do, inertia will work in favor of democracy.
Heather Gerken (2012), a preeminent legal scholar, convincingly advances precisely such a progressive vision of federalism:

It is a mistake to equate federalism’s past with its future. State and local governments have become sites of empowerment for racial minorities and dissenters, the groups that progressives believe have the most to fear from decentralization. In fact, racial minorities and dissenters can wield more electoral power at the local level than they do at the national. And while minorities cannot dictate policy outcomes at the national level, they can rule at the state and local level. Racial minorities and dissenters are using that electoral muscle to protect themselves from marginalization and promote their own agendas.

While Gerken shrewdly observes that federalism can be used toward progressive ends, she does not presuppose that federalism has a particular moral or partisan valence. I echo that sentiment. We cannot assume the value of federalism a priori because its effects are contingent on politics. At the same time, federalism is itself a determinant of politics, not just on the institutional level (shaping laws, norms, policies) but also on the mass level (shaping how people engage with politics in response to policies).

Homing in on the latter process, I advance an account that provides a key metric for evaluating federalism: political equality. Though federalism can both constrain and enable democratic participation, presently and as far as antipoverty policy is concerned, it does more of the former. U.S. federalism simply lacks the design features that would allow it to do otherwise. Fiscal equalization measures deemed central in other federal polities (Canada is a close example) are not even on the table in the United States (Ahmad and Craig 1997). Provisions like that of Section 106 of the German constitution – which explicitly requires equality for all persons wherever they live – are nonexistent in the United States and not even up for discussion.

Freeman and Rogers highlight fiscal federalism with a redistributive element across and within states as especially important. I concur. So much of Medicaid’s story is about costs and budgets. A program that everyone thought would be small and inexpensive has become a “threat” to budgets everywhere. Through its more expansive taxing and borrowing powers, the federal government has the tools and flexibility to manage that threat more effectively than subnational entities (Peterson 1981, 1995). Still, the feds have continually tried to pass much of the buck to the states, and states have done their own fair share of buck passing both up and down the intergovernmental ladder. In a context of devolution, this has meant that even generous states and counties have to pull back and ration benefits (Hoffman 2012; Olson 2010).
It has also meant that unequal economic standing across and within states is closely tied to disparate access to Medicaid. This has political consequences because it sends messages to denizens about the fairness, structure, and efficacy of our government. Other federal polities make a more concerted effort to equalize resources across subnational units. In the absence of such exertions, the United States’ unique brand of fiscal freewheeling means that there are fewer constraints on the extremes of federalism and enormous gaps in services that policy beneficiaries face, despite their shared membership in the same political community.

The findings offered here warrant caution in response to simplistic plans to increase state or local flexibility without attending to the corresponding dangers of widening geographic inequality. Paul Ryan’s (R-WI) budget proposals (2012–2016) are demonstrative. Ryan and others are in favor of block-granting Medicaid in order to give states the freedom to innovate and improve the efficiency of the program. Without addressing the drastically different positions that states and localities occupy with respect to the resources they can command to steer such a massive undertaking, relinquishing so much control is a frightening prospect for democracy. Even when the federal government apportions more resources to poorer states in an attempt to respond to economic realities, it is often the poorest states with the most to gain from federal intervention that are most resistant to that intervention (for political, cultural, and other reasons). This means that the “floors, not ceiling” approach that Freeman and Rogers promote is doubly important. Often, however, the inclination is toward making the floor as low as possible. Moreover, the heights of both the floor and the ceiling have distinct implications for how beneficiaries experience policies and the attendant quality of their democratic citizenship.

Perhaps in 1965, when Medicaid first began, the differences in outcomes (of all sorts) between states that aggressively implemented the program (New York) and those that ardently resisted it (Arizona) were simply attributable to geographic diversity in policy preferences and states’ inclination to innovate. However, it was likely not long before those differences began to feed back into the very systems that structure equality of opportunity. For those left uninsured: sicker populations who are more vulnerable to medical catastrophes are also less well positioned to push for change in the system. And as I show throughout this book, even for those who are insured via Medicaid, the unequal contextually varied nature of the program can dampen the proclivity to engage in political activity of all sorts. In the long term,
this certainly has implications for the kinds of political opportunities we might expect for marginalized populations in the states and localities that are most deficient in distributing policy resources. This may be one reason why, despite the broad and wide appeal of Medicaid among low-income people of all different political and social persuasions, the program has been consistently vulnerable to political attack. Medicaid’s political susceptibility is a symptom of a much larger ailment. It is a marker of an uneven democracy where citizenship is differentiated across place. The antidote to this is a bold, critical, morally infused, and empirically rooted reenvisioning of the relationship between federalism and democracy in the United States.

Fragmented Democracy does not achieve such reenvisioning, but it points toward a method for enacting it: centering on those who are most deeply affected by federalist social policy, registering their experiences, and identifying the ways that political processes fail to incorporate them as full and equal participants in American democratic practices. Ultimately, such an exercise is not actually about federalism. It is about the depth of our commitments as a putatively democratic polity. Federalism is simply an institutional mechanism through which we see such commitments (or lack thereof) ordained. As such, “the impetus for social justice as equality … and democracy will not be found – either positively or negatively – in federalism itself “(Simeon 2006: 43).

Federalism is both a producer of politics (the emphasis of this book) and a product of politics. Riker (1975) reasoned that the latter observation was cause for deeming federalism epiphenomenal and derivative of other political forces. But it is precisely because federalism is subject to alteration via the political system that we must understand it and, based on our knowledge, change it. This book offers such knowledge: federalism acts as a purveyor of political inequality by unevenly eroding the political capacity of social policy beneficiaries in particular locales. Having evidence of this, we now face the much more compelling task of deciding what to do about it. As we confront that dilemma, we would do well to incorporate and center the experiences of Medicaid beneficiaries as well as other racially and economically marginal groups who live everyday in the interstices of our fragmented democracy and whose voices are vital to the cause of setting it right.
Appendix A

Qualitative Interviews

The qualitative part of this project is based on sixty-one in-depth interviews with Medicaid beneficiaries and stakeholders in thirteen states (Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Michigan, Missouri, New Jersey, New York, North Carolina, Pennsylvania, and Vermont). Forty-five of those interviews were with beneficiaries and sixteen were with stakeholders. Stakeholders were people who have close interactions with beneficiaries; this group included six public benefits attorneys, nine employees of nonprofit organizations that advocate directly for Medicaid beneficiaries, and one high-level state bureaucrat.

LOGIC AND PROCESS OF INTERVIEWS

The methodological approach underlying this book’s qualitative research design is that of case study logic (Small 2009; Yin 2003). Since interview data are such a central part of this project, it is worth taking the time to clarify the significance of case study thinking. It is helpful to begin with the alternative: sampling logic. Mario Small (2009: 24) summarizes the main aspects of sampling logic:

Sampling logic refers to the principles of selection associated with standard survey research. In a sampling model, the number of units (e.g. individuals) to be studied is predetermined; the sample is meant to be representative; all units should have equal (or known) probability of selection; and all units must be subject to exactly the same questionnaire … The objective is statistical representativeness.

Case study logic casts sampling logic as an (at times) inappropriate tool for the job of careful and in-depth qualitative investigation. In a case
study design, interviews proceed sequentially so that each additional case provides information that will be used to further hone the research questions and insights. As a result, the number of cases is not predetermined and the content of the questionnaire is not constant (Small 2009). The goal is to continue interviews until they yield little new information (saturation).

A sequential process of data collection was key in this study. I used information from early interviews to shape those that came later. Interviews with beneficiaries prior to 2012 (four out of forty-five) were unstructured. I conducted them before my ideas were fully formed. In these conversations, I introduced a few major topics (i.e., economic challenges, health care, politics) and simply engaged in conversation. Though relatively unfocused, these early interviews were crucial because they pointed me to Medicaid and gave me a sense of how the program mattered to beneficiaries.

By 2012, I developed a focused research agenda and constructed an interview guide. The interviews with beneficiaries that occurred after this point (forty-one out of forty-five) were semi-structured. The trained interviewers (whom I will discuss in a subsequent section) and I used this guide to facilitate conversation with beneficiaries (the questions in the guide are included at the end of this Appendix). Having a guide ensured that at least some questions came up consistently. However, we did not strictly follow the guide and we certainly did not use it in the manner in which a survey instrument would be used (i.e., with sampling logic in mind). Instead, we leveraged it as a template for conversation rather than as a hard constraint. The purpose of the qualitative interviews was to generate ideas, hypotheses, and explanations. The strategy was inductive. Since I did not understand the processes connecting Medicaid policy to political participation at the beginning of this research, I left room for beneficiaries and stakeholders to enlighten me. I took special care to ensure that the conversation was open and flexible enough for beneficiaries to bring up things that I would not have thought to ask them. (In retrospect, this is where some of the most poignant insights came from.) The four research assistants (RAs) who interviewed beneficiaries were trained to take a similar approach. I encouraged them to establish rapport, to probe when something was unclear, to follow leads that went off script, and to be conversational. As a result, though the interviews contained similar enough kinds of information to be comparable, they were each different. Those differences yielded constructive variation. This is not acceptable per the standards of sampling logic (where representativeness and equal...
treatment/probability are the goals), but it is consonant with case study logic (where research leads are pursued by adapting prior information).

In contrast to the interviews with beneficiaries, interviews with stakeholders were unstructured and I personally conducted all of them. I used no guide. Since all of the stakeholders were engaged in direct work with beneficiaries, I simply asked them about the work they did and let the conversation unfold organically from there. The sequential element was still crucial here: most of my interviews with stakeholders occurred later in the research process (after 2013). I identified stakeholders based on what beneficiaries had previously told me (about lawyers helping them, navigators signing them up for benefits, etc.). Moreover, when I spoke with stakeholders I had the knowledge that I gained from beneficiaries in mind, so I asked questions meant to clarify, corroborate, or extend the narratives beneficiaries had offered. When beneficiaries talked about how difficult and frustrating Medicaid fair hearings could be, I followed up by asking lawyers to describe the fair hearing process in detail. This kind of complementarity was vital. Had I not interviewed dozens of beneficiaries first, I would not have known which stakeholders to reach out to or what to talk to them about. Notably, stakeholders were highly educated, very informed, and often quite assertive. So my conversations with them were not constrained by the ideas I had developed in my prior interviews with beneficiaries. To the contrary, stakeholders were unpredictable. In my interviews with them, I learned things that I could not have anticipated. In that sense, sequentially interviewing beneficiaries and then stakeholders clarified issues until I reached the point of saturation (the last two interviews told me little that I had not heard before).

CASE SELECTION

The strategy for case selection centered on the goal of theoretical range (Yin 2003). Because I knew Medicaid was very different across state and local contexts (even before I realized that this book would be about federalism), the first dimension I emphasized was geography. I interviewed beneficiaries from states with varying population sizes (Iowa versus New Jersey) and from states that were racially heterogeneous (Illinois, New York) and those that were more homogenous (Idaho, Vermont, Iowa), as well as from states where Medicaid was being expanded and had a reputation for generosity (New York) and those where it was not expanding and where benefits were reputedly stingy (Georgia and North Carolina). I also aimed for beneficiaries in large cities (Detroit, New York
City, Chicago), in suburbs and small cities (Marietta, Georgia; Ann Arbor, Michigan), and in rural areas of Michigan and New York. Finally, in light of the racial heterogeneity of the Medicaid population, I interviewed beneficiaries across racial and ethnic lines. None of this was meant to achieve representativeness in a formal sense but it was meant to provide range.

I also selected some beneficiaries because of their political activities. Most of the beneficiaries whom I initially interviewed were inactive politically, especially around issues related to Medicaid. Later in the interview process, I used social media and the friendship networks of beneficiaries to identify a cadre of very engaged beneficiaries (like Riley and Kay, who were highlighted in Chapter 7). I sought them out with the logic of theoretical replication in view: this is a process by which very different cases are examined in order to highlight matters of theoretical interest (Small 2009: 25). The interviews with activist beneficiaries illuminated pathways and barriers to engagement and the role of federalism in shaping the possibilities of advocacy.

RECRUITMENT PROCESS

Participants were recruited in several ways: through flyers posted at community health centers, hospitals, and bus stops; through face-to-face interactions at local Medicaid offices; and through snowball recruitment via previous interviewees who recommended fellow beneficiaries. I recruited stakeholders by directly contacting their organizations and asking them for an interview.

INTERVIEWERS

I conducted most of the interviews personally. However, since I am an English-speaking African-American woman of Caribbean decent, I took extra steps to ensure variation in the race and language of the interviewers. This helped to provide reference points for addressing how my ethnic and racial positioning might have affected the interview process. For this purpose, trained RAs conducted thirteen of the interviews. A trained bilingual RA interviewed four Spanish-speaking Latino beneficiaries (in Spanish) in Florida. This was a supplement to several interviews that I personally conducted with English-speaking Latinos (in New York and Georgia). The Spanish-language interviews were meant to safeguard against the possibility that language bias was obscuring critical aspects of beneficiaries’ experiences. Those interviews consisted of longer and more
detailed conversations with Latino beneficiaries than the ones that I conducted in English, so it did appear that there was a benefit to utilizing a Spanish-speaking RA.

In addition to hedges against bias related to language, I also considered the role of race. Two trained RAs who were white interviewed seven white women and one black woman. Again, this supplemented the interviews that I personally conducted and provided a sense of whether interviews across racial boundaries yielded significantly different observations. White beneficiaries did not talk much more or say anything observably distinct to the white interviewer compared to me. On the other hand, the black woman interviewed by a white female RA said significantly less and did not mention race (which was quite unusual among the black beneficiaries that I interviewed personally). Though I cannot draw any ironclad inferences from these necessarily idiosyncratic instances, race did not appear to impact interviews with white beneficiaries as much as it did those with black beneficiaries. I suspect this is because white beneficiaries do not consciously view their experiences with Medicaid through the prism of race (or alternatively, do not feel comfortable articulating such a perspective to strangers, even another white person) while black beneficiaries do, but would only tell a black person so.

Finally, a trained male interviewer (of South Asian decent) interviewed one African-American male beneficiary. As in the other instances, this was to provide a reference point for assessing whether male beneficiaries would discuss their experiences with Medicaid differently with a male interviewer than they had with me. This did not appear to be the case.

** BENEFICIARY DEMOGRAPHICS **

In terms of demographics, 82 percent of the beneficiaries interviewed were women; 73 percent had at least one child; 42 percent were African-American, 27 percent white, and the remaining 31 percent were Latino or Asian; 25 percent were immigrants and 45 percent had (or had a child with) a serious health condition. Interviewees ranged in age from early twenties to early sixties and had spent an average of nine years on Medicaid (although that ranged from less than one year to more than twenty).

** DATA COLLECTION AND ANALYSIS **

The semi-structured interviews lasted as long as 103 minutes; the average interview was fifty minutes. Some interviewees kept in contact with me,
so I was able to have multiple conversations with them after the initial interview. Interviews took place in a variety of public places chosen by the participants (libraries, coffee shops, parks, etc.) and sometimes over the phone. Interviewees were paid $25 and the interviews were recorded. After transcription and an initial round of general thematic coding, I conducted a second round of coding specifically focused on identifying circumstances in which interviewees referenced the relevance of state, county, or local contexts. Coding was done using the Web-based software Dedoose. The primary purposes of the interview data were to: 1) help generate hypotheses for the quantitative analysis by illuminating relevant factors that I could have otherwise overlooked; 2) to further corroborate and explain the quantitative results (this purpose was specifically for interviews that took place after the quantitative analysis was complete) 3) to provide insights about aspects of the relationships between Medicaid, federalism and political participation that went beyond the scope of available quantitative data.

INTERVIEW GUIDE

PERSONAL BACKGROUND

Introduction (after conversation to establish rapport): I am going to begin by asking you some questions about your personal background and your experiences with Medicaid.

a. Could you start by telling me a little bit about yourself? [Probes: Where are you from? Where did you grow up?]
b. If respondent has not already mentioned this: Are you employed? If so, what do you do for a living? If not, how long have you been unemployed and what did you do before?
c. Are you, your child, or both of you enrolled in a program that provides government health services, often called Medicaid?
d. If respondent has not already mentioned this: What is the name of the program? Who is enrolled?
e. How long have you (or your child) been enrolled?
f. What did you do for health care before you were enrolled?

Pre-enrollment

a. Can you tell me a bit about what led you to apply and enroll? Can you remember when the idea first occurred to you or how you initially thought to apply?
b. Did you know you were eligible? How did you know you were eligible?
c. At the time you decided to apply, did you have any fears or concerns going into the application/enrollment process?
d. What did you hope to get from [program name]?
e. How long did you expect to be enrolled?

**Enrollment Process**

a. If you can think about the day you first applied for [program name], can you tell me what that was like? What do you remember from that day?
b. Follow-up: Was it easy to apply?
c. When you first applied, were you able to talk to someone to get directions about all the things you had to do to get enrolled?
d. How would you describe the people you spoke with at the agency?

**Program Usage and Experience**

a. Have you (or your child) actually used [Medicaid] benefits to cover doctor visits, hospital stays, health clinic visits, or for anything else? How often?
b. What has it has been like getting the care you need through the program?
c. How has it been accessing care? For example, finding a doctor, getting prescriptions filled, etc. [Probe: Easy? Challenging? Why?]
d. What has the quality of the care you’ve received been like? Can you explain why or give an example?
e. Do you ever think that doctors, caseworkers, or anyone treats you differently or thinks of you differently because you are insured through Medicaid?
f. In general, do you think that other people (neighbors or friends) view you differently for being a part of the program?
g. Do you view yourself any differently?
h. Where do you go (physically) to handle matters related to your Medicaid benefits?
i. When you go there, what is it like?
   [Potential probes: Have you ever noticed the presence of security personnel at the office? Have you ever interacted with them or seen anyone else do so? Have you ever noticed any signs on the wall at
the office? Can you remember what kinds of things they said? Are you allowed to keep your phone turned on or talk on your phone in the office? If not, how do you feel about this? Do you bring your children with you when you visit the office? Are there any rules about what your children can or cannot do (example: they must sit down, they cannot make noise, etc.)? If so, how do you feel about this?

j. What is it like when you talk to the people working at the office? [Potential probes: Are you usually given the time to say what you need to and explain your situation? Are things explained to you in detail?]

k. Have you received Medicaid in more than one state? In your experience, does the program vary from state to state? If so, how?

Resistance

a. Was there ever a time you had a complaint or problem with the program, your benefits, eligibility, enrollment, services, or anything else?

b. If so, what was it? [If there was more than one:] tell me about the others?

c. Did you do anything in response to this problem? If so, what? If not, why not?

d. Have you ever raised a complaint or grievance in the time you have been in the program? If so, what was it about? How was it handled? How did you feel about the way it turned out?

e. If respondent has not already said this: Was there ever a time you had a complaint or problem but didn’t say anything about it? Why not? How do you feel about the issue now?

f. In general, if someone in the program were to raise an issue or challenge a caseworker’s decision, how do you think things would turn out?

g. Do you think you have much influence with your caseworker or whomever you deal with in the program? Do you think you have any say over what happens to you in the program?

h. Overall, how would you say you are treated in the program?

Politics

a. Do you think Medicaid is any different from other government programs?
Appendix A

b. Do you think you share any common political interests with other Medicaid beneficiaries? Why or why not?
c. If a group of people who had Medicaid were working together for changes in agency policies or client rights, would you participate?
d. Would you be willing to sign a petition? How about attend a meeting? How about take part in a protest or rally?
e. Do you think such a group would be successful? Why or why not?
f. Groups like the one I described do not get started very often; why do you think people in programs like [program name] don’t organize to fight for benefits and other things?
g. Can you tell me what politics is to you? Describe what you think of when you think about politics or when you hear that word.
h. Do you participate in politics in any way? Describe how or tell me about why you don’t.
i. Do you think politics matters? Tell me more about how or why.
j. Do you think there is anything that happens with the Medicaid program that can be considered “politics”?
k. Do you think what you experience with Medicaid is connected to local, state, or federal politics? If so, how?
l. Do you think Medicaid beneficiaries have much influence in politics? Why?
m. Throughout the country, various states are cutting back on Medicaid and other health care programs for the poor in order to save money. What do you think about this?
n. Do you think there is anything that people who use these programs can do to stop cuts from being made?
o. What do you think about the health care reforms passed in 2010?
p. Has anything changed about Medicaid over the past few years since health care reform has been implemented?
Appendix B

Statistical Tables

*Civic Attitude* is a scale based on respondent ratings of how important the following civic activities are: 1) reporting a crime; 2) volunteering; 3) serving on a jury; 4) serving in the military; 5) voting. Respondents rated these activities as important, somewhat important, or not important.

*Polparticipation* is an index of political behavior indicating how many ways respondents participated in the following political activities: 1) taking part in a political group; 2) taking part in a political rally or demonstration; 3) voting.

*Geographic Disparity* measures variation in overall mortality rates among counties within states. Information was gathered from the United Health Foundation’s Health Rankings data.

*Welfare Employees* measures the ratio of state welfare employees to the number of residents living in poverty (standardized).

*Health Center Revenue* measures the proportion of revenue that Federally Qualified Community Health Centers in a state receive from Medicaid.

*Hospital Beds* measures the number of for-profit hospital beds per 1,000 state residents.

*Scope of Services* is a measure of state’s provision on non-mandatory services in seven distinct categories: 1) Services by type or target group; 2) Women’s services; 3) Services delivered by specific providers; 4) Rehabilitation services; 5) Devices and equipment; 6) Drugs; 7) Transportation. State performance in these categories is gauged to create a measure of the scope of services offered by each state. Data were gathered from Public Citizen Health Research Group.
### Table B1 Summary Statistics

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<tr>
<th>Variables</th>
<th>Mean</th>
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<th>Max</th>
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<td>0.497</td>
<td>1 = Female</td>
<td>2 = Male</td>
</tr>
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<td>0.969</td>
<td>1 = Excellent</td>
<td>5 = Poor</td>
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<td>1 = Yes</td>
<td>2 = No</td>
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<td>2 = No</td>
</tr>
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<td>5.889</td>
<td>16</td>
<td>64</td>
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<td>1 = Yes</td>
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<td>1 = Yes</td>
</tr>
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<td>1 = Everyday</td>
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<td>0 = No</td>
<td>1 = Yes</td>
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<td>1 = 0–49% pov line</td>
<td>5 = 300% pov line</td>
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<td>1 = less than HS</td>
<td>4 = College or grad</td>
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<td>1 = Yes</td>
<td>2 = No</td>
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<td>1 = Yes</td>
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<td>Kids</td>
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<td>10 = Ten Kids</td>
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* Variables requiring further explanation
### Table B2: Medicaid and Political Outcomes (Basic Regression)

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Standard errors in parentheses

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## Table B3 Medicaid and Political Outcomes (Expanded Models)

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Standard errors in parentheses

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Table B4 Medicaid and Political Outcomes (Matched Data)

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Standard errors in parentheses

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### Table B6 Medicaid and Political Participation across States

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Standard errors in parentheses

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### Table B7  State Contextual Factors and Medicaid Beneficiaries’ Political Behavior

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Level 1 N: 2,517
Level 2 N: 343

Standard errors in parentheses

*** p < 0.01, ** p < 0.05, * p < 0.1
### Table B9  Medicaid and Political Participation: Perceptions of Neighborhood Disorder and Cohesion

<table>
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<td>Medicaid</td>
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<tr>
<td>(0.325)</td>
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<tr>
<td>Sex</td>
<td>-0.04</td>
</tr>
<tr>
<td>(0.053)</td>
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</tr>
<tr>
<td>Age</td>
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<tr>
<td>(0.002)</td>
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<tr>
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<tr>
<td>(0.097)</td>
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<tr>
<td>Latino</td>
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<tr>
<td>(0.084)</td>
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<tr>
<td>Income</td>
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<td>(0.007)</td>
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<td>Education</td>
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<td>(0.008)</td>
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<tr>
<td>Nativity</td>
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<tr>
<td>Health</td>
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<tr>
<td>Perceptions of Cohesion</td>
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<td>(0.039)</td>
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<tr>
<td>Perceptions of Disorder</td>
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<tr>
<td>(0.129)</td>
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<tr>
<td>Perceptions of Disorder (Quad)</td>
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<tr>
<td>Disorder (Quad) * Medicaid</td>
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<td>Neighborhood Poverty</td>
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<td>(0.283)</td>
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<tr>
<td>Neighborhood Race (Black)</td>
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<tr>
<td>(0.121)</td>
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</table>

| Level 1 N            | 2,518       |
| Level 2 N            | 343         |

Standard errors in parentheses

*** p < 0.01, ** p < 0.05, * p < 0.1
I MEDICAID, POLITICAL LIFE, AND FRAGMENTED DEMOCRACY

1 This name and the others used in this book are pseudonyms. Details about the qualitative interviews are provided in Appendix A.

2 Swartz and Sommers (2014) show that Medicaid expansion does not induce significant cross-state migration, debunking the “welfare magnet” hypothesis in the case of Medicaid. They do find small net migration effects, so some people likely migrate in response to Medicaid availability. This is consonant with the picture that emerges in this study. Medicaid may not commonly induce mobility, but it factors into decision-making processes about where to live, and it can, on occasion, either prevent beneficiaries from moving or prompt them to do so.

3 Though see Hopkins (2018) for an important perspective on the increasing nationalization of politics.

4 Relatedly, I understand “citizens” to be members of the political community as dictated by geographic boundaries, irrespective of legal status or formal documentation.

5 I deploy the term “federalist” to describe the federated structure of the U.S. political system and the policies most affected by that structure. As I mean it, “federalist” social policies are those policies that differ significantly across states (and sometimes localities) as a consequence of federalism. I do not use the term “federalist” in (either direct or indirect) reference to the Federalist Papers, the Federalist Party that existed from the late 1790s to the early 1800s, or the well-known conservative/libertarian group called The Federalist Society.

6 This is especially true because the ACA eliminated asset tests for non-elderly adult Medicaid beneficiaries whose eligibility is based on modified adjusted gross income (MAGI). This applied to all states.
For example, Medicaid is a key provider of long-term care for elderly Americans (a provision that eats up a disproportionate share of the program’s budget). Medicaid also provides health insurance coverage for those who are disabled and “medically needy” (Grogan and Patashnik 2003). These populations are important, but not the central focus of this book.

In this instance I refer to the technical designation of “low-income,” which applies to those between 100 percent and 199 percent FPL. Throughout this book, I sometimes use this term more colloquially.

Most scholars agree that these disparities are not due to the Medicaid program itself. Instead, they stem largely from the ways that social determinants of health predispose beneficiaries to a range of health problems (Frakt et al. 2011).

These groups are more positively constructed and tend to have more political power than other groups of beneficiaries; they are also more likely to be drawn from the ranks of the middle class (Schneider and Ingram 1993).


Much of the event was recorded and is available via YouTube: www.youtube.com/watch?v=iNb8ROFU7x4.


These numbers are based on a compilation of information from a wide variety of newspaper sources from around the country.

Though the “qualitative”/”quantitative” distinction is familiar and helpful for making this work legible to others, I am skeptical of its veracity.

2 DEMOCRATIC CITIZENSHIP AND CONTEXTUALIZED POLICY FEEDBACK

Barron v. Mayor of the City of Baltimore, 32, U.S. 243 (1833).

A wharf is a structure built on the shore of a harbor or riverbank where ships can dock.

Among other things, the Fifth Amendment prohibits the government taking private property for public use without compensation.

Specifically, section 1 of the Fourteenth Amendment reads: “All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of...
life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”

5 See also Beam, Conlan, and Walker 1983, Erk 2006, and Landau 1973 for more thoughts in this vein. Landau (1973: 173) offers this humorous and resonating response to the muddled conceptual thicket of the federalism literature: “Having wandered again through the literature on federalism, I emerge with a prayer: would that our language were standardized — just a few technical terms would suffice. When I first took this trip, I found federalism proper, dual federalism, cooperative federalism, centralized federalism, mature federalism, national federalism, and what was then the ‘new’ federalism. I am now obliged to add creative federalism, dynamic federalism, contract federalism, the ‘new’ new federalism and, Lord help us, permissive federalism. In Heaven’s name, what goes on here?” I have no new version of federalism to add to this long lineage.

6 See Article I, Section 8 of the U.S. Constitution.

7 See Article VI of the U.S. Constitution.

8 Madison confirms this view of federalism in Federalist 51 when he says, “In the compound Republic of America, the power surrendered by the people is first divided between two distinct governments, and then the portion allotted to each subdivided among distinct and separate departments.”

9 There is no universally agreed upon timeline for the development of federalism in the United States. The typologies of federalism that I assert here and the general timeline connected to them serve the purpose of broad historical sketching. It is worth acknowledging that scholars do not agree about these typologies, and that additional types exist (see footnote 5 in this chapter).

### 3 FEDERALISM, HEALTH CARE, AND INEQUITY

1 This is most apparent in the original exclusion of agricultural and domestic workers from Social Security provisions, which rendered nine out of ten African-American women workers ineligible (Mettler 1998b).

2 [https://memory.loc.gov/cgi-bin/ampage?collId=llsl&fileName=001/llsl001.db&recNum=728](https://memory.loc.gov/cgi-bin/ampage?collId=llsl&fileName=001/llsl001.db&recNum=728)


4 Figure 3.1 taken from “A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage,” a 2012 report by Kaiser Commission on Medicaid and the Uninsured.

5 Research suggests that it does. Though this book does not address specific questions about Medicaid and motherhood, the ethnographic work of legal scholar Khiara Bridges concretizes the processes through which the implementation of Medicaid shapes how pregnant women experience the state. Bridges details the (often unsettling) ways that “state subsidization of pregnant women’s medical expenses via Medicaid functions as a carrot that entices women to submit themselves to state supervision, management, regulation and discipline” (2008: 69).
6 This is based on the 2015 Current Population Survey. Washington, DC is excluded. For rankings, see http://kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=0&selectedDistributions=black&sortModel=%7B%22collId%22:%22Black%22,%22sort%22:%22desc%22%7D.

7 This is based on the 2015 Current Population Survey. Washington, DC is excluded. North Carolina, Oklahoma, Tennessee, and Texas were tied for eleventh place with 15 percent poverty rates. For rankings, see http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Total%22,%22sort%22:%22desc%22%7D.

8 Arizona’s entire Medicaid program is run through a 1115 Waiver and has been since its (late) beginning, though the state has recently applied for an amendment.


10 I offer details about Indiana’s Medicaid expansion at the beginning of the next chapter.


12 As detailed in the interview guide included in Appendix A, I asked beneficiaries the following: “Do you think what you experience with Medicaid is connected to local, state, or federal politics? If so, how?” Every person interviewed said yes and most provided an explanation for that answer.

13 I am not claiming that beneficiaries move in order to maximize benefits. However, my qualitative interviews suggest that they often notice how moving across states, counties, and neighborhoods changes access to benefits and experiences with the program.

4 STATE POLICY AND POLITICAL MIS(EDUCATION)

1 Bruch and colleagues (2010) are a notable exception. In one part of their seminal article, the authors consider how variation in state TANF regimes bears upon political participation. They find significant effects, but the precise mechanisms and implications of the findings are underexplored.

2 To be clear, coverage effects that stem from expansion are distinct from (but related to) experiential effects that stem from the actual processes beneficiaries go through once enrolled in Medicaid. Increased participation in the wake of wide-scale Medicaid expansion can be explained by participatory upticks among beneficiaries and non-beneficiaries who are responding in the short-term to expansionary policies. Though important to chart, such coverage effects do not tell us much about Medicaid’s more enduring influence on actual beneficiaries (most of whom have experiences with the program during times of both expansion and retrenchment). My focus is on this latter point, as it best helps us gain traction on the political lives of Medicaid beneficiaries.

3 Stakeholders represent or advocate for beneficiaries. This group includes public benefits lawyers, directors of nonprofit organizations, and frontline workers in organizations tasked with connecting beneficiaries to helpful...
resources. Stakeholders provided a different, but complementary and often corroborative perspectives on program experiences.

4 For more detail on the qualitative methods used in the book, see Appendix A.

5 The states from which interviewees hailed were: Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Michigan, Missouri, New Jersey, New York, North Carolina, Pennsylvania, and Vermont.

6 Thematic coding and analysis were conducted using Dedoose, a Web application for mixed-methods research.

7 This was likely the shift to managed care that occurred in Florida circa 2013.

8 NICU is an acronym that stands for neonatal intensive care unit. NICUs specialize in the care of ill or premature newborn infants.

9 Though this is not usual, it is a striking example (Swartz and Sommers 2014).

10 I limit myself to the third wave because this is the only wave in which FFS asks questions about political activity (as such, it was not possible to estimate panel models due to lack of available data on the dependent variables in multiple waves).

11 There were 7,529 respondents interviewed in wave three with a response rate of 77 percent.

12 The National Longitudinal Study of Adolescent Health (ADD Health) is a school-based survey of a nationally representative sample of students who were attending grades seven to twelve in 1994–1995. I used the third wave of that data, which provide a snapshot of the students as young adults between the ages of eighteen and twenty-six. Despite the truncated age range, ADD Health boasts a large sample (N = 4,882) and detailed questions about health insurance status and political participation (not an easy combination to find). ADD Health is a program project designed by J. Richard Udry, Peter S. Bearman, and Kathleen Mullan Harris and funded by grant P01-HD31921 from the National Institute of Child Health and Human Development, with funding from seventeen other agencies. Special acknowledgment is due Ronald R. Rindfuss and Barbara Entwisle for assistance in the original design.

13 Such an experiment was conducted in Oregon in 2008. The researchers who conducted that experiment have now linked the results to voting records to observe the effect of Medicaid on voting, but have not published the results yet. Regardless, such data present problems with external validity precisely because the relationship between Medicaid and voting in Oregon is likely very different than it is in other places. Ultimately, experimental results from a single state are helpful, but cannot adjudicate the core questions at stake here.

14 This is an index that reflects whether respondents: 1) were part of a political group; 2) took part in a political rally or demonstration; 3) voted. See Appendix for summary statistics.

15 The FFS asks respondents whether they or their children are currently on Medicaid, so this measure reflects engagement with the policy on the part of the individuals or on behalf of their children. The results are unchanged by controlling for which was the case.

16 Civic attitudes were measured using a scale combining respondents’ ratings of the importance of five activities: voting, serving in the military, jury duty, volunteering, and reporting a crime.
17 These are general self-reports where respondents are asked, “How is your health?” and select from five responses ranging from poor to excellent. The results are robust to additional types of controls for health like whether respondents had visited the emergency room in the past year and whether they have a serious health problem that limits the work they can do.

18 Alternative estimation via ordered, probit-produced equivalent results.

19 Given the plethora of models, I present point estimates and standard errors for the main variable of interest (Medicaid). Full models are provided in the Appendix.

20 Since the FFS data contain information on mothers and fathers from the same family, I ran alternative models clustering by family. The nested data structure does not appear to influence the results.

21 This is true whether expanded models are based on original or matched data.

22 I selected covariates for matching that were likely to influence both the treatment and outcomes, while omitting variables that could be affected by the treatment (e.g., health) and thus induce post-treatment bias (Stuart 2010). Matching did not eliminate the imbalance between the treatment and control groups, but it did substantially reduce it.

23 These additional controls account for important and potentially confounding demographic patterns.

24 This includes eligibility expansions to new Medicaid populations or the provision of services that were not covered before (e.g., transportation). So, for example, during this period Illinois expanded eligibility for children and parents, Texas discontinued coverage for medically needy adults, and so on.

25 This includes whether they cut eligibility for certain groups, reduced specific service offerings, or initiated co-pays. During this period, six of the fifteen states included in the analysis reduced the services offered, eight of the fifteen cut eligibility, and seven of the fifteen initiated co-pays.

26 This variable is based on a ranking compiled by a national nonprofit organization (Public Citizen) in a report entitled “Unsettling Scores: A Ranking of State Medicaid Programs.”

27 This is the number of welfare bureaucrats divided by the number of state residents living below the poverty line.

28 Each of these states has at least 130 Medicaid beneficiaries represented in the survey.

29 Scope of services is an exception: this variable sometimes exhibits stronger effects among non-beneficiaries.

30 Most notably, omitted variable bias, a problem that plagues all cross-sectional research based on observational data.

5 PARTICULARISTIC RESISTANCE IN COUNTY CONTEXTS

1 The work of Franklin 2017 is a notable exception.

2 The policy feedback literature generally views interactions with welfare bureaucracies as an independent variable by assessing their impact on voting and other forms of mainstream political action. This is quite distinct from
viewing such help seeking as *a political outcome itself*. Joe Soss is exceptional among feedback scholars in positing the latter view.

3 I draw this terminology from Soss and Weaver 2016.

4 Some states require Medicaid managed care enrollees to first complete the internal managed care organization appeals process before beginning the state fair hearing process.

5 I submitted FOIA requests to states across the country. A few states (like Florida and New York) provided such information quickly and with little fanfare. Other states (like Georgia and Pennsylvania) claimed to have no records relevant to the request. Still other states (like Virginia) acknowledged having the records but would not release them.

6 Because I did not have data on state actions, I calculated appeal rates by dividing the number of appeals (per county-year) by the number of Medicaid beneficiaries (per county-year).

7 Admittedly, it is hard to interpret these rates without knowing the numbers of adverse actions taken against beneficiaries. Perhaps beneficiaries appeal less in Florida because they have less reason to (e.g., there are fewer sanctions). States did not provide me with this information, so it is hard to tell. However, if recent research documenting social policy implementation in Florida is any indication, this is not a likely explanation (Soss et al. 2011).

8 I omit income, a core element of SES, because it is more highly correlated with other variables in the model and would introduce more issues with confounding. (Note that when I include median household income or county poverty levels in the models, education remains significant while these variables generally do not.)

9 This is a rough proxy for detecting race effects because more fine-grained longitudinal county-level data were not available.

10 The lack of equality between the mean and variance suggests that a Poisson model is inappropriate and the likelihood ratio test of alpha confirms that the negative binomial model is the better choice.

11 A Hausman test indicates that fixed effects is a more appropriate choice than random effects in this case.


6 PEOPLE, PLACES, AND SOCIAL POLICY IN THE CITY

1 It is worth noting that there is a long-standing debate over whether people-based policies are a more effective salve for urban woes than place-based policies (Glaeser 2000). I believe that the answer to that must be determined by evidence-based evaluations of specific policy initiatives. To date, evidence suggests that both kinds of policy approaches have some merit. (On this, see Neumark and Simpson 2014.) While this is not a matter I can fully take up here, this chapter does generally speak to the political upshots of debates about people- and place-based policies.
City-level figures on Medicaid populations are hard to come by. I calculated these by using publicly available county-level Medicaid enrollment data for cities in which county and city boundaries largely overlap. The data are from 2010, which is before Medicaid expansions have occurred, so the most recent numbers are likely higher in cities that have benefited from the ACA’s expansion of Medicaid.

I focus on perceptions because I believe they are the main mechanism for shaping attitudes and actions (Michener 2013).

There is no shortage of scholarly disagreement about how best to define the concept of disorder. I agree that there are substantial problems with the idea (see Kubrin 2008). I also realize that notions of disorder are racialized and have been used to advance policies that disproportionately impact people of color. For example, disorder has been used to justify broken windows”, a form of policing that often prompts outsized punitive responses to minor criminal(ized) infractions. One need not accept such policies nor affirm the unsavory purposes for which disorder can be deployed to acknowledge its function in urban life. So, while I take a critical stance toward disorder and its associated racial projects, I nonetheless contend that it captures (however imperfectly) phenomena that are important for properly conceptualizing neighborhoods.

Neighborhood clusters are ecologically meaningful and geographically contiguous aggregations of census tracts that are internally homogeneous across key indicators of race and class.

This index ranges from 0 to 7 with a mean of 1 and a standard deviation of 1.3.

This is measured as a scale of how much of the following respondents observe in their neighborhoods: trash, graffiti, vacant properties, public drinking, public drug use, and incidents of robberies. For simplicity, I converted this continuous scale into a categorical form that indicates whether perceptions of disorder were low, moderate, or high. The category low = perceptions of disorder were at least half a standard deviation below the mean, middle = perceptions within half a standard deviation of the mean, and high = perceptions more than half a standard deviation above the mean.

This is measured as a scale of how respondents rate their neighborhoods according to the following criteria: how close-knit the neighborhood is, whether there are adults in the neighborhood children can look up to, whether people in the neighborhood get along, whether adults in the neighborhood know who children are, whether parents in the neighborhood know their children’s friends, whether neighbors are willing to help each other, whether parents know each other, whether neighbors share the same values, and whether neighbors can be trusted. Again, I converted this continuous scale into a categorical form that indicates whether perceptions of cohesion were low, moderate, or high. The category low means perceptions of cohesion were at least half a standard deviation below the mean, middle means perceptions within half a standard deviation of the mean, and high means perceptions more than half a standard deviation above the mean.
In the case of disorder, the interaction is with the quadratic form of the perceptions variable.

Since Medicaid was a dummy variable (0 = no Medicaid insurance, 1 = Medicaid insurance) and perceptions of disorder was a categorical variable (1 = low, 2 = moderate, 3 = high) (see footnote 8 for details), when the two are interacted, the resulting variable is equal to zero for all non-beneficiaries. Figure 6.2 depicts patterns for interactive scores above zero, so it is limited to beneficiaries, which reflects the phenomenon of interest in this chapter.

7 POLICY ADVOCACY ACROSS A FRAGMENTED POLITY


Excluding the elderly (those over sixty-five who are dually eligible for Medicare).

See Kaiser Family Foundation State Health Facts: http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chipenrollment/?currentTimeframe=0&sortModel=year%7B%22collId%22:%22Total%20Monthly%20Medicaid%20FCHIP%20Enrollment%22,%22sort%22:%22desc%22%7D.

I did not count how many distinct posters there were. However, I looked at the page daily for nearly two years and observed many different posters.

Sadly, Riley passed away unexpectedly at the age of forty-nine in early 2017.

In Gideon v. Wainwright (1963), the U.S. Supreme Court found a right to counsel in criminal cases. This requires that counsel be appointed for indigent defendants in state court facing imprisonment due to felony charges. In Argersinger v. Hamlin (1972), the court again supported the right to counsel in criminal cases. This requires that counsel be appointed for indigent defendants in state court facing imprisonment due to misdemeanor charges. No similar federal rights exist for civil cases.

8 FEDERALISM AND POLITICAL INEQUALITY


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