The Politics of Medicaid and Insurance Coverage Expansion: Voters, Interest Groups, and Policy-Making

The Politics of Medicaid and Insurance Coverage Expansion: Voters, Interest Groups, and Policy-Making

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Abstract

Health insurance coverage and politics are intertwined. This dissertation will examine how voters respond when there are changes to health care policies, why state legislatures and state executives act to address health care workforce shortages, and how interest groups utilize the political system to effectively pass policies.

Chapter 1 evaluates the effect of coverage expansion on voter participation. One of the recognized benefits of increased health coverage is that it leads to improved financial wellbeing for beneficiaries. With improved financial status individuals may be more likely to engage in activities that previously had access barriers. One potential barrier that health insurance may alleviate is the barrier to voting. This paper will address 1) whether improved health insurance coverage and availability of Medicaid creates the observed effects; 2) whether improved voting participation resulted following the expansions of health insurance coverage; and 3) whether there is a threshold at which coverage expansions no longer effect voting behavior. We examine two states, Massachusetts following the 2006 coverage expansions and Florida following the 2014 coverage expansions.

Chapter 2 examines the political conditions necessary for states to act to increase home care worker wages. Home care workers are among the largest and fastest growing segments of low-wage workers. In many states home care workers earn near hourly minimum wage. Medicaid is the primary payer for long-term care services and services provided in the home and community settings by home care workers. Medicaid's large share of the home care market

implies that policy made by a state Medicaid program could have a significant effect on home care worker wages in the private market. In recent years, state legislatures have taken actions to increase the wages for home care workers in the Medicaid. We examined 48 attempted wage increases and 34 successful wage increases from 2013-2018 to determine what political factors increase the likelihood that a state will increase home care worker wages. Union membership in the state, females in the legislature, and more professional legislatures were associated with increases to home care worker wages.

Chapter 3 evaluates the changing role of direct democracy in health policy using Medicaid expansion as a case study. From November 2017 through November 2018 four states voted to expand through ballot initiative and only one voted to expand Medicaid through the legislature. Why have states decided to use this method of policy making, instead of passing the law through the legislature and governor? Setting Medicaid eligibility through direct democracy represents a growing change in how health policy is made in states and how ballot initiatives are used to change health care programs. The four Medicaid expansions are representative of this shift in method of policy making and were a way to overcome legislative obstructions through the traditional policy processes in states. These ballot initiatives passed because Medicaid expansion is popular among voters, interest groups advocating for these changes were well organized and funded, and they utilized local and national organizations to influence voters.

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Chapter One

Health Care on the Ballot: The Role and Limits to Health Insurance Coverage in Voting

1.1 Introduction

The expansions of individual market health insurance and Medicaid coverage have increased the number of people covered by health insurance. One of the recognized benefits of increased health coverage is that it leads to improved financial wellbeing for beneficiaries. With improved financial status individuals may be more likely to engage in activities that previously had access barriers. One potential barrier that health insurance may alleviate is the barrier to voting. This paper will address 1) whether improved health insurance coverage and availability of Medicaid creates the observed effects; 2) whether improved voting participation resulted following the expansions of health insurance coverage; and 3) whether there is a threshold at which coverage expansions no longer effect voting behavior. Using difference-in-differences this research compares voting participation in counties with high insurance gain and similar counties without significant changes to insurance coverage using propensity score matching. We examine two states, Massachusetts following the 2006 coverage expansions and Florida following the 2014 coverage expansions. We show that the expansion of insurance coverage increased voter participation rates by 0.41% for the midterm election and 1.34% for the presidential election in counties with high insurance gains in Florida. In Massachusetts turnout decreased by 0.9% percent in presidential elections. Insurance coverage could have the effect of increasing voter participation when there are moderate or lower levels of voter participation and insurance coverage prior to the expansion of health coverage but not when the state has high levels of voter participation and insurance coverage prior to insurance reform. The political divisiveness of the Affordable Care Act could have had the effect of increasing voter participation.

1.2 Background

In 2006, Massachusetts instituted large-scale health care reforms that increased the number of people that received health insurance coverage. These reforms were extended nationwide in 2014. The reformed system implemented a set of state-based marketplaces to purchase insurance and regulated the private individual and small group insurance markets to allow more people to access these insurance products. Both reforms created an individual requirement to purchase health insurance through the tax code. The reforms expanded affordability through subsidies for people that purchase private insurance and through the expansion of Medicaid for low-income residents. Because of these reforms, nearly 20 million Americans have gained health insurance since 2010. While insurance rates have improved across demographic groups including gender, race, age and income, the people who have primarily benefited from these coverage expansions include people with moderate to low-income and those without a college degree (B. Garrett and Gangopadhyaya 2016). In 2012 the Supreme Court ruled that states could determine whether they would expand Medicaid coverage to legal residents of the state who make under 138 percent of the federal poverty level (approximately $16,600 for an individual in 2017). All but 14 states have taken up the Medicaid expansion as of January 2019, and health insurance coverage rates have improved in states that have elected not to expand Medicaid, although more modestly than states that took up the expansion.

The expansion of Medicaid coverage has been linked to increased voter participation both in observational studies of the Affordable Care Act's coverage expansions and in the randomized trial of the Oregon Health Insurance Experiment (Baicker and Finkelstein 2018; Haselswerdt 2017). The effect appears to be temporary and increases voter participation in the election following the coverage expansion but there is little evidence that the magnitude of the effect persists in future elections (Baicker and Finkelstein 2018; J. Clinton and Sances 2017). Previous

studies have focused on the voter participation in Medicaid expansion states compared to non-expansion states in the 2014 midterm election (J. D. Clinton and Sances 2018). Clinton and Sances look at Medicaid expansion states and non-expansion states and examine counties on the states' border. Aside from statewide elections that may have galvanized more people to the polls, economic conditions and voter makeup are largely similar in these areas. Haselswerdt finds an increase in voter registration and greater voter participation in counties in states that expanded Medicaid coverage. Clinton and Sances look at rates of voter participation in expansion and non-expansion states and find a lower rate of voter drop-off between the 2012 presidential election and the 2014 midterm election in states in states that expanded Medicaid compared to states that did not. Both studies find that the effect of Medicaid expansion on voter participation was minimal in percentage of voters; however, in comparison to other factors that have been shown to increase voter participation these effects are significant.

This paper will build upon the past research to examine whether the increased voter participation is a result of not just increased Medicaid participation but increased health insurance provision. This paper will examine whether the mechanism of providing financial security through health insurance allows more people to participate in voting by comparing different groups of people that gained insurance through coverage expansions. This paper will also examine whether there is a threshold at which increases to health insurance coverage do not have an effect on voter participation. To do this, we will examine the experience in two states, Massachusetts and Florida, to determine whether an expansion of insurance coverage led to an increase in voter participation and whether there are limitations to these effects.

Proposed Mechanism for Voting Effect

The proposed mechanism through which health insurance coverage affects voting is that people experience an increase in financial security when they have health care insurance coverage and this improved financial security allows them to be more able to participate in democracy. We know that health insurance coverage and increased Medicaid coverage give people greater financial security (Cook, Dranove, and Sfekas 2010; Baicker et al. 2013; Dussault, Pinkovskiy, and Zafar 2016). Financial security can lead to greater voter participation for three reasons: financial security can provide 1) people with greater time and resources to vote, 2) improve trust in government institutions, or 3) create an interest group of beneficiaries that vote to defend their financial security interests from cuts or other reductions. Each of these theories will be outlined in this paper. Increases to voter participation may be observed among middle- and higher-income populations as well. Higher income individuals as well as lower income individuals could see greater voter participation because of 1) a community effect, which has been shown to drive increased voter participation; 2) increased voter registration among all income groups, made more possible through the reforms; 3) a defined constituency among higher income earners; and 4) a backlash effect from people who oppose expansions of health insurance coverage and who vote against the policies. Each of these potential alternative hypotheses for the mechanism of increased voter participation will also be analyzed below.

First, when looking at who votes, it is crucial to examine who does not participate in voting. In the 2016 presidential election, approximately 55.7% of eligible voters participated in the election, putting the United States at 26th out of 32 comparable nations. The voter participation rate in 2014 was 36.4% of eligible voters, typical for midterm elections (DeSilver 2018; PBS NewsHour 2014). People with greater financial security or higher income individuals participate in government activities at higher rates than low-income individuals according to

several analyses of survey data (Leighley and Nagler 1992, 2014; Mettler 2018). People with greater education attainment are more likely to vote than people with a high school degree (Verba, Burns, and Schlozman 2003; Burden 2009). Older people are more likely to vote with younger individuals being the least likely to vote (Fry 2018; Campbell 2003). Race and ethnicity is also a factor in voting participation with blacks having the highest rates of turnout in recent elections and Hispanic and Asians having lower rates of turnout (Parlapiano and Pearce 2016). Education, age, and income are among the contributing factors that affect voting behavior, but income is often highly correlated with each age and education. In addition, comparative analysis has shown that countries with more generous welfare benefits are associated with higher rates of voter participation (Hicks and Swank 1992; Fumagalli and Narciso 2012). The United States ranks lower internationally in generosity of welfare benefits, but benefits are heterogeneous between states with some states providing significantly more benefits than others. This indicates that the United States could potentially have heterogeneous voter participation rates as a result of more generous welfare benefits. One of these benefits may include more generous offering of health care coverage through expanded Medicaid eligibility or access to the individual health insurance marketplace.

Financial security could lead to more people voting because people with greater financial security have the time and means to be participate in democracy. People who have greater access to financial resources are able to structure their time differently. Financial security allows people to have the time to learn about the election process and becoming more engaged with local civic opportunities. Rosenstone and Hansen show that education and income allow people to overcome the costs of voting. They show that those with wealth are often more mobilized to vote either because they are able to overcome these costs or are encouraged to vote through efforts by

political actors to mobilize higher-income individuals (Rosenstone and Hansen 2003). There are a number of reasons that increased financial resources have been found to have a direct impact on voting behavior. For example, commuting time has been identified as a leading indicator of why lower income individuals have depressed political participation (Newman, Johnson, and Lown 2014). With greater resources, commuting times are improved with less dependence on public transportation or closer proximity to job opportunities. While health insurance coverage may improve financial security, particularly for those with high health care costs, it is unlikely that this financial security would directly and immediately change commuting behavior. With improved financial security, low-income individuals are also more able to afford the costs associated with voting: travel, time off of work, and the costs associated with registering to vote. Voter registration often requires people to show proof of residency or IDs which lower income individuals are less likely to have (Barreto, Nuño, and Sanchez 2009). Resources are often needed to stay informed about the candidates and ballot measures through time and access to media. Financial security could lead to more stable housing that would allow registration to become seamless. This change resulting from insurance coverage's financial stability would likely happen over time and to a smaller group of people to have a considerable effect on voting behavior.

Another hypothesis is that lower income individuals might have greater trust in government as a result of receiving that government benefit. This greater trust could be a result of reduced stigma, an interest in government because they have directly benefited by a government program, and a feeling that the government has been responsive to their needs. Each of these reasons for increased trust in government will be analyzed. Research on the effect of trust in government and change in political behavior has largely focused on the effect of social

welfare benefits and the benefits available to middle-class Americans, predominately universal benefits. There is some indication that means tested, social welfare programs may have a dampening effect on voter participation (Soss 1999). Reforms resulting from the Affordable Care Act could have had the effect of improving trust in the government. Low-income populations often face administrative complexity and burdens when interacting with the government to receive eligible benefits. That negative interaction could contribute to a sense that the government is not working for them and that their participation in democracy does not matter as much as other people in other income groups. The Affordable Care Act affected the way that people interacted with the Medicaid program in all states regardless of whether they decided to expand Medicaid. The definition of income was standardized across states and states were prohibited from accounting for an individual's assets for income-based categories of Medicaid. The way people applied for coverage was also standardized across health care programs. All applicants for individual market insurance, small group, and income-based categories of Medicaid could apply for coverage through the internet, in libraries, or over the phone, outside of the structure of the welfare system. This meant that Medicaid applicants are less likely to interact with the welfare system and potentially there is less stigma and negative association with applying for the programs. This could mean that a person who applies for Medicaid coverage after these reforms went into effect have a better association with government services than the same person who applied for Medicaid before these reforms were put into effect. The person applying for services more recently may be more likely to vote than the person that may have seen dampened voter participation prior to the reforms. Therefore, the dampening effects on voter participation found in Soss's work may not have been evident for Medicaid beneficiaries and newly enrolled adults in the individual health insurance market.

The experience of higher income people after receiving a government benefit can show whether beneficiaries associate this benefit with a government working for them or have an increased interest in public policy. The more trust a person has in the government, they have a greater likelihood of voting (Mettler 2018). A person's participation in voting and their trust in government is not explicitly related the size of benefits that they receive. Higher income individuals often receive greater financial benefit from government policies; however, they are often hidden benefits in the form of tax reductions. Lower income individuals often receive benefits in the form of more explicit benefits either through cash assistance or housing. Higher income groups are more likely to participate in political activity than lower income groups. Receipt of explicit government benefits may lead to a different understanding of the role of the government. However, survey research shows that there is little difference in views of government between income groups except on views of welfare programs (Parker, Doherty, and Kiley 2016). People that have negative views of welfare programs tend to be middle income. This paper will address the question of whether positive experiences with government programs have the effect of increased participation in voting.

A final hypothesis is that people with improved financial security could be voting to defend this benefit. In order for people to defend a benefit it must be explicit that they are receiving the benefit and that the benefit requires their voter participation to defend (Campbell 2003). It may be true that receiving a welfare or explicit benefit such as Medicaid is to some extent associated with greater satisfaction the program; this does not translate into increased association with government benefits or voter participation among the population receiving the benefit. Surveys have shown that people who have gained coverage through the coverage expansions as part of the Affordable Care Act have been generally satisfied with their

experience, particularly for Medicaid beneficiaries in Medicaid expansion states (M. L. Barnett and Sommers 2017). Evidence has shown that higher income groups will vote to defend their explicit benefits, but it may not hold that lower income individuals are more likely to vote to defend their explicit benefits.

This research will only show if overall voter participation levels rose rather than whether lower income individuals are more likely to vote. Therefore, several hypotheses can explain why voter participation rates will rise, potentially with higher income individuals. People with greater financial resources may be influenced by higher rates of voting participation in their community, known as the community effect. Researchers have found that people that belong to similar communities who have higher voting participation rates are more often to vote among certain racial and ethnic communities (Lien 2004). Increases to voter participation can be explained by these communities growing.

A second reason people with higher incomes may have higher voter participation is that they are more likely to be registered to vote. The gap in income voter participation rates is reduced when measured by those who are registered to vote (DeSilver 2018). Because housing is more variable for low-income voters and voter registration is required to be updated every time a person moves, a low-income voter is more likely to have out-of-date registration that would prohibit them from voting (Phinney 2013).

The final theory that explains why high-income voters may participate in democracy more often is that people are activated to vote based on a backlash to policy that benefits another group. This effect is most often seen when policies are visible as are policies that aide low-income people. For example, there was a backlash to the passage of the Affordable Care Act, due in part to the sense that certain low-income or minority groups were being helped by the policies

in the Affordable Care Act while other higher income groups were taxed or did not benefit (Skocpol and Williamson 2016).

Whether the Affordable Care Act is a redistributive program or universal program is open to debate. The Affordable Care Act has been viewed of by the public in polling as a means tested program because lower income individuals primarily benefited from the subsidies and Medicaid expansions that made health care more affordable. The Affordable Care Act's tax subsidies were paid for in part by increases in taxes health care industries and high-income earners making the law a redistributive program. At the same time, other policies such as the insurance protections, particularly the requirement to cover people with pre-existing conditions, can be seen as universal since they benefit all income groups. Similarly, more recent polling has indicated that the policies protecting pre-existing conditions are the most salient policies of the law. Polling data has indicated that lower income Americans are the most likely to say that the policies of the Affordable Care Act have benefited them, indicating that the law has a more redistributive welfare benefit (Chattopadhyay 2018). The partisan nature of the Affordable Care Act indicates that people view the law through their political affiliation rather than their income class. The polarized nature of the program may indicate that it is a universal policy, however parties have differing views on income and these views may indicate that the public views the Affordable Care Act as redistributive (Chattopadhyay 2018). If the Affordable Care Act's coverage expansions are viewed as redistributive the backlash effect may be driving increased turnout.

Voter registration

Prior research has shown that there is an effect of Medicaid expansion coverage on increased voter participation. This effect is seen in the 2014 midterm elections immediately following the expansion of coverage (Haselswerdt 2017; J. D. Clinton and Sances 2018). In

addition to political participation the authors find an increase in voter registrations and is suggested as a likely cause for the increase in voter participation (J. D. Clinton and Sances 2018). Medicaid expansion and the 2014 coverage expansions may be a cause of increased voter registration because the National Voter Registration Act of 1993 or the Motor Voter Law. This law requires that states and the federal government include voter registration options on applications for government services including Medicaid and coverage provided through state run insurance marketplaces (Arit 2014). The option to fill out a voter registration form is made more available because of the coverage expansion. The availability this option does not mean that it is the only cause of more people registering to vote. For example, a health insurance bill could be used as proof of residency or a person may remain in the same place of residency, both factors would increase registration unrelated to the increase in opportunities to register to vote.

The requirement to have the option to register to vote at the time of application aides the theory that there is a threshold that people overcome with health insurance coverage. People that are more likely to vote as a result of coverage expansion may have already been over a certain threshold potential to become voters. They may have already surpassed a certain income or resource level that would have prevented them from voting. The addition of voter registration could make these people active voters. People who have not yet met that resource threshold or have not met other barriers to becoming active voters may not be affected by the addition of health insurance coverage and would remain inactive voters.

This research will not focus on who votes or how policies are affected by who votes. Voter participation has an impact on policies that states enact. However, this research will focus on whether overall voter participation rates change as a result of the coverage expansions, not on who votes, how individuals vote, or the results of the change in voter participation and behavior.

1.3 State selection

In order to analyze to what extent increased health insurance coverage plays a role in the proportion of people that vote in an area this research will look at changes within a state. The research will examine both the increased take up of existing Medicaid eligible benefits and the increase in private insurance coverage. Internal state analysis allows a better comparison of statewide office elections because voter participation may be different between states on account of statewide races. Internal state analysis also accounts for any changes to voting laws such as restrictions on identification or policies on voter registration. One assumption is that voting laws are relatively uniformly implemented across the state. Local officials and counties may implement state policies differently. For example, poll locations or availability of registration forms may vary. Statewide election laws such as deadlines for registration, poll hours, and availability of second language voter information should be uniform across a state. Coverage expansion policies are also uniform across the state, but the number of people who gain coverage is likely to be heterogeneous. Reasons for this heterogeneity are that uninsurance rates prior to the coverage expansions varied across the state and who gained insurance will vary. A state with variance in insurance gains within the state and heterogeneity in voting participation is ideal for determining whether an increase in voting participation is caused by an increase in insurance uptake.

Florida represents a useful case study as a state at the national average in voter participation rates and significant but heterogeneous increases in insurance coverage. Unlike other studies, looking at Florida allows us to examine the effect of increased insurance coverage more broadly than focusing on Medicaid expansion coverage. Florida is a state that has not expanded Medicaid coverage through the Affordable Care Act, but many counties in Florida

have seen large increases in insurance coverage through either increased Medicaid participation among the previously eligible or increased private insurance participation. At the same time, other counties in Florida (particularly with high portions of the population over age 65 and currently enrolled in Medicare and unaffected by the Affordable Care Act's coverage expansions) have seen little increase in insurance coverage. Similarly, people over the age of 65 vote in consistently higher rates. Because these people live in similar counties they serve as a control for the treatment effect of increased health insurance coverage in counties where younger, often minority populations live. Florida is representative of the broader country in terms of voter participation and ranks near the national average.

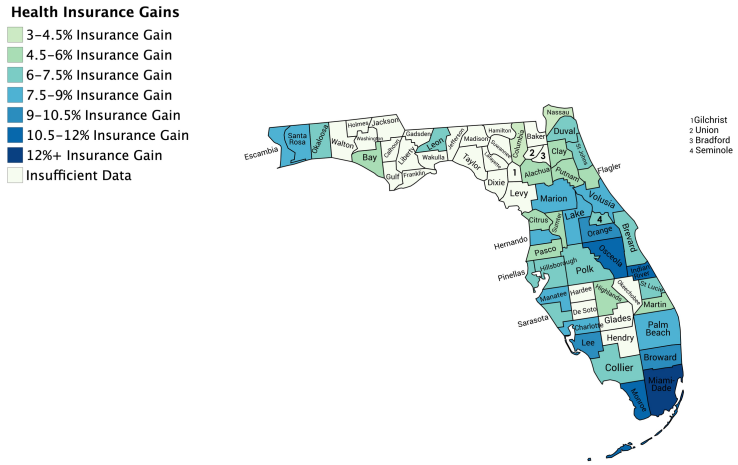


Figure 1.1 Health Insurance Gains in Florida

Florida had a high rate of uninsurance prior to the coverage expansions and had insurance gains that mirrored national averages. Following the 2014 coverage expansions, Florida uninsurance rates decreased without Medicaid expansion for three primary reasons. First, people who were previously excluded from the individual health insurance market, either because of a pre-existing condition or the high cost of coverage, were able to purchase coverage at affordable rates. Second, people who were previously eligible for Medicaid but unenrolled signed up for Medicaid, known as the welcome mat effect (Hudson and Moriya 2017). Finally, people that were previously eligible to purchase private coverage took up insurance because of the

individual mandate made insurance coverage a requirement, the marketplace made purchasing easier to compare comprehensive plans, and federal subsidies made this coverage more affordable. In Medicaid expansion states, insurance gains were higher because low-income people were eligible for coverage at low cost through Medicaid.

The second main objective of this study is to understand whether there is a ceiling or limit in the extent that health insurance coverage could have an effect on voter participation. To determine whether the effect exists in states with high levels of insurance coverage and higher voter participation states, Massachusetts was selected as a comparison. Higher voter participation may mean that the people gaining health insurance may already be regular voters or may have other barriers to insurance such as income. Additionally, Massachusetts had a high rate of insurance coverage prior to the reforms of 2006. In Massachusetts, the uninsurance rate for fell from approximately 8% in 2006 to 3% in 2008, a 5% decrease (Chin et al. 2016). Florida had an uninsurance rate of 20% in 2010 and that rate fell to 12.5% in 2016 for a 7.5% decrease (J. Barnett and Berchick 2017). While the proportion of people who gained insurance is within a few percentage points, this research will examine whether there is an uninsurance level that is a threshold or point that having additional people insured no longer makes a significant difference in voting behavior.

Massachusetts's 2006 health reforms were the first in the nation and the Affordable Care Act's coverage expansions were based on these reforms. The reforms included the expansion of Medicaid and allowed individuals who were higher income to purchase health insurance plans on a marketplace with financial assistance. The health insurance reforms resulted in a decrease in the uninsurance rates and have been associated with improved financial health among those who benefited (Long, Stockley, and Dahlen 2012; Mazumder and Miller 2016).

The 2006 health reforms in Massachusetts and the 2014 national coverage expansions provide two natural experiments to more closely examine whether the policies of expanding health insurance coverage have an effect on voting behavior. Massachusetts enacted their reforms with the support of the legislature, governor, and general public. There was no significant opposition to the reforms from industry groups. The state had an interest in ensuring that the reforms were successful for three reasons: first, the model was being discussed as a possible option to pursue on the national level; second, the state had previous health reform attempts that had been repealed following a less successful rollout; and third, the state wanted to prevent any potential backlash for other legislative agendas.

The political will of politicians in Massachusetts runs contrary to the 2014 reforms in Florida. The Affordable Care Act was passed in 2010. At the time, Rick Scott was a conservative activist running advertisements against the passage of the law and would later use that political experience to run for governor of Florida in 2010. As governor, Scott rejected any federal funding through the Affordable Care Act and participated in a lawsuit that would make the Medicaid expansion optional for states (Sack 2011; State of Florida v. United States Department of Health and Human Sevices 2010). Aside from a short period in 2014 and 2015 where Governor Scott considered support of the Medicaid expansion, he publicly opposed the expansion of Medicaid and neither he nor the

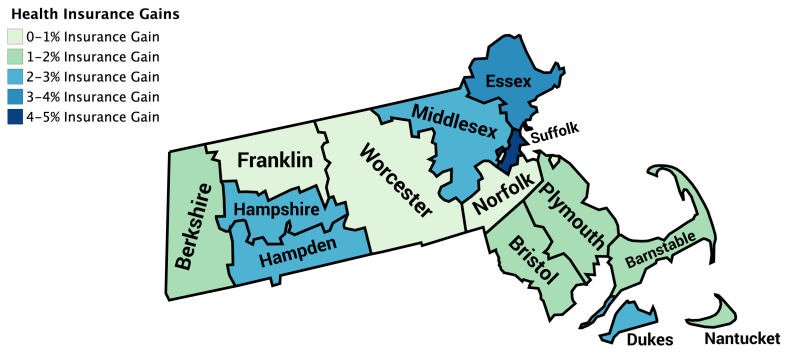


Figure 1.2: Health Insurance Gains in Massachusetts

legislature acted to promote participation in the health care reforms. The state did not participate in the Medicaid expansion and decided to use the federal health insurance marketplace rather than build a state-based health insurance marketplace. Florida passed a law that prohibited people to be compelled to purchase insurance and asked voters to weigh in on a constitutional amendment opposed to the Affordable Care Act (Wing 2012). Despite the political opposition to the coverage expansion, Florida saw an increase in health insurance coverage following the expansion through both the private insurance market and the existing Medicaid program. Over the same period the economy improved, contributing to the decrease in uninsurance.

One hypothesis is that local leaders may be actively working to increase voter participation and improve the experience that local beneficiaries have with the government to improve voter participation. Florida represents a good example of a state that actively prevented state and local leaders from encouraging civic participation. Because the state was politically opposed to the health insurance reforms we would expect to see a lower level of health insurance coverage as compared to states that took advantage of all federal opportunities. Trust in the state government may increase voter participation and when government leaders help people receive government benefits they may build this trust. Under those conditions we would expect to see depressed voter participation in Florida as compared to other comparable states that took a more active role to increase health coverage. It is possible that local non-profits and community organizations worked to increase participation in the health reforms and trust in these non-governmental organizations increase civic participation. It is also possible that people gained a greater amount of trust in the federal government as a result of the federal tax credits and reforms. However, in the case of Florida, state policy makers and government leaders did not try

to increase enrollment so there is no direct link between increased coverage and increased trust in state government.

Massachusetts and Florida have similar laws on how people register to vote with a few exceptions. Both states require people to register either in person or online prior to election day, both states do not have same day or automatic voter registration, and both states have similar restrictions on absentee ballots over the period that is analyzed. Since Massachusetts has a state-run marketplace, the option to register to vote was given when people purchased insurance. In Florida, the state does not allow felons to vote while in Massachusetts voting rights are restored after a person leaves prison but people in prison do not have the ability to vote. Florida's felon voter laws have been enforced in a manner that has led to approximately one in ten black men unable to vote in the state (Sentencing Project 2016). In total approximately 1.6 million Floridians could not register to vote because of this policy. No significant changes were made to the policy over the time period analyzed.

1.4 Methods

The natural experiment of the coverage expansions of 2006 and 2014 present an opportunity to study the change in voter behavior following the expansions of coverage. For Florida a quasi-experimental design will compare counties that experienced high rates of insurance coverage gains against counties that received less high insurance coverage gains, both within Florida. A quasi-experimental design will also compare counties in Massachusetts that experienced the reforms against counties outside of the state that did not undergo the reforms. The period that will be examined in Florida is 2010-2016 with the 2010-2012 elections for pre-reform period and the 2014 and 2016 elections for the post reform period. For Massachusetts compared to counties outside of Massachusetts, the period analyzed will be 2000-2012 with

2000-2005 being the pre-reform period and 2007-2012 being the post reform period and 2005-2006 being a transition period.

Data Sources

Income level and insurance rate is measured using total insurance rates using the American Community Survey (ACS) Small Area Health Insurance Estimates (SAHIE). Data on demographics of the uninsured prior to 2009 was taken using the *IPUMS-CPS* (Flood et al. 2018). Population estimates to derive eligible voters and to estimate the total population over 65 and under 18 were based on estimates from the U.S. Census Bureau- Population Estimates. The Department of Commerce-Bureau of Economic Analysis "NAICS- Employment in all Industries" was used to determine the employment rate.

Presidential and statewide election total ballots by county were collected from the *CQ Voting and Elections Collection.* In 2010 and 2014 Florida held gubernatorial races which were used to determined voter turnout. The measure of county can encapsulate multiple Congressional Districts therefore the governor's race was used instead of federal office. Voting Participation was determined using the total number of people participating in the highest statewide election divided by the total number of people over the age of 18 in the county. Non-citizens and former felons may be unable to vote but would be counted in the individuals over the age of 18 by the Census. This method accounts for both the number of voters and the change in voter registrations.

The assumption of parallel trends is observed by examining voter participation in the previous two elections in control and treatment counties. To check the balance of the unmatched counties we examine the local common support. We see that prior to the propensity score matching we have significant imbalance between the control and treatment counties. This

imbalance is further illustrated in Figures 1.3 through 1.6. This plot shows that the control counties and the treatment counties are imbalanced. The balance of income, unemployment, uninsurance, and age in the control counties is significantly less than those factors in the treatment counties. To resolve the imbalance, counties are matched, checking the balance using the imbalance function. Unmatched, the L1 score is at 1, indicating imbalance. After matching, based on propensity scores, an L1 score of 0.166 for Massachusetts and 0.175 for Florida is shown, indicating greater balance. Propensity score matching was done using average income, education levels, mean age and proportion of the population over the age of 65, unemployment levels, and insurance coverage prior to expansion.

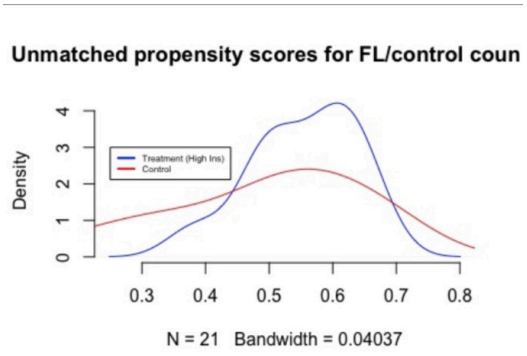


Figure 1.3: Unbalanced Propensity Scores Florida

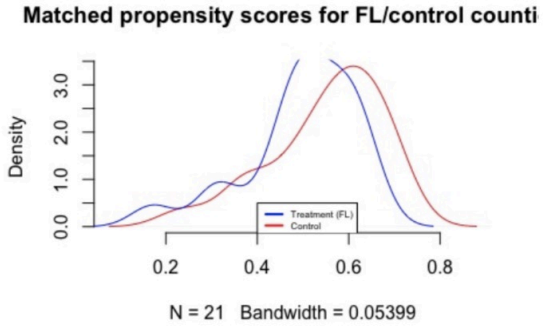


Figure 1.4: Balanced Propensity Scores Florida

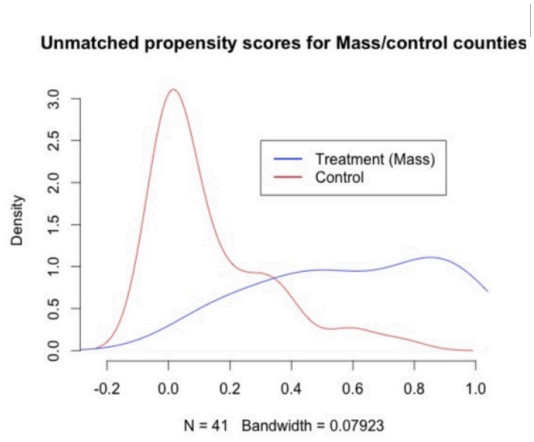


Figure 1.5: Unbalanced Propensity Scores Mass.

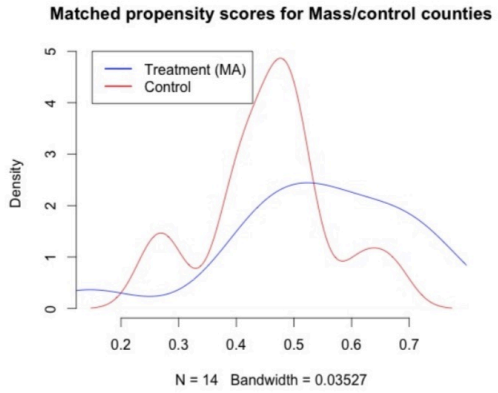


Figure 1.6: Balanced Propensity Scores Mass

Because there are both limited numbers of counties and matched control counties as well as a limited number of elections to show an impact, the counties are bootstrapped to extend the results and find standard errors. Using difference-in-difference with propensity score matching we will compare counties with high rates of those newly insured in the proceeding midterm and presidential elections against counties in Florida with lower rates of newly insured in the midterm and presidential election following the reform. The treatment group for Florida will be the counties that saw an increase in insurance coverage from 2010 to 2015 over the statewide average. In Florida the state saw an insurance increase of 7.35% over this period with counties ranging from 3.5% increase to 15% increase.

Table 1.1 Demographic Distributions Florida, uninsured and insured

	FL Treatment Counties	Control Counties	t
Distribution of Counties			
2010 Income	$44,086	$45,686	0.72
2016 Income	$51,038	$52,224	0.41
Median Age	44.7%	45.2%	0.19
Unemployment % in 2016	5.88%	6.32%	0.63
College % in 2016	17.14%	17.18%	0.03
Percent below poverty in 2016	13.92%	13.84%	-.0.07
Insurance Rate in 2010	78.70%	83.71%	4.71**
Insurance Rate in 2016	87.66%	89.29%	1.89
Uninsurance Rate Change 2010-2016	8.95%	5.59%	-7.24**
Means pre-insurance reform			
Vote Share 2010	38.68%	44.33%	3.24**
Vote Share in 2012	57.68%	63.58%	3.29**
Means post-insurance reform			
Vote Share in 2014	40.10%	45.37%	2.95**
Vote Share in 2016	58.60%	63.31%	2.98**

Table 1.2 Demographic Distributions Massachusetts, uninsured and insured

	MA Counties	Control Counties	t
Distribution of Counties			
2006 Income	$56,423	$54,824	-0.58
2008 Income	$61,660	$58,964	-0.80
Percent of Pop. +65	13.95%	14.47%	0.49
Uninsurance Rate in 2006	11.95%	19.93%	5.82
Uninsurance Rate in 2007	10.13%	19.68%	7.08
Unemployment % in 2006	6.44%	6.27%	-0.35
Means pre-insurance reform			
Vote Share 2000	54.57%	45.39%	-4.87
Vote Share in 2004	62.07%	63.07%	0.35
Means post-insurance reform			
Vote Share in 2008	63.79%	62.27%	-0.59
Vote Share in 2012	63.71%	59.20%	-1.85

1.5 Results

Florida

In 2013, Florida had an uninsurance rate of 22% for non-elderly adults that mirrored the national average of 20% prior to the expansion of health insurance coverage in 2014. In 2016 the uninsurance rate among the non-elderly nationally fell to 10.3% while it remained at approximately 14.6% in Florida, a 7.7% decrease in the state compared to a 10% decrease nationwide. Florida voting rates mirror national averages with 62.8% of eligible voters voting in 2012 compared to a national average of 58.6%. The state has a larger share of people over the age of 65 and Latin Americans than the national average. Approximately 20% of the state's population was over 65 in 2017 and one in four residents were Hispanic compared to 15% over 65 and 18% Hispanic nationally. The state is geographically diverse with large urban centers in Miami, Orlando, Jacksonville, and Tampa with large suburban cities and some more rural areas near the Alabama and Georgia borders. The economic conditions and education levels of Florida citizens match national averages. In 2016 the median income in the state was $51,145,

approximately 14% of Floridians were living in poverty and 29% of Floridians held a college degree compared to a median income of $57,600, 12.7% living in poverty, and 33.4% holding a college degree nationally.

Overall, Florida saw an unmatched treatment effect in midterm voting from 2010 to 2014 of 0.38% in counties with above average insurance increases compared to counties with below average. From 2012 to 2016 counties with greater insurance increases saw a 1.19% increase in voter participation in presidential elections. Counties that had greater gains in insurance had lower levels of voter participation prior to the expansion of health insurance coverage. This corresponds to the fact that areas of Florida are home to higher levels of retired individuals who are also more likely to be insured and have higher voter participation and counties with lower income individuals who are more likely to be uninsured and less likely to vote. Counties with the latter group saw greater voter participation gains in both the midterm and presidential elections.

Using propensity score matching we are able to match control and treatment counties based on demographic characteristics (average income, median age, the unemployment rate, percent of population with a college degree, uninsured in 2010) and found that the midterm elections saw a treatment effect of 0.41% and the presidential election saw a matched treatment effect of 1.34% increase in voter participation. Because there are only 20 treatment and control counties in the study these results are bootstrapped with replacement to determine the confidence intervals. These results are statistically significant at the 0.05 level.

Table 1.3: Unmatched treatment effect of increased health insurance coverage on voter participation in Florida Midterms

State	Participation Pre-reform	Post-reform	Difference
Florida High Insurance	38.68248	40.10726	1.424776
Control Counties	44.32818	45.36891	1.040733
Effect			0.384043

Table 1.4: Unmatched treatment effect of increased health insurance coverage on voter participation in Florida Presidential

State	Participation Pre-reform	Post-reform	Difference
Florida High Insurance	57.68081	58.60004	0.9192326
Control Counties	63.57971	63.30699	-0.2727242
Effect			1.191957

Table 1.5: Matched treatment effect of increased health insurance coverage on voter participation in Florida Midterms

State	Participation Pre-reform	Post-reform	Difference
Florida Treat	38.04	39.49	1.45
Control Counties	44.33	45.37	1.04
Effect			0.41

Table 1.6: Unmatched treatment effect of increased health insurance coverage on voter participation in Florida Presidential

State	Participation Pre-reform	Post-reform	Difference
Florida Treat	56.95488	58.02909	1.074211
Control Counties	63.57971	63.30699	-0.2727242
Effect			1.346935

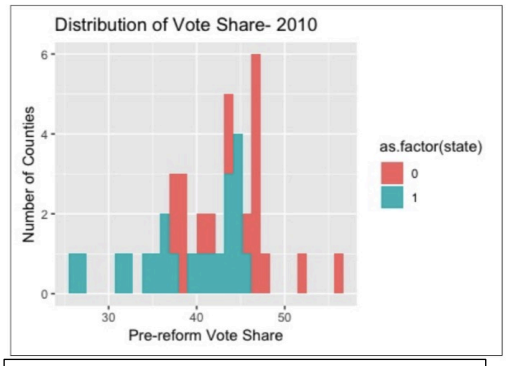


Figure 1.7: Unmatched Midterm Florida

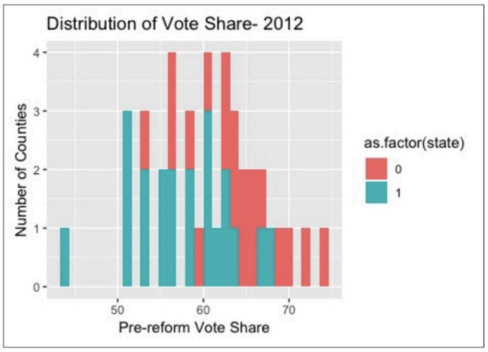


Figure 1.8: Unmatched Pres. Florida

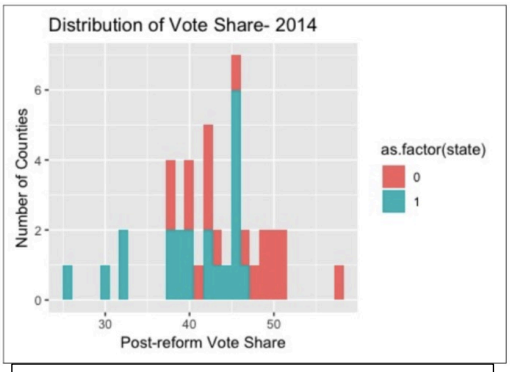


Figure 1.9: Unmatched Midterm Florida

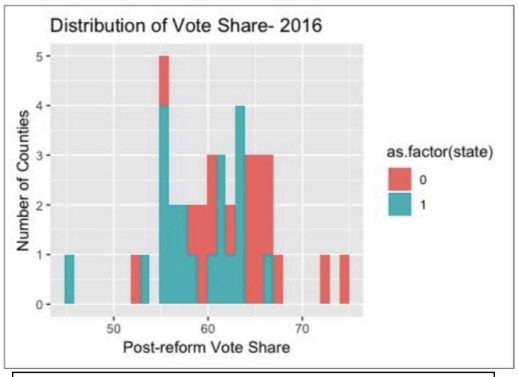


Figure 1.9: Unmatched Pres. Florida

Using propensity score matching we are able to match control and treatment counties based on demographic characteristics (average income, median age, the unemployment rate, percent of population with a college degree, uninsured in 2010) and found that the midterm elections saw a treatment effect of 0.41% and the presidential election saw a matched treatment effect of 1.34% increase in voter participation. Because there are only 20 treatment and control counties in the study these results are bootstrapped with replacement to determine the confidence intervals. These results are statistically significant at the 0.05 level.

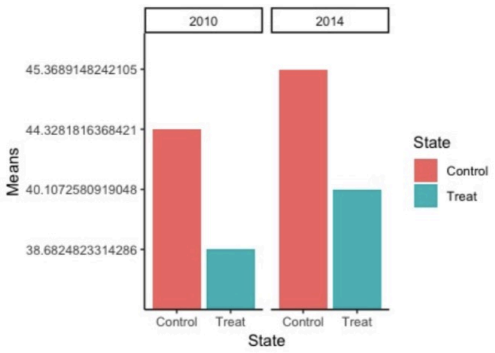


Figure 1.10: Unmatched Results Midterms

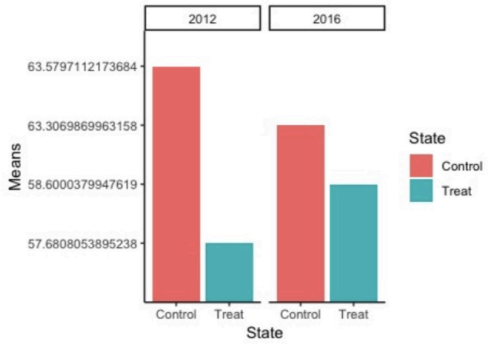


Figure 1.11: Unmatched Results Presidential

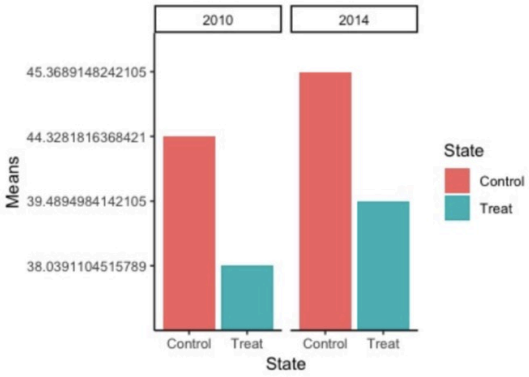


Figure 1.12: Matched Results Midterms

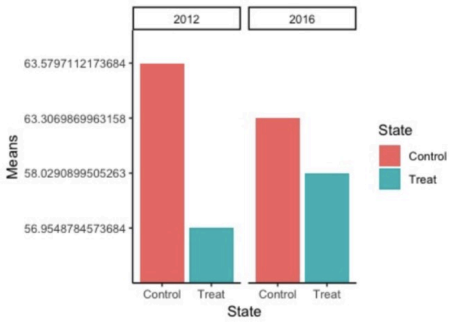


Figure 1.13: Matched Results Midterms

Florida saw an increase in voter participation following the increase in health insurance coverage in counties that saw higher rates of insurance coverage gain. Counties have been matched on factors that could influence the voter participation outside of the increase in insurance coverage in the area. Improved income could be a factor in increasing voter participation however since the counties were matched on income a growth in income should not be a factor. Florida saw a greater change in the presidential election turnout due to the change in insurance status than in the midterm election. This might be because greater portions of non-regular voters turn out to Presidential elections than midterm elections. Additionally, the effect of insurance coverage could be more significant two years after the expansion of coverage. The lag may be because the uninsurance rates continued to decline in the 18-month period following

the coverage expansions and it may take time for the financial effect of health insurance coverage to be felt by families.

Table 1.7: Bootstrapped results Florida Midterm

State	Mean Difference Pre-Post reform	S.E.	95% Conf Int
Treatment	1.379674	0.5621258	(0.04132745, 2.218314)
Control Counties	1.185702	0.5837178	(0.09909402, 2.233648)
Effect	0.1939721		

Table 1.8: Bootstrapped results Florida Presidential

State	Mean Difference Pre-Post reform	S.E.	95% Conf Int
Treatment Counties	0.9777895	0.2988344	(0.4183074 , 0.9916337
Control Counties	-0.379904	0.513575	(-1.186402, 0.4030674)
Effect	1.357693		

Massachusetts

Massachusetts has a higher percentage of people that are insured compared to the national average. In 2004 prior to the 2006 reforms, 11.7% of the non-elderly population was uninsured. In 2008, 5.7% of the non-elderly adult population was uninsured, meaning 6% of the population gained coverage over that period. Massachusetts has a higher rate of voter participation than the national average. In 2012 65.9% of Massachusetts eligible residents voted compared to the national average of 58.6%. There were approximately 6.8 million people living in Massachusetts in 2017. Massachusetts is whiter than national averages with 72.2% of the Massachusetts population identifying as white, non-Hispanic compared to the national average of 60.7% identifying as white non-Hispanic in 2017. Massachusetts has an urban center in the Boston metropolitan area and rural areas in Cape Cod and Western Massachusetts while the broader Boston area is suburban. Massachusetts is relatively wealthier and more educated than the national average. In 2017 the average income for a Massachusetts resident was $70,954, 10.5% of residents were living in poverty and 41.2% of the population had completed a college

degree compared to a national annual income of $55,322, 12.3% living in poverty and 30.3% of the population holding a college degree.

Over the time period analyzed, Massachusetts saw an increase in voter participation. In Massachusetts we saw an unmatched treatment effect in the 2006 and 2010 midterm elections of negative 0.03. Once we have matched counties based on propensity score matching we see that there is a treatment effect of -0.0173, meaning that Massachusetts saw a voter participation rate decrease of nearly two percent following the expansion of health insurance coverage in the state. However, due to the small sample size, these results were bootstrapped with replacement. Following the propensity score matching and bootstrapping the results indicate a treatment effect of negative 0.009. That would indicate that Massachusetts saw a voter participation rate decrease of nearly one percent following the expansion of health insurance coverage in the state. These results are statistically significant at the 0.05 level.

Table 1.9: Unmatched treatment effect of increased health coverage, Massachusetts

State	Participation Pre-reform	Post-reform	Difference
Massachusetts	0.6032	0.6375	0.0342
Control Counties	0.5423	0.6073	0.065
Effect			-0.0308

Table 1.10: Matched treatment effect of increased health coverage, Massachusetts

State	Participation Pre-reform	Post-reform	Difference
Massachusetts	0.6032	0.6375	0.0342
Control Counties	0.5460	0.5975	0.0515
Effect			-0.0173

Table 1.11 Bootstrapped Results, Massachusetts

State	Mean Difference Pre-Post reform	S.E.	95% Conf Int
Massachusetts	0.0351	0.0037	(0.0290, 0.0429)
Control Counties	0.0440	0.0107	(0.0251, 0.0608)
Effect	-0.0090		

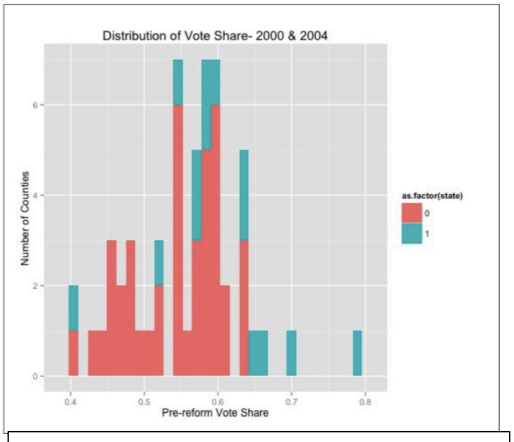


Figure 1.14: Unmatched Results, Before

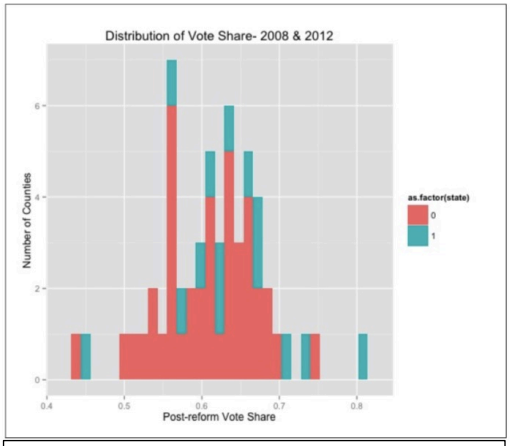


Figure 1.15: Unmatched Results, After

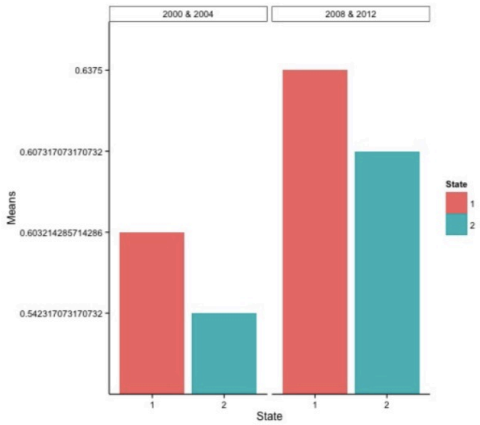


Figure 1.16: Unmatched Results, Mass (Red) Treatment (Blue)

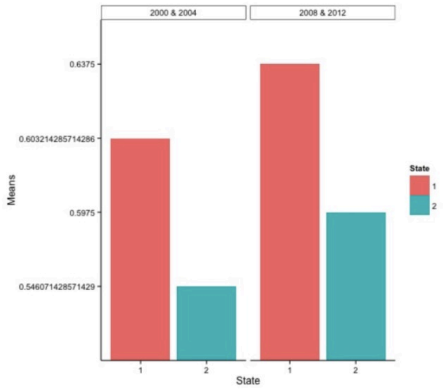


Figure 1.17: Matched Results, Mass (Red) Treatment (Blue)

One reason that we may not see a positive treatment effect of insurance expansion in Massachusetts is that Massachusetts had a higher than average rate of both insurance and voter participation prior to the reforms in 2006. While the 2006 reforms reduce the rates of the uninsured, the changes affected a smaller proportion of the population than in states with a higher uninsurance level prior to the reforms. The reforms in Massachusetts primarily helped

people living below the poverty line, people living in poverty, people with less than a high school diploma, and people aged 18-24. People who were over the age of 35 and non-Hispanic whites made up a larger portion of the uninsured after the reforms.

Comparison of Uninsured and Insured in Florida and Massachusetts Before and After Reform

The average income, education, and health status of the uninsured before the health reforms in Massachusetts and Florida looked different from one another. There are more uninsured people that fall below the poverty level and twice the poverty level in Florida than in Massachusetts. This is likely because Massachusetts has more insurance programs that benefit low-income people and had a higher Medicaid income eligibility for low-income parents. The uninsured population in Massachusetts has a higher level of education on average before and after reforms than in Florida. The high school graduation rate is higher in Massachusetts and the education system ranks highly. More people in Florida report having a disability and are uninsured than in Massachusetts, but a greater portion of the uninsured in Massachusetts are disabled. There are a portion of the disabled population who is unable to qualify for benefits in both states, but with more uninsured, they make up a smaller portion of the uninsured in Florida.

Table 1.12: Demographics in the Change in Uninsured, Massachusetts and Florida

	Uninsured Massachusetts 2005	Massachusetts 2005	Uninsured Massachusetts 2008	Massachusetts 2008	Net Change Uninsured Massachusetts	Uninsured Florida 2013	Florida 2013	Uninsured Florida 2016	Florida 2016	Net Change Uninsured Florida
Total Population	545,000	*6,328,000*	319,000	*6,421,000*	-319000	3,835,202	*18,778,532*	3,211,340	*19,621,207*	-1466537
Sex (Percent Female)	44.60%	*51.50%*	29.40%	*51.50%*	-15.20%	47.10%	*51.60%*	46.90%	*51.60%*	-0.20%
Income										
Percent of People Living Under the Federal Poverty Level	31.00%	*15.00%*	14%	10%	-12.00%	27.30%	*16.30%*	27.50%	*18.10%*	-1.60%
Percent of People Living between 100 and 200 percent of the Federal Poverty Level	27.00%	*14.00%*	21.00%	12.30%	-4.30%	31.80%	*21.30%*	30.70%	*21.20%*	-1.00%
Moved within the last year	25.60%	*12.10%*	12.10%	*7.90%*	-9.30%	22.40%	*15.70%*	21.10%	*15.60%*	-1.20%
Percent Living with a Disability	16.40%	*13.60%*	18.20%	*11.40%*	4.00%	7.00%	*12.90%*	7.30%	*13.30%*	-0.10%
Race										
American Indian or Alaska Native	0.40%	*0.20%*	0.40%	0.20%	0.00%	0.50%	*0.30%*	0.40%	*0.30%*	-0.10%
Asian	7.00%	*5.40%*	5.00%	4.80%	-1.40%	2.80%	*2.50%*	2.70%	*2.60%*	-0.20%
Black or African American	10.10%	*6.70%*	8.00%	6.10%	-1.50%	19.20%	*15.70%*	19.10%	*15.90%*	-0.30%
Hispanic or Latino	19.00%	*9.00%*	18.00%	8.30%	-0.30%	36.80%	*23.00%*	37.50%	*24.20%*	-0.50%
White	82.30%	86.80%	64.00%	82.70%	-14.20%	70.30%	*76.50%*	70.60%	*76.10%*	0.70%
Two or More Races	0%	*0.70%*	5.00%	1.90%	3.80%	2.10%	*2.30%*	2.30%	*2.50%*	0.00%
Percent White Non Hispanic	59.00%	*78.00%*	72.40%	78.90%	12.50%	40.20%	*57.30%*	39.50%	*55.70%*	0.90%
Foreign Born	27.10%	*14.40%*	26.90%	*14.40%*	-0.20%	36.10%	*19.50%*	36.60%	*20.10%*	-0.10%
Education										
Less than a High School Graduate	18.70%	*12.00%*	10.80%	*11.30%*	-7.20%	21.70%	*13.60%*	21.40%	*12.50%*	0.80%
High School Graduate	32.30%	*27.40%*	36.10%	*26.70%*	4.50%	36.50%	*29.70%*	36.70%	*29.00%*	0.90%
Some College or Associates Degree	20.20%	*23.70%*	17.30%	*24.00%*	-3.20%	28.10%	*30.10%*	28.10%	*30.20%*	-0.10%
Bachelors Degree or Higher	18.80%	*36.90%*	22.30%	*38.10%*	2.30%	13.70%	*26.70%*	13.90%	*28.20%*	-1.30%
Age										
Under 18 Years	11.70%	*23.50%*	9.60%	*22.70%*	-1.30%	12.80%	*21.30%*	11.30%	*20.70%*	-0.90%
18 to 24 Years	23.90%	*9.30%*	20.50%	*10.30%*	-4.40%	16.00%	*9.10%*	14.60%	*8.80%*	-1.10%
25 to 34 Years	27.60%	*13.40%*	22.90%	*12.60%*	-3.90%	21.60%	*12.10%*	22.60%	*12.50%*	0.60%
35 to 44 Years	14.70%	*16.00%*	19.30%	*14.70%*	5.90%	18.50%	*12.60%*	18.50%	*12.10%*	0.50%
45 to 54 Years	12.50%	*15.60%*	15.90%	*15.40%*	3.60%	18.00%	*14.40%*	18.40%	*13.80%*	1.00%
55 to 64 Years	8.30%	*11.40%*	10.10%	*11.50%*	1.70%	11.80%	*12.70%*	13.00%	*13.10%*	0.80%
65 Years or Older	0.10%	*10.80%*	1.80%	*13.80%*	-1.30%	1.30%	*17.80%*	1.60%	*19.00%*	-0.90%
10%+ Decrease	4-10% Decrease	4-10% Increase	10%+ Increase							

After the reforms, the uninsured populations of Massachusetts and Florida still look very different from one another. In Florida, the remaining uninsured are much more likely to be low-income, foreign born, and less well educated than the uninsured in Massachusetts. The reductions in uninsurance in Florida had equal effects across education, race, income and gender. The reductions in uninsurance in Massachusetts primarily benefitted the low-income, women, people under the age of 24, and those with less than a high school degree. The uninsured population in Florida remains larger and has a lower average income with many of the uninsured

having incomes below the poverty line. This also indicates that many of the remaining uninsured in Florida may be eligible for Medicaid expansion.

The difference between the uninsured populations before reform indicate that there are a greater portion of people living near the threshold to become voters in Florida than there are in Massachusetts prior to reform. The reforms in Massachusetts primarily helped lower income, less educated, and younger individuals, while the reforms in Florida benefited all demographics. People that were benefited by the reforms in Massachusetts fall into categories that are less likely to vote. As hypothesized, having insurance coverage may not be enough to overcome certain barriers that prevent a person from voting. However, people that have already overcome certain economic and bureaucratic limitations on becoming voters may become voters with the addition of health insurance coverage. In Florida, a greater portion of the population that was uninsured had met the economic and registration condition to become potential voters and the addition of health insurance coverage makes them more likely to vote. In Massachusetts the uninsured population may have been well below the threshold to become potential voters and the addition of health insurance could not raise them over the threshold.

The fact that we see a negative effect of health insurance on voter participation could be because the people who gained coverage in Massachusetts were under the threshold of becoming potential voters. The addition of health coverage did not make them significantly more likely to vote. Health insurance coverage has a limited effect on voter participation because access to health care and the financial protection of insurance cannot overcome the effects of poverty. A sense that the government is more responsive to a person's needs, a greater interest in the policies that affect their lives, and a reduction in the negative stigma may increase voting behavior, but the negative effects of mobility, available time and information, and resources to

vote may be more significant. Florida sees a positive effect of voter participation following the expansion of coverage. This may be because there was a greater portion of potential voters who had overcame the threshold to become a voter and have gained health insurance.

1.6 Limitations

Financial security may not be the mechanism of higher voter participation because health insurance has been changing to rely on higher cost sharing accruing to individuals. As a result, private insurance coverage may provide less financial security over the period analyzed. Factors at the local level in Florida could have influenced the insurance rates. Florida changed the design of the Medicaid program in 2014 to expand an existing managed care demonstration waiver statewide. This change could have influenced the number of people who gained insurance coverage. An assumption is made that the number of people who are ineligible to vote based on felony or immigration status remains consistent. It is possible that there is some heterogeneity in counties over time due to either a change in immigration patterns or voting laws, although there is no evidence that immigration patterns or the residence of former felons significantly changed over this period.

External factors such as interest in a particular election, the local weather conditions, or higher voter participation during a presidential cycle could impact the results of this analysis. While propensity score matching can reduce the difference between counties, it is difficult to control for the level of competitiveness in a local election or local weather conditions. Voting behavior is significantly different in midterm elections following a new presidential election and in competitive presidential elections compared to re-election years. The selection of elections could cause some of observed treatment effect. While matching should mitigate the effect of the difference turnout on midterm and presidential elections, there could be a factor that is not

controlled for that influences both increased insurance uptake and voting participation in these elections. The results may also be specific to the two states and not generalizable to the broader country. While the selection of these states was chosen to mirror the health insurance market in an expansion and non-expansion state, there are factors that could make the market of Florida and Massachusetts look very different from the rest of the country.

Conclusions

Voting participation and health insurance coverage are both closely tied with improved financial security. One of the most consistent finding when studying the impact of coverage expansions and a reduction in the number of uninsured Americans is that people see improved financial security. The people that benefitted the most from the coverage expansions of 2006 and 2014 were lower income residents and people with less stable financial situations. For example, people who are self-employed, people with a pre-existing condition, or people that work for employers that do not offer health coverage. These are often the same type of people that are less likely to participate in voting. As health insurance reduces the barriers to voting we are more likely to see people participate in voting. In Florida we see that providing health insurance to the uninsured has the effect of also improving voter participation. We see that when there is an increase in health insurance coverage for a state with high rates of uninsurance and average voter participation that people appear to be more likely to participate in voting.

However, when coverage expansions occur in a place with high insurance coverage and high voter participation, insurance coverage appears to depress voter participation. This is indication that the effect of insurance coverage on voter participation is localized depending on the circumstances in the state and local area. In some parts of the country the improved financial security, access to voter registration, or backlash effect could cause more people to vote, in other

areas it might not have an effect or could lead fewer people to turnout to vote than would otherwise.

This research does not hypothesize on who is more likely to vote or how they vote when the uninsured gain coverage. It could be hypothesized that when people are financially better off, they are more likely to participate in voting. It could also be that when people see improved financial wellbeing of their neighbors, people are more likely to vote based off this perceived change. How voters vote and who are more likely to vote following the expansion of health insurance coverage is a topic of future study. Whether health insurance coverage creates a constituency of beneficiaries who vote based off of their vested interest in health insurance policies remains to be studied. It is also unclear whether voters associate the benefit of health insurance coverage with the government and see improved trust in the government as a result.

Prior research on low-income voters indicate that factors such as reduced knowledge of the voting process and issues, lack of paid time off to vote, and accessibility of polling locations cause depressed voter participation rates. Improved financial stability may remove these barriers to voting among low-income individuals, but there are limits to the amount health insurance has an effect on voting behavior. This paper follows to the previous research by indicating that the increased financial stability of health care coverage can increase voter participation for certain populations but other factors that prevent people from voting may have larger, more significant effects.

Chapter Two

Why States Raise Wages: Politics and Home Care Worker Wage Increases

2.1 Introduction

Home care workers are among the largest and fastest growing segments of low-wage workers. In many states home care workers earn near hourly minimum wage. Medicaid is the primary payer for long-term care services and services provided in the home and community settings by home care workers. Medicaid's large share of the home care market implies that policy made by a state Medicaid program could have a significant effect on home care worker wages in the private market. In recent years, state legislatures have taken actions to increase the wages for home care workers in the Medicaid program following federal action and improvements in state budgets after the 2008 Recession. We examined 48 attempted wage increases and 34 successful wage increases from 2013-2018 compared against states that did not act (n=319) to determine what political factors increase the likelihood that a state will increase home care worker wages. Union membership in the state, females in the legislature, and more professional legislatures were associated with increases to home care worker wages. For every additional 100 union members per 100,000 people there was on average a 7.17% (95% CI: (0.86%, 13.86%), p=0.0425) increase in the likelihood of the state pursuing greater wage increases and a 5.03% (95% CI: (0.51%, 9.74%), p=0.0466) increase in the likelihood of successfully doing so. For every one-percentage point increase of females in a state legislature there was a 10.99% (95% CI: (4.81%, 17.55%), p=0.0017) increase in the likelihood of an attempt and an 8.79% (95% CI: (3.47%,14.39%), p=0.0033) increase in the likelihood of successfully increasing wages. Lower proposed wage increases were associated with a greater likelihood of successful passage. This research can help inform how state policy makers respond to home care workforce shortages.

2.2 Background and Literature Review

The public has an interest in regulating the home care industry because 1) the state-run Medicaid program is a primary payer for home care services; 2) to improve the health of the population, the public is interested in beneficiaries receiving skilled labor; and 3) the home care industry's monopsony power has led to a market failure. States have the authority to act in cases of market failure and may decide to increase competition among home health agencies through antitrust regulation or to set a wage floors for the industry through Medicaid. This paper will examine the political factors that have led states to take the second option to act on increasing wages for home care workers.

Traditionally, long-term care was primarily provided in institutional settings or nursing facilities and has been the responsibility of the state. Over the last fifty years, Medicaid shifted care for recipients of long-term services and supports (LTSS) from nursing facilities to home and community-based service (HCBS) settings (Wilhelm et al. 2015). Starting in 2013, Medicaid spending on HCBS benefits exceeded spending on institutional care (Wenzlow, Eiken, and Sredl 2016).

An estimated 4.2 million Americans receive LTSS benefits through Medicaid (MACPAC 2017). Medicaid spent $151 billion on LTSS in 2014 accounting for approximately 51% of the total $310 billion expenditures on LTSS (Reaves 2015; Martin et al. 2016). Medicaid contracts with home health agencies who hire and manage home care workers, either directly through reimbursements or indirectly through contracts with managed care organizations. Alternatively, Medicaid may directly pay home care workers through consumer directed programs or other payment programs. Medicaid's financial resources are constrained by state budgets that are determined by the legislature. To maximize profits under these constrained resources, home care agencies are incentivized to keep wages low.

Previous research has indicated that economic factors in a given state are the leading indicator of whether a state decides to pursue a HCBS waiver program. This research did not account for a variety of political factors at the state level and has not been updated to account for changes in these programs. The economic recessions of the 2000s saw expansions of the HCBS benefit despite poor economic conditions that would suggest reductions in services. One key reason that states have encouraged the adoption of HCBS is that HCBS is often significantly cheaper than nursing facility care. HCBS settings have a median annual cost of $45,800 compared to $91,250 for nursing facility care in 2015 (Reaves 2015). Therefore, shifting spending from nursing facilities to HCBS settings could reduce the overall cost of LTSS to the state.

The growing market for HCBS providers may influence greater adoption of home care services and policy changes. Home care is the fastest growing low-wage industry and home care workers are forecasted to remain a growing proportion of the labor force (Howes 2015; Seavey and Marquand 2011). Indeed, demand for home care services is increasing as the population ages and a growing number of people require these types of services and this increased demand for new workers has led to a shortage of workers (Rowe, Fulmer, and Fried 2016). Despite these market forces in favor of home care workers, low wages and poor job satisfaction result in high rates of turnover, which may be linked to lower quality of care provided to patients. Additionally, the home care industry has consolidated in recent years, leaving open the potential for companies to possess and exercise monopsony power. An efficiency rationale for state action is increased wages may increase the supply of workers to this market and have the additional effect of improving the retention rates thereby alleviating the shortage of workers. This could in turn improve the quality of care. There is little current evidence on policy efforts aimed at

improving home care workers' wages, these wages, and downstream quality effects. Prior research has focused on the political forces that are associated with the adoption of the HCBS programs and found that political factors have little effect on whether states take up an HBCS waiver.

This research studies the legislative efforts aimed at increasing the wages of home care workers, which may differ from the implementation of HCBS waiver programs in Medicaid. Certain political factors may influence whether states make policy decisions to increase wages. After enactment, these policies create interest groups and beneficiaries that are helped by these policies. These interest groups may influence higher payment rates or improvements to the programs. Prior to benefiting from the programs, these groups were not organized or aware of the benefit.

Pay as a Way to Improve Retention Rates

Over a given year, turnover rates for home care workers are estimated to be between 44 and 65% (Seavey and Marquand 2011). Wage levels have been tied to low job satisfaction and are a factor in the industry's high turnover rate. However, one survey has shown that the amount home care workers are paid is unrelated to turnover intent and turnover (Rosen et al. 2011). This same survey found that turnover was predicted by low job satisfaction and lack of health insurance coverage for the workers. One critique of this study is that low wage may be a factor in surveyed low job satisfaction and that increased wages improve job satisfaction (Seavey and Marquand 2011; Benjamin and Matthias 2004; R. I. Stone 2004; Bishop et al. 2009). Whether or not pay is a main factor in job retention, pay is one of many influences on home care worker job satisfaction.

State Medicaid programs have an incentive to reduce turnover rates and associated costs and improve the quality of care beneficiaries receive. Increasing wages may lead to higher retention rates, greater competition for employment in home care agencies, and greater employee satisfaction. All of these factors may lead to better job performance and improved quality of care.

The home care industry is made up largely of low-skilled, low-pay workers. Home care workers have lower levels of education (55% with high school diploma or less) and contain a larger proportion of immigrants (23% foreign born) than the general US population (Seavey 2010). Home care often has few opportunities for career advancement, with few management positions but many low-skill positions. Home care workers experience high levels of workplace burden. Experiences such as abusive work environments and unsanitary conditions are associated with higher rates of depression and high rates of job dissatisfaction, named behind low pay as reasons for job dissatisfaction (Geiger-Brown et al. 2007).

Home care workers are typically paid at or near a state's minimum wage (Thomason et al. 2018). Investments in training and good work environments for home care workers have been shown to be associated with increased care quality through reduced re-hospitalizations, reduced emergency department utilization, increased transitions to community living, and reduced long-term care costs (Jarrín et al. 2014; Robison et al. 2012).

What Influences States to Propose and Enact Legislation

State legislatures and executive agencies are driven to change policy based on (1) rational economic analysis and political influences from the (2) internal make-up of the policy-makers and (3) external interest groups, and (4) a path dependence, or past policy decisions that lead to future policy decisions (D. Stone 2011). (1) Prior research has led to the conclusion that well

preforming economies and a high demand for services would lead the state to act to provide benefits and potentially solve the shortage by raising wages, regardless of political influences. More often, political influences such as interest groups affect the decisions of policy-makers. (2) The structure of the state's governing institutions, such as the level of professionalization of the legislature, could make policy-makers more likely to act. The number of liberal members who favor higher wages for low-income workers or the number of women legislators who tend to put forward domestic policy priorities could influence the decision making of policy makers. (3) External interest groups can move the policy agenda by influencing policy makers with campaign contributions or voter mobilization, among other ways of influencing political actors. In this case, external interest groups may include unions and the potential supply of home care workers. Home care worker agencies may also be an organized interest group, yet the extent that they may influence policy-makers and how that influence may vary across states is less clear. (4) States may have taken actions or instituted programs that have created constituencies and conditions that may influence future policy-making, a concept known as path dependency. How these political influences (2-4) are related to the decision to increase home care worker wages will be analyzed below.

Legislature and Policy Maker Characteristics

The level of professionalization of state legislatures varies significantly across the country. Approximately half of state legislatures meet part-time or every other year and, in such states, legislators spend approximately half of their time on legislative duties. Some legislatures meet year-round and in most of these states, legislators spend more than three-quarters of their time on legislative activities. Legislators' pay varies significantly, with some legislators paid on per-day rate or and others paid an annual sum. The annual sum varies between $200 for a two-

year house member term in New Hampshire to over $110,000 annually for California members. Full-time legislatures may have over a thousand paid legislative staff, while part-time, less professionalized legislatures may have fewer than 100 staff serving the legislative body (NCSL 2017). Similarly, in more professional legislatures, members may have three or more personal staff while in less professional legislature a staff member may serve several members. There is evidence that more professionalized legislatures are more responsive to aggregate constituency concerns (Maestas 2000). But it is not clear that professionalized legislatures vote on larger state budgets than non-professionalized legislatures (Malhotra 2008).

Legislatures and executive branches with more Democratic members are more likely to pass policies that increase wages and benefit social welfare programs. The influence of a Democratic party electorate will also determine whether social welfare policies are introduced and enacted (Fellowes and Rowe 2004). Democratic party control often leads to the introduction of more legislation to increase the minimum wage, but not necessarily enacting more minimum wage increases (Whitaker et al. 2012). Democratic governors are more likely to allocate a larger portion of their budgets to social welfare programs including Medicaid (Beland and Oloomi 2017).

Legislatures with a higher portion of female representation are more likely to introduce and pass policies dealing with women, children, and families (Thomas 1991; Holman and Mahoney 2018; Bratton 2005). As the number of women in a legislature increases, the number of women's interest bills passed by that legislature also increases (Crowley 2004; Bratton 2005). Female legislators tend to express more liberal welfare policy preferences than their male counterparts (Poggione 2004). Not only are home care workers primarily female (89%), but the beneficiaries who receive home care services are also primarily female (61%) (Seavey 2010;

Agency for Healthcare Research and Quality 2012). Home care is not always included in analysis of policies related to women's issues; care for families and for those who are affected by changes to home care policies can be categorized as a policy affecting women and families, providing a liberal social welfare benefit.

The Role of Unions in Home Care

Over the last several decades, the membership of both private sector and public sector unions has decreased. Despite this membership decline, public sector unions have remained considerably strong in political influence within states. One place where public sector unions have grown in membership is in the home and personal care workforce (P. R. Smith 2007). In 1999, the Service Employees International Union (SEIU) began representing the interest of direct care (home care) workers in Los Angeles, beginning the growth of union representation in this sector. Home care workers that are paid directly by Medicaid agencies are defined as public sector employees, while those employed under an agency may not fit that definition (P. R. Smith 2007). Home care workers and unionized home care workers are a growing portion of the electorate and the general population. The potential growth in this sector is an area of expected growth in union membership.

Several studies have shown that unions have played a positive role in both the job satisfaction and wages of home care workers (Boris and Klein 2015). A survey of Los Angeles home care workers found union participation was associated with better job satisfaction (Delp et al. 2010). Similarly, California unionization efforts were shown to lead to improved working conditions, higher wages, and improved job satisfaction (Howes 2004). National studies focusing on nursing home employees found that the unionization of employees led to higher

wages with improved labor productivity effects, and found no decline in care quality or reduced staffing levels (Sojourner et al. 2015).

Home care workers are disproportionately foreign born, with 22% of home care workers being foreign born compared to a national average of 13.4% (Seavey 2010). States with more foreign-born home care workers may have a greater supply of potential workers. A greater supply of workers could increase the downward pressure of wages because of a reduced demand for labor. On the other hand, a greater supply of home care workers could also act as an organized interest group that could advocate for higher wages. States vary significantly on the proportion of their population who are foreign born, in part because of policies that may attract workers from outside of the country. Ideally it would be best to know the number of home care workers that are in a state who are foreign born to be able to compare what effect the supply of workers could have on wages. The heterogeneity of the portion of the total population that is foreign born may serve as a proxy for the potential supply of home care workers in the state.

Medicaid Policy Influence

The three primary ways that states pay for HCBS services are: home health services state plan benefit, personal care services state plan benefit, and Section 1915(c) HCBS waivers. All states offer both the mandatory home health benefit and the Section 1915(c) benefit. States vary significantly in the generosity of these benefits, the eligibility requirements, and how quickly state policy-makers initially acted to provide these benefits (N. A. Miller et al. 2001).

All states are required to cover HCBS through Medicaid and the Home Health benefit that mirrors the Medicare Home Health benefit. Medicaid allows the payment of HCBS services through two alternative programs that circumvent the traditional home care payment process. First, the state may elect to take up the Personal Care Services (PCS) state plan option that

provides a certain number of hours of personal care services to Medicaid beneficiaries living in the home. Thirty-four states offer this benefit outside of the Medicaid Home Health benefit which is a costlier service that requires supervision by licensed nurses (Office of the Assistant Secretary for Planning and Evaluation 2016). Home health agencies typically contract directly with Medicaid agencies or managed care entities under this benefit. PCS programs show lower rates of complications due to diabetes, dehydration, congestive heart failure, and pressure ulcers (AHRQ 2012). Second, the Cash and Counseling demonstration program was implemented in 15 states and gave beneficiaries cash allowances to spend on goods or services to meet their personal care needs. The Cash and Counseling program reduced the unmet needs of Medicaid beneficiaries in large part because it allowed people who had no alternative option the ability to receive services. The program also was associated with lower risk of falls and urinary tract infections and were not more susceptible to additional adverse health outcomes (De Milto 2015; Carlson et al. 2007). The Cash and Counseling demonstration has ended but the program has continued through the direct care worker optional benefit in the Medicaid program.

The effect of these alternative programs on home care worker wages is unknown. Medicaid policies allowing direct payment of home care workers by patients are perceived by unions and those representing the home care worker industry to play a role in distorting the market for home care workers (Pamela Harris, et al., v. Pat Quin Governor of Illinois, et al. Brief for Amicus Curiae of the Paraprofessional Healthcare Institute (PHI) in Support of Respondants 2013). The Cash and Counseling program allows individuals to purchase home care services at a price unrelated to rates determined by state Medicaid agencies. Since the programs are voluntary, the beneficiaries electing self-directed care may have higher mental acuity and need fewer services. The lower level of need may put downward pressure on the wage rates of home care

workers. However, beneficiaries may pay higher wages than the rates set by Medicaid, potentially increasing the rate set by Medicaid agencies because they are unaware of the rates set by Medicaid. Both of these programs have been shown to increase the number of people who are eligible to receive home care services, which could increase the demand for home care workers and drive up wages. Little research has been done to illustrate the relationship between these policies and home care wages.

The 2010 Affordable Care Act allowed states to expand Medicaid coverage to low-income earners making under 138% of the federal poverty level (FPL). Through 2018, 33 states and the District of Columbia have expanded their Medicaid programs to these individuals. Thus, Medicaid expansion may provide health insurance coverage for low-income home care workers. State policy-makers may be less likely increase worker wages because they see workers as having gained a benefit through Medicaid expansion. Medicaid expansion may mean that states have fewer available resources in the state budget since the state pays a portion of the expanded Medicaid costs.

Hypothesis

This study aims to evaluate the political factors that influence whether states decide to (1) propose increases to home care worker wages and (2) enact increases home care worker wages. Of particular interest are the relationship between home care workers' wages and (1) levels of participation in public sector unions, (2) the proportion of females in state legislatures, (3) the professionalization of the legislature, (4) the partisan makeup of the state, and (5) the existing Medicaid programs in a state. This independent variation will allow us to evaluate which factors make it more likely for states to first propose and then to adopt home care worker wage increases. We anticipate that states are more likely to propose measures to increase wages when

there are more people participating in public sector unions and when there are more females in the legislature. We expect that states with these characteristics would be more likely to enact legislation compared to states with less union participation and fewer female state legislators, given the same set of economic circumstances.

2.3 Methods

Data

Legislative records, Medicaid state plan amendments (SPA), and news reports from 2013 through 2018 were analyzed to determine the actions, if any, that state decision makers took to increase wages for home care workers. There are a number of avenues through which these changes could be made. The executive branch of a state may decide that home care workers should receive a higher minimum wage and instruct the state's Medicaid agency to go through the procedural requirements to do so. In other states, a change in the payment rate for home care workers requires an act of the legislature. In both of these cases, the state can submit a change to the state plan, waiver, or modify a managed care contract. SPAs must be submitted to the federal government, and these plans are available on the Centers for Medicare and Medicaid Services (CMS) website. Not all changes to home care worker wages will appear in CMS documents. Changes to the contracts with managed care organizations may be submitted to CMS through 1915(a) or 1915(b) waivers, but changes to wages may not be included in these submissions. Managed care contracts are typically not released publicly, so not all actions of the state to modify wages will be captured in the data.

From these administrative records, we counted the number of actions in each state to increase wages for home care workers in a given year, whether these actions resulted in any increased in any increased wages for home care workers in the same year, and the size of the

wage or payment increase, if any. Any wage increase found in these documents will be compared against state SEIU membership numbers submitted to the Department of Labor Office of Labor-Management Standards reported from local chapters and classified by state.

Covariate data come from a number of sources. PCS programs and Cash and Counseling program participation was determined using the Kaiser Family Foundation Kaiser Commission on Medicaid and the Uninsured (KCMU) Medicaid Benefits Database and analysis from the CMS Cash & Counseling Demonstration and Evaluation (CCDE). Data on state demographic characteristics and economic conditions comes from the American Community Survey. The number of women in state legislatures was derived from the National Conference of States Legislatures (NCSL) Women in Legislatures Database. The proportion of Democrats in state legislatures is derived from the NCSL State Partisan Composition database. A professionalization score of 1-5 was given to each state based on the proportion of time spent in the legislature, compensation of legislators, and total staff based off of the NCSL Survey of State Legislators.

Observations are at the state-year level, and our sample includes both the District of Columbia and Puerto Rico (n=319). While most states only have one action per year, states could have attempted more than one action in a given year. For example, one attempt to increase wages may have been unsuccessful and a smaller wage increase may have been passed in the same year. We count each attempt separately.

Empirical Approach and Statistical Analysis

We used a four-part analytic approach to explore the relationship between state characteristics and state-driven attempts to increase wages for home care workers. First (1), we examined the relationship between state political factors and state actions to increase wages,

regardless of whether or not the action is successful. Next (2), we examined the relationship between state political factors and successful state actions to increase wages, unconditional on having attempted. Then (3), whether the size of the proposed wage increase is related to the state proposing and successfully increasing wages and (4) we examine the relationship between state political factors and the size of the wage increase. Finally, (5) we examined whether existing features of a state's home health aide and nursing assistant wages and number of employees and the Medicaid program were related to a state's attempt to increase home care worker wages.

For each part above, we conducted multivariate regression analysis with the state actions, state successful actions, and size of wage increase as the outcomes of interest. We use logistic regression to model state attempts at wage increase in a given year (where 1 indicates an attempt and 0 indicates no attempt) and the conditional success of the attempts in the same year. We model the amount of a successful wage increase with an OLS specification analysis including the amount of the wage. This wage increase amount was not adjusted for cost-of-living or other factors, such as the base rate.

Political factor covariates included in analyses (1-3) are the proportion of the population per 100,000 people in a public sector union, the proportion of Democrats in the state house, the proportion of women in the legislature, the legislature's professionalization score, and the proportion of the population that is foreign born. We also adjusted for normalized state gross domestic product (GDP) and the portion of the state's population over the age of 65 in a given year. The standard errors for each model are clustered at the state level to account for autocorrelation.

To determine whether the attempts were driven by home health worker wages or employment in the state we used a similar logistic regression (1-3) to model any attempt and

successful attempts. Finally, to determine whether the existing Medicaid programs have a relationship with an attempt and successful attempts to increase home care worker wages we conduct a similar logistic regression model (1-3).

Table 2.1: Correlation Coefficient Matrix of Used Variables

	Union	Foreign Born	Democrats	Female Leg	Professional Leg	State GDP	Over 65
Union	1.00	0.32	0.25	0.25	0.25	0.36	0.07
Foreign Born	0.32	1.00	0.58	0.35	0.49	0.69	-0.17
Democrats	0.25	0.58	1.00	0.47	0.40	0.23	0.20
Female Leg	0.25	0.35	0.47	1.00	0.07	0.02	0.08
Professional Leg	0.25	0.49	0.40	0.07	1.00	0.61	-0.11
State GDP	0.36	0.69	0.23	0.02	0.61	1.00	-0.23
Over 65	0.07	-0.17	0.20	0.08	-0.11	-0.23	1.00

2.4 Results

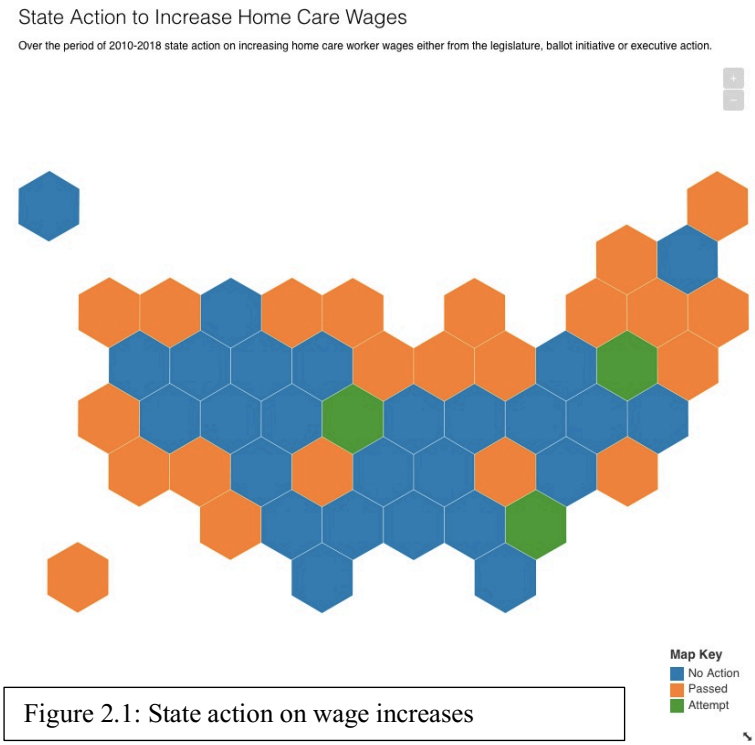


Figure 2.1: State action on wage increases

There have been 48 attempted increases in state wages and 34 successful (70.8%) wage increases from 2013 through 2018. In the US, 506,710 home care workers live in states that have enacted wage increases and 312,810 workers live in states that have not enacted these increases.

This analysis finds that the unions present in the state and the number of females in the state legislature are associated with an increase in the likelihood that a state will undertake any attempt to increase home care worker wages, given the economic conditions and population of seniors. The likelihood that a state will take up an increase in wages is 15.05%. For every additional 100 union members per 100,000 people there was on average a 7.17% (95% CI:

0.86%, 13.86%) increase in the likelihood of the state pursuing greater wage increases. For every one percentage point increase in females in a state legislature, there was a 10.99% (95% CI: 4.81%, 17.55%) increase in the likelihood of an attempt to increase wages.

Table 2.2: Any Attempt to Introduce Wage Increases, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	anyattempt	
	(1)	(2)
Union Members per 100,000	0.069***	0.069**
	(0.025)	(0.031)
Foriegn Born	−0.069	−0.069
	(0.050)	(0.055)
Democrats in House	−1.327	−1.327
	(1.902)	(1.830)
Females in Legislature	0.104***	0.104***
	(0.031)	(0.029)
Professionalization of Legislature Score	0.413	0.413
	(0.317)	(0.375)
log(State GDP)	0.252	0.252
	(0.363)	(0.362)
Percent of Population Over 65	0.185	0.185
	(0.117)	(0.148)
Constant	−10.892**	−10.892**
	(4.717)	(4.741)
Observations	301	301
Log Likelihood	−111.156	−111.156
Akaike Inf. Crit.	238.311	238.311
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.3: Marginal changes in any attempt to increase home care worker wages by political characteristic

Characteristic	Marginal Effect	Lower Bound	Upper Bound
Intercept	-0.0000	-0.0000	-0.2018
Union	0.0717	0.0087	0.1386
Foreign Born	-0.0663	-0.08378	0.0406
Democrats	-0.2651	-0.0073	8.5834
Females	0.1099	0.0481	0.1754
Professional	0.5114	-0.7253	2.1493
Log(State GDP)	0.2858	-0.6330	1.6158
Over 65	0.2030	-0.9009	0.6064

Whether the state proposes a successful attempt to expand wages is associated with the presence of unions and whether the state has a higher portion of women in the legislature given similar economic conditions and population of seniors. The probability that a state will successfully adopt a wage increase is 10.66%. For every additional 100 union members per a population of 100,000 there is a 5.03% (95% CI: 0.51%, 9.74%) increase in the likelihood of

successfully passing a wage increase. For every additional one percentage point increase in females in the state legislature there is an 8.79% (95% CI: 3.47%,14.39%) increase in the likelihood of successfully increasing wages.

Table 2.4: Successful Attempts to Introduce Wage Increases, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	successattempt	
	(1)	(2)
Union Members / 100,000 People	0.049*	0.049**
	(0.028)	(0.022)
Foreign Born	−0.042	−0.042
	(0.055)	(0.048)
Democrats in House	−1.140	−1.140
	(2.084)	(1.733)
Females in Legislature	0.084**	0.084***
	(0.034)	(0.026)
Professional Legislature Score	0.664**	0.664*
	(0.333)	(0.384)
log(State GDP)	−0.129	−0.129
	(0.382)	(0.327)
Percent of Population Over 65	0.213	0.213
	(0.130)	(0.135)
Constant	−7.463	−7.463
	(4.874)	(4.694)
Observations	301	301
Log Likelihood	−93.880	−93.880
Akaike Inf. Crit.	203.759	203.759
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.5: Marginal changes in successful attempts to increase home care worker wages by political characteristic

Characteristic	Marginal Effect	Lower Bound	Upper Bound
Intercept	-0.0006	-0.0000	4.6801
Union	0.0513	0.0051	0.0975
Foreign Born	-0.9589	-0.8720	0.05456
Democrats	-0.3197	0.0698	8.5532
Females	0.0880	0.03488	0.1439
Professional	0.9434	-0.9147	3.1288
Log(State GDP)	-0.8792	-0.4629	0.6699
Over 65	0.8792	-0.9506	0.61104

Successful attempts are more likely to occur if the amount of the wage increase is lower, given the same political and economic conditions. For every one dollar increase in the home care wage, there is a corresponding average of 73.74% (95% CI: -55.88%, -97.31%) decrease in the odds of a successful wage increase attempt occurring. There was no relationship between the

amount of the wage increase and the political factors given the economic conditions in the state and the population of seniors.

Table 2.6: Successful Attempts and wage amount, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	Successful attempt	
	(1)	(2)
Increase Amount	−0.305*	−0.305**
	(0.183)	(0.142)
Union Membership	−0.027	−0.027
	(0.057)	(0.049)
Foreign Born	0.177	0.177
	(0.175)	(0.154)
Democrats	−3.670	−3.670
	(6.851)	(4.807)
Female Legislators	−0.030	−0.030
	(0.090)	(0.106)
Professional Legislature	1.713	1.713*
	(1.368)	(1.000)
log(State GDP)	−2.720	−2.720**
	(1.834)	(1.321)
Over 65	−0.335	−0.335
	(0.542)	(0.453)
Constant	37.072	37.072**
	(26.113)	(18.780)
Observations	47	47
Log Likelihood	−23.096	−23.096
Akaike Inf. Crit.	64.192	64.192
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.5: Marginal changes in wage amount by political characteristic

Characteristic	Marginal Effect	Lower Bound	Upper Bound
Intercept	1.2589e+16	0.2994	1.219845e+32
Wage amount	-0.7374	-0.5588	-0.9731
Union	-0.9736	-0.8841	0.0722
Foreign Born	0.1935	-0.8271	0.6138
Democrats	-0.0254	-0.8827	0.6138
Females	-0.9706	-0.7885	0.1947
Professional	4.5429	-0.7801	29.9385
Log(State GDP)	-0.0659	-0.0049	-0.9775
Over 65	-0.7153	-0.2943	0.7383

Table 2.8: Wage amount and political characteristics, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	actionamount	
	(1)	(2)
I(union/100)	−0.016	−0.016
	(0.048)	(0.046)
Demh	−2.057	−2.057
	(5.178)	(3.959)
FB16	0.166	0.166**
	(0.140)	(0.076)
FemaleLeg	0.036	0.036
	(0.078)	(0.063)
ProfessionalLeg	−0.590	−0.590
	(0.706)	(0.520)
log(StateGDP)	0.249	0.249
	(0.902)	(0.705)
Over65	0.061	0.061
	(0.350)	(0.344)
Constant	−1.181	−1.181
	(12.290)	(9.750)
Observations	47	47
Log Likelihood	−100.050	−100.050
Akaike Inf. Crit.	216.101	216.101
Note:	*p<0.1; **p<0.05; ***p<0.01	

There is no relationship between whether a state attempted to increase wages and the existing home care or nurse aid worker wage in the state. Similarly, there is no relationship to whether this attempt was successful and the existing home care or nurse aid worker wage. There is also no relationship to the number of home care or nurse aid workers employed in the state and whether the state attempted or successfully attempted to increase wages.

Table 2.9: Any attempt and Home Health Aide and Nursing Aide, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	any attempt	
	(1)	(2)
Number of Home Health Aids	0.00001	0.00001
	(0.00001)	(0.00001)
Average Wage of Home Health Aides	−0.107	−0.107
	(0.212)	(0.259)
Wage of Nursing Aides	−0.064	−0.064
	(0.191)	(0.234)
Number of Nursing Aides	0.00001	0.00001
	(0.00001)	(0.00001)
Observations	313	313
Log Likelihood	−129.599	−129.599
Akaike Inf. Crit.	267.197	267.197
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.10: Successful attempts and Home Health Aide and Nursing Aide, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	success attempt	
	(1)	(2)
Number of Home Health Aides	0.00001	0.00001
	(0.00001)	(0.00001)
Average Wage of Home Health Aides	−0.254	−0.254
	(0.245)	(0.259)
Wage of Nursing Aides	0.057	0.057
	(0.220)	(0.234)
Number of Nursing Aides	−0.00000	−0.00000
	(0.00001)	(0.00001)
Observations	313	313
Log Likelihood	−105.214	−105.214
Akaike Inf. Crit.	218.427	218.427
Note:	*p<0.1; **p<0.05; ***p<0.01	

There is no relationship between whether the state had an existing Medicaid alternative HCBS program and whether the state would take an action to increase wages, with the exception of whether the state decided to expand Medicaid. In that instance, if the state expanded Medicaid it is more likely to attempt to expand wages and more likely to successfully expand wages. If the state decides to expand Medicaid, there is a 170.74% (95% CI: 19.75%, 512.08%) increase in the odds of any attempt to increase wages. This may seem counter-intuitive because a state may see

less of a need to improve the benefits of low-wage workers if the low-wage workers have benefited from the Medicaid expansion. Potentially, there is another factor at play in the decision to expand Medicaid and the decision to increase home care worker wages.

Table 2.11: Any attempt and Existing Medicaid Programs, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	any attempt	
	(1)	(2)
PCA	0.331	0.331
	(0.340)	(0.407)
Cash and Counseling	−0.028	−0.028
	(0.353)	(0.415)
Expansion	0.996***	0.996**
	(0.360)	(0.416)
Constant	−2.553***	−2.553***
	(0.373)	(0.387)
Observations	319	319
Log Likelihood	−130.062	−130.062
Akaike Inf. Crit.	268.124	268.124
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.12: Marginal changes in any attempt to increase home care worker wages by Medicaid program characteristic

Characteristic	Marginal Effect	Lower Bound	Upper Bound
Intercept	-0.0779	-0.0365	-0.1662
PCA	0.3930	-0.6268	2.0954
Cash and Counseling	-0.9728	-0.4315	1.1930
Expansion	1.7073	0.1975	5.1208

There is no relationship between whether a state participates in a PCS benefit or Cash and Counseling program and whether they attempt or successfully increase wages. There is no relationship between the unions in the state and the existence of the PCS programs or Cash and Counseling Programs. There is a positive correlation between the Medicaid expansion and the proportion of union membership in a state. States that have decided to expand Medicaid have an average of 695 additional union members per 100,000 people.

Table 2.13: Successful attempts and Existing Medicaid Programs, Logit Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	success attempt	
	(1)	(2)
PCA	0.561	0.561
	(0.412)	(0.413)
Cash and Counseling	−0.294	−0.294
	(0.418)	(0.419)
Expansion	1.225***	1.225***
	(0.437)	(0.392)
Constant	−3.204***	−3.204***
	(0.473)	(0.429)
Observations	319	319
Log Likelihood	−102.612	−102.612
Akaike Inf. Crit.	213.225	213.225
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.14: Marginal changes in successful attempts to increase home care worker wages by Medicaid program characteristic

Characteristic	Marginal Effect	Lower Bound	Upper Bound
Intercept	-0.0406	-0.0336	-0.1804
PCA	0.7517	-0.6194	2.1325
Cash and Counseling	-0.7454	-0.4279	1.2119
Expansion	2.4047	0.2558	4.8370

Table 2.15: Union Participation and Existing Medicaid Programs, Linear Regression with standard errors (1) and clustered robust standard errors (2)

	Dependent variable:	
	union	
	(1)	(2)
PCA	155.615	155.615
	(95.272)	(184.875)
Cash and Counseling	−262.529**	−262.529
	(106.126)	(257.248)
Expansion	695.081***	695.081***
	(96.206)	(241.072)
Constant	117.426	117.426
	(90.821)	(113.868)
Observations	319	319
Log Likelihood	−2,591.975	−2,591.975
Akaike Inf. Crit.	5,191.951	5,191.951
Note:	*p<0.1; **p<0.05; ***p<0.01	

Table 2.16: Demographic Information of All Variables

Statistic	Mean	St. Dev.	Min	Pctl(25)	Pctl(75)	Max
Union Members	64,928.230	250,798.800	0	28.2	32,777	1,734,040
PCA	0.615	0.491	0	0	1	1
Cash and Counseling	0.288	0.457	0	0	1	1
Population	6,284,855	7,197,166	584,910	1,791,484.0	7,001,715	39,296,476
Foreign Born	8.992	6.090	1.600	4.35	13.5	27
Unemployment16	7.067	2.123	2.800	5.825	8.125	17.7
Average Income	$57,480.83	$11,117.34	$19,775	$50,862.5	$65,358.2	$78,916
% Population over 65	15.215	1.847	10.1	14.4	16.125	19.4
% Population with Disability	13.29	2.400	9.6	11.575	14.525	21.7
Medicaid % Spent on HCBS	51.829	11.344	27.200	43.600	57.000	79.200
HCBS Spending	$1,581,370,865	$2,270,304,483	$132,785,898	$398,771,322	$1,738,536,674	$12,851,412,378
FMAP	59.896	8.524	50	50	66.260	76.390
Dem 2016 Presidential Vote %	44.616	12.186	21.900	35.550	51.300	90.900
Portion of Females in Legislature	24.738	7.546	13.200	19.275	29.700	46.200
Professional Legislature Score	3.0	1.048	1	2	3	5
Uninsurance %	9.569	3.213	3.0	7.275	11.95	18.2
Home Health Aid Wage	$12.13	$1.59	$8.80	%11.04	%13.38	%16.32
Number of Home Health Aids	16,069.02	29,548	5200	2,855	15,415	192,460
Wage of Home Health Aid	$13.68	$1.79	$9.91	$12.47	$14.74	$18.24
Number of Nurse Aids	27,962.69	26,325.63	370	7,792.5	36,795	98,570
States Expanding Medicaid	0.635	0.486	-	-	-	-
Medicaid LTSS Enrollment	103,721.5	135,483.4	7,450	23,327	117,350.5	798,485
Medicaid HCBS Enrollment	69,867.28	101,757.2	1,879	16,394.75	84,305.5	634,830

Table 2.17: Correlation Coefficient Matrix of All Variables

	Union	DemSen	DemHouse	HHAids	Expan	Foreign	Female	ProLeg	StateGDP	Over65
union	1.00	0.18	0.23	0.27	0.28	0.31	0.25	0.26	0.37	0.06
dem_senate	0.18	1.00	0.91	0.11	0.45	0.54	0.52	0.33	0.19	0.23
dem_house	0.23	0.91	1.00	0.27	0.49	0.59	0.48	0.48	0.28	0.19
Home Health Aids	0.27	0.11	0.27	1.00	0.12	0.48	0.03	0.50	0.61	-0.07
Expansion	0.28	0.45	0.49	0.12	1.00	0.29	0.42	0.27	0.13	0.06
Foreign_Born	0.31	0.54	0.59	0.48	0.29	1.00	0.35	0.52	0.70	-0.18
Female_Leg	0.25	0.52	0.48	0.03	0.42	0.35	1.00	0.08	0.03	0.07
Professional_Leg	0.26	0.33	0.48	0.50	0.27	0.52	0.08	1.00	0.60	-0.10
State GDP	0.37	0.19	0.28	0.61	0.13	0.70	0.03	0.60	1.00	-0.22
Over65	0.06	0.23	0.19	-0.07	0.06	-0.18	0.07	-0.10	-0.22	1.00

2.5 Discussion

Demand for care provided by home health aides is increasing as baby boomers age. Similarly, states have shifted from providing care for people in need of long-term services from nursing facilities to the homes and communities. The home care profession has a high rate of turnover, which increases the demand for skilled workers in this field. The low wages that home care workers receive is a contributing factor to the low job satisfaction that drives low retention rates in the market. Home health agencies contract with Medicaid and have the market power to determine wages in the home care market. There is evidence that the home health industry

market has been consolidating as a result of an increased emphasis on integrated services (Home Care Alliance of Massachusetts 2018). The consolidation could allow home care agencies to maintain a downward pressure on wages due to a lack of competition in the home care employee market.

The public has an interest in regulating the home health industry because 1) the public Medicaid program is a primary payer for these services; 2) to improve the health of the population, the public is interested in beneficiaries receiving skilled labor; and 3) there is a market failure if an industry has monopsony power. States have the option to regulate cases of market failure either by increasing competition among home health agencies through antitrust regulation or by regulating wages by creating a wage floor that the industry must meet. Since Medicaid is the financing source for home care services, states have the ability to create a wage floor either through increasing the state minimum wage for all industries or through legislation that is focused on the Medicaid reimbursement policy.

The political case for undertaking an increase to wages occurs when there is a greater portion of women in the legislature and a union presence in the state. A greater portion of women in the legislature has been associated with greater action on policies that impact women and families. Women legislators are more likely to sponsor bills related to these issues and support them in passage. Home care worker wages have not historically been treated as a policy issue that affects women and families, however since these workers are primarily female and HCBS labor largely falls to women whether paid or unpaid, this evidence makes a case for issues affecting home care workers to be considered as issues that affect women. Unions have also been shown to advocate for higher wages and influence policy decisions related to worker wages. This evidence is consistent, demonstrating that a union presence in a state will make it more likely

that states will take up and will act to increase wages. Unions may directly influence home care agencies or may advocate for changes to policy among state legislators or executive agencies.

Potential limitations of this research could include the fact that home care agencies and state Medicaid programs may decide to increase wages outside of the legislative and formal Medicaid process. These informal changes to wages may improve wages in the industry and improve worker retention in the short-term. However, since these wage increases are not formalized through lawmaking and formal Medicaid process changes, the effects may be temporary and may not fully address the problems of monopsony power among home health care agencies driving lower wages.

The evidence of the relationship between existing Medicaid programs and wage increases indicates that PCS and Cash and Counseling are unrelated to wage increase attempts and union membership while Medicaid expansion is related to both wage increase attempts and union membership. These programs are directly related to what may influence the wages in the home care worker industry because both programs enhance the number of beneficiaries that can receive home care services. In the case of Cash and Counseling, the beneficiary determines the wages, potentially bringing down the wages of home care workers. Medicaid expansion's relationship with union participation could be related to other factors such as the higher portion of Democrats in states with high union participation or unions pushing for the expansion of Medicaid as part of other legislative priorities. Medicaid expansion does not necessarily lead to greater union participation and greater union participation may not directly lead to a state deciding to take up the Medicaid expansion.

2.6 Conclusion

As home health care grows due to increased demand more states will be faced with the decision of how to respond to the growing demand for services and the need to retain skilled workers. The decision to increase wages lies with each state's legislature and the executive branch and their decisions may be influenced based on outside groups. State legislatures and state executive branches are more likely to respond to the influence of unions to increase wages for home care workers given similar economic and political conditions. A higher number of females in the legislature indicates a greater likelihood of attempting and successfully passing wage increases for home care workers. Future research can evaluate whether increased worker wages leads to improved quality of care or improved retention rates.

Chapter Three

The Increasing Role of Direct Democracy in Health Policy: Medicaid Expansion Ballot Initiatives in the 2017 and 2018 Elections

3.1 Introduction

The 2012 Supreme Court decision on the Affordable Care Act found the federal government could not force states to accept the law's Medicaid expansion, leaving each state to determine whether or not to participate. Twenty-four primarily Democratic states decided to take up the Medicaid expansion prior to the January 1, 2014 start date of this new category of eligibility. In the three years following 2014, states have been slower to adopt the policy and at the start of 2017 only an additional seven states had joined the expansion. From November 2017 through November 2018 four states voted to expand through ballot initiative and only one voted to expand Medicaid through the legislature. Why have states decided to use this method of policy-making, instead of passing laws through the legislature and governor? Setting Medicaid eligibility through direct democracy represents a growing change in how health policy is made in states and how ballot initiatives are used to change health care programs. The health care topics that are voted on are becoming more related to national political debates and involve more significant changes to state-run programs. The four Medicaid expansions are representative of this shift in method of policy making and were a way to overcome legislative obstructions through the traditional policy processes in states. In these states, the legislatures and governors did not expand Medicaid because they are responsive to a smaller group of voters rather than the general population of the state. These ballot initiatives passed because Medicaid expansion is popular among voters, interest groups advocating for these changes were well organized and funded, and they utilized local and national organizations to influence voters. In many of the remaining states left to expand Medicaid, the ballot initiative process appears to be a more promising vehicle to overcoming the veto points in both the state legislature and the governor's

office to expand Medicaid. The sizable change in how policy is made requires further evaluation of whether ballot initiatives are an effective tool to state health care policy making.

This paper will first, analyze the history behind health care-related ballot initiatives in the United States. We will examine whether health care has grown as an issue that is presented to voters, what kinds of issues are being voted on, and who is more likely to vote on these issues. Next, we will use the Medicaid initiatives as case studies of the changing role of ballot initiatives in health care. We will evaluate why state policy-makers in these states have not expanded Medicaid despite public polling in favor of the policy. We will answer how states were able to use ballot initiatives to circumvent the traditional legislative policy-making process by examining the public opinion in the state, the interest groups that were formed and supported the measure, how the campaign was financially supported, and the history of ballot initiatives in the state. We will analyze whether using the ballot initiative process is an effective way to make policy with the criteria that the policy represents public opinion, is efficiently implemented, and responds to complex health policy decisions with evidence to support the public, state budget, and beneficiaries of the policy. This analysis and the experiences of these states will inform the limitations and prospects for future Medicaid expansions through ballot initiatives.

3.2 Background

The Affordable Care Act was passed in 2010 with a requirement for all states to expand Medicaid to all adult citizens (and certain qualifying immigrants) with incomes under 133% of the federal poverty level, with a 5 percent income disregard. States received 100% federal funding to cover the cost of the expansion, continuing at 90% after 2020. The Supreme Court ruled in the 2012 *NFIB v Sebelius* decision that the Medicaid expansion would be a decision left to the states. States were given the option to expand coverage at any point between 2010 and

2014 using existing funding structures. Twenty-four states and the District of Columbia elected to take up the Medicaid expansion and began enrollment in October 2013 with benefits beginning in January 2014 when the enhanced federal funding began. From January 1, 2014 through January 1, 2017 seven additional states elected to expand either following elections that changed the make-up of the legislature or following a debate within the legislature with support of the governor. Many of the states that decided to expand coverage in the three years following the expansion did so with federal waivers to amend the existing Medicaid law.

States vary significantly in whether and how citizens can put forward ballot measures through direct democracy. All states with the exception of Delaware require the public to ratify constitutional amendments. While only 26 states and the District of Columbia allow citizens to vote on citizen-led initiatives and referenda statewide, all states allow citizens to vote through some form of direct democracy whether that be local initiatives, recall elections, or constitutional amendments. Ballot initiatives refer to citizen led policy changes that require petition through a signature gathering process. Referendum are ballot measures that require an act of the legislature where the public may vote to sustain or overturn a decision made by the legislature. In 1898, South Dakota became the first state to allow citizens to put forward initiatives and referendum and several states in the Mountain and Western region amended their constitution to include this option during the same period. The most recent state to include this process is Mississippi who added the initiative process in 1992.

In 2017, Maine became the first state to use the ballot initiative process to expand Medicaid through the Affordable Care Act. The next year, three states, Nebraska, Idaho, and Utah, passed similar ballot initiatives. Using ballot initiatives to pass Medicaid expansion has been a consideration by several states prior to the successful use by Maine. Montana attempted to

expand initially through a ballot initiative but failed to collect enough signatures in 2013 for the 2014 ballot (Johnson 2014). In 2013, Ohio attempted to include a Medicaid expansion on the ballot but the effort ended when the governor decided to expand using his authority (Higgs 2013). In 2014, 19 counties and the city of Kenosha in Wisconsin put forward and passed a ballot measure that gave support to the state expanding Medicaid (McCollum 2014). In 2017, advocates in Missouri began the process to bring Medicaid expansion through an initiative for the 2018 ballot (Jaspen 2017). These attempts to expand Medicaid were not successful in moving the legislature in the case of Wisconsin or getting on the ballot in the case of Missouri, Ohio, and Montana.

Table 3.1: State Attempts to Pass Medicaid Expansion through Ballot Initiative

State	Year	Result
Montana	2013	Did not collect enough signatures
Ohio	2013	Governor elected to expand
Montana	2014	Did not collect enough signatures
Wisconsin (19 counties /Kenosha)	2014	Passed. Non-binding resolution.
Missouri	2017	Did not collect enough signatures
Maine	2017	Passed
Idaho, Nebraska, Utah	2018	Passed

It is not uncommon for states to use the ballot initiative process to change the funding of the Medicaid program. For example, Oregon voters in 2018 passed an initiative that would uphold the state's taxing system of health insurers and hospitals that funds the state's Medicaid program. Similar ballot initiatives on Medicaid funding have been decided in Alabama, Arizona, California, Louisiana, Maine, Missouri, and Oklahoma. These ballot initiatives are more likely to be approved than not. While several states have put forward ballot initiatives that would require the state to set up a new health care system or encourage the country to pursue health care reform, no large-scale

eligibility change to the Medicaid program had been successfully pursued through ballot initiative prior to the 2017 Maine Medicaid expansion question.

This paper will analyze the history of ballot initiatives in the United States, the role that ballot initiatives have played in health policy, and trends in health care-related ballot initiatives. Ballot initiatives have increasingly become a way for the electorate in states to raise health care policies and circumvent obstruction from the legislature and executive branch. This paper will examine why the legislature and executive branch in four states were not responsive to the views of the public on Medicaid expansion and did not pass this policy despite public opinion support. Using Medicaid expansion as case studies, this paper will outline the four state expansions of Medicaid through the ballot initiative process in 2017 and 2018. We will analyze how Medicaid expansion passed through the ballot initiative process when it had failed to pass through the legislature, despite several years of attempts to pass the policy. We will examine the role of public opinion, national and local organizations, campaign spending, and historic role of the ballot initiative in the state that have led to the passage of the policy. Finally, we will analyze whether making policy through direct democracy is an effective way to pass policies. Effective policies are defined for these purposes as policies that are supported by the public, policies that are efficiently implemented, and policies that use evidence to make decisions that are in the best interest of the public, the state budget, and the beneficiaries and other groups or individuals that receive the benefit of the policy change. On these criteria we will determine whether passing Medicaid expansion through the ballot initiative process was an effective avenue for health care policy making in the future.

3.3 Literature Review

Direct Democracy Growth

The role of ballot initiatives in shaping public policy has grown over the course of the last few decades. Historically, ballot initiatives had stemmed from the political history of more libertarian states, particularly in the Western United States. Direct democracy is believed by scholars to have an effect on state policy by allowing groups outside of the legislature to make laws directly or alter the way that the state government is run (Bowler and Donovan 2004). Researchers have looked into the effect of direct democracy on a number of facets of American life. There has not been research on how the ballot initiatives are changing the health care policy directions or how health care is playing a role in ballot initiatives. There is evidence that the growth in the use of policy making through direct democracy is more positive for low-income populations (Radcliff and Shufeldt 2016). This is related to this particular research because this research shows that ballot initiatives are being used to provide health benefits to low-income individuals.

State Responsiveness

State governments, like the federal government, have increasingly become partisan in recent decades, leading to state leaders being more responsive to their party's electorate (Shor and McCarty 2011; McGhee et al. 2014). There has been a growing disconnect between public opinion and policy making which could lead to biased representation (Bartels 2016). There is similar evidence that politicians are more responsive to the needs of high-income groups, particularly Republican politicians (Bartels 2016). In the states that have not expanded Medicaid, the legislators and executives that have blocked the expansion are primarily Republican and Medicaid benefits the needs of low-income groups. What has caused this growing polarization is less clear. Partisanship may result from and has grown to increasingly become a factor in voting behavior (Bafumi and Shapiro 2008; Bafumi and Herron 2010).

Whether politicians are more responsive to ballot initiatives is not fully understood. Researchers have found that ballot initiatives could cause legislators to pre-empt groups that are seeking policy change through initiative and similarly, initiatives could drive the policy agenda in the legislature (Matsusaka 2005; Gerber and Hug 2001). Using evidence from referenda in California, there is some research that Democratic politicians are in congruence with the needs of poor neighborhoods, it is not clear that state legislators are more responsive to these groups (Brunner, Ross, and Washington 2013).

State Responsiveness to Public Opinion on Medicaid Expansion

In this research we will show that voters favored Medicaid expansion and had a favorable view among the citizens in the states. Medicaid expansion has enjoyed high approval in polling nationally, in states that have not expanded Medicaid coverage, and in states that have taken up the ballot initiatives. In the remaining states that have not expanded Medicaid following the passage of the ballot initiatives, 59% of the population was in support of their state expanding Medicaid (Kirzinger, Wu, and Brodie 2018b). The Medicaid program has consistently had support with the public; 74% of the public held a favorable view of the program in 2005 and again in 2017 (Blendon et al. 2006; Kirzinger, Wu, and Brodie 2018a). It is unclear whether the Medicaid expansion has garnered additional support or increased awareness in recent years. The program gained additional national media attention following the 2017 Affordable Care Act repeal debate in Congress and has been discussed as a "third rail" in national politics (Sorian 2017). Public opinion of the Affordable Care Act may be linked to whether or not respondents live in states that have expanded Medicaid (J. D. Clinton and Sances 2018). States that decided to expand Medicaid had populations that were more favorable to the Affordable Care Act. Indeed, states that expanded Medicaid in early years may have largely been congruent with the

public opinion of their states (Grogan and Park 2017). Congruence with public opinion is not necessarily a measure of responsiveness to public opinion and researchers have found that states are only responsive to white opinion and racial resentment factors (Grogan and Park 2017). However, this difference between races and opinion of Medicaid may have changed in recent years. As we have demonstrated, general public opinion in non-expansion states favors Medicaid expansion. We will examine how the public opinion has changed in the states that have taken up expansion initiatives to become more favorable to Medicaid expansion in recent years and show that state policy-makers were not responsive to that change in public opinion.

Interest Group Response

We will examine how, at the state level, Medicaid ballot initiatives affect the behaviors of interest groups, state executive agencies, and the legislature. We will also explore how well they represent the preferences of the public, compared with legislative processes. Ballot initiatives have been shown to potentially increase the number of interest groups in a state because people are more likely to enter political participation due to a specific initiative (Boehmke and Bowen 2010). This paper will examine the interest groups that were formed and will show how the interest groups responded to efforts to change the Medicaid expansion policy after the initiative passed.

Campaign Spending Influence on Direct Democracy

Research had indicated in the past that campaign spending on initiatives is not a determinant of the outcome (Bowler and Donovan 1998). Much of this research took place prior to changes in campaign finance laws. Since then, there has been a significant growth in spending on initiative campaigns. More recent research has used polling data to show that campaign spending can have an influence on driving either voter preference or voter turnout to influence

the results of the election (de Figueiredo, Ji, and Kousser 2011). Campaign spending may have a greater influence on the results of ballot initiatives than other forms of influencing voters, including face-to-face interactions (Rogers and Middleton 2015). This study evaluated twelve ballot initiatives in Oregon and found that the spending by a political action committee opposed to the measures was able to significantly sway the preference of voters who would have otherwise voted in favor of the initiatives. The spending did not affect voter turnout or the drop-off rate of people not completing their ballots, indicating that campaign spending alters voter preference.

Direct Democracy as Efficient Policy Making

The debate of whether direct democracy represents the preference of voters shows mixed evidence (Lax and Phillips 2001). Voters are more likely to vote against initiatives than how they express their opinion in public opinion polling. Evidence suggests that voters can be influenced against passing policies through initiative. Campaign spending can lead to rejection of ballot initiatives (E. Garrett and Gerber 2001). Complex ballots and convoluted ballot language are associated with voters preferring to vote against measures or not select a preference. Ballot initiatives face a voter preference against the measure, in other words people are more likely to vote against a measure than respond favorably to a measure in a public opinion poll (Bowler, Donovan, and Happ 1992).There is research to show that in areas with frequent use of direct democracy, voters are more likely to seek out political information, be more engaged in the electoral process, and participate in voting (Donovan, Tolbert, and Smith 2009; Bowler and Donovan 2002; Tolbert, McNeal, and Smith 2003). This research has largely focused on ballot initiatives in general or research has focused on specific issues related to abortion, the death

penalty, and gay rights rather than those focused health care more broadly or policies related to health care coverage and financing.

3.4 Part 1: The Increasing Role of Ballot Initiatives in Health Care

Health care ballot initiatives have not been systemically studied, however the use of ballot initiatives in health care is copious. Many of the health care issues that are voted on mirror national political health care topics. For instance, in recent years states have voted on drug pricing, single payer health care, and the legality of the Affordable Care Act. We will examine whether health care ballot initiatives have grown as portion of the total number of ballot initiatives and how this growth compares to other policy issues that states traditionally have taken the lead on. We will examine whether ballot initiatives and specifically ballot initiatives related to health care have been more prominent in certain regions of the country and or in specific states. We will examine whether the health care topics that ballot initiatives cover have changed over time. We will examine how the subjects have trended over recent years. We will explore whether what factors, such as region of the country and topic of the initiative, are more likely to lead to successful ballot initiative proposals.

3.5 Methods

Database

Using a database of ballot initiatives from the National Conference of State Legislatures (NCSL), a sum of all ballot initiatives was collected from 1902-2018 from all states and the District of Columbia for each year. For these purposes, ballot initiatives included include initiatives, legislative and popular referenda, and other statewide and local municipality questions put before voters for a direct vote. Ballot initiatives that were on general election,

primary elections, and special elections were included. The NCSL database divides initiatives by topic, type of ballot initiative, whether the measure passed, and the vote counts. Topics were created by NCSL staff and collected from state legislative records. The database has been used in similar research and captures a complete list of initiatives, given then limited history of direct democracy processes in states. One limitation is that health care initiatives may be defined differently by NCSL than how others would define health care initiatives. For example, a hypothetical workplace safety initiative related to truck drivers could be defined as a transportation or health issue. NCSL provides one topic per ballot initiative.

Health care and transportation initiatives were pulled for comparison. Transportation, like health care, is a state-level policy that has some federal financing, regulation, and policy influence. Transportation has had a similar number of ballot initiatives as health care in the last decade, this makes it a good proxy for comparison of how many ballot initiatives have been introduced over the course of the history of ballot initiatives. Other ballot initiative topics that could have been used as comparison primarily focus on state process or state governance structures rather than a division of policy that the legislature may act on but instead the policy details are designated to the general public. Education could be an alternative topic to compare against health care because it meets the same criteria of state-level policy with federal financing, regulation, and policy influence. However, education has considerably more ballot initiatives, many of which are local funding changes making the policy less comparable because of the local, rather than state level nature of the policy and degree of initiatives.

For each health care initiative, the year of the vote, the state, the region as defined by the Centers for Medicare and Medicaid Services (CMS) state regions, and the result of the election were recorded. The subtopic of health care was classified based on qualitative text classification

methods. The subtopics were defined into 19 categories based on the text of the ballot question and common themes between the ballot initiatives. The topics are: biomedical research, children's health, dental regulation, environmental health, medical education, health care insurance, hospital construction and service areas, medical marijuana, Medicaid expansion, mental health, physician regulation, prescription drugs, public health funding and regulation, reproductive health, services for seniors and people with disabilities, sexually transmitted diseases, tax increase to fund unspecified state health services, vaccine regulation, and worker injury regulation. For measures that could be classified into more than one topic, the ballot initiative was classified by: 1) the name of the measure, 2) what topic a majority of the funding was directed, and 3) how it was described in the media. Only one topic was assigned to each measure.

Table 3.2: Increase in total, health care, and transportation initiatives

	Total Initiatives	Health Care Initiatives	Transportation Initiatives
Total	8,194	322	648
Average increase /year *(confidence interval)*	0.934*** *(0.620, 1.248)*	0.035 *** *(0.021, 0.048)*	0.007 *(-0.017, 0.030)*
Mean portion of total initiatives	-	5.1%	16.0%
Average increase/year (confidence interval)	-	0.0119 *(-0.036, 0.060)*	-0.174*** *(-0.282, -0.065)*

Statistical Analysis

Using linear regression, the rate of growth of initiatives and initiatives focused on health care and transportation were analyzed. To determine which topics of initiatives and which regions had a greater likelihood of passage, a linear regression model was used with year of passage as determining variable.

Figure 3.1: Growth in health care ballot initiatives (red) compared to transportation initiatives (blue) in each election cycle

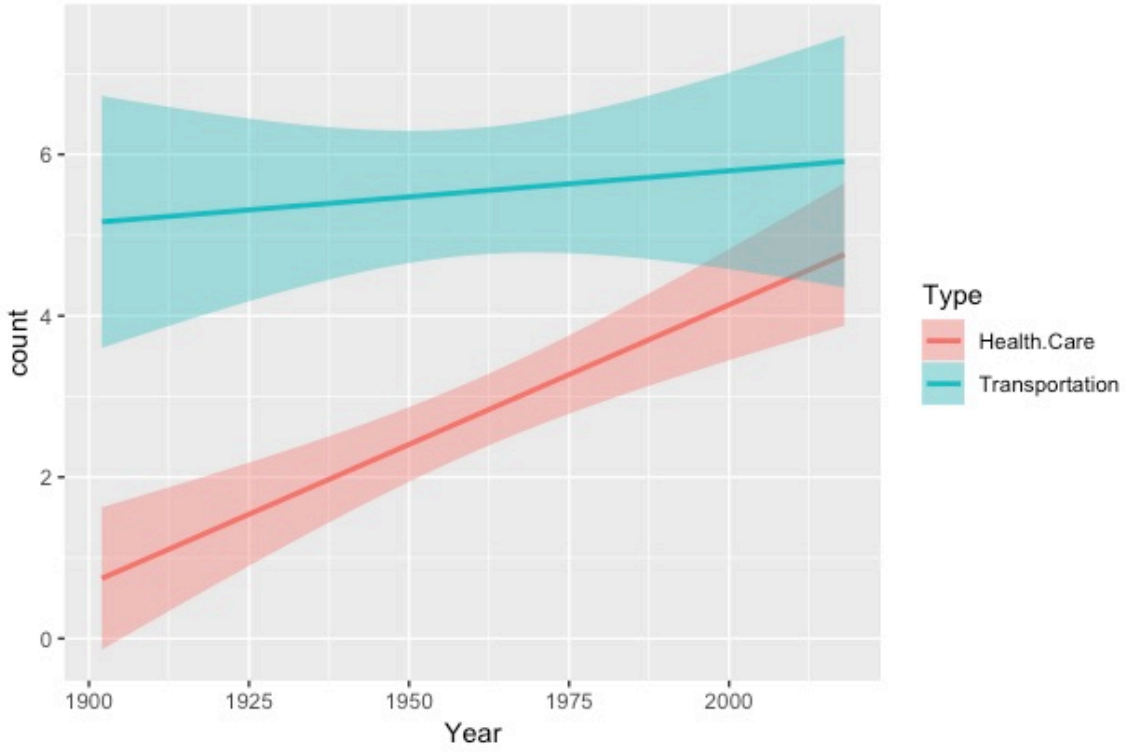
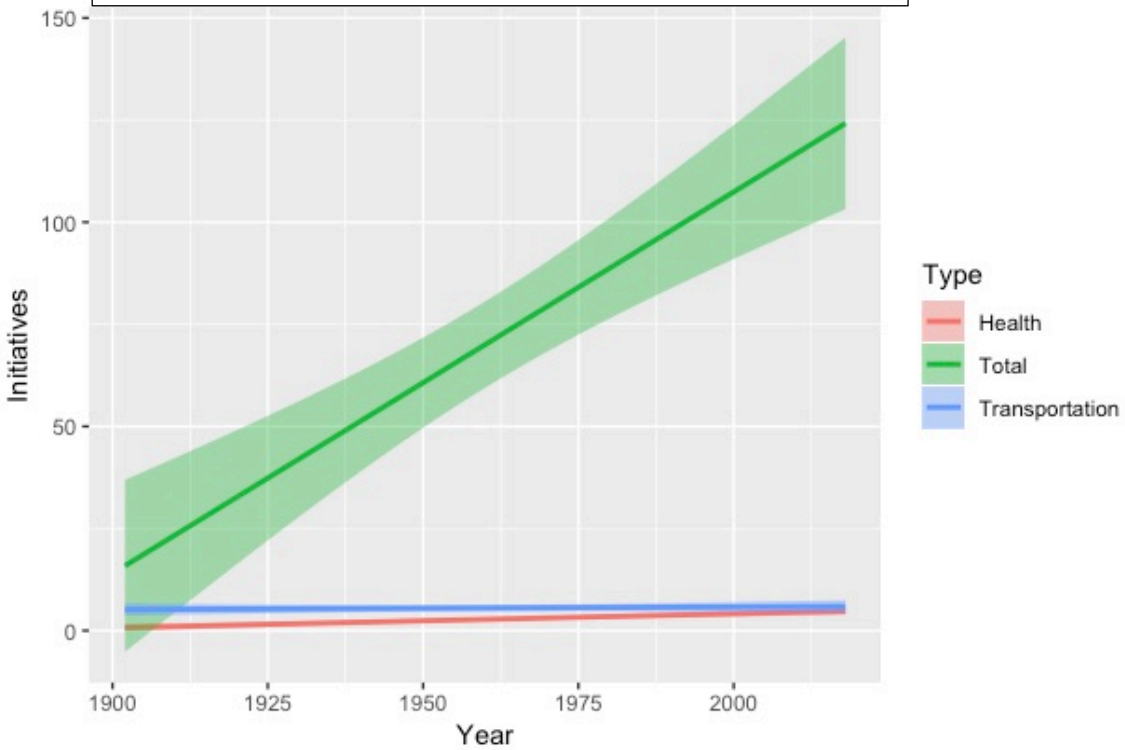


Figure 3.2: Health care and transportation initiatives in comparison to the total number of ballot initiatives (green)



The increased role of ballot initiatives in the policy process

Both the total number of ballot initiatives and ballot initiatives focused on changes to the health care system have grown in recent years. The total number of ballot initiatives have grown to an average of 101 ballot initiatives per a year in the last decade or 171 ballot initiatives on the ballot in Presidential or Midterm election years. Ballot initiatives have grown rapidly at a rate of approximately one new ballot initiative per a year in the United States.

Ballot initiatives focused on health care have grown at a rate of 3.5% annually, or an additional 3.5 health care ballot initiatives every decade. Ballot initiatives focused on health care have grown as a portion of the total ballot initiatives as well, although to a much smaller degree. The proportion of ballot initiatives that are focused on health care has been increasing 1% annually.

Ballot initiatives on health care have grown five times faster than on transportation. Ballot initiatives focused on transportation have grown at a rate of 0.65% annually. This is noteworthy since this means that transportation has been decreasing as a share of the total ballot initiatives.

Regions

California has had the greatest number of health care-related ballot initiatives with a total of 56, 25 of which have passed. Following California, Oregon and Arizona have had the next most health care-related ballot initiatives. Maine has followed these three states with 20 ballot initiatives, all of which successfully passed (See Figure 3.1). Most of the health care-related ballot initiatives have come from the Western and Mountain region with a small portion stemming from New England states. The Mid-Atlantic and Midwest have had the least number of health care-related ballot initiatives and until recently the Southeast did not see ballot initiatives (see Figure 3.4). Many of the states and regions that have not seen ballot initiatives

related to health either have only local initiatives rather than statewide processes or have a direct democracy process that limits what can be put on the ballot.

Figure 3.3: Health Care Ballot Initiative by State

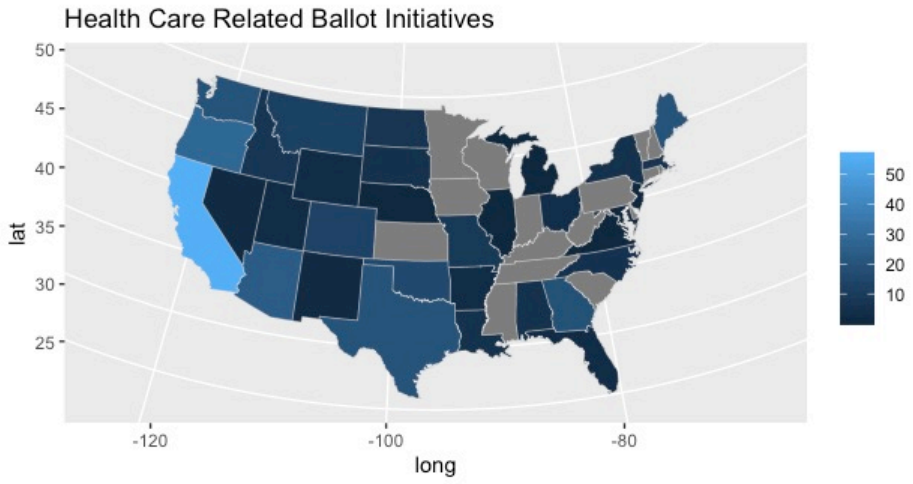


Figure 3.4: Health Care Ballot Initiative by Region

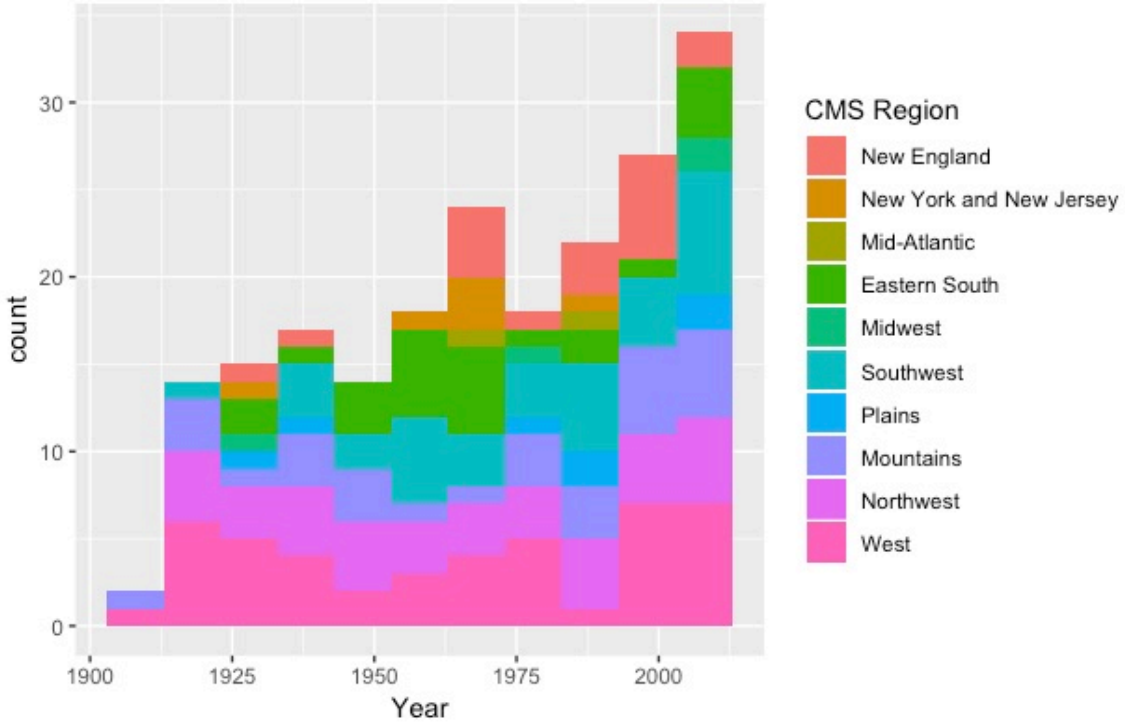


Table 3.3: Ballot Initiative Topics

Health Care Topic	Ballot Initiatives
Hospital Construction and Service Areas	74
Physician Regulation	54
Health Insurance	36
Mental Health	24
Taxes	19
Public Health	18
Health for Seniors and People with Disabilities	17
Dental Regulation	12
Worker Injury Regulation	11
Medicaid Coverage expansion	8
Provider Medical Education Payments	7
Sexually Transmitted Diseases	7
Biomedical Research	6
Children's Health	5
Prescription Drugs	5
Reproductive Health	5
Environmental Health	4
Medical Marijuana	4
Vaccine Policies	4

Health Care Topics Covered

The most common health care related ballot initiatives were those focused on hospital construction and defining hospital service areas and there are 74 ballot initiatives fitting this description. The next most common topic was physician regulation, dominated in part by regulations on chiropractic and other alternative forms of medicine. These two issues have remained a consistent presence over the history of health care ballot initiatives the last hundred years (see Figure 3.5). Mental health, public health regulation, health insurance changes, and tax policies are also common topics. The least common topics include medical marijuana regulation, environmental health, and vaccine policy. Health care topics tend to be grouped by topic and region over the history. For example, California has consistently voted on regulation of chiropractic services while the issue has rarely been addressed in other parts of the country. Ballot initiatives related to worker injury and worker compensation was common in the 1940s and 1950s and became more common again in the 1980s and 1990s as the issue gained more attention.

Figure 3.5: Health Care Ballot Initiative Topics

Trends in Health Care Ballot Initiative Topics

Ballot initiatives have followed the trends of health care focuses at the national level. The change in focus is in part due to emerging technology, disease, and financial burdens, and in part, a result of changes in the political values and issue attention of the time. For example, following the outbreak of the AIDS epidemic several states began to have ballot initiatives focused on disclosure around sexually transmitted diseases. Medical marijuana and regulating the cost of prescription drugs have grown to be a greater focus of ballot initiatives in recent years. Following the national attention focused on the Terri Schiavo Supreme Court case, several states instituted initiatives related to regulation of physicians and health facilities for practices around end-of-life care. There have been four initiatives related to reproductive health in recent years.

This has coincided with the growth of political polarization and the national political prominence of reproductive health and abortion.

While many trends have focused on health care policy that is under the domain of the state, some have focused on federal health care topics and federal health reforms. Shortly before and following the passage of Medicare in 1965, states had more initiatives focused on the financial and health care needs of seniors and people with disabilities. In the 1990s, several states passed initiatives encouraging health insurance reforms at the national level. Following the passage of the Affordable Care Act, several states began proposing and passing initiatives that prevented the state from implementing key portions of the Affordable Care Act and would assert values of choice and competition in the health insurance marketplace. In recent years, politicians have introduced single payer legislation at the federal level and in 2016 Colorado proposed an initiative to establish a single payer health care system in the state that ultimately did not pass.

Ballot initiatives have been used to extend health care to certain medically needy populations since 1942. Idaho passed an initiative to provide residents over the age of 65 small monthly grants to pay for health care expenses, over two decades before the Medicare program. This ballot initiative created a new program and specified the benefits and eligibility.

It is more common that ballot initiatives are used to fund expansions of health services than create new programs. Expansions of Medicaid have been made through increasing funding through ballot initiatives. Georgia was the first state to use the process in 1988 with the creation of the Indigent Trust fund that would maintain funding for medical care and expand Medicaid services for the existing eligible population (Howard, Fleischmann, and Engstrom 2017). The initiative was amended four years later to specify that the funds would be used exclusively for the expansion of Medicaid, primary health care for low-income populations, and rural health

programs. Georgia has used the initiative process prior to this ballot initiative to pass additional funding to establish programs that would encourage doctors to practice in the state through medical education payments. Similar to the creation and amendment of the indigent health program, the funding of the medical education program was a constitutional referendum, and the voting approval process was used because of the increase in funding necessary to pursue the policy goal.

Oregon was the first state to use the ballot initiative process to try to pass specific expansions of Medicaid eligibility beyond the current federal structure. However, Oregon's ballot initiatives were used as funding sources or revenue-generating mechanisms designed to be in conjunction with legislative bills to expand coverage. In 2000, the state voted on an initiative that would direct the money the state collected from a nationwide tobacco lawsuit settlement to fund an expansion of Medicaid and in 2002 the state passed an increase in its cigarette tax to fund expansions of Medicaid coverage. The initiatives were supported by the then-Governor John Kitzhaber who ran on and worked in the legislature to pass expansions of Medicaid eligibility and coverage. Neither Oregon nor Georgia used the ballot initiative process to directly change state policy on Medicaid eligibility, instead using them as tools to finance or consider expansions of coverage. Both of these attempts to increase coverage in Medicaid proceeded the Affordable Care Act's Medicaid expansion.

Ballot Initiative Passage

Approximately 61.9% of all health care related ballot initiatives have successfully passed with passage varying by region, and topic. Ballot initiatives that originate in Western, Mountain and Plain states are less likely to pass than ballot initiatives that originate in New England (see Table 3.4). Ballot initiatives related to physician regulation, prescription drugs, reproductive

health, taxes, sexually transmitted diseases, and vaccines are less likely to pass. Public health ballot initiatives are more likely to pass. Ballot initiatives related to health insurance are equally as likely to pass as they are to not pass (see Table 3.5).

Table 3.3: Passage rate likelihood by region

	Dependent variable:
	CMSRegion)
CMSRegion)2	14.957
	(979.610)
CMSRegion)3	14.957
	(1,696.734)
CMSRegion)4	−0.105
	(0.666)
CMSRegion)5	−2.303**
	(0.995)
CMSRegion)6	−0.815
	(0.586)
CMSRegion)7	−1.833**
	(0.831)
CMSRegion)8	−1.224**
	(0.582)
CMSRegion)9	−1.710***
	(0.539)
CMSRegion)10	−1.339**
	(0.548)
Constant	1.609***
	(0.490)
Observations	320
Log Likelihood	−196.596
Akaike Inf. Crit.	413.193
Note:	*p<0.1; **p<0.05; ***p<0.01

Table 3.4: Mean Topic Passage Rate

	Passage
Topic)Children's Health	−0.200
	(0.277)
Topic)Dentist Regulation	−0.417*
	(0.229)
Topic)Environmental Health	−0.500*
	(0.295)
Topic)GME	0.000
	(0.255)
Topic)Health Insurance	−0.500**
	(0.202)
Topic)Hospital Building	−0.230
	(0.194)
Topic)Marijuana	−0.250
	(0.295)
Topic)Medicaid Expansion	−0.125
	(0.247)
Topic)Mental Health	−0.083
	(0.209)
Topic)Physician Regulation	−0.611***
	(0.197)
Topic)Prescription Drugs	−0.800***
	(0.277)
Topic)Public Health	−0.444**
	(0.216)
Topic)Reproductive Health	−0.600**
	(0.277)
Topic)Senior Health	−0.294
	(0.217)
Topic)STD	−0.571**
	(0.255)
Topic)Taxes	−0.526**
	(0.214)
Topic)Vaccines	−0.750**
	(0.295)
Topic)Worker Injury	−0.455*
	(0.232)
Topic)AA	−0.500
	(0.494)
Constant	1.000***
	(0.187)
Observations	321
Log Likelihood	−195.149
Akaike Inf. Crit.	430.299
Note:	*p<0.1; **p<0.05; ***p<0.01

Legislating through ballot initiative has primarily been used to fund broad concepts of increased insurance coverage or to advocate for greater insurance coverage. The aforementioned revenue generating measures and other taxing questions have been directed to broad categories of the state budget that fund health coverage. Several states have put forward ballot questions that ask their state to address issues in the private health insurance market and health care reforms. With the exception of the single payer policy in Colorado, these ballot initiatives did not require the state to make significant changes to their Medicaid programs or to establish new programs. The recent trend of states using the ballot initiative process to change Medicaid

eligibility levels and require the state to make significant changes in the state-run Medicaid program represents a new use of the initiative process.

3.6 Part 2: Medicaid Expansion Ballot Initiatives, Case Studies from Four States

The use of direct democracy and ballot initiatives to pass Medicaid expansion represents a new way in which the ballot initiative process is being used to change health policy at the state level and affect national politics. The four states that have used the ballot initiative process to pass Medicaid expansion represent differing internal dynamics around the decision to expand Medicaid. In all states, the legislature or the executive branch have attempted to expand Medicaid through the legislative process but have failed to successfully pass a Medicaid expansion. In all cases, public opinion has favored the expansion of Medicaid in recent years and key health care related interest groups have been in favor of expansion, yet the legislature was not responsive to these forces. In some states, the legislature demonstrated their support for the expansion of coverage through successfully securing the votes to pass expansion but could not gain the support of the executive. In other states, the legislature opposed expansion and actively worked to pursue alternatives and obstruct the passage of the legislation. In all cases, the ballot initiatives have seen opposition by the legislature or executive branch to efficiently implement the policy as passed by the public.

In the following pages, we will summarize the political make-up of the state legislature, executive, and general public within each state that enacted the Medicaid expansion ballot initiatives. We will examine why these states did not pass Medicaid expansion through the legislature, the ways that they have used the ballot initiative process in the past and how they used it in this case, and how the political actors within the state responded to the ballot initiative after it was passed. Using these comparisons, we will analyze why the states had failed to pass

Medicaid expansion, whether the legislature and executive was being responsive to the needs of the residents, and why direct democracy was viewed as a viable alternative to passing Medicaid expansion in these states.

3.7 Maine – Question 2

The Maine effort to expand Medicaid had been prevented primarily by Governor LePage's opposition to furthering Democratic Party policies and expansions of social welfare programs. The state had the support of the legislature and local interest groups for several years. After the ballot initiative was passed, implementation was stalled for over a year because of ensuing political and legal debate brought by the governor.

Table 3. 5: Expansion Ballot Initiative Results

	Yes	No	Margin	Outcome
Maine	203,080 (58.95%)	141,436 (41.05%)	61,644 (17.9%)	Passed
Idaho	365,107 (60.6%)	237,567 (39.4%)	127,540 (21.2%)	Passed
Nebraska	356,891 (53.6%)	309,533 (46.4%)	47,358 (7.2%)	Passed
Utah	555,651 (53.3%)	486,483 (46.4%)	69,168 (6.9%)	Passed

Maine is a Democratic leaning state, although it has elected statewide Republicans including the conservative former Governor Paul LePage. The state is primarily white, with a slightly greater proportion of the population living in poverty. The state became the first to use the ballot initiative process east of the Mississippi in 1908 (Black 1912). The state has proposed 20 health care related ballot initiatives that all have passed. Many of these initiatives are related to extending mental health care services, fund the construction of hospitals, and extend health services to children. The process to submit a ballot initiative requires action by the legislature but the state does not have a requirement that votes come from across the state (*Maine State Constitution* 2013).

Over the period from 2012 through 2017 at least one branch of the Maine legislature passed Medicaid expansion six times while under both Democratic and Republican control. Republican Governor Paul LePage vetoed these attempts five times (Goodnough 2018). The legislature did not have enough votes to overcome the veto for each of these attempts and in the case of a 2016 action the legislature failed to pass a reconciled version of the bill because they did not have the votes to override a veto (K. Miller 2016). The governor reduced and eliminated certain benefits that had previously been available in the state's generous Medicaid program and instituted policies to add additional restrictions on Medicaid eligibility (Thistle 2018, Riley 2013).

Mainers for Health Care was the main political action committee (PAC) supporting the initiative (Dunlap 2017). The group was a coalition of several existing local groups. The group had the support of many local and national health care and community organizations (Mainers for Health Care 2017). Mainers for Health Care and several other PACs raised $2.67 million in support of the ballot initiative (Maine Ethics Commission 2017a). The Sixteen Thirty Fund and Fairness Project contributed the largest amount to the group with more than $865,000 and $1.05 million respectively. The Welfare to Work PAC opposed the measure and had the support of Governor LePage and several other prominent Republican state leaders. The group raised $427,785 (Maine Ethics Commission 2017b).

Polling in the state indicated that the measure would pass with 69% in favor of the initiative in the weeks leading up the to vote (Kliff 2017). More rigorous evaluation of Maine's Medicaid expansion favorability in the period before August 2013 indicated that Maine voters were in favor of expansion, slightly above the 50% mark. The same analysis did not put the decision of the state legislature and governor on Medicaid expansion in the category of

incongruent or in the category of congruent with public opinion at that time (Grogan and Park 2017). Meaning that the state legislature and governor were not being responsive to the voters nor were they going against the will of the public. Public opinion may have changed following the successful implementation of Medicaid expansions in other states and the more visible debate over Medicaid expansion in the state and at the federal level.

The ballot initiative passed with 203,080 votes in favor of the Question and 141,436 votes against or a 58.95% to 41.05% margin. For the year following the passage of the law, Governor LePage refused to implement the Medicaid expansion. On three separate occasions the court ordered the governor to expand Medicaid as passed by the ballot initiative. After electing a Democratic governor in 2018 the newly elected Governor Mills directed the Maine Department of Health and Human Services to expand Medicaid in January of 2019 (Lawlor 2019).

The main obstacle to passage of Medicaid expansion prior to the initiative was the governor's veto. While Maine's initiative process does not allow for a governor to overturn the results of the direct democracy election, Governor LePage used some existing structures in Maine law to slow the implementation and contest the initiative through the courts. The executive office remained a structural barrier or a veto point for the policy to proceed after the passage of the initiative.

3.8 Idaho – Proposition 2

Idaho has had a rich history of passing ballot initiatives related to health and was the first state to enact a new health care financing program through ballot initiative. Idaho's resistance to the expansion of Medicaid has been both with the legislature and to a lesser extent the governor's office. However, the executive branch and a portion of the legislature supported the efforts of the ballot initiative.

Idaho is a solidly Republican state with nearly half of the state's voters registered as Republican and 11.1% of voters registered as Democrats (Idaho Secretary of State 2018c). The state has higher rates of poverty, lower education rates, and a greater portion of the population is white than national averages (US Census Bureau 2018).

Idaho began using initiatives in 1911 and modeled the state's process off of the ballot initiative process in California (Weatherby and Stapilus 2005). Idaho was the first state to use the ballot initiative process to extend health care services to elderly adults. The only other health care related initiatives have been for the expansion of mental health services and the construction of hospitals. The state faced a backlash to the initiative process in the 1990s and additional restrictions were placed on the signature requirements and the distribution of signatures across the state (Schmidt 1991). To put a measure on the ballot, signatures are required from at least half of the legislative districts across the state.

Table 3.6: Ballot Initiative Requirements

	Maine	Idaho	Nebraska	Utah
Signature Requirement	10% of voters in previous gubernatorial election	6% of voters in previous general election	7% of registered voters at the deadline	10% of voters in previous presidential election
Number of Signatures	61,123	56,192	84,908	113,143
Statewide Requirement	None	18 of 35 districts need 6% of registered voters	33 of 93 counties need 5% of registered voters	26 of 29 senate districts need 10% registered voters
Time Allowed to Collect	18 months	18 months or by May 1st	2 years	315 days
Other Requirements	Required action or inaction by legislature	N/A	N/A	Legislature review

Over the course of the 2012 through 2018 legislative sessions Medicaid expansion or funding for a state run health insurance program for people under the poverty level were brought before the Idaho legislature seven times (Norris

2019). In 2016 the legislature voted to block the passage of a Medicaid expansion, but the legislative leadership formed a bipartisan committee to examine potential options to expand coverage in the Medicaid coverage gap (Russell 2016). Without the Medicaid expansion, eligibility levels for Idaho's existing Medicaid program were low and childless adults could not receive Medicaid. The state had a $33.9 million program to provide financial assistance for people with high medical costs, a program that could be redirected to Medicaid expansion (Russell 2018).

The primary organizations that worked to expand Medicaid Reclaim Idaho and Idahoans for Healthcare. Together, the two committees raised $1.78 million and spent $1.77 million (Idaho Secretary of State 2018a). They gathered financial support from top donors, including the Fairness Project, St. Luke's Health System, the Idaho Medical Association and the Idaho Hospital Association. The coalition of supporters included many local and national health care, education, and law enforcement related organizations. Reclaim Idaho utilized a political strategy of garnering public support from top Republican lawmakers. On October 30, 2018 over a week prior to the election, the then Governor Butch Otter came out publicly in support of the initiative and appeared in an advertisement endorsing the plan (Baker 2018). Opposition was led by a PAC entitled "The Work, Not Obamacare PAC. The group was affiliated with members of the Idaho Freedom Foundation, a prominent conservative organization in the state (Dalvin 2018). The committee raised $59,915 and spent $36,344, amounting to $1/30^{th}$ of what groups in favor of the proposition had spent (Idaho Secretary of State 2018a). The Work, Not Obamacare PAC had the support of 21 state legislators and passed a non-binding resolution opposing the Medicaid expansion effort through the Idaho Republican party at the GOP convention in June 2018.

Polling in Idaho indicated that Medicaid expansion was favored by 61% of voters and 20% of voters were opposed to the expansion shortly before the initiative's election (Bernick 2018). In 2017, a similar poll found that 70% of Idahoans supported Medicaid expansion, prior to the ballot initiative being introduced by supporters (Barnhill 2017). This favorable polling represents a shift in public opinion in the state. In 2013, less than 45% of Idahoans supported Medicaid expansion, putting the state's decision not to expand as congruent with public opinion at the time (Grogan and Park 2017). The shift in public opinion could be a result of broader understanding of the Medicaid expansion following the implementation in other states, including most states neighboring Idaho or a result of a broader understanding of the Medicaid expansion following the national attention resulting from the repeal debate.

The final election results had the yes vote on Proposition 2 winning with 365,107 votes to 237,567 votes against or a 60.58% to 39.42% margin (Idaho Secretary of State 2018b). Following the election, the head of the Idaho Freedom Foundation's Board of Directors filed a lawsuit that was ultimately found to be without merit in the Idaho Supreme Court to block implementation of the initiative (Russell 2019). In April of 2019 the legislature passed a set of "sideboards" that added work requirements to certain Medicaid expansion beneficiaries and put additional restrictions on eligibility and enrollment in the expansion group. The efforts to enact these restrictions on coverage were met with resistance from the Reclaim Idaho activists that had worked to pass the initiative. The legislature passed restrictions to the ballot initiative process, but newly elected Governor Little ultimately vetoed these changes and the legislature failed to override the veto. Activists from Reclaim Idaho organized, spoke before the legislature, and petitioned the governor to veto these changes and the governor cited legal concerns as well as the vocal opposition for the reasons he chose to veto the measure (Sewell 2019).

Idaho had been moving toward finding a solution to cover people without health insurance prior to the effort to pass the Medicaid expansion through referenda. The legislature was able to add certain restrictions to the Medicaid expansion and the ballot initiative process, but these restrictions were met with political activism from groups that were formed to pass the policy. The grassroots community organizations and coalitions have demonstrated an ability to continue engagement after the election, consistent with literature on activism created through the initiative process. Idaho governors have shown less resistance to the Medicaid expansion policy and there was greater Republican support for Medicaid expansion in the state than several other states.

3.9 Nebraska – Initiative 427

Nebraska has come close to expanding Medicaid through the legislature in the past and the main opposition has come from the governor and the right wing of the legislature. The state has fewer veto points to passing policies than other states due to the structure of the state government institutions. Although the state does not have a history with passing ballot initiatives related to health care, it had a strong group of social organizations that backed the efforts.

Nebraska has a unique state legislative party dynamic as it is the only state with both a unicameral and a non-partisan legislative branch. The state has elected Republicans into the governor's office, Senate, House of Representatives, the state legislature, and for the Presidency consistently in recent decades. Nebraska is largely white and rural. The state has a higher portion of the population living in poverty than the national average, but the median income mirrors the national median income.

Nebraska has never passed a ballot initiative related to health care prior to the Medicaid expansion initiative. However, the state has a long history with the ballot initiative process and

has voted on 112 ballot initiatives since the process began in 1912. In recent years, voters have seen one question on their ballot each year and have voted on issues related to the death penalty, minimum wage, and term limits. The state legislature has put limits on the initiative process several times, particularly during the 1990s when a greater portion of the ballot initiatives focused on pay and term limits for the legislature (Schmidt 1991; D. A. Smith 2004).

Members of the legislature introduced six bills from 2013 through January 2018 that would expand Medicaid (Norris 2018b). All of these bills with the exception of two failed to pass through committee. In 2014, on the legislature's second attempt to pass Medicaid expansion, the bill received a 27-21 vote (Millman 2014). Since this did not reach the limit to overcome a veto, the bill was tabled and never sent to the governor. The second bill that passed through the state's Health and Human Services Committee in 2016 used a similar structure to the health care reform attempts that came out of Arkansas and Indiana. The plan used premium assistance for low-income workers to purchase coverage through the health insurance marketplace and provided workforce training. The legislative session ended without a floor vote on the bill. Despite this legislative support, Republican Governors Dave Heineman (who served from 2005-2015) and Pete Ricketts (who served from 2015-Present) opposed the attempts to expand (Ricketts 2015; O'Hanlon 2014).

Ballot initiatives require signatures to equal seven percent of people who are registered to vote at the time of the signature gathering deadline, a higher threshold than in many states. Supporters paid $727,178.67 to collect the signatures in Nebraska for the Medicaid initiative. After advocates submitted the required number of signatures to appear on the ballot, a lawsuit was filed by members of the state's Republican party in opposition to the putting the measure on the ballot (Stoddard 2018a). Ultimately, the state Supreme Court determined that the sponsors of

the initiative followed Nebraska initiative law and that the measure could appear on the ballot (Stoddard 2018b). The expansion plan included a requirement that a state would not make eligibility more difficult for Medicaid expansion than for any other group (Nebraska Secretary of State 2018). This means that without legislative change the state could not submit a waiver or any additional cost-sharing or enrollment barriers for enrollees.

Insure the Good Life was a political action committee that was formed in support of the Medicaid expansion ballot initiative from several established groups that focus on social safety net programs. The Insure the Good Life committee received $2.86 million and spent $2.61 million with the Fairness Project and several organizations in Nebraska being the primary donors (Nebraska Accountability and Disclosure Commission 2018). Opposition to the measure in Nebraska primarily came from Republican members of the legislature and the local chapter of the Americans for Prosperity group. No groups in opposition of the initiative formed a political action committee specifically to organize in opposition of the initiative so the amount spent by these groups was not made public.

There was no public polling on Nebraska's ballot initiative prior to the vote. While there was no recent polling asking for level of support of expansion, polling in 2017 indicated that a minority of residents supported rejecting the Medicaid expansion (Joyce 2018). In 2013, less than 45% of Nebraskans were in favor of the Medicaid expansion, putting the state's decision to not expand as congruent with public opinion at the time (Grogan and Park 2017).

The initiative was passed in Nebraska with 356,891 votes in favor and 309,533 votes opposed (53.6% to 46.4%). In the months following the passage of the policy, the Insure the Good Life group disbanded and closed their website. The supporters that had existed prior to the question continue to be active in the Medicaid expansion conversation. In February of 2019,

Governor Ricketts submitted a budget that included recommendations on how to pay for the 10% state cost of the Medicaid expansion (Ricketts 2019). However, the following April, the governor announced that he would delay the implementation of the Medicaid expansion by a year and ask for a waiver from the federal government to add a work requirement to the Medicaid expansion.

Table 3.7: Amount of money raised on ballot initiatives

	In support	In opposition	Total (approximate)
Maine	$2.67 million	$427,785	$3.10 million
Idaho	$1.78 million	$36,344	$1.82 million
Nebraska	$2.86 million	NA	$2.86 million
Utah	$3.8 million	$34,943	$3.83 million

Nebraska had the support of the legislature in passing Medicaid expansion and, the like Maine, the governor represented the obstruction of the passage of expansion and continued to obstruct the implementation. While the state did not have a history of making health policy through ballot initiative, the state has had a history with passing recent initiatives and voters are familiar with the process. The state had established groups that came together to pass the bill and later disbanded to return to their prior work. Unlike Idaho, the initiative process did not maintain an active base of constituents.

3.9 Utah- Proposition 3

The Utah legislature was far along in a plan to cover people that were unable to qualify for federal subsidies or be eligible to purchase Medicaid when the ballot initiative was passed. The state has not had a history with health care related ballot initiatives changing policy and the initiative process has not led to policy change in the state. The weak history with the initiative process and power of the initiative in changing policy led to much of the initiative being rejected by the Utah legislature.

Utah is often considered one of the most solidly Republican states in the country, having voted for Republican presidential candidates by at least a 18 point margin since the 1964 election (Cohen 2012). Like the other three states, the population of Utah is more predominately white than national averages, but unlike the other states, Utah has higher rates of education, higher median income, and fewer people living in poverty than the national average.

Table 3.8: Polling on Initiatives

	Maine	Idaho	Nebraska	Utah
2013 Polling Range	50-52% in favor of expansion	<45% in favor of expansion	<45% in favor of expansion	<45% in favor of expansion
2017-2018 Polling	69% in favor of expansion	61-70% in favor of expansion	NA, although <45% in favor of rejecting expansion	59% in favor of expansion

Utah has used the ballot initiative process twice for health care related initiatives before the passage of the Medicaid expansion. One ballot initiative was focused on the construction of hospitals in 1986 and failed to pass. The second was a legislative referral in 1990 that asked the state to divide the responsibility of providing health care services to cities and counties. Legislative referrals are sent to the legislature but there is no requirement for the legislature to act. The state has had an initiative process in place since 1900 and was the second state to use the process. Utah did not successfully pass a citizen led initiative until 1960 and the state has a low rate of success, with only four of the twenty citizen led initiatives having passed prior to the Medicaid expansion bill. The state has approved several legislative referrals, many of which end up passing. After an initiative has passed in Utah the legislature and governor have opportunities to amend the policy.

In 2015 and 2016, Utah debated Medicaid expansion and was met with opposition in the legislature. A compromise was reached in 2016 to expand Medicaid to the state's homeless population. In 2018, prior to the passage of the Medicaid expansion initiative, the legislature

passed, and the governor signed a bill that included a modified and restricted Medicaid expansion. This plan included a work requirement, limits on medical expenditures, and an automatic repeal if the federal matching rate is reduced (Norris 2018a). The plan would extend coverage up to approximately 100 percent of the federal poverty level and the state requested an enhanced federal matching rate. The plan would have covered approximately half of the population that would be eligible for Medicaid expansion through the initiative. The state submitted the plan to the federal government through an 1115 waiver request and was awaiting approval from the federal government prior to the vote on the initiative.

The initiative was unique in that it included a way to pay for the state's share of the cost of the Medicaid expansion. The policy included an increase to the state sales tax of 0.15% in order to fund the state's portion of the Medicaid expansion. The other initiatives voted on in 2017 and 2018 did not specify a funding source. Another unique portion of this ballot initiative is that the measure required that the state does not reduce benefits or payment rates below what was set prior to January 1, 2017 (Proposition 3 2018).

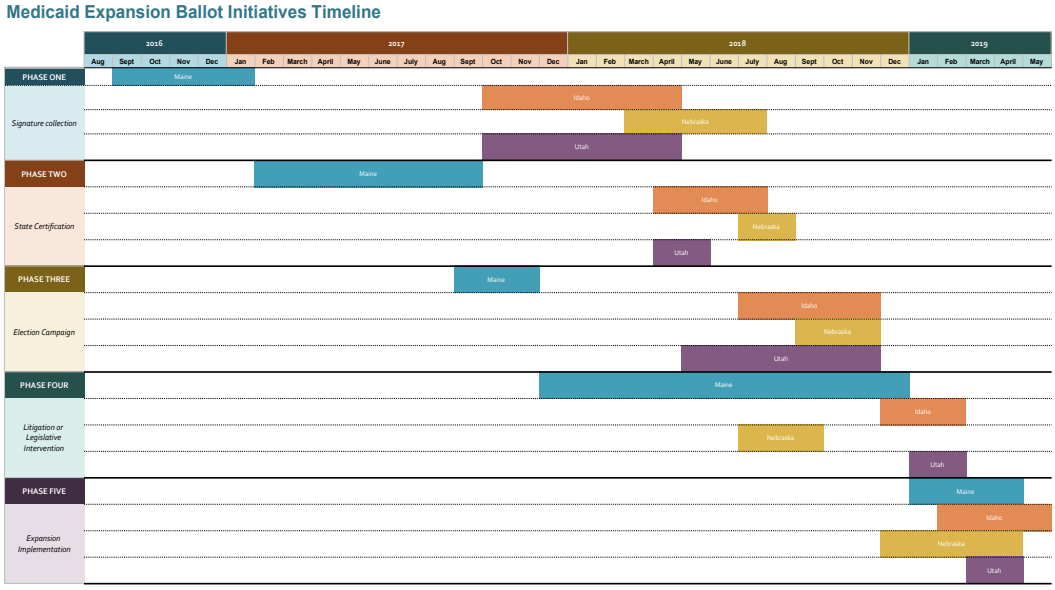
Utah Decides Healthcare was the main group of grassroots supporters of the ballot initiative. The committee reported $3.8 million in donations (Utah Disclosures 2018). The measure also gained significant support from health care groups, national groups focused on progressive causes, and the religious community with many prominent faith leaders supporting the bill (Proposition 3 2018). In opposition, the group No on Proposition 3 was formed and raised $34,943.24. The funding was supplied by in-kind support entirely by the group Americans for Prosperity. The Republican Governor Gary Herbert was the most prominent individual to express opposition to the Proposition 3 effort. Opposition also included many Republican members of the state legislature.

Polling in the weeks prior to the election indicated that 59% of likely voters supported Proposition 3 (Wood 2018). In 2013, less than 45% of Utah residents were in favor of the Medicaid expansion, meaning that the legislature's decision to not expand was congruent with public opinion (Grogan and Park 2017). Again, this difference in the support for Medicaid expansion could have been a result of seeing other states expand or the heightened awareness following the repeal discussions in 2017 and the awareness by the initiative campaign, among other potential reasons.

Utah voters passed the Medicaid expansion ballot initiative by 555,651 votes to 486,483 votes or 53.32% in favor to 46.68% opposed to the initiative. In the next legislative session following the passage of the amendment the legislature immediately took up amending the initiative. The governor submitted a budget estimate that the Medicaid expansion would cost more than was originally estimated, triggering the ability for the legislature to act. Amendments to the expansion included partially expanding Medicaid to 100% of the poverty level and adding work requirements to eligibility among several policies intended to reduce participation in the program (State of Utah 2019).

Utah does not have a history with ballot initiatives related to health care passing major legislation or policy changes. Legislative changes through the ballot initiative process are often passed as suggestions than policy determinations in the state. The state proposed and sent reforms to the federal government prior to the passage of the ballot initiative. Collectively, the political history, the opposition and the structural barriers in place in Utah meant that while the ballot initiative was able to pass the direct initiative process, the legislature was able to put significant restrictions on the policy.

Figure 3.6: Timeline of Initiatives



3.9 Discussion

Direct democracy gives advocates and policy makers an alternative vehicle to potentially passing policy at the state level when traditional legislative routes present a barrier. In the case of Medicaid expansion, all ballot initiatives have passed despite the fact that the legislature or executive branch of the states had opposed attempts to expand. The initiatives have demonstrated how campaigns can form and activate the electorate and how national and local organizations can raise funds. However, all initiatives have seen opposition to the passage and implementation of the initiatives that have prevented the policies from being implemented in the timeframe or criteria that was on the ballot. States have seen legal and legislative challenges before or following the election, active campaigning against the measure, or objections to the ballot initiative process. State history and political factors are deterministic of the resistance that the policies face following passage of the ballot initiative, just as they were prior to the passage of the ballot initiative. The sources of this resistance resemble the sources of the resistance prior to the expansion ballot initiative and the state's history the ballot initiative process within the state.

In this discussion, we will examine 1) the legislature and executive's responsiveness to public opinion, 2) the role of national and grassroots interest groups, 3) to what extent voters' decisions were influenced through the ballot initiative process, 4) prior use of the ballot initiative and 5) whether passing health policy through direct democracy results in effective policy making.

Legislature and executive's responsiveness to public opinion

In all of the states examined, public opinion favored expanding Medicaid and voters approved of expanding Medicaid through the ballot initiative at the time of the vote, but the policy previously had lower support in the past. In these states, support for Medicaid expansion rose over the period of 2013 through 2017 and 2018. When the legislatures and governors initially decided to not take the Medicaid expansion, they were responding to public opinion among the general public. As mentioned previously, that the difference in public opinion between white voters and minorities indicates that the states were more responsive to white residents. As we have seen with these four states the populations of the general public are much more heavily white than the national population. Race could be a factor in the states' responsiveness and in the change to support for Medicaid expansion among the general public. At some point following the expansions of coverage, the public opinion shifted in these states and the legislature and governors were no longer responding to the will of the public. Future research should examine how this shift in public opinion varied by race and the factors that may have caused this change in opinion. The lack of responsiveness to public opinion may be a main reason that the ballot initiative has gained in popularity in recent years. Initiatives are seen as a way to be responsive to general public opinion.

One reason that state legislatures and governors may not be responsive to the public is that polarization in state governments means that state representatives are responsive to members

of their parties, rather than the general population. For many politicians there is little incentive to appeal broadly and there may be a disincentive to appeal broadly because they could see a primary challenger from the extremes of the party. Governors face an incentive to appeal more broadly to the needs of the state than state representatives who represent a particular region. In Maine, the governor did not have an incentive to appeal broadly because he was not up for reelection. In Idaho, the outgoing governor faced the same incentive but supported the proposal. In Nebraska and Utah, the governors were not term-limited and remained neutral in the debate over the initiatives. The legislatures, on the other hand, are incentivized to appeal to voters in their party which explains why the three Republican states saw opposition in the legislature prior to the initiatives being proposed. The appeal to the extremes of their party also explain why the legislatures moved to add requirements to the proposals after their passage.

The role of national and grassroots organizing in influencing the election

Medicaid expansion has long been a policy debate among national progressive and health related organizations. The polarized nature of the Medicaid expansion debate has put the conversation at the front of Presidential campaigns. The polarized nature of the policy has led many Republican states and legislatures to reject the expansion despite statewide polling in non-expansion states that show that citizens are in favor of their states expanding coverage. For these reasons, using the ballot initiative process to sidestep the legislative and gubernatorial veto points to expand coverage has garnered the attention of national policy groups and media attention.

Each of the ballot initiatives gained the support of national organizations through either funding or endorsements. The media coverage of these ballot initiatives has focused on the grassroots organizing and petition gathering of local political leaders in support of these policy changes. While these efforts have been spearheaded by local groups, the funding has been

largely given by wealthy donors, national organizations, and national interest groups. The opposition to these policy proposals have largely been from state political leadership with the help of regional chapters of larger national organizations who primarily provide in-kind support. In both cases, the appearance of grassroots organizing is backed by strong financial interests and voters are influenced by the donations of larger groups.

The main financial contributor across these four ballot initiatives has been the Fairness Project. The PAC has previously and concurrently supported several attempts to increase the minimum wage through a ballot imitative process. In the 2018 ballot initiative process, the Fairness Project spent over $6 million on the Medicaid expansion initiatives in Nebraska, Utah, and Idaho. Some of the activities that the money helped pay for included data analytics and digital expertise, according to state financial disclosure forms.

Health care politics have increasingly been dominated by the voices of patients through the advocacy and testimonial evidence, but this was not the case in the Medicaid expansion debate. The advocates in favor of the policy change were made up largely of local or national disease groups or provider organizations that support or would benefit from the Medicaid expansion or who represent the interests' beneficiaries but are often not always beneficiaries themselves. Groups opposed to the policy change were largely representatives from the state government that had opposed Medicaid expansion in the past and local chapters of national conservative groups that have historically been opposed to expansions of social welfare programs. Absent from many of these groups is low-income residents who would be helped by the Medicaid expansion. While they may have been part of the argument in favor of the expansion or members of the coalitions collecting signatures, they were not part of the listed organizations that contributed financially or were included as cosponsors of the initiatives. Their

presence in newspaper articles was less present than the provider and lobbying groups supporting the initiatives and the political figures involved in the passage of the policies.

Voter's decisions influenced by the ballot initiative process

Evaluating if voters have been influenced by the Medicaid expansion campaigns can focus on the amount of spending that groups in favor or opposed to the policies spent. Under this evaluation criteria, the organizations in favor of the ballot initiatives outspent groups in opposition to the policy in all states that undertook the ballot initiatives. One limitation of using campaign spending as a measure of voter influence is that it depends on the accuracy of state campaign finance reporting. Using this as a measure assumes that voters are influenced by the official amount that was reported by the official organizations rather than if they were influenced by the spending that may have been done by groups who did not report to the state. Another limitation is that influence could have been made by endorsements or other monetary means.

As previously mentioned, the proponents of the Medicaid expansion ballot initiatives had the support of large national organizations, local chapters of national organizations, and many local community organizations. The groups had the support of Democratic statewide political leaders in all cases, however, in all states with the exception of Idaho's outgoing governor, the governors, who are likely the most recognized state official, did not support the Medicaid expansion efforts, although with the exception of Maine did not actively campaign against the measure. Voters may have been influenced by the support of the trusted interest groups for example, the AARP or American Cancer Society has high levels of trust among the public and the support of these interest groups could drive support among members and the general public. Voters may have been influenced by trusted political leaders and could have paid attention to the issue as a result of the campaigns that these leaders ran. The influence from political leaders

would likely have polarized the electorate since political support was divided based on party. We would expect to see the ballot initiatives pass more narrowly if Republican voters were influenced by their political leaders since the states voted for Republicans in higher margins in previous elections. Because the ballot initiatives passed with high margins in all states, influence from the political leadership does not appear to have caused the already Republican electorate in these states to follow their party leadership and vote against the policies. However, political leaders may have influenced some voters to vote against the ballot initiative. In this case, support for the ballot initiative would have been higher without their opposition. Idaho's highest level of support and highest vote margin conforms with the theory that opposition from Republican leadership may influence voters because in Idaho, the governor supported the initiative and there was little opposition from Republican leadership to sway voters.

Voters may have decided to vote against the initiative because of influences from campaigns or because of the nature of ballot initiatives. Support for these ballot initiatives weakened from polling done in the state prior to the election to the final vote totals. When polling asks whether voters are in favor of Medicaid expansion it does not use the same wording as the measures on the ballot and allows people to answer that they are not sure. Prior research has shown that when ballots are more complex or the wording on ballots is more complex, people tend to vote against the measures. The weakened support could be a result of undecided voters deciding against the measures. People who are undecided about the Medicaid policy may not have been exposed to the national attention that the Medicaid expansion has received. Research has also shown that a certain portion of the population votes against ballot initiatives regardless of the substance of the proposed policy because the electorate tends to lean more conservative than the general public and the electorate.

Use of the ballot initiative process for effective making policy

While ballot initiatives have led four states to expanding Medicaid, legislating through the ballot initiative process may not be a successful way of running public programs. Effective policies would be a policy favored by the public, be efficiently implemented, and use evidence to make decisions that are in the best interest of the public, the state budget, and the beneficiaries and other groups or individuals that receive the benefit of state dollars. Making policy through direct democracy accomplishes the goal of producing a policy that is favored by the public. The Medicaid expansion ballot initiatives have shown that passing ballot initiatives does not necessarily lead to efficient implementation. State policymakers are able to slow or impede voter approved policies without a clear consequence. Despite the fact that evidence from other state's Medicaid expansions were used as arguments to pass of these initiatives, it is not clear that voters are able to weigh the evidence and needs of the state when making complex policy decisions. Voters may be influenced by campaign spending and interest groups for ballot initiatives that may sway the results of the election. While ballot initiatives have caused an increase in social welfare program, it is not always clear that policies passed through direct democracy would consistently grow these programs or would be designed to benefit the population. One example of how the ballot initiative process can be used to retrench social services is the passage of several initiatives aimed at preventing states from implementing the Affordable Care Act in the years immediately following the passage of the law. These initiatives were politically popular and efficiently implemented but the population may not have fully understood the implications of voting for these policies.

Within ballot initiatives focused on Medicaid, voters are inconsistent on whether or not they would like to expand the program if they face the cost. In November of 2018, a funding

initiative in Montana that would increase cigarette taxes to fund the Medicaid expansion failed to pass. The initiative faced heavy opposition from the tobacco industry. On the other hand, a similar proposition was put before voters in Oregon in 2018 that would maintain the funding of the state's share of the Medicaid expansion. The initiative called for a tax on health insurance companies and certain hospitals. The ballot initiative known as Oregon Measure 101 passed 61.68% to 38.32% on January 23, 2018. These two propositions were tied to Medicaid expansion because they were written as tax increases to fund the state's share of the Medicaid expansion. However, both of these states had already made the decision to expand coverage and in neither case put forward the possibility to end or reduce the expansion to the voters. Both of these policy questions are more similar to the tax questions that voters have faced than the policy questions of whether or not the state should extend health coverage to people who would qualify under the Medicaid expansion; however, the public's support for Medicaid expansion is tied into the decision to fund these programs. Whether tax increases related to health care pass is similar to the existing questions of whether voters find the arguments for a tax increase compelling.

Prospects for future ballot initiatives and potential unintended consequences of pursuing policy through ballot initiative

Pursuing Medicaid expansion through ballot initiative could have positive coalition building consequences that further the goals of advocates and negative consequences that deter direct democracy and expansions of coverage. Other states could decide to pursue this method of Medicaid expansion if they deem direct democracy a successful way of creating policy. Groups that have formed could create coalitions that continue to advocate for causes similar to Medicaid expansion and raising Medicaid into political prominence could garner additional public support

and political awareness of the program. State legislatures have begun to enact restrictions to the ballot initiative process in response to this policy, making future policy changes through direct democracy more difficult. Similarly, raising the public perception of Medicaid could make the program a greater target for lawmakers to add restrictions on coverage.

Using the ballot initiative process to create policy creates several unforeseen consequences for both Medicaid policy and for the future of the initiative process. Medicaid policy being determined by direct democracy could create a situation in which the policies are defined by what is politically popular rather than what may be best for maintaining the financial health of the program, financial health of Medicaid providers, or the physical health of the Medicaid beneficiaries. For example, it is possible that policies such as instituting work requirements could pass through a ballot initiative and could reduce the number of people eligible for Medicaid and the amount that hospitals and doctors receive in payments. Just as Medicaid expansion has high rates of favorability among the public, requiring Medicaid beneficiaries to work in order to receive benefits enjoys similar support. Legislating through the ballot initiative process could also cause state legislatures to put additional restrictions on the ballot initiative process and make it less likely that future ballot initiatives could pass through the same mechanism, as has begun to happen following the 2017 and 2018 efforts.

The threat of a potential ballot initiative could cause legislatures to act as Matsusaka and Gerber and Hug have shown. Legislatures could pass a policy such as Medicaid expansion in a manner they see fit rather than pass what is designed by advocates when faced with the thread of a ballot initiative. There is little evidence that the threat of Medicaid expansion ballot initiatives has caused state legislatures to act to date because no state has proactively passed expansion after it has been reported that a ballot initiative is being drafted. Ohio had considered a ballot initiative

before the governor acted in 2013 but the process was in the early stages before the governor expanded. Following the actions of state legislatures in non-expansion states could provide insight on this dynamic going forward.

Advocates have pointed to, most notably, Florida and Missouri for potential future ballot initiatives. In both of these states, efforts have begun to organize signature gathering and completing the necessary steps to put the initiatives on the ballot for the 2020 general election. Florida holds a significant portion of the national number of remaining uninsured and people who are too poor for Medicaid but fall below the federal poverty level and are unable to receive subsidies to purchase insurance. Florida came close to expanding Medicaid in the 2015 legislative session but ultimately could not garner the support of the legislature despite the support of the conservative governor. Florida presents a unique problem for proponents of Medicaid expansion through ballot initiative because ballot initiatives that would change state policies require a 60% margin. Missouri has had two attempts to pass Medicaid expansion through a ballot initiative in the past. Both states have executive and legislative branches that have demonstrated opposition to Medicaid expansion in the past and both states have used the ballot initiative process for health care related issues less than 10 times. Other states that have potential avenues for expansion through the ballot initiative process include Mississippi, Oklahoma, South Dakota and Wyoming. Of these states, Mississippi has never passed or proposed a ballot initiative related to health care and South Dakota and Wyoming have had limited experiences with health care related ballot initiatives. The initiatives that have been proposed and passed in Oklahoma have focused on hospital construction and regulation.

In all of these states the state processes to implement a policy through ballot initiative could be met with resistance by the state's political institutions who have traditionally been

responsible for making policy decisions. The lack of experience with direct democratic initiatives and structural opposition to Medicaid expansion will likely mean that the states may see resistance in implementation of the Medicaid expansion even if the initiatives are passed by voters. The evidence from the ballot initiative process in Maine, Idaho, Nebraska, and Utah show that even if support is garnered among the public in a general election, the state legislative and executive branches can prevent the policy from being efficiently implemented or implemented as the policy was written.

State legislatures can respond to the threat of expansion through ballot initiative by choosing to expand or choosing to make it more difficult to pass policy though direct democracy. In 2019, there were signs that state legislatures have begun to react to the increase in the ballot initiatives, in response to initiatives that change policy typically reserved for the legislature. In the 2019 legislative session, policies were introduced in state legislatures that would put limits on the ability for ballot initiatives to qualify because of additional restrictions on the state-wide nature of the requirement (Armour 2019). State legislatures have historically responded to ballot initiatives by weakening the laws around direct democracy, including in the states examined here (Gerber and Hug 2001; Matsusaka 2005). In 2019, states have proposed adding additional requirements for petitioners to collect more signatures and more signatures from rural parts states. In the passage of the Medicaid expansion ballot initiatives, Idaho, Nebraska, and Utah had already included requirements that petitioners must collect signatures from the entire state. This requirement has the effect under the current national political landscape of favoring policy proposals that are led by or benefit conservative or Republican policies because rural areas are predominately more Republican. The policy also has the effect of making it more difficult to meet the standard. As was seen in the 2017 and 2018 process for groups to introduce and meet

states' ballot initiative requirements, the states that had higher requirements for consideration, the amount of time that signature gatherers and the amount of money spent gathering signatures would increase. Changing state policy to add additional requirements for ballot initiatives may make these policy proposals less likely in the future.

The groups that led the supporters of the ballot initiatives have continued to be politically active and advocate for the implementation of the Medicaid expansion. In Maine, the groups that led the campaign for the ballot question became a party to the lawsuit against Governor LePage. In Utah and Idaho, the same groups that came together as political action groups during the campaign organized against the legislatures' attempts to roll back the policies by organizing protests and testifying before the legislature in favor of maintaining the initiatives as passed. The organizations have also shown an intention to work to sign beneficiaries up for Medicaid expansion coverage once that option is available. The continued work of these organizations represents a shift in political activism at the local level. The process of passing the Medicaid expansion through ballot initiative has created an active political constituency, similar to the work of Boehmke and Bowen that has shown that ballot initiatives can create interest groups. This is notable for Medicaid since it is a program that has had little support among many national and grassroots advocacy groups. This new constituency of interested political groups in the Medicaid program contributes to the understanding that Medicaid has grown into a more prominent political issue.

The success of the Medicaid expansion ballot initiatives also suggests that the American public supports Medicaid and expanding coverage through Medicaid. Polling on Medicaid over the years has shown that it has received high levels of favorability among the general public. Discussion of Medicaid as a third rail in American politics has grown following the 2017

Affordable Care Act repeal debate in Congress. The Republican plans included a significant reduction in the Medicaid budget through block grants or per-capita caps and an elimination of the Medicaid expansion. Ultimately, the plans failed to pass with the Senate ultimately opposing it over concerns about the financial impact of Medicaid on state budgets and the effect of Medicaid on patients. Patient advocates objected to the Medicaid budget reductions with protests and organized lobbying efforts. All four of the Medicaid ballot initiatives passed following this demonstration of Medicaid as a politically viable program. It is unclear whether the ballot initiatives were influenced by the federal political debate on Medicaid or whether the votes reiterated the long-held favorable public opinion of Medicaid.

3.9 Conclusions

Passing Medicaid expansion through ballot initiative represents a profound change in how health policy is made in the United States and presents significant uncertainty in whether it is the most effective way to make policy. Voters are faced with a growing number of policy questions through ballot initiatives. Health care is growing share of total and growing number of ballot initiatives put before voters each year. The health care topics that are being voted on by the public have changed throughout the last century with topics increasingly being part of a national political discussion. While direct democracy in health care had more often been used to amend the regulatory, infrastructure, and taxing priorities of the state increasingly direct democracy is being used to make significant health care policy decisions that had typically been left to the legislature and executive branch.

Following years of failed attempts to pass Medicaid expansion in states that had been resistant to enacting the policy and national political and partisan attention, organizations that had the financial backing of national groups introduced citizen led ballot initiatives to enact

Medicaid expansion. The initiatives have been met with substantial resistance from the political elites that have been opposed to the Medicaid expansion in the past. A state's history with ballot initiatives and its history with Medicaid expansion attempts partially determines how the state reacts to the passage of the Medicaid expansion. Medicaid expansion policy is evolving and the future of Medicaid expansion in these states may look different from how they were passed by voters through the initiatives. It is clear that Medicaid expansion remains a politically contentious policy debate in states, even when the effort to expand through direct democracy is successful.

States will continue to use ballot initiatives to influence broader policy decisions. Partisan and financially influential organizations will continue to be active in these efforts because of the nature of partisan and fiscal importance health care. Medicaid policy will likely remain intertwined with the ballot initiative process because of the state-based nature of both Medicaid and direct democracy. The substantial shift in how health policies are made generates significant uncertainty, demanding a greater understanding of the causes and repercussions of this method of making policy.

Appendix

Timelines of Ballot Initiative Process:

Maine:

Below is a timeline of the initiative process for Question 2, the Medicaid expansion 2017 ballot initiative:

- October 28, 2016 - The ballot initiative gained the approval of the Maine Secretary of states to begin collecting signatures.
- December 15, 2016 – Maine Equal Justice Partners reported more than 65,000 signatures had been collected from 16 counties.
- January 25, 2017 – 70,302 signatures were submitted to the secretary of state for approval.
- February 24, 2017- The Secretary of State certified the necessary signatures with 66,434 valid signatures for the ballot initiative to be sent to the legislature to be considered for the next legislative session.
- April 27, 2017 – The state Senate voted to postpone a vote on the initiative and the measure was certified for the ballot.
- August 2, 2017 – The Secretary of State drafted the ballot initiative to be adopted as Question 2. The public was allowed to comment on the draft ballot wording until September 1, 2017. The draft ballot wording called Medicaid expansion an expansion of health insurance, a point that would later bring questions from opponents of the referendum.

- August 22, 2017 – Six current and former Republican legislators send a comment to the Secretary of State asking for the expansion to be called "taxpayer-funded health benefits" or "government-funded health benefits" instead of "health insurance."
- August 24, 2017 – Governor Paul LePage commented to the media on his opposition to calling Medicaid health insurance.
- September 7, 2017 – The Maine Secretary of State, Matt Dunlap, released the official ballot question with Medicaid described at "health coverage" rather than insurance.

Idaho:

Below is a timeline of the waiver request and approval process:

- October 16, 2017: Reclaim Idaho submitted the measure to the state for consideration on the ballot.
- November 10, 2017: Deputy Attorney General Scott Keim responded to the request saying that a provision in the measure that required the state to immediately implement through an emergency clause could be problematic.
- February 2, 2018: Reclaim Idaho had collected 10,000 signatures.
- March 20, 2018: Reclaim Idaho had collected 29,000 signatures.
- April 30, 2018: Reclaim Idaho had collected 60,000 signatures, surpassing the required 56,192.
- July 17, 2018: Idaho Secretary of State Lawerence Denney announced that the measure had qualified for the ballot with 75,134 verified signatures. The measure met the requirement of at least 6 percent of registered voters in 21 of 35 legislative districts.

Nebraska:

Below is a timeline of the Nebraska Medicaid expansion initiative process:

- March 9, 2018: the ballot initiative was filed and approved for signature gathering
- July 5, 2018: Supporters filed more than 133,000 signatures for the ballot initiative
- August 24, 2018: Secretary of State John Gale certified the ballot initiative with 104,477 valid signatures, nearly 20,000 more than the required 84,908.

Utah:

Below is a timeline of the steps that were taken to put the initiative on the ballot.

- October 2, 2017: The initiative was filed with the lieutenant governor.
- March 26, 2018: The lieutenant governor's office reported that 51,951 signatures had been submitted and 39,588 had been verified.
- April 16, 2018: On the deadline to submit signatures, proponents of the initiative reported collecting approximately 165,000 signatures.
- May 29, 2018: the lieutenant governor certified the measure for the ballot. Supporters ended up submitting 147,280 valid signatures and met the minimum threshold in in 26 of 29 state Senate districts, receiving approximately 34,000 more signatures than the minimum to qualify.

Comparison of Details of Ballot Initiative Process in Medicaid Expansion Initiative States

	Maine	Idaho	Nebraska	Utah
Politics:				
- **2016 Election Results**	Dem- 3 Electoral Votes Rep- 1 Electoral Vote	59% Support for Republican	59% Support for Republican	45.9% Support for Republican (21% for Republican third party candidate)
- **US Senate**	Split: 1 Republican, 1 Independent	Republican	Republican	Republican
- **Governor During Election**	Republican	Republican	Republican	Republican
- **Legislature Control 2012-2018**	Split	Republican	Republican	Republican
Demographics (2017):				
- **% White (73% National Average)**	95.0%	91.7%	88.1%	90.9%
- **Education - % with Bachelor's Degree or Higher (30.9% National)**	30.3%	26.8%	30.6%	32.5%
- **Median Household Income ($57,652 National)**	$53,024	$50,985	$56,675	$65,325
- **% Living in Poverty (11% National)**	11.1%	16.9%	14.6%	9.7%
- **% Without Insurance (10.2% National)**	10.0%	11.9%	9.6%	10.1%
- **Key Challenges**	It is estimated by 2026 one in four Mainers will be over the age of 65. The state's aging population and depressed growth in workers indicate that the state faces depressed tax revenue and economic growth (Murphy 2018)	The Idaho economy has suffered a loss of the timber and mining industries which has led to a reduction in the presence of unions in the state (Cotterell 2014).	With a growth of 4.4 percent in population growth since 2010, Nebraska has ranked in the top third of states in terms of population growth.	The state has one of the lowest unemployment rates in the country and the economic growth that the state has experienced in recent years is due in part to the state's immigrant population (Chaney and Nunn 2019)
Ballot Initiative History:				
- **Year Began Process**	1908	1911	1912	1900

	Maine	Idaho	Nebraska	Utah
- **Number of Health Care Initiatives**	20	8	1 (Medicaid expansion)	2
- **Topics Covered**	Mental health, medical marijuana, children's health	Hospital construction, dental regulation, mental health, senior health	N/A	Hospital construction and regulation
Medicaid Expansion Attempts:				
- **Number of previous attempts**	6 (5 passed the legislature)	7 (None passed legislature)	6 (None were sent to governor, one passed legislature)	3 (One compromised non-expansion plan passed the legislature and was being implemented)
- **Recent Medicaid Changes**	Prior to the LePage administration, the state had significantly expanded their existing Medicaid program known as DirigoHealth, the state elected to reduce benefits under the program and end the coverage expansions.	2016 legislative leadership formed a bipartisan committee to examine potential options to expand coverage for people below 100 percent of the federal poverty level, known as the coverage gap	Hospitals in Nebraska had concerns about uncompensated care because they did not see a significant reduction in uncompensated care following the passage of the Affordable Care Act, Nebraska saw a decrease in enrollment	In 2018 plan was passed that would extend coverage up to approximately 100 percent of the federal poverty level, included a work requirement and limits on medical expenditures.
Organizations Involved:				
- **Key Leaders in Favor**	Mainers for Health Care	Reclaim Idaho, Idahoans for Healthcare	Insure the Good Life	Utah Decides Healthcare
- **Key Groups Supporting**	Maine Center for Economic Policy, the Maine Equal Justice Partners, Maine's People's Alliance, Maine Voices Network and Planned Parenthood of Northern New England, Maine Chapter of the American Association of University Women, Bangor Area Homeless Shelter, Maine Children Alliance, the Maine	St. Luke's Health System, the Idaho Medical Association, the Idaho Hospital Association, American Heart Association, and the American Lung Association, Idaho School Boards Association and the Idaho Education Association, The Idaho Sheriffs Association	AARP Nebraska, the ACLU of Nebraska, Our Revolution, National Council of Jewish Women of Nebraska, PFLAG Grand Island, and the League of Women Voters of Nebraska, Greater Omaha, the Nebraska Hospital Association, Planned Parenthood Voters of Nebraska, Health Center Association of Nebraska, Nebraska	Utah chapters of the AARP, National Council of Jewish Women, League of Women Voters, and a variety of local groups that are working to combat hunger or homelessness, Utah Medical Association, the American Cancer Society, prominent faith leaders

	Maine	Idaho	Nebraska	Utah
	AFL-CIO, Maine League of Women Voters, Maine Hospital Association, several specialty and primary care provider groups, and the Maine Medical Association		State Education Association and the Service Employees International Union	
- **Key Politicians in Support**	Attorney General Janet Mills, Democratic Congressional Representative Chellie Pingree, former Senator George Mitchell,	Governor Butch Otter, State Representative Christy Perry	Democratic nominees for governor and lieutenant governor and many candidates and current state legislators as well as the Nebraska Democratic Party	Democratic nominees for state legislature
- **Key Leaders Opposed**	Welfare to Work PAC	The Work, Not Obamacare PAC	No organized group	No on Proposition 3
- **Key Groups Opposed**	The Maine Republican Party, National Federation of Independent Businesses in Maine	Idaho Freedom Foundation, Idaho Republican party,	Americans for Prosperity	Americans for Prosperity
- **Key Politicians Opposed**	Governor LePage, Maine Commissioner of the Department of Health and Human Services Mary Mayhew,	21 state legislators, Attorney General, Janice McGeachin, US Representative Raul Labrador	Republican members of the legislature	Republican Governor Gary Herbert, Republican members of the state legislature
Post-Election Outcome				
- **Lawsuit**	Lawsuit filed against Governor LePage for failing to implement. Was found 3 times that he was required to implement.	Filed after passage by Idaho Freedom Foundation. Court found lawsuit had no merit.	Filed after the measure was submitted to the ballot, was deemed to have no merit.	N/A
- **Legislature Action on Medicaid**	Legislature funded Medicaid expansion	Legislature added work requirements and other restrictions on eligibility	Legislature questioned governor's decision to delay	Legislature passed amended version of the initiative that resembled 2018 plan
- **Governor Action on Medicaid**	Republican governor did not implement. Democratic governor	Governor signed work requirement addition	Governor delayed implementation and indicated intention to request work requirement	Governor signed work requirement and partial expansion bill

	Maine	Idaho	Nebraska	Utah
	implemented in first months in office.			
- **Action on Ballot Initiative Process**	N/A	Legislature passed additional restrictions on ballot initiatives, governor vetoed	N/A	N/A

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