

June 2019

## Reexamining the Impact of Medicaid Expansion in a Post-Affordable Care Act Environment from a Critical Race Perspective

Ty Price Dooley

*University of Memphis*, [tpdooley@memphis.edu](mailto:tpdooley@memphis.edu)

Follow this and additional works at: <https://digitalscholarship.tsu.edu/jpmsp>

Part of the [Health Policy Commons](#), [Inequality and Stratification Commons](#), [Political Science Commons](#), [Public Policy Commons](#), and the [Social Policy Commons](#)

---

### Recommended Citation

Dooley, Ty Price (2019) "Reexamining the Impact of Medicaid Expansion in a Post-Affordable Care Act Environment from a Critical Race Perspective," *Journal of Public Management & Social Policy*: Vol. 26 : No. 1 , Article 3.  
Available at: <https://digitalscholarship.tsu.edu/jpmsp/vol26/iss1/3>

This Article is brought to you for free and open access by the Journals at Digital Scholarship @ Texas Southern University. It has been accepted for inclusion in *Journal of Public Management & Social Policy* by an authorized editor of Digital Scholarship @ Texas Southern University. For more information, please contact [rodriguezam@TSU.EDU](mailto:rodriguezam@TSU.EDU).

---

# Reexamining the Impact of Medicaid Expansion in a Post-Affordable Care Act Environment from a Critical Race Perspective

## **Cover Page Footnote**

I would like to thank Tess Dooley for her assistance in getting this project started. I would also like to thank Charles Menifield and reviewers for their helpful feedback.

# Reexamining the Impact of Medicaid Expansion in a Post-Affordable Care Act Environment from a Critical Race Perspective

Ty Price Dooley  
University of Memphis

*The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 drastically transformed the health care system in the United States. This paper examines the factors influencing state decisions relative to Medicaid expansion in a post-ACA environment through the lens of Critical Race Theory. This study incorporates economic, geographic and health variables into a model of post-ACA-Medicaid decision-making by using logistic regression to examine State Medicaid expansion from 2010 to 2014. The size of the minority population in state, tobacco use and southern distinctiveness are significant predictors of decision making relative to Medicaid expansion. Findings support that racialized decision-making, particularly in the South, continue to play a significant role in state-level policymaking.*

**T**his paper examines factors influencing state decisions relative to Medicaid expansion in a post-ACA environment through the lens of critical race theory (CRT) and its effects on at-risk populations. To address the issue of racial disparity in state-level health policy, CRT provides a useful framework. Central to CRT is that racism is pervasive and impacts every aspect of institutional decision-making in the United States. This research area is of particular interest in that it examines the impact of state-level decision-making on minority populations related to Medicaid expansion post-ACA.

The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) transformed the health care system in the United States. The ACA's Medicaid expansion was viewed as a critical component in addressing racial disparities in the U.S. healthcare system, particularly as it relates to increasing access to care. Racial disparities in the U.S. have been well documented by scholars, with data showing that African Americans suffer disproportionately lower levels of care and treatment as compared to their white counterparts (James 2017; Wheeler & Bryant 2017; Beller 2005; Nelson 2002; Fiscella et al. 2000; Williams & Rucker 2000). These disparities can be traced to social inequalities based on race

in the U.S. Race is a major basis of division in the U.S. and is a critical factor that is linked to the social, cultural, and economic structures of American society from its founding. Thus, racial disparities in health care reflect a historic legacy of race-based segregation in American society that can still be felt in communities of color.

Since the enactment of the ACA in 2010, 32 states and the District of Columbia have chosen to expand Medicaid. The funding formula for Medicaid reimbursement under the ACA was dramatically impacted by the passage of the law. Under the law, the Federal Medical Assistance Percentage (FMAP) increased federal reimbursements to states that chose to expand Medicaid to 100 percent for the first 3 years, followed by 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. In exchange for increased federal reimbursements, states would be required to expand their eligibility requirements to all households that had an income of up to 138% of the federal poverty rate with individuals under the age of 65. In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court held that states could opt out of the Medicaid expansion provisions of the ACA without penalty. Thus, in this post-ACA environment, characterized by federal reimbursements of ninety percent or more, coupled with states having wider implementation options, other factors beyond the traditional notions of party control should play a role in state Medicaid expansion decision-making relative to minority populations.

## Background

Medicaid is a program administered jointly by the federal and state governments that provides health insurance benefits to low-income families, individuals with disabilities, and certain benefits to senior citizens supplemental to Medicare coverage. This partnership between the states and the federal government has two components. The first component involves federal matching funds, which encouraged the states to establish Medicaid (Schneider 1997). The second component provides some flexibility for states as it relates to the operation of the Medicaid program relative to eligibility and benefits (Schneider 1997).

Medicaid was first enacted as part of the Medicare Bill, Public Law 89-97, in 1965. President Lyndon B. Johnson at the signing stated this bill would “improve a wide range of health and medical services for Americans of all ages” (Johnson 1965, p. 21).

In the last eighteen years, Medicaid has expanded to a wider range of the American public, in part due to legislative and regulatory action. In 1995, 33.4 million Americans were enrolled in Medicaid, resulting in a \$159.9 billion expenditure (Foster 2010). As of November 2014, Medicaid enrollment increased to over 68 million Americans, with expenditures exceeding \$508 billion (Department of Health and Human Services 2015). Medicaid is a critically important program in the U.S., as it is the second largest health care program following Medicare based upon expenditures, and the largest single health care program based upon the number of enrollees (Truffer, Klemm, Wolfe, Rennie, and Shuff 2013). As a consequence, the implementation of health-related services, via Medicaid, is an expensive burden for states (Greipp 2002).

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (ACA), into law. In his remarks at the signing ceremony, the President stated that the ACA “enshrined...the core principle that everybody should have some basic security when it comes to their health care” (Obama, 2010, p.3).

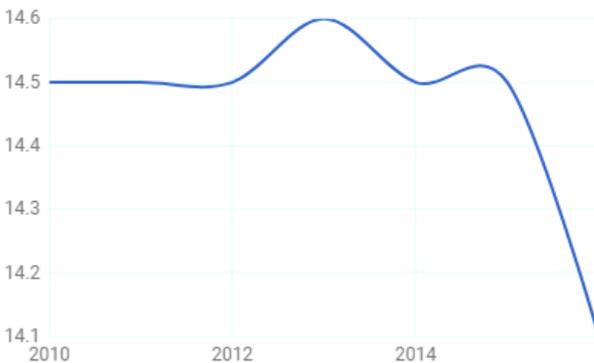
The ACA provided basic security regarding health care to many Americans using a three-pronged approach. First, individuals would be required to have minimum essential health insurance coverage (MEC) or pay a tax penalty, unless an exception applies. Second,

individuals would have expanded access to affordable health insurance coverage through the expansion of Medicaid and the Children's Health Insurance Program (CHIP), insurance market reforms requiring coverage of children as dependents until age 26, the elimination of exclusions from coverage for pre-existing health conditions, the creation of insurance exchanges, and incentives and penalties for employers to offer health insurance coverage to full-time employees working at least 30 hours per week. Third, the ACA would lead to the creation of a transformation within the health care system necessary to contain costs.

Effective April 1, 2010, the ACA permitted states to cover more individuals on Medicaid. States were able to receive federal matching funds for covering some additional low-income individuals, specifically adults without children and families under Medicaid for whom federal funds were not previously available. The ACA expanded Medicaid eligibility by 2014 to all Americans under the age of 65, whose family income was at or below 138% of FPL. States would receive 100% federal funding for individuals covered due to Medicaid expansion during the first three years of applicability. As previously stated, the Federal Medical Assistance Percentage falls to lower rates in subsequent years, stabilizing in 2019 and beyond at 90 percent. States would have to cover the remaining balance moving forward. The ACA is predicated on the notion that states comply with the expansion of Medicaid for newly eligible individuals, but also maintain its current federal matching funds for Medicaid for preexisting persons and families.

Several states challenged the constitutionality of Medicaid expansion as enacted by the ACA. The U.S. Supreme Court reviewed the issues of the constitutionality of the individual mandate and Medicaid expansion in *National Federation of Independent Business v. Sebelius*. In 2012, the Court upheld the constitutionality of the individual mandate; however, in a surprising decision, seven justices declared the mandatory Medicaid expansion unconstitutional. Led by Chief Justice John Roberts, five justices halted the complete elimination of Medicaid expansion by limiting the federal government's power of mandated enforcement; thereby allowing states an option to opt-out of expanding Medicaid without the penalty of jeopardizing all federal Medicaid matching funding.

**Figure 1: Black Percentage Uninsured of total Population 2010 to 2016**



Source: U.S. Census, American Community Survey.

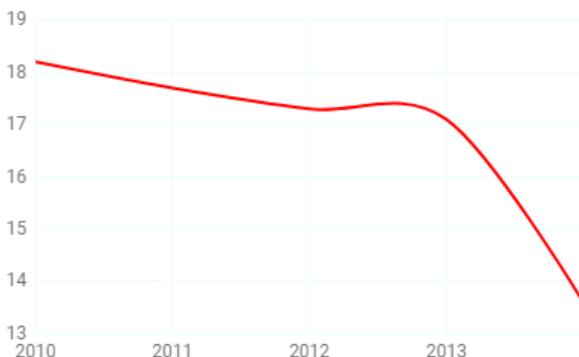
Initial estimates in 2010 by the Centers for Medicaid and Medicare Services (CMS) claimed that the ACA would expand coverage to 34 million Americans. CMS estimated that

more than one-half of those 34 million Americans, 18 million in total, would gain coverage due to the Medicaid expansion provision of the ACA. Among the states that expanded Medicaid coverage, more than 15 million people have enrolled in Medicaid or CHIP, with significant increases in coverage among black and brown populations (Kominski, Nonzee, & Sorensen 2017; Heintzman, Bailey, DeVoe, Cowburn, Kapka, Duong, & Marino 2017). These data seem to confirm previous studies that indicated that healthcare affordability was a factor in the lack of insurance among African Americans (Fiscella et al. 2000; Potosky et al. 1998; Mutchler & Burr 1991).

Figure 1 shows the number of uninsured African Americans as a percentage of the total population of the uninsured in the U.S. as reported by the American Community Survey, a division of the U.S. Census Bureau. Also, it illustrates the impact of the ACA on the African-American population as a percentage of the total population in the United States from 2010 to 2016. A significant reduction in the percentage uninsured from 14.5 percent to 14.1 percent occurred during the indicated time frame.

Figure 2 details an even more dramatic decline in the African American uninsured rate by focusing on the African American population in the U.S. from 2010 to 2014. As the Figure shows, there was a nearly five percentage point decline from 18.2 to 13.6. The data outlined in Figure 1 and Figure 2 illustrate the overall impact that the ACA's Medicaid expansion has had on African Americans.

**Figure 2: Black Percentage Uninsured 2010 to 2014**



Source: U.S. Census, American Community Survey.

The American Community Survey (ACS), conducted by the United States Census Bureau, is the largest household survey in the country, with approximately 3 million individuals surveyed in the public-use file each year. State geographical information is available in the ACS based on approximately 2,350 “public use microdata areas” (PUMAs). PUMAs are mutually exclusive areas within states that are populated with at least 100,000 individuals. The ACS is one of the primary sources used by the federal government to evaluate health insurance coverage (Smith & Medalia 2014).

### Review of Related Literature

Past research reveals that political party control plays an outsized influence on whether or not a state expanded Medicaid. I posit that the factors associated with Medicaid expansion in a post-ACA environment are complex.

Prior to the implementation of the ACA, party control of the legislature was statistically significant in determining spending levels for Medicaid (Brown 1995; Kouser 2002). Additionally, Grogan (1994) found that single party control of a state (both the legislature and the governor's office) was significant in determining Medicaid spending levels. In a post-ACA implementation study, Barrilleaux and Rainey (2014) examined state executives and found that governors' partisanship and the composition of the state legislature impacted substantively on a governor's decision to expand Medicaid. Thus, any initial conversation on Medicaid expansion among states under ACA necessarily began with a focus on party control and the partisan ideological underpinnings that are at play. This supposition was discussed by Jones, Bradley, and Oberlander (2014); Jacobs & Callaghan (2013); and Oberlander (2011). These scholars capably detailed the opposition to Medicaid expansion in Republican-controlled states. This is consistent with the increasingly partisan nature of party control found within state legislatures (Aldrich & Battista 2002; Wright & Schaffner 2002). Research in this area indicates that the party that controls the legislature produces unified voting blocks and sets the agenda (Clark 2012; Battista & Richman 2011). Party control of the legislature may not be the sole factor impacting the Medicaid expansion decision-making process under the ACA. I posit that other factors impact the decision-making process regarding Medicaid expansion and that decision-making under the ACA offers a unique opportunity to examine the decision processes of the various states in a way that one could not do prior to the passage of the ACA in 2010.

The point of distinction when comparing Medicaid expansion under the ACA relative to studies prior to 2010 is that those studies conducted prior to ACA passage only looked at the relative expansion of various Medicaid benefits. Due to the 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius*, states had a real opportunity to accept sweeping changes to their Medicaid programs along with the substantial subsidy of the cost. Thus, in post-ACA implementation, several studies have revisited Medicaid decision-making to find additional factors that play a role in state decision-making processes. In their study, Mayer, Kenter, and Morris (2015) employed a dependent variable of five additive measures of ACA support and examined the impact of both political and socioeconomic indicators on state policy decisions. They found a correlation between public health need and traditionalistic political culture. Travis, Morris, Mayer, Kenter, and Breaux (2016) found that Southern states were distinctive relative to their Medicaid decisions, with the executive driving the decision-making process. Race may also be a factor impacting state decision-making in Southern states (Travis et al. 2016).

This paper builds on these studies by incorporating racial, economic, and health indicators into a broader explanatory model of post-ACA Medicaid decision-making. Predictor variables for the model include race, obesity, tobacco use, unemployment, poverty rate, under 18 poverty rate, southern distinctiveness, and total party control of a state.

## **Race**

Due to the disproportionate impact of lower levels of income as a group, African Americans and Hispanic residents are more likely not to have insurance and experience increased health related issues (Lillie-Blanton & Hoffman, 2005; Kirby & Kaneda, 2013). These groups benefit from Medicaid expansion (Racine et al., 2001; Lillie-Blanton & Hoffman 2005; Kirby & Kaneda, 2013; Clemans-Cope et al., 2012). As it relates to the decision-making process on whether a state would choose to expand Medicaid, previous studies have indicated that as the percentage of the non-White population increases in a state, social safety net programs

akin to Medicaid are less likely to be adopted and expanded (Orr, 1976; Wright, 1977; Plotnick & Winters, 1985).

### **Unemployment and Poverty Rate**

The unemployment and poverty rates are key indicators of a state's overall economic health and are key predictor variables that impact decision-making for state Medicaid expansion in a post-ACA environment. State spending related to Medicaid expansion should impact employment rates by making workers healthier and, in turn, more productive (Stronks, Van De Mheen, Bos, & Mackenbach 1997). Poverty rate continues to have a profound effect on states in both social and cultural terms. The ACA originally was designed to standardize health care options and expand coverage to many people in the uninsured population that were at or near the poverty line (Holahan, Buettgens, Carroll, & Dorn 2012). Relative to Medicaid, the poverty rate of a state can serve as a metric of health care access and utilization disparities relative to low-income populations (Gornick & Swift 2002). The decision to opt out of Medicaid expansion creates a considerable gap in health care coverage for low-income residents of a state (Crowley & Golden 2014). These gaps in coverage exacerbate social risk factors for these at-risk populations within a state and have negative effects on the broader community within that state (Hacker 2004). Consequently, I posit that among states that have chosen to expand Medicaid in a post-ACA environment, unemployment and poverty rate would be factors that would influence a state in deciding to expand Medicaid.

### **Obesity and Tobacco Use**

This model also incorporates both obesity and tobacco use as predictors of Medicaid expansion in a post-ACA environment. These two variables were selected due to their impact on state policymaking. States have identified both tobacco use and obesity as major drivers of preventable health related costs that impact public health expenditures. Obesity and tobacco use are identifiable and replicable risk factors that impact the major causes of death in the U.S. (Yoon et al. 2010; Danaei et al. 2010; Murray et al. 2006). Of these, obesity is perhaps the most impactful. Excess body weight is associated with negative effects on longevity and productivity and places a substantial burden on the health care system (Wang et al. 2011). Rates of obesity in the U.S. have increased over the past 25 years, to the extent that over 35 percent of Americans are obese (Ogden et al. 2012). In their study, Eckel and Krauss (1998) identified obesity as a serious risk factor for coronary heart disease, on a par with tobacco use, physical inactivity, and high blood cholesterol. Van Itallie (1985) linked higher rates of mortality for overweight young adults when compared to overweight adults over the age of 45.

A study of population and mortality figures from the Bureau of the Census and the National Center for Health Statistics found that the diseases with the largest contribution to mortality disparities across the U.S. are chronic diseases and injuries with well-established risk factors, of which obesity and tobacco use were leading contributors (Murray et al. 2006). A subsequent study of population and mortality figures using additional data obtained from the National Health and Nutrition Examination Survey and the Behavioral Risk Factor Surveillance System concluded that disparities in tobacco use and adiposity, among other risk factors, explained a significant proportion of disparities in mortality from cardiovascular diseases and cancers, and some of the life expectancy disparities in the U.S. (Danaei et al. 2010). In a study commissioned by the CDC, researchers found that being overweight and a smoker were major modifiable risks for four of the five leading causes of death in the U.S. (Yoon et al. 2010). Moreover, researchers have identified strong support in the U.S. for health

care policies designed to prevent and treat obesity and tobacco use related health concerns (Fuemmeler et al. 2007).

### **Southern Distinctiveness**

The geographic South is a distinctive region in the United States, historically, culturally, and economically. This model incorporates Southern Distinctiveness as a predictor. Prior research has demonstrated the linkage between the geographic South and Medicaid expansion (Travis et al. 2016). Moreover, cultural attitudes relative to race vary by region (Fosset & Kiecolt 1989).

### **Critical Race Theory**

Critical race theory has emerged as an effective analytical lens to understand institutional phenomena. This paper breaks new ground through the application of CRT to the field of public policy decision-making. CRT draws from a broad literature in the areas of ethnic studies, law, sociology, education, and public health (Ladson-Billings & Tate 1995; Tate 1997; Ladson-Billings 1998; Aguirre 2000; Powell 2007; Viruell-Fuentes, Miranda, & Abdulrahim 2012; Feagin & Bennefield 2014; Ford 2016). Critical race theory owes its origins to critical legal theory, which is based on postmodernity and the postmodern school of thought.

Previous research in the area of Medicaid expansion, prior to the implementation of the ACA, demonstrated that the timing of state Medicaid policy adoptions related significantly to party control in the state legislature (Brown 1995; Kouser 2002; Grogan 1994; Clark 2012; Battista & Richman 2011). However, with the additional resources provided under the ACA, it seems likely that other factors can be examined that could reveal additional insights relative to state decision-making. Thus, in a post-ACA environment, with fiscal constraints ameliorated to a high degree, CRT provides a useful starting point for understanding the internal and external determinants that drive policy adoption; with the caveat that for most of its history, public policy in the U.S., relative to the institutions, processes, and conventions, were not developed or designed for African Americans or other marginalized populations. In their study of the racial dimensions of U.S. healthcare and public health systems, Feagin and Bennefield (2014) point to the need for new conceptual paradigms to assess racialized health disparities in the U.S. due to the racist realities of contemporary American society.

At its core, CRT is based on the notion that race and racism is structurally ingrained in our system of governance, going back to the very origins of the founding of the U.S. But what is more relevant today is that the laws, remedies, and policies that have been constructed since the 1960s are steeped in racist ideologies that continue to perpetuate white privilege. White privilege is a structural feature of the social, economic, and political order of the U.S. Structurally, it is a pervasive all-encompassing state in which white persons both benefit and are spared from injustices imposed on persons of color (Bloom 2008). Policies associated with redlining practices that kept African Americans from purchasing homes in certain neighborhoods, loans provided to African Americans at higher interest rates than their white counterparts, the criminalization of the public-school system that disproportionately impacts black and brown communities are all examples of public policies that perpetuate white privilege.

Central to CRT is the idea that race is social construct that is not empirical nor objective. Further, the social construct of race has no biological or genetic derivative. Rather,

race is a construct designed solely to advantage a specific population at the expense of all others at the founding of the U.S. The outcomes of the racialized constructs enshrined in the U.S. Constitution, at its founding, have produced artifacts that are pervasive in our system of governance to the extent that it has racialized public policy decision-making. In essence, every institution derived from the rational-legal framework constructed by the U.S. Constitution is racist. The racialized disparities produced are profound, systematic, and cumulative (Gooden 2015). In practical terms, this means that racism is difficult to combat through formal rational legal methodologies based around notions of race neutral policy outputs with formalized implementations that do not take into account issues related to equity and prior discriminatory practices. Ultimately, race neutral policies perpetuate the status quo in U.S. public policymaking by maintaining white privilege. Operating within that construct, CRT emerges as a paradigm that offers insights into social justice related issues in the U.S. Relative to this study, internal and external determinants will focus on state racial indicators that may impact the decision-making process of Medicaid expansion in a post-ACA environment.

### **Methods and Model Specification**

The data from the present study were drawn using a longitudinal design from 2010 to 2014. Forty-nine states were examined (Nebraska was excluded due to the unicameral nature of its legislature) using quantitative methods that provided substantive and theoretical insights into whether the articulated independent variables of race, obesity, tobacco use, unemployment, poverty rate, under 18 poverty rate, southern distinctiveness, total party control of a state, and governor's party affiliation impacted the dichotomous dependent variable, Medicaid expansion. Initially, the overall distribution of the data collected was examined. The purpose of running descriptive statistics was to learn about the content of the populations and to reveal the scope of the data within those populations. Next, bivariate association tests were conducted to determine the strengths and direction of the associations between variables in the data. Variables that were highly correlated, not consistent with the literature, were excluded from the models detailed. Additionally, Hosmer-Lemeshow goodness of fit tests were run for each model to detect if there were misspecifications relative to the models detailed. No misspecifications were indicated. Finally, logistic regression models were constructed to examine the relationship between the dependent and predictor variables. A Durbin-Watson test was performed on the panel data to check for issues related to auto collinearity. The test did not reveal auto correlation issues.<sup>1</sup> Data were obtained on whether or not a state expanded Medicaid from both the National Conference of State Legislatures (2015) as well as the Kaiser Family Foundation (2015) for 2010 through 2014. Medicaid expansion was coded as a dichotomous variable, where states that chose to expand Medicaid

---

<sup>1</sup> The Durbin Watson test is a number that tests for autocorrelation in the residuals from a statistical regression analysis. A Durbin-Watson test statistic is always between 0 and 4. A value of 2 means that there is no autocorrelation in the sample. Values from 0 to less than 2 indicate positive autocorrelation and values from more than 2 to 4 indicate negative autocorrelation. The results for Model 1 = 2.12, Model 2 = 1.916, Model 3 = 2.155 indicate autocorrelation was not found in the sample. Model 1 examined both Democrat and Republican total party control states; Model 2 examined the partisan decision-making of state executives, and Model 3 examined states where only Republicans were in total party control of the state. A fourth model examined the relationship between Medicaid decision-making by race in the 12 states that constitute the contiguous geographic South in the U.S. A state was coded 1 if they expanded Medicaid and 0 if they did not. Additional tests were conducted to check independent variables for multicollinearity. I tested the p value at .05, and .001. The null hypothesis was rejected at the p < 0.05 level of significance.

were coded as a 1, and states that did not expand Medicaid were coded as a 0. Data on the ratio of the minority population for states were obtained from the U.S. Census Bureau for 2010 through 2014. Data for tobacco use by state came from the Centers for Disease Control and Prevention. Political party affiliation for both state legislative bodies and the state executives came from the National Conference of State Legislatures. These data were used to construct the variables: total party control of a state<sup>2</sup>, governor's party affiliation, and Republican Party control of a state<sup>3</sup>. Each of these variables was dichotomous. Total party control was coded as 1. The absence of total party control in a state was coded as 0. Governor's party affiliation was coded as a 1 for Democrat, and coded as a 0 for Republican. The presence of total Republican Party control was coded as a 1, and lack of total Republican Party control of a state was coded as 0. Using unemployment data from the Bureau of Labor Statistics, unemployment rates were expressed as the ratio of the number of unemployed individuals in a state to all individuals currently in the labor force. Poverty rate information was collected from the U.S. Census Bureau's Small Area Income and Poverty Estimates for 2010 through 2014. These data were used for both poverty and under age 18 poverty variables in the model. Obesity data collected from Trust for American's Health for 2010 through 2014 were used to construct a dichotomous variable. Southern distinctiveness, comprised of the states from the U.S. South, where 1 was coded to indicate southern and 0 not southern. Race is coded as a continuous variable; expressed as the ratio of white only to non-white population for each of the 12 states in the model. The states are South Carolina, Mississippi, Florida, Alabama, Georgia, Louisiana, Texas, Virginia, Arkansas, North Carolina, Tennessee, and Kentucky.

## Findings

Table 2 presents the output across each of the three models. The first model, which included basic socioeconomic and health categories, suggested that party control was a key indicator of state decision-making in a post-ACA environment. This finding was consistent with other studies in the literature (Grogan 1994; Jones, Bradley, and Oberlander 2014; Jacobs & Callaghan 2013; Oberlander 2011; Aldrich & Battista 2002; Wright & Schaffner 2002) and reinforces the overwhelming nature of partisan motivations impact on state-level decision-making. Another finding within Model I dealt with the negative relationship of southern distinctiveness to Medicaid expansion decision-making. Southern states were less likely to expand Medicaid. Additionally, tobacco use and level of unemployment in a state were both statistically significant with a negative relationship to Medicaid expansion. States with higher levels of unemployment or higher levels of tobacco use were less likely to expand Medicaid.

The output for Model 2 is consistent with previous research regarding the significance of gubernatorial decision-making relative to Medicaid expansion (Barrilleaux, & Rainey 2014). Interestingly, a larger non-white population seems to have a positive relationship relative to gubernatorial decision-making on Medicaid expansion. In this model, southern distinctiveness and tobacco use were also significant factors that negatively impacted gubernatorial decision-making.

---

<sup>2</sup> Total party control of a state refers to a single party having majorities in both houses of a state legislature and controlling the governor's mansion.

<sup>3</sup> Republican Party control of a state refers to the Republican Party controlling majorities in both houses of a state legislature and controlling the governor's mansion.

**Table 2: Logistic Regression Models Predicting Medicaid Expansion**

	Model 1		Model 2		Model 3	
Southern Distinctiveness	-2.847*	(1.217)	-1.575*	(.609)	-3.769*	(1.619)
Tobacco Use	-.208*	(.104)	-.144	(.074)	-.127	(.183)
Poverty (Under 18)	-.052	(.340)	-.012	(.254)	-.558	(.552)
Poverty	.330	(.494)	.049	(.358)	.945	(.834)
Unemployment	-.579**	(.181)	-.291*	(.116)	-.213	(.329)
Obesity	.115	(.112)	.107	(.080)	.355	(.290)
Minority Pop	2.929	(2.014)	3.934*	(1.455)	7.844	(4.643)
Total State Control	3.043**	(.666)	-----	-----	-----	-----
Governor's Party Affiliation	-----	-----	1.510**	(.377)	-----	-----
Constant	-2.208		-1.251		-12.928	
Model $\chi^2 =$	73.099	p.<.05	59.546	p.<.05	12.725	p.<.05
Pseudo R <sup>2</sup> =	.52		.317		.267	
n =	164		242		97	

Note: Standard errors in parenthesis

\*p<.05, \*\*p<.001

Model 3 examined only the states with Republicans in control of both the legislature and the governor's office. Only southern distinctiveness was significant in that model, which was consistent with the finding of previous research (Travis et al. 2016).

The data for Model 4 in Table 3 examined the 12 states that comprise the geographic South. Model 4 indicated that the articulated independent variable of race did impact Medicaid expansion among Southern states.

This study confirms previous findings relative to Medicaid research regarding Southern distinctiveness and the impact of gubernatorial decisions. Across all three models where Southern distinctiveness was included; it was statistically significant and had an inverse relationship relative to Medicaid expansion. Southern states were less likely to expand Medicaid compared to the rest of the country. Coupled with the results from Model 4, which showed a strong inverse relationship relative to the size of the minority population in a state,

a picture emerges of racialized health policy decision-making in the South. Southern states with substantial minority populations tended not to expand Medicaid.

**Table 3: Logistic Regression Model Southern Medicaid Expansion by Race**

	Model 4	
Minority Pop	-13.476	(5.561)*
<b>Constant</b>	1.537	
Model $\chi^2 =$	7.720	p<.05
Pseudo R <sup>2</sup> =	.28	
n =	60	

Note: Standard errors in parenthesis \*p<.05, \*\*p<.001

### Discussion

This study builds on recent research on Medicaid policy decision-making post-ACA using CRT. First, this study examined Medicaid policy choices by states in a post-ACA environment looking for non-political party related factors that impacted that process. This study found that the post-ACA environment looked remarkably like the state decision-making environment pre-ACA. Specifically, single-party control of a state (Grogan 1994) and the party affiliation of the state executive (Barrilleaux & Rainey 2014) were statistically significant indicators of state Medicaid expansion. Race has long been a contributing factor to the decision-making process for social programs at the state level (Grogan & Park 2017). In the post-ACA era, it was posited that the landscape surrounding state-level decision-making may have shifted, due to the extensive transformation in public health policy brought about by the ACA. In this emerging paradigm, race would no longer be a significant contributing factor in the process of policy-making. The data in this study does not support those conclusions. In both Model 2 and Model 4, race is significant relative to Medicaid decision-making. The former examines the decision-making of governors about Medicaid expansion, and the latter focuses only on Southern states. Republican governors had a greater likelihood of considering race as a factor in choosing not to expand Medicaid. This is consistent with the central theme of CRT, which is the prevalence of racialized power embedded within the structures and institutions of our society. I contend the findings from Model 2 illustrate a significant finding about gubernatorial decision-making in a racialized Southern environment. I posit that state executives may be more responsive to interest group pressures vis-à-vis state legislatures, and perhaps more susceptible to being influenced by groups engaged in racialized identity politics. Findings from Model 4, which demonstrated that race was a factor in Medicaid expansion decision-making in the South, support this assertion. This data point holds particular weight when examining public health related initiatives in the South, and helps to explain why a region in dire need of health resources would choose to reject them. Clearly, the fiscal benefits from Medicaid expansion do not

outweigh the racialized power dynamics in the South for states with large African American populations.

This point can be illustrated by a closer examination of Arkansas and Mississippi. These two states border each other. Each of these states is in the southern region of the country, and both have parts of the Delta region. Both states have some of the highest rates of poverty in the country, and both have roughly the same overall population. What distinguishes the states is the minority population. Mississippi has a non-white population of approximately 40%, while Arkansas has a non-white population of approximately 20%. Arkansas expanded Medicaid, while Mississippi did not. It is likely that the size of the non-white population in Mississippi influenced the decision not to expand Medicaid.

The results of the analysis have implications for those concerned with developing strategies to reduce racialized decision-making. Racialized power structures are commonplace in our society and reflected in our policy-making institutions. Additionally, studies have shown that groups that benefit from the existing paradigm, which perpetuates particular racial group dominance, will tend to explain away disparities in racial outcomes (Norton & Sommers 2011; Lowry, Knowles, and Unzueta 2007; Esses & Horson 2006). This is a nervous area of government (Gooden 2015). CRT seeks to disrupt and transform these racialized power relations regardless of the actors involved, focusing on interventions that impact the processes associated with Whiteness and the privileges that come with them, rather than the social construct of white people. The policy implications of alleviating racialized health disparities are clear; access to care, via Medicaid expansion, should move beyond the elimination of financial barriers. The voluntary nature of Medicaid expansion should be reexamined in light of the data presented here.

## **Conclusion**

Scholars of state-level decision-making have described the ways in which policy decisions occur, particularly as it relates to partisan control. While this factor is relevant in both pre-ACA and post-ACA decision-making, this study identifies other factors that have policy implications in the arena of healthcare reform. Additionally, policymakers may be more cognizant of the role that racialized decision-making plays in the construction of their decisions, which might allow for more positive policy outcomes.

One of the critiques of critical race theory is that it fails to provide methodological constructs of a quantitative nature that support some of its baseline propositions. This paper seeks to fulfill that role within the context of health-related decision-making. This research builds upon the work of other policy scientists in the pre-ACA era, illustrating that even in a post ACA environment, race-based decision-making processes still hold sway. Future studies can improve this line of research by expanding the time frame of the study, adding a state-level racial attitudes component, and increasing the sample size with improved data on state-level policy decisions.

**Ty Price Dooley**, Ph.D. is an Assistant Professor and Program Coordinator for the Master's Program in Public and Nonprofit Administration at the University of Memphis. Dr. Dooley received his Ph.D. in Public Policy from the University of Arkansas and was a Center for Online Learning Research and Service Faculty Fellow, a former Southern Regional Education Board Doctoral Fellow, and a Benjamin Lever Doctoral Fellow. His research interests focus on areas related to education policy, at-risk populations, and human capital development. Dr. Dooley's research has been featured in the *Journal of Youth & Society*, *e-mentor* and the London School of Economics Public Policy Blog. He is an active member of the American

Society for Public Administration; the Network of Schools of Public Policy, Affairs, and Administration, and the American Political Science Association. Dr. Dooley has designed and developed community engagement symposiums and has appeared, as a political analyst, on the Arkansas Education Television Network's Arkansas Week and Minority Matters.

Prior to being named an Assistant Professor at the University of Memphis, Dr. Dooley served on the faculty at the University of Illinois Springfield and at the University of Central Arkansas. Additionally, he has taught state politics at the University of Texas at Dallas. He has served on various academic committees and has taken part in the development of new academic programs. Email: [tpdooley@memphis.edu](mailto:tpdooley@memphis.edu)

## References

- Aguirre Jr, A. (2000). Academic storytelling: A critical race theory story of affirmative action. *Sociological Perspectives*, 43(2), 319-339.
- Arkansas Medicaid. (2017). Request to Amend Arkansas Works Demonstration Waiver. Retrieved July 27, 2017, by <https://www.medicaid.state.ar.us/>.
- Artiga, S., & Rudowitz, R. (2014). January. Medicaid Enrollment Under the Affordable Care Act: Understanding the Numbers. Washington, DC: The Henry J. Kaiser Family Foundation.
- Aldrich, J. H., & Battista, J. S. C. (2002). Conditional party government in the states. *American Journal of Political Science*, 164-172.
- Barrilleaux, C. J., & Miller, M. E. (1988). The political economy of state Medicaid policy. *American Political Science Review*, 82(04), 1089-1107.
- Barrilleaux, C., & Rainey, C. (2014). The politics of need examining governors' decisions to oppose the "Obamacare" Medicaid expansion. *State Politics & Policy Quarterly*, 14(4), 437-460.
- Beller, G. A. (2005). Disparities in health care in racial and ethnic minorities. *Journal of Nuclear Cardiology*, 12(6), 617.
- Berry, F. S., & Berry, W. D. (2007). Innovation and diffusion models in policy research. In P. Sabatier (Ed.), *Theories of the policy process* (pp. 223-260). Boulder, CO: Westview Press.
- Berry, F. S., & Berry, W. D. (1999). Innovation and diffusion models in policy research. In P. Sabatier (Ed.), *Theories of the policy process* (p. 169). Boulder, CO: Westview Press.
- Blum, L. (2008). White privilege: A mild critique. *Theory and Research in Education*, 6(3), 309-321.
- Cantor, J. C., Thompson, F. J., & Farnham, J. (2013). States' commitment to Medicaid before the Affordable Care Act: trends and implications. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 50(1), 71-84.
- Coleman Battista, J., & Richman, J. T. (2011). Party pressure in the US state legislatures. *Legislative Studies Quarterly*, 36(3), 397-422.
- Brown, R. D. (1995). Party cleavages and welfare effort in the American states. *American Political Science Review*, 89(01), 23-33.
- Centers for Disease Control and Prevention. (2014). State Tobacco Activities Tracking and Evaluation System. Retrieved from Centers for Disease Control and Prevention: [cdc.gov](http://cdc.gov)
- Centers for Medicaid and Medicare Services. United States Department of Health and Human Services Centers for Medicare and Medicaid Services Office of Information

- Products and Data Analysis. 2013 CMS Statistics. CMS Pub. No. 03504. Washington, D.C., 2013. [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2013\\_final.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf).
- Clark, J. H. (2012). Examining parties as procedural cartels: Evidence from the US states. *Legislative Studies Quarterly*, 37(4), 491-507.
- Clemans-Cope, L., Kenney, G. M., Buettgens, M., Carroll, C., & Blavin, F. (2012). The Affordable Care Act's coverage expansions will reduce differences in uninsurance rates by race and ethnicity. *Health Affairs*, 31(5), 920-930.
- Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., & Zapata, D. (2016). Early impacts of the Affordable Care Act on health insurance coverage in Medicaid expansion and non- expansion states. *Journal of Policy Analysis and Management*.
- Crowley, R. A., & Golden, W. (2014). Health policy basics: Medicaid expansion. *Annals of Internal Medicine*, 160(6), 423-425.
- Daley, D. M., & Garand, J. C. (2005). Horizontal diffusion, vertical diffusion, and internal pressure in state environmental policymaking, 1989-1998. *American Politics Research*, 33(5), 615-644.
- Danaei, G., Ding, E. L., Mozaffarian, D., Taylor, B., Rehman, J., Murray, C. J., & Ezzati, M. (2009). The preventable causes of death in the United States: comparative risk assessment of dietary, lifestyle, and metabolic risk factors. *PLoS Med*, 6(4), e1000058.
- Decker, S. L., Kostova, D., Kenney, G. M., & Long, S. K. (2013). Health status, risk factors, and medical conditions among persons enrolled in Medicaid vs uninsured low-income adults potentially eligible for Medicaid under the Affordable Care Act. *Jama*, 309(24), 2579-2586.
- DeNavas-Walt, C., Proctor, B., and Smith, J. (2010) Income, poverty, and health insurance coverage in the United States: 2009. *Current Population Reports: Consumer Income*. US Department of Commerce, Economics and Statistics Administration, US Census Bureau (2010): 1.
- Department of Health and Human Services. (2015). Medicaid & CHIP: November 2014 Monthly Applications, Eligibility Determinations and Enrollment Report. Centers for Medicare & Medicaid Services. Washington, D.C. <http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-november-2014-application-eligibility-and-enrollment-report.pdf>.
- Department of Health and Human Services. (2015). Notice. Annual Update of the HHS Poverty Guidelines. *Federal Register* 80, no. 2015-01120 (January 15, 2015): 3236-3237. <https://federalregister.gov/a/2015-01120>.
- Eckel, R. H., Krauss, R. M., & AHA Nutrition Committee. (1998). American Heart Association call to action: obesity as a major risk factor for coronary heart disease. *Circulation*, 97(21), 2099-2100.
- Esses, V. M., & Hodson, G. (2006). The role of lay perceptions of ethnic prejudice in the maintenance and perpetuation of ethnic bias. *Journal of Social Issues*, 62(3), 453-468.
- Feagin, J., & Bennefield, Z. (2014). Systemic racism and US health care. *Social Science & Medicine*, 103, 7-14.

- Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *Jama*, 283(19), 2579-2584.
- Ford, C. L. (2016). Public health critical race praxis: An introduction, an intervention, and three points for consideration. *Wis. L. Rev.*, 477.
- Fossett, M. A., & Kiecolt, K. J. (1989). The relative size of minority populations and white racial attitudes. *Social Science Quarterly*, 70(4), 820.
- Foster, R. S. (2010). Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended, Office of the Actuary, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. Analysis for Administration and Congress. Washington, D.C. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf).
- Frederickson, G. (2005). The state of social equity in American public administration. *National Civic Review*, 94(4), 31-38.
- Frederickson, H. G. (2015). *Social equity and public administration: Origins, developments, and applications*. Routledge.
- Frumkin, N. (2000). *Guide to economic indicators*. ME Sharpe.
- Fuemmeler, B. F., Baffi, C., Mâsse, L. C., Atienza, A. A., & Evans, W. D. (2007). Employer and healthcare policy interventions aimed at adult obesity. *American Journal of Preventive Medicine*, 32(1), 44-51.
- Gooden, S. T. (2015). *Race and social equity: A nervous area of government*. Routledge.
- Gornick, M. E., & Swift, E. K. (2002). Disparities in health care: Methods for studying the effects of race, ethnicity, and SES on access, use, and quality of health care. The Institute of Medicine. Washington, DC: US Department of Health and Human Services, 1-39.
- Greipp, M. E. (2002). Forces driving health care policy decisions. *Policy, Politics, & Nursing Practice*, 3(1), 35-42.
- Grogan, C. M. (1994). Political-economic factors influencing state Medicaid policy. *Political Research Quarterly*, 47(3), 589-622.
- Grogan, C.M., & Park, S.E. (2017). The racial divide in state Medicaid expansions. *Journal of Health Politics, Policy and Law*, 42(3), 549.
- Gruber, J. (2001). Tobacco at the crossroads: the past and future of smoking regulation in the United States. *The Journal of Economic Perspectives*, 15(2), 193-212.
- Hacker, J. S. (2004). Privatizing risk without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States. *American Political Science Review*, 98(02), 243-260.
- Heintzman, J., Bailey, S. R., DeVoe, J., Cowburn, S., Kapka, T., Duong, T. V., & Marino, M. (2017). In low-income Latino patients, post-Affordable Care Act Insurance disparities may be reduced even more than broader national estimates: evidence from Oregon. *Journal of Racial and Ethnic Health Disparities*, 4(3), 329-336.
- Holahan, J., Buettgens, M., Carroll, C., & Dorn, S. (2012). November. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. Washington, DC: The Henry J. Kaiser Family Foundation.
- Inskeep, S. (Narrator). (2017, July 19). *Governors Also Have a Stake in Health Care Overhaul* [Radio broadcast episode]. Morning Edition. Washington, DC: National Public Radio.

- Jacobs, L. R., & Callaghan, T. (2013). Why states expand Medicaid: Party, resources, and history. *Journal of Health Politics, Policy and Law*, 38(5), 1023-1050.
- Jacobs, L., & Skocpol, T. (2015). *Health care reform and American politics: what everyone needs to know*. Oxford University Press.
- James, S. A. (2017). The strangest of all encounters: racial and ethnic discrimination in US health care. *Cadernos de saude publica*, 33, e00104416.
- Johnson, L. B. (1965). Remarks by President Johnson with President Truman at Signing of Medicare Bill, Public Law 89-97, 18-23. Retrieved July 21, 2015 from <https://www.cms.gov/About-CMS/Agency-Information/History/downloads/CMSPresidentsSpeeches.pdf>.
- Johnson, N. J., & Svava, J. H. (Eds.). (2011). *Justice for all: Promoting social equity in public administration*. Armonk, NY: M. E. Sharpe.
- Jones, D. K., Bradley, K. W., & Oberlander, J. (2014). Pascal's wager: health insurance exchanges, Obamacare, and the Republican dilemma. *Journal of Health Politics, Policy and Law*, 39(1), 97-137.
- Kaiser Family Foundation. Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision. Retrieved July 19, 2015, by <http://www.kff.org/healthreform/8348.cfm>.
- Kaiser Family Foundation. Medicaid Expansion in Arkansas. Retrieved July 28, 2017, by <http://www.kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>.
- Karch, A. (2007). Emerging issues and future directions in state policy diffusion research. *State Politics & Policy Quarterly*, 7(1), 54-80.
- Kominski, G. F., Nonzee, N. J., & Sorensen, A. (2017). The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations. *Annual Review of Public Health*, 38, 489-505.
- Kousser, T. (2002). The politics of discretionary Medicaid spending, 1980–1993. *Journal of Health Politics, Policy and Law*, 27(4), 639-672.
- Kirby, J. B., & Kaneda, T. (2013). 'Double jeopardy' measure suggests Blacks and Hispanics face more severe disparities than previously indicated. *Health Affairs*, 32(10), 1766-1772.
- Ladson-Billings, G., & Tate, W. F. (1995). Toward a critical race theory of education. *Teachers College Record*, 97(1), 47.
- Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *International Journal of Qualitative Studies in Education*, 11(1), 7.
- Lillie-Blanton, M., & Hoffman, C. (2005). The role of health insurance coverage in reducing racial/ethnic disparities in health care. *Health Affairs*, 24(2), 398-408.
- Lowery, B. S., Knowles, E. D., & Unzueta, M. M. (2007). Framing inequity safely: Whites' motivated perceptions of racial privilege. *Personality and Social Psychology Bulletin*, 33(9), 1237-1250.
- Lowry, W. R. (2005). Policy reversal and changing politics: State governments and dam removals. *State Politics & Policy Quarterly*, 5(4), 394-419.
- May, P. J. (2015). Implementation failures revisited: Policy regime perspectives. *Public Policy and Administration*, 30(3-4), 277-299.
- Mayer, M., Kenter, R., & Morris, J. C. (2015). Partisan politics or public-health need? *Politics and the Life Sciences*, 34(02), 44-51.
- Murray, C. J., Kulkarni, S. C., Michaud, C., Tomijima, N., Bulzacchelli, M. T., Iandiorio, T. J., & Ezzati, M. (2006). Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Med*, 3(9), e260.

- Musumeci, M. (2012). A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion.
- Mutchler, J. E., & Burr, J. A. (1991). Racial differences in health and health care service utilization in later life: the effect of socioeconomic status. *Journal of Health and Social Behavior*, 342-356.
- Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566 (2012).
- National Conference of State Legislatures. States Implement Health Reform, Medicaid and the Affordable Care Act. Accessed July 19, 2015. <http://www.ncsl.org/documents/health/HRMedicaid.pdf>
- Nelson, A. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, 94(8), 666.
- Norton, M. I., & Sommers, S. R. (2011). Whites see racism as a zero-sum game that they are now losing. *Perspectives on Psychological Science*, 6(3), 215-218.
- Obama, B. (2010). Remarks by The President And Vice President At Signing Of The Health Insurance Reform Bill, 1-3. Retrieved from <https://obamawhitehouse.archives.gov/photos-and-video/video/president-obama-signs-health-reform-law#transcript>.
- Oberlander, J. (2011). Under siege—The individual mandate for health insurance and its alternatives. *New England Journal of Medicine* 364, no. 12 (2011): 1085-1087.
- Office of the Actuary, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. 2010 Actuarial Report on the Financial Outlook for Medicaid, by Christopher J. Truffer, John D. Klemm, Christian J. Wolfe, and Kathryn E. Rennie. Report to Congress, Washington, D.C., 2010. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2010.pdf>.
- Office of the Actuary, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. 2012 Actuarial Report on the Financial Outlook for Medicaid, by Christopher J. Truffer, John D. Klemm, Christian J. Wolfe, Kathryn E. Rennie, and Jessica F. Shuff. Report to Congress, Washington, D.C., 2012. <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>.
- Ogden, C. L., Carroll, M. D., Kit, B. K., and Flegal, K. M. (2012). Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010. *JAMA*, 307(5), 483-490.
- Orr, L. L. (1976). Income transfers as a public good: An application to AFDC. *The American Economic Review*, 66(3), 359-371.
- Plotnick, R. D., & Winters, R. F. (1985). A politico-economic theory of income redistribution. *American Political Science Review*, 79(02), 458-473.
- Potosky, A. L., Breen, N., Graubard, B. I., & Parsons, P. E. (1998). The association between health care coverage and the use of cancer screening tests: results from the 1992 National Health Interview Survey. *Medical Care*, 257-270.
- Powell, J. A. (2007). Structural racism: Building upon the insights of John Calmore. *NCL Rev.*, 86, 791.
- Racine, A. D., Kaestner, R., Joyce, T. J., and Colman, G. J. (2001). Differential impact of recent Medicaid expansions by race and ethnicity. *Pediatrics*, 108(5), 1135-1142.
- Rawls, J. (1971). *A theory of justice*. Cambridge, Mass: Belknap Press of Harvard University Press.

- Reynolds, G. H. & Denning, B. P. (2013). National Federation of Independent Business v. Sebelius: Five Takes. *Hastings Constitutional Law Quarterly*, 40(807).
- Rosenbaum, S., & Westmoreland, T. M. (2012). The Supreme Court's surprising decision on the Medicaid expansion: How will the federal government and states proceed? *Health Affairs*, 31(8), 1663-1672.
- Shafritz, J. M., & Russell, E. W. (2005). *Introducing public administration*. Upper Saddle River, N.J.: Pearson Education.
- Schneider, S. K. (1998). The impact of welfare reform on Medicaid. *Publius: The Journal of Federalism*, 28(3), 161-174.
- Schneider, S. K. (1997). Medicaid section 1115 waivers: Shifting health care reform to the states. *Publius: The Journal of Federalism*, 27(2), 89-109.
- Shelly, B. (2013). The bigger they are: Cross-state variation in federal education and Medicaid waivers, 1991–2008. *Publius*, 43(3), 452-473.
- Smith, J. C., & Medalia, C. (2014). *Health insurance coverage in the United States: 2013*. Washington, DC: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census.
- Sobel, R. S. (2014). The elephant in the room: why some states are refusing to expand Medicaid. *Applied Economics Letters*, 21(17), 1226-1229.
- Sommers, B. D., Tomasi, M. R., Swartz, K., Epstein, A. M. (2012), Reasons for the wide variation in Medicaid participation rates among states hold lessons for coverage expansion in 2014. *Health Affairs*, 31(5), 909-919.
- Stronks, K., Van De Mheen, H., van den Bos, J., & Mackenbach, J. P. (1997). The interrelationship between income, health and employment status. *International Journal of Epidemiology*, 26(3), 592-600.
- Svara, J. H., & Brunet, J. R. (2005). Social equity is a pillar of public administration. *Journal of Public Affairs Education*, 253-258.
- The National Association of Community Health Centers. Medicaid: To Expand or Not Key Economic Arguments used on Both Sides. State Policy Report # 45. Washington, D.C., 2013. <http://www.nachc.com/client/Medicaid%20Economics.pdf>.
- Thompson, F. J. (2013). Health Reform, Polarization, and Public Administration. *Public Administration Review*, 73(1), S3-S12.
- Travis, R., Morris, J. C., Mayer, M., Kenter, R., & Breaux, D. A. (2016). Explaining State Differences in the Implementation of the Patient Protection and Affordable Care Act: A South/Non-South Comparison. *Social Science Quarterly*, 97(3), 573-587.
- Truffer, C. J., Klemm, J. D., Wolfe, C. J., Rennie, K. E., and Shuff, J. F. (2013). Actuarial Report on the Financial Outlook for Medicaid. Office of the Actuary, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. Report to Congress, Washington, D.C. <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf>.
- Trust for American's Health. 2009-2014 Obesity rates by state. Accessed July 19, 2015. [www.healthyamericans.org](http://www.healthyamericans.org).
- U.S. Department of Labor, Bureau of Labor Statistics. (2016). Local area unemployment statistics, 2010-2014. Retrieved July 16, 2016, from <http://www.bls.gov/lau/#tables>
- U.S. Census Bureau (2017). Selected Characteristics of the uninsured in the United States, 2010-2016 American Community Survey 1-year estimates. Retrieved June 12, 2018, from

- [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_16\\_1YR\\_S2702&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2702&prodType=table)
- U.S. Census Bureau (2017). Health insurance coverage status by age (Black or African American alone), 2010-2014 American Community Survey 1-year estimates. Retrieved June 12, 2018, from [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_14\\_1YR\\_C27001B&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_C27001B&prodType=table)
- U. S. Census Bureau. (2010, 2011, 2012, 2013). American FactFinder fact sheet: 2010 through 2013 White only. Retrieved February 18, 2015, from <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?ftp=table>
- U.S. Census Bureau. (2014). American FactFinder fact sheet: White only. Retrieved July 16, 2016, from <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?ftp=table>
- U.S. Census Bureau. (2016). Small area income and poverty estimates: By State and county. Retrieved July 16, 2016, from <http://www.census.gov/cgi-bin/saige/saige.cgi>.
- Van Itallie, T. B. (1985). Health implications of overweight and obesity in the United States. *Annals of Internal Medicine* 103(6), 983-988.
- Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, 75(12), 2099-2106.
- Wang, Y. C., McPherson, K., Marsh, T., Gortmaker, S. L., & Brown, M. (2011). Health and economic burden of the projected obesity trends in the USA and the UK. *The Lancet*, 378(9793), 815-825.
- Watson, S. D. (2015). Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion. *Yale Journal of Health Policy, Law, and Ethics*, 15(1), Article 12.
- Wheeler, S. M., & Bryant, A. S. (2017). Racial and ethnic disparities in health and health care. *Obstetrics and Gynecology Clinics*, 44(1), 1-11.
- White, J. (2013). Cost Control after the ACA. *Public Administration Review*, 73(1), S24-S33.
- Wilk, A. S. & Jones, D. K. (2014). To extend or not to extend the primary care "fee bump" in Medicaid? *Journal of Health Politics, Policy and Law*, 39(6), 1263-1275.
- Williams, D. R., & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review*, 21(4), 75.
- Woolley, J. T., & Peters, G. (2008). *The American presidency project*. Santa Barbara, CA. Available from World Wide Web: <http://www.presidency.ucsb.edu/ws/?pid=27123>.
- Wright, G. C. (1977). Racism and welfare policy in America. *Social Science Quarterly*, 57(4), 718-730.
- Wright, G. C. & Schaffner, B. F. (2002). The influence of party: Evidence from the state legislatures. *American Political Science Review*, 96(2), 367-379.
- Yoon, P. W., Bastian, B., Anderson, R. N., Collins, J. L., Jaffe, H. W. and Centers for Disease Control and Prevention. (2014). Potentially preventable deaths from the five leading causes of death--United States, 2008-2010. *MMWR*, 63(17), 369-74.