The Impact of Monetary Contributions on Medicaid Expansion Decisions in the 50 States

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Research Question

American health policy has been subjected to a recent spike in politically polarizing legislative debates, while outside interests attempt to gain access and influence to policymakers in their decision-making process. The current implementation of the Affordable Care Act (ACA) has been politically divisive at the national level – with Democrats typically in support of the entire bill and Republicans typically opposed to the entire bill, but many policymakers at the state level have made their own decisions on what to do when implementing certain ACA portions. For example, Republican governors Christie (NJ) and Brewer (AZ) both successfully pushed their state policymakers to accept Medicaid expansion, a major portion of the massive health reform bill, which almost all Republican Congressmen are opposed to. At the same time, health interest groups have spent more money than any other sector of interest at the state level in the last couple years advocating in support of the ACA. It is apparent that lobbyists and political influences have focused many of their resources on this complex area of policy. Therefore, what explains the variance in state decisions on the Medicaid expansion program?

There is very little research on what influences state health policy. What little research there is available has produced mixed results on how much influence outside interests exert (Hojnacki, Kimball, Baumgartner, Berry, Leech, 2012, p. 4). The Medicaid expansion program is unique for analysis purposes for two reasons. First, the ACA is one of the first "common denominator health laws," meaning it is a national health law all 50 states will be exposed to, unlike typical health laws that vary from state to state. Second, the Supreme Court's 2012 decision to give states the option to accept Medicaid expansion has created interesting variation in the states' implementation of the program.

The findings of this research are important for health care interest groups in the US, especially in future health reform debates when the groups want to know if they have the ability to influence policy decisions. More specifically, some of the key players involved include the State Medical Associations, State Hospital Associations, health insurance groups, and pharmaceutical companies. Other interested parties include the federal Centers for Medicare and Medicaid Services, state governors and state party organizations.

The dependent variable is whether or not a state accepts Medicaid expansion. Originally, the Affordable Care Act required all 50 states to expand Medicaid eligibility levels to an ACA-established minimum. Any state that refused to expand its program would lose all Medicaid funding from the federal government. However, a 2012 Supreme Court decision ruled that the federal government could not withhold Medicaid funding for states refusing to expand Medicaid. This decision effectively allowed state officials to opt out of providing Medicaid coverage to residents between the ages of nineteen and sixty-five who have a household income below 138% of the federal poverty level. Twenty-six states have chosen to do so (The Advisory Board Company, 2013). While many in the health care field believe Medicaid expansion, mostly paid for by the federal government, will help provide insured medical coverage for low-income Americans who currently cannot pay for their medical care, others believe the federal and state government should not increase public funding when the country already has a debt problem.

This paper will specifically look at interest group activity as a potential factor to explain a state's Medicaid expansion decision. Scholars generally have looked at activity, which includes both interest group density (the number of health groups registered in each state) and interest groups' monetary contributions to political campaigns, to explain policy outcomes. They have

often included other factors to explain policy decisions, such as the political party of the state government (both the governor and state legislature) and public opinion on the issue.

However, according to Potters and Sloof (1996), most studies on interest group power only give insight into a particular, confined aspect of interest group politics. This lack of the entire political picture often weakens interest group influence findings. Previous studies find interest groups' campaign contributions to government officials to have an influential effect on policy outcomes. However, these findings currently lack the concept of interparty competition. This paper argues that the monetary contributions from health interest groups matter more in states with a high level of interparty competition because as electoral races between Democrats and Republicans get more competitive, political candidates will rely more heavily on outside groups' campaign contributions in order to win future close elections.

To analyze this concept, I use two binary logistic regression models to test whether health interest groups' monetary contributions have marginal effects on a state's decision to implement Medicaid expansion across levels of interparty competition. The first binary logistic regression model tests total support money and total opposition money. The second binary logistic regression model tests only support money, but to Democrats and Republicans separately. I use marginal effects to plots clarify the substantive effects of the conditional impact of interparty competition on monetary contributions and how this influences states' Medicaid expansion decisions. I find statistical significance in both logistical regression models and my interaction model.

Literature Review

During the last two decades, there has been an upsurge in theoretical and empirical studies on the behavior and political influence of interest groups. Political economics has moved

away from the previous common assumption known as the median voter model toward a more realistic theory involving outside forces, such as interest group power (van Winden, 2003). However, there is still an ongoing debate in the scholarly literature on the real influence of organized interest groups on US policy. There are currently three major schools of thought to explain interest group influence: no influence at all, influence via interest group density, and influence via campaign contributions. Moreover, it is still important to consider other factors often cited as influential in policy outcomes, such as government control (political party) and public opinion.

Many people in the general public assume special interests sway politicians through their lobbying and campaign contributions, even when the public constituents are opposed to what the interest groups are supporting. Yet, some scholars have found no substantive effect of interest group activity on policy outcomes, especially the initial studies on the topic. For instance, there are several findings that have failed to find a connection between monetary contributions to policymakers and influence on policy outcomes (Berry, 1977; Wright, 1985; Schlozman and Tierney, 1986; Gais and Walker, 1991; Nownes and Freeman, 1998). More recent research has found only a slight connection between interest group money and gaining influence on policy decisions (Grossmann, 2012, p. 185; Heaney, 2006, p.909). An example of this is Burstein and Linton's finding (2002, p. 397) that interest groups' monetary contributions have a significant impact on policy decisions only forty-five percent of the time, making their findings no more than suggestive. The most recent finding about a lack of interest group influence comes from a second study by Burstein (2003). He argues that when a major issue is at hand and a government official must decide how to vote, political party, ideology, and public opinion matter much more than what interest groups want. Not only does Burstein's research add to the argument that

interest groups do not influence policy often, but it also highlights other factors influencing policy outcomes.

A second group of scholars emphasize the number of interest groups registered to lobby as important in their studies. Over the years, these studies have yielded mixed results. In terms of simple numbers, business interests dominate at both the national and state levels in the U.S. (Lowery and Brasher, 2004). There are still some disagreements as to whether or not the number of interest groups lobbying has any effect on policy outcomes. Schlozman and Tierney (1986) argue that the sheer number of groups indicates their influence in public policy. On the other hand, Heinz, Laumann, Nelson and Salisbury (1993) argue the very presence of so many groups suggests they are inherently disadvantaged in the public policy process to be lobbying so frequently.

Accurate data on the actual size and diversity of the interest group community has always been hard to find because a "comprehensive registry of groups lobbying all institutions of the US government does not exist" (Holyoke, 2011, p. 13). However, it is generally agreed that the number has increased over the years. The number of groups registered to lobby the federal government in 1960 was 614 (Milbrath, 1963). The number grew to 1,326 by 1981 (Walker, 1983). Expanding on Walker's findings, other studies identified 6,601 organized interest groups in 1986 (Schlozman & Tierney, 1986). In 1991, there were approximately 14,500 groups registered to lobby in Washington (Petracca, 1992).

Most scholars agree it is difficult to pin down the exact year of this interest group explosion, but the number today is enormous, which has injected a new level of competition into politics. The interest group explosion is not only apparent at the federal level. Nownes and Newmark (2008, p. 107) state that only about 15,000 groups were registered to lobby in the

states in 1980, but that number more than doubled to 37,401 by 2008, increasing the average from 300 to 748 groups per state.

Many scholars find that interest groups have more influence on policy decisions as the number of interest groups registered to lobby in a state increases. Similarly, others state that interest group density, the number of lobbyist groups per capita, more accurately explains policy outcomes. The two measurements describe the same phenomenon in different dimensions. Lewis (2005) credits higher density with more influence because it conveys messages to policymakers more frequently, urgently, and efficiently. Similarly, Gray, Lowery, and Benz (2013) argue that a high density of health advocacy groups increases the likelihood of states adopting health reform. Gray and Lowery (1995) argue that the higher the number of interest groups in a state, the more likely that state's legislature will have legislative gridlock on any issue. Conversely, Bowling and Ferguson (2001) find that as the number of interest groups in a state increases, the more gridlock there is in policy areas that typically have partisan disagreement and less gridlock in areas that lack partisan disagreement. Gray and Lowery (1997) argue that as the density of interest groups increases, the population of PACs in that community increases as well.

Finally, McKay (2012) analyzes the number of interest groups influencing policy outcomes from a different angle. She argues that policymakers are fond of their jobs and are thus more interested in avoiding criticism than in receiving praise. Therefore, they are more likely to listen to interest groups opposed to a bill rather than to groups in support of a bill because they would rather continue the status quo than adopt a new law that is possibly resisted by the public. She finds that it takes three point five support groups to counteract the effects of one negative group on policy outcomes.

The final school of thought about interest groups' influence on policy outcomes looks at groups' monetary contributions to campaigns of government officials and whether or not this essentially buys the special interests influence. This argument is derived from the theory often known as the investment theory of party competition, which was developed by Thomas Ferguson (1995). In his model, Ferguson argues that political candidates appeal not to voters, but to investors able to advance candidates in their campaigns.

The interest group explosion that injected competition into state politics compels PACs to form and contribute more money to elected officials in order to fight for influence. Specifically, Lowery, Gray, Benz, Deason, Kirkland and Sykes (2008, p. 87) found that although affiliated health PACs (those connected to a health interest organization registered to lobby) accounted for only 23.8% of all health PACs, they were responsible for 76% of all monetary contributions, while unaffiliated PACs accounted for 76.1% of the state health PAC population but were only responsible for 24% of all contributions. Similar to national level results where affiliated PACs contributed 86% of all monetary contributions in all areas of policy combined, (Tripathi, Ansolabehere, and Snyder, 2002, p. 133) it seems interest groups contribute money as a strategy to strengthen their lobbying efforts.

Neustadtl (1990) claims that Congressional voting decisions result from the cumulative influence of a number of factors, including the wishes of their constituents, political allies, relevant interest groups, and their own feelings. Many scholars in past decades failed to find a connection between monetary contributions to electoral campaigns and influence on policy outcomes. However, there has been a fair amount of agreement over the years on the claim that campaign contributions from outside interests does indeed increase their *access* to candidates (Gopian, 1984; Langbein, 1986; Malbin, 1980; Sabato, 1984). This leads many to ask whether or

not access can translate into real influence. Recent studies (Tripathi, Ansolabehere and Snyder, 2002; Gray and Lowery, 1997; Lowery, Gray, Benz, Deason, Kirkland and Sykes, 2008) find a much stronger relationship between lobbying interest groups and monetary contributions than previous studies. Additionally, Stratmann (1998) finds that an interest group's monetary contributions are both a successful attempt to purchase Congressional votes and to influence future elections.

Gordon (2001) adds a new element to the conversation: the influence of campaign contributions depends on the vote context. Since much of the research on campaign contributions and legislative voting behavior has shown ambiguous results, she finds that contributions have a stronger effect on those legislative votes that are crucial to the outcome of the legislation because not all votes are created equal. Therefore, even though contributions may influence only a small number of the total votes, they have a significant impact on the overall legislative outcome because they may "swing" legislators on the fence.

As Neustadtl (1990) points out, it is important to consider the cumulative influence of all factors affecting a policy decision. Therefore, Burstein and Linton (2002) study the direct impact of political parties, interest groups and social movement organizations on policy. They provide evidence that all three types of organizations have a substantial impact on public policy decisions except when public opinion is taken into account – then the organizations do not have as large of an effect. Burstein and Linton also argue that political parties have a greater impact than interest groups. This is a natural assumption by many in the field, especially on gridlock issues that are highly partisan, as Bowling and Ferguson (2001) claim.

Furthermore, Democratic gubernatorial and legislative control make it more likely a health reform policy that expands the scope of government by adding new programs or spending

more money will pass, and Republican control makes it more difficult (Miller, 2005; Gray, Lowery & Benz, 2013). Democratic control of the state legislature predicts how much states spend on optional Medicaid spending (Kousser, 2002). Thus, the political party of both the governor and in control of the state legislature is expected to affect a state's decision on the Medicaid expansion program, as Democrats are more likely to favor it than Republicans.

Additionally, most studies in the literature include public opinion as a possible explanation for policy outcomes, as stated by Miller (2005), who finds that public opinion is the most frequently studied political determinant of state policy analyses. Several scholars agree that public opinion reduces interest group influence (Burstein & Linton, 2002; Burstein, 2003), especially on very salient issues the general public is aware of (Grasse & Heidbreder, 2011). However, Abramowitz (1980), finds that specific policy votes, except very few, have any salience with the general public. Furthermore, there are mixed results on public opinion's influence on health policy specifically because it is such a complex issue area that most citizens do not understand. Yackee (2009) finds that citizen ideology positively influences the passage of medical malpractice reforms in state policy, but Gray, Lowery, & Benz (2013) argue that on a more holistic scale, public support for health reform is sometimes very strong; other times it is very against reform. Therefore, since public opinion is usually not a decisive factor in policy outcomes but can alter the effects of other factors, it should be included in any health policy analysis.

Another often-cited factor to explain state policymaking decisions is legislative professionalism. According to Squire (2007), professionalism is "typically associated with unlimited legislative sessions, superior staff resources, and sufficient pay to allow members to pursue legislative service as their vocation" (Squire, p. 212). Higher salaries allow legislators to

devote more time to lawmaking, which means they often serve longer terms and are more informed, effective legislators. Additionally, legislatures that meet more days per year give the legislators more time to develop proposals and consider difficult policy decisions.

There are several competing arguments about what causes state level government officials to make health policy decisions. Much of the literature thus far has focused on the number of interest groups registered to lobby, campaign contributions from the interest groups, the political party of government officials, and public opinion as factors determining policy outcomes. Scholars in recent years have found more substantive results about interest group influence than their predecessors. What is missing in previous studies is the electoral concern element of policy decision-making. Walker (1969), argued that an elected official facing a closely contested election would be more likely to advocate newer, more expansive programs because these programs pleased a lot of the voters. More recently, Pracht (2007) and Boushey (2010) discover tighter electoral races cause governors to listen to outside interests more often when making their policy decisions because money is at stake and needed for reelection. This concept is known as interparty competition and indicates the level of competition between the Democratic and Republican parties for control of government (Gray, Hanson, Kousser; 2013). When examining states' Medicaid expansion decisions, I argue that the level of interparty competition in a state matters because tighter electoral races make the interest groups' monetary contributions to campaigns more important. Specifically, this research will analyze whether health interest groups' monetary contributions to both Democrats and Republicans have marginal effects on a state's decision to implement Medicaid expansion across levels of interparty competition.

Theory & Hypothesis

The literature thus far on how interest groups influence policy is divided into three main theories: no influence, influence via the number of registered groups, and influence via campaign contributions. This paper applies the final theory mentioned in the literature, Ferguson's (1995) investment theory of party competition, to health policy – a very salient, complex and politically polarizing topic. As the cost of political campaigns has skyrocketed in contemporary politics, the logic of money driven political systems has become more and more applicable, especially as the number of interest groups has exploded in recent years. Ferguson's theory states that political candidates do not appeal to voters anymore, but instead appeal to investors able to advance their political campaigns. According to this theory, state policymakers and interest groups develop a contractual relationship: the interest groups contribute money to government officials' campaigns, and in return, the government officials are supposed to make policy decisions aligning with the wishes of the groups.

I argue that monetary contributions give interest groups influence on policy outcomes. However, what is missing from previous studies that use the investment theory of party competition is interparty competition. Interparty competition is the level of electoral competition between Democrats and Republicans in a state, with 0.5 equaling no competition and 1.0 equaling perfect competition. I hypothesize that the interest groups' monetary contributions matter *more* in states that have a high level of interparty competition because the more competitive the electoral races between Democrats and Republicans are, the more political candidates will need campaign contributions from outside groups in order to win future close elections.

Additionally, I argue that interest group density influences a state's Medicaid expansion program outcome. Since a high interest group density allows groups to convey messages to policymakers more frequently and efficiently, a high number of health interest groups in a state will probably expose more policymakers to pro-Affordable Care Act lobbying.

It is also often believed that policymakers' legislative professionalization scores have an impact on their policy decisions. For instance, Squire finds that legislators with higher professionalization scores are more likely to implement complex policies since they view themselves as legislating for a career (Squire, 2007). Therefore, since the Affordable Care Act is very complicated, I argue that those legislators are more likely to accept the Medicaid expansion program.

> Hypothesis 1 **(H1)**: *As interparty competition in a state increases, high total monetary contributions (Democrats and Republicans, combined) by health interest groups in support of the ACA make it more likely a state will accept the Medicaid expansion program.*
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> Hypothesis 2 **(H2)**: *As interparty competition in a state increases, high monetary contributions to Democrats by health interest groups in support of the ACA make it more likely a state will accept the Medicaid expansion program.*
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> Hypothesis 3 **(H3)**: *As interparty competition in a state increases, high monetary contributions to Republicans by health interest groups in support of the ACA make it more likely a state will accept the Medicaid expansion program.*
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> Hypothesis 4 **(H4)**: *As interest group density in a state increases, it is more likely that the state will accept the Medicaid expansion program.*
>
> Hypothesis 5 **(H5)**: *As a state's legislative professionalization score increases, it is more likely that the state will accept the Medicaid expansion program.*

In modern, competitive politics, health interest groups are spending more money than they have ever before (Hacker & Pierson, 2010) and more than every other interest sector (Landers and Sehgal, 2004). The recent political battle over the implementation of the Affordable Care Act has accelerated this phenomenon. Therefore, according to the investment

theory of party competition, by contributing huge sums of money to both Democrats and Republicans at the state level, health interest groups are attempting to enter into a contractual relationship with the policymakers in the hopes that those policymakers will subsequently make a decision on the ACA's Medicaid expansion program that aligns with what the interest groups want. The question then is whether or not the policymakers will hold up their end of the contract and actually vote for Medicaid expansion like the interest groups call for. This paper theorizes that those government officials facing an upcoming tight election (both Democrats and Republicans) will make a Medicaid expansion decision aligning with what the interest groups want because they greatly need those interest groups' campaign contributions to win reelection.

Data & Methods

I test two binary logistic regression models and one interaction model. A binary logistic regression model is used to measure the relationship between a categorical dependent variable and one or more independent variables to predict outcomes of the dependent variable. All three models use the logarithm of monetary contributions (support money to Democrats, support money to Republicans, total support money, and total opposition money). This recalculation accounts for the disparity in the amount of money candidates are receiving in the states and makes the states with large amounts of money (such as Illinois and Texas) more comparable to the states with small amounts of money (such as Vermont). I include robustness tests for all three models.

The first model regresses a state's decision to implement Medicaid expansion on total monetary contributions from health groups in support of the ACA, total monetary contributions from health groups in opposition to the ACA, and interparty competition. I include four additional independent variables in the models: the number of groups registered to lobby, interest

group density in each state, the state's legislative professionalization, and citizen ideology. I control for public opinion on Medicaid expansion, whether or not the state joined the 2010 Supreme Court lawsuit, the political party of the governor in each state and the political party in control of each state's legislature. I expect to find that my variables of interest are statistically correlated with my dependent variable.

The second model is an interaction model to test the conditional relationship between the total monetary contributions from health groups in support of the ACA and interparty competition to see how this influences states' decisions on Medicaid expansion. I use a marginal effects plot for the interaction test to clarify substantive effects at every unit level.

The third model regresses a state's decision to implement Medicaid expansion on monetary contributions in support of Medicaid expansion to Democrats, monetary contributions in support of Medicaid expansion to Republicans and interparty competition. Again, I include four additional independent variables in the models: the number of groups registered to lobby, interest group density in each state, the state's legislative professionalization, and citizen ideology. I control for public opinion on Medicaid expansion, whether or not the state joined the 2010 Supreme Court lawsuit, the political party of the governor in each state and the political party in control of each state's legislature.

Data for the dependent variable, state decisions on Medicaid expansion, are drawn from the Advisory Board Company (http://www.advisory.com, 2013). States that did not accept Medicaid expansion are coded zero (0) and states that accepted Medicaid expansion are coded one (1). The summary of the data is found in Appendix 1. The data are roughly normally distributed, with 24 states choosing not to accept Medicaid expansion and 26 states choosing to

accept it. This gives the dependent variable a mean of 0.52, as noted in Appendix 1 along with all other descriptive statistics for the variables.

Data for all interest group monetary contributions to Democrats and Republicans come from the Institute on Money in State Politics in 2012 (http://www.followthemoney.org). I attempt to measure both support and opposition money in the first model. Since the majority of health interest groups support the ACA, it is difficult to find accurate, abundant data on monetary contributions given by groups in opposition to the ACA. Therefore, when measuring opposition, rather than focusing on the monetary numbers alone, I look at the strength of the groups based on their presence in each state. This could mean an opposition group gives massive amounts of money in only a handful of states, or contributes a steady amount in almost every state.

Since the opposition money data is not as reliable as one would like, I also test a model that includes money from groups in support of Medicaid expansion to both Democrats and Republicans but omits money from groups opposed to Medicaid expansion. The groups in support of Medicaid expansion are all national associations that contributed money to state level Democratic and Republican politicians. Their monetary contributions are highly monitored, making the data for this variable very accurate. They are the National Medical Association, the National Hospital Association, the College of Emergency Physicians & Nursing Home Association, the Hospital Corporation of America, and the National Healthcare Association. The strongest groups in opposition to Medicaid expansion (or the ACA in its entirety) are the National Federation of Independent Business, Americans for Prosperity, Americans Legislative Exchange Council, and PhRMA.

As expected, the range for both support money to Democrats and support money to Republicans is large because states with a higher population inherently have higher expenditures

and more politicians receiving contributions. There are six outliers to be noted. First, Illinois Democrats received $705,038 and Texas Republicans received $1,490,073. On the other end of the range, Connecticut, Mississippi, Wyoming, and Hawaii Republicans received zero monetary contributions from these particular health groups in 2012.

Interparty competition represents how close the states are to perfect competition between the political parties for control of government. This variable comes from a dataset calculated by Gray, Hanson, and Kousser (2013) and is called the Ranney competition index. It ranges from 0.500 (no competition) to 1.000 (perfect competition). With a mean of 0.86618, the data lie closer to perfect competition than zero competition in each state. Even though this Ranney competition index is calculated for the period 2007-2011, Gray, Hanson, and Kousser (2013, p. 89) state interparty competition is a long-term phenomenon and should be relatively stable within a few years of the calculation.

Data for the number of registered lobbyists in each state and interest group density also come from the National Institute on Money in State Politics in 2012 (http://www.followthemoney.org). Registered lobbyists are the groups and individuals able to lobby state elected officials on behalf of their clients, while interest group density is the number of interest groups represented by a lobbyist per capita in each state. Both of these variables have a large range, most likely because some states have denser populations than others, which naturally creates more interest groups.

Many scholars have cited public opinion as a common reason states make major policy decisions, therefore I will include it in the analysis. There currently are no public opinion data on where the population stands on Medicaid expansion broken down by state, so I use two other similar measures instead. First, I include the state's 2010 citizen ideology score, which comes

from William Berry et al.'s studies. Their indicator of citizen ideology measures "the average location of the active electorate in each state on a liberal-conservative continuum" in terms of the kinds of policies the citizens prefer (Berry et al., 2010, p. 117).

The second way I measure a state's public opinion is by using President Obama's share of the popular vote in the 2012 election. These data come from the U.S. Election Atlas (http://www.uselectionatlas.org). Since the Affordable Care Act was a highly cited issue in the 2012 election, using public support for Obama gives a close indication of public opinion on the Affordable Care Act's Medicaid expansion. According to the mean, President Obama won 48.12% of the popular vote in 2012, but this ranged from 24.67% in Utah and 70.55% in Hawaii.

Legislative professionalization is also included because it is often cited as influential on state policy decisions. I use Squire's 2003 legislative professionalization index, which includes legislative salaries, session length, and staff resources in the computation. The scores range from 0.027 as least professional (New Hampshire) to .626 as most professional (California).

I also include whether or not a state joined the 2010 Supreme Court lawsuit against the ACA as a variable. It is dichotomous, with zero (0) meaning the state did not join, and one (1) meaning the state did join the lawsuit. Typically, more Republican-controlled states joined the lawsuit, as expected. This data comes from the Health Care Lawsuit website (http://www.healthcarelawsuit.us/).

Data on the political party of the governor in 2012 comes from the National Governors Association. Republican governors are coded zero (0) and Democratic governors are coded one (1). The only previous Independent governor, Rhode Island's Lincoln Chafee, switched his registration to a Democrat in 2012. The political party of the governor is a dichotomous variable, and there are 30 Republican and 20 Democratic governors.

Data for the political party in control of each state's legislature in 2012 is from StateScape Policy Tracking and Analysis (http://www.statescape.com, 2012). Republican control of the state legislature is coded zero (0), split control where Republicans and Democrats each control one house is coded one (1), and Democratic control is coded two (2). Since Nebraska has a nonpartisan, unicameral legislature, it is coded one (1) as well. The mean is 0.84, which shows there are more states with a Republican-controlled state legislature than a Democrat-controlled legislature.

I expect to find both models 1 and 3 are statistically significant at less than a .05 level of significance, which is determined by the t score. I also expect to find the pseudo r^2 at a moderate .25 or above. I expect to find that my variable(s) of interest are significant at the .05 level, which is determined by the f score. Finally, I expect the marginal effects plots to be statistically significant at less than a .05 level of significance.

Results

Table 1 reports the results of the two binary logistic regression models, Models 1 and 3, and the interaction model, Model 2. Model 1 reports both monetary contributions from groups in support of the ACA and monetary contributions from groups opposed to the ACA. Model 2 also includes both total support money and total opposition money, but measures the interaction between support money and interparty competition. Model 3 reports the logistic regression model with the monetary contributions to Democrats in support of the ACA and the monetary contributions to Republicans in support of the ACA. Several variables are statistically significant.

Variables with high correlations with one another should be noted. Not surprisingly, support money to Democrats and support money to Republicans have a 73.5% correlation. The

political party in control of the state legislature and states' decisions on Medicaid expansion is also correlated at 62.6%, probably because most states use their legislature as the final decision-maker when implementing policy. Also not surprising, the number of lobbyist groups registered in each state and interest group density are correlated at 68.3%. Lastly, the data in both models 1 and 3 explains the outcomes very well, as per the pseudo r^2 levels.

In model 1, when both support and opposition money are taken into account, interparty competition is statistically significant. This means that the more competitive states' electoral races are between Democrats and Republicans, the less likely the state will implement the Medicaid expansion program. This implies many complex policy decisions are still political and policymakers have concerns about reelection. Additionally, the total opposition monetary contributions is significant and negative at the 90% level, suggesting candidates tend to oppose the Medicaid expansion program if they receive large monetary contributions from opposition groups. Finally and as expected, both Democratic governors and Democratically-controlled state legislatures are more likely to accept Medicaid expansion than Republican state officials.

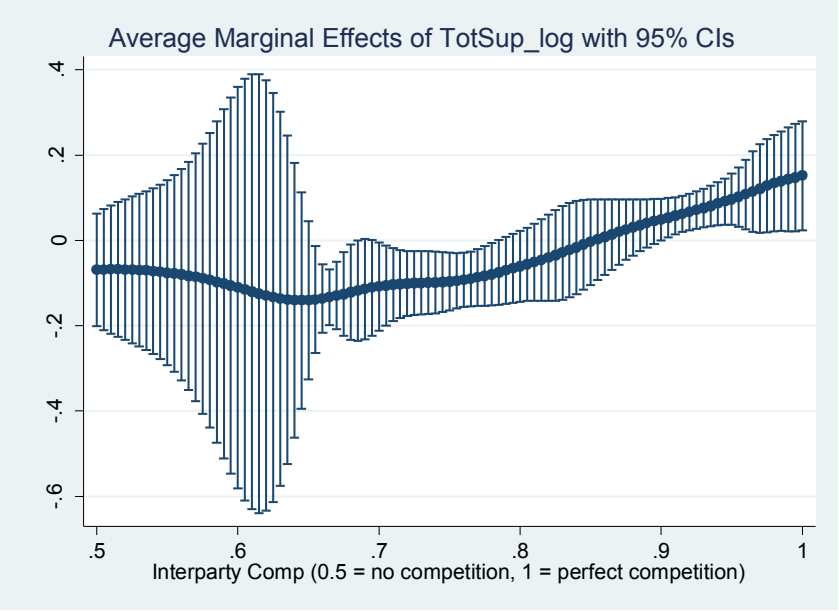
Table 1
State Decision on Medicaid Expansion Program[1]

Variables	Model		
	Support & Opposition Money	**Interaction of Support $ & Interparty Competition**	**Support Money to Dems & Reps**
Total Support Money Contributions	.43(.83)	-18.5(7.3)	-
Total Opposition Money Contributions	-.42(.22)^	-0.37(.33)	-
Support Money Contributions to Democrats	-	-	2.32(.92)*
Support Money Contributions to Republicans	-	-	-2.01(.73)**
Total Support Money#Interparty Competition	-	21.67(7.87)**	-
Interparty Competition	-13.8(6.84)*	-262.1(86.03)	-7.27(8.67)
Number of Lobbyist Groups	.002(.001)	.0006(.002)	.004(.002)^
Interest Group Density	-.001(.001)	-.0001(.002)	-.001(.001)
Citizen Ideology	.13(.10)	.21(.11)	.013(.12)
Legislative Professionalization	18.96(14.02)	24.59(7.02)	15.78(7.78)*
Joined 2010 Lawsuit	3.17(2.07)	2.68(2.51)	3.16(1.60)*
Public Opinion	-6.49(12.94)	-24.7(21.5)	-6.36(13.95)
Governor Party Identification	4.88(2.4)*	6.53(3.96)	3.96(1.86)*
Party in Control of State Legislature	2.06(.73)**	7.60(1.79)	1.84(1.1)^
Constant	.31(10.7)	219(80.6)	-.53(9.29)
N size	44	44	46
Log pseudo likelihood	-13.07	-8.51	-11.95

[1] Coefficients are reported with standard errors in parentheses.
Note: ^ p > .10, * p > .05 ** p > .01, two tailed test

The interaction model, Model 2, shows the conditional relationship between total support money and interparty competition is statistically significant at the 99% level. As expected as per **H1**, as electoral races between Democrats and Republicans get tighter in a state, monetary contributions from support groups matter more. This relationship is presented in the marginal effects plot in Figure 1 below. As hypothesized, in states with electoral races that are not competitive (0 level on y-axis), money does not make any difference in the decision to accept Medicaid expansion. However, once interparty competition reaches .89 (x-axis), total support monetary have a substantive effect on states' Medicaid expansion decisions. This means that as a state's electoral races get more competitive, the large amounts of monetary contributions from support groups make it more likely state policymakers will accept Medicaid expansion.

Figure 1



In Model 3, support money is analyzed separately for Democrats and Republicans and several variables are significant. As per **H2**, higher monetary contributions to Democrats from health groups in support of the ACA make it more likely that state will implement the Medicaid expansion program. However, high monetary contributions to Republicans from health groups in support of the ACA make it less likely the state will implement the Medicaid expansion program, which is opposite of what I hypothesized in **H3**. This means that even though Republican policymakers are receiving electoral contributions from support health groups, they are still probably making policy decisions according to political party lines instead of what the support health interest groups want.

Three other variables are statistically significant in Model 3. Surprisingly, if a state joined the 2010 Supreme Court lawsuit against the Affordable Care Act, it is more likely to accept the Medicaid expansion program. This is opposite of what one would expect because most states sued in order to prevent the ACA from becoming the law of the land. A possible explanation is that even Republican-controlled states are willing to implement Medicaid expansion, which is a

less polarizing issue than other aspects of the ACA law, such as the insurance exchanges. Secondly, as expected, states with Democratic governors are more likely to accept the Medicaid expansion program. Finally, as I hypothesized in **H5,** states with high legislative professionalization scores are more likely to accept the Medicaid expansion program. To highlight this relationship more, I subsequently tested the marginal effects of legislative professionalization in Model 3 (see Appendix 2). When all other variables are held at their means, states with the lowest possible legislative professionalization score of 1 translate to a 44.5% chance of implementing the Medicaid expansion program. The relationship is stronger as legislative professionalization increases, so that when a state has a score of 6 (highest possible), there is a 99% chance the state accepted the Medicaid expansion program.

Two additional variables in Model 3 are significant at the 90% level. As expected, states with more lobbyists and states with Democratically-controlled state legislatures suggest a higher likelihood that the state accepts Medicaid expansion.

Conclusions and Implications

This paper asked what causes states to make their decision on the Medicaid expansion program, a major piece of the ACA. I argued that monetary contributions from the health organizations in support of the program makes states more likely to accept Medicaid expansion, and this money has an even greater impact in states with high interparty competition. The results of my analysis support my hypothesis for monetary contributions to Democrats **(H2)**, but surprisingly showed the opposite effect of what I expected to see for monetary contributions to Republicans **(H3)**.

Model 3's unexpected results where high monetary contributions from health interest groups in support of the ACA made it less likely a state would implement MEP is most likely

because the states that refused to implement Medicaid expansion even after receiving monetary contributions from health interest groups in support of the expansion are going to stick to what their political party wants, regardless of the implications this will have on future electoral concerns. These results surprisingly do not align with the expected contractual relationship aspect of the investment theory of party competition. Even though health interest groups contributed huge sums of money to Republicans' campaigns, the policymakers did not subsequently make policy decisions aligning with the wishes of the groups they receive money from, which in this case, would be to accept Medicaid expansion.

Another possible explanation for the results is that the phenomenon is a very recent development, so the data on monetary contributions is still somewhat difficult to measure with the upmost precision. If possible, future research on this topic should try to find more accurate opposition money data in order to find the effect of support and opposition money battling one another on a policy decision. However, the statistically significant conditional relationships between both total support money and interparty competition on decisions to implement Medicaid expansion is extremely interesting so it would be helpful to study this relationship more.

In terms of policy implications, the surprising results would lead me to argue contributing money to candidates' campaigns is not always the way for health interest groups to convince government officials to implement a policy aligning with the views of the groups. If an electoral race is tight between a Democrat and Republican, contributing money to the Democrats will influence their policy decisions, but contributing money to the Republicans will not change their decision on health care. In this particular research, the Republicans that refused to implement Medicaid expansion were probably set on their decision from the very beginning (similar to

Republican leaders at the national level) and receiving monetary contributions from the health interest groups was never enough to make Republican officials accept Medicaid expansion. However, in states with little competition or extremely high competition in their races, the monetary contributions started to influence Republicans' decisions on Medicaid expansion. The best example of this is Ohio: with a high interparty competition level of 0.926, heavy contributions to Republicans, and both a Republican governor and Republican-controlled state legislature, the state still decided to accept Medicaid expansion. It is possible the monetary contributions the officials received persuaded them to accept Medicaid expansion. Further studies, ideally at a larger level with more observations, could help to explain this interesting effect.

Appendices

Appendix 1

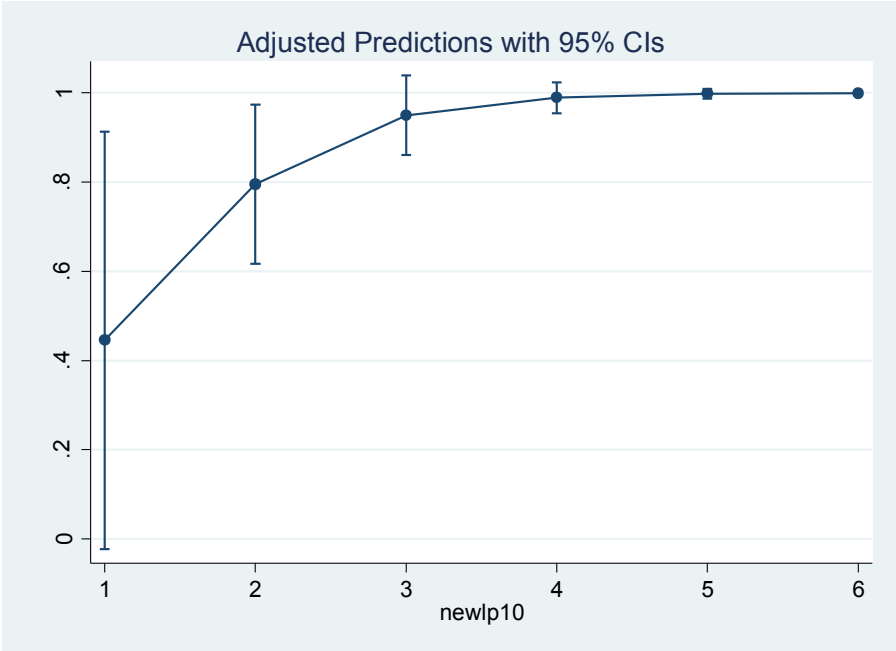
Summary table for Medicaid Expansion Program (MEP)

Variable	Observations	Mean	Standard Dev.	Minimum	Maximum
MEP Decision	50	.52	.50	0	1
Total Support Money Contributions	47	11.73	1.60	7.72	14.39
Total Opposition Money Contributions	45	8.87	2.16	3.04	12.78
Support Money Contributions to Democrats	47	10.59	1.61	6.70	13.47
Support Money Contributions to Republicans	46	11.16	1.86	6.21	14.21
Interparty Competition	50	.87	.08	.69	1
Number of Lobbyists	50	511.9	457.61	54	1564
Interest Group Density	50	1,136.76	953.33	162	4,729
Citizen Ideology	50	47.43	15.47	18.07	86.18
Legislative Professionalization	50	.18	.16	.027	.63
Joined 2010 Lawsuit	50	.54	.50	0	1
Public Opinion	50	.48	.10	.25	.71
Governor Political Party	50	.40	.49	0	1
Political Party in Control of State Legislature	50	.84	.93	0	2

Appendix 2
Margins Results for Medicaid Expansion Program (MEP)

	Margin	Std. Error	Z score	P > |z|	[95% Conf.	Interval]
Legislative Professionalization						
1	.445	.239	1.86	0.062	-.023	.913
2	.795	.091	8.74	0.000	.617	.974
3	.950	.045	20.88	0.000	.860	1.04
4	.989	.018	56.12	0.000	.955	1.02
5	.998	.005	185.42	0.000	.987	1.01
6	.999	.001	680.17	0.000	.997	1.00

Note: N = 46



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