

THE STATE OF RACE: AN EXAMINATION OF RACE &
STATE DEVELOPMENT OF PUBLIC POLICY

By

Tekisha Dwan Everette

Submitted to the

Faculty of the College of Arts and Sciences

of American University

in Partial Fulfillment of

the Requirements for the Degree

of Doctor of Philosophy

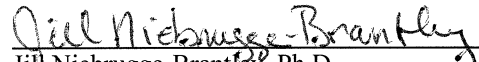
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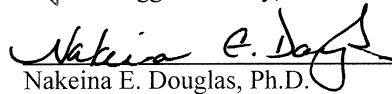
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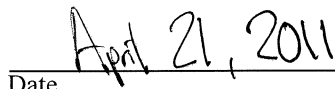
Jill Niebrugge-Brantley, Ph.D.



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Dean of the College of Arts and Sciences



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DEDICATION

This study is dedicated to my mother Janice Ruth Everette Banks (1950-1998). You are the reason for all and all that I am! Your spirit remains with me and is the inspiration that guides me.

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ABSTRACT

This study examines the association between race and public policy. Utilizing publicly available data to conduct a secondary analysis, this study specifically examines state policies concerning Medicaid, the State Children's Insurance Program, reinsurance, high risk pools, and state-only funded programs to analyze the role race plays in the development of state health care coverage efforts. Building on the conceptual framework developed by several authors (Hero and Tolbert 1996; Douglas 2005), this study examines whether the level of state policy implementation of widely supported health care coverage expansions vary based on the presence of high uninsured minority populations. It is the author's intention for this study to add to the sociological examination of societal institutions, namely public policy, and how such institutions reinforce a racial hierarchy in society. Furthermore, the intention is to add to the field of policy studies by filling a void in the research regarding race, health care policy, and policymaking. This study comes forth during a pivotal moment in society as the public dialogue around health care reform reached a pinnacle with the passage of the Patient

Protection and Affordable Care Act passed in 2010 and implementation and continued debate rages on.

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CHAPTER 1

INTRODUCTION

One of the most—if not *the* most—significant way by which society allocates resources is through public policy. Public policy is a product of the larger society, embodying the formal and informal rules that govern relationships among and between institutions and individuals (Burnstein 1991). Primarily developed in governmental and legal structures/domains, public policy establishes and reinforces prevailing notions of social hierarchy, which typically encompass deeply-embedded beliefs concerning race, class, gender, sexuality, age, and nationality (Weber 2001). Thus, public policy can overtly or subtly propagate domains of oppression that discriminate against certain groups—making public policy development worthy of examination. Because the development of public policy is based on either a divergence or convergence with the political will of the group in question, it has targeted various constituencies throughout history. For example, gender issues in the U.S. came to the forefront during the early 20th century with the suffragette movement, eventually resulting in the 19th Amendment which prohibited state and federal agencies from gender-based restrictions on voting. Similarly, the topic of race and public policy, which has its origins with the importation of slaves, has also been characterized by a number of significant legislative actions that have either suppressed the rights of the underrepresented (e.g., Jim Crow laws) or sought to uphold them (e.g., desegregation of schools, etc.); and like other constituency-based

areas of public policy, race continues to be important for understanding the stratification of American society and public policy.

In 1903, activist and scholar, W.E.B. DuBois (1994, v) declared that the “problem of the twentieth century [was] the problem of the color line.” Now, more than a century later, race remains an important factor in American society. While it is true that overt, “politically-incorrect” signs of racism have been removed—for example, “White-only” signs in public facilities and mandated seating at the back of the bus for African Americans—race and racism have not gone away. Instead, race has become so entrenched in our political and policymaking institutions, that the issue of race and racial discrimination has become “more indirect, more subtle, more procedural, and more ostensibly non-racial” (Pettigrew 1979, 118). As a consequence, even though conditions have generally improved for racial and ethnic minorities in this country, certain important benchmarks indicating racial equality are still absent. Examples of this racial divide are seen in recent studies and reports that have examined income inequality (U.S. Census 2008) wealth inequality (see Bucks 2006), graduation rates (see Swanson 2004), and unemployment rates (see Department of Labor 2005; 2009). Specifically, racial minorities tend to have lower median incomes, less wealth accumulation, lower graduation rates and higher unemployment rates, indicating that racial inequality continues to be embedded in the institutional framework of our society.

Another institution that continues to be impacted by racially-based inconsistencies is the health care system, in part due to public policy initiatives that support health care. Several studies and reports have linked race and ethnicity to health care disparities in the United States (Institute of Medicine 2003b; Agency for Healthcare Research and Quality

2006, 2009; Andersen, Rice, and Kominski 2007).¹ Even when controlling for socioeconomic factors, studies have shown that racial and ethnic minorities receive lower quality care, have higher mortality, and higher disease rates for several conditions (i.e. diabetes and hypertension) compared to Whites (Mayberry, Mili, and Ofili 2000; Institute of Medicine 2003b; Barr, 2008). Disparate outcomes in health, health care, and access to health care for racial and ethnic minorities date back to the origins of Western civilization and Western medicine (Byrd and Clayton 2001; 2003). Specifically looking at the United States, much of the data on the subject of race and health care indicate that racial and ethnic minorities have fared the worst health care outcomes since the origins of this country (Byrd and Clayton 2001; 2003). Structurally, racial and ethnic health disparities can be linked to the overarching hierarchy of race and ethnicity that was the common place pattern of American society. Because race influences who has health care coverage, who has access to health care, the level of treatment one receives within the health care system, and subsequent health outcomes, the health care system as it exists today can be considered an oppressive system. As research has shown, access to quality health care is a complex issue involving more than whether or not one has health insurance (Institute of Medicine 2001). While merely having health insurance coverage does not guarantee access to health services, evidence confirms that those without coverage have even less access to care than those who are covered (Brown, Wyn, and Teleki 2000; Institute of Medicine 2001). Health insurance is the most commonly-used vehicle to access health care services (Institute of Medicine 2001)—primarily because it mitigates costly out-of-

1. For the purposes of this paper health disparities is defined as “a population-specific difference in the presence of disease, health outcomes, or access to health care” (HRSA, 2000).

pocket expenses (Brown, Wyn, and Teleki 2000). In the absence of a national health care plan providing coverage to all Americans, a number of states have implemented innovative approaches for expanding health care coverage to the uninsured. However, not all states have implemented needed strategies to expand coverage for those without insurance. This geographic discrepancy in the number of uninsured who have access to health care coverage leads to the important question: Why haven't most (or all) states developed and implemented more innovative policies to ensure that their residents have health care coverage? Does the race of a state's uninsured citizens serve as a factor? In response, this study will investigate the relationship between race and public policy using secondary data to examine if the race of the uninsured has an impact on existing state-level policies that expand health care for the uninsured.

Purpose of the Study

The purpose of this study is to examine the relationship between race and the development of state-level policy regarding health care coverage in order to ascertain if there is, indeed, a racial component in policymaking. While several studies exist that analyze the development of state public policy and race in the areas of welfare, education, and economics, the examination of race and health care policy at the state level is an understudied area. The objective of this study, therefore, is to shed more light on the subject of race and health care policy across the 50 states and the District of Columbia. Through an analysis of the racial composition of the uninsured and public policy development at the state level, this study seeks to address the following three questions:

- 1) Does the race/ethnicity of the uninsured influence public policy at the state level?
- 2) What, if any, patterns emerge from the data concerning race, state, and health care policy?
- 3) What are the social justice implications of the findings from questions 1 and 2?

In terms of outcomes, it is anticipated that observations will support the hypothesis that race is associated with state health care policy related to coverage expansions.

Furthermore, it is anticipated that this association will demonstrate that in states with high uninsured minority populations, fewer public policy innovations have been developed to expand health care coverage.

Definition of Concepts

Race

This study employs a sociological viewpoint of race. Therefore, race is defined as a social construct linked to perceived biological differences, often demarcated along the lines of phenotypical or somatic characteristics, i.e. skin color, hair type, eye shape, etc. (Miles 1989; Malik 1996; Weber 2001). These various physical characteristics are in turn believed to be intrinsically related to moral, intellectual, and other nonphysical attributes and abilities (van den Berghe 1967). Despite a long tradition of linking race to biological determination, many scientists have concluded that there is no biological basis for race (Miles 1989; Miles and Torres 1999; Omi and Winant 2001). While many scientists have concluded that race has no biological significance, social scientists have continued to

define, analyze, and attempt to understand race because of the lived reality of people in society who feel the impact of race as a tool of social organization and oppression (Miles and Torres 1999). Allan Johnson (2001, 21), interpreting the work of James Baldwin, said it best asserting that the “basic aspect of social reality [is that] most of what we experience as ‘real’ is a cultural creation.”

According to Weber (2001), race is a socio-historical and geographically/globally contextual concept. Within Western society, race has been used as a tool of dominance. Malik (1996) explained that the social significance of race in modern society stems from the need to explain inequalities within a capitalist society based on the perceived innate inequality of a “race,” rather than on the deliberate need to create an underclass based on physical differentiation. Racial categories are formed and transformed over time at a macro level (Omi and Winant 2001), and are then ascribed to individuals, who in turn are socialized as to the meaning of their individual racial category. This racial categorization has an impact on the social roles, social relations, and social status/standing within a society, which subsequently helps to determine access to scarce resources (Weber 2001), power and privilege in society (Johnson 2001). This definition of race, therefore, provides an important conceptual lens to understand the health care policy decisions that states make with regard to people of different racial backgrounds.

Health Care

Every industrialized country—except the United States—offers guaranteed health care coverage to each and every citizen. In fact for many countries, health care is a guaranteed constitutional right (Quadagno 2005). Even with the recent passage and

enactment of the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), the United States does not ensure access to quality, affordable health care (including health insurance) to citizens under the age 65 (Institute of Medicine 2001). While the recent reforms to the U.S. health care system will reduce the number of uninsured, alter the ways by which people obtain/purchase health care (i.e., the ability to purchase health insurance through state exchanges), and increase the affordability of health insurance, the fact remains that there is not a universal, guaranteed method for receiving health services or health insurance in this country. Most Americans who have health insurance currently access their coverage through a mix of public and private mechanisms. There are four main mechanisms for health insurance coverage:

- 1) the Medicaid program,
- 2) the Medicare program,
- 3) the State Children's Health Insurance Program (SCHIP), and
- 4) private commercial coverage either through employer-based coverage or through the individual market.²

As shown in Figure 1, of the Americans with health insurance, over half have employment-related insurance (52.3 percent), 4.7 percent purchase health insurance on

2. Consistent with studies conducted by the Institute of Medicine (2001), this study does not consider the provision of non-portable care provided on the basis of an entitlement or service as health insurance (e.g. Indian Health Service and the Military and Veterans Health Care System).

their own, 26.5 percent receive some form of public insurance,³ and 15.4 percent of the American population is uninsured.

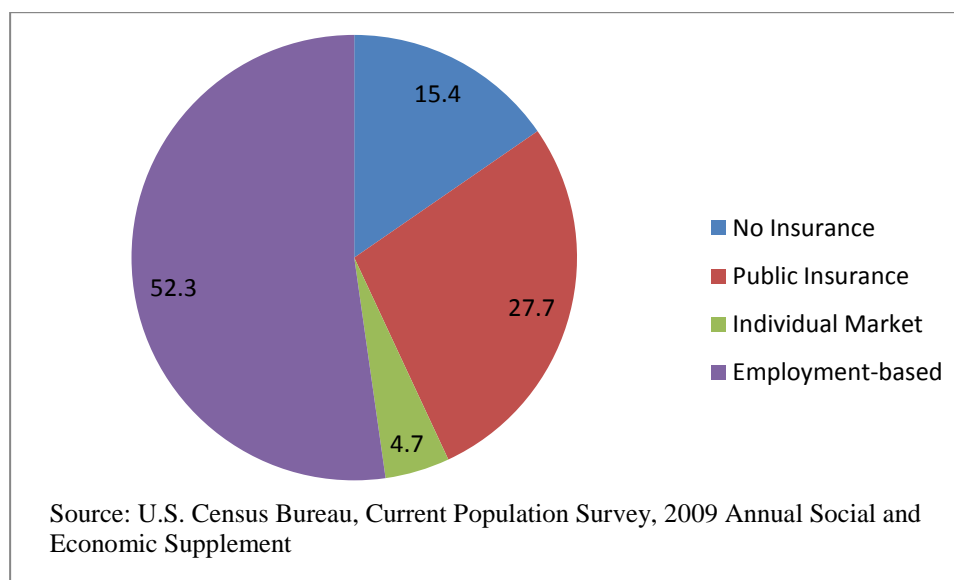


Figure 1. Coverage by Source of Health Insurance for U.S. Population

With public insurance being the second most prevalent mechanism for obtaining health insurance coverage, this study focuses on several public mechanisms through which the federal government provides states sufficient latitude to formulate programs to expand access to health insurance for the civilian non-elderly: the Medicaid and SCHIP programs.⁴ Additionally, this study focuses on three state initiatives designed to expand access to health insurance that are not based on federal programs: state-only funded

3. This number includes individuals covered through Medicaid, Medicare, and the military system (either active duty or veteran).

4. This study is focused on programs designed to expand access to care for non-military Americans who are under the age of 65. The emphasis is placed on non-military because the military has a health care system designed to provide health care services to its active duty, retired, and veteran personnel. The emphasis is placed on those under the age of 65 because the Medicare program guarantees access to health coverage to all Americans over the age of 65.

programs, state reinsurance, and high-risk pools, all of which will be described in a following section.

The Medicaid program, which is designed to help low-income children, families, and individuals, is the primary source of health care coverage for about 58 million Americans (Kaiser Commission on Medicaid and the Uninsured 2010). The Medicaid program was created in Title XIX of the Social Security Act Amendments of 1965, and is funded jointly by both federal and state governments. State participation in the Medicaid program is voluntary, but all 50 states and the District of Columbia participate. The federal government provides general foundational guidelines for categories of eligibility and services, after which states can establish their own additional eligibility criteria, their own rates for cost-sharing, and the kind/type of services available to their Medicaid recipients. This flexibility means that Medicaid coverage and benefits vary from state to state. Nonetheless, benefits tend to be fairly comprehensive for the poorest Americans and dependent children, including medical, dental, prescription, and mental health coverage. As a requirement of participation, states must submit to the Centers for Medicare and Medicaid Services (CMS), the federal agency with responsibility and oversight for the Medicaid program, individualized state plans. States are also allowed to submit amendments to their state plan (known as State Plan Amendments or SPA) but these amendments must be approved by CMS. States can also apply for waivers which allow them to implement innovative projects in line with the objectives of Medicaid (i.e., Section 1115 Research and Demonstration Projects), or alter aspects of state-based Medicaid delivery for some or all of their eligible recipients (i.e., Section 1915 (b) waivers). Either waiver requires CMS approval.

In 1997, Title XXI of the Balanced Budget Act created the State Children's Health Insurance Program (SCHIP). At the time, this program was the largest, sustained health care program developed since Medicaid and Medicare in 1965. The goal of SCHIP was to expand health care coverage for "targeted low-income children." For the purposes of SCHIP, a targeted low income child was defined as a child under the age of 19 whose family income was above the state Medicaid eligibility level but less than 200% of the Federal Poverty Line (FPL)—or whose family had an income 50% higher than the Medicaid eligibility in states where the Medicaid eligibility level was at or above 200% FPL at the enactment of SCHIP (Ways and Means Green Book 2004). States were given the autonomy to use SCHIP funds in a number of ways: to expand Medicaid, to develop a separate SCHIP program, or to combine their Medicaid and SCHIP programs to provide more and better coverage. It should be noted that the SCHIP program particulars vary from state to state in terms of who is covered. For example, some states have opted to expand coverage to children with families who have income more than 200% FPL though their state Medicaid eligibility did not exceed 200% FPL. Others have opted to extend coverage for the entire family of eligible children. In general, approximately 7 million children have health insurance coverage through the SCHIP program for all or part of the year (Kaiser Commission on Medicaid and the Uninsured 2010). In 2009, the program was reauthorized for an additional four and half years.

Medicaid and SCHIP are federal-state partnerships requiring a financial commitment from each. However, some states have developed health care coverage programs designed to expand coverage that are not connected to any federal program or

funding. Three such mechanisms are (1) state-only funded coverage programs, (2) reinsurance programs, and (3) high-risk pools.

State-only funded programs expand health care coverage for the uninsured through the use of innovative strategies that combine available state-based resources to build a health care program without the use of federal funding. By solely using state funds, states have more flexibility in developing the programs, especially around issues such as the benefit structure and eligibility requirements, which are usually mandated in federal programs (Wheatley 2000). Due to the lack of federal funding to support the programs, state-only funded programs tend to be narrow in the scope of benefits and also tend to have waiting lists and/or enrollments caps.

Reinsurance programs provide states with another mechanism for increasing health care coverage. In simple terms, reinsurance is insurance for insurance companies (Annis 2005; Swartz 2005; Wikler and Fish-Parcham 2008). These programs can reduce premiums by moving high-cost enrollees to a third-party insurer. Reinsurance programs protect the primary insurance company by helping to pay for all or part of medical claims that exceed a certain dollar amount (Swartz 2005; Wikler and Fish-Parcham 2008). This is especially important for small insurance companies who are more susceptible to financial loss—as would be the case when a company experiences an increase in the number of high-cost medical claims in any given year combined with a smaller pool of covered individuals to spread the risk (Wikler and Fish-Parcham 2008). With the assurance of state government reinsurance, insurance companies are more apt to offer coverage to high-risk populations, e.g., small businesses and people with multiple chronic diseases, in addition to opening the door for new insurers to enter the market (Swartz

2005; Wikler and Fish-Parcham 2008). Reinsurance programs can be established in connection to other mechanisms to make health care coverage more affordable, e.g., small business insurance plans, purchasing pools, and expanded coverage in the individual market (Chollet 2004).

A high-risk pool is a nonprofit association developed at the state-level that offers comprehensive health insurance benefits to individuals with pre-existing health conditions, who otherwise would be unable to obtain coverage on the private market (National Association of State Comprehensive Health Insurance Plans 2009). Typically, these pools have strict eligibility requirements and call for at least one of the following requirements to be in place: (1) the individual must be uninsurable as demonstrated by proof of being denied coverage, (2) the individual must demonstrate insufficient access to health insurance to meet his or her health needs, (3) if available private coverage is too expensive, the individual must be able to document that fact, and (4) the applicant must be able to prove that he or she is afflicted with a specific condition covered by the high-risk pool program (State Coverage Initiatives 2009).

Even though there are other mechanisms through which individuals can access health care coverage, the focus of this study will be on Medicaid, SCHIP, state-only funded programs, reinsurance, and high-risk pools. These programs have been chosen for analysis because Medicaid and SCHIP are the two largest health care programs that have devolved to the state for design and implementation, and all of these programs represent the most widely-used strategies for expanding health care access (Wheatley 2000; Holahan, Weil, and Wiener 2003). These programs also tend to have some similar

characteristics across states, thereby making them amenable for cross-state comparisons and analyses.

The Uninsured

The Institute of Medicine (IOM) defines the uninsured as “persons with no health insurance and no assistance in paying for health care beyond what is available through charity and safety-net institutions [i.e. free clinics or hospital charity care]” (IOM 2001, 1). According to the U.S. Census Bureau, 15.4 percent of all Americans are uninsured, which equates to approximately 46.3 million people (US Census Bureau, 2009).

There are several demographic, social, economic, and geographic characteristics of the uninsured worth noting in the context of this study. Minorities have disproportionately high uninsurance rates, with 31 percent of Hispanics, 31 percent of American Indian and Alaska Natives, 19 percent of African Americans, and 17 percent of Asians being uninsured in 2008 (as compared with 11 percent of Whites) (US Census Bureau, 2009). Moreover, nearly 10 percent of all children under the age of 18 are uninsured and 20 percent of all non-elderly adults are uninsured. The largest age segment among the uninsured are young adults between the ages of 25 and 34.

As described earlier, most people with health insurance obtain coverage through their employer (see Figure 1). However, it is important to note that 81 percent of the uninsured live in families that have at least one person in the home who is employed, with nearly 67 percent having at least one full-time worker in the home (US Census Bureau, 2009). Nearly 62 percent of the uninsured have an income of less than \$50,000 per year, with 30 percent having incomes less than \$25,000 a year. Thirty-eight percent

of the uninsured have a high school diploma and 26 percent do not have a high school diploma. Geographically, the uninsured live primarily in the Southern (43.5 percent) and Western (27 percent) regions of the United States.

Overview of Chapters

This study contains five chapters, beginning with the Introduction. Chapter 2, the Literature Review, provides the theoretical framework for this study and the relevant socio-historical and on the subjects of race, social policy, and health care policy by reviewing available literature on these subjects. A discussion of previous work and theoretical perspectives is also included. Chapter 3 outlines the research design for this study. The chapter gives a detailed description of the data collection procedures, measurement procedures, and includes a discussion of how the resulting data were used to address the research questions examined in this study. The chapter also includes a discussion of the study's limitations. Chapter 4 contains a detailed description and interpretation of the results of the data collection according to the methodology described in the previous chapter. This chapter presents the findings through the integrated use of text, tables, figures, and other illustrations that enhance the reader's understanding of the results. This chapter summarizes, evaluates, and interprets the results in the context of the research questions and hypotheses presented in Chapter 1. Finally, Chapter 5 concludes the study by summarizing the research presented and provides suggestions for future work. This chapter includes a discussion of the implications of this work in the context of social justice, specifically as it relates to public policy.

CHAPTER 2

LITERATURE REVIEW

In an attempt to assess whether there is an association between race and health care policy at the state level, this chapter will: (a) provide the theoretical framework, (b) the relevant socio-historical context on the subjects of race, social policy, and health care policy; (c) examine trends in relevant research on race and public policy, and health care, and (d) discuss the overall significance of this type of examination.

Theoretical Framework

Organized in the mid-1970s, Critical Race Theory (CRT) is a theoretical movement committed to examining, critiquing, and changing the relationship between race, racism, and power. CRT was developed by legal scholars and activists grounded in postmodern, liberation traditions. Informed by neo-Marxism and other oppositionist movements, critical race theory focuses on the historical role of the law in perpetuating privilege in society (Crenshaw 1995; Delgado and Stefancic 2000; 2001).

Born from the critical legal studies (CLS) and radical feminism movements, CRT originated as a critique to the shortcomings of CLS. CLS scholars challenged the traditional view of law as neutral, arguing rather that the legal system legitimizes the oppressive social hierarchy of society (Delgado and Stefancic 2001; Yosso 2005). Founding scholars of the CRT movement believed the work of CLS scholars focused more on critiquing traditional notions of the law rather than developing or offering

suggestions to transform the system.⁵ These founding scholars offered that the inability of CLS to develop recommendations to transform the system hinged on its fallacy in not including the role of race and racism into the analysis (Crenshaw 1995; Yosso 2005). CRT emerged from three central notions: (1) it is critical to understand the role of the law in developing, perpetuating, and reinforcing racial subordination and dominance (as well as other forms of oppression), (2) the social construction and representation of race and racial power in American society must be challenged (Crenshaw 1995), and (3) strategies must be identified and offered to transform the relationship between the law and race (Crenshaw et al. 1995; Delgado and Stefancic 2001; Yosso 2005).

There is not a formal “canonical set of doctrines or methodologies” (Crenshaw et al. 1995, xiii) subscribed to in the critical race movement. Instead, there are six basic tenets that serve as the guiding principles of the movement: (1) racism is the standard, ordinary experience in society and not an abnormal occurrence; (2) racism serves the interests of both white elites and the working class; (3) race is a social construct; (4) different races have different origins and lived experiences; (5) the lived experiences of people is based on the intersection of identifies; and (6) people of color have a unique standpoint from which they can speak about race and racism (Crenshaw et al. 1995; Delgado and Stefancic 2001).

- 1) *Racism is the standard, ordinary experience in society and not an abnormal occurrence.* The basic premise of CRT is that race and racism are normal, everyday parts of society, both of which are essential to understanding the

5. Founding/principal founders of the CRT movement include: Derrick Bell, Alan Freeman, Kimberlé Crenshaw, Angela Harris, Charles Lawrence, Mari Matsuda, Patricia Williams, and Richard Delgado, among others.

functions of the US society (Bell 1992). With race and racism being so “ordinary” it thereby makes it all the more difficult to identify and fix the issue (Delgado and Stefancic 2001).

- 2) *Racism serves the interests of both White elites and will proceed until the interests of people of color and those of White elites converge.* This is called interest convergence, which argues that racial equality/equity in society will only be pursued so long as it meets the interests of white elites and the working class (Bell 1992; Milner 2008).
- 3) *Race is a social construct.* Race is a socially produced construct that is created and recreated over time. There is no scientific basis for race but as explained in Chapter 1, race holds significance in American society and in CRT based on the ascribed meanings placed on race.
- 4) *Different races have different origins and lived experiences.* This concept, known as differential racialization, embodies the notion that each racial group has its own history in society. The depiction and treatment of each racial minority group varies over time based on the prevailing needs of the dominant group (Delgado and Stefancic 2001).
- 5) *The lived experiences of people is based on the intersection of identities.*
Intersectionality is an important tenet of CRT. Individuals do not experience the world discretely based on their race, gender, class, or sexuality, but rather people simultaneously experience the world through a combination of identities and therefore can both be privileged as well as oppressed within society (Delgado and Stefancic 2001; Johnson 2001; Weber 2001; Young and Dickerson 1994).

6) *People of color have a unique standpoint from which they can speak about race and racism.* The lived experiences and different histories with oppression in American society provide people of color with a unique ability to speak about race and racism in ways that Whites are unlikely able to communicate or to know. CRT encourages society to look to the faces at the bottom of society to best understand the functions of race and racism in society (Bell 1992; Matsuda 1995).⁶ CRT promotes the use of storytelling and people of color are encouraged to share their stories regarding race and racism and the law/legal system.

Although critical race theory began within the legal discipline, it has quickly moved to other disciplines, including but not limited to education, psychology, political science, and sociology. Critical race theory is different from many traditional academic disciplines in that it supports an activist agenda. Critical race theorists believe that it is not enough to simply understand social situations and how society is stratified along racial lines, but rather it is important to change and transform our situation for the better (Delgado and Stefancic 2001). With its central focus on race and the law, combined with its activist agenda, critical race theory serves as an excellent analytical tool to evaluate health care policy at the state level with race as the focal point of analysis.

Socio-Historical Context

6 . Derrick Bell (1992) coined the term “faces at the bottom of the well,” and Mari Matsuda (1995) used the term “looking to the bottom” in explaining that notion of looking to those who are the least advantaged in the system to include their voice and to understand issues from their lens, specifically here to understand the race and racism in American society.

A search for literature/studies chronicling the experiences of racial and ethnic minorities in the development of the health care system and/or detailing racial and ethnic minority access to health care as measured by health insurance produced minimal results. Where extensive information was available, the literature heavily relied on the African-American experience in society contending that because African Americans are the longest and largest non-indigenous minority group in America, understanding the African-American experience in relation to the health care delivery system in the U.S. serves as a good vantage point in understanding the experience of other minorities (Byrd and Clayton 1991; 2000; 2002).⁷ More research by Byrd and Clayton (2003) published as a part of the Institute of Medicine's book on health disparities entitled *Unequal Treatment*, chronicled the experiences of racial and ethnic minorities in America in an effort to provide the history of racial and ethnic health disparities. Though this work focused on health disparities related to outcomes rather than access, what follows combines research from the work of Byrd and Clayton (2003), their additional research focused on African-American disparities (1991; 2000; 2002), and several related sources with a history of health insurance in America to provide a historical context for this study.

To fully examine the association between health care policy and race, it is first important to understand the health care system and specifically health insurance, in the context of race and ethnic relations in America (Pedraza and Rumbaut 1996). Race and ethnic relations in American society have a long and sordid history (Pedraza and

7. While several historic studies have examined health care and the African-American experience in the U.S. (DuBois, 1906; Lewis 1942; Cobb 1947; 1948, and 1981; Morais 1967), the work of Byrd and Clayton has been the most extensive historical description to date.

Rumbaut 1996). The use of race and ethnicity to create and promote social and economic inequality in society has been a central characteristic of U.S. history (Pedraza and Rumbaut 1996). American society was shaped on the premise of the social and economic (including health care) needs of the dominant group – European Americans –being placed above those of racial and ethnic minorities. This notion of racial and ethnic inequality is rooted not only in the practice of colonialism and forced immigration but is immortalized in the formation of the laws, policies, and institutions that constitute American society. As the country developed the foundational laws, structures, and systems (such as the Declaration of Independence, immigration and naturalization laws, and the Bill of Rights), racial and ethnic minorities (e.g. Native Americans, Blacks,⁸ Chinese, and Japanese) were purposefully excluded (Takaki 1993; Omi and Winant 1994). Examples of this exclusion are evident in the hundreds of years of slavery that excluded African Americans from full citizenship. During slavery, African Americans were at most considered three-fifths of a person by the Constitution and not afforded any rights or protections of the document. Although freed from the institution of slavery in 1863, African Americans fought for over 100 years for their full rights accorded to all citizens under the Constitution, including the right to vote. Native Americans went through a long history of turmoil with European American colonists and despite being the original inhabitants of the land, Native Americans were not granted the right to vote until 1924 (Byrd and Clayton 2003). Asian-Americans were brought to America as industrial workers in the mid-1800s but were not allowed to become citizens, even if they were

8. Use of the terms Blacks and African-Americans are used synonymously throughout this study. Use of one term over the other will fluctuate to reflect either the historical term used at the time and/or a cited author's use of the term.

born in America, until 1952 (Takaki 1993). Examples of exclusion from the rights and privileges of being an American citizen experienced by racial and ethnic minorities is also evident in the health care system (Byrd and Clayton 1991), including health insurance.

As the health care system and the advent of health insurance developed, racial and ethnic minorities continued to be marginalized in the process. From its beginnings the health care system was stratified along racial differences (Rosenberg 1987; Byrd and Clayton 2000; 2001; 2003).⁹ Most European Americans received their care in the home while racial and ethnic minorities were relegated to care in sub-standard institutions (Byrd and Clayton 1991; 2000; 2001; 2003). For example, African Americans received their care through a system of care referred to as the slave health subsystem (Byrd and Clayton 2000). The slave health subsystem was a system of care that relied on a mix of non-professional and semi-trained health care providers such as “traditional [spiritual] healers, root doctors, granny midwives and nurses, overseers and planters’ wives” that was sometimes supported by professionally trained physicians (Byrd and Clayton 2003, 525). This health system ultimately proved inadequate as the traditional African healers were faced with ailments and disease unknown to them and they were not supported in a regular or consistent manner by professionally trained health care providers (Byrd and Clayton 2000). It is important to note that in the rare cases of free African Americans during this time, they fared even worse treatment in the health system as they were excluded from both the slave health subsystem and the mainstream health care system;

9. These authors also recognized class as a means of stratification in the health care system. For the purposes of this study, racial differences are the focus, as race is highly related to social class but it not the same and is understudied in relation to the development of health care policy.

this was also true for other racial and ethnic minorities (Byrd and Clayton 2001). Native Americans had little, if any interaction with the main health care system in society until the late the 1800s (Trennert 1998). Until that time, much like the experience of African Americans, their health care relied on medicine men and healers who were unfamiliar with the ailments and disease brought to America by Europeans (Trennert 1998).

As hospitals became a part of the American health system in the 1700s, creating the basis for public health care in America, racial and ethnic minorities faced discrimination in these institutions as well (Byrd and Clayton 2000; 2001). Primarily designed for health care for the poor, public hospitals were not used by non-ethnic European Americans (Byrd and Clayton 2000). Where racial and ethnic minorities were allowed into these typically overcrowded public hospitals or other health institutions for the poor (e.g. almshouses, clinics, etc) they were segregated and given the poorest accommodations (Rosenberg 1987; Byrd and Clayton 2000). As the public health system continued to grow, public hospitals remained a much needed but woefully underfunded, inferior system of care concentrated in major metropolitan centers, which tend to be the loci of racial and ethnic minorities (Byrd and Clayton 1991; 2000).

As health insurance burgeoned in America, racial and ethnic minorities were excluded from benefitting from health insurance by virtue of their exclusion from the paid labor force or from fraternal organizations that collectively bargained for health insurance benefits (Byrd and Clayton 2000). Until the late 19th century, the health care system had very few health insurance programs to help finance the cost of medical care (Byrd and Clayton 2000; Employment Benefits Research Institute 2002). Before then, the only program that could be considered health insurance was the U.S. Marine Hospital

Service, which was designed to extend health care benefits to merchant marines, who were required to have a portion of their wages deducted for this service (Byrd and Clayton 2000; Employment Benefits Research Institute 2002). This program excluded racial and ethnic minorities as it was created at a time when racial and ethnic minorities (mostly African Americans and Native Americans at this point in history) were typically excluded from the paid laid labor economy.

With much of the major activity building the health insurance system occurring after the Civil War and into the 1900s, health insurance was largely a function of employment-based benefits during periods in which relatively few racial and ethnic minorities participated in the industries or in unions establishing the benefits (Employment Benefits Research Institute 2002). Not only were racial and ethnic minorities not involved in the paid labor force, but as previously mentioned, they were excluded from the rights and benefits of full citizenship at this time, justifying differential access to health insurance benefits. In the few instances where states became involved in health insurance benefits/programs in the late 1800s, it happened in states like Massachusetts, New York, and Connecticut where racial and ethnic minorities were not that populous (Employment Benefits Research Institute 2002).

Race has played a significant factor in the development of American society. The great doctrines and foundational institutions marking the beginning of American society initially excluded all racial and ethnic minorities. The health care system, including health insurance, is no exception. As much of the U.S health care system and health insurance system were developed, racial and ethnic were excluded from reaping the full benefits of the system as afforded to European Americans. This historical connection

between race and the U.S. health care system warrants an examination of the practical realities of race and health care policy.

Race and Public Policy

Much in the vein of critical race theory, several authors argue that race is central to the analysis of public policy and policymaking. Samuel Myers Jr. (2002) argues race should be a central component of policy analysis. Stating that race has largely been ignored as a substantive area of inquiry, Myers proposes the use of race analysis defined as “the systematic application of the tools of historical and cultural analysis to understand the social and economic circumstances facing blacks and other racial minority group members” (170). Race analysis is multi-disciplinary, drawing inspiration from history, psychology, economics, sociology, and biology. Race analysis is useful across various professions, with legal scholars, political scientists, sociologists, and, generally, those specializing in ethnic studies, using race analysis as a framework for their research. While race has experienced a more prominent focus of analysis in the field of sociology (at various historical points), race and the use of race analysis have been understudied and underutilized by those who analyze, develop, and/or implement public policy (Myers 2002).

Despite the relative absence of race analysis in the field of public policy, a growing body of research highlights that race continues to be an important issue in several public policy areas. Several authors (Hero and Tolbert 1996; Hero 1998, 2007; Soss, Schram, Vartanian, and O’Brien 2001; Douglas 2005; and Soss, Fording, and

Schram 2008) have made race the focal point of their analysis in understanding state public policy related to social and economic policies.

Recognizing that state policies result from the “cooperation, competition, and conflict” between and among dominant and subordinate groups for scarce resources, Hero and Tolbert (1996) offer evidence that racial and ethnic diversity is essential to understanding state policy and the variation in policy between states (854). Putting forth what is formally defined as the *racial diversity thesis* (Hero and Tolbert 1996; Hero 1998; 2007),¹⁰ the authors critique other studies that have examined state policy and highlight that previous examinations of state policy have largely ignored race as a significant factor in state policy development. The racial diversity thesis recognizes the significant history race/ethnicity has played in shaping American policy by placing race at the center of analysis. The racial diversity thesis contends that policy outcomes in a state are directly related to the level of racial diversity in the state (Hero and Tolbert 1996; Hero 2007). Specifically, Hero and Tolbert demonstrate that examining a state’s racial and ethnic diversity (including white ethnic groups from Southern and Eastern Europe) explain policy variation among states and that it can also indicate the disparate impact of public policy on a minority groups (Hero and Tolbert 1996; Hero 1998; 2007).

To explore racial and ethnic diversity, the authors categorized states into three groups: homogeneous states (states with small minority populations, small populations of white ethnics, and large white populations),¹¹ heterogeneous states (states with moderate

10. Hero later renames the racial diversity thesis as the social diversity thesis and over the better part of decade between 1996 and 2007 the author uses the two terms interchangeably.

11. Hero’s racial diversity thesis includes an examination of racial and ethnic groups typically defined as “minority groups,” e.g. African-Americans, Asians, and Hispanics/Latinos. His work also

sized minority and white populations, and large white ethnics populations), and bifurcated states (states with large minority populations and large white populations, and small white ethnic populations (Hero and Tolbert 1996; Hero 1998; 2007). Using regression analysis to examine the relationship between racial and ethnic diversity and state policies, the authors found an inverse relationship between racial diversity and policy outcomes. That is, when examining education and social policy (measured by infant mortality and Medicaid expenditures), in the aggregate, policy outcomes were particularly poor in bifurcated states - states with large minority and large white populations (Hero and Tolbert 1996). Hero and Tolbert (1996) further contended that when the policies examined were separately analyzed by race, policy outcomes were particularly poor for minorities (specifically African Americans and Latinos) in homogenous states.

In addition to the work of Hero and Tolbert, research by Soss, Schram, Vartanian, and O'Brien (2001) also examined the role of race in public policy at the state level. In the article, *Setting the Terms of Relief: Explaining State Policy Choices in the Devolution Revolution*, Soss et al. (2001) discovered that race was a significant factor in whether states adopted "get-tough" policies in the Temporary Assistance to Needy Families (TANF) law developed in 1996. Soss et al. (2001) examined welfare policy in all 50 states because it was a policy moment in which all states reacted at the same time to a federal policy mandate and the federal government devolved some of its responsibility to the states in a way that gave states a great deal of flexibility to be innovative in

examines "White ethnics," e.g. whites of Eastern and Southern European descent. For this purpose, Whites in this section refers to Whites of Northern and Western European descent.

implementation.¹² The authors created an index welfare stringency that looked at the strength of sanction policy, strict work requirements, strict time limits, and family caps. States could score between 0-4 based on a point allocation where a state was given one point for each of the following: having a family cap, having a time limit that was shorter than the federal limit of sixty months, having a work requirement of less than twenty-four months, and having strong sanctions (Soss et al. 2001, 385). Using logistic regression, found that there was a racialized component to welfare policy decisions at the state level (though they were unable to state how race influences welfare policy). Specifically, the authors found that states with more minorities in their caseloads were more likely to score higher on their policy severity index and were more likely to adopt the most restrictive policies regarding sanctions, time limits, and family caps (Soss et al. 2001). Ultimately, the authors cautioned that state devolution could provide new opportunities to further race inequality in society, especially as it is related to African Americans (Soss et.al 2001).

Later building off of this finding, Soss, Fording, and Schram (2008) developed the racial classification model, which examined how race and racial composition influence the policy choices and outcomes in states. Specifically looking at the devolution of welfare policy the authors examined why certain states passed jurisdiction of welfare policy to the local level and the impact such “second-order” devolution had on

12. Devolution is the defined by the Merriam-Webster Dictionary “the transference (as of rights, powers, or responsibility) to another; especially the surrender of powers to local authorities by a central government.” Therefore state devolution refers to the transference of federal authority/responsibility to states.

racial groups.¹³ The authors develop the racial classification model, which infuses sociological theory related to social classification with public policy. There are three foundational tenets to the racial classification model. First and foremost, the authors acknowledged that categorization of people is a basic factor of society and that policymakers use social classifications to develop policy solutions to targeted groups in society (Soss, Fording, and Schram 2008). Next the authors offer that in instances where racial minorities are thought to be prominent or are in fact prominent, in the policy context (e.g. welfare policy), policymakers are likely to use race as the means of classification, which in turn impacts policy choice. The last tenet of the racial classification model explains that the perceptions and stereotypes of racial groups held by policymakers are associated with racially disparate policy outcomes. That is, as policymakers seek policy solutions for target groups, stereotypical notions of a racial group are contrasted against those of another and become associated with policy differences applied to individuals and/or groups (Soss, Fording, and Schram 2008). Soss, Fording, and Schram (2008) contend that the racial classification model is a model that explains the sufficient (not necessary) conditions in which racially disparate policy actions can occur (2008). Testing the model on the question of welfare policy, Soss, Fording, and Schram (2008) found that race explains the welfare policies developed in a state and the outcomes/impacts related to second-order devolution on racial and ethnic minority groups. Relative to welfare policies, the authors conclude that “racial

13. Second order devolution refers to the transference of authority/responsibility from states to local governments.

differences have shaped policy choices, and policy choices, in turn, have shaped racial differences” (2008, 551).

In Douglas’ (2005) work, the author applies the concept of racial and ethnic analysis by considering the role of race in three state-levels policy areas: felony disenfranchisement, unemployment insurance, and health care (only the SCHIP program). In this study, the author examined the racial composition of the 50 U.S. states and the District of Columbia and the level of restrictiveness imposed in the states across the three policy areas. Douglas (2005) sought to prove an association between race and public policy by examining the relative level of diversity in a state (using the national U.S average for each racial group as the baseline) and the restrictiveness of the policies developed by the state. Policy restrictiveness was measured relative to a state’s implementation of maximum guidelines at or above the requirements outlined in the federal regulations related to felony voting rights, unemployment insurance, and SCHIP eligibility policies (Douglas 2005). Like the previous studies of Hero and Tolbert (1996) and Soss et al. (2001), Douglas’ (2005) study showed a connection between the racial composition of a state and state policy variation. Specifically, for two of the three policy areas (voter disenfranchisement and unemployment insurance), Douglas found that states with high minority populations had more restrictive policies.

Health Insurance, the Uninsured, and Community

Much of the research that has been conducted on the health care system can be characterized into several broad categories: access, coverage, quality, cost of health

care/cost containment, and the administration of health care. In some cases, studies have been produced that have looked at a cross-section of these issues, e.g. coverage and access to health care (see IOM 2001).

Studies focused on coverage and access, and/or quality, either in whole or in part, have examined the health care system and the disparate treatment/outcomes experienced by individuals along several of the domains of oppression, particularly race (see Yaruba 1977; Hummer 1993; Brown, Wyn, and Teleki 2000; IOM 2003a, 2003b; Ikemoto 2006). Of these studies, only a few have narrowed in on the impact uninsurance rates have on communities by analyzing the geographic location of the uninsured and the characteristics associated with communities with high rates of uninsurance (see Brown, Wyn, and Teleki 2000; IOM 2003a). Using indicators such as the access to a usual source of care, delaying or foregoing necessary care, and not seeing a physician during the course of the previous year, these studies have demonstrated that socio-economic factors, race, and place are related to one's ability to access health care. However, few studies have focused on examining the relationship between race and health care policy related to expanding health care coverage to the uninsured. Despite this, there are several studies highlighting the importance of health insurance in accessing health care and/or the lack of health insurance coverage on the community.

Two studies of interest examine the relationship between health care coverage, the uninsured and the impact on geographic communities. In a study by Brown, Wyn, and Teleki (2000), the authors examine the relationship between health care insurance and access to health care in 85 metropolitan statistical areas (MSAs) across the United

States.¹⁴ The authors were largely interested in an analysis of class and place, rather than race and place. Specifically, the study examined the differences in health insurance coverage and access to care among low-income and moderate-income residents between the ages of 18-64. Among their findings the authors determined that residents in high uninsured cities (defined as being above the average uninsured rate for the average of the 85 MSAs) had a more difficult time accessing necessary care than those residents living in cities with low uninsured rates (defined as being below the average uninsured rate for the average of the 85 MSAs). The authors also found that high uninsured MSAs had less generous Medicaid programs. While race was not the focal point of their analysis, Brown et al. examined race and found significant differences among minority resident's access to employer-based health care coverage (the primary source of insurance for most Americans) regardless of where they lived. The study showed that where a person lives and the overall rate of uninsurance in an area have a direct relationship to access to care and ability to obtain coverage. Brown, Wyn, and Teleki (2000) noted that cities and municipalities have little authority over expanding health care coverage but states have greater authority to develop approaches to expand coverage.

In a 2003 IOM study entitled *A Shared Destiny*, the authors assess the community impact of having uninsured residents on health care services. In this study, community was defined in terms of geographic location and broadly examined at the state and regional levels. Looking at health care institutions (hospitals, trauma centers) and

14. The Office of Budget and Management defines a metropolitan statistical area (MSA) as “an area containing a recognized population nucleus and adjacent communities that have a degree of integration with that nucleus” (OMB, 2000). The Federal government uses MSAs to collect data and frequently report statistics based on MSA geographic areas (OMB, 2000).

providers (primary care and specialty), the authors found that communities with high uninsurance rates have reduced access to care (IOM 2003a). This study did not specifically examine race but highlights the critical link between high uninsured rates and lack of health care services, which impacts not only those who are uninsured but also those who have insurance.

Summary/Significance of the Study

The research from Hero and Tolbert (1996), Soss et al. (2001), Douglas (2005) Soss, Fording, and Schram (2008) each highlight that race is a significant factor in policymaking and in understanding the outcomes of public policy on individuals/groups in society. Their work also illuminates the continued need to explore the relationship between race and state policy. The studies from Brown, Wyn, and Teleki (2000) and the Institute of Medicine (2003a) highlight the importance of examining health care coverage at the state/local level to understand the impact on the uninsured and the community as a whole. Expanding the work of these authors and grounded in critical race theory, this study examines race and policymaking as it pertains to health care policy and its development at the state level. Specifically, expanding on the work of these authors, this study seeks to understand if the race of the uninsured matters in connection with health care policy to expand health insurance at the state level and if so, what are the implications of this connection.

This study is timely as the United States turns its attention to reforming the health care system. States have long been viewed as laboratories for policy innovation (New State Ice Company v. Liebmann 1932; Guo and Buss 2003). The federal government has

looked to the states for innovative examples of policy reform. For example, in forming what became the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the federal government used innovations from states to guide welfare reform and in the end devolved a great deal of authority in tailoring the Temporary Assistance to Needy Families (TANF) program to the states. As with welfare reform, the federal government has turned to state innovations in health care policy for reform examples and have allotted a great deal of responsibility and flexibility in certain aspects of health reform to states to implement the new law. For these reasons, it is important that policymakers and advocates understand the relationship between race and public policy, especially as it relates to health care policy and access. Unfortunately, there have been few national studies examining race and health care policy at the state level. This study takes an initial step toward filling this void.

CHAPTER 3

METHODOLOGY

As shown in the literature, there is a link between race and public policy (Hero and Tolbert 1996; Soss et al 2001; Douglas 2005; Soss, Fording, and Schram 2008). The objective of this study, therefore, was to examine the relationship between race and public policy in an effort to understand the disparate outcomes of public policy on different racial groups, specifically as it related to health care policy at the state level. Through analysis of the racial composition of the uninsured and public policy development at the state level in all 50 states and the District of Columbia,¹⁵ the goal was to establish whether there was an association between the race of the uninsured and the number of policy innovations used to expand health care access in the states.¹⁶ Toward that end, this study examined the various patterns that emerged from the data concerning race, state, and health care policy.

Data Analysis Method

This examination was conducted using secondary data. Secondary data analysis involves the use and subsequent reanalysis of data collected by someone else for a

15. The U.S. territories were excluded from this analysis because the laws governing their federal health care programs are not the same as those in the U.S. Additionally, due to variations in state/local governance they do not have the exact state programs that were examined in this study. Lastly, the data on the territories is not readily accessible.

16. From this point forward, any reference to “states” includes all 50 states and the District of Columbia.

different purpose than intended when the information was originally collected (Hakim 1982; Stewart and Kamins 1993; Babbie 2001). Use of secondary data analysis in this study afforded the opportunity to examine the relationship between race and public policy in a cost-effective and time-efficient manner using previously published data. This research technique has a long and noteworthy history in the social sciences, especially sociology. For example, one need only look to Emile Durkheim's (1897) work, *Suicide*, in which he analyzed existing government records to explore the differing suicide rates among Protestants and Catholics, or Ida B. Wells-Barnett, who used statistics, interviews, and secondary accounts in her late 19th century pamphlets, *Southern Horrors* (1892) and *The Red Record* (1895), to document lynching and its causes.

Secondary data analysis has become one of the most popular research methods due to the inexpensive nature of conducting such analyses and the accessibility of large data sets collected and archived in central repositories, e.g., the U.S. Census Bureau and the Inter-University Consortium for Political and Social Research at the University of Michigan (Babbie 2001; Schutt 2007). In addition to being cost-effective, secondary data analysis allows the researcher to take advantage of the professional expertise of those initially involved in designing and executing the data collection of the original project (Babbie 2001; Freese 2009). Moreover, secondary data analysis provides the opportunity to use previously collected data to examine questions about social life, such as existing or burgeoning societal issues for which such data could prove illuminating (Hakim 1982; Babbie 2001).

Unit of Analysis

This study examined race and public policy in all 50 states and the District of Columbia. Individual states have long been regarded as test sites for innovation at the “micro” level before becoming more widely adopted at the federal level. Supreme Court Justice Louis Brandeis, for example, believed that states were laboratories of innovation, writing “that a single courageous state may...try novel social and economic experiments without risk to the rest of the country” (New State Ice Company v. Liebmann 1932). While the U.S. has experienced a significant growth in the federal government, many of the policies enacted on the federal level provide states with flexibility in implementation to conform policy to local needs and circumstances (Sribnick 2008). Additionally, in the absence of federal action or direction, states have experimented with solutions to social and economic issues facing their citizens. Given the latitude states have in implementing and enacting certain public policies, it is important to understand what factors are associated with state policymaking decisions—particularly those associated with issues of health. Thus, examining the question of the race of the uninsured as a factor in health policy innovations at the state level is a worthy endeavor and is the focus of this study.

Data Collection

For this study, data was collected, processed, and coded between May 2009 and June 2010 using publicly available data from several sources related to the year 2009. Specifically, the data used for this study focused on the race and ethnicity of the uninsured and information related to state health policy innovation. Data used in this study came from governmental entities such as the U.S. Census Bureau and the U.S.

Department of Health and Human Services, non-profit institutions including the Kaiser Family Foundation, the National Conference of State Legislators, and the Robert Wood Johnson State Coverage Initiatives (SCI), as well as one academic health policy institute—the Georgetown University Health Policy Institute’s Center for Children and Families. Data from these entities were used based on accessibility to standard data from all 50 states and the District of Columbia, and the reputation of each organization. In most cases, data from each source was checked against another source to ensure that the most accurate and currently-available data was utilized in assessing state public policies related to health care access.

Data Sources

The U.S. Census Bureau

The U.S. Census Bureau, a division of the U.S. Department of Commerce, is the primary federal government source for data about the nation’s people and economy (Census Bureau 2009). The U.S. Census Bureau conducts a number of censuses and surveys on a range of topics related to demographics and economics at varied time intervals, including the Constitutionally-mandated U.S. Decennial Census. Data from the U.S. Census Bureau is publicly available and accessible, either in summary via the internet or in full form through the use of the Bureau’s data retrieval tool, Data Ferret. By request, the Bureau can also provide data on varied media, including CD-ROM files.

Of the many surveys undertaken by the U.S. Census Bureau, the Bureau collects health insurance data through three national surveys: the Current Population Survey's

Annual Social and Economic Supplement (CPS ASEC), the American Community Survey (ACS) and the Survey of Income and Program Participation (SIPP). Each survey uses different data collection methods, different samples, and different methodologies for calculating the resulting estimates. Due to these differences, it was important to examine details of each survey to determine the most appropriate survey for this study. In the end, data from the CPS ASEC was selected as the most viable source of pertinent information for the current study.

For over 50 years, the Census Bureau has conducted the Current Population Survey (CPS) for the Bureau of Labor Statistics. The CPS is a monthly survey of about 50,000 households, scientifically sampled to represent the civilian non-institutional population (DeNavas-Walt 2009). From the sample, estimates are then calculated for the entire nation, which subsequently provide information for model-based estimates for individual states. Information is collected on various labor force issues (e.g., employment and earnings) and demographics (e.g., age, race, and sex). Each year, from February through April, the Census Bureau adds supplemental questions to the CPS in order to generate information for the ASEC-related portion of the survey, which is obtained from about 78,000 households (Census Bureau 2009).¹⁷ For example, the CPS ASEC contains 30 questions related to health insurance coverage. If respondents answer “no” to each of those 30 questions, they are considered “uninsured.” In such cases, they are then asked a confirmation question to verify that they were, in fact, without coverage or were

17. The ASEC has produced health insurance coverage estimates, asking the same or similar question for nearly 25 years.

uninsured for the entire year in question (DeNavas-Walt 2009).¹⁸ CPS ASEC results on health insurance coverage are commonly used by policymakers, advocates, and researchers as a source for understanding and reporting the number of uninsured on both a national and state level.

Although the U.S. Census Bureau produces high quality, comprehensive data on a variety of topics, it is not without its share of criticism. One of the major critiques is that census data tends to underestimate population and demographic information, particularly related to race and ethnicity. This critique has most often been levied by state and local governments and civil rights organizations, since the federal government tends to rely on census data to allocate resources to state and local governments (Stewart and Kamins 1993).

An additional criticism of census data has focused on the racial and ethnic classifications utilized in the census. Critics have argued that these classifications are ambiguous and confusing (Cox 1994). The Census has also been criticized by civil rights organizations who argue that the relatively recent change in the 2000 Census that permits a “multiracial” classification will eventually result in the undercounting of racial minority groups over time (Williams 2007). Despite these critiques, the U.S. Census Bureau is still considered the most comprehensive and up-to-date source for demographic data, including racial and ethnic data, and served as the best secondary data source for the purposes of this study.

18. Questions related to health care coverage are asked about the previous year.

U.S. Department of Health and Human Services

The Department of Health and Human Services (HHS) is the governmental agency responsible for “protecting the health of all Americans and providing essential human services” (HHS 2010). The department oversees 11 agencies including the Center for Medicare and Medicaid Services (CMS). CMS has jurisdiction over the Medicare and Medicaid programs, as well as the State Children’s Health Insurance Program (SCHIP). The Medicaid and SCHIP programs operate as a partnership between the federal government and individual states; thus, CMS serves a critical role in monitoring, regulating, and reporting on these programs.

Given the stringent reporting requirements that CMS demands of states, this data is considered a reliable source for obtaining information regarding the Medicaid and SCHIP programs. The data used in this study were collected from three primary CMS sources: (1) Medicaid State Plan Amendment data, (2) the Medicaid State Waivers and Demonstrations List, and (3) SCHIP Annual Reports. It should be noted that in several instances, data available through CMS were not available for the Program Year 2009. In those cases, information was retrieved from the state program website, the Kaiser Family Foundation, and the Georgetown University Health Policy Institute’s Center for Children and Families.

Kaiser Family Foundation

Established in 1948, the Kaiser Family Foundation (KFF) is one of the premier non-profit, non-partisan institutions on health care policy in the United States. KFF produces both primary and secondary research, in addition to comprehensive policy

analysis. Two specific programs operated by KFF proved to be useful for this study—the Kaiser Commission on Medicaid and the Uninsured (KCMU) and the State Health Facts website. Both programs provide state data on eligibility requirements for Medicaid and SCHIP, as well as utilization rates by various demographics for all 50 states and the District of Columbia. The KFF data used for this study originated from a national survey commissioned by KCMU in 2008.

National Conference of State Legislators

The National Conference of State Legislators (NCSL) is a bipartisan, non-profit organization serving the state legislators and staff of the 50 states and the District of Columbia. In existence since 1975, NCSL’s mission includes the “[promotion] of policy innovation and communication among state legislatures” (NCSL 2010). It serves as a repository of information regarding various policy issues across the states. Of particular use to this study, NCSL collects data on policy innovations introduced and/or enacted at the state level on health care. The NCSL data utilized in this study came from the state profiles detailed in the report, *State Health Programs to Cover the Uninsured, 2009* (2010). Specifically, the data in this report was used to cross-reference information on state-specific innovations unrelated to the Medicaid and SCHIP programs (though the report includes information regarding state Medicaid and SCHIP programs).

State Coverage Initiatives

The State Coverage Initiatives (SCI) is a program of the Robert Wood Johnson Foundation (RWJF). RWJF’s core mission is to “improve the health and health care of all

Americans” (RWJF 2010). Administered by AcademyHealth, SCI focuses on providing information regarding state health care policy initiatives. Like NCSL, SCI’s primary audience is state policymakers, for whom they provide policy and technical assistance on developing coverage expansions. The SCI data used for this study was primarily found in annual reports produced by SCI entitled *State of the States* (Trinity et al. 2008; Napel et al. 2009; Napel et al. 2010).

Center for Children and Families at Georgetown University Health Policy Institute

The Center for Children and Families is a non-partisan policy and research center located at the Georgetown University Health Policy Institute. CCF produces research and strategies to expand and improve health coverage for America’s children and families at the federal and state levels (CCF 2010). Data from CCF regarding state Medicaid and SCHIP programs were used in this study to cross-reference information retrieved for other sources.

Method

This study builds on the research previously completed by Hero and Tolbert (1996) and Douglas (2005) who both studied race and public policy by examining disparities between white populations and minority populations across the states. Building on models developed by these authors, I coded each state based on the racial and ethnic composition of the uninsured and then analyzed that information with respect to the level of expansion policies in that state.

The first step involved completing an analysis of the race and ethnicity of the uninsured by state. In an effort to determine the racial distribution of the uninsured by state, I relied on Census Bureau population data from March 2007 (reporting data on the uninsured in the year 2006) and March 2008 (reporting data on the uninsured in the year 2007) as documented by CPS ASEC.¹⁹ Similar to the 2000 U.S. Decennial Census, the CPS collects racial and ethnic data according to the guidelines set forth by the Office of Management and Budget (OMB) in October 1997 (Greico and Cassidy 2001).²⁰ The CPS identifies two major ethnic groups: Hispanic/Latino or non-Hispanic/Latino, and five racial categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. Using the racial and ethnic definitions identified by the U.S. Census Bureau, this study indentified the following racial categories as racial minority groups: Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and Hispanic/Latino.

Table 1 contains the racial and ethnic composition of the uninsured in total and by state. These numbers were calculated by averaging 2007 and 2008 CPS ASEC data. Nationally, Whites comprised 58 percent of the uninsured, compared to the aggregate non-White uninsured of 43 percent.²¹ Hispanics were the largest minority group represented in the uninsured, accounting for 25 percent. African Americans comprised 12

19. The combined years 2007 and 2008 were used to minimize the impact the recession had on the number of the uninsured. According to the Census Bureau, the recession peaked in December 2007.

20. The U.S. Census Bureau, through its decennial census and other surveys, provides information on individual and household characteristics for all fifty states and the District of Columbia.

21. Totals may not add up to 100 percent due to rounding.

percent of the uninsured, while Asian-Americans accounted for 4 percent. The two groups with the lowest percentage of uninsured members were American Indian/Alaskan Natives (1 percent) and Native Hawaiian/Pacific Islanders (0.2 percent). The low percentage of American Indian/Alaska Natives and Native Hawaiian/Pacific Islanders is directly related to the overall population rates for these two groups.

Table 1. Percentage of Uninsured by Race

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
US	58	43	25	12	4	1	0.2
Alabama	57	43	10	32	0.3	0.2	0
Alaska	66	34	4	4	5	20	1
Arizona	56	45	36	3	1	4	1
Arkansas	65	35	10	22	1	2	0
California	51	49	37	4	7	1	0.4
Colorado	62	38	30	4	2	2	0.2
Connecticut	59	41	21	16	3	0.2	0.4
Delaware	56	44	20	19	5	0	0.0
District of Columbia	28	72	20	48	3	1	0.0
Florida	56	43	27	14	2	0.2	0.1
Georgia	47	54	19	31	3	0.1	0.4

Table 1 continued

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Hawaii	25	76	13	1	46	2	14
Idaho	80	21	18	0.0	0.2	2	0.3
Illinois	56	44	22	17	4	1	0.0
Indiana	76	24	12	11	0.3	0.4	0.0
Iowa	80	20	11	5	3	1	1
Kansas	72	27	16	6	4	2	0.1
Kentucky	83	17	6	10	1	1	0.1
Louisiana	52	49	7	40	1	0.4	0
Maine	96	4	1	1	2	0.3	0
Maryland	46	54	20	29	5	0.2	0.2
Massachusetts	74	27	11	9	7	0.1	0
Michigan	69	31	6	21	3	1	0
Minnesota	69	32	16	7	6	3	0
Mississippi	42	59	6	49	1	3	0.0
Missouri	76	24	5	17	2	0.1	0.1
Montana	80	20	4	0.4	0	15	1
Nebraska	72	29	17	7	1	4	0
Nevada	56	44	31	5	5	2	1
New Hampshire	88	13	7	1	4	1	0
New Jersey	52	49	29	13	6	0.2	1
New Mexico	51	49	31	2	1	15	0
New York	50	50	23	19	8	0.4	0
North Carolina	56	45	17	22	2	4	0
North Dakota	69	31	6	1	1	24	0
Ohio	75	25	8	16	1	1	0
Oklahoma	67	34	12	8	1	13	0
Oregon	65	35	20	1	2	11	1

Table 1 continued

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Pennsylvania	75	26	7	16	3	0	0
Rhode Island	69	30	18	8	3	1	0
South Carolina	55	45	10	32	2	1	0
South Dakota	75	26	9	1	0.3	16	0.1
Tennessee	71	29	12	14	2	1	0.2
Texas	52	47	38	7	2	0.3	0.1
Utah	69	32	24	2	2	2	2
Vermont	95	5	1	1	2	1	0
Virginia	56	44	18	19	7	0.1	0.1
Washington	70	31	18	5	4	3	1
West Virginia	96	4	1	3	0.2	0	0
Wisconsin	72	28	15	7	3	3	0
Wyoming	86	14	12	1	0	1	0

Source: Current Population Survey's Annual Social and Economic Supplement (CPS ASEC), 2007 & 2008 data; *Note:* AA=African American, AI/AN=American Indian/Alaskan Native, NH/OPI=Native Hawaiian/Other Pacific Islander. Chart displays rounded percentages.

Deviating from the minority-majority index developed by Hero and Tolbert (1996) to measure racial/ethnic diversity, this study employed Douglas' (2005) model, which used a baseline figure to classify states—in this case the national percentage of the uninsured for each racial category. The Douglas model (2005) of using the national average as a baseline figure was selected for this project for several reasons. First, Douglas' model looks at the composition of the state's population for each race allowing for a clear analysis of how policy varies by state based on the presence of each racial group. Conversely, Hero and Tolbert's model considered diversity as a ratio of racial and ethnic group population to that of the White population. For this study, the interest was on the association of any racial group and policy innovation, rather than the comparison

of the relative size a racial group to that of Whites in a state. Secondly, as the search for other studies examining the relationship between the racial composition of the uninsured and state health care access policy (specifically health insurance) resulted in minimal research directly exploring this question, the Douglas model was a model for this initial inquiry. Furthermore, given Douglas' initial examination of SCHIP policy, it was worthy to explore the model and expand it for the use of this study.

For each racial category, if a state had higher than the national percentage of the uninsured for that group, it was designated as "high" for this measurement. Conversely, if a state had lower than the national percentage of the uninsured for that group, it was designated as "low" for this measurement.

Table 2 displays states classified as having high racial and ethnic uninsured populations. In 31 states, Whites accounted for a greater percentage of the uninsured than the national percentage. When all non-White populations were aggregated, 19 states had high minority uninsured populations. Examining each racial and ethnic category revealed that 21 states had high Black/African American uninsured populations. There were also 21 different states (with some overlap) with high American Indian/Alaskan Native uninsured populations. A total of 14 states exceeded the national percentage of 0.2 percent of their total uninsured population for Native Hawaiian/Other Pacific Islanders, while 11 states and 8 states exceeded the national percentages for Asians and Hispanics, respectively.

Table 2. States with High Racial and Ethnic Uninsured Populations

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Alabama				X			
Alaska	X				X	X	X
Arizona		X	X			X	X
Arkansas	X			X		X	
California		X	X		X		X
Colorado	X		X			X	
Connecticut	X			X			X
Delaware		X		X	X		
District of Columbia		X		X			
Florida		X	X	X			
Georgia		X		X			X
Hawaii		X			X	X	X
Idaho	X					X	X
Illinois		X		X			
Indiana	X						
Iowa	X						X
Kansas	X					X	
Kentucky	X						
Louisiana		X		X			
Maine	X						
Maryland		X		X	X		
Massachusetts	X				X		
Michigan	X			X			
Minnesota	X				X	X	
Mississippi		X		X		X	
Missouri	X			X			
Montana	X					X	X

Table 2 continued

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Nebraska	X					X	
Nevada		X	X		X	X	X
New Hampshire	X						
New Jersey		X	X	X	X		X
New Mexico		X	X			X	
New York		X		X	X		
North Carolina		X		X		X	
North Dakota	X					X	
Ohio	X			X			
Oklahoma	X					X	
Oregon	X					X	X
Pennsylvania	X			X			
Rhode Island	X						
South Carolina		X		X			
South Dakota	X					X	
Tennessee	X			X			
Texas		X	X				
Utah	X					X	X
Vermont	X						
Virginia		X		X	X		
Washington	X					X	X
West Virginia	X						
Wisconsin	X					X	
Wyoming	X						
Total	31	19	8	21	11	21	14
Percentage	60.8%	37.3%	15.7%	41.2%	21.6%	41.2%	27.5%

Source: Current Population Survey's Annual Social and Economic Supplement (CPS ASEC), 2007 & 2008 data. Note: an x denotes the state has a high percentage of uninsured for that category.

Table 3 displays states with low racial and ethnic uninsured populations. In total, 20 states had lower than the national percentage of uninsured Whites, while 32 states had low uninsured non-White populations. There were 43 states with low uninsured Hispanic/Latino populations, which represented less than the national percentage for this group. In terms of uninsured Asians, 40 states could be categorized as being lower than the national percentage. In 37 states, Native Hawaiian/Other Pacific Islanders comprised less than 0.2 percent of the uninsured population. Finally, 30 different states (with some overlap) had lower than the national percentage of Black/African Americans or American Indian/Alaska Natives among the uninsured.

Table 3. States with Low Racial and Ethnic Uninsured Populations

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Alabama	X	X	X		X	X	X
Alaska		X	X	X			
Arizona	X			X	X		
Arkansas		X	X		X		X
California	X			X		X	
Colorado		X		X	X		X
Connecticut		X	X		X	X	
Delaware	X		X			X	X
District of Columbia	X		X		X	X	X
Florida	X				X	X	X
Georgia	X		X		X	X	
Hawaii	X		X	X			
Idaho		X	X	X	X		

Table 3 continued

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
Illinois	X		X		X	X	X
Indiana		X	X	X	X	X	X
Iowa		X	X	X	X	X	
Kansas		X	X	X	X		X
Kentucky		X	X	X	X	X	X
Louisiana	X		X		X	X	X
Maine		X	X	X	X	X	X
Maryland	X		X			X	X
Massachusetts		X	X	X		X	X
Michigan		X	X		X	X	X
Minnesota		X	X	X			X
Mississippi	X		X		X		X
Missouri		X	X		X	X	X
Montana		X	X	X	X		
Nebraska		X	X	X	X		X
Nevada	X			X			
New Hampshire		X	X	X	X	X	X
New Jersey	X					X	
New Mexico	X			X	X		X
New York	X		X			X	X
North Carolina	X		X		X		X
North Dakota		X	X	X	X		X
Ohio		X	X		X	X	X
Oklahoma		X	X	X	X		X
Oregon		X	X	X	X		
Pennsylvania		X	X		X	X	X
Rhode Island		X	X	X	X	X	X

Table 3 continued

State	White	Non-White	Hispanic	Black/AA	Asian	AI/AN	NH/OPI
South Carolina	X		X		X	X	X
South Dakota		X	X	X	X		X
Tennessee		X	X		X	X	X
Texas	X			X	X	X	X
Utah		X	X	X	X		
Vermont		X	X	X	X	X	X
Virginia	X		X			X	X
Washington		X	X	X	X		
West Virginia		X	X	X	X	X	X
Wisconsin		X	X	X	X		X
Wyoming		X	X	X	X	X	X
Total	20	32	43	30	40	30	37
Percentage	39.2%	62.7%	84.3%	58.8%	78.4%	58.8%	72.5%

Source: Current Population Survey's Annual Social and Economic Supplement (CPS ASEC), 2007 & 2008 data. Note: an X denotes the state has a low percentage of uninsured for that category.

After each state was classified according to the racial/ethnic composition of the uninsured, states were examined based on policy innovations used to expand health care access. Hero and Tolbert (1996) created two indices to measure racial/ethnic diversity: (1) a minority diversity index (a ratio of minorities to Whites), and (2) a white ethnic diversity index (which totaled the state's percentage of European ethnics). The authors then used those diversity indices in their examination of state policy. In a subsequent study, Douglas (2005) examined race and public policy in three policy areas by measuring the restrictiveness of public policy relative to the minority population in a state.

Inspired by the work of these authors, I examined state health care coverage expansion policies through the development of an index. The index was scored according to the following programmatic/policy criteria:

- Aspects of Medicaid and SCHIP eligibility;
- Programs funded with state dollars only;
- Reinsurance programs; and
- High-risk pools.

These criteria were chosen for several key reasons. First, they are of interest to the researcher. Second, research examining state health care policy strategies to expand health care access has focused on two of the policy areas included in this study (state-only funded programs and high-risk pools), in addition to a third component not included in the present research (tax incentives) (Guo and Buss 2003).²² Lastly, Medicaid and SCHIP were included because the federal government accords states a certain degree of autonomy in designing these programs. With such latitude, decisions about which programmatic components to implement are left to the state, making Medicaid and SCHIP highly appropriate for examination.

To develop the index, data were gathered on state health care policies, after which states were scored based on 17 questions. The following section describes the questions and provides an explanation of why each particular policy innovation was examined.

22. I am excluding tax incentives based on the inability to find recent national information on the use of this health policy innovation in states.

Health Policy Innovations Selected for This Research

Medicaid

Eligibility

Medicaid is a federal-state partnership through which the federal government provides matching funds to state governments who opt to administer a Medicaid program. The federal government provides guidelines that serve as minimum requirements that states must adhere to in order to receive federal matching funds for their program. These guidelines include definitions of eligible populations, services that must be offered, and operational guidelines (including general enrollment practices) that must be followed. Populations that must be covered under the federal government's guidelines are called "mandatory" eligibility groups (see Figure 1).²³ States, however, have the flexibility to cover optional populations (see Figure 2). States may apply for federal waivers in an effort to draw down federal funds to cover these populations, or they may opt to provide coverage for these optional groups using state funds only.

One of the most popular mechanisms for expanding coverage to more individuals at the state level has been through eligibility expansions in the Medicaid program. Due to this mechanism and the greater flexibility states have in opting to cover populations above the minimum federal guidelines, the first indicator evaluated for the index used in

23. Because this study focuses on policy innovations related to access to care for the uninsured, this study will not focus on mandatory services outlined in the federal government's requirements for Medicaid.

- Children under age 6, who are below 133% FPL^{*}
- Children ages 6 - 19, who are below 100% FPL
- Pregnant women \leq 133% FPL
- Parents below state's AFDC eligibility level as of July 1996
- Elderly and disabled Supplemental Security Income (SSI) beneficiaries, who are below 75% FPL
- Certain working disabled adults
- Medicare dual eligibles²⁴

Source: Ways and Means Green Book, 2004.

*FPL = Federal Poverty Line

Figure 2. Medicaid Mandatory Populations²⁵

- Non-mandatory age children above 100% FPL^{*}
- Pregnant women >133% FPL
- Parents with income above the state's AFDC eligibility level as of July 1996
- Disabled and elderly above the SSI level but below 100% FPL
- Any other low-income population listed in the mandatory category who is covered above the FPL cutoff for that group

Source: Ways and Means Green Book, 2004.

*FPL = Federal Poverty Line

Figure 3. Medicaid Optional Populations

24. Dual eligibles are Medicare beneficiaries with income low enough to qualify for Medicaid.

25. All mandatory and optional populations have been included in these charts; however, this study specifically focuses on children and non-elderly adults. Therefore, elderly and disabled populations are not examined.

this study concerned the eligibility levels that states employed for their Medicaid programs as of January 2009. To assess eligibility expansions, the following questions were asked:

1. Does the state cover optional infants in the Medicaid program?
2. Does the state cover optional children in the Medicaid program?
3. Does the state cover optional pregnant women in the Medicaid program?
4. Does the state cover childless adults in the Medicaid program?
5. Are parents covered in the Medicaid program at or above the national median state Aid to Families with Dependent Children (AFDC) cutoff from July 1996?²⁶

Enrollment Practices

States have flexibility in developing their enrollment practices. In general, only a third of those eligible for health insurance programs like Medicaid are actually enrolled—in part due to laborious, time-intensive enrollment procedures (Kaiser Commission on Medicaid and the Uninsured 2009). Two policy innovations implemented by states to reduce barriers to enrollment include eliminating the asset test and instituting presumptive eligibility. Each option is only available for certain populations.

Asset Test Elimination. Enrollment eligibility for Medicaid is based on defined income and resource criteria—and these must be within the income limits described in

26. With the passage for the Personal Responsibility Work and Reconciliation Opportunity Act (P.L. 104-193), Medicaid eligibility was decoupled from welfare eligibility. Now, parents only become eligible for Medicaid if their income meets the state eligibility level for AFDC in July 1996. Due to the difficulty in obtaining comprehensive data on 1996 AFDC levels, the national median was used in this study.

Figure 1, or as defined based on the states eligibility criteria for optional populations (U.S. House Committee on Ways and Means 2004). Specifically, a state can use an asset test to measure the level of non-income-related assets available to an individual applying for Medicaid.²⁷ If a state chooses to do this, it must define a specified methodology to count assets and establish a specific asset standard for eligibility. States also have the option to eliminate the asset test for certain groups.

Presumptive Eligibility. States can also provide Medicaid coverage on a limited basis to children and pregnant women who have been deemed to meet certain required income thresholds by a qualified organization or provider; this is called presumptive eligibility (Kaiser Commission on Medicaid and the Uninsured 2009). Presumptive eligibility does not replace the formal Medicaid eligibility process, but rather it provides immediate health coverage to those who may not have access to care or who otherwise may not know they could be eligible for Medicaid.

To assess innovations related to Medicaid enrollment practices, the following questions were asked:

6. Is there an asset test in the Medicaid program for any mandatory population?

27. Assets counted include financial instruments such as savings accounts and certificates of deposit, personal property, e.g., an automobile above a specified value, and real estate excluding the individual's home.

7. Does the state have presumptive eligibility for children or pregnant women in Medicaid?²⁸

Cost-Sharing

Out-of-pocket expenses related to health insurance are referred to as cost-sharing. Cost-sharing can be in the form of enrollment fees, premiums, deductibles, copayments, coinsurance, or other charges imposed by the health insurer and paid by the insured (U.S. House Committee on Ways and Means 2004). Cost-sharing is commonly used in private insurance, but is also a feature of many public insurance plans, e.g., Medicaid. Prior to 2006, states could not impose cost-sharing and related premiums on children under the age of 18 in the Medicaid program. However, with the passage and enactment of the Deficit Reduction Act of 2005 (P.L. 109-171), states began to have more flexibility to impose cost-sharing and premium requirements. Research in this area shows that implementing cost-sharing and/or premiums are a barrier to access both in terms of enrollment and utilization of services. This is due to the fact that cost-sharing requirements can place a significant financial burden on low-income Medicaid recipients. Based on the notion that the absence of cost-sharing increases enrollment, state innovation in cost-sharing was assessed by the following question:

8. Does the state have cost-sharing requirements for children in Medicaid?²⁹

28. Women diagnosed with breast or cervical cancer can also be considered for presumptive eligibility. However, this study is specifically concerned with non-elderly, uninsured populations, who do not qualify for disease-specific eligibility.

29. Children were specifically examined based on the change in federal law allowing for cost-sharing on this particular population within Medicaid.

State Children's Health Insurance Program (SCHIP)

Eligibility

Like Medicaid, SCHIP is a federal-state partnership. How it differs from Medicaid, however, is in respect to its target population. As explained in Chapter 1, SCHIP is designed to provide coverage for targeted low-income children in families whose income exceeds state Medicaid eligibility. According to federal guidelines, a SCHIP eligible child is 19 years or younger, comes from a family with an income at or below 200 percent of the federal poverty line, and does not qualify for Medicaid. States, however, have a certain degree of flexibility in designing eligibility rules for SCHIP coverage, such as including children over 200 percent of the federal poverty line and covering parents of eligible children. In some cases, states have even received approval to cover adults who do not have dependent children. With such flexibility, states have enacted some or all of these policy innovations to reduce the number of uninsured adults and children. Due to these conditions, this study assessed SCHIP eligibility expansion through the following questions:

9. Does the state expand eligibility for SCHIP above 200 percent of the federal poverty level?
10. Does the SCHIP program cover parents of eligible children?
11. Does the SCHIP program cover adults without dependent children?

Enrollment Practices

Similar to the Medicaid program, states have the same flexibility in determining enrollment practices for the SCHIP program. To assess innovations related to SCHIP enrollment practices, the following questions were considered:

12. Is there an asset test for the SCHIP program?

13. Does the state have presumptive eligibility for SCHIP?³⁰

Cost-Sharing

Under SCHIP, states have the option to impose cost-sharing on certain beneficiaries. Although the amount can vary, cost-sharing under SCHIP cannot exceed 5 percent of the total annual family income. The amount of cost-sharing a state can impose on children and families is based on several factors, such as the design of the program (e.g., whether the program is a combined SCHIP/Medicaid or a separate SCHIP program), income levels, and services.

Based on research indicating that the absence of cost-sharing increases enrollment, state innovation was assessed by the question:

14. Does the state have cost-sharing requirements for SCHIP beneficiaries?

Other Health Policy Innovations

States have used other policy innovations to expand access to either publicly funded or private health insurance. Three such innovations examined in this study include state funded health insurance programs, reinsurance programs, and high-risk pools.

30. Presumptive eligibility in SCHIP can only be used for children.

State Funded Programs

State funded health insurance programs are solely supported by state general funds or through assessments imposed by the state, which are then directly appropriated for use in unique health programs designed to increase/expand health insurance coverage. These programs are innovative and worthy of examination in this study because states who have chosen to implement such programs do so without any federal matching support (as they would receive through Medicaid and SCHIP waived expansions). Based on this option, states were evaluated for the index based on the question:

15. Does the state operate a fully state-funded health care expansion program?

Reinsurance Programs

Over the last two decades, states have used reinsurance programs as a health reform mechanism to expand coverage (Annis 2005; Wikler and Fish-Parcham 2008). As previously described in Chapter 1, reinsurance programs can lead to lower premiums for uninsured individuals and for small businesses who have opted not to provide health insurance to employees due to the high cost of coverage (Annis 2005; Wikler and Fish-Parcham 2008). State reinsurance programs can operate with or without public subsidies (Wikler and Fish-Parcham 2008). Since reinsurance programs are a policy innovation thought to decrease the number of uninsured by making coverage more affordable and widely offered to individuals and small businesses, this innovation was included in the index by assessing each state through the question:

16. Does the state offer a reinsurance program?³¹

High-risk Pools

Over 30 years ago, a small number of states responded to the need to offer health insurance to “uninsurable” individuals by creating high-risk pools. High-risk pools provide health insurance to individuals who (1) have been denied insurance due to a pre-existing medical condition(s), (2) were offered insurance coverage on the private market that exceeded the rates offered by the high-risk pool, or (3) were diagnosed with a medical condition, e.g. diabetes, epilepsy, HIV/AIDS, or other conditions, that under state law automatically qualified the person for acceptance into the high-risk pool (NCSL 2005; National Association of State Comprehensive Health Insurance Plans 2009). Implementing high-risk pools extends insurance to an uninsured population most in need of health coverage since they have pre-existing conditions that require treatment and management. For the purposes of this study, states were assessed for the index by the question:

17. Does the state have a high-risk pool?

Index Scoring Criteria

For each of the 17 questions noted above, every state was assigned either a 0 (zero) for a response that corresponded to a less expansive health policy, or a 1 (one) for a “yes” response (indicating a more expansive health policy). The scores were then

31. For the purposes of this study it did not matter whether a state had a subsidized reinsurance program or an unsubsidized program as both are thought to expand private coverage by making it more affordable.

tabulated, with the lowest possible composite index score being 0 and the highest possible composite score being 17. The higher the score on the index, the more expansive the health care policy was in that state, i.e., more state policy innovations related to health care access had been enacted in that state [0 = least expansive, 17 = most expansive].

The last step in this process involved an analysis of the states based on two criteria: (1) the racial/ethnic composition of the uninsured and (2) the level of state innovation related to health care policy as measured by the composite index score each state received. Once this information was determined, the differences between the racial composition of the uninsured and the level of state innovation related to health policy were examined. Comparisons were made to explore differences between states with high White uninsured populations, states with high minority uninsured populations, and states with high uninsured populations for the five individual minority groups (Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and Hispanic/Latino). Ultimately, this study was expected to reveal if racial patterns existed in state health care policy. This information would then answer the question of whether there was an association between race and state health care policy development.

Limitations

This study has several limitations worth noting. First, the use of secondary data analysis has some inherent limitations. Researchers using secondary data analysis—in this case survey data from sources such as the U.S. Census Bureau—have to be mindful that the results are socially constructed artifacts resulting from the processes and choices

that framed the original project (Dale, Wathan, and Higgins 2008). To address this limitation, it is important to fully understand the research design of the original project and the process by which the original data were collected.

Additionally, there is the issue of data quality. Typically, a researcher who uses secondary data is not the primary investigator on the original project, which was the case for this study. Therefore, any details regarding sampling errors, errors in data collection, or measurement issues are sometimes unknown to the researcher.

Beyond the research methodology described herein, it is important to note that this study did not take into account previously-studied assumptions for variations in state public policy, e.g., economics, political culture, and interest groups. This was not intended to invalidate or minimize these influences or to make a statement about the relevance of examining other variations, rather, this study focused specifically on race and ethnicity as a possible influential factor in shaping access to state-provided health care services because of the socio-historical relevance of race in American society.

Another limitation associated with this study is that it represents a snapshot in time of health policy development. The study is not longitudinal in design, nor does it explore other policy areas/issues. The goal of this study is to contribute to the dialogue on race/ethnicity and public policy by specifically looking at health care policy as it relates to access. Finally, this study is not causative in nature but rather seeks to demonstrate an association between race/ethnicity and public policy.

Despite these limitations, this study adds to the dialogue on how race bias impacts policy and the daily lives of American racial minority group members. As such, this

study represents a significant contribution to the socio-political study of race and health care policy in American society.

CHAPTER 4

ANALYSIS

This chapter presents the empirical results of this study, which assesses the association between the racial/ethnic composition of a state and policy innovation. The first section discusses the results of the innovation index according to individual state scores, after which an analysis of the state results based both on the racial composition of the uninsured and a state's level of policy innovation.

The innovation index was created by scoring each state based on the presence or absence of the 17 health policy innovations outlined in Chapter 3 within a state. The lowest composite score a state could receive on the innovation index is 0, indicating the state had not implemented any of the studied policy innovations, and the highest score is 17, indicating a state had implemented all of the policy innovations examined. Based on the median score, the index was divided to establish two categories: low innovation (0-8) and high innovation (9-17). The actual analysis yielded no states at the conceptual ends of the index, with no state scoring lower than 5 or higher than 14 (see Figure 4 for an example of a "low" and "high" innovation state).

“Low” Innovation State: Any state with a score at or below the median (between 0 and 8)

- Example: Utah (score = 5). Of the 17 policy innovations examined in this study, Utah only implemented 5 (covers optional parent population, does not require cost sharing in Medicaid for children, has presumptive eligibility in Medicaid, does not have an asset test for SCHIP, and has a high risk pool).

“High” Innovation State: Any state with a score above the median (between 9 and 17)

- Example: New Mexico (score = 14). Of the 17 policy innovations examined in this study, New Mexico received a score of 14 because the state had implemented all but the following three innovations (the state does not cover childless adults, does have presumptive eligibility for SCHIP, and does not have a separate SCHIP program—therefore, they could not score on the question of expanded SCHIP eligibility above 200%FPL).

Figure 4. Explanation of a Low and High Innovation State

Table 4 presents a compilation of state scores based on level of innovation (without regard to the racial composition of the uninsured in each state). The majority of the states,³² 54.9 percent (28 states) had innovation scores in the lower half of the index, which indicates a lower level of policy innovation. Comparatively, 45.1 percent of states (23 states) had scores in the higher half of the index. A closer examination of patterns that emerged from the actual score of each state revealed several interesting regional patterns discussed below.

32. For ease in reporting the findings of this study, from this point forward use of the word “states” means the 50 continental U.S. states and the District of Columbia.

Table 4. States Grouped by Innovation Index Score

Innovation Score	State (n = states within score category)					Total Number of States (%)
Low (0-8)	Score = 5 Alabama Florida Texas Utah West Virginia	Score = 6 Georgia Nevada North Dakota Oregon Virginia	Score = 7 Indiana Maine Mississippi Pennsylvania Rhode Island South Dakota Wyoming	Score = 8 Arizona California Delaware Hawaii Idaho Iowa Kansas Minnesota Missouri North Carolina Tennessee		n=28 (54.9%)
High (9-17)	Score = 9 Alaska Colorado Illinois Kentucky Louisiana Maryland Michigan Montana Nebraska Ohio South Carolina Vermont Washington	Score = 10 Arkansas District of Columbia New Hampshire New York Oklahoma Wisconsin	Score = 11 Massachusetts New Jersey	Score = 12 Connecticut	Score = 14 New Mexico	n=23 (45.1%)

According to the U.S. Census Bureau, states are grouped into four broad geographic regions: Northeast, Midwest, South, and West (see Figure 5). The first regional pattern that emerged is that the majority of states located in the Southern region of the United States received scores in the lower half of the index (58.8 percent), indicating low levels of policy innovation. This pattern was true for both Midwest and Western states, with 58.3 percent and 61.5 percent of states receiving scores in the lower half of the index respectively. In contrast, states in the two-thirds of Northeast states received scores in the higher half of the index (66.6 percent) thus, indicating a higher level of policy innovation. As reflected in Table 4, 26 percent of the states with high innovation scores are Northeast states, as opposed to 10.7 percent of the states with lower scores being Northeast states.

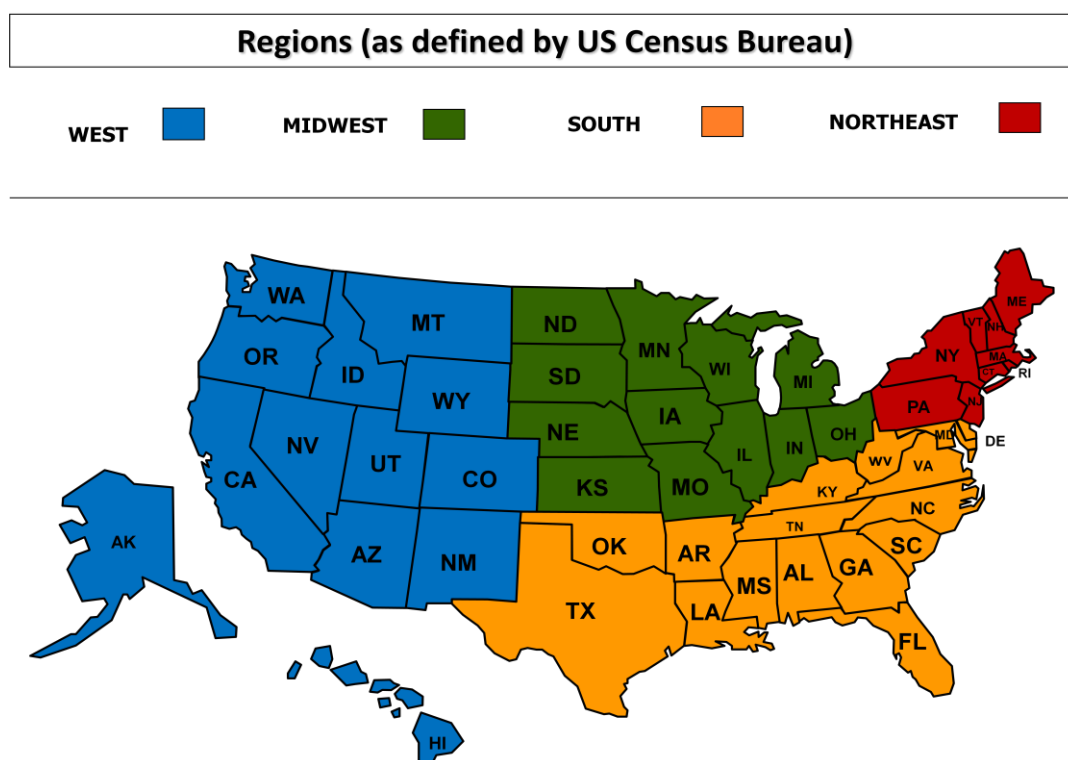


Figure 5. Census Regions of the United States

Additional regional patterns based on innovation scores were revealed when the low and high ends of each half of the index were examined. Specifically, among the states with the lowest level of policy innovations (Alabama, Florida, Texas, Utah, and West Virginia—each of which received a 5), 80 percent are located in the Southern region. As noted earlier, the median index score and the highest score on the lower half of the index was a score of 8. The majority of states receiving this score (Arizona, California, Delaware, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, North Carolina, and Tennessee) are Midwest or Western states (72 percent). With respect to the higher half of the index, the lowest score a state could receive and be considered a high innovation state was a score of 9. Thirteen states received this score (Alaska, Colorado, Illinois, Kentucky, Louisiana, Maryland, Michigan, Montana, Nebraska, Ohio, South Carolina, Vermont, and Washington), and these states were evenly distributed among the Midwest, South, and West regions; only one state (Vermont) deviated from this regional pattern. The highest score on the higher half of the index was 14 and only one state (New Mexico, located in the Western region) received this score.

An examination of the innovation scores falling between the low and high endpoints of the each half of the index revealed other interesting regional patterns. Of the states with a score of 6 (Georgia, Nevada, North Dakota, Oregon, and Virginia), 40 percent were located in South and another 40 percent are located in West. The seven states receiving a score of 7 represented every region without any discernable regional pattern. Half of the states receiving the score of 10 were located in the South, with the remaining half divided between the Northeast and Midwest regions. All of the states receiving the two immediate scores below the highest index score (scores 11 and 12,

representing Massachusetts, New Jersey, and Connecticut) are located in the Northeastern region.

Once the states were assigned a composite innovation index score, the association between the race/ethnicity of the uninsured and the level of state health policy innovation, as reflected in the composite state score was examined. To determine this outcome, states were analyzed using data on the racial composition of the uninsured (see Table 2 in Chapter 3) in combination with the composite score from the innovation index results (Table 4 above). Table 5 presents a cross-tabulation of the results for all 50 states and the District of Columbia with high uninsured populations in the seven categories previously defined for race/ethnicity (White, non-White, Hispanic, Black/African American, Asian, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander), and the level of state health policy innovation (low innovation and high innovation). As detailed in the next paragraph, the results indicate that the racial composition of a state's uninsured population is associated with the level of policy innovation, particularly for minority racial and ethnic groups.

With the states almost equally split between low and high innovation, the findings suggest no striking difference in the level of policy innovation among states with a high White uninsured population. Specifically, of the states with high White uninsured populations, 51.6 percent showed low levels of innovation (scores between 0-8) compared to 48.4 percent of the high White uninsured states with high levels of innovation (scores between 9-17). Conversely, states with high aggregate non-White uninsured populations were more likely to have a low level of policy innovation. Of the states with high non-White uninsured populations, 57.9 percent showed low levels of

innovation—in comparison to only 42.1 percent of the states with high non-White uninsured populations with high policy innovation index scores.

Table 5. High Race and Ethnic Uninsured States by Low/High Innovation Score*

Racial/Ethnic Group	Low Score (0-8)	High Score (9-17)
(#of high uninsured states)	(% of states with low score)	(% of states with high score)
White (n=31)	16 states (51.6%)	15 states (48.4%)
Non-White (n=19)	11 (57.9%)	8 (42.1%)
Hispanic (n=8)	5 (62.5%)	3 (37.5%)
Black (n=21)	10 (47.6%)	11 (52.3%)
Asian (n=11)	6 (54.5%)	5 (45.5%)
AIAN (n=21)	12 (57.1%)	9 (42.8%)
NHOPI (n=14)	9 (64.3%)	5 (35.7%)

*States are the unit of analysis, therefore the numbers in the Low Score and High Score columns represent the number of states in each respective category. For example, of the 31 states with high White uninsured populations, 16 states had low innovation scores.

In contrast, when examining states with disaggregated high minority uninsured populations, four of the five minority groups displayed observable differences between high and low innovation. Nearly 63 percent of states with high Hispanic uninsured

populations showed low levels of innovation, while only 37.5 percent of states with high uninsured Hispanic populations had high policy innovation index scores. Of the states with high Asian uninsured populations, 54.5 percent had low levels of innovation, as opposed to the 45.5 percent with high levels of innovation. More than half the states with high American Indian/Alaska Native uninsured populations had lower levels of innovation (57.1 percent). Finally, the majority of states with high Native Hawaiian/Other Pacific Islander uninsured populations were associated with lower levels of innovation (64.3 percent). Though the results confirmed a slight variation between the levels of innovation and Black/African-American uninsured populations, a greater percentage of states with high Black/African-American uninsured populations had a high level of innovation (52.3 percent versus 47.6 percent).

To further explore racial variations in health policy innovations, it was necessary to compare the differences between the levels of policy innovation across the states with high uninsured populations for the six individual racial and ethnic groups. Beginning first with a comparison of states with high White uninsured populations against those with high non-White uninsured populations, the results of this analysis confirmed that states with high White uninsured populations were more likely to have high policy innovation than states with high non-White uninsured populations (48.4 percent as compared to 42.1 percent). A comparative analysis of states with a high percentage of uninsured Whites and states with a high percentage of uninsured for each racial/ethnic minority group validated that states with high White uninsured populations were more likely to have high policy innovations than states with high minority uninsured populations. Interestingly,

this pattern held true for all states with high minority uninsured populations—*except for states with a high percentage of uninsured Black/African Americans*. It should also be noted that states with high uninsured Native Hawaiian/Other Pacific Islanders were the least likely to have high innovation among all of the minority groups, followed by states with high uninsured Hispanics.

Summary

The overall results of the study confirmed the connection between the racial/ethnic composition of the uninsured and policy innovation in terms of health insurance coverage. These findings support the study's hypothesis that states with high uninsured minority populations have fewer policy innovations that expand health insurance coverage as measured by the innovation index. When states were compared by the racial composition of the uninsured and by their composite index scores, states with high minority uninsured populations were more likely to institute fewer policy innovations than states with high White uninsured populations. The only anomaly to this pattern was reflected in states with a high number of uninsured Black/African-Americans. Explanations for this observed anomaly are discussed fully in the following chapter.

The study also revealed interesting regional patterns regarding policy innovation. One of the most interesting regional patterns of the innovation scores indicated that states in the Northeast were more likely to have high levels of health policy innovation as measured by the innovation index. This finding is particularly interesting as vast majority of the states in the Northeast, 78 percent, have high White uninsured populations and low

aggregate non-White populations.³³ Only two states deviated from this racial/ethnic pattern.³⁴ Of further interest, only one state received the highest index score (New Mexico) and this state has a high non-White uninsured population and low White uninsured population. While this study did not hypothesize any observed regional patterns, the regional patterns revealed surprising and intriguing results directly related to the secondary question of this study regarding patterns related to race, state, and health care policy.

33. In alpha order these states are: Connecticut, Maine, Massachusetts, New Hampshire, Pennsylvania, Rhode Island, and Vermont.

34. New York and New Jersey

CHAPTER 5

SUMMARY AND CONCLUSIONS

This chapter discusses the results presented in the previous chapter with respect to the research goals. In particular, this concluding summary reviews the findings and social justice implications of this research as they relate to public policy.

Because public policy in America both establishes and reinforces social norms and values, it can purposefully or inadvertently serve as a source of oppression and domination in society, depending on the affected constituency. Simultaneously, public policy also represents the main source of enacting and reinforcing society's commitment to Constitutional promises of equality and justice for every member of society. In other words, public policy represents the legal legitimization of the social hierarchy of our society as it either upholds egalitarianism or maintains an inequitable status quo. As such, examining the impact of any given constituency on the enactment of public policy is a worthwhile endeavor. This study, therefore, specifically examined race/ethnicity as a core constituency variable in policymaking.

Once the strong point of analysis in society, race has become a declining area of study in understanding the stratification of American society and public policy. Race-related issues have taken a back seat to other variables that have stratified American society, such as gender, socioeconomic status, sexual preference, ageism, etc. Despite

this shift in focus, this study confirmed that the historical relevance of race remains a significant point of contention in American society.

Employing critical race theory as its theoretical framework, this study used secondary data to examine the association between race/ethnicity and public policy by analyzing data on the racial composition of the uninsured in the states and state policy innovations with respect to health insurance coverage. Using the national average of the uninsured for each racial group as baseline data, states were designated as either “high” or “low” uninsured states for each of the racial and ethnic groups defined by the U. S. Census Bureau. Subsequently, each state was scored according to its level of its policy innovation as measured by 17 variables related to Medicaid, SCHIP, state- funded only programs, reinsurance, and high-risk pools. As the final step of this analysis, a cross tabulation was carried out that compared a state’s racial composition and the level of policy innovation; this comparison enabled the researcher to determine if there was an association between the race/ethnicity of the uninsured and the level of policy innovation in the state.

Consistent with results from previous studies (Hero and Tolbert 1996; Hero 1998, 2007; Soss et al 2001; Douglas 2005; Soss, Fording, and Schram 2008), this research confirmed an association between race/ethnicity and certain public policy decisions. Specifically, this study demonstrated that the racial composition of a state’s uninsured can impact the level of policy innovation related to health care access in that state. As shown herein, states with high uninsured minority populations in the aggregate were more likely to have low policy innovation (as measured by the policy innovation index) in comparison to states with high White uninsured populations. Even when the data were

disaggregated, this racial pattern held across all races except one. That is, when compared to high White uninsured states, states with high uninsured Hispanic, Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Islander populations were more likely to have low policy innovation. Moreover, the data revealed that states with high Native Hawaiian/Other Pacific Islanders uninsured populations were the most likely to have low levels of policy innovation, followed by states with high Hispanic uninsured populations. The only states not fitting this general pattern were those with high Black/African-American uninsured populations. A possible rationale for why states with high Black/African-American uninsured populations did not adhere to this association centers on the impact of the historical reliance on the Black-White binary as related to race relations on efforts to eliminate long-standing racial and ethnic disparities through the expansion of health care insurance.

As noted in the socio-historical overview in Chapter 2, Blacks/African-Americans represent the longest, non-indigenous population in the United States (Byrd and Clayton 2000). This longstanding relationship between Blacks/African Americans and Whites—which has been characterized by well known oppression and inequality—has led to what is known as the “Black-White binary.” This term refers to a “paradigm that considers Black-White relations central to race analysis” (Delgado and Stefancic 2001, 142). In other words, the lens through which society has typically examined race relations, racial injustices, or racial disparities has historically relied on a comparison of Blacks/African Americans to Whites, as opposed to other ethnic or racial groups. Over time the notion of race and/or a racial minority has essentially become synonymous with Black/African Americans (Delgado and Stefancic 2001; Yosso 2005).

Given recent efforts to eliminate racial disparities in health care, simultaneously focus on the uninsured, it is reasonable that the Black-White binary has shaped efforts in society. Therefore, as noted above it is likely that states with high Black/African-American uninsured populations do not fit the pattern of lower levels of policy innovation because of deliberate efforts to reduce racial disparities in health care by acting to expand health care coverage. As previously explained, access to health care alone does not ensure quality care, nor does it ensure the elimination of disparate outcomes; however, it is a critical factor in an individual's ability and decision to seek health care when needed. Given the attention to eliminating health disparities and the historical tendency to view race as being equivalent to Black/African American, a probable explanation as to why states with high Black/African-American uninsured populations were shown to have higher policy innovation could be that these states acted to increase access to health care in an effort to decrease racial health disparities, thereby resulting in higher innovation in these states.

A second, but related, explanation of this anomaly is the growing tension in American society over the provision of health care and health care access for immigrant populations. Even though Blacks/African Americans are still defined as "other" in relation to Whites, (Omi and Winant 1994), Blacks/African Americans are not viewed as "foreigners" or "immigrants" as are members of other racial groups such as Hispanics or Asians. Moreover, since Blacks/African Americans have long fought (and continue to fight) for equality in society, their self-advocacy efforts related to the rights afforded to American citizens are not met with questions related to citizenship status. This cannot be said of other non-indigenous minority groups—and particularly people of

Hispanic/Latino descent, whose citizenship is often called into question. This discrepancy represents another reasonable explanation as to why states with high Black/African-American uninsured populations fared better along the policy innovation index than other high minority racial/ethnic uninsured states.

The explanations suggested above for the policy innovation discrepancies that emerged from the data should not be mistaken for tacit approval or adherence to positive notions of the Black-White binary in society. In fact, continued oversimplification of race/ethnic relations, domination, and oppression with respect to any particular racial or ethnic group negatively impacts the advancement of structurally transforming race in society. Moreover, any view of race in America that has somehow purposely favored Blacks/African Americans could easily result in hyper-vigilant attention and attacks on Blacks/African Americans (e.g. promotion of policy solutions to social problems that are rooted in perceived behavioral and attitudinal characteristics rather than structural and institutional improvements) and serve as a barrier to developing opportunities among marginalized racial and ethnic groups to pool resources and power to fight against injustice (Delgado and Stefancic 2001).

Implications of the Findings

The results of this study reveal there is a relationship between race of the uninsured and the level of policy innovation in states. This finding has several micro and macro implications worth noting.

On the micro level, that of the individual, lack of access to health care exacerbates racial and ethnic health disparities and impairs the personal health and abilities of the individual. The personal health of the individual is directly tied to the ability of the individual to be a part of society and to fully actualize their potential and their desires in society. Individual health and lack of access to health care is in tension with the sovereign right to the pursuit of life, liberty, and happiness espoused in the Declaration of Independence. Additionally, lack of access to health care can impact the personal health choices of the individual, which could have a generational impact on health care and health practices in the family.

On the macro level, as mentioned above, lack of access to care can impair the health of the individual, which limits the labor capacity of the individual and thereby reducing human labor power in society over time. Therefore, having large pools of uninsured individuals, who lack access to necessary health care, places the producing power and economic ability of the U. S. at risk.

Lastly, the IOM study (2003) and the Brown et al. study described in Chapter 2, share that high uninsurance rates have macro level implications as it relates to access to necessary services in the broader community. That is, these studies indicate that presence of high uninsured rates in communities is related to reduced access to health care services even among those with insurance.

Social Justice Implications

Critical race theory (CRT) requires researchers to go beyond explaining or seeking to understand institutional situations that are impacted by race, racism, and

power. CRT commands the researcher to seek ways to promote social justice and greater equity by transforming the relationship between societal institutions and race. However, defining and identifying benchmarks for social justice is no small feat.

Scholars have defined social justice in a number of ways and each definition frames the subsequent solutions aimed at ending injustices in society. Two complementary definitions significant to understanding social justice in the context of this study come from the work of Mills (1959) and Young (1990). Mills (1959) conceived social justice as “informing the powerless of the structural causes of their social problems so that they can act to create social change” (Langton and Kammerer 2004, 9). Some years later, Young (1990) defined the concept in the following way: “Social justice means the elimination of institutionalized domination and oppression” (15). Although these two interpretations are similar, Mills (1959) defined social justice as a process, whereas Young defined it in terms of its outcome or product. Young (1990) further stated: “Social justice concerns the degree to which a society supports the social arrangements necessary for people to develop their capacities and express their experiences and to participate in determining their own actions without coercion” (37). These definitions were significant to the understanding of social justice for this study for two reasons: (1) they both supported the transformation commanded by critical race theory, and (2) they both supported the scholar-activist notion of research and theory by placing emphasis on empowering people to positively affect their lives (Kershaw 2003).

Both these definitions of social justice involve examining existing structural and/or institutional processes in order to eliminate oppression and domination so that affected groups can be empowered to change their social conditions. Both require society

to look beyond merely redistributing goods in an effort to create a just society (Young 1990). Instead, these definitions of social justice call for the transformation of inequitable processes, procedures, policies, laws, actions, and social interactions to ones that encourage empowerment of all people without regard to race, place, or other personal or perceived characteristics.

If the goal is a more socially-just society with respect to health care access, the findings of this study suggest that all stakeholders must first understand that there is an association between the racial composition of the uninsured and the health care policy innovations implemented in a state. Once this relationship is recognized, it is imperative that actions are taken to address any race-based inequities that create variations in service coverage. To achieve the goal of more equitable health care access (i.e., social justice), three recommendations are suggested: (1) enhancing participatory government, (2) addressing the “maldistribution” of health care access through policy changes at the state level, and (3) carrying out the historical role of the federal government as an equalizer in society. The following sections discuss these three recommendations in detail.

Recommendation #1: Participatory Government, Looking to the “Faces at the Bottom of the Well”

Critical race theory espouses that the personal standpoint of oppressed individuals or groups in society are unique to those persons or cohorts (Bell 1992; Matsuda 1995; Crenshaw et al. 1995; Delgado and Stefancic 2001). In other words, the experience of the oppressed in society can only be truly and accurately voiced by those who have been marginalized. A natural extension of this assertion is that the oppressed in society must

have the opportunity to actively participate in any policy decisions that impact their lives. This does not mean participation for participation's sake. To be truly meaningful, those who have experienced social injustice must have a say in rectifying any structural barriers that have prevented them from being treated equitably. This means removing barriers to becoming members of decision making bodies at all levels of government (i.e., federal, state, county, city, etc.). This includes but is not limited to barriers to running for public office, e.g. funding costs associated with political campaigns that favor a politics of fundraising over a politics of qualification. It is recognized that not everyone has the will or desire to run for elected office. Thus, the notion of participatory government also extends to promoting more than just formal interest-group politics. That is to say, participatory government should not eliminate organized interest groups who advocate for their individual/collective causes rather, participatory government should foster multiple opportunities to engage oppressed people or groups in the decision-making process as equitably as possible. This would include developing mechanisms for more citizen access to policymakers. It should also include more frequent and open dialogue on matters such as health care access, which actively seeks the opinions of the people most impacted by the proposed policy change (or absence of policy change). For example, in our technologically-advanced era, people should be able to freely and equally offer ideas to policymakers via phone, email, regular mail, in person meetings, and they should be able to do so at various times during the day, night, and week to accommodate the varied schedules of the citizenry. Not only should citizens have this wide access to policymakers but the policymakers should be responsive to the questions, suggestions, and concerns in an active and continuous way. Policymakers should not act on issues impacting

populations without seeking the opinions of those likely to be impacted by policy changes, as well as understanding the impact of proposed policies on those most affected. In the policymaking process, the definition of experts should be expanded to include those whose lived experiences bring to bear an expertise that bureaucrats, technocrat, and elected officials might otherwise have themselves.

It must be stressed that the burden for change should not only be on policymakers at the top. As Mills (1959) reminded us, there is a significant onus on the part of the oppressed to participate in enacting any social change they want to see in society. This corresponds to Bok (1992) who asserted that every great social advancement begins with the grassroots push of organized activists who band together to create change. While interest-convergence among dominant and subordinate groups has played an active role in when social change occurs and the outcomes of the change, significant social change nonetheless begins with the persistent agitation of the people. This means the people “at the bottom of the well” - those marginalized in society - must think and plan outside of any structures that oppress them in order to formulate strategies that promote social justice and they must work to participate in bringing that justice to life.

Relating the concept of participatory government to the findings of this study, state policymakers (which include governors, legislators, regulators, and bureaucrats) must work to ensure that any policymaking efforts aimed at either constricting or expanding health care access must include the opinions of those who will be impacted by the policy change prior to the development and implementation process. In short, policymakers must ensure a fair and just process that includes participation from the “faces at the bottom of the well” (Bell 1992) without coercion or fear of reprisal. With

respect to health care access, this study indicates that stakeholders involved in the development of health care policy should remove any structural impediments that prevent the voices of the uninsured from being heard—especially those of racial and ethnic minorities. Furthermore, it is incumbent upon the racial and ethnic groups identified in this study as being marginalized and those privileged in the system to work to restructure and redefine the oppressive relationship between race and policy, thereby eliminating the negative impact the racial composition of a state’s uninsured has on health care access policy.

Recommendation #2: Addressing the Distribution of Health Care Access

Young’s (1990) definition of social justice warns that merely redistributing goods is not sufficient to ensure a socially just society; however, it is a component of social justice. In other words, the redistribution of goods is a means to social justice as opposed to the end result. The findings of this study confirmed that race was associated with state policy variations in health care access. In keeping with Young, therefore, one method for transforming the relationship between race and health care policy is to equalize the distribution of health care access. In part, recent reforms to the health care system represent important equalizing steps in this effort—although the path to access reform has been a rocky one.

Historically, significant tensions have surrounded the distribution/redistribution of health care access in the United States. Although the notion that health care access is a basic human right was adopted by the United Nations in 1948 as a part of the Universal Declaration of Human Rights, and several countries have identified health care as a basic,

constitutional right, the United States has yet to make this declaration (Quadagno 2005; Byrd and Clayton 2000).³⁵ Disagreements concerning health care as a right center on complex ideological and philosophical questions—namely, is health care truly a “right,” and if it is, who should be the responsible for oversight, policymaking, funding, etc? Should the provision of health care rest with the federal government or should states be responsible for ensuring equitable access to health care? While this contentious and multifaceted debate on whether health care access is a right rages on, health reform law, which was passed in 2010, stated that health care access is the shared responsibility of both the federal government and the states. The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) defined broad reforms that will be implemented at the state level—many of them with broad discretion left to the states to define.

At a time when the United States health care system is undergoing significant reformation and a lot of responsibility is left to individual states, the findings of this study cautions that all stakeholders in the process (e.g., policymakers and health care recipients) must understand any biases that are inherent in the public policy choices implemented at the state level, as well as how those biases impact overall policy outcomes. Specifically, one goal of health care reform is to ensure that access is distributed more widely among those who are uninsured.³⁶ This study demonstrated that

35. It should be noted that the 44th President of the United States, Barack Obama, campaigned on the notion that health care is a human right and has been quoted several times since being inaugurated and espousing this belief. Yet, this notion is still heavily debated in the political discourse.

36. There are other stated goals of the health reform law, e.g. covering the underinsured and making coverage more affordable; however, these goals are not expressly related to the stated goals and outcomes of this research.

the presence of large uninsured minority populations in a state has a relationship to the level of health care policy innovation in that state. Particularly, states with large uninsured Native Hawaiian/Other Pacific Islander, Hispanic, American Indian/Native American, or Asian populations were found to be less likely to implement policy strategies to make health care more accessible.

Based on this finding, states must make informed policy decisions for delivering health care access to its citizens that are unrelated to the racial composition of the uninsured or the general population. This recommendation is especially critical at a time when states are considering exercising such options as applying for innovation waivers, which would allow them to circumvent provisions of the federal health reform law by implementing alternatives that meet affordability and coverage benchmarks. This directly links to the findings of this study since states that are granted such waivers will have significant autonomy in choosing policy alternatives that, if not careful, could have connections to the racial the composition of the target populations in the state.

Recommendation #3: Federal Government as the Societal Equalizer

As espoused by the Constitution, states play a central role in developing and implementing public policy that impacts the lives of its citizenry, especially related to the health and general welfare of citizens (Bok 1992; Hero 1998). Even though states play a significant role in developing public policy, the federal government has an equal, and in many respects superseding, responsibility to ensure that the promises and rights embodied in the Constitution are realized for every citizen. This role is achieved through

the development, implementation, and enforcement of public policy at the national level. Historically, this has often meant intervening, either legislatively or judicially, to correct injustices perpetuated by states or to fill voids left vacant through the lack of action by states (Bok 1992).

Federal interventions have been necessary to correct many racially and ethnically based injustices in society. Throughout history when efforts to preserve states' rights were synonymous with maintaining prejudicial racial hierarchies, the federal government interceded to counteract these injustices (Bok 1992; Douglas 2005). In particular, the "Reconstruction Amendments" to the Constitution (the 13th, 14th, and 15th amendments) represent significant examples of federal interventions. These amendments abolished slavery, established equal protection under the law, and ensured voting rights for all citizens. Later, the federal government had to take further corrective action (either through proclamation, legislation, regulation, or litigation) to remedy injustices associated with Jim Crow laws, poll taxes and other barriers to voting rights, segregated schools, and various employment discriminations that continued despite the enactment of the Reconstruction Amendments to the Constitution. In broad terms, when needed the federal government served as the equalizer in society, counteracting the social injustices perpetuated and reinforced by states. To some extent, current federal health care reform measures represent a national effort to remedy racial bias in health care policy choices at the state level.

Based on the findings of this study and the historical role of the federal government in mitigating social injustice in society, the federal government must be mindful of the association between race and policy choices as indicated by this study and

act accordingly. Specifically, as states seek to expand health care access to more of the uninsured through the implementation of health reform (as described above), they must ensure that policy choices are not negatively based on the racial composition of the uninsured. The federal government has a concurrent responsibility to monitor and act to ensure this as well.

It must be stressed that meaningful, positive social change has never come to fruition without the input of a concerned citizenry. In each instance noted above when the federal government intervened to correct an injustice, the root cause for federal action was a movement of the people—a grassroots motivated effort. Therefore, when policy choices are made at the state level, it is not only the role of the federal government to ensure that such choices are not associated with race, but is also the role of the citizenry to act to make certain this in does not occur. This does not shift the weight of the responsibility from the federal government to serve the role of an equalizer but it acknowledges that while the federal government has played a critical role in correcting injustices in society, it cannot be absolved of its own oppressive history, actions, and behaviors. As such, the work of removing structural impediments and fostering inclusiveness among those targeted by any policy intervention is the dual responsibility of both policymakers at the national level and the citizenry that the government serves.

Conclusions and Future Research

The conclusions and suggestions for future research described below are based on a historical examination of race/ethnicity and health care access policy trends at the state level. The central finding of this study was that in the aggregate, the race/ethnicity of the

uninsured proved to be a factor in state-level variations of policy innovations related to health care access. Prospective work could examine any trends in policy development and health care access associated with race or ethnicity over time. That is, future research could examine if policy innovation remains level, increases, or decreases over time as the racial composition of the state's uninsured population changes. Such data would provide a longitudinal view of how states act to constrict or expand health care access as the race/ethnicity of the target population changes. Additionally, future research could use the data presented in this study to build a predictive model of how states might act in implementing health care if the association between race/ethnicity and policy innovation observed in this study persisted. This information would involve building a regression model to determine probable state outcomes. Additional modeling could be done to determine if other ascribed variables, including race, explain the variation in state health policy. Lastly, additional research in this area could examine the policy choices states implement as a result of health care reform, which could then be used to establish whether the association between race/ethnicity and health care access policy described in this study, as well as the predictions in the aforementioned proposed predictive model, held.

Limitations

It should be acknowledged that this study examined one public policy area—namely, health care access—and therefore cannot be applied to all public policy areas. Moreover, this study used one approach to racial analysis and does not make the claim that there is a racial component to all policymaking. Rather, the goal of this study was to

build off the previous work in the area of race and public policy by filling the void of examining health care policy at the state level through the sociological lens of race.

Contributions to the Literature

My hope is that the work conducted for this study helps to inform the relationship between race/ethnicity and health care access policy so that policymakers at the state and national level will make informed decisions that are more inclusive. This study serves not only as a contribution to the socio-political study of race and policy in American society, but ultimately it should be used to encourage efforts by those oppressed by the system, those privileged by the system, policymakers, and the general public to change and to eliminate the relationship between race and the institution of policy. Although these goals are ambitious, for the scholar-activist they represent important steps toward a socially just society.

This work on its own and in tandem with the work of previous authors demonstrates that race still matters in American society. Until society deals with the impact that race and ethnicity has on policy and begins to do the tough work of eliminating this structurally oppressive relationship, people of color will never fully realize the promises embodied in the U.S. Constitution. Because states serve an important role in ensuring that the promises of the Constitution are actualized for their citizens (Bok 1992; Hero 1998), it is imperative that state policymakers and those affected by state-level decisions are consciously aware of how oppression can be perpetuated by public policy choices instituted at the state level. Social justice requires nothing less than for our

society to identify and rid itself of oppressive structures and processes that leave racial and ethnic minority groups at the bottom of the well (Bell 1992).

APPENDIX A

DATA CODEBOOK

The following is the data codebook for the health policy innovations selected for this study. The table identifies the position of each variable in the data file, the variable name as listed in the data file, the question examined to ascertain the data, the value coded for each finding, and the data sources used to acquire the information. Also provided is a quick reference list providing the full name for any acronym used in the codebook to for each data source. The names are in alphabetical order. For a full description of each data source refer to Chapter 3. Each data source is appropriately noted in the references listed at the end of this study.

List of Abbreviations for Data Sources

FUSA = Families USA

KFF = Kaiser Family Foundation

KCMU = Kaiser Commission on Medicaid and the Uninsured

NASCHIP = National Association of State Comprehensive Health Insurance Plans

NCSL = National Conference of State Legislators

SCI = State Coverage Initiatives

Position	Variable	Variable Label/Values/Data Source
1	OPINFANT	<p><i>Does the state cover optional infants in the Medicaid program?</i></p> <p>Yes = Coverage above 133% FPL = more expansive = 1</p> <p>No = Coverage at or below 133% FPL = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
2	OPCHILD	<p><i>Does the state cover optional children in the Medicaid program?</i></p> <p>Yes = Coverage above 100% FPL = more expansive = 1</p> <p>No = Coverage at or below 100% FPL = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
3	OPPREG	<p><i>Does the state cover optional pregnant women in the Medicaid program?</i></p> <p>Yes = Coverage above 133% FPL = more expansive = 1</p> <p>No = Coverage at or below 133% FPL = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
4	OPCHLSSAD	<p><i>Does the state cover childless adults in the Medicaid program?</i></p> <p>Yes = Coverage of Childless Adults = more expansive = 1</p> <p>No = Absence of Coverage of Childless Adults = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>

Position	Variable	Variable Label/Values/Data Source
5	OPPARENTS	<p><i>Are parents covered in the Medicaid program at or above the national median state AFDC cutoff from July 1996?</i></p> <p>Yes = Eligibility meets or exceeds 42% FPL = more expansive = 1</p> <p>No = Eligibility is below 42% FPL = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
6	MEDASSET	<p><i>Is there an asset test in the Medicaid program for any mandatory population?</i></p> <p>Yes = Presence of an asset test in any group = less expansive = 0</p> <p>No = Absence of an asset test for all groups = more expansive = 1</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
7	MEDCOSTCH	<p><i>Does the state have cost-sharing requirements for children in Medicaid?</i></p> <p>Yes = Presence of a cost-sharing requirement = less expansive = 0</p> <p>No = Absence of a cost-sharing requirement = more expansive = 1</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
8	MEDPRESELG	<p><i>Does the state have presumptive eligibility for children or pregnant women in Medicaid?</i></p> <p>Yes = Presumptive eligibility for either group = more expansive = 1</p> <p>No = Presumptive eligibility for both groups = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU</p>

Position	Variable	Variable Label/Values/Data Source
9	CHPPARENT	<p><i>Does the SCHIP program cover parents of eligible children?</i></p> <p>Yes = Coverage of Parents = more expansive = 1</p> <p>No = No coverage of Parents = less expansive = 0</p> <p>Data Source: FUSA Report 2009</p>
10	CHCHLSSAD	<p><i>Does the SCHIP program cover adults without dependent children?</i></p> <p>Yes = Coverage Adults w/out Dep. Children = more expansive = 1</p> <p>No = No coverage Adults w/out Dep. Children = less expansive = 0</p> <p>Data Source: FUSA Report 2009</p>
11	CHPELG	<p><i>Does the state expand eligibility for SCHIP above 200 percent of the federal poverty level?</i></p> <p>Yes = Above 200 FPL is more expansive = 1</p> <p>No = At or below 200 FPL is less expansive = 0</p> <p>*States that do not have separate SCHIP programs were given 0 because their asset test indicator would show under Medicaid</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
12	CHPASSET	<p><i>Is there an asset test for the SCHIP program?</i></p> <p>Yes = Presence of an asset test = less expansive = 0</p> <p>No = Absence of an asset test = more expansive = 1</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>

Position	Variable	Variable Label/Values/Data Source
13	CHPCOST	<p><i>Does the state have cost-sharing requirements for SCHIP beneficiaries?</i></p> <p>Yes = Presence of a premium requirement = less expansive = 0</p> <p>No = Absence of a premium requirement = more expansive = 1</p> <p>Data Source: KFF State Health Facts</p>
14	CHPPRESELG	<p><i>Does the state have presumptive eligibility for SCHIP?</i></p> <p>Yes = Presence of presumptive eligibility = more expansive = 1</p> <p>No = Absence of presumptive eligibility = less expansive = 0</p> <p>Data Source: KFF State Health Facts & KCMU December 2009 Report</p>
15	STFUND	<p><i>Does the state operate a fully state funded health care expansion program?</i></p> <p>Yes = Presence of a state funded program = more expansive = 1</p> <p>No = Absence of a state funded program = less expansive = 0</p> <p>Data Source: NSCL & SCI</p>
16	REINSUR	<p><i>Does the state offer a reinsurance program?</i></p> <p>Yes = Presence of a reinsurance program = more expansive = 1</p> <p>No = Absence of a reinsurance program = less expansive = 0</p> <p>Data Source: SCI</p>

Position	Variable	Variable Label/Values/Data Source
17	HIRISK	<p><i>Does the state offer high-risk pools?</i></p> <p>Yes = Presence of a high risk pool = more expansive = 1</p> <p>No = Absence of a high risk pool = less expansive = 0</p> <p>Data Source: NASCHIP, NCSL, & SCI</p>

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