

**The Interest Group Battle Over Health Reform:
The Surprising Impact of Public Advocates**

Research and Practice Article
March 1, 2015

ABSTRACT

Objectives: We examined the decisions of the 50 US states with regard to the option of expanding Medicaid along with a number of potential influences on each state's choice.

Methods: We developed a measure of relative state progress toward Medicaid reform adoption and used ordinal logistic regression to analyze the effect of each state's economic circumstances, established policy frameworks, partisan control of state government, and lobbyists for businesses, medical professionals, unions, and public interest organizations on Medicaid reform adoption.

Results: The 9,201 lobbyists working on health reform in state Capitols exerted a strong and significant impact. Controlling for confounding factors (including partisanship and existing policy frameworks), we find that business and professional lobbyists exerted a negative effect on state Medicaid implementation and, unexpectedly, public interest advocates and health union lobbyists exerted a positive statistical effect.

Conclusions: Four million adults lack coverage because they live in the 22 states that refused to expand Medicaid. Although political party and lobbyists for private interests present significant barriers in these states, legislative lobbying on behalf of the uninsured appears likely to be effective.

The Patient Protection and Affordable Care Act (ACA) aims to expand health coverage of low-income individuals by broadening Medicaid eligibility to incomes below 138 percent of the federal poverty level (\$16,105 per year for an individual in 2014). The Supreme Court's June 2012 ruling weakened the ACA's power to expand Medicaid by giving states the option of adopting the expansion without the threat of losing existing funding. While the Court struck the stick of financial penalty, the ACA continues to dangle attractive carrots in front of states - full funding of newly eligible individuals from 2014 to 2016 and 90% after 2020. The financial incentives have produced, however, uneven adoption as 22 states rejected expansion. The result is that approximately four million poor uninsured adults fall into the "coverage gap" - their income falls below eligibility for the ACA's insurance exchange tax credits and above the cutoff for Medicaid in states that did not expand the program.¹ Pinpointing why states accept or reject Medicaid expansion has urgent implications for the funding of medical providers and the health of lower income people.^{2 3 4 5}

The dominant account for Medicaid's uneven implementation is the straight-jacket of political partisanship.^{6 7} This is consistent with research on national and state politics that identifies the partisan control of executive and legislative offices as the "workhorse" of decision making.^{8 9 10 11} The "party rules" explanation for Medicaid expansion captures an unmistakable pattern: all 13 states where Democrats had unified control over the executive and legislative branches [in 2014](#) adopted it while it was only rejected by states where the GOP enjoyed unified [control of](#) government or wielded a veto through its control of one lever of constitutional power.

If the party rules account is accurate, the consequences for safety net providers and the health of low-income people is unavoidable.

The problem, however, is that partisanship is not a sufficient account of health reform implementation. After all, 21 states where Republicans wield power – including Arizona, Iowa, New Mexico, Ohio, Pennsylvania, New Jersey, North Dakota, and others - rejected their Party’s national position and implemented reform.

There has been little systematic study, though, of the influences on state adoption of Medicaid beyond partisanship with few exceptions.¹² State affluence is one possible offset of partisanship – though not as health reformers expected. The ACA’s advocates confidently predicted that generous financial terms would entice states – especially the less affluent – to expand Medicaid, but research on state politics and health policy points to a more dour expectation: states with weaker economies are fiscally constrained from committing even modest additional resources while more affluent states are better positioned to seize Washington’s good deal and embrace innovation and new federal initiatives.^{13 14 15}

A second potential break on partisanship is the inertial dynamics of the established policy frameworks in states. Studies of established government programs point to a pattern of “path dependency” – states with generous social provisions and competent administrative capacity that earn the confidence of politicians tend to develop along similar trajectories.^{16 17} New Jersey illustrates a potential pattern that is consistent with prior research:^{18 19 20} its history of administrative competence and generous programs for the vulnerable including the State Children’s Health Insurance Program (SCHIP) pressure Republican lawmakers to continue to pursue these traditions by adopting Medicaid expansion.

Tim 2/28/2015 8:49 AM

Deleted:

Larry Jacobs 3/2/2015 5:32 PM

Deleted: a growing group of

Larry Jacobs 3/2/2015 5:32 PM

Deleted:

Larry Jacobs 3/2/2015 5:33 PM

Deleted:

The pressure of interest groups and lobbyists on legislators is a third potential influence on Medicaid adoption. A number of studies of policy making and health reform detect the advantages of businesses and professions compared to advocates to raise the funds and hire more lobbyists with better access.^{21 22 23 24 25} Resource advantages are not, however, synonymous with influence on policy. Prior research suggests that as the number of lobbyists representing private interests rises, they tend to compete with each other and counteract their advantages.^{26 27 28 29} In health reform, hospitals that served poor people and the medical profession geared to general practice and community care pressed for Medicaid reform, but specialized physician associations (representing oorthopedists, urologists, and others) joined insurers and employer organizations (including large umbrella groups like the U.S. Chamber of Commerce) that worried about meddlesome regulations and higher taxes to pay for expanded programs.^{30 31 32}

The resource advantage of business and professional [organizations](#) can also be offset by lobbyists for consumers, unions, and religious or charitable groups who leverage alternative sources of political influence – grass-roots protests, letter-writing, investigations that instigate media scrutiny, and appeals to voters.³³ Consider the closely-studied example of smoking: well funded lobbyists for the tobacco industry won government subsidies and lax regulation for decades until businesses outside tobacco organized in response to the health costs they absorbed and, especially, advocates for public health mobilized to put smoking on the agenda as a public health problem and pressured lawmakers to change policy.^{34 35}

In short, prior research suggests competing sources of political pressure: a rise in number of lobbyists can increase the influence of business and professions as well as public interest groups and unions. There are several caveats, however: the effect of lobbyists [for](#) business and professional [organizations](#) can be offset by intense disagreement, and the presence of public

interest and union lobbyists is often muted because scarce organizational resources limit their inability to afford lobbyists.

Tim 2/28/2015 8:50 AM
Deleted: of

Tim 2/28/2015 8:50 AM
Deleted: and

Larry Jacobs 3/2/2015 5:33 PM
Deleted: -

I. Methods

Most measures of Medicaid reform omit important variations in state policy making by collapsing decisions to adopt into the simple categories of accepting expansion, rejecting it, or remaining uncommitted.³⁶ A further hurdle is that previous research does not offer clear guidance for appropriate measures of reform as it was geared to studying an established program.^{37 38} We adopt a new approach tailored to measuring relative state progress through five stages of development toward greater compliance with federal requirements. The first stage is state application for at least one “Level One” federal grant to finance planning for health reform implementation.¹ The application process for obtaining these grants requires a concerted effort from state government to detail how it will use federal funds to comply with the ACA.

While a federal planning grant indicates a general intent to prepare for reform and identify options, the second level is more important and moves toward actual state approval of the Medicaid expansion – the Governor’s public announcement of support for the reform. Gubernatorial support for reform is a necessary (though not sufficient) step; the executive branch takes the initiative for planning and the state’s chief executive must sign (as oppose to veto) enacted legislation to authorize the expansion.

¹The ACA originally intended Level One grants from the federal government to help states plan health exchanges; over time, states used these funds to plan for health reform more broadly including analysis and planning to consider the option of expanding Medicaid.

The third level of relative state progress accounts for states seeking a federal waiver to implement some sort of Medicaid reform related to the ACA. All states in this category have made the decision to implement some form of Medicaid reform without adopting the original model stipulated by the ACA and CMS. The fourth step towards greater federal compliance is federal approval of a state's waiver request, signifying that a state's solution to reform complies with the intent of the ACA. Five states have reached this status to this point: Arkansas, Iowa, Pennsylvania, Indiana and Michigan. Finally, the fifth and highest level of state implementation is its adoption of Medicaid expansion as expressly stipulated under the ACA in order to comply fully with its requirements. (Appendix provides detailed information on each stage as well as on the variables described below.)

[Insert Figure 1 About Here]

Our measure of state Medicaid expansion, which is presented in Figure 1, shows the partisan patterning of reform: the strongest development occurs in the Democratic-controlled states of California, Connecticut, and Hawaii and lags most in the Republican states of Texas, South Carolina, and Louisiana. But Figure 1 also shows that the “partisan rules” account fails to fit the wide variation in actions by states in which Republicans wielded constitutional power: from the states with full Republican control of the state government that adopted the full Medicaid expansion (like Arizona, Ohio and North Dakota) and the 5 that received federal approval for their waivers (Arkansas, Indiana, Iowa, Michigan, and Pennsylvania) to those that are spread across three categories of weaker progress.

To explain the relative progress of states towards Medicaid implementation, we created four sets of explanatory variables. The first variable accounts for political party control of state government. This additive measure scores states based on increasing Democratic control of state

Tim 3/2/2015 5:35 PM

Comment [1]: If we keep WI and UT here we need one more sentence about variations in this category. The footnote discussed in our emails would also go here.

FROM LRJ: Gee, why not leave it at this concise statement? The less said, the better.

Tim 2/28/2015 8:55 AM

Deleted: -

Tim 2/28/2015 8:55 AM

Deleted: Colorado, Massachusetts

Tim 2/28/2015 8:56 AM

Deleted: Minnesota

Tim 2/28/2015 8:56 AM

Deleted: 3

Tim 2/28/2015 8:55 AM

Deleted: -

government including the governorship and both branches of the state legislature. Scores on this measure ranged from zero to six with three points awarded for Democratic control of the governorship or both branches of the state legislature and 1 point given for Democratic control of only one legislative chamber.ⁱⁱ Bivariate analysis provides strong support for the “party rule” account that simply treats state health reform decisions as a function of party control – there is a strong and positive correlation between Medicaid reform progress and party control of state government (Pearson $r = .61$, $p < .01$)

The second explanatory variable is economic affluence, which is measured as per capita personal income and is based on population data from the 2010 Census and state-level per capital personal income data collected by the Bureau of Economic Analysis (averaged over the four quarters of 2010). Bivariate analysis finds a modest, positive relationship between economic affluence and Medicaid reform implementation (Pearson $r = .33$ $p < .05$). This suggests that affluence – rather than a weak economic circumstances (as some health reformers predicted) – is associated with state implementation.

The third set of variables measures two elements of inertial dynamics – the trajectory of established Medicaid policy and state administrative capacity. We constructed an additive scale to measure the existence and generosity of past state Medicaid programs toward children, pregnant women, working parents, the medically needy, and childless adults. Each group is scored on a zero-to-two scale with higher scores representing more generous benefits; a

ⁱⁱ We also tested models which used separate measures for party control of the governorship and the state legislature. The governor measure was a dummy variable for whether or not there was a Democratic governor and the legislature measure was a three point measure – “1” represented unified Republican control, “5” split party control, and “0” Republican control. Using this alternative specification yielded substantively identical results to those seen in Table 1. We chose to use the single additive party measure in our analysis because it increased the degrees of freedom in our model and simplified our analysis and presentation.

Timothy H Callaghan 3/2/2015 5:52 PM

Comment [2]:

FROM LRJ: I switched the directionality

Tim 2/28/2015 8:57 AM

Deleted: ..

Larry Jacobs 3/2/2015 5:52 PM

Deleted: Republican

Tim 2/28/2015 8:58 AM

Deleted: 3

Tim 2/28/2015 8:58 AM

Deleted: 2

Tim 2/28/2015 8:58 AM

Deleted: 1

Larry Jacobs 3/2/2015 5:52 PM

Deleted: Democratic

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

Timothy H Callaghan 2/23/2015 1:00 PM

Formatted: Font:12 pt

composite measure was created by combining these results.³⁹ As expected, state decisions to move toward adopting the ACA's Medicaid expansions are highly correlated with the generosity of past policy decisions to widen access (Pearson $r = .56$; $p < 0.01$).

Tracking state administrative capacity in the area of health policy is daunting; we built a rough gauge by cumulatively measuring both the capacity of states in a common area of responsibility (insurance oversight) as well as more specific capabilities related to aiding the poor and vulnerable such as opening high-risk pools to the medically needy.ⁱⁱⁱ Critically, the measure shows strong face validity: states considered to have high administrative capacity like Massachusetts and Connecticut scored considerably higher than states considered to have lower administrative capacity like Alabama.⁴⁰ In addition, bivariate analysis shows – as expected – a positive correlation between state administrative capacity and Medicaid reform progress (Pearson $r = .33$; $p < .05$).

The fourth set of variables builds on prior research⁴¹ by measuring the number of individuals registered to lobby on health policy in the most recent year publicly available in each state for three sectors: businesses and professional organizations; unions; and public interest and non-profit organizations. Registering to lobby is an indicator of participation in the legislative process – attending hearings, directly pressuring individual lawmakers, or supporting a political action committee.^{iv} Our data collection identified 7,300 lobbyists who worked for businesses or

ⁱⁱⁱ We tracked insurance oversight because it was the kind of broad state function that serves as a proxy to legislators about state capacity in health care even though it is not specifically connected to the Medicaid program.

^{iv} Our analysis concentrates on the lobbyists working for organizations with the most intense interests in health policy – insurers, medical providers, and professional medical associations.

professional health organizations, 1,675 contracted by health advocacy organizations, and 226 for unions in the health sector.^y Due to concerns that simple counts alone may serve as a proxy for state size as opposed to the concentration of types of lobbying groups, the variables in our analysis use a measure of the number of each type of lobbyists per 100,000 residents in each state. These estimates were generated using 2010 Census population estimates in each state and the lobbyist counts for each health sector. Bivariate analysis provides mixed support for the importance of health organization lobbyists to health reform. Unions exert a positive and significant effect on Medicaid reform decisions (Pearson $r=.3973$ $p<.05$) while health advocacy organizations and professional and business organizations have no significant bivariate influence on Medicaid reform progress. Of course, these correlations do not take into account other potential influences on state decisions.

Our analysis of correlations suggest, at least initially, that the “party rule” account is inadequate given the potential influence of a range of other factors. Multivariate regression analysis is needed, however, to sort out the relative effect of the four sets of competing factors that often influence state policy making.

We used ordinal logistic regression to analyze the distinctive effects of our four sets of independent variables on state Medicaid expansion. Ordinal logistic regression is justified

We put less attention on umbrella business associations from outside of health policy which harbored diffuse interests in health care. Our data is based on each state’s roster of registered lobbyists and the organizations they work for.

^y Our counts are not exclusive: a lobbyist who worked for an advocacy organization and a professional organization was counted towards both lists.

Tim 2/28/2015 9:00 AM

Deleted: C

Tim 2/28/2015 9:00 AM

Deleted:

because the dependent variable (relative state progress in implementing Medicaid expansion) is measured along six ordered points.^{vi}

II. Results

Political parties are a potent force in state Medicaid adoption, according to the results presented in Table 1. In particular, increasing Democratic control of state government is a positive and significant predictor of state decisions to progress towards adopting Medicaid expansion.

[Insert Table 1 About Here]

The impact of party control and the weakness of some of the other potential predictors of Medicaid expansion helps to explain how the “party rules” account of health reform has taken hold. Table 1 also shows that state economic circumstances, which many advocates believed would push states to accept the federal government’s generous financing offer failed to exert a statistically significant effect. This finding suggests that the pull of partisanship overwhelms the lure of Medicaid’s generous financing and contradicts the expectations of the ACA’s advocates and previous research.

In addition, state decisions on Medicaid expansion were not markedly driven by path dependence. The variable for existing administrative capacity was not statistically significant, indicating that state decisions on Medicaid adoption were not locked-in by the inertial dynamics

^{vi} We tested for multicollinearity given its prevalence in comparative state research and the correlation among some of our independent variables. Although a certain degree of multicollinearity is unavoidable with the type of variables we examined, the tolerance and variance inflation factor for our model suggests that the inter-correlations between our variables are not problematic.

Tim 2/28/2015 9:00 AM

Deleted: Increasing

Larry Jacobs 3/2/2015 5:55 PM

Comment [3]: Why are we not dismissing both path dependent variables? If policy trajectory is not significant at .10 level or better, please dismiss both IVs as I did in earlier draft. If policy trajectory does reach .10 sig, pls put that in table.

Tim Response: AJPH does not allow marginally significant findings to be presented as significant results in Tables. So we can talk about it but we can't show it. There is always the option of using some other symbol besides the star to delineate the marginally significant effect

FROM LRJ: We want spotlight on lobbyists. Killing this off is good for our case,.

of past institutional competence. State history of providing generous health care for the vulnerable was also not significant in statistical terms.

The inadequacy of the “party rule” account is revealed, however, by the effects of organized associations. The lobbyist variables in the model point to a new dimension in the state battle for Medicaid reform that extends beyond partisanship.

We find strong evidence that professional and business groups, health advocacy organizations, and health unions all exert significant effects on state progress towards Medicaid implementation. The negative and significant effect of business and professional lobbyists on reform confirms a longstanding finding of the advantage of private interests. In substantive terms, higher numbers of business and professional lobbyists in state capitols retarded progress toward adopting Medicaid.

What is surprising, however, are the strong positive and significant findings for health care unions and, especially, public interest advocates. As the number of lobbyists for these often out-numbered groups increased relative to state population, states moved closer to the full adoption of the Medicaid expansion stipulated by the ACA. This suggests that raising the otherwise marginal profile of lobbyists for public advocacy and health union groups gives supporters of Medicaid reform an opportunity to stress its broad community benefits and to alert lawmakers to potentially salient costs that might trigger public scrutiny (such as hospital insolvency).

Vermont illustrates the influence of interest groups on Medicaid reform progress. Vermont stood out nationally both as a Medicaid reform leader (see Figure 1) and as hosting large numbers of public interest and private sector lobbyists (the counts for each ranked in the top five in the country). By contrast, Texas exhibited little progress implementing Medicaid’s

Larry Jacobs 3/2/2015 5:54 PM
Deleted: Moreover, a

Larry Jacobs 3/2/2015 5:54 PM
Deleted: was a positive predictor of reform but its coefficient was only marginally

Tim 2/28/2015 9:00 AM
Deleted: .

Tim 2/28/2015 9:00 AM
Deleted: s

Tim 2/28/2015 9:01 AM
Deleted:

Tim 2/28/2015 9:01 AM
Deleted: gropus

Tim 2/28/2015 9:03 AM
Deleted: California

Tim 2/28/2015 9:03 AM
Deleted: California

Tim 2/28/2015 9:06 AM
Deleted: Alaska, Idaho, and Wyoming

expansion and they exhibited [one of the](#) lowest counts for both types of lobbyists: lawmakers faced comparatively less pressure from public interest advocates and more from business and professional associations that were not slowed by the countervailing effects of competition.

Tim 2/28/2015 9:06 AM
Deleted: three
Tim 2/28/2015 9:07 AM
Deleted: in these states

What is particularly impressive about the steady and significant effects of public interest advocates is that they hold up alongside powerful controls for alternative influences on lawmakers. Even amidst the potentially confounding effects of partisan polarization, economic affluence, the inertial dynamics within states, and the well-funded pressure from businesses and professional[s], lobbyists for public interest groups still wielded influence.

Tim 2/28/2015 9:01 AM
Deleted:
Tim 2/28/2015 9:08 AM
Deleted: California

The circumstances in [Vermont](#) were especially conducive for reform: reform-friendly interest group composition (a relatively high density of public advocates) and Democratic Party control. Conversely [Texas](#) saw Republican Party control with the opposite interest group mix. There were also a few states (notably like [Nebraska](#)) in which conservative legislatures overwhelmed reform-friendly conditions.

Tim 2/28/2015 9:08 AM
Deleted: Alaska, Idaho, and Wyoming
Larry Jacobs 3/2/2015 9:23 PM
Deleted: Florida

The cases that are particularly relevant for the future of Medicaid expansion are those in which partisanship was counteracted by reform-friendly interest group composition. New [Mexico](#) and [North Dakota](#) saw Republican control of at least one branch of government with among the most dense public lobbyist populations in the country. Conservative Governors in both states signed the ACA's Medicaid expansion.

Tim 2/28/2015 9:09 AM
Deleted: Jersey
Tim 2/28/2015 9:09 AM
Deleted: Michigan

III. Discussion

Four million adults lack the coverage funded by the new Medicaid expansion because states chose not to adopt it and its extraordinarily generous matching formulas. The “party rules” account that has dominated discourse over health reform suggests that these uninsured

Americans are doomed to suffer the health consequences in states where Republicans wield power and that the safety-net providers who treat them face dire financial prospects.

Our findings indicate, however, a quite different scenario: reformers can take concrete steps to widen the reach of Medicaid expansion in states with Republicans in power. Well-organized public interest groups along with unions have succeeded in states where they deploy lobbyists.

Although public interest advocates and health union lobbyists have opportunities to influence health reform, business and professional associations enjoy advantages that present two – potentially correctable – challenges to further widening the number of states adopting Medicaid reform. First, public interest and health union advocates often lack the resources to marshal even a rudimentary presence in state Capitols. According to our analysis, business and professional lobbyists formed a veritable army – they garrisoned 146 lobbyists in each state on average with no state armed with less than 25. By contrast, public advocate lobbyists were severely out-muscled - some states had had as few as 4 and they averaged just 34 across all states (more than 4 times less than the lobbyists for private interests).

Expanding support for public advocates lobbyists in states where they are not meaningful present is a concrete step for advancing Medicaid reform across the country – even in states with Republican lawmakers.

Second, business and professional groups currently enjoy a more consistently influential presence in state Capitols but they are vulnerable to divisions that dissipate their resource advantages. The initial trepidations toward health reform among certain large insurers and businesses (such as UnitedHealth and Walmart) shifted as Medicaid expansion has progressed in ways that bolstered their bottom lines and failed to hurt them as they feared.

Tim 2/28/2015 9:11 AM
Deleted: -

Tim 2/28/2015 9:11 AM
Deleted: !

The prospects for expanding Medicaid in states that have thus far refused and bringing coverage to the millions of vulnerable citizens without health coverage can be improved with concrete attention to the nature and sources of influences on state policy making.

Larry Jacobs 3/2/2015 9:24 PM
Deleted: hard-headed and

References

- ¹ Garfield, Rachel, Anthony Damico, Jessica Stephens, and Saman Rouhani, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Kaiser Family Foundation, Nov 12, 2014 <http://ow.ly/IyHDG>
- ² Institute of Medicine. 2002. "Care without Coverage: Too Little, Too Late," National Academy Press
- ³ Institute of Medicine. 2001, "Coverage Matters: Insurance and Health Care," National Academy Press
- ⁴ Kaiser Commission on Medicaid and the Uninsured, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?" August 2013.
- ⁵ Neuhausen, Katherine, Anna C. Davis, Jack Needleman, Robert H. Brook, David Zingmond, and Dylan H. Roby. 2014. "Disproportionate-Share Hospital Payment Reductions May Threaten The Financial Stability Of Safety-Net Hospitals." *Health Affairs*. 33 (June): 988-996.
- ⁶ Oberlander, Jonathan. 2011. "Under Siege — The Individual Mandate for Health Insurance and Its Alternatives." *New England Journal of Medicine*. 364 (March 11): 1085-1087.
- ⁷ Béland, D., Rocco, P., & Waddan, A. 2014. Implementing health care reform in the United States: Intergovernmental politics and the dilemmas of institutional design. *Health Policy*, 116(1), 51-60.
- ⁸ Bafumi, J., & Shapiro, R. Y. 2009. A new partisan voter. *The Journal of Politics*, 71(01), 1-24.
- ⁹ Doan, A. E., & McFarlane, D. R. 2012. Saying no to abstinence-only education: An analysis of state decision-making. *Publius: The Journal of Federalism*, 42(4), 613-635.
- ¹⁰ Layman, G. C., Carsey, T. M., Green, J. C., Herrera, R., & Cooperman, R. (2010). Activists and conflict extension in American party politics. *American Political Science Review*, 104(02), 324-346.
- ¹¹ Deering, C. J., & Shelly, B. 2009. State Resistance to Federal Mandates: A Cross-Case Analysis. In APSA 2009 Toronto Meeting Paper.
- ¹² Ayanian, J. Z. 2013. Michigan's approach to Medicaid expansion and reform. *New England Journal of Medicine*, 369(19), 1773-1775.
- ¹³ Cantor, J. C., Thompson, F. J., & Farnham, J. 2013. States' Commitment to Medicaid before the Affordable Care Act: Trends and Implications. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 50(1), 71-84.
- ¹⁴ Welch, Susan, and Kay Thompson. 1980. "The impact of federal incentives on state policy innovation." *American journal of political science*. 715-729.
- ¹⁵ Satterthwaite, S. B. 2002. Innovation and diffusion of managed care in Medicaid programs. *State & Local Government Review*, 116-126.
- ¹⁶ Pierson, Paul. 2000. "Increasing Returns, Path Dependence, and the Study of Politics."
- ¹⁷ Mettler, Suzanne and Joe Soss. 2004. "The Consequences of Public Policy for Democratic Citizenship: Bridging Policy Studies and Mass Politics." *Perspectives on Politics* 2 (1): 55-73.
- ¹⁸ Miller, E. A. 2005. State health policy making determinants, theory, and methods: A synthesis. *Social Science & Medicine*, 61(12), 2639-2657.
- ¹⁹ Gold, M., Sparer, M., & Chu, K.. 1996. Medicaid managed care: lessons from five states. *Health Affairs*, 15(3), 153-166.
- ²⁰ Holahan, J., Zuckerman, S., Evans, A., & Rangarajan, S. (1998). Medicaid managed care in thirteen states. *Health Affairs*, 17(3), 43-63.

-
- ²¹ Schattschneider, E. E. 1964. *The Semisovereign People*. New York: Holt, Rinehart and Winston.
- ²² Schlozman, K. L., & Tierney, J. T. 1986. *Organized interests and American democracy*.
- ²³ Olson, M. 1965. *The Logic of Collective Action*. Harvard University Press.
- ²⁴ Eaton, Joe. 2010. "Lobbyists swarm capitol to influence health reform." Center for Public Integrity. February 24, 2010. <http://www.publicintegrity.org/2010/02/24/2725/lobbyists-swarm-capitol-influence-health-reform>.
- ²⁵ Daniels, Melissa. 2014. "Interest groups' lobbying tally tops \$500M in Pennsylvania." TribLive. July 4, 2014. <http://triblive.com/politics/politicalheadlines/6344518-74/lobbying-million-spending#axzz382rXOuMC>
- ²⁶ Browne, William P. 1990. "Organized Interests and Their Issue Niches: A Search for Pluralism in a Policy Domain." *Journal of Politics* 52(4): 477-509.
- ²⁷ Cigler, Allan J. 1991. "Interest Groups: A Subfield in Search of an Identity." In *Political Science: Looking to the Future*. ed. William Crotty. Evanston, IL: Northwestern University Press.
- ²⁸ Heinz, J. P., Laumann, E. O., Nelson, R. L., & Salisbury, R. H. 1993. *The hollow core. Private Interests in the National Policy Making*, Cambridge, London.
- ²⁹ Jacoby, W. G., & Schneider, S. K. 2001. Variability in state policy priorities: An empirical analysis. *Journal of Politics*, 63(2), 544-568.
- ³⁰ Feng, Charles. 2012. "Doctors' Groups Applaud Health Care Ruling". ABC News. June 29, 2012. <http://abcnews.go.com/Health/medical-organizations-respond-aca-ruling/story?id=16673570>
- ³¹ Carlson, Joe. 2013. "N.Y. Catholic health system wins ruling against contraception mandate". *Modern Healthcare*. December 16, 2013. <http://www.modernhealthcare.com/article/20131216/NEWS/312169935>
- ³² Pear, Robert. 2009. "Doctors' Group Opposes Public Insurance Plan". *The New York Times*. June 10, 2009. <http://www.nytimes.com/2009/06/11/us/politics/11health.html>
- ³³ Nownes, A. J., & Freeman, P. 1998. Interest group activity in the states. *The Journal of Politics*, 60(01), 86-112.
- ³⁴ Goldstein, A. O., & Bearman, N. S. 1996. State tobacco lobbyists and organizations in the United States: crossed lines. *American Journal of Public Health*, 86(8_Pt_1), 1137-1142.
- ³⁵ Givel, M. 2006. Punctuated equilibrium in limbo: The tobacco lobby and US state policymaking from 1990 to 2003. *Policy Studies Journal*, 34(3), 405-418.
- ³⁶ Kaiser Family Foundation. 2014. "Status of State Action on the Medicaid Expansion Decision, 2014." <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- ³⁷ Buchanan, Robert J., Joseph C. Cappelleri, and Robert L. Ohsfeldt. 1991. "The Social Environment and Medicaid Expenditures: Factors Influencing the Level of State Medicaid Spending." *Public Administration Review* 51 (1): 67-73.
- ³⁸ Grogan, Colleen M. 1999. "The Influence of Federal Mandates on State Medicaid and AFDC Decision-making." *Publius: The Journal of Federalism* 29 (3): 1-30.
- ³⁹ Grogan, Colleen M. 1994. "Political-Economic Factors Influencing State Medicaid Policy." *Political Research Quarterly* 47 (3): 589-622.
- ⁴⁰ Gold, M., Sparer, M., & Chu, K.. 1996. Medicaid managed care: lessons from five states. *Health Affairs*, 15(3), 153-166.

⁴¹ Goldstein, A. O., & Bearman, N. S. 1996. State tobacco lobbyists and organizations in the United States: crossed lines. *American Journal of Public Health*, 86(8_Pt_1), 1137-1142.