Wal-Mart Welfare:
Business, Workers, and the Politics of Health Policymaking in Maryland and South Carolina

Nicole Kazee
Yale University
Nicole.kazee@yale.edu
Prepared for the Miller Center of Public Affairs Fellowship Conference
May 2008

DRAFT: Please contact author for revised version before citing.

Starting in the late 1980s, the federal government began to gradually shift welfare state policymaking authority to the states. One of the most notable areas in which states have increased flexibility is in determining which residents are eligible for public health programs. There are a number of reasons to expect that states would use this new authority to expand eligibility in these programs beyond the federally mandated minimum levels.[1] First, a strong provider lobby that benefits from Medicaid has emerged to protect and fight for the program. Second, there is a general consensus among political elites and the public that it is important and desirable for governments to provide health care for poor and near-poor residents, particularly children, even when they are not part of the welfare system. Finally, there is substantial concern about the growing number of uninsured residents and the negative impact this has on states, both in terms of the cost of health care and the detrimental impact on indicators such as infant mortality. The federal matching funds that come with Medicaid and the State Children's Health Insurance Program (SCHIP) make these programs the most economical way to attack the problem of the uninsured.

However, despite the willingness in most states to expand program eligibility and the incentives for doing so, not all states have successfully done so.[2] In children's coverage, the general trend has been upward: most states have expanded the program at some point, and few have contracted eligibility. However, many states still cover children at levels regarded

[1] Of course, the expectation is not that states will expand eligibility to a high level on an absolute scale. States with Democratic majorities, wealthy states, and states that start with higher eligibility levels will almost certainly have higher eligibility levels today. However, we can expect that states will want to raise eligibility beyond federally mandated minimums.

[2] States have gained flexibility in a number of areas related to health policy. However, this analysis will focus exclusively on eligibility levels for several reasons. First, since eligibility in most government programs is set as a percent of the federal poverty level, it is easily measurable and comparable across policies (and reveals more about program content than spending totals). Second, eligibility levels are arguably the most political decisions when it comes to public health programs. They are the most visible and easily comprehensible features, and are most often set by legislatures. Other features, such as particular benefits covered or provider reimbursement rates, are frequently determined by agency bureaucrats, or appear as fine print in bills that seem to have little effect on legislators' decisions.

even by relevant lawmakers as too low, while others have continued to expand eligibility even after their levels are well beyond those recommended by the federal government. Medicaid coverage for adults has been even less consistent. Although many states have expanded eligibility for parents, some have kept their levels at the bare minimum, and others have actually cut eligibility levels. Some states have simply been better able to expand their programs than others.

The most obvious explanations for these policy decisions are ideology and financial capacity: liberal or wealthy states are more likely to expand programs than conservative or poor states. To some extent, these factors are helpful in understanding choices, and there are patterns. However, as I will explain, ideology and finances are vastly insufficient as explanatory variables. Instead, whether or not states are able to successfully expand eligibility in these programs seems to depend on four factors unique to state policymaking.

First, two features of state-level *party politics* affect policy choices in ways that can be instrumental to blocking or aiding expansions: the pragmatism of state Republicans (which frequently pushes them to support expansions), and the nature of inter-branch relations. Second, *interest group politics* are different at the state level. When eligibility in public programs is expanded, this often brings employers into the policy debate. At the state level, employers can either thwart expansions due to funding mechanisms they oppose, or individual employers or organizations can have a *positive* impact on the likelihood of passage by highlighting the positive impact on state businesses. Third, *centralized state legislatures* give a handful of individuals sufficient power to control the fate of agenda items. These leaders can either capitalize on latent support for expansion, or serve as barriers that ensure these supportive feelings are not acted upon. Finally, the attitude state leaders have about their

expectations for future budgets, or *wealth mentality,* can have a positive or negative impact on their willingness to enact new spending measures.

These dynamics of state policymaking will be demonstrated through comparative case study analysis in two "most different" states: Maryland and South Carolina.[3] As a liberal, wealthy state, Maryland has historically provided generous social benefits. Maryland's CHIP program has been successfully expanded several times, and further expansions are continually on the radar. However, adult coverage languished at pre-welfare reform levels for many years, despite efforts to raise them. What explains the inability of the state to expand coverage for adults? And why did the state successfully pass an expansion in 2007 after so many years of failure? South Carolina, a significantly poorer, more conservative state, has offered less generous health care coverage. Until very recently, attempts to expand coverage for both children and adults have been abject failures, and eligibility levels remained at minimum levels. Why did they remain low despite a host of reasons to expect otherwise? And why have the barriers to expansion seemed to erode in the last year, allowing children's expansion in 2007, and potentially expansion of adult eligibility in 2008?

Most of our understanding of policy decisions in the American welfare state is based on analysis of federal politics. However, as the epicenter of policy choices has shifted to a new venue, and as the policies themselves change form and function, our theories have lost much of their explanatory capacity. This paper explores possible ways to understand American policymaking in this new political environment.

---

[3] The information provided in this paper comes primarily from a series of 33 interviews conducted with government and interest group leaders in Maryland and South Carolina. Interviews lasted between 30 and 90 minutes, and were conducted in Maryland in spring 2007 (with several follow-up interviews taking place after the November 2007 Medicaid expansion) and South Carolina in fall 2007 and spring 2008. All interviews were confidential, and are coded here by type of interviewee and state (therefore "Business Interview MD1" refers to the first business interviewee in Maryland). Numbers are assigned chronologically by date of interview. In Maryland, interviews were supplemented by government documents housed in the Department of Legislative Services, including recordings of hearings and the contents of bill files (e.g., letters from interest groups and constituents, transcripts of hearings, and fiscal notes). Similar files were unavailable in South Carolina.

Unpacking the Theory

Our general understanding of welfare state policymaking, based on a large body of research on cash assistance and other anti-poverty programs, might lead us to predict exactly the opposite of what I'm suggesting here. That is, theories of the welfare state give us reasons to expect that states would *lower* eligibility levels in public health programs. First, the "welfare magnet" hypothesis suggests that states do not want to enact generous anti-poverty programs for fear of attracting poor residents. In other words, devolution should lead to a race to the bottom. This expectation is precisely why liberal reformers didn't want to give states authority over health reform (Sparer 1996, 24). Second, scholars have long argued that targeted government programs are politically vulnerable, and that there are few political incentives to expand them (Grogan and Patashnik 2003, 67-8). We would expect this to be particularly true in the last twenty years, when there has been a strong anti-welfare backlash at the national level against means-tested government entitlement programs. This backlash was particularly prominent among conservatives, and under conservative administrations we generally saw contraction of government programs. Third, states have been experiencing severe budget deficits, which we expect to constrain social programs.

However, these theories do not apply to the post-welfare-reform health policy environment. All of the above expectations make one or both of the following faulty assumptions: A) that public health programs retain their basic character when eligibility is expanded and B) that state level policymaking will resemble federal policymaking.

Public health programs actually change quite substantially when eligibility is expanded beyond the welfare population. Expansions often mean that these programs benefit not only the poor, but also many low- to middle-income workers and their families. Health care is joined by food stamps, child care subsidies, and tax credits to make up a

system of public benefits that increasingly targets these working families. I call this new system "Wal-Mart Welfare" for its implications for both workers *and* their employers. Public health care programs allow many firms with low-wage employees to externalize some of their biggest – and growing – labor costs, while reducing demand for higher wages, increasing productivity, and reducing absenteeism (Burton et al. 1999; Marquis 2005, 454; Blumberg et al. 2000, 57). This means that, *ceterus paribus,* employers are likely to prefer public health programs with high eligibility levels. However, the funding mechanism for program expansions matters substantially, since they frequently impose direct costs on employers. One of the primary political effects of Wal-Mart Welfare is that programs begin to behave less like targeted means-tested programs and more like universal programs because their sphere of influence expands. Grogan and Patashnik (2003) call this phenomenon "universalism within targeting."

Therefore, because means-tested programs with higher eligibility levels benefit working families and their employers as well as the poor, states that choose expansions are potentially *more* economically competitive – not less, as the welfare magnet hypothesis would predict. These programs, if they are indeed magnets for any group, will draw low-income working families and the companies that employ them (or, at very least, prevent these groups from exiting the state in search of more favorable conditions).

In a number of ways that will have a significant impact on health policy choices, state policymaking will not resemble national policymaking. First, partisanship can be expected to be less rigid at the state level, where political pragmatism often trumps party politics. State politicians want to make the decisions that will help their states be the most competitive, even if this doesn't necessarily fit within a consistent ideological framework. Welfare offers an instructive example. The anti-welfare backlash of the early 1990s, which had its epicenter

in the Republican Party, was thought to negatively affect all means-tested antipoverty programs, particularly those associated with cash assistance (such as Medicaid). Republicans have been particularly interested in keeping Medicaid lean, and despite initial support for the SCHIP program, significant partisan differences have emerged as a number of states have expanded eligibility far beyond what many Republicans intended or think is appropriate. However, at the state level, support for Medicaid can transcend party lines: within states, there is vast agreement among political actors about ideal eligibility levels. And in almost all states, there is consensus that public health programs should cover the poor, and that states should do everything they can to help the deserving uninsured (i.e., children and working adults). This consensus is based on the benefits brought to a state when it expands health coverage through Medicaid, including a healthier population, at costs that are heavily subsidized by the federal government.

In addition, the condition of inter-branch relations can potentially reshape partisan politics. When the relationship between the governor and legislature are acrimonious, this is likely to unite the legislature in the effort to thwart a common enemy. This can have two effects: it gives the minority party more power, and it shifts the legislative agenda in the ideological direction opposite the governor. Powerful examples of this phenomenon can be observed in both South Carolina and Maryland, and have led to unpredictable outcomes.

The second way that state politics will not mimic federal politics is in the role of employers as an interest group. First, states are often very sensitive to the preferences of local employers because they need jobs and investment. Therefore, employers can exercise what is known as structural power – that is, political power they achieve simply by virtue of their economic position in the state. Rather than business groups having to lobby on particular issues, policymakers make decisions based on their anticipated reactions. Partly

for this reason, employers are thought to have more political influence at the state level than in Washington, D.C. (Gormley 1986, 605).

Second, a considerable amount of evidence has shown that at the federal level the business community A) must be united to have political impact and B) is generally limited to blocking unfavorable policies, rather than pushing favorable policies, due to collective action problems. However, at the state level, employers can have a positive impact on getting expansions enacted. This is because powerful individual political actors have greater influence in a small venue; it only takes one or more prominent business leaders to create the impression (true or not) that public health programs may actually be pro-business. This view, when presented by a respected state employer, can provide cover for moderate legislators to vote in favor of program expansions. In this way, disunity at the state level can actually make employers more influential. The business community does not necessarily need to overcome its collective action problems to positively impact state policy decisions.

Other interest groups have a higher burden of proof, and cannot rely on their importance to the economy to ensure that their preferences will be considered. They must demonstrate that their demands are coming from voters, which requires a strong, visible, credible grassroots effort. Only when health advocacy groups can bring large numbers of constituents to the table are they likely to play a significant role in public program decisions.

Third, state legislatures are smaller, more intimate venues than the U.S. Congress. In bodies where power is highly centralized (including both Maryland and South Carolina), a few individuals are capable of either putting an issue high on the agenda, or blocking it entirely (regardless of the will of the majority). In such legislatures, the explanation of policy decisions or non-decisions may rest in the particular preferences of one such leader.

Finally, the role of budgets is likely to be somewhat different at the state level. State capacity can't be the only – or even necessarily the main – explanation for why some states expand coverage and others don't. Both of my case studies show examples of program expansion when there was little money to spend. This is partly due to simple political will to insure more state residents through programs that are partially subsidized by the federal government. But expansions are frequently funded with sources outside the general fund, which may be impervious to budgetary problems. In recent years, the most common options have been cigarette or employer taxes, the proceeds from which are designated for health reform. In addition, eligibility is something that can be expanded without straining the budget (while states cut costs in other ways, such as enrollment freezes, benefit reductions, stricter enrollment procedures, provider reimbursement rates, etc.). Expanding eligibility is often a political move that satisfies public and elite demand but masks the underlying reality about the generosity of the program (Ross et al. 2008).

But even beyond the reality of financing decisions and state capacity, state legislative decisions are shaped by how they identify themselves financially, or what I call *wealth mentality*. A state with a *rich-state mentality* expects to have money in the future, regardless of whether the money is currently available. Having a rich state mentality means that it is possible to enact new spending programs even in times of budget deficits, and although there may be cuts to programs, they are not inevitable. On the other hand, a *poor-state mentality* leads a state to consider its budgetary situation more carefully because the expectation is that there will not be money in the future. Even in times of budget surpluses, a poor state mentality leads to great hesitation in enacting new spending. The fear of unfunded mandates in the future is a substantial constraint. These attitudes are not

necessarily reflected in a state's current budgetary situation, yet they can have a substantial impact on the likelihood of expansion.

In sum, we should expect states to expand eligibility beyond federally mandated minimum levels. Whether they actually do seems to be a product of unique features of state-level partisan politics, interest group politics, legislative centralization, and wealth mentality.

Setting the Stage: State Backgrounds

Maryland is certainly among those states that would be expected to have high absolute eligibility levels. Maryland residents are among the most liberal in the country (Berry et al (1998)), and Democrats have dominated state government for decades. Maryland has a strong *pro-government mentality*, which makes it ideologically predisposed to generous social provision. Part of the basis for this attitude in Maryland is its proximity to Washington, D.C., and the substantial government investment and jobs in the region (Business Interview MD4; Government Interview MD9).[4] Government capacity also affects generosity in social programs, and by all accounts Maryland is an extremely wealthy state. The economy is dominated by high-skilled, high-paying jobs, largely in technology. In 2005, per capita income was well above the national average (BEA 2007, http://bea.gov/bea/regional/spi/default.cfm?satable=SA30). Because of its long history of wealth, Maryland has a classic rich-state mentality (Business Interview MD3). Many government programs reflect both the pro-government and rich-state mentalities in Maryland. Its state minimum wage, at $6.15 an hour, was (until 2008) above the federal minimum, and in 2007 it became the only state in the country to enact a living wage for state contracted employees. It was the second state in the nation to enact a state earned income

[4] There is some evidence to support this. For example, 31 percent of employed adults in Prince George's County work for government, compared with 14.6 percent nationally (Census 2000, Summary File 3, Matrices P26, P39, P40, and P51).

tax credit, a refundable tax break for low-income working adults with children, and this credit is among the most generous in the country.

Maryland is a state where there is little ideological controversy about the importance of generous health programs. Republicans in the state, most of whom are relatively moderate, voice little opposition in principle to public health programs. Employers' groups are also broadly supportive of means-tested public health programs (Business Interviews MD2, MD4, and MD5). There is a specific reason that elites in Maryland are particularly predisposed to support generous health programs: its unique "all payer" hospital rating system means that those with insurance pay directly for those without. Children's health coverage, available to all children in families earning less than 300 percent of the poverty level, certainly reflects this consensus: it is among the highest in the country. Adult health coverage, however, is an anomaly. Adults in Maryland can only access public health care if they earn below 30 percent of the poverty line. In November 2007, after many years of efforts, this was finally expanded to 116 percent.

South Carolina's electorate and government, by contrast, is significantly more conservative that Maryland's (although, like many southern states, it has only recently become majority Republican). Whereas Maryland's ideology is heavily shaped by a pro-government mentality, South Carolina's is based in part on an *anti-tax mentality*. 33 percent of the legislature and Governor Mark Sanford signed the Americans for Tax Reform's "No Tax" pledge in 2007 (http://www.atr.org/content/pdf/2007/sept/091007ot-statepledge.pdf). The pledge carries great weight, particularly in elections – candidates have been known to lose because of their refusal to sign the pledge, or because they reneged on an earlier pledge (Advocate Interview SC3; Business Interview SC2). South Carolina is also a staunch right-to-work state, with broad opposition to unions even among Democrats

(Business Interview SC2). It also has substantially less state capacity than Maryland. Median per capita income was in the bottom ten in the nation in 2005, at $28,352. The South Carolina economy has struggled in the inevitable shift from manufacturing (where jobs have largely moved overseas) to a low-wage service economy (DuPlessis 2002; Talhelm 2004). Just as importantly for government spending, the state quite clearly identifies as a poor state, making it unlikely to enact expansions during tight budget years, and wary of them even when budgets are strong (Advocate Interview SC3; Government Interview SC8).

South Carolina's government programs reflect its anti-tax and poor state mentalities. It is one of only five states with no minimum wage law, and it has no state EITC. TANF benefits are among the lowest in the country (Green Book 2004, table 7-11). There is a general consensus that the state should provide health benefits to poor residents (and in the case of children, to nonpoor residents as well), but eligibility in health programs has been at minimum levels until recently. Under the SCHIP program, children were initially eligible at only 150 percent of the poverty level (the lowest level allowable), and this was only expanded to 200 percent in summer 2007. Adult coverage is similarly low, although not substantially lower than other states, at 50 percent of the poverty level (although generous income disregards allow working families at higher levels to access the program). Perhaps for the first time, legislators are optimistic that an expansion could pass in the current session.

We would not expect Maryland and South Carolina to make similar policy decisions, and indeed they have not. However, two important sources of common ground emerge. First, neither state legislature has made cuts to Medicaid or SCHIP eligibility since the early 1990s, despite numerous years of sometimes quite damaging budget deficits when cuts were made to other government programs and other aspects of public health care. Even more importantly, there is broad consensus in both states about the virtue of increasing Medicaid

and SCHIP eligibility beyond their initial levels. This is quite notable, and distinguishes these programs from other income-tested government programs. It also indicates that it is not likely to be ideology or traditional partisanship that determines whether either state expands public programs.

Coverage for adults (Medicaid)

States gained authority over Medicaid eligibility levels for adults through the 1996 welfare reforms, which severed the link between Medicaid and cash assistance (in which recipients had historically enrolled simultaneously). All states have had to decide whether to keep the federally-mandated minimum eligibility levels, which are linked to former AFDC eligibility in each state, or to apply for waivers to increase thresholds. In recent years, Medicaid expansions achieved through waivers have been the preferred way for states to reduce the number of working uninsured adults (Mehren 2006). As of January 2008, the average eligibility threshold for parents was 99 percent of the federal poverty level, though it ranged substantially from a minimum of 11 percent of poverty (in Alabama) to 275 percent (in Minnesota).[5]

In both Maryland and South Carolina, eligibility thresholds for adults are predictably lower than for children.[6] However, while Maryland has among the highest eligibility limits in the country for children, its adult coverage is well below the national average – and below

[5] Eight states offer separate state-only programs for adults, or have obtained waivers that allow them to offer a reduced form of Medicaid coverage to adults at substantially higher income levels than in their normal Medicaid program. These higher eligibility limits have been included in the average, which means that, if anything, the numbers overstate the case. When these special programs are omitted from the analysis, the average threshold drops to 73 percent of FPL.

6 There are three broad reasons why states are likely to cover children at higher levels than adults. First, focusing on children is a smart strategy in terms of getting support from the public and political elites because children are seen as a deserving group (Hasenfeld and Rafferty 1989, 1028; Cook and Barrett 1992, 217; Weaver et al. 1995). The second reason is that spending taxpayer money on children is easy to justify politically because it is an inexpensive population to cover (Government Interviews MD5 and MD7). Finally, since federal matching rates are higher for children than adults, there is a built-in incentive for states to actively choose children over parents.

even South Carolina. This offers perhaps the best evidence that ideology and state wealth are not sufficient explanatory factors.

Maryland

Throughout the 1980s, Maryland's Medicaid program was more generous than it is today, and was supplemented by a similar program for working adults without children. In 1991 and 1992, however, Maryland found itself facing massive budget deficits that were among the worst in the country (Oliver 1998, 62). Under the leadership of Governor William Donald Shaefer, a conservative, Rooseveltian Democrat, the state began to make substantial cuts to social programs. As part of this process, the administration lowered eligibility for parents under the Medicaid program, and eliminated the separate program for working adults entirely ("Bad Medicine: Balancing Maryland's Budget by Cutting Medicaid" 2005, 3). Adults under Medicaid could now only qualify if they earned less than 30 percent of the federal poverty level.

Even after the recession passed and the state was once again financially comfortable, there was little talk of reinstating higher eligibility levels, or of increasing eligibility at all. Children's coverage, as discussed below, received constant attention, the vast majority of which was related to expansion. From 1987 to 2006, almost all health care expansion bills introduced in the General Assembly – nineteen out of twenty – were partly or fully related to children. One 1990 bill would have temporarily expanded coverage for adults, and six other bills packaged Medicaid expansion for adults alongside expansion for children. Not a single one of these adult-related bills even went to the floor for a vote.

But as the legislative debate continued to focus on children, advocacy groups slowly started investigating ways to expand eligibility for adults. The most significant event was the founding of the Maryland Citizens' Health Initiative in 1999, with the goal of reaching

universal health coverage in the state.[7] By 2002, MCHI had cobbled together a complicated plan for universal coverage, known as Health Care for All!, and its extensive coalition of backers became known as the Health Care for All! coalition. The backbone of the plan was public program expansion, including Medicaid expansions that would gradually increase eligibility to all parents under 200 percent of the federal poverty level (a massive increase), funded with a tobacco tax increase and broad employer mandates. Filed in 2003 and 2004 as The Public-Private Partnership for Health Care Coverage for All Marylanders (HB726 and SB557 in 2003; HB1008 and SB737 in 2004), the bills were vigorously debated in committees in both years but never sent to the floor for votes.

Virtually the only opposition to the bills came from business groups, which vehemently opposed the mandates (which would have required most employers to cover their workers or pay a percentage of payroll tax into the Medicaid fund). In Senate hearings on the 2004 comprehensive plan, mainstream business groups, including the Maryland Chamber of Commerce, the Maryland NFIB, the Maryland Retail Association, Wal-Mart, and Marylanders for Responsible Healthcare Solutions (a coalition of business and trade associations), presented forceful economic arguments (Senate Finance Committee 2004). Although similar bills were introduced in 2005 (HB1144) and 2006 (HB1510), it became clear that Medicaid expansion was not going to occur in this form.

In 2005, the coalition began to work on a different tactic that they thought would mitigate this opposition, narrowing the bill to fund only Medicaid expansion through an employer mandate on the largest employers in the state (of which, notably, only Wal-Mart would actually qualify). This legislation, officially titled the Fair Share Health Care Fund Act but known as the "Wal-Mart Bill," drew national attention. It was heavily pushed by state

[7] The below discussion comes largely from Advocate Interviews MD1 and MD2.

health advocates and unions, including national organizations such as the Service Employees International Union (SEIU), which provided substantial funds for advertising and grassroots lobbying (Green and Nitkin 2005).

But one of the most visible supporters was also one of the most surprising: Giant Food, a massive unionized supermarket that was one of the four companies to employ more than 10,000 workers in Maryland. In a letter to the General Assembly, Vice President of Government Affairs Barry Scher wrote "We will be very out front with this issue to support the Health Care for All Coalition effort" (Scher 2004). He was joined by a handful of other business organizations, including the American Minority Contractors and the Baltimore Minority Business Group, and a few individual small business owners. Less public or vocal, but still supportive behind the scenes, was another large grocery chain, Safeway (Senate Finance Committee 2005; Government Interview MD3).

Opposition to the bill came almost exclusively from the business community. Not surprisingly, Wal-Mart led the charge, hiring twelve lobbyists in the state (Wagner 2005). The Maryland Chamber of Commerce and the National Federation of Independent Business/Maryland also came out early and strongly against the bill. They disliked the bill for two notable reasons. First, they worried about the exit threat. If Maryland imposed a tax on large employers that neighboring states didn't have, this would drive away jobs and limit future business expansion. Second was the "slippery slope" argument – the fear that the payroll tax would be extended to more employers in the future (Business Interviews MD1 and MD2, (Worcester 2005). The purpose of the funds – to expand eligibility in the Medicaid program to an undetermined level – was not a source of controversy.

In April 2005, the Assembly successfully passed the Fair Share law, and, as promised, Republican Governor Ehrlich promptly vetoed the bill. At the start of the 2006 legislative

session, the General Assembly dealt him a crushing blow with a veto override. Maryland had become the first (and, ultimately, only) state to enact a Fair Share law. But the legislation would be doomed by the complicated and ambiguous ERISA laws. In 2007, before any money had been collected, the bill was overturned by a Fourth Circuit District judge.

By this point, the issue of Medicaid coverage was coming to a political head. With almost 800,000 uninsured residents, more than half of whom were working adults (Smitherman 2007b), state leaders were increasingly embarrassed by how few poor residents qualified for state health care (Government Interview MD5). Delegate Pete Hammen, newly minted Chair of the House Health and Government Operations Committee, decided to pursue expansion full throttle, focusing on increasing eligibility for adults under Medicaid as a baseline for reform (Government Interview MD8). He proposed increasing eligibility for all adults – both parents and childless adults – to 116 percent of the federal poverty level, and expanding MCHP to cover all children (those over 400 percent of poverty would buy into the program at actuarily fair premium levels). This time, expansions would be financed with a $1 cigarette tax increase rather than employer taxes. With a hard push by Hammen and other members of the leadership, HB757 passed easily in the House (102 to 37). But almost immediately, Hammen ran into a virtual blockade by the Senate leadership, at least in part due to timing: Maryland was suddenly facing projected budget deficits of over $1.5 billion, and many Senators were concerned about the costs of a major health expansion (Government Interviews MD3, MD4, and MD8). Budget concerns, however, largely provided cover for the Senate leadership to stall on the bill. Senate President Mike Miller had his own reasons to block this particular bill. Most importantly, he desperately wanted something for which he was willing to bargain: slot machines. Miller stuck to his guns,

refusing to bring the bill to the Senate floor for a vote despite the existence of ample votes in its favor (Smitherman 2007a).

The business community stayed largely out of the debate, although they were courted by MCHI, which wanted representatives from corporate America in their Health Care for All! coalition. The bill was openly supported – though not *actively* supported – by several business groups, including the Greater Baltimore Committee, the Washington Board of Trade, Giant Food, and the Maryland Hospital Association. None of them lobbied for the bill in any way, with the lone exception of the Washington Board of Trade, which submitted written testimony in support of the bill but refused to provide oral testimony at the committee hearings (Advocate Interview MD1; Business Interview MD5). The Maryland Chamber of Commerce and the Maryland Retailers, both of which supported Medicaid expansion in principle, had qualms with the cigarette tax and had opposed similar earlier bills (Government Interview MD8). However, in the 2007 debate, both groups remained formally neutral (Business Interview MD2). The Maryland Retailers even indicated to Delegate Hammen that they would support a smaller cigarette tax increase or an income tax increase as a way to fund Medicaid expansion (Business Interview MD4).

In the fall of 2007, Governor O'Malley called a special legislative session to deal with the budget crisis. Ironically, it was during this session that the long-awaited Medicaid expansion finally passed and was signed into law. O'Malley used his executive power and political skill to navigate the divergent demands of Busch and Miller, brokering a compromise whereby slot machines would be voted on by the public in 2009 (Wagner 2007). The more controversial cigarette tax was replaced with general budget funds. With the loss of tobacco revenue, the bill became much less comprehensive, with no MCHP expansion, and caps on enrollment and eligibility for childless adults should funding run out. However,

with the passage of SB6 in October of 2007, adults in Maryland could now access Medicaid with incomes up to 116 percent of the federal poverty level, an almost three-fold increase over previous levels.

Why did adult coverage stagnate in Maryland, despite a general consensus that the levels were too low, strong efforts by health advocates and legislative leaders to pass legislation expanding eligibility, and continually expanding children's coverage? Why was the first successful expansion the highly controversial and ultimately doomed Wal-Mart bill? And why was the state finally able to pass Medicaid expansion for parents in 2007? The primary explanations seem to lie in legislative centralization that allowed individual leaders to block or push expansions, interest group politics (particularly employers), party politics (particularly inter-branch hostility), and the rich-state mentality.

First, centralization in the legislature gave individual legislative leaders extraordinary power to determine whether health expansion appeared on the agenda and was seriously considered. For many years, the absence of leaders who chose to prioritize adult health coverage prevented the issue from even appearing on the radar, despite general support for expansion. Instead, legislative leaders such as Michael Busch chose to focus on children's coverage. After the long battle over employer mandates, Pete Hammen used his role as committee chair to force consideration of expansions funded in other ways. But he was thwarted by Senate President Mike Miller, who refused to bring the bill to the floor despite ample support among legislators. It was only when he stepped aside, placated by an unrelated compromise, that the bill finally passed and adult eligibility moved above the national average. This kind of individual power is rarely seen at the national level, and only exists in states where power is highly concentrated.

The second explanation of Maryland's Medicaid choices involves *interest group politics*. At the state level, interest groups outside of the business community need to demonstrate the electoral relevance of their priorities. Health advocates in Maryland, as discussed below, were highly successful at this type of grassroots politics, but initially directed all of their efforts toward children's coverage. This left little energy or resources to devote to parental coverage.

Once advocacy groups did begin to push expansion for adults, they made a fatal mistake: they proposed financing it with controversial taxes that triggered substantial employer opposition. From 2003 to 2007, the mainstream business community's opposition to employer mandates was virtually the only damaging argument against the legislation. These employers were able to prevent Medicaid expansion from even leaving committee, largely by convincingly arguing that the taxes threatened the business climate in the state. By choosing to significantly limit the bill to only the largest employers in 2005, legislators and health advocates were making a strategic accommodation – not a philosophical shift – made to mitigate business opposition (Advocate Interview MD2; Senate Finance Committee 2004).

Even in the debates over Fair Share, the anti-mandate business groups were able to narrow the reach of the bill. First, Johns Hopkins and Northrop Grumman (which, along with Giant and Wal-Mart, were the only two employers in the state large enough to fall under the bill) were able to negotiate the rather arbitrary terms of the legislation to make it less costly for themselves (Senate Finance Committee 2004, 2005). In addition, anti-mandate business groups were able to retain limits on the legislation, extracting promises from key legislators that the mandate would never be expanded beyond the very largest employers (Business Interview MD2). The business community had effectively squeezed the

Assembly into limiting their mandates – initially conceived as a way to make all employers contribute their fair share and substantially fund public health care for uninsured adults – to one company. This is power indeed.

But once the bill had been so substantially narrowed that it only targeted the largest employers, this threatened the unity the business community had previously displayed – and that studies of federal policymaking would suggest is essential to influence. The Wal-Mart bill invited the open support of a handful of business owners and created the impression of division in the business community. It is not necessary to know whether business support for Fair Share was widespread. The *appearance* of division weakened the anti-mandate message considerably, reducing its legitimacy and giving moderate pro-business advocates in the legislature the cover to support the bill. In fact, many have suggested that Giant Food's support was crucial to the final tally (Green and Nitkin 2005) (Government Interview MD6). In this way, the business community was able to affect policy choices in Maryland both by blocking earlier proposals and helping ensure the successful passage of the later proposal.

The third important variable in Maryland's Medicaid policymaking has been *party politics,* which also helps explain why expansion for adults was first passed in the form of the controversial and doomed Wal-Mart bill. By the early 2000s, there was broad consensus that adult eligibility was too low and a growing political will to rectify the situation. However, there was *not* broad agreement on the merit of employer taxes as the funding source, and even less agreement on the desirability of a Wal-Mart tax. In order to understand why enough legislators voted in favor of the Fair Share legislation not only to successfully pass the bill, but also to override a veto, it is important to understand the relationship between the Democratic Assembly and the Republican Governor, Bob Ehrlich. Ehrlich's administration had been characterized by unwillingness to compromise and staunch partisan

divisions. The result was what observers described as extremely hostile, partisan "Capital Hill politics" (Business Interview MD5). This environment unified the legislature against its common enemy, and also gave liberal Democrats disproportionate power in the legislature because of the desire to thwart Ehrlich's priorities. The General Assembly began to pass legislation it knew the governor would be forced to veto, such as the nation's first state living wage bill (Government Interview MD6). Ehrlich indicated early on that he would fight a Wal-Mart bill, which "solidified and impassioned" conservative Democrats in leadership positions who might not have otherwise supported such a bill, such as Senate President Mike Miller (Government Interview MD4). In the end, contentious inter-branch relations between the legislature and executive combined with the role of Giant to ensure the passage of Medicaid expansion in the form of the Wal-Mart Bill.

What was the role of state wealth in Maryland's Medicaid policy? A rich-state mentality means that budget concerns are only likely to derail expansion efforts if legislative leaders want them to. In 2007, Mike Miller initially used budget problems as justification for blocking passage of the expansion bill, but by all accounts his real motivation was his desire to hold the bill hostage in exchange for slot machines. Once he was satisfied, he allowed the bill through *during a special session to deal with the budget crisis*. It passed easily. The primary role of the rich-state mentality in Maryland, then, was to create a sense of guilt about low coverage, which built over time and eventually led to action once leaders made it a priority.

South Carolina

South Carolina covers parents at 50 percent of the poverty level through the Low-Income Families (LIF) program. This level represents the eligibility level under AFDC as of 1996, which makes it the minimum level the state could legally use, and was automatically set once welfare reforms were implemented (Advocate Interview SC2). It wasn't until the early

2000s that South Carolina leaders began to take Medicaid expansion for adults seriously. This was not long after Maryland leaders did so, but the process was very different. In Maryland, health advocates and legislative leaders began to think about ways they could expand coverage for adults. In South Carolina, legislative leaders found themselves with a potential funding source, a cigarette tax increase, and decided that Medicaid should be on a short list of programs to benefit from added revenue. Although expanding Medicaid has fairly broad support, if the cigarette tax increase doesn't pass, or if it isn't tied to Medicaid, there will almost certainly be no new activity to expand the program to more adults. In other words, the cigarette tax battle *is* the Medicaid battle in South Carolina, and it is impossible to explain one without the other.

This does not indicate a lack of genuine support for Medicaid expansions. Instead, it reflects political and strategic problems with pursuing other funding sources. The poor state mentality makes the state highly reluctant to enact new general fund spending, even when budgets are flush. Second, unlike in Maryland, there has been a genuine lack of leadership to push the idea of Medicaid expansion on its own. South Carolina funded children's coverage expansions in the late 1980s without a cigarette tax increase, but relied heavily on the leadership efforts of two officials who prioritized the issue. Finally, like the employer tax in Maryland, the cigarette tax was a strategic choice that seemed obvious to legislative leaders. It remains an untapped source of funding that could potentially solve part of the health care problem without negatively affecting budgets. Also like Maryland, this strategic choice has come with its own set of baggage that has shaped the policy debate more than the health policies themselves – and largely become the primary barrier to expansion.

There are a number of reasons that a cigarette tax increase has gained a supportive audience in an agricultural, conservative state such as South Carolina. First, at 7 cents a

pack, it is currently the lowest in the nation. As neighboring states like North Carolina and Virginia have raised their taxes, South Carolina's tax has become an increasing source of embarrassment for many government leaders. The public is broadly supportive of an increase (a January 2006 poll found that 71 percent of likely voters in South Carolina would support a cigarette tax increase used to fund health care or smoking cessation programs (Davenport 2006)). In addition, the tobacco lobby has weakened considerably. Where heavy-hitters such as Philip Morris and RJ Reynolds once contributed substantial campaign funds and had close relationships with legislative leaders (particularly long-time House Speaker Wilkins), by the 1990s the industry had diminished substantially, and ethics legislation prevented the type of financial support it had been providing (Government Interviews SC1 and SC3).

The first effort occurred in 2002, and the funds brought in by a tax increase would almost certainly have gone directly into the Medicaid fund (although likely for payment increases for health care providers rather than eligibility expansions (Government Interview SC3). By most accounts there were enough Democratic votes to pass a bill (Government Interview SC3), but it was unsuccessful. Responsibility for defeat of the bill belongs squarely on the shoulders of Governor Jim Hodges, who was terrified of passing a tax increase in an election year (Hammond 2002; Frieden and Sheinin 2002, Government Interview SC3). Hodges not only convinced Democratic legislators to vote against the bill, but also to vote in favor of a procedural change that would designate a cigarette tax increase as a general tax increase – a debatable definition at best, and one with significant consequences. According to South Carolina law, general tax increases must be initiated in the House (the body more staunchly opposed to tax increases in principle) (Advocate Interview SC3, Business

Interview SC2). The anti-tax mentality – and, more importantly, the *fear* of the anti-tax mentality among more conservative voters in the state – doomed the bill.

In 2006, the issue surfaced again, this time more directly linked to Medicaid expansion for adults. Representative Paul Agnew, a neophyte Democratic House member, became the lead sponsor of a bill that would have used revenues from a cigarette tax increase to fund an increase in Medicaid eligibility, in addition to an option for small businesses to buy into the program. This was modeled on a similar plan in Oklahoma, and largely devised by three groups: the Appleseed Legal Justice Center (among the few prominent progressive organizations in the state, with a highly effective lobbyist), South Carolina Fair Share, and the Small Business Chamber of Commerce (Advocate Interviews SC2 and SC3; Business Interview SC1; Government Interview SC1). It was again an election year, and many legislators, particularly those that had signed anti-tax pledges, balked at the prospect of voting in favor of any kind of tax increase (Business Interviews SC2 and SC4; Government Interview SC1). The subcommittee voted favorably on the bill, but the leadership "didn't bless it" because of tax concerns, and the full committee voted it down (Government Interview SC1). Again, the anti-tax mentality in the state had its way.

In 2007 it was back, this time proposed and heavily promoted by committee member Rex Rice, a Republican who had lost his chairmanship because of his 2002 support of a cigarette tax increase (Government Interview SC5). Rice attached the increase to a Medicaid expansion for parents (from 50 percent of FPL to 100 percent). It successfully came out of subcommittee, but Speaker Bobby Harrell, who wanted desperately to make the proposal revenue neutral, removed the Medicaid provision and attached a grocery tax cut instead. It was one of very few times that Harrell has openly and actively involved himself in a popular bill, and he successfully "twisted some arms" to make the switch (Advocate Interview SC2;

Government Interview SC5). The legislative session ended before action could be taken, and it was tabled until the following year.

Over the last seven months, momentum for a cigarette tax increase has continued to build, and many consider this year the best chance for success. The House bill that passed in 2007 is now in Senate committee (minus the grocery tax cut, which was enacted separately at the end of the 2007 session). An "overwhelming majority" of Senators, perhaps two-thirds, are likely to vote for an increase, contingent on how the money would be spent (Government Interview SC8). There is little consensus on this, aside from a general belief among supporters in both Houses that it should be tied to health care (Government Interviews SC4 and SC6). There are a number of options percolating in the Senate committee, most of which mirror those proposed by a group of business and health industry leaders called the Covering Carolina Collaborative.

The Collaborative, which has been watched closely by most political actors since it began its deliberations, includes major corporate players in the state: the South Carolina Hospital Association, the South Carolina Medical Association, the South Carolina Alliance of Health Plans (represented largely by Blue Cross), and the South Carolina Chamber of Commerce. The Chamber's presence has been particularly important. In particular, the Chamber has long advocated for a cigarette tax increase, having joined the now-defunct tobacco coalition, funded by the Hospital Association, several years ago. Earlier this year, the Collaborative released a four point proposal for health reform in the state, two of which have been seriously considered by the legislature: a straightforward expansion of the LIF program to 100 percent of FPL, or a tax credit for small businesses and individuals earning below 250 percent of poverty (http://www.coveringcarolinacollaborative.com/proposal). (The hope is to run the latter option through the state Medicaid program, allowing the state

to claim federal matching funds. It is not clear whether this is possible (Government Interview SC7).) The tax credit option has broad support, particularly in the business community. In November of 2007, over 70 percent of state NFIB members reported in a member ballot that they would support the General Assembly passing "a law providing a state income-tax credit for small businesses that purchase health insurance while increasing the state cigarette excise tax."[8] The business community, which is generally supportive of a tobacco tax increase, is "cohesive around the tax credit plan," with less support for Medicaid expansion (Government Interview SC8).

In early April, the Senate committee voted favorably on a 43 cent increase (bringing the tax up to 50 cents, still well below the national average of $1.02), tied exclusively to Medicaid expansion. The justification – highly pragmatic, given that three members on the subcommittee are Republican – is that options that use the Medicaid program are thought to give the most "bang for our buck" (Government Interview SC8). Although the outlook is admittedly good, Governor Sanford has threatened to veto the measure, and whether the legislature could muster enough votes to override him is an open question (Government Interviews SC3, SC6, and SC7).

South Carolina has many incentives for expanding its Medicaid eligibility for adults, which remains well below the national average. It even has an obvious funding source that is highly popular among state residents and has been seriously considered for the last six years. What, then, have been the barriers to expansion? And why might they finally be overcome this year? There seem to be four key factors: centralization of leadership in the state, party politics (including conservative electoral politics and inter-branch hostility), interest group politics, and the poor state mentality.

[8] Results provided by current state NFIB director, Gary Selvy.

Given the close connection between Medicaid expansion and the cigarette tax, one thing clearly serves as the primary hurdle to expansion: the anti-tax mentality in the state. It has derailed most of the serious efforts to increase the tax, and may continue to serve as an insurmountable hurdle in the current session. However, the problem is not the mentality itself, but two institutional and political features of South Carolina policymaking that allow this mentality to have decisive influence. First, centralization in the legislature allows the Speaker of the House to dominate legislative proceedings. In fact, several interviewees – including a former governor and Senate president – have identified the Speaker as the single most influential person in the state (Government Interviews SC3 and SC4). Long-time Speaker Wilkins was a formidable character who was closely aligned with the tobacco industry and unwilling to bend on the issue of cigarette taxes (Government Interview SC1). He used his power to strip Representative Rice of his subcommittee chairmanship when Rice sponsored a bill to increase the tax. Although the new Speaker, Bobby Harrell, is not as uncompromising on the issue, he nevertheless used his power to singlehandedly remove the health care component of the legislation and ensure that it was revenue neutral.

Second, conservative *electoral politics* have led many legislators to sign anti-tax pledges. For Democrats, it is general elections that concern them, since being painted as a leader who increased taxes can be a death knell (Government Interview SC3). Governor Hodges was able to capitalize on this fear when he convinced Democrats to vote against passage in 2002. For Republicans, it is primary challenges that shape their tax-related legislative decisions. Conservative Republicans who commit to revenue neutrality are promised substantial campaign resources from groups such as Club for Growth and Americans for Tax Reform (Advocate Interview SC3; Business Interview SC2). Therefore, while ideological opposition to public program expansion is often at the root of national level policy debates, at the state

level it seems to be a more specific anti-tax mentality. The funding mechanism dooms expansions, not the principle of the expansions themselves.

But the nature of current *inter-branch relations* in the state actually seems to be reshaping the politics of the anti-tax movement in a way that could help the cause in the 2008 session. The South Carolina legislature is extremely hostile toward the Governor, despite both being Republican. This hostility is largely attributed to his unwillingness to compromise with legislative leaders (Business Interview SC; Government Interviews SC3 and SC4). His intransigence has been taken to its farthest extreme with taxes: he is a close ally of the Club for Growth, and refuses to sign any measure that isn't revenue neutral. That the anti-tax mentality has become associated with the legislature's biggest enemy has increased its willingness to pass popular tax increases that he would be forced to veto.

What about *interest group politics* in South Carolina? Two segments of the business community have gotten involved in Medicaid expansion for adults. The South Carolina Chamber of Commerce, through their involvement in the tobacco tax coalition and, even more crucially, the Covering Carolinas Collaborative, has been visibly supportive of Medicaid expansion (Dykes 2006). A number of key legislators have indicated the importance of this support to any efforts currently under consideration (Government Interview SC8). In addition, the Small Business Chamber of Commerce – a relatively new group completely unaffiliated with the state Chamber and largely made up of trade associations – has been actively involved in promoting Medicaid expansion, including a small business buy-in to the program (Werner 2006).

To date, the involvement of these groups has not been able to overcome the anti-tax hurdles. However, their support has the potential to be crucial to any 2008 votes on the cigarette tax and health care. It is important to note that both of these groups are thought to

be particularly influential with Democrats. Although the state Chamber has historically been closely allied with the Republican party, in recent years there has been a substantial rift between them, largely precipitated by controversial property tax legislation in 2006 (Business Interviews SC3 and SC5; Government Interview SC5). The Small Business Chamber of Commerce is dominated by the Trial Lawyers Association, and even though it is largely written off by other business groups and conservative legislators, Democrats often look to the group (and particularly the media-savvy leader, Frank Knapp) for business credibility (Business Interviews SC2 and SC3; Government Interview SC3). (Ironically, these two groups have a highly contentious relationship.) The business community appears to be somewhat divided on the issue of Medicaid expansion, with most groups lukewarm on the cigarette tax increase itself and generally unsupportive of new unfunded mandates such as Medicaid expansion. The pro-expansion groups, the state Chamber and the Small Business Chamber, will likely have a positive influence by demonstrating how Medicaid expansion could benefit businesses in the state and make South Carolina – a state struggling to keep up with the new economy – more competitive in the region.

The state's *wealth mentality* has also been instrumental in shaping decisions about Medicaid expansion. This has affected South Carolina policymaking more than in Maryland, since a poor-state mentality can serve as a substantial constraint on government programs. In South Carolina, this has been true even though there is an external funding source. The legislature's greatest fear is of enacting unfunded mandates that cannot be sustained. In the case of a cigarette tax, this fear is quite reasonable, since the revenue stream is likely to decrease over time as fewer people smoke. This mentality must be overcome by powerful leaders, interest group politics, and changing partisan politics, all three of which seem to be occurring today.

Children's Health Coverage (Medicaid and SCHIP)

Devolution of children's health coverage to the states began in the late 1980s, when the federal government instituted a series of policy changes that opened Medicaid to more children and pregnant women and gave states greater flexibility in determining who would be eligible. This was the first time that states had to make independent choices about who to cover under the public program, and partially at their own expense. As a result, only some states chose to expand health eligibility for children beyond the federally mandated minimum requirements.

The more substantial federal change came with the enactment of the State Children's Health Insurance Program (SCHIP), a program similar to Medicaid but targeted at children in families with higher earnings. States had the ability to design their own programs, administered through Medicaid or as separate children's programs. The recommended eligibility threshold was 200 percent of the federal poverty level, but in 2006, 15 states had thresholds higher than 200 percent, while 10 states were below 200 percent. The average threshold was 226 percent, ranging from 140 percent (in North Dakota) to 400 percent (in Massachusetts).

Children's health coverage has diverged substantially in Maryland and South Carolina. Maryland has kept children's coverage almost permanently on the political radar, actively debating proposals to expand coverage even during times of budgetary strain, and even after its eligibility levels (at 300 percent of poverty) were among the highest in the country. South Carolina, on the other hand, initially chose to cover children at the lowest possible level. However, it has increased coverage twice in the years since, and as of late spring 2008 will cover children at the recommended 200 percent threshold.

Maryland

In 1987, Maryland quickly took advantage of the new state flexibility, passing legislation to allow pregnant women and small children below 100 percent of the federal poverty level to have coverage under the state's Medical Assistance Program.[9] After several unsuccessful attempts in 1989, eligibility was increased again in 1992, when the state created the Maryland Kids Count program. This program matched the maximum levels allowable under federal Medicaid law at the time. The timing of this expansion is noteworthy – it occurred during a time of substantial budget deficits in the state, when other social programs (including Medicaid coverage for adults) were on the chopping block (Lippincott and Thomas 1993, 132-3). Serious attempts to expand eligibility further were made in 1997 and 1998, and even though they were successfully passed in both houses of the legislature, differences between the bills could not be reconciled and they died without further action.

In 1998, the Maryland General Assembly enacted the state's CHIP program, which covered all children up to 200 percent of the poverty level. The bill passed 109 to 25 in the House, and unanimously in the Senate. At the time, Maryland was one of 22 states to cover children at 200 percent of poverty or higher. In 2000, the assembly made the defining move, extending the program (now called the Maryland Children's Health Program (MCHP)) to children up to 300 percent of the poverty level. The legislation stipulated that all families above 200 percent of the poverty line would pay modest premiums. The inclusion of premiums was critical for the support of fiscal conservatives, who opposed an entitlement program that they saw as excessively generous. However, in general there was little opposition to the bill from interest groups or constituents (Bill Files for SB201 and HB2).

[9] State laws generally include pregnant women alongside children and infants, rather than with adults.

Despite the fact that at 300 percent of the poverty level Maryland's eligibility thresholds were already among the highest in the country, the legislature has continued to consider further expansions. In every year from 2003 to 2006, the Health Care for All! coalition proposed comprehensive coverage bills that would extend the MCHP program to all children, though those above 350 or 400 percent of poverty (depending on the bill) would buy into the program at actuarily fair premium levels. This fit the trends occurring in other states, such as Illinois with its AllKids program, that were trying to enact universal coverage for children. The Health Care for All! bills were complex and included multiple parts; the MCHP proposals were neither the most controversial nor the highest priority for proponents (both of these honors would go to expansion of adult coverage).

The last serious actions taken on MCHP were two 2007 bills that would have expanded the program's reach to all children. Both bills were taken quite seriously. One of these (HB132) included only children's coverage; it passed in the Senate 42 to 4, but died in the House. The other (SB149) was part of a more comprehensive bill that aimed to expand coverage for everyone, including adults – and, like earlier similar bills, children's coverage was not the highest priority. This bill, discussed above, passed in the House but was blocked in the Senate for reasons unrelated to children's coverage. (The final version of the bill, passed in November 2007, included only expansion for adults.) Eligibility thus remains at 300 percent of the poverty level, with cost sharing for all families with incomes above 200 percent of poverty. Today, Maryland is one of ten states to cover children at three times the poverty level or higher.

Why did Maryland successfully expand children's health coverage to such a high level, when not all states were as successful, and when adult health coverage languished at what many considered to be an embarrassingly low level? The reasons seem to be rooted in

party politics, centralized power in the legislature, interest group politics, and the rich-state mentality.

Maryland's *party politics* are characterized by relatively moderate Republicans. Although South Carolina Republicans are largely supportive of health coverage for the poor and near poor, they begin to have reservations about covering middle-class families. In Maryland, opposition to the expansion to 300 percent of poverty was not so substantial that it couldn't be mitigated by the inclusion of co-payments. Serious philosophical opposition did not appear, even from fiscal conservatives, until there were discussions about expanding the program above 300 percent of poverty.

Second, *centralization of power in the legislature* allowed one strong leader to keep children's health coverage high on the agenda: Michael Busch. As chair of the House Economic Matters Committee during the 1998 creation and 2000 expansion of MCHP, Busch continually pushed the program. Committee chairs in particular have disproportionate influence in the Maryland legislature, using their gatekeeping powers to determine the legislative agenda (Lippincott and Thomas 1993, 136). Busch used this role to ensure that expansion bills got fair hearings and were generally reported favorably out of committee (Advocate Interview MD3). In 2003, as Speaker of the House, Busch created a new institutional home for health policy, the House Health and Government Operations Committee. This further streamlined the health policymaking process, making it easier for bills to pass (Government Interview MD7). Despite widespread support for generous children's coverage, Busch's advocacy was necessary to keep it high on the agenda.

Third, *interest group politics* helped children's health coverage expansions succeed. In particular, one health advocacy group was able to overcome its influence deficit (relative to business groups) and make the issue about constituents. As one of the most politically savvy

and well-respected advocacy groups in the state, MCHI devoted the vast majority of its resources to children's health (Government Interview MD5). One of its greatest strengths was visibility: the group could always bring large grassroots coalitions to Annapolis to loudly demand consideration of bills (Government Interview MD7). According to one high-level official, on any day that a children's health issue is on the docket, "the streets are filled" (Government Interview MD5). This is important because interview subjects repeatedly indicated that they are influenced by the presence of constituents (Government Interview MD9). Politicians, as vote maximizers, feel that an issue must be important if the room is filled. Alongside Michael Busch's leadership, these activities helped keep children's coverage high on the agenda.

What about business groups? In a state where most lawmakers want high eligibility levels, the business community does not have to get involved. However, employers did not oppose expansions, despite a record of opposing other costly government programs (Government Interview MD2). In addition, the lack of explicit tax increases kept employers from protesting the expansions. By staying out of the debate and choosing not to protest a ballooning government program, they eliminated a formidable source of opposition and enabled bill passage.

Finally, the *rich-state mentality* has helped justify expansions even when there were budget deficits. Lawmakers feel a strong responsibility to take care of needy residents, partly because they identify their state as wealthy and thus capable. In the absence of other barriers, this mentality is likely to keep momentum high.

South Carolina

When South Carolina enacted its CHIP program (called Partners for Healthy Children, and administered through Medicaid) in 1997, eligibility for children ages 1 to 18

was set at 150 percent of the poverty level; infants and pregnant women would continue to be covered up to 185 percent. At first glance, it appears to be a typical story of a means-tested entitlement program in a poor, conservative, southern state, in which government leaders have no incentive to grant access to anyone but the neediest residents.

But there are two reasons why this initial assessment would be wrong. First, the state has a surprising tradition of generous children's coverage. In 1986, South Carolina was among the first states to expand Medicaid coverage for children beyond federal minimums. In fact, South Carolina leaders were largely responsible for pushing the federal government to allow states to increase their eligibility levels in the first place. By all accounts, this was almost exclusively the work of Governor Dick Riley (who later became Secretary of Education under President Clinton) and his Secretary of Health and Human Services, Sarah Shuptrine (Advocate Interview SC1; Government Interview SC2). While Shuptrine pounded the pavement both in Columbia and on Capital Hill, Governor Riley made skillful use of the state's limited gubernatorial powers, creating executive bodies over the legislature that would push his long-term policy priorities (Herbers 1986). As of 1996, the state covered all but the oldest children at maximum allowable levels. This history suggests that it would be wrong to assume South Carolina is somehow inherently unable or unwilling to provide generous health coverage to its poor residents.

Second, there is broad consensus in the state that children's health coverage has been too low. Even Republicans have generally supported expansion, at least up to 200 percent of poverty (Government Interview SC8). In fact, the legislature *did* expand the program to 165 percent of poverty in 2000, despite an impending budget crunch. (The budgetary problems did force the Medicaid agency to roll back eligibility almost immediately after passage.)

But perhaps the best indication that South Carolina legislators are largely supportive of higher eligibility levels for children is the experience of 2007. Democratic leaders, including minority leader Harry Ott and long-time Ways and Means heavyweight Gilda Cobb Hunter, decided that this was the year to push for expansion (Advocate Interview SC2; Government Interview SC5). They were aided by Health, Human Services, and Medicaid subcommittee chair Tracy Edge, a conservative Republican who had promised Ott that he would expand the program "when he could." With the budget suddenly flush in 2007, Democratic leaders leaned on him to make good on his word, and Ott personally negotiated with pockets of opposition on the Ways and Means committee to ensure their support (Government Interview SC7).

South Carolina is a state where most legislative changes occur through the budget process (there are fewer stand-alone bills than in other states) (Government Interview SC3), and CHIP expansion was no exception. When the final budget submitted at the end of the session included funding for children up to 200 percent of poverty, there was little opposition in either the House or the Senate (Government Interviews SC5 and SC8). Governor Sanford exercised his line item veto authority to jettison the CHIP budget proviso, but was overridden in an almost unanimous vote. In 2008, long after the fleeting budget surpluses of the previous year had disappeared, Governor Sanford proposed eliminating the new CHIP expansion (which had not yet been implemented by the Department of Health and Human Services). Both houses of the legislature "laughed at him" (Advocate Interview SC3).

If support for SCHIP eligibility expansion was so widespread, as the recent experience would indicate, why did it stagnate for so long? What barriers prevented

expansion, and how were they overcome in 2007? There are three reasons: the poor state mentality, institutional centralization, and party politics (particularly inter-branch relations).

First, the *poor-state mentality* in South Carolina prevented expansion for many years. Legislators have had the political will, but not the means – and the state has proven reluctant even when the money *was* there. Legislative leaders are terrified of program expansions that cannot be funded in future years – and they expect that future years will be lean regardless of the present situation (Government Interviews SC3 and SC8). The state also worries that it cannot possibly help all of its poor residents, since there are so many. Because of this poor-state mentality, budget surpluses need to be combined with strong leadership efforts that put SCHIP coverage high on the agenda. This is precisely what occurred in 2007: the money was there (Advocate Interview SC3; Government Interview SC7), and the Democratic leadership hounded powerful committee chairs to push the bill to the floor for a vote.

But how was the Democratic leadership able to steer anything through the legislature, given its minority status? The main explanation seems to involve *party politics*. The hostility between Governor Sanford and the Republican legislature discussed above has unified the legislature, which must behave in a bipartisan fashion if it is to override Sanford's many vetoes. In order to retain support from Democrats on the issues they prioritize, Republican leaders have been forced to accommodate Democrats on particular issues (Government Interview SC3). It appears that part of the reason that the leadership allowed SCHIP to move forward was that the two most notable Democratic leaders, Harry Ott and Gilda Cobb Hunter, demanded it. (And since Democrats are currently more united than Republicans (Government Interview SC4), they are likely to stand together behind their legislative priorities.) Once it was on the floor for a vote, latent support for children's health care expansion made the result a foregone conclusion (Advocate Interview SC3).

Third, South Carolina also boasts a *highly centralized legislature,* where a handful of leaders are capable of blocking or aiding particular bills. But unlike in Maryland, the legislative leaders have not prioritized expansion. Republicans, who hold the key leadership positions, are generally reluctant leaders on the issue. A Republican House member confided that most Republicans are supportive of SCHIP, but they don't want to be "caught out in front" supporting a government program (Government Interview SC5). In most years, Democratic leaders do not have sufficient agenda control to play this leadership role.

Interest group politics does not seem to play a substantial role in children's coverage in South Carolina. This is partly because, unlike in Maryland, South Carolina does not have a strong health advocacy group that can harness voter opinion. Children's advocacy groups are generally quite weak, and even though they occasionally beat the drum for expanded eligibility, they have not had the platform, the resources, or the political savvy to be heard (Advocacy Interviews SC 1 and SC2). The business community has been largely indifferent to SCHIP expansion. Many business leaders do not see the relevance of the program to their own bottom lines (Advocate Interview SC2; Business Interviews SC3 and SC4). The main exception seems to be the Small Business Chamber of Commerce, which stood alongside progressive advocacy groups in openly advocating for expansion (Advocate Interview SC2; Business Interview SC1). Their support was based largely on the fact that an expansion would help working families, many of whom are employed by small businesses (Business Interview SC1). But there is little indication that even Democratic legislators were swayed by this activity, either in terms of keeping the issue on the agenda or enabling the bill's passage. Party politics, centralization of power, and the poor-state mentality are much more likely explanatory variables for the trajectory of children's health coverage in the state.

Conclusion

The current model of welfare state policymaking, which uses means-tested versus universality as the key dividing line that shapes our expectations, is largely a product of choices made by scholars.[10] For many years, the emphasis was overwhelmingly on national-level policymaking, and this is still the case in studies of health policy. State-level analyses are largely quantitative, using spending as the key variable of interest. In addition, state welfare policy almost always means cash assistance. This paper asserts that these gaps in the scholarly work have led us to misunderstand contemporary social policymaking, which increasingly occurs at the state level, increasingly focuses on policies that have the potential to support work (rather than replace it), and increasingly involves decisions more complex than spending.

Maryland and South Carolina represent extremely different cases. Maryland, the wealthy, heavily Democratic state, has continually expanded children's coverage, and despite having eligibility levels among the highest in the nation, considers expansion even today. Yet its adult coverage has been well below the national average, and it took ten years after welfare reform for the state to use its new flexibility to increase eligibility levels in Medicaid. South Carolina, a relatively poor, extremely conservative state, has covered both children and adults at the lowest possible levels for most of its recent history. However, in the last year we have seen activity in both areas, including successful expansion of children's coverage in 2007 that was extremely popular among members of both parties.

Despite these differences in state characteristics and policy choices, there are clear patterns in terms of what shapes their health policy decisions – and these patterns are not necessarily based on the factors we would expect. Whether states expand eligibility is not about general political will, since most political actors in the system have agreed that

[10] See Howard (1999) for a discussion of the potential flaws in this model.

eligibility levels should be raised beyond what they were when flexibility was first granted. It is not about ideology, at least in the sense that Republicans are expected to oppose expansion of public health programs. In both states, Republicans generally do not oppose at least modest expansions. It is also not just about budgets, since both states have demonstrated the willingness to expand programs in times of budget deficits and *not* expand programs in times of budget surpluses, even when the will to do so was present. Rather, there are four political and institutional explanations that seem to have determined whether these states were able to expand public health programs.

In order for the general political will to be translated to successful legislation, the issue must be a high enough priority to appear on the agenda, and on this there is not consensus. The first consideration that will determine whether this happens is *wealth mentality*. A state's expectations about its future wealth largely determine whether budgets will be substantial constraints. South Carolina's poor-state mentality makes it reluctant to enact new spending measures because of its fear of unfunded mandates. Maryland's rich-state mentality, on the other hand, means budgets are less constraining. A prime example of this is the passage of substantial expansions in adult health coverage through Medicaid, which occurred during a special 2007 session called to deal with the budget crisis.

A second factor that helps determine whether expansions will be on the agenda is *centralization of leadership*. Leaders must prioritize the issue in order for it to gain serious consideration ahead of other desirable policy items. This kind of leadership can also be a barrier to expansion, as powerful individual leaders can serve as veto points, thwarting the will of the majority. In Maryland and South Carolina, two highly centralized legislatures, the House Speakers, Senate Presidents, and chairs of the most important committees have the power to fill this role. They have exercised their power by either putting the full force of

their influence behind public health expansions (e.g., creating institutional pathways to facilitate passage or negotiating terms with other leaders to clear the way) or *blocking* expansions (e.g., by refusing to send a bill to the floor for a vote or twisting arms).

A less common political feature that can help determine whether a policy appears on the agenda is *hostile inter-branch relations*. In states where the relationship between the governor and the legislature is antagonistic, policies are likely to follow a unique political logic that does not resemble normal partisan politics. The first effect is a more unified legislature that works together as a common enemy of the governor. This unification can give the minority party unusual influence, as it has done in South Carolina, where Democratic leaders ensured that children's health expansion would appear on the agenda in 2007. The second effect is an ideological shift in the legislature, whereby more extreme policies are passed and defiantly handed to the governor. This was seen in Maryland, where a moderately Democratic legislature began to enact extremely liberal legislation, including the infamous Wal-Mart bill. (Interestingly, this decision had a negative effect on Medicaid for adults, as the policy was so far outside of the mainstream that it did not survive court scrutiny.) We may observe both increased Democratic influence and an ideological shift to the left in South Carolina's current battle over the cigarette tax.

Once eligibility expansion is on the agenda, the outcome depends largely on how it is funded (and which opposing forces will be triggered by the source). Perhaps the best indicator that the funding source will be the sticking point, rather than the principle of public program expansions, is that expansions financed with general funds have seen little opposition in either state (for example, children's health expansion in South Carolina and adult expansion in Maryland, both in 2007). In South Carolina, the cigarette tax has been the sole funding opportunity for expanding access to Medicaid for parents. This tax has

triggered the opposition of key legislative leaders, which have been able to singlehandedly block bills. In addition, conservative electoral politics in the state have limited the willingness of many Republican legislators to enact a tax increase. However, it seems that other factors are likely to overcome this anti-tax mentality in the current session.

The final source of opposition, triggered by the funding source, is employers. Although business owners are likely to benefit indirectly from public program expansions, these benefits can be negated if the funding mechanism imposes costs on employers. Interestingly, many recent state reforms have attempted to finance health expansions in exactly this way. Even in states that have historically been seen as anti-business, such as Maryland, unified opposition from the business community can thwart expansions – or at least force bill designers to shift their strategies. The best example of this is Medicaid expansion for adults, where employers successfully blocked proposals for several years, and pushed proponents into a corner where they felt that their only option was the Wal-Mart bill.

The other important role of employers is positive. Individual employers, by actively supporting public program expansions, can create the impression of disunity in the business community. This can legitimize the funding source and give moderate policymakers the cover to vote in favor of something other parts of the business community would oppose. This occurred in Maryland (with Giant and the Wal-Mart bill), and may be occurring now in South Carolina (with the Chamber of Commerce and the cigarette tax increase tied to Medicaid expansion). This role is unlikely to be seen at the national level, where the business community on the whole is unable to unite in favor of positive change, and individual business leaders do not have the clout or institutional access to affect choices.

Contrary to what many believe about means-tested antipoverty policies, state authority will not necessarily lead to a downward spiral. With public health programs, states

actually have substantial incentives to expand eligibility. The puzzle, then, is why some states *successfully* enact expansions and others don't. What political and institutional barriers prevent expansions from passing, and how are those overcome? The explanation, it seems, cannot be found by extrapolating from national to state politics. State policymaking follows its own political logic that has substantial implications for millions of working adults and their families.

Works Cited

"Bad Medicine: Balancing Maryland's Budget by Cutting Medicaid."2005. Maryland Budget and Tax Policy Institute.

Beland, Daniel. 2004. "Fighting 'Big Government': Frames, Federalism, and Social Policy Reform in the United States." *Canadian Journal of Sociology* 29 (2).

Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. 1998. "Measuring Citizen and Government Ideology in the American States, 1960-93." *American Journal of Political Science* 42 (1):327-48.

Blumberg, Linda J., Lisa Dubay, and Stephen A. Norton. 2000. "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP." *Journal of Health Economics* 19:33-60.

Burton, Wayne N., Daniel J. Conti, Chin-Yu Chen, Alyssa B. Schultz, and Dee W. Edington. 1999. "The Role of Health Risk Factors and Disease on Work Productivity." *The Journal of Occupational and Environmental Medicine* 41 (10):863-77.

Cook, Fay Lomax, and Edith J. Barrett. 1992. *Support for the American Welfare State: The Views of Congress and the Public*. New York, NY: Columbia University Press.

Davenport, Jim. 2006. "Supporters Rally Around New Push for Cigarette Tax Increase." *Myrtle Beach Sun News/Associated Press*, February 10.

DuPlessis, Jim. 2002. "Ban on Minimum Wage Hikes has Widespread Support." *The State*, June 9, F3.

Dykes, David. 2006. "Chamber Puts Workers' Comp on its To-Do List." *The Greenville News*, September 21, 9A.

Frieden, Jaymi, and Aaron Sheinin. 2002. "New Front Opens in Medicaid Battle." *The State*, April 27, B1.

Gormley, William T., Jr. 1986. "Regulatory Issue Networks in a Federal System." *Polity* 18 (4):595-620.

Green, Andrew A., and David Nitkin. 2005. "Union Uses State in Wal-Mart Fight." *The Baltimore Sun*, April 15, 1A.

Grogan, Colleen, and Eric M. Patashnik. 2003. "Universalism within Targeting: Nursing Home Care, the Middle Class, and the Politics of the Medicaid Program." *Social Service Review* March

Hammond, James T. 2002. "Smith Backs Cigarette Tax Hike to Fund Medicaid." *The Greenville News*, March 11, 1A.

Hasenfeld, Yeheskel, and Jane A. Rafferty. 1989. "The Determinants of Public Attitudes Toward the Welfare State." *Social Forces* 67 (4):1027-48.

Herbers, John. 1986. "South Carolina Extends Health Care for Its Poor." *The New York Times*, March 31, A15.

Howard, Christopher. 1999. "The American Welfare State, or States?" *Political Research Quarterly* 52 (2):421-42.

"The Key Issues." 2003. *The Post and Courier*, January 12, 9A.

Lippincott, Ronald C., and Larry W. Thomas. 1993. "Maryland: The Struggle for Power in The Midst of Change, Complexity, and Institutional Constraints." In *Interest Group Politics in the Northeastern States*, ed. R. J. Hrebenar and C. S. Thomas. University Park, PA: The Pennsylvania State University Press.

Marquis, Susan M. 2005. "The Role of the Safety Net in Employer Health Benefit Decisions." *Medical Care Research and Review* 62 (4):435-57.

Mattera, Philip, and Anna Purinton. 2004. "Shopping for Subsidies: How Wal-Mart Uses Taxpayer Money to Finance its Never-Ending Growth." Good Jobs First.
Mehren, Elizabeth. 2006. "State Make Own Plans for Health Insurance." *LA Times*, June 25.
Monardi, F, and S A Glantz. 1998. "Are Tobacco Industry Campaign Contributions Influencing State Legislative Behavior." *American Journal of Public Health* 88 (6):918-23.
Oliver, Thomas R. 1998. "The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland." *The Milbank Quarterly* 76 (1):59-101.
Ross, Donna Cohen, Aleya Horn, and Caryn Marks. 2008. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.
Scher, Barry F. 2004. "Letter to Senator Thomas Middleton." Annapolis, MD: Department of Legislative Services, Bill file for HB1284.
Smitherman, Laura. 2007a. "Health Care Bill Passes in House." *The Baltimore Sun*, March 17.
———. 2007b. "Health Care Viewed as Key Issue in 2008." *The Baltimore Sun*, April 16.
Sparer, Michael S. 1996. *Medicaid and the Limits of State Health Reform*. Philadelphia, PA: Temple University Press.
"Special Report: Children Losing Health Coverage."2002. Washington, DC: Families USA.
"The State Children's Health Insurance Program."2007. The U.S. Congress: Congressional Budget Office.
Talhelm, Jennifer. 2004. "As Many Struggle, Employment Becomes Key Issue in Senate Election." *The State*, August 8, A1.
Wagner, John. 2005. "Wal-Mart Girds for Battle on Md Bill." *The Washington Post*, November 17.
———. 2007. "O'Malley Increases Influence With Wins on Taxes and Slots." *The Washington Post*, November 20, A1.
Weaver, R. Kent, Robert Y. Shapiro, and Lawrence R. Jacobs. 1995. "Public Opinion on Welfare Reform: A Mandate for What?" In *Looking Before We Leap: Social Science and Welfare Reform*, ed. R. K. Weaver and W. T. Dickens. Washington, D.C.: Brookings Institution Press.
Werner, Ben. 2006. "S.C. Health Insurance Costs on Rise." *The State*, September 11, H6.
Wolfe, Alan. 1998. *One Nation, After All: What Middle-Class Americans Really Think About: God, Country, Family, Racism, Welfare, Immigration, Homosexuality, Work, the Right, the Left, and Each Other*. New York, NY: Viking Penguin Press.
Worcester, Roc. 2005. "Email to Senator Thomas Middleton." Annapolis, MD: Department of Legislative Services, Bill file for SB790.