

“Rights without Access”: The Political Context of Inequality in Health Care Coverage in the U.S. States

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Abstract

The question of how the American political process shapes inequality remains unsettled. While recent studies break ground by linking inequality to political institutions, much of this work focuses on national-level income inequality. The literature is lacking in its examination of inequality in other issue areas at the subnational level. This research explores how partisanship in government affects subnational-level inequality in health care coverage in the context of racial diversity. Using a new Gini-coefficient measure of inequality in health insurance coverage, we find a negative relationship between the seat share of Democratic representatives and inequality in health care coverage but only in states with racially diverse populations. Moreover, Democratic-controlled state legislatures mitigate the negative impact of racial diversity on inequality in health care coverage. These results highlight the importance of examining the partisan foundation of health care inequality in the context of racial diversity.

Keywords

inequality, health insurance coverage, party government, state politics

Introduction

Over the past few decades, the United States has witnessed a dramatic rise in the level of inequality among citizens, prompting concerns that the growing concentration of wealth in the hands of a few threatens the core democratic principles of equal political

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voice and government responsiveness to citizens' wishes (Gilens 2005; Jacobs and Skocpol 2007). According to Dahl (1971, 1), "a key characteristic of a democracy is the continued responsiveness of the government to the preferences of its citizens, considered as political equals." Although recent research demonstrating the increasing inequality in the American political system has sparked a renewed interest in understanding the linkage between political representation and inequality, the general concern about how class bias influences the policymaking process and outcomes is not a new phenomenon. Schattschneider (1942, 34), for example, argued that "the flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent."

The growing economic inequality in the United States has garnered the interest of politicians, journalists, and political scientists over the past decade (Bartels 2008; Gilens 2005; Jacobs and Skocpol 2007; Kelly 2004). A number of studies have documented the disparity in political participation of rich versus poor citizens (Schlozman, Verba, and Brady 2012). Schlozman et al. (2012, 14) note that "inequalities in activity are likely to be associated with inequalities in governmental responsiveness." This, in turn, produces policies that enhance economic inequality (Bartels 2008), and those policies contribute to the level of economic inequalities existing within society (Kelly 2004). While political scientists have explored the linkages between politics, policies, and economic inequality, it is less clear whether these linkages also exist across other types of inequality concerns. Moreover, many of these studies have examined income inequality at the federal level and only recently has attention turned to investigating inequality at the subnational level in the United States (Kelly and Witko 2012; Rigby and Wright 2013).

This research focuses on the broad issue of inequality in the United States but expands the scope of inquiry to inequality in health care coverage. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, which marked the most comprehensive reform of the American health care system since the Johnson Administration. One of the major goals of the health care reform efforts was to reduce the number of uninsured Americans, which was then estimated to include nearly 46.3 million Americans (DeNavas-Walt et al. 2011). The rising number of uninsured Americans represents one of the most critical challenges facing the American democracy. Inequality in access to health care has far-reaching consequences for population health outcomes in addition to the economic vitality of individuals and the overall American health care system. The failure of government in achieving universal, and equal access to, health insurance is a significant factor in generating inequality in the United States (Soss, Hacker, and Mettler 2007). Thus, it is important that we gain better insight into the political factors that enhance and diminish inequalities in health care coverage.

Extending previous studies that focus on the national government and income inequality, this research presents a comparative institutional approach to decipher the partisan foundation of inequality in health care at the state level, whereby both market conditioning and state politics have profound distributional effects. We utilize the Current Population Survey's Annual Social and Economic Supplement and develop two Gini-coefficient measures for inequality in market-based private health insurance coverage and post-redistribution overall health insurance coverage across nine family

income groups from 1996 to 2009. We conceptualize inequality in health insurance coverage as a political consequence of the partisan politics at the state level. We also examine the conditional effect of partisan government on health care inequality in the context of racial diversity. We find that state government institutions substantially affect the level of inequality in health care and that the link between inequality and partisan control of government is altered by racial diversity. Our findings suggest that putting partisan politics in the racial diversity context provides a more complete picture about the partisan foundation of inequality in the states.

Party Government and Inequality

One major political development that marks redistributive politics in the United States is that political parties polarize on economic and fiscal policies along class lines (Avery and Peffley 2005; Brown 1995; Jacobs and Skocpol 2007; McCarty, Poole, and Rosenthal 2006; Page and Jacobs 2009). At the national level, political parties have reasserted themselves as the engine for making economic and social policies, which have far-reaching distributional consequences. The emergence of “legislative parties”—characterized by great partisan power over the organization of legislative committees—and the polarization in Congress have been considered to be a major political cause of income inequality (Bartels 2008).

Some recent studies suggest that government has profound influence over inequality in society through both market conditioning and changes in public policy (Barrilleaux and Davis 2003; Bartels 2008; Bradley et al. 2003; Kelly 2004; Langer 2001). As Kelly (2004) contends, the distributional force of government is twofold. Government can influence the distributional process by using tax policies, subsidies, and labor-market regulations to condition how private firms would pay for their employees and cover their various social risks. Government can also use explicit redistribution policies to change the distribution of wealth, income, and risks (Kelly and Witko 2012). Partisan government shapes both stages of the distributional process and thus is a key political determinant of inequality.

While many attribute differential government responsiveness to the wealthy constituents as an artifact of participation bias (Hill and Leighley 1992; Hill, Leighley, and Hinton-Anderson 1995; Leighley and Nagler 1992), others argue that the party system has a central role in the representation of diverse interests (and in particular, the disadvantaged). The disadvantaged organize and articulate their interests through the election of Democratic or left-of-center representatives, who espouse redistributive policies that favor the poor. Once in office, Democratic representatives pass policies that grant government a greater role in redistributing resources from the rich to poor (or expanding access in health care to all citizens), and these policies in turn affect the distribution of wealth (or other forms of well-being). A few empirical studies suggest that Democratic control of the national government institutions produces more liberal policies and Republican control produces more conservative policies (Alt and Lowry 1994; Erikson, Wright, and McIver 1993; Garand 1985).

Although scholars have examined partisan differences in social policies at the sub-national level (Barrilleaux and Bernick 2003; Filindra 2012; Garand 1985; Grogan and

Rigby 2008), far less is known about the *distributional consequences* of these policies beyond the economic realm. Recent scholarship suggests that partisan differences in redistributive politics not only affect the income distribution but also determine the scope of shared risk responsibilities in society (Hacker 2004). The distribution of risks can have a profound impact on particular groups in society. For example, if risk is shifted to the individual, then the economically disadvantaged may be disproportionately affected when they are excluded from the social protection. Health care is a major policy area to further examine the partisan foundations of inequality in risk distributions. The relative inequality that characterizes the American health care system shapes the scope of shared risk responsibility in the society. While the rich can rely on their private resources and the market system to cover their health care needs, the poor and other socially disadvantaged groups heavily rely on government resources to obtain health care coverage. Therefore, the generosity of government health care programs largely decides the distribution of covered health risks between social classes.

Party Government in the Context of Racial Diversity: Explaining Health Care Inequality

Party Government and Health Care Inequality

Recent scholarship has begun examining the link between partisan politics and health care inequality in the United States. Similar to prior studies that focus on state-level income inequality (Flavin 2012; Kelly and Witko 2012; Rigby and Wright 2013), these studies show that partisan control of government affects who is included and excluded from the social protection in health insurance through market conditioning and explicit redistributive policies.

As Kelly (2004, 41) states, market conditioning occurs when government actions change private firms' wage and social benefits arrangements for workers from which they would otherwise choose to do in a completely *laissez-faire* market system. In the issue area of health care, government actions can affect workers' access to private health insurance coverage. First, in many states, small business employees and low-wage workers are most likely to be uninsured (Blumenthal 1999; Paul 2011). State governments differ substantially in their regulations on employment-based health insurance coverage and tax-credit incentives for encouraging small businesses to offer health insurance. Small-business employees and low-wage workers would be more likely to access private insurance coverage in states with generous tax-credit incentives and protective health insurance mandates (e.g., California, New York, and Hawaii) than in states with minimum health insurance regulations (e.g., Texas) or offers no tax incentives for small business coverage (e.g., South Dakota). Furthermore, workers can also mobilize through unionization to bargain more government regulations on private insurance markets. Studies find evidence that job-based health insurance coverage is positively associated with unionization (Paul 2011). As partisan differences in tax incentives and regulating health insurance coverage are evident at the state level, party government can indirectly shape inequality in private health insurance coverage. Gray

et al. (2010, 86) observe that prior to the 1990s, a few states have committed to reforming regulations and policies regarding private health insurance coverage, but “by 1994 there was a Republican upsurge in many states reducing legislative and gubernatorial support for extensive health care reform.”

Party government also shapes health care inequality through redistributive public health care programs. Partisan differences concerning the scope of government responsibility in health care have led to legislative failures in passing universal health care coverage reforms (Gray et al. 2010). National-level government inaction in the face of market-inequality and insecurity (Hacker 2006) and state-level incremental changes make the American health care system a weak safety net for low-income individuals and families. Second, the literature suggests that which party controls the statehouse matters for the level of generosity of redistributive health care spending. For example, Kousser (2002) identifies a robust relationship between Democratic legislative control and discretionary Medicaid spending in American states from 1980 to 1993. Grogan (1994) demonstrates that Democratic legislative control is positively related to states’ Medicaid spending levels. Gray et al. (2010) find that Democratic-controlled state legislatures substantially reduce the likelihood of legislative decisions endorsing no-actions pertaining to universal health care reforms. Conversely, a Republican-controlled legislature increases the likelihood of no-actions in universal health care reforms. This is consistent with research by Grogan and Rigby (2008), which finds that Democrats are more likely to expand health care coverage for the poor. Others (Jacobs and Callaghan 2013; Kail, Quadagno, and Dixon 2009) find that both state health care reform and Democratic control of the state legislature are negatively associated with the proportion of state population without health care coverage.¹

Partisan politics can even influence the effectiveness of bipartisan programs. In their study on State Children’s Insurance Program (SCHIP), Grogan and Rigby (2008) find that although SCHIP was enacted as a bipartisan policy at the national level, state implementation of SCHIP has been increasingly partisan. They find that states controlled by the Democratic Party have more generous SCHIP eligibility levels than states controlled by the Republican Party. They also find a positive relationship between the proportion of Democratic legislators and the generosity of SCHIP eligibility levels.

In sum, the partisan composition of state legislatures has an important effect on the distribution of private health care coverage. It is also a primary factor in determining the generosity of public health care programs, which are designed to provide social insurance against health risks to children, the elderly, and the poor. Without public health care coverage, these vulnerable groups would not be able to have a health care safety net by relying on market-based resources. As states are able to set more inclusive eligibility rules and spend more in public health care programs such as Medicaid and SCHIP, inequality in health care will be reduced. Therefore, we expect the following:

Hypothesis 1: States with a large seat share of Democratic representatives have lower health care inequality than states with a large seat share of Republican representatives.

The sheer partisan balance in state legislatures may not be sufficient to prompt new policies, such as expanding health care coverage to benefit the economically disadvantaged. The call for more redistributive government health care spending and more inclusive health care coverage requires substantial expansions in eligibility levels and revisions of government budgets. These policy efforts that equalize health care coverage across income groups represent a great scope of government responsibility on which the two parties have an ideological divide. As such, which party strongly controls the legislative institution matters regarding the priority of policymaking. If the left-wing party enjoys a supermajority in a state legislature, it would be able to enact more redistributive policies. For example, Heckelman and Dougherty (2010) find that Democratic-controlled governments have higher redistributive taxes than Republican-controlled governments. In other words, states' ability to enact more generous redistribution policies differs depending on whether the Democratic Party enjoys the majority (or supermajority) necessary for passing tax bills and raising revenues. Furthermore, the literature on income inequality suggests that the rich benefit disproportionately from the status quo bias—characterized by ponderous policy changes under institutional gridlock (Enns et al. 2014). In states where the Democratic Party does not have a majority (or supermajority) required for passing tax bills and raise revenues, a great institutional obstacle may be encountered when trying to change the status quo bias to enact policies that expand health insurance coverage and reduce health care inequality. Thus, we expect the following:

Hypothesis 2: States with a Democratic majority or supermajority that reaches or surpasses the threshold for passing tax bills have lower health care inequality than states without the Democratic majority or supermajority required for passing tax bills.

Racial Diversity and the Conditional Effect of Democratic State Legislatures

The partisan politics of redistribution in the American states cannot be fully understood without considering the important context of racial diversity (Fording 1997; Hero and Tolbert 1996; Johnson 2001; Matsubayashi and Rocha 2012; Soss, Fording, and Schram 2008; Wright 1976). State politics and policy scholars have documented that racial diversity affects median voter's policy positions in the redistributive policy areas (Matsubayashi and Rocha 2012) and alters government policy responsiveness to mass preferences (Krueger and Mueller 2001). As Hochschild and Weaver (2007, 161) describe, "The American structure of poverty and inequality is itself highly racially inflected." The significance of race and ethnicity in state politics and policy has also been highlighted in a number of works (Fording 1997; Hero 1998; Hero and Tolbert 1996; Key 1949; Soss et al. 2008). Regarding health care inequality, research has demonstrated that minorities are more likely to be uninsured (Carrasquillo et al. 1999), and therefore, the racial and ethnic composition of states may signal how pervasive inequality in access to health care coverage is. In addition, previous research shows a negative relationship between minority diversity and state spending on Medicaid (Grogan 1994; Hero and Tolbert 1996; Plotnick and Winters 1985).

Referencing the Solid South, in *Southern Politics*, V. O. Key asserted that “over the long run the have-nots lose in a disorganized politics.” This assertion came from his analysis of the factional one-party politics that dominated the Deep South during the Jim Crow era. Moreover, Key (1949, 307) argued that “[i]n two-party states the anxiety over the next election pushes political leaders into serving the interests of the have-less elements of society.” Key’s contention of the importance of organized political competition and coalition politics for the fortunes of the economically disadvantaged connects nicely with the research on partisan responsiveness, which highlights the constructive role of parties in structuring political conflict in plural societies (Schattschneider 1942).

State politics and policy scholars often view state legislatures as mobilizing institutions for diverse constituent preferences. Legislative parties, as the product of social cleavages, build and maintain their political coalitions differently in homogeneous contexts wherein voters largely share the same core values and in racially heterogeneous contexts wherein voters do not share the same core values (Hero 1998). The racial diversity contexts shape states’ policy orientations. Elected political institutions such as state legislatures are expected to produce more liberal social policies in diverse contexts than that in homogeneous contexts. As Hero (1998, 69) substantiates, “[Racial] heterogeneity suggests the need for a government that is sufficiently strong to establish and maintain a modicum of social order in a diverse social and economic setting.” The presence of a large proportion of racial/ethnic minority population increases the share of voters in the lower end of the income distribution and thus shifts the overall popular demand on redistribution toward a more liberal direction (Matsubayashi and Rocha 2012; Tolbert and Hero 2001). Therefore, when responding to the median voter’s policy position, a Democratic-controlled state legislature is expected to produce more liberal policies in racially diverse states compared with those produced by a Democratic-controlled state legislature in homogeneous states.

Although a high level of racial diversity (i.e., large minority population) might be associated with whites’ strong opposition to generous redistribution (Johnson 2001), such a “racial backlash” effect can be strongly moderated by the Democratic Party (Krueger and Mueller 2001). Krueger and Mueller (2001) contend that in ethnically heterogeneous states, intergroup competition between white and black voters could lead to a decrease in policy responsiveness to blacks’ social needs—a racial backlash effect of racial diversity. Nevertheless, such a racial backlash effect decreases as the strength of the Democratic Party coalition increases because a strong Democratic Party coalition that incorporates more minority voters would better respond to minorities’ social needs by producing more generous redistributive policies. Therefore, we expect the following:

Hypothesis 3: Democratic-controlled state legislatures reduce health care inequality more substantially in states with a high level of racial diversity than in states with a low level of racial diversity.

Data and Method

Health Care Inequality

In the context of health care, inequality concerns the unequal distribution of health care resources or unequal distribution of risks (Davis 1991; O'Donnell, Doorslaer, Wagstaff, and Lindelow 2005). We measure health care inequality by evaluating how health insurance coverage is distributed across different income levels from 1996 to 2009. Relying on the extensive literature that focuses on measuring and assessing inequality, we estimate a Gini-coefficient measure of inequality in health insurance coverage across nine family-income groups. Conceptually, the Gini-coefficient measure is an index of relative inequality based on group (or cumulative population) distributions of an outcome indicator, such as income (Atkinson 1970; Blackorby and Donaldson 1978; Hao and Naiman 2010). This measure of societal-level relative inequality has been used by scholars who study social disparity in health outcomes (Macenback and Kunst 1997; Sergeant and Firth 2006) and socioeconomic inequality in access to health care (Kakawani, Wagstaff, and van Doorslaer 1997; van Doorslaer, Masseria, and Koolman 2006; Zhu and Johansen 2014).

Data for computing the Gini-coefficient measure of relative inequality are drawn from the U.S. Census Bureau's CPS Annual Social and Economic Supplement (ASEC).² Using individuals' responses concerning whether they were covered by health insurance, we tabulate individual-level count data on health insurance coverage based on nine family-income groups for each state and year. We then rank-order the income groups in each state-year sample from low to high. Inequality is evaluated based on the relationship between the cumulative population distribution ranked by income and the cumulative distribution of health insurance coverage (i.e., based on a generalized Lorenz Curve). To deal with the variation in cost of living across the states and the varying CPS sample by state and year, we apply weights to the Gini-coefficient measure based on the CPS sample size of each income group and the state-level consumer price index (CPI). We compute two versions of the Gini-coefficient measure of inequality: market-based private health insurance coverage and overall health insurance coverage. The Gini-coefficient measure of inequality in market-based private health insurance coverage only takes into account employment-based and privately purchased health insurance coverage and does not consider government-provided coverage. This measure evaluates the uneven distribution of privately provided health care across income groups. The Gini-coefficient measure of inequality in overall health insurance coverage takes into account both publicly and privately funded health insurance plans. It shows the level of inequality in health care coverage after accounting for government redistribution.

Table 1 illustrates the CPS data and the Gini-coefficient measure of post-redistribution inequality with a few state-year cases. Massachusetts 2007 represents a case with a low level of post-redistribution health care inequality in our sample, with a weighted Gini inequality score of 0.295. California 2007 and Texas 2007 represent moderate and high levels of health care inequality, respectively. As Table 1 shows, the Gini-coefficient measure of inequality and the overall uninsured rates are two related, but different, concepts. The Gini-coefficient measure pinpoints the relative distribution of health care

Table 1. The Gini-Coefficient of Inequality in Overall Health Insurance Coverage across Nine Family-Income Groups.

Observation	\$0	\$1–4,900	\$5,000–9,999	\$10,000–14,999	\$15,000–24,999	\$25,000–34,000	\$35,000–44,999	\$50,000–74,999	\$75,000+	%Insured	Gini
MA 2007											
Insured	71	110	236	264	489	469	602	916	2,870	95.60	0.295
Sample size	98	115	248	290	528	514	628	976	2,943		
CA 2007											
Insured	417	317	737	1,142	2,560	2,735	3,639	5,417	12908	82.47	0.309
Sample size	717	513	959	1,547	3,776	3,711	4,691	6,368	14014		
TX 2007											
Insured	226	237	652	804	1,804	1,714	2,211	3,243	6,949	75.26	0.407
Sample size	474	401	918	1,304	2,873	2,642	3,171	4,187	7,733		
Perfect equality											
Insured	97	75	189	230	351	520	723	992	2,281	100	0
Sample size	97	75	189	230	351	520	723	992	2,281		

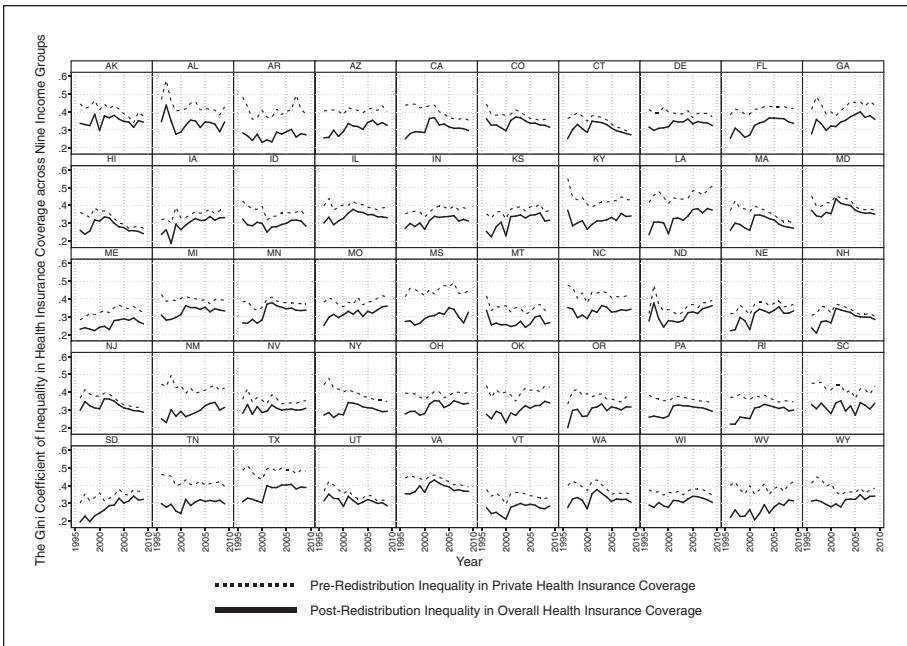


Figure 1. The gini-coefficient of inequality in pre- and post-redistribution health insurance coverage.

coverage based on the underlying income distribution (i.e., class-based social hierarchy). The inequality score increases as the risk of being uninsured for the poor and for the rich polarizes.

Figure 1 shows pre- and post-redistribution health care inequality across the 50 states from 1996 to 2009. We observe substantial cross-state variation based on the levels of inequality in both pre- and post-redistribution health insurance coverage. For example, Massachusetts and Hawaii, as two leading states in regulating employment-based health insurance, have relatively low levels of inequality in private health insurance coverage. These two states also have generous public coverage through Medicaid and SCHIP and therefore, low levels of inequity in overall health insurance coverage. A few southern states, such as Georgia, Louisiana, and Texas have high levels of inequality in both private and overall health insurance coverage. We also observe different state trends regarding how inequality in health care changes from 1996 to 2009, with many states witnessed a persistently high level of pre-distribution inequality in health care coverage. Although government redistributive health care programs (e.g., Medicaid and SCHIP) reduce market-based inequality, some states (e.g., Georgia, Louisiana, North Dakota, South Dakota, and Oklahoma) still experienced a substantial increase in their inequality scores. A few leadings states in universal health care reforms (e.g., Hawaii, Massachusetts, and New York), nevertheless, have experienced declines in health care inequality. The difference between pre- and post-redistribution inequality in

health insurance coverage also varies across the 50 states, with Arizona, New Mexico, and most southern states showing constant and large differences between the two measures and other states (e.g., Hawaii, Massachusetts, New York, and New Jersey) having smaller differences between the two measures. The large “gap” between the two inequality measures in these states is driven by an exceptionally high level of inequality in private health insurance coverage, indicating that market-based insurance coverage in these states discriminates against the poor even more disproportionately compared with those in other states. One possible explanation is that these states have large African American and Hispanic populations, who are disproportionately excluded from accessing private health insurance coverage. Last but not least, the “gap” between pre- and post-redistribution inequality in health insurance coverage also reflects how much public health insurance provision equalizes the distribution of health care. Because states have substantially different income eligibility levels for their Medicaid and SCHIP programs, the equalization effect of public coverage through Medicaid and SCHIP differs across states.

Democratic Seat Share

The partisan balance of state legislatures can affect the provision of health insurance coverage and the degree of inequality in access to health care coverage in the states. We measure the Democratic seat share in state legislatures by combining the proportion of Democratic legislators in the two legislative chambers to reflect partisan control of the critical policymaking institution. The legislative branch has an important role in formulating and passing health care laws and allocating state funds to finance public health care plans. These fiscal decisions will affect both public and employment-based health insurance provisions. As previously mentioned, we expect a negative relationship between the Democratic seat share and health care inequality.

Democratic Supermajority

Our second hypothesis focuses on the strength of the Democratic control of state legislatures. We draw from the Klarner (2003) dataset on government party control and include a dummy variable for *Democratic Supermajority*, which indicates whether Democrats have the majority or supermajority of votes necessary for passing tax bills.³

Racial Diversity

We consider the racial composition of state populations as an important context that influences the effectiveness of the Democratic-controlled state legislature, because prior studies have found that racial and ethnic diversity affects social inequality, social policy, and substantive representation of the economically disadvantaged in American states (Hawes and Rocha 2011; Hero 1998; Hero and Tolbert 1996; Matsubayashi and Rocha 2012). We follow Hero and Tolbert (1996) and measure *Racial Diversity* as an index bounded between 0 and 1. Specifically, the racial diversity index is calculated as

Diversity = $1 - \sum(p_i)^2$, whereby p_i refers to the population size (proportion) of a racial/ethnic group i . Both the number of different racial/ethnic groups and the size of each group are positively associated with the diversity index.

Political and Policy Controls

We include a few political and policy controls that affect state-level health care inequality. First, *Democratic Governor* is a dummy variable coding Democratic gubernatorial control, because the executive branch of the government also affects redistributive politics. *Citizen liberalism* is the Berry et al. (1998) measure of the ideological leanings of citizens. Research has demonstrated that states vary substantially in the ideological leanings of their citizens (Berry et al. 1998). The Berry et al. measure relies upon election results and congressional roll call votes to gauge citizen ideology longitudinally across all U.S. states. The indicator can take on values from 0 to 100, with higher numbers indicating greater liberalism. We also control for union representation for workers, assuming that greater union representation would be associated with better working benefits and thus equalizes workers' access to health care. *Union Density* is measured as the percentage of state population who are members of a labor union or an employee association similar to a union as well as workers who report no union affiliation but whose jobs are covered by a union or an employee association contract.

Second, we control for states' differences in their health care policies. *Government Health Care Spending* is measured as the share of government spending on Medicaid and Medicare in total health care spending. Using this variable from the National Health Expenditure Data (State Health Expenditures), we control for the varying levels of public spending on financing health insurance and services. Because public health insurance programs, particularly Medicaid, redistribute health care resources toward the poor, we would expect that government health care spending reduces inequality in health care coverage. *Universal Healthcare Bills* is a replication and extension of the Gray et al. (2010) measure on states' policy innovations in expanding health care access. Following Gray et al. (2010), we use the National Conference of State Legislatures (NCSL) database on universal health care reforms to identify bills proposed and enacted during 1996–2009. Five types of policy actions are then coded based on a 1–5 ordinal scale. Specifically, 1 refers to a state that commissioned a study on universal health care reform, 2 refers to bill introduction, 3 refers to passage of a bill by one chamber, 4 refers to passage of a bill by two chambers, and 5 refers to signing of a bill into law by the governor.

Economic Controls

We control for state-level economic conditions that affect both the private and public health care coverage. Using the U.S. Bureau of Economics' personal income statistics, we include *State Per Capita Income* as a control of state wealth. *Insurance Coverage*

for Part-Time Workers is measured as the percentage of private sector part-time employees eligible for health insurance who are enrolled in health insurance plans. *Unemployment* measures state-level unemployment rate as a control of labor-market risks. These economic variables are included because labor-market biases affect individuals' health insurance access. The risk of being uninsured is disproportionately distributed to people with low-income, part-time jobs, and those who are unemployed (Holahan 2010).

Model Specification

We apply a pooled cross-section-time-series design to the empirical models. Because our data track health care inequality across states in 14 years, we perform the Augmented Dickey–Fuller test and Phillip–Perron test for panel unit-root. Statistical tests confirm that the two dependent variables are panel stationary. Taking into account cross-state heterogeneity, we estimated the pooled models for both pre- and post-redistribution health care inequality using a hierarchical linear mixed effects (HLM) specification (Baltagi 2008; Gelman and Hill 2006). More specifically, we estimate a random coefficient model (RCM) with varying intercepts by state. In our case, a static specification with fixed-effect state dummies is not appropriate because of the near-perfect collinearity between state fixed effects and the dummy variable for *Democratic Supermajority*. A full set of fixed-effect state dummies also makes statistical inference rely purely on within state variation. In our empirical contexts, substantively important variation in political institutions exists across states rather than within states. As such, RCM is a more efficient way to deal with cross-state heterogeneity (Zhu 2013). To further consider the fact that both the national and state governments can influence redistributive politics (Kelly and Witko 2012), we include a full set of year-dummy variables to absorb unobserved national-level factors such as the partisan control of government branches at the national level, national policy changes in a particular year, and market crisis.⁴

Findings

Table 1 reports the statistical findings based on the pooled CSTS analysis, with only linear terms for all the explanatory variables. Table 2 adds an interaction term between *Democratic Seat Share* and *Racial Diversity* to evaluate the conditional hypothesis (Hypothesis 3). Both models are estimated using the Maximum Likelihood (ML) method (Graubarde and Korn 1996). The two linear models in Table 1 are the baseline models, which help to show how coefficients may (or may not) change once adding an interaction term between *Democratic Seat Share* and *Racial Diversity*. Overall, the two sets of models render comparable results regarding all control variables.

In Table 2, we find a negative and significant relationship between *Democratic Supermajority* and inequality in health care. The average pre- and post-redistribution Gini inequality scores are lower in states with a Democratic majority or supermajority necessary for passing tax bills. The average marginal difference is around 0.008.

Table 2. Partisan Government and Inequality in Health Insurance Coverage: American States from 1996 to 2009.

Variable	Model (1)	Model (2)
	Pre-redistribution inequality	Post-redistribution inequality
Democratic seat share	-0.031 (0.021)	-0.038* (0.018)
Democratic majority	-0.008† (0.004)	-0.008† (0.004)
Racial diversity index	0.081** (0.023)	0.055** 0.015
Democratic governor	-0.0004 (0.002)	-0.005* (0.002)
Citizen liberalism	-0.00001 (0.0002)	-1.45e-06 (0.0002)
Union density	-0.003** (0.001)	-0.0004 (0.0004)
ΔGovernment health spending	-0.001 (0.001)	-0.002* (0.001)
Universal health care bills	0.0004 (0.001)	-0.0003 (0.001)
Unemployment	0.007** (0.001)	0.003** (0.001)
Per capita income	0.005** (0.001)	0.005** 0.001
Part-time job coverage	-0.012 (0.010)	-0.009 (0.010)
Constant	0.180** (0.033)	0.125** (0.027)
State-level random effects		
Constant	0.0243** (0.003)	0.0151** (0.002)
Residual	0.023** (0.001)	0.022** (0.001)
N	637	637

Significance levels: †10%. *5%. **1%.

Comparing the two institutional variables, Democratic seat share has a somewhat greater substantive impact on inequality than the presence of a Democratic supermajority. Thus, we find evidence supporting Hypothesis 2.

Table 2 also confirms our general expectations regarding the political and economic control variables. We find that *Union Density* is negatively associated with pre-redistribution inequality in health care but has no effect on post-redistribution health care inequality. An increase in government health care spending and the presence of a Democratic governor, however, significantly reduces post-redistribution health care inequality. Both unemployment risk and state wealth are positively associated with pre- and post-redistribution health care inequality. In other words, the distribution of health insurance coverage across income groups is more unequal when there is a high level of unemployment risk and in richer states.

Table 3 includes an interaction term between *Democratic Seat Share* and *Racial Diversity* to test Hypothesis 3. Model (3) is estimated by taking the pre-redistribution inequality measure as the dependent variable. Model (4) is estimated for the post-redistribution inequality measure. We find significant interactive effects between the two variables in both models. To substantively interpret how *Democratic Seat Share* affects

Table 3. Partisan Government and Inequality in Health Insurance Coverage In the Context of Racial Diversity: American States from 1996 to 2009.

Variable	Model (3)	Model (4)
	Pre-redistribution inequality	Post-redistribution inequality
Democratic seat share	0.122** (0.035)	0.042 (0.031)
Racial diversity	0.325** (0.051)	0.189** (0.045)
Democratic seat share × Diversity	-0.433** (0.083)	-0.239** (0.074)
Democratic majority	-0.009* (0.004)	-0.007† (0.004)
Democratic governor	-0.001 (0.002)	-0.005* (0.002)
Citizen liberalism	-0.0003 (0.0001)	-9.80e-06 (0.0002)
Union density	-0.002** (0.001)	-0.0003 (0.004)
Government health spending	-0.001 (0.001)	-0.002* (0.001)
Universal health care bills	-0.0003 (0.001)	-0.0003 (0.001)
Unemployment	0.006** (0.001)	0.003 0.001
Per capita income	0.004** (0.001)	0.004** (0.001)
Part-time job coverage	-0.013 (0.010)	-0.008 (0.010)
Constant	0.133** (0.033)	0.102** (0.028)
State-level random effects		
Constant	0.022** (0.003)	0.015** (0.002)
Residual	0.023** (0.0007)	0.022** 0.0007
N	637	637

Significance levels: †10%. *5%. **1%.

health care inequality in the context of racial diversity, we generate conditional marginal effects figures based on models (3) and (4) (Brambor, Clarke, and Golder 2006).

Figure 2(a) plots the marginal effect of *Democratic Seat Share* on pre-redistribution health care inequality across the full range of the *Racial Diversity* measure. The share of Democratic representatives in state legislatures exhibits a significant and negative impact on pre-redistribution health care inequality only when the level of racial diversity is relatively high (*Racial Diversity Index* greater than 0.4). In states with relatively homogeneous populations, *Democratic Seat Share* has no effect on pre-redistribution health care inequality. In states with extremely heterogeneous populations, *Democratic Seat Share* has a small and positive marginal effect on pre-redistribution health care inequality. These findings suggest the relationship between the partisan composition in state legislatures and inequality in health care is contingent upon the level of racial diversity in states. Market-based health care inequality can only be substantially reduced when the Democratic Party is combined with a diverse constituent coalition (i.e., in heterogeneous states). This finding offers support for Hypothesis 3.

Because of the symmetrical nature of multiplicative interactions between two independent variables, the model specification in Table 3 (model (1)) means that the effect of *Racial Diversity* on inequality is also moderated by *Democratic Seat Share* (Berry, Golder, and Milton 2012). Figure 2(b) further validates the symmetric nature of the interaction relationship and provides consistent support for Hypothesis 3. Figure 2(b) shows, when the Democratic seat share in state legislatures is small, *Racial Diversity* is positively associated with inequality in pre-redistribution inequality in health insurance coverage. The positive relationship between racial diversity and inequality, however, is moderated by the presence of a large share of Democratic legislators (greater than 60% Democratic legislators).

Figure 3 plots the similar conditional effects of *Democratic Seat Share* on post-redistribution inequality in health insurance coverage. Figure 3(a) shows a similar story about how the marginal effect of *Democratic Seat Share* varies along the racial diversity index. We find that *Democratic Seat Share* significantly reduces the level of post-redistribution health care inequality in states with moderate and high level of racial diversity. In extremely homogeneous states, however, the share of Democratic representatives does not change the level of health care inequality. Figure 3(b) shows a positive relationship between *Racial Diversity* and post-redistribution inequality in health insurance coverage in states where the share of Democratic legislators is small and moderate. The positive relationship between racial diversity and post-redistribution health care inequality diminishes as the share of Democratic legislators increases. In states where *Democratic Seat Share* is equal to or is greater than 60%, *Racial Diversity* does not increase post-redistribution inequality in health insurance coverage. Figure 3 provides consistent support for Hypothesis 3.

In addition, the coefficients associated with *Democratic Seat Share* and *Racial Diversity* have changed substantially from the two linear models in Table 2 to the two interaction models in Table 3, highlighting the importance of considering the interactive relationship between these two variables. Prior studies that focus on the role of party government in shaping economics largely ignore racial diversity as an important demographic context. Our findings suggest that the impact of party government on health care inequality is conditional upon the diversity of state populations. Our findings also suggest that party government can also have an indirect impact on health care inequality by mitigating the negative effect of racial diversity.

Concluding Discussion

In this article, we uncover substantial levels of inequality in health care coverage across the states from 1996 to 2009. Our empirical models find that which party controls the pivotal policymaking institutions matters for understanding the degree of inequality in health care coverage. At the state level, the provision of health care is largely a function of political institutions, labor-market bias, and racial diversity. We discover a positive relationship between racial diversity and inequality in health insurance coverage, finding that the average Gini inequality score is higher in states with heterogeneous populations than in homogeneous populations. Changes in government health spending, furthermore,

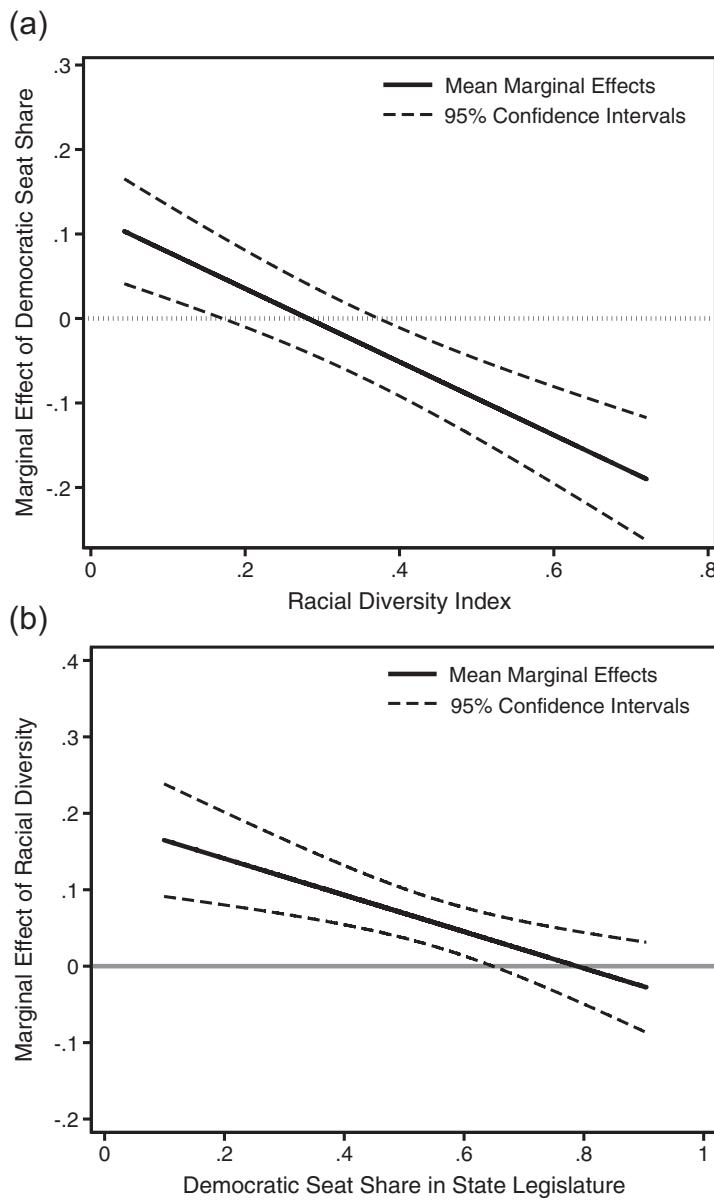


Figure 2. The conditional effect of partisan government on pre-redistribution inequality in health insurance coverage.

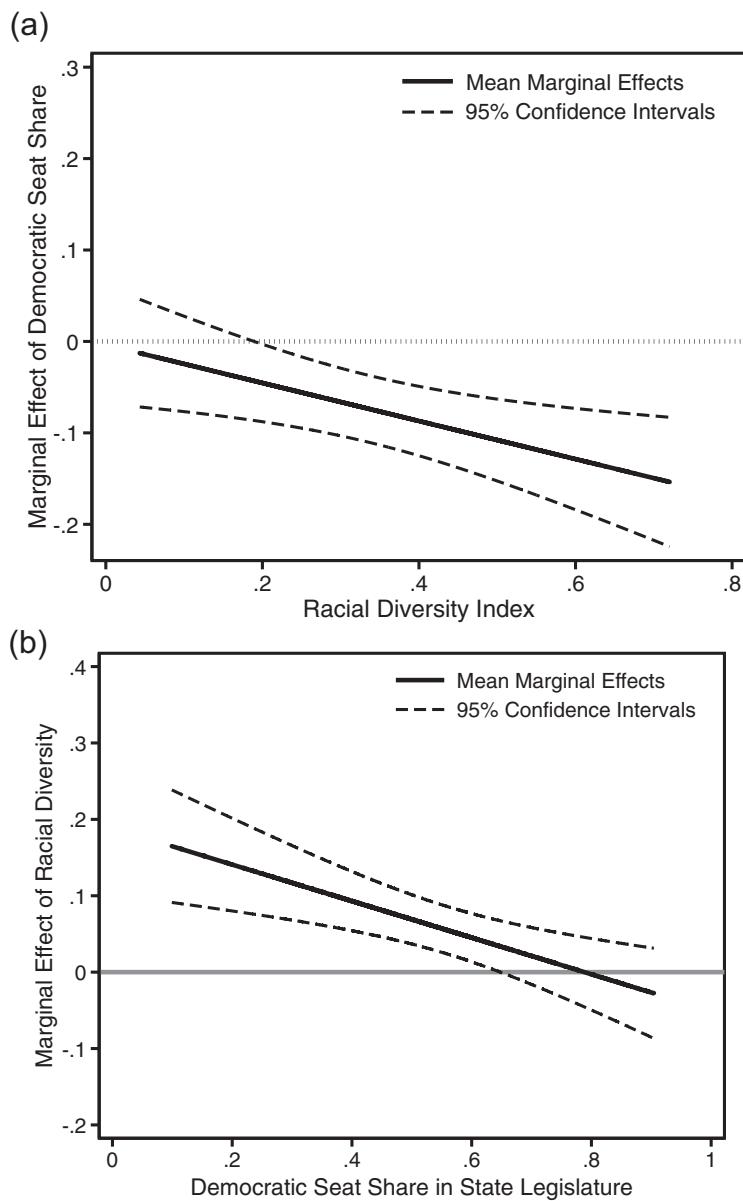


Figure 3. The conditional effect of partisan government on post-redistribution inequality in health insurance coverage.

are also found to be negatively associated with inequality in access to health care. Health insurance coverage is distributed across low- and high-income groups more equally in states with increased government health care spending than in states where government health care spending is much less due at least in part to budget cuts.

Moreover, we identify racial diversity as an important factor for understanding whether the Democratic Party is effective in conditioning the distribution of private health insurance coverage and using public coverage to equalize the overall health insurance coverage. Our findings suggest that the strength of Democratic control of the legislature in reducing inequality in access to health insurance coverage depends on the composition of its core constituent coalition. One possible explanation is that racially heterogeneous states would have more low-income ethnic minority individuals, who may experience greater market discrimination in the labor market and only some of them (not all of them) can qualify for state Medicaid and SCHIP coverage. When the left-wing party influence is absent or weak in state legislatures, racial/ethnic minority's needs may not be adequately represented in the policymaking process, thus, leading to increased health care inequality. These varying marginal effects of *Democratic Seat Share* and *Racial Diversity* call for future research that seeks to further explore how racial politics intertwine with both the market-conditioning process and explicit government redistribution.

One limitation of this article is that we do not explicitly theorize how racial diversity may influence the distribution of private health insurance and government-funded health insurance differently. Although we find evidence for both mechanisms of state governments' distributional forces—market conditioning (i.e., impacting the private market-based insurance coverage) and explicit redistribution—our findings show nuanced differences regarding how *Democratic Seat Share* and *Racial Diversity* interactively shape inequality in private and overall health insurance coverage. In racially homogeneous states, *Democratic Seat Share* exhibited no significant marginal effects on post-redistribution health care inequality, while having a small but positive marginal effect on pre-redistribution private health insurance coverage. Consistently, in states with low and moderate level of Democratic seat share, racial diversity exhibits greater positive marginal effects on pre-transfer inequality than those on post-transfer inequality. These nuanced differences point toward the need for future research on how partisan control of state governments combined with the racial diversity context may have different implications for pre- and post-redistribution health care inequality.

Our findings build upon the recent work that links inequality to political institutions, yet we broaden the scope by examining the provision of health care in the American states. Key findings regarding how subnational-level political institutions shape health care inequality are consistent with recent empirical work on income inequality, thereby generalizing the institutional theory of inequality. Our findings suggest that putting partisan politics in the racial diversity context provides a more complete picture about the partisan foundation of inequality in the states. How well the uneven distribution of health care coverage is addressed upon complete implementation of the Affordable Care Act is largely dependent on the 50 state governments.

Future research should also more fully investigate the *types* of policy innovations utilized in the states to ameliorate inequalities in the distribution of health care coverage. Given our finding of a central role of partisanship in the provision of health care insurance coverage, future work examining the effectiveness of specific kinds of reforms offered at the state level to reduce disparities in health insurance coverage is a natural extension of our work. The state's role in implementing key provisions of the Affordable Care Act, such as the expansion of Medicaid and the creation and maintenance of state health insurance exchanges, will provide a unique opportunity to examine how different types of policies advanced by Democrats and Republicans influence health care outcomes and how this relationship differs in accordance with racial and ethnic diversity of the state.

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Authors' Note

The Online Appendix can be accessed from Ling Zhu's research website: <https://lingzhu2012.wordpress.com/author/lingzhu2012>.

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Notes

1. With very few exceptions (see Cummins 2011), the empirical literature on health care in general points toward a negative link between Democratic control of government and the level of generosity of public health care provisions.
2. The CPS ASEC asked respondents about their health insurance coverage during the past 12 months prior to when they were surveyed. Therefore, we use CPS ASES data from 1997 to 2010 to measure health care inequality from 1996 to 2009. In the online appendix, we offer detailed information about how we code individual-level CPS insurance coverage data and the steps by which we compute the two Gini-coefficient measures of health care inequality in Figure 1.
3. In some states, a majority can pass tax bill, but in other states, a supermajority is necessary. This variable takes into account the variation in these chamber rules.
4. In the online appendix document, we present two robustness checks for the model specification: (1) checking for multicollinearity among explanatory variables and (2) an alternative model specification treating political institution variables and the two government

health policy variables as endogenous regressors. We find no evidence for troublesome multicollinearity. The alternative model specification yields results that would lead to the similar substantive relationship regarding how *Democratic Seat Share* and *Racial Diversity* interactively affect health care inequality.

Supplementary Material

The online appendices are available at <http://sppq.sagepub.com/supplemental>.

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