

Administrative Responsiveness to the Disadvantaged: The Case of Children's Health Insurance

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ABSTRACT

Issues of administrative responsiveness to the disadvantaged (as distinct from formal policy responsiveness) possess important implications for American democracy. In this regard, the administrative practices that facilitate or impede enrollment, or take-up, in social programs deserve attention. This study focuses on two means-tested programs in the context of American federalism, Medicaid and the State Children's Health Insurance Program. Based on an in-depth analysis of seventeen states, we develop an index of administrative responsiveness to the disadvantaged related to take-up. We then explore some possible sources of variation in responsiveness rooted in the task environment, political ideology, good government culture and practice, and signals from political principals. Our findings point to the need to refine and expand upon existing explanations of state variation in social programs. Among other things, this study suggests the political importance of international (not interstate) population mobility and gubernatorial leadership (rather than bureaucratic autonomy) in shaping administrative responsiveness to the disadvantaged. It also points to the need for a contingent approach in examining whether the greater presence of racial minorities tends to depress such responsiveness.

Students of American politics and pluralism have long emphasized that certain groups face power deficits. As E. E. Schattschneider (1960, 35) observed over four decades ago, "The flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent." Analysts note that lower-income citizens often lack the money, time, information, skill, and organizational connections to participate effectively in the political process. Their voting participation rates tend to be lower than those of the more affluent. Moreover, the "social constructions" of disadvantaged citizens are often negative, further vitiating the willingness of politicians to reach out to them (e.g., Schneider and Ingram 1993; Winston

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2002). Although the more affluent at times speak out on behalf of the less fortunate, the basic political weakness of low-income citizens presumably means that government policies tend to be less responsive to their preferences and needs than to those of better-off individuals and groups.

The assessment and debate about bias in the political system have tended to focus on the formal policies that governments adopt. However, the issue of administrative responsiveness to the disadvantaged also deserves attention. Do agencies that primarily serve disadvantaged clienteles feature less capacity (e.g., qualified staff, information technology, facilities) and less commitment to client service than agencies that serve a broader cross-section of the public? Researchers have for decades suggested that this is the case. The issue of administrative responsiveness to the less fortunate became particularly salient during the 1960s with the emergence of the Lyndon B. Johnson administration's War on Poverty. Public bureaucracies were seen as insensitive to the poor and in dire need of reform (Sjoberg, Brymer, and Farris 1966; Weatherley 1979). With the fading of the War on Poverty by the early 1970s, several streams of inquiry continued to raise concerns about administrative responsiveness to the disadvantaged. Those touting the policy implementation perspective provided evidence of well-intentioned efforts to help the poor that went awry (Pressman and Wildavsky 1973). Others plumbed the behavior of street-level bureaucrats (or frontline workers) in the delivery of social services and came away pessimistic about administrative sensitivity to the disadvantaged (e.g., Handler 1986; Lipsky 1980; Weatherley 1979). In addition, market-based alternatives, such as school choice, have not necessarily worked to the benefit of less privileged citizens (e.g., Fiske and Ladd 2000).

Although myriad studies have documented minimal administrative responsiveness to the disadvantaged, the existing evidence does not universally support this view. In this regard, one line of inquiry has focused on factors in the environment of public agencies (such as court intervention, the political liberalism of a state, or the strength of sympathetic groups) that can fuel greater responsiveness (e.g., Keiser 1999; Keiser and Soss 1998; Melnick 1994; Mezey 2000; Peterson 1970; Stone 1984). Another set of studies has zeroed in on public agencies themselves as a source of such responsiveness, whether via "representative bureaucracy," professionalism, or some other vehicle (e.g., Behn 1991; Peterson, Rabe, and Wong 1986; Selden, Brudney, and Kellough 1998).

Sifting through the evidence, it becomes readily apparent that administrative responsiveness to the disadvantaged varies over time and across agencies. A major unfinished task for students of public administration is to calibrate the degree of such responsiveness in diverse settings and to explain variations in its presence. This article takes one step toward enhancing such knowledge by focusing on a major sphere of social policy in the context of American federalism—government efforts to provide low-income children with health insurance under Medicaid and the State Children's Health Insurance Program (CHIP). More specifically, we assess the degree to which states adopted client-friendly administrative practices that facilitated enrollment in these programs. The first portion of this article identifies factors that commonly damp down participation by intended beneficiaries; then, the second portion examines this "take-up" problem in the context of Medicaid and CHIP. Drawing on a field network analysis of seventeen states, we derive an index of administrative responsiveness to the disadvantaged related to enrollment practices. Having found considerable variation in state scores on this index, we explore four possible explanations related to the task environment (especially race and problem intensity), political ideology, "good government" culture and practices, and signals from

political principals. In presenting these findings, we recognize that an in-depth analysis of a minority of states cannot be seen as a rigorous exercise in testing hypotheses. But it can, in the classic tradition of qualitative comparative analysis, provide a more nuanced understanding of a phenomenon and generate theoretically relevant propositions (Lijphart 1971). In this regard, our findings point to the need to refine existing explanations of administrative responsiveness to the disadvantaged.

RESPONSIVENESS AND GATEKEEPING

In considering administrative responsiveness to the disadvantaged, key distinctions deserve attention at the outset. Such responsiveness should be differentiated from “policy liberalism,” which encompasses general statutory provisions that define a program’s beneficiaries, specify the benefit, identify providers of the benefit, and appropriate funds. In contrast to these general policy provisions, administrative responsiveness involves decision making by the implementing agents in response to enacted laws. Such responsiveness may emanate from provisions of the law that directly order these agents to adhere to certain practices (e.g., a requirement that all applicants rejected for benefits have rights to appeal). It may also arise from the day-to-day discretion exercised by executives, managers, and frontline workers as they interpret the statute and implement the program. For our purposes, the concept of “responsiveness,” which has been subject to countless definitions and treatments (see Saltzstein 1992), denotes the degree to which implementing agents exert effort to provide assistance to disadvantaged individuals who are eligible for benefits under an existing law.¹ “Disadvantaged” refers to people with low incomes, some special physical or mental handicap, or some stigmatized ascriptive characteristic (e.g., race). Responsiveness to the disadvantaged is not a surrogate term for “good administration,” whether defined in terms of efficiency, effectiveness, or accountability. Such responsiveness can serve these and related values but does not necessarily do so.

In considering administrative responsiveness to the disadvantaged, processes that affect client participation in social programs loom large in importance. To the degree that administrative practices make it easier for targeted beneficiaries to learn about program benefits, to traverse the eligibility process successfully, and to remain on the rolls, participation rates in a program tend to be higher. A participation, or take-up, rate equals the number of individuals accurately enrolled in the program divided by the number in the general population who meet the legal criteria to receive the program benefits. The actions of administrative gatekeepers not only affect the allocation of concrete benefits to individuals, but they also have broader political ramifications. Soss (1999), for instance, notes that enrollment processes provide clients with opportunities for political learning whereby they draw lessons not only about how to deal with a particular public program but also about the broader nature of government (see also Nelson 1980).

The passage of laws that promise benefits to certain categories of the disadvantaged by no means guarantees that administrative agencies will spring into action to assure high take-up rates. Programs at times succeed in signing up only a small fraction of those who

¹ The exact meaning of responsiveness in a given context can be complex. As used here, it indicates the willingness of administrative agents to respond sympathetically to the preferences of members of disadvantaged groups over the short term. It does not deal with the issue of whether the disadvantaged know what is best for themselves over the longer term—whether they have “appropriate” preferences.

are legally entitled to benefits. For instance, the Early, Periodic, Screening, Diagnostic, and Treatment Program, a federal Medicaid initiative to provide preventive care and treatment to poor children, has consistently signed up well under half of the targeted beneficiaries (Sardell and Johnson 1998). Other studies have documented how limited outreach, the geographic location of eligibility offices, and an array of other enrollment practices have undercut participation in the Food Stamp Program (Brandon, Plotnick, and Stockman 1994; Fossett, Gais, and Thompson 2001; Tschoepe and Hinderer 1998). Evidence like this has prompted scholars in both the United States and Europe to argue that “non-take-up” in social programs is substantial and should be a major target for research (Nelson 1980; Prottas 1981; Van Oorschot 1991).

Several factors, among others, can depress participation in these programs. The characteristics of the clients themselves at times loom large. For instance, immigrants with minimal English skills and insecurities about the legal status of their families may be less likely to learn about the program and reluctant to apply even if they do hear about it. Other individuals pride themselves on avoiding “handouts” from the government. Still others may not apply because they believe the program benefit adds little value to their lives (e.g., parents who reason that their uninsured children can receive treatment at hospital emergency rooms).

But while the characteristics of clients undoubtedly affect take-up, government policies and administrative practices also do much to shape participation. Policymakers in some cases view limited take-up as an explicit goal. For instance, in the wake of the federal welfare reform act of 1996, many states have openly pursued a policy of diversion when dealing with applicants for cash assistance. Employing this approach, eligibility workers try to dissuade applicants from becoming dependent on welfare even though they technically meet the criteria to receive cash benefits. In this context, low participation rates become a badge of program success.

In other instances, low take-up stems less from the explicit preference of policy-makers than from the importance they assign to a competing performance indicator—false positive eligibility errors. These errors occur when individuals who are not legally entitled to benefits from a social program in fact obtain them. The importance assigned to these errors partly stems from their heavy symbolic overlay—their ability to trigger concerns, deeply rooted in American culture, that social programs will throw open the gates to abuse by undeserving freeloaders. The salience of these errors to officials can also derive from the financial penalties attached to them. In this regard, the federal government has fostered “quality control systems” that monitor these error rates and penalize states for poor performance on this indicator. A preoccupation with avoiding false positives in turn tends to fuel false negative errors (denying enrollment to those who meet eligibility criteria) and to reduce take-up rates (Brodkin 1986; Mendeloff 1977).

Low participation rates can also reflect efforts by implementing agents to cope with the gap between high demand for public services and limited resources with which to meet this demand. Certain administrative practices in essence become a way of rationing a benefit (Prottas 1981). Rationing can occur through information control. Potential participants may not know about the program at all or be uncertain about the eligibility criteria and how to enroll. Rationing can also take place by heightening the transaction costs that are associated with applying to the program and remaining on the rolls (e.g., by requiring extensive documentation of assets). Stigma also serves as a rationing mechanism. Administrators at times adopt unpleasant and degrading enrollment practices that

reinforce negative cultural stereotypes about applicants for means-tested programs (Goodsell 1981; Stuber and Kronebusch 2004).

TAKE-UP AND CHILDREN'S HEALTH INSURANCE

Issues of low participation rates and administrative responsiveness to the disadvantaged dramatically surfaced as the federal government and the states moved to extend children's health insurance during the 1990s. Federal mandates approved in 1989 and 1990 required states participating in Medicaid to insure children under age six in families with incomes up to 133 percent of poverty. The mandates also stipulated that states gradually extend Medicaid coverage to all uninsured children over five and under nineteen from poor families by 2002. The passage of CHIP in 1997 reinforced this emphasis. The new law promised states a more generous federal match rate than that which applied to Medicaid if they expanded insurance coverage to additional low-income children. Responding to these developments, states moved aggressively to increase eligibility for publicly funded health insurance for children. By almost any standard, these developments reflected a burst of policy liberalism within the American political system.

In many states a substantial gap between policy promise and program performance soon surfaced, however. Though data limitations make precise estimates of take-up rates extremely difficult,² assessments of enrollment trends in many states, as well as related analyses, indicate that participation rates for children left much to be desired (e.g., Kronebusch 2001; Selden, Banthin, and Cohen 1998, 1999).³ As of 2001 the Urban Institute estimated that out of some 9.5 million children under nineteen without health insurance, 50 to 80 percent met income and related criteria to be enrolled in either Medicaid or CHIP (Kenney, Haley, and Dubay 2001). In sum, the United States could take a huge stride toward solving the problem of uninsured children if state governments energetically implemented existing laws. Achieving this objective would, however, require a substantial degree of administrative responsiveness to the disadvantaged.

While low participation rates in social programs often generate little concern among policymakers and key stakeholders, this circumstance did not apply in the case of children's health insurance. To an extraordinary degree, the administration of Bill Clinton in the period from 1997 through 2000 made the greater participation of children in Medicaid and CHIP a priority. The president and the first lady orchestrated a series of public events that were designed to draw attention to the issue. The president also created a task force on the subject and exhorted the federal bureaucracy and the states to do all that they could to foster enrollment in these programs. The federal agency responsible for the health

2 A participation rate equals the number of individuals accurately enrolled (i.e., without eligibility errors) in a program at a given point in time divided by the number of individuals in the population who could qualify for benefits. In the case of Medicaid and CHIP, problems with both the dividend and divisor vitiate efforts to calibrate take-up rates. First, the federal Department of Health and Human Services has not been able to generate valid, timely enrollment data by state for Medicaid. Even the most astute analysts, such as the Kaiser Commission on Medicaid and the Uninsured, face problems of missing data when attempting to track Medicaid enrollment trends (e.g., Ellis, Smith, and Rousseau 2003). Our research team managed to collect average monthly enrollment data on children from most, but not all, states. Second, estimations of the universe of children who could qualify for benefits in a state are far from simple. While considerable effort might yield rough estimates of the number of uninsured children below a certain income level in a state in a given month, the calibration of other factors related to eligibility for Medicaid and CHIP (e.g., assets, length of time without insurance, age) is daunting.

3 The take-up rate appeared to be well under 70 percent for families who were not eligible for cash assistance.

Table 1
 Medicaid and CHIP Enrollment Practices: Sample States

Arizona	Michigan	Texas
Colorado	Missouri	Utah
Florida	New Jersey	Washington
Georgia	New York	West Virginia
Kansas	Ohio	Wisconsin
Maryland	Oregon	

insurance programs, then the Health Care Financing Administration, provided funds for outreach, offered “best practice” guidelines, and dispatched missives to the states to bolster participation rates (Thompson and Gais 2000). Although this emphasis did not continue when George W. Bush arrived in Washington in 2001, neither the incoming president nor the federal bureaucracy moved to disavow or overtly undercut this enrollment initiative. Major private foundations, advocacy groups, and think tanks also joined those who urged vigorous efforts to enroll low-income children in Medicaid and CHIP. The Robert Wood Johnson Foundation, for example, committed well over \$50 million to its “Covering Kids” initiative.⁴ Groups such as the Children’s Defense Fund and National Governors Association endorsed practices designed to facilitate enrollment. Think tanks, such as the Urban Institute in Washington, unleashed a steady barrage of reports and briefs on the factors involved in facilitating take-up. Rarely, if ever, has such a constellation of actors from the public and private sectors done so much to support the enrollment of low-income individuals in a means-tested social program.

SAMPLE AND INDEX OF RESPONSIVENESS

This study employs a field network approach to assess the degree to which seventeen states adopted client-friendly enrollment practices for uninsured children.⁵ While the chosen states (see table 1) are not a random sample, they vary on a wide range of attributes that may be pertinent to explaining state variation in enrollment practices—wealth, political liberalism, size, population, region of the country, and more. The field network approach has a long tradition in the study of intergovernmental grant programs (Nathan 1982). With funding from the Robert Wood Johnson Foundation, research associates in the seventeen states worked with a central team to arrive at a common set of questions about enrollment practices for Medicaid and CHIP. The research associates then employed case analysis methodology (e.g., interviews, site visits, review of public documents) to address systematically each of the questions in preparing state field reports. The reports generally covered the period from 1995 to 2002.

4 Under this initiative, the foundation provided grants to state and local coalitions (usually public and nonprofit agencies) to advocate “best practices” that were designed to facilitate the enrollment of children in Medicaid and CHIP. Coalitions in virtually all states proved successful in obtaining these grants.

5 Our analysis paid careful attention to possible outliers—states that had substantive and statistical properties so different from the others as to skew our overall findings. This examination of each state ultimately led us to drop one that had been part of our original sample, namely, Tennessee. Tennessee is a very special case because in 1993 it received a waiver from the federal government to launch a comprehensive, one-of-a-kind experiment with its Medicaid program called TennCare. Enrollments in the program boomed in 1994, and the percentage of uninsured citizens dropped dramatically. By 1995, therefore, Tennessee had a radically different program from any other state in our sample and, if anything, was inclined to make take-up practices less client-friendly to damp down the surge in enrollment.

Ideally, of course, it would be preferable to study all fifty states, but funding limitations precluded that approach. Readily available data sets on pertinent administrative practices in the fifty states cover only a handful of indicators. The field reports allow us to break new research ground through a more intensive, well-rounded exploration of the qualitative factors that define and shape administrative responsiveness to the disadvantaged related to take-up. Although comparative analysis of a small number of cases does not permit definitive hypothesis testing, it can point to the limits of existing knowledge while generating propositions that can help guide subsequent research.

To determine the degree to which states strove to facilitate the enrollment of low-income children in Medicaid and CHIP, we developed a ten-variable index of administrative responsiveness to the disadvantaged (ARD) that focused on three spheres—marketing, enrollment and renewal processes, and performance management. These items at the time reflected widely held views on the most important “best practices” among public and private supporters of efforts to insure children. They also emanated from initial discussions with our research associates in each state concerning the most important factors likely to affect take-up. The scores on each of the ten variables largely derive from a content analysis of the seventeen field reports by three members of the central research team. Criteria for coding the reports on each of the ten variables were developed. After reading the reports, the central team met to discuss the initial rankings. Since a few reports were not as thorough on each item as desired, the team engaged in some follow-up inquiry to collect additional information. Further discussion enabled the team to reach consensus on the scores assigned to each state on each item.⁶ For each indicator in the index, a state received a score ranging from one (least responsive) to five (most responsive).

Two of the variables in the ARD index focus on *marketing*—the degree to which officials went out of their way to publicize their programs. An array of studies suggests that many low-income parents lack information about the eligibility of their children for Medicaid and CHIP (e.g., Kenney, Haley, and Dubay 2001; Perry et al. 2000; more generally, Weiss and Tschirhart 1994). Two factors came under the microscope in our effort to gauge state effort in this sphere. One probed whether states had employed diverse mass media, accepted available federal monies for outreach, and generally solicited the collaboration of health care providers, various community groups, and private firms to enhance take-up. A second tapped the degree to which states creatively used public schools to reach uninsured children. Proponents of best practice tend to see the schools (especially students who receive free or reduced-price lunches) as potentially the single most important vehicle for reaching potential beneficiaries (e.g., Harper 2003).

The ARD index also focuses on *enrollment and renewal practices* in Medicaid and CHIP. Practices that reduce the transaction costs to low-income people of getting their children enrolled and then keeping them insured point to greater administrative responsiveness. Six indicators received attention here. First, we assessed states in terms of the vigor of their frontline outreach. A critical issue in managing enrollment in means-tested programs has to do with incomplete application and renewal forms. Administrative

6 Because of the need for follow-up inquiry with respect to certain items, we did not compute a coefficient of intercoder reliability based on an initial reading of the field reports. It deserves emphasis, however, that the three reviewers achieved unanimity in the initial coding of five of the ten items in the index and very substantial agreement with respect to the remaining items. Where differences existed, we resolved them by additional inquiry and further discussion. The final scores reflect a consensus among the two authors and a third professional staff member involved in the project.

passivity with respect to missing information usually means that substantial numbers of individuals fail to become or remain eligible for program benefits. Extra efforts by front-line workers to obtain the necessary information or process the applications in its absence usually facilitate enrollment. Two other indicators in this subset focused on eligibility criteria—the elimination of both asset tests and the requirement for a face-to-face interview to apply for or renew benefits. Efforts by administrators to monitor the assets of clients (as distinct from their income) and to conduct face-to-face interviews can be time-consuming and place substantial burdens on low-income individuals.

A fourth variable in this component of the ARD index referred to enrollment spans. In this regard, the “gold standard” of practice under existing law is to grant children continuous eligibility for one year, once they have made it through the application gates. Under continuous eligibility, shifts in family income do not affect the eligibility status of the child for the year, and parents face no obligations to report changes in their economic circumstances. The fifth and six indicators of more responsive enrollment and renewal processes focused on the degree of program integration between Medicaid and CHIP. Although the 1997 CHIP legislation gave states the option of using the new federal monies to extend their Medicaid coverage to children, most states chose to set up separate CHIP programs. The establishment of a distinct program immediately raises issues of administrative coordination. Will children eligible for Medicaid but not for CHIP be smoothly referred by CHIP administrators to Medicaid (and vice versa)? Or will they fall between the cracks after being denied eligibility for CHIP and wind up uninsured (and vice versa)? Variable five credited states that chose to dodge this problem entirely by making CHIP part of their Medicaid programs.⁷ Variable six probed the degree to which states used common application and renewal forms for Medicaid and CHIP to ease referral.

Finally, the practices of agencies with respect to *performance management* provide important insights into administrative responsiveness. The existing literature of public management emphasizes the role of measurable goals in shaping organizational behavior and achieving effectiveness (e.g., Behn 1991). In this regard, we focused first on the degree to which administrators established the take-up of children as an important performance indicator, monitored enrollment carefully, and rewarded employees for fostering greater take-up of qualified children. Second, we assessed the extent to which administrators downplayed or disregarded a potent competing indicator, false positive eligibility errors. Since an emphasis on avoiding these errors has often inclined states to adopt enrollment practices that yield more false negatives and depress take-up, states that placed *less* emphasis on reducing false positive errors received higher ARD scores.

In order to determine an overall ARD score, we added the variable scores on each dimension—marketing, enrollment/renewal, and performance management, respectively. Since we lack definitive evidence that any one dimension is more important than another in facilitating take-up, we then equalized the weights assigned to each of the three dimensions and totaled them. This yielded an ARD index where state scores could potentially range from a low of eighteen to a high of ninety.⁸ The index has a modest reliability coefficient

⁷ These states received the top score of five. The scores of the states with separate programs ranged from one to four, depending on the degree to which they strove to foster seamless referral between Medicaid and CHIP beyond sustaining a joint application/renewal form.

⁸ We multiplied the nominal scores on the marketing and performance dimensions (which had two variables each) by three. Hence, each dimension has a maximum score of thirty points and a minimum score of six.

Table 2
State ARD Scores Overall and by Dimension

	Marketing	Enrollment/Renewal	Performance Management	Overall
High				
Missouri	27	28	24	79
Washington	27	28	21	76
Wisconsin	24	25	24	73
Ohio	24	25	21	70
Medium				
Michigan	21	25	21	67
Maryland	21	24	21	66
New Jersey	21	24	21	66
Georgia	21	23	21	65
Kansas	15	27	21	63
West Virginia	18	26	18	62
Colorado	24	19	18	61
New York	15	23	21	59
Low				
Oregon	18	20	18	56
Arizona	15	25	15	55
Utah	18	18	18	54
Florida	21	20	12	53
Texas	21	18	12	51
Mean	21	23	19	63
Standard Deviation	3.7	3.2	3.4	7.9

(Cronbach alpha = .66). This suggests the need to assess causal forces that might affect each of the three dimensions in addition to the overall ARD score.⁹

Table 2 presents the various scores for each state. It indicates that all of the sample states had to some degree adopted practices designed to enhance program participation for low-income children by 2002. Among the three dimensions that compose the ARD index, states tended to achieve the highest scores in their enrollment and renewal practices. They were especially likely to eliminate the asset test for eligibility and the requirement for a face-to-face interview. The great majority of states in the sample also promulgated joint application and renewal forms for Medicaid and CHIP. States were slightly less vigorous in their marketing activities. While most of them made a general effort to publicize the program, they were less aggressive in forging links to schools. States were the least inclined to adopt performance management and measurement systems conducive to take-up.

While states in general had adopted many client-friendly practices as of 2002, table 2 also indicates that the forces of federalism loomed large. States varied considerably in their ARD scores, ranging from a high of seventy-nine in the case of Missouri to a low of fifty-one in Texas. In general terms, four states (Missouri, Ohio, Washington, and Wisconsin)

⁹ Correlations among the variables in the ARD index tend to be positive but not especially strong. We believe that ARD does much to convey overall state effort in this domain. But its limits in capturing a single underlying dimension point to the importance of relating various independent variables to each of ARD's three dimensions and to each of its ten constituent variables. For the latter see note 16.

emerged as pacesetters and five states (Arizona, Florida, Oregon, Texas, and Utah) lagged behind. The remaining eight states clustered in the middle.

A question that naturally arises in considering ARD is whether it captures something more than commonly studied measures of policy liberalism. If states that adopt generous formal policies also score high on ARD, it might prompt skepticism that a focus on administrative responsiveness adds much value to the study of social programs. In order to plumb this issue, we examined the relationship between the ARD scores of the sample states and two measures of health policy liberalism—income thresholds for eligibility for children’s health insurance (which ranged from a high of 350 percent of poverty in New Jersey to a low of 200 percent in several states) and Medicaid spending effort by states from their own resources (U. S. General Accounting Office 2003). Since eligibility for cash assistance continues to be one gateway to Medicaid enrollment, we also examined the level of association between ARD and a measure of welfare policy stringency developed by Soss et al. (2001).¹⁰ A correlational analysis lends credence to the view that administrative responsiveness does not automatically accompany formal policies that seek to assist the disadvantaged. Medicaid spending effort is unrelated to ARD scores. While states with more generous eligibility thresholds feature more client-friendly administrative practices ($r = .47$), this measure still leaves over 75 percent of such responsiveness unexplained. Several states with less generous income thresholds, such as Wisconsin, achieved ARD scores well above the mean. As might be expected, greater welfare stringency is negatively related to ARD. But the relationship ($r = -.38$) does not attain statistical significance at the .10 level and accounts for a relatively small percentage of the variance in ARD.

POSSIBLE SOURCES OF VARIATION IN ARD

In seeking to account for variation among the states in ARD, we examined four general explanations, focused on the task environment, political ideology, “good government” culture and practice, and signals from political principals.

Task Environment: Race and Problem Intensity

Recent studies have highlighted factors in the task environment of state government to explain variation in policies toward disadvantaged citizens. Race has loomed especially large in these analyses. For instance, Soss and associates analyzed the degree to which states adopted “get-tough” policies toward the poor in the wake of welfare reform in 1996. They found that policymakers in states with higher percentages of African Americans on the welfare rolls tended to adopt more punitive welfare practices than their counterparts in states with lower percentages (Soss et al. 2001, 390; see also Fellowes and Rowe 2004; Keiser, Mueser, and Choi 2004). A high percentage of minorities in a state presumably makes it more likely that means-tested social programs come to be seen as sops to groups with whom the majority population feels little solidarity. Greater minority presence may link these programs to negative racial stereotypes and increase the stigma associated with participating in them. In order to

10 With pertinent controls for price differences, spending effort reflects Medicaid expenditures from state sources divided by total taxable resources in that state. The Soss et al. (2001) welfare stringency measure includes stricter sanctions, work requirements, time limits, and family caps.

examine the possible role of race in shaping ARD, we focused on the percentage of Latinos and percentage of African Americans in a state's population, as of 2000.

In addition to race, problem intensity (that is, the degree to which states have a high percentage of uninsured children) deserves attention. While some research suggests that states with more acute problems may be more strongly motivated to ameliorate them (e.g., Fellowes and Rowe 2004), other considerations prompted us to adopt a contrary hypothesis—that states with greater percentages of uninsured children will take fewer steps to make their enrollment processes client-friendly. At least two kinds of dynamics could yield this result. One has roots in concerns about *surge control*. Our field reports found that administrators in some states were concerned that rapid enrollment growth might tax their administrative capacity and precipitate unwelcome fiscal and political pressures.¹¹ Concerns about such surges may be greatest in states with a higher percentage of uninsured children. A second and related explanation draws on theories of *interstate economic competition* (e.g., Peterson and Rom 1990, 54–56). Such competition allegedly prompts state officials to emphasize policies that appeal to firms, productive workers, affluent individuals, and investors. In contrast, they have much less incentive to retain or attract lower-income citizens who often need various forms of public assistance. This model of competitive federalism holds that any one state seeks to avoid “excess responsibility” for the nation's disadvantaged. Hence states with disproportionate numbers of uninsured children may conceivably encourage administrative practices that are designed to make the state less attractive to this group. In exploring this possibility, we are *not* suggesting any propensity of states to race to the bottom in the case of children's health insurance. We are only probing whether this factor might constrain states with more acute problems from going all out to eliminate barriers to enrollment.

To explore the relationship between ARD and problem intensity, we rely on U.S. Census Bureau estimates of uninsured children from families with incomes at 200 percent of poverty or less in each state for the years 1995–97 (three-year average). Using a figure on the percentage of uninsured from this period is preferable to later years because it reduces the need to address questions of causation. Obviously, more administratively responsive states may well have smaller uninsured populations *because* of client-friendly enrollment practices. Since most states did not make much headway in creating such enrollment practices until after 1997, the use of the 1995–97 figure militates against this causal interpretation. In addition to the racial variables and percentage of uninsured, we examined the relationship between ARD scores and several other environmental variables—two measures of state wealth, unemployment rates, and the percentage of the population below poverty.¹²

Political Ideology and Partisanship

The political liberalism of states could be an important factor explaining variation in ARD. Keiser (1999), for instance, found that greater Democratic Party control of state

11 For example, administrators in Oregon initially wanted to decline a substantial grant from the Robert Wood Johnson Foundation to foster take-up for fear that additional enrollments would create cost pressures and a political backlash. They accepted the grant after intervention by the governor.

12 The data are generally from 2000. Unemployment and poverty rates reflect three-year averages for the period 1998–2000. The data on total taxable resources per capita represent the average from 1996–98 (U.S. General Accounting Office 2003, 30–31).

governments heightened their propensity to put more people on the disability rolls. Soss and associates (2001) note that conservative states more readily imposed “get-tough” sanctions on welfare recipients (see also Fellowes and Rowe 2004; Keiser and Soss 1998). Still others have shown that citizens’ ideological orientations in a state strongly predict the social policies it adopts (e.g., Erikson, Wright, and McIver 1993). Given these and related studies, we examined three commonly used measures of political liberalism as possible sources of ARD in the case of children’s health insurance. Two indicators derived from the work of Berry and associates (1998).¹³ The first, government ideology, focused on the degree to which Democrats controlled the legislature and governor’s office during the period from 1995 through 2002, along with estimates of the ideological positions of these policymakers. The second, citizen ideology, placed states on a liberal-conservative continuum through a formula that examined the voting records of members of Congress and their challengers from that state from 1995 through 2002. Finally, we selected a more direct measure of public attitudes, the degree to which people in a state identify themselves as conservatives or liberals (Erikson, Wright, and McIver 1993).¹⁴

“Good Government” Culture and Practice

Higher ARD scores may also be a function of “good government” culture and practice in a state, especially a tradition of strong public administration. Mead (2004), for example, argues that the efficacy of a state’s welfare reform efforts in no small measure depends on the degree to which the state has a culture and institutional characteristics that are generally conducive to effective policy formulation and implementation. In order to explore this possibility, we employed two sets of measures. One drew on Elazar’s (1984) familiar typology of state political cultures—a framework that sorts states into moralistic, individualistic, and traditionalistic categories. Moralistic states feature a general commitment to using government to serve higher moral ends, to citizen involvement in political life, and to efficient, accountable public administration that strives for “best practice.” In contrast, traditionalistic states more readily emphasize the status quo, the domination of government by those at the top of the social structure, and minimal citizen participation.¹⁵

In an effort to tap “good government” practice, we also used a more direct measure of state administrative capacity, based on an extensive survey conducted by the Government Performance Project (GPP) at Syracuse University (2003). The GPP graded states from “A” to “F” on five dimensions of administrative capacity. For the purposes of our analysis, we used the average grade a state earned on all these dimensions (scored one to twelve) as a summary measure of state administrative capacity. We also examined the relationship between ARD and two GPP dimensions that might be particularly relevant to achieving

13 We are indebted to the authors for providing us with updated measures of these two variables.

14 State conservatism scores equal the number of citizens who identify themselves as conservative minus the number who identify themselves as liberal. These basic political identifications tend to be relatively constant over time.

15 To test this hypothesis we created two dummy variables—the presence or absence of a moralistic culture and the presence or absence of a traditionalistic culture. We also created a dichotomous measure to examine the possible relevance of Elazar’s individualistic culture. It did not achieve a robust, statistically significant relationship with ARD.

higher ARD scores—the degree to which a state had gone further in adopting an administrative orientation based on “managing for results” and the extent to which it had done more to employ information technology.

Signals from Principals

A final explanation focuses on the extent to which ARD flows from signals sent by key principals—the governor, the legislature, the courts, and, on occasion, citizen initiatives through votes on ballot measures. In considering various principals, the role of governors seems particularly likely to be pivotal in shaping ARD. Gais (2000), for instance, notes the degree to which strong governors dominated the implementation of state welfare reform and contrasts it with the weakness of state legislatures in these processes. If the preferences of principals fail to account for much of the variance in ARD, it would suggest the potential relevance of two other explanations. It could be that the behavior of administrators substantially derives from direct pressures they perceive in their task environment unmediated by political principals. Or it could reflect a significant measure of bureaucratic autonomy, whereby the values and understandings of administrators themselves play a key role in shaping ARD.

The state field reports provide enough qualitative evidence to afford insight into the role played by key political principals in shaping responsiveness. In this regard, we coded three variables from the reports on a scale of one to five. The first variable focused on gubernatorial leadership. Did the governor of the state send strong signals that signing up children for health insurance ranked high on his or her list of priorities? A second measure probed the signals sent by legislatures, courts, and citizens (e.g., through votes on health insurance ballot measures, as was the case in Arizona). Finally, we examined the degree to which administrators perceived their political principals as sending clear signals about budget constraints or cost cutting independent of their posture on health insurance issues. We hypothesized that administrators who sensed acute concerns about program costs among policymakers would be less inclined to promote changes that would make enrollment easier.

FINDINGS

The far left column in table 3 provides the simple correlation between our independent variables and ARD. Where results achieve statistical significance at the .10 level or lower, the table also presents the unstandardized regression coefficient derived from incorporating a single independent variable into an ordinary least squares regression. This analysis points to a strong negative relationship between ARD and two task environment variables, especially percentage of Latinos, but also percentage of uninsured children in the 1995–97 period. The table also suggests that proactive support from the governor is a key catalyst for ARD. The variables tapping political ideology and good government culture and practice generally predict less. Some tendency exists, however, for traditionalistic states and those where citizens more readily identify themselves as conservatives to feature lower ARD scores.

To explore further the potential significance of these factors in explaining variation among the states, we examined their relationship to each of the three dimensions of

Table 3
The Relationship between ARD and Selected Independent Variables (*N* = 17)

	Pearson <i>R</i>	Unstandardized Regression Coefficient	Adjusted Standard <i>R</i> ²	Error
Task Environment				
% black	.15			
% Latino	−.68***	−.62***	.43	.17
% uninsured	−.51**	−.54**	.21	.24
% unemployed	−.14			
% poverty	−.33			
Per capita income	.23			
Taxable resources per capita	.17			
Political Ideology and Partisan Control				
Government ideology—Democratic	.30			
Liberal citizen ideology—Congress	.19			
Conservative citizen identification	−.45*	−.51*	.15	.26
Good Government Culture and Practice				
Moralistic	.30			
Traditionalistic	−.49**	−8.38**	.19	3.82
Focus on results (GPP)	.01			
Greater IT capacity (GPP)	.39			
Total performance capacity (GPP)	.39			
Signals from Principals				
Governor’s stance	.57**	4.28**	.28	1.58
Other principals	−.02			
Fewer cost-cutting signals	.31			

*significant at .10 level; **significant at .05 level; ***significant at .01 level. GPP, Government Performance Project.

ARD—marketing, enrollment/renewal, and performance management.¹⁶ Table 4 indicates that three of the independent variables (percentage Latino, governor’s stance, and percentage uninsured in 1997) tend to sustain their predictive power for two of the three dimensions of our ARD measure—enrollment/renewal and performance management. All five predictors achieve statistically significant relationships with the performance management dimension. However, none of the variables account for much variation in the marketing dimension. (Calculations with respect to all the independent variables explored in table 3 produced a similar null finding with respect to marketing.) What accounts for this differential pattern in our ability to explain the marketing dimension of ARD? We do not have

16 We also examined the relationships between our predictor variables and each item in the ARD index. In this regard, three items in the enrollment/renewal dimension loomed large—the decision to eliminate the asset test as a criterion of eligibility and the two measures of structural integration between Medicaid and CHIP. Both percentage of Latinos and percentage of uninsured demonstrated an especially negative relationship with each of the three items. Gubernatorial support demonstrated a relatively strong positive association with them. In the case of the performance management dimension, both a proactive targeting of children and a deemphasis on false positive eligibility errors were especially unlikely in states with substantial Latino populations, a higher percentage of uninsured children, and traditionalistic political cultures. A proactive governor tended to be positively associated with the two items, especially the decision to relax concern about eligibility errors. Percentage of conservatives was negatively associated with both performance variables though not at very robust levels.

Table 4
Relationships between the Three Dimensions of ARD and Selected Independent Variables ($N = 17$)

	Marketing			Enrollment/Renewal			Performance Management		
	Unstandardized Regression Coefficient	Adjusted R^2	Standard Error	Unstandardized Regression Coefficient	Adjusted R^2	Standard Error	Unstandardized Regression Coefficient	Adjusted R^2	Standard Error
% Latino	-.12	.08	.11	-.21**	.26	.08	-.29***	.55	.06
% Uninsured (1997)	-.09	-.03	.13	-.19*	.13	.10	-.26**	.29	.09
Conservative Citizen Identification	-.09	-.04	.14	-.19	.11	.11	-.23**	.18	.11
Traditionalistic Culture	-2.05	.00	2.03	-1.43	.02	1.78	-4.9***	.44	1.33
Governor's Stance	.81	-.01	.90	1.79**	.29	.65	1.67**	.24	.68

*significant at .10 level; **significant at .05 level; ***significant at .01 level.

a definitive answer. Conceivably, measurement error was greater in the case of this dimension of ARD compared to the other two, though we have no compelling reason to believe this is so. Of potentially greater significance is the fact that a different set of administrative agents tended to handle marketing, as opposed to enrollment and performance issues. As a rule, states contracted with an array of private firms to handle their information campaigns. In contrast, practices with respect to enrollment and performance management tended to fall within the bailiwick of government's traditional social service agencies. Whatever the exact reason for this finding, future studies of ARD related to take-up should be alert to the possibility that marketing may well respond to a different set of causal forces than enrollment/renewal or performance management.

Assessment of the bivariate relationships in tables 3 and 4 affords little insight into the explanatory power of the independent variables relative to one another and overall. Addressing this issue statistically requires that we simultaneously regress several of the more predictive variables on ARD. In considering this approach, however, we faced the problems of having a small number of cases and substantial multicollinearity among the five key predictor variables. States with low ARD scores simultaneously tend to have proportionately larger Latino populations, greater percentages of uninsured children, passive governors, traditionalistic cultures, and conservative citizens. While we tentatively explored several regression models (all of which emphasized the special importance of percentage Latinos as a predictor),¹⁷ we ultimately adopted an alternative two-pronged approach in generating the core propositions discussed in the next section. First, we supplemented the statistical findings with a careful review of the qualitative evidence pertaining to the sample states. Second, we adopted a principal component approach to multicollinearity suggested by Kennedy (1998, 189). In this regard we subjected the five, intercorrelated predictor variables to a factor analysis. Table 5 shows that these variables all primarily load on one factor, which can be labeled "environmentally constrained gubernatorial leadership." After creating scores for each state based on the weightings in table 5, this factor can account for 49 percent of the variance in ARD. If we delete the marketing dimension from the ARD measure, the factor can explain 58 percent of the variance in the combined enrollment/renewal and performance scores.

The factor analysis suggests that states with higher percentages of Latinos and uninsured children and, to a lesser degree, with more conservative, traditionalistic cultures tend to have governors who are less likely to prioritize enrollment in Medicaid and CHIP. Proposition 5 in the next section of this article more fully explicates the dynamics that may undergird the impact of this factor on ARD.

¹⁷ Percentages of uninsured children and Latinos are strongly correlated ($r = .86$). Hence, we cannot determine the degree to which ARD emanates from racial/illegal alien concerns, as distinct from problem acuity and the desire for surge control. Since percentage Latino consistently predicted more about ARD, however, we dropped the uninsured variable and entered this ethnic measure in a series of regressions with two other predictor variables, exploring all possible combinations with governor's stance, traditionalistic culture, and conservatism. In the resulting three regressions, percentage Latino sustains statistical significance at the .10, .05, and .03 levels, respectively. The model with the best fit (adjusted R^2 of 45 percent) incorporates percentage Latino, governor's stance, and traditionalistic culture. If one enters all four of the independent variables in a regression, percentage Latino achieves statistical significance at the .11 level. In all the regressions the signs of the remaining predictors are in the expected direction but are not statistically significant at the .10 level or lower. (This finding concerning statistical significance may well derive in part from the small number of cases and high degree of multicollinearity.) If one deletes the marketing dimension from the ARD measure, a similar pattern emerges. The model with the best fit (see above) can account for 54 percent of the variance in the modified ARD index.

Table 5
Factor Analysis of Predictive Variables

Factor 1—Environmentally Constrained Gubernatorial Leadership	Factor Loadings after Varimax Rotation	
% Latino	.89	Eigen value = 2.83
% Uninsured (1997)	.84	
Traditionalistic	.70	
Governor's Stance	-.69	
Conservative Citizens	.61	

DISCUSSION: CORE PROPOSITIONS

The quantitative and qualitative evidence from this analysis of ARD in the context of take-up for children's health insurance provides support for five general propositions.

- Proposition 1. In the context of intergovernmental grant programs, concerted efforts by the federal government to foster administrative practices conducive to take-up can make considerable headway, especially with the support of private foundations and others. Nevertheless, states will continue to vary considerably in ARD.

The field reports do not permit us to track state ARD scores precisely from one year to the next; however, qualitative evidence from the sample states strongly suggests that substantial effort by the federal government, private foundations, and others encouraged virtually all states in our sample to adopt administrative practices that were likely to facilitate the enrollment of children in Medicaid and CHIP (see also Fossett, Gais, and Thompson 2001). The states took steps to enhance the flow of information about program benefits, to streamline enrollment/renewal processes, and to initiate performance management practices supportive of take-up. These state initiatives in all probability yielded positive enrollment outcomes. The participation of low-income children in Medicaid and CHIP increased in all of the sample states from 1997 to 2002. The percentage of children below 200 percent of poverty without health insurance declined in all of these states, except West Virginia. Take-up rates, while difficult to calibrate, probably increased as well (e.g., Selden, Hudson, and Banthin 2004). While all states responded to federal entreaties to make their enrollment practices more client-friendly, they continued to vary greatly in ARD. The remaining propositions afford some insight into the possible sources of this variation.

- Proposition 2. Racial factors may well help explain administrative responsiveness to the disadvantaged in state social programs, but the nature and magnitude of racial effects depend on the substantive policy domain and the target group.

The findings of this study are consistent with the thesis of Soss et al. (2001) and others that the greater presence of certain minority groups in a state can lead to policies and administrative practices that are less responsive to the disadvantaged. But this study also sends a clear signal that health policy may well differ appreciably from other domains, such as cash assistance. Contrary to other studies focused on welfare, the greater presence

of African Americans in a state did not trigger lower ARD scores. Instead, states where Latinos represented a greater proportion of the population adopted fewer client-friendly enrollment practices. It deserves note that this finding does not simply reflect patterns emanating from two or three states with very large Latino populations. Among the eight states with ARD scores below the median of sixty-three, for instance, only West Virginia had a negligible Latino presence, at 1 percent (see table 2). In contrast, New Jersey was the only state with an ARD score above the median to have an appreciable Hispanic population (13 percent).¹⁸ (To be sure, like all of our findings, the pattern with respect to Latinos could reflect sample bias. But anecdotal evidence from nonsample states with large Hispanic populations, such as California, does not appear to vitiate our proposition.)¹⁹

What accounts for the difference between African Americans and Latinos in their implications for ARD? In the case of black citizens, health insurance for children in all probability does not conjure up images of morally unworthy people lining up to obtain benefits. Medicaid and CHIP not only target children but increasingly the offspring of working parents, groups that more readily escape stigma. Thus, health insurance appears to carry far less negative symbolic baggage than cash payments or the provision of food stamps to adults (see also Cook and Barrett [1992, 98], who found that Medicaid recipients tend to be seen as more “deserving” by the public than those receiving welfare payments.) A similar argument might, of course, apply to low-income Latino children. But a critical difference also exists. Bias toward programs for Latino children may have roots in the perception that many of them are “illegals” who do not really belong in the United States—that their parents come for free services, to take jobs from Americans, and to send their earnings back to their home countries.

This study has no way of knowing precisely how widespread these kinds of sentiments are. However, qualitative evidence from states with large Latino populations and geographic proximity to Latin America suggests the potency of this form of bias. One wing of the Republican Party in these states has been quite vocal in its call for a tougher stance on immigration and has exploited this theme in election campaigns.²⁰ Some states, such as Colorado, have focused policy cuts specifically at illegal immigrants (Jordan 2004). In addition, “get-tough” ballot propositions targeted at this group have frequently won support from voters. In 2004, for instance, a substantial majority of Arizona voters approved

18 Aside from West Virginia, all states with ARD scores below the median had Latino populations of at least 8 percent, with five at 15 percent and higher. Seven of the states with scores above the ARD median had Latino populations of less than 8 percent; six of the states in this cluster ranged from 2 to 5 percent.

19 California represents an especially interesting case because of its pattern with respect to our five predictor variables. It ranks high on percentage of Latinos and uninsured children, two indicators that presumably depress ARD. It also does not appear that California governors during the 1995–2002 period placed a high priority on health insurance for children. (Governor Pete Wilson at various points campaigned against providing social services to “illegals,” and Governor Gray Davis, while more sympathetic, emphasized education policy.) However, California is not a traditionalistic or highly conservative state. This pattern leads us to predict that California would probably rank higher in ARD than states such as Arizona, Florida, and Texas but would be unlikely to cluster with our highest-scoring states and might well rank below the ARD median. In a preliminary effort to explore this matter, we examined secondary sources (Lutzky and Zuckerman 2002) and obtained information related to five variables of our ARD measure. The findings point to a mixed pattern, one that is consistent with our expectations. California scores well on ARD measures related to asset tests, oral interviews, and continuous eligibility but considerably lower on two measures related to the structural integration of Medicaid and CHIP.

20 In the 2004 race for the Senate in Oklahoma, the Republican National Committee ran a television ad claiming that the Democratic candidate had made it easier for illegal immigrants to obtain public benefits and “cross our borders and take our jobs” (*New York Times* 2004).

Proposition 200—a measure aimed at cutting off social program benefits to illegal immigrants. Proponents of this initiative planned to place similar propositions on the ballot in other states with substantial Latino populations, including Colorado, Florida, Texas, and Utah (Crawford 2004). Additionally, more systematic analysis indicates that Latino parents often perceive that they face discrimination when they seek to obtain public health benefits for themselves and their children (Hill et al. 2004).

- Proposition 3. Theories of interstate economic competition as a force for less administrative responsiveness to the disadvantaged in states with more acute problems may well be less potent than comparable explanations rooted in the international mobility of populations. Concerns about magnet effects, surge control, and program legitimacy at times tend to target other countries rather than other states.

This study found support for the proposition that states with more acute problems of uninsured children tend to score lower on ARD. Our findings with respect to Latinos further buttress this view. Language and cultural factors, as well as other concerns, have generally prompted Latinos to be less aggressive about applying for Medicaid and CHIP than other groups (e.g., Stuber and Kronebusch 2004). Because Latino children are harder to enroll, states with higher percentages of these children probably need to foster greater ARD than states with smaller Latino populations to achieve similar participation rates. In fact, however, states with proportionately more Latinos (that is, those with a more acute take-up challenge) tend to adopt less client-friendly practices.

This pattern suggests that any concerns state officials have about surge control and becoming a health care magnet have less to do with standard theories about interstate economic competition and more to do with international population flows. Officials in states with substantial percentages of Latinos tend to worry less about attracting disadvantaged citizens from other states—a driving force in theories of competitive federalism. Instead, they sense that a constellation of factors associated with a higher standard of living make the United States in general and their states in particular a powerful magnet for low-income individuals from Latin America. While in theory international migration to the United States is subject to immigration controls, the country's borders in the south have been quite porous. The illegal immigrant population has grown dramatically in several states.²¹ Hence, low ARD in states with substantial percentages of Latinos may be seen as one element in a broad pattern of practices that are designed to make these states less inviting to illegal immigrants.

More specifically, a high percentage of Latinos tends to elevate the concerns of officials about surge control and program legitimacy. In this regard, state patterns on one of the performance management variables in the ARD index deserve note. During the time frame of this study, the federal government reduced pressures on states to minimize false positive eligibility errors. Most states in our sample did not assign great importance to this performance indicator. States with substantial Latino populations, however, were more inclined to continue their focus on minimizing false positive eligibility errors. This propensity probably reflects their sensitivity to the broad public sentiment

21 For instance, the illegal immigrant population in Arizona has grown by an estimated 400 percent over the last fifteen years to some 350,000 people (LeDuff 2004).

against providing illegal immigrants with government benefits. Failure to control these error rates could trigger a public backlash and undermine program legitimacy.

Proposition 4. The ideological and partisan dispositions of states tend to have less impact in the case of health policy and in the case of administrative matters.

This study found a significant relationship between ARD scores and two broader measures of state ideology—presence of a traditionalistic culture and greater conservative identification among the citizenry. However, these relationships were less robust than those achieved by our other predictor variables.

Unlike several studies of state variation in social programs, this analysis did not find partisan dominance (as measured by a government ideology measure) to be a potent predictor of state ARD scores. To be sure, this finding could partly reflect the general measure of partisan control we have selected. For instance, additional analysis suggests that Democratic governors are somewhat more inclined than their Republican counterparts to foster greater ARD. But the relationship is not very strong, and support for children's health insurance is often bipartisan.²² Consider, for instance, the two governors in our sample who did the most to support take-up for uninsured children. One was the late Mel Carnahan, a Democrat from Missouri. His interest in and commitment to enrolling children did much to make his far-from-liberal state the leader in our sample in terms of facilitating take-up. The other was Christine Todd Whitman, the Republican governor of New Jersey during most of this period. Working with a Republican legislature, she successfully fought for some of the most generous eligibility criteria for children in the country (up to 350 percent of poverty). While her efforts did not penetrate administrative practices as much as Carnahan's did in Missouri, New Jersey had an ARD score well above the mean.

We suspect that the muted effects of state partisanship and ideology on ARD emanate in part from the more positive social construction of health as distinct from other social policies (e.g., cash assistance) and of the children of working parents as a target group. These more limited effects may also stem from the fact that the practices embedded in ARD often appear technical and do not carry the symbolic overtones that fuel the ideological passions that are frequently evident in social policy debates.²³

Proposition 5. Environmentally constrained gubernatorial leadership significantly shapes administrative responsiveness to the disadvantaged, but the characteristics of the implementing agents may ultimately play a critical role as well.

While forces in the environment of administrative agencies may to some extent affect ARD directly, this study points to gubernatorial leadership as an important mediating variable. Consistent with earlier findings on welfare reform, efforts to facilitate the enrollment of children in Medicaid and CHIP appear to depend less on signals from such

²² To measure partisan control of the governor's office, we computed for each state the number of years in the period from 1995 through 2002 that a Democrat served as governor. This measure correlated at .41 with state ARD scores, but it did not achieve statistical significance at the .10 level or lower.

²³ Consistent with this argument, several of our measures of political ideology predicted more about the formal policy liberalism of states than about ARD.

political principals as legislatures and courts and more on what elected governors choose to prioritize. The apparent impact of the governor on ARD is consistent with conventional notions of executive-centered democratic accountability in public administration. Rather than achieving “bureaucratic autonomy” by flying below the radar screen of political principals or by possessing sufficient political muscle to follow their own preferences, implementing agents respond to signals from the chief executive. Endorsement of this conclusion, however, must be tempered by two considerations.

First, the factor analysis in table 5 suggests that the presence of certain environmental forces in a state (especially percentage Latinos, but also high rates of uninsured children and conservative, traditionalistic political cultures) reduces the likelihood of gubernatorial leadership on behalf of take-up. This could be a function of electoral politics where candidates favorable to ARD have difficulty getting elected. Alternatively, it may be that once in office governors in these less hospitable states see client-friendly take-up processes as having too many political and economic costs. Whatever the exact causal mechanism, governors stand out among political principals in mediating, or transmitting, pressures from the environment to administrative agents concerning ARD. By the same token, the environmental variables we have highlighted account for less than half of the variance in the propensity of governors to support take-up. This suggests that the values of governors, *per se*, play an independent role in shaping ARD.

Second, it deserves note that the environmentally constrained gubernatorial leadership factor still leaves about half of the variance in ARD unexplained. Conceivably, administrators are directly responding to forces in their environment that this study has not explored (e.g., greater pressure and involvement by nonprofit advocacy groups in some states). But we strongly suspect that much of the remaining variance is shaped by characteristics of administrative agents that we could not fully calibrate in this study—their organizational cultures, the professionalism of their staffs, the degree to which they are “representative bureaucracies,” and more.

CONCLUSION

This study reaffirms that administrative responsiveness to the disadvantaged does not flow automatically from formal policies that seek to assist this group. Therefore, specifying the circumstances under which administrative agents act to facilitate or impede enrollment in social programs should be a major focus for public administration research. Our study takes a step toward advancing knowledge of this subject by assessing variations in state commitment to client-friendly enrollment processes in the case of Medicaid and CHIP. Through a qualitative comparative analysis of seventeen states, we have been able to explore the nature and sources of ARD in ways that often escape less intensive studies that draw on larger data sets. While our method does not permit us to test hypotheses definitively, it has generated five propositions that call for refinement in existing explanations of ARD. These propositions can help set the table for subsequent analyses that employ larger samples in a diverse array of social programs.

More broadly, future inquiry into ARD should focus on practices in operation after individuals become beneficiaries. In the context of Medicaid and CHIP, for instance, health care providers from one state to the next vary considerably in the degree to which they foster access to high-quality services for enrollees. Nor should the exploration of ARD stop at the boundaries of social programs. Regulatory activities, such as those provided by the

police and environmental agencies, should also garner attention. Ultimately, advances on these research fronts will illuminate the circumstances under which public administration counteracts or reinforces the propensity of Schattschneider's (1960) heavenly chorus to sing with an upper-class accent.

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