COVERAGE, COST, AND COINSURANCE: HOW DO THE AMERICAN STATES COMPARE AND WHAT DETERMINES CALIBER CARE?

A Thesis
by
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Abstract

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Studies of employer sponsored health insurance plans often focus on single case studies, or single dimensions of coverage. For example, scholars have not considered how the states compare to one another, or whether or not these plans can be explained by internal determinants unique to a respective state. This study conducts the first comprehensive analysis of employer sponsored health insurance in the American states for state employees, while simultaneously examining the influence of political, social, and economic factors. The byproduct of this analysis is a series of ranked indices that compare the states across ten dimensions of health coverage and three dimensions of costs for in- and out-of-network services. Beyond this, the examination draws broader lessons for the relationship between federalism and health policy in the United States.

Acknowledgments

to

Dr. Adam J. Newmark

This thesis is the first-fruit of the theoretical and methodological training of which I have received from you over the past two years, and as an expression of gratitude I wish to dedicate in your name. Throughout your mentorship of me, you have always evaluated my work liberally; it is my hope that you will approach these pages in the same light.

Dedication

to

My lovely grandparents, William and Debra Chapman

Thank you for being my two greatest confidants.

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Foreword

This thesis is formatted using *The American Journal of Political Science'*s style guide. This journal is a peer-review journal owned by Wiley-Blackwell, and is the leading professional organization for political science.

Chapter One: An Introduction to Examining Employer Sponsored Health Insurance Plans in the American States

In a federalist nation like the United States, decentralization often results in idiosyncrasies amongst the states. This is especially true when examining variation in employer sponsored health insurance (ESHI) plans offered by each of the American states to state employees. In this thesis, I argue that the scope of the states' health plan options serves as a proxy for how the state prioritizes healthcare. I explore not just the variation in scope of their ESHI plan options, but also examine theoretical explanations of the variation in scope of these health plans. This analysis is imperative for three predominant reasons: (1) To bridge the gap in the literature; (2) To provide a way of assessing commitment to healthcare; and (3) To examine how the states treat their workers. Existing literature consists of individual case studies of state health plans that revolve around narrow foci (e.g. Clark 2010; Robinson et al. 2008). Existing studies focus on narrow policies and are largely composed of single state examinations. The absence of a comprehensive study of state health plans denotes the ripeness of this research. Simply put, no one has completed such an analysis. This thesis provides a cross-sectional examination of all the fifty states' ESHI plans. This comparison is necessary to evaluate the way in which states differ in regard to their prioritization of access to and quality of healthcare for their citizenry. Additionally, this serves as a proxy for both the ways in which the states treat their employees and the level of commitment they maintain to healthcare. For example, Mississippi ranks 50th in wealth, with the lowest average income in the United States, but has the highest out-of-pocket maximum, meaning that a working family of four could end up with $17,100 in medical bills. In comparison, a family of four in Delaware has an out-of-pocket maximum of only $2,000. It is not uncommon for governors to tout their commitment to

healthcare, regardless of whether the state actually provides significant healthcare options. Governor Laura Kelly of Kansas made the following statement and the state has ten plans all offering comprehensive coverage to state employees: "Ensuring affordable, quality healthcare for employees across the state is one of my top priorities." On the other hand, while Governor Jay Inslee of Washington issued an executive order on improving the health and access to healthcare of state employees, the state only offers one plan option that provides limited coverage.

The overarching goal of this analysis is best understood in two parts—to measure the scope of each state's average ESHI plan and to explore their political, social, and economic roots. To adequately address each of these parts, they are divided into two separate chapters. Chapter two focuses on exploring the state of health policy scholarship, examining ESHI plans in the American states, and creating a theoretical and empirically based set of ranked indices across various dimensions of health coverage and costs. Chapter three applies internal determinant theory to examine causal linkages between political, social, and economic factors and health coverage and costs associated with state ESHI plans. Each chapter concludes with an exclusive discussion of the chapters' analysis. Finally, chapter four provides a concluding discussion on the implications of both analyses in tandem. The byproduct of this analysis is comparative ranked indices of the American states across ten dimensions of health coverage and three dimensions of health costs. I examine these rankings empirically to disentangle casualties between political, social, and economic factors and state health plans. Beyond widening our understanding of the substance and politics of health policy in the American states, this thesis draws broader lessons for the analysis of federalism and decentralization in the United States.

Chapter Two: Examining the Scope and Dimensionalities of ESHI Plans in the American States

Following the passage of the Affordable Care Act (ACA), scholarship regarding health policy has proliferated (Beland, Rocco, and Waddan 2016). However, these works largely consist of single case studies of health policy in a given state. Even fewer scholars focus exclusively on ESHI plans offered by states to state employees (for an exception, see Gruber and McKnight 2016). Those that do tend to examine a single dimension of health benefits for state employees, such as retirement health benefits (e.g. Clark 2010; Robinson et al. 2008).

In a broader sense, however, there is a considerable amount of relevant literature that needs to be reviewed to appropriately conceptualize ESHI plans and to develop corresponding rankings of the states. This study contributes to the literature by expanding the scope of research to include a coherent analysis of each of the fifty states across ten dimensions of ESHI plans offered to state employees. The following subsections provide an overview of research that describes an array of concepts related to health policy.

Employer Sponsored Health Insurance

Employer sponsored health insurance (ESHI) is a colloquialized term used to refer to a health policy or set of policies that are chosen by an employer—in the case at hand, the states—to offer to eligible employees and their dependents (Stanton 2004).

Role of Vertical Federalism and Decentralization

The devolution and dissemination of power to the states during the Reagan Presidency resulted in national health policy stalemate, leading Rich and White (1996) to opine that "we are on the threshold of a new era of federalism in healthcare" (Rich and White 1996, 81). Relatedly, other scholars conceptualize federalism as a pendulum, swinging back and forth between state

and federal dominance (Nathan 1993). Peterson (1995) examines and tests various models of federalism, distinguishing policies into three groups, theorizing that certain models, when integrated with certain policy groups, lead to optimal policy implementation outcomes. This effort becomes constrained, however, because a single model cannot explain how and why federalism interacts with specific programs in certain ways. Essentially, America's federalist system and consequent devolution have led to the variation in state health plans.

Clark (2010) examines the coverage of retiree health insurance plans for public school teachers, building off of the work of Robinson et al. (2008) and their compilation of each of the American states' retiree health plans. Clark's (2010) overarching finding is notable variation across the states in terms of their retiree health plans for teachers, asserting that there are "major differences in these plans and their costs across the states" in terms of provisions, funding methods, degree of government subsidy, and the costs incurred for the state governments (Clark 2010, 439). This serves as a systemic account of the decentralized nature of the states and their corresponding ESHI plans.

Doonan (2013) offers the most sophisticated account to date of the role of federalism and decentralization post-ACA. Doonan (2013) iterates the importance of considering idiosyncratic internalities within the states and health policy in tandem, suggesting that "understanding how federalism plays out is essential to understanding health policy" (Doonan 2013,7). Pross, Geissler, and Busse (2017) emphasize this point, asserting that health systems, in terms of quality accountability, lack both integration and standardization, both of which are results of vertical federalism and decentralization. Doonan (2013) continues this line of thought, calling for a more nuanced analysis of federalism and health policy, stating that extant studies lacked an

explanation for the variation between states in regard to health policy and the policy process more broadly.

The Role of Public Salience and Cost Transparency

While there are few studies that analyze the quality of health plans in the American states, those that have been conducted place considerable emphasis on public salience and cost transparency (Guadagnoli, Landrum, Peterson, Coahart, Ryan, and McNeil 2000; Pross, Geissler, and Busse 2017). Guadagnoli, Landrum, Peterson, Coahart, Ryan, and McNeil (2000) conduct a survey embedded experiment to determine the effect of health performance reports in the state of

Washington for state employees. The authors conclude that when state employees review the Consumer Assessment of Health Plans (CAHPS), a compilation of collected data from consumers regarding healthcare experiences, they are more likely to switch plans and report that they are confident in their decision (Guadagnoli, Landrum, Peterson, Coahart, Ryan, and McNeil 2000). These findings warrant tests of validity and generalizability, as the CAHPS is one of the largest collective efforts to develop consumer-based measures of ESHI plan performance (Guadagnoli, Landrum, Peterson, Coahart, Ryan, and McNeil 2000).

Along with public saliency comes the concern of price as this information becomes salient to consumers. Royalty and Solomon (1999) define "price" as the employee's out-of-pocket premium cost. In this vein, it is fitting to now provide a discussion of the role of price sensitivity in ESHI plans and plan selection.

Price Sensitivity and Limited Networks

In their analysis of the impact of limited network insurance plans for state employees in Massachusetts, Gruber and McKnight (2016) find that consumers are price sensitive in their

decision to opt into various ESHI plans. Limited network plans reduce costs primarily because the limited network size also decreases as price reductions occur (Buchmueller and Feldstein 1997; Cutler and Reber 1998; Gruber and McKnight 2016; Royalty and Solomon 1999). This suggests that quality of healthcare and the price of healthcare have an inverse relationship. Moreover, in regard to state employees in Massachusetts, the authors also find that financial incentives have a notable effect on the decisions made by consumers. In the case of Massachusetts, the Group Insurance Commission (GIC), the insurance plan for state employees, offered a three-month premium holiday that prompted ten percent of enrollees to transition to limited network plans (Gruber and McKnight 2016). Price sensitivity is heterogeneous in nature, however, as demonstrated by Strombom, Buchmueller, and Feldstein (2002). The authors conclude that new hires and younger hires are far more price sensitive than their older counterparts (Strombom, Buchmueller, and Feldstein 2002).

Consumer Assessment of Health Plans (CAHPS)

The CAHPS makes it easier for consumers to evaluate and choose the best ESHI plans for themselves and their families. The adult survey contains questions that ask respondents to rate the care received regarding twenty-four items that measure ten various health plan domains (Hays et al. 1999). In this vein, it is appropriate to use these measures as guidance in constructing the various criteria that I examine to construct the ranked indices.

In the analysis, I theorize that the areas of coverage and costs are interrelated. The discussion that follows provides the conceptual and logistical backbone to this theoretical postulation.

Theoretically Oriented Dimensions of Coverage and Costs

As the literature suggests, coverage and costs are imperative components to consider when examining health policy. Medical experts opine various areas of health coverage and access to such areas of service are essential for obtaining propitious health outcomes. In this section, I review eighteen areas of healthcare (urgent care coverage; emergency care coverage; emergency medical transportation; inpatient facility coverage; outpatient facility coverage; surgical coverage; x-ray coverage; imaging coverage; mental health therapy coverage; substance abuse therapy coverage; rehabilitative therapy coverage; chiropractic care coverage; maternity office visit coverage; maternity delivery coverage; home health service coverage; hospice coverage; primary care coverage; and prescription drug coverage) that are integral to overall healthcare coverage, as well as three areas of healthcare costs (monthly premiums; overall deductibles; and out-of-pocket maximums). I categorize these areas of healthcare into seven conceptual groupings that make logistical and operational sense. Moreover, to avoid the pitfalls of arbitrariness, it is important to note that these eighteen elements are categorized into these seven groupings based on the existing literature. Subsequent sections test these prima facie categorizations empirically.

Urgent Care, Emergency Care, and Emergency Medical Transportation

Weinick, Burns, and Mehrotra (2010) characterize urgent care centers as ameliorating establishments, mitigating patient frustrations with the limited availability of primary care providers and incessant wait times of emergency departments. The American Academy of Urgent Care Medicine suggests that as of late, the number of emergency rooms has decreased, while the incursion of patients continues to increase (Weinick, Burns, and Mehrotra 2010). The Center for Medicare and Medicaid services reports the median wait time patients experience

before being seen by a provider in the emergency department in each of the American states (Weinick, Burns, and Mehrotra 2010).While inter-state variation is notable (an average wait time of 14 minutes in CO and UT and an average wait time of 53 minutes in MD), the longest wait time observed at one of Georgia's emergency departments was a median wait time of 143 minutes. Contrarily, 90% of patients who utilize urgent care centers see a provider within 30 minutes or less (Memmel and Spalsbury 2017). Because of this, urgent care centers and individuals' reliance on their services have developed considerably in the United States, beginning in the early 1970s. The resources and services offered by urgent care centers are convenient, in that they serve as repositories for timely treatment of acute illnesses (Memmel and Spalsbury 2017).

Scherer, Lühmann, Kazek, Hansen, and Schäfer (2017) perform a cross-sectional observational study and find that in recent years, a steady increase in the number of individuals seeking out emergency care is notable. More specifically, Vaillancourt and Stiell (2004) note that heart disease is the primary cause of mortality in the Western world and seek to empirically examine the relationship between cardiac arrests and health outcomes when individuals are treated in an emergency setting. They find a positive association between emergency care services and low mortality rates relative to an absence of emergency care services. Additionally, Fauer, Wallner, Davis, Choi, and Friese (2020) examine the association between emergency department visits and health outcomes in patients' first year diagnoses of hematologic malignancies and find significant covariation. In essence, emergency departments and their analogous aid are imperative when considering overall health outcomes.

Gupta, Savu, Sheldon, Raj, Kaul, and Sandhu (2020) examine the relationship between emergency medical transportation usage and health outcomes. Gupta et al. (2020) find that patients who arrive by ambulance have favorable, short-term prognoses relative to patients experiencing similar conditions who did not arrive via ambulance. Eliakundu, Cadilhac, Kim, Bladin, Grimley, Dewey, Donnan, Hill, Levi, Middleton, Anderson, Lannin, and Kilkenny (2021) perform a multicenter national data linkage study that analyzes factors associated with health outcomes for patients with acute strokes and their method of transportation. Eliakundu et al. (2021) find that patients who arrive by ambulance arrive faster and are more likely to receive reperfusion therapy than patients who arrive via personal transport. Essentially, access to urgent care centers, emergency rooms, and emergency medical transportation improves health outcomes. Therefore, access and coverage of these services are important components to consider when ranking the states and their respective plans for in-network and out-of-network services.

Inpatient and Outpatient Surgical Facilities and Surgery

Weiser, Regenbogen, Thompson, Haynes, Lipsitz, Berry, and Gawande (2008) examine the amount and availability of surgical care, ranging from minor surgical procedures to major operations. Weiser et al. (2008) conclude that means of access to surgery should be considered a public health concern, in which public health efforts and surgical surveillance should be established. In their analysis, they find that surgery occurs as considerable rates, asserting that access to and coverage of surgical procedures are requisite. Others examine the importance of surgery access and coverage more narrowly, focusing on health outcomes in particular areas. For example, Manchanda and Gaba (2018) find surgical intervention is the most effective option for approaching ovarian cancer; Ahola, Vasama, Vornanen, Sand, and Laukkarinen (2017) find a

statistically significant correlation between lower mortality rates and pancreatic surgery; and Insaf, Sommerhalter, Jaff, Farr, Downing, Zaidi, Lui, and Zutphen (2021) suggest that access to surgery and its auxiliary facilities serve as a mediator for health outcomes in cases of congenital heart defects in adolescents and adults. These findings iterate the importance of examining the states' inpatient facility, outpatient facility, and surgery coverage rates for in-Network and out-of-network services.

X-Rays and Other Imaging Devices

Pogue and Wilson (2018) refer to x-ray and other imaging technologies as 'central pillars' in the metaphorical medical toolbox. Moreover, they assert that, "taken together, these technologies form the basis for the vast majority of diagnostics and therapeutics in use in clinical medicine" (Pogue and Wilson 2018, 1). Martel-Villagrán, Arias-Medina, and García-Mardones (2020) note the usefulness of x-rays in the diagnosis process of hypophosphatemic rickets, but assert that their usefulness is not limited to this particular area, iterating their importance as a medical tool generally. More specifically, Singhvi and Bon (2020) evaluate how chest CT imaging can benefit COPD patients who are at risk for comorbidities. Geuzinge, Heijnsdijk, Obdeijn, Koning, and Tilanus-Linthorst (2021) examine the role of MRIs and breast cancer in women and find that it aids in early cancer detection (95%). In effect, access to and coverage of x-ray and other imaging services are important considerations.

Mental Health, Substance Abuse, Rehabilitative Therapies and Chiropractic Care

Sporinove, Manns, Tonelli, Hemmelgarn, MacMaster, Mitchell, Au, Ma, Weaver, and Quinn (2019) find that mental health disorders are associated with higher healthcare costs and poor health coverage, iterating the subsequent dire health policy implications. Moussas and Papdopoulou (2017) suggest that substance abuse as a health problem is correlated with serious

psychological and psychiatric dimensions, specifically in regard to depression and anxiety. Akyuz and Kenis (2014) expresses the dire importance of physical therapy modalities, and more broadly, rehabilitation praxis. Finally, Blanchette, Stochkendahl, Borges Da Silva, Boruff, Harrison, and Bussieres (2016) provide a systematic review of the effectiveness and economic costs associated with chiropractic care. In doing so, they find that neglecting chiropractic care is the leading cause of disability across the world, demonstrating the importance of physical therapy and chiropractic care. In this vein, access to these services are imperative. Therefore, these elements of coverage are examined.

Maternity Visits and Child Delivery Services

Hunter, Devane, Houghton, Grealish, Tullish, and Smith (2017) take a woman-centered approach to examining maternity care. In their analysis, they find that optimal health outcomes for mothers and children require partnership in staff continuity and availability, health coverage choice, individualized care, and practice organization. In essence, maternity visits and child delivery services are imperative when considering overall health outcomes.

Home Health Services and Hospice Care

Werner, Coe, Qi, and Konetzka (2018) explore the association of patient outcomes with patients discharged home with home healthcare versus patients discharged without home healthcare. The patients who utilized home healthcare showed improvements in functional status much quicker than those who did not receive home healthcare. Additionally, these individuals fared with lower rates of hospital readmission. Chow and Pickens (2020) find that end-of-life care is essential for efficacious care and that it continues to be utilized more and more frequently, compared to times past. In this light, both home health services and hospice care need to be considered when assessing the comprehensiveness of health plans.

Primary Care and Prescription Drugs

Starfield (1994) colloquializes primary care as "the backbone of a rational health services system" (Starfield 1994, 1129). While other areas of care are important, Starfield (1994) suggests that in addition to emergency care, primary care is central, while other forms of care are secondary and tertiary. Preventative services such as immunizations are a common form of primary care. As Kunze and Groman (2017) express, "vaccinations belong to the ten most effective public health achievements worldwide" (Kunze and Groman 2017, 203). The very nature of this statement expresses the imperative nature of vaccinations within primary care. Additionally, they conclude that primary drugs are essential for optimal health outcomes in not just children, but also in adults. Thomas and Lorenzetti (2014) draw similar conclusions in their historical analysis of prescription drug use. Essentially, preventative measures are becoming more consumptive. Taken together, primary care and its components, including prescription drugs are critical services to consider when evaluating coverage.

Data, Measurement, and Methodology

Definition and Measurement of Coverage and Cost

Determining what constitutes a *good* health plan is largely open to interpretation. Health plans with a broad scope of coverage indicate one interpretation of a *good* health plan. We might consider lower coinsurance rates as well, placing more subsidization requirements on the state than the plan's consumer. In a normative sense, comprehensive healthcare can be understood as an inherently *good* thing. The next issue, then, is how to conflate *good* health coverage with palatable costs. While many would agree that dilatant coverage is desirable, such coverage typically comes at a cost—higher payments, be it high monthly premiums, overall deductibles, and/or out-of-pocket maximums. This inverse relationship begs the question: What is a better

indicator of a *good* health plan, comprehensive coverage or economical costs? To best disentangle this query, I include measures of both coverage and costs. In effect, I establish dimensions of coverage and dimensions of cost. Coverage represents the percent of coverage provided by the mean ESHI plan for each of the states. These percentages are calculated across each dimension of coverage examined. Costs represent the quantitative cost associated with monthly premiums, overall deductibles, and out-of-pocket maximums for the mean ESHI plan for each of the states. These treatments essentially produce three dependent variables that I examine across the aforementioned dimensions of coverage and costs. I evaluate coverage with two dependent variables, in-network coverage and out-of-network coverage. I examine these across each dimension of coverage in subsequent sections. Cost represents one dependent variable, that is comprised of premiums, deductibles, and out-of-pocket maximums. The consideration of these three variables in tandem aims to clarify their interrelationships, along with an examination of internal determinants to understand the state rankings. It is my hope that the following discussion will prompt further examination of ESHI plans in the American states.

Ranking the States: Comparative Indices of Coverage and Costs

Many states offer multiple plans to state employees. While the units of analysis in this examination are the states, not the individual plans, to truly analyze the states in a substantive and comparative manner, I first review their respective plans. Following the passage of the Affordable Care Act, health insurers and self-funded employers alike are required to provide their enrollees with plan document synopses, commonly referred to as a Summary of Benefits and Coverage (SBC). Essentially, the document provides consumers with an overview of plan information that proves useful when comparing plan options. These documents are available for public access through each of the states' Office of State Human Resources. I use SBCs to obtain

substantive information regarding coverage and degree of coverage for each coverage area included in the analysis. Beyond serving as a convenient heuristic for data collection, SBCs also provide a medical glossary that is useful for operationalization purposes. In order to quantify these plans, over the course of five months of data collection, I evaluate 141 elements of costs and coverage by reading each states' ESHI plan (each of which are discussed in detail in Appendix A). When empirically examined, we see that some of these theoretical presumptions lack statistical support.

The concepts that go into these measures of coverage and costs are: urgent care coverage; emergency care coverage; emergency medical transportation; inpatient facility coverage; outpatient facility coverage; surgical coverage; x-ray coverage; imaging coverage; mental health therapy coverage; substance abuse therapy coverage; rehabilitative therapy coverage; chiropractic care coverage; maternity office visit coverage; maternity delivery coverage; home health service coverage; hospice coverage; primary care coverage; prescription drug coverage; individual employee monthly premium rates; employee and spouse monthly premium rates; employee and child/ren monthly premium rates; employee, spouse and child/ren monthly premium rates; individual overall deductibles; family overall deductibles; individual out-of-pocket maximums; and family out-of-pocket maximums. Each of these elements of costs are represented by the quantitative costs associated with the states' average ESHI plan. The plan year that I analyze is based off of the most recent health plan(s) the state has available for public access and are available for public access through each of the states' Office of State Human Resources. These data are from the years 2020 or 2021. From here, I produce average measures of ESHI plans for each of the fifty American states. Apart from six states, (AL; ME; MN; MT; NV; WA), the remaining states offer their employees a variety of plans to choose from, ranging

in costs and coverage. Employees are then able to select which plan is most befitting the employee and, in many cases, their families. The forty-four states that offer two or more health plan options are averaged for each element of coverage. I compute these averages by area of coverage, producing mean percentages of coverage for each element covered. These mean percentages produce an average ESHI plan for each of the states. This produces a true measure of coverage for a given service that allows for comparison and ranking relative to other states and their subsequent coverage rankings. For example, the state of Michigan offers its employees six health plan options for purchase. Of these six plans, five cover out-of-network coverage for emergency medical transportation via ambulance. Therefore, 83% of their plans offer said coverage. The plans also differ in percent of coverage, ranging from 90-100% coverage. The mean percent of coverage is 98%. Thus, to develop this true measure, the following is computed: (0.83)*(98). In sum, Michigan's out-of-network coverage for emergency medical transportation is 81.34%. This computation of true coverage is consistently applied to states in similar scenarios in each of the coverage areas analyzed. I then compare, in relative terms, these averages across states and across coverage areas, producing ranked indices of the states.

Dimensional Groupings Among the States

As discussed previously, the dimensions of coverage and costs that I analyze comprise theoretically oriented groupings. In terms of face validity, these groupings make sense. For example, x-ray and imaging are analogous services that one would expect are interrelated. If these habitual assemblages are correct, the data should provide empirical evidence of the existence of statistically significant relationships across these dimensions. If the average ESHI plans in the states provide similar coverage and similar costs across these predefined dimensions, a factor analysis should reveal underlying groupings along which the states would be ordered

according to their scope of coverage and affordability of cost. The results of the factor analyses are discussed below, with loads reported in each discussion of each dimension of coverage and cost. As the ensuing discussion shows, the majority of dimensional groupings I theorize as existing, are indeed empirically sound. Factor analysis allows the theoretically based groupings to be tested empirically, determining if the data share a relationship beyond the bounds of conceptual groupings.

The following section empirically tests these conceptual groupings by performing exploratory factor analysis that utilizes pro max rotation. Exploratory factor analysis is appropriate to assess the validity and reliability of the theoretical groupings constructed previously. Additionally, the oblique rotation allows for the corresponding eigenvectors to be situated in a way that produces a simple structure. From here, such calculated factors can be related to theoretical postulations. A discussion accompanies each tabular visualization.

State ESHI Indices—Comparative Rankings of Coverage

The complexity of ranking the states is largely evident by the lack of scholarship on the topic. Additionally, coverage is a multifaceted matter. To aptly account for its comprehensive nature, I consider coverage for both in-network and out-of-network services. In the order presented above, I perform factor analysis on each element of coverage that contrive each dimensional grouping discussed above. This permits the ability to determine if it is suitable to rank the states on the conceptual rankings previously developed, or if the concepts are empirically unrelated. This analysis provides evidence that many of the dimensions are empirically supported. These groups serve two primary purposes: (1) It allows for the extraction of maximum common variance, reducing the large number of variables; and (2) It transforms the data into easily scorable elements, making ranked indices possible.

Urgent Care, Emergency Care, and Emergency Medical Transportation

I first perform exploratory factor analysis of urgent care, emergency care, and emergency medical transportation rankings for each of the states' average ESHI plans. In addition to this grouping making theoretical and logistical sense, empirically a clear relationship is of note. This determines and confirms that across this dimension, there is a single factor, in which five of the six elements go together. Factor loadings confirm this relationship, in which in-network urgent care (0.74), emergency care (0.90), and emergency medical transportation (0.55) are related to out-of-network emergency care (0.46) and emergency medical transportation (0.61). Out-of-network urgent care does not load on the same factor and has a reported loading of -0.39. However, I include this element of coverage because it is indicative of the quality of care. Moreover, I conduct a reliability analysis of each item, resulting in a Cronbach's alpha of 0.83.

Table 1 State Rankings for In-Network and Out-of-Network Urgent Care, Emergency Care, and Emergency Transportation Coverage

Rank	State	**Rank**	State
1	UT	**26**	MN
2	IL	**27**	MT
3	OR	**28**	CO
4	DE	**29**	TX
5	NM	**30**	MD
6	AK	**31**	WI
7	RI	**32**	IA
8	MA	**33**	ND
9	SD	**34**	MO
10	VT	**35**	ID
11	NV	**36**	HI
12	FL	**37**	KS
13	WY	**38**	IN
14	MI	**39**	OH
15	PA	**40**	GA
16	AZ	**41**	ME
17	NC	**42**	NE
18	OK	**43**	AL
19	TN	**45**	KY
20	MS	**45**	WV

21	SC	**46**	CT
23	CA	**47**	AR
23	WA	**48**	NY
25	NH	**49**	VA
25	NJ	**50**	LA

This table is based on the mean rankings that each of the states maintain across the areas of in-network and out-of-network urgent care, emergency care, and emergency transportation.

Table 1 displays state rankings across the coverage dimension of urgent care, emergency care, and emergency medical transportation. Since these concepts go together empirically, the ranks are based on both in- and out-of-network coverage rates. Across this dimension, Utah is the evident leader; Louisiana the laggard. On average, the state of Utah subsidizes 97.8% of the cost of services, whereas Louisiana only covers 41.7% of the cost, leaving the consumer responsible for the majority of the expenses. This distinction has even greater bearing when considering wealth disparity between these states. Utah ranks 12st in wealth, while Louisiana ranks 47th.

Inpatient and Outpatient Surgical Facilities and Surgery

I first perform exploratory and confirmatory factor analysis of inpatient surgical facility, outpatient surgical facility, and surgical coverage, both in- and out-of-network for each of the state average ESHI plans. This confirms that two factors exist across these elements of coverage, in which the in-network elements and out-of-network elements neatly load on their own respective factors. The following items load on factor one: out-of-network inpatient surgical facility (0.99), outpatient surgical facility (0.99), and surgical coverage (0.99). Similarly, the analogous in-network items load on factor two: in-network inpatient surgical facility (0.97), outpatient surgical facility (0.99), and surgical coverage (0.98). These empirical groupings justify splitting these services into separate rankings. Additionally, the Cronbach's alpha for in-network is 0.99 and 0.99 for out-of-network. Table 2.A presents the

average rankings for the states across this dimension of coverage for in-network services, while Table 2.B presents the average rankings for out-of-network scenarios.

Table 2.A State Rankings for In-Network Inpatient Facility, Outpatient Facility, and Surgical Coverage

Rank	State	Rank	State
1	AK	**27**	CA
1	MS	**27**	NH
1	PA	**28**	NC
1	UT	**29**	MT
6	IL	**40**	AL
6	VT	**40**	AR
8	AZ	**40**	FL
8	MA	**40**	ID
10	SC	**40**	IN
10	SD	**40**	MO
11	NV	**40**	ND
12	OR	**40**	OH
14	IA	**40**	TN
14	NJ	**40**	VA
15	WV	**40**	WI
20	MI	**41**	KS
20	NM	**42**	GA
20	OK	**43**	MD
20	RI	**45**	HI
20	WY	**45**	LA
21	WA	**46**	KY
23	CO	**48**	CT
23	NE	**48**	ME
24	MN	**49**	NY
25	TX	**50**	DE

This table is based on the mean rankings that each of the states maintain across the areas in-network inpatient facility, outpatient facility, and surgical services.

Table 2.A presents state rankings based on in-network coverage rates for inpatient and outpatient surgical facilities, as well as surgical services. Across this dimension of coverage, there is less variation in coverage rates, as is evident with the prominent presence of tied rankings. Alaska, Mississippi, Pennsylvania, and Utah rank 1st, while Delaware ranks 50th.

Table 2.B State Rankings for Out-of-Network Inpatient Facility, Outpatient Facility, and Surgical Coverage

Rank	State	**Rank**	State
1	MA	**26**	CT
2	UT	**29**	ID
3	IA	**29**	NY
4	MS	**29**	SC
8	AK	**30**	KY
8	MT	**31**	RI
8	NH	**32**	NJ
8	ND	**33**	MN
9	NM	**34**	SC
10	HI	**35**	PA
11	NC	**36**	NE
12	ME	**37**	MI
23	AL	**39**	IL
23	CA	**39**	TX
23	FL	**40**	AR
23	IN	**41**	NV
23	MO	**43**	KS
23	OH	**43**	OK
23	OR	**44**	CO
23	VA	**45**	AZ
23	WA	**47**	VT
23	WI	**47**	WV
23	WY	**48**	MD
24	TN	**50**	DE
25	GA	**50**	LA

This table is based on the mean rankings that each of the states maintain across the areas out-of-network inpatient facility, outpatient facility, and surgical services.

Table 2.B tells a different story, however. While the rankings are based on the same dimension of coverage as Table 2.A, it is evident that when services are out-of-network, state ESHI plans and their coverage rates for these services vary on the basis of network. While Delaware remains a laggard, Louisiana follows suit, also ranking 50th. Moreover, Massachusetts ranks 1st, as opposed to 8th when in-network (see Table 2.A).

X-Rays and Other Imaging Devices

In remaining consistent with the aforementioned methodology, I conduct exploratory and confirmatory factor analysis of x-rays and other imaging device coverage. From a strictly theoretical perspective, it makes sense that the like nature of these services warrants the construction of a single dimension of health coverage, as opposed to treating the services exclusively. I test this theoretical postulation by performing factor analysis. This confirms their theoretical grouping, as can be noted from factor loadings. The following items load on factor one: out-of-network x-ray coverage (0.99) and imaging coverage (0.99). In network x-ray coverage (0.99) and imaging coverage (0.99) load on factor two, empirically justifying the construction of separate ranks. Cronbach's alpha is then used to assess internal consistency and scale reliability. This confirms that in-network (= 0.99) and out-of-network (= 0.99) groupings, across this dimension of coverage is appropriate. In this vein, Table 3.A presents the average rankings for the states across this dimension of coverage for in-network services, while Table 3.B presents the average rankings for out-of-network services.

Table 3.A State Rankings for In-Network X-Ray and Imaging Coverage

Rank	State	Rank	State
1	AK	**26**	NC
1	MS	**28**	MT
1	PA	**28**	TX
1	UT	**29**	WV
1	VT	**41**	AL
6	IL	**41**	AR
7	AZ	**41**	CO
8	NV	**41**	FL
10	SC	**41**	ID
10	SD	**41**	IN
11	OR	**41**	MO
12	NJ	**41**	ND
13	NM	**41**	OH
19	IA	**41**	TN
19	MA	**41**	VA
19	MI	**41**	WI
19	OK	**42**	GA
19	RI	**43**	MD
19	WY	**45**	HI
20	NE	**45**	LA
21	MN	**46**	KY
22	KS	**47**	CT
25	CA	**48**	ME
25	NH	**49**	NY
25	WA	**50**	DE

This table is based on the mean rankings that each of the states maintain across the areas in-network x-ray and imaging services.

Table 3.A displays state rankings across the coverage dimension of x-ray and other imaging devices when accessed in-network. As is the case for in-network inpatient and outpatient surgery facilities and surgical services as discussed above (see Table 2.A), Alaska, Mississippi, Pennsylvania, and Utah also tie for 1st across this dimension of coverage, with Vermont following suit. Also similarly, Delaware provides the poorest coverage for these

services. Finally, it is evident that this dimension is less variant rich in terms of coverage rates than other dimensions, with approximately one-fourth of the states ranking 41st .

Table 3.B State Rankings for Out-of-Network X-Ray and Imaging Coverage

Rank	State	Rank	State
1	MS	**26**	CT
1	UT	**30**	ID
3	MA	**30**	ME
7	IA	**30**	NY
7	MT	**30**	SC
7	NH	**31**	KY
7	ND	**32**	NJ
8	NM	**33**	MN
9	OR	**35**	PA
10	HI	**35**	SD
11	NC	**36**	NE
12	TN	**37**	MI
24	AL	**38**	IL
24	AK	**40**	KS
24	CA	**40**	TX
24	FL	**41**	AR
24	IN	**42**	OK
24	MO	**43**	NV
24	OH	**44**	CO
24	RI	**45**	WV
24	VA	**46**	AZ
24	WA	**47**	VT
24	WI	**48**	MD
24	WY	**50**	DE
25	GA	**50**	LA

This table is based on the mean rankings that each of the states maintain across the areas out-of-network x-ray and imaging services.

Table 3.B displays state rankings for out-of-network x-ray and other imaging devices. When comparing these rankings with the aforementioned in-network rankings in Table 3.A, we see that Mississippi and Utah retain their leader rankings of 1st, whereas Alaska drops to 24th, Pennsylvania drops to 35th, and Vermont drops to 47th. Delaware remains at 50th, tying with Louisiana. Translating these artificial rankings into real-world examples stresses the implicatory

nature of these differences: A Vermont state employee's coverage, after having met their deductible, subsidizes in-network x-ray and other imaging services completely. However, the same services for the same employee when provided out-of-network, requires that the consumer pay for 98.4% of the cost, even after their deductible has been met.

Mental Health, Substance Abuse, Rehabilitative Therapies and Chiropractic Care

When considering these elements of coverage, it makes sense that these treatments are related. Exploratory and confirmatory factor analysis test this theoretical categorization and yields support. Much like previously discussed dimensions of coverage, factor loadings suggest that these services are related on the basis of network. The following items load on factor one: out-of-network mental health (1.0), substance abuse (1.0), chiropractic care (0.88), and rehabilitative (0.83) services. Relatedly, the same services, when out-of-network load on factor two. The consequent loadings are: in network mental health (0.98), substance abuse (0.97), chiropractic care (0.75), and rehabilitative (0.74) services. Cronbach's alpha confirms that these groupings are reliable, with in-network services ($\alpha = 0.94$) and out-of-network services ($\alpha = 0.98$). Table 4.A presents the average rankings for the states across this dimension of coverage for services provided in-network, while Table 4.B presents the average rankings for the states across this dimension of coverage when services are provided out-of-network.

Table 4.A State Rankings for In-Network Mental Health, Substance Abuse, Chiropractic Aid, and Rehabilitative Coverage

Rank	State	**Rank**	State
1	AK	**26**	TN
1	DE	**27**	AL
1	LA	**28**	NE
1	MA	**29**	TX
1	MI	**30**	CO
1	NV	**31**	MD
1	PA	**32**	MN
1	RI	**33**	FL
1	VT	**34**	ME
1	WV	**35**	WA
11	IL	**36**	MT
12	AZ	**37**	NH
13	NM	**38**	NC
15	CA	**39**	MS
15	SC	**40**	OH
16	UT	**41**	GA
17	IA	**46**	ID
18	NJ	**46**	IN
19	OR	**46**	MO
20	WY	**46**	VA
21	ND	**46**	WI
22	KS	**47**	KY
23	OK	**48**	NY
24	SD	**49**	HI
26	AR	**50**	CT

This table is based on the mean rankings that each of the states maintain across the areas in-network mental health, substance abuse, chiropractic aid, and rehabilitative services.

Table 4.A provides state rankings for the coverage dimension of mental health, substance abuse, and rehabilitative therapies, as well as chiropractic aid, in-network. Twenty percent of the states tie for 1st: Alaska, Delaware, Louisiana, Massachusetts, Michigan, Nevada, Pennsylvania, Rhode Island, Vermont, and West Virginia. Perhaps of most interest are Delaware and Louisiana. As the previously discussed tables show, these states have consistently

been ranked near the bottom, yet here they are ranked at the top. Across this dimension, Connecticut is ranked last.

Table 4.B State Rankings for Out-of-Network Mental Health, Substance Abuse, Chiropractic Aid, and Rehabilitative Coverage

Rank	State	**Rank**	State
1	MA	**26**	CT
2	ND	**28**	ID
4	MS	**28**	NY
4	UT	**29**	SC
5	NM	**30**	KY
9	AK	**31**	NJ
9	IA	**32**	KS
9	MT	**33**	SD
9	NH	**34**	GA
11	ME	**35**	PA
11	OR	**36**	FL
13	HI	**37**	NE
13	TN	**38**	MI
14	NC	**39**	IL
15	MN	**40**	TX
23	AL	**41**	AR
23	CA	**42**	OK
23	IN	**43**	NV
23	MO	**44**	CO
23	RI	**45**	AZ
23	WA	**46**	WV
23	WI	**47**	VT
23	WY	**48**	MD
24	VA	**50**	DE
25	OH	**50**	LA

This table is based on the mean rankings that each of the states maintain across the areas out-of-network mental health, substance abuse, chiropractic aid, and rehabilitative services.

Table 4.B provides state rankings for the coverage dimension of mental health, substance abuse, and rehabilitative therapies, as well as chiropractic aid, for out-ofnetwork. The majority of the in-network leaders for these services drop ranking, with Massachusetts being the only state to remain ranked at 1st. Interestingly, Delaware and Louisiana, two of the ten leaders in-network, tie for 50th. In fact, Delaware and Louisiana

provide 100% coverage for these services, after consumers' deductibles have been met when provided in-network, but provide no coverage for the same services out-of-network, regardless of deductibles.

Maternity Visits and Child Delivery Services

Considering these elements of coverage through a conceptual lens results in an acknowledgement of their congenital relationship. From this logistical standpoint, it makes sense that these services be considered together. Moreover, the literature iterates the importance of both components for health outcomes of both mother and child (see Hunter et al. 2017). To assess these notions of relatedness, I perform exploratory and confirmatory factor analysis. In doing so, it becomes evident that, both theoretically and empirically, it is pertinent to rank the states based on their in-network and out-of-network comprehensiveness of coverage. Out-of network maternity office visits (0.97) and child delivery services (0.98) load on factor one, while in-network maternity office visits (0.77) and child delivery services (0.78) load on factor two. Additionally, in-network ($\alpha = 0.80$) and out-of-network ($\alpha = 0.98$) services across this dimension of coverage produce statistically significant measures of scale reliability. Table 5.A presents the average rankings for the states across this dimension of coverage for services in network, while Table 5.B presents the average rankings for the states across this dimension of coverage when services are provided out-of-network.

Table 5.A State Rankings for In-Network Maternity Visits and Child Delivery Coverage

Rank	State	**Rank**	State
1	AK	**27**	LA
1	MA	**27**	TX
1	MS	**31**	CA
1	PA	**31**	NH
1	UT	**31**	TN
1	WV	**31**	WA
7	IL	**32**	ME
8	VT	**34**	DE
11	AZ	**34**	NC
11	NV	**36**	AL
11	SD	**36**	ND
12	OR	**37**	MT
14	AR	**45**	FL
14	SC	**45**	ID
16	OK	**45**	IN
16	RI	**45**	MO
17	NJ	**45**	NY
19	MD	**45**	OH
19	NM	**45**	VA
20	IA	**45**	WI
21	CO	**46**	KS
23	MI	**47**	GA
23	WY	**48**	HI
24	NE	**49**	KY
25	MN	**50**	CT

This table is based on the mean rankings that each of the states maintain across the areas in-network maternity visits and child delivery services.

Table 5.A displays state rankings for in-network maternity visits and child delivery coverage. Six states tie for 1st, many of which have ranked as leaders across aforementioned dimensions: Alaska, Massachusetts, Mississippi, Pennsylvania, Utah, and West Virginia. On the opposing end of the index, Connecticut ranks 50th.

Table 5.B State Rankings for Out-of-Network Maternity Visits and Child Delivery Coverage

Rank	State	**Rank**	State
1	MA	**26**	GA
3	MS	**27**	CT
3	UT	**30**	ID
4	ND	**30**	NY
5	IA	**30**	SC
8	AK	**31**	KY
8	MT	**32**	NJ
8	NH	**33**	MN
9	NM	**34**	SD
10	OR	**35**	PA
11	HI	**37**	IL
12	ME	**37**	NE
13	NC	**38**	MI
14	TN	**40**	NV
25	AL	**40**	TX
25	CA	**41**	AR
25	FL	**43**	KS
25	IN	**43**	OK
25	MO	**44**	CO
25	OH	**45**	WV
25	RI	**46**	AZ
25	VA	**47**	VT
25	WA	**48**	MD
25	WI	**50**	DE
25	WY	**50**	LA

This table is based on the mean rankings that each of the states maintain across the areas out-of-network maternity visits and child delivery services.

Table 5.B displays state rankings for out-of-network maternity visits and child delivery coverage. When comparing these rankings with the aforementioned in-network rankings in Table 5.A, we see that Massachusetts is the only state that remains ranked 1st, whereas Alaska drops to 8th, Mississippi and Utah drop to 3rd, Pennsylvania drops to 35th, and West Virginia drops to 45th. Also, in the case above (see Table 5.A), Connecticut ranked poorest, however when services are provided out-of-network, Connecticut offers better relative coverage, ranking 27th. Instead,

Delaware and Louisiana tie for 50th, iterating a systematic trend across dimensions. These poor rankings exemplify tangible dilemmas for new mothers who rely on ESHI plans in Delaware and Louisiana. If Delawarean or Louisianian women give birth at a facility out-of-network, or if their obstetrician is not in-network, they are responsible for all costs associated with such services. Learish (2020) finds that the average cost of childbirth in Delaware is $11, 391 and $16,272 in Louisiana, while the average cost is around $8,800 in Maryland and Nebraska.

Home Health Services and Hospice Care

Aforementioned literature suggests that home health services and hospice care are both imperative and conceptually similar elements of healthcare. To assess this, I perform exploratory and confirmatory factor analysis. This affirms the correspondence of these items, with in-network home health services (0.90) and hospice care (0.90) loading on the first factor and out-of-network home health services (0.84) and hospice care (0.87) loading on the second factor. Moreover, I perform reliability analyses, with Cronbach's alpha scores of 0.92 for in-network services and 0.88 for out-of-network services. Table 6.A presents the average rankings for the states across this dimension of coverage for in-network services , while Table 6.B presents the average rankings for the states across this dimension of coverage when services are provided out-of-network.

Table 6.A State Rankings for In-Network Home Health Services and Hospice Care

Rank	State	**Rank**	State
1	AK	**26**	CA
1	DE	**27**	NC
1	NH	**28**	OH
1	PA	**29**	KS
1	VT	**31**	IA
1	WV	**31**	TX
7	IL	**40**	AL
8	AZ	**40**	AR
9	NV	**40**	FL
10	MA	**40**	ID
11	MN	**40**	IN
13	SC	**40**	MO
13	SD	**40**	ND
14	OR	**40**	VA
15	NJ	**40**	WI
16	WA	**41**	GA
17	MT	**42**	TN
22	MI	**44**	HI
22	NM	**44**	LA
22	OK	**45**	KY
22	RI	**47**	CT
22	WY	**47**	MS
23	MD	**48**	ME
25	CO	**49**	NY
25	NE	**50**	UT

This table is based on the mean rankings that each of the states maintain across the areas in-network home health services and hospice services.

Table 6.A provides state rankings for the coverage dimension of in-network home health services and hospice care. Six states tie for 1st: Alaska, New Hampshire, Pennsylvania, Vermont, West Virginia, and perhaps most surprisingly, Delaware. As previously discussed Delaware is typically ranked near the bottom. Moreover, Utah is typically a leader, however across this dimension of coverage, when in-network, it ranks 50th.

Table 6.B State Rankings for Out-of-Network Home Health Services and Hospice Care

Rank	State	Rank	State
1	NH	**29**	ID
2	MA	**29**	IA
3	MT	**29**	NY
5	AK	**29**	SC
5	ND	**31**	KY
8	ME	**31**	NJ
8	NM	**32**	SD
8	OR	**33**	PA
9	HI	**34**	NE
10	NC	**35**	MI
13	FL	**36**	TX
13	OH	**37**	AR
13	WI	**39**	KS
21	AL	**39**	OK
21	CA	**40**	NV
21	IN	**41**	IL
21	MO	**42**	UT
21	RI	**43**	CO
21	VA	**44**	WV
21	WA	**45**	AZ
21	WY	**46**	VT
23	GA	**47**	MD
23	TN	**50**	DE
24	CT	**50**	LA
25	MN	**50**	MS

This table is based on the mean rankings that each of the states maintain across the areas out-of-network home health services and hospice services.

Table 6.B provides state rankings for the coverage dimension of out-of-network home health services and hospice care. Unlike in-network coverage, when these services are provided out-of-network, New Hampshire is the evident leader, ranking 1st. Delaware, Louisiana, and Mississippi tie for poorest coverage, ranking 50th. As this analysis has already shown, network proximity matters. This dimension of coverage conveys just that: A state employee of Delaware is not responsible for any of the costs associated with home health

services or hospice care if said services are provided in-network. However, the same employee is responsible for 100% of the costs if the care is provided out-of-network.

Primary Care and Prescription Drugs

As the previous section suggests, primary care and prescription drug coverage are fundamental elements of healthcare and as such must be taken into consideration when constructing state rankings. Conceptually, it makes sense to assume these services go together. However, exploratory and confirmatory factor analysis suggests that these items are not related. Additionally, Cronbach's alpha measures of scale reliability are particularly low While an empirical relationship between these elements does not exist, it would be erroneous to omit these dimensions from the analysis. In this vein, it is suitable to rank the states on these elements singularly. Table 7.A presents the average rankings for the states across two dimensions of coverage--in-network primary care visits and prescription drug coverage. The first ranks represent primary care coverage. The second ranks, those presented in parentheses, represent prescription drug coverage. Table 7.B presents the same rankings when services are out-of-network.

Table 7.A State Rankings for In-Network Primary Care and Prescription Drug Coverage

Primary Care				Prescription Drugs			
Rank	State	**Rank**	State	**Rank**	State	**Rank**	State
1	AK	**27**	NE	**1**	AK	**26**	KS
2	CA	**27**	ND	**1**	CA	**29**	AR
3	DE	**28**	OR	**1**	DE	**29**	NH
4	IL	**34**	FL	**1**	IL	**29**	TN
5	LA	**34**	IN	**1**	IN	**30**	NJ
6	MA	**34**	IA	**1**	LA	**34**	AL
7	MI	**34**	ME	**1**	MD	**34**	ME
8	MS	**34**	OH	**1**	MA	**34**	NE
9	NV	**34**	WY	**1**	MI	**34**	ND
10	OK	**35**	KS	**1**	MS	**39**	GA
11	PA	**36**	TX	**1**	MT	**39**	IA
12	RI	**37**	CO	**1**	NM	**39**	OH
13	UT	**38**	MN	**1**	NC	**39**	VA
14	VT	**39**	WA	**1**	OK	**39**	WA
15	WV	**42**	GA	**1**	OR	**40**	TX
16	AZ	**42**	MO	**1**	PA	**41**	HI
17	MD	**42**	NC	**1**	RI	**42**	CO
18	NM	**46**	ID	**1**	SC	**43**	NY
19	NH	**46**	MT	**1**	SD	**45**	ID
23	AR	**46**	VA	**1**	UT	**45**	KY
23	SC	**46**	WI	**1**	VT	**46**	CT
23	SD	**47**	CT	**1**	WI	**47**	NV
23	TN	**48**	KY	**1**	WY	**48**	FL
24	NJ	**49**	HI	**24**	AZ	**50**	MN
27	AL	**50**	NY	**25**	MO	**50**	WV

This table is based on the rankings that each of the states maintain across two individual areas of in-network coverage—primary care visits (first leftmost rankings) and prescription drug (second, rightmost rankings) coverage. These dimensions are not interrelated, therefore separate rankings are provided for each element.

Table 7.A displays state rankings for in-network primary care and prescription drugs. As the factor analysis indicates, these are two separate dimensions of coverage. Because of their conceptual likeness, Table 7.A displays the rankings for both dimensions. First, the rankings of in-network primary care are displayed. Then, the rankings of in-network prescription drugs are displayed, moving left to right. Across this dimension, Alaska provides the best coverage for primary care visits (1st), subsidizing 100% of post-deductible costs. New York, on the other hand, offers the poorest coverage for primary care visits (50th), leaving plan

consumers responsible for approximately one-third of post-deductible costs. Prescription drug coverage is notably less variable, with 46% of the states tying for 1st: Alaska, California, Delaware, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Wisconsin, and Wyoming. Minnesota and West Virginia, however, provide no prescription drug coverage, tying for 50th.

Table 7.B State Rankings for Out-of-Network Primary Care and Prescription Drug Coverage

Primary Care				Prescription Drugs			
Rank	State	**Rank**	State	**Rank**	State	**Rank**	State
1	MA	**28**	ID	**1**	MA	**27**	KS
2	ND	**28**	NY	**1**	MI	**27**	OK
3	TN	**28**	SC	**1**	MT	**28**	MO
5	MS	**29**	KY	**1**	NC	**29**	IL
5	UT	**30**	NJ	**1**	OR	**50**	CA
8	AK	**31**	MN	**1**	UT	**50**	DE
8	IA	**32**	SD	**8**	AL	**50**	FL
8	NH	**33**	MT	**8**	ND	**50**	GA
11	ME	**34**	PA	**11**	NM	**50**	ID
11	NM	**35**	NE	**11**	TN	**50**	IN
11	OR	**36**	MI	**11**	WA	**50**	LA
12	HI	**37**	TX	**12**	NJ	**50**	MN
13	NC	**38**	IL	**13**	HI	**50**	MS
23	AL	**40**	AR	**16**	CO	**50**	NE
23	CA	**40**	FL	**16**	KY	**50**	NV
23	IN	**41**	OK	**16**	NY	**50**	NH
23	MO	**42**	NV	**17**	AK	**50**	PA
23	OH	**43**	CO	**18**	AZ	**50**	RI
23	RI	**44**	WV	**19**	TX	**50**	SC
23	VA	**45**	AZ	**20**	ME	**50**	SD
23	WA	**46**	VT	**21**	MD	**50**	VT
23	WI	**47**	MD	**22**	CT	**50**	VA
23	WY	**50**	DE	**23**	IA	**50**	WV
24	GA	**50**	KS	**25**	AR	**50**	WI
25	CT	**50**	LA	**25**	OH	**50**	WY

This table is based on the rankings that each of the states maintain across two individual areas of out-of-network coverage—primary care visits (first leftmost rankings) and prescription drug (second, rightmost rankings) coverage. These concepts are not interrelated, therefore separate rankings are provided for each element.

Table 7.B displays state rankings for out-of-network primary care and prescription drugs. As the factor analysis indicates, these are two separate dimensions of coverage. Because of their conceptual likeness, Table 7.B displays the rankings for both dimensions. First, the rankings of out-of-network primary care are displayed. Then, the rankings of out-of-network prescription drugs are displayed, moving left to right. Across this dimension, Massachusetts provides the best coverage for primary care visits (1st), subsidizing 100% of post-deductible costs, while Delaware, Kansas, and Louisiana offer the poorest primary care coverage (50th), subsidizing approximately 90% of associated costs. As is the case for in-network coverage (see Table 7.A), out-of-network prescription drug coverage is notably less variable, with six states tying for 1st— Massachusetts, Michigan, Montana, North Carolina, Oregon, and Utah—and twenty-one states tying for 50th— California, Delaware, Florida, Georgia, Idaho, Indiana, Louisiana, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming. Some of the laggard states are particularly interesting, considering that a few have been, across many dimensions, leaders, such as Mississippi, Pennsylvania, and Vermont.

The following section presents and describes additional comparative rankings of the states and their corresponding average ESHI plans. These rankings address the second dependent variable of this analysis—costs.

State ESHI Indices—Comparative Rankings of Costs

Premiums

When evaluating healthcare costs associated with ESHI plans, it is important to assess premiums. Most ESHI plan premiums are dependent on the number of individuals benefiting from said plan. Therefore, when ranking the states across this cost dimension, I consider the following: employee premiums, employee and spouse premiums, employee and dependent

premiums, and family premiums. From a conceptual perspective, this grouping makes sense, as each item represents a flavor of plan premiums. To assess this theoretical arrangement I perform exploratory and confirmatory factor analysis. The accordance of these items in relation to one another is supported empirically, in employee premiums (0.70), employee and spouse premiums (0.97), employee and dependent premiums (0.92), and family premiums (0.91) all loading on a single factor. Additionally, the Cronbach's alpha for these items is 0.67. In effect, Table 8.A presents the average plan premium rates for individual employees. Table 8.B presents the average rankings for the states across this dimension of cost. Unlike dimensions of coverage, the various elements of costs considered are not constrained by whether or not services are rendered in- or out-of-network.

Table 8.A Plan Premiums for Individual Employees by State

State	Monthly Rate	State	Monthly Rate
AL	$115.00	**MT**	$30.00
AK	$68.00	**NE**	$138.32
AZ	$36.32	**NV**	$43.94
AR	$123.93	**NH**	$43.33
CA	$980.55	**NJ**	$74.30
CO	$43.38	**NM**	$104.59
CT	$93.86	**NY**	$114.71
DE	$54.04	**NC**	$97.00
FL	--	**ND**	$670.40
GA	$128.58	**OH**	--
HI	$293.33	**OK**	$607.90
ID	$66.00	**OR**	$800.22
IL	$99.25	**PA**	$8.68
IN	$190.09	**RI**	$119.62
IA	$92.00	**SC**	$53.69
KS	$70.90	**SD**	$0.00
KY	$106.76	**TN**	--
LA	$126.32	**TX**	$0.00
ME	$23.55	**UT**	$165.66
MD	$85.04	**VT**	$176.02
MA	$208.96	**VA**	$36.33
MI	$109.57	**WA**	--
MN	$210.72	**WV**	$89.86
MS	$20.50	**WI**	$141.50
MO	--	**WY**	$79.28

This table is based on the monthly premium rate for an individual employee based on the states' average ESHI plans. Florida, Missouri, Ohio, Tennessee, and Washington monthly premium rates for individual employees cannot be reported because plan premiums are based off of particular jobs and subsequent services.

Table 8.A displays the average monthly premium rates for individual employees. The raw data better reflect the idiosyncrasies and real world implications than the artificial rankings. State employees in South Dakota and Texas do not pay a monthly premium if they are the only consumer (1st), whereas Californians (50th) and Oregonians (49th) pay $981 and $800, respectively. On average, individual plan consumers in the American states pay $154.27 monthly for individual coverage.

Table 8.B State Rankings for Plan Premiums

Rank	State	Rank	State
1	VA	**26**	MS
2	AZ	**28**	GA
4	DE	**28**	KY
4	NH	**29**	AL
5	NJ	**30**	WI
6	SC	**31**	PA
7	CO	**32**	NE
9	ME	**33**	UT
9	WY	**34**	NC
10	ID	**35**	VT
11	AK	**36**	IN
13	MT	**37**	NY
13	NV	**38**	MA
14	MD	**39**	MN
15	IL	**40**	HI
16	WV	**41**	OK
17	CT	**42**	ND
18	NM	**43**	OR
19	IA	**44**	CA
21	KS	**45**	SD
21	TX		
22	MI		
23	RI		
24	AR		
26	LA		

This table is based on the mean rankings that each of the states maintain across the areas of employee premiums, employee and spouse premiums, employee and dependent premiums, and family premiums.
Florida, Missouri, Ohio, Tennessee, and Washington plan premiums are based off of particular jobs and subsequent services, therefore averages could not be computed.

Table 8.B displays state rankings for monthly plan premium costs. Across this dimension of costs, Virginia offers the most economical premium rates, while South Dakota offers the most financially taxing. A Virginian family of four pays $115.33 per month for health insurance, while a family of four's monthly premium rate can be upwards of $2,000, depending on the employee's annual income. How do these differences relate to the wealth of the people in these states? Virginia ranks 18th, while South Dakota ranks 26th. Not only do South Dakotans, on average, pay more for health insurance, they are also poorer.

Deductibles and Out-of-Pocket Maximums

Much like monthly premiums, overall deductibles and out-of-pocket costs contribute to the quality of health plans offered to consumers. On the basis of prima facie, these elements should have real-world implications for employees when a range of plans are offered to choose between. For example, an insured state employee in Michigan is responsible for meeting a $250 deductible before coinsurance rates apply, whereas an individual in Nebraska must first meet an individual deductible of $3,150. Additionally, a family of four in Delaware will not have to pay more than $2,000 for healthcare services out-of-pocket, whereas a family of four in Pennsylvania have a much higher out-of-pocket maximum of $17,100. In this vein, overall deductibles and out-of-pocket maximums for individuals and families are important to include when developing a quantitative measure and empirical assessment of the quality of healthcare in the states. The parallelism associated with overall deductible and out-of-pocket rates makes sense logistically. Exploratory factor analysis does not warrant empirical support for combining them, however. Instead, overall deductible rates for individuals (0.96) and families (0.96) load on the first factor, while out-of-pocket maximums for individuals (0.95) and families (0.96) load on the second factor. Reliability analyses are 0.97 for individual and family deductibles, and 0.97 for out-of-pocket maximums. These neatly sorted factor loadings and measures of reliability suggest that the two types of costs should be considered separately. Table 9.C presents the average state rankings for overall deductible costs and average state rankings for out-of-pocket maximum costs.

Table 9.A Overall Deductibles for Individual Employees by State

State	Overall Deductible	State	Overall Deductible
AL	$1866.67	**MT**	$400.00
AK	$350.00	**NE**	$3150.00
AZ	$375.00	**NV**	$0.00
AR	$525.00	**NH**	$2100.00
CA	$500.00	**NJ**	$871.43
CO	$1183.33	**NM**	$1000.00
CT	$2187.50	**NY**	$2583.33
DE	$500.00	**NC**	$1633.33
FL	$800.00	**ND**	$1000.00
GA	$1616.67	**OH**	$1200.00
HI	$1850.00	**OK**	$625.00
ID	$1500.00	**OR**	$250.00
IL	$170.83	**PA**	$633.33
IN	$1550.00	**RI**	$875.00
IA	$12.50	**SC**	$850.00
KS	$1250.00	**SD**	$575.00
KY	$1540.00	**TN**	$1200.00
LA	$1000.00	**TX**	$1728.57
ME	$1100.00	**UT**	$500.00
MD	$814.29	**VT**	$178.57
MA	$250.00	**VA**	$2045.00
MI	$250.00	**WA**	$250.00
MN	$50.00	**WV**	$425.00
MS	$300.00	**WI**	$1750.00
MO	$1216.67	**WY**	$600.00

This table is based on the overall deductible for an individual employee based on the states' average ESHI plans.

Table 9.A displays the average overall deductibles for individual employees. As the data indicate, overall deductibles range from $0 in Nevada (1st) to $3,150 in Nebraska (50th). For the average Nebraskan, meeting this deductible costs six percent of their average annual income. On average, individual plan consumers must meet an overall deductible of $983.64 before their ESHI plan provides coverage.

Table 9.B Out-of-Pocket Maximums for Individual Employees by State

State	Out-of-Pocket Maximum	State	Out-of-Pocket Maximum
AL	$4033.33	**MT**	$3775.00
AK	$3000.00	**NE**	$5300.00
AZ	$3000.00	**NV**	$1500.00
AR	$6750.00	**NH**	$4100.00
CA	$2500.00	**NJ**	$5971.43
CO	$2266.67	**NM**	$2000.00
CT	$3812.50	**NY**	$5746.67
DE	$1000.00	**NC**	$4500.00
FL	$2750.00	**ND**	$2666.67
GA	$3850.00	**OH**	$3000.00
HI	$4850.00	**OK**	$4200.00
ID	$6850.00	**OR**	$1500.00
IL	$2000.00	**PA**	$8550.00
IN	$6500.00	**RI**	$1875.00
IA	$1125.00	**SC**	$6100.00
KS	$4083.33	**SD**	$3875.00
KY	$6430.00	**TN**	$4225.00
LA	$4000.00	**TX**	$5114.29
ME	$3333.33	**UT**	$5000.00
MD	$4335.71	**VT**	$6714.29
MA	$1700.00	**VA**	$2600.00
MI	$1000.00	**WA**	$2000.00
MN	$2583.33	**WV**	$3916.67
MS	$8550.00	**WI**	$3166.67
MO	$3650.00	**WY**	$2000.00

This table is based on the out-of-pocket maximum for an individual employee based on the states' average ESHI plans.

Table 9.B displays the average out-of-pocket maximums for individual employees. Outof-pocket limits range from $1,000 in Delaware and Michigan to $8,550 in Pennsylvania. While Pennsylvania is only 7% wealthier than Delaware and Michigan, Pennsylvanians out-of-pocket limits are nearly nine times higher.

Table 9.C State Rankings for Overall Deductibles and Out-of-Pocket Limits

Overall Deductibles				Out-of-Pocket Maximums			
Rank	State	**Rank**	State	**Rank**	State	**Rank**	State
1	NV	**26**	RI	**1**	DE	**26**	TN
2	IA	**27**	OK	**1**	MI	**27**	SD
3	MN	**29**	ME	**3**	IA	**28**	LA
4	VT	**29**	NM	**4**	NV	**29**	GA
5	IL	**30**	ND	**5**	MA	**30**	AL
6	MS	**31**	SC	**6**	RI	**31**	KS
8	MA	**32**	CO	**7**	OR	**32**	NH
8	MI	**34**	OH	**11**	IL	**34**	MD
9	CA	**34**	TN	**11**	NM	**34**	WV
11	OR	**35**	MO	**11**	WA	**35**	NC
11	WA	**36**	KS	**11**	WY	**37**	HI
13	AK	**37**	ID	**12**	CA	**37**	OK
13	AZ	**38**	IN	**13**	MN	**38**	UT
14	PA	**39**	KY	**14**	VA	**39**	ID
15	MT	**40**	GA	**16**	FL	**40**	TX
17	DE	**41**	TX	**16**	ND	**41**	NE
17	UT	**42**	NC	**17**	CO	**42**	NJ
19	AR	**43**	WI	**20**	AK	**43**	SC
19	WV	**44**	AL	**20**	AZ	**44**	KY
20	SD	**45**	HI	**20**	OH	**45**	NY
21	WY	**46**	VA	**21**	WI	**46**	IN
22	FL	**48**	CT	**22**	ME	**47**	VT
23	LA	**48**	NH	**23**	MO	**48**	AR
24	MD	**49**	NY	**25**	CT	**50**	MS
26	NJ	**50**	NE	**25**	MT	**50**	PA

This table is based on the rankings that each of the states maintain across two individual areas of cost—overall deductibles (first leftmost rankings) and out-of-pocket maximums (second, rightmost rankings). These concepts are not interrelated, therefore separate rankings are provided for each element.

Table 9.C displays state rankings for overall deductibles and out-of-pocket maximums. As the factor analyses indicate, these are two separate dimensions of costs. Because of their conceptual likeness, Table 9 displays the rankings for both dimensions. First, I display the rankings of overall deductibles. Then, I present the rankings of out-of-pocket maximums.

In terms of overall deductibles, Nevada ranks 1st, not requiring an individual or family to meet a deductible before coinsurance applies. Nebraska (50th), however, requires that an individual meet a deductible of $3,150 and a family meet a deductible of $6,300 before the state subsidizes

any costs. Across the dimension of out-of-pocket maximums, Delaware and Michigan (1st) have the lowest maximum threshold, capping out-of-pocket costs for individuals at $1,000 and for families at $2,000. On the other hand, Mississippi and Pennsylvania allow out of-pocket costs until an individual reaches $8,550 and until a family reaches $17,100. While the rankings themselves are constructions, their substance are of note: costs have real-world implications for consumers of ESHI plans.

Discussion of Coverage and Costs of ESHI Plans

This chapter began as an effort to explore and quantify the scope of ESHI plans offered to state employees in the American states. In doing so, we now have a greater understanding of health insurance in the American states, coupled with quantitative rankings that meaningfully illustrate the relationship between the states and healthcare, as well as interstate relations through comparative rankings. It is my hope that these measures I develop can be applied in many areas of health policy research. While this study only considers ESHI plans offered to state employees, it encapsulates the potential for improving health plans, both in terms of coverage and costs, to consumers more broadly.

The breadth and dimensionalities of this spatial healthcare assessment, as factor analyses confirm, consist of an array of elements both in terms of coverage and costs. Unsurprisingly, the rankings are variable, depending on the coverage or cost. While these rankings are mere constructs, their substance has indelible implications for both plan consumers and health policy more conventionally. Beginning with idiosyncrasies, coverage rankings vary both across dimensions of coverage, as well as on the basis of network proximity. As the tables suggest, some states rank higher across some dimensions of coverage and costs, while lagging across others. Such variation is readily apparent when considering coverage in the state of Utah.

Across the dimensions of urgent care, emergency care, emergency medical transportation; inpatient facility, outpatient facility, surgical services; maternity visits and child delivery; and prescription drug coverage, Utah ranks first, or second in quality coverage. However, across the dimensions of home health services and hospice care, Utah ranks 50th (in-network) and 42nd (out-of-network), respectively. Similarly, Louisiana ranks 1st for in-network mental health, substance abuse, chiropractic aid, and rehabilitative care; in-network prescription drug coverage; and 5th for in-network primary care. However, across the dimensions of in- and out-ofnetwork urgent care; out-of-network inpatient facility outpatient facility, surgical services; x-ray and imaging; mental health, substance abuse, chiropractic aid, rehabilitative services; maternity visits and child delivery; and prescription drug coverage, Louisiana ranks 50th. Moreover, in terms of costs, Virginia ranks 1st for premiums costs (lowest), in which an individual employee, on average, pays $36.33 and a family of four pays $115.33 monthly. Across the dimension of overall deductibles, however, Virginia ranks 46th. In this scenario, the same individual has an overall deductible of $2,045 and the same family has an overall deductible of $4,090.

Apart from these apparent idiosyncrasies, patterns in the data do emerge. Considering these rankings in relation to one another, across dimensions of both coverage and costs, we are met with a notable degree of consistency. Across these ten dimensions of coverage and three dimensions of costs, concordance exists. In this light, across all thirteen dimensions, regardless of network, Massachusetts and Pennsylvania are our evident leaders, systematically ranking best nine times, with Alaska and Utah a close second. Rankings are also largely dependent on whether or not a particular service is provided in or out-of-network. This remains evident when considering the factor loadings discussed in the above subsections. In this vein,

across the same dimension of coverage, some states rank well for in-network coinsurance rates, while ranking poorly for the same dimension when care is provided out-ofnetwork. Coverage rates related to inpatient and outpatient surgical care, when received innetwork, are most comprehensive in Pennsylvania (1st), with comparable rates of subsidization for Illinoisans (6th). However, for state employees in these states who receive analogous care out-of-network, coverage rates decreased markedly, with Pennsylvania ranking 35th and Illinois ranking 39th, respectively. Similarly, Vermont provides the best coverage (1st) for x-ray and other imaging services when performed in-network, while providing nearly the poorest coverage when performed out-of-network (47th). Mental health, substance abuse, and rehabilitative therapies and chiropractic aid care, as well as home health services and hospice care is most comprehensive in Delaware when obtained in-network (1st) while the least comprehensive coverage for said services are also in Delaware when out-of-network (50th). California provides comprehensive coverage rates for in-network primary care (2nd), while providing mediocre coverage rates for primary care when a provider is out-of-network. Finally, both Wisconsin and Wyoming provide the best coverage rates for prescription drugs when such are prescribed in-network (1st), while simultaneously providing the worst coverage rates for prescription drugs out-of-network (50th). Essentially, when evaluating the states' ESHI plan coverage rates, provider networks matter.

When developing definitions and operationalizations of the dependent variables—coverage and costs—on the basis of prima facie, it could be assumed that an inverse relationship exists between quality coverage and affordability. After all, both comprehensive coverage and economical costs are probable indicators of a *good* health plan. The data show support for this postulation. As noted above, Massachusetts and Utah, systematically, provide

the most comprehensive coverage rates. Across the three dimensions of costs, these states are laggers. Moreover Massachusetts ranks 38th across the dimension of premiums, 8th across the dimension of overall deductibles, and 5th across the dimension of out-of-pocket limits. Relatedly, Utah ranks 33rd, 17th, and 38th across the respective dimensions of costs. The information presented here begs the question of why states have more comprehensive coverage. In the following chapter, I address the political, social, and economical factors to explain the rankings produced in this chapter.

Chapter Three: What Explains the States' Rankings Across Dimensions of Coverage and Costs?

Following the seminal research of Walker (1969) and Gray (1973), the study of policy diffusion has become a crux of the state politics subfield of political science. This fertile research ground produces a wide array of scholarship, in which scholars examine a variety of public policy flavors. Policy variation across the American states exemplifies the late Justice Louis Brandeis' notion of the states as 'laboratories of democracy.' This variation across the fifty state polities begs the question: *What* explains the idiosyncratic characteristics of policies across the states? The majority of research on the 'diffusion of innovations' attempts to answer this question. Diffusion studies, when mapping the spread of policy, are usually situated around three models—the organizational diffusion model, the regional diffusion model, and the internal determinant model. The organizational diffusion model is concerned with groups of people who spread policy by interaction in professional settings, such as conferences and meetings (Rogers 1995; Rogers and Shoemaker 1971). Regional diffusion models, also referred to as geographic diffusion models, measure the effect geography has on the likelihood of an innovation being diffused (Rogers 1995). Berry and Berry (1990) conclude that the organizational diffusion model demonstrates the power of neighboring states, that contiguous states have a higher probability of innovation adoption if the states nearby have already innovated. The final model, the internal determinant model, is more complex than the former in that it includes multiple factors. While this analysis is not a diffusion study, the research does provide insight into the explanators for why both coverage and costs are better (worse) across the states. I employ the internal determinant model in this research. The following section provides an overview of the

theoretical components of internal determinant modeling, accompanied with the hypotheses I test in this chapter.

Internal Determinant Theorization and Expectations

Internal determinant modeling is the theoretical framework that undergirds this analysis. It refers to a theoretical approach that suggests an array of factors internal to the states explain their policy outputs. Many scholars explore the role of the states' wealth, such as per capita income and excess resources (e.g. Gray 1973; Walker 1969). Others emphasize different internal variables, like interparty competition, political culture, higher education levels, and legislative professionalism (Rogers 1995; Walker 1969). Extant studies that examine state welfare spending, model these state government spending efforts as a function of a state's political, social, and economic factors (Barrilleaux, Holbrook, and Langer 2002; Fording 2001;Volden 2002). Squire (1992) and Boehmke and Skinner (2011) find that legislative professionalism drives innovativeness. Using event history analysis, Berry and Berry (1990) situate their data in a way that considers internal characteristics and neighboring influences. In doing so, it is possible to predict the likelihood of policy adoption at a particular time when these neighboring state influences and internal characteristics are known. Many single policy analyses provide empirical support for this theory (Shipan and Volden 2006; Tolbert, Mossberger and McNeal 2008). Beland, Rocco, and Waddan (2016) extend this notion in their analysis of the role of federalism and state politics in regard to implementation of the Affordable Care Act (ACA). Beland, Rocco, and Waddan (2016) suggest that intrastate variables can be used as predictors of policy outcomes, specifically in regard to health policy. The remainder of this section provides an overview of the internal determinants that are

examined in this chapter, accompanied with a discussion of scholarship respective to each germane variable.

Partisanship

Morehouse (1981) notes the importance of party in state policy outputs, stating:

> The single most important factor in state politics is the political party. It is not possible to understand the differences in the way sovereign states carry out the process of government without understanding the type of party whose representatives are making decisions that affect the health, education, and welfare of its citizens (1981, 29).

Campbell, Converse, Miller, and Stokes (1960) assert that partisanship serves as an important indicator of political behavior across various domains. Butler and Pereira (2018) suggest that partisanship can be used as a heuristic, echoing Popkin's (1991) notion of low information rationality. Policy-makers are constrained by finite resources and time, making complex policy familiarization exhausting (Hall and Deardorff 2006; Weyland 2005). Thus, using partisanship as a decision heuristic is useful. Box-Steffensmeier, Arnold, and Zorn (1997) find evidence that policy makers do indeed rely on partisanship when making decisions. Hibbs (1977) examines macroeconomic policy outcomes and finds that they are not endogenous to the economy, but rather are significantly influenced by partisanship. Gerber (2013) concludes that partisanship matters in determining local climate change policy outcomes. Rueda (2008) finds that partisanship is inherently linked to inequality and thus plays a role in the generosity of welfare allowances. In their analysis of congressional foreign policies from 1975-1996, Souva and Rohde (2007) find evidence that partisanship influences foreign policies. Partisanship plays a deciding role in the functionality of legislatures (Butler and Powell 2014), as well as in other political processes (Levendusky 2013). Moreover, Grossback, Nicholson-Crotty, and Peterson (2004) conclude that the

likelihood of policy increases when innovative policies are derived from governments that are most like them in terms of partisanship. Finally, Butler and Pereira (2018) explore the role of partisanship in their experiment of partisan policy endorsements, suggesting that policy diffusion is largely characterized by partisan bias.

Following Petrocik's (1996) seminal application of 'issue ownership' theory, in which political parties 'own' certain policy domains/issues, a considerable amount of scholarship has been generated, distinguishing the role that parties and consequent partisanship play in policy outputs. Lachat (2014) suggests that issue ownership can be best understood in two parts—(1)'Associative ownership,' in which a party is considered to care more than the other party about a given issue; and (2) 'Competence ownership,' in which a party is perceived as bestowing the best solutions in regard to a given issue. Wright (2012) finds that the Republican party owns issues relating to the conserving the economy, while the Democratic party owns issues relating to increased public spending to mitigate the effects of unemployment. Holian (2004) notes that the Republican party maintains an advantage on issues related to crime. Dulio and Trumbore (2009) and Goble and Holm (2009) both assert that the Republican party 'owns' the national security policy realm. Moreover, Bailey and Rom (2004) note that Democrats are more apt to support state spending for health and welfare policies. In this vein, it makes sense for Democratic elected officials to support greater spending for ESHI plans, resulting in more comprehensive coverage and better rankings, as these plans are quintessential health policy outputs. Therefore, I offer the following hypotheses:

> ***(H1): Lawmakers' Partisanship Hypothesis:*** *States with a greater percentage of Democratic lawmakers will rank higher on coverage and costs than states with relatively fewer Democratic lawmakers.*

(H2): Governors' Partisanship Hypothesis: *States with Democratic governors will rank higher on coverage and costs than states with Republican governors.*

Divided and Split Branch Government

Divided government has been found to serve as a barrier to policy innovativeness (Fiorina 1982; Holbrook and VanDunk 1993; Ranney 1976). Hansen (1983) finds that innovations relative to tax adoptions are more likely to occur under conditions of unified government. Alt and Lowry (1994) refer to the Democratic party as the 'high-demand' party (representing constituents who favor greater public spending) and the Republican party as the 'low-demand' party (representing constituents who disfavor greater public spending). In their analysis of the role of partisan control of American state governments on state spending and taxing levels, they find that divided legislatures prevent the high- (low) demand party from achieving their optimal level of spending. Similarly, Alt and Lowry's (2000) analysis of the politics of fiscal adjustments in divided governments makes note of the advantage of "homogenous preferences for fiscal scale within parties," in which unified government allows parties to meet their goals. Contrarily, divided government is characterized by bargaining and compromise, absent unilateral partisan control. Fiorina (1992) suggests that divided government maintains an imperative role in the policy process, considerably impacting the efficiency and effectiveness of legislators. Moreover, he suggests claims that dispute the impact of divided government (e.g., Dye 1966; Mayhew 1991) are erroneous, asserting that "we are beyond such elementary school expectations" (Fiorina 1992, 405). These findings justify the following expectations, primarily because the comprehensiveness of ESHI plans are contingent on allotted state spending. Extending Alt and Lowry's (2000) notion that state spending is higher under conditions of unified government, we can expect unified governments, particularly unified

Democratic governments to spend more on health policy, therefore providing greater subsidization of coverage costs. This reduces the coinsurance burden of plan consumers and, in effect, produces more comprehensive coverage and subsequently better rankings. In this vein, I propose the following hypotheses:

> ***(H3) Divided Government Hypothesis:*** *States with divided government will have poorer rankings than states with unified government.*
>
> ***(H4) Unified Republican Government Hypothesis:*** *States with unified Republican government will have poorer rankings than states with unified Democratic government.*

Mayhew (1991) challenges the 'conventional wisdom' that unified government is necessary to produce optimal policy outputs. Additionally, he suggests that there is not a correlation between unified government and policy innovation, stating that "unified versus divided control has probably *not* made a notable difference during the post-war era" (Mayhew 1991, 179). Beyond Mayhew's (1991) postulation, Lindblom's (1959; 1979) notion of incrementalism suggests that divided government should not affect ESHI plans when the plan was developed decades ago. As Lindblom (1959; 1979) suggests, policies generally do not deviate from the previous period's version. Much like a state budget, it is logical to presume that changes are incremental in nature. Therefore, I offer the following null hypothesis:

> ***(H3-N) Null Divided Government Hypothesis****: State rankings are unrelated to divided government of state legislatures.*

Fiorina (1992) suggests that there are partisan configurations for a government defined by two-party competition and comprised of a bicameral legislature and an executive. Alt and Lowry (1994) emphasize this point, and divide such configurations into three distinct conceptualizations—unified party government, divided party government, and split-legislature

government. I extend the latter configuration of split-legislature government and offer the following hypothesis:

> **(H5) Split-Branch Government Hypothesis:** *States with split-branch government will not be statistically different than states with unified government.*

Public Opinion and Its Effects on Public Policy

In *Politics, Economics, and the Public: Policy Outcomes in the American States,* Dye (1966) examines the importance of politics in the policy process. In his analysis, Dye (1966) focuses on the extent to which political factors influence policy outcomes in comparison to the extent of influence economic factors bear by analyzing five policy areas—education, transportation, welfare, tax/revenue, and public regulatory policy. Dye (1966) concludes that economic factors warrant greater explanatory power than do political factors. Moreover, Dye (1966; 1984) suggests that economic factors are, essentially, the only eminent determinant of state policy outcomes.

The landmark work of Erikson, Wright, and McIver (1993), *Statehouse Democracy: Public Opinion and Policy in the American States,* and their subsequent findings are situated rather antithetical to Dye's (1966) assertions. Erikson, Wright, and McIver's (1993) main dependent variable is the ideological tendency of states' public policies in their examination of the effects of public opinion on state policy. Their work suggests that public opinion matters a great deal. Additionally, in their time series analysis (1988-1992), they find that ideology in particular begins to warrant more explanatory power as time passes in explaining variation in public policy. Dunlap's (2007) findings solidify those of Erikson, Wright, and McIver (1993) ideology matters, specifically in the case of state spending. Stimson, MacKuen, and Erikson (1995) find a strong correlation between public policy and public opinion, independent of partisanship and refer to this as 'dynamic representation,' which to these authors is the basic

measuring block of democracy. 'Rational anticipation' is the coined phrase that Stimson et al. (2013) use to refer to the causal relationship of public opinion on policy change, in which elite behavior is influenced by the public's mood.

Reemphasizing Popkin's (1991) low-information rationality, ideology too can be used as a decision heuristic in regard to policy preferences for both elected officials and the 'active electorate' (Erikson, Wright, and McIver 1993, 14). This effect might be epiphenomenal due the fact that governments that share the same partisanship frequently share the same ideological position, causing them to use like approaches during the policy process (Grossback, Nicholson-Crotty, and Peterson 2004).

In their analysis of welfare spending in the American states between 1990 and 1996, Barrilleaux and Bernick (2003) find that supplementary security income (SSI-S) payments increase with greater citizen liberalism. With respect to welfare and criminal justice policy, Fording (2001) finds that state ideology warrants direct influence. Bailey and Rom (2004) find that citizen ideology is a significant correlate of AFDC benefits and access. Boehmke and Skinner (2011) suggest that ideologically similar states exhibit innovative proclivities. Caughey and Warshaw (2015), in their analysis of citizen policy liberalism scores in the American states from 1972-2012, find that liberalism of state publics can serve as a proxy for the liberalism of the respective state's policies. Caughey and Warshaw (2015) offer a more nuanced account of the relationship between attitudes and preferences of ordinary citizens and policy outputs than do Erikson, Wright, and McIver (1993). This is largely because Erikson, Wright, and McIver (1993) and others are not measuring public opinion, but rather use symbolic ideology—people's stated ideology—to gauge the public mood. The idea is that if and when more citizens identify as liberal (conservative), we can assume public opinion is trending in the progressive (conservative)

direction. However, this may not be the case. It is possible that more people identify as more liberal (conservative), but do not become any more receptive to progressive (conservative) *policies* or *ideas.* Caughey and Warshaw (2015) on the other hand employ operational ideology, in which they ask dozens of survey questions asking citizens about their preferences on *policies* to measure public opinion. Their data extend past Erikson, Wright, and McIver's accounting for state liberalism scores from 1936-2014. In doing so, they produce dynamic measures of state policy liberalism scores that are estimated separately for both economic and social policies. These data are based on dataset of one hundred and fifty continuous and categorical state policies (Caughey and Warshaw 2015). At the end of the day, however, Erikson, Wright and McIver (1993) and Caughey and Warshaw (2015) offer the same conclusion: public opinion drives state policy adoptions. Thus, I offer the following hypothesis:

> ***(H6) Policy Liberalism Hypothesis:*** *The share of states' citizens who prefer liberal (conservative) policy outputs is positively (negatively) associated with better (poorer) state rankings.*

Political Culture

Public policies and budget outputs are influenced not just by political and economic variables, but also by a state's cultural forces (Hanson 1991; Wildavsky 1985). Elazar (1966) developed the categorization of American states as three distinct political cultures—moralistic, individualistic, and traditionalistic. The triad of political cultures established by Elazar (1966) serve as an attempt to provide contextual meaning to the various interpretations and belief systems held by the inhabitants of the states regarding the role of political parties, the role of government, and the need for involvement of the citizenry in the democratic process. 'Moralistic' cultures maintain that the role of the political system is to attain the greatest good for the polity; 'Individualistic' cultures view the political system as a marketplace for

perspectives and actions that are decided by public demands; 'Traditionalistic' cultures view the role of the political system to maintain the status quo. While Elazar's (1966) treatment of the cultures as mutually exclusive has been subject to some critique (Parens 1994), many scholars have found that Elazar's (1966) typology warrants explanatory power.

Relationships between political culture and individual political attitudes and behaviors are known to exist (Hanson 1980; Lowery and Sigelman 1982). Johnson (1976), using the Grey Innovation Index, shows that moralistic and individualistic states have more innovative policy outputs than traditionalistic states. Moreover, Johnson (1976) also finds that moralistic and individualistic states have larger governmental expenditures per capita than traditionalistic states in areas of social welfare. Fitzpatrick and Hero (1988) solidify this point, asserting that moralistic states demonstrate both greater economic equality amongst citizens and greater policy innovations. The culture-public expenditure relationship has been examined with multiple methodologies, each finding significant correlation (Luttbeg 1971). Koven and Mausolff (2001) evaluate the applicability of political culture and its implications on state spending. They find that political culture is useful in explaining variation in state spending policy between jurisdictions, urging future scholars to not ignore its inclusion in internal determinant modeling. Widavsky (1985) notes that people persistently construct and reconstruct their cultures through the decision-making process. Erikson, Wright, and McIver (1993, 175) state that their data offer "startlingly strong support" for Elazar's (1966) typology. Lieske (1993) employs Elazar's cultures to explain voter turnout, voter registration, and educational expenditures.

Koven and Mausolff (2001) note that Elazar's (1966) cultures explain an array of public policies, including AFDC payments, local government revenues, welfare tax burdens, and welfare expenditures. Boeckelman (1991) explores the prominent issue of economic

development with the American states and finds that state development policy outcomes are predicted largely by political culture. Koven and Mausolff (2001) blanketly encompass the appropriateness of applying Elazar's political culture triad when examining policy outputs, stating:

> There are a number of reasons for using Elazar's framework to operationalize culture in this study: (a) it lends itself to predictions about the willingness of different cultures to support government spending; (b) it has been well researched and generally found to be at least as valid an indicator of culture as other measures, including those based on updated demographic data; and (c) because of its basis in early migration patterns, it provides a test of the influence of cultural history on current policy (2001, 6).

Morgan and Watson (1991) use Elazar's typology to examine the innovations of policy, finding that moralistic states facilitate more liberal and innovative policies; traditionalistic states show the opposite result. Mead (2004) investigates the link between state governments and their corresponding political cultures in regard to welfare reform. They employ Elazar's political cultures and find a notable correlation between culture and ability to reform; moralistic states perform best, even when control variables are used. Considering the crux of moralistic culture, the role of government is best understood as an active entity responsible for ensuring the general welfare of the public. The broad concept of general welfare can reduced more narrowly to focus on the way in which healthcare is a pillar of welfare. Essentially, caring for the public, theoretically, extends to ensuring quality healthcare. Therefore, I offer the following hypothesis:

> ***(H7) Moralistic Culture Hypothesis:*** *Moralistic states will have better rankings than individualistic and traditionalistic states.*

Unionization

To Przeworski and Wallerstein (1982), the political ramifications of unionization are "straightforward," due to the "general agreement that, other things equal, union movements

representing a large share of voters are better able to influence policy" (Przeworski and Wallerstein 1982, 232). Moreover, following the work of Key (1949), virtually all subsequent scholarship has adopted his fixation on social class. Radcliff and Saiz (1998) emphasize this by stating the study of welfare policy is perhaps the most visible example (e.g., Dye 1984; Hill and Leighley 1992). Other issues of class that have been examined include policy liberalism (Wright, Erikson, and McIver 1987), tax progressivity (Dubofsky and Dulles 1984; Kazin 1995), and education spending (Radcliff and Saiz 1998). Bloch (1993) finds that the voting behavior of members of Congress is significantly influenced by the percentage of unionization. This coincides with the work of Allen and Campbell (1994) who find evidence that the progressivity of policy increases "as the organizational strength of labor rises" (Allen and Campbell 1994, 174).

While the role of unions in American politics is less apparent than in social democracies in Western Europe (Cameron 1984; Hicks and Swank 1992), some scholars still account for it when attempting to explain various policy outcomes. Radcliff and Saiz (1998) test the relationship between unionization and spending in the American states from 1964-1982 and find that the strength of the labor movement across the United States serves as a principal determinant of state policy liberalism. In their analysis, they find support for a correlation between the presence and organizational strength of unions and progressive tax codes and liberal policy in general. Grieder (1992) considers the impact of the labor movement through a class lens and suggests that a stronger labor movement is endogenous to more liberal policies, in that it produces a strong voice for the working class. Goldfield (1986) offers a similar perspective, stating that the impact of unions "ultimately… is rooted in their membership size." Masters and Delaney (1987) analyze the impact of unions on financial contributions to parties and candidates

and find that low membership limits financial support for progressive candidates. Delaney, Fiorito, and Masters (1988) suggest that this curtails the "capacity for unions to engage in politics," and thus results in less liberal policy: unions matter.

Budd (2004) suggests that the presence of unions can have a positive effect on the quality of healthcare offered. One useful indicator of unions is based on whether or not a particular state is a "right-to-work" state, in which a state prohibits union security between labor unions and employers. Unions employ both traditional and non-traditional collective bargaining strategies to improve the quality of care received (Budd 2004). Relatedly, Hostetter and Klein (2019) conclude that as healthcare costs rise, there is an influx of unions mobilizing collectively to make healthcare more accessible and price conscious by partnering with states. Ash, Seago, and Spetz (2014) conclude that, contrary to previous scholarship, health labor unions should not be conceptualized as self-interested organizations. Rather, their findings suggest that health labor unions help to improve the quality and accessibility to healthcare, even for those outside of a given organization.

Radcliff and Saiz (1998) summarize extant literature and advocate for the inclusion of unionization measures in future policy research, stating: "Our understanding of the policy process, and perhaps democratic politics more generally, is impoverished to the extent that we fail to consider the importance of labor organization…" (Radcliff and Saiz 1998, 123). Therefore, I put forth the following hypothesis:

> ***(H8) Unionization Presence Hypothesis****: States that are not right-to-work states will have better rankings than right-to-work states.*

Taken together, these variables should matter for health policy outputs. As the literature suggests, the number of liberal elites are frequently correlated with progressive policy outputs.

Logistically, it makes sense that this should extend to health plans, a subset of progressive policies. In this vein, improving health policies is largely considered a progressive, or liberal issue, therefore we should expect liberal preferences to communicate a desire for better plans. Moralistic states correlate with liberal policy outputs and increased spending on said policies, so we should see moralistic states offer better ranked plans. Unified government has been empirically shown to facilitate more innovative policy outputs than divided, or split branch government. Considering the partisan nature of health policy, we should expect unified Democratic government to warrant better state rankings than unified Republican government in terms of coverage and costs. Unionization should matter for health policy because unions try to bring home benefits to workers. Finally, slack resources, specifically states' fiscal health and degree of legislative professionalism should matter, as wealthier states logistically can afford to subsidize more costs which, in effect, facilitates better coverage and subsequently better ranks.

Data, Measurement, and Methodology

While producing state rankings is of meaningful interest, its utility is limited absent an exploration of *why*. To ameliorate this limitation, I examine explanatory political, social and economic factors, empirically. First, I discuss the variables in this analysis, and then I explain the modeling.

Dependent Variables

The dependent variables discussed in the previous chapters—coverage and cost—extend to this chapter. Coverage consists of ten dependent variables, each of which are extrapolated from the dimensional groupings discussed in the previous chapter (e.g., The first dependent variable is the average coverage rate for in- and out-of-network urgent care, emergency care, and emergency medical transportation). The subheadings in the following section depict these

variables. Relatedly, cost consists of three dependent variables that are also based on the groupings from chapter two (e.g., The dependent variable, *premium*, is based on the average monthly premium rates for individual premiums, employee and spouse premiums, employee and dependents premiums, and family premiums).

Independent Variables

Several of the theoretical based and control variables examined are lagged by one year. As Berry and Berry (1990) note, legislative sessions generally begin in January, forcing legislators to make policy decisions based on the previous year's fiscal and economic data. These specifications are discussed in greater detail below. Lawmakers' partisanship ($LPrtsp_{it}$) is treated as two variables, *Democratic Representatives* and *Democratic Senators. Democratic Representatives* represents the share of lower chamber (House) lawmakers who are Democrats minus the share of lower chamber (House) lawmakers who are Republicans. This formulation is the same for upper chambers, in which *Democratic Senators* represents the share of upper house (Senate) lawmakers who are Democrats minus the share of upper house (Senate) lawmakers who are Republicans. These data are sourced from the National Conference of State Legislatures' partisan composition database. While this analysis is not time series, one can still anticipate that the party of the governor and legislature matter in terms of influencing a policy developed over time. This notion is perhaps best communicated by Aldrich and Rohde's conditional party government (CPG). As the parties, and subsequently policy issues, have been sorted as a byproduct of heightened polarization, Democrats exert issue ownership over healthcare and health policy (Wright 2012). Following the premise of CPG, we should expect Democratic elected officials to homogenously support more comprehensive health coverage, and in effect, influence ESHI policy outputs. In this vein, the number and presence of Democratic elected

officials matter. *Divided government* ($DGovt_{it}$) represents the degree to which there is unilateral party control of both the legislative and executive branch. The variable is dichotomous in nature and maintains the value of one if the governor and both legislative chambers are controlled by the same party, zero otherwise. *Split branch government* ($SBGovt_{it}$) represents the degree to which there is unilateral party control of both legislative chambers, regardless of gubernatorial control. These data are sourced from the National Conference of State Legislatures' partisan composition database. *Policy liberalism scores* (PLS_{it}) are based off of Caughey and Warshaw's (2014) measures. These data are sourced from Caughey and Warshaw's Harvard Dataverse. Political culture ($PClt_{it}$) is treated as three variables, *Traditionalistic States, Individualistic States,* and *Moralistic States.* These variables are each dichotomous in nature and maintains the value of one if a given state maintains the corresponding political culture, zero otherwise. These data are sourced from Elazar's (1966) original typology. *Unionization* is a dichotomous variable, maintain the value of zero if the state is a right-to-work state, zero otherwise. These data are sourced from the National Conference of State Legislatures. Alaska and Hawaii are not included in Elazar's (1966) original classification of the states, therefore they will not have a political culture. Additionally, Democratic Representatives, Democratic Senators, divided government, and Split branch government measures cannot be applied to Nebraska due to their nonpartisan and unicameral legislature.

Control Variables

In order to appropriately estimate the impacts of the aforementioned variables on the innovativeness and scope of ESHI plans in the American states, I include a series of political and economic control variables (see Table 11). The organizational capacity of state legislatures has an impact on the innovativeness of policies (Squire 1992; Walker 1969). Boehmke and Skinner

(2011) describe the role of organized state legislatures as facilitating "a fertile ground for policy outputs" (2011, 16). The various dimensionalities of organized legislative bodies (i.e., the mean of employees per legislator, the mean salary of legislators, and the length of the legislative session) have been colloquialized as 'slack resources' and legislative professionalism (Boemke and Skinner 2011; Squire 1992; Volden 2002). Single policy studies have found empirical support for the correlation between legislative professionalism and policy adoptions, such as the diffusion of smoking bans (Shipan and Volden 2006). Therefore, *slack resources* (SR_{it}) is operationalized using Squire's (1992) method which compares the previously specified three components of statehouses to Congress. These data are sourced from Squire's (2017) most recent calculations and are accessed through Squire's Harvard Dataverse. This technique iterates Polsby's (1975) notion that Congress is America's most professional political institution.

Following the vernacular put forth by Walker (1969), innovative 'leaders' are typically wealthier states (Shipan and Volden 2008). Moreover, literature on welfare policy denotes a correlation between increased welfare spending and the respective state's economic capacity (Hanson 1984; Plotnick and Winters 1985). For example, Bailey and Rom (2004) find that states with higher poverty rates correlate with less access to AFDC, Medicaid, and SSI-S benefits. I seek to control for this factor by employing *fiscal health* (FH_{it-1}), a control variable of state wealth that is operationalized as state revenue minus state spending (Berry and Berry 1990). In order to ensure that the model represents the potential of *fiscal health* causing innovative ESHI plans, but innovative ESHI plans not affecting *fiscal health, fiscal health* must be lagged one year (*t-1*). These data are sourced from the 2019 Cooperative Congressional Election Study. Table 11 provides summary statistics for each of the variables discussed in this section.

Table 11: Summary Statistics of Independent and Control Variables

Independent Variable	Range	Mean	Standard Deviation
Democratic Representatives	-66 to 99	-9.33	39.24
Democratic Senators	-33 to 34	-3.8	16.8
Democratic Governors	0 to 1	0.5	0.51
Policy Liberalism	-2.53 to 2.51	0.04	1.43
Traditionalistic States	0 to 1	0.33	0.48
Individualistic States	0 to 1	0.31	0.47
Moralistic States	0 to 1	0.35	0.48
Unified Republican Government	0 to 1	0.47	0.50
Unified Democratic Government	0 to 1	0.31	0.47
Split Branch Government	0 to 1	0.98	0.14
Right to Work State	0 to 1	0.54	0.5
Fiscal Health	-8591157 to 40800000	2987306	6431731
Legislative Professionalism	0.048 to 0.629	0.23	0.11

The Model

To estimate the impact of internal determinants on the innovative scope of state ESHI plans, I use the following specifications, where Cov_{it} represents the comprehensive scope of a

state's average ESHI plan coverage and where Cos_{it} represents the costs (monthly premiums, overall deductibles, and out-of-pocket limits) of a state's average ESHI plan. These specifications can be best understood as the following equations:

$$\mathbf{Cov_{it} = \alpha_1 FH_{it-1} + \alpha_2 SR_{it} + \beta_1 LPrtsp_{it} + \beta_2 DGovt_{it} + \beta_3 SBGov_{it} + \beta_4 PLS_{it} + \beta_5 PClt_{it} + \beta_6 U_{it}}$$

$$\mathbf{Cos_{it} = \alpha_1 FH_{it-1} + \alpha_2 SR_{it} + \beta_1 LPrtsp_{it} + \beta_2 DGovt_{it} + \beta_3 SBGov_{it} + \beta_4 PLS_{it} + \beta_5 PClt_{it} + \beta_6 U_{it}}$$

Performing OLS Regression: Identifying Causal Relationships Between Healthcare and Political, Social, and Economic Factors

In this section, I present the results of Ordinary Least Squares (OLS) regressions across the dimensional groupings of coverage and costs. OLS allows for the prediction of explanatory variables, determining the strength of these variables and their subsequent relationship. This allows one to empirically determine which political, social, and economical elements impact health policy in the American states. I present regression results for each dimension of coverage first, then do the same for costs. Each dimension is accompanied with a discussion of the regression results. Examining these elements allows us to draw meaningful conclusions that translate into real-world implications. The subsequent section compliments the previous chapter with an explanatory backbone, producing a more nuanced understanding of the intricacies of health policy in the decentralized American polity.

Table 12: Ordinary Least Squares Regression of In-Network and Out-of-Network Urgent Care, Emergency Care, and Emergency Medical Transportation Services

	In-Network and Out-of-Network
Democratic Representatives	-0.07 (0.19)
Democratic Senators	-0.31 (0.45)
Democratic Governors	3.04 (10.76)
Policy Liberalism	3.83 (4.26)
Individualistic States	-7.56 (7.95)
Moralistic States	-5.58 (7.03)
Unified Republican Government	-0.15 (12.05)
Unified Democratic Government	4.10 (8.46)
Split Branch Government	-6.95 (18.05)
Right to Work State	5.47 (8.60)
Fiscal Health	-2.31 (4.88)

Legislative Professionalism	19.34 (33.69)
Constant	25.05 (20.58)

Traditionalistic political culture is the baseline category.
*p<0.1; **p<0.05; ***p<0.01

Table 12 presents the results of my OLS regression examining the factors that affect rankings of the dependent variable assessing urgent care, emergency care, and emergency medical transportation (see Table 1). As indicated in the previous chapter, given the interrelatedness of in-network and out-of-network services, I constructed the rankings, including both of these for each of the three services. As independent variables, here and throughout the following regressions, I include *Democratic representatives*, *Democratic senators*, *Democratic governors*, *Policy liberalism*, *Individualistic states*, *Moralistic states*, *Unified Republican government*, *Unified Democratic government*, *Split branch government*, *Right-to-work state, Legislative professionalism*, and *Fiscal health*. These variables are used in each of the models. As Table 12 suggests, these results provide no evidence to support the hypotheses introduced in the beginning of this chapter. Because of this, Mayhew's (1991) notion that divided government does always impede the passage of legislation cannot be refuted.

Inpatient and Outpatient Surgical Facilities and Surgery

Table 13: Ordinary Least Squares Regression of In-Network and Out-of-Network Inpatient and Outpatient Surgical Facilities and Surgery

	In-Network	Out-of-Network
Democratic Representatives	-0.19 (0.19)	-0.17 (0.17)
Democratic Senators	-0.09 (0.45)	-0.14 (0.41)
Democratic Governors	-1.20 (10.80)	-21.55 ** (9.73)
Policy Liberalism	4.60 (4.26)	3.35 (3.84)
Individualistic States	-1.92 (7.97)	-6.99 (7.19)
Moralistic States	-7.34 (7.05)	-12.34* (6.35)
Unified Republican Government	-6.90 (12.09)	-26.11** (10.90)
Unified Democratic Government	3.72 (8.49)	7.87 (7.65)
Split Branch Government	0.37 (18.11)	-14.73 (16.32)
Right to Work State	4.48 (8.63)	3.19 (7.77)
Fiscal Health	-6.46 (4.90)	-6.08 (4.41)
Legislative Professionalism	3.38 (33.80)	45.68 (30.46)

Constant	27.71 (20.65)	56.10 (18.61)

Traditionalistic political culture is the baseline category.
*p<0.1; **p<0.05; ***p<0.01

Table 13 provides regression results for both in- and out-of-network coverage rankings for inpatient and outpatient surgical facilities, as well as surgical services. The results suggest that this dimension of coverage, when services are rendered in-network, are insulated from political, social, and economical factors. The lack of statistical significance on these coefficients yields support for **H3-N**, in which divided government does not appear to have bearing on coverage and coinsurance rates. The same variables tell a different story for out-of-network scenarios, however. The negative and significant coefficient on *Democratic governors* indicates that if a state's governor is a Democrat, that state has better, more comprehensive coverage across this dimension. This finding supports **H2**. The negative and significant coefficient on *Moralistic states* suggests that states whose political culture is comprised of conceptualizing the government as a conduit for the advancement of public interest, have better rankings and, consequently, better coverage across this dimension of care, supporting **H7**. Finally, a negative and significant coefficient on *Unified Republican government* exists. Contrary to **H4**, this finding indicates that the presence of unified Republican government promotes more comprehensive coverage and thus better rankings.

X-Ray and Imaging Devices

Table 14: Ordinary Least Squares Regression of In-Network and Out-of-Network X-ray and Imaging Devices

	In-Network	Out-of-Network
Democratic Representatives	-0.15 (0.20)	-0.24 (0.16)
Democratic Senators	-0.16 (0.49)	-0.03 (0.38)
Democratic Governors	-1.53 (11.43)	-26.53 *** (0.38)
Policy Liberalism	5.13 (4.51)	0.30 (3.55)
Individualistic States	-3.58 (8.44)	-1.79 (6.64)
Moralistic States	-7.41 (7.46)	-7.44 (5.87)
Unified Republican Government	-2.55 (12.80)	-33.65 *** (10.08)
Unified Democratic Government	6.92 (8.98)	8.81 (7.07)
Split Branch Government	-0.45 (19.17)	-13.99 (15.09)
Right to Work State	5.33 (9.13)	-3.71 (7.19)
Fiscal Health	-4.36 (5.18)	-4.94 (4.08)
Legislative Professionalism	24.78 (35.77)	46.50 (28.17)

Constant	22.02 (21.56)	61.61 (17.20)

Traditionalistic political culture is the baseline category.
*p<0.1; **p<0.05; ***p<0.01

Table 14 consists of regression results for both in- and out-of-network x-ray and imaging coverage rankings. Much like the previously discussed dimension, in-network services and their coverage rates appear to be independent of the determinants considered. In this vein, support for **H3-N** exists: divided government does not appear to have bearing on coverage rates and subsequent state ranks. However, the same determinants do have bearing when services are out-of-network. The negative and significant coefficient on *Democratic governors* suggests that states with Democratic governors tend to have better coverage rates when it comes to x-rays and other imaging devices. This supports **H2**. Contrary to **H4**, this finding indicates that the presence of unified Republican government does not impede comprehensive coverage and state rankings.

Table 15: Ordinary Least Squares Regression of In-Network and Out-of-Network Mental Health Therapy, Substance Abuse Therapy, Rehabilitative Therapy, and Chiropractic Care

	In-Network	Out-of-Network
Democratic Representatives	-0.30 (0.18)	-0.26 * (0.16)
Democratic Senators	0.01 (0.44)	0.13 (0.38)
Democratic Governors	3.96 (10.36)	-26.0 *** (9.08)
Policy Liberalism	-0.17 (4.09)	-0.31 (3.58)
Individualistic States	2.43 (7.65)	-1.64 (6.71)
Moralistic States	0.91 (6.76)	-9.10 (5.93)
Unified Republican Government	6.21 (11.60)	-31.65 *** (10.17)
Unified Democratic Government	2.36 (8.14)	7.39 (7.14)
Split Branch Government	-9.59 (17.37)	2.16 (15.24)
Right to Work State	2.69 (8.28)	-2.90 (7.26)
Fiscal Health	1.20 (4.70)	-3.11 (4.12)

Legislative Professionalism	-4.38 (32.43)	43.96 (28.44)
Constant	28.34 (19.81)	45.42 (17.38)

Traditionalistic political culture is the baseline category.
*p<0.1; **p<0.05; ***p<0.01

Table 15 displays regression results for both in and out-of-network coverage rate rankings for mental health, substance abuse, and rehabilitative therapies, as well as chiropractic care. As is the case across the two previously discussed dimensions, in-network coverage rates for these services are not dependent on the variables I examine. Moreover, no empirical evidence exists that indicates divided government matters. This supports **H3-N**. On the contrary, these services and their corresponding coverage rates, when out-of-network, are influenced by such factors. The negative and significant coefficient on *Democratic representatives* indicates that the more Democratic lawmakers a state has, the better coverage their average plan offers across this dimension. This finding supports **H1**. Similarly, a negative and significant coefficient on *Democratic governors* suggests that if a state's governor is a Democrat, that state has better, more comprehensive coverage across this dimension, supporting **H2**. Finally, the negative and significant coefficient on *Unified Republican government* does not support my initial hypothesis. Instead, this suggests that the presence of unified Republican government does not impede comprehensive coverage and state rankings.

Table 16: Ordinary Least Squares Regression of In-Network and Out-of-Network Maternity Visits and Child Delivery Services

	In-Network	Out-of-Network
Democratic Representatives	-0.30 (0.18)	-0.26 (0.16)
Democratic Senators	0.01 (0.44)	0.13 (0.38)
Democratic Governors	3.96 (10.36)	-26.00 * (9.08)
Policy Liberalism	-0.17 (4.10)	-0.31 (3.59)
Individualistic States	2.43 (7.65)	-1.64 (6.71)
Moralistic States	0.91 (6.76)	-9.10 (5.93)
Unified Republican Government	6.21 (11.60)	-31.65 * (10.17)
Unified Democratic Government	2.36 (8.14)	7.39 (7.14)
Split Branch Government	-9.59 (17.37)	2.16 (15.24)
Right to Work State	2.69 (8.28)	-2.90 (7.26)
Fiscal Health	1.20 (4.70)	-3.11 (4.12)
Legislative Professionalism	-4.38 (32.43)	43.96 (28.44)
Constant	28.34 (19.81)	45.42 (17.38)

Traditionalistic political culture is the baseline category.

*p<0.1; **p<0.05; ***p<0.01

Table 16 provides regression results for both in and out-of-network coverage rankings for maternity visits and delivery services. The aforementioned trend of in-network independence continues, in which the determinants examined appear to have no bearing. This simultaneously, across this particular dimension of coverage, suggests that divided government does not impact rankings.When maternity visits and delivery services are accrued out-of-network, however, political factors matter. First, the negative and significant coefficient on *Democratic governors* indicates that states whose governors are Democrats have better coverage rates and, consequently, better rankings across this dimension, supporting **H2**. Interestingly, however, the negative and significant coefficient on *Unified Republican government* suggests that the presence of such does not result in poorer rankings, nullifying **H4**.

Home Health Services and Hospice Care

Table 17: Ordinary Least Squares Regression of In-Network and Out-of-Network Home Health Services and Hospice Care

	In-Network	Out-of-Network
Democratic Representatives	0.12 (0.17)	0.03 (0.16)
Democratic Senators	-0.37 (0.41)	-0.38 (0.40)
Democratic Governors	1.46 (9.87)	-25.97 *** (9.44)
Policy Liberalism	2.00 (3.89)	-2.46 (3.72)
Individualistic States	-5.52 (7.29)	-0.47 (6.96)
Moralistic States	-2.57 (6.44)	-3.94 (6.16)
Unified Republican Government	5.02 (11.05)	-29.38 *** (10.57)
Unified Democratic Government	9.23 (7.76)	8.31 (7.42)
Split Branch Government	4.10 (16.55)	-6.18 (15.83)
Right to Work State	17.88 ** (7.88)	0.23 (7.54)
Fiscal Health	-3.10 (4.48)	-2.48 (4.28)
Legislative Professionalism	27.27 (30.90)	33.11 (29.54)
Constant	4.34 (18.88)	51.27 (18.05)

Traditionalistic political culture is the baseline category.

*p<0.1; **p<0.05; ***p<0.01

Table 17 displays regression results for both in and out-of-network coverage rankings for home health services and hospice care. The lack of statistical significance on unified government coefficients suggests that divided government does not impact in-network coverage for home health services and hospice care. The positive and significant coefficient on *Right-to-work state* indicates that states that prohibit union security agreements between labor groups and employers have poorer coverage across this dimension, supporting **H8**. When rendered out-of-network, these services are influenced notably by the party of the corresponding states' governor. The negative and significant coefficient on *Democratic governors* offers support for **H2**. Finally, while the coefficient on *Unified Republican government* is significant, as anticipated by **H4**, it is negative instead of positive. Essentially, across this dimension, unified Republican government does not bar comprehensive coverage rates and subsequent state rankings.

Primary Care and Prescription Drugs

Table 18: Ordinary Least Squares Regression of In-Network and Out-of-Network Primary Care

	In-Network	Out-of-Network
Democratic Representatives	0.01 (0.15)	-0.24 (0.18)
Democratic Senators	-0.03 (0.37)	0.09 (0.42)
Democratic Governors	14.27 (8.83)	-14.15 (10.06)
Policy Liberalism	0.75 (3.48)	-0.60 (3.97)
Individualistic States	1.77 (6.52)	-0.44 (7.43)
Moralistic States	3.08 (5.76)	-6.32 (6.57)
Unified Republican Government	12.12 (9.89)	-24.38 ** (11.27)
Unified Democratic Government	1.87 (6.94)	0.63 (7.91)
Split Branch Government	-10.95 (14.80)	-5.37 (16.87)
Right to Work State	7.11 (7.05)	-6.91 (8.04)
Fiscal Health	-4.76 (4.00)	-1.85 (4.56)
Legislative Professionalism	-4.69 (27.63)	27.33 (31.49)
Constant	20.90 (16.88)	49.51 (19.24)

Traditionalistic political culture is the baseline category.
*p<0.1; **p<0.05; ***p<0.01

Table 18 consists of regression results for both in- and out-of-network primary care. As has been the case across many dimensions of coverage, in-network coverage rates and their corresponding state rankings are not influenced by most of the independent variables. In this vein, there is support for **H3-N**: divided government, across this dimension, does not influence ESHI plans. When primary care services are rendered out-of-network, however, political factors do have bearing. This is notable when considering the negative and significant coefficient on *Unified Republican government*. The direction of the coefficient results in poorer coverage or rankings.

Table 19: Ordinary Least Squares Regression of In-Network and Out-of-Network Prescription Drug Coverage

	In-Network	Out-of-Network
Democratic Representatives	0.03 (0.11)	-0.32 (0.22)
Democratic Senators	-0.13 (0.26)	0.90 * (0.52)
Democratic Governors	-1.91 (6.27)	-18.61 (12.46)
Policy Liberalism	3.22 (2.48)	-4.59 (4.92)
Individualistic States	-6.15 (4.63)	15.91 * (9.20)
Moralistic States	-4.27 (4.10)	5.10 (8.13)
Unified Republican Government	6.89 (7.03)	-17.59 (13.95)
Unified Democratic Government	12.56 ** (4.93)	1.00 (9.80)
Split Branch Government	-31.52 *** (10.52)	-31.64 (20.90)
Right to Work State	9.55 * (5.01)	4.85 (9.96)
Fiscal Health	-3.90 (2.85)	8.10 (5.65)
Legislative Professionalism	24.64 (19.64)	-46.04 (39.00)
Constant	49.28 (12.00)	23.83 (3.26)

Traditionalistic political culture is the baseline category.

*p<0.1; **p<0.05; ***p<0.01

Table 19 consists of regression results for both in- and out-of-network prescription drug coverage. In-network coverage, across this dimension, is influenced by political factors more so than any of the aforementioned dimensions. The positive and significant coefficient on *Unified Democratic government* does not support my theorization that the presence of unified Democratic government would result in comprehensive coverage and better rankings. Instead, across this dimension, unified Democratic government within a given state does not result in better ESHI plans. Additionally, my initial hypothesis (**H5**) regarding split branch government becomes nullified for in-network prescription drug coverage. Instead, split branch government does not impede coverage rates and subsequent rankings. Support does exist for **H8**, however. The positive and significant coefficient on *Right-to-work state* suggests that states that maintain right to work laws offer ESHI plans with less comprehensive coverage rates. Interestingly, out-of-network prescription drug coverage is not as influenced by the examined determinants as its in-network analog. Across this dimension, for out-of-network prescription drugs, political culture is the only influential variable. The positive and significant coefficient on *Individualistic states* suggests that states that are classified as individualistic based on Elazar's (1966) typology have less comprehensive coverage and poorer rankings across this dimension. This makes sense when considering the reliance on the marketplace that individualistic cultures maintain. Essentially, these states remain frugal, placing larger coinsurance responsibilities on the ESHI plan consumer. Finally, divided government, across this dimension, does not influence ESHI plans.

Premiums, Overall Deductibles, and Out-of-Pocket Maximums

Table 20: Ordinary Least Squares Regressions of Premium Costs, Overall Deductibles, and Out-of-Pocket Maximums

	Premiums	Overall Deductibles	Out-of-Pocket Maximums
Democratic Representatives	0.10 (0.18)	-0.17 (0.18)	-0.05 (0.16)
Democratic Senators	-0.41 (0.41)	0.20 (0.43)	-0.41 (0.39)
Democratic Governors	-2.11 (9.06)	1.09 (10.21)	-13.61 (9.38)
Policy Liberalism	2.26 (3.57)	1.46 (4.03)	0.70 (3.70)
Individualistic States	-1.72 (7.31)	-2.29 (7.54)	-5.73 (6.93)
Moralistic States	3.11 (6.05)	-8.06 (7.54)	-10.25 * (6.12)
Unified Republican Government	-5.49 (9.98)	-1.39 (11.44)	-17.96 * (10.51)
Unified Democratic Government	-6.42 (7.08)	0.88 (8.03)	-9.93 (7.38)
Split Branch Government	-10.25 (15.10)	17.75 (17.13)	18.61 (15.74)
Right to Work State	6.22 (7.43)	1.59 (8.16)	-11.09 (7.50)
Fiscal Health	2.25 (4.20)	3.54 (4.63)	9.68 (4.26)
Legislative Professionalism	37.73 (30.89)	-25.74 (31.96)	-4.31 (29.37)
Constant	24.41 (16.98)	14.90 (19.53)	35.36 (17.95)

Traditionalistic political culture is the baseline category. *p<0.1; **p<0.05; ***p<0.01

Table 20 displays regression results for the three dimensions of the second dependent variable—cost. As seen in chapter two, these dimensions do not empirically go together, but conceptually, they are related. Therefore, dimensions are regressed independent of one another, however the results are compiled in one table. Across the dimensions of both premiums and overall deductibles, it appears as though the political, social, and economic factors examined do not impact these costs. Divided government does have bearing on the monthly costs or overall deductibles plan consumers and their families face. Out-of-pocket maximums are not insulated from such factors, however. Instead, across this dimension political culture and unified government seem to matter. Beginning with political culture, as hypothesized, moralistic states have lower out-of-pocket maximums and therefore better rankings. This is evident by the negative and significant coefficient on *Moralistic* states. When considering the nature of moralistic culture this makes sense: the role of government is to be active and to serve the general welfare of the public. In this context, ensuring affordability can be understood in this light. This supports **H7**. Support does not exist for **H4**, however. Instead, the negative and significant coefficient on *Unified Republican government* indicates that the presence of unified Republican control in a given state does not correlate with higher costs for plan consumers and poorer rankings.

The regressions performed across the aforementioned dimensions of coverage and cost of average ESHI state plans indicate that, in certain contexts, political, social, and economic factors warrant predictive power. Table 21 presents gradients of interpretability, in which each independent variable is accompanied with a percentage that represents the percentage of the time in which it is statistically significant.

Table 21: Summary Percentages of Predictive Power

Independent Variable	Predictive Percentage
Democratic Representatives	5.56%
Democratic Senators	5.56%
Democratic Governors	27.78%
Policy Liberalism	0%
Individualistic States	5.56%
Moralistic States	11.11%
Unified Republican Government	38.89%
Unified Democratic Government	5.56%
Split Branch Government	5.56%
Right to Work State	11.11%
Fiscal Health	0%
Legislative Professionalism	0%

This table is based on aggregated measures of the eighteen regressions performed. The percentages represent the percent of the instances in which said independent variable is statistically significant.

Discussion of The Interaction Between Political, Social, and Economic Factors and Health Policy in the American States

At the center of the presented theoretical argument is the notion that the scope of ESHI plans offered to state employees is impacted and can be explained by political, social, and economical elements, internal to the American states. Thus, I argue that the ten

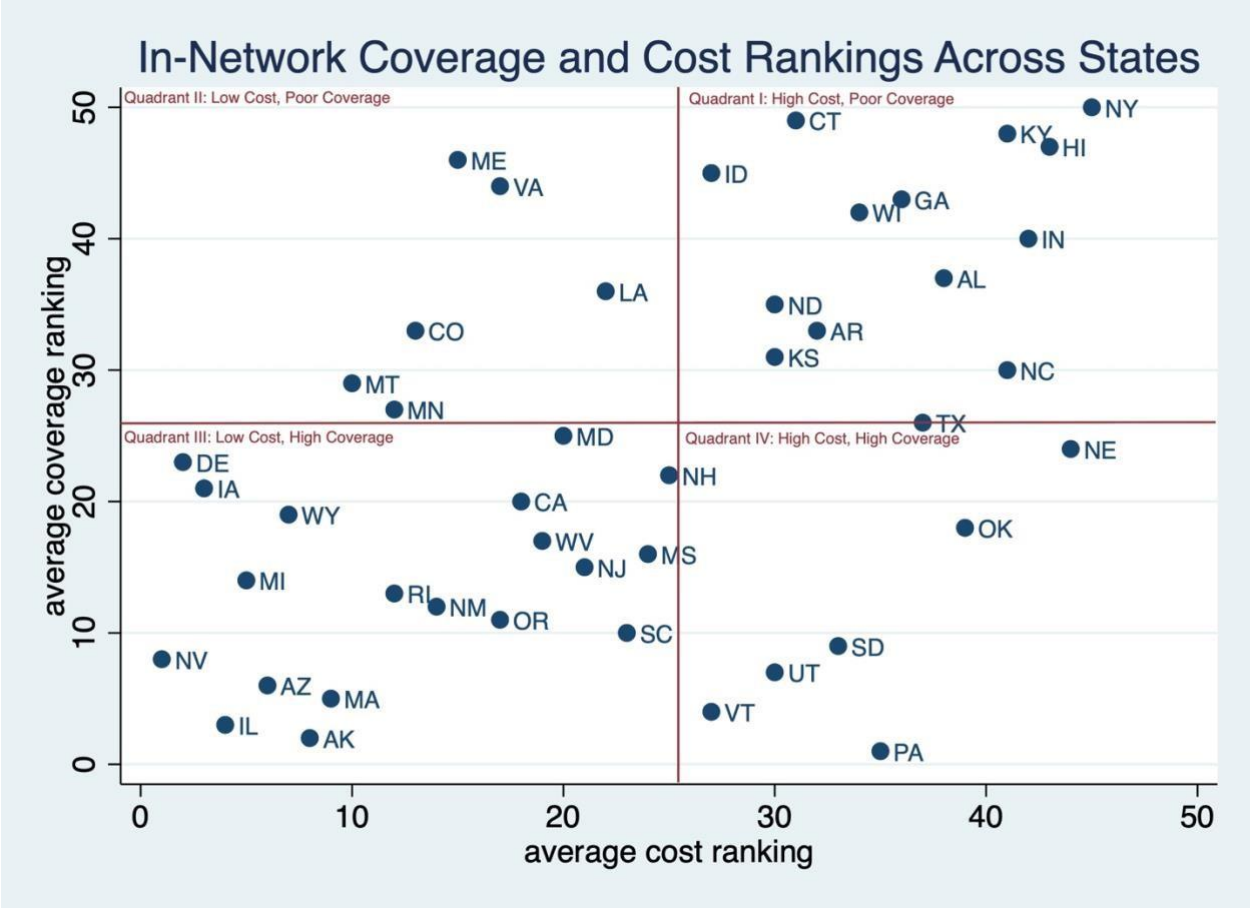
dimensions of health coverage and three dimensions of costs are determined by the these variables.

In this chapter, I test this theoretical conception by examining the scope of the average ESHI plans across the American states. Specifically, I examine the relationship between each independent variable and the average rankings across each dimension of both coverage and cost. Despite the notably broad focus of the analysis, empirically I find limited support for the theoretical argument that we might expect should determine the scope of coverage. This discussion closes by elucidating that the most critical test of the theoretical modelling involves the interplay of Democratic governors and unified Republican governments (see Table 21). The former variable supports the aforementioned theoretical postulation; the later, however, does not. While it makes logistical sense for unified government to produce more optimal policy than divided government, my treatment of unified government as two independent variables on the basis of party control, when tested, tells a story quite antithetical to the general consensus of existing partisanship and spending literatures. Contrary to these earlier findings, across this policy area in instances where unified government is significant, Republican control does not bar comprehensive coverage or economically palatable costs. Simply put, the scope of ESHI plans in the American states and, in effect, their relative rankings, operate in concert with internal state characteristics.

Chapter Four: Concluding Remarks and Broader Implications

As chapter two indicates, the states vary in terms of rank across dimensions of both coverage and costs. While these differences are meaningful, to illustrate the omnipresent, real-world implications of these rankings, I compute average coverage rankings across the ten dimensions of coverage to produce an average coverage ranking for each of the states' in- and out-of-network coverage. I do the same for costs. I then plot the average rankings across the ten dimensions of coverage with the average cost rankings. This allows us, essentially, to determine if state employees are getting what they pay for, or put another way, to determine which states have inexpensive and good coverage, expensive and good coverage, inexpensive, poor coverage, and expensive and poor coverage. I categorize these plan classifications into quadrants for easier interpretation. Figure 1 depicts the relationship between overall in-network coverage and cost rankings. Figure 2 displays the same relationship for out-of-network services.

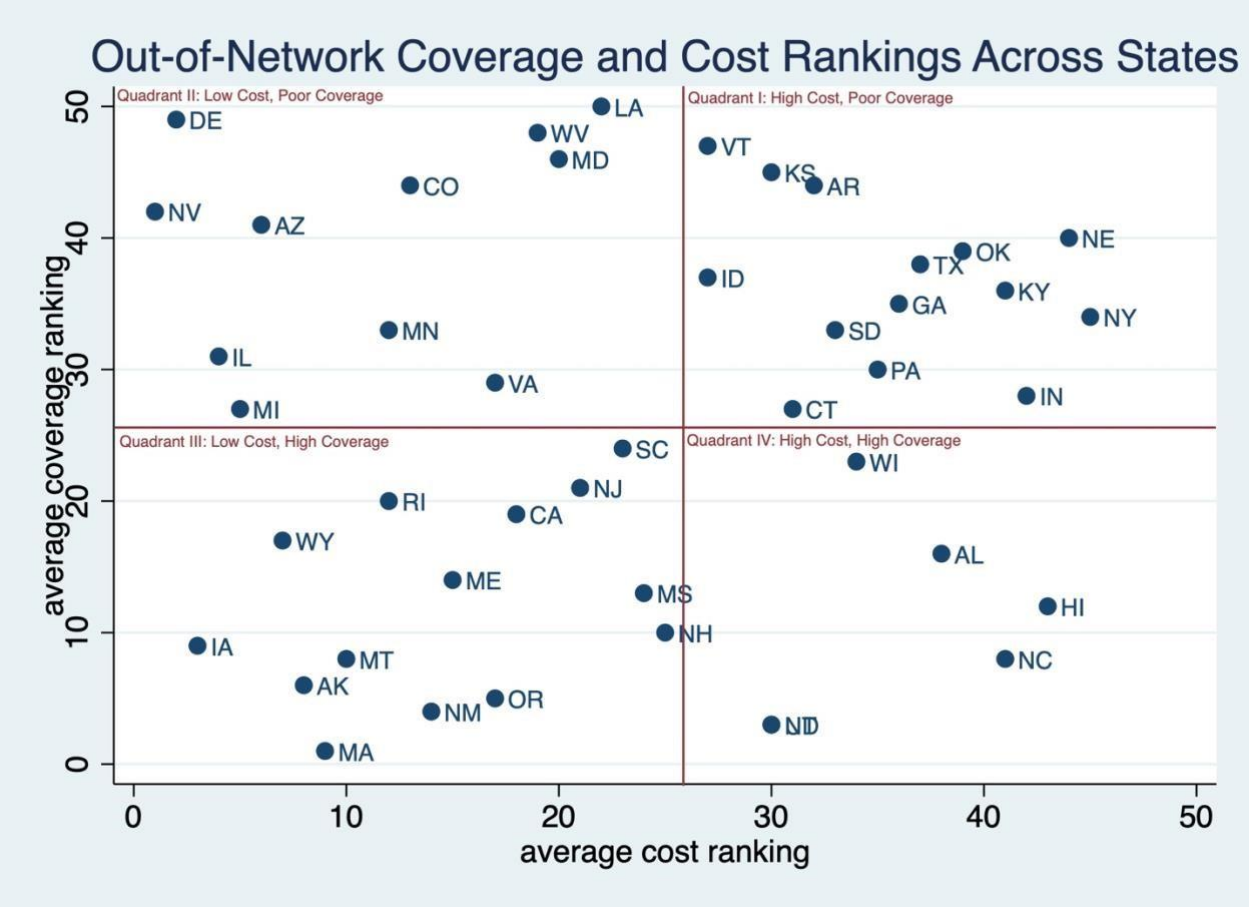
Figure 1: In-Network Coverage and Cost Rankings Across States



In keeping consistent with rank formulation in chapter two, a lower coverage ranking indicates better, more comprehensive coverage. Similarly, a lower cost ranking represents more economical costs. In this vein, ESHI consumers' optimal goal would be to fall into Quadrant III: Low Cost, High Coverage. For in-network services, thirty-eight percent of the states fall into this categorization. Across the ten dimensions of coverage and three dimensions of cost, Alaska and Illinois offer the best coverage with palatable costs. Alaska ranks first for coverage and approximately seventh for costs. Illinois' plan is even cheaper with comparable coverage. Consumers in these states not only pay far less than consumers in other states, they also have more comprehensive coverage for in-network services. Contrarily, states in Quadrant I face the

greatest burden—high costs and poor coverage. New York state employees pay the most in terms of monthly premiums, overall deductibles, and out-of-pocket maximums, while also being responsible for much larger coinsurance obligations. Hawaii plan consumers face a similar reality, ranking around 47th for coverage and 44th for cost. Unlike Alaskans and Illinoisans, state employees in New York and Hawaii face a disparate dilemma—high plan costs do not translate into comprehensive coverage.

Figure 2: Out-of-Network Coverage and Costs Across States



As depicted in earlier chapters, provider networks play a prominent role in determining the quality of health plans. While some states remain consistent across networks, others provide great in-network coverage and poor out-of-network coverage. This is evident when comparing

Figure 1 and Figure 2. For instance, Figure 1 suggests that Delaware, Illinois, and Nevada offer in-network coverage that is affordable and comprehensive, falling into Quadrant III. The same three states, however, offer poorer coverage at a higher cost for the same services out-ofnetwork. Massachusetts offers the best out-of-network coverage to cost ratio, ranking 1st for coverage and 8th for costs. North Carolina transitions out of Quadrant I: High Cost, Poor Coverage in Figure 1 into Quadrant IV: High Cost, High Coverage. While costs remain relatively similar, coverage becomes more comprehensive, moving from 30th to 8th. North Carolinians are likely more accepting of this reality, in which they are getting what they pay for. Nebraskans, on the other hand, are largely responsible for the majority of out-of-network heath care costs, while also paying high premiums, overall deductibles, and out-of-pocket maximums.

The importance of the American states and their role in policymaking in a decentralized polity iterates Supreme Court Justice Louis Brandeis' conceptualization of states as "laboratories of democracy." These proverbial laboratories serve as useful inceptions to policy areas, in this instance health policy, in which they act as fifty units of analysis. Moreover, and as Karch (2007) suggests, states feature underlying similarities to one another, while simultaneously varying in terms of politically relevant attributes. This amalgam iterates the appropriateness of using the states as venues to examine multifarious political phenomena, in which it is possible to expose causal relationships about policymaking in a meaningful and valid manner. ESHI plans in the states are an experiment that these laboratories are conducting and are deserving of such examination.

The analytical framework of this thesis suggests that ESHI plans in the American states can be quantified, compared, and ranked. Additionally, these ranks are affected by causal mechanisms situated around internal state characteristics, including elements of

political, social, and economic phenomena. Chapter one explores and quantifies the scope of ESHI plans offered to state employees in the American states. These rankings are produced across the ten dimensions of coverage and three dimensions of costs we explore, allowing for greater understanding of both individual states and their degree of comprehensive coverage, as well as the relative relationship across states. Chapter two presents a theoretical argument for *why* the states presume their rankings by exploring two specifications—coverage and costs. Empirical tests indicate support for aspects of these specifications, allowing certain dimensions of health policy to be predictive.

In sum, this thesis addresses two primary questions. First, how do ESHI plans in the American states rank across dimensions of coverage and cost in relation to one another? Second, what internal determinant factors explain these rankings? The implications of this research are noteworthy. Prior to this analysis, no attempts have been made to quantify ESHI plans in the American states and consider them comparatively. Additionally, extant scholarship that has been discussed in previous chapters is largely situated around single case studies, or single dimensions of coverage. This research ameliorates these limitations and offers an understanding and quantification of these plans for health policy researchers and entrepreneurs to consider. Additionally, the theory development sheds insight as to which political, social, and economic factors are of most importance when strategically considering the production of optimal ESHI plans. While I believe this research will offer prominent utility, it is erroneous to believe the work is complete. In a Lindblomian (1959; 1979) sense, we are still muddling through. The progress made identifies avenues for future research. One particularly fruitful path for future research on health policy in the American states is to examine certain factors that may affect the generalizations put forth in this study. Extending this analysis in a time-series-cross-sectional

(TSCS) manner would allow for a more nuanced understanding of the role of changes in political and institutional contexts in regard to policy outputs. Beyond this, many important questions arise and remain unanswered. Do specific actions have a more profound impact on the scope and subsequent rank of a given state ESHI plan? Are certain conditions more conducive to producing *better* ranks and facilitating *better* ESHI plans beyond the political, social, and economic factors considered here? In this vein, does electoral competition matter? Answering any of these questions will make a valuable contribution to the analytical framework described in this thesis, as well as to the literature more broadly. As the previous discussion of the models suggest, consistencies and inconsistencies within the literature and this research exist. Variables that frequently matter, for example fiscal health, lack statistical significance in this research. This could be a product of time's arrow, in which a shortcoming of this research is the lack of a time-series component. These limitations, however, make for fertile ground for future scholarship.

My goals here were ambition ones: To construct comparative rankings of the American states on the basis of healthcare, while also disentangling explanatory mechanisms for their ranks. The extent to which I have done so, naturally, will be determined by the reader. I have sought to cultivate an analysis that, to the greatest extent possible, remunerates both the goals just discussed, as well as the two overarching goals of the social sciences: the development of a theoretical model and the subsequent empirical testing of it. I end this thesis precisely where it began—with the acknowledgement that federalism, decentralization, and laboratories of democracy facilitate idiosyncrasies amongst the American states and their respective policy outputs. This is exactly why I find the American states as interesting polities to study. I believe that readers will know more about health policy in the American states after reading this thesis, but note, and anticipate that future iterations of it will further expand our collective

understanding. In this sense, this study shares a common feature with laboratories of democracy, in that it provides an opportunity for further experimentation and examination in an evolving inquiry to answer important questions.

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Appendix A: Operationalization Table

Number	Variable	Operationalization	Indicator	Scale
1	***plan_name***	The name of said plan.	Plan name listed.	Nominal
2	***cov_year***	The year in which said plan provides coverage.	Coverage year listed.	Interval
3	***sing_prem***	The monthly premium rate of a single employee.	Monthly premium rate of a single employee listed.	Ratio
4	***fam_wo_sp***	The monthly premium rate of an employee and their child/children.	Monthly premium rate of an employee and their child/children listed.	Ratio
5	***fam_w_sp***	The monthly premium rate of an employee, their child/children, and their spouse.	Monthly premium rate of an employee, their child/children, and their spouse listed.	Ratio
6	***over_deduc_ind***	The overall deductible per calendar year for an individual.	Overall deductible for individual listed.	Ratio
7	***over_deduc_fam***	The overall deductible per calendar year for a family.	Overall deductible for family listed.	Ratio
8	***oop_lim_ind***	The out-of-pocket limit for an individual under said plan.	Out-ofpocket limit for individual listed.	Ratio
9	***oop_lim_fam***	The out-of-pocket limit for a family under said plan.	Out-ofpocket limit for family listed.	Ratio

10	***less_np***	Will one pay less if a network provider is used?	0=no, 1=yes,	Dichotomous
11	***ref_spec***	Does one need a referral to see a specialist?	0=yes, 1=no	Dichotomous
12	***ret_ben***	Does the state offer retirement health benefits?	0=no, 1=yes	Dichotomous
13	***IN_inpat_cov_dmy***	Does the plan offer in-network inpatient hospital facility coverage?	0=no, 1=yes	Dichotomous
14	***IN_inpat_cov***	What percent of the in-network inpatient hospital facility costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
15	***IN_inpat_cov_cp***	What copay does one have to pay for innetwork inpatient hospital facility services?	Copay requirement listed.	Ratio
16	***OUT_inpat_dmy***	Does the plan offer out-of-network inpatient hospital facility coverage?	0=no, 1=yes	Dichotomous
17	***OUT_inpat_cov***	What percent of the out-of-network inpatient hospital facility costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
18	***IN_surg_dmy***	Does the plan offer in-network surgery coverage?	0=no, 1=yes	Dichotomous
19	***IN_surg***	What percent of the in-network surgery costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal

20	***IN_surg_cp***	What copay does one have to pay for innetwork surgery services?	Copay requirement listed.	Ratio
21	***OUT_surg_dmy***	Does the plan offer out-of-network surgery coverage?	0=no, 1=yes	Dichotomous
22	***OUT_surg***	What percent of the out-of-network surgery costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
23	***IN_urg_dmy***	Does the plan offer in-network urgent care coverage?	0=no, 1=yes	Dichotomous
24	***IN_urg***	What percent of innetwork urgent care costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
25	***IN_urg_cp***	What copay does one have to pay for innetwork urgent care services?	Copay requirement listed.	Ratio
26	***OUT_urg_dmy***	Does the plan offer out-of-network urgent care coverage?	0=no, 1=yes	Dichotomous
27	***OUT_urg***	What percent of outof-network urgent care costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
28	***OUT_urg_cp***	What copay does one have to pay for outof-network urgent care services?	Copay requirement listed.	Ratio
29	***IN_xray_dmy***	Does the plan offer in-network diagnostic x-ray and test coverage?	0=no, 1=yes	Dichotomous

30	***IN_xray***	What percent of innetwork diagnostic xray and test costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
31	**IN_xray_cp**	What copay does one have to pay for innetwork diagnostic xray and test services?	Copay requirement listed.	Ratio
32	***OUT_xray_dmy***	Does the plan offer out-of-network diagnostic x-ray and test coverage?	0=no, 1=yes	Dichotomous
33	***OUT_xray***	What percent of outof-network diagnostic x-ray and test costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
34	***IN_img_dmy***	Does the plan offer in-network imaging (CT/PET, scans, MRIs) coverage?	0=no, 1=yes	Dichotomous
35	***IN_img***	What percent of innetwork imaging (CT/PET, scans, MRIs) costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
36	***IN_img_cp***	What copay does one have to pay for innetwork imaging (CT/PET, scans, MRIs) services?	Copay requirement listed.	Ratio
37	***OUT_img_dmy***	Does the plan offer out-of-network imaging (CT/PET, scans, MRIs) coverage?	0=no, 1=yes	Dichotomous
38	***OUT_img***	What percent of outof-network imaging	Coinsurance percentages subsidized by insurance	Ordinal

		(CT/PET, scans, MRIs) costs are covered?	provider listed.	
39	***IN_pcp_vis_dmy***	Does the plan offer in-network primary care provider visit coverage?	0=no, 1=yes	Dichotomous
40	***IN_pcp_vis***	What percent of innetwork primary care provider visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
41	***IN_pcp_vis_cp***	What copay does one have to pay for innetwork primary care provider services?	Copay requirement listed.	Ratio
42	***OUT_pcp_vis_dmy***	Does the plan offer out-of-network primary care provider visit coverage?	0=no, 1=yes	Dichotomous
43	***OUT_pcp_vis***	What percent of outof-network primary care provider visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
44	***IN_outpat_vis_dmy***	Does the plan offer in-network outpatient physician/surgeon visit coverage?	0=no, 1=yes	Dichotomous
45	***IN_outpat_vis***	What percent of innetwork outpatient physician/surgeon visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
46	***IN_outpat_vis_cp***	What copay does one have to pay for innetwork outpatient	Copay requirement listed.	Ratio

		physician/surgeon services?		
47	***OUT_outpat_vis_dmy***	Does the plan offer out-of-network outpatient physician/surgeon visit coverage?	0=no, 1=yes	Dichotomous
48	***OUT_outpat_vis***	What percent of outof-network outpatient physician/surgeon visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
49	***IN_tel_dmy***	Does the plan offer in-network Telehealth coverage?	0=no, 1=yes	Dichotomous
50	***IN_tel***	What percent of innetwork Telehealth costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
51	***IN_tel_cp***	What copay does one have to pay for innetwork Telehealth services?	Copay requirement listed.	Ratio
52	***OUT_tel_dmy***	Does the plan offer out-of-network Telehealth coverage?	0=no, 1=yes	Dichotomous
53	***OUT_tel***	What percent of outof-network Telehealth costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
54	***IN_emer_dmy***	Does the plan offer in-network emergency room visit coverage?	0=no, 1=yes	Dichotomous

55	***IN_emer***	What percent of innetwork emergency room visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
56	***IN_emer_cp***	What copay does one have to pay for innetwork emergency room visit services?	Copay requirement listed.	Ratio
57	***OUT_emer_dmy***	Does the plan offer out-of-network emergency room visit coverage?	0=no, 1=yes	Dichotomous
58	***OUT_emer***	What percent of outof-network emergency room visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
59	***OUT_emer_cp***	What copay does one have to pay for outof-network emergency room visit services?	Copay requirement listed.	Ratio
60	***IN_mat_vis_dmy***	Does the plan offer in-network maternity office visit coverage?	0=no, 1=yes	Dichotomous
61	***IN_mat_vis***	What percent of innetwork maternity office visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
62	***IN_mat_vis_cp***	What copay does one have to pay for innetwork maternity office visit services?	Copay requirement listed.	Ratio
63	***OUT_mat_vis_dmy***	Does the plan offer out-of-network maternity office visit coverage?	0=no, 1=yes	Dichotomous

64	***OUT_mat_vis***	What percent of outof-network maternity office visit costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
65	***IN_mat_del_dmy***	Does the plan offer in-network childbirth/delivery coverage?	0=no, 1=yes	Dichotomous
66	***IN_mat_del***	What percent of innetwork childbirth/delivery costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
67	***IN_mat_del_cp***	What copay does one have to pay for innetwork childbirth/delivery services?	Copay requirement listed.	Ratio
68	***OUT_mat_del_dmy***	Does the plan offer out-of-network childbirth/delivery coverage?	0=no, 1=yes	Dichotomous
69	***OUT_mat_del***	What percent of outof-network childbirth/delivery costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
70	***IN_lab_dmy***	Does the plan offer in-network lab and pathology exam coverage?	0=no, 1=yes	Dichotomous
71	***IN_lab***	What percent of innetwork lab and pathology exam costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal

72	***IN_lab_cp***	What copay does one have to pay for innetwork lab and pathology exam services?	Copay requirement listed.	Ratio
73	***OUT_lab_dmy***	Does the plan offer out-of-network lab and pathology exam coverage?	0=no, 1=yes	Dichotomous
74	***OUT_lab***	What percent of outof-network lab and pathology exam costs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
75	***IN_immu_dmy***	Does the plan offer in-network routine immunizations and preventative services coverage?	0=no, 1=yes	Dichotomous
76	***IN_immu***	What percent of innetwork immunizations and preventative services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
77	***IN_immu_cp***	What copay does one have to pay for innetwork immunizations and preventative services?	Copay requirement listed.	Ratio
78	***OUT_immu_dmy***	Does the plan offer out-of-network routine immunizations and preventative services coverage?	0=no, 1=yes	Dichotomous
79	***OUT_immu***	What percent of outof-network immunizations and preventative services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal

80	***IN_mh_dmy***	Does the plan offer in-network mental health facility services coverage?	0=no, 1=yes	Dichotomous
81	***IN_mh***	What percent of innetwork mental health facility services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
82	***IN_mh_cp***	What copay does one have to pay for innetwork mental health facility services?	Copay requirement listed.	Ratio
83	***OUT_mh_dmy***	Does the plan offer out-of-network mental health facility services coverage?	0=no, 1=yes	Dichotomous
84	***OUT_mh***	What percent of outof-network mental health facility services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
85	***IN_sa_dmy***	Does the plan offer in-network substance abuse facility services coverage?	0=no, 1=yes	Dichotomous
86	***IN_sa***	What percent of innetwork substance abuse facility services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
87	***IN_sa_cp***	What copay does one have to pay for innetwork substance abuse facility services?	Copay requirement listed.	Ratio
88	***OUT_sa_dmy***	Does the plan offer out-of-network substance abuse facility services coverage?	0=no, 1=yes	Dichotomous

89	***OUT_sa***	What percent of outof-network substance abuse facility services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
90	***IN_chiro_dmy***	Does the plan offer in-network chiropractic services coverage?	0=no, 1=yes	Dichotomous
91	***IN_chiro***	What percent of innetwork chiropractic services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
92	***IN_chiro_cp***	What copay does one have to pay for innetwork chiropractic services?	Copay requirement listed.	Ratio
93	***OUT_chiro_dmy***	Does the plan offer out-of-network chiropractic services coverage?	0=no, 1=yes	Dichotomous
94	***OUT_chiro***	What percent of outof-network chiropractic services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
95	***OUT_chiro_cp***	What copay does one have to pay for outof-network chiropractic services?	Copay requirement listed.	Ratio
96	***IN_thera_dmy***	Does the plan offer in-network rehabilitative, physical, speech and/or occupational therapy coverage?	0=no, 1=yes	Dichotomous

97	***IN_thera***	What percent of innetwork rehabilitative, physical, speech and/or occupational therapy services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
98	***IN_thera_cp***	What copay does one have to pay for innetwork rehabilitative, physical, speech and/or occupational therapy services ?	Copay requirement listed.	Ratio
99	***OUT_thera_dmy***	Does the plan offer out-of-network rehabilitative, physical, speech and/or occupational therapy coverage?	0=no, 1=yes	Dichotomous
100	***OUT_thera***	What percent of outof-network rehabilitative, physical, speech and/or occupational therapy services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
101	***IN_hhs_dmy***	Does the plan offer in-network home health services coverage?	0=no, 1=yes	Dichotomous
102	***IN_hhs***	What percent of innetwork home health services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
103	***OUT_hhs_dmy***	Does the plan offer out-of-network home health services coverage?	0=no, 1=yes	Dichotomous

104	***OUT_hhs***	What percent of outof-network home health services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
105	***IN_hospc_dmy***	Does the plan offer in-network hospice services coverage?	0=no, 1=yes	Dichotomous
106	***IN_hospc***	What percent of innetwork hospice services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
107	***OUT_hospc_dmy***	Does the plan offer out-of-network hospice services coverage?	0=no, 1=yes	Dichotomous
108	***OUT_hospc***	What percent of outof-network hospice services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
109	***IN_med_eq_dmy***	Does the plan offer in-network medical equipment coverage?	0=no, 1=yes	Dichotomous
110	***IN_med_eq***	What percent of innetwork medical equipment is covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
111	***OUT_med_eq_dmy***	Does the plan offer out-of-network medical equipment coverage?	0=no, 1=yes	Dichotomous
112	***OUT_med_eq***	What percent of outof-network medical equipment is covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal

113	***IN_amb_dmy***	Does the plan offer in-network ambulance services coverage?	0=no, 1=yes	Dichotomous
114	***IN_amb***	What percent of innetwork ambulance services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
115	***IN_amb_cp***	What copay does one have to pay for innetwork ambulance services ?	Copay requirement listed.	Ratio
116	***OUT_amb_dmy***	Does the plan offer out-of-network ambulance services coverage?	0=no, 1=yes	Dichotomous
117	***OUT_amb***	What percent of outof-network ambulance services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
118	***IN_alle_dmy***	Does the plan offer in-network allergy testing and treatment coverage?	0=no, 1=yes	Dichotomous
119	***IN_alle***	What percent of innetwork allergy testing and treatment services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
120	***IN_alle_cp***	What copay does one have to pay for innetwork allergy testing and treatment services?	Copay requirement listed.	Ratio
121	***OUT_alle_dmy***	Does the plan offer out-of-network allergy testing and treatment coverage?	0=no, 1=yes	Dichotomous

122	***OUT_alle***	What percent of outof-network allergy testing and treatment services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
123	***IN_dru_dmy***	Does the plan offer in-network prescription drug coverage?	0=no, 1=yes	Dichotomous
124	***IN_dru***	What percent of innetwork prescription drugs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
125	***IN_dru_cp***	What copay does one have to pay for innetwork prescription drugs?	Copay requirement listed.	Ratio
126	***OUT_dru_dmy***	Does the plan offer out-of-network prescription drug coverage?	0=no, 1=yes	Dichotomous
127	***OUT_dru***	What percent of outof-network prescription drugs are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
128	***IN_ee_dmy***	Does the plan offer in-network annual eye exam coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal
129	***IN_ee***	What percent of innetwork annual eye exam services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
130	***IN_ee_cp***	What copay does one have to pay for innetwork annual eye exams?	Copay requirement listed.	Ratio

131	***OUT_ee_dmy***	Does the plan offer out-of-network annual eye exam coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal
132	***OUT_ee***	What percent of outof-network annual eye exam services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
133	***OUT_ee_cp***	What copay does one have to pay for outof-network annual eye exams?	Copay requirement listed.	Ratio
134	***IN_gla_dmy***	Does the plan offer in-network eyeglasses and/or contact lenses coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal
135	***IN_gla***	What percent of innetwork glasses and/or contact lenses are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
136	***OUT_gla_dmy***	Does the plan offer out-of-network eyeglasses and/or contact lenses coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal
137	***OUT_gla***	What percent of outof-network glasses and/or contact lenses are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
138	***IN_den_dmy***	Does the plan offer in-network dental check-up coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal

139	***IN_den***	What percent of innetwork dental check-up services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal
140	***OUT_den_dmy***	Does the plan offer out-of-network dental check-up coverage?	0=no, 0.5=yes, but only for child/children, 1=yes	Ordinal
141	***OUT_den***	What percent of outof-network dental check-up services are covered?	Coinsurance percentages subsidized by insurance provider listed.	Ordinal

Vita

Mackenzie Ridge Dobson was born in Asheville, North Carolina. She graduated from McDowell Early College and McDowell Technical Community College in May 2018. The following autumn, she entered Appalachian State University to study Political Science and in May 2020 she was awarded a Bachelor of Science in Political Science. She continued her scholarly career at Appalachian State University the following academic year, pursuing a Master of Arts in Political Science. In August 2021, she will be pursuing a PhD in Political Science at the University of Virginia, with a focus on American Politics and Research Methodology.