「한국공공관리학보」 제33권 제3호(2019. 9): *1~28*
DOI http://dx.doi.org/10.24210/kapm.2018.33.3.001

Institutional Analysis of Intergovernmental Policy: A Case of Medicaid Program*

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Abstract

As the largest jointly funded policy, Medicaid has been a locus of tension between federal and state government since it was created. This paper tries to determine the factors that influence Medicaid expenditures by focusing on the federal and state relationship, and tries to show how this relationship and state institutional factors affect Medicaid policy implementation. This paper considers intergovernmental relations as an important institutional arrangement to maximize policy benefits based on the rational choice approach and federalism. This paper found that factors separately influence total Medicaid expenditures and the State share amount, for Medicaid reflects state spending behavior depending on the relationship with the federal government. Also this paper found that federal and state relationship influences increase or decrease of Medicaid benefits per recipient.

Key Words: Federalism, Federal Grant Program, State Medicaid

* This work was supported by the National Research Foundation of Korea Award (NRF-2016S1A3A2924832).
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Ⅰ. Introduction

Medicaid is jointly funded by federal and state governments to provide health care for the poor(Barrilleaux & Miller, 1988; Weissert, 1992[1]); Ladenheim & Kee, 1998). As the largest jointly funded program, Medicaid has been a locus of tension between federal and states governments, as they have been concerned about increasing Medicaid costs(Ladenheim & Kee, 1998). Where can we find the causes of Medicaid spending growth? Some scholars point out that program costs dramatically vary state by state and these variations cannot be explained by the size of the state or other demographic factors(Holahan & Cohen, 1986; Schneider, 1988).

Many scholars have contributed an explanation for the rapidly growing costs of the Medicaid program, or have sought to identify factors influencing Medicaid expenditures. Barrilleaux and Miller's(1988) study explained Medicaid spending by developing a market-based model and limiting their research focus on decision making for welfare policy in states. Schneider et al.(1997) focused on states' discretion regarding Medicaid, especially bureaucratic discretion, by focusing on the adoption of optional services by discerning an underlying pattern across the states. Weissert & Weissert(2000) examined the role of state legislative staff in health policy making by focusing on the relationship between legislators and their staff. Their qualitative study found that state legislative staff influence a large part of decision making process. Schneider(1988) included national and state-level policy variables to find determinants of the level of spending by using variables indicating general national economic conditions (i.e. poverty rate and consumer price index for medical care) and variables related to states' policy control system (i.e. level of government which is responsible for program administration)and demands. Buchanan et al.(1991) examined it by using a model that focuses on economic, political, and implementation processes.

Although there are many studies that try to identify factors influencing the Medicaid program, it is difficult for them to explain the reasons for increasing Medicaid expenditures by focusing on influences from the two levels of government and the political environment around Medicaid policy implementation. Weissert(1992) pointed several reasons of escalation in Medicaid spending during the early 1990s, and mentioned eleven enactments

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1) Medicaid is a voluntary grant-in-aid program; therefore, the federal requirements are conditions of aid. States refer to the federal requirements as mandates(Weissert, 1992).

for several federal mandates expanding Medicaid eligibility and services from 1984 to 1990 such as the Omnibus Budget Reconciliation Act of 1986, 1987, 1989 and 1990, and the Deficit Reduction Act of 1984. Therefore, we thought that one of the most important factors is the political environment around the Medicaid program associated with the federal mandates and state discretion. This study tries to explain the influence of the relationship between federal government and states on Medicaid expenditure by examining the national political environment around the Medicaid program. Specifically, we show how factors exert a separate influence on total Medicaid expenditures including federal grants and State share amount because Medicaid reflects a state's spending behavior depending on the relationship with the federal government. For example, we expect that when the federal government emphasizes shared responsibility on Medicaid, it would be positively related to total Medicaid expenditures, but it would not necessarily show a positive relationship with State Medicaid expenditures if a state does not want to spend as much as the federal government expects. In other words, an increase in total Medicaid expenditures does not mean that a state spends more for Medicaid policy implementation. In the same way, increasing total Medicaid expenditures does not mean increasing benefits for a recipient. But this can be only shown by separating the amount of Medicaid expenditures from total spending, State share amount, expenditures per enrollee, and state expenditures per enrollee. In sum, we tried to understand differences in policy outcomes of states, namely Medicaid expenditures, more specifically by looking at the relationship between federal and state government as an institutional arrangement of the Medicaid program, and by looking at the differences in each state's institutional arrangements. An institutional rational choice theory is used to test the research question: what are the factors influencing states' Medicaid expenditures? And we seek to find answers by focusing on federal-state relationships and state institutional decisions. We employ four dependent variables in this study; 1)total Medicaid expenditure, 2)Medicaid expenditure per recipient, 3)total state share amount and 4)state share amount per recipient.

Ⅱ. Theoretical Background

1. Intergovernmental Relationship and US Medicaid Policy

In political science and legal scholarship, federalism refers to a mode of organizing a

political entity that grants partial autonomy to geographically defined subdivisions of the polity(Friedrich, 1968; Duchacek, 1970; Dikshit, 1975; Blumstein, 1994; Rubin & Feeley, 2008). In other words, geographic subdivisions must exercise exclusive jurisdiction over set of issues, namely discretion reserved to the subdivisions(Rubin & Feeley, 2008). Ladenheim & Kee(1998) divided federalism into two dimensions; structural and functional. They posited that structures of federalism in the US were characterized as dual, coordinate or divided federalism in the early days of the nation, and had been characterized as compound or shared federalism during most of 20th century.

They suggested that, the "debate in the 104th Congress over the future of Medicaid…was more than a budget debate(1998)." They examined the issue in relation to that part of federalism that deals with the division and balance of roles between the federal government and states. As Dinan stated, "nor were state officials free of federal constraints … but states were more influential than in recent years in gaining flexibility in implementing federal legislation"(2008). The federal government delineates general goals and promotes them by providing funds to cover a certain population and mandated services based on state income level, but the authority for the specifics of the program is delegated to each state-level government (Schneider 1988; Schneider et al., 1997). For example, states have the authority to determine the targeting of recipients (eligibility), types of optional services provided, reimbursement process and amount of payments for the service provider, unit of implementation, and so on(Buchanan et al., 1991; Weissert, 1992; Grogan, 1999).

Nevertheless, debates on the relationship between the federal government and states on Medicaid program implementation continue. The debates are often concerned with the limits and requirements on states imposed by the federal government(Ladenheim & Kee, 1998). In this context, states have tried to secure discretion over decision making for the program; on the other hand, the federal government has exerted influence on specific medically-needy populations not only for categorically-needy populations. Although states have considerable policy discretion, OBRA(Omnibus Budget Reconciliation Act) of 1986 reduced states flexibility on Medicaid by setting national minimum income eligibility levels and economically reasonable reimbursement rates for providers by changing eligibility, service provision, or reimbursement rates(Merlis, 1993; U.S. GAO, 1995; Ladenheim & Kee, 1998). However, these unfunded federal mandates brought about a significant fiscal burden for states, and until the early 1990s, the relationship between the federal government and the states was adversarial as states strategized to inflate federal reimbursement

levels(Lipson, 1993; Grogan, 1999). The 104th Congress drew a picture for the future of the Medicaid program on the basis of dual or coordinated federalism by proposing Medicaid reform, and brought forward a plan to eliminate Medicaid and replace it with a block grant to the states. A block grant gives full discretion to state governments, and it means divided control on policy implementation(Ladenheim & Kee, 1998). The plan limited unfunded federal mandates, and expanded controllability of the Medicaid program to states to reduce the financial burden on the federal government. Volden(1999) showed that if the proposal had been accepted and funding changed to block grants, it would have led to little or no state reduction in welfare payments. However, President Clinton vetoed the proposal and emphasized intergovernmentalcollaboration and experimentation as an alternative to encourage a closely coordinated state-federal partnership as meaning "cooperative or shared control" of the Medicaid program(Ladenheim & Kee, 1998). This intergovernmental collaboration and experimentation means that the Medicaid program should be under the influence of the federal government but should allow state discretion according to each state's condition.

However, there were concerns that the national government dominated the states by using unitary coercive federalism(Wright, 1988). Weissert & Schram(2000) mentioned there was concern that the trend would be toward more nationalization, but they pointed out there were also predictions of decentralization during the 106th congress.

This is why we included the years of study from the start of the 105th Congress (1997) which was the starting point of the Clinton administration's emphasis on shared or compound federalism, to the first two years of the first administration of George W. Bush(2003) which emphasized dual or coordinate federalism to reflect the influences on the division of power between federal and state governments and the political environment of Medicaid policy implementation. This study expects different patterns of federal influences on Medicaid expenditures between the President Clinton administration and the President Bush administration.

Next, we discuss how federalism can be associated with institutionalism. Currently, with the rethinking of government, the concept of governance is used as a synonym for government(Frederickson & Smith, 2003). Williamson(1985, 1996) saw governance structure as institutional arrangements, namely, specific guidelines which are designed by trading partners to mediate economic relationships. The concept of governance allows more flexibility for policy implementation because governance structures can be described along a spectrum, with market and hierarchy at the poles. As mentioned earlier, we see

federalism as an institutional arrangement which reflects the relationship between levels of governments. We explain federalism with the concept of governance as explained by the new institutional economics. This research discipline explains that institutions exist to reduce transaction costs, so that institutions are created by a rational intention to reduce inefficiency. This explanation is based on two crucial behavioral assumptions for actors: bounded rationality, a term first used by Simon(1947), and opportunism reflecting self-interest seeking behaviors. This research tradition has been developed and expanded to study not only economic institutions but also political institutions(Buchanan & Tullock, 1962; Mueller, 1979, 1989; McKelvey, 1976; Riker, 1981; Enelow & Hinich, 1984), and explains the existence of political institutions as a purposeful human rational choice. Therefore, the rational choice approach is at the center of the analysis in answering the question "why institutions exist" which has been the ultimate inquiry of the new institutional economics. The rational choice perspective is also used to explain the effects of political institutions on public policy, including macroeconomic policy, welfare policy, budgets, regulation and technology policy(Shepsle, 1989; Weingast, 1996; Klein, 1999). Based on the concept of governance which can be understood as a spectrum of institutional choices in the perspective of the rational choice approach, we assume that the federal and state relationship influenced by the national political environment and each state's condition with Medicaid policy implementation is one type of institutional arrangement to minimize institutional inefficiency and to protect minimum policy requirements. Therefore, we understand federalism as an institutional basis embedded in the Medicaid program since the program's beginning, although this relationship has experienced several changes.

2. Application to the Medicaid Policy Implementation

As North(1990) stressed, reduction of transaction costs is a key impetus for the establishment of institutions. This is because institutions become a guideline for actors to follow, which reduces uncertainties and transaction costs from obtaining information, monitoring, and enforcement by organizing each actor's behavior through the institutional mechanism(Williamson, 1981; North, 1990; Ostrom, 1990, 1999). We understand that intergovernmental policies, or federalism, reflect the federal-state relationship as one of the institutional mechanisms to maximize policy benefits by minimizing the costs of the policy implementation. Nicholson-Crotty(2004) suggested that the massive scale of fiscal

federalism makes the federal government delegate its power to sub-national government, but also shows that the states inflate the federal share of Medicaid expenditure at their discretion. He assumed that the policy goals between the federal and states government might not be congruent from the perspective of goal conflicts based on the principal-agent theory. We recognize that the behavior which inflated the federal share expenditures occurred from the organizational in efficiency produced by bounded rationality and opportunism during the policy implementation. Although Medicaid is an entitlement program[2], the states can create programs that fit their specific needs. The rational choice approach provides a useful lens to examine this phenomenon occurring in the intergovernmental policy area. States might be more likely to expand the resources supported by the federal government to increase their authority and influence by increasing their resource availability. For example, the states might move toward provision of optional services and try to get more federal funds. Our hypotheses are based on the explanations of self-interest seeking behavior and opportunism between the levels of government which the rational choice theory argues.

First, the federal government is an important institutional arrangement in Medicaid policy implementation. Holahan and Cohen(1986) found that higher federal matching rates were associated with higher Medicaid expenditure, but Buchanan et al.(1991) showed negative relations with Medicaid expenditure, although it was not statistically significant at all levels. The federal government has a policy goal to provide equal medical access for all fifty states by setting minimum requirements. However, all states have different economic, political and social conditions, so states' policy preferences would be different from that of the federal government. This is the major reason to secure policy discretion and flexibility for the states to reduce organizational inefficiency. Empirically, although the exact percentage of the federal share is based on income levels within each state, it can never be less than 50 percent and no more than 83 percent of total Medicaid funds (Buchanan et al., 1991). According to the data from theCenters for Medicare and Medicaid Services(CMS), the federal percentage ranges from a low of 50 percent for many states up to 79 percent for Louisiana in fiscal year 1997 during the time period of this study (from 1997 to 2003).

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2) Entitlement program means mandatory program. Mandatory programs have to be provided to all people who meet the eligibility requirements specified in the law as a permanent program. But entitlements are often not funded for a specific amount; instead Congress typically uses such language as "there are authorized to be appropriated such sums as may be necessary to carry out the provisions" of the law(Rahm, 2004:61).

Also, only Louisiana, Texas, and Georgia experienced a decrease in the federal share percentage during those fiscal years.[3] We use the federal share percentage in this study as one of variables for measuring influence from the federal government on Medicaid programs in an institutionally embedded relationship.

We hypothesize that influences from the federal government might be different depending on the dependent variables we employed.

H1: Increase in the federal aid percentage will be "positively" related to the "total Medicaid expenditures" because the first goal of federal funds is to cover minimum requirements.

H1-1: Increase in federal aid percentage will be "negatively" related to the Medicaid "expenditures per enrollee" in that covering people under the FPL would have priority over providing more various services for the federal government.

H1-2 & H1-3: If the policy goal of federal and state government is congruent, an increase of federal aid percentage will be related to an increase of "State Medicaid expenditures and State per enrollee costs."

National political influence measures the characteristics of the federal-state relationship (federalism). During the President Clinton administration(1997-2000), cooperative or shared federalism was emphasized. On the contrary, we expected dual or coordinated federalism(decentralization) would be emphasized with the start of the Bush administration (2001-2003) based on party register that reflected policy orientation.

H2 & H2-1: The Clinton administration should be "positively" related to total Medicaid expenditures and per enrollee costs, but if the policy goal of state government is not congruent with that of federal government, it would be "negatively" related to total State Medicaid expenditures and per enrollee state costs because cooperative or shared federalism emphasizes a more supportive and positive role of federal government on Medicaid program implementation, which results in a budget increase without an increase in state share amount.

H2-2 & H2-3: The Bush administration should be "negatively" related to total Medicaid expenditures and per enrollee costs, but if the policy goal of state government is not congruent with that of federal government, it would be "positively" related to total State Medicaid expenditures and per enrollee state costs because dual or coordinated federalism

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3) Federal percentage was decreased from 62% to 61% in Georgia, and from 63% to 62 % in Texas. In the case of Louisiana, federal percentage was dramatically decreased in the fiscal year of 1998 into 70% from 79%, and increased 3% until fiscal year of 2003.

emphasizes state discretion on Medicaid program implementation.

Second, we consider the factors influencing state discretion in Medicaid policy implementation. We assume that elected officials persue their self-interest maximization based on the rational choice theory; political officials seek re-election. Legislators' concerns as rational individuals are about the median voter's preference, since their authority and power ultimately come from election. Tiebout's study(1956) explains a pattern of political behaviors with responsiveness to the median voter's preference. Medicaid is classified as a redistributive policy area, and this is intended to help low income families, disabled people, and children from low income households, etc. (Hanson, 1984; Groggin, 1987; Matland, 1995; Weissert & Goggin, 2002). In other words, Medicaid might be out of the realm of the median voter's interest.

Political officials are influenced by ideology which is represented by party registration. Belonging to a party has a relationship to one's ideology, and voters of ten vote based on their party preferences. Party registration is associated with a policy orientation that is favorable toward redistributive policy or not, such as the Medicaid program (Hanson, 1984). In this study, we expect that states with more democratic political environments are more willing to provide generous Medicaid programs(Buchananet et al., 1991; Grogan, 1999).

H3: The presence of Democratic governors will be positively related to the all dependent variables.

H4: If the ideology of a state's citizens and political leaders is more liberal, it should be positively related to the all dependent variables.

In addition, Congress delegates their authority to the executive when the external transaction costs of delegating are less than the internal transaction cost of making policy through the legislative process (Epstein & O'Halloran, 1999). We expect that if the dominant legislative party of the Senate and the House and that of governor are congruent (referred to as unified government in this study), costs of delegation would be higher because internal monitoring costs and information asymmetries could be reduced. Therefore, legislators will not delegate more power to bureaucrats when the government is unified. Based on the assumption that unified government will not delegate, party registration will be the most influential factor for elected officials.

H5: If the dominant party of the Senate and the House and that of the governor are unified by the Republican Party, it should be negatively related to the total Medicaid expenditures, total expenditures per enrollee, the State Medicaid expenditures and State

Medicaid expenditures per enrollee.

H6: If the dominant party of the Senate and the House and that of the governor are unified by the Democratic Party, it should be positively related to total Medicaid expenditures, total expenditures per enrollee, State Medicaid expenditures and State Medicaid expenditures per enrollee.

Third, Congress passes laws and establishes programs, but Congress also gives authority to make rules and regulations with regard to carrying out the laws. Based on our theoretical framework, rational elected officials would delegate when their political benefits are bigger than the costs. At the same time, the length of the legislative career would be one factor of authority delegation. The legislators' time is limited, so there is little time for legislators to learn their roles and to acquire expertise. Moreover, state legislators turn over more quickly than members of Congress(Weissert & Weissert, 2000). In this situation, state bureaucrats should be helpful to reduce uncertainty by gathering information and making recommendations regarding policy options in that they have served in a subject area for a relatively longtime(ibid.)

On the other hand, as rational individuals seeking self-interest, both bureaucrats and elected officials are not congruous with their policy goals in a bureaucratic setting (; Waterman & Meier, 1998; Moe, 1985). Congress delegates its authority to the executive when the external transaction costs of delegating are less than the internal transaction costs of making policy through the legislative process (Epstein & O'Halloran, 1999). When legislators decide whether they delegate or not, some critical factors which reduce external transaction costs are the professionalism of bureaucrats, or agency expertise, and the recognition of limited resources like time and human resources. However, the delegation depends not only on efficiency of policy implementation, but also political efficiency. This means that the legislator is highly motivated by self-interest-reelection-as a rational individual, and this also affects his/her decision of whether to delegate powers to the bureaucracy or not(Henisz & Zelner, 2004). In the case of the Medicaid program, state bureaucrats have discretion over adoption of optional programs. Some scholars find that the federal government and elected officials in the states are more concerned about the broad parameters of the program, such as financing and eligibility issues(Schneider, 1995; Schneider et al., 1997). This is because setting eligibility and financing affect smore broad constituents, and it is directly related to their political interests. Institutionally, the range of beneficiaries is basically settled by federal law, but it can be determined by state discretion more broadly. It shows why we can consider the federal and state relationship, namely

federalism, as an institutional arrangement to maximize policy benefits. Based on the theoretical assumptions, we predict that

H7 & 7-1: If the State political discretion measured by levels of eligibility is set more broadly, it will be positively related to total Medicaid spending and State Medicaid spending because it will affect more people who want to have Medicaid policy benefits.

H7-2 & 7-3: The State political discretion measured by levels of eligibility would be negatively related to Medicaid spending per enrollee and the State Medicaid spending per enrollee because setting eligibility more broadly would cover more peoples within the limited Medicaid resource.

In the same manner, if elected officials do not have health policy as their priority they would be unwilling to pay the high transaction costs of learning and managing a new issue (Hall, 1996; Weissert & Weissert, 2000). However, once authority delegation is carried out, it may produce principal-agent problems. Epstein and O'Halloran(1999) found that the problems of delegation stem from Congress's principal-agent problems of oversight and control. Thus, we predict that higher bureaucratic discretion would increase the state Medicaid expenditure by maximization of their self-interest behavior, thus seeking more resource controllability.

Furthermore, a responsible department or agency is a critical formal institution affecting policy implementation. The Medicaid program is implemented by a single organization in some states; while in other states it is delegated to plural organizations. Williamson(1975, 1986) proposed that the problems of information asymmetry and disparity are somewhat solved by increasing internal organizations. He suggested that internal organizations help to reduce opportunism produced by the tendency to misuse information asymmetry. Perrow(1986), however, pointed to several limitations of this argument. Instead, he considers organizational coordination costs. Expansion of an organization brings about high coordination costs, and trade connections can easily be inefficient. In addition, organizational coordination costs induce unexpected interactions generating unnecessary costs. He also pointed to an opportunism problem which reduces inter-organizational trust and the tendency toward politicization and manipulation of incentive systems(ibid). On the basis of this argument, we assume that the existence of plural organizations involved in identical policy implementation generate inefficiency such as coordination costs, information asymmetries, and unproductive competitions caused by opportunism. Each organization in charge of Medicaid policy attempts to expand authority and power, and this is often seen in the political mechanism of budget allocations. Thus, we predict that

〈Table 1〉 Variables used in this study

Variable	Specific Measurement
Dependent Variables	Total Medicaid Expenditure (variable transformation into natural logarithm)
	Medicaid Expenditure per Recipient (variable transformation into reciprocal square root)
	State Medicaid Expenditure (variable transformation into natural logarithm)
	State Medicaid Expenditure per Recipient (variable transformation into reciprocal square root)
Independent Variables	
Federalism	Percentage of Federal Share Amount (fpercent)
	National Political Environment: Measured as two dummy variables (Equal to 1 if Bush administration (Bush), otherwise 0; and equal to 1 if Clinton administration (Clinton), otherwise 0.
State Discretion	
Political Discretion (eligibility)	Percentage of people enrolled in Medicaid program among people below the FPL
Bureaucratic Discretion (discretion):	Numbers of Department in Charge (singular=0, plural=1)
State Political Condition	
Governor	Dichotomy variable (Republican=0, Democrat=1)
Citizen ideology score	
Government ideology score*	
United Government	Measured as two dummy variables (Equal to 1 if Democratic Party control across legislature and governor, otherwise 0 (Dunified);and equal to 1 if Republican party control, otherwise 0 (Runified))
Medical Needs	Number of Enrollee (enrollee / unit: thousand)
Control Variables	
South	Dichotomy variable (Equal to 1 if a state is belong to southern region, 0 otherwise)
Poverty Rate (poverty)	Percentage of Below the Federal Poverty Level (FPL)
* See Berry et al.(1998) for more information.	

the existence of plural organizations in charge results in an increase in quantity of resources used due to inefficiency and high transaction costs.

H8: The existence of plural organizations in charge would result in an increase in Medicaid expenditures.

Ⅲ. Research Design

1. Data and Methods

This study employs panel-data from 1997 to 2003. We set the time period for constructing data from 1997 to 2003 because 1997 is the first year after President Clinton articulated the "federal-state partnership" for Medicaid in reaction to the proposals in the 104th Congress, and 2003 is the last year of the first administration of President Bush. The data on Medicaid expenditures, enrollees, and recipients, were acquired from Centers of Medicare & Medicaid Services(CMS). Poverty and population data from the U.S. Census Bureau were used, and data on the party of governors, the Senate and the House of each state were acquired from the Book of States. We use the updated measurements of the ideology of citizens and government developed by Berry et al,(1998). The numbers of departments or agencies related to Medicaid programs were obtained by browsing each state's official web site in 2006.

〈Table 2〉 Mean of variables 1997-2003

Variables	1997	1998	1999	2000	2001	2002	2003
Total Expenditure ($, thousand)	3.18 billion	3.36 billion	3.58 billion	3.89 billion	4.3 billion	4.89 billion	5.21 Billion
Total Expenditure per Recipient	5483.737	5509.725	5824.055	6092.406	6375.822	6669.468	6839.953
Total State Expenditure ($, thousand)	1.38 billion	1.46 billion	1.56 billion	1.68 billion	1.85 billion	2.11 billion	2.17 billion
State Expenditure per Recipient	2224.640	2202.440	2337.580	2426.700	2536.800	2681.000	2655.200
Number of Enrollee (thousand)	641.58	630.52	620	669.3	716.02	786.42	838.2
State Political Discretion (eligibility, %)	89.54	91.78	98.36	105.12	107.96	112.06	109.52
Federal Share Amount (%)	60.46	60.84	60.86	61.02	61.16	60.74	62.62
Poverty Level (%)	12.578	12.204	11.438	10.89	11.282	11.672	12.562
Income per Capita ($)	21638.46	26018.48	27254.76	27973.14	29019.12	29672.7	30512.02

2. Measurement

1) Dependent Variables

We employed four dependent variables. Some scholars used only the total Medicaid expenditure as a dependent variable (Schneider, 1988; Buchanan et al, 1991), but this does not give information about the actual number of service recipients' or their amount of benefits, because the simple total amount of expenditure is largely affected by state population and economic conditions. Therefore, the amount of Medicaid expenditure per recipient adds more information to help understand Medicaid program implementation. Also, we tried to figure out unique factors influencing state Medicaid outcomes by employing state share amount and state share amount per recipient as dependent variables. We try to show how factors separately influence total Medicaid expenditures and the State share amount, for Medicaid reflects state spending behavior depending on the relationship with the federal government. We expect that increasing total Medicaid expenditure does not necessarily bring about increase in state budget for Medicaid. The natural logarithms of the total Medicaid expenditure and total state Medicaid expenditure were used, and the reciprocal square roots were used for the Medicaid expenditure per enrollee and the state expenditure per enrollee because these variables show highly skewed distributions. After transformation, the distributions of the four dependent variables were normally distributed.

2) Independent Variables

(1) Federal influence variables

We include two variables to measure the federal influence and the influence from the federal-state relationship on Medicaid; 1) Percentage of the federal share amount (fpercent), and 2) National political influence(national). National political influence is measured as two dummy variables, Bush variable which is expected to show dual or coordinated federal-state relationship and Clinton variable which is expected to show shared or compound federal-state relationship.

(2) State discretion variables

We measured state discretion by two factors; political discretion(eligibility) and

bureaucratic discretion(number of department involved in Medicaid program). Although Schneider's(1997) analysis said that optional service adoption is left in the realm of bureaucratic discretion, bureaucrats and political officials affect each other. Adopting a program is closely related to budget allocation; consequently, it is difficult to see that adoption of optional services is determined by bureaucrats solely. Therefore we use the number of department of agencies related to the Medicaid program as a proxy measure for bureaucratic power on Medicaid implementation.

In addition, we calculated the degree of generosity in political discretion on setting eligibility. We measured the level of eligibility of each state with the percentage of number of Medicaid enrollees divided by number of people below the FPL. This shows how broadly the range of people who fall below the FPL is covered by state Medicaid programs.[4] Our data indicates that the eligibility differs from the state tothe state. For instance, the largest gap, found in Hawaii, covered the smallest percentage, about 22% of the people below the FPL in 1997, and Vermont was recorded as the state that covered the largest per centage of the people below the FPL by covering 216% in 2001.

(3) State political institution variables

States with more liberal political environments are more willing to provide generous Medicaid programs by increasing Medicaid expenditure levels. Some studies employed a state ideology index(Buchanan, 1991; Grogan, 1999; Hanson, 1984), and the others used political party for their studies(Grogan, 1999). We use citizen and government ideology scores measured by Berry et al,(1998) and higher scores mean that a state is more liberal. We include the political party of the governor, and unified government variables as two dummy variables. If the governor, the majority party of the House and the Senate are all member of the Democratic Party(Unified government by the Democratic Party), we give them 1 otherwise, 0, and if the governor and the majority party of the House and the Senate are all Republican Party(Unified government by the Republican Party), we also give them 1 otherwise, 0.

(4) Medical needs variable

We used number of enrollees as a proxy measurement of medical needs. Some scholars used numbers of recipients to measure medical needs, and expected that greater numbers

4) See table 2

of Medicaid recipients in a state should indicate a greater demand for Medicaid services(Schneider, 1988; Buchanan et al, 1991). However, we thought that, although all enrollees were not recipients of the benefits or the Medicaid program, they expressed their medical needs by enrolling in the program because they met the eligibility requirements and had the potential to receive the benefits in their situation.

(5) Control variables

We included the south variable and poverty rate variable as control variables. The Medicaid program is for low income families, the disabled, and children from low income households, so poverty rate is closely related to Medicaid implementation. Also generally, non-southern states feel their health care system is better than that of southern states(Beyle,1988; Schneider, 1988). Many studies confirm that southern states initiated health services actively to make up for the federal cutback during the 1990s.

Ⅳ. Result and Analysis

The result of this analysis is presented in Table 3 through Table 6. For the model for total Medicaid expenditure for selected years from 1997 to 2003(Table 3), the coefficient for shared federalism has a significant negative influence on total Medicaid expenditures contrary to expectation for 1997 and 1998. But it shows a significant positive influence on total Medicaid cost as our expectation for 2000. The coefficients for dual federalism are positive and statistically significant for all years contrary to our expectation. Eligibility variables have a statistically significant positive influence on Medicaid total expenditures for all years as expected. Also multiple organizations show a statistically significant positive influence on Medicaid total expenditures. Also, a state which has more liberal criteria for enrolling the Medicaid program has greater total Medicaid expenditures. Schneider(1988) said the Medicaid program is an entitlement program, so the size of the recipient population is a critical determinant of the amount of money needed to provide services. However, his analysis shows a negative influence on total Medicaid expenditures which is contrary to our findings. As expectation, when the citizenry was more liberal, total Medicaid expenditures increased from1997 to 2000, and costs per enrollee increased from 1997 to 2000, and 2003.

〈Table 3〉 Time-series cross-sectional analysis on Total Expenditure for Medicaid

Variables	Coefficients
Percentage of federal matching fund	-.0042(.0034)
Shared federalism (Clinton administration97)	-.0986 (.0546)**
Shared federalism (Clinton administration98)	-.0702(.0544)
Shared federalism (Clinton administration00)	.1357 (.0543)***
Dual federalism (Bush administration01)	.2931(.0558)***
Dual federalism (Bush administration02)	.4694(.0584)***
Dual federalism (Bush administration03)	.4769 (.0597)***
Governor	-.0126 (.0239)
Government ideology	-.0002 (.0005)
Citizen ideology97	.0046 (.0013)***
Citizen ideology98	.0045 (.0014)***
Citizen ideology99	.0033 (.0013)**
Citizen ideology00	.0026 (.0013)**
Citizen ideology01	.0008 (.0013)
Citizen ideology02	.0008 (.0012)
Citizen ideology03	.0012 (.0014)
Unified government by the Republican Party	-.0208 (.0189)
Unified government by the Democratic Party	-.0104 (.0189)
Eligibility97	.0005 (.0004)**
Eligibility98	.0007 (.0006)**
Eligibility99	.0012 (.0005)**
Eligibility00	.0013 (.0005)***
Eligibility01	.0016 (.0005)***
Eligibility02	.0011 (.0006)**
Eligibility03	.0013 (.0006)**
Number of department	.8292 (.1809)***
Enrollee	.00004 (.00002)
South	.3089 (0721)***
Poverty rate	.0066 (.0049)
Constant	20.7663 (.2652)
R-square: Within = 0.9285, Between = 0.2963, Overall = 0.3264	
Standard errors in parentheses +significant at 10%;* significant at 5%;** significant at 1%;***	

Second, although the model for total Medicaid expenditures shows significant influences from the Bush administration(dual federalism) and number of departments, only shared federalism shows a statistically positive influence on Medicaid expenditures per enrollee

〈Table 4〉 Time-series cross sectional analysis on Total Expenditure per Enrollee for Medicaid

Variables	Coefficients
Percentage of federal matching fund	1.05e-06 (5.33e-07)**
Shared federalism(Clinton administration97)	.000036 (.00001)***
Shared federalism (Clinton administration98)	.000039 (.00001)***
Shared federalism (Clinton administration99)	.000038 (.00001)***
Shared federalism (Clinton administration00)	.000016 (.000013)
Dual federalism (Bush administration02)	-8.12e-06 (.000013)
Governor	-7.53e-06 (5.12e-06)
Government ideology	1.07e-07 (1.25e-07
Citizen ideology97	-1.40e-06 (2.62e-07)***
Citizen ideology98	-1.07e-06 (2.84e-07)***
Citizen ideology99	-7.23e-07 (2.78e-07)***
Citizen ideology00	-7.01e-07 (2.68e-07)***
Citizen ideology01	-4.30e-07 (2.65e-07)
Citizen ideology02	-3.64e-07 (2.52e-07)
Citizen ideology03	-5.49e-07 (2.86e-07)*
Unified government by the Republican Party	2.51e-06 (4.04e-06)
Unified government by the Democratic Party	3.03e-06 (4.09e-06)
Eligibility97	1.91e-06 (9.79e-08)***
Eligibility98	1.65e-06 (1.25e-07)***
Eligibility99	1.37e-06 (1.19e-07)***
Eligibility00	1.22e-06 (1.09e-07)***
Eligibility01	1.13e-06 (1.09e-07)***
Eligibility02	1.17e-06 (1.16e-07)***
Eligibility03	1.11e-06 (1.11e-07)***
Number of department	-7.24e-06 (.00001)
Enrollee	3.91e-09 (4.05e-09)
South	-2.36e-08 (.00001)
Poverty rate	.00001 (9.98e-07)***
Constant	.00011 (.00004)
R-square: Within = 0.7990, Between = 0.3753, Overall = 0.4759	
Standard errors in parentheses +significant at 10%;* significant at 5%;** significant at 1%;***	

for all years. In addition, eligibility variables have a statistically significant positive influences on Medicaid expenditures per enrollee for all years similarly to the result of the first model, but the coefficients shows a much smaller impact on Medicaid costs per enrollee than total Medicaid expenditures.[5)] These findings show that adding more

Medicaid enrollees has a positive influence on both total Medicaid expenditures and Medicaid costs per enrollee, but it is less influential on Medicaid costs per enrollee. Contrary to our expectation, the percentage of federal matching funds shows a statistically significant positive relationship with the Medicaid expenditure per enrollee. Level of poverty has a significant positive influence on Medicaid expenditures per enrollee, but it is not a significant variable on total Medicaid expenditures.

Table 5 and Table 6 illustrate federal-state relationships and state political and administrative influences on state expenditures and state expenditures per enrollee for the Medicaid program. Table 5 shows the statistically significant negative influence of the federal share per centage on state expenditures for Medicaid[6]. In short, the percentage of federal share amount has a positive influence on total Medicaid expenditures per enrollee, but when the federal government is more supportive, a state government reduces its budget for Medicaid(see Table 5), but increases spending for Medicaid costs per enrollee(see Table 6). Also, dual federalism has a statistically significant positive influence on State Medicaid spending for all years(see Table 5), and shared federalism shows a statistically significant positive influence on State Medicaid spending per enrollee for all years(see Table 6). If our assumption is correct, this shows that the policy goal of the federal and state governments might not be congruent with each other. The number of departments related to Medicaid policy is statistically significant and positively influences state Medicaid expenditures only. Furthermore, the coefficients for eligibility show a statistically significant positive influence on state Medicaid expenditures(see Table 5) and state Medicaid expenditures per enrollee(See Table 6). Similarly with the results of the first and the second models, citizen ideology has a significant positive influence on state Medicaid expenditures for 1997 and 1998, but it shows significant negative influence on State Medicaid expenditures per enrollee from 1997 to 2000, and 2003. The results suggest that the political philosophy of citizens is more influential than the ideology of government for implementation of a redistributive policy such as the Medicaid program.

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5) The dependent variable for this analysis is transformed into a reciprocal square root to address the skewed distribution problem.

6) The dependent variable for this analysis is transformed into a reciprocal square root to address the skewed distribution problem.

〈Table 5〉 Time-series cross sectional analysis on State Expenditure Medicaid

Variables	Coefficients
Percentage of federal matching fund97	-.0333 (.0036)***
Percentage of federal matching fund98	-.0333 (.0039)***
Percentage of federal matching fund99	-.0350 (.0039)***
Percentage of federal matching fund00	-.0332 (.0038)***
Percentage of federal matching fund01	-.0318 (.0038)***
Percentage of federal matching fund02	-.0319 (.0039)***
Percentage of federal matching fund03	-.0339 (.0038)***
Shared federalism (Clinton administration98)	.0543 (.1681)
Shared federalism (Clinton administration99)	.2484 (.1728)
Shared federalism (Clinton administration00)	.2447 (.1708)
Dual federalism (Bush administration01)	.2901 (.1717)*
Dual federalism (Bush administration02)	.4638 (.1668)**
Dual federalism (Bush administration03)	.6265 (.1634)***
Governor	-.0242 (.0261)
Government ideology	-.00005(.00006)
Citizen ideology97	.0044 (.0014)**
Citizen ideology98	.0040 (.0015)**
Citizen ideology99	.0023 (.0014)
Citizen ideology00	.0022 (.0014)
Citizen ideology01	.0007 (.0014)
Citizen ideology02	.0008 (.0013)
Citizen ideology03	.0010 (.0015)
Unified government by the Republican Party	-.0271 (.0201)
Unified government by the Democratic Party	-.0125 (.0206)
Eligibility97	.0005 (.00051)
Eligibility98	.0006 (.00065)
Eligibility99	.0012 (.00062)**
Eligibility00	.0013 (.00057)**
Eligibility01	.0011 (.00058)***
Eligibility02	.0011 (.00061)**
Eligibility03	.0011 (.00059)**
Number of department	.8256 (.16814)***
Enrollee	.00005 (.00002)**
South	2997(.0754)***
Poverty rate	.0082 (.0052)
Constant	21.9412 (.3411)
R-square: Within = 0.9203, Between = 0.4658, Overall = 0.4810	
Standard errors in parentheses +significant at 10%;* significant at 5%;** significant at 1%;***	

〈Table 6〉 Time series cross sectional analysis on State Expenditure per Enrollee Medicaid

Variables	Coefficients
Percentage of federal matching fund	.0000115 (8.51e-07)
Shared federalism (Clinton administration97)	.000063 (.00001)***
Shared federalism (Clinton administration98)	.000051 (.00002)**
Shared federalism (Clinton administration99)	.000051 (.00002)**
Shared federalism (Clinton administration00)	.000040 (.00002)**
Dual federalism (Bush administration01)	.000012 (.00002)
Dual federalism (Bush administration02)	-.000025 (.00002)
Governor	-000014 (8.21e-06)*
Government ideology	1.95e-07 (2.00e-07)
Citizen ideology97	-2.38e-06 (4.20e-07)***
Citizen ideology98	-1.63e-06 (4.55e-07)***
Citizen ideology99	-1.06e-06 (4.46e-07)**
Citizen ideology00	-1.03e-06 (4.30e-07)**
Citizen ideology01	-6.11e-07 (4.25e-07)
Citizen ideology02	-4.59e-07 (4.03e-07)
Citizen ideology03	-9.80e-07 (4.58e-07)**
Unified government by the Republican Party	3.24e-06 (6.48e-06)
Unified government by the Democratic Party	5.79e-06 (6.56e-06)
Eligibility97	2.83e-06 (1.57e-07)***
Eligibility98	2.46e-06 (2.00e-07)***
Eligibility99	1.99e-06 (1.90e-07)***
Eligibility00	1.79e-06 (1.74e-07)***
Eligibility01	1.65e-06 (1.75e-07)***
Eligibility02	1.70e-06 (1.87e-07)***
Eligibility03	1.61e-06 (1.77e-07)***
Number of department	-.000015 (.000016)
Enrollee	7.72e-09 (6.46e-09)
South	.00001 (.00001)
Poverty rate	.00001 (1.60e-06)***
Constant	-.00037 (.00006)
R-square: Within = 0.7924, Between = 0.7893, Overall = 0.7994	
Standard errors in parentheses +significant at 10%;* significant at 5%;** significant at 1%;***	

V. Discussion and Conclusion

This study addresses the question of which factors influence the level of Medicaid expenditure by examining federal-state relationships and state institutional factors. We understand that intergovernmental policies are one of the institutional mechanisms to maximize policy benefits by minimizing costs from policy implementation. The empirical finding in this study has important implications for understanding intergovernmental policies.

Federal funds are designed to equalize the ability of states to provide health care(Buchanan et al., 1991). As Table 2 shows, the means of the percentage of the federal share amounts show incremental changes. It shows that the federal government seeks to achieve its policy goal that to cover medically-needy populations at the national standard. Also this share cannot be more than 83% of the total expenditures in order to maximize policy benefits by allowing state discretion. The results show that the percentage of federal matching funds is influential not only on Medicaid expenditures per enrollee, but also on state Medicaid share amounts and that per enrollee. Holahan and Cohen(1986) observed that higher federal matching rates were associated with higher Medicaid spending. They argued that being given federal funds lowers a state's burden. Our study shows that federal funding is associated with lower "state" Medicaid expenditures, but it does not have any influence on total Medicaid expenditures. Therefore, we can conclude that federal funds lower a state's burden but we cannot say "higher federal support results in higher Medicaid expending." It lowers only the state share amount, and is not related to an increase in total Medicaid budget. However, increase in federal funds brought about increase in Medicaid expenditures per enrollee. This shows that support from the federal government is used to increase benefits per enrollee. If the policy goal of the federal government for Medicaid is to expand the range of beneficiaries by including more people who need medical help, increasing federal funds is not effective way to achieve the goal. Our study shows that federal funds are used to increase benefits per enrollee, and we carefully expect that each state government's Medicaid goal is to increase benefits for an eligible person, not to cover more people. Even though the federal government seeks to expand beneficiaries of Medicaid from the categorically-needy population to the medically-needy population, the results of this study might arise from higher state burdens in covering the population set by the federal standard, and state government efforts to lower their burden might increase benefits per enrollee instead.

Second, the national political environment demonstrates very strong influences on both total Medicaid expenditures and costs per enrollee. Contrary to our expectation, dual federalism has a relationship to higher total Medicaid expenditures. But we need to consider other factors such as the national economic situation because the coefficients were getting larger during our research period. Also, dual federalism brings about a significant increase instate Medicaid spending. This shows that state governments increase their budget for Medicaid when their policy discretion is emphasized. However, it is not related to an increase in benefits per enrollee.

Shared relationship has a negative relationship to total Medicaid expenditures, but has positive relationship to total Medicaid expenditures per enrollee and state expenditures per enrollee. Contrary to dual federalism, it does not show any significant affect on State Medicaid spending. This result is in the same context of using federal funds in that when the federal government emphasizes a supportive and positive role(shared federalism) on Medicaid it brings about increasing Medicaid benefits per enrollee. However, we might conclude that when the federal government plays a supportive and positive role for a policy implementation, state government does not spend their own budget for the policy and uses the federal support to increase policy benefits for eligible policy beneficiaries who are under a state government's institutional setting. In other words, when the supportive role of the federal government is emphasized a state increases Medicaid benefits within the boundary of eligible people. And when the federal government emphasizes the policy discretion of a state government it brings about increasing Medicaid expenditures in both levels of government. We might conclude that dual federalism needs the responsibility of both levels of government in the case of Medicaid. If this is true, it would be difficult because of the goal conflict between federal and state government, but we could conclude that the policy goal(to cover more people or to increase benefits for eligible people) of Medicaid could be set differently depending on the federal and state relationship.

Third, state discretion influences the total Medicaid expenditures and expenditures per enrollee. Specifically, Medicaid programs are significantly influenced by political discretion in determining eligibility. As our analysis indicates, more liberal eligibility requirements lead to an increase in Medicaid expenditures, but it brings about a relatively small increase in Medicaid expenditures per enrollee. This would be because Medicaid has redistributive policy characteristics. Its policy area defines clearly that it is a program for the poor, the disabled, and children from low income families. Therefore, covering all the

population who fall under the standard of the federal government would be the first policy goal of Medicaid, and service expansion could be considered after certain groups and services are covered. While Colorado included over 200% of its population below the poverty line in 2003, Montana included only about 60% of its population among the population below the poverty line during the same year.

In addition, this study shows that the degree of liberalism of citizens is associated with an increase in total and state Medicaid spending but it is associated with a decrease in Medicaid spending per enrollee. This means that a liberal state tends to increase the range of policy beneficiaries who will be covered than to increase the coverage of a policy beneficiary who is already covered.

However, this study has several limitations. First of all, we could collect data for number of departments in 2006 only. Also, this study shows a statistically significant political influence on Medicaid expenditures, so we need to include more years for better and stronger arguments. In addition, some excluded variables could have influenced Medicaid policy implementation. For example, Medicaid can be implemented by state government or local government. Weissert and Schram(2000) point out the impact of federal-state actions on local government as a key implementation concern. Therefore, local government might be an influential variable, but there is no official data on this.

Despite data limitations, this study shows implications of institutional influences on intergovernmental policy implementation. This study adds to an understanding of the factors which account for Medicaid policy outcomes in the context of inter-governmental relationships from 1997 to 2003, and how state institutional variables, in fact, influence not only on total expenditures but also on state share amounts and on each enrollee. This provides greater understandings of federal-state relationships and how institutions work in providing Medicaid services.

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논문투고일: 2019.9.11 / 심사일: 2019.9.17 / 게재확정일: 2019.9.25