Could Racial Disparities in Coverage due to Medicaid Administrative Burden be Rooted in Racist Origins?[1]

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Racial and ethnic disparities in health insurance coverage are known, but we know little as to whether structural determinants shaping coverage disparities are rooted in racism. Using a novel database of Medicaid administrative burden linked to historical lynching data and the 2001-2006 Annual Social and Economic Supplement of the Current Population Survey, we explore the plausibility that Medicaid administrative burden–the difficulty potential enrollees face in gaining entry into the program is 1) partly associated with historical lynching, and 2) whether lynching–as a proxy for long-standing racial animosity–could be a root cause to coverage disparities between Blacks and Whites. We find: 1) states with a higher number of reported historical lynchings–one of the more horrific forms of racialized violence–tended to have comprehensively burdensome administrative enrollment processes relative to states with little or no lynching history, 2) uninsurance among Blacks and Whites is higher in states with higher numbers of lynchings, and 3) Black Medicaid enrollment is lower in states with a higher number of lynchings.

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"Decades, even generations, may pass between exposure to systemic racism and evidence of its health damages, obscuring the connection. Research indicates how diverse experiences of racism contribute to racial or ethnic disparities in health by setting in motion various sequential causal pathways. The pathways' complexity and length often makes it difficult to detect their origins—the underlying but unseen causes (Braveman et al. 2022)."

In Medicaid's 60-year history, the program has been a major component of the United States (US) healthcare system and a key means for accessing needed care among many of the nation's most economically vulnerable and underserved. Program eligibility is shaped by states' own eligibility guidelines, and eligibility guidelines are a key policy determinant shaping not only program access, but plausibly broader inequities in health insurance coverage and health. State decisions on how to administer Medicaid can facilitate health improvement in the short run as well as over the life course (Wherry and Meyer 2016; Boudreaux, Golberstein, and McAlpine 2016; Goodman-Bacon 2016; Miller and Wherry 2019). Medicaid coverage, or health insurance more generally, has important financial benefits in addition to health protections (Sommers and Oellerich 2013; Zewde and Wimer 2019; Zewde et al. 2021; Remler, Korenman, and Hyson 2017; Korenman and Remler 2016; Shadowen et al. 2022; Miller et al. 2021; Callison and Walker 2021). As decisions to expand access to Medicaid can be welfare-enhancing, decisions to restrict Medicaid access can have important negative consequences. Many state decisions to restrict Medicaid access can be rooted in political and social ideologies, but they can also be motivated in part by racial discrimination. In this study, we explore potential legacies of racism and how these legacies may shape states' Medicaid programs and whether they contribute to the Black-White health insurance coverage gap.

When the Affordable Care Act (ACA) was first adopted in 2010, large Black-White disparities in health insurance coverage existed: nearly 20% of Blacks were uninsured compared with 13% of Non-Hispanic Whites (Artiga, Hill, and Damico 2022). Following the implementation of the Affordable Care Act's Medicaid expansion and subsidy provisions in

2014, the Black-White uninsurance gap narrowed to 11% uninsured among non-Hispanic Blacks and 8% among non-Hispanic Whites. Coverage increases among Blacks were largely driven by the Medicaid expansion, which conferred eligibility to adults without dependents up to effectively 138% of the federal poverty level. As of 2019, 28% of Blacks aged 19-64 were covered by Medicaid compared with 16% of Whites (Artiga, Hill, and Damico 2022). However, the reduction in Black-White coverage gaps is likely less than it would have been if all states had adopted the Medicaid expansion.

While resistance to the Medicaid expansion was principally political in nature, there is evidence that it was driven by racialized politics. In 2014, only half of US states were planning to move ahead with the Medicaid expansion after the US Supreme Court effectively ruled this optional, and Southern states with large Black populations were especially unlikely to plan to move forward with expanding Medicaid (Nolen, Beckman, and Sandoe 2020). Lanford and Quadagno (2015) found that underlying racial resentment was closely linked with decisions to expand Medicaid or not, with lower racial sympathy and higher aggregate levels of racial resentment correlated with stronger resistance to expanding Medicaid (Lanford and Quadagno 2015a). Grogan and Park (2017) found that racialized politics can be linked to democratic deficits across states whereby Medicaid expansion decisions were responsive to White public opinion about the ACA and Medicaid relative to public opinion among non-Whites (Grogan and Park 2017). Similarly, Tesler (2012) found that racial attitudes had a significantly larger impact on health care opinions in the Fall of 2009 during Obama's presidency than they had in the two decades prior before Obama became the face of the ACA, suggesting that the racialized conflicts of the Obama Presidency had spillover effects on welfare politics (Tesler 2012). While public support for the Medicaid expansion could be high at the state level–particularly overall public support for the ACA–state adoption decisions are positively related to White opinion and do not

respond to nonwhite support levels. As of May 2024, there are 10 states that have not expanded under the ACA (KFF 2024); and the Black-White coverage is larger among the states that have not expanded (Baumgartner, Collins, and Radley 2023).

A substantial literature has been devoted to examining the role of racialized politics and racial resentment in states' political resistance to the implementation of the Affordable Care Act's Medicaid expansion (J. D. Michener 2021; Grogan and Park 2017). Studies have found lower racial sympathy and higher racial resentment to be associated with stronger resistance to Medicaid expansion decisions (Lanford and Quadagno 2015b). Fording and Patton (2019) found that in states where Medicaid beneficiaries are primarily White, Governors who expanded Medicaid were more likely to be rewarded politically, whereas states where Medicaid beneficiaries are primarily non-white have not expanded Medicaid (Fording and Patton 2019). Michener (2021) points to other ways that racialized politics undermined the ACA as a tool for addressing inequality (J. D. Michener 2021). More recently, several states used Section 1115 waivers to adopt work requirements as a condition for Medicaid eligibility, and this feature was expected to undermine the Medicaid program and fall disproportionately on Black enrollees (Dylan Scott 2018; Georgetown University Health Policy Institute 2020).

Although a key aim of the ACA was to expand access to health insurance, adopting onerous administrative procedures can confer hidden costs on program claimants. Sufficiently burdensome procedures can effectively deter enrollment, contribute to discontinuities in benefit receipt, and ration services even among those who are eligible (Herd and Moynihan 2020). By making the process of claiming benefits complex and difficult to navigate, administrative burden exerts a form of "policymaking by other means" – administratively excluding potentially eligible persons.

The equity implications of administrative burden and procedural barriers are not entirely clear, and we know little regarding the roots to administrative burden in the Medicaid program. Administrative guidelines delegate more discretion to street-level case workers who may be influenced by implicit bias to confer benefits on those they consider more "deserving" and exclude those they find to be less deserving (Haeder, Sylvester, and Callaghan 2021; Lanford and Quadagno 2015b; Poteat et al. 2020). This could plausibly provide one pathway where harsher administrative guidelines fall disproportionately on non-White enrollees (Ray, Herd, and Moynihan 2023).

In our study, we explore a potential root cause to the design of states' Medicaid procedures. For those approaching Medicaid with an equity lens, we believe undoing barriers to Medicaid requires a better understanding of the formation of these inequities (Fashaw-Walters and McGuire 2023)–some of which were embedded in the program since Medicaid's inception in 1965 as a manifestation of racist ideals (Tripoli et al. 2021; Perkins and Somers 2022).

Conceptual Motivation

How states operationalize enrollment guidelines can mirror broader feelings of social policies and government aid programs. For example, a sample of politicians were more in favor of imposing arduous procedures for accessing social programs if they held right-wing ideologies (Baekgaard, Moynihan, and Thomsen 2021). Herd & Moynihan (2018) noted the potential distributive consequences of administrative burden in terms of the tendency of burdensome rules to deter those with fewer resources from accessing benefits more (Herd and Moynihan 2018). Moreover, representative bureaucracy theory suggests passive racial and ethnic representation can produce active representation–policies that benefit minorities (Meier, Wrinkle, and Polinard 1999).

Racial Animosity shaping US Healthcare Programs

A substantial literature has been devoted to examining the role of racialized politics and racial resentment in states' political resistance to the implementation of the Affordable Care Act's Medicaid expansion (J. D. Michener 2021; Grogan and Park 2017). Studies have found lower racial sympathy and higher racial resentment to be associated with stronger resistance to Medicaid expansion decisions (Lanford and Quadagno 2015b). Fording and Patton (2019) found that in states where Medicaid beneficiaries are primarily White, Governors who expanded Medicaid were more likely to be rewarded politically, whereas states where Medicaid beneficiaries are primarily non-white have not expanded Medicaid (Fording and Patton 2019). Tesler (2012) found that racial attitudes had a significantly larger impact on health care opinions in the Fall of 2009 during Obama's presidency than they had in the two decades prior before Obama became the face of the Affordable Care Act, suggesting that the racialized conflicts of the Obama Presidency had spillover effects on welfare politics (Tesler 2012).

However, the racialized politics observed surrounding the ACA's Medicaid expansion are not new–patterns of racialized politics in Medicaid and other social policies have long been a defining feature of the American welfare state. For instance, Lieberman (2002) has extensively detailed how national social insurance programs created in the 1930s excluded coverage to jobs filled primarily by women and people of color thereby accommodating a system of racial exploitation and domination (Lieberman 2002). Likewise, the early delegation of poor relief to the hands of the states empowered cities with the largest black and Latino populations to spend less on poverty relief and to rely on private rather than public funds for welfare provision (C. Fox 2012). Quadagno (1988) detailed how race was integral to New Deal politics and the development of Social Security (J. Quadagno 1988). In a detailed historical account, Quadagno

(1994) demonstrates that because FDR needed Southern support to get his policies through Congress, he agreed to exclude African-Americans from the core of programs of the Social Security Act as Southern Congressman refused to support any legislation that put money in the hands of Southern Sharecroppers (J. S. Quadagno 1994). Racialized politics of the welfare state did not stop with the Civil Rights movement, however. It continued throughout the War on Poverty in the 1960s, shaping job training programs as unions refused to admit black men and suburban homeowners resisted low-income housing programs that might invite minorities into their communities.

Racialized politics also shaped the early politics of Medicare and Medicaid, this time in a positive direction, wielding the monopsony power of the plan to force hospitals to desegregate or forgo all Medicare funding. Johnson's assistant secretary of health, Philip Lee, MD, insisted that hospitals receiving the new Medicare funding for their elderly patients follow the Civil Rights Act by ending discrimination against their patients on the basis of race (Duff-Brown 2021).

However, even as de jure forms of discrimination were outlawed following the Civil Rights Movement and societal norms governing race relations gradually transformed to normalize racial integration, policies and practices have evolved from more overtly racist to more covertly racist but with no less dispossessing effects. Soss, Fording & Schram (2011) detail both the historical continuities of welfare reform in the 1990s with previous forms of racialized politics and the changes ushered in by a new form of poverty governance combining the old wine of paternalism with new a disciplinary turn towards neoliberalism and a heavier involvement of the carceral state (Soss, Fording, and Schram 2011). Today, racial divisions still pattern policy outcomes despite declines in explicit racial discourse and the seemingly race-neutral design of contemporary welfare policies. Overt violence and discrimination has been replaced with a form

of poverty governance that continues to operate as a means of social control (Soss, Fording, and Schram 2011).

Subtle applications of "administrative burden" can make the process of claiming benefits complex and difficult to navigate. Ray, Herd & Moynihan (2022) argue administrative burdens– while appearing to operate through facially neutral rules and via claims that burdens are necessary for reasons unrelated to race–may nevertheless be racialized. As Ray et al. (2023) suggest, "racialized burdens neatly carry out the 'how' in the production of racial inequality while concealing, or providing an alibi for the 'why'" (Ray, Herd, and Moynihan 2023). While sympathetic caseworkers and administrators may try to work around this organizational architecture and may personally oppose it, ultimately, bureaucratic agents are accountable to higher-level policy directives. For instance, states may require frequent in-person Medicaid renewals and stringent income tests while not allowing exceptions for assets such as vehicle ownership. The disproportionate application of these rules in more racially diverse states where African-Americans comprise a large share of Medicaid beneficiaries may constitute a hidden form of racialized social control.

However, precisely because policymakers' motives are hidden and cloaked behind a veil of race neutrality, the racialized intent is difficult to prove empirically. Studies examining institutionalist underpinnings of the racialized welfare state rely on historical analysis of archival data and emphasize institutional features as causal forces but cannot definitively demonstrate continuities between past and present policies. Studies of racial attitudes, for their part, tend to use survey data to demonstrate how the stated racial preferences of individual whites undermine public support for welfare (Martin Gilens 1995; Brooks and Manza 2008; M. Gilens 2009). However, while these approaches provide a useful window into the individual-level social psychological processes that underlie policy opinions, they treat race relations and policy

outcomes as a mass of individual attitudes, thereby neglecting the historical and structural roots of attitude formation.

This study takes a different approach and instead uses historical lynching data to examine the long-run persistent power of racism in shaping contemporary Medicaid politics. First, we explore whether health insurance coverage disparities are attributable to historical lynching patterns. Then we investigate the associations between Medicaid policies and historical lynching. We believe our findings may help provide new insights into the extent that policymaking–particularly those governing access to and the administration of public assistance programs like Medicaid–are replacing more overt forms of physical racialized violence with covert forms of racialized structural burdens.

Legacy Effects of Lynchings and other Racial Violence in Public Policy

Although lynchings are no longer as frequently used as they once were as a form of racialized terror, it was not until 2022–100 years following the first attempt to pass a federal level anti-lynching bill–when President Joe Biden signed the Emmett Till Antilynching Act in March 2022. after being passed by both the House of Representitives and the US Senate and raising lynching to the level of a hate crime (McDaniel and Moore 2022; Rep. Rush 2022) . The first attempt at a federal antilynching law was in January 1921 under a bill sponsored by U.S. Representative Leonidas Dyer [MO] when the bill was stalled in the US Senate (Harvey 1949). Opposition to passing legislation to criminalize racial lynchings could be a reflection of inherent racial animosity but are often characterized as a matter for states by states' rights proponents (Rable 1985; Ford 1948). Obstruction to the federal-level antilynching efforts were historically concentrated in Southern states–particularly states with higher levels of anti-Black violence

(Pinar 2001; Cook, Logan, and Parman 2018b), and we hypothesize administrative burdens could be a reflection of institutionalized racial animosity and anti-Black attitudes.

Although there is considerable temporal distance between Medicaid's inception and the period of extensive use of lynchings, historical lynchings can leave a legacy adverse effects that can linger intergenerationally. While the violence associated with lynching may be less prevalent, the racist ideals that motivated lynching can emerge in other ways–such as stunting economic opportunity and even via policy making. For example, frequent occurrences of racialized violences towards Blacks and African-Americans in the late 1800s and early 1900s have been associated with reductions in Black economic productivity including wealth formation and segregation away from areas that could be economically advantageous (Gabriel and Tolnay 2017; Cook 2014; Cook, Logan, and Parman 2018a). Other work finds historical lynching to be associated with increasing the Black-White wage gap largely by suppressing Black income and earning opportunities (Christian 2017). Lynching has also been associated long-run health inequities such as being correlated with the social factors contributing to lower life expectancies among Blacks in the US (Kihlström and Kirby 2021). Lastly, prenatal exposure (i.e., in utero) to area-level lynching have been shown to be associated with lowered life expectancies for Black men (Vu et al. 2023).

Lynchings were an outcome of a culture of hate that was well-established prior to the first lynchings were recorded. Furthermore lynchings reflect only one type of racialized violence, so similar acts of violence may not be classified as lynchings and the reported number could be an undercount on the true number of lynchings. Other acts such as racialized mob violence, prolonged torture, and their subsequent deaths (e.g., the Rosewood Massacre) may not be captured in lynching data (Beck and Tolnay 2019; Chavez 2023; Pittman 2023). As lynchings and related acts were public events, they normalized racial violence and ill feelings towards

Blacks. Because families would attend these events, they can facilitate intergenerational transmission of anti-Black racism such that the feelings remain even if lynching practices have subsided. For this reason, we hypothesize that historical lynchings would be correlated with political ideology and feelings about the role of publicly (i.e., government) funded programs. For example, there is a politically partisan divide as to whether to pay attention to the long-run effects of slavery in the US. Twenty-five percent of Republican and Republican-leaning survey participants in a Pew Research Center survey considered it a good thing to focus attention on the history of slavery relative to 78% of Democrats and Democratic-leaning survey takers (Pew Research Center 2021).

Scholarship on lynchings, especially those carried out against African-Americans in the postbellum South, have pointed to both their instrumental and their symbolic character (Buckser 1992). The purpose of lynchings was to maintain the social order, but also as a ritual to dispossess and terrorize the African-American population to reinforce the deeper moral order of the time. Thus, there is good reason to believe the symbolic nature of lynchings can have lasting cultural effects and that more contemporary rituals within the current legal and political context, such as the strict surveillance of welfare use, can can be considered a modern variation of the application of racialized social control.

METHODS

Data Sources

1. Current Population Survey

Our weighted coverage estimates were derived using the 2001 to 2006 (calendar years 2000-2005) waves of Current Population Survey's (CPS) Annual Social and Economic Supplement—also known as CPS' March Supplement. The CPS' ASEC is a suitably large

nationally representative database developed by the US Census Bureau encompassing all 50 states and the District of Columbia (DC). We use the harmonized version developed by the Integrated Public Use Microdata Series (IPUMS) program at the University of Minnesota (Flood et al. 2023). Weighted coverage estimates were produced for a) the full sample of adults, b) non-Hispanic Whites, and c) non-Hispanic Black/African-Americans. Our pooled analytic sample includes 747,176 non-elderly adults aged 18-64 with 122,000-126,000 sample persons in each year across the six study years.

2. Historical Lynching Data

We are using historical lynching patterns at the state-level to approximate a measure of structural racism. Specifically, we use historical lynching data aggregated to the state level with the cumulative number of reported lynchings 1877 to 1950. This lynching data was provided by the Lynching in America project at the Equal Justice Initiative (Equal Justice Initiative 2017). So that our findings are not driven by differences in the state's population and differences in the absolute number of lynchings across the states, we standardize the states' number of lynchings per 10,000 population using each state's 1920 population obtained from the US Census Bureau via IPUMS (Ruggles et al. 2024). Although not outlawed nationally until 2022, the frequency of lynchings had begun to decline by the 1930s (Tuskegee University Archives 2021). For this reason, we used the 1920 population counts as they represent a midpoint to standardize the number of lynchings as a per capita calculation.

3. State-Level Medicaid Generosity Index

Fox and colleagues developed a composite univariate index to capture state-level variation in Medicaid eligibility generosity and Medicaid administrative ease (A. M. Fox 2021).

The Medicaid Generosity Index (MGI) is a novel database containing information on state- and year-specific Medicaid enrollment, eligibility determination, and renewal guidelines for Medicaid and CHIP for all 50 states and the District of Columbia. Higher levels on the eligibility index correspond to higher composite income-eligibility thresholds for the Medicaid program. Higher levels on the administrative ease index indicates the states adopted administratively easter, less cumbersome process for enrollment in Medicaid (e.g., removing face-to-face interviews, shorter wait times for eligibility determinations, presumptive eligibility); states with lower values on the index have cumulatively more burdensome administrative policies and processes. As a supplement, we detail the component Medicaid policies used to construct the indices in Appendix Table A1.

Empirical Strategy

With the CPS, we use linear regression models to examine the correlation between historical lynching and health insurance coverage status (i.e., whether uninsured or not) and whether the sample person is on Medicaid. To better focus on Black-White coverage gap, all analytical samples were limited to non-Hispanic Black and non-Hispanic White adults. All regressions are estimated using linear probability models with standard errors robust to clustering at the state-level, and our preferred model specification is outlined below:

$$Y_{ist} = \alpha + \sum_{j=2}^{4} \beta_j HistoricalLynchingQuartile_s{}^{j} + \gamma Black_i +$$

$$\sum_{j=2}^{4} \delta_j (HistoricalLynchingQuartile_s{}^{j} \times Black_i) + \Gamma X_i + \theta_{st} + \eta_t + \varepsilon_{ist}$$

Y_{ist} reflects the outcome for person i in state s during year t of the study period 2000-2005. β_j is the coefficient on quartile j (2, 3, 4) signifying the difference in level of the outcome among Whites relative to Whites in the 1st quartile ($j = 1$, i.e., the quartile of states with the fewest per capita lynchings per 10,000 Black population). $Black_i$ is a dummy variable indicating the

sample person is Black. Our key terms of interest are the interaction between being Black and living in the states with increasing levels of lynching intensity. For example, if the outcome is Medicaid enrollment, we know Blacks are disproportionately represented in the Medicaid program, we anticipate γ>0. However, if there are disparities that can be attributed to varying levels of historical racism, then we anticipate Black Medicaid enrollment to decline with increasing intensity of lynching exposure. If this were the case, then we should expect δ_2>δ_3>δ_4 as this coincides with increasing levels of historical lynching and our proxy measure for more embeddedness of structural racism.

In addition to our main effects and key interaction terms, we include the following person-level controls represented in X_i: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). As for time-varying state-level factors in θ_{st}, we use the Correlates of State Policy Database to control for the following (Grossmann et al., 2021): 1) an aggregate measure of political ideology—the relative difference in the share of the state's expressing Liberal ideologies relative to the share expressing Conservative ideologies, and 2) a dummy variable indicating Republican control over the state's legislature (i.e., Upper and Lower houses) and the governorship. States with a larger share if ideologically Liberal persons may have more expansive eligibility guidelines for Medicaid with fewer administrative burdens that could contribute to coverage disparities. However, as states with Republican leanings are more likely to impose more arduous and restrictive Medicaid guidelines, some of our findings could be due to differences in state level political representation.

RESULTS

Regional Variation in Exposure to Historical Lynching

In Figure 1, we present variation in the cumulative number of lynchings reported between 1877 and 1950 per 10,000 a) total population and b) Black population. In each panel, the darker shades reflect states with higher rates of historical lynching. Panel A contains the number of lynchings per total population, while Panel B reflects the standardized number of lynchings relative to the state's Black population. Although relatively rare events, lynchings were most commonly performed in the US South–particularly among former slaveholding states (See figure 1, panel A). However, panel B highlights variation in lynchings relative to the state's Black populations (See figure 2, panel B). While lynchings were not exclusively used as racialized violence, they were among the most disruptive and fearful tactics used to terrorize, intimidate, and control the actions of Black Americans (Lartey and Morris 2018). For example, Whites made up the predominant share of lynching victims–generally as punishment for accused crimes–in southwestern and western frontier states until 1900; thereafter White representation among lynchings began to rapidly decline (Seguin and Rigby 2019).

Historical Lynching and Coverage Patterns

Ultimately, our objective is to determine whether and how these factors manifest as coverage disparities. Figure 2 presents the coverage levels for the full sample of adults, Whites, and Blacks using the pooled sample. Presented are both the unadjusted means for coverage status (Panel A) and source of coverage (Panels B and C) as well as a fitted line to capture the trends in coverage. Panel A presents the shares of the sub-sample without health insurance coverage of any kind at the time of the survey (i.e., uninsured) across the levels of lynching intensity–

quartiles of lynchings per 10,000 Black residents in the state. Panel B presents the share of residents with private health insurance coverage, and panel C indicates the share of respondents with Medicaid.

In panel A, the uninsured rate trends upward as the intensity of historical lynching increases in our full sample. However, we do not see as much of an increase in uninsured for Whites as we do for Blacks. The differences in starting points between the full sample, the White sub-sample, and Black sub-sample highlight coverage gaps already well documented in the literature particularly gaps that existed prior to the Affordable Care Act's major health reforms to address disparities in access to health insurance coverage (Guth et al. 2023; Guth, Artiga, and Pham 2020; Ammula and Published 2023). The uninsured rate is higher across all four levels of historical lynching exposure for the full sample and for Blacks relative to Whites, and the positive relationship between lynching intensity and uninsurance is visually discernable for Blacks and less so for Whites.

In panel B, we assess the relationship between lynching intensity and private health insurance coverage. The patterns reflect coverage gaps between Whites and non-Whites, particularly the Black-White private coverage gap. The private coverage means decline slightly with intensity, but declines in Medicaid coverage among Blacks with respect to state lynching intensity are more observable. While Blacks are more likely to be enrolled in Medicaid than Whites, the Black-White gaps decline with increasing lynching intensity (See panel C). This decline in the gap is because of declining enrollment among Blacks in the higher quartiles relative to the lower quartiles. Among Whites, there is no discernable relationship between lynching exposure and Medicaid enrollment.

Characteristics of States by Levels of Historical Lynching

Table 1 presents the summary characteristics across states by historical lynching intensity. Noteworthy is that Black residents are overrepresented (14% versus 11% nationally) among states in the 3rd quartile of lynching per 10,000 Black population. The 2nd and 3rd quartiles have higher shares of the population that did not complete high school. States in the 2nd quartile have the smallest share of rural residents, and expectedly states in the Northeast are only in the 1st and 2nd quartiles of historical lynching, while the South has the largest shares from the 3rd and 4th quartiles.

Because our analytical sample will only include non-Hispanic Blacks and non-Hispanic Whites, we include Table 2 to provide a comparison of our two racial groups under evaluation. Relative to Whites, Black Americans had comparatively lower levels of education, were more likely to report as having poor health or have a disability that limits their ability to work. A larger share of Blacks lived in urban/metropolitan areas relative to whites. Fifty-six percent of the Blacks in the sample lived in southern states, and 46% lived in states with the highest average number of lynchings per total population. However, 78% of Blacks lived in states composing the 2nd and 3rd quartiles of lynchings per Black population.

Regression Results of the Association between Historical Lynching and Coverage

In our regression analyses, we limit the analytical sample to persons identifying as non-Hispanic Whites and non-Hispanic Blacks so that we may better explore the association between structural racism, as proxied by historical lynching patterns across states, and health insurance coverage gaps between Blacks and Whites.

Tables 3-5 contain our key regression results. Moving from left to right each panel, introduces additional controls into our regressions assessing differences in coverage status between Whites and Blacks. Regressions in column (1) include only year fixed-effects, while

column (6) includes our most constrained regressions with the inclusion of the most controls. Table 3 is our evaluation of the association between historical lynching and whether the sample person was uninsured at the time of the survey. In the base column (1), we do not observe any statistical or substantive differences between whether a White sample person is uninsured between the 1st and 2nd quartiles of historical lynchings. However, the uninsured rate is monotonically higher in the 3rd (2.4 percentage points [PP], $p<0.05$) and 4th (3.2 PP, $p<0.05$) quartiles relative to the 1st quartile. This pattern is generally consistent across the remaining model specifications. Turning to the key focus of our study, we observe larger risks uninsurance risks for Black residents in states in the higher quartiles of historical lynching. In the 4th quartile, Black residents were an additional 6.3 PPT ($p<0.01$) more likely to be uninsured than White residents in the same group of states. Moving from left to right, the coefficient on this interaction term is 29% (5) and 44% (6) smaller than the unrestricted regression without including additional controls beyond year effects. However, our findings still suggest Black residents in states with the most extensive lynching histories were almost 5 percentage points (39% in relative terms) more likely to be uninsured than White residents in states among the first quartile of lynchings per capita.

One plausible explanation for the change in the magnitude of the coefficient of the interaction term between being Black and being in the 4th quartile (i.e., highest) of states with historical lynchings is differing access to employer-based health insurance or other forms of private coverage (e.g., non-group). However, there was about a 10% change in the point estimate (i.e., 5.25 [$p<0.01$] versus 4.74 [$p<0.01$]) moving from column (3) to column (4) after we introduced occupational fixed effects into our regressions. Doing so did not change the relationship or any inferences at this point, but they could suggest part of the reduction in magnitude is partly explained by differing access to private insurance coverage. However, our

findings in Table 4 do not suggest that private coverage and disparities in private coverage vary across states' levels of historical lynching.

Our findings in Table 5 suggest the net coverage disparities are driven by differing levels of Medicaid enrollment across Whites and Blacks. While Black Americans are enrolled in Medicaid at a substantially higher rate (i.e. 4.6 PP [$p<0.01$] - 10.9 PP [$p<0.01$]), much of the difference is explainable by disparities in income, poverty, education, and employment as we move from columns (2) to (3); even more of this difference is explained by differences in self-reported health moving from (4) to (5). Of interest to our study is that Medicaid participation appears to decline among Blacks as we move from the lowest quartile (-0.49, p=n.s.) of lynchings per 10,000 Blacks to the highest (i.e., 4th) quartile (-2.68, p=n.s.).Although our key findings from this table fail to meet the $p<0.05$ threshold of statistical significance the point estimates on the interaction terms signifying the difference in coverage for Blacks relative to Whites in the 3rd and 4th quartile states are roughly comparable in columns (1) and (6). In column (6), we introduce controls for political ideology and political control of the state's legislature and governorship. States with more ideologically Liberal leanings would tend to favor policies expanding access to public assistance such as Medicaid. Republican-controlled governments tend to be less likely to support and implement policies that would expand access to such programs and are historically more likely to adopt policies restricting such access. However, our regression estimates from column (6)--particularly in our Medicaid analyses–remain unchanged after adding these additional state-level controls.

As a complement to our key analyses in Table 3, we alter our model specification such that instead of using the cumulative number of historical lynchings per 10,000 Black population as our key source of exposure to racialized violence, we use lynchings per 10,000 total population. In Appendix Table A3, the patterns are not as consistent as they were relative to table

3's results, but Black residents with more intense lynching histories tended to be at elevated risk of being uninsured relative to Whites and experience a declining likelihood of being on Medicaid.

In Appendix Table A4, we explore whether our findings are sensitive to year effects. Appending our preferred model specification, we focus on the three-way interaction between lynching history, race, and the year of the survey. We do not find evidence to suggest the potential coverage disadvantage largely differs across years, so we will continue using our pooled sample.

Sub-Group Analyses of the Association between Historical Lynching and Health Insurance Coverage

Table 3-5 reflect our key analyses; however, we recognize they can be biased because they include persons for whom Medicaid would not be a relevant source of coverage because of income eligibility. For example, only 10% of adults nationwide were Medicaid-enrolled in 1999-2000 (Mills 2001), and 13% in 2005-2006 (Denavas-Walt, Proctor, and Smith 2007). Most persons on Medicaid are impoverished, but the income thresholds partly shaping Medicaid eligibility vary from state to state. To better capture the relationship between historical lynching and coverage among the relevant population–the population closer to being Medicaid eligible. To do so, we stratify our sample in two ways: a) by poverty status and b) by education level. In 2000, people without a high school diploma were the single largest group of non-elderly adults aged 18-64 enrolled on Medicaid at 27% (Mills 2001). The second largest group included adults with only a high school diploma (16%). Almost 43% of Medicaid enrollees have limited education, and Kaestner et al (2017) examined trends in labor force participation following the ACA's Medicaid expansion by also limiting their study sample to limited education adults

(Kaestner et al. 2017). As education and income are positively correlated with each other (Card 1999), limiting our sample to those with low education provides another way to capture a larger share of plausibly Medicaid-eligible persons.

In Table 6-8, we examine whether there is heterogeneity in the relationships of interest across our sub-groups. Compared to our analyses using the full sample, more of our findings for uninsured status can be attributed to adults living below the poverty as well as adults with limited education. Although not statistically significant or consistent across each specification, Blacks appeared to be at some relative disadvantage in terms of coverage among states with more intensive lynching histories. This pattern was more readily identifiable among the sub-sample with limited education (See Table 6, column 4) especially when compared to the sub-samples with more education where there was no clear presence that structural racism was deterring coverage among groups that might 1) have access to other sources of coverage, or 2) less susceptible to administrative complexities in navigating the Medicaid program. The findings from table 7 echo our main findings as we observe no evidence that historical lynching was affecting access to private coverage. In table 8, the findings from column 4—particularly that Black persons with limited in states in the 4th quartile of states were less likely to be enrolled in Medicaid when compared against a Black person in states without such an intensive lynching history (e.g., quartile 1).

Lynching and Medicaid Policies

In our following results, we explore some of the potential mechanisms through which lynchings may affect coverage among Blacks relative to Whites. In particular, we explore whether there are differences in states' Medicaid eligibility and administrative guidelines. We fit the relationship between the Medicaid policies of interest and historical lynching

nonparametrically using a kernel-weighted local polynomial smooth regression line. While a fitted regression line can also be used, we fit the relationship non-parametrically as to not impose monotonicity and linearity in assessing the relationship between lynching and state Medicaid policy decisions.

Figure 3 presents the composite Medicaid eligibility index (panel A) and composite Medicaid administrative ease (panel B) indices for 2000 and 2005 plotted against the quartiles of historical lynching. As the intensity of historical lynching increases, the average of states' composite eligibility indices tends to decline, and this relationship is identical in 2000 and 2005. In panel B, we observe Medicaid administrative easing declines as historical lynching intensity increases for 2005 but not for 2000. A plausible reason for the lack of a clear relationship in between lynching and the 2000 index is because there was relatively little variation in administrative guidelines across the states in the immediate aftermath of welfare reform in the late 1990s (Grogan & Patashnik, 2003; Sawhill & Haskins, 2002). Evaluating the relationship between composite measures that shape Medicaid accessibility is useful and informative, but we use the following figures to assess linkages between historical lynching and our indices component measures. Figure 4 presents the relationship between lynching and the upper-income limits determining Medicaid eligibility for a) parents, b) pregnant women, and c) young children aged 1-5.

In each panel for Figure 4, there is a downward-sloping relationship between the income thresholds and historical lynching. However, the steepest decline exists for parents as the average upper-income limit for states in the first quartile of historical lynching is 115% and 120% of the federal poverty limit (FPL) in 2000 and 2005, but 80% FPL and 73% FPL among the fourth quartile in 2000 and 2005 (See Panel A). The mean upper-income limit for children in 2000 and

2005 is comparable at around 180% FPL in the first quartile of historical lynching and 173% FPL in the fourth quartile.

In figure 5, we assess the relationship between the 2000 and 2005 indicators of Medicaid administrative ease and historical lynching. In contrast to the inverse relationship with states' Medicaid income thresholds, the relationship between lynching and individual components from the administrative ease index is mixed. The share of states with 12 months of continuous eligibility in 2000 and 2005 increases with historical lynching, but presumptive eligibility for children–the extent that children can be enrolled at the point of service–declines with lynching intensity (Panel D). While only available in years 2005 and beyond, the share of states that eliminated face-to-face interviews (Panel F) and asset tests (Panel G) as a condition of eligibility is higher among states in the first quartile of historical lynching intensity and lower among states in the higher quartiles.

DISCUSSION

To summarize, we find that 1) Historical lynchings are associated with more comprehensively burdensome administrative rules relative to states with little or no lynching history, 2) Uninsurance among Blacks and Whites is higher in states with higher numbers of lynchings; and 3) Black Medicaid enrollment is lower in states with a higher number of lynchings. Our results are not intended to be causal or conclusive. However, we do believe that this empirical work can build on the extensive institutionalist and behavioral scholarship that has previously documented the extent to which racialized politics has shaped the American welfare state and the Medicaid program more specifically (e.g., Lieberman, 2002; Quadagno, 1988, 1994; Soss, Fording & Schram, 2011; Michener, 2018). Additionally, we believe that our exploratory work can 1) call attention for new investigations into how the legacies of racism may

manifest in the operations of policies whom a disproportionate share of Black and other non-White groups disproportionately benefit from, and 2) motivate others to investigate the intergenerational formations of inequality attributable to racialized policymaking.

Our findings highlight some potential linkages between racial animosity, Medicaid administrative burden, and coverage status. While prior empirical research has examined how the imposition (or relaxation) of burdensome rules affects Medicaid participation rates (A. M. Fox, Stazyk, and Feng 2020; A. Fox, Feng, and Reynolds 2023), this research had not explicitly explored racial disparities in insurance coverage associated with administrative burden in the Medicaid program.

Administrative easing in Medicaid enrollment could allow for easier entryway into the Medicaid program but undoing administrative hurdles with racists origins could prove politically difficult. Our findings were consistent with prior case studies of minority Medicaid enrollees facing greater difficulty in the Medicaid enrollment and re-enrollment processes (J. Michener 2018). How more burdensome administrative practices are applied across racial groups would require more in-depth inquiry beyond our present study, but we hope our findings can inform future directions for outlining administrative burdens in Medicaid with greater precision.

Our findings support prior work that has detailed the racialized politics of other social programs, particularly the experience of welfare reform and the transition from the relatively generous AFDC program to the comparatively disciplinary and paternalistic Temporary Assistance for Needy Families (TANF) program. Soss, Fording & Schram (2011) demonstrate how ‘reformed’ welfare has been wielded as a disciplinary force against the poor- the “left hand” of the carceral state. They painstakingly detail what they refer to as the “persistent influence of race” on the by demonstrating continuities with past racialized politics of the welfare state. Today, TANF is another public program associated with alleviating families from poverty and

providing needed financial relief; however, like Medicaid, this program's benefits tend to be less generous in states with higher concentrations of Black residents (Hahn et al. 2017). Variation in state guidelines with respect to TANF parallel the variation in guidelines for Medicaid administrative burden in our own study as Southern states account for a disproportionate share of the states with the most burdensome Medicaid administrative guidelines, and Southern states account for the majority of the United States' Black residents. Likewise, the introduction of work requirements adopted by many states as a condition of expanding Medicaid can be understood as part of a greater disciplinary turn in the Medicaid program rooted in racial resentment and efforts to exert social control over certain groups (Haeder, Sylvester, and Callaghan 2021).

While we have contributed empirical precision to the estimates of the dispossessing effects of historical lynchings on present-day racial inequities in access to Medicaid, this work is unable to disentangle the precise mechanisms through which the long arm of history produces present-day inequities via the adoption of burdensome administrative rules. Cumbersome ordeals such as complexity and 'red tape' can "exacerbate the very inequality that disability programs are intended to reduce" (Deshpande and Li 2019); however the exact mechanisms through which they do so are uncertain and warrant more rigorous evaluation.

How the burdens are experienced on a granular level are not knowable from our study, but we suggest the following potential pathways racially motivated administrative burdens could contribute to disparities. First, burdens may be applied disproportionately to minorities prior to their universal removal (discretion). Second, racialized minorities face greater resource-related challenges that may amplify the effects of procedural barriers and administrative burdens. Third, unintentional spillovers from social policy debates onto the politics of Medicaid (e.g., racial resentment over the election of Obama or immigration politics) (Brown, 2013). Particularly for Hispanics and groups that are more affected by immigration status (Pillai and Artiga 2022; Haley

et al. 2020; Twersky 2022; Watson 2014), the "chilling effect" of additional burdens (psychological and otherwise) tied to anxiety over immigration status may be exacerbated by increasing burdens or reduce with administrative easing ("chilling effect").

Activists, researchers, and those in the policy community are calling for Medicaid to be leveraged more as a vehicle for achieving health equity. For example, Medicaid enrollees are disproportionately Black (20%) and Hispanic (29%) (KFF 2023). Being overrepresented in Medicaid, means Medicaid could be used to either undue disparities created by inequity, or bolster health disparities steeped in institutional racism. Work by Leitner, Hehman, and Snowden found that states with higher levels of explicit and implicit racial bias–defined as racial animosity towards non-Whites–had lower per-enrollee Medicaid spending (Leitner, Hehman, and Snowden 2018).The key findings from the study were: 1) Southeastern states tended to have the highest levels of racial bias and the lowest levels of per-person spending, and 2) the negative relationship between per-person spending was stronger in states where the income gap between Blacks and Whites was smaller.

Racism can creep into the administration of public programs such as Medicaid. Improving our understanding as to how bigotry and ill will towards minoritized communities or public debate concerning reproductive rights, could lead to more targeted efforts to improve the viability of advancing health equity via the Medicaid program (Guth et al. 2023). In absence of federal intervention, state politics can impede program uptake in multiple dimensions of Medicaid policy beyond eligibility guidelines such as work requirements, comprehensively burdensome eligibility determinations, and spending decisions consistent with findings from prior work (C. Fox, 2012). In this case, racial bias affects spending levels, but could also influence Medicaid reimbursement rates or even Medicaid provider network adequacy standards, and administrative burdens which fall disproportionately on Black and even Hispanic enrollees.

Limitations

Our study is not without limitation. The relationship between coverage and historical lynching is non-linear, and not precisely measured in our key regression estimates. We also do not observe a monotonic increase in the Black-White disparity that could be attributable to increasing lynching intensity across the states (e.g., moving from the 2nd to 4th quartiles). One explanation for lack of monotonicity is that Black residents were more prevalent among states in the 2nd and 3rd quartiles of states based on their historical lynchings per 10,000 Black population. While we found some evidence that Blacks were less likely to be enrolled in Medicaid in states with more intense lynching histories, Blacks as a share of the population may also trigger more stringent administrative burdens at the point of enrollment that are applied disproportionately to Black potential Medicaid enrollees relative to White enrollees and potential enrollees.

Our results may also be subject to aggregation bias. Our approach imposes the idea that exposure to lynching was uniformly distributed across the states. Lynchings were highly localized, and most studies examining the effects of lynchings over leverage county-level variation rather than aggregate state-level variation. We chose to aggregate lynching to the state level for our study because that is where the key variation in Medicaid eligibility and administrative guidelines exist.

Medicaid administrative burden yields that same disadvantage to subgroups of our study groups. This is part of our study's exploration—that exposure to a common source of administrative burden would materialize different outcomes among Blacks relative to Whites. We had no way of testing for the presence of discrimination in how guidelines were applied differently for racial and ethnic minorities versus Whites, that this is a potential cause for

disparities in enrollment in Medicaid or other public programs is not unsubstantiated (Michener, 2018; Moreno & Mullins, 2017; Sirpal, 2014). This is our justification for assessing whether coverage gaps and different constellations of Medicaid eligibility and administrative guidelines could be attributed to historical lynching patterns–our proxy measure for structural racism.

CONCLUSION

Our findings suggest easing the processes for Medicaid enrollment and renewals may have a positive impact on addressing disparities in health insurance coverage. Racial gaps in health insurance coverage are well established, though easing access to Medicaid could provide one pathway to alleviating racial and ethnic coverage gaps. However, using Medicaid as a vehicle to achieving health equity may first have to reconcile the plausibly racist origins that shaped the Medicaid program. Improving our understanding as to how bigotry and ill will towards minority communities or public debate concerning reproductive rights, could lead to more targeted efforts to improve the viability of advancing health equity via the Medicaid program (Guth et al. 2023). From there, more investigations are needed to quantify and better understand the potential health consequences of structural racism being embedded in Medicaid.

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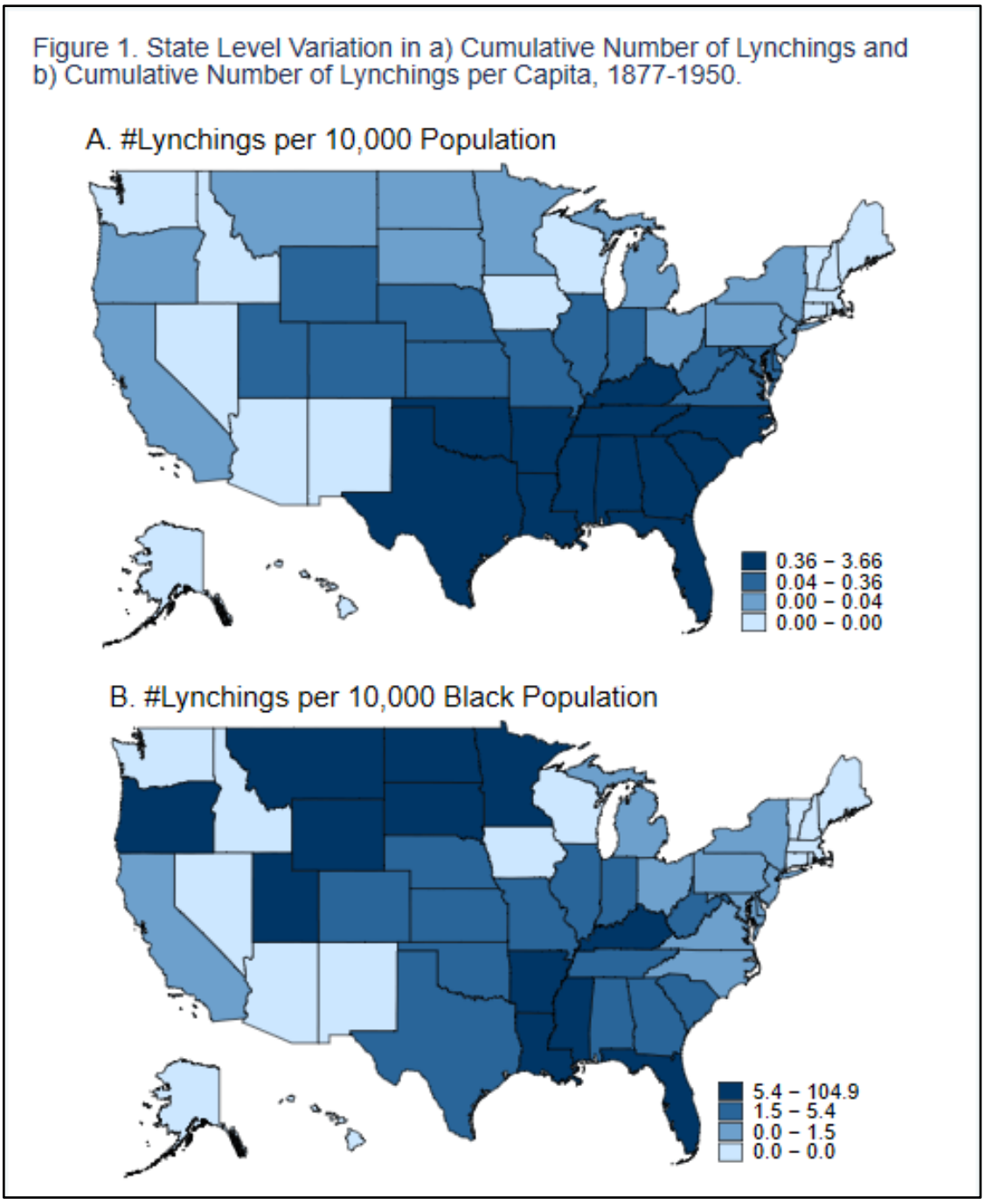
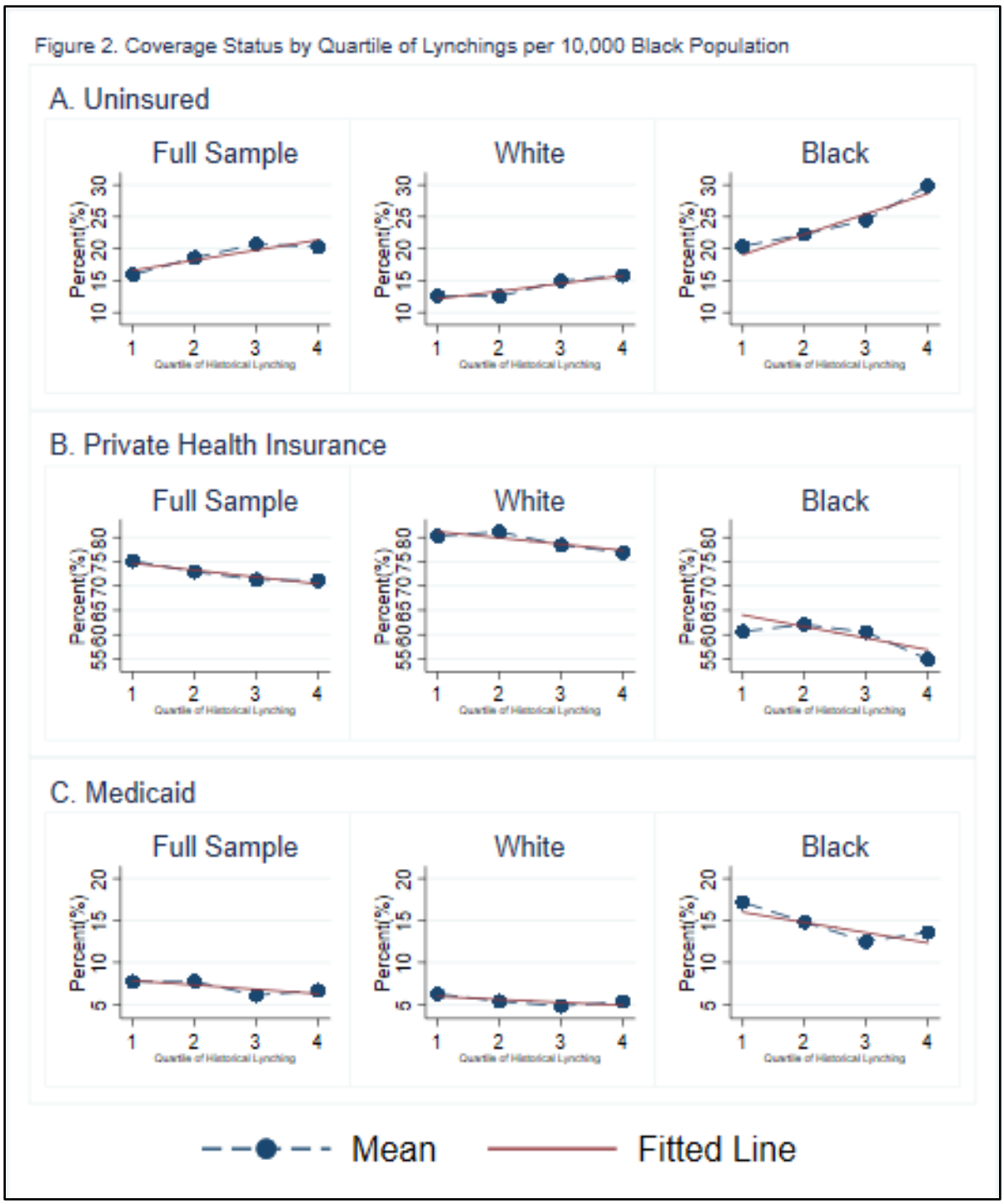
FIGURES & TABLES

Figure 1. State Level Variation in a) Cumulative Number of Lynchings and b) Cumulative Number of Lynchings per Capita, 1877-1950.



Source: Authors' own analysis of historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per 10,000 population using states population counts from the 1920 Census as the denominator.



Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: All means in the above figures are weighted to reflect the survey's complex sampling strategy. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9).

Table 1. Summary Characteristics of States by Levels of Historical Lynching.

		Quartile of Historical Lynching			
	Full Sample	1st	2nd	3rd	4th
Age	40.3	40.5	40.3	40.0	40.5
Sex					
%Female	50.7	50.2	50.9	50.7	50.8
%Male	49.3	49.8	49.1	49.3	49.2
Race/Ethnicity					
%White/Non-Hispanic	68.2	76.3	64.0	67.6	73.1
%Black/Non-Hispanic	11.7	4.0	12.4	14.0	12.6
%Other Race/Non-Hispanic	6.2	8.0	8.0	4.0	3.6
%Hispanic (any race)	14.0	11.7	15.7	14.4	10.6
%Married	57.8	58.0	56.5	59.2	58.8
%Not a US Citizen	9.7	8.2	12.4	7.7	7.6
Parental Status					
%Parent	46.7	46.3	47.0	47.0	45.6
#children in household	0.9	0.9	0.9	0.9	0.9
Education					
%Did Not Complete High School	12.8	10.4	13.1	14.0	12.1
%HS Diploma/GED	31.2	30.9	30.4	31.9	32.1
%Associate's Degree/Some College	29.2	30.7	28.1	29.1	31.2
%BA/BS+	26.7	28.0	28.3	24.9	24.7
Total family income ($)	67408.6	69137.0	71569.2	63363.2	62133.8
Self-Reported Health					
%Excellent Health	31.1	33.9	31.0	29.8	31.1
%Good/Very Good Health	58.3	56.7	58.8	58.7	57.6
%Fair Health	7.5	6.8	7.3	8.0	7.7
%Poor Health	3.2	2.6	2.9	3.6	3.7
Disabled	7.9	7.6	7.7	8.0	8.4
Rural/Urban Residency					
%Rural/Non-Metropolitan Area	17.0	21.3	9.5	21.8	24.0
%Urban/Metropolitan Area	83.0	78.7	90.5	78.2	76.0
Region					
%Northeast	18.9	34.5	33.6	0.0	0.0
%Midwest	22.6	20.2	17.9	34.5	15.1
%South	35.6	0.0	19.0	59.9	68.3
%West	22.9	45.3	29.5	5.6	16.6
N	747,176	178,626	244,391	185,873	138,286

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: All statistics in the above table are weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9).

Table 2. Summary Characteristics by Race Group.

	Full Sample	Black	White
Age	41.0	39.0	41.4
Sex			
%Female	51.1	54.8	50.5
%Male	48.9	45.2	49.5
%Married	58.1	37.1	61.7
%Not a US Citizen	2.8	5.5	2.3
Parental Status			
%Parent	45.1	46.4	44.9
#own children in household	0.8	0.9	0.8
Education			
%Did Not Complete High School	8.6	15.7	7.4
%HS Diploma/GED	32.1	37.0	31.3
%Associate's Degree/Some College	30.9	30.7	30.9
%BA/BS+	28.4	16.5	30.5
Total family income ($)	70489.4	46564.7	74584.8
Self-Reported Health Status			
%Excellent Health	32.0	23.6	33.4
%Good/Very Good Health	57.4	59.9	56.9
%Fair Health	7.4	11.7	6.7
%Poor Health	3.2	4.8	3.0
%Disabled	8.3	12.4	7.6
Rural Urban Residency			
%Rural/Non-Metropolitan Area	19.0	11.5	20.3
%Urban/Metropolitan Area	81.0	88.5	79.7
Region			
%Northeast	19.8	17.2	20.3
%Midwest	25.7	18.1	27.0
%South	36.6	56.0	33.3
%West	17.9	8.7	19.5
Lynchings per 10,000 Total Population			
1st Quartile	14.5	4.9	16.1
2nd Quartile	35.3	29.6	36.3
3rd Quartile	19.8	19.7	19.8
4th Quartile	30.4	45.9	27.8
Lynchings per 10,000 Black Population			
1st Quartile	14.5	4.9	16.1
2nd Quartile	39.6	44.0	38.9
3rd Quartile	29.5	34.6	28.6
4th Quartile	16.4	16.5	16.4
N	582,102	81,045	501,057

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: All statistics in the above table are weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9).

Table 3. Regressions of the Association between Uninsurance and Cumulative Historical Lynching per 10,000 Black population.

	(1) uninsured	(2) uninsured	(3) uninsured	(4) uninsured	(5) uninsured	(6) uninsured	(7) uninsured
2nd Quartile	-0.088	0.37	0.24	0.41	0.31	-0.29	-0.47
	(0.78)	(0.73)	(0.69)	(0.67)	(0.67)	(0.68)	(0.63)
3rd Quartile	2.37**	2.72**	1.99*	2.25**	2.12**	1.48**	1.38**
	(1.01)	(1.06)	(1.01)	(1.03)	(1.03)	(0.69)	(0.66)
4th Quartile	3.19**	3.38**	2.43*	2.40**	2.31**	1.66**	1.40*
	(1.45)	(1.50)	(1.22)	(1.18)	(1.15)	(0.77)	(0.71)
Black	7.78***	4.50***	-0.017	0.61	0.74	0.77	0.81
	(0.68)	(0.63)	(0.72)	(0.70)	(0.65)	(0.73)	(0.72)
2nd * Black	1.95*	2.01**	2.56***	2.46***	2.34***	2.19***	2.20***
	(1.08)	(0.87)	(0.82)	(0.81)	(0.75)	(0.81)	(0.81)
3rd * Black	1.73	2.18	2.55**	2.29*	2.24*	1.93	1.86
	(1.26)	(1.34)	(1.15)	(1.20)	(1.12)	(1.18)	(1.19)
4th * Black	6.27***	5.96***	5.25***	4.74***	4.47***	3.48***	3.46***
	(1.49)	(1.58)	(1.09)	(1.10)	(1.08)	(0.87)	(0.87)
Observations	582,102	582,102	582,102	582,094	582,094	582,094	572,222
White Mean in Quartile 1	12.6	12.6	12.6	12.6	12.6	12.6	12.6
Demographics	No	Yes	Yes	Yes	Yes	Yes	Yes
Economic	No	No	Yes	Yes	Yes	Yes	Yes
Occupation Fixed Effects	No	No	No	Yes	Yes	Yes	Yes
Health Status	No	No	No	No	Yes	Yes	Yes
Regional Fixed Effects	No	No	No	No	No	Yes	Yes
Political/Ideological	No	No	No	No	No	No	Yes
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Standard errors in parentheses

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.

Note: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. Regressions in the full model (Column 6) include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Table 4. Regressions of the Association between Private Health Insurance Coverage and Cumulative Historical Lynching per 10,000 Black population.

	(1) prvtcvg	(2) prvtcvg	(3) prvtcvg	(4) prvtcvg	(5) prvtcvg	(6) prvtcvg	(7) prvtcvg
2nd Quartile	0.88	0.030	0.34	0.57	0.64	0.60	0.88
	(1.24)	(1.13)	(1.10)	(0.94)	(0.93)	(0.57)	(0.57)
3rd Quartile	-1.88	-2.47*	-1.01	-1.11	-0.97	-1.11**	-0.93*
	(1.39)	(1.41)	(1.08)	(0.98)	(0.97)	(0.53)	(0.54)
4th Quartile	-3.38*	-3.66*	-1.78	-1.58	-1.50	-1.26	-0.90
	(1.91)	(1.93)	(1.36)	(1.17)	(1.21)	(0.80)	(0.69)
Black	-19.7***	-15.4***	-6.81***	-6.97***	-6.28***	-6.28***	-6.31***
	(2.66)	(2.53)	(1.34)	(1.20)	(1.09)	(1.09)	(1.09)
2nd * Black	0.60	1.09	0.060	-0.14	-0.37	-0.32	-0.30
	(3.13)	(2.93)	(1.58)	(1.43)	(1.33)	(1.35)	(1.34)
3rd * Black	1.76	1.91	1.22	1.15	0.93	1.23	1.27
	(3.10)	(3.07)	(1.68)	(1.55)	(1.47)	(1.49)	(1.50)
4th * Black	-2.28	-1.31	0.35	0.39	0.027	0.71	0.74
	(3.43)	(3.40)	(1.69)	(1.49)	(1.40)	(1.18)	(1.20)
Observations	582,102	582,102	582,102	582,094	582,094	582,094	572,222
White Mean in Quartile 1	80.3	80.3	80.3	80.3	80.3	80.3	80.3
Demographics	No	Yes	Yes	Yes	Yes	Yes	Yes
Economic	No	No	Yes	Yes	Yes	Yes	Yes
Occupation Fixed Effects	No	No	No	Yes	Yes	Yes	Yes
Health Status	No	No	No	No	Yes	Yes	Yes
Regional Fixed Effects	No	No	No	No	No	Yes	Yes
Political/Ideological	No	No	No	No	No	No	Yes
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Standard errors in parentheses

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.

Note: $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. Regressions in the full model (Column 6) include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Table 5. Regressions of the Association between Medicaid Enrollment and Cumulative Historical Lynching per 10,000 Black population.

	(1) medicaid	(2) medicaid	(3) medicaid	(4) medicaid	(5) medicaid	(6) medicaid	(7) medicaid
2nd Quartile	-0.87	-0.53	-0.72	-0.98	-0.97	-0.39	-0.54
	(0.65)	(0.63)	(0.66)	(0.59)	(0.59)	(0.53)	(0.56)
3rd Quartile	-1.45*	-1.23	-1.88***	-1.97***	-1.98***	-0.42	-0.49
	(0.84)	(0.81)	(0.69)	(0.66)	(0.63)	(0.51)	(0.54)
4th Quartile	-0.91	-0.80	-1.58**	-1.68**	-1.67**	-0.30	-0.45
	(0.69)	(0.58)	(0.64)	(0.66)	(0.64)	(0.61)	(0.64)
Black	10.9***	9.37***	5.76***	5.43***	4.71***	4.64***	4.62***
	(2.58)	(2.43)	(1.89)	(1.78)	(1.61)	(1.63)	(1.63)
2nd * Black	-1.47	-1.81	-1.39	-1.19	-0.90	-0.49	-0.53
	(2.88)	(2.75)	(2.15)	(2.03)	(1.87)	(1.84)	(1.83)
3rd * Black	-3.22	-3.66	-3.38*	-3.17*	-2.92*	-2.69	-2.68
	(2.71)	(2.58)	(1.99)	(1.89)	(1.70)	(1.71)	(1.70)
4th * Black	-2.69	-3.28	-4.17**	-3.89**	-3.35*	-2.68	-2.66
	(2.73)	(2.55)	(1.98)	(1.87)	(1.70)	(1.70)	(1.71)
Observations	582,102	582,102	582,102	582,094	582,094	582,094	572,222
White Mean in Quartile 1	6.30	6.30	6.30	6.30	6.30	6.30	6.30
Demographics	No	Yes	Yes	Yes	Yes	Yes	Yes
Economic	No	No	Yes	Yes	Yes	Yes	Yes
Occupation Fixed Effects	No	No	No	Yes	Yes	Yes	Yes
Health Status	No	No	No	No	Yes	Yes	Yes
Regional Fixed Effects	No	No	No	No	No	Yes	Yes
Political/Ideological	No	No	No	No	No	No	Yes
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. Regressions in the full model (Column 6) include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Table 6. Regression Results of Association between Cumulative Historical Lynching per 10,000 Black Population and Uninsured among Sample by a) Poverty and b) Education Status.

	(1) uninsured	(2) uninsured	(3) uninsured	(4) uninsured	(5) uninsured	(6) uninsured
2nd Quartile	-0.47	-1.13	-0.50	-0.094	-1.43**	0.39
	(0.63)	(1.80)	(0.57)	(1.02)	(0.67)	(0.46)
3rd Quartile	1.38**	1.46	1.32**	2.10**	1.25*	0.91**
	(0.66)	(1.98)	(0.58)	(0.98)	(0.74)	(0.40)
4th Quartile	1.40*	2.24	1.24*	1.80	0.96	1.04*
	(0.71)	(2.15)	(0.62)	(1.12)	(0.68)	(0.52)
Black	0.81	-3.65	2.25***	-1.65	3.51***	3.16***
	(0.72)	(2.53)	(0.70)	(1.00)	(1.07)	(0.55)
2nd * Black	2.20***	4.46*	1.37	3.16***	1.02	0.17
	(0.81)	(2.59)	(0.91)	(1.17)	(1.19)	(0.83)
3rd * Black	1.86	6.42*	0.22	2.81*	-0.044	-0.38
	(1.19)	(3.39)	(1.07)	(1.50)	(1.65)	(0.66)
4th * Black	3.46***	3.96	2.40**	3.81***	2.39	1.10
	(0.87)	(3.20)	(0.97)	(1.12)	(1.59)	(0.81)
N	572,222	49,896	522,198	230,543	177,848	163,723
Group	Full Sample	<100% FPL	>100% FPL	Up to HS Diploma	Some College/AA/AS	BA/BS+

Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. All regressions include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Table 7. Regression Results of Association between Cumulative Historical Lynching per 10,000 Black Population and Private Health Insurance Coverage among Sample by a) Poverty and b) Education Status.

	(1) prvtcvg	(2) prvtcvg	(3) prvtcvg	(4) prvtcvg	(5) prvtcvg	(6) prvtcvg
2nd Quartile	0.88	2.70**	0.85	0.53	1.97***	-0.25
	(0.57)	(1.33)	(0.54)	(0.83)	(0.65)	(0.55)
3rd Quartile	-0.93*	-0.49	-0.87*	-2.20***	-0.37	-0.21
	(0.54)	(1.41)	(0.49)	(0.66)	(0.66)	(0.51)
4th Quartile	-0.90	0.26	-0.92	-1.34	-0.36	-0.62
	(0.69)	(1.34)	(0.68)	(0.90)	(0.71)	(0.72)
Black	-6.31***	-3.76**	-6.15***	-4.87**	-7.50***	-6.08***
	(1.09)	(1.71)	(1.35)	(1.82)	(1.57)	(1.32)
2nd * Black	-0.30	-3.08	0.054	-0.61	-0.59	1.24
	(1.34)	(1.86)	(1.60)	(1.96)	(1.82)	(1.66)
3rd * Black	1.27	-0.62	1.61	2.15	0.93	1.79
	(1.50)	(2.47)	(1.59)	(2.17)	(2.08)	(1.35)
4th * Black	0.74	-0.16	0.91	1.45	-0.051	1.90
	(1.20)	(2.03)	(1.43)	(1.89)	(1.97)	(1.48)
Observations	572,222	49,896	522,198	230,543	177,848	163,723
Group	Full Sample	<100% FPL	>100% FPL	Up to HS Diploma	Some College/AA/AS	BA/BS+

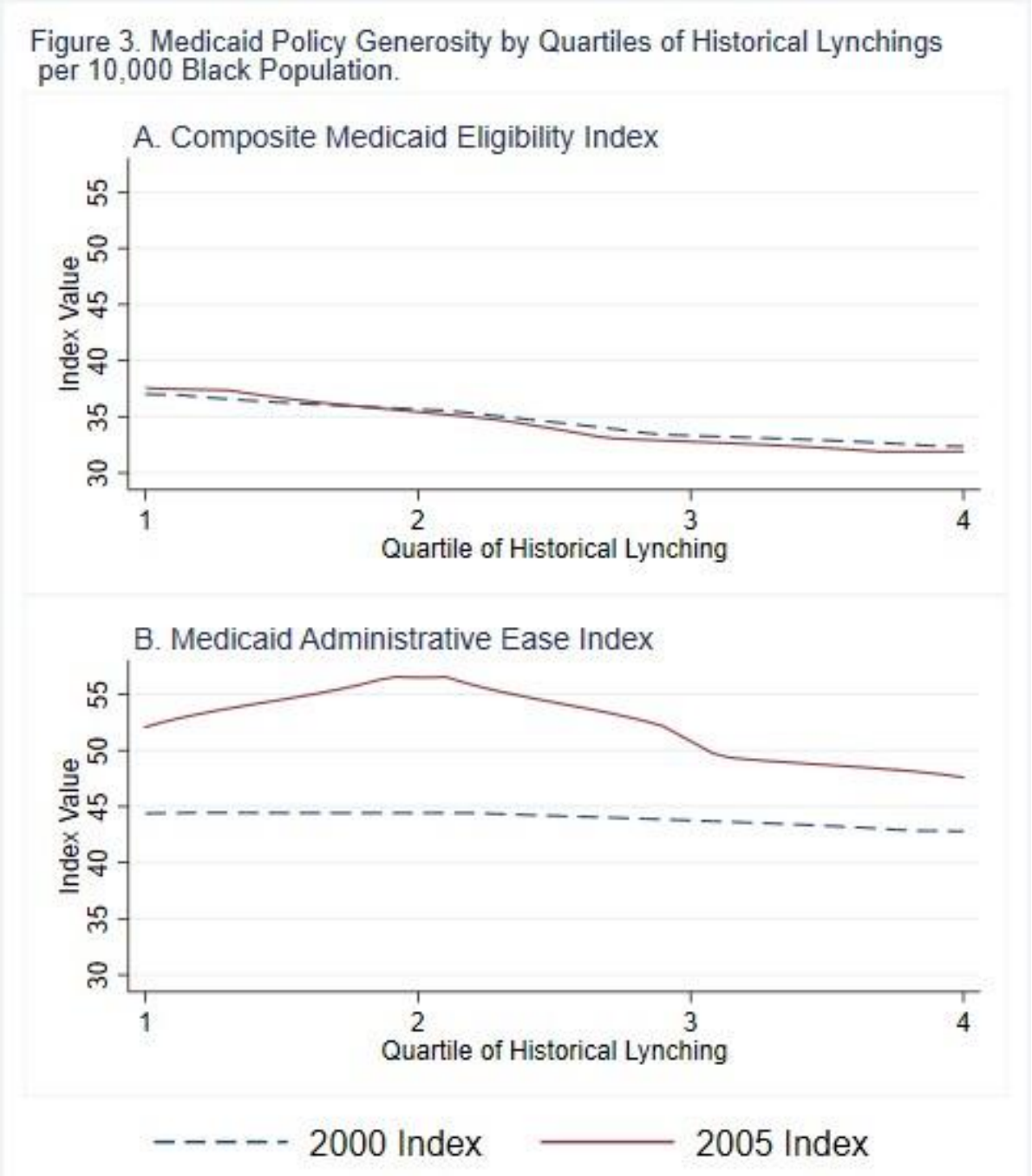
Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. All regressions include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Table 8. Regression Results of Association between Cumulative Historical Lynching per 10,000 Black Population and Medicaid Enrollment among Sample by a) Poverty and b) Education Status.

	(1) medicaid	(2) medicaid	(3) medicaid	(4) medicaid	(5) medicaid	(6) medicaid
2nd Quartile	-0.54	-0.53	-0.54	-0.54	-0.74	-0.027
	(0.56)	(1.48)	(0.53)	(1.20)	(0.50)	(0.17)
3rd Quartile	-0.49	-0.53	-0.52	-0.10	-0.87*	-0.50***
	(0.54)	(1.83)	(0.49)	(1.11)	(0.49)	(0.16)
4th Quartile	-0.45	-1.65	-0.32	-0.61	-0.31	-0.17
	(0.64)	(2.11)	(0.55)	(1.26)	(0.57)	(0.18)
Black	4.62***	7.61***	2.82**	6.47***	2.75**	0.70
	(1.63)	(2.48)	(1.29)	(2.14)	(1.26)	(0.71)
2nd * Black	-0.53	-0.84	0.024	-1.77	1.46	0.52
	(1.83)	(2.71)	(1.44)	(2.31)	(1.46)	(0.91)
3rd * Black	-2.68	-5.72*	-1.24	-4.68**	-0.81	0.62
	(1.70)	(2.91)	(1.38)	(2.18)	(1.35)	(0.82)
4th * Black	-2.66	-2.60	-1.71	-4.07*	-0.64	-0.48
	(1.71)	(2.97)	(1.45)	(2.22)	(1.38)	(0.86)
N	572,222	49,896	522,198	230,543	177,848	163,723
Q1_Mean	.9	1	0	.9	0	0
Group	Full Sample	<100% FPL	>100% FPL	Up to HS Diploma	Some College/AA/AS	BA/BS+

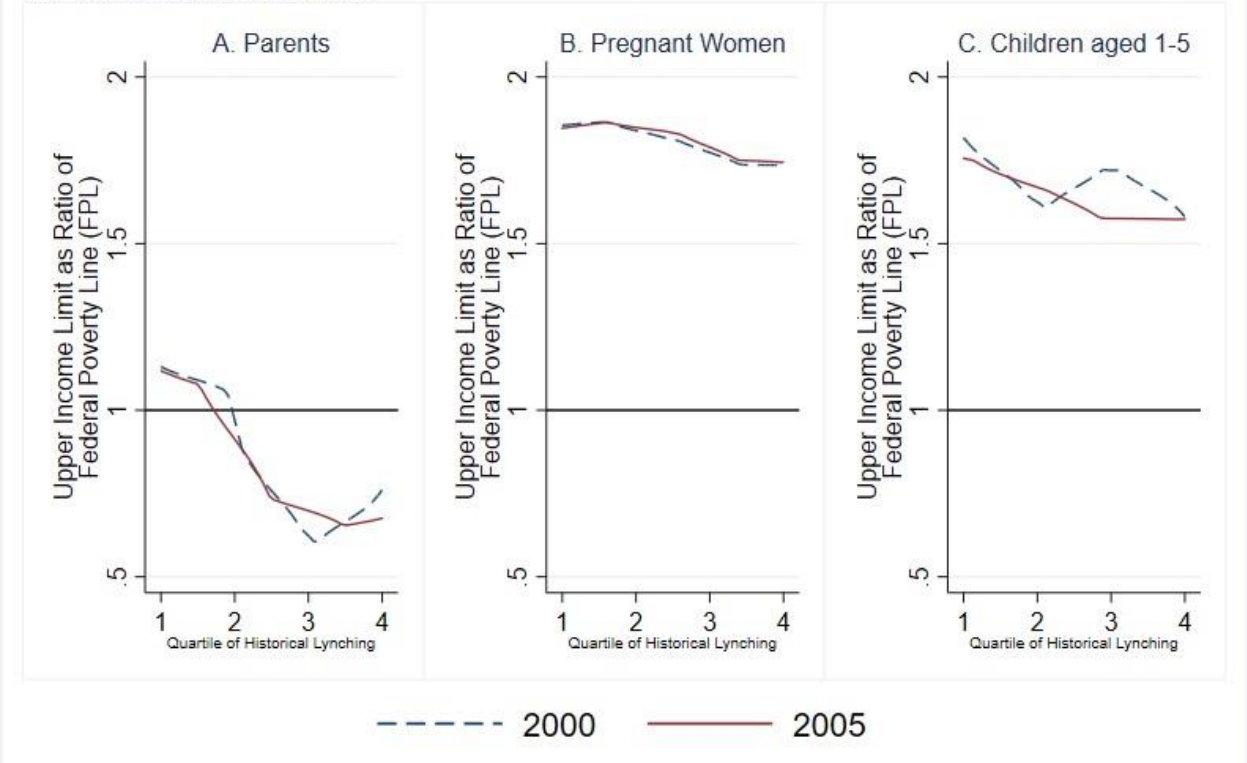
Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: * p < 0.10, ** p < 0.05, *** p < 0.01. All regressions results are survey-weighted to reflect the complex sampling strategy of the Current Population Survey. The ranges for each quartiles in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). All regressions use a covariance matrix to account for clustering at the state-level. All regressions include the following controls: demographics (age, sex, marital status, number of children in the household, US citizenship, rural/non-metropolitan residency), economic controls (education attainment, poverty status, income level, employment status), occupational fixed effects, self-reported health and disability status, and Census regional sub-division (New England, Middle Atlantic, East North-Central, West North-Central, South Atlantic, East South-Central, West South-Central, Mountain, Pacific). Lastly, we control for ideology and whether Republicans control the state's 3 levels of government: the governorship and the state's legislature (i.e., upper and lower houses).

Figure 3. Medicaid Policy Generosity by Quartiles of Historical Lynchings per 10,000 Black Population.



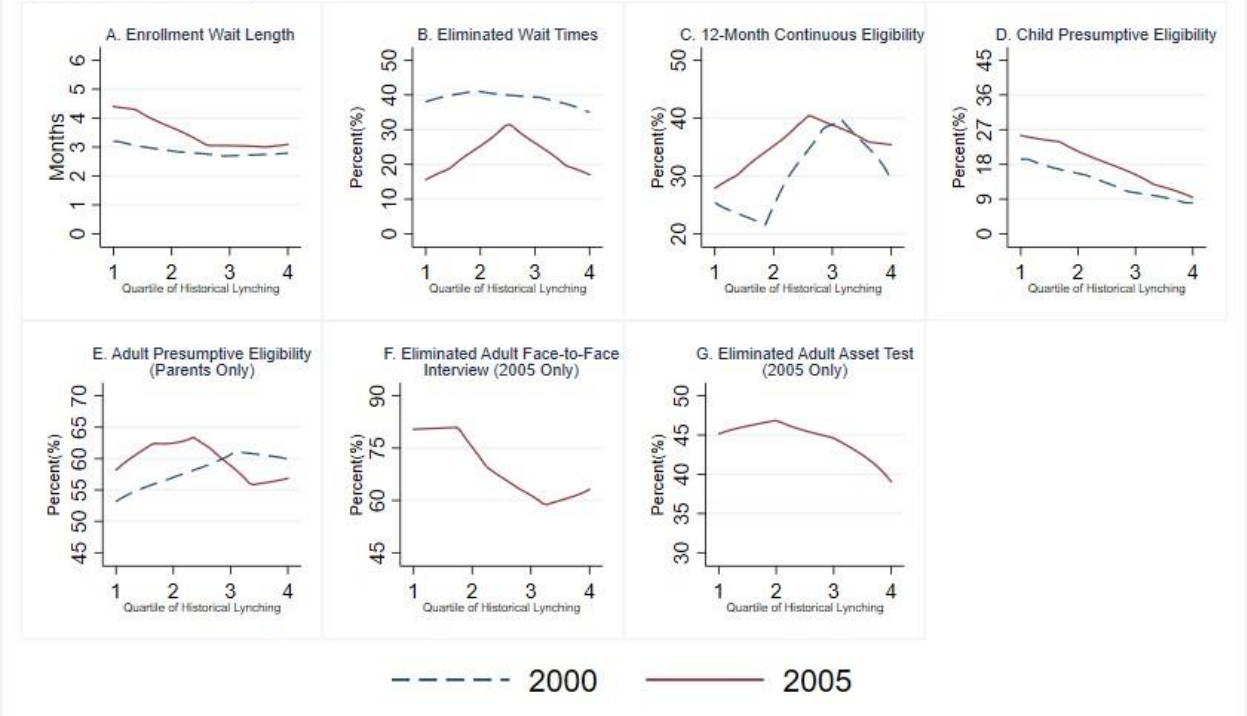
Source: Authors' own analysis of the Medicaid Generosity Index merged to historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per 10,000 population using states population counts from the 1920 Census as the denominator.

Figure 4. Upper Income Limits by Medicaid Eligibility Category and Quartile of Historical Lynchings per 10,000 Black Population.



Source: Authors' own analysis of the Medicaid Generosity Index merged to historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per 10,000 population using states population counts from the 1920 Census as the denominator.

Figure 5. Medicaid Administrative Ease Indicators by Quartile of Historical Lynchings per 10,000 Black Population.



Source: Authors' own analysis of the Medicaid Generosity Index merged to historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per 10,000 population using states population counts from the 1920 Census as the denominator.

APPENDIX

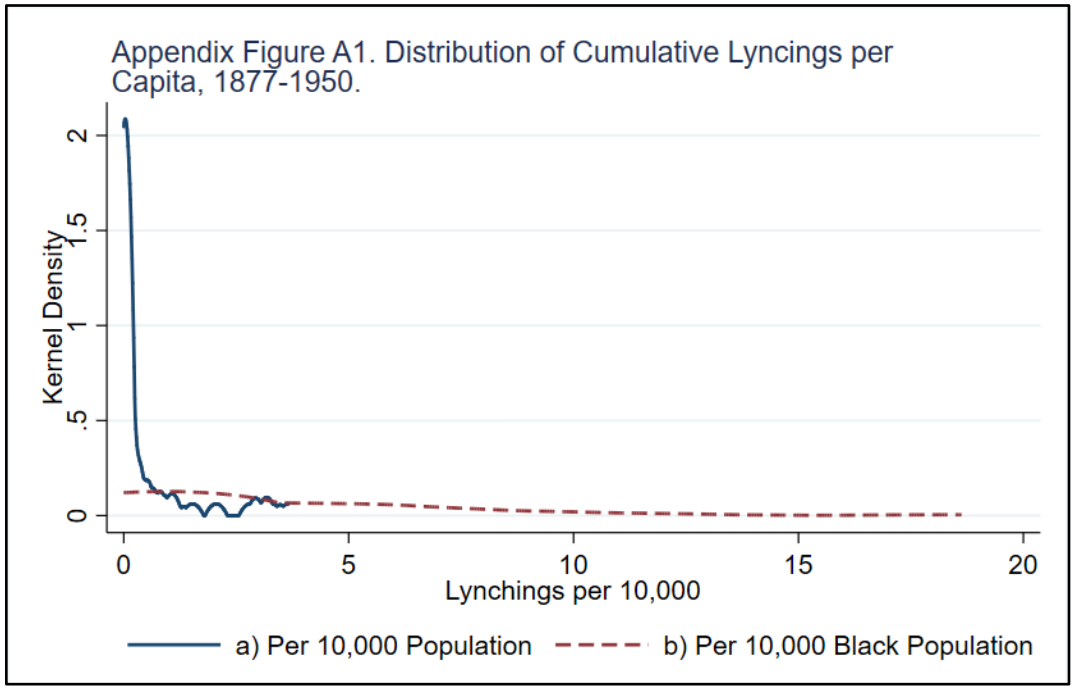
Appendix Table A1: Medicaid Eligibility and Administrative Policy Rule Coding

Cost Category	Description	Coding Justification	Codes
NA- Eligibility	Income Eligibility for Children less than 1 year old	Income Eligibility Threshold for Children less than 1 year old	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility for Children 1 to 5 years old	Income Eligibility Threshold for Children 1 to 5 years old	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility for Children 6 to 18 years old	Income Eligibility Threshold for Children 6 to 18 years old	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility for State Separate Program (SSP)	Income Eligibility Threshold for Separate State Children's Health Insurance Program. For states that do not have a SSP, the values for the average income eligibility limit across the three age groups is used.	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility, Children (<=18)	This measure represents the average income eligibility index across all categorical eligibility groups	
NA- Eligibility	Income Eligibility for Pregnant Women	Income Eligibility Threshold for Pregnant Women	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility for Parents	Income Eligibility Threshold for Parents	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility for No Dependent Adults	Income Eligibility Threshold for Adults (no dependents) [this measure is 0 for all states prior to the Affordable Care Act of 2010 which provided federal funds for states to expand Medicaid to this categorical eligibility group. Some states implemented the Medicaid expansion early, others late, others not at all. Income eligibility remains 0 for all years that an expansion is not implemented.	(income eligibility limit) / 4
NA- Eligibility	Income Eligibility Index	This measure represents the average income eligibility index across all categorical eligibility groups.	Income eligibility children (<=18) + PW +Parents + Adults no Dependents)/4
NA- Eligibility	Income Eligibility Index (weighted)	This measure is the same as Income Eligibility Index except that we add weights to each sub-index in accordance to how many people a higher income eligibility threshold will be likely to make eligible for the program.	Adults no Dependents=0.4; parents =0.2; PW=.1; Children=0.3

NA-Immigrant Eligibility	Medicaid for LPR children during five-year bar	The 1996 Welfare Reform (PRWORA) introduced a "5-year bar" on legal permanent residents in which they are not allowed to use public benefits such as Medicaid. However, states have flexibility to use state only funds to cover immigrant permanent resident children and the 2009 CHIPRA reauthorization also allowed to states to optionally relax this rule.	1=Yes; 0=No
NA-Immigrant Eligibility	Public health insurance for unauthorized immigrant children	Federal funds may not go to cover Medicaid for unauthorized immigrant children. However, some states use state only funds to cover unauthorized children through other mechanisms.	1=Yes; 0=No
NA-Immigrant Eligibility	Public health insurance for LPR adults during five-year bar	The 1996 Welfare Reform (PWORA) introduced a "5-year bar" on legal permanent residents in which they are not allowed to use public benefits such as Medicaid. However, states have flexibility to use state only funds to cover immigrant permanent residents through state only funds. Prior to the ACA adults without dependents regardless of immigration status generally were not eligible for Medicaid.	1=Yes; 0=No
NA-Immigrant Eligibility	Public health insurance for unauthorized immigrant adults	Federal funds may not go to cover Medicaid for unauthorized immigrant children. However, some states use state only funds to cover unauthorized children through other mechanisms. Only D.C. offers some form of public health insurance to unauthorized immigrant adults.	1=Yes; 0=No
NA-Immigrant Eligibility	Medicaid for LPR pregnant women during five-year bar	The 1996 Welfare Reform (PRWORA) introduced a "5-year bar" on legal permanent residents in which they are not allowed to use public benefits such as Medicaid. However, states have flexibility to use state only funds to cover immigrant permanent resident pregnant women and the 2009 CHIPRA reauthorization also allowed states to optionally relax this rule.	1=Yes; 0=No
NA-Immigrant Eligibility	Medicaid for unauthorized immigrant pregnant women	Federal funds may not go to cover Medicaid for unauthorized immigrant pregnant women. However, some states use state only funds to cover unauthorized children through other mechanisms. Only D.C. offers some form of public health insurance to unauthorized immigrant adults.	1=Yes; 0=No
NA-Immigrant Eligibility	Medicaid for LPRs after five-year bar	The 1996 Welfare Reform (PWORA) introduced a "5-year bar" on legal permanent residents in which they are not allowed to use public benefits such as Medicaid. States also have the flexibility to restrict access to legal permanent residents even after the five-year bar.	1=Yes; 0=No
Learning	Enrollment, Eliminate Asset Test, Parents	States have long had the discretion under federal law to not impose an asset or resource test for Medicaid eligibility.	1=Yes; 0=No

Learning	Enrollment, Eliminate Asset Test (SSP or Medicaid)	States have long had the discretion under federal law to not impose an asset or resource test for Medicaid eligibility.	1=Yes; 0.5=Eliminates for one but not the other; 0=No
Learning	Enrollment, Eliminate Face-to-face Interview (SSP or Medicaid)	Federal law does not require face-to-face interviews at the time of application or renewal in either Medicaid or CHIP. Requiring parents who often lack flexibility to leave work to appear in person to apply for or renew coverage for their children makes it more difficult for parents to seek or retain that coverage.	1=Yes; 0.5=Eliminates for one but not the other; 0=No
Learning	Enrollment, Eliminate Face-to-face interview, parents	States have long had the discretion under federal law to not impose an asset or resource test for Medicaid eligibility.	1=Yes; 0=No
Learning	Presumptive Eligibility, Medicaid	States can authorize "qualified entities" -- health care providers, community-based organizations, and schools, among others -- to screen for Medicaid and CHIP eligibility and immediately enroll children who appear to be eligible.	1=Yes; 0=No
Learning	Presumptive Eligibility, SSP	States can authorize "qualified entities" -- health care providers, community-based organizations, and schools, among others -- to screen for Medicaid and CHIP eligibility and immediately enroll children who appear to be eligible.	1=Yes; 0=No; na=Not applicable
Learning	Presumptive Eligibility, Pregnant Women	The ACA broadened the use of presumptive eligibility to parents and childless adults by allowing states that use qualified entities to presumptively enroll children or pregnant women to extend the policy to parents, adults, and other groups.	1=Yes; 0=No
Learning	Presumptive Eligibility, Parents	The ACA broadened the use of presumptive eligibility to parents and childless adults by allowing states that use qualified entities to presumptively enroll children or pregnant women to extend the policy to parents, adults, and other groups.	1=Yes; 0=No
Learning	Presumptive Eligibility, Childless Adults	The ACA broadened the use of presumptive eligibility to parents and childless adults by allowing states that use qualified entities to presumptively enroll children or pregnant women to extend the policy to parents, adults, and other groups.	1=Yes; 0=No
Learning	Enrollment, Express Lane Eligibility, Medicaid	Express Lane Eligibility (ELE) allows states to enroll children in Medicaid based on findings from other programs, like SNAP.	1=Yes; 0=No
Learning	Enrollment, Express Lane Eligibility, SSP	Express Lane Eligibility (ELE) allows states to enroll children in CHIP based on findings from other programs, like SNAP.	1=Yes; 0=No; na=Not applicable

Compliance	Enrollment Wait Length	States may impose a waiting period to become eligible for enrollment in Medicaid (states range from 0-12 months)	1-(# of months/12)
Compliance	Continuous Eligibility, Medicaid	States have an option to provide 12-month continuous eligibility to children, which enables them to provide more stable coverage by disregarding changes in income until renewal.	1=Yes; 0=No
Compliance	Continuous Eligibility, SSP	States have an option to provide 12-month continuous eligibility to children, which enables them to provide more stable coverage by disregarding changes in income until renewal.	1=Yes; 0=No
Compliance	Renew, Eliminate Face-to-face Interview, SSP or Medicaid	Same description as for enrollment	1=Yes; 0=No
Compliance	Renew, Frequency, SSP or Medicaid	Lower frequency of renewal constitutes less administrative burden	# of months/12
Compliance	Renew, Express Lane Eligibility, Medicaid	Express Lane Eligibility (ELE) allows states to renew children in Medicaid based on findings from other programs, like SNAP.	1=Yes; 0=No
Compliance	Renew, Express Lane Eligibility, SSP	Express Lane Eligibility (ELE) allows states to enroll or renew children in CHIP based on findings from other programs, like SNAP.	1=Yes; 0=No; na=Not applicable
Compliance	Telephone Renewals	Telephone renewals ease administrative burden as opposed to having to renew in person.	1=Yes; 0=No
Compliance	Processing Automated Renewals	Similar to data-driven enrollment, under the ACA, states are to use electronic data when available to renew coverage without requiring an individual to fill out a renewal form or provide documentation. This approach minimizes paperwork for individuals and reduces workloads for states.	1=Yes; 0=No
Compliance	Prepopulated Renewal Form	If a renewal cannot be completed based on available data, states are expected to send a pre-populated notice or renewal form to the enrollee and to allow individuals to renew by phone.	1=Yes; 0=No
Compliance	Renew, Eliminate Face-to-face Interview, Parents	Same description as for enrollment	1=Yes; 0=No
Compliance	Renew, Frequency, Parents	Lower frequency of renewal constitutes less administrative burden	# of months/12



Source: Authors' own analysis of historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per 10,000 population using state population counts from the 1920 Census as the denominator.