Tasha is a twenty-five-year-old Orlando native raising a small child on her own while working part-time and going to college full-time. When I met her in early 2013, she had been on Medicaid for nearly her entire life: first as a child, then as a teenager, then as a new mother. When I asked Tasha what struck her most about using Medicaid for all of those years, she quickly declared: “the clinics.” I probed and she explained this:

On Medicaid … you are assigned to a certain clinic. So, it’s like you have to be in there with all of these people and I don’t like that … I remember in high school getting my tooth pulled and I had to go to this clinic where I’d see bums and stuff outside and I was like [oh] man!

Tasha’s comments focused more on the local context where she received Medicaid benefits as on the services themselves. Living in high-poverty parts of the city meant that she had to go to clinics in downtrodden areas, and this made her experience of Medicaid uncomfortable. Darius, a middle-aged man from Chicago, offered a complementary account by describing the differences in the way Medicaid offices operate on the North and South sides of the city:

On the North Side you go in and basically you talk to somebody and they will get you on the computer, get you the stuff and get you out of there … and somebody sits down with you and [they] tell you what your benefits are and everything … Well now, over here [on the South Side], it seems like so many people, there [is a] backlog … they get tired with so many people coming in … On the North Side I have never had to stand in line … I went in there and got out real fast.

Melissa, a woman from Florida, similarly suggested that at Medicaid offices in West Orlando, “you’re treated differently.” And Zolene, a
Detroit expat living in Ypsilanti, Michigan informed me that one reason she was glad to be out of Detroit was because with “Detroit Medicaid 99.9 percent of the time you have to go outside of your community to see a good doctor.” These beneficiaries were all African-Americans from poor, racially isolated neighborhoods. When I asked them to talk about their experiences with Medicaid, their responses were refracted through the prism of urban inequality. Such observations point toward a question that has been neither asked nor answered about the relationship between federalism and social policy in cities: how do intracity disparities influence policy feedback processes?

**FEDERALISM GOES TO THE CITY**

Since it is not obvious why a book about Medicaid and federalism should focus on cities, it is worth taking a moment to explain. The arms of federalism are far-reaching: they go “all the way down” through states and into assorted substate entities (Frug and Barron 2008; Gerken 2010; Hills 1999; Peterson 1993; Rich 1993). These entities do not have the same degree of autonomy as states, and they do not have as much leverage for making constitutional claims to sovereignty (Gerken 2010), but they nonetheless enter the fray of intergovernmental power sharing via (at least) three avenues. First, cities (or other kinds of municipalities) can be granted power by states (for a variety of reasons, including political commitments to localism and any other state prerogatives that incentivize decentralization). Second, cities can wrest power from states. For example, in places where city delegates are well represented in state government (e.g., Chicago) or where the state government is run from the city center (e.g., Atlanta, Denver), cities do not have complete autonomy, but they do (at times) have the power to override state-level decisions (Frug and Barron 2008). Finally (and relatively rarely), cities can be given power by the federal government that is separate from that of the states. For example, the Community Development Block Grant program (CDBG), a policy descendent of Lyndon Johnson’s Model Cities program, was enacted under Richard Nixon in 1974. Approximately 80 percent of CDBG funds were allocated to metropolitan areas and provided directly to localities, bypassing state authorities. CDBG was thus designed as a largely federal-local program (Wong and Peterson 1986).

Given the range of ways that cities are implicated in multilevel struggles for state power, they are part and parcel of assessing federalism, especially with regards to social policy. The economic, social, and political
security of urban areas hinges on intergovernmental decisions that influence the flow of social policy benefits into cities. Such decisions, in turn, depend on the dynamic relationships between the national center and its periphery, as well as those between subnational units (e.g., states and cities). This web of connections is defined by federalism and it has consequences for the economic and political life of cities.

Since the 1970s, there has been extensive disinvestment from cities on the part of both federal and state governments. This has left cities with a relative dearth of place-based resources (i.e., resources specifically delineated to places as opposed to people), and that deficit contributes to the deterioration of the most needy parts of cities. Put simply: macro-institutional forces of federalism have played a part in generating urban deprivation (Frug and Barron 2008; Warren 1974). This is germane to the extent that urban conditions structure the relationship between social policy and political capacity. Recall the contextualized feedback (CF) model offered in Chapter 2. Key to the CF model is that federalism configures contexts and sets the stage for the design, implementation, and constraints of public policy. Neighborhood environments may act as formidable constraints. Residents’ immediate surroundings can cultivate or amplify the political influence of state and federal policies. It is for this reason that the urban fortunes (or misfortunes) engendered by federalism implicate policy feedback processes.

THE LIMITED CITY AND PEOPLE-BASED POLICY

Cities are major actors that are at times conspicuously absent from the mainstream discourse on federalism. The circumstances of metropoles have ebbed and flowed in tandem with the transformations of federalism over the past fifty years. In 1969, Daniel Patrick Moynihan asserted that “there is hardly a department or agency of the national government whose programs do not in some way have important consequences for the life of cities, and those who live in them” (Moynihan 1969: 11). Within ten years of this declaration, the tide began to turn. For several decades, both federal and state support for cities has waned (Bissinger 1997; Eisinger 1998; Kincaid 1999, 2001; O’Connor 1999; Weir 1996). With a strong emphasis on local control and fiscal belt-tightening, President Ronald Reagan spearheaded the dramatic shift of national antipoverty policy away from place-based policies that tackled the unique challenges of indigent locales and toward people-based policies that provided individuals with relief from penury (Katz 1995; Kincaid 1999, 2001, 2011;

As shown in Figure 6.1, federal grants-in-aid to state and local governments for resources distributed directly to people (such as Medicaid) have increased markedly since the mid-1970s, while outlays for programs aimed at places have plummeted.

Despite often contentious relationships between national, state, and city governments, cities still receive large infusions of resources from national and state governments, but in the form of assistance for people-based programs, with little commitment to places. In 1978, roughly 15 percent of city revenues came from federal aid; today that number is in the range of 1 percent to 3 percent (Kincaid 1999). Between 1980 and 1990, the Reagan and Bush administrations slashed grants to cities by 46 percent (Katz 1995). Funds for low-income housing dried up, Community Development Block Grants were cut by 25 percent, urban jobs programs disappeared, and general revenue sharing – which had formerly provided cities with flexible funding – was eliminated (Katz 1995; Kincaid 2011). As suburban politicians began dominating state legislatures, similar declines occurred in state aid to cities (Katz 1995; Weir 1996). With their well-noted fiscal constraints, cities were not equipped to step in and take on the redistributive role of higher governments (Peterson 1981). Moreover, though local grassroots organizations

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**Figure 6.1** Federal grants-in-aid to state and local governments for persons and places

sometimes rallied to fill the gaps, they proved even more limited than city governments and too frequently accommodated or exacerbated the preexisting boundaries of inequality (Garrow 2015).

Importantly, there is no evidence that this change in the direction of funding was because place matters less for life outcomes. Indeed, the best available evidence demonstrates that place is as important as ever for economic security and mobility (Chetty and Hendren 2015). As national funding for place-based programs decreased, urban poverty and residential segregation – two of our nation’s most enduring place-based challenges – were also on the rise (Bischoff and Reardon 2014). The turn away from place-based federal assistance was not a product of changing needs, it was the upshot of shifting political terrain. A confluence of forces soured the national political standing of cities: white flight, tumbling urban populations, federally subsidized suburbanization, and tough fiscal crises all contributed (Katz 1995). As these developments unfolded, the power of urban electorates was eroded, and both the national government and the states devoted fewer resources to cities (Eisinger 1998; Katz 1995).

What are the implications of these developments for policy feedback processes? There is evidence that place-based resources uniquely affect the material conditions of cities (Neumark and Simpson 2014; Partridge and Rickman 2006). So, to the degree that federalism has a corrosive influence on such resources, it plays a role in structuring the urban landscape. That landscape then bears on the micro-political effects of social policy, connecting federalism to urban processes of contextualized feedback.

MEDICAID BENEFICIARIES ROLLING DEEP IN THE CITY

Medicaid is an especially worthwhile lens through which to consider how such processes operate. Cities contain outsized shares of the nation’s poorest populations and are common sites for major medical institutions. Medicaid beneficiaries are thus disproportionately likely to live in urban centers. To put it quite colloquially, Medicaid beneficiaries roll deep in cities. Table 6.1 shows the percentage of various urban populations that are insured via Medicaid. The percentages for adults and children are separate since they vary so widely. The average numbers for each state are provided for reference. As shown, cities like Los Angeles, Philadelphia, and especially New York (the data are broken down by the four largest boroughs in New York City) have a high density of Medicaid
beneficiaries. For example, in Queens, New York (where I grew up!), nearly 50 percent of children and 20 percent of adults receive health coverage through Medicaid. And that pales in comparison to the Bronx, where nearly 63 percent of children and 33 percent of adults are enrolled in Medicaid. The people represented by those statistics are spread across neighborhoods. As they navigate their surroundings, they encounter conditions that shape how they experience Medicaid. If this leads to differential policy feedback, then the disadvantages of urban inequality intersect with social policy in democratically significant ways.

### Neighborhoods Matter (and Federalism Does Too)

As the national government and states make major funding decisions concerning Medicaid, cities must contend with the needs of their denizens in the face of unpredictably shifting policy trajectories. To boot, the powerful forces of economic deprivation and racial segregation generate a difficult quandary: the communities with the highest density of Medicaid beneficiaries are often the places where racial and economic marginality intersect most perniciously. As the attestations of the folks quoted at the opening of this chapter suggest, this can lead to distinct policy experiences for beneficiaries within the city, producing political effects that are differentiated by place.

#### Table 6.1 Medicaid Density in Urban Centers

<table>
<thead>
<tr>
<th>State or City</th>
<th>Average (child)</th>
<th>Average (Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>45.6</td>
<td>22.8</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>50.0</td>
<td>26.0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>34.3</td>
<td>12.2</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>53.3</td>
<td>20.6</td>
</tr>
<tr>
<td>Illinois</td>
<td>37.8</td>
<td>14.6</td>
</tr>
<tr>
<td>Chicago</td>
<td>42.2</td>
<td>10.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>30.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Denver</td>
<td>39.9</td>
<td>11.0</td>
</tr>
<tr>
<td>New York</td>
<td>30.5</td>
<td>14.9</td>
</tr>
<tr>
<td>Bronx</td>
<td>62.6</td>
<td>32.5</td>
</tr>
<tr>
<td>Queens</td>
<td>46.4</td>
<td>19.8</td>
</tr>
<tr>
<td>Kings (Brooklyn)</td>
<td>50.1</td>
<td>26.0</td>
</tr>
<tr>
<td>New York (Manhattan)</td>
<td>40.1</td>
<td>15.8</td>
</tr>
</tbody>
</table>
Though little research directly explores this, tangential scholarly knowledge substantiates its pertinence. Social scientists spanning several disciplines have consistently demonstrated that cities are bastions of inequality and that neighborhoods exert tremendous social and economic influence (Chetty and Hendren 2015; Chetty, Hendren, and Katz 2015; Dreier, Mollenkopf, and Swanstrom 2004; Jargowsky 1997; Massey and Denton 1993; Sampson 2013; Sharkey 2013; Wilson 1987). Building on this, political scientists have established the significance of neighborhoods for political participation (Alex-Assensoh 1998; Cohen and Dawson 1993; Gay 2012; Huckfeldt 1979; Huckfeldt and Sprague 1993; Michener 2013). Economists have also shown that local contexts shape the effectiveness of antipoverty policy (Blank 2005; Partridge and Rickman 2006). In sum, neighborhoods matter for people, politics, and policy – and federalism matters for neighborhoods (Keating and Krumholz 1999; Warren 1974).

With this in view, I inquire about how urban contexts shape denizens’ experiences of Medicaid. Drawing on in-depth interviews, I develop hypotheses about how neighborhoods structure the Medicaid-to-politics link. I then examine survey data to test those hypotheses.

MEDICAID AND URBAN INEQUALITY: MAPPING THE PATHWAYS OF INFLUENCE

It is not patently evident how local context is related to Medicaid policy. Fortunately, the beneficiaries I spoke to elaborated on how neighborhood-level processes of political learning occurred. Foremost in these descriptions were references to the maze of institutions that Medicaid entangled beneficiaries in: hospitals, community health centers, social service departments, nonprofits, and schools. Since many of these organizations were located in the neighborhoods where beneficiaries lived, whatever occurred within them simultaneously reflected the realities of place and policy – a distinction that beneficiaries rarely made. That is why when Tasha considered Medicaid she thought of “clinics” and the frightening people who loiter near them, Kim remembered the “nasty” lady at the welfare office “down on Western Ave.,” and Lucy recalled the neighborhood school that would not enroll her children unless they got the very immunization shots that Medicaid was refusing to pay for (she wondered: “Couldn’t the school talk to the Medicaid people?”).

These beneficiaries conveyed narratives that prominently featured local institutions and they readily supplied commentary on the significance of
neighborhoods in relation to their experience of Medicaid. Such observations did not surface among middle-class beneficiaries who resided in more advantaged places. Instead, neighborhoods mattered most for those upon whom they conferred the most disadvantage: African Americans living in poverty. And they mattered enough that beneficiaries consistently referenced neighborhoods with no prompting on my part. In fact, at the time I was conducting the interviews, I did not fully grasp the relevance of neighborhoods, so I did not ask directly about them. Nevertheless, many beneficiaries independently underlined this aspect of their lives because it was part and parcel of their thinking about Medicaid.

Specifically, interviewees noted two facets of local context that sensitized them to policy dynamics in politically relevant ways: 1) neighborhood disorder; 2) neighborhood social cohesion. Beneficiaries living in places they perceived as disorderly and socially dislocated recounted negative and disempowering experiences with Medicaid. Let’s consider the significance of each factor from the viewpoint of beneficiaries.

Disorder from Daphne’s Perspective

I follow Skogan (2012: 174) in characterizing disorder as “unsettling or potentially threatening and perhaps unlawful public behaviors” and “overt signs of negligence or unchecked decay as well as the visible consequences of malevolent misconduct.” Indicators of disorder include public drinking or drug use, visible litter or paraphernalia, vandalism, graffiti, drug sales, street fights, and more. Hospitals, clinics, and Medicaid offices located in neighborhoods plagued by disorder bring difficult contextual realities to the fore at inopportune times: during medical emergencies, when a child is sick, or when a tooth is aching. Visceral reactions to potentially “dangerous” people loitering outside of a place to which you must go in order to secure health services does not cultivate confidence in Medicaid or the government that subsidizes it.

To illustrate the complex and multivalent ways that place matters in this regard, I highlight Daphne, the young black woman from Syracuse introduced in Chapter 1. Remember that Daphne has been on Medicaid for her entire life, and her “whole family” was enrolled as well (including her mother, grandmother, aunt, and brother). Though Medicaid was all Daphne had known, she realized that it was different from private insurance. For much of her life, Daphne’s mother took care of the details of enrollment and recertification. But as soon as she turned eighteen, she
was required to apply on her own. This was her first indication of something distinct about Medicaid. She observed that:

Some of my friends, they stay on their parents’ until they’re like twenty-four, twenty-five or six. Yeah, so they stay until they’re twenty-six and I just thought that was interesting that they could stay until they’re twenty-six and then they have to get their own policy, but when you’re on Medicaid, when you’re eighteen you have to get your own and you have to apply.

Though the application process itself was rather smooth, Daphne faced some of the challenges that I have discussed in previous chapters regarding staffing, agency responsiveness, and overcrowding. Crucially, many of these difficulties were associated with a specific health center that had special significance for Daphne:

*I really don’t like going to the health center. It’s an older building. It’s a lot of people. A lot of people, they’re there, they’re kind of upset, the waiting rooms are always filled. You’ve got to go in – people be waiting hours, and some people have kids and they’ve got jobs they’ve got to get to, so they get annoyed or they start getting irritated and start raising their voices or being impatient, like just frustrated. I don’t know if they even have air conditioning in there. I don’t even like going … But yeah, it’s just a long process and then I feel like the people in the back [who] work there, I feel like they’re understaffed and people are frustrated with them so they just are not the most pleasant people to speak to* (emphasis mine).

Before long, Daphne extended her observations to the neighborhood surrounding the clinic:

*It’s kind of like downtown … I mean, like right there you have the shelter. And then a lot of people who go to the Salvation Army shelter, a lot of them are on drugs and stuff … I would hear about people being robbed over there, being robbed early in the morning. It’s just, you’ve got to be careful. There’s a lot of sketchy people over there. And it’s definitely downtown. There’s a lot of sketchy people downtown. A lot of people don’t go downtown. A lot of the wealthier people go to Armory Square, but you wouldn’t see the wealthy people downtown. You’d see them in the nicer part of downtown like the Armory Square. You wouldn’t really see black people over there [in Armory Square]. But *I wouldn’t say [the clinic] is in a good neighborhood. It’s kind of going toward the hood. It’s like right down the street [from the hood] (emphasis mine).*

Later in the interview, Daphne reiterated, “I just don’t like going to the health center. I do try to avoid it.” But she could not avoid it because her aunt has “special needs” and had to be taken to appointments at the health center. Daphne even noted memories of going to the center as a child. When she thought of Medicaid, she had years of experiences
linking the program with a particular place and that place represented disorder: robbery, open drug use, homeless shelters, and people loitering.

Interestingly, when the conversation turned to politics and power, Daphne's views continued to be filtered through a prism of place. Take this exchange, for example:

**ME:** Do you think if people who were on Medicaid wanted to do anything to change the program or change Medicaid policy, do you think they have any power? Do you think they would be able to do that?

**DAPHNE:** I don't know how they can. I don't know if they do have any power to change it, but I believe they would like to change things and how everything works. Because it's ridiculous how you get treated and how you [can] be in the office for hours. I bet that doesn't go on in Fayetteville or Cicero or North Syracuse. That's just unheard of. People are in and they're out when they have appointments ... I feel like it is different in different places ... [like] say if you're at an Olive Garden or you go to a Burger King, they treat you really different.

**ME:** Okay, so do you think that those experiences that you just described, do you think they have anything to do with the political system?

**DAPHNE:** Yeah, I think everything has to do with politics, just there's like winners or losers. I can't really describe. I think everything has to do with politics. They don't care about the poor unless they want the black vote. I know Hillary Clinton was visiting upstate New York and New York [City]. *The hoods and stuff like that, you never see her in there.* And I just heard her say, like people have videos of her saying different things and contradicting herself, and yeah, I just feel like everything has to do with politics.

**ME:** So ... what do you think the main barriers are that prevent Medicaid beneficiaries from being able to have an influence?

**DAPHNE:** Well, I just think a lot of Medicaid people ... I feel like sometimes I don't really think they understand politics, and a lot of them are not really well educated. So sometimes it's kind of frustrating to sit and listen when you don't really know what they're talking about, or just hear terms and you just don't really know the basic economics. I kind of know more because I go to college and I talk to people about it. I definitely had to learn certain things, because I didn't really know what it meant ... I just think a lot of people, when the polls are open, if people have jobs, like low-income jobs that they're working, some people work like two to three jobs just to make ends meet, so I don't even think they have time to go to the polls to vote. And I just think a lot of people have trouble with the law. I don't even think they can vote, if you have like a felony or something. Like I know our population deal[s] with mass incarceration, so even that too. So I feel like sometimes the system, it's made for us to stay down and to stay on Medicaid ... it's hard to get out of it, to climb out.

As a young black woman from a rough neighborhood, Daphne proved impressively familiar with the many barriers to political participation facing people in her community. She suspected that political elites like Hilary Clinton avoided communities like hers (“the hoods and stuff like...”)
that”) and she sensed that outcomes would be different for people who lived elsewhere (“Fayetteville or Cicero or North Syracuse”). All of this created a wellspring of mistrust that flowed into her outlook on policy. For example, when I asked Daphne her thoughts on “Medicaid expansion,” she keenly homed in on the fact that the expansion had not happened uniformly across states:

I don’t really like the state choosing things. Yeah, I don’t really trust the state and the politicians. I don’t know. I just think everybody having the same access and it being the same everywhere, I think that would be more helpful instead of having all these rules and here and there, and you’ve got to apply for insurance. I wish it was just nationwide, like you’re just not insured if you’re insured in New York State but if you move somewhere else you have to reapply. I know a lot of jobs moved, like Chrysler was big in upstate New York and then they moved to Detroit, and people had to move with their jobs and you probably discouraged them from moving because they probably wouldn’t qualify for insurance there and they’d have to stay here and loss of a job they had out of high school making good money. I don’t know. Like I just wish it was the same nationwide and not just the state, because I don’t think the state could be trusted, honestly. We can’t even trust our police force.

Throughout her life, Daphne had traumatic experiences with the police in Syracuse. She told me that police targeted neighborhoods like hers and the people living in them. Because of this, she did not trust the police and by extension, she did not trust New York State. Such localized perspectives came to define her attitudes toward Medicaid policy (“I wish it was the same nationwide”).

Like Daphne, many of the African-American beneficiaries I spoke with described the physical conditions of neighborhoods in the course of explaining their experiences with Medicaid. Mabel, an African-American woman in her early sixties who lived on the South Side of Chicago, explained the difference between applying for Medicaid on the South Side and doing so when she had lived in “middle-class” suburbs. On the South Side, the building was “nasty” and the line was out of the door. Mabel was so turned off by the environment that she did not even stay long enough to apply. Though she was a diabetic and needed health coverage, she chose to go home rather than to wait in the place where had gone to apply. Alternatively, during a brief stint living in the suburbs, she experienced something very different:

When I was in the suburbs you didn’t see the welfare office because I lived in a part of the suburbs, middle class or whatever. They didn’t have any welfare office, you know what they have? … the welfare office is in the bank building and I went...
in there to get a medical card and I was out in like ten minutes. They are very kind and very nice and very helpful, but you couldn’t do that here [on the South Side]... there’s a difference.

Mabel eventually had to move from the suburbs back to the city for “financial reasons.” By the time of our interview, her Medicaid enrollment had lapsed, but she was reluctant to go to the local office to reenroll. Instead, she had been making do by going to a health clinic. Recent news that Cook County would be closing some of its clinics was causing her major stress, enough that she contemplated applying for Medicaid again.

I’m afraid that when they do [close the clinics], if this goes any further, then I’m going to be broke. And I can’t still afford to pay my insurance or my medical bills, I can’t afford to pay ... I do need to go and stand in somebody’s line to get some medical help.

Soon after discussing her medical situation, I asked Mabel what, if anything, people like her could do to change such situations and what role the government should play. Her response betrayed a dim view of politics:

I don’t know what, but I’m sure there is something that we can do. You know, like vote. It’s supposed to be making a difference if you vote ... and it did make a difference in November [2008], but we vote for everything else and we don’t get it ... that is why you ask me about government, I’ll be saying I do not know what’s going on there.

Mabel had a vague sense that people should be able to do something and that voting might be related; she viewed the election of Barack Obama as a signal that voting sometimes worked, but when it came to the specifics of her life, she was hard-pressed to see how the government had been very helpful. Things like the deteriorated conditions of the building where the Medicaid office was located were very proximate signals of disorder that directly shaped her experiences with public policy.

Social scientists across a range of disciplines have accumulated evidence of the multifaceted effects of disorder on social, economic, psychological, and political outcomes (Casciano and Massey 2011; Christie-Mizell and Erickson 2007; Hill et al. 2005; Michener 2013). This growing literature confirms that disorder works mainly by shaping the lenses through which residents view their communities and their experiences within them (Hwang and Sampson 2014; Michener 2013; Murphy 2012; Sampson and Raudenbush 2004; Wallace, Louton, and Fornango 2015). Daphne’s narrative demonstrates something else about neighborhood disorder: it structures people’s experiences with social policy in ways that reflect
badly upon government. Given this, I hypothesize that there will be a stronger negative association between Medicaid and political participation in neighborhoods perceived as disorderly (H1).

Neighborhood Social Cohesion: Making It Through Together

As a key aspect of urban life, social cohesion is the network of relationships, values and norms of residents in a neighborhood (Friedkin 2004; Rios, Aiken and Zatura 2012). Cohesion facilitates access to concrete goods and services; without it, people must navigate neighborhood minefields alone. That means not having people who can tell you about the high quality clinics or nursing homes to go to, the right doctors to see, or the best social service organizations to get you signed up for Medicaid. Though not as prominent in my conversations as disorder, networks were often invoked by the beneficiaries I spoke with. In particular, they described how social connections equipped them with the knowledge necessary to adeptly traverse local terrain. Frankly, even (relatively) economically advantaged beneficiaries needed such knowledge to avoid ending up in places that are detrimental vis-à-vis Medicaid. Take Kay, for example. She made an effort to ensure that her family’s move from Iowa to Minnesota would land them in just the right part of Minnesota: near the children’s hospital of their choice and in a neighborhood with the best services. She explains it this way:

We talked to Brian’s neurosurgeon … and said, “Tell us what you know” … And so he said there’s a few social workers in the organization he really trusts and then he said, “Let me see if one of them appears today.” … So they pulled a social worker in, and so she explained to us how the counties manage the Medicaid, and so she said, versus if you go to a more heavily populated county, there’s more people pulling for those dollars. She said, “You know, it’s supposed to be divided up per capita, but if you imagine a lot of people needing those dollars, the kids with special needs may not get as much as they could in a less populated area.” So then knowing that, then we began the search of which school district has the best services for children with special needs and then we talked to several doctors, several families, I talked to parents, and then figured out where that was, and then homed into that county, that school district, here is a neighborhood that we can buy in.

As a middle-class, well-educated person, Kay forged connections that went beyond her neighborhood. Her family had the resources to select into the place that would best meet her son’s needs. Most low-income beneficiaries do not have such networks, nor can they freely choose the best place to live. What they can do is leverage local ties to more successfully
navigate community institutions and service providers. Lucy gave several examples of how she uses her familiarity with the community to help when she sees her “friends struggling.” For instance, she noted that “some of my friends, they go to a doctor’s office. There are predominately white doctors … but I go to a doctor’s office where it’s Indian doctors who are already a minority … so I do not get treated [in] any different way [there].” By passing such information onto her friends, Lucy helps them avoid instances of racial discrimination that many beneficiaries described having. Similarly, Terrie remarked that she and a friend who is also on Medicaid have been “helping each other out with [Medicaid] since we met.” Most arresting is Louisa’s story of learning about which local hospital should be avoided at all costs because of an experience that her friend, a fellow beneficiary, had told her about. Louisa described the hospital’s treatment of her friend in horrid specificity saying:

She was on Medicaid when she had her baby [and] they actually left a piece of her placenta in there, in her stomach. So you know … when you are pregnant you stay at the hospital maybe two days, then they release you; she went home [and] started having real high fevers and … she had to go to the emergency room. She’s been in and out the emergency room for a while because of the placenta, piece of her placenta being left.

Indeed, when I used snowball techniques to recruit interviewees, some beneficiaries could easily point me to friends who were in the program. Others however, drew total blanks and said that they did not know any other Medicaid beneficiaries. Such social linkages (or lack thereof) may bear upon beneficiaries’ ability to cope with (or avoid) Medicaid’s place-specific challenges, and thus affect how they experience the program. If so, Medicaid should have a stronger negative effect on local political engagement among those who view their neighborhoods as socially disconnected (H2).
neighborhoods. While the CCAHS’ singular emphasis on Chicago limits its breadth, it offers unparalleled depth. First, it covers a much wider range of variables than the traditional data sets that political scientists rely on. Second, Chicago contains widely recognized neighborhoods that closely match the CCAHS neighborhood clusters. This ensures that the geographic level of analysis that demarcates neighborhoods accurately represents local residents’ experiences of neighborhood spaces. Third, Chicago is a preeminent urban center that, while not representative in a strict sense, is a strong basis for asserting the relevance of a particular urban phenomenon. If Chicago neighborhoods shape the way Medicaid policy effects political participation, then there is good reason for inquiring about whether the same holds true in other places.

I base the analyses on a composite measure of participation that captures a wide range of nonvoting political activities, many of which are directly or indirectly linked to the local environment. This index of political activities combines information about whether respondents have engaged in the following activities over the past twelve months: (1) signing a petition; (2) attending a political meeting or rally; (3) working on a community project; (4) participating in demonstrations, protests, or boycotts; (5) participating in a group that took local action for reform; (6) participating in an ethnic, nationality, or civil rights organization; (7) participating in a labor union.  

The control variables are standard for models of political participation: age, sex, education, income, race (indicators for African-American and Latino, respectively), nativity (whether the respondent was born in the United States), and health. I also control for neighborhood characteristics: the local rate of family poverty and the proportion of African-American residents.

The key independent variable is a measure based on respondents’ report of their source of health insurance. Approximately 8 percent of the CCAHS sample was enrolled in Medicaid.

Given the use of observational data and its accompanying limitations, these analyses aim to explore the relationships between Medicaid, political behavior, and neighborhood context, but cannot support unequivocal causal arguments about those relationships. Though I do not to claim dispositive certainties, I present important evidence that the relationship between Medicaid and political engagement is contingent upon neighborhood context.

I address the nested structure of the data (some of the variables are measured at the level of the neighborhood) via multilevel modeling.
Multilevel regression is an approach well suited to questions that involve hierarchical data (Raudenbush and Bryk 2002; Steenbergen and Jones 2002). I begin by using the CCAHS data to duplicate the findings from Chapter 4 (which were based on the Fragile Families Survey). This baseline model (see Appendix B, Table B8) estimates a multilevel regression with the political participation index as the outcome, Medicaid receipt as the key independent variable, and all of the individual-level control variables. It also includes the two contextual variables (neighborhood race and neighborhood poverty). The results confirm a significant negative relationship between Medicaid and political participation, even after controlling for local contextual factors.

Next, I move on to the more nuanced analysis suggested by the hypotheses developed in this chapter. Extending the baseline model, I add a variable for perceptions of neighborhood disorder and one for perceptions of social cohesion. Since prior research indicates that perceptions of disorder can display a curvilinear relationship with participation, I also include a quadratic term to account for potential nonlinearity (Michener 2013). Finally, since the hypotheses point to interactive effects (i.e., the relationship between Medicaid and participation will vary based on perceptions of disorder [H1] and cohesion [H2]), I add interactions between Medicaid and the perceptions variables. For simplicity, these continuous scales are converted into categorical variables indicating whether perceptions of disorder and cohesion were low, moderate, or high.

The results show that perceptions of cohesion and disorder are significantly and positively associated with political engagement. Individuals who score high on the neighborhood cohesion scale are more likely to participate (see Appendix B, Table B9). Disorder is also positively correlated with participation, which may seem counterintuitive, but since the quadratic disorder term is negative and significant, this denotes that the relationship is curvilinear. Participation rises along with negative perceptions of disorder, but at a decreasing rate. So those with moderate perceptions of disorder are most likely to participate, while those at the extremes (either most or least aware of disorder) are less likely to take political action.

The key findings for our purposes concern the interaction terms. How do perceptions of disorder and cohesion moderate the link between Medicaid and participation? First, the results reveal a significant association between participation and the interactive disorder term. Since interactions can be difficult to interpret, I display this correlation graphically in
Figure 6.2. The figure highlights patterns among Medicaid beneficiaries, showing that beneficiaries who perceive very little disorder in their neighborhoods are most likely to participate, while those who perceive the most disorder are least likely to do so (unlike the direct effect of perceptions of disorder, the interactive effect is linear). Since the standard deviation of the participation index was 1.3, the decrease shown represents a little less than one-third of a standard deviation.

Unlike disorder, there was no significant interactive association between Medicaid and neighborhood social cohesion. This does not prove such a relationship is nonexistent, but it means the analyses do not corroborate its existence. Keeping in mind that the number of Medicaid beneficiaries in the sample was relatively small and the interactive variables were highly correlated (0.70), it is possible that the CCAHS data are not best suited for detecting an interactive association between Medicaid and cohesion. It is also possible that cohesion is not enough of a driving factor to exert an effect over and above disorder. Disorder certainly loomed larger in the qualitative accounts than cohesion did. While cohesive networks are useful for navigating the challenges of Medicaid, they do not mark its very infrastructure. By comparison, disorder is more profound.
and harder to ignore. Robberies and drug addicts near the biggest clinic in town, long lines of beneficiaries stretching down the litter-filled and dangerous block outside the Medicaid office – these experiences trigger a memorable and visceral reaction and they forge a link between the harsh realities of urban inequity and the limited capacity of the very state that is providing health benefits.

Such possibilities aside, I do not offer the final word on whether the non-significance of the cohesion interaction indicates that it has no effect, or whether the data and analysis utilized here simply cannot detect such an effect. These relationships are important enough that the analyses offered here should not be considered the final word, but the opening salvo.

Perhaps most incisively, the non-significance of the social cohesion interaction suggests that the significant interaction between perceptions of disorder and Medicaid is not simply reflective of a nonspecific pattern that will emerge anytime one interacts a proxy for neighborhood disadvantage with Medicaid enrollment status. This is not simply a case of people who live in “bad” neighborhoods participating in politics less because they are poor (and thus more likely to be Medicaid beneficiaries) or because they experience negative environmental externalities. The intervention I make is more pointed: particular kinds of neighborhood conditions (i.e., those that connect disorder to the local institutions that supply Medicaid services) bear upon the experiences of Medicaid beneficiaries and thus shape the program’s individual-level political effects. The crux is this: though Medicaid beneficiaries take political action less frequently in general, those beneficiaries who face certain kinds of contextual challenges (specifically, high levels of perceived disorder) participate even less (after accounting for individual socioeconomic factors, neighborhood poverty, neighborhood racial composition, and more).

CITIES MATTER

I submit multipronged evidence that the places in which policies are enacted shape their political consequences. As intimated by the contextualized feedback framework, I build on the tradition of policy feedback, with an added focus on how contextual conditions shape the interpretive effects of social policy. Bridging the tacit divide separating research on social contexts from studies of policy feedback, I illuminate a neglected nexus between policy and place. Productively merging meso- emphases on social policy with micro-orientations toward concrete urban environments, I find that experience with Medicaid dampens the proclivity for
local political activism among beneficiaries who perceive disorder in their neighborhoods more than it does for beneficiaries who are not as cognizant of disorder.

Policy feedback processes do not unfold apart from larger contexts of inequality. To the degree that urban inequality leads to divergent perceptions of phenomena like neighborhood disorder, it can also amplify disempowering feedback cycles. In this light, investments in people-based policies like Medicaid are perhaps best complemented by initiatives to improve the places where beneficiaries live (Blank 2005; Partridge and Rickman 2006). However, when intergovernmental conflicts pit national or state authorities against cities, wide scale support for place-based policy dwindles. Take for example, President Trump’s threat to rescind federal funds from immigrant-friendly “sanctuary cities.” A battle between cities and the federal government over the proper jurisdiction of their powers is possible only because of the federated structure of our political system. Yet, if such a scuffle leads to decreased federal funding for cities, then place-based urban policies will suffer and urban denizens’ primary form of federal support will be through people-based policies like Medicaid. The evidence I present in this chapter highlights one (additional) reason why that is problematic. People and places are closely intertwined, so implementing people-based policies in places marked by deprivation can undermine the democratic life of those very communities.

In a milieu of contentious federalism marked by urban retrenchment, policies that are exclusively people-based may exacerbate the deep inequalities that presently plague American cities. To be clear, the problem is not federalism. Nor is it people-based policies. Both can be leveraged for the good of marginalized populations. The challenge lies in harmonizing people- and place-based policies in ways that draw on the strengths of each, while mitigating their weaknesses. What does this look like in practice? Ultimately, policy makers (and the citizens who empower them) must decide the details. My primary purpose is to signal that we should take great pause when policies are designed to serve floating people without recognizing their attachment to places. A well-functioning institution of federalism should emphasize the prerogatives of both. Katz and Bradley (2013) give us a glimpse of what they think that this implies for federalism:

The federalism that best serves the cities and metros that drive economic development in the 21st century is not the traditional “dual sovereignty” that splits power between federal and state governments according to subject matter – but a form of collaborative federalism in the service of cities and metros that set priorities
People, Places, and Social Policy in the City

and lead implementation. This requires a re-sorting of the roles and responsibilities of government that focuses on how the constitutional sovereigns – the state and federal governments – interact with their city and metro partners across the private and public sectors to co-produce the public good.

House Representative James E Clyburn (D-SC) has for years advanced his own, more concrete vision of what place-sensitive federal policy should look like. Clyburn has repeatedly advocated for the 10–20–30 initiative, a proposal requiring that at least 10 percent of federal funds for a given economic project be devoted to counties that have had at least 20 percent poverty rates for more than thirty years. (These places are called persistent-poverty counties.) When Clyburn was able to get a 10–20–30 provision applied to the 2009 Recovery Act, it prompted $1.7 billion worth of economic development projects in low-income urban and rural communities across the nation. This policy tool only dictates how funds that have already been appropriated are distributed (10 percent goes to persistently poor counties); it does not introduce any additional costs. In addition, the 10–20–30 plan benefits both rural and urban counties, both Democratic and Republican constituencies. For this reason, Clyburn offers it as a bipartisan strategy for addressing place-based poverty.

I do not introduce Clyburn’s idea as a solution to the now decades-long neglect of the unique problems faced by poor communities in the United States. That would be premature. Further still, truly transformative political strategies to balancing place-based and people-based needs will necessarily involve infusing resources, not only reshuffling them. Nevertheless, I bring up 10–20–30 to illustrate a policy possibility: it is an alternative approach to poverty alleviation that incorporates states, counties, and cities with a focus on the economic and political incorporation of marginal groups. The findings offered in this chapter suggest that an investment in policies that prioritize such imperatives doubles as an investment in American democracy.