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Is a Legacy of Racism Shaping Racial Coverage Gaps through the Medicaid Program?[1]

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Racial and ethnic disparities in health insurance coverage are known, but we know little as to whether legacy racism could be shaping racial coverage gaps through Medicaid policy. Using a novel database of Medicaid administrative policies linked to historical lynching data and the Current Population Survey's 2001-2006 Annual Social and Economic Supplement, we explore the plausibility that Medicaid eligibility and administrative burdens–the difficulty potential enrollees face in gaining entry into the program–are 1) partly associated with historical lynching, and 2) whether lynching–as a proxy for long-standing racial animosity–could be determinant to coverage disparities between Blacks and Whites. We find evidence some fraction of the health insurance coverage disparities is associated with legacies of racialized violence toward American Blacks–as measured by historical lynching. The extent that legacy racism is shaping coverage disparities through under-participation in Medicaid by Blacks is mixed from our study; however, we do observe some patterns consistent with Medicaid policies corresponding to historical lynching. Our findings highlight some potential links between racial animosity, coverage disparities, and Medicaid operations. Our findings also support prior work detailing racialized politics shaping other social programs.

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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 healthcare among many of the nation's most economically vulnerable and medically underserved. Program eligibility are a key policy determinant shaping not only program entry, but plausibly broader inequities in health insurance coverage and health. State decisions in administering Medicaid can facilitate health improvement in the short run as well as over the life course (Boudreaux et al., 2016; Miller & Wherry, 2019; Wherry et al., 2018; Wherry & Meyer, 2016). As decisions to expand access to Medicaid can be welfare-enhancing, decisions to restrict Medicaid access can have important negative consequences.

While Medicaid policy debates can run politically contentious, framing around Medicaid can include discussions of moral obligations to those in need, fiscal responsibility, ideological alignment, to outright political opposition (Rozier & Singer, 2016). Although state decisions to restrict Medicaid access could be attributable to political and social ideology differences, whether they are also motivated in part by racial discrimination is less pronounced. Medicaid has a key role in shaping coverage disparities, and this study explores the extent that Medicaid policies, health insurance coverage disparities between Black and White Americans could be attributable to legacy racism. In particular, we explore whether historical lynching–a frequent tool of racialized violence–is associated with differences in health insurance coverage status and Medicaid enrollment. 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 (Hill et al., 2024). Following the ACA's full implementation, the Black-White uninsurance gap narrowed to 11% uninsured among non-Hispanic Blacks and 8% among non-Hispanic Whites through 2022. 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 (Hill et al., 2024). However, the reduction in Black-White coverage gaps is smaller than it would have been if all states had adopted the Medicaid expansion.

Resistance to the Medicaid expansion has been principally political in nature, but there is evidence suggesting the decisions were 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 core ACA provision optional, and Southern states with larger Black populations were especially unlikely to plan to move forward with expanding Medicaid (Nolen et al., 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 & Quadagno, 2015). Grogan and Park (2017) found that racialized politics can be linked to democratic deficits across states whereby Medicaid expansion decisions were a) responsive to White public opinion about the ACA and Medicaid expansion relative to public opinion among non-Whites and b) unresponsive to nonwhite support of the ACA (C. M. Grogan & Park, 2017). Tesler (2012) found that racial attitudes had a significantly larger impact on health care opinions early into then-President Obama's presidency compared to the two decades

prior before Obama became the face of the ACA, suggesting that the racialized conflicts of the Obama Presidency had spillover effects onto how many felt about the federal government and healthcare reform (Tesler, 2012). As of June 2024, 10 states that have not expanded under the ACA (KFF, 2024); and the Black-White coverage gap is larger among the states that have not expanded relative to the states that expanded Medicaid eligibility under the ACA (Baumgartner et al., 2023). 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 & Patton, 2019).

While eligibility guidelines are a key pathway of entry into Medicaid, adopting onerous administrative procedures can confer hidden costs on program claimants that create uncertainty about eligibility status, deter initial enrollments, and create coverage disparities in maintaining enrollment among otherwise eligible persons (Bradley Corallo et al., 2021; Corallo & Mehta, 2021; Pillai & Artiga, 2022; Sugar et al., 2021; Williams et al., 2022). Sufficiently burdensome procedures make the process of seeking and maintaining benefits complex and difficult to navigate. Although states are provided substantial latitude in how they operate and administer their programs, enacting administrative burden are effectively "policymaking by other means" whereby, on one hand, expand guidelines to include larger shares of a one group, they can apply administrative burdens disproportionately to another group as a means to exclude potentially eligible persons (Herd & Moynihan, 2018, 2020; Ray et al., 2023).

In our study, we explore a plausible contributor to Medicaid's design across the states and whether this contributor to Medicaid program design may shape coverage disparities. First, we explore whether health insurance coverage disparities are associated with 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.

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 et al., 2021). The potential distributive consequences of administrative burden in terms of the tendency of burdensome rules to deter those with fewer resources and more time constraints from accessing benefits more frequently (Herd & Moynihan, 2018). Moreover, representative bureaucracy theory suggests passive racial and ethnic representation can produce active representation–policies that benefit minorities (Meier et al., 1999).

Racial Animosity shaping US Healthcare and Social Programs

Racialized politics observed surrounding the ACA's Medicaid expansion are not new (Nolen et al., 2020)–patterns of racialized politics in Medicaid and other social policies have long been a defining feature of the American welfare state. For instance, 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, p. 2). 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 more on private rather than public funds for welfare provision (C. Fox, 2012). Racialized politics 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 Congressmen refused to support any legislation that put money in the hands of Southern sharecroppe(J. S. Quadagno, 1994). Racialized politics of the welfare state did not stop with the Civil Rights movement; rather, they 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. Then-president 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 evolved from overtly racist to more covertly racist. For example, even though racial discrimination in healthcare facilities was outlawed–via a financial penalty–healthcare facilities remain largely racially segregated (Alexander & Currie, 2017; Arnett et al., 2016; Ko & Ponce, 2013; Smith, 2007; White et al., 2012). In short, although racial violence and discrimination in the form of lynchings largely disappeared by the early 20th century, researchers have demonstrated how these more overt forms of racial terror have been

replaced with a form of poverty governance that continues to operate as a covert means of racialized social control (Soss et al., 2011).

Racial Animosity and Medicaid Policy

While the most recent major policy changes to Medicaid were whether states expanded eligibility under the ACA, Medicaid's origin were not so different. After mathing federal funds were made available to Medicaid being enacted federally in January 1966 (i.e., federal matching funds were made available to states), only 26 states adopted Medicaid by January 1967, and it was not until October 1982 when all states had adopted Medicaid (The Henry J. Kaiser Family Foundation, 2012). During this time, only state former Confederate state (Lousiana [July 1966]) in addition to three other former slave-holding states adopted Medicaid: Kentucky (July 1966), Maryland (July 1966), and Delaware (October 1966). With respect to the ACA's Medicaid expansion, 7 (Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas) of the 10 remaining non-expansion states are former slaveholding states and former members of the Confederacy.

For states resistant to adopting Medicaid in the 1960s and later expanding Medicaid under the ACA, that resistance can shape how they administer the program as well as shape participation and Medicaid experiences. Racial resentment could shape Medicaid operations and influence Medicaid's capacity to affect health equity (Braveman et al., 2022; A. H. Chen & Ghaly, 2022; Nolen et al., 2020; Tripoli et al., 2021; Twersky, 2022; Yearby et al., 2022). Michener highlights how federalism–the 'partnership' between states and the federal government–can contribute to disparities in navigating the Medicaid program (J. Michener,

2018). Furthermore, racialized politics that undermined the ACA may contribute to health inequality in other ways (J. D. Michener, 2021).

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 (Ray et al., 2023). 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 et al., 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 requiring 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 states where African-Americans comprise an outsized share of Medicaid beneficiaries may constitute a hidden form of racialized social control.The racialized application of administrative burdens may therefore be considered a form of institutional isomorphism - a continuation of past exclusionary policies in a new, more hidden, form (Ray, 2019).

However, 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 (Brooks & Manza, 2008; Gilens, 1995, 2009). While these approaches provide a useful window into individual-level social psychological processes underlying 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.

Legacy Effects of Lynchings and Racial Violence

Scholarship on lynchings, especially lynchings carried out against African-Americans in the postbellum South, point 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 cultural beliefs held by many at the time. Thus, there is 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.

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 & 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 (Ford, 1948, p. 19; Rable, 1985). Obstruction to the federal-level antilynching efforts were historically concentrated in Southern states–particularly states with higher levels of anti-Black violence (Cook et al., 2018a; Pinar, 2001), and we hypothesize restrictive and administratively burdensome Medicaid guidelines could be a reflection of institutionalized racial animosity and anti-Black attitudes.

Although there is temporal distance between Medicaid's inception and the period of extensive use of lynchings, historical lynchings can leave a legacy of adverse effects that 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 policymaking. Frequent occurrences of racialized violence 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 (Cook et al., 2018b; Gabriel & Tolnay, 2017). Other work found 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 with long-run health inequities such as being correlated with the social factors contributing to lower life expectancies among Blacks in the US (Kihlström & Kirby, 2021). In utero exposure to area-level lynching is associated with lowered life expectancies for Black men (Vu et al., 2023).

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 (ASEC)—also known as CPS' March Supplement. The 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). 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 plausible midpoint to standardize the number of lynchings as a per capita calculation.

Figure 1 presents variation in the cumulative number of historical 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 & 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 & Rigby, 2019). To supplement Figure 1, we provide Appendix Figure A1 to highlight the distribution of lynchings per population and per Black population.

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: a) whether uninsured or not, b) have a private health insurance plan, and c) 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. The model specification for our estimating equation is 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 $\gamma>0$. 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 $\delta_4>\delta_3>\delta_2$ 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 updated 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 (Erikson et al., 1994), 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

Historical Lynching and Health Insurance 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 ACA's reforms to address disparities in access to health insurance coverage (Guth et al., 2020, 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

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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.

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Regression Results of the Association between Historical Lynching and Coverage

Tables 3 contain our key regression results. In column (1) are the regression results when the outcome is whether the sample person was uninsured, column (2) reflects whether they had public health insurance, and column (3) reflects whether they had Medicaid coverage at the time of survey completion. In the first quartile of historical lynching, Blacks are more likely to be uninsured than Whites, but this difference is not statistically significant. However, we do observe that Blacks are 2.2 PPT ($p<0.01$), 1.9 (p=n.s.) and 3.4 PPT ($p<0.01$) more likely to be uninsured than Whites in the 2nd, 3rd, and 4th quartiles of historical lyncing (See Table 3, Column 1). In Column (2), there are no statistically significant differences between Blacks and Whites with respect to historical lynching across states, so we can assume the 6.3 PPT ($p<0.01$) lower likelihood of having private coverage is relatively constant across all the states. In Column (3), we observe that White participation in Medicaid does not vary across levels of historical lynching across the states, but Black participation is plausibly sensitive to historical lynching patterns even after we include all of the controls described in our Methods section. On net, Blacks are 4.6 PPT ($p<0.01$) more likely to be enrolled in Medicaid than Whites among states in the 1st quartile of historical lynching. However, this difference is lower–albeit not statistically significantly so–in states with higher levels of historical lynching.

As a complement to Table 3, we explored how sensitive our findings were to the inclusion of additional covariates in Appendix Tables A2-A4. 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.

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Introducing additional controls did not change the nature of the relationship between historical lynching across Blacks and Whites. Additionally as there was no evidence of a statistically significant interaction between being Black and lynching history with respect to having private coverage, this finding increases the plausibility that net coverage gaps between Blacks and Whites could be attributable to differences in Medicaid participation across historical lynching levels.

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

Our full sample regressions presented in Table 3 are limited in that they include people for whom Medicaid was not a relevant source of coverage because they were income-ineligible or because prior to more recently, men were largely excluded from Medicaid eligibility. Here, we present our subgroup analyses by poverty level (i.e., <100% FPL, >100% FPL) in Figure 3, and by gender/sex in Figure 4. In these figures, we present plots of the key terms of interest, the interaction between being a Black person and the level of historical lynchings for their state of residence. We also include the main effect on the 2nd, 3rd, and 4th quartiles, but we will focus on the interaction terms to evaluate the relative differences between Blacks and Whites in higher levels of historical lynching. Appendix Tables A5 is provided to include the full regression results for Figure 3, and Appendix Table A6 contains the full regression results to complement Figure 4.

In Figure 3, the elevated differences in uninsurance for Blacks in states among the 2nd and 4th quartiles of historical lynching were concentrated among lower-income households below 100% FPL (Panel A). This is not surprising as relatively few states during this period had

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income eligibility thresholds that were above 100% FPL. There is no difference in how private health coverage corresponds to historical lynching across Blacks and Whites in low- or higher-income households (Panel B). Similar to the results from Panel A, the lower Medicaid participation rates in accordance with increasing levels of historical lynching was concentrated in households below 100% FPL–albeit concentrated in the 3rd quartile. In Figure 4, we can observe the: a) coverage disparities (See Figure 4, Panel A), and b) declining Medicaid participation rates (See Figure 4, Panel C) at higher levels of historical lynching were concentrated among Black women.

Sensitivity Analysis Using State Fixed Effects

As an additional robustness check on our regression model specification, we perform an additional regression using state-level fixed effects in Appendix A7. All of our regressions until now included regional fixed effects. Although states within a region may have collectively more similar ideologies than relative to states clustered in another region, this approach may mask differences in politics, ideologies, and broader association with legacies of racism and attachment to racist practices that are unique, but time-invariant, to each state. In Appendix Table A7, we replace our regional fixed effects with state fixed effects. There are no main effects on the quartiles of historical lynching as they are fully absorbed by the state fixed effects. The coefficients on our interaction terms of interest, however, are statistically indistinct from those presented in Table 3 for each of our regressions.

Lynching and Medicaid Policies

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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 5 presents the Composite Medicaid Eligibility Index (panel A) and composite Medicaid Administrative Ease Index (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 (C. 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 6 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.

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In each panel for Figure 6, 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 7, 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 evidence that some fraction of the health insurance coverage disparities is associated with legacies of racialized violence toward American Blacks–as measured by historical lynching. The extent that legacy racism is shaping coverage disparities through underparticipation in Medicaid by Blacks is mixed from our study; however, we do

observe some patterns consistent with Medicaid policies corresponding to historical lynching. We do not believe that it is lynching itself that could be driving the differences in coverage–likely through under-enrollments among plausibly eligible Black persons, but that lynching is associated with how eligibility and enrollment guidelines are enforced. We show, on net, that states with higher levels of lynchings relative to their Black population have 1) higher uninsured rates among Blacks, 2) declining Medicaid enrollments, 3) lower upper-income limits, and 4) are more likely to have face-to-face interviews and asset tests as a condition of enrollment during our study period.

With these findings, we seek to demonstrate through empirical illustration that more explicit forms of racialized exclusion have been replaced with more implicit forms of racialized exclusion in the contemporary period that show continuity with the past. Our exploratory findings are not intended to be causal or conclusive, but we believe our findings help point to new areas of exploration in how public programs can reinforce as well as mitigate health inequality. We hope that our study can motivate others to investigate potential root causes of health inequality that are embedded in public programs such as Medicaid or any other publicly-funded programs that could be affected by racialized politics. We also hope this empirical work can build on the extensive institutionalist and behavioral scholarship documenting the extent to which racialized politics has shaped the American welfare state and the Medicaid program more specifically (Lanford & Quadagno, 2015; Lieberman, 2002; J. Michener, 2018; J. Quadagno, 1988; J. S. Quadagno, 1994; Soss et al., 2011).

Prior research examined how easing burdensome enrollment rules affects Medicaid participation rates (A. Fox et al., 2023; A. M. Fox, Feng, et al., 2020; A. M. Fox, Stazyk, et al., 2020), but this research had not explicitly explored racial disparities in insurance coverage

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associated with administrative burden in the Medicaid program. 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.

Activists, researchers, and those in the policy community are calling for Medicaid to be leveraged more as a vehicle for advancing health equity (Allen et al., 2022; A. H. Chen & Ghaly, 2022; Guth et al., 2023; Rosenbaum et al., 2022). Relative to the US population, Medicaid enrollees are disproportionately Black (20%) and Hispanic (29%) (KFF, 2023). However, while being overrepresented in Medicaid could serve to reduce health and non-health disparities, depending on how states implement their programs, participation in Medicaid could also be experienced as an exclusionary and punishing form of poverty governance (Soss et al., 2011). Georgia, for example, is 33% Black and 11% Hispanic (U.S. Census Bureau, 2024), and Blacks and Hispanics make up 45% and 15% of the Medicaid population (KFF, 2023). Expanding Medicaid in Georgia was projected to lower the uninsured population by at least 300,000 persons and uninsured rate among Blacks and Hispanics by 45% and 11% (Simpson & Banthin, 2024). Georgia has yet to expand Medicaid per the ACA, but they are using a section 1115 waiver to 1) raise the income eligibility limit to 100% FPL–which will include parents as well as childless adults, but doing so with 2) work and community engagement requirements. Some fear this approach to 'expanding' Medicaid will place undue burden on the enrolled and eligible to maintain their eligibility and will result in avoidable coverage discontinuities among the eligible and threaten their ability to maintain access to health care (Rosenbaum, 2023). Others fear work

requirements such as this will fall disproportionately on minoritized enrollees (L. Chen & Sommers, 2020; Collins et al., 2018; Dylan Scott, 2018), and it is plausible this expansion could worsen coverage gaps. The introduction, and proposal, of work requirements adopted by many states as a condition of expanding Medicaid could then 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 et al., 2021; Snowden & Graaf, 2019).

Structuring the enrollment entry is a broad way of shaping the Medicaid program; however, state legislatures can also determine the extent of their financial and nonfinancial investments into the Medicaid program. Leitner, Hehman, and Snowden found that states with higher levels of explicit and implicit racial bias–racial animosity towards non-Whites–had lower per-enrollee Medicaid spending (Leitner et al., 2018). They found: 1) Southeastern states with the highest levels of racial bias had 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. While Medicaid's role in alleviating racial-ethic health disparities is known, adequate funding (e.g., reimbursement rates for physicians) and sufficiently robust provider networks are necessary for this to occur (Allen et al., 2022; Benitez, Callison, et al., 2024; Benitez, Freed, et al., 2024). Temporary Assistance for Needy Families (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). Variations 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.

Limitations

Our study is not without limitations. The relationship between coverage and historical lynching was non-linear, and not precisely measured in our key regression estimates. We did not observe a monotonic increase in the Black-White coverage disparity that could be attributable to increasing lynching intensity across the states (e.g., moving from the 2nd to 4th quartiles). One explanation for the lack of monotonicity could be that Blacks as a share of the population may have a moderating effect on the intensity which Medicaid's administrative guidelines were applied and having a higher share of Blacks in the the broader Medicaid population may trigger more stringent application of the enrollment guidelines during the initial application and eligibility redetermination phases. With respect to lynching histories, Black residents were more prevalent among states in the 2nd and 3rd quartiles relative to the 1st and 4th.

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 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. We do believe variation in local-level exposure to lynching could illuminate more insights into how legacy racism becomes embedded and operationalized into interpersonal accounters between local Medicaid and other public assistance offices, and that should be pursued in future inquiry.

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. Though 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 (Hing et al., 2024; J. Michener, 2018; J. D. Michener, 2021, p. 20; 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.

While our study uses historical lynching rates as a proxy measure for structural racism that could be embedded in Medicaid, future investigations could use this historical source of racialized violence and discrimination to more precisely isolate the extent that racialized politics rather than political preferences among elected officials are a driver for Medicaid policy decisions. Both are possible, and we do not want to conflate that the two ideals are interchangeable with one another. Because racialized politics can be hidden behind superficially race-neutral premises (e.g., lower taxes, 'small government') among conservative elected officials and legislators, it will be important for future studies to consider study designs and approaches that can better identify racialized politics contributing to Medicaid policy development, implementation, and their consequences.

Conclusions

Our findings highlight some potential links between racial animosity, coverage disparities, and Medicaid operations. Our findings also support prior work detailing racialized politics shaping other social programs. Easing processes for Medicaid enrollment and renewals

may have a positive impact on addressing disparities in health insurance coverage, but we recognize more empirical studies are needed to affirm this claim. Additional studies designed to improve our understanding as to how racism and bigotry shape and reinforce health inequality are needed. Furthermore, more investigations dedicated to quantifying the short- and longer-run impacts of racism embedded in Medicaid could illuminate specific pathways through which Medicaid can advance health equity in the future.

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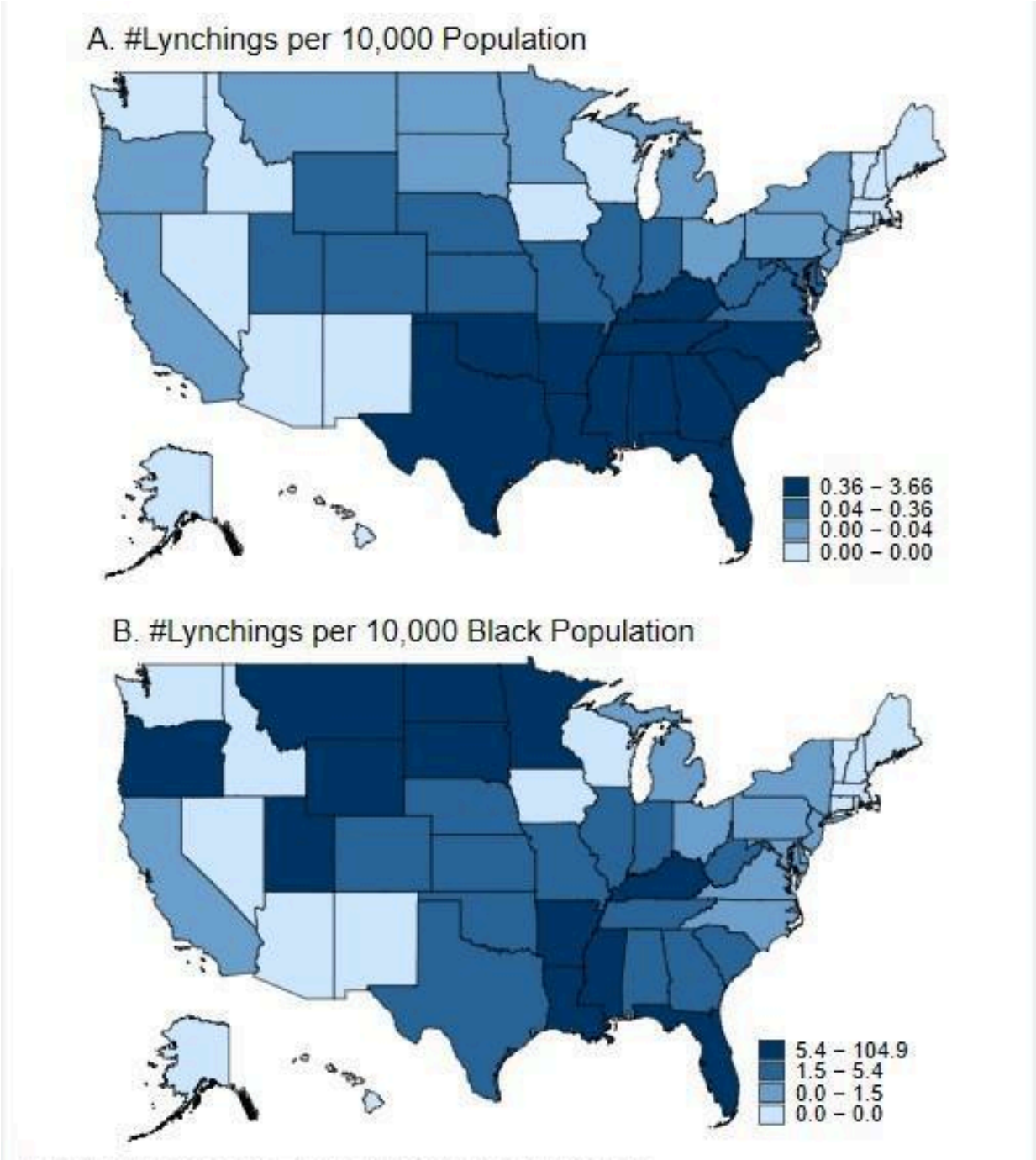
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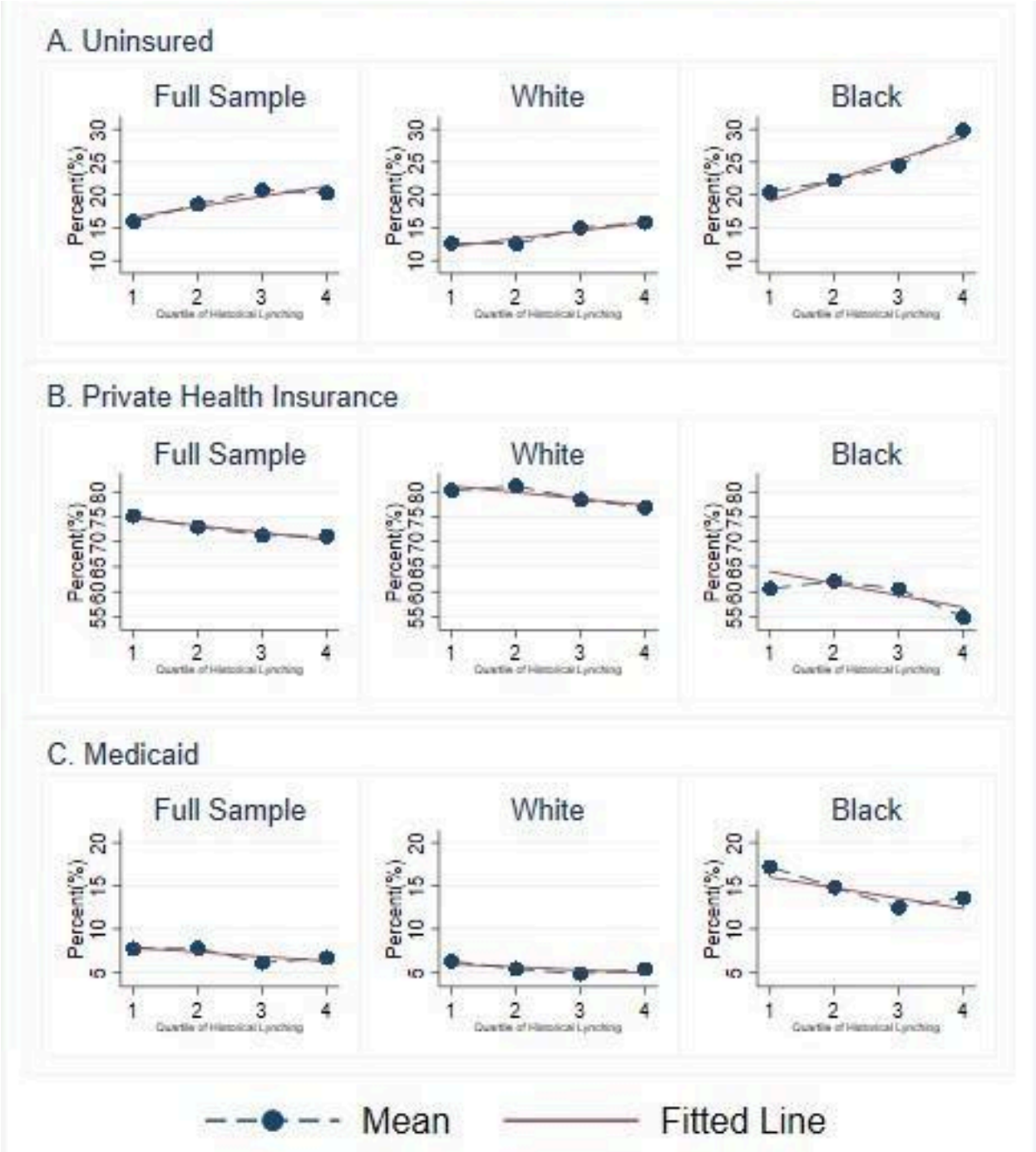
FIGURES & TABLES

Figure 1. State Level Variation in the Cumulative Number of Lynchings a) per 10,000 Total Population and b) per 10,000 Black Population.



Source: Author's own analysis of historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per capita (10,000) were estimated using the Census 1920 population counts as the denominator.

Figure 2. Coverage Status by Level of Historical Lynchings per 10,000 Black Population.



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 quartile 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).

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

	Full Sample	Quartile of Historical Lynchings per 10,000 Black Population			
		1st No Recorded Lynchings	2nd	3rd	4th
Age	40.3	40.5	40.3	40.0	40.5
%Female	50.7	50.2	50.9	50.7	50.8
%Male	49.3	49.8	49.1	49.3	49.2
%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
Number of 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
Annual Household Income	67408.6	69137.0	71569.2	63363.2	62133.8
Health Status Indicators					
%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 Residence					
%Rural/Non-Metropolitan	17.0	21.3	9.5	21.8	24.0
%Urban/Metropolitan	83.0	78.7	90.5	78.2	76.0
United States Census 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.

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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).

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Table 2. Summary Characteristics by Race Group.

	(1) Full Sample	(2) Black	(3) White
Age	41.0	39.0	41.4
%Female	51.1	54.8	50.5
%Male	48.9	45.2	49.5
Age	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
Number of 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
Health Status Indicators			
%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 Residence			
%Rural/Non-Metropolitan	19.0	11.5	20.3
%Urban/Metropolitan	81.0	88.5	79.7
United States Census 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
Quartile of Lynching History			
Lynchings per 10,000 Black Population			
1st	14.5	4.9	16.1
2nd	39.6	44.0	38.9
3rd	29.5	34.6	28.6
4th	16.4	16.5	16.4
Lynchings per 10,000 Total Population			
1st	14.5	4.9	16.1
2nd	35.3	29.6	36.3
3rd	19.8	19.7	19.8
4th	30.4	45.9	27.8
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 quartile 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).

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Table 3. Regression Results of Association between Coverage Status and Cumulative Historical Lynching per 10,000 Black population.

	(1) Uninsured	(2) Private Health Insurance	(3) Medicaid
Coefficient			
2nd Quartile	-0.47	0.88	-0.54
	(0.63)	(0.57)	(0.56)
3rd Quartile	1.38**	-0.93*	-0.49
	(0.66)	(0.54)	(0.54)
4th Quartile	1.40*	-0.90	-0.45
	(0.71)	(0.69)	(0.64)
Black	0.81	-6.31***	4.62***
	(0.72)	(1.09)	(1.63)
2nd * Black	2.20***	-0.30	-0.53
	(0.81)	(1.34)	(1.83)
3rd * Black	1.86	1.27	-2.68
	(1.19)	(1.50)	(1.70)
4th * Black	3.46***	0.74	-2.66
	(0.87)	(1.20)	(1.71)
Observations	572,222	572,222	572,222
Mean for Whites in 1st Quartile	12.6	80.3	6.3

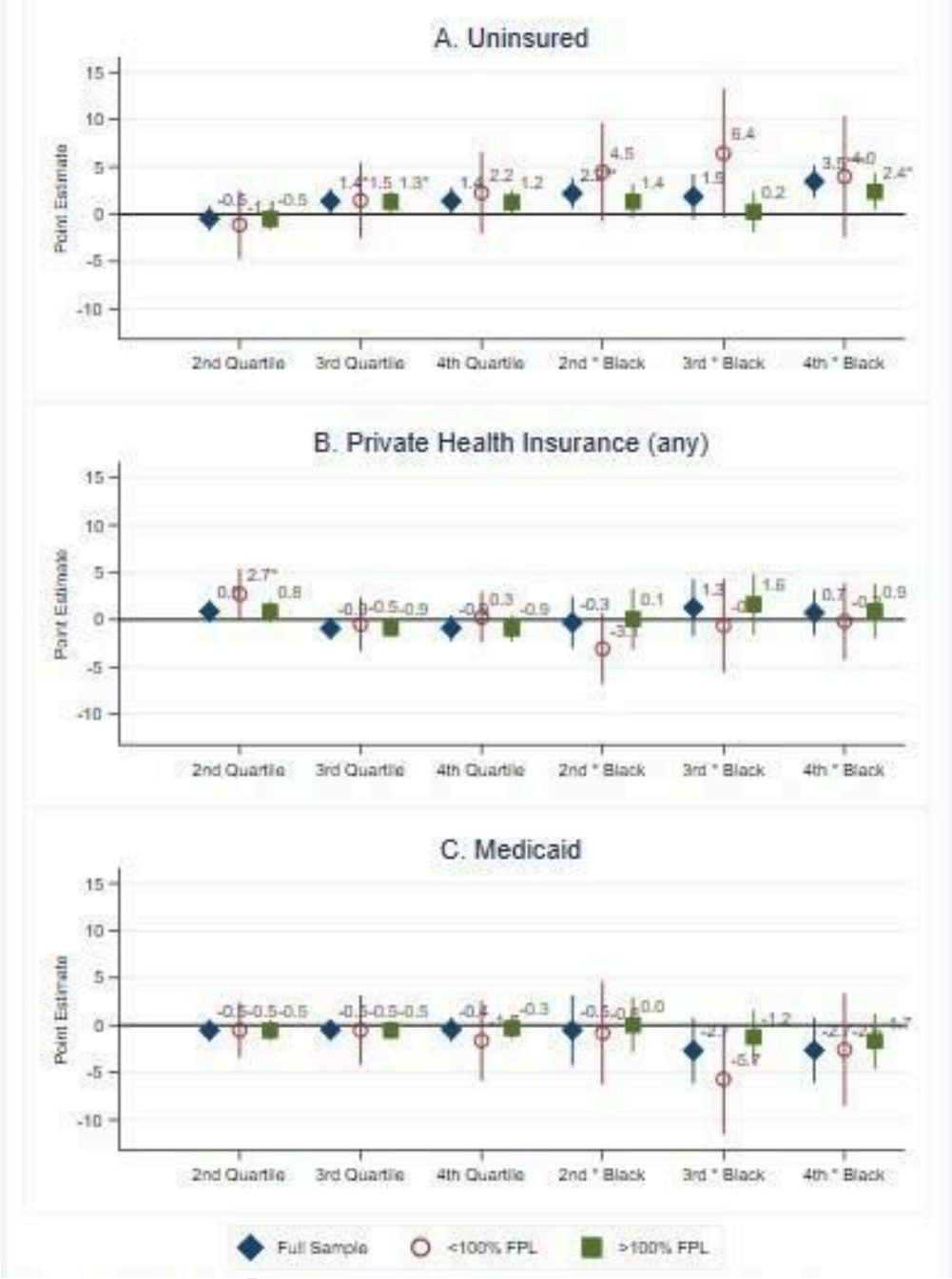
Standard errors in parentheses

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 quartile 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).

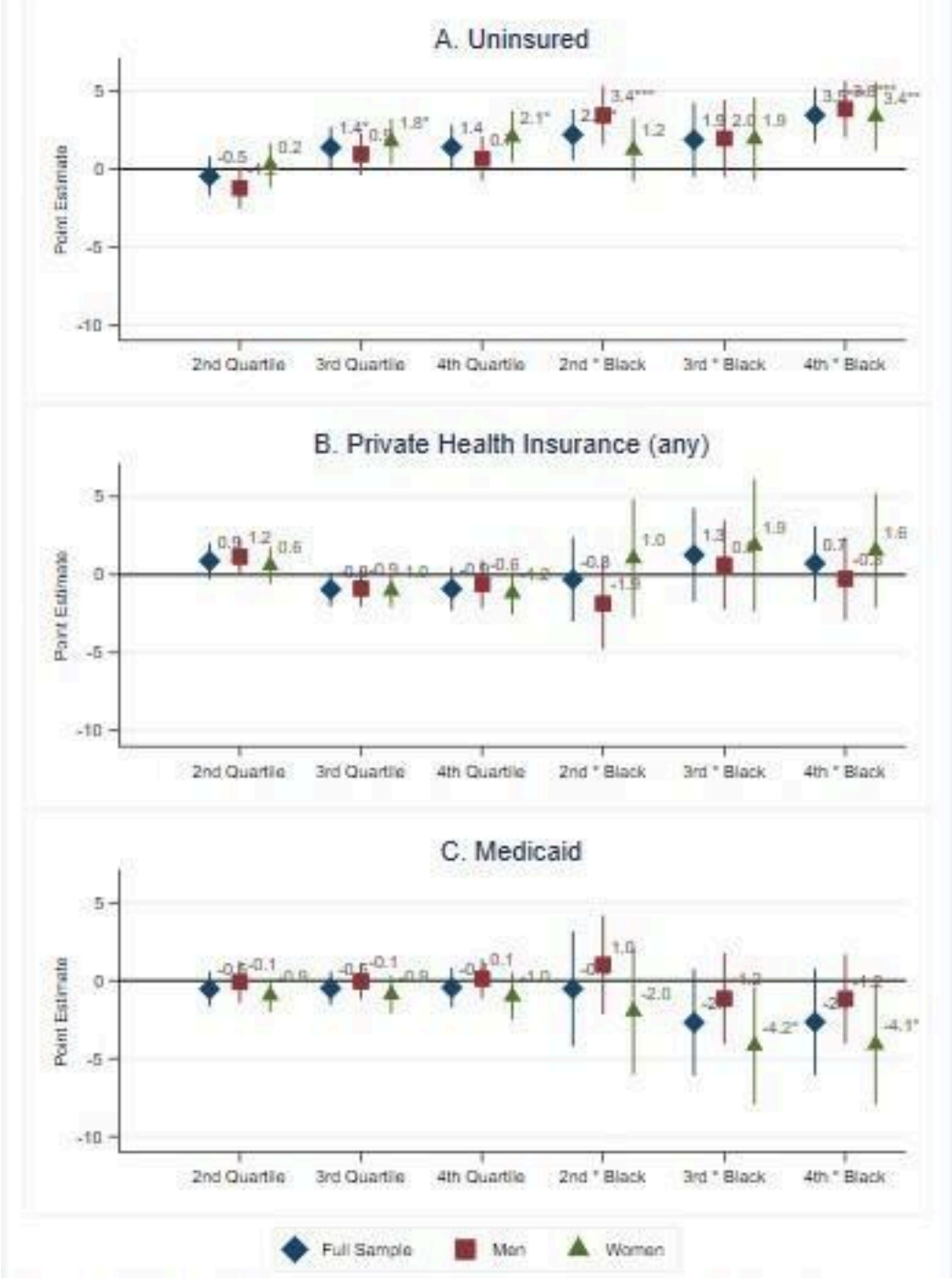
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Figure 3. Regression Coefficients of Differences in the Association between Coverage Status and Historical Lynching Stratified by Poverty Level.



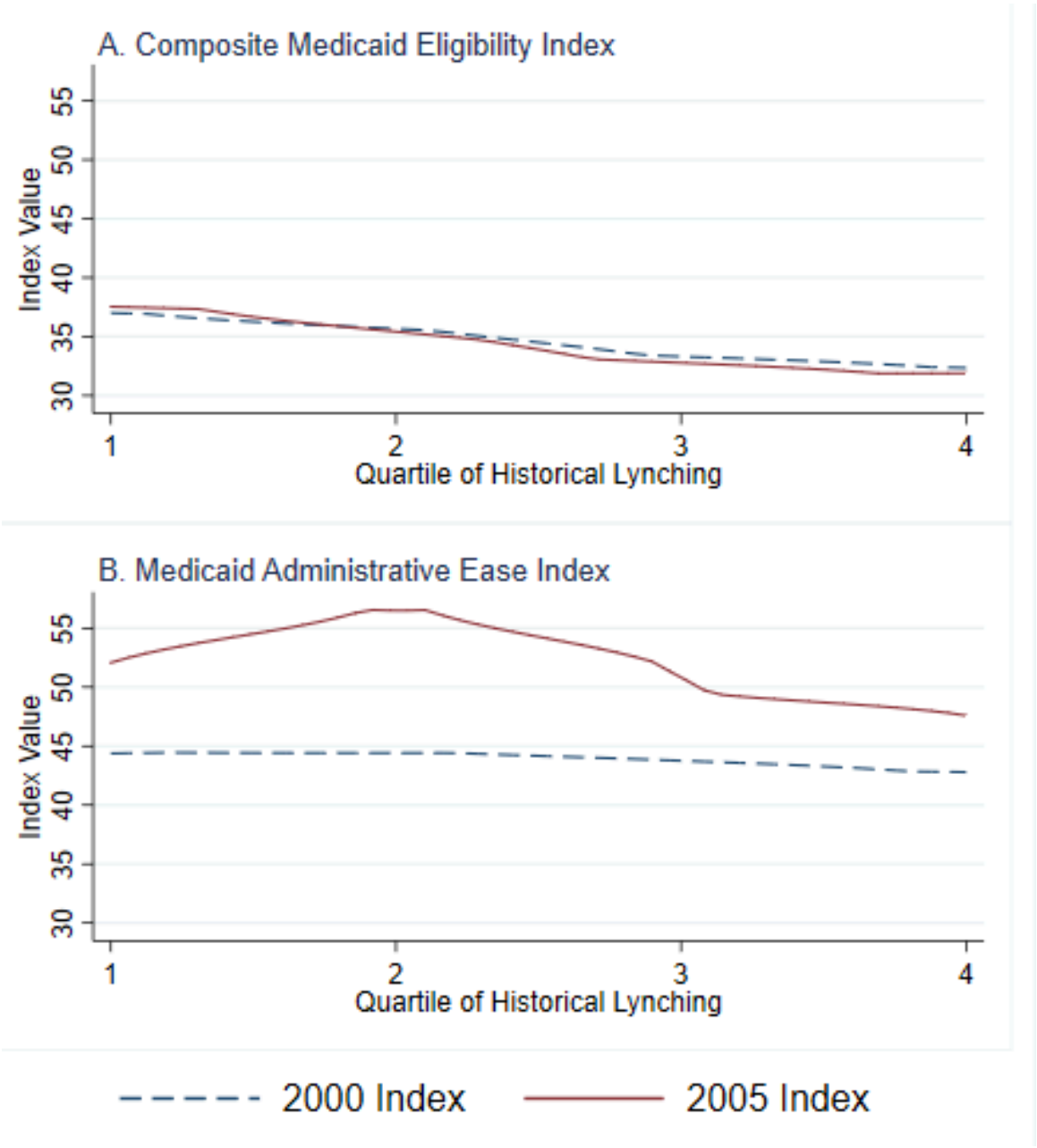
Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted 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 4. Regression Coefficients of Differences in the Association between Coverage Status and Historical Lynching Stratified by Sex/Gender.



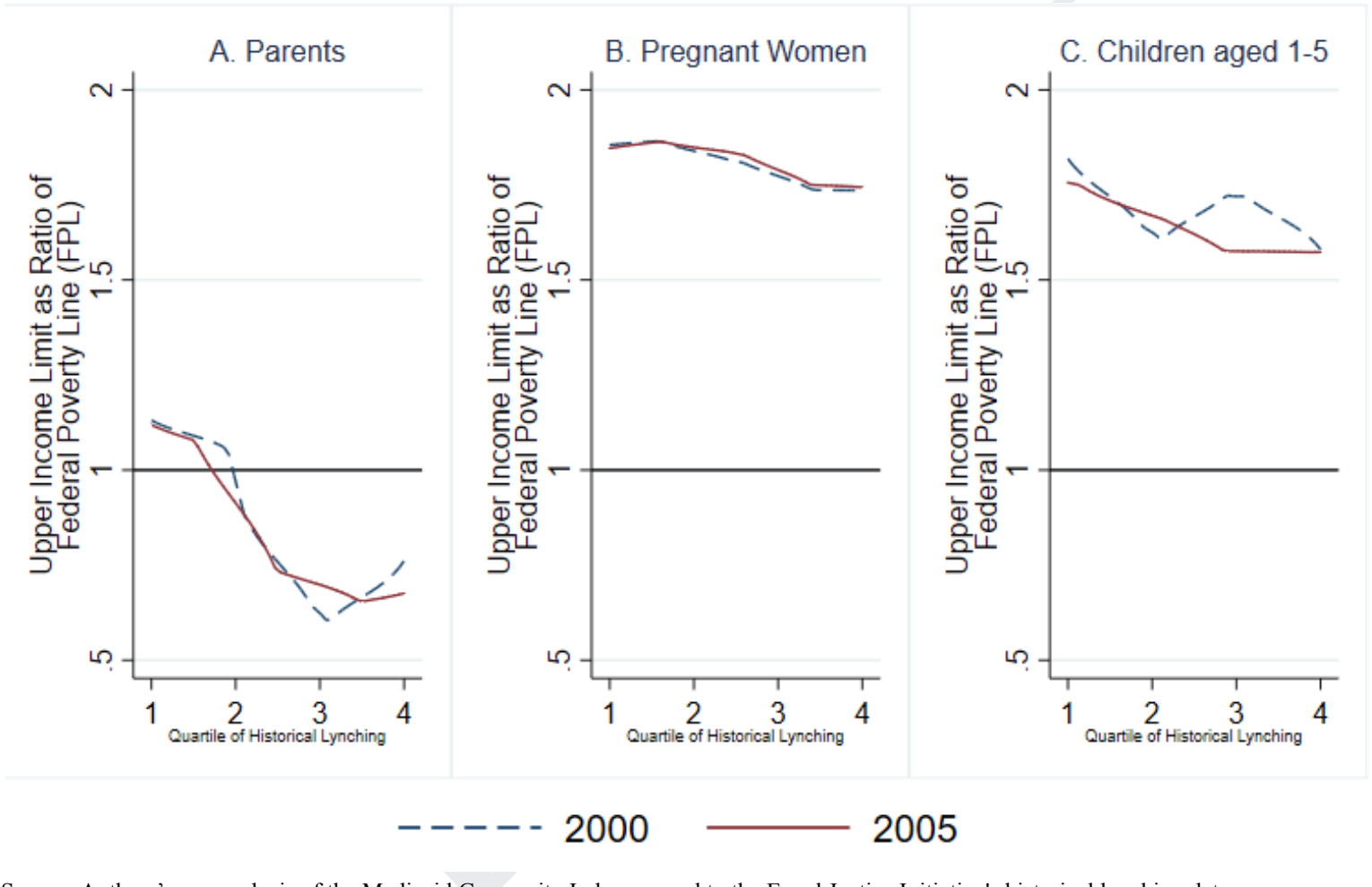
Source: Authors' own analysis of the 2001-2006 (Calendar Year 2000-2005) Current Population Survey's Annual Social and Economic (ASEC) Supplement merged to the Equal Justice Initiative's historical lynching data.
Note: $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. All regressions results are survey-weighted 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 control for : 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 5. Medicaid Policy Generosity by Quartiles of Historical Lynching per 10,000 Black Population.



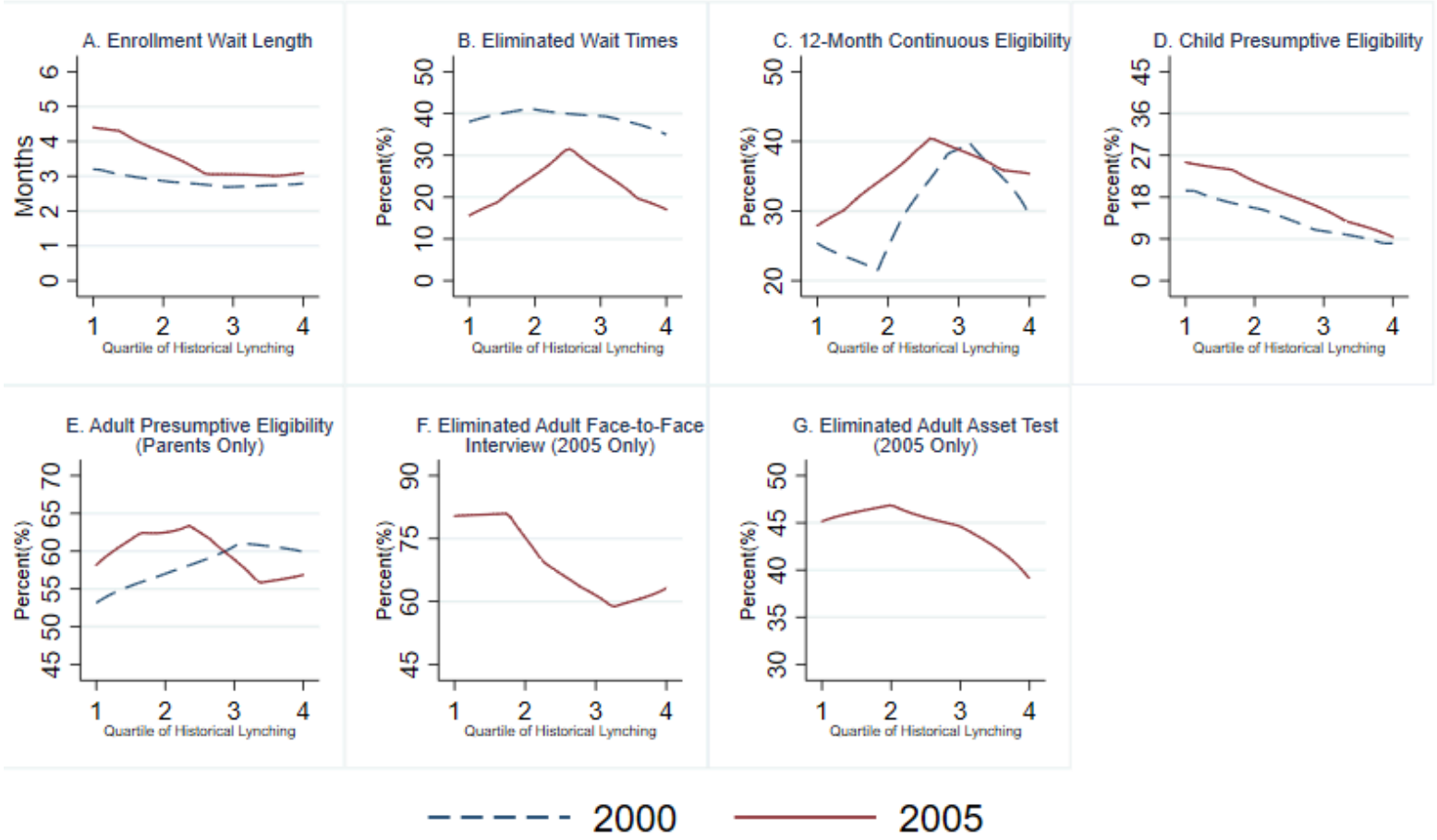
Source: Authors' own analysis of the Medicaid Generosity Index merged to the Equal Justice Initiative's historical lynching data.
Note: Quartile ranges in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). The horizontal line at 1 signifies 100% of the Federal Poverty Line (FPL).

Figure 6. Upper-Income Limits by Medicaid Eligibility Category and Quartile of Historical Lynchings per 10,000 Black Population.



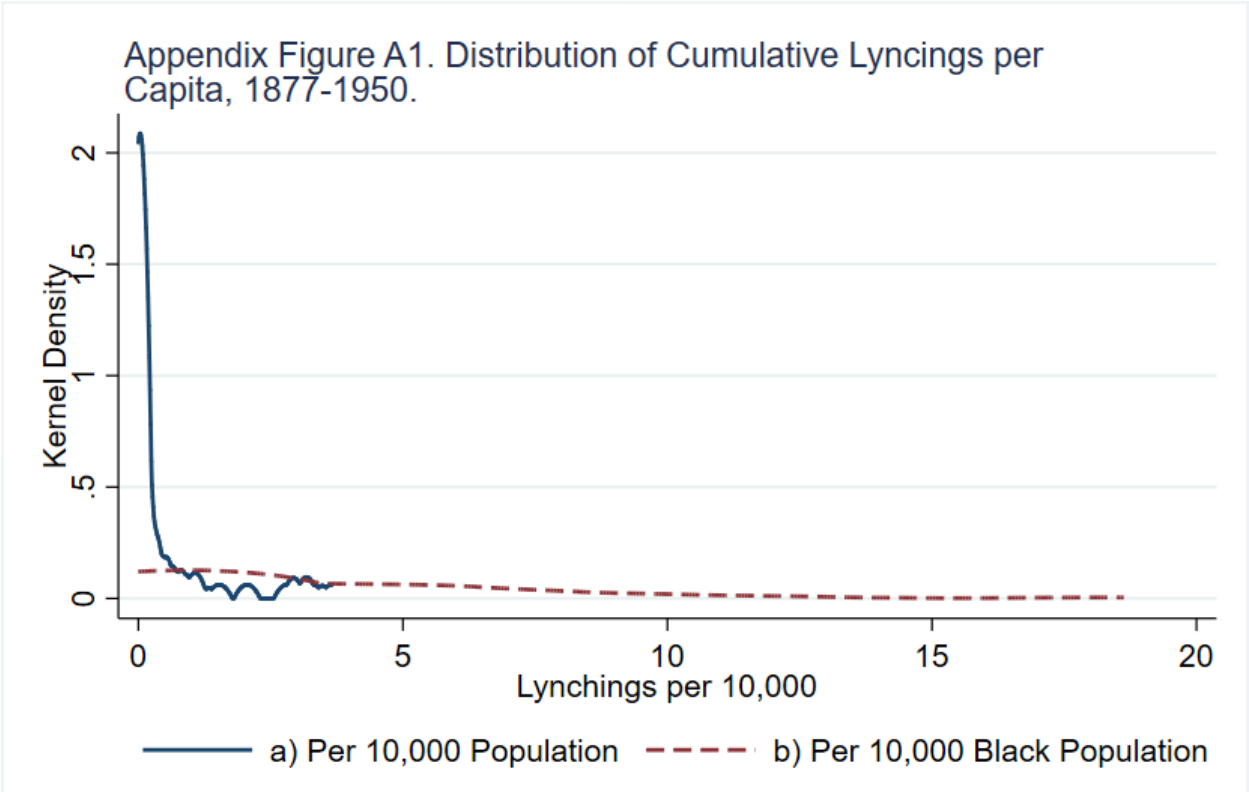
Source: Authors' own analysis of the Medicaid Generosity Index merged to the Equal Justice Initiative's historical lynching data.
Note: Quartile ranges in terms of lynchings per 10,000 Black population are as follows: 1st (0-0), 2nd (0.052-1.55), 3rd (2.12-5.44), and 4th (5.72-104.9). The horizontal line at 1 signifies 100% of the Federal Poverty Line (FPL).

Figure 7. 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 the Equal Justice Initiative's historical lynching data.
Note: Quartile ranges 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). The horizontal line at 1 signifies 100% of the Federal Poverty Line (FPL).

APPENDIX



Source: Authors' own analysis of historical lynching data obtained from the Equal Justice Initiative.
Note: Lynchings per capita (10,000 population) were estimated using the Census' 1920 population as the denominator. The interquartile ranges were a) 0.0-0.364 lynchings per 10,000 total population and b) 0.0-5.45 lynchings per 10,000 Black population.

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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

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Appendix Table A2. Regression Results of Association between Coverage Status 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)
N	582,102	582,102	582,102	582,094	582,094	582,094	572,222
Mean for Whites in 1st Quartile	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
OccupationFE	No	No	No	Yes	Yes	Yes	Yes
Health	No	No	No	No	Yes	Yes	Yes
Regional_FE	No	No	No	No	No	Yes	Yes
Political	No	No	No	No	No	No	Yes
Year_FE	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).

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Appendix Table A3. Regression Results of Association between Private Health Insurance (any) 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)
N	582,102	582,102	582,102	582,094	582,094	582,094	572,222
Mean for Whites in 1st Quartile	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
OccupationFE	No	No	No	Yes	Yes	Yes	Yes
Health	No	No	No	No	Yes	Yes	Yes
Regional_FE	No	No	No	No	No	Yes	Yes
Political	No	No	No	No	No	No	Yes
Year_FE	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).

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Appendix Table A4. Regression Results of Association between Medicaid enrollment 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
Mean for Whites in 1st Quartile	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
OccupationFE	No	No	No	Yes	Yes	Yes	Yes
Health	No	No	No	No	Yes	Yes	Yes
Regional_FE	No	No	No	No	No	Yes	Yes
Political	No	No	No	No	No	No	Yes
Year_FE	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).

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Appendix Table A5. Regression of Association between Uninsured Status and Cumulative Historical Lynching per Capita by a) Poverty, and b) Education Status.

	Uninsured			Private Health Insurance			Medicaid		
2nd Quartile	-0.47	-1.13	-0.50	0.88	2.70**	0.85	-0.54	-0.53	-0.54
	(0.63)	(1.80)	(0.57)	(0.57)	(1.33)	(0.54)	(0.56)	(1.48)	(0.53)
3rd Quartile	1.38**	1.46	1.32**	-0.93*	-0.49	-0.87*	-0.49	-0.53	-0.52
	(0.66)	(1.98)	(0.58)	(0.54)	(1.41)	(0.49)	(0.54)	(1.83)	(0.49)
4th Quartile	1.40*	2.24	1.24*	-0.90	0.26	-0.92	-0.45	-1.65	-0.32
	(0.71)	(2.15)	(0.62)	(0.69)	(1.34)	(0.68)	(0.64)	(2.11)	(0.55)
Black	0.81	-3.65	2.25***	-6.31***	-3.76**	-6.15***	4.62***	7.61***	2.82**
	(0.72)	(2.53)	(0.70)	(1.09)	(1.71)	(1.35)	(1.63)	(2.48)	(1.29)
2nd * Black	2.20***	4.46*	1.37	-0.30	-3.08	0.054	-0.53	-0.84	0.024
	(0.81)	(2.59)	(0.91)	(1.34)	(1.86)	(1.60)	(1.83)	(2.71)	(1.44)
3rd * Black	1.86	6.42*	0.22	1.27	-0.62	1.61	-2.68	-5.72*	-1.24
	(1.19)	(3.39)	(1.07)	(1.50)	(2.47)	(1.59)	(1.70)	(2.91)	(1.38)
4th * Black	3.46***	3.96	2.40**	0.74	-0.16	0.91	-2.66	-2.60	-1.71
	(0.87)	(3.20)	(0.97)	(1.20)	(2.03)	(1.43)	(1.71)	(2.97)	(1.45)
Observations	572,222	49,896	522,198	572,222	49,896	522,198	572,222	49,896	522,198
Mean for Whites in 1st Quartile	12.6	32.3	11.1	80.3	34.2	83.8	6.30	31.3	4.4
Subgroup	Full Sample	<100 % FPL	≥100% FPL	Full Sample	<100% FPL	≥100% FPL	Full Sample	<100% FPL	≥100% FPL

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. 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).

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Appendix Table A6. Regression of Association between Coverage Status and Cumulative Historical Lynching per Capita by Sex/Gender.

	Uninsured		Private Health Insurance		Medicaid	
	Men	Women	Men	Women	Men	Women
2nd Quartile	-1.21*	0.24	1.16*	0.59	-0.10	-0.94*
	(0.66)	(0.69)	(0.60)	(0.59)	(0.66)	(0.54)
3rd Quartile	0.95	1.76**	-0.87	-1.01*	-0.050	-0.89
	(0.66)	(0.73)	(0.58)	(0.55)	(0.56)	(0.60)
4th Quartile	0.67	2.06**	-0.59	-1.18*	0.12	-1.00
	(0.71)	(0.82)	(0.77)	(0.69)	(0.63)	(0.74)
Black	1.46*	0.59	-5.31***	-7.28***	2.17	6.55***
	(0.76)	(0.94)	(1.09)	(1.75)	(1.34)	(1.82)
2nd * Black	3.44***	1.23	-1.86	1.05	1.01	-1.97
	(0.94)	(1.01)	(1.45)	(1.90)	(1.58)	(2.02)
3rd * Black	1.96	1.92	0.63	1.88	-1.16	-4.17**
	(1.23)	(1.32)	(1.43)	(2.11)	(1.45)	(1.88)
4th * Black	3.84***	3.37***	-0.25	1.56	-1.18	-4.09**
	(0.91)	(1.11)	(1.33)	(1.83)	(1.43)	(1.91)
Observations	273,066	299,095	273,066	299,095	273,066	299,095
Mean for Whites in 1st Quartile	14.2	11.1	79.6	80.9	4.9	7.60

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. 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).

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Appendix Table A7. Regressions of Association between Coverage Status and Historical Lynching Patterns using State Fixed Effects.

	(1) Uninsured	(2) Private Health Insurance	(3) Medicaid
Black	0.82	-6.50***	4.92***
	(0.65)	(1.10)	(1.52)
2nd * Black	2.19***	-0.097	-0.80
	(0.74)	(1.32)	(1.73)
3rd * Black	1.94	1.08	-2.97*
	(1.16)	(1.49)	(1.59)
4th * Black	2.50***	1.85	-2.84*
	(0.88)	(1.17)	(1.58)
Observations	572,222	572,222	572,222
Mean for Whites in 1st Quartile	12.6	80.3	6.3

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. 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 state-level fixed effects. 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).

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