

THE POLITICS OF EXPANDING MEDICAID IN REPUBLICAN-LED STATES: LESSONS FROM
ARIZONA, INDIANA, AND TENNESSEE

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ABSTRACT

David Adler: The Politics of Expanding Medicaid in Republican-led States: Lessons from Arizona, Indiana, and Tennessee
(Under the direction of Jonathan Oberlander)

This study examined the question of why some states led by Republicans expanded Medicaid to 138% of the federal poverty level as allowed by the Affordable Care Act, while nationally most Republican governors and legislatures resisted expansion. Through in-depth case studies, I explored how policymakers and stakeholders addressed Medicaid expansion in Arizona, Indiana, and Tennessee.

While all three states studied are unique, I identified six themes that influenced the Medicaid expansion decision in each of the states: prior Medicaid history in the state, the relationship between the governor and legislature, the language used to discuss Medicaid expansion, stakeholder coalitions, the political environment, and federal-state negotiations. The state's previous history of Medicaid policy emerged as the most influential factor shaping state decisions, with states that had previous popular expansions being more ready to expand. Negative experiences, such as restricting coverage expansions under TennCare, left a lasting legacy that proved impossible to overcome. Other important factors that facilitated Medicaid expansion in GOP-led states included having a governor who was an advocate and knew how to work with a legislature, conservative voices speaking in favor of expansion, and hospitals willing to pay an assessment to cover the cost.

This work informs a plan for how the Robert Wood Johnson Foundation can more effectively work to influence policy at the state level by finding ways to engage a more diverse set of stakeholders and by working to engage more people in voting activities to ensure their preferences are heard in the policy process.

For Cole, who had the dubious distinction of being a deputy dean at home and at work for the past four years.

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TABLE OF CONTENTS

LIST OF TABLES	xiii
LIST OF ABBREVIATIONS.....	xiv
CHAPTER 1: INTRODUCTION.....	1
CHAPTER 2: LITERATURE REVIEW	5
Search Methods and Inclusion/Exclusion Criteria	5
Results	7
How did state-level political and stakeholder dynamics shape Medicaid policy decisions prior to the ACA?	7
How have state-level political and stakeholder dynamics shaped ACA implementation? ...	13
How have state-level political and stakeholder dynamics shaped decisions to expand Medicaid under the ACA?	15
Discussion	18
CHAPTER 3: METHODOLOGY	22
Case Selection	22
Data Collection.....	25
Analysis	27
Limitations	29
CHAPTER 4: ARIZONA	32

Sebelius v. NFIB Meets Proposition 204	32
Building Support for Expansion.....	34
The Governor Decides to Expand	37
The Fight	40
Post Enactment.....	46
Analysis	47
Governor.....	47
Legislature.	47
Coalition.	48
Political environment.....	48
Language and framing.....	49
Federal-state negotiation and previous history.....	49
Conclusion.....	50
CHAPTER 5: INDIANA	51
Healthy Indiana Plan	51
Mitch Daniels and the Affordable Care Act.....	52
Pence and Medicaid Expansion.....	54
The Governor and the Legislature.....	54
Coalition Politics and Moving Forward on HIP 2.0	56
Negotiations with CMS	62

Analysis	65
Governor and legislature.	65
Previous Medicaid history and language.....	65
Coalition and federal-state negotiations.	66
Conclusion.....	67
CHAPTER 6: TENNESSEE.....	68
Medicaid in Tennessee before the ACA: The TennCare Experience	68
From <i>NFIB</i> Decision to Insure Tennessee	70
The Plan and the Special Session.....	77
After the Special Session.....	82
Analysis	83
Governor and legislature.	83
Coalition.	83
Language.	84
Political environment.....	84
Previous history.	85
Federal-state negotiations.....	86
Conclusion.....	86
CHAPTER 7: LOOKING ACROSS THREE STATES	87
Previous History	87

Dynamic Between the Governor and Legislature	89
Political Environment.....	92
Coalitions	94
Language	98
Federal-State Negotiations	99
Conclusions	100
CHAPTER 8: MEDICAID EXPANSION AFTER THE 2016 ELECTIONS	102
Arizona	104
Indiana	106
Tennessee	108
Medicaid Expansion in the Trump Administration.....	109
CHAPTER 9: PLAN FOR CHANGE	110
Increased Access to Care.....	110
Focus on messengers as much as message.....	111
Broaden existing work to build evidence.	112
Build public support.	115
Give grantees more freedom to interact with legislators.....	115
Increasing Civic Engagement.....	118
Voter registration.....	119
Platforms for informed debate.....	120

Conclusion.....	121
APPENDIX A: INTERVIEW GUIDE FOR INTEREST GROUPS.....	122
APPENDIX B: INTERVIEW GUIDE FOR POLICYMAKERS	125
APPENDIX C: INTERVIEW GUIDE FOR RESEARCHERS AND INFORMANTS OUTSIDE THE STATE.....	128
REFERENCES	130

LIST OF TABLES

Table 1. States Categorized by Partisan Control, Whether They Expanded Medicaid, and Whether Barack Obama Won the State in the 2012 Presidential Election.....	23
Table 2. Re-election Status of Republicans in the State House of Representatives who Supported Medicaid Expansion in Arizona.....	43
Table 3. Re-election Status of Republicans in the Senate who Supported Medicaid Expansion in Arizona.....	43
Table 4. Partisan Composition of State Legislatures at the Time of Medicaid Expansion Debate in Arizona, Indiana, and Tennessee.....	92
Table 5. Percentage of the Popular Vote in Each State That Went to the Republican or Democratic Presidential Nominee in Each Year (displayed as % votes for Republican candidate/% of votes for Democratic candidate).....	94

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
AHA	American Heart Association
AHCA	American Health Care Act
AHCCCS	Arizona Health Care Cost Containment System
AMA	American Medical Association
AFP	Americans for Prosperity
CMS	Centers for Medicare and Medicaid Services
FPL	Federal Poverty Level
HCFA	Health Care Financing Authority
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
NFIB	National Federation of Independent Businesses
RWJF	Robert Wood Johnson Foundation

CHAPTER 1: INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA), which aimed to expand health insurance coverage to millions of Americans. The ACA built on existing sources of health insurance, including employer-based coverage, Medicare, and Medicaid. Indeed, one major way the ACA sought to cover the uninsured was by expanding Medicaid to anyone earning less than 138%¹ of the federal poverty level (FPL) (Kaiser Family Foundation, 2013).

Congress enacted the Medicaid program in 1965. Traditionally, it has covered certain categories of low-income persons, including children, pregnant women, parents of dependent children, individuals with disabilities, and people aged 65 and older. The states and the federal government jointly finance Medicaid, with the federal government matching state expenditures at rates between 50–74% (for fiscal year 2015). The ACA provided states with 100% federal funding for newly eligible populations, with that support gradually declining until it reaches 90% in 2020 for subsequent years (Kaiser Family Foundation, 2015b).

Historically, states have had discretion to determine coverage eligibility for additional groups of people and income thresholds. For example, in Alabama parents of dependent children are only eligible if they earn up to 18% of the FPL, while Tennessee covers parents up to 100% of the FPL. However, prior to the ACA's enactment, adults without dependent children generally

¹ The ACA specifies that Medicaid will cover individuals and families earning less than 133% of the FPL with a 5% income disregard, making the cut-off effectively 138%. Throughout this study, I refer to full expansion as 138% of the FPL except when referring to specific state decisions in which the state references 133% of FPL. Both figures refer to the full expansion of Medicaid under the ACA.

could not gain coverage through Medicaid unless states obtained a waiver from the federal government or fully funded the coverage of these adults with state funds. As a result, non-elderly, non-disabled adults without children could not qualify for Medicaid in the vast majority of states (Kaiser Family Foundation, 2010, 2015b).

The path of the ACA and Medicaid took an unexpected turn when the Supreme Court decided in the *National Federation of Independent Business (NFIB) v. Sebelius* case in June 2012 that the federal government could not make existing Medicaid funding dependent on expanding the program. The court effectively made Medicaid expansion optional for states, leaving it up to them to decide whether to accept or reject expansion, and the much higher financial matching rate for newly eligible participants that went with the expansion. Consequently, governors and state legislatures took central stage in deciding potential Medicaid expansion (Perkins, 2013).

While this situation shifted a great deal of decision-making power from the federal government to the states, it was not unique in the history of Medicaid. States have long had significant discretion over many terms of their Medicaid programs, and they have sought to tailor their programs in ways that suited their needs (Thompson, 2012; Thompson & DiIulio, 1998). It is not only state governments that have tried to shape the program to meet their interests; a variety of stakeholder groups have also sought to shape Medicaid programs to advance their own interests (Olson, 2010). The question about whether to accept the Medicaid expansion after the Supreme Court decision became another moment during which partisan and interest group politics came into play.

To date, state decisions about whether to accept federal funds to expand Medicaid to childless adults earning less than 138% of the FPL have largely, though not exclusively, fallen

along party lines. States with Republican governors and GOP-majority legislatures have mostly rejected the expansion, while states with Democratic governors and legislatures have all accepted it. Some states with split governments, such as New Mexico, Nevada, and New Jersey have accepted the expansion. However, there are notable exceptions to this partisan pattern, including Alaska, Arizona, Indiana, Iowa, Michigan, North Dakota, Ohio, and Pennsylvania, which are all states that had both Republican governors and legislative majorities that agreed to expand the program (National Conference of State Legislatures, 2017a; The Advisory Board, 2017).

This dissertation examines the question of why some Republican-led states expanded Medicaid under the ACA while others did not, and particularly what role interest groups played in these debates. Specifically, it consists of three state case studies: one that expanded Medicaid in a traditional way; one that expanded through a waiver that included less common features of Medicaid; and one that chose to not expand the program.² This study helps identify what roles stakeholders played in Medicaid expansion debates, the positions that different stakeholders took, the strategies they used to influence states' decisions and shape public debates over expansion, and how much policymakers took stakeholders' positions into consideration. I also examine factors such as the state's history of Medicaid reforms, the political ambitions of key actors in the debate, the willingness of hospitals to pay an assessment to finance Medicaid expansion, and unique political conditions in each state that may have had an effect. I use key informant interviews as well as news articles, scholarly articles, government documents and grey literature about these states' Medicaid expansion debates as the primary means of data collection. By conducting in-depth case studies that include key informant interviews, I provide insight into

² The question of distinguishing between a traditional and nontraditional expansion is complicated by the fact that many states have grown their Medicaid programs over the years by adapting the design of the program through state plans of 1115 waivers. In this study a "nontraditional expansion" refers to states that included features such as cost-sharing or exclusions from coverage that were not previously approved by CMS as part of a 1115 waiver.

not just why, but how these states arrived at their respective policy outcomes regarding Medicaid expansion.

The stakeholder groups that I focus on are hospitals and physicians, businesses, and consumer advocacy and faith-based organizations. I decided to study these groups for one of two reasons. Either the literature I reviewed suggested these groups have been involved in shaping Medicaid policy, or I observed these groups participating in Medicaid policy conversations at the state level. The states from which case study subjects were chosen are states with a Republican governor and at least one house of the legislature controlled by Republicans at the time of expansion decisions. My goal was to compare how these debates developed in these states and to understand which factors may explain why certain Republican-led states expanded Medicaid under the ACA and others did not.

I use the analysis to inform a plan for change regarding the policy advocacy, research, and civic engagement work that the Robert Wood Johnson Foundation (RWJF) funds. As a senior program officer at RWJF, my work focuses on supporting consumer advocacy and policy change, often around issues connected to Medicaid. Understanding more about what leads some states to expand Medicaid and others to not, even though they appear to share similar political environments, can be valuable for this work. The insights gained from this study may help me to change who or how we fund work to influence state health policy.

CHAPTER 2: LITERATURE REVIEW

Search Methods and Inclusion/Exclusion Criteria

Numerous scholars have written about the politics surrounding the ACA as well as the politics of Medicaid and stakeholders' attempts to influence Medicaid policy. This literature review places my study in the context of previous work and explains how it adds to existing knowledge about Medicaid politics both before and during ACA implementation, as well as the broader politics of ACA implementation. There are three questions this literature review seeks to address:

- 1) How have state-level political and stakeholder dynamics shaped Medicaid policy decisions at the state level prior to the ACA?
- 2) How have state-level political and stakeholder dynamics shaped ACA implementation?
- 3) How have state-level political and stakeholder dynamics shaped decisions to expand Medicaid under the ACA?

To answer these questions I conducted three searches in PAIS (originally the Public Affairs Information Service, but now officially known as PAIS), an index managed by Proquest that focuses on public affairs and public policy. The first search looked for articles about the politics of state decisions on Medicaid policy before the ACA. For this search I used the keywords "Medicaid" and "state" and either "politics" or "stakeholder" in the abstract. I searched for peer-reviewed and grey literature in English. I searched from January 1, 1995 to December 5, 2015. PAIS uses a stemming feature for searches, so terms such as "state" and "stakeholder" return results for the plural version of these words as well.

The second search identified articles about ACA implementation and state-level political and stakeholder dynamics. I conducted a search using the key words “Affordable Care Act” “state” and “politics or partisan or implementation” in the abstract. I limited this search to peer-reviewed and grey literature articles published since the ACA’s March 23, 2010 enactment. I limited my search to articles published in English.

The third search focused on state decisions on whether to expand Medicaid under the ACA. Since this topic only became relevant after June 28, 2012, when the Supreme Court made the expansion optional with *NFIB v. Sebelius*, I searched for articles published after this date using the key words “Medicaid expansion” and “Affordable Care Act” in the abstract. I searched in English for peer-reviewed and grey literature.

Because so many articles came from the *Journal of Health Policy, Politics and Law*, I hand searched for the terms “Medicaid” and “Policy” in the title or abstract for articles published since January 1995. In addition, I included articles and books that were suggested by my advisor, committee members, other researchers, and coworkers.

I applied the following inclusion criteria to the articles found:

- 1) Article or book dealt with state-level Medicaid or ACA policy decisions;
- 2) Article or book addressed stakeholder politics surrounding Medicaid or the ACA at the state-level;
- 3) Article or book dealt with the politics of ACA implementation at the state-level.

I also applied the following exclusion criteria to my search results:

- 1) Article or book provided a descriptive analysis of impact of ACA on coverage rates;
- 2) Article or book dealt exclusively with federal policy;

- 3) Article or book focused exclusively on the intricacies of one state's Medicaid reforms;
- 4) Article or book dealt solely with the economic impact of the ACA or Medicaid;
- 5) Article or book was a news article.

Results

How did state-level political and stakeholder dynamics shape Medicaid policy decisions prior to the ACA? States historically have had a great deal of discretion in designing their Medicaid policies, and therefore these programs have varied substantially across the country. The Medicaid statute requires states to cover certain populations, including low-income children, parents with dependent children, pregnant women, people with severe disabilities, and senior citizens. At the same time, many states have expanded that eligibility to cover additional populations, such as adults without dependent children or parents at higher incomes than required. Medicaid coverage for some of these categories is paid solely from state funds, while other populations can be covered with a mix of federal and state funding. Similarly, while certain services must be covered, such as inpatient hospital care, states have had the option to add other services, such as hearing aids and physical therapy. Likewise, states have broad discretion about how much to pay physicians and other providers who participate in the program (Rose, 2013; Sparer, 1996b).

Medicaid has often been considered a “poor people’s” program. Established in 1965 alongside Medicare, it was created as a means-tested program that was associated with the poor, disabled, and other disadvantaged groups (Brown & Sparer, 2003; Olson, 2010). Brown and Sparer (2003) suggested that the state variations in program eligibility and covered benefits and the fact that beneficiary populations are less clearly defined in Medicaid than in Medicare has allowed policy entrepreneurs, individuals inside or outside the government who seek to create or

adapt policy, to gradually expand the program and to more easily introduce new innovations, such as managed care. Whereas Brown and Sparer saw this variation as a potential benefit for Medicaid, Katz Olson (2010) viewed the program as subject to various commercial interests at the expense of the low-income populations Medicaid is meant to help. In particular, she argued that nursing homes have benefited tremendously from Medicaid payments while generally providing very low-quality care. She also cites Medicaid managed care companies as profiting off of Medicaid payments while the ultimate recipients have very little access to services.

Managed care adoption is one way scholars have studied the role of partisan politics in health policy, finding that Democratic controlled governments tend to reduce enrollment in capitated or risk-based managed care (Kim & Jennings, 2012; Pracht, 2007). Specifically, Pracht (2007) found that an increased percentage of Democrats in the legislature was associated with lower enrollment in capitated managed care, while more evenly divided legislatures were associated with increased enrollment. This effect disappears when looking at primary care case management, which is considered less restrictive than capitated managed care because case management does not impose the same spending restrictions that capitation does (Pracht, 2007). Kim and Jennings (2012) examined risk-based managed care and concluded that unified Democratic control of the governorship and legislature was associated with lower enrollment in risk-based managed care.

Other studies suggest that Democrats tend to be more willing to spend the money necessary to expand eligibility and benefits, while Republicans are less likely to do so (Kousser, 2002; Lukens, 2014; Sardell & Johnson, 1998). When studying discretionary spending for Medicaid services, Kousser (2002) found that Republican controlled state legislatures resulted in less discretionary spending, but it was not significant whether the governor was a Republican

or Democrat. Lukens (2014) concluded that unified Republican control of state government is associated with fewer children eligible for Children's Health Insurance Program (CHIP) coverage compared to divided or Democratic controlled states. Lukens goes on to conclude that unified Democratic control also results in greater Medicaid eligibility among parents. In fact, the partisan divide is more pronounced for adults. This distinction is important for my study because adults make up the vast majority of the expansion population and the politics surrounding that decision are likely to be different than the politics of previous decisions to expand coverage to children. In fact, it is possible that the previous expansions specifically addressed children and left adults uninsured because of the contentious politics surrounding expanding Medicaid coverage to adults.

Lukens (2014) argued that the Republican preference for containing costs negated any preference for increased payment to providers. Prior studies (Kronebusch, 1993), in contrast, suggested that Republicans favored increased provider payments over increased eligibility for coverage. Sardell and Johnson (1998) looked specifically at the adoption of Early and Periodic Screening, Diagnosis and Treatment in the 1990s and found that Republican governors advocated for loosening the requirements to provide these benefits to children covered by Medicaid because of concerns about a loss of state flexibility and increased cost.

Together these articles offer empirical evidence that party control of the governors' office and legislatures does have an effect when it comes to state health policy. In general, Democratic governors and legislatures have favored covering more people and adding benefits, and have resisted limitations on access through managed care. Importantly, in some cases it is the legislature more than the governor that has shaped these decisions (Kousser, 2002).

Health care providers (*e.g.*, hospitals, physicians, and nursing homes) have also had a role in shaping state-level health policy (Kousser, 2002; Kronebusch, 1997; Lukens, 2014; Olson, 2010). Olson (2010) argued that providers are particularly effective at lobbying at the state-level, where Medicaid policy is often determined, and have been able to shape the program to fit their interests. Both she and Kronebusch (1997) have argued this is particularly true for nursing homes, which receive a large share of Medicaid's total payments.

There is also evidence that physicians and hospitals have been able to influence Medicaid policy. Lukens (2014) concluded that while the percent of physicians belonging to the American Medical Association (AMA) in a state does not affect Medicaid eligibility levels for children, increased membership does correlate with increased eligibility for parents. Similarly a larger proportion of doctors and hospitals belonging to the AMA and American Hospital Association, respectively, have been associated with increased reimbursement levels. Kousser (2002) found that the “influence of the medical industry’s lobbyists...appears to influence optional expenditures” (p. 664). Pracht’s (2007) conclusion that an increased number of hospital beds per capita was associated with lower enrollment in primary care case management (which might decrease hospitalization) also suggests that the strength of the hospital industry can shape Medicaid policy. Kronebusch (1997) asserted that providers are a politically powerful stakeholder group in Medicaid politics because without them the program cannot operate. He argued that providers are particularly interested in reimbursement rates and coverage for additional services, and are less concerned with expanding eligibility for the program. The ability of health care providers to shape Medicaid payments and policies must be seen in the context of low Medicaid provider reimbursement rates, which cause many states to struggle to attract enough providers to participate in their programs (Kaiser Family Foundation, 2015b).

While the role of partisan politics in shaping Medicaid policy is not surprising, unions emerged from the literature as an unexpected factor in shaping health policy. Labor unions representing health care workers apparently have been able to influence health policy in some states to their benefit, or at least the strength or density of unions is associated with health policy that favors health care workers (Lukens, 2014; Pracht, 2007; Sparer, 1996b). Lukens (2014) showed that an increase in union density was associated with more generous eligibility standards for children in CHIP or Medicaid, and Pracht (2007) found that in states where more workers were represented by unions, there was less capitated managed care, which is seen as a threat to health care jobs. Similarly, Sparer (1996) found that one of the reasons why New York has spent much more per Medicaid enrollee than California has been the ability of interest groups, particularly unions, to influence the state officials who oversee the Medicaid program to increase the reimbursement rates that health care workers are paid through Medicaid. The influence of unions is worth considering as a variable that may help to explain why some states governed by Republicans were able to expand Medicaid while others were not.

While much of the Medicaid-politics literature focuses on the role of stakeholders who stand to benefit financially from the program, there are also a limited number of sources that have looked at the role of beneficiaries or potential beneficiaries in shaping state Medicaid programs. For instance, some scholars have looked at the role of AARP in shaping state-level Medicaid policy as a way of understanding consumers' role in health policy (Gray, Lowery, & Godwin, 2007; Lukens, 2014). However, because AARP represents people over 50, the influence of that organization may not be a perfect proxy for consumers and beneficiaries in general, and certainly represents a different demographic than much of the Medicaid expansion population. At the same time, the fact that AARP is a national group allows for interstate comparisons,

which can offer some insight into how Medicaid beneficiaries have been able to shape the program. Presumably this national presence and ability to compare across states is why AARP was the consumer group that appeared in the literature, despite the fact that this organization's involvement in Medicaid policy is limited by the group it represents. Lukens (2014) found that AARP has a mixed effect on payment rates. At the state-level, larger percentages of seniors belonging to AARP correlates with increased Medicaid payment rates, but the influence of AARP³ relative to other lobbying groups is associated with lower payment rates. Lukens suggested this outcome may reflect that seniors support Medicaid in general, but have mixed views on payment rates that may benefit nonelderly Medicaid recipients.

Kronebusch (1997) argued that groups that have traditionally received public benefits have varying levels of political influence and garner different levels of political sympathy. For example, seniors and children often garner more sympathy from policymakers. Seniors are also an important voting bloc. According to Kronebusch, poor adults, on the other hand, are usually seen as less deserving and as a group do not hold as much political sway. As a result, they often have less influence on Medicaid policy.

As previously noted, outside of certain required eligibility and benefit parameters, states have broad flexibility in terms of how they structure their Medicaid programs. In addition to the interest group politics that have shaped how states have used this flexibility, there is an additional dimension of negotiations between the federal government and state governments that has affected the individual programs. States have typically sought to maximize the amount that the federal government will pay for the overall cost of Medicaid while minimizing the amount

³ Lukens utilized an interest group influence variable to rate the relative influence of groups against one another to identify which groups have the most influence. He used a variable created by Ronald Hrehbenar and Clie Thomas.

that states are responsible for out of their general funds. Furthermore, states have often used waivers under Section 1115 of the Social Security Act as a means to achieve increased flexibility within the program. These waivers, commonly referred to as 1115 waivers, allow states to experiment with different program designs if they are able to keep the federal cost of the program equivalent to the cost without a waiver. These waivers have been the policy tool for much of the experimentation in Medicaid (Olson, 2010; Rose, 2013; Sparer, 1996a; Thompson, 2012; Thompson & DiIulio, 1998).

How have state-level political and stakeholder dynamics shaped ACA implementation? ACA implementation at the state level has been an object of controversy and partisanship. The decision about whether or not to expand Medicaid was preceded by two years of wrangling over the decision about whether or not to set up state-based insurance exchanges and how to implement a high-risk pool. These decisions were highly partisan (Dinan, 2014; Jones, Bradley, & Oberlander, 2014; Rigby, 2012) and also fit into a history of negotiations between states and the federal government about implementation of large-scale policy initiatives (Haeder & Weimer, 2015; Jones et al., 2014).

Health insurance exchanges (*i.e.*, organized markets where consumers can shop for health coverage) could have been a piece of the ACA that Republican governors supported. The idea of an organized marketplace was one that many Republicans had previously embraced, and the fact that states were free to set up their own exchanges could be seen as a way of preventing the federal government from taking over the insurance marketplace in a given state (Jones et al., 2014). However, the political context proved to be more important than the question of whether or not Republicans could support the idea of an exchange. The ACA passed Congress along strictly partisan lines, and many states saw a rise in Tea Party influence following the ACA's

enactment. The fact that exchanges were ideologically consistent with traditional Republican health policy ideas or that states usually take up participation in federal programs did not matter. The polarized partisan politics of the ACA were such that most Republicans at the state level opposed anything related to the proposed legislation (Dinan, 2014; Haeder & Weimer, 2015; Jones et al., 2014; Rigby, 2012).

Rigby (2012) developed a framework for categorizing resistance to the ACA based on whether states joined a lawsuit challenging the law, enacted legislation opposing the law, or passed up federal dollars to implement it. The factors she examined to explain this resistance included public opinion, party control, state capacity, and the size of the policy change in the state required by the ACA (p. 1). She demonstrated that while public opinion explained some of the resistance, the most important factor was the party affiliation of elected officials. In Rigby's analysis, economic factors, such as the state's overall income, wealth of the state or the level of economic stress the state was experiencing, did not affect the level of state political resistance. Furthermore, partisan politics were stronger predictors of whether a state would oppose the ACA than the number of uninsured people who would gain coverage through Medicaid. In other words, despite the fact that the law would have done more to help Texas and Louisiana than many other states, leaders in those states showed no interest in implementing core elements of the ACA (Rigby, 2012).

While the ACA is not the first program to require state cooperation with the federal government, it varies in some important ways from other implementation efforts. Looking at the Pre-existing Condition Insurance Program, state exchanges, and Medicaid expansion, Haeder and Weimer (2015) concluded that ACA implementation was similar in many ways to the implementation of other health policies in that implementation across states was often

inconsistent and gradual. Exploring the history of policies such as the Kerr-Mills Act, the original Medicaid program, Disproportionate Share Hospital Funding, and CHIP, they argued that implementation was often uneven, and that some states required more beneficial financial arrangements or flexibility in order to participate. In the ACA, the Department of Health and Human Services (HHS) continuously provided flexibility to states in order to encourage them to establish their own exchanges, or at least part of their own exchanges. HHS moved deadlines and even created the idea of partnership exchanges in which states could take on certain aspects of running an exchange without the full responsibility. Similarly, the federal government has provided flexibility for states to opt in to the Medicaid expansion at any time, and has been willing to offer alternative expansion options. Yet despite this flexibility, there continues to be significant resistance by many states to major provisions (exchanges and Medicaid expansion) of the law's coverage expansion. The partisan divide over and the state resistance to the ACA is stronger than it has been for other programs (Dinan, 2014; Jones et al., 2014; The Advisory Board, 2017).

How have state-level political and stakeholder dynamics shaped decisions to expand Medicaid under the ACA? The decision about whether or not to expand Medicaid has largely fallen on party lines, with states led by Republican legislatures and governors generally resisting expansion and states run by Democrats accepting it. However, there have been notable exceptions, with nine Republican governors agreeing to expand Medicaid (Callaghan & Jacobs, 2016; Dinan, 2014; Jacobs & Callaghan, 2013; Rose, 2013). According to Jacobs, Callaghan (2013), and Flagg (2016), these Republican governors were the subject of “cross pressure,” with partisan politics pulling them in one direction (rejecting expansion) and other state-level factors such as administrative capacity, state affluence, and historical reform efforts pulling them in

different directions.

Scholars have identified a variety of factors that have influenced state decisions on Medicaid expansion. Jacobs and Callaghan (2013) emphasized the role of party control, state affluence, previous decisions to expand eligibility to optional populations (*e.g.*, parents), and administrative capacity as factors that have affected the position of different states on Medicaid expansion. They found that all four factors correlated with a state's decision with whether to expand. Alternatively, Rose (2015) pointed to voter support for Medicaid expansion, budgetary considerations, such as the potential for federal Medicaid dollars to offset state expenditures on health-related programs, the formation of diverse coalitions in support of expansion, and high need due to large uninsured populations as pressures that pushed against the partisan impulse to resist expansion.

Callaghan and Jacobs (2016) further explored the influence of public interest, business, professional, and union lobbyists on Medicaid expansion decision-making. The authors relied on publicly available information to create numeric values for different influences as well as Medicaid expansion progress, and their conclusions were based on a quantitative analysis as opposed to key informant interviews. They argued that lobbyists working on behalf of health advocacy organizations devoted to a group of beneficiaries had an impact on decisions to expand Medicaid, whereas lobbyists who represented business interests did not. Notably, Callaghan and Jacobs (2016, pp. 309-310) concluded that business and professional associations opposed Medicaid expansion because of increased regulation and higher tax requirements. In contrast, Rose (2015) pointed out that business groups have advocated for Medicaid expansion in many states. This suggests that further work is needed to clarify the role of business groups in the Medicaid expansion debate.

Rose (2015) delved deeper into a fewer number of states that have expanded Medicaid to understand the politics behind the decisions. In Arizona, Governor Jan Brewer was the first Republican governor in a state with a GOP-majority legislature to support the expansion. She was eventually able to persuade the legislature to vote for expansion, but needed to “throw all her political capital into the crusade...” (p. 72). She refused to sign any legislation until the state legislature passed Medicaid expansion. She cited both the financial benefits and the fact that voters had approved Medicaid expansions in the past to support her efforts (Rose, 2015).

In Nevada, Governor Brian Sandoval had an easier time expanding Medicaid because he was working with a Democratic legislature. He used primarily fiscal reasons to justify expansion. In addition, Rose (2015) cited the state’s high uninsured rate (23%) and heavy lobbying from the health care industry as reasons for his decision to support expansion. Lobbying was also a factor in Governor John Kasich’s decision to expand Medicaid in Ohio, where a coalition of hospitals, business groups, and religious organizations advocated for Medicaid expansion. As opposed to Governor Brewer, who was able to persuade the Arizona legislature to go along with her proposal, Kasich could not sway the Ohio legislature and went around them through the state’s Controlling Board, which oversees budgetary issues. Kasich’s appeals to legislators emphasized the moral imperative of expanding insurance to the poor (Rose, 2015).

Medicaid decisions in Ohio and Wisconsin also demonstrated signs of the cross pressures that influence state decisions and the extent to which specific state circumstances factored prominently into Medicaid expansion decisions (Flagg, 2016). Flagg wrote in-depth case studies about these two states and found that the states’ history with health reform and the specifics of the policy-making process mattered. For example, in Wisconsin Scott Walker was able to cover additional populations because of a pre-existing eligibility expansion. He managed to support

expanded coverage while maintaining his conservative credentials by avoiding accepting the Medicaid expansion under the ACA. Similarly in Ohio, unique circumstances made the expansion feasible. The state constitution allows for public referendums. Because Kasich's bill to limit collective bargaining was overturned through such a referendum the year before, it seemed likely that a referendum could pass that would expand Medicaid. The potential for the referendum, which would have amended the state constitution, made the speaker of the Ohio House of Representatives more willing to figure out a way to expand Medicaid. The presence of the Controlling Board, which is tasked with overseeing certain capital and operational expenses, gave Kasich and the legislature an opportunity to approve the expansion without a legislative vote. Flagg found that in Ohio, interest groups were active and unified, and that a strong coalition helped Kasich advance his desire to expand Medicaid. While interest groups in Wisconsin were less active, it is difficult to tell if that is because even absent the ACA's Medicaid expansion, so much of the Medicaid expansion population was already covered through the prior Badgercare expansion (Flagg, 2016).

Discussion

From this literature review it is evident that partisan politics and stakeholder interests have long shaped Medicaid policy, and the current debate about expansion under the ACA is part of a long history of negotiation between states and the federal government. One crucial determinant of state-level decisions about Medicaid policy is party control of state government. Historically, Democratic governors and legislators have been more willing to expand populations and services covered by Medicaid than Republicans, though whether the legislature or the governor is the driving force behind expanding Medicaid varies. For this reason, I am studying

states that have both a Republican governor and at least one house of the legislature controlled by Republicans since both are important factors.

There is a common pre-ACA pattern in Medicaid politics: states work to shape the program to their liking (and the interests of stakeholders) and typically try to get the best deal they can from the federal government. This is an important history to consider because in the case of the ACA, states are getting a much higher matching rate than they have historically received, yet many are still unwilling to expand. This suggests that Medicaid expansion decisions are being driven by factors other than states' financial interests, and that partisanship may be playing an even greater role in Medicaid politics than it has in the past.

Looking at the literature on Medicaid politics, there are multiple stakeholders that have sought to shape state Medicaid programs. Physicians, hospitals, beneficiaries (who are made up of a range of different groups, from older adults in long-term care to lower-income families with children eligible for Medicaid), unions, and managed care companies all have a stake in how Medicaid programs are designed. There is no one consistent pattern for how these stakeholders exert influence on Medicaid policy, but in many cases the more organized and well-represented a constituency is, the better its ability to influence public policy. In the literature I reviewed there were multiple cases where the percentage of possible stakeholders belonging to a membership group affected policies in the direction that group would intend, such as less capitated managed care enrollment in states with high union membership. While these studies cannot conclude that there is a cause and effect relationship between the strength of the interest groups and the policy outcomes those interest groups would be expected to advocate, the strength of the groups often predicts the final decision.

The literature on interest group influence on Medicaid politics underscores the program's heterogeneity. Medicaid policy is comprised of an array of policy domains, including provider payment policy, enrollee eligibility standards, and benefits. Stakeholder groups may have more influence or be more politically active on some policy domains within Medicaid than others. Put another way, the influence of interest groups is likely to vary not just according to the power and resources of the group, but also by policy area.

It is also evident that some beneficiaries are considered more worthy than others. Children and the elderly are often seen as more deserving of help. Given that more of the expansion population would be childless adults, understanding the way this group has been portrayed would be an important addition to the literature on the politics of Medicaid. In the same way that not all populations are given equal attention, not every decision surrounding Medicaid is made in the same way. While stakeholders have had an active influence on adopting or resisting managed care, it is not at all certain that their influence was the same over decisions to expand Medicaid under the ACA.

From this literature review, it is clear that while states and the federal government have often negotiated over Medicaid policy and implementation of health policy more broadly, ACA implementation has been more highly partisan than other policy implementation efforts. Democrats have been much more likely than Republicans to expand Medicaid under the ACA as well as set up state-based marketplaces to purchase insurance.

Despite the highly partisan nature of Medicaid expansion under the ACA, there are eight states that have expanded Medicaid while Republicans controlled both the governor's office and at least one house of the legislature. While some researchers have offered explanations by looking at the relative influence of different stakeholder groups or the motivations of governors

as stated publicly, there is only one study that used key informant interviews to understand how the expansion came about. That study showed the importance of in-depth case studies for understanding the dynamics that led to expansion in Republican states, in which a combination of the current Medicaid program, political pressures, and stakeholder interests could explain expansion decisions.

My study will focus on the strategies and methods that government actors and non-governmental interest groups used to influence the Medicaid expansion debate and place those debates in the context of the state's history with Medicaid policy, the political considerations of the governor and key legislators, and any other particularly notable considerations, such as hospitals in the state being particularly dependent on Medicaid for sustainability. The literature I reviewed focused more on correlations among different factors as well as the history of states' Medicaid policies, but did not focus as much on the specific strategies of how politicians and interest groups exerted influence. That question of not just whether there is a relationship among the influence of certain groups and outcomes, but how that influence was exerted is one of the gaps that this study will fill. Furthermore, very few of the studies that examined the politics of ACA implementation analyzed the role of beneficiaries. Researchers who studied previous decisions to expand Medicaid to new groups, change reimbursement rates, or adopt managed care limited their assessment to the role of AARP, which may not be generalizable to groups that represent other beneficiaries. There were also conflicting accounts of the role of business in pushing for Medicaid expansion under the ACA. Therefore, providing new information about the role of business in Medicaid expansion under the ACA would be a valuable contribution to the existing literature. Together these in-depth cases studies will offer new insight into the politics of Medicaid policy.

CHAPTER 3: METHODOLOGY

In order to answer the question about why some Republican-led states expanded Medicaid under the ACA and what role stakeholders, state politics, and other factors played, I conducted case studies of three GOP-controlled states, including Arizona, which expanded Medicaid through traditional means; Indiana, which expanded Medicaid via an alternative method that included elements such as increased cost-sharing, contributions to a health savings account, or premiums that had not previously been allowed by CMS; and Tennessee, which chose not to expand. For the purposes of this research, I have defined Republican-led states as those that have both a Republican governor and at least one chamber of the state legislature controlled by Republicans. I used several variables to select states that were comparable in terms of partisan dynamics.

Case Selection

In order to decide which states to study, I created a list of states that were led by Republicans when they expanded Medicaid, or that were led by Republicans as of July 1, 2016, which is the study's cutoff date for classifying expansion and non-expansion states. I also categorized states by whether Barack Obama won the state in the 2012 presidential election. Orange columns include states that voted for Obama in 2012, and states in green columns did not. This variable was added in order to control for the state's political environment, and help identify states that are similar both in their leadership and political environment. A Republican-led state that voted for Obama in a presidential election may have more moderate leaders and a

different political environment than a Republican-led state that did not vote for Obama. In Table 1, I have coded states with an asterisk to indicate expansion through an alternative to traditional Medicaid, and states that have two Republican senators are shaded a darker color of either orange or green. I included this distinction as another factor to estimate how strongly Republican leaning the electorate tends to be. Pennsylvania was the only state that had a gubernatorial shift from Republican to Democrat since expansion, so I eliminated it from the analysis (National Academy for State Health Policy, 2016; National Conference of State Legislatures, 2017a; The Advisory Board, 2017; New York Times, 2012).

Table 1

States Categorized by Partisan Control, Whether They Expanded Medicaid, and Whether Barack Obama Won the State in the 2012 Presidential Election

R-led State, ^a Expanded Medicaid, Voted Obama in 2012	R-led State, Has Not Expanded Medicaid, Voted Obama in 2012	R-led State, Expanded Medicaid, Did Not Vote for Obama in 2012	R-led State, Did Not Expand Medicaid, Did Not Vote for Obama in 2012
Iowa*	Florida	Arizona	Alabama
Michigan*	Maine	Alaska	Georgia
Ohio	Wisconsin	Indiana*	Idaho
Pennsylvania		North Dakota	Kansas
			Mississippi
			Nebraska
			North Carolina
			Tennessee
			Texas
			Utah
			South Carolina
			South Dakota
			Oklahoma
			Wyoming

^aR-led = Republican-led

Given that I wanted to hold constant whether a state voted for Obama in 2012, I could have either chosen to compare among states that voted for him in that election or among states that did not. I chose from among states that Barack Obama did not win in 2012 because there are more states like this than Republican-led states that Obama won. Consequently, these states may be more representative of prevailing Republican ideology and more useful both for understanding the political dynamics in most GOP-led states and ultimately informing a plan of change that would help RWJF support efforts to ensure access to health care and health-related services in all states. Furthermore, since these states may be considered more solidly Republican, the fact that four of them expanded Medicaid raises a particularly interesting question about what happened in these states to make them break from partisan trends. From these states (the green columns), I wanted to explore one traditional Medicaid expansion, one alternative expansion, and one non-expansion in order to compare how political dynamics played out in these different situations and to observe whether there were patterns in how stakeholder dynamics, state history, or other features affected the states' outcomes in terms of Medicaid expansion.

Bearing this reasoning in mind when choosing my case studies, I decided on Arizona because it is relatively populous and expanded Medicaid in a traditional way (The Advisory Board, 2017). Looking at the column of states that did not expand, Tennessee emerged as a good comparison. With 6.6 million residents, it has a comparably sized population as Arizona. For the nontraditional expansion, I chose Indiana. It was the only state in the green category that had a nontraditional expansion, and with 6.7 million residents it is in a similar category as Tennessee and Arizona in terms of population (United States Census, 2016). Given that Indiana has one instead of two Republican senators (United States Senate, 2016), it is possible that it is slightly less Republican than the other two states, but it is within a similar ballpark. The three states are

all fairly consistently Republican in their electoral politics, have similar sized populations, and a mix of urban and rural residents. For these reasons, these states make more sense to compare than South Dakota, Wyoming, or Nebraska, which are relatively sparsely populated. No three states will be perfect comparisons, but they are three states that I can compare and assume that some underlying political factors are fairly consistent across them.

Data Collection

For each state, data collection consisted of key informant interviews, news articles, position papers, government documents, and policy briefs, as well as peer-reviewed and grey literature. I read approximately 50 newspaper articles from each state's most widely read daily newspaper. I identified articles by searching archives for "Medicaid expansion" and "ACA" and then read articles that were focused on the political dynamics of expanding. I used this information to create a timeline and identify people both in and out of state government who played an active role in the expansion debates.

I conducted between six and eight interviews in each state, as well as two interviews with staff members of national groups that work directly with states for a total of 24 interviews. Informants were identified in a number of ways: names that appeared in relevant newspaper articles, people I knew that had been involved in Medicaid expansion debates through my own work, through outreach to stakeholder groups I assumed may have been involved, or names that came up during interviews or readings. In each state I interviewed a combination of representatives from each of the following groups:

- 1) Foundations;
- 2) Governor staff and other executive branch staff members;
- 3) Clinician groups;

- 4) Hospitals and hospital associations;
- 5) Chambers of Commerce;
- 6) Consumer groups;
- 7) State-based researchers;
- 8) National groups that provide technical assistance to states; and
- 9) State legislators.

The complete interview guides, for informants in the state government, outside the state government, and from national groups, are included as Appendices A, B, and C. These interviews were semi-structured, with participants asked the same questions, but with modifications to allow conversation to flow naturally. I also added references to events or circumstances that I learned were important from reviewing documents ahead of time. I found that presenting myself as well-versed in some of the basic history of the state allowed informants to speak in greater detail about their work.

I traveled to each state capital for a two-day site visit during which time I conducted most of the interviews. I visited Phoenix in October of 2016, Nashville in December of 2016, and Indianapolis in January of 2017. In several cases I conducted interviews over the phone when scheduling did not allow for in-person contact. Interviews lasted between 21 minutes and 58 minutes, with an average length of 32 minutes. In two cases, interviews with two informants at the same organization were conducted together. I recorded interviews using either a telephone bridge line or a portable digital recorder. To maintain confidentiality, I saved recordings on a password protected computer and the names of interviewees were not noted on the files. I kept a separate file that linked the interview file names to the person on a different computer, which

was also password protected. A professional service, TranscribeMe, transcribed the audio recordings into Word files.

Through interviews, I explored the questions of which stakeholders were able to influence the governor and legislature to pursue (or resist) Medicaid expansion, and what strategies groups used in their efforts to shape the Medicaid expansion debates. I also asked about other factors that explained expansion decisions. Additionally, I looked for information about when different groups were active. Recognizing that some groups may have been more involved in specific negotiations around tradeoffs about policy decisions, while others may have been more involved with building public support, I was attentive to contradictions or agreement among stakeholders. For example, does everyone agree that the hospitals were the most influential or does each group think they were the most influential? Similarly, was the public message different than what was going on in private conversations? As important as understanding when there was consensus, it was also critical to understand where groups differed in their understandings of what happened.

The proposal for this research was reviewed by the University of North Carolina at Chapel Hill's Institutional Review Board and was deemed exempt from ongoing review (15-2734).

Analysis

I had two goals in working with the data I collected: 1) giving a complete picture of what happened; and 2) exploring how and why events happened in order to understand what role state history, politics, and stakeholder engagement played in the question of why some states expanded Medicaid and others did not. The first step in data analysis was constructing a timeline from newspaper articles. I did this before conducting interviews and it served as a skeleton to

hang additional information on. After site visits I wrote short 2 page notes about key themes that emerged. This helped identify the overarching themes that would guide the analysis. I used Creswell's (2014, p.198) eight steps for coding the qualitative data, including:

- 1) Reading all transcripts to get a sense of the whole;
- 2) Working through one document intensively;
- 3) Making a list of topics;
- 4) Applying this list to topics and adjusting as necessary;
- 5) Reorganizing topics as appropriate;
- 6) Creating codes;
- 7) Performing a preliminary analysis;
- 8) Recoding as necessary.

I read all transcripts to identify themes. I developed a list of six themes: 1) governor and legislator dynamics; 2) state's previous Medicaid policy history; 3) language used in Medicaid debate; 4) coalitions; 5) political environment; and 6) federal-state negotiations. After identifying those themes, I then color-coded the transcripts by hand to identify each of these themes in the interviews.

As I worked with the data from multiple sources, I sometimes found it necessary to search for additional materials, such as composition of the state legislature, election results, and additional background material about a state's history of Medicaid policy. There was a significant amount of back and forth in cross-referencing interview materials, newspapers, and other sources.

After constructing notes and coding the data I set about writing each of the three case studies. In consultation with my advisor I settled on a format of incorporating themes into a description of what happened in each state, and followed each description of how events unfolded and what themes were present with a short discussion of the six themes. In different states, some themes were more important than others. In each of the three cases I avoided drawing comparison among states. After the three cases were complete, I looked across the cases for overarching insights that addressed the original research questions.

Limitations

Though I have tried to select states for study that can yield insights on the dynamics of Medicaid expansion in Republican-led states, the experiences of Arizona, Indiana, and Tennessee cannot necessarily be generalized to other states. Because this is a comparison of just three states, I cannot draw definitive conclusions about the factors facilitating or impeding Medicaid expansion in other GOP-led states. The findings from this study will describe the ways stakeholder and interest groups participated in debates about Medicaid expansion in these three states and what other factors explain the states' decisions. Because I specifically chose states that went against a partisan trend, they may not be representative of other states. This is particularly true for the role of policy legacy. These three states had distinctive Medicaid policy legacies that may not be representative of a larger selection of states. Despite these limitations, these case studies can help identify key determinants of decision-making on Medicaid expansion, which are likely relevant in other Republican-led states

A further limitation is the reliance on key informant interviews. I asked informants to describe the role of their organization as well as the role of other organizations in the debates over Medicaid expansion. All of these actors are engaged in ongoing policy debates, and they

may not have wanted to portray themselves in a certain way. For example, a hospital association may want to present itself as more politically powerful than it really is. By the same token, some hospital associations may want to appear less connected to a particular administration than they actually were. In most cases, these actors will have a perspective on how they are viewed. Informants may either aggrandize or minimize their role in these debates based on the reputation they want to maintain. In particular, in Tennessee where the question of Medicaid expansion is still on-going, numerous informants were quite cautious in how they spoke and asked that certain parts of interviews be kept off the record.

While I conducted these interviews in my role as a student and not an employee of RWJF, I was transparent about my work at the foundation. The fact that I work for a funding group may also have caused informants to portray their work as particularly important or aligned with what they thought would help them obtain future funding.

Similarly, I recognize that despite assurances of confidentiality, respondents may be interested in portraying themselves in a particular way. The need to maintain confidentiality also created limitations in the writing process. Quotes are not attributed to individuals, nor even anonymized individuals, such as informant 1. Multiple quotes from the same anonymized source could become easily identifiable to someone familiar with these states. Therefore, when using key informant interviews as materials, I present either overall syntheses of informant responses or unattributed quotes. In the case study write-ups, materials not attributed to printed material comes from key informant interviews.

A further limitation is what information is unknowable through interviews or publicly available information. A governor may have a political ambition in his or her head that s/he has not spoken to anyone about. Similarly, there may be secret negotiations that I will not be able to

learn. It is important to recognize that there is always a possibility that something important is truly undetectable through interviews. In addition, people who are part of the same debate may have contrasting explanations of decisions or report divergent perspectives on events.

Response bias is an additional limitation of this study. I reached out to individuals who had worked in the executive branch of the state government, legislators, and interest groups outside of government. I had very little response from legislators and from interest groups that had opposed expansion. Newspaper accounts, government reports, letters between governors and legislatures, and other documents helped to round out the information I was able to gather, but the fact remains that I heard more from groups that supported expansion than those that opposed it. I was only able to interview one state legislator, though other sources of information rounded out the interviews. At the same time it is important to note that in general I had more direct input from people close to the governors.

Recall bias is a perennial issue in conducting qualitative research, and it is possible that the contentious 2016 presidential election made this problem worse. I conducted interviews immediately before (Arizona) and soon after (Indiana and Tennessee) a polarizing and surprising election. It is possible that informants regarded an earlier time as more bipartisan, or that their views of potential negotiations between parties were shaped by the election. Furthermore, the fact that the governor of Indiana whom I was asking questions about had become the vice-president elect may have changed what people were willing to say or how they regarded him in hindsight.

CHAPTER 4: ARIZONA

Arizona's Medicaid expansion fits into a clear narrative with Governor Jan Brewer as the protagonist fighting against a resistant legislature. Her support for Medicaid expansion reflected a combination of sympathy for people who would not have coverage and state budget concerns. Once Governor Brewer decided she was in favor of expansion, a coalition led by the Arizona Chamber of Commerce worked hand in hand with her and fought hard to win legislative approval. Strong polling numbers and a coalition of conservative spokespeople helped the governor's cause, as did the state's existing Medicaid policy, which required Arizona to cover most of the expansion population already. Nonetheless, it proved to be a difficult legislative fight. The governor and the expansion coalition eventually prevailed by engaging in a concerted lobbying effort.

Sebelius v. NFIB Meets Proposition 204

Arizona's response to the June 2012 Supreme Court decision in *NFIB v. Sebelius*, which essentially made expanding Medicaid under the ACA a state option, was shaped by Arizona's existing expansion of Medicaid eligibility. In 2000, voters passed an initiative, Proposition 204, to expand Medicaid to childless adults who earned up to 100% of the FPL. At the high point of enrollment under Proposition 204, the state enrolled 227,000 childless adults in Medicaid coverage (Brewer, 2013b). In addition to expanding the eligibility criteria for Medicaid, Proposition 204 required the state to maintain expanded coverage if it had the financial ability to do so. Arizona was hit hard by the economic recession of 2008–2009, and since the state did not

have the funds to support this expansion, it froze enrollment for childless adults in 2011. By January 2013, the number of enrolled adults had fallen to 86,000 (Brewer, 2013b). The ACA created both an opportunity and a quandary for Arizona. If Arizona could access federal money to cover childless adults through the ACA but did not do so, it could have been in violation of Proposition 204 since the enabling legislation required the state to cover the expansion population if funds were available (Robb, 2012).⁴

The 1115 waiver that allowed Arizona to cover childless adults up to 100% of the FPL was scheduled to come up for renewal in January 2014. The state asked CMS in 2012, following the *NFIB v. Sebelius* decision, if they could expand Medicaid eligibility up to 100% of the FPL under the ACA, which would have met Proposition 204's requirements. CMS, however, responded that Arizona had to do the full expansion to cover childless adults up to 133% FPL. The state would not have been able to cover the population they had already expanded to under Proposition 204 without the federal matching funds. The idea of having to disenroll the remaining population was very unattractive to the governor. While the state was able to freeze enrollment without significant backlash, the governor's office feared the backlash of taking a benefit away from people. One informant describe the fear in the following way:

We had actually done something like that prior to this. We went in and eliminated certain benefits. They were optional benefits under Medicaid, including some transplants coverage. We did a medical study, determined every person that had had these transplant procedures had died. And so we eliminated those, and the newspaper started a death watch. And all these people started coming forward, 'We're going die,' and they determined it was like 100 people that were eligible for these. And ultimately, the legislature caved and restored the benefits.

⁴ One informant indicated that Arizona's Medicaid policy was also shaped by a previous lawsuit, *Arnold v. Sarn*, which required services for people with serious mental illness. This lawsuit was only mentioned once, but is worth noting as an additional legal factor that may have shaped the Medicaid expansion decision under the ACA.

The difference between freezing enrollment and taking away benefits was pronounced. Even when it came to children, who are often a more sympathetic group for the public than adults, policymakers found that freezing enrollment was politically palatable while actively taking a benefit away was not.

But we learned a very important lesson about removing a benefit someone already holds versus freezing a population, not letting anybody new get that benefit. At the same time period, we had frozen our children, our program, and not a peep. We dropped that population by like 15,000 kids, and nobody's said anything. But if you remove something from somebody, some with a lot-- so we were very leery about kicking people off of their healthcare.

Arizona basically had three choices. "One, we could kick everybody off. Two, we could do our own, with no federal subsidy with the 77,000⁵. Or three we could expand." The federal government and Proposition 204 had effectively "painted them into a corner."

Building Support for Expansion

Before Governor Brewer decided to pursue the Medicaid expansion, a coalition began meeting to work together to push the governor to make the decision to expand Medicaid. The coalition included most of the lobbyists for the stakeholder groups, including several hospital systems. There was, however, some difference of opinion among hospitals about how important the Medicaid expansion was to them. Larger hospitals, like Mayo, were not that concerned because they did not rely on Medicaid to the same extent as other hospitals. "Mayo did not participate because they don't do Medicaid...They don't accept Medicaid, Medicare. You have to pay and then you bill your Medicaid but they don't ace the reimbursement." That description is not entirely accurate, since other reports estimate that Mayo would earn \$750,000 annually by

⁵ The 77,000 refers to the number of adults who were still enrolled through Proposition 204, but would no longer be eligible for federal matching if CMS did not approve the waiver that would allow the state to enroll childless adults up to 133% of the FPL. In certain documents, the remaining number of adults in the Proposition 204 expansion is cited as 86,000. The number may have changed over time since the enrollment freeze was meant to gradually reduce the number.

having more people covered by Medicaid (Fischer, 2013). However, the majority of Mayo's services in Arizona are focused on specialty and transplant services, (Christie, 2013) and so they were not going to see the same drop in uncompensated care. This set them apart from hospitals that relied heavily on Medicaid, particularly when it came to negotiations with the state about a provider assessment that would help the state pay for its share of the new costs associated with expansion. For the smaller rural hospitals that were in danger of closing, the Medicaid expansion was a much more crucial issue. Informants indicated that the hospital association was going through turmoil separate from the Medicaid expansion issue, including a number of member hospitals leaving the association, and was not in a position to lead this effort. Notably, the hospital association did not respond to multiple requests for an interview.

That early coalition recognized that the business community had to get behind the Medicaid expansion. From meeting notes and agendas that a member of the coalition provided, the earliest members included many of the hospitals and behavioral health providers. Physician and nurse groups were not represented, and there was relatively little mention of physicians and nurses in stakeholder interviews. In addition to building support in the media and meeting with the governor, the coalition identified a schedule of meetings with the Arizona Chamber of Commerce to ask them to take on the issue. This corroborates what an informant said about the hospitals approaching the Chamber. Both the Greater Phoenix Chamber and the Arizona Chamber joined the effort, and one informant said it was surprising that the Arizona Chamber became so involved on the issue because they are usually more conservative. In fact the Arizona Chamber did not speak up about cuts to Arizona's CHIP program, which is usually a more bipartisan issue. While the Arizona Chamber acknowledged that it was not a fan of the ACA, they were strongly supportive of the Medicaid expansion for financial reasons (Reinhart, 2013a).

They pointed to the burden on employers of rising premiums because of the costs hospitals incurred from treating uninsured patients—costs they believed were shifted to employers. They specifically identified the proposition 204 enrollment freeze as a cause of increased uncompensated care and cost shifting affecting employers' premiums. The chamber also regarded the provision of the expansion that would fund the state's share of the expansion population from a provider assessment as a positive development for the state's budget. Furthermore, they cited the increased employment in the hospital sector as a reason to support the expansion (The Arizona Chamber Foundation, 2013).

The strong coalition had mutual financial interests. The hospitals preferred to pay an additional assessment to cover the state's share of Medicaid expansion if it meant less uncompensated care. The assessment was not only less money than the cost of uncompensated care, but more predictable for the hospitals. Predictability was a motivating factor for the state as well. The hospital assessment was a reliable way to fund Medicaid, and both the state and the hospitals benefitted from the additional federal money. The mutually beneficial financial arrangement was central to the willingness of the governor to support Medicaid expansion.

In addition to lobbying by important stakeholders, the governor reportedly was also swayed by stories of people losing coverage. St. Lukes Initiative (now Vitalyst) had supported the Council of Human Services Providers to collect stories about people struggling with behavioral health problems, and informants thought those stories may have influenced the governor. St. Luke's also supported polling conducted by an advisor to the governor, Chuck Coughlin, which showed support for expansion. Because the polling was conducted by someone whom the governor trusted, it was more likely to affect the governor's thinking than if it had just been done by an advocacy group. As a sign of the pragmatism involved in the work of the

coalition, it was evident Mr. Coughlin was not the coalition's first choice as a pollster to work with, but they knew he was trusted by the governor, which is why they worked with him. Two respondents mentioned the governor's experience with a close family member who had mental health challenges, and suggested that her own experience may have shaped her views. Moreover, the business community approached the governor and told her that they saw the need for expansion. Another informant directly tied her support for Medicaid expansion to her well-known controversial stance on immigration because without expansion legal immigrants could buy subsidized coverage below the 100% FPL threshold while citizens could not. This particular argument appears in the governor's budget in the section on the need for Medicaid expansion as well (Brewer, 2013b).

The Governor Decides to Expand

According to someone who worked closely with the governor, staff members in the Brewer administration who were assessing the issue through a budgetary perspective saw Medicaid expansion as a necessity. They talked to her chief of staff who was convinced about the need for expansion, and he talked to the governor. Through the Christmas holidays of 2012 the governor weighed her options and finally decided to move forward with the expansion, though she left her staff and others full of suspense. As Brewer's 2013 State of the State address approached, it was uncertain whether she would support Medicaid expansion. Her budget director had two versions of the budget printed to leave the door open. The Medicaid expansion was in the initial State of the State speech that Brewer prepared, but then she took it out at the last minute. However, the governor reversed course and put the expansion into the speech when she delivered it on January 15, 2013. The informants could not say for sure whether the governor was really going back and forth or if she initially took it out to keep the press from getting ahead

of her announcement, as they would have an advance copy of the speech. If she did intentionally keep the version of the speech with the announcement away from the press, it demonstrates a keen sense of strategy on the governor's part.

The other notable part of the governor's framing during her State of the State address was how strongly she established herself as both an opponent of President Obama and Obamacare. When Brewer got to the part of her speech that addressed Medicaid, she said "Nor can we simply wag our finger at the federal government. Trust me: I tried that once" (Brewer, 2013a). Presumably she was referring to her controversial greeting of President Obama when he came to Arizona and the photograph of her pointing her finger at him on the tarmac. She went on to explain how hard she has fought against the ACA in court and that she refused to set up an exchange. The message was plain: she was not proposing this policy out of any mixed feelings about the ACA or President Obama, but simply the facts of the situation. Brewer touched on a combination of arguments, including the fact that Arizona tax dollars would go to other states if Arizona did not expand Medicaid coverage, to the fact that the expansion was a good deal for the state, saying

With the realities facing us, taking advantage of this federal assistance is the strategic way to reduce Medicaid pressure on the State budget. We can prevent health care expenses from eroding core services such as education and public safety, and improve Arizona's ability to compete in the years ahead (Brewer, 2013a).

Brewer also pointed to the Arizona Health Care Cost Containment System (AHCCCS), Arizona's name for their Medicaid program, as the "nationally-recognized gold standard for cost-effective, managed care in this country." The other topics she talked about were the ability to provide health care to low-income Arizonans, the economic benefits, and the risks that rural hospitals faced in dealing with uninsured patients. She also mentioned that Arizona tax dollars would be going to other states if Arizona did not expand, and she discussed the "circuit breaker"

that would roll back eligibility if the federal government subsequently reduced funding for the Medicaid program. She tried to minimize the expansion by referring to “agreeing to expand our Medicaid program just slightly beyond what Arizona voters have twice mandated,” emphasizing both that the public had supported previous expansions, and that this would not be going far beyond those previous expansions (Brewer, 2013a). This last point in particular reflects what several informants expressed as a preference for talking about “Medicaid restoration” as opposed to expansion. The idea was that early on they hoped to use ACA funds to re-open the enrollment for adults up to 100% of the FPL and not expand to 133% FPL, although when CMS denied that request they could not refer to “Medicaid restoration” any more.

Before moving on from Medicaid to other priorities, the governor told the story of Shelby, a young girl with a debilitating disease that was treated successfully at the Translational Genomics Research Institute Center for Rare Childhood Disorders in Arizona. She also noted that with the hospital assessment and the federal funds, the general fund would not bear responsibility for the cost of expansion (Brewer, 2013a). This combination of the success of Arizona’s Medicaid program, the financial benefits, the fact that voters had approved a previous expansion, and the impact on patients were the combination of rationales she relied on in explaining her decision.

Brewer would return to this theme of emphasizing her conservative credentials when talking about the Medicaid expansion. At a rally in March of 2013, she said “I’ve always been proud to be a member of a pro-life party...I refuse to stand by and let this many people needlessly suffer, especially when we have a solution” (Reinhart, 2013b). Her stance was that of a devout anti-Obama conservative who had looked at the issue and despite everything she hated about the ACA and Obama, thought it was in Arizona’s best interest to expand Medicaid.

The Fight

When Governor Brewer announced her intention to expand Medicaid, it began a months-long heated debate within the Arizona legislature. The immediate reactions were mixed. Heather Carter (R-Cave Creek), the House Health Committee Chair, said “This sure sounds like a win-win for our economy and the right thing to do.” Other Republicans took a wait and see approach or voiced steadfast opposition (Sanchez, 2013). Based on both newspaper accounts and key informant interviews, there was a strong coalition of providers, consumer groups, religious groups, law enforcement, and the state Chamber of Commerce in support of expansion. Along with the governor and her staff, this coalition actively lobbied the legislature. In anticipation of the need to wage a lobbying effort, the Arizona Chamber of Commerce hired Jaime Molera, a lobbyist with his own firm, to lead the campaign.

The coalition was able to bring unusual and unexpected voices to this campaign. As one informant said, “All the advocacy groups that you would normally assume would back something like this back it. But there was a conscious decision not to put them in the limelight because...this really needed to be talked about...through a more conservative lens.” The informant went on to say, “She [Brewer] fought with legislators in her party...Having the backing of the liberal children’s groups is not that helpful.” Other groups that were involved included advocacy organizations, like the American Cancer Society and the American Heart Association (AHA) as well as Valley Interfaith, which is an interfaith group that is considered somewhat right of center. Law enforcement also became part of the coalition because they were seeing people with behavioral health problems end up in jail, and they did not want that to continue. The sheriffs and the county attorneys participated in the coalition. Both groups believed that people with behavioral health problems who did not receive adequate treatment

tended to end up in the criminal justice system. “We also had folks from law enforcement, fire...we had some sheriffs. From a criminal justice though—ideally we could get everybody the treatment and healing they need, so they never end up encountering the criminal justice system.” The governor and the coalition continued to rely on both economic and moral arguments that Brewer had outlined in her State of the State speech, continually talking about the need for care as well as the economic arguments and the benefit to the state.

For much of the spring of 2013, the debate continued, with Republican leadership in both chambers opposed to bringing the question to a vote. Most of the pro-expansion efforts focused on Republicans in the legislature since Democrats supported the expansion. However, the coalition had to keep Democrats from making the situation too politically difficult for the governor. “The trick there was to keep pressure on them to not be greedy, as well as to not put the governor in a political corner where she would lose Republicans.”

One of the key questions with which the legislature wrestled was whether the assessment on hospitals, which would offset the state’s share of the cost of expansion, was a tax, which would have required a 2/3 majority instead of a simple majority in the legislature. The Republican leadership in both houses argued it was a tax (Reinhart, 2013c), but the Brewer administration insisted it was not. In the end, the legislature moved forward under the assumption it was not a tax; that issue eventually triggered a court battle.

An additional theme that came up in Arizona’s Medicaid expansion debate was the power of polling. There was a very strong sense that the public support for this mattered greatly, and the coalition put much effort into polling. In April of 2013, during the debate in the legislature about expansion, more than half of Arizona voters said they favored the expansion, and nearly half of Republican voters said they supported it. Voters who identified as Tea Party Republicans were

twice as likely to oppose as to support it (Reinhart, 2013f). Stakeholders also said that Brewer's popularity increased during the legislative fight, although there were no published reports of Brewer's popularity that would validate that assertion.

The pro-expansion coalition's emphasis on polling reflected their view that this was a campaign that required both direct lobbying and building public support. Several respondents spoke of town hall meetings, public forums, and working with the press on a local level. They invited the press to events, published op-eds, and the governor appeared on conservative radio talk shows. Another informant mentioned that the population of Arizona is not as conservative as the legislature, and that the legislature is somewhat skewed because of primaries that foster competition from the extremes while the districts are not that competitive.

The Arizona legislature, people will tell you who poll, is basically much more conservative than the electorate as a whole...we're not nearly as conservative as people think we are, but the legislature is very conservative, and part of that is because of the way...we have very few competitive districts, and all the decisions pretty much that influence the legislature's composition are made in the primary. They're [primaries] held in August where reasonable people aren't in Arizona. Normal people don't stay in Arizona in August.

The idea that the underlying support was there among the voters and that there were enough moderates to pass expansion were key features of the campaign.

As an indication of how strategic the stakeholders involved were about who the right messengers were and what kind of campaign was needed, St. Luke's, which funded early work around Medicaid expansion, stepped aside as the Chamber took the lead because the foundation felt they were not really needed.

The governor and the coalition worked very closely together, and they focused on getting the votes they needed in the legislature, targeting specific elected officials in order to secure a majority for Medicaid expansion. Informants identified legislative primary challenges as a key

concern for legislators, and the coalition offered to protect those who would be most vulnerable to a challenge from the right by raising money for them and also by ensuring there would be conservative voices who supported them. Interview respondents were proud that none of the Republicans who had supported expansion lost their next election. Election data largely confirms this assertion with the caveat that a few members did not seek re-election (Tables 2 and 3; Arizona Legislature, 2015.; Ballotpedia, 2014).

Table 2

Re-election Status of Republicans in the State House of Representatives who Supported Medicaid Expansion in Arizona

Representative	2014 Election Result
Kate Brophy McGee	Re-elected
Heather Carter	Re-elected
Douglas Coleman	Re-elected
Jeff Dial	Ran for State Senate and won
Doris Goodale	Did not seek re-election
Ethan Orr	Won primary; lost general, but member page says he's been in office since 2013
Frank Pratt	Re-elected
Bob Robson	Re-elected
T.J. Shope	Re-elected

Table 3

Re-election Status of Republicans in the Senate who Supported Medicaid Expansion in Arizona

Senator	2014 Election Result
John McComish	Did not seek re-election
Steve Pierce	Re-elected
Bob Worsley	Re-elected
Rich Crandall	Died
Adam Driggs	Re-elected

While much of the conversation in the media and at public events was about budgets and rural hospitals that would close, the coalition did not ignore the human element. Numerous people mentioned a young man with hemophilia who testified to the legislature that he would die without treatment, and that he wanted to be a productive member of society. Several informants expressed an opinion that such stories were particularly effective with more conservative lawmakers.

The main opposition to Medicaid expansion came from the Goldwater Institute, an organization that describes itself as supporting limited government and protection of states' rights and some Republican lawmakers, particularly those in leadership positions in the House and Senate. Senate President Andy Biggs was a forceful opponent who resisted bringing the Medicaid expansion bill to a vote. He supported maintaining the enrollment freeze and said "At bare minimum we have three years to watch 'Obamacare' implode while we don't have to suffer." He went on to say "Republicans hate this and they're not going to vote for a Republican in a primary who supported this." Andy Tobin, the House Speaker was similarly resistant to bringing the governor's plan to the floor (Reinhart, 2013d). Legislators also questioned the adequacy of care provided by Medicaid and the frustration that they could not insert copays and premiums into the program design as part of the expansion.

In terms of outside groups, informants mentioned Americans for Prosperity (AFP) as a group that organized against Medicaid expansion, but there was no evidence that AFP ran a concerted campaign to oppose the effort. Informants reported debating with representatives from the Goldwater Institute at town hall meetings, and Goldwater put out a number of statements and issue briefs opposing the expansion (Corieri, 2014). Goldwater Institute's opposition focused on the expansion being a part of Obamacare and adding to the national debt. The idea of federal

versus state money was unconvincing to fiscal hawks who saw all government support for health care as essentially a drain on the taxpayer. The Goldwater Institute's opposition generally relied on the argument that the federal financing was less generous than it looked after the first few years and that this would ultimately cost Arizona money, particularly if more people who were currently eligible enrolled at a lower matching rate and if the circuit breaker (*i.e.*, the provision that Arizona would end the expansion if it cost more than expected) was not enforced. Furthermore, they argued that the issue of state money versus federal money was irrelevant because Arizona taxpayers have to support both (Corieri, 2014).

By April 2013 it was becoming clear that the coalition could probably get enough votes to pass the budget with Medicaid expansion, but the House and Senate Republican leadership was unwilling to bring it to a vote (Reinhart, 2013d). The governor made no effort to hide her frustration with the leadership in the legislature. In May of 2013, the governor put a moratorium on signing legislation enacted by the legislature until they approved the Medicaid expansion. She explained this position in no uncertain terms to Senate President Andy Biggs in her veto of a bill that would have defined the free exercise of religion (notably, unrelated to Medicaid). Her letter stated:

I regret being forced to write this letter...I warned that I would not sign additional measures into law until we see resolution of the two most pressing issues facing us: adoption of a Fiscal 2014 State Budget and plan for Medicaid. It is disappointing I must demonstrate the moratorium was not an idle threat.

Arizonans enrolled in the Arizona Health Care Cost Containment System (AHCCCS) face a different sort of deadline. Without legislative action, an estimated 63,000 AHCCCS members will lose their coverage on January 1, 2014. Fortunately, this need not happen. We have a Medicaid Restoration Plan that will maintain coverage for those in need, honor the will of Arizonans who have twice voted to expand Medicaid, save our General Fund, keep Arizona tax dollars in Arizona, and protect rural and safety-net hospitals. (Brewer, 2013c)

After the legislature adjourned without voting on Medicaid expansion, Brewer called a special session on June 12, 2013. Arizona's legislative rules allow a simple majority of legislators to bring a bill to the floor. While there had been discussion about replacing Biggs and Tobin for the special session that did not happen. Biggs and Tobin essentially gave up stopping the bill from coming to the floor (Rau, Reinhart, & Sanchez, 2013; Reinhart, Sanchez, Rau, & Pitzl, 2013; Reinhart, Sanchez, & Rau, 2013). On June 13th the bill to expand Medicaid passed despite objections from the Republican leadership in both houses. The final vote counts were 18-11 in the Senate and 33-27 in the House, with nine Republican representatives and five senators crossing party lines to join Democrats. Notably, the issue of whether the hospital assessment was a tax was not fully resolved. The legislature voted on it and adopted it on the assertion that it was not a tax because the legislature had given permission to the executive authority to handle the revenue side. That issue continued to be debated for the next several years (Reinhart, 2013e).

The legislative fight over Medicaid expansion made Republican legislators who opposed the expansion resentful. During the final vote, some conservative lawmakers went so far as to call themselves the "minority" party, even though Republicans held the majority of seats, underscoring the extent to which Republicans who did not support expansion felt sidelined (Reinhart, 2013e). In a somewhat contradictory way, however, one informant said that since the decision, people who opposed the expansion in the legislature and elsewhere have said they knew it was what needed to be done, but they could not come out in favor of it at the time because...they "couldn't make the politics work themselves."

Post Enactment

The Arizona legislature's enactment of Medicaid expansion did not necessarily end the fight about Medicaid under the ACA. Arizona allows any bill by the legislature to go to the

public for a referendum. The Chamber, hospitals, and insurers raised money for an education campaign to keep a referendum from getting the necessary signatures to get on the ballot. The coalition did not believe a referendum would pass, but they were afraid it would have been much more expensive to defeat a referendum than to prevent it from going forward. Ultimately, the referendum did not get to a vote, but there was a lawsuit, which eventually resulted in the Arizona Court of Appeals deciding that the assessment did not count as a tax (Christie, 2017).

Analysis

Governor. Governor Jan Brewer was a driving force behind Arizona's Medicaid expansion. The image of Brewer that emerges from this story is that of a determined political leader who set out to achieve a policy victory regardless of what it took. According to one informant, "She was determined to get this done and she pulled around her the people who could try to make it happen, and they are take-no-prisoner people." According to another source, "When she decided something was going to happen and she cared about it, it happened and that was just the end of it." Her willingness to use both her bully pulpit and veto power to push the legislature is evidence of her tenacity. This commitment on the part of Brewer has been noted by other scholars. Rose (2015) pointed out that Brewer "threw all her political capital into the cause." Simply put, Medicaid expansion would not have happened without Brewer pushing for it the way she did.

Legislature. The legislature was in a very different place than the governor on the issue of Medicaid expansion. Informants agreed that the effort to get the legislature to approve Medicaid expansion was a fight. One important point that stands out is that there were moderate Republicans who could be convinced to vote for expansion. The coalition to expand Medicaid

did not try to get Tea Party Republicans to vote for Medicaid expansion. Instead they worked to make it possible for moderate Republicans to vote for the bill. But the important point is that moderates were in the state legislature to begin with.

Coalition. The coalition in Arizona was notable for being well-organized and focused. They understood that they did not need to convince all legislators, and that they had to protect Republican leaders who voted for expansion in their subsequent primary elections. The coalition saw the balance between building public support by making the issue popular among the voters, but also assuring the elected officials that they would be supported for what could be an unpopular vote. Furthermore, the coalition was cognizant of the political dynamics and emphasized the more conservative voices and less traditional supporters of Medicaid in their advocacy efforts. This tactic was crucial in a state where elections are primarily fought in the primaries and the biggest threat for Republican legislators is from the political right wing.

Political environment. The supporters of Medicaid expansion in Arizona benefitted from the fact that substantial underlying support for Medicaid existed in the state. Informants noted that there was strong polling data to support expansion and a sense that the general public was less conservative than the legislature. The public had also voted to support eligibility expansions before. Furthermore, the legislature had enough moderate Republicans and Democrats to pass the expansion. While Arizona was controlled by Republicans in the executive and legislative branch and had voted against Obama in both of his elections, the state's political tendencies may not have been as deeply conservative as other states with the same election profiles.

Language and framing. The coalition relied on both moral and financial arguments and did not have a strong preference for one or the other. Interviewees talked about using different messages with different legislators and in different town hall settings. The emphasis was less on overriding message discipline (*i.e.*, having one message they repeated over and over) and more on using language that would resonate with a given audience. The coalition tried to emphasize that most of the people covered were those who the state was already trying to cover before the ACA. However, after CMS said that Arizona had to expand to keep the support for the previous expansion, the coalition had to modify that language and acknowledge that the proposed expansion went beyond just restoring eligibility to 100% of the FPL. The coalition wanted to keep the Medicaid expansion issue separate from the larger Obamacare debate, but it does not seem that they could really separate the two issues.

Federal-state negotiation and previous history. The insistence by CMS that Arizona embrace a full expansion or else lose the current expansion through their 1115 waiver had a dramatic effect on the governor's options because of how it interacted with the state's existing Medicaid policy, specifically Proposition 204. Arizona may have faced a lawsuit if it rescinded coverage, and the federal government held firm that expansion was an all or nothing proposition, which left the state with no workable solutions besides a full expansion.

In addition to the specific legal framework governing Medicaid in Arizona, interviewees from different groups talked about the generally positive view of Arizona's Medicaid program. They all thought this generally positive view helped the expansion effort. According to my interviews, policymakers from other states would come to Arizona to learn about AHCCCS. The Arizona state legislature has to periodically renew funding for state agencies. Even during the Medicaid expansion debate, the legislature renewed funding for AHCCCS for 10 years, which

was taken as a sign of confidence in the program since the legislature had the option of only renewing AHCCCS for three years.

Conclusion

Medicaid expansion advocates had a number of factors working in their favor in Arizona. The economic incentives lined up in favor of expansion, and the legal framework in which the governor and coalition operated made it difficult to ignore the expansion opportunity. The non-expansion scenario not only meant covering fewer people at higher cost, but also a possible lawsuit. After deciding to support Medicaid expansion, Governor Brewer fought aggressively to pass it. The effort also was fueled by a coalition of interests (many of whom did not usually support government and welfare programs), including the Chamber of Commerce, hospitals, faith groups, and law enforcement. The coalition was practical and in aiming to secure a legislative majority identified lawmakers who needed to be convinced it was safe to vote for expansion. The coalition was also very organized and effective. Arizona had a political environment that was politically conservative, but not hostile to Medicaid. The public had voted in favor of previous expansions, and polling indicated they were supportive. Consequently, elected officials in favor of expansion could reasonably believe they had public support for what they were doing. Together, these factors made Medicaid expansion under the ACA possible in Arizona.

CHAPTER 5: INDIANA

Several themes stand out from Indiana's Medicaid expansion debate. The first is that most informants drew a sharp distinction between Medicaid expansion and the Healthy Indiana Plan (HIP) 2.0, which was the name for Indiana's program to expand Medicaid coverage to adults under the ACA. Second, there was not a debate about Medicaid expansion so much as an evolving conversation among policymakers and stakeholders about covering more people but not relying on a "broken" Medicaid system. It was less a question of yes and no and more a question of looking at options. Third, the main negotiation over Medicaid expansion was between the state and federal governments, rather than among groups within the state. In fact, interest groups pressured CMS to accept Indiana's waiver application as much as they pressured the state government to expand Medicaid.

Healthy Indiana Plan

Before the ACA, Indiana had expanded health care coverage through the Indiana Check Up Plan, which included tax credits to small businesses to offer coverage and wellness programs, increasing the age of dependent coverage to 24, funding for tobacco cessation and immunization programs, expanding Medicaid coverage to pregnant women who qualified up to 200% of the FPL, increasing children's coverage under CHIP from 200% to 300% of the FPL, and raising Medicaid reimbursement rates. The Check Up Plan also created HIP, a program to cover childless adults up to 200% of the FPL through a Medicaid 1115 waiver (Academy Health, 2008). Enrollment in HIP was capped for non-caretaker (*i.e.*, nonparent) adults at 36,500

enrollees and included monthly sliding-scale contributions to a Personal Wellness and Responsibility (POWER) account, which would be used to pay for health care services. In fact, the first \$1,100 of medical expenses were paid out of the POWER account before the insurance component kicked in, which introduced a level of cost-sharing to the program (Irvin, 2010; Verma, 2012).

Republican Governor Mitch Daniels crafted the Indiana Check Up Plan, and a Democratic House and Republican Senate passed the enabling legislation in 2007 (Indiana Family and Social Services Administration, 2017). The vote was 70-29 in the house and 37-13 in the Senate. HIP was funded partially by a 44 cent per pack increase in cigarette taxes (Schneider, 2007a). Both Republican and Democratic legislators spoke highly of the plan at the time of its passage. Democratic State Senator Vi Simpson (D-Ellettsville) said,

He [the governor] stuck his political neck out. He not only put out a cigarette tax for us to consider, he also recognized the importance of the uninsured population and how we all pay for every single person who doesn't have health insurance. (Schneider, 2007b)

Key informants generally saw the original HIP as a positive, pragmatic step towards increased health coverage. Advocates, as well as providers, all describe HIP as an approach to providing coverage that gave people “skin in the game” in the form of cost sharing, which was generally popular with the public and enrollees. Medicaid eligibility for non-caretaker adults had previously been set at 22% of the FPL (Academy Health, 2008), and HIP was seen as a positive step toward covering more people.

Mitch Daniels and the Affordable Care Act

In 2011, after Congress enacted the ACA but before the Supreme Court decided *NFIB v. Sebelius*, the Indiana legislature passed SB 461, which addressed several issues related to the

ACA. Most important for the context of this dissertation, it identified Indiana Check-Up as the vehicle for expanding Medicaid and enacted changes that would put the plan in line with the Medicaid requirements of the ACA. The legislation also included several elements that were meant to undermine the ACA, such as a provision that no one in Indiana would be required to purchase health insurance (Daniels, 2011; Indiana General Assembly, 2011). It passed the Senate 28-21 and 61-35 in the House. The House vote was almost strictly along party lines, with one Democrat voting for the bill. In the Senate only Republicans voted in favor. All Democrats and nine Republicans voted against it (Indiana General Assembly, 2011).

Based on the partisan nature of the vote, it looks like the legislation was mainly seen as a repudiation of the ACA. In looking back, informants thought the existence of HIP before the ACA was an important point and contributed to the government and stakeholders in Indiana being able to separate HIP 2.0 from the larger Medicaid expansion debate. Somewhat ironically, this law, which included provisions meant to undermine the ACA, may have made it comparatively easier for Indiana to expand Medicaid under the ACA after the Supreme Court made it optional by defining an Indiana-specific mechanism for expansion.

In the same year, Daniels also signed Executive Order #11-01 in 2011 to establish a health benefits exchange as a nonprofit entity. There were also early inter-agency working groups to examine ways of developing the exchange, but they did not make much progress before Mike Pence became governor (Kaiser Family Foundation, 2015a). While Governor Daniels was certainly not publicly a supporter of the ACA (Daniels, 2010), his actions showed a willingness to figure out a path forward that made sense for Indiana.

Pence and Medicaid Expansion

As both a candidate for governor and once elected, Mike Pence simultaneously criticized the ACA and Medicaid and expressed a willingness to cover additional Indiana citizens through HIP. As the GOP candidate for governor, Pence reacted to the *NFIB v. Sebelius* decision by saying that “Medicaid is a broken system” and that the flexibility the majority opinion gave to states was a small compensation for increased taxation and burdens (Groppe & Schneider, 2012). Later in the campaign, he reiterated his view of Medicaid as a “deeply flawed health care bureaucracy,” but did indicate an openness to using HIP as a way to expand coverage, a position he continued to express after the election (Cook, 2012; Groppe, 2012). The governor’s stance was echoed by stakeholders who said that while Pence was “openly critical of Medicaid, he never said he would not consider an expansion. We listened very carefully, and he never said that he would not consider expansion.” One group noted Pence’s attitude about Medicaid was, “I can still resist the president’s [Obama’s] position while finding something that’s going to be fiscally good and beneficial to my citizens.”

The Governor and the Legislature

The question of Medicaid expansion did not involve any significant amount of negotiation between the legislature and the governor. The legislature had also become more solidly Republican by the time Pence took office in 2013, with 37 Republicans to 13 Democrats in the Senate and 69 Republicans to 31 Democrats in the House. Key informants indicated that the governor was operating with authority in place from the legislature to negotiate a waiver under the authority granted by SB 461 in 2011.⁶ They noted:

⁶ Informants did not refer to the bill specifically. They referred to existing authority.

Under Governor Daniels, they had authorized the governor to make decisions on the health care exchange as well as expansion. And so, it wasn't required that the legislature pass anything to support this, though they did express interest and, in a sense, support for the approach the governor was using.

And it wasn't something—because we already had the HIP plan in place, it wasn't really something that the legislature had to vote on. So that made it easier too.

Not everyone agreed that the legislature had given the governor a blank check in advance. “Well, that [legislative approval] was a question—that's a question that was up for discussion, and so what they did is they ran it through the legislature and got approval for what they were attempting to do administratively.” It is uncertain if this person was thinking about the 2011 authority granted to Daniels or other legislation. There was a bill (SB 551), which required

the office of Medicaid policy and planning (office) to negotiate with the United States Department of Health and Human Services (HHS) for a Medicaid state plan amendment or Medicaid waiver concerning expansion of Medicaid. Requires the office of the secretary of family and social services to report to the state budget committee and the health finance commission if negotiations are unsuccessful. (Indiana General Assembly, 2013)

The General Assembly website lists a Senate vote count, but the last action recorded by the House was a referral to the Ways and Means committee. The fact that the bill was approved by the Senate but not the House explains why there was some disagreement about whether the legislature had given the governor a blank check to negotiate.

The latitude that Pence had to negotiate without the need for legislative approval was even noted in Tennessee where an informant thought, “So like you think in the case of Indiana where they didn't have to have the legislative approval, very different dynamic than in our state.” One informant in Indiana thought that this was because of the solid Republican control

of the General Assembly, which meant that the legislature (or at least its Republican leadership) assumed it shared a common philosophy with the governor and thus would not challenge him.⁷

Democrats in the legislature would have preferred a more traditional path to Medicaid expansion, although given their minority status in the legislature they were not in a position to push.

And there were some Democrats in the House and in the Senate who—it was really hard for them because I think they really wanted Medicaid expansion, but here’s the door that we’re going to use, and it really is kind of sour grapes. If you don’t support this, then we’re not going to get any Medicaid expansion.

Democrats did not press for a more traditional expansion given their limited negotiating power. Informants in Indiana saw the options for increased coverage as a choice between HIP 2.0 and nothing.

Coalition Politics and Moving Forward on HIP 2.0

During the period when Governor Pence was leaving the door open to a HIP-style expansion, two things were happening simultaneously: 1) He was negotiating with CMS to allow Indiana to expand Medicaid using HIP 2.0; and 2) a coalition in Indiana was keeping the issue on the political agenda. The main coalition advocating for Medicaid expansion was the Cover Indiana campaign, which grew out of the Indiana Coalition for Human Services. It included many human service organizations, such as food banks and faith organizations, as well as traditional health care advocates, such as Covering Kids and Families Indiana. That coalition

⁷ The suggestion that the partisan concordance of the legislature and governor was an enabling factor in expansion is worth noting because it reflects a view from stakeholders in Indiana. The question of whether solid Republican control was consistently an enabling factor will be dealt with in depth in Chapter 7, “Looking Across Three States.”

worked collaboratively with the state hospital association, although the association also worked independently.

On the advocacy side, the work focused on keeping the issue alive and creating demand for the expansion. One person described Cover Indiana as working to “keep pushing him [Governor Pence], and pushing him, and keep making it an issue that he couldn’t ignore and he couldn’t simply walk away from.” However, there was disagreement among interviewees about how large the public push had been. Someone who was involved in the Medicaid expansion effort described rallies and op-eds, and another interviewee who had been involved, but slightly more peripherally, thought that it was mostly lobbyists meeting with the administration. In terms of op-eds, there were several (Stone, 2013; Thomas & Gayle, 2012), although that does not mean it was a central strategy. These two points of view about the extent of the campaign’s publicity are compatible. There was a public-facing campaign, but it appears to have been limited. In part, that is because the coalition moved fairly quickly from the question of Medicaid expansion and “closing the gap” to working on the details of HIP 2.0. As one respondent noted,

Once the governor said, ‘We’re not going to extend Medicaid in the traditional sense because it’s broken and needs to be fixed and we don’t think it’s the right way to go’ the hospitals got on board, businesses got on board...you had a few detractors that said, ‘Well, we’re concerned about the caps, the potential for a cap, and we think that Medicaid is the way to go...There were some more liberal groups...a few that said ‘You’re not going to get everybody that you need to get unless you do the Medicaid expansion.

Throughout the negotiation between Indiana and CMS and within Indiana about coverage expansion, the notions of “consumer-driven health care” and “skin in the game” came up numerous times. The HIP 2.0 waiver that CMS eventually approved includes premiums and

health savings accounts, which were referred to as Personal Wellness and Responsibility (POWER) accounts. Key features of HIP 2.0 include:

- 1) For the newly eligible adult populations, with incomes between 0% and 138% of the FPL, they would pay premiums, which go into the POWER account.
- 2) For people with incomes between 100 and 138% of poverty who pay premiums they would be enrolled in HIP Plus which includes expanded benefits and reduced cost-sharing. For this population, failure to pay premiums can result in a 6-month lock out from coverage.
- 3) For people below 100% the FPL, failure to pay premiums results in enrollment in HIP Basic, which includes reduced services and increased cost sharing.

CMS denied Indiana's request for work referral as a condition of receiving Medicaid benefits, and also denied Indiana's request for a waiver from Early and Periodic Screening, Detection and Treatment for 19 and 20 year olds in the HIP Basic plan (Kaiser Family Foundation, 2015a).

While informants (both advocates and non-advocates) acknowledged that advocates representing consumers would have preferred a more traditional expansion, they were certain that "talk of traditional Medicaid expansion was never a viable option in this state." Although there was some reluctance to accept the provision of HIP 2.0 that would disenroll a member for not paying premiums, there was an overwhelming sense that there was only one option and there was really no leverage to push for a more traditional expansion. Advocacy groups largely took the same position as Democrats in the legislature, which was to acknowledge the

shortcomings of the plan as they saw them, but to participate in and support the governor's plan as the only viable path toward increased coverage.

The Indiana Chamber of Commerce was not an official part of the coalition, however, they did weigh in on the HIP 2.0 plan. The Chamber was less concerned about whether to expand or not and more concerned with the effects of expansion. In particular, they expressed concern about the potential state share of the expansion that Indiana would eventually have to cover. The Chamber was supportive of the HIP 2.0 plan both because of a clause that said that Indiana could back out if it did not have state resources available, and because HIP 2.0 reimburses medical providers at higher rates than traditional Medicaid. The higher reimbursement rates for providers were a salient point for the Chamber. The Vice President for Health Policy, Mike Ripley, wrote in the *Indianapolis Star* that "Reimbursement rates for Medicaid typically result in healthcare providers being put in position to recover such losses by increasing prices for private-sector employers and their employees through cost shifting" (Ripley, 2014). The cost shift was a significant issue for the Chamber and their support of HIP 2.0 was tied to the belief that covering more people at Medicare rates (as opposed to lower Medicaid rates) would help ameliorate the cost shift that drove up employer-sponsored coverage premiums.

The Indiana Hospital Association supported Medicaid expansion from the beginning. They were involved in both keeping the issue alive on a public agenda as well as speaking to the governor's staff directly about the importance of expansion. The association launched a website, Expand Indiana, which included videos, fact sheets, and other resources explaining the benefits of both coverage expansion and then more specifically HIP 2.0 (Indiana Hospital Association,

n.d.). In 2013, the hospital association commissioned a report from the Center for Health Policy at the University of Nebraska Medical Center to examine the impact of Medicaid expansion in Indiana. The report showed an increase in coverage through Medicaid expansion as well as increased revenue to the state and relief from the cost-shift of the uninsured to individuals' and families' insurance premiums (Stimpson, Wilson, Nguyen, & Shaw-Sutherland, 2013). A short animated video on the site emphasized the gap in coverage for people making too much to qualify for Medicaid, but not enough to qualify for subsidies in the marketplace (Indiana Hospital Association, n.d.).

When it was apparent that HIP 2.0 would be the vehicle for expansion, the hospital association worked with the governor's staff, including Seema Verma from SVC Consulting, to craft the plan. They also worked with their member hospitals to make sure that the media and others heard from hospitals about the importance of expanding coverage. The hospital association both sought to explain the importance of expanding coverage versus having a gap in who was covered and the specific benefits of HIP 2.0. A fact sheet from the association proclaimed that "The sense of urgency cannot be understated. Hospitals want to see HIP 2.0 quickly approved by CMS and implemented so that coverage can begin as early in 2015 as possible" (Indiana Hospital Association, 2014). The question of Medicaid expansion in Indiana was as much (or more) about convincing CMS to accept Indiana's method for expansion as it was for convincing the governor and the legislature about the importance of expanding.

Another piece of the debate that came up in interviews was that starting in 2020, the state would be responsible for a greater share of the increased cost of Medicaid. Several respondents noted that concern and that the hospitals' willingness to cover that cost was part of what made

the deal work. “Hospitals agreed to pick up the state portion of the expenses once the federal payments started going down...we still have some state funds that will cover some of that, but hospitals agreed to pick up the remaining pieces.” According to the Indiana Family and Social Services website:

The Healthy Indiana Plan 2.0 (HIP 2.0) will be funded in part through Indiana’s existing cigarette tax revenues that support the current Healthy Indiana Plan (HIP) program, as well as funds from the Hospital Assessment Fee (HAF). The HAF is an existing program that was authorized by the Indiana General Assembly in 2011, reauthorized in 2013 and codified in statute at Ind. Code §16-21-10 through 2017.

The HAF is assessed against all licensed acute hospitals and private psychiatric hospitals, and was designed to increase hospital inpatient and outpatient reimbursement to align with the level of payment that would be paid under the federal Medicare program...The State and the Indiana Hospital Association (IHA) have reached a mutually beneficial agreement regarding the use of the HAF to fund a HIP expansion. (Indiana Family and Social Services Administration, 2014)

The agreement about the assessment as well as the recognition that there was more to be gained by working toward a HIP 2.0 plan than standing in the way showed what most respondents described as a collaborative environment. One person joked, “I mean it’s corny, but people in Indiana are pretty nice. Collaboration is a value we that we have, and even in a contentious general assembly, there still is a pervasive sense of collaboration.” In addition to the positive view of HIP, some respondents also talked about the generally strong financial situation in which Daniels had left the state as a factor that allowed Indiana to consider the possibility of expanding coverage.

The state political environment could have also affected the policy situation. Notably, Indiana had only one Republican United States senator instead of two, as in the other states included in this study. Indiana also voted for Barack Obama in the 2008 presidential election.

This raises the possibility that Indiana was less conservative in its political environment than Arizona and Tennessee, which the less divisive politics could reflect.

One element of HIP 2.0 that numerous stakeholders commented on was the higher provider payment rates offered compared to traditional Medicaid. It came up numerous times as a reason why HIP 2.0 was a good plan for both providers and consumers. In interviews, informants routinely referred to “Medicare rates.” The hospital association’s statement on key points of HIP 2.0 refers simply to “higher reimbursements” (Indiana Hospital Association, 2014). According to Kaiser Family Foundation, Indiana intended to raise Medicaid rates to 75% of Medicare rates (Kaiser Family Foundation, 2015). For context, Medicaid fees in Indiana had traditionally been lower, with Medicaid fees standing at 55% of Medicare fees in 2012 (Zuckerman & Goin, 2012). While it is clear that the rates paid to providers in HIP 2.0 were set to be higher than traditional Medicaid rates, it not clear from my interviews and other sources whether rates ended up as 75% or 100% of Medicare rates. Furthermore, rates for different services varied between 75% and 100% of Medicare rates, which could have also contributed to the confusion.⁸

Negotiations with CMS

There were extensive negotiations between Indiana and the federal government over Medicaid expansion. Through the spring of 2013 the Pence administration discussed the possibility of using HIP as a vehicle for expanding coverage with HHS Secretary Kathleen Sebelius. The Obama and Pence administrations did not come to an agreement during 2013

⁸ In a follow up conversation about the discrepancy, an interviewee did hypothesize that the rates may have been adjusted down because claims for the expansion population were higher than expected. The Kaiser Family Foundation shows that for Indiana’s Medicaid rates overall, the Medicaid: Medicare fee ratio (for participants in fee for service Medicaid) varies between 75 and 100% of Medicare rates depending on the service (Kaiser Family Foundation, 2017c).

(Groppe, 2013). CMS did, however, allow the existing HIP program to keep people enrolled while discussing the question of expanding Medicaid (Groppe & Russell, 2013). On May 15th, 2014 Pence unveiled HIP 2.0 and officially submitted the waiver plan for consideration to CMS (Borggoetz, 2014; Groppe & Borggoetz, 2014).

Many respondents talked about the long negotiation with CMS. Hospitals in particular expressed concern about the pace of negotiations. One informant said,

And then that [CMS approval] took a long time...we were very hopeful that we'd get this done. I mean, hospitals lost something through the ACA, and if you didn't have that coverage expansion, we'd certainly be hurting more than we are.

Another stakeholder said that

in addition to talking to the [Pence] administration and trying to build a support internally in Indiana for just an environment where, politically, broadly, that expansion would be well received, we also kind of trained our sites on CMS saying, 'Please expedite this.'

Stakeholders also engaged Indiana's congressional delegation to push CMS to speed up the review. This theme of the desire for a speedy approval is consistent with material the hospital association distributed to its members as well, which encouraged them to speak up about the need for an approval of the waiver (Indiana Hospital Association, 2014).

At the same time that the state and federal governments were negotiating, there was a parallel negotiation between state and federal advocacy groups. Advocacy groups in Indiana, such as Covering Kids and Families, traveled to Washington to talk about the waiver application both to CMS and to national advocacy groups, such as Families USA and Georgetown Center for Children and Families. As one person stated,

It did kind of put us in an odd position with a lot of the national advocates, and we understood that, okay, this may not be exactly what you think it is, but at the same time, don't stand in the way of the only thing that we have available to us.

In other words, HIP 2.0 was not consumer groups' favored model of Medicaid expansion, but in Indiana it was the only politically feasible route. Furthermore, the Indiana groups thought that there were attractive features for consumers, such as higher reimbursement rates.

The Indiana Coalition for Human Services, which housed the Cover Indiana campaign, submitted comments to CMS after Indiana's waiver was submitted. Their comments reflected the sentiment that the waiver was not perfect, but that they supported it, and that a speedy approval was important to them. The letter urged an "expedited approval" of the state's HIP 2.0 plan but also suggested options for protecting consumers, such as an appeals process if a consumer is disenrolled, as well as concerns about other provisions, such as work requirements (Sklar, Nord, & Slabosky, 2014).

After much negotiation and pressure from both the Pence administration and interest groups, CMS approved Indiana's waiver on January 28, 2015 (Rudavsky & Groppe, 2015; Services, 2015). CMS's announcement stressed the balance of state-specific elements, such as POWER accounts and premiums for some members, while rejecting certain elements that would restrict access, such as work requirements and lock-out periods for people below 100% of the FPL (CMS, 2015). Indiana Hospital Association President Doug Leonard expressed his gratitude to Governor Pence for "his leadership on this critical issue and commend[ed] his administration for their many months of hard work to obtain approval and prepare for implementation" (Indiana Hospital Association, 2015). Pence's statement upon receiving approval reflects his steadfast praise of HIP 2.0 and criticism of Medicaid. "I believe Medicaid is not a program we should expand. It's a program we should reform—and that's exactly what we're accomplishing" (Rudavsky & Groppe, 2015).

Analysis

Governor and legislature. Governor Mike Pence emerges from the Indiana Medicaid story as a pragmatic conservative. While he was critical of Medicaid, Pence was also open to HIP 2.0 from the beginning of his administration. Having authorized the governor to negotiate the terms of using HIP as a vehicle for expansion before Pence was in office, the legislature played very little role in the Medicaid expansion discussion. Most of the groups focused their efforts at the Pence administration, not the legislature. Given the history of SB 461 and the fact that informants did not talk about the legislature as a complicating factor in expansion, legislators seemed to have a lot of trust in the governor to pursue Medicaid expansion in a way that they were comfortable with.

Previous Medicaid history and language. In Indiana, HIP 2.0 existed as a separate entity from Medicaid expansion. The distinction was pronounced enough that most key informants drew the distinction between Medicaid expansion and HIP 2.0 without being asked about it. Whether these groups always saw this difference or they had come to adopt the language of the Pence administration around the Medicaid expansion is impossible to know, but it is clear that HIP 2.0 and Medicaid expansion meant two different things to people. These quotes from interviews show how deeply HIP 2.0 and Medicaid expansion were separate in people's minds:

- “So we knew that we weren’t going to get a Medicaid expansion. So the question was what else could we do?”
- “We were neutral on Medicaid expansion...What we supported, and we supported it wholeheartedly, was to help the Indiana plan expansion ...”

- “The HIP model is something they definitely embraced as a positive and supportive thing for the state. They didn’t really see HIP, nor did we try to define HIP as any form whatsoever of expansion that would be affiliated directly with Obamacare.”

The original HIP program that Governor Daniels enacted allowed Pence to draw a crucial distinction between HIP 2.0 and Medicaid expansion. The “skin in the game” components of HIP allowed the governor to talk about the broken Medicaid system while still moving to cover more people through the ACA.

Most respondents noted that they quickly turned away from the term “Medicaid expansion.” They relied on “coverage expansion” or “closing the coverage gap” as ways to talk about the need for helping uninsured residents of Indiana. Fact sheets and websites produced by the hospital association emphasized economic benefits, but also identified the problems for poor working families in not having a coverage option (Indiana Hospital Association, n.d.). In Indiana, the Medicaid expansion debate did not depend so much on moral or economic arguments as much as it focused on promoting coverage expansion and HIP 2.0 versus embracing Obamacare and expanding Medicaid.

Coalition and federal-state negotiations. The stakeholders involved in the coverage expansion policy were defined by a sense of practicality and cooperation. There was an overriding recognition that HIP 2.0 would be the vehicle for expansion, and the coalition could be most effective in working out the details as opposed to arguing for a more traditional expansion. Furthermore, the coalition members were involved in both pressuring the governor to move forward and on CMS to approve the waiver. They saw their role as not only influencing

state politics, but federal politics as well.

Conclusion

Indiana was the state without a debate. The move to expand Medicaid under the ACA benefitted from legislation enacted under Daniels to use an existing waiver as a vehicle for expansion before the Supreme Court's *NFIB* decision. This allowed the conservative Republican governor Mike Pence to effectively separate Indiana's HIP 2.0 plan from Medicaid expansion in a way that permeated all conversation. A coalition kept the issue moving both at the state and federal levels, but avoided pushing beyond what the governor and legislature was likely to support.

CHAPTER 6: TENNESSEE

The Medicaid expansion debate in Tennessee is noteworthy for the amount of time the state spent negotiating with CMS, the forceful opposition of conservative groups, the shadow that the history of TennCare, Tennessee's Medicaid program, cast over the Medicaid debate, and a lack of coordination and leadership among the governor and the stakeholder coalition supporting expansion. While Governor Bill Haslam worked to craft an expansion plan with CMS and attempted to win legislative approval for it, he never put his own political capital behind it, and the legislature never supported him. Elected Republicans had a hard time supporting Medicaid expansion if their colleagues would not. Meanwhile, AFP fought effectively against any expansion. Finally, the state's history of expanding coverage dramatically under TennCare and then having to rescind it complicated efforts to expand Medicaid.⁹

Medicaid in Tennessee before the ACA: The TennCare Experience

TennCare was created in 1993 during the last year of Democratic Governor Ray McWherter's administration as a plan to transform Tennessee's Medicaid program into a system of managed care while dramatically expanding health insurance to poor Tennesseans. McWherter secured the General Assembly's approval for the plan in six weeks. He obtained federal approval from the Health Care Financing Authority (HCFA), the previous name of CMS,

⁹ Tennessee was also distinctive among the three case studies in that several interviewees asked to go on and off the record. This speaks to the lingering tensions among stakeholders. It also means that examples of some of the problems in Tennessee that would implicate stakeholders could not be discussed in this dissertation.

five months after the legislature approved the plan. TennCare began 46 days after HCFA approved it in January of 1994 (Myers, 2007).

TennCare grew in enrollment and costs over the next eight years, and it encountered difficulties with managed care organizations. By 2001, it covered 1.4 million people and faced a \$342 million budget shortfall. After a number of lawsuits regarding covered benefits and program implementation, the Democratic governor Phil Bredesen pulled the plug on the TennCare expansion in 2005 (Meyers, 2007). The state disenrolled 320,000 TennCare participants and cut benefits for the remaining adults, but maintained benefit levels for children in the program (Chang & Steinberg, 2014).

The history of TennCare featured prominently in discussions of Medicaid expansion under the ACA in Tennessee. Reflecting on the legacy of TennCare, one person described it in the following way:

Tennessee Medicaid program expanded in such dramatic ways, more so than Medicaid's ever seen...even the ACA doesn't come close to what TennCare did in 1994, where they basically said, 'We're going to cover all uninsured, any income. And we're going to cover benefits that never have been covered before. We're going to take off all benefit limits'...It was kind of like those late night commercials...There's more; There's more.

Others talked about the growth of the program and the need to make painful decisions to scale it back.

One year where it particularly got real bad was it ended up being about \$600 million in state dollars. And even in a great, great year, the state doesn't bring in \$600 million in new revenues. So they literally were looking at other state agencies in which you're going to reduce to kind of feed this TennCare.

Another respondent talked about how the program "started consuming close to 40% of all state dollars here." The resulting financial stress led to discussions about instituting an income tax in Tennessee, which was a deeply unpopular idea. While not all the facts and figures quoted by the

informants were accurate, the sentiment does reflect an important political legacy of TennCare, which produced a large, fast expansion of Medicaid followed by a painful retrenchment.

From *NFIB* Decision to Insure Tennessee

Between the 2012 Supreme Court ruling that essentially made Medicaid expansion a state decision and December 16, 2014, Republican Governor Bill Haslam and his administration were engaged in a three-party negotiation, simultaneously working out the details of a waiver with CMS that would allow Tennessee to expand through a nontraditional plan and navigating a skeptical legislature, with Republican supermajorities in both chambers. Republicans held 28 out of 33 seats in the Senate, and 73 out of 99 seats in the House (National Conference of State Legislatures, 2017b). Immediately following the Supreme Court decision, Governor Haslam was noncommittal about pursuing a Medicaid expansion (Wileman & Sisk, 2012). He did, however, express interest in using Medicaid dollars to buy private coverage for Tennesseans (Barton, 2013). Haslam was not strongly committed to the issue though. As one person said, “I think everybody feels like Haslam thought he should do it. Wasn’t really committed to it, kind of check the box and said, “I’m for it.” Similarly, another person thought the issue was never a good fit for Haslam. “He’s a consensus country club Republican, and this was not a consensus country club Republican issue.” Nonetheless, Haslam did enter into negotiations with CMS about how he could potentially expand Medicaid in Tennessee.

The negotiations between Haslam’s administration and CMS went on for more than a year and focused on what could be included in a waiver that would allow the state to expand eligibility and introduce copayments and other program elements not traditionally associated with Medicaid (Barton, 2013; Chris Sisk, 2013). These

negotiations spanned the change in leadership at the U.S. Department of Health and Human Services when Sylvia Matthews Burwell took over as Secretary from Kathleen Sebelius. While negotiations were complicated under both Sebelius and Burwell, they were reportedly easier with Burwell, whom respondents thought was more focused on the policy than the politics. They described Burwell as delving deeper into the specific technical issues that Tennessee was exploring.

At the same time that the governor's administration was negotiating with CMS, Republicans in the state legislature were resistant to the governor moving ahead without their approval (Sisk, 2013). On March 6, 2014 the state Senate voted on legislation that had already passed the House, which required the governor to have legislative approval for Medicaid expansion (Sisk, 2014). According to one informant, the governor did not try very hard to stop that law from passing. Another noted that TennCare had been associated with the governor acting without much oversight from the legislature, which may explain why such legislation was important to many lawmakers.

The history of TennCare clearly impacted the legislature's thoughts on the ACA's Medicaid expansion. As one respondent said,

There aren't many legislators around today who lived through that [TennCare contraction]. But there are enough who did who talk about it, and anyone who follows politics in the state remembers that, and so there's just a tremendous fear. And that was one of the arguments against expansion was, what happens if funding changes and we can't hold up our end of the bargain and we have to disenroll people.

TennCare history came up as a major reason why legislators feared expanding the Medicaid program. The biggest concern was that at some point the financing would not work and legislators would be responsible for ending the program, which would be extremely unpopular. To a lesser, but noticeable extent there was a sense that Tennessee

had worked hard to bring the Medicaid budget under control and there just was not an appetite for seeing Medicaid expand.

The Tennessee Hospital Association, the Tennessee Chamber of Commerce, the Nashville Chamber of Commerce, Business Roundtable, advocacy groups, and hospitals were all involved in pushing for Medicaid expansion. There are differences of opinion about how closely these stakeholders were working together. While ostensibly there was one coalition anchored by the hospital association, the non-hospital groups did not feel closely connected to the coalition. The business groups were focused on their members and on working with the legislature on their own, and there was not always a consistent strategy among the different stakeholder groups. While there was limited coordination, representatives of stakeholder groups recalled situations where things were not as coordinated as they could have been. Although there were also stakeholders who referred to having a large and broad coalition, one of the members of the coalition referred to members of the coalition as “passing each other in the dark.”

In particular, consumer advocacy groups were not always coordinated with the more established stakeholders (such as the hospitals and chamber of commerce) with consumer groups often preferring more public and confrontational tactics, such as singing hymns during a committee hearing, while other groups preferring to figure out ways to work with legislators. This question about what tactics would work in a state that had become as conservative as Tennessee came up in relation to the more confrontational members of the coalition, with respondents saying, “And as those supermajorities have grown, it’s made this type of advocacy, that radical element, completely irrelevant.”

Among some informants there was a belief that confrontational tactics from groups who were perceived as liberal would have very little impact on conservative lawmakers.

Perhaps the most notable issue was how little the governor did to establish leadership to this coalition. One legislator said, “You had lots of different cooks in the kitchen from an advocacy lobbyist standpoint, and I think people weren’t sure who they were working with.” That sense that there was a lot of effort, but not necessarily the most coherent campaign came up a few times.

The pro-Medicaid expansion coalition encountered other problems. Several member of the coalition believed that having hospitals arguing for a policy that was going to benefit them financially was not the most effective strategy, and that from the advocacy point of view the consumer groups were too liberal to make an impression on legislators who had to cast difficult votes. State government officials saw even some religious groups involved as too liberal. Episcopalian priests were vocal in favor of Medicaid expansion, but they did not represent the more evangelical and conservative denominations that dominated areas outside of Nashville.

In an effort to appeal to more conservative audiences, the coalition commissioned Bill Fox from the University of Tennessee at Knoxville, who was known to be conservative, to write a report that described the impact of Medicaid expansion in Tennessee. The report concluded that the expansion would bring \$1.14 billion to Tennessee and help support rural hospitals. Fox also noted that the population that would be covered by expanded Medicaid was more likely to be employed than the existing TennCare population, and that an additional 25,000 veterans would be covered. These points, coupled with the argument that an insured population creates a healthier

workforce (Fox, 2015) seemed designed to show a business-friendly, conservative point of view on Medicaid expansion.

The messages in Fox's report echo the language of groups working to support Insure Tennessee, the name of the governor's plan for Medicaid expansion. They talked about the loss of rural hospitals, the economic impact, and the number of people who were uninsured. The Chamber of Commerce emphasized the business and financial benefits of expansion, such as the potential for job creation from federal dollars flowing into Tennessee, financial support for hospitals (which are a major industry in Nashville), and the potential for Medicaid expansion to reduce uncompensated care, and thus avoid a cost-shift for employers providing insurance.

The forces opposed to Medicaid expansion communicated multiple messages. One was that Medicaid was broken and does not work. More than one respondent talked about how several studies about Medicaid came out during the time expansion was being debated and opposition groups used these studies to make the case that Medicaid delivered poor care, that people did not get healthier, and that eventually people had to have benefits reduced. One stakeholder said, "And so they just had this very generic slide deck that pointed to things like that, used an example of a proposed Medicaid cut, benefit cut, in Connecticut, Rhode Island, somewhere in New England." This stakeholder suggested that the coalition pushing for expansion was not prepared for countering what he called "selective truths." They had not prepared opposition messages the way he thought they needed to.

The overriding language used by the opposition was that Obamacare was bad and even a Tennessee solution to Medicaid expansion was just another form of Obamacare.

One quote that stood out came from a member of the hospital coalition, indicating that legislators asked, “How are they going to pay for it, with Chinese money? I don’t know how many times I heard that.” The Chinese money referred to the allegation that Obamacare was adding to the national debt. It also underscored that for groups opposed to the Medicaid expansion the idea of the federal government versus the state government paying for the expansion was not a convincing argument because ultimately they saw an increased burden on taxpayers. Furthermore, respondents noted that legislators expressed skepticism that the generous federal match for Medicaid expansion would last. This sentiment seemed to echo the difficulties of TennCare disenrollment as well as reflecting the hostility to Obamacare. It also reinforces the idea that the promise of federal support for the new Medicaid population was not a persuasive argument in Tennessee.

Nearly all the stakeholders discussed the role of AFP and the Beacon Center as groups that fought hard to stop Medicaid expansion in Tennessee (neither group responded to requests for an interview). AFP, a national conservative network with state chapters supported by David and Charles Koch, in particular proved effective at mobilizing vocal opposition to Medicaid expansion. They lobbied legislators directly, and during the proposal hearing they brought in individuals to portray mass opposition.

We [the expansion coalition] tried to educate them [legislators]. We had experts in there educating them, but every expert we had we had push back from the AFP...we did not realize that AFP was going to get involved and they going to push back on this. I mean, it was huge.

The ability of AFP to portray itself as large and powerful was a recurring theme in the interviews. In describing why legislators seemed so torn, one stakeholder described a legislator who had lost her seat.

There had been a member of the leadership team of the Republican legislature that the NRA had attacked, the AFP had attacked. She lost in her race and that just created this fear. AFP, particularly had kind of an influence outsized to their real impact...AFP were very crafty in its claim of credit for her loss. And that gave them position in this whole Medicaid expansion thing particularly.

This person suggested there were actually several reasons why this legislator lost her seat, but it was AFP's ability to take credit for it that helped make the organization so powerful. Participants in the expansion debate viewed AFP as very effective at grassroots organizing. The Beacon Center, a conservative think tank in Tennessee, also worked on the policy analysis that supported the anti-expansion position.

The other opponent of expansion was the NFIB. According to informants, NFIB was fiercely opposed, but did not take on the same kind of public role as AFP or the Beacon Center. Perhaps the most important role that NFIB played was in canceling out the support that the Chamber of Commerce offered. NFIB's opposition made it harder for the pro-expansion coalition to argue that Insure Tennessee would have economic benefits for the state.

TennCare's political legacy may also explain why the pro-Medicaid expansion coalition did not work well together. Two informants brought up the divisions that the TennCare history created between the TennCare department and the consumer advocacy organizations. During the period of TennCare's expansion and then contraction, the Tennessee Health Justice Center filed lawsuits, which were cited as a reason why there was sometimes a lack of trust between state officials and consumer advocates. That mistrust was evident in the comments of one respondent who suggested that the lawsuits over benefits may have been part of the unsustainable financial situation surrounding TennCare that eventually led to the state having to disenroll people. Regardless of the reality of what happened to TennCare, the perception affected the Medicaid expansion debate.

Beyond the legacy of TennCare, the prospects for Medicaid expansion in the state were diminished by many politicians' strong opposition to the ACA and the belief that the federal government would not honor its commitments. One interviewee spoke in detail about their perception that Congress had been unreceptive to input from states during the ACA's passage. Another stakeholder argued that the Medicaid decision gave legislators the chance to "promote themselves as battling against Obamacare." The concern about the federal government also manifested itself in the view that Washington would pull the rug out from under the state. One informant stated, "The most consistently repeated argument was that the federal government was going to give us this incentive to get engaged, and they are going to leave us hanging at the end of the agreement," commented one informant. This distrust was likely exacerbated by the TennCare experience, but also reflected both intense opposition to the ACA and President Obama.

Between the legislature essentially tying the hands of the governor by passing legislation that required their approval for expansion and AFP organizing opposition, 2014 was a year when the forces opposed to Medicaid expansion were able to strengthen, while the pro-expansion constituents were still having a hard time figuring out how to actually win legislative approval for whatever plan the governor introduced. As one respondent said, "The ground game hadn't been firmed up about how things were going to go." That was the environment into which Governor Haslam unveiled his plan at the end of 2014.

The Plan and the Special Session

On December 16, 2014, Governor Haslam finally released his plan, Insure Tennessee (Boucher, Wileman, & Fletcher, 2014). His Medicaid expansion proposal included the Volunteer Plan and the Health Incentives Plan. The Volunteer Plan would

help people purchase insurance offered through their employer if they had the option. The Healthy Incentives Plan featured a Health Reimbursement Account (*i.e.*, a health savings account), which put money into a savings account if members participated in healthy behaviors. For people above the poverty line, the plan would require copayments and premiums (Boucher et al., 2014).

On January 9th, 2015 Governor Haslam called a special session of the legislature to consider the Insure Tennessee plan. The timing of his announcement and his decision to call a special session were both criticized by stakeholders. Releasing the plan right before Christmas and New Year's gave the opposition time to get organized, and stakeholders thought that the special session put an unnecessary amount of attention on the issue. The significance of these perceived tactical missteps is impossible to separate from the larger issue that the governor did not have a legislative strategy. It was not obvious who his champions in the legislature would be and how he would assemble a majority. The governor had not coordinated with a legislative sponsor or fully engaged interest groups that could have been helpful. A number of people off the record said that the governor was not able to play brass knuckle politics, meaning he avoided conflict and generally preferred to push issues with broad appeal, such as making community college more affordable. That both made Medicaid expansion a peculiar issue for him to focus on and may have reduced his chances of success.

The governor faced long odds in the legislature, given that Republicans had a supermajority—they held 28 out of 33 seats in the Senate and 73 out of 99 in the House (Boucher, 2015c; National Conference of State Legislatures, 2017b). While one respondent pointed out that statewide offices were usually held by relatively moderate

officials, the legislature was different. For the most part, legislative contests were competitive strictly in the primaries, and the threat was usually from the right. As one informant explained:

We and probably North Carolina, maybe Oklahoma, are some of the most Republican states. So what would have been the benefit [of expansion]? Because when you put that kind of pressure on members, their races are decided in the primary. They don't have to worry about any Democrat running against them in any district.

Another informant noted that, "This state has become really, really red over the years since I've been here." There were a number of people who commented on how Tennessee had flipped from a predominantly Democratic state to a deep red state and that there had been widespread support for Donald Trump during the Republican primaries and the rhetoric of ACA repeal.

Describing the national political climate surrounding the ACA, one respondent noted that it was surprising how resistant states were given their willingness to accept federal money in other contexts.

But they [federal government] failed to see how the political dynamic of the country had changed in the couple of years between recovery and the ACA. And whether it was base, cynical political opportunism or just resistance against the president...The concept of free federal money wasn't appealing to people.

Despite the long odds, there was some sense of optimism as the session opened. Ron Ramsey, the Republican Senate speaker and lieutenant governor, despite being staunchly conservative, offered his willingness to consider the plan and indicated that his main concern was the need to negotiate with the Obama administration (Fletcher & Boucher, 2015). One stakeholder said, "He [Ramsey] spoke very gently. It was positive. It was not like we [the coalition] were screwed." On the other hand, the House speaker, Beth Harwell, said very little about the plan (Fletcher & Boucher, 2015). The same stakeholder who commented positively

about Ramsey, said: “She [Harwell] went radio silent. Totally disappeared. Which our governor saw that and realized, Oh s***, I’m hanging my people out to dry.” The overriding sentiment from people who had been involved was that no Republican was willing to take an unpopular vote for a bill that would not pass eventually, and so if the speaker was not willing to risk her standing to push the bill through the House, there was no reason for the Senate speaker to put his members at risk either, and the governor was not going to push him if the bill could not eventually pass. Harwell’s silence made support for expansion look like all risk and no reward for Republicans who supported it.

At the end of January, Speaker Harwell announced she would send the bill to expand Medicaid through three committees, Insurance and Banking, Health and Finances, and Ways and Means. Yet the chances of the bill passing all three committees, particularly Insurance and Banking, appeared limited. *The Tennessean* described the Insurance and Banking committee as “stacked with conservative lawmakers.” Fifteen out of the 20 committee members were Republican, and seven of them had cosponsored legislation to prohibit any form of Medicaid expansion (Boucher, 2015c). Informants reported that when the Senate president realized the House speaker was not fully behind the legislation, he was afraid that people would take a difficult vote that would not eventually lead to anything. Consequently, some observers believe he designed a specific Senate committee structure to ensure the bill would not get out of committee.

The special session opened on February 2, 2015 and brought advocates on both sides of the debate to the statehouse. According to respondents, the AFP put great effort into defeating Insure Tennessee. This organization came up in nearly every interview as an outspoken voice opposed to expansion. One interviewee told a story about the

hearings during the special session to discuss Medicaid expansion. He acknowledged that AFP was smart by having all of the people they brought in wearing “bright red t-shirts that said AFP-Tennessee on them.” He continued, “Don’t worry about visiting with legislators, just go sit in the committee rooms. And so when we would try to go into the committee rooms, it’s already full of red t-shirts. And the optics of that were that AFP had overrun the capital.” Because the pro-Insure Tennessee groups were wearing suits, they did not stick out. AFP thus managed to project an outsized influence. This exemplified what many supporters of Medicaid expansion saw as AFP’s understanding of how to mobilize a large grassroots effort that gave the appearance of public opposition to the Insure Tennessee proposal.

The Medicaid expansion coalition also found that their research and messages did not hold up against the opposition. In the same way that the groups opposed to Medicaid expansion used studies and facts to argue against expansion before the plan was introduced, they continued to do so during the special session. “They [groups opposed to expansion] cited the Oregon expansion study that focused...it focused on inner city Portland and ED utilization there. But they used the outcome of that study broadly as saying that’s what happened in Oregon.” The pro-expansion coalition thought their messages and facts would persuade, but they had not planned on how to counter opposition messaging.

The decision came on February 5, 2015 after more than a year of negotiations with CMS, months of lobbying, and much effort on both sides of the debate. The bill to expand Medicaid was considered by the Senate Health and Welfare committee, which had been created for the special session. The eleven-member committee voted the bill

down seven to four, with seven Republicans voting against the bill, and three Republicans joining the lone Democrat to support it. Once the bill failed to get out of committee it had no legislative future (Boucher, 2015d, 2015e).

After the Special Session

During the short special session, Speaker Harwell offered to undertake an effort to create an alternative plan if Haslam's plan failed (Boucher, 2015d). Following the defeat of Haslam's proposal in the special session, there were several attempts to restart a legislative process to expand Medicaid. Several Democratic legislators proposed legislation that would have allowed Haslam's plan to go forward, but they did not garner any Republican support (Boucher, 2015b). A Democratic legislator, Jeff Yarbrow, wanted the attorney general to say that the legislature had never had the right to require Haslam to seek permission. Like other attempts to revive expansion, that effort went nowhere (Boucher, 2015a). There were ongoing protests by advocacy groups, and an attempt to revive the legislation, which made it to the Senate Commerce and Labor Committee, however, it was voted down by Republicans, 6-2 (with support from one Republican and one Democrat) and one Republican abstention (Sher, 2015). Speaker Harwell was the target of a series of billboard campaigns sponsored by an independent philanthropist, Martha Ingram, urging her to do something about the uninsured problem in Tennessee, and eventually Harwell convened a task force that was designed to come up with options for reforming Medicaid and possibly expanding it (Boucher & Fletcher, 2016). The task force recommended a plan that would start by enrolling veterans and people with a diagnosis of mental illness as an experiment to assess the possibility of a broader

expansion (Fletcher & Egbert, 2016). Yet these proposals also failed to attract much support. Efforts to expand Medicaid in Tennessee thus floundered.

Analysis

Governor and legislature. Governor Haslam emerged from key informant interviews as a popular governor who attempted to expand Medicaid, yet was not willing to engage in the kind of brass-knuckles politics that would have been required to get it passed. Numerous respondents talked about the governor's popularity and how much political capital he had, but they also described his lack of enthusiasm for expansion as well as several strategic missteps. Haslam did not put himself at the head of a campaign, rather he and his administration handled the technical issues and let the plan sink or swim on its own in the legislature.

Republicans in the legislature were deeply mistrustful of any attempt by the governor to move without them, and they passed a law to restrict his ability to do so. In addition to the fact that the governor did not really have a plan for working his proposal through the legislature, the Republican leadership in the House and Senate were not fully in sync with each other. Senate leadership did not want to move without the House and vice versa. As a result, none of the leaders were willing to take a political risk without assurances from other legislators that those risks would pay off with a legislative victory.

Coalition. The state hospital association led a coalition to expand Medicaid and at different times there were other groups who joined them, but there was never a coalition operating in solid lock step with each other. Coalition members sometimes had different visions of how coordinated they were, which itself suggests a lack of coordination. Furthermore, the coalition did not have members capable of persuading the conservative legislators whose votes

they needed in order to pass Medicaid expansion. There was a fundamental mismatch between the voices coming out in support of the plan and those who the legislators listened to.

The stakeholders opposed to expansion, specifically AFP, were well-organized and focused. AFP had managed to both create fear among legislators and present itself as bigger and more powerful than perhaps they actually were. The forces opposed to Medicaid expansion used optics and powerful political pressure to prevail.

A quote from a stakeholder about the governor and the expansion coalition sums up the situation well, “I think they should have acknowledged it as a political problem at the outset.” AFP and Republicans in the legislature were arguing about Obamacare and mistrust of the federal government, while the expansion side was arguing about the details of the policy. Ultimately, those details did not matter compared to the political risks involved in supporting something that was ultimately a part of Obamacare.

Language. While the governor and supporters of expansion focused on economic benefits and the conservative elements of Insure Tennessee, they could never really disentangle Insure Tennessee from Obamacare. Given the state’s history with TennCare and the ACA, it is impossible to know if there was different language that would have appealed to the legislators who were resistant to expansion. The reliance on facts and figures, though, ultimately proved less persuasive than the appeal to the idea of resisting the federal government and financial sustainability for the state.

Political environment. Multiple respondents talked about the strong conservatism of Tennessee and the importance of primary voters. The political dynamics worked against any policy that could be seen as an embrace of Obamacare, and the threat from the right wing of the

Republican party seemed much more important than a need to reach swing voters. This conservatism was particularly pronounced in the legislature. While the governor was more moderate, the legislature was shaped by a large contingent of Republicans who were further to the right.

The state's voting history confirms this sentiment. Donald Trump won the state by more than 20 percentage points in the 2016 election (New York Times, 2016). Chapter 7 will compare the election results across states. However, based on both the election results and stakeholder interviews, it appears that Tennessee was more deeply conservative than the other states in this study.

Despite the political conservatism of the state, polling did indicate significant public support for Insure Tennessee both before the 2015 special session and after. A poll released in February 2015 showed that 49% of people who had heard of the plan supported it, while only 11% opposed it, and 40% had not made up their minds (Rau, 2015), and by May 2016, 63% of Tennesseans either supported or strongly supported the plan, while only 17% opposed or strongly opposed the plan, and 12% neither supported nor opposed the plan. These poll results were consistent with earlier polls from May and November of 2015 (Locker, 2016).

Previous history. TennCare's legacy was a consistent theme in explaining the failure of Insure Tennessee. The rapid expansion of Medicaid under TennCare, the subsequent budget problems, and the need to disenroll people was a story etched into the minds of every person involved in the ACA Medicaid expansion discussion. There was no space to have a conversation about Medicaid expansion that did not tap into the state's troubled experiences with TennCare.

Federal-state negotiations. Haslam's administration spent more than a year negotiating the terms of Tennessee's Medicaid expansion in a way that would be acceptable to both the federal government and conservative state legislators. Ultimately, the finer points of that plan were less important than the political reality that Medicaid expansion was unpopular and did not have the political support necessary in the legislature.

Conclusion

The failure of Governor Haslam's Medicaid expansion plan in Tennessee was due to a combination of factors: a difficult history in the state of expanding and then contracting Medicaid eligibility; a conservative political climate; a hesitant legislature; an ineffective governor; and a well-organized and vocal opposition from AFP. The support of different stakeholders, such as consumer groups, hospitals, and the business community, was not enough to overcome this opposition. Furthermore, the governor did not seem to have the political acumen or willingness to fight the opposing forces. Perhaps even a politically effective governor could not have prevailed against the many obstacles to Medicaid expansion in Tennessee. Yet with stronger leadership from the governor, expansion would at least have had a better chance.

CHAPTER 7: LOOKING ACROSS THREE STATES

This study sought to shed light on critical questions regarding the politics of Medicaid expansion under the ACA. Why did some Republican-led states expand Medicaid while others did not? What role did interest group politics, previous state history with health care reform, and other factors play in these decisions? And what important themes and lessons emerge from these cases studies of two GOP-led states that expanded Medicaid and one that did not? Six themes cut across the case studies and serve as useful tools for understanding key lessons, including prior Medicaid history in the state, the relationship between the governor and legislature, the language used to discuss Medicaid expansion, stakeholder coalitions, the political environment, and federal-state negotiations. This chapter explores the lessons from the three case studies as they relate to each of these themes. When appropriate, outside literature will be used to elucidate these patterns and ideas.

Previous History

Perhaps the strongest factor influencing a state to expand Medicaid despite the prevailing partisan tide was the state's previous history with the program. In Arizona, the state's particular circumstance with being required to cover adults up to 100% of the FPL and CMS's refusal to allow the state to claim enhanced matching without expanding to 138% FPL meant that they had a strong fiscal incentive to expand. Arizona would have ended up with a budget shortfall and uninsured people if they did not choose to do so. This unique situation was key in explaining why Governor Brewer decided to expand and why she fought as hard as she did.

While the circumstances were different, Indiana's previous history with Medicaid expansion and negotiation with CMS made expansion through HIP 2.0 easier. Because the original HIP program was supported by a partially Democratic legislature and a popular governor, and the legislature had already decided to use HIP as a vehicle for expansion, the post-NFIB decision was much easier. Governor Pence was able to separate HIP 2.0 from Medicaid expansion in his state more so than governors in either Tennessee or Arizona were able to separate their proposed expansions from Medicaid. In fact, in the study Indiana was the only state that truly created a distinction between the state's plan and Medicaid expansion as part of the ACA.

In Tennessee, state history worked against Governor Haslam's efforts to expand Medicaid. Even though Insure Tennessee included many of the same elements that would appeal to conservatives as HIP 2.0 did, Haslam was not able to separate it from the ACA the way that Pence could, partly because of TennCare's history. Stakeholders consistently talked about the long shadow of TennCare and how going through a long and painful disenrollment process made lawmakers very hesitant to expand again. They were skeptical about enhanced funding from the federal government and the ability of the program to be sustained.

While each of these situations is different, the common element is that success (or perceived success) tends to breed further success. HIP's popularity gave Pence the freedom to move on HIP 2.0, while the checkered history of TennCare made it much more difficult for Haslam to negotiate. Similarly, Proposition 204 in Arizona created a situation for Medicaid expansion shaped by previous state history. That proposition put the governor in a unique position in which she could either expand coverage and help the state budget, or cut enrollment and lose federal funds and thus put the state in a worse financial situation. Overall, what we can

learn from these three cases is that prior popular Medicaid expansions created a political environment that was more conducive to accepting the ACA's Medicaid expansion, while less positive experiences with prior Medicaid expansions made it more difficult to extend program eligibility under the ACA. This speaks to the importance of policy legacies and lessons drawn about prior experiences with programs in shaping contemporary politics and policymaking.

The question of how a state's policy legacy shapes decisions for years to come is a rich area of research. Miller (2008) has shown that litigation and administrative oversight work in tandem and also shape the actions of stakeholders beyond the specifics of the cases that were litigated. In other words, the effect of a court decision may go far beyond the specific case or the specific area of law that was brought to the court. Administrative bodies may develop regulations with a court decision in mind or redouble efforts to avoid the conflict that was at the center of the lawsuit. In this way the outcome of a legal battle can affect a whole range of policy. This seems particularly relevant in Arizona where the fear of a lawsuit over maintaining coverage established by Proposition 204 motivated the executive branch to act. Similarly, Chen and Weir (2009) showed how state approaches to regulating risk pools based on state-specific circumstances continued to shape state health policy decisions for decades, even in states such as Massachusetts and California, which are politically similar to each other. This approach is useful in putting Arizona, Indiana, and Tennessee into a larger context of state policy legacy. The legacies of Proposition 204, the Healthy Indiana Plan, and TennCare differentially shaped how these states responded to the opportunity to expand Medicaid under the ACA.

Dynamic Between the Governor and Legislature

Governor Brewer in Arizona and Governor Haslam in Tennessee make for an important comparison since both of them faced legislatures that were not supportive of Medicaid

expansion. Brewer was often described as being absolutely dogged about achieving her legislative priorities once she had set them, while Haslam was depicted by informants as a significantly weaker figure. Brewer's conservative credentials gave her the opportunity to be more liberal on the Medicaid issue without worrying about challenges to her political credibility. Furthermore, she was not running for governor again and had not expressed interest in other elected offices.

Brewer became a fierce advocate for Medicaid expansion. She used her bully pulpit consistently and forcefully to create support for her plan. Haslam, on the other hand, was quite timid when it came to expressing support for expansion. While he publicly supported it and made a case for why it was a good idea, he did not push the legislature or risk his own political capital for the effort. In Republican-led states that required legislatures to approve expansion active and effective gubernatorial support may be a necessary albeit not sufficient condition for enacting Medicaid expansion.

Governor Pence was in a different position in terms of his legislature. He did not need legislative approval in the same way that Brewer or Haslam did. On the other hand, it is plausible that had the legislature truly opposed Pence's plan to use HIP 2.0 as a way to cover more people, they could have thwarted his efforts. The Indiana situation is an example of where the legislature and the governor were of a similar mind and cooperated on Medicaid expansion. Governor Pence did not get ahead of the legislature, and they did not get in his way.

The lesson from examining how three governors navigated Medicaid expansion is that setting a goal, understanding the obstacles, and moving forward strategically is critical. Brewer knew she had to contend with a segment of her legislature, including the leadership in both chambers, which opposed her plan, so she prepared herself for a conflict and eventually

triumphed. Pence had support of the Indiana legislature for his approach, stayed with that approach and never came into a conflict with the legislature. Haslam, on the other hand, had an uphill battle with the legislature and was neither able to push them nor work with them the way Brewer and Pence had.

The state legislatures that each governor had to deal with were different in important ways. In Arizona, there were enough moderate Republicans who could be convinced to vote for expansion if conditions were right, and if the legislative leadership would let a vote happen. The votes were there for Brewer if she was willing to work for them. Given that Democrats in both states were generally supportive, Brewer had a much easier road of finding the votes she needed. In Arizona, Republicans controlled 17 out of 30 (56%) Senate and 36 out of 60 (60%) House seats. By comparison, Tennessee's legislature in 2015 included 28 Republicans out of 33 (84%) in the Senate, and 73 out of 99 (73%) in the House. In 2014, when much of the activity in Indiana regarding Medicaid expansion took place, Republicans held 37 out of 50 seats (74%) in the Senate and 69 out of 100 (69%) in the House (Table 4; National Conference of State Legislatures, 2017b). Recognizing that Republicans were usually more resistant to Medicaid expansion than Democrats, the legislative makeup in each state shows that Brewer had the easiest legislature to work with, Haslam the most difficult, and Pence had a legislature somewhere in between.

Table 4

Partisan Composition of State Legislatures at the Time of Medicaid Expansion Debate in Arizona, Indiana, and Tennessee

State	Senate % Republicans	House % Republicans
Arizona	56%	60%
Indiana	74%	69%
Tennessee	84%	73%

The dynamics between legislatures and governors in these three states echo a theme that surfaced in the literature review about how Republican legislatures differ from Republican governors when it comes to Medicaid. Kouser (2002) found that in states with a larger proportion of the legislature controlled by Republicans discretionary Medicaid spending decreased, but that the control of the governorship did not have the same effect. In both Arizona and Tennessee the Republican legislature took a more ideologically pure position than the Republican governor, and some interviewees credited primary threats for the legislature's more antagonistic view toward Medicaid expansion. In Arizona, Indiana, and Tennessee, Republican governors emerged as pragmatic conservatives in favor of Medicaid expansion, a testament in part to the program's powerful fiscal pull on states.

Political Environment

While all three states in this study were led by Republicans, there are differences in their political environments that may help to explain the various outcomes of Medicaid expansion. Indiana had only one Republican senator and had voted for Barack Obama in the 2008 presidential election, so there was always the possibility that it was less conservative than the

other two states. Using presidential election results as a measure of how Republican a state is, Tennessee is more Republican than the other two. Indiana became more Republican over the last three election cycles, while Arizona became less so (Table 5; NBC, 2012; New York Times, 2008; New York Times, 2016). Votes in a presidential election are not a perfect proxy for the political environment in which state officials operate. Turnout is usually higher for presidential elections than for state off-cycle elections, and specific candidates may cause voters to side with or against the party with which they identify. Keeping those caveats in mind, there is a strong case to be made that Tennessee had a more conservative political environment than the other two states. Even when attempting to control for similar partisan tendencies in these three states, there were different levels of partisan intensity that shaped how elected officials acted. Since I chose Tennessee specifically to include a state that did not expand Medicaid, it is also possible that my sampling strategy specifically led me to a state that was more intensely partisan. In order to understand how variations in partisan intensity affected outcomes in a more generalizable way, I would have to look at a greater number of states.

Table 5

Percentage of the Popular Vote in Each State That Went to the Republican or Democratic Presidential Nominee in Each Year (displayed as % votes for Republican candidate/% of votes for Democratic candidate).

	2008 Election	2012 Election	2016 Election
Arizona	53.8/45	54/44	48.1/44.6
Indiana	49/49.9	54/44	56.5/37.5
Tennessee	56.9/41.8	59/39	60.7/34.7

Note. Red indicates the state went for a Republican, and blue for the Democrat.

Coalitions

Another key theme from the case studies is the importance of stakeholder coalitions. Coalitions in Arizona, Indiana, and Tennessee all shared common elements. In all three, chambers of commerce, hospitals, and consumers were supportive of expansion. There were, however, significant differences in how these coalitions formed and worked with elected officials. In Arizona, the coalition was anchored by the Arizona Chamber of Commerce and managed by an outside lobbyist. The coalition also worked in close coordination with the governor, and more liberal members of the coalition understood that they were often not the most effective voices for expansion. The coalition also raised money for legislators who might be at risk of losing their seat because of an unpopular vote on Medicaid expansion. In short, the Arizona stakeholder coalition ran a concerted campaign in connection with the governor, which proved highly effective.

The efforts of the Tennessee coalition had several shortcomings compared to the Arizona campaign. The most significant was that the governor did not work as closely with the coalition

in the same way that Arizona's governor did. Furthermore, the Tennessee coalition did not have the same focus on targeting specific legislators whose votes were crucial for Medicaid expansion to pass, nor did they figure out how to protect individual representatives from difficult votes. It was more of a broad campaign, and there was not the same level of strategizing. Furthermore, Tennessee's expansion coalition was anchored by hospitals, who had a more self-interested role which made their motivation suspect to lawmakers. Having the Arizona Chamber of Commerce take the lead in that state made the effort appear to be about the economic benefit more broadly than the hospitals were able to portray. There was also evidence to suggest that Tennessee did not have the same level of strategizing among members in terms of understanding whose voice would carry weight with conservative lawmakers.

The Indiana coalition was closer to the Arizona coalition in terms of working with the governor and having more of a concerted strategy, but they were in a very different situation. The Indiana coalition was practical in terms of their goals. They knew that a traditional expansion was not on the table, so they focused instead on making the HIP 2.0 expansion as good as it could be. To a large extent, the Indiana coalition was working both to influence the governor and the legislature as well as CMS.

Overall, the evidence from these three cases suggests that a well-coordinated campaign can help a governor pass a controversial policy. The strongest coalitions in this study showed a level of pragmatism about how to get votes and the realities of the opposition that elected officials would face. They also understood their limitations and did not waste time on advancing policies that had no chance of passage. However, because the strongest coalitions also worked closely with the governors, it is hard to discern what their influence would look like in a situation where the governor was not a strong advocate. Based on these cases, it appears that a strong

coalition is an important component of passing controversial legislation, but it cannot replace a governor's influence.

The Medicaid politics literature suggests that interest groups can affect the outcome of state health policy decisions and that providers are particularly influential (Kousser, 2002; Kronebusch, 1997; Lukens, 2014; Olson, 2010; Pracht, 2007; Pracht & Moore, 2003; Sparer, 1996b). The leadership and anchor of the different coalitions varied across the three states, yet my findings reveal the limitations of provider influence in the politics of Medicaid expansion. . In Arizona, the hospitals were a driving force, but they worked primarily through the Arizona Chamber of Commerce. This was partly due to the fact that the Arizona Hospital Association was going through some turmoil, which made it difficult for them to take on the issue. Using Tennessee and Arizona as data points, having the chamber in the lead versus the hospitals appeared to be an advantage. In Tennessee, the hospitals were the anchor of the coalition and did not achieve their intended outcome. There were suggestions that the hospitals advocating for something that would benefit them was too brazen to be effective. While both the literature review and the case studies showed that stakeholders generally advocate positions that benefit themselves, there was something in Tennessee about having the hospitals as a visible and central force that worked against the coalition's efforts. However, since there were many other factors working against expansion in Tennessee, it is not clear to what extent, if any, that hospitals served as a liability in this campaign. In Indiana, the hospitals also took the lead and the results were positive. In the two states where Medicaid expansion passed, consumer groups and public interest groups recognized that they were not the most influential, and so they allowed other organizations that might appeal more to conservative lawmakers to take the lead. In Tennessee, there was less clarity among the coalition in terms of identifying the best messengers for their

goals. Again, many things worked against expansion in Tennessee, so it is difficult to identify any one fatal flaw. What is clear, though, is that the coalition was less organized and less cognizant of effective messengers compared to the other two states.

Tennessee stood out among the three cases for the strength of opposition from nongovernmental groups, namely AFP and the Beacon Center. While the Goldwater Institute vocally opposed expansion in Arizona, most of the opposition came from inside the legislature, not outside groups. AFP put substantial effort into defeating Insure Tennessee, and its determined opposition had an impact on the effort to expand that was unique among the three states. In Indiana there was minimal opposition to HIP 2.0 from politicians or interest groups that were opposed to expanding coverage, though there was opposition from liberal groups that wanted a more traditional expansion. But that was never a significant force in shaping that discussion.

Another aspect of the coalitions that was very important was hospitals' willingness to pay an assessment to offset the states' share of the costs of expansion. Beyond creating political pressure for expansion, hospitals in the two states that successfully expanded coverage (Indiana and Arizona) helped by offsetting the costs of expansion. They preferred the stable payments from lowering the uninsured rate, enabling the state to draw on generous federal matching funds without using state dollars. This compromise was critical in both states. The question of how states used hospital assessments to finance their share of Medicaid is long and controversial, with the federal government often trying to minimize states' ability to rely on provider assessments, while states tried to maximize it (Coughlin & Zuckerman, 2002). Currently, all states except Alaska rely on some kind of provider assessment to help finance their Medicaid programs (Kaiser Family Foundation, 2017b).

Language

There was no consistent relationship between the specific language that coalitions and governors used to promote Medicaid expansion and the outcomes of these debates. While this study did not measure the number of times governors or coalitions used different words or phrases, key informants and newspaper articles in all three states indicated that expansion advocates relied on a mix of humanitarian and financial reasons for justifying the effort to push expansion. There was no evident relationship between framing and successfully passing Medicaid expansion.

In all three states, governors and coalitions tried to separate the states' efforts from the ACA and the Obama administration. In Arizona and Tennessee this effort failed. Despite using the terminology of Medicaid restoration in Arizona and Insure Tennessee in Tennessee, opponents in both states consistently referred to the effort as Medicaid expansion and Obamacare. In Arizona, the coalition in support of Medicaid expansion managed to win despite this, but in Tennessee they were unable to overcome the Medicaid expansion stigma. In Indiana, there was a noticeable difference. In that state, Governor Pence was able to separate HIP from Medicaid in a way that other states could not. Whether the linguistic distinction between Medicaid and HIP 2.0 in Indiana facilitated expansion, or whether the same factors (*e.g.*, a history of state innovation) that made expansion through HIP 2.0 possible also made this linguistic separation possible is hard to know. In any event, the distinction stuck in Indiana in a way it did not in the two other states.

While coalitions and governors in the three states had varying success using language to distance their expansion plans from Obamacare, the fact that they all made an effort to do so reflects the highly partisan nature of ACA politics (Dinan, 2014; Haeder & Weimer, 2015; Jones,

Bradley, & Oberlander, 2014; Rigby, 2012). In particular, the inability of Governor Haslam and a coalition of interest groups in Tennessee to convince their legislature that the Insure Tennessee plan crafted through intense negotiation with CMS was a good deal for the state demonstrated the intense partisanship of this issue. One respondent from a national organization noted that the Obama administration had reasons to think that states would eventually take the money the way they had in other programs that involved federal-state partnerships. Yet the ACA triggered sustained ideological and partisan opposition, which in many states overwhelmed the appeal of fiscal federalism

Across the three states, the role of evidence and analysis was similar. In all three states, the proponents of Medicaid expansion had facts and figures to support the economic and human benefits of expansion. In Tennessee, that research did not break through the political impasse, even when it came from researchers who were known to be more conservative. In addition, in Tennessee the effort to expand Medicaid was hurt by the opposition's use of research that called into question Medicaid's effectiveness at increasing access to high quality medical care. Having solid research is important, but countering opposition research can be even more important. A similar situation played out in using polling information. In both Tennessee and Arizona, supporters used polling data to demonstrate that there was public support for expansion, but in Tennessee that data did not change the outcome. While data might be important, it does not always convince.

Federal-State Negotiations

The role of the federal government, specifically CMS, in defining the terms of the debate around Medicaid expansion in the three states studied was significant. In Arizona, CMS's refusal to allow the state to cover adults up to the FPL without expanding to 133% of the FPL forced the

governor's hand. The pressure from CMS was essential to achieving full expansion because of how that firm line related to Arizona's existing commitment to cover adults up to 100% of the FPL. Arizona had created an obligation through Proposition 204 to maintain coverage for adults up to 100% of the FPL if the state had the money. The governor and her staff thought they were open to a lawsuit if they did not take the federal expansion dollars. That existing state-specific situation meant CMS could "painted them into a corner" by insisting that Arizona expand up to 133% of the FPL or lose the funds that had been helping the state cover adults up to 100% of the FPL.

Both Indiana and Tennessee engaged in long negotiations with CMS over the terms of the waiver to allow them to expand. CMS was willing to negotiate about program design features, such as cost-sharing, which allowed at least Indiana to expand. Because Indiana did not have the same kind of existing constraint as Arizona, Pence could have more easily walked away from negotiations with CMS if the governor did not get the deal he wanted. In Tennessee, the long negotiations were a cause of frustration but ultimately may not have had much of an effect on the ultimate outcome.

Conclusions

While there are themes that emerge across the three states, this study also affirms the old adage that "if you've seen one state, you've seen one state." Each of the three states had unique features that worked in concert to either promote or prevent Medicaid expansion. Putting aside idiosyncrasies for a moment, it is clear that a governor who is willing to be a champion for a difficult policy is important, as is a coalition that will work pragmatically to fight for it. The strength of those factors matters, although it is possible that there are political obstacles that they cannot overcome. Perhaps most important is state history. A positive sense of the state's history

with Medicaid was a strong predictor of expansion success, and a history of failure was a predictor of failure to expand Medicaid.

One additional conclusion is that dividing states into red and blue can tell us a lot about how states respond to Medicaid expansion, but it also obscures important variation among Republican-led states. Certainly these three states, chosen for similar partisan composition, are more alike politically in many ways than either is to a state that has a solid Democratic government, such as Vermont or Connecticut. At the same time, there differences in how solidly Republican these states were. The states differed by the size of Republican majorities in the legislature and the Looking beyond easy-to-capture measures of partisanship is important for understanding how health policy will play out at the state level.

A state's history with Medicaid expansion was a strong factor in whether a Republican-led state was able to expand Medicaid under the ACA. A committed governor and a strong coalition were also important determinants of whether expansion efforts succeeded or not. Notably, even among Republican-led states there were significant differences in terms of how conservative the legislatures were, the size of the Republican majority, and the political environment, all of which may have affected whether a state ultimately expanded Medicaid under the ACA or not.

CHAPTER 8: MEDICAID EXPANSION AFTER THE 2016 ELECTIONS

On November 8, 2016, Donald J. Trump was elected President of the United States, while Republicans maintained their majorities in the House of Representatives and Senate, giving the GOP unified control of the federal government (Flegenheimer & Barbaro, 2016). Trump's election was yet another curve ball for the ACA Medicaid expansion, since a key pillar of his campaign was repealing the ACA. While this study focuses on events that took place before the 2016 election, it is worth briefly examining what effects the election had on Arizona, Indiana, and Tennessee, and what these developments illustrate about how the federal environment affects state politics surrounding Medicaid.

During the first seven months of the Trump administration, Congressional Republicans made several attempts to pass legislation that would repeal major portions of the ACA. Congress's first legislative attempt to repeal and replace the ACA was the American Health Care Act (AHCA). The AHCA would have phased out enhanced funding for the Medicaid expansion after 2020 and imposed a per capita cap and limits on federal payments to states for Medicaid. It would have also changed some of the private insurance regulations and subsidies in the ACA, though many ACA policies would have been left in place (Kaiser Family Foundation, 2017a). The AHCA passed the House of Representatives by a 217 to 213 vote after amendments were added to allow states to opt out of certain insurance regulations, a change that was important to conservative lawmakers (Roubien, 2017). However, the GOP held only a narrow 52-48 majority in the Senate, making passage of repeal legislation difficult. The bills that Republicans considered in the Senate, including the Better Care Reconciliation Act and Graham-Cassidy

amendment, would have either altered or completely eliminated the Medicaid expansion under the ACA. Like the AHCA, the Senate bills capped federal expenditures for Medicaid (Kaiser Family Foundation, 2017a). These bills never passed the Senate, nor did a so-called “skinny repeal” plan, which would have repealed the ACA without a replacement (Roubien, 2017).

However, in December 2017, as part of a broader tax bill, Congressional Republicans succeeded in overturning a major Obamacare provision, repealing the ACA’s individual mandate penalty for not obtaining insurance (Jost, 2017). Meanwhile, the Trump administration continues to pursue ways to alter the impact of the law. The administration has cut in half the length of the open enrollment period for the ACA’s health insurance marketplaces, and substantially reduced funding for advertising and in-person assistance. Furthermore, it ended cost-sharing reduction payments to insurers, which reimburse carriers for giving financial help, as required by the ACA, to lower-income consumers for out-of-pocket expenses (Roubien, 2017; Soffen, 2017). Trump has also issued executive orders that could expand the use of short-term insurance policies that are not subject to ACA regulations and allow some individuals to buy less comprehensive plans through employer associations (Soffen, 2017).

The Trump administration has been clear that it intends to allow states more flexibility under 1115 and 1332 waiver authority. On March 14, 2017, HHS Secretary Tom Price and CMS administrator Seema Verma sent a letter to governors signaling both their skepticism about the expansion of Medicaid under the ACA and interest in granting states more flexibility to design Medicaid programs (Price & Verma, 2017). Price and Verma described a new “federal and state Medicaid partnership.” They argued that “the expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working age adults without dependent children was a clear departure from the core, historical mission of the program.” Verma reiterated this position in a

November 7, 2017 speech in which she promoted the concept of work requirements in Medicaid, stating, “Believing that community engagement requirements do not support the objectives of Medicaid is a tragic example of the soft bigotry of low expectations consistently espoused by the prior administration” (Cunningham, 2017). This new flexibility raises the question of how Medicaid expansion will continue to play out in Arizona, Indiana, and Tennessee in this new political environment. What follows are brief updates on how the shifting federal environment has affected governors’ and stakeholders’ positions and actions regarding Medicaid expansion in the three states that I studied.

Arizona

Arizona’s current governor, Republican Doug Ducey, has expressed mixed opinions about Medicaid. He opposed efforts to restructure and reduce Medicaid funding through Senate ACA repeal bills and expressed concern about losing Medicaid funding (Pradhan, 2017). In a follow-up call with one of the initial key informants in the state, that stakeholder said Ducey had expressed concerns to the Arizona congressional delegation about enacting laws that would harm Arizona’s well-functioning Medicaid program. However, after a phone call from President Trump he publicly supported the Graham-Cassidy proposal (Sanchez, 2017).

Ducey began the process of altering Arizona’s Medicaid program before Trump’s election. His actions were guided by requirements the Arizona Legislature has imposed in 2015 through SB 1092, which required the state to apply to CMS every year for a waiver that would allow the state to require “able-bodied adults” to prove they were looking for work and to impose a five-year lifetime coverage limit on these individuals (Arizona Health Care Cost Containment System, 2017). In 2015, Ducey’s administration sought to amend their waiver to allow the state to charge enrollees copays for certain services and require participants to pay 2% of their income

into a health savings account. Savings accounts could be used to pay for non-covered services, like vision and dental services if the participant met wellness requirements and either enrolled in school or participated in a work search program. These restrictions would apply to the population who were between 100% and 138% of the FPL as well as some previously covered non-caretaker adults (Christie, 2015). On September 29, 2016, during the final months of the Obama administration, CMS Acting Administrator Andrew Slavitt approved the waiver. Slavitt allowed Arizona to go forward with the requirement for enrollees to pay into a health savings account, but rejected provisions that would have imposed a five-year lifetime limit on enrollment and the requirement that participants look for a job (Theobald, 2016).

Following the 2016 election and the subsequent signals of new state flexibility from CMS, Governor Ducey has again sought to cap enrollment in Medicaid at five years for able-bodied adults and to impose requirements that able-bodied adults either work or look for a job while receiving Medicaid benefits. The waiver is currently under review at CMS and has drawn largely negative responses from advocates for poor Arizonans. Joan Serviss, executive director of the Arizona Coalition to End Homelessness, in a written comment to AHCCCS opposing the new requirements, wrote that “AHCCCS provides relief from the uncertainty of poverty, which we know has more tangled roots than simply a lack of work or education” (Innes, 2017). The informant I spoke to said there was concern from a number of stakeholder groups about the work requirements, particularly for people age 55 and older who may have difficulty finding a job. Despite the divisive rhetoric at the federal level, the respondent noted that the coalition that had worked together to pass the expansion under the Brewer administration still met and maintained communication among themselves. However, the response to proposed changes in Medicaid

from the Ducey administration did not activate the same kind of energy among hospitals, the Chamber of Commerce, and consumer groups that the initial expansion fight inspired.

Indiana

I conducted my two-day site visit to Indiana in January 2017, a little more than two months after the election. While Trump had not yet been inaugurated, I was able to ask about how the election might change the situation for Medicaid in Indiana. Trump had already announced that he would nominate Seema Verma to serve as CMS administrator, and that announcement gave stakeholders confidence. They generally viewed her as someone who understood Medicaid and had shown an ability to address complicated problems in a way that worked for Indiana. At that time there was a lot of uncertainty about whether Republicans in Congress would really repeal the ACA. There were also many discussions at the federal level about block grants for Medicaid. Stakeholders thought that there was interest by the state and providers in using the increased flexibility of block grants to redesign Medicaid programs and use funds in different ways.

The current governor of Indiana, Republican Eric Holcomb, walked a fine line regarding federal efforts to repeal the ACA and reform Medicaid. He publicly supported ACA repeal and at the same time suggested he wanted to protect Indiana's ability to cover its citizens through the state's Medicaid program. In particular, he has pointed to the success of HIP 2.0 as an example of how Indiana was able to provide coverage to more people. Yet despite his desire to maintain HIP 2.0, he supported the Graham-Cassidy proposal, which could have threatened financing for the Indiana plan (Holcomb, 2017; Smith, 2017; Weixel, 2017).

In July of 2017, Holcomb sought modifications to Indiana's HIP 2.0 plan to allow the state to require certain recipients to either find employment or participate in job-training

programs (Associated Press, 2017). Work requirements were one component of Indiana's original HIP 2.0 proposal that CMS had denied, and the question of whether the new administration (and a CMS led by Verma) will now approve them is a highly anticipated decision. As the state awaits this decision, the consensus that surrounded the adoption of HIP 2.0 shows signs of fraying. Both Indiana Legal Services and individual hospitals are voicing concern about the administrative burden and the complexity of the new requirement. A spokesperson for Saint Joseph Health System, which operates hospitals and other health care facilities in north central Indiana, also expressed concerns about how difficult the requirement will be to administer in an "already strained and limited resource system" (Groppe, 2017).

At the same time, a follow-up conversation with one of the stakeholders from my initial study yielded a slightly different perspective. This informant thought that the Holcomb administration was more interested in feedback and input from stakeholders than the Pence administration and that some of the changes to Indiana's program that were getting less attention were potentially beneficial. For example, the Holcomb administration is considering ways to simplify how contributions to the POWER account are calculated, so that participants' contributions would not change every time their incomes changed. Contributions would be calculated based on income tiers and less subject to change because of small income fluctuations. This respondent did express concern about the ability of some participants to find jobs to comply with the work requirement, particularly in rural areas. Many people would likely qualify for exemptions, but the administrative hurdles might still be daunting depending on how the requirement is implemented.

Tennessee

I visited Tennessee in February of 2017, several weeks after Trump was inaugurated. The national picture about repealing and replacing the ACA was not clear, and most interviewees thought that the question of Medicaid expansion would depend on what happened federally and that there would not be much of an opportunity to move forward until the national discussion was settled. A number of stakeholders commented that negotiating with the Trump administration could be politically easier than the Obama administration. However, they thought that because the state legislative session in 2017 would end before the federal replacement for the ACA was could be in place, nothing was going to happen in the near term.

According to one of the initial stakeholders in Tennessee that I followed up with, the governor had been largely quiet on the issue of repeal. Nonetheless, the governor had presented his views at different times. He stated that the AHCA had the potential to be good for Tennessee (Gervin, 2017a). In reference to the Graham-Cassidy plan, Haslam said he supported “a plan that responsibly and adequately funds block grants to states and provides maximum flexibility and control to states” (Gervin, 2017b).

Governor Haslam has also indicated that he is not interested in another push to expand Medicaid in Tennessee. Following the failure of Congress to pass an ACA repeal and replacement bill in March 2017, Haslam stated that it was too early to consider another special session to consider Medicaid expansion (Ebert, 2017). In July, Tennessee House Speaker Beth Harwell, a Republican who also led the state’s task force examining paths to Medicaid expansion, announced she would run for governor (Ebert, 2017).

Despite that role, Harwell has not brought up Medicaid expansion as part of her campaign and neither have any of the other Republican candidates. Democratic candidates,

however, have said they support it. Advocacy groups, such as the Tennessee Justice Center and the Tennessee Health Care Campaign are still discussing the issue, but many other stakeholder groups are working on other issues because Medicaid expansion is not politically feasible right now. The prospect of negotiating with a Trump administration has not made the politics of Medicaid expansion more palatable to the governor or Republican legislature.

Medicaid Expansion in the Trump Administration

While it is beyond the scope of this study to fully examine how the Republican control of Congress and the White House will change the state-level dynamics of Medicaid expansion, a few trends are emerging. States are asking for approval of Medicaid waivers that had been previously denied by the Obama administration, specifically work requirements and limits on enrollment. CMS has signaled an interest in considering these policies, and they are likely to be adopted by more states during the Trump administration.

Without a presidential administration that opposes such restrictive policies, stakeholders may find they will need to speak up more forcefully to try and prevent their states from adopting tighter restrictions on Medicaid eligibility. At the same time, in these three states many of the same dynamics have been at play since before the election. The issues in Indiana appear slightly more contentious than they were previously, but there is on-going collaboration among the stakeholders who were part of the HIP 2.0 expansion, and the Republican governor is still able to separate Indiana's Medicaid program from the federal debate. Stakeholder groups also appear to continue to be working together in Arizona. The election did not change circumstances significantly in Tennessee, where Medicaid expansion still lacks the political support to move forward.

CHAPTER 9: PLAN FOR CHANGE

The RWJF uses an action framework to organize its work. The framework “identifies priorities...for driving measurable, sustainable progress and improving the health and well-being of all people” and consists of four action areas, which correspond to the desired final outcomes of improved population health, well-being, and equity. The four action areas include: 1) making health a shared value; 2) fostering cross-sector collaboration; 3) creating healthier, more equitable communities; and 4) strengthening integration of health systems and services. Within each of these areas are drivers of health. There are two drivers that are particularly relevant to this study: 1) increased access to high quality health care; and 2) increased civic participation (Robert Wood Johnson Foundation, 2017). This chapter will explore how to apply the lessons from this study to help achieve those goals. These recommendations for a plan for change are based on the evidence from the three case studies as well as my own knowledge of the current interests of the foundation and how it has funded similar efforts in the past. This plan is organized by the two drivers I am addressing: increased access to care and increased civic participation. It is important to note that this plan for change reflects my own thoughts based on this study and does not reflect the views of the Robert Wood Johnson Foundation, nor does it reflect all the factors that shape the work of the foundation.

Increased Access to Care

One way to increase the number of people with access to coverage (a means to the end of increased access to care) is to increase the number of states that have expanded Medicaid eligibility to 138% of the FPL, as is still an option through the ACA. Based on the three case

studies I conducted, there are several efforts that the foundation could support that would facilitate this policy change. At the outset, it is worth noting that no strategy works all of the time or in every situation. Indeed, one of the main lessons from looking across the three case studies is that state context is very important, and that the specific dynamics of state policy and politics change what tactics will work in that state. Many of the foundation's existing efforts are designed to allow for state customization, and this study confirms the soundness of that strategy. At the same time, several promising strategies emerge from my study that could be applied more generally.

Focus on messengers as much as message. One conclusion I draw from the three case studies was how little the specific messages mattered. There are some notable exceptions. In Indiana, stakeholders knew the term “Medicaid expansion” was not politically viable, so they talked about “coverage expansion” or “closing the gap.” Additionally, in Indiana, HIP 2.0 carried a different meaning than Medicaid. In Arizona, the governor preferred the term “Medicaid restoration” to emphasize that the state had already expanded Medicaid for citizens who were up to 100% of the FPL, but that language did not really stick because the state had to expand to 138% FPL. Yet beyond these specific instances there was surprisingly little mention of messaging research or the political consequences of using certain words. In Arizona, Governor Jan Brewer talked about the economic effects of Medicaid expansion as well as the human toll on people of not having coverage. The coalition of groups in Indiana that were working on coverage expansion similarly used a number of different messages, as did the coalition in Tennessee. RWJF spends millions of dollars a year on message research. Some of that money could be better spent by cultivating messengers.

In all three states, the chances for Medicaid expansion were strengthened by utilizing groups who were influential among conservatives, while establishing the perfect message was less important. While the more traditional proponents of increased Medicaid coverage were important in raising the profile of the issue, it took more conservative voices like the Chamber of Commerce to appeal to Republican lawmakers. In states where the politics of Medicaid expansion are difficult, an effective effort may have to include pressure from multiple stakeholder groups in order to appeal to the policy makers who will be key to the decision. The necessity of having a range of stakeholders in a coalition is directly tied to another key point that emerged from the three case studies: messengers matter as much as messages.

At times RWJF has defaulted to message research because it is easy to control a grant that funds such studies. We can select a communications firm and agree relatively easily on the final deliverable. Funding message research and giving it to advocates makes us feel confident that we are contributing to a campaign for health reform, but it turns out that this approach may not be as important as we think. While messaging work can be valuable, particularly when trying to figure out how to talk about a new or controversial issue (*e.g.*, work requirements) it would help to pair it (or even in some cases replace it) with programs that cultivate a range of advocates from across the political spectrum. This could include bringing in more leaders from private business, business associations, law enforcement, religious institutions, and other unexpected sectors. At the very least, the foundation should acknowledge and appropriately scale the amount of resources that go into message versus messenger development.

Broaden existing work to build evidence. RWJF has consistently funded important and influential research about coverage issues. In fact, research the foundation supported at the Urban Institute was cited by the Supreme Court in their *King v. Burwell* decision, which found that

consumers in the federal health insurance marketplace could legally receive premium subsidies (Wartell, 2016). The foundation should maintain its commitment to research, but also recognize two important points: 1) the logo on the research matters; and 2) there needs to be more point by point analysis of opposing arguments. Stakeholders who were involved in Medicaid expansion debates noted that research from groups known to be supportive of coverage expansion had limited value because the findings were easily dismissed as reflecting a political orientation.

The foundation could also do more to support the kind of policy research that national policy research organizations like the Urban Institute do at state universities, which might have more appeal to local policymakers. Research from an institution that seems familiar to policymakers and less identified with national politics may be more credible in local discussions. In Indiana, research from the University of Nebraska that was commissioned by the hospital association did hold some weight in the Medicaid expansion debate. However, this may not be a fool-proof strategy. For example, in Tennessee a paper by a known conservative researcher that showed the benefits of Medicaid expansion failed to persuade important policymakers. In general though, the question of who writes the research follows the same logic as the messenger versus message lesson. What is said may not be as important as who is saying it. Funding research through state institutions is not going to be a silver bullet. On the margins it could help in some states to have research that looks more home-grown and less connected to a group with a clear point of view. This does not need to be an either/or proposition. The foundation can continue to fund national level research while also supporting state-based research institutions. At the very least, the foundation could experiment by funding more research through state institutions and using media analysis or other types of assessment to determine if this research is more influential at the state-level compared to studies done by national groups. AcademyHealth's State-University

Partnership Learning Network, which works to build partnerships between state government and state research universities (AcademyHealth, n.d.), may be an existing entity that the foundation could tap for this work.

One opportunity to try this approach to research is with the proliferation of 1115 and 1332 waivers that states are currently proposing. While the federal government can (and in some cases must) require states to conduct an evaluation to analyze the cost and cover effects of such waivers, those evaluations are often overseen by the same people who are advancing the policy idea. RWJF can play an important role in independently evaluating these new methods of delivering Medicaid benefits and regulating the private insurance market. As the foundation does this it can consider building a national network of researchers that can take advantage of common methods and topics while housing the individual evaluations in state-based institutions that are likely to seem credible to multiple audiences, such as state policymakers, governors, health care providers, and consumers.

Similarly, the foundation could do more to develop research that specifically addresses arguments against coverage expansion. In Tennessee, proponents of Medicaid expansion were caught off guard by research suggesting that Medicaid did not work or that there was not as clear a case for the health benefits of expanding Medicaid as their own research had suggested. They may have benefitted from being as prepared to counter opposing arguments as they were poised to offer their own arguments in favor of Medicaid expansion. RWJF has wrestled with the issue of whether to release research that specifically addresses criticism of some of the foundation's positions, like expanded coverage. There are two issues. The first is that such research can look more partisan, since these arguments usually originate from or are echoed by elected officials. The second is the theory that repeating a false (or misleading) claim only serves to reinforce that

message, even if the misleading claim is refuted. My suggestion is to develop counter arguments and release them in a more limited way to advocates or stakeholders who could use it effectively. The foundation might also couple this kind of information with guidance on the best way to use messages that specifically speak to opposition messaging. In general this means providing counter points, but not repeating the original misleading information. That way it is available to those who need it, but does not create an appearance of partisanship or potentially serve to reinforce inaccurate statements.

Build public support. Informants mentioned polling numerous times as an important factor in why conservative politicians were willing to pursue or vote for Medicaid expansion. In Tennessee, polling supported expansion, but that was not enough for the legislature. Public sentiment is best understood as a necessary but insufficient condition for expanding coverage. Furthermore, broad public support is less important than support among constituencies that can determine the outcome of elections. Across the three states to varying extents, stakeholders talked about the power of primary voters to sway the interests of elected officials in taking certain positions. In order to use public support as an effective tool, the foundation may have to target advertising and media in a way that it has not done before—specifically trying to change the mind of more conservative audiences. This tactic has to be used in conjunction with the previously stated idea of focusing on messengers as well as messages. It also brings up some of the questions about the foundation’s limits as a private foundation, which will be discussed later in this chapter.

Give grantees more freedom to interact with legislators. In all three cases, the decision about Medicaid expansion depended on the state’s legislature. In Arizona and Tennessee, the legislature was the most difficult challenge (successfully met in Arizona, unsuccessfully in

Tennessee). This is less true in Indiana, although the governor's freedom to operate depended on the existing approval of the legislature. While this dynamic may not be true in every state that has rejected Medicaid expansion to date, based on this study it is fair to conclude that legislators are critical in these decisions. The experiences of Arizona and Tennessee with Medicaid expansion show that legislators can be harder to convince than governors of the need to take a certain policy action. Engaging with legislators presents several challenges for the foundation.

As a private foundation, RWJF is prohibited by the Internal Revenue Service (IRS) from engaging in lobbying activity or earmarking grant funds for lobbying. Failure to comply with these restrictions can result in the IRS charging a private foundation an excise tax on these funds. As a result, foundations like RWJF are careful to avoid funding either direct or grassroots lobbying efforts. Direct lobbying involves an interaction with a lawmaker to influence legislation whereas grassroots lobbying involves interactions with the public in order to encourage them to engage with lawmakers (IRS, 2015b).

The foundation is explicit that its funds cannot be used for lobbying. It is also clear that directly engaging with a legislative official and expressing a view on legislation is considered lobbying. However, creating and distributing nonpartisan analysis that references legislation is acceptable as long as it is distributed broadly (Robert Wood Johnson Foundation, 2011). These distinctions can become complicated and the lines between prohibited lobbying and permitted advocacy are not always clear. Often grantees steer far away from permitted activities for fear of being seen as lobbying.

The IRS is quite specific that foundations cannot earmark dollars for legislative purposes. At the same time, the IRS indicates that foundations can give general operating support grants to

501(c)3 public charities that lobby so long as funds are not earmarked by the foundation for lobbying purposes (IRS, 2015a). In fact, the IRS gives this specific example:

A public charity that has received a general support grant informs the grantor foundation that, as an insubstantial part of its activities, it attempts to influence the state legislature with regard to changes in mental health laws. The use of the grant is not earmarked for the legislative activities of the public charity. The grant is not a taxable expenditure even if it is later used by the recipient charity in its legislative activities. (IRS, 2015a)

One option the foundation should consider is making general operating support grants to organizations that are well positioned to work with legislators on issues such as Medicaid expansion or other topics where the line between lobbying and policy advocacy may be harder to define. This funding could also support organizations to more broadly interact with legislators about the potential benefits and costs of Medicaid outside of specific legislative decisions. General operating support grants allow organizations to use funds in any way that 501(c)3 organizations are allowed to, which is a broader range of activities than the IRS permits for private foundations (Adler, 2015).

In cases where general operating support would either not be feasible or preferable, the foundation can consider re-granting funds to an organization that has funds that do not come from a private foundation and are therefore less restricted in terms of lobbying. Re-granting involves making an award to an organization that then uses its own process to make awards to other organizations. An example is the foundation's current advocacy effort focused on childhood obesity, Voices for Healthy Children. While the details of the program are not entirely relevant for this plan for change, the salient point is that the foundation has awarded a good deal of the funds to the American Heart Association (AHA), which then awards grants to coalitions that are leading advocacy efforts around different policy issues. Depending on the issue, there may be lobbying involved, so the AHA is able to use RWJF funds to support non-lobbying

aspects of the work and combine the award with grants from the AHA's unrestricted funds so that the coalition can do the full scope of work needed.

This need to engage legislators more directly at times than the foundation is able to support is crucial based on the lessons from Arizona. The coalition there moved from trying to persuade legislators generally about the importance of Medicaid expansion and began targeting specific legislators in a much more focused way. Given the success of the Medicaid expansion campaign in Arizona, this could be an important strategy. Over the years, RWJF grantees have sometimes had to stop short of fully engaging legislators because of the restrictions on using foundation funds for lobbying. Funding in these different ways would allow grantees to use RWJF funds for permissible advocacy activities, while relying on non-foundation funds for lobbying efforts that may be necessary to successfully achieve policy change.

Increasing Civic Engagement

The question of civic engagement is also directly related to the issue of Medicaid (and more broadly coverage) expansions. In the two cases (Arizona and Tennessee) where state legislators played an active role in the Medicaid expansion debate, the issue of who (and how small of a population) they represented came up. For example, in Tennessee a stakeholder talked about how statewide elected officials, such as the governor and U.S. senators, were generally more moderate than the state legislators who represented smaller constituencies. In Arizona, a stakeholder commented on the strength of the primary voters. Some of this has to do with how districts are drawn and with low turnout for primaries, but some of it may be attributed to low voting levels overall. Only 54% of the voting age population in the United States voted in 2012 (Robert Wood Johnson Foundation, 2017). Midterm Congressional elections have even lower turnout. In Tennessee for example, in 2012 only 29% of eligible voters voted, and only 74% of

eligible voters were registered. This put Tennessee second to last in voter turnout nationwide and below the national average in terms of voter registration (Pew Charitable Trusts, 2016).

Voter registration. The question of how citizens are represented through voting has been studied by a number of researchers. Leighly and Nagler (2013) found that there is a persistent class bias in voting, with wealthier Americans voting more than poorer ones. They also found that voters are economically more conservative than non-voters. The distinct policy preferences of the wealthiest Americans toward more limited public spending has been studied by Paige, Bartles, and Seawright (2013) who found that the wealthiest 1% of Americans are politically active and distinctly less inclined to spend public money on health care than the rest of the population. While there is more to explore in the question of how voting affects policy, these scholars' work is important to consider in a state like Tennessee. If only 29% of eligible voters are deciding the make-up of the state government, and that electorate is skewed toward wealthier and more economically conservative voters, it is not surprising that Medicaid expansion would not be politically feasible in the legislature. This is true even if the proposals are fairly popular, as polls indicated they were in Tennessee. If policy is going to reflect the needs of the population, people need to vote, and they cannot vote if they are not registered. Therefore, one way to advance health policy in states is to increase the number of people (and particularly the number of people who rely on Medicaid) who vote.

Private foundations can engage in voter registration efforts, but they have to comply with certain IRS regulations. An organization that is funded by a foundation to carry out voter registration must be a 501(c)3 and conduct voter registration in at least five states over more than one election cycle. There are also further restrictions on how much of the grantee's budget can be spent on voter registration and where their other funds come from (Alliance for Justice, 2012).

In order to comply with these regulations, the foundation would need to invest for a number of years in groups that meet these criteria. This is a feasible option for the foundation.

Platforms for informed debate. While a good deal of the success of the Medicaid expansion campaign in Arizona was due to savvy political tactics, there is an important role for informed debates. Such platforms, whether they are in person or online can help bring a larger swath of the public into important policy debates and thereby improve civic engagement. The question of how Medicaid funding supports a state's infrastructure, as well as how changes to the program could help or hurt different populations, are important issues to flesh out for policymakers as well as the general public. Particularly as debate about Medicaid is likely to switch from expansion or non-expansion to more technical waiver issues, such as whether to expand to 100% of the FPL or 138%, or whether to impose work requirements, drug testing, and other new measures, there will be a need to discuss and explore the ramifications of these decisions.

Given the need for factual information to inform state-level debates and the skepticism of many existing organizations, a new kind of organization may be needed to fill this role. A new organization in Tennessee may be an example of this kind of institution. The Sycamore Institute is explicitly designed to offer factual information to the legislature. They were founded in 2015 and have intentionally brought together a board and staff that has worked under Democratic and Republican administrations (The Sycamore Institute, 2017). The North Carolina Institute of Medicine may also be a model that could help advance informed debate (North Carolina Institute of Medicine, n.d.). While it is far too early to know if this kind of institution can shift the legislative conversation to more fact-based policy discussions as opposed to heated political conversations, it is worth exploring and experimenting with supporting organizations like this.

Conclusion

This study demonstrated that a state's decision about expanding Medicaid is influenced by multiple factors. RWJF will never be able to influence all of these factors, or even most of them. However, the foundation can support coalitions, analysis, and engagement with policymakers that may help to meet its stated goal of ensuring access to health care.

Furthermore, this study showed how state legislators often held different views than the state's voters overall, and even in some cases the voters in their district. Increasing voting rates could lead state legislators to take positions more consistent with the state's voters. This could help the foundation to meet two of its goals: increased access to health care and increased civic participation.

APPENDIX A: INTERVIEW GUIDE FOR INTEREST GROUPS

Introduction

Thank you for your time. As I mentioned I am a graduate student at the University of North Carolina, Chapel Hill and am writing my dissertation on the politics of Medicaid expansion and how expansion debates played out at the state level. I am also a program officer at the Robert Wood Johnson Foundation, but it is in my role as a student that I am conducting these interviews

I will not attribute any quotes to individuals and will not use any material that you tell me is off the record. I do plan on discussing how different stakeholders in a state approached the issue of Medicaid expansion and identifying the groups that I spoke to. Are you comfortable with that? In order to really focus on what you're saying and have an accurate account of this interview, I would like to record our conversation. Is that ok with you?

Opening Question (once we're recording):

1. Just to have it on record, I'm going to ask you again if I have your permission to record our interview. And as I said I am not going to attribute quotes to individuals and will not use any material you tell me is off the record. I will list the organizations with whom I spoke. Are you comfortable with that?

Key Questions:

1. How long have you been at [organization]?
2. Where were you previously?
3. How was your group involved in the Medicaid expansion debate?

4. Who were the key groups in favor of Medicaid expansion in your state and what were their main arguments for expansion?
5. Who were the key groups opposing expansion and what were their main arguments against expansion?
6. Which groups do you think were most effective?
7. How did the governor view Medicaid expansion?
8. How about the legislature? How did it differ by party?
9. What was your organization's strategy for advancing its position on Medicaid expansion?
 - a. Did you form alliances with other groups? If so, what groups?
 - b. Did you work with legislators or the governor? If so, how?
 - c. Did you take part in or sponsor a public campaign? If so, please explain.
 - d. Did you directly engage the media?
 - e. What were your groups' arguments in support of or opposed to Medicaid expansion? Were the same arguments made for the public and to decision makers, or did they vary?
10. How effective or ineffective do you believe those strategies turned out to be?
11. What factors do you think were ultimately most significant in determining the outcome of the Medicaid expansion debate in your state?
12. Since the Medicaid decision was made, has your group's views on its impact changed at all?

13. Is there anything else about Medicaid expansion, the debate in your state, and your organization's role in the debate that really stands out for you?

14. Are there key reports/documents that I should look at?

Closing Questions:

1. Is there anything from how this debate played in your state out that you think could be applied to other states?
2. Thinking about foundations and other outside groups, are there ways that these organizations can help break political deadlock when it comes to health policy?

Thank you

APPENDIX B: INTERVIEW GUIDE FOR POLICYMAKERS

Introduction

Thank you for your time. As I mentioned I am a graduate student at the University of North Carolina, Chapel Hill and am writing my dissertation on the politics of Medicaid expansion and how expansion debates played out at the state level. I am also a program officer at the Robert Wood Johnson Foundation, but it is in my role as a student that I am conducting these interviews

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Opening Question (once we're recording):

1. Just to have it on record, I'm going to ask you again if I have your permission to record our interview. And as I said I am not going to attribute quotes to individuals and will not use any material you tell me is off the record. I will list the organizations with whom I spoke. Are you comfortable with that?

Key Questions

1. How long have you been at [fill in appropriate office]?
2. Where were you before?
3. What were the governor's views and positions on Medicaid expansion and its potential impact on the state?

3. How about the legislature? How did it differ by party?
4. How did the governor talk about the expansion? Legislators from different parties?
5. What role did the governor's office/legislature play in shaping the Medicaid expansion debate?
6. Who were the key groups in favor of Medicaid expansion in your state and what were their main arguments for expansion?
7. Who were the key groups opposing expansion and what were their main arguments against expansion?
8. How effective do you think these groups were in advancing their position?
9. What were your governor/legislator/your strategy for shaping the Medicaid expansion debate? (Exact wording depends on whether I am talking to a staffer or an elected official. The question is meant to get at the strategy of an individual)
 - a. How did you seek to frame the issue of Medicaid expansion?
 - b. Did you work with outside groups or other parts of state government? If so, which ones?
10. How effective or ineffective do you believe those strategies turned out to be?
11. What factors do you think were ultimately most significant in determining the outcome of the Medicaid expansion debate in your state?
12. What difference do you think interest groups ultimately made to that outcome?
13. Do you think the media played an important role?
14. Since the Medicaid decision was made, has [governor/legislature's] views on its impact changed at all?
15. Have stakeholder views changed since the decision was made?

16. Is there anything else about Medicaid expansion, the debate in your state, and your organization's role in the debate that really stands out for you?

17. Are there key reports/documents that I should look at?

Closing Questions:

1. What lessons do you think can be drawn from your state that could be applied to other states?

2. Thinking about foundations and other outside groups, are there ways that these organizations can help break political deadlock when it comes to health policy?

Thank you

APPENDIX C: INTERVIEW GUIDE FOR RESEARCHERS AND INFORMANTS OUTSIDE THE STATE

Thank you for your time. As I mentioned I am a graduate student at the University of North Carolina, Chapel Hill and am writing my dissertation on the politics of Medicaid expansion and how expansion debates played out at the state level. I am also a program officer at the Robert Wood Johnson Foundation, but it is in my role as a student that I am conducting these interviews

I will not attribute any quotes to individuals and will not use any material that you tell me is off the record. I do plan on discussing how different stakeholders in a state approached the issue of Medicaid expansion and identifying the groups that I spoke to. Are you comfortable with that? In order to really focus on what you're saying and have an accurate account of this interview, I would like to record our conversation. Is that ok with you?

Opening Question (once we're recording):

1. Just to have it on record, I'm going to ask you again if I have your permission to record our interview. And as I said I am not going to attribute quotes to individuals and will not use any material you tell me is off the record. I will list the organizations with whom I spoke. Are you comfortable with that?

Key Questions:

1. Can you tell me a little bit about your organization?
2. How long have you been there?
3. Were you involved in the Medicaid expansion debate and if so, how?

4. Who were the key groups in favor of Medicaid expansion in the state and what were their main arguments for expansion?
5. Who were the key groups opposing expansion and what were their main arguments against expansion?
6. How did the governor view Medicaid expansion?
7. How about the legislature? How did it differ by party?
8. How did non-governmental stakeholder groups involved advance their position?
9. Why do you think Medicaid expansion passed/did not pass in blank state?
10. What factors do you think were ultimately most significant in determining the outcome of the Medicaid expansion debate in your state?
11. What difference do you think interest groups ultimately made to that outcome?
12. Is there anything else about Medicaid expansion, the debate in [fill in] state that really stands out for you?
13. Are there key reports/documents that I should look at?

Closing Questions:

1. What lessons do you think can be drawn from your state that could be applied to other states?
2. Thinking about foundations and other outside groups, are there ways that these organizations can help break political deadlock when it comes to health policy?

Thank you

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