

**Medicaid Expansion and the States: Implementation, Politics, and the
Affordable Care Act**

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Health Services Organization and Policy)
in the University of Michigan
2018

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Dedication

For Jennifer, Felix, and Edith for being my “still point of the turning world.”

Acknowledgements

I came to the University of Michigan in the Fall of 2011 after being accepted into the Masters in Health Services Administration program. Seven years later I not only have received my Masters but a PhD from the greatest University in the world. These past seven years have been humbling, enriching, and rewarding. I am incredibly grateful for all of the support that I have received from the faculty in Health Management and Policy. In particular, during my Masters training, I want to thank Dr.'s David Mendez, Richard Hirth, and Christy Lemak. Each of you supported and encouraged me to continue my education in the doctoral program. Without your guidance, support, and kindness I would not have even started on this journey.

Any success that I have had during my time in the doctoral program has been a result of the people that I have collaborated with and learned from. Most prominently are my dissertation co-chairs Dr.'s Scott Greer and Holly Jarman. I cannot imagine more supportive and helpful mentors. Additionally, I have been blessed with an outstanding committee. Professor Nicholas Bagley, Dr. Charles Ragin, and Dr. Barry Rabe, each have provided incredible insights and helped improve this project. I have learned much from my encounters with them, both academically and professionally. It truly takes a village and I would not have had a modicum of success without Mindy Niehaus-Fukuda, Tyra Sampson, Kaitlyn Taylor, and Brenda Bernhardsson.

For the past three years I have had the unbelievable opportunity to work with Dr. Angela Beck and the rest of the Behavioral Health Workforce Research Center here at the

University of Michigan. Dr. Beck, as well as Jessica Buche and Cory Page have nurtured and supported me in more ways than they know.

My experiences in Health Services, Organization and Policy would not be complete without the friendships and collaborators I have met and will continue to work with from this program. I met David Jones my first week after moving to Ann Arbor and he has been far more generous in his time and efforts than I deserve. His friendship has been invaluable and I look forward to continuing to work together. Charley Willison has always lent an optimistic ear during doubts and challenges. Michael Rozier has been a wonderful collaborator and friend. I also want to thank each of the individuals in my cohort: Betsy Cliff, Dori Cross, Zach Levinson, John Richardson, and Sasha Zhou. I count myself lucky to have been able to associate with you over the past five years. I look forward to following each of your careers as you continue your interesting and important work. Lastly, I want to thank the residents of M3331, Betsy Cliff, John Richardson, and Qing Zheng. Dissertating is not easy, but sharing an office with each of you made my day a little brighter and a little better.

Lastly, I would never have been able to accomplish anything without the loving support of Jennifer, Felix, and Edith. At the end of even the most discouraging day, I would come home to hugs, kisses, Legos, and Barbie's. Every morning I would write out my list of things I needed to do during the day and I would always start my list by writing down a short phrase from T.S. Eliot from his Four Quartets: "at the still point of the turning world". Regardless of what was happening around me, the challenges, stress, and disappointment that I might face, you three have always been and will always be the still point by which my world rotates around. Thank you for your support, your patience, and your sacrifices you have made for me.

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Abstract

When the Supreme Court held in June 2012 that states were not required to expand their Medicaid program under the Affordable Care Act (ACA), it reset the politics of health reform at the state level, creating a natural experiment to understand implementation decisions. With a generous reimbursement from the federal government, economic benefits for businesses and health systems, and coverage for the previously uninsured, states had much to gain by expanding Medicaid. Yet, the political divisions which emerged during Congressional debate and passage of the ACA marked the implementation of the Medicaid expansion. With 18 states rejecting implementing the Medicaid expansion, what explains state decision-making and the Medicaid expansion? I find that partisanship matters, but the Medicaid expansion has had a destabilizing effect on the Republican Party; the institutional design, organized interests, waivers, and national events have influenced whether and how a state decides to implement the Medicaid expansion.

Implementation decisions are complex social phenomena, influenced by several interacting factors. One common account of ACA implementation decisions has focused on the role of partisanship. While Democrats have embraced the Medicaid expansion, Republicans have a much more complicated connection with the policy. Of all the states that have rejected the expansion, all but one is has a Republican governor and majority control over both chambers of the legislature. Yet, more than forty percent of Republican governors and a third of Republican majority control state legislative chambers have voted to expand Medicaid.

To examine the implementation of the Medicaid expansion, I conducted in-depth comparative case studies across three states. To facilitate case selection, I used fuzzy set/Qualitative Comparative Analysis (fsQCA), which identified three “pivot” cases, Arizona, Michigan, and Utah, for analysis. Each of the three Republican controlled states was on the brink of expanding or not their Medicaid programs. I collected two types of data to detect variations in implementation across the cases. First, I conducted semi-structured key informant interviews across each of the case study states. Second, I analyzed thousands of documents, including written and oral legislative testimony, legal material, and government and think-tank reports related to the expansion.

Gubernatorial support was necessary, but not sufficient, to explain state decision-making for implementing the Medicaid expansion. Across each of these cases, the Medicaid expansion created divisions between traditional economic interests and ideologically driven factions within the Republican Party. Supportive Republican policymakers attempted to overcome these intra-party divisions by leveraging the idiosyncratic institutional design to pressure or bypass oppositional legislators. Additionally, organized interests influenced whether and how a state implemented the Medicaid expansion. The role of organized interests was moderated by the ability of these groups to stay unified, the timing of their mobilization in response to the Supreme Court decision, and the intensity of their policy preferences. Waivers gave supporters of the Medicaid expansion flexibility to pursue “reforms” to change the calculus of policymaker perception of Medicaid expansion and expand coalition formation within the legislature, while pushing the Medicaid program in more conservative directions. Lastly, the national political environment influenced whether and how a state implemented the Medicaid expansion. By 2017, each of the states had entered a period of stasis with Medicaid, only for the Trump administration

and its shifting politics and policy around Medicaid to unsettle the programs, causing states to reevaluate and adapt their expansions to the new environment.

Chapter 1: Medicaid Expansion and the States

“The operations of the federal government will be most extensive and important in times of war and danger; those of the State governments, in times of peace and security.”

- James Madison, Federalist No. 45

The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) was the culmination of a decades long effort to increase access to health care for millions of Americans (Blumenthal and Morone 2010). The law represents the most significant development in health policy since the passage of Medicare and Medicaid as part of Johnson’s Great Society fifty years earlier (Obama 2016). Touting the significance of the ACA, an optimistic Barack Obama remarked at the signing of the ACA that “For as we mark the turning of spring, we also mark a new season in America” (White House 2010).

However, the politics of health reform and the implementation of the ACA are shaped by two different themes which have chilled Obama’s predicted spring. First, despite the immensity of the political accomplishment for Obama, the signing of the ACA did not turn over a new political season in America, rather political battles over the implementation of the law ramped up in the months and years since March 2010. Second, the political battles over implementation of the law became especially important at the locus of implementation, the states. While health reform was national in focus, the actual implementation of the law was largely conducted at the

state level (Greer 2011). Taken together, how health reform actually looks in the state is largely determined by how and who implements the law (Kersh 2011, Rigby 2012).

One of the chief goals of the ACA is to increase insurance coverage within the United States. Health reform contains a several different components to promote this goal, including the provision of cost-sharing reductions, subsidies, insurance exchanges, and Medicaid expansion; the last of which is responsible for more reduction in the uninsured after the implementation of the ACA (Freaun, Gruber et al. 2017). While the ACA is national in scope and supported by the federal government, much of the law requires state participation, support, and administrative capacity for implementation.

The Supreme Court ruling in June 2012 added additional authority for implementation to the states when it held that the federal government couldn't force a state to expand their Medicaid program. Since the June 2012 ruling 18 states have rejected the Medicaid expansion. While state implementation decisions are complex social phenomena, one common explanation has focused on partisanship and ideology (Jacobs and Callaghan 2013, Rigby and Haselswerdt 2013, Jones, Bradley et al. 2014, Jones, Singer et al. 2014). General trends bear out the importance of partisanship on implementation decisions. Democrats have uniformly embraced the Medicaid expansion, while Republicans have a much more complicated relationship with the policy. Of all the states that have rejected the Medicaid expansion, all but one has been led by a Republican governor, as well as Republican majority control over both chambers of the legislature. Yet, more than a forty percent of Republican governors and a third of Republican majority control state legislative chambers have voted to expand Medicaid.

I am examining the Medicaid expansion implementation decisions made by states, how the politics of health reform have been shaped by the Medicaid expansion, and the factors that

have contributed to whether and how a state decided to implement the ACA Medicaid expansion.

What explains implementation by states?

Partisanship is an important, but incomplete, factor in explaining state decision-making in implementing the Medicaid expansion. In addition to partisanship, a supportive governor is necessary, but not sufficient, for a state to expand Medicaid. No state has implemented the Medicaid expansion without a supportive governor. The experiences of Kansas and Maine point to the necessity of a supportive governor; Paul LePage (ME) and Sam Brownback (KS) have both vetoed expansion legislation that was supported by a coalition of Republican and Democratic legislators in their states.

There are important theoretical considerations when examining the decision to expand Medicaid. States, particularly ones led by Republican policymakers, have to grapple with the tradeoff of transactional federalism while navigating the dynamics of a highly partisan and polarized policy. Republican policymakers need to weigh the financial benefits for individuals, business, and state budgets, with the appearance of capitulating with and embracing Obamacare. Theoretically, state decision-making around the Medicaid expansion gets to the core of contemporary federalism, where a highly polarized and partisan policy environment is the new norm. Medicaid expansion is a case study of the broader theoretical challenges which federated states and policymakers need to navigate.

The flexibility provided by the Supreme Court created divisions within the Republican Party across each of the states. As Republican policymakers grappled with the tradeoffs inherent in the implementation of the Medicaid expansion, the fault line emerged within the party between traditional economic interests and ideologically driven factions. The Medicaid

expansion represents a substantial transfer of capital between the federal and state governments. The ACA provides a more generous federal-state financial match than any other previous time in the history of the program. States that have reject expansion stand to lose more than eight billion dollars in federal payments (Holahan, Buettgens et al. 2013, Price and Eibner 2013, Hartman, Martin et al. 2017, Lassman, Sisko et al. 2017, Sommers and Gruber 2017). The economic benefits of implementing the expansion also positively impacted business and the labor market (Gooptu, Moriya et al. 2016, Leung and Mas 2016, Ayanian, Ehrlich et al. 2017, Garrett, Kaestner et al. 2017, Kaestner, Garrett et al. 2017). Expansion has also resulted in reductions in uncompensated care costs for provider organizations (Dranove, Garthwaite et al. 2016, Nikpay, Buchmueller et al. 2016, Freedman, Nikpay et al. 2017, Lindrooth, Perrailon et al. 2018, Wu, Fingar et al. 2018).

While the economic benefits were attractive to a portion of state policymakers in the Republican Party, the rise of Tea Party and other grass roots conservative movements emphasized ideological purity above all else (Zernike 2010, Kabaservice 2012, Grossmann and Hopkins 2016). For this faction of the Republican Party, rejecting the Medicaid expansion provided state policymakers the opportunity to hamstring the overall effectiveness of President Obama's signature domestic policy. While this faction of the Republican Party was supportive of business and hospital interests, they viewed the Medicaid expansion and its supporters as promoting the expansion of government and they would not support its implementation in their state.

Institutional Design

There were several mechanisms that Republican policymakers were able to leverage to overcome or exacerbate intra-party divisions between traditional economic interests and

ideologically driven factions. First, policymakers were able to leverage the institutional design, or rules of the game, within a state to pressure their colleagues. In certain cases, like with Arizona Governor Jan Brewer, the institutional design of the state could only be accessed by an executive, like the use of vetoes and calling special sessions. However, legislators were also able to change the dynamics between the executive and legislative branches, like when Utah Republicans passed and Governor Gary Herbert signed legislation that limited the options of the executive in seeking implementation of the Medicaid expansion. The use of institutional design was used by both supportive and oppositional policymakers.

Organized Interests

Additionally, state-specific organized interests played a role at overcoming the divisions within the Republican Party. These groups influenced whether and how a state was able to implement the Medicaid expansion. There are three key themes which emerged from the role of organized interests on the Medicaid debate. First, coalitions of supportive organized interests formed in the wake of the Supreme Court decision. These coalitions generally included state hospital associations, Chambers of Commerce, small business associations, provider groups, and civic organizations; the key element for these coalitions was the ability to remain unified in their efforts to influence the implementation of the Medicaid expansion. Second, the timing of mobilization amongst the coalition in response to the Supreme Court decision mattered in explaining their overall effectiveness. Lastly, the resource allocation and intensity of preferences within the organized interest community influenced whether and how a state expanded Medicaid.

Medicaid Waivers

The availability of Medicaid waivers created political flexibility for policymakers to construct their own “reforms” of the Medicaid expansion program. Waivers allow states, with

federal approval, to modify existing programmatic components within existing statute. The use of waivers provided two benefits to supporters of expansion. First, it changed the calculus of policymaker perception of the Medicaid expansion. One of the common refrains from supportive policymakers was that through the waiver, the state had fundamentally altered the Medicaid program, creating a model for other states to emulate. Supporters of expansion, they argued, were not supporting the ACA or even Medicaid, but something new, uniquely created for their state and their citizens. Second, waivers allowed new possibilities in legislative coalition formation. When Republican policymakers were developing waiver programs they had to thread a needle that would be attractive to Republicans in the legislature, not repulse Democratic support, and be approved by the federal government. Because Democratic support was uniform, the expansion waivers were consistently focused on attracting Republican support, leading these programs to make Medicaid more conservative in nature, by including premiums, cost-sharing, work requirements, changed benefit structure, and lifetime eligibility limits (Singer, Nelson et al. 2017).

National Political Environment

There were two primary effects of implementing the Medicaid expansion in a federated system like the United States. First, states had the opportunity to learn from each other. While states were pursuing waivers, they were not creating new programs out of new cloth. Rather, there were policy feedback loops across the states, where policymakers were learning what the federal government would approve, as well as other states' experiences with costs and enrollment projections. Second, national events shaped states' response to implementing the Medicaid expansion. The surprising election of Donald Trump in 2016 shook states from a period of policy stasis. The Trump administration pierced this stasis by altering the politics

and policy of Medicaid. One of the first actions undertaken by the recently confirmed Health and Human Services Secretary (HHS) Tom Price and Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma was to announce that the Medicaid expansion was a “departure from the core, historical mission of the program”, which the new administration would remedy by empowering “all states to advance the next wave of innovative solutions” with a focus on privatization and state flexibility with waivers (Price and Verma 2017).

Medicaid Expansion: Obama, Congress, and the Supreme Court

Prior to his victory in the 2008 presidential election, candidate Barack Obama demonstrated limited proficiency with health care policy. During the first in a series of issue-specific Democratic presidential forums during the primary campaign, the candidates met in March 2007 to discuss health care. Obama, especially in comparison with his rivals Hillary Clinton and John Edwards, was “vague and platitudinous” when remarking on his health care plans, only offering general recommendations and focusing on expanding coverage for children (Heilemann and Halperin 2010). Though he did promise that he would judge the success of his first term in office by whether he has delivered reform which “every American deserves and that our system can afford” (Heilemann and Halperin 2010), Obama’s campaign platform was filled with aspiration but lacked specific policies for health reform.

Once elected to the Presidency and learning from the failures of the Clinton presidency, Obama provided general principles for reform to Congress, including increasing access to health insurance, regulation of private insurers, raising taxes and trimming existing programs to cover the cost of expansion of coverage, and bending the cost curve. Within these broad parameters

Obama allowed Congress to flesh out what health reform should actually look like (Morone 2010).

Congressional Action on Medicaid Expansion and Health Reform

Though Obama deferred to Congress on the development of health reform, Congressional debate around the Medicaid expansion was marked by the near absence of any real debate. Congressional observers noted that “there was no Democratic senator who articulated a vision – or even just an explanation – of what was being done and why” (McDonough 2011). Republicans, filling this void, argued as Senator John Cornyn did, that health reform “would consign sixty million Americans to a health care “gulag” called Medicaid” (Congressional Record 2009).

All of the Democrat’s best laid plans for health reform were nearly derailed by the unanticipated election of Scott Brown in Massachusetts. At the start of Obama’s first term, he enjoyed large majorities in both the Senate (55-41) and House of Representatives (256-178). The only solace for Republicans was their ability to block a super-majority of Democrats in the Senate. When longtime Republican Pennsylvania Senator Arlen Specter switched to the Democratic Party in April 2009, Democrats were unimpeded in their efforts to pass legislation, if they could remain unified. Tragically, with the Senate and House concurrently worked on health reform legislation, the Senate’s most vocal leader for health reform, Ted Kennedy (D-MA), passed away from brain cancer. While Congress was on the cusp of passing health reform, Massachusetts held a special election to pick Kennedy’s successor.

In January 2010, filling the seat which had been held by a Kennedy for over fifty years was little-known State Senator and Republican Scott Brown. Brown not only represented the State of Massachusetts in the Senate, the first Republican elected to the Senate in nearly forty

years, but was also the all-important forty-first vote in the Senate, blocking Senate Democrats filibuster-proof super majority (Jacobs and Skocpol 2015). By this point, both the House and the Senate had passed health reform legislation which was broadly in agreement with each other, but still varied in several key ways. One aspect where variation existed between the Senate and House versions of health reform was around reforms to the Medicaid program. In general, the Senate version was more conservative in scope than its House counterpart. In the case of the Medicaid expansion, both versions of health reform bills included a Medicaid expansion, but the Senate version required more state funding for expansion and lower eligibility limits (Hersenzhorn 2009). Handcuffed by Brown's election, House Democrats consented to the previously passed Senate version of health reform without offering any amendments or the ability to negotiate with their Senate counterparts in a conference committee.

Just prior to signing the ACA into law in March 2010, President Barack Obama remarked that "after a century of striving, after a year of debate, after a historic vote, health care reform is no longer an unmet promise" (White House 2010). After outlining the benefits that reform will have immediately and in the future, Obama optimistically remarked that "In a few moments, when I sign this bill, all of the overheated rhetoric over reform will finally confront the reality of reform" (White House 2010). Rather, in the first four years of the ACA, health reform was beset by two lawsuits settled by the Supreme Court, over fifty Congressional attempts to repeal part of or all of the law, and riding angst partially due to health reform, Republicans were able to retake majority control of the House of Representatives and Senate in the 2010 and 2014 midterm elections. Against Obama's hopes, the overheated rhetoric took on a new degree after the ACA was signed into law.

Noticeably absent from President Obama's remarks at the signing of health reform was any mention about the role of Medicaid in assuring access to health coverage for millions of Americans. Obama's remarks rather focused on the cost-reduction elements of reform and the potential benefit of insurance exchanges to increase access to affordable care. Obama might have overlooked lauding the effect of the Medicaid in his remarks because in every practical sense expansion was assumed. As designed in the ACA every state was basically required to implement the program. States were nominally given the option to reject expanding Medicaid as called for in the ACA, but they risked losing all federal Medicaid funds for failing to implement the ACA expansion. With Medicaid accounting for nearly a quarter of total state budgets, it was unlikely that a state could afford to take a stand against expanding Medicaid.

As originally legislated, Medicaid would undergo its most thorough overhaul in its history through the ACA. Rather than a patchwork approach to the healthcare safety-net, where variations in eligibility and programmatic details varied from state to state, the ACA sought to nationalize Medicaid. The ACA set a new national income standard for eligibility, where all individuals below 138% of the federal poverty level (\$15,800 for a single individual or \$32,319 for a family of four, in 2016 dollars (Watson 2016)) were eligible for Medicaid. For the first time, Medicaid coverage was available for the healthy, single, and childless adults. The Congressional Budget Office (CBO) estimated Medicaid rolls would increase by sixteen million because of the ACA and would cost \$345 billion over the first ten years of reform (Congressional Budget Office 2010). However, all of the coverage projections and financial analysis though went out the window two years after the ACA was signed into law.

NFIB v. Sebelius

Opposition to the ACA was so rampant that Republican policymakers signed laws requiring Attorney Generals to sue the federal government for encroachment of state's right before the ACA was even passed (Murphy 2010), culminating in a lawsuit filed against health reform seven minutes after Obama signed it into law. Fourteen states originally filed suit against the constitutionality of the ACA, though the number of plaintiffs swelled to include twenty-seven states by the time the Supreme Court heard the case. Initially, legal analysts gave little thought to the arguments outlined by the states (Persily, Metzger et al. 2013). But as the lawsuit divided District and Appeals Courts, observers noted that the seemingly "off the wall" arguments now were in danger of undermining the ACA (Balkin 2012).

At its heart, the lawsuit raised questions about the appropriate balance of power between state and federal governments. Two main components of the ACA were at issue in the lawsuit – the individual mandate and Medicaid expansion. Over three days, the Supreme Court heard arguments related to the applicability of the Tax Anti-Injunction Act on the individual mandate, the constitutionality of the individual mandate under the Commerce, Tax, and Necessary and Proper Clauses of the Constitution, the constitutionality of the Medicaid expansion under Congress' Spending Clause, and the severability of the Individual Mandate from the rest of the ACA (National Federation of Independent Business et al. v. Sebelius 2012).

The plaintiffs argued that Congress had overstepped the bounds of the Spending Clause in the Constitution when it created the Medicaid expansion. Article 1, Section 8 of the Constitution reads that "Congress shall have Power...to provide for the common Defense and general Welfare of the United States." The Supreme Court had long held this clause to mean that Congress could attach certain conditions to ensure that Congress' wishes are met when appropriating funds to the states. Prior Supreme Court rulings had appended four factors which

legislation must meet to uphold the Spending Clause: related to general welfare, unambiguously stated, clearly related to the program’s purpose, and otherwise not unconstitutional. Prior Supreme Court rulings from 1937 and 1987 also found that a financial inducement as part of legislation could become unconstitutionally coercive (*Steward Machine Co v Davis* 1937, *South Dakota v. Dole* 1987).

In a complicated, surprising, and fractured finding (See Table 1), seven Justices, across two separate opinions, held that the Medicaid expansion under the ACA was unduly coercive. The Roberts ruling, signed by Justices Breyer and Kagan, held that the terms of rejecting Medicaid expansion in the ACA are equivalent to an “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion” (*National Federation of Independent Business et al. v. Sebelius* 2012) and that the ACA Medicaid program was a “shift in kind, not merely degree” (*National Federation of Independent Business et al. v. Sebelius* 2012) from the original Medicaid program and therefore the funding for the two programs should not be inextricably linked by health reform.

	Roberts	Scalia	Kennedy	Thomas	Ginsburg	Breyer	Alito	Sotomayor	Kagan
Medicaid expansion is unconstitutionally coercive	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
HHS Secretary enforcement authority can be limited	Yes	No	No	No	Yes	Yes	No	Yes	Yes
The entire ACA should be ruled unconstitutional	No	Yes	Yes	Yes	No	No	Yes	No	No

With the finding that the Medicaid expansion was unconstitutional under the ACA, the justices then considered the appropriate remedy. Roberts, again with Breyer and Kagan and in a concurring opinion from Justice's Ginsburg and Sotomayor found that the constitutional violation was fully remedied by prohibiting the Secretary of HHS from withdrawing existing Medicaid funds if a state fails to comply with the Medicaid expansion statute in the ACA. Practically, the Supreme Court found that the Medicaid expansion "remains available to any state that affirms its willingness to participate" (National Federation of Independent Business et al. v. Sebelius 2012). With the Supreme Court ruling, opponents and critics of health reform could now re-wage the political fight over health reform in fifty state capitals and further work to impede the intent of the ACA.

State Decisions on Medicaid Expansion

Even in the wake of the Supreme Court decision, with the enhanced federal match rate to finance the Medicaid expansion, the Obama administration believed that eventually all states would agree to the expansion (Pear 2012). Even as public opinion for the law in general was unfavorable, a larger share of the public was supportive of expanding Medicaid, (Kaiser Family Foundation 2013), a trend which has increased over time (Kirzinger, Sugarman et al. 2017). Historically, when federal funds have been made available for states to expand coverage for their populations, states have tended to accept the money, regardless of budgetary pressures, economic indicators, and partisan alignment. Obama believed that Republican governors would eventually conclude that Medicaid expansion was "a good deal for their state" (White House 2014).

Beyond the financial benefits of expansion, there has been positive benefits for the individual. These benefits include a reduction in the rate of uninsured (Price and Eibner 2013), increased financial well-being (Hu, Kaestner et al. 2016), and educational attainment (Brown,

Kowalski et al. 2015, Cohodes, Grossman et al. 2015). Medicaid coverage also matters for the health status of the newly eligible. After implementing the Medicaid expansion, the likelihood of reporting fair or poor health and the reporting of functional limitations both decreased (Jacobs, Duchovny et al. 2016), as well as improvements in mental health (Baicker, Taubman et al. 2013), and a reduction of health disparities (Meyer and Wherry 2012, Wherry, Miller et al. 2015) that extend into adulthood (Miller and Wherry 2014).

Yet, there were a variety of reasons why policymakers opted out of implementing the Medicaid expansion. Even as the Supreme Court had “settled” the constitutional question of health reform, Republican governors continued to argue that the law was the result of federal overreach and fundamentally altered the dynamics of power between the state and federal government. Governor Rick Perry, in a letter to Secretary Kathleen Sebelius remarked that “I oppose both the expansion of Medicaid as provided in the Patient Protection and Affordable Care Act and the creation of a so-called “state” insurance exchange, because both represent brazen intrusions into the sovereignty of our state” and would make Texas a mere appendage to the federal government in health care (Perry 2012).

Additionally, even with the generous financing for the expansion populations, two concerns over costs shaped state responses. The increased FMAP did not include individuals who had previously been eligible for Medicaid but had not enrolled in the program. Policymakers, fearing the financial ramifications of this “woodwork” effect, were concerned about the budgetary implications for their state (Sommers, Arntson et al. 2013). These concerns were supported by Massachusetts’ reform implementation prior to the ACA, which resulted in enrollment increasing by sixteen percentage points (Sonier, Boudreaux et al. 2013). Early indications after the ACA was implemented seem to bear this concern out, where even

non-expansion states saw an average of 2.6 percent increase in Medicaid enrollment (Wachino 2014).

Additionally, governors and state policymakers had grown increasingly sensitive to the costs associated with operating their Medicaid programs, even with federal government subsidizing the costs. In the decade prior to the passage of the ACA, Medicaid spending had increased by sixty-three percent. Opponents of expansion pointed to an already overextended federal government that would soon no longer be able to support the generous reimbursement required by the legislative language of the ACA. Governors of states, particularly those who had to annually balance their budgets, argued that even having to pay ten cents of every dollar for the newly eligible was too high a cost for the state.

Lastly, some policymakers view Medicaid as “broken” and ineffective in providing care. During the debate over health reform, Republican Senators called Medicaid the “most dysfunctional delivery system that exists in the American health care system” (Richard Burr (R-NC)) and a “gulag” that doesn’t provide access (John Cornyn (R-TX)). These policymakers often point to research findings that call the benefit of Medicaid coverage into question, most prominently the Oregon Health Insurance Experiment that did not find statistically significant associations between Medicaid enrollment and physical health (Baicker, Taubman et al. 2013) and challenges associated with finding access to care by physicians who accept Medicaid patients (Sommers and Kronick 2016).

Governors

At the center of the implementation decision-making process are governors.

Governors hold a unique position within states because they are ultimately responsible for approving budgets, can request and negotiate for federal Medicaid waivers, and can draw attention to specific policies. Only a handful of states allow the governor to unilaterally act

to expand Medicaid without any legislative input or approval, but outside of a handful of states, the legislature have followed the preferred stance of the governor on whether to expand Medicaid.

Table 1:2 Gubernatorial Party and Expansion Decision

	Expanding	Not Expanding
Republican Governor	AK, AZ, IN, IA, MI, NV, NJ, NM, ND, OH	AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, WI, WY
Democratic Governor	AR, CA, CO, CT, DE, DC, HI, IL, KY, LA, MD, MA, MN, MT, NY, NH, OR, PA, RI, VT, WA, WV	VA

Within days of the Supreme Court ruling, similar polarized dynamic, which occurred in Congress, emerged from statements made by governors about expanding Medicaid. In the three weeks after the Supreme Court decision, thirteen Democratic governors expressed a desire to expand Medicaid. By the end of 2012, ten Republican governors released statements indicating their opposition to expanding Medicaid in their state. However, in several instances the initial negative reaction from governors transformed into support for the policy.

Time Periods in State Decisions

There are several key junctures in the trajectory of state decision’s to opt-in or out of Medicaid expansion. The first six months after the Supreme Court rulings offers no real surprises in state decisions. States at both political extremes, such as Hawaii, New York, and Vermont and Texas, Alabama, and Oklahoma, acted swiftly to accept or reject the expansion.

As states begin the planning process for implementing Medicaid expansion, a second time period in implementation decisions emerges. This period is marked by decisions from

pivot states, where the politics of Medicaid was much more contested. Brian Sandoval (R-NV), was the first Republican governor to expand Medicaid. In his press release announcing his support for the expansion, Sandoval was circumspect about his support for Medicaid. He remarked that “I have never liked the Affordable Care Act...I am forced to accept it as today’s reality and I have decided to expand Nevada’s Medicaid coverage” while noting the financial impact that expanding Medicaid will have on his state (Sandoval 2012). Sandoval’s decision was quickly followed by his fellow Republican Governor, Susana Martinez of New Mexico, who also declared her support for the expansion.

The 2013 legislative session was a vitally important time for the Obama administration in persuading states to go along with the Medicaid expansion. The rollout for the Medicaid expansion was slated for January 2014 and with the variation in the timing and scope of legislative sessions, if a state did not act in their 2013 session, they would miss out on one year of federal money. However, only three additional states led by Republican governors – North Dakota, Arizona, and New Jersey would expand Medicaid, while ten of their Republican counterparts would reject the expansion. Eleven states led by Democratic governors expanded Medicaid during this same time period.

	Expanding	Not Expanding
June - December 2012	DC, CT, HI, NY, VT, NV	TX, AL, OK
January – June 2013	NM, MN, ND, CO, KY, MD, WV, AZ, CA, NJ, WA	ID, GA, NC, SC, KS, NE, MS, WI, ME
July – December 2013	IL, MA, RI, DE, MI*, AR*, OH, OR, IA*	SD
January – June 2014		MO

July – December 2014	PA*	VA
January – June 2015	IN*, NH*	TN, WY, UT, FL
July – December 2015	AK, MT*	
January – June 2016	LA	
* State received federal approval for a Section 1115 Waiver		

Starting in September 2013, a third time period of state decisions emerges after Arkansas pursues the first Section 1115 Waiver under the ACA. Section 1115 Waivers allow states to modify, or waive, certain regulatory requirements related to the operation, financing, and eligibility of their Medicaid programs (Thompson 2012). Though these waivers have been in use since 1962, it has only been in the last twenty years when they have become more popular amongst states. Arkansas’ Democratic Governor Mike Beebe led the first effort to leverage a waiver to expand Medicaid in his state. Facing long odds of passing traditional Medicaid expansion in his conservative state, Beebe’s administration devised a plan called the “private option”. The Arkansas plan called for the state to put all of the newly eligible beneficiaries into the private market and purchase insurance on the state’s exchange, using all of the money that the federal government would have spent on increasing the public insurance program. Republican governors who want the financial benefits of expansion but feared public backlash against support for health reform now could claim that they were reforming Medicaid, not expanding it (Grogan, Singer, and Jones 2016).

By the end of 2013 two additional states, Michigan and Iowa, both led by Republican governors, expanded Medicaid using Section 1115 Waivers. Additional states expressed interest in following Arkansas’ example and pursue a waiver, including Ohio, Missouri, Tennessee, Utah, and South Dakota. Though, none of the preceding states have successfully

implemented an expansion via waiver. By the end of 2015, four additional states were successful in expanding Medicaid via waiver – Pennsylvania, Indiana, New Hampshire, and Montana. Arizona, which had implemented a traditional Medicaid expansion in 2013, also received a waiver to modify their existing Medicaid program in 2016; waivers were increasingly seen as a potential path forward for states to implement the Medicaid expansion (Jones, Singer et al. 2014).

While there is a general trend towards more states participating in the Medicaid expansion, many barriers remain for states to expand. Evidence of the difficulty in getting additional states to expand Medicaid can be seen in experiences of Utah, Tennessee, and Wyoming. All three states are led by Republican governors and Republican dominated legislatures. Even though the Governor and key legislatures had pushed for expansion of Medicaid in these states, they ultimately came up short in their efforts. Conservative states which had successfully expanded Medicaid via waiver also have run into trouble. Arkansas, which was the poster-child of waiver states, is required by state statute to approve funding reauthorization every year. After several key supporters of the private option lost re-election, each subsequent reauthorization has growing increasingly more fraught.

Overview of the Book

The remainder of the book follows this outline. In Chapter 2 I examine literature related to theories of federalism, state decision-making, and partisanship in the United States. In this chapter, I argue that the Medicaid expansion has important theoretical considerations for our understanding of contemporary transactional federalism, particularly as it relates to policymaking and implementation in a hyper-partisan political environment.

In Chapter 3 I highlight the methods employed in the project. To understand implantation decisions made by the states, I conducted in-depth comparative case studies across three states. Selection is of utmost importance for case studies and to facilitate the selection I used fuzzy set/Qualitative Comparative Analysis (fsQCA), which identified three “pivot” cases, Arizona, Michigan, and Utah, for analysis. fsQCA used Boolean algebra and a set theoretic approach to aid in the understanding of complex social phenomena. I am particularly interested in examining states that were right on the brink of expanding or not expanding their Medicaid programs. I collected two types of data to detect variations in implementation across the cases. First, I conducted semi-structured key informant interviews across each of the case study states, employing stratified sampling and chain sampling methods within each state. Second, I collected and analyzed thousands of documents, including written and oral legislative testimony, legal material, and government and think-tank reports related to the expansion.

In Chapters 4-6 I individually analyze each of the included case studies. In Chapter 4 I examine how intra-party divisions, institutional design, and policy entrepreneurs led to the failed efforts to expand Medicaid in Utah. In Chapter 5 I analyze how Jan Brewer was able to leverage her vested powers and organized interests were able to implement expansion in Arizona. In Chapter 6 I explore how the economic history and timing of expansion influenced Michigan’s efforts to implement the Medicaid expansion. In Chapter 7 I provide an overview of the key themes, which emerged collectively across the cases, as well as provide insight into how the findings can be applied to other policy domains.

Chapter 2: How We Got Here or Theories of Federalism, State Decision-Making, and Partisanship in the United States

“To look for a continuation in harmony between a number of independent unconnected sovereignties, situated in the same neighborhood, would be to disregard the uniform course of human events, and to set at defiance the accumulated experience of ages.”

- Alexander Hamilton, Federalist No. 6

When the Supreme Court took up in the lawsuit against the ACA, it was concerned with the proper balance of power between the federal and state government. Issues of federalism are not new to the Courts (Sprague 1968, Cross and Tiller 1999, Friedman 1999), nor is federalism new to political theory. Once the Supreme Court determined the federal government had overstepped their legal bounds with the structure of the ACA, issues of state decision-making and implementation emerged as an important theoretical concept. Below, I explore theories of federalism and state decision-making which have been developed to explain social policy. From these theories and frameworks, I highlight components which are meaningful in explaining state decision-making and implementation around the Medicaid expansion. Lastly, I investigate the most prominent contemporary explanation of the implementation of Medicaid expansion, partisanship. I argue that the Medicaid expansion has important theoretical considerations for our understanding of contemporary transactional federalism in the United States.

Federalism in the United States

The study of federalism has brought to bear an extensive array of theories and models examining the governance of the United States political system. Broadly speaking, federalism is concerned with the study of different levels and roles of government, how they operate, develop and implement policy, and share autonomy and power given to each level of government (Elazar 1987, Greer 2005, Bednar 2008). Questions about power dynamics between Washington, D.C. and state capitals, state autonomy, and the nationalization of the federal system have shaped federalism literature. While central to our nation's founding and a topic of study ever since, the history of federalism in the United States and its study has been marked by great fluctuations along "a continuum in terms of national-state relations" between no involvement to cooperative relations between the different levels of government (Zimmerman 2001).

American federalism is a Constitutional creation; the 10th Amendment establishes Police Powers and states that "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the States respectively, or to the people." This amendment connects Washington, D.C. with fifty independent state capitals. The inevitable tension which arises in such a political system is the result of finding the "proper balance of power between the national government and the states" (Krause and Bowman 2005). This very fluidity and ambiguity innate to the federal system allows for political battles over the authority to control specific activities (Robertson 2005).

Dual Federalism

In the earliest stages of the United States, the system of governance was marked by a system of "dual federalism", which was informed by the 10th Amendment. In practice, this meant that there were two separate spheres of governments, with minimal overlap in the roles and responsibilities between the national system of government and the individual states, and no

hierarchy or power differential (Corwin 1950, Kincaid 1996). The powers of the national government were fairly limited and prescribed, with responsibility for defense, foreign relationships and treaties, and interstate commerce. The States on the other hand had primary responsibility for criminal justice, education, welfare, and infrastructure development (Elazar 1962, Schutze 2009). The divided spheres of influence were often times self-imposed by federal policymakers. For example, in 1854, President Franklin Pierce vetoed legislation which would have provided land grant funds for states to build and operate hospitals for the mentally ill, arguing that the law would have resulted in federal overreach into the domain of state and local welfare programs (Pierce 1854, Sparer 2010).

Even as the roles and responsibilities between governments were thought of as clearly delineated, arguments over the size, scope, and hierarchy of government occurred. The Republican Party, during this time period, favored policies for an expansive national government, whilst the Democratic Party sought to keep national government limited in scope (Silbey 1985, Foner 1995). During this early era of the Republic, the federal courts were often called upon to adjudicate disputes between state and federal governments (Friedman 1999). For example, in 1819, the Supreme Court in *McCulloch v. Maryland* unanimously held that the federal government had implied powers, going beyond what was specified in the Constitution, extending the authority of the federal government, which was further reinforced by later Supreme Court cases (Marshall 1819, Low, Jeffries et al. 2016). The Civil War offered a visceral manifestation of the political conflict over the scope and responsibilities of government (Bestor 1964, Walker 1995), as well as the addition of the Fourteenth Amendment, by assuring due process and equal protection under the law, reinforced Congressional authority over the states (Zuckert 1992). The politics of the post-civil war era also supported an expansive federal government, with Republicans holding the White House for all but eight years from 1869 to

1913, the Senate for all but four years during the same time period (Walker 1995, Watts 1998, Peterson 2012).

Cooperative Federalism

In 1955, the congressionally empaneled Commission on Intergovernmental Relations released its initial report to President Truman and Congress. Spurred by “existing confusion and wasteful duplication of functions and administration” and that “the activity of the Federal Government has been extended into many fields which, under our constitutional system, may be primary interest and obligation of the several States”, the group was commissioned to “study the proper role of the Federal Government in relation to the States” (1953). Rather than dual spheres of influence where different levels of government do not interact in forming policy, what emerged from the report was a model of federalism that emphasized a cooperative approach to governance (Wright 1978) between federal, state, and local governments (Anton 1989, Dye 1990, Peterson, Rabe et al. 2010).

There were a series of changes in the United States that led to this shift towards a more cooperative model of federalism. With a globalizing economy supported by technological improvements in transportation and communication, industry was able to access national and international markets. States no longer held leverage over industries, which threatened their ability to generate consistent, taxable income. In this void, the federal government increased their regulatory presence, but which increased the complexity of the regulatory environment (Weiser 2003). Further increasing the financial power of the federal government was the passage of the Sixteenth Amendment in 1913, creating a permanent income tax (Pollack 2014), and provide grants and aid to state and local governments (Kincaid 1990, Galle 2008), expanding the types of financial and political tools the federal government could leverage to encourage state and local

government behavior. From a policy perspective, there was a shift in the types of policies which the federal government should pursue (New Deal and Great Society programs) which would “bridge historic cleavages of race, class, and residence” and that were focused on “policy activism of the federal government” (Kincaid 1990). These policies required both a strong federal government, as well as participation from multiple levels of government to help implement complex regulatory policies (Weiser 2001).

From the state government perspective, these changes, particularly the increased capital from the federal government, acted as an impetus to modernize and professionalize their own workforce. With a more professionalized government, agencies, and bureaucracy, states were equipped to become increasingly involved in policy development, regulation, and implementation of complex social programs (Malhotra 2006, Grissom and Harrington 2013). This had the effect of creating a system of cooperation between national and state governments, creating a semi-structured organization of policy experts across different levels of government (Seidman 1970, Thompson and Burke 2009) and a conduit by which government grant-in-aid could travel from the national to local level, with increased bargaining between each level of government and subject matter expertise.

Fiscal Federalism

Cooperative federalism, with its ideals of collaboration and aligned incentives relied on federal funds to act as the lubricant to grease the wheels when inevitable conflict between the federal and state government occurred. Fluctuations in the total amount of federal grants to state and local governments tracks with the overall utility of cooperative federalism models in the United States (Rodden 2002). In the wake of the Great Depression and the development of the modern administrative state in the United States (Lawson 1994), there were three large changes

in federal government activity and financing which foreshadowed their growing role in incentivizing states. First, the overall size of government economic activity increased, with government receipts tripling in the latter half of the 20th Century (Sagoo 2005). Second, the federal government substantially increased their spending in the wake of the Great Depression and New Deal programs. By 1930, federal spending was less than half of combined state and local governments. By 1947 the federal government spent nearly three times as much as states and local governments (U.S. Census Bureau 2011). Lastly, with Roosevelt's New Deal, the federal government and their revenue was further injected in the financing and administration of welfare programs that previously been within the domain of local governments and private charities (Wallis 1991, Patterson 2015). The responsibility of the federal government in these policy domains was further intensified by Johnson's Great Society and the implementation of Medicare and Medicaid, federal aid for education, housing assistance, and other welfare programs (Milkis and Mileur 2005).

As the federal government grew in size and fiscal power, theorists sought to understand these financial ramifications on federalism. Fiscal federalism is concerned with understanding and designing an efficient system for the implementation of policy and is divided into "first generation" and "second generation" fiscal federalists. Charles Tiebout argued that states and localities would be able to provide for a wider range of demand functions than a national government with minimal variation. Variation amongst state and local governments would result in better matching of individual policy preferences with policy provision by the federal government (Tiebout 1956). Taking this economic focused theory, the first generation fiscal federalists were concerned about achieving the optimal governmental level for policy implementation (Oates 1972), which they called the "decentralization theorem" (Oates 1999).

This group of scholars argued that the federal structure of governance allowed for the most efficient allocation of resources. If the government could assign policies, funding, and implementation to the correct level of government it could minimize the negative externalities of a policy and maximize policies with individual preferences.

Second-generation fiscal federalists call into question the assumption that an optimal policy assignment is possible. Rather, policymakers in this school of thought are seen as rent-seekers, who are more concerned with their own outcomes rather than the proper assignment of where a policy should originate or be implemented (Weingast 2009). Government systems and programs should be created to account for this type of behavior amongst policymakers and bureaucrats.

The “price of federalism”, for Peterson, is due to politician’s incentives that lead the federal government to inefficiency. Cities, which are in tune with attracting skilled labor and capital, are disposed to policies which are focused on development. State and federal governments therefore ought to be tasked with social policy, because they are more immune to pressures of mobile capital, labor movement, and deeper reserves of revenue (Peterson 2012). At the same time, Congressional politicians seek opportunities to credit-claim in development policy and are averse to redistributive policies and avoiding blame from constituents.

Coercive Federalism

These shifts in social policy culminated in the federal government not only using grant programs to support states in achieving their own goals, but as a means to achieving federal policy objectives. Prior to the 1960’s, federal grants were “conceived by or in cooperation with the states and were designed to serve essentially state purposes” (Wilson, DiIulio Jr et al. 2016).

Prior to the Johnson administration, state and local governments would pressure the federal government to provide aid to build infrastructure, education, and grants for specific occupations which the states deemed to be of utmost importance. During the 1960's, the federal government began to devise grant programs "based less on what states were demanding and more on what federal officials perceived to be important national needs" (Wilson, DiIulio Jr et al. 2016). To enforce state participation in achieving federal objectives, Congress began enacting sanctions which would require states to bring their state into compliance with federal wishes or risk losing federal funds from grant programs (Howard and Walker 1984).

Along with a shift in the types of programs that were funded by the federal government, financial transactions during this era were also marked by the trend towards unfunded mandates enacted by Congress and passed on to the states. These mandates became a 'free' way for Congress to get its way while keeping the federal budget in check (Conlan and Beam 1992, Posner 1998, Posner 2007). Expressing displeasure at the financial constraints placed on the states from these mandates, state leaders pressured the end of unfunded mandates, culminating in the passage of the Unfunded Mandates Reform Act in 1995. Subsequent Congressional legislation, including the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, provided states the flexibility of block grants for policy implementation, though placed new requirements on state policymakers and agencies (Posner 1998, Weaver 2000, Winston 2002).

Shifts in the financial relationship between the federal and state government wasn't the only symptom of a fraying and more coercive inter-governmental relationship. It was also marked by the abrogation of state and local power in many policy domains and the dominance of the federal government overall (Posner 2007). One indication of the more antagonistic

relationship was in the level of federal preemption of state and local laws, with more than half of all examples of federal preemption occurred during the 1970s and 1980s (U.S. Advisory Commission on Intergovernmental Relations 1992).

This is not to say that states lack means by which they are able to influence national policymaking. Yet, it is precisely the abundant and varied types of state recourse which continued to propagate coercive federalism. Famously called the “laboratories of democracy”, states have the opportunity to innovate in the design of federal programs and to align their incentives with receptive members of Congress or the Presidency (Ramano 2006, Nathan 2008, Reeve, Ashe et al. 2015). Waivers offer a potential means for states to modify existing federal regulations to meet their political or policy ends and can act as a connection between politically amicable state and federal executives (Singer 2016, Singer, Nelson et al. 2017). The judicial branch, particularly during the Rehnquist and Roberts’ courts, has invalidated several congressional statutes on federalism grounds, asserting that Congress exceeded their enumerated powers, providing Attorneys General with legal decisions to contest perceived federal overreach (Cross and Tiller 1999, Waltenburg and Swinford 1999, Fallon Jr 2002, Dinan 2011). Lastly, intergovernmental lobbying by the National Governors Association, National Conference of State Legislatures, and other associations have provided a mechanism for states to stress their interests in federal legislation and in meeting with federal officials (Cammisa 1995, Herian 2011, Nugent 2012); during the federal rule-making process provides a particularly opportune time for states to lobby for administration of laws in a more amenable fashion (Gais and Fossett 2005, Sharkey 2009).

Political Polarization and Partisanship

Contemporary politics in the United States has been marked by political polarization and partisanship at levels unseen in over a century. DW Nominate scores, which indicate the

mean Congressional member for the Republican and Democratic Party, highlight how elite polarization permeates through the ACA and Medicaid expansion. Currently, the United States has a higher degree of political polarization between the average members of both parties in Congress than at any other time since Reconstruction (See Figure 2.1 below). This polarization is manifested not only through the DW Nominat scores, but also in voting records related to the health reform. Famously, only two Republicans voted in support of health reform and neither vote was for the final iteration of the bill. Attempts to “repeal and replace” the ACA have similarly been polarized along political party lines.

Yet, it is not only the response from political elites which has shaped contemporary federalism, but also the general public. There is a similar divergence on public polling since passage of the ACA between political parties. Since April 2010, a majority of Democrats have consistently held a favorable view on health reform; during the same time period there has never been a month when more than a quarter of identified Republicans has had a favorable view on health reform (See Figure 2.2).

Figure 2.1: Political Party Polarization

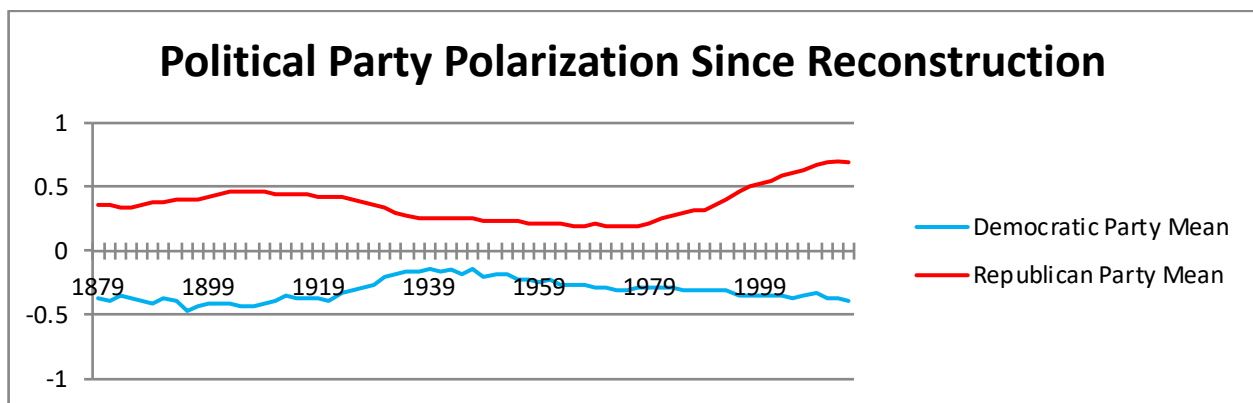
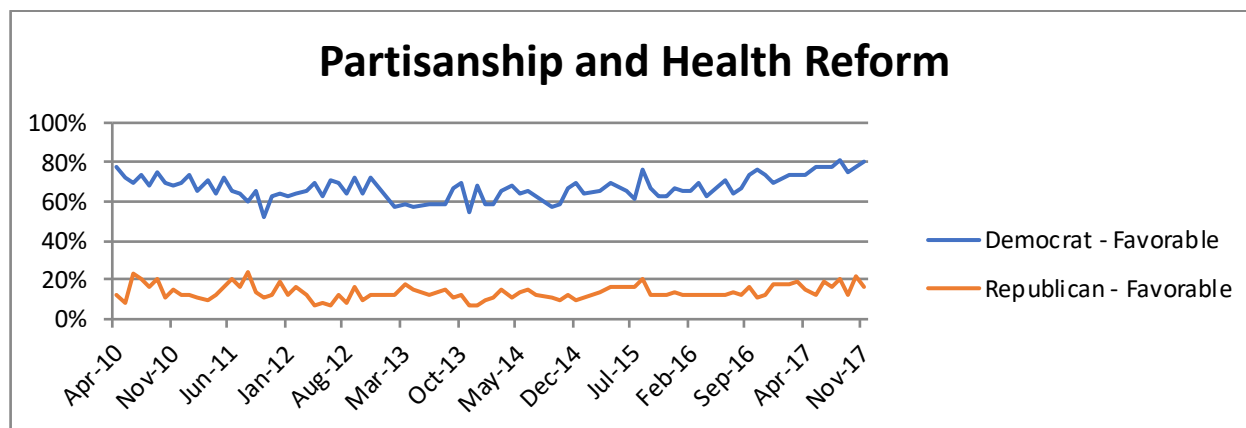


Figure 2.2: Partisanship and Health Reform



The visual representations of the figures above underscore the growing divide within contemporary American society along partisan lines. The growing partisanship and polarization between the parties has been well documented across a host of different groups and people. As Figure 1 details above, Congress has increasingly grown more divided as parties, but there is also evidence of conflict extension, where Congressional members of political parties have grown increasingly divided across major policy dimensions in American politics (Layman and Carsey 2002, Layman, Carsey et al. 2006). It also should be noted that polarization amongst the two political parties is not symmetrical; the Republican Party in Congress has grown increasingly more fractured, compared with their Democratic counterparts (Hare and Poole 2014).

The levels of polarization seen in Congress has also been mirrored within state legislatures as well (Shor and McCarty 2011, Shor 2014). Polarization amongst state legislatures, particularly important for our understanding of Medicaid expansion, influences the types of policies which a state chamber would pursue and implement (Kirkland 2014). What results from this state policymaker polarization is “fragmented federalism”, or the

creation of different implemented policies at the state level, creating differences in finances, regulations, and program planning (Bowling and Pickerill 2013).

Political polarization can also influence the other branches of federal and state government. The administrative state is infused with politics (Balla 2012, Metzger 2015), with researchers arguing that bureaucrats and agencies are rent-seekers (Stigler 1971, Niskanen 2017), self-interested (Laffont and Martimort 2009), or captured by industry (Laffont and Tirole 1991, Dal Bó 2006). Additionally, Congress' and the Executives ability to define, incentive, and threaten administrators to match their own preferences can lead to agencies which mirror the prevailing views of the legislative and executive branch (Weingast and Moran 1983, McCubbins and Schwartz 1984, Hammond and Knott 1996, Devins and Lewis 2008). Similar findings have been replicated amongst state level agencies as well (Scholz, Twombly et al. 1991, Wood and Waterman 1991, Meyers and Vorsanger 2007).

Similarly, the judicial branch has been affected by polarization (Smith 1990, Sunstein, Schkade et al. 2007, Clark 2009). There are a number of mechanisms by which broader polarization influences the judiciary. Judicial selection, either through elections or appointment by the Executive Branch and confirmed by the Senate is tinged by political party and identity (Bartels 2015, Kritzer 2015, Devins and Baum 2017). As polarization at the national level has occurred, there has been an increase in the extremity of the judges selected (Binder 2008). The most visible of the judicial branch, the Supreme Court, has always had ideological divisions, but the polarization of the Court has increased over the past fifty years (Clark 2009, Gooch 2015, Baum 2017). The public's view of the judiciary has also shifted over time, from what used to be the branch held in highest regard by the general public, to viewed now as political actors in a political sphere (Sinozich 2016, Gallup News 2018).

While there are clear indications of polarization within the three branches of state and federal government, polarization of the mass public is not as clear-cut. Fiorina and Abrams argue that there is no evidence that the American public has grown more polarized, though party sorting – the overlap between party identification and policy views – has increased (Fiorina and Abrams 2008). Yet, Abramowitz and Saunders and others have found the opposite, that that polarization is a bottom-up phenomenon encouraged by engaged partisans within society (Abramowitz and Saunders 2008, Baldassarri and Gelman 2008, Jacobson 2012, Hill and Tausanovitch 2015). Yet, it is important to note that independent of the mechanism for polarization in the general public, there have been secondary effects of polarization. Including individuals sorting on where they decide to live (Johnston, Jones et al. 2016) and the types of organizations that an individual identifies with (Baldassarri 2011). Polarization has also been linked to how the general public views members of the other political party (Iyengar and Westwood 2015), issue-blaming and unwillingness to compromise (Wolf, Strachan et al. 2012) and trust members of the opposite party less (Kaltenthaler and Miller 2012). How the general public views polarization is not static, nor is it uniformly distributed through society, but is influenced by prior levels of political activity and engagement (Westfall, Van Boven et al. 2015).

Yet, traditional discussions of polarization, as highlighted above have focused on divisions between the Republican and Democratic Parties. In reality, the fissures which have emerged because of the Medicaid expansion have had far-reaching intra-party effects as well, particularly within the Republican Party (Hertel-Fernandez, Skocpol et al. 2016). These divisions have emerged between individuals, policymakers, and organizations which are interested in ideological purity and individuals, policymakers, and organizations which hold traditional economic interests (Skocpol and

Hertel-Fernandez 2016). While I argue that partisanship is an important component of understanding state decision-making and implementation, it can obscure other important factors which contribute to whether and how a state decides to expand Medicaid (Jones, Singer et al. 2014). These additional factors are highlighted below in examining theories explaining state behavior and implementation decision-making.

Explanations of State Behavior

The ACA Medicaid expansion follows a long history of regulations and legislation which have expanded coverage, benefits, and state reimbursements for the Medicaid program (Funigiello 2005, Smith and Moore 2015). Medicaid eligibility prior to the ACA was not a static policy, rather over time the federal government either required or encouraged states to expand the benefits packages to include more individuals (See Table 1).

Table 2:1 All Federal expansions of Medicaid coverage prior to ACA	
Title of Legislation	Eligibility Changes
Social Security Act of 1965	Requires eligibility for Aid to Families with Dependent Children (AFDC) cash assistance recipients
Social Security Amendments of 1972	Requires eligibility for Supplemental Security Income (SSI) recipients
Deficit Reduction Act of 1984	Requires expansion to cover children up to age 5, first-time pregnant women, and pregnant women in 2-parent unemployed families who are eligible for AFDC
Consolidated Omnibus Budget Reconciliation Act of 1985	Requires expansion to cover pregnant women in 2-parent families
Omnibus Budget Reconciliation Act of 1986	Optional expansion to cover pregnant women and children up to age 5 below 100% FPL
Omnibus Budget Reconciliation Act of 1987	Optional expansion to cover pregnant women and infants below 185% FPL Optional expansion to cover children up to age 8 below 100% FPL
Medicare Catastrophic Coverage of 1988	Requires expansion to cover pregnant women and infants below 100% FPL

Family Support Act of 1988	Requires 12 month coverage for families exiting AFDC coverage Requires expansion to 2-parent unemployed families eligible for AFDC
Omnibus Budget Reconciliation Act of 1989	Requires expansion to cover pregnant women and children up to age 6 below 133% FPL
Omnibus Budget Reconciliation Act of 1990	Requires expansion to cover children 6-18 below 100% FPL
Balanced Budget Act of 1997	Optional expansion to cover working disabled individuals below 250% FPL without SSI
Ticket to Work and Work Incentives Improvement Act of 1999	Optional expansion to cover working disabled individuals below 250% FPL with premiums
Breast and Cervical Cancer Treatment and Prevention Act of 2000	Optional expansion to cover uninsured women who screen positive for breast or cervical cancer
The Children’s Health Insurance Reauthorization Act of 2009	Optional expansion to cover lawfully present children and pregnant women, residing for under 5 years in the U.S.
The Patient Protection and Affordable Care Act of 2010	Requires expansion to adults below 138% FPL
Source: Adapted from data contained in the Kaiser Family Foundation “The Medicaid Resource Book”	

Because there is such a dynamic history of the federal government either requiring or giving states the option to expand coverage to different population subgroups, a body of research has developed to understand and explain state behavior related to the implementation of Medicaid and welfare programs. I provide an overview of some of these theories, portions of which are useful in thinking through the ACA Medicaid expansion. However, it should be noted that there are methodological and theoretical limitations which lessens their explanatory strength. The ACA operates in a political and economic environment which differs substantially from the times of these earlier scholars, which makes it difficult to apply these theories to contemporary issues of federalism and state behavior. Here, I am not arguing that “the past is prologue” but there are useful developments in this literature that informs contemporary thinking about the Medicaid expansion.

Inter-Party Competition Theory

In his book on southern politics, V.O. Key sought to explain the behavior of southern states during the New Deal era. While predating the existence of the Medicaid program, Key (and his acolytes) offers insights into the importance of political party, their dynamics within a state, and how it influences implementation decisions. During the time period of Key's study, southern states were all governed by the Democratic Party. Yet, Key argued that factions within the party acted as a substitute for multiple parties (Key 1949). One of Key's central arguments, labelled the Inter-Party Competition Theory, is that when there are multiple parties vying for election and power within a state, a state is more likely to pursue generous welfare policies for their citizens in an effort to win votes and ensure reelection (Key 1949). Similar results were found in other regions, including New England (Lockard 2015) and the Midwest (Fenton 1966). Similarly, states with two actual political parties follow a similar trajectory as the theory espoused by Key (Barrilleaux 2000, Fleck 2001, Barrilleaux, Holbrook et al. 2002, Sørensen 2014).

The Inter-Party Competition Theory is helpful in identifying the role that political parties play in implementation decisions made by the states. In the case of political parties, there is a robust literature which has developed in the wake of the ACA. These theories hold that political parties matter in explaining state implementation of the Medicaid expansion, where Democrats controlling the levers of government are more likely to expand Medicaid (Margalit 2013). Jacobs and Callaghan have found correlational support between party control and Medicaid expansion decisions (Jacobs and Callaghan 2013); Rigby and Haselswerdt's analysis of implementing insurance exchanges had similar findings, with partisanship playing a prominent role in explaining implementation decisions made by the states (Rigby and Haselswerdt 2013). Even at

the individual level, Henderson and Hillygus find that party identification was strongly related to opinion of health reform and whether a state should implement different components of the ACA (Henderson and Hillygus 2011).

Socioeconomic Determinants of Eligibility Expansion

In response to the Inter-Party Competition Theory, a new set of theorists developed a series of explanations for state behavior which was focused on the predictive value of socioeconomic factors within a state on welfare policies. In these early models of the effect of socio-economic factors, such as per capita income, percentage of state population residing in urban areas, and the percentage of industrial workers, were linked with an expansion of a welfare program (Dawson and Robinson 1963), though not party competition. These findings were supported by Thomas Dye, who found that there is little empirical evidence to support the view that partisanship and party competition spurs expanded welfare policy, but rather the socioeconomics of a state were connected to explaining state policy behavior (Dye 1966). The main findings of the Socioeconomic Determinants Theory was supported by studies of other welfare and health related programs (Welch and Thompson 1980, Tweedie 1994).

Before the implementation of the ACA, researchers had found that economic need predicts expenditure and expansion of Medicaid program outcomes. Kim and Jennings found that a state's economic climate shaped much of the development of the state's Medicaid program (Kim and Jennings 2012). Other research conducted prior to the ACA found that state economic factors contributed to the level of expenditure and generosity of a state's Medicaid plan, explaining more of the variation of expenditures than political explanations (Buchanan, Cappelleri et al. 1991, Schneider and Jacoby 1996, Dilger 1998, Kitchener, Carrillo et al. 2003).

While the Medicaid expansion has improved the quality and care for resource challenged individuals (Han, Nguyen et al. 2015, Griffith, Evans et al. 2017, Soni, Hendryx et al. 2017, Xiao, Zheng et al. 2018), poorer states have been less likely to implement the component of health reform (Travis, Morris et al. 2016, Hines 2017, Rhubart 2017).

While this earlier research honed in on the role of per-capita income to explain state behavior, the relationship is not necessarily unidirectional, nor is it exhaustive of socio-economic factors that contribute to state decision-making. For example, amongst Medicaid managed care plans (Sparer 2012) there is an inverse per-capita income relationship, with financial incentives (such as the kind which are part of the ACA) more likely to spur action amongst poorer states to increase Medicaid enrollment in managed care plans (Kim and Jennings 2012). Other market forces, including physician saturation (Barrilleaux and Miller 1988), prior eligibility rates (Buchanan, Cappelleri et al. 1991), and employment rates have been linked with Medicaid spending and generosity (Penden and Brooks 1981, Cromwell, Hurdle et al. 1986).

The socio-economic theory is attractive because with a generous reimbursement from the federal government, conventional economic theory assumed that resource challenged states would be more inclined to expand Medicaid (Rosenbaum and Westmoreland 2012, Ayanian, Ehrlich et al. 2017). This rationale is particularly striking in response to the Great Recession of 2007. State budgets, particularly Medicaid, which is counter-cyclical, were strained to meet the challenges of balanced budget requirements (Ku 2003). On one level, the Medicaid expansion under the ACA can be thought of as a massive transfer of capital from the federal to state government. The work related to socio-economic influences on state decision-making would have us believe, similar to the Obama administration, that the Medicaid expansion is too good a

deal for states to pass up. A clear understanding of the fiscal effects of expansion should be considered when analyzing the implementation decisions by states.

Institutional Design, Organized Interests, and Strategic Actors

While it is important to understand the role of political parties on implementing policies, particularly around the Medicaid expansion, there are other actors and organizations which influence state decision-making and behavior. In a reexamination of Key's southern states, Robert Mickey offers important insights into the political development of policy implementation. Mickey argues that true democratic rule did not exist in the South until the 1970s, with the Jim Crow south working to limit federal and judicial oversight. He specifically highlights the role that strategic actors and the institutions of a state play in the types of policies which are implemented (Mickey 2015).

Strategic actors, particularly governors, committee and legislative leadership, and content experts within a state wield substantial power related to decision-making and implementation. This was especially true for health reform, which relied so heavily on state policymakers to implement different components of the law. In the case of governors, (Barrilleaux and Rainey 2014, Haeder and Weimer 2015, Rocco 2015), even if they could not act unilaterally in their efforts to implement Medicaid expansion, they still held power in shaping policy alternatives (Marshall 2005), bringing attention to the issue (Eyler and Zwald 2015), and to pressure other actors to act (Flagg 2016). Additionally, physicians, hospital executives, and insurers who are also legislators have specialized knowledge of health care and health policy and can lead discussions and have outsized importance during debate over implementation of reform.

Similarly, organized interests, both state-based and nationally focused, can also influence state-decision making and implementation decisions, across a variety of policy domains (Sabatier and Mazmanian 1980, Kingdon 2003, McDonnell and Weatherford 2013). Organized interests in

the traditional Medicaid program have influenced eligibility and benefit plans (Grogan 1994, Grogan 1999) and the ACA itself was particularly open to organized interest influence because of the multilevel nature of the policymaking and implementation (Robbins 2010). Organized interests who lobbied in support or opposition of health reform or the Medicaid expansion were able to continue their lobbying at the state level and to influence outcomes. Medicaid implementation serves a diversity of different organized interests that are served by the program (elderly, children, low-income, pregnant) and that financially benefit (providers, insurers, hospitals) from the program. This can create an interconnected group of ostensibly diverse organizations which share common ground related to the Medicaid program and can broker deals during implementation and decision-making (Kronebusch 1997, Heaney 2006, Callaghan and Jacobs 2016). At the same time, oppositional groups, particularly those who are national in scope or well-resourced, can leverage their expertise, money, and influence at the state level and frustrate the implementation of health reform (Skocpol and Hertel-Fernandez 2016).

The institutional design, the rules and regulations which govern policymaking within a state, influences who has the power to make decisions in implementing the Medicaid expansion and the process that legislation needs to follow prior to and after enactment. The branches of government at the state level can vary in substantial ways, including formal rules that govern the length of time for a session, power of the governor, and committee chairs; as well as more informal rules and norms, like majority caucus support for any legislation prior to debate (Liverani, Hawkins et al. 2013, Béland, Rocco et al. 2015). Further challenging the implementation of health reform and the necessity of understanding institutional design is the complexity of the ACA, the number of components contained in the law, and the level of

institutional coordination necessary between the federal and state levels of government (Béland, Rocco et al. 2014).

Path Dependency

The implementation decisions which a state makes are not conducted within a policy vacuum. Rather, they are influenced by previous actions undertaken by the state and policymakers (Lipset and Rokkan 1967) and the “causal relevance of preceding stages in a temporal sequence”(Pierson 2000). In the case of Medicaid expansion, state decision-making is informed by prior interactions with the program and the federal government, even before the ACA, where the “historical legacies” of social policy effect the contemporary politics around a policy domain (Greener 2005, Brady, Marquardt et al. 2016). State policymakers experience and exposure to a particular policy domain or program can increase the likelihood that they are positively amenable to the program. Additionally, if a state has already invested capital and human resources into developing a program they are more apt to continue to invest in that particular program (Barnes, Gartland et al. 2004). While there are challenges to the role that path dependency has on policy implementation, both in health policy (Brown 2010) and other areas (Kay 2005), an understanding of these prior experiences help shape our understanding of contemporary debate around the Medicaid expansion.

Political Culture and Political Ideology

For Daniel Elazar, political culture is “the particular pattern of orientation to political action in which each political system is embedded” (Elazar 1972). This orientation is important to the extent that it affects politicians and citizens whilst influencing the political behavior in each state. Political culture theorists explain the types of government policies a state would pursue, devising three different types of culture - traditionalistic, individualistic, and moralistic

(Elazar 1972), with the latter the most likely to have generous social policies, including Medicaid coverage. Within this framework, there is an emphasis on civic and citizen engagement; with those traits amongst the general public being linked to policy specific welfare policy outcomes (Caputo 2010, Nabatchi 2014, Chandra, Miller et al. 2016).

Subsequent researchers have sought to operationalize Elazar's political culture variables, with findings suggesting that the culture of a state does influence their propensity to expend government spending on health programs (Sharkansky and Hofferbert 1969, Fitzpatrick and Hero 1988). A proxy measure for political culture created by Charles Johnson found that indices of political culture and religious affiliation are significantly correlated with states decisions to expand welfare and health coverage (Johnson 1976, Lowery and Sigelman 1982, Morgan and Watson 1991, Mead 2004), electoral victories (Fisher 2016), and state budgets (Koven and Mausolff 2002). A series of additional measurements of political culture, including measurements of racial and ethnic diversity (Hero and Tolbert 1996), social capital (Putnam 2001) and other multi-dimensional assessments of culture have been developed (Lieske 1993, Lieske 2010) and linked to implementation decisions.

Ideology

The political culture of a state can be manifested in a variety of different ways, including the personal ideology of the general public and policymakers. Ideology, or how individuals think that government and policy should operate, shapes outcomes across a variety of policy domains, including health policy (Rubin 2008, Herwartz and Theilen 2014, McCarty, Poole et al. 2016). When Medicare and Medicaid was initially introduced, passed, and implemented in 1965, there was disagreement between the two political parties on the role and structure of the programs, but there was also shared governance and support for the programs (Marmor 1970, Oberlander 2003,

Olson 2010). Yet, over time ideological divisions emerged between the political parties, both over Medicaid, but also other health programs (Grogan and Rigby 2009, Oberlander and Lyons 2009). These divisions are evident in the 2012 party platforms, where the Democrats promised to strengthen Medicaid and resist efforts to defund or otherwise change the program and including healthcare as necessary for “economic security”(Democratic National Committee 2012).

Whereas, Republicans characterized Medicaid as leading to out-of-control spending, contributing to budget deficits, and in desperate need of reform by providing more freedom to the states to operate their own programs (Republican National Committee 2012).

Grogan and Rigby’s examination of conflict behind the implementation of the SCHIP program highlights the role that ideology has on the outcome of health policies, with shifting ideological preferences over the first ten years of SCHIP’s existence as the main factor related to the collapse in support for the previously bipartisan SCHIP plan (Grogan and Rigby 2009).

Similarly, Jones et al. found similar evidence for ideology’s impact on the ACA and the implementation of insurance exchanges. Insurance exchanges had, prior to the ACA, been viewed as a bipartisan policy that would be embraced by Republicans because of the autonomy given to states, as well as the market-oriented nature of the marketplace. However, conservative states did not embrace exchanges, with only a quarter of the states implementing the initially bipartisan policy, with ideological restraints contributing to Republican policymakers refusal to take control over a state operated exchange (Jones, Bradley et al. 2014). Ideology has led state policymakers to change the programmatic design of the program and the use of waivers by state policymakers (Thompson and Gusmano 2014, Baker and Hunt 2016, Grogan, Singer et al. 2016, Singer, Nelson et al. 2017) as well as the public opinion towards health reform broadly (Brodie, Deane et al. 2011).

Medicaid Expansion, Federalism, and Implementation Decisions

This chapter has focused on two literatures related to the Medicaid expansion. First, the Medicaid expansion has been shaped by the federated system which has taken place in. The ACA Medicaid expansion as a program contains elements of several of the prior forms of federalism in practice and theory. The structure of the Medicaid program, with the federal government setting guidelines and states responsible for administering the program, is an example of cooperative federalism. Yet, as the health reform legislation was originally written (prior to the Supreme Court decision in June 2012), it more closely follows a coercive federalism model. Any state that chose to not implement the expansion would have lost all federal funding for the program. Additionally, the structure of the ACA Medicaid expansion also accounted for the transactional component of the program, with a higher than normal level of federal expenditure and reimbursement for the expanded population. The tradeoffs of fiscal federalism and the proper level of government involvement in the implementation of expansion and the fiscal and transactional benefits within the law which can be leveraged to incentivize implementation at the fore of the ACA Medicaid expansion.

Yet, none of these previous models of federalism have accounted for the current state of politics in the United States. The Medicaid expansion offers a window on contemporary American federalism. These prior models of federalism have been influenced by external events and contemporary federalism, with its highly partisan and polarized policy environment has certainly shaped implementation of the Medicaid expansion. States and policymakers have to grapple with the tradeoffs of financial transactionalism while navigating one of the most polarized policies in recent history.

Second, the state decision-making and implementation literature grew in importance in the wake of the Supreme Court decision. Understanding state behavior is complex and I argue that implementation does not draw upon a single component. Partisanship has been the most prominent explanation for state decision-making and the ACA Medicaid expansion. It is certainly an important factor, but a focus solely on partisanship can obscure other meaningful factors which contributes to state implementation decisions. Implementation stems from a collection of complex and intersecting factors. Understanding state behavior requires a theoretical framework that draws from a variety of different literatures, including ideology, political parties, the socioeconomic and demographic breakdown of a state, prior policy experiences, and organized interests. Indeed, the various components which are important in state implementation decisions vary across each of the states as well.

In the case studies presented hereafter, I highlight how these factors shaped whether and how a state implemented the Medicaid expansion. The specific combination of factors which influenced state implementation decisions varied across each of the three case-studies. The implementation of the Medicaid expansion, which has previously been explained primarily through a partisanship lens, is actually more complex than that superficial account. The case studies highlight a diversity of factors that help and hinder state implementation of the Medicaid expansion.

Similarly, the case studies also highlight the challenges and opportunities that states, operating in a federated system, have with implementing the Medicaid expansion. The role of the federal government was particularly important for implementation in several ways. First, for supportive policymakers and states, the opportunity to apply for waivers allowed for states to politically “thread a needle” to appease Republicans who might be opposed to a traditional

expansion program, while also retaining the support of Democrats and the Obama administration. Second, federalism allowed states to learn from each other and to incorporate policy feedback in their negotiations with the federal government. Additionally, states that might be interested in expanding Medicaid via a waiver can observe, talk to, and mirror existing policy components (cost-sharing, work effort, private options) which early “pioneer” states had incorporated as part of their expansion efforts. Finally, the 2016 presidential election caused a seismic shift in the direction of the federal government. The election of Donald Trump shifted what policies were possible for states to pursue in their efforts to implement the Medicaid expansion. Taken collectively, the fact that the Medicaid expansion was being implemented in a federated system is an important element in understanding the politics of health reform and Medicaid policy.

Chapter 3: Methods: Case Selection, Interview Guides, and Document Analysis

“In disquisitions of every kind there are certain primary truths, or first principles, upon which all subsequent reasoning must depend.”

- Alexander Hamilton, Federalist No. 31

The use of an in-depth case study approach to understanding policy analysis and implementation decisions has a number of benefits, which have been articulated by prior scholarship (Stonecash 1996, Collier, Seawright et al. 2004, Rogowski 2004, McGrath 2009, Brown 2010). These benefits include a holistic and in-depth understanding of a timeline of implementation and decision-making, the perspective of key strategic actors within a state, and more context for understanding socially complex politics and policies (Zainal 2007).

Case-studies are particularly appropriate for my research questions. I am investigating how the politics of health reform been shaped by the Medicaid expansion and the factors which have contributed to whether and how a state decides to implement the program under the ACA. States vary in any number of substantial ways, including in their formalized rules, regulations, and norms which govern the political processes. Additionally, much of politics is dependent on the people within state government – their experiences, their expertise, their ideology, their interactions with other political actors, bureaucrats, and organizations – and these influence policymaker behavior and decision-making within a state. These important nuances and variation across states are difficult to categorize in a meaningful way through traditional quantitative

methods (Hennink, Hutter et al. 2010). Rather than treating these variations as a black box or an error term, a case study appreciates and captures these nuances, providing in-depth knowledge of the decision-making and implementation of the Medicaid expansion in a state.

The set of logical propositions as outlined by Mill provide the basic assumptions of the comparative method. These assumptions include variations across the selected cases, a fixed number of cases to select from, a complex system to study, and multiple causes to an identified effect (Mill 1884). This comparative approach is helpful in clarifying understanding of the factors which can contribute to implementation decisions. My analytic plan is composed of two components. First, I employ the comparative method across all three of case study states (Lijphart 1971, Snyder 2001, Pennings, Keman et al. 2006). This approach allows me to study “patterns of diversity” (Ragin 1987) across my selected states, to identify variation, and detect common themes which emerge from key-informant semi-structured interviews, archival records, text analysis, and discourse (Ragin 2014). Additionally, I conducted within-case analysis of each of the individual states. This portion of the analytic plan was more focused on the causal mechanism occurring within a state over time, using process tracing methods (Tansey 2007, Beach and Pedersen 2013). Process tracing is a tool of qualitative analysis, which systematically exams political and social phenomena (Collier 2011), by analyzing trajectories of changes, sequences, and causation within a state (Mahoney 2010).

Below, I highlight my methodological approach to this project. First, I outline my use of fuzzy-set/ Qualitative Comparative Analysis (fsQCA) methodology. This methodology uses a set-theoretic approach and Boolean algebra to aid in case selection and to understand the types of conditions which are necessary for particular outcomes of interest, in this case implementation of Medicaid expansion. Following a brief introduction to the method, I summarize the different

types of data that I collected for input into the case selection analysis using fsQCA. Second, I briefly overview the three states included in the case studies and the similarities and differences across the states. Third, I provide an overview of my key informant interview sampling - starting with a stratified initial sampling approach, followed by chain sampling techniques. This is followed by a discussion over the coding process of the interviews. Lastly, I discuss the types of documents that were collected, the discourse and text analysis approach that I employed in the project, and the coding process of the documentation.

Case Selection – Overview of the fsQCA Method

Case selection for qualitative studies is of utmost importance in the comparative method (Seawright and Gerring 2008, Small 2009). In the case of selecting of three states to include in a study of Medicaid expansion, there are 19,600 different combinations of potential states which could be selected (Following from the combinations equation with $n=50$ states which were given the opportunity to expand Medicaid and a sample of $r=3$ case studies; $n!/(r!(n-r)!)$). With such a range of potential states to select from, it is important to have a clear methodological approach for the case selection process (Blatter and Haverland 2012). There are several different types of cases which a case selection process can maximize; for example, cases can be chosen for their diversity, influence, deviance, or some other characteristic (Goertz 2006).

I am interested in examining marginal, or pivot, cases. In the weeks after the Supreme Court decision in June 2012 a group of governors and states expressed their opposition and support for the Medicaid expansion, sorting along partisanship lines. Rather than focus on these types of states, I am focused on the states where the decision-making process was less habitually partisan. Instead, I examine states where the decision-making process and implementation

decisions were closely decided within the state. The case selection for the case studies are informed by the logic of the comparative method as articulated by Lijhart and others (Lijphart 1971, Ragin 1987, Collier 1993, Snyder 2001) and the development of fsQCA (Ragin 2000, Ragin 2008).

fsQCA leverages a set-theoretic approach and Boolean algebra to analyze complex social phenomena and to identify multiple, interacting variables associated with each policy outcome. Additionally, fsQCA supplies a pathway analysis for selecting cases for an in-depth, case study analysis. A set theoretic comparative approach is particularly useful when there are causally complex patterns, multiple different outcomes (e.g. state expands Medicaid, state does not expand Medicaid, state expands Medicaid via a Section 1115 waiver, state implements partial expansion of Medicaid via a Section 1115 Waiver), and discordant prior results as to explaining the importance of specific factors in implementing the ACA (Mendel and Korjani 2013).

The case selection process through fsQCA requires the collection of a series of different variables and data that are related to the outcome of interest. Table 1 includes the variables that were included in the fsQCA case selection process, followed by a more in-depth examination of the components included in the case selection analysis. The variables included in Table 1 for the fsQCA case selection analysis followed from a literature review of prior scholarship on the implementation decisions, state decision-making, and related political science and public policy literature. In several cases, I highlight how prior literature collected and operationalized their data collection and how I differ from this previous work.

Table 3:1 Variables for fsQCA Analysis					
Political Factors					
Electoral Vulnerability	Legislative Majority Control/Margins of Control	Vote Share for Obama in 2008	Polarization of Legislature		
Civic Factors					

Public Opinion of Health Reform	Number of Letters to Editor and Editorials	Voter Turnout 2008	Percent of State with College Education		
Prior Medicaid Experience					
Generosity of Medicaid Program, Pre-ACA	Number of core components of insurance exchange implemented	Number of Medicaid Waivers			
Economic Factors					
Percent of Individuals Who are Eligible for Expanded Benefits	Economic Costs of Expansion	Number of hospitals per capita	Penetration Rate of Medicaid Managed Care plans		
Interest Group Factors					
Political Contributions from Pharmaceutical Organizations or Individuals	Political Contributions from Insurance Organizations or Individuals	Political Contributions from Hospitals Organization or Individuals	Political Contributions From Health Services Organizations or Individuals	Political Contributions From Health Professionals Organizations or Individuals	Political Contributions From Health Policy Organizations or Individuals
Institutional Factors					
Restrictions on Executive Action	Legislative Staff Supports/Bureaucratic Capacity	Term Limits/Legislative Professionalism			
Demographic Factors					
Age of Population	African-American Population Percent	Gender Population Percent			

Political Factors

As highlighted above, the politics of enacting the ACA has seemingly trickled down to the state level in the implementation of the ACA. While I argue that political ideology and political party does not explain the totality of state’s decision to expand Medicaid, it is an important factor to understand a state’s decision. Nor does politics have a singular definition. Rather, the politics of the Medicaid expansion encompasses a variety of dimensions, which the variables included here capture.

Electoral Vulnerability

The politics of health reform are polarized to such a degree that the proportion of elected policymakers who are electorally vulnerable (both Republican and Democrat) can influence the types of policies undertaken and enacted (Lazarus 2009). As such, politicians in a state which has fewer toss-up seats would be more concerned about the threat of a primary challenger. In a more conservative state, this can act as a barrier against expanding Medicaid. Vulnerability was defined by the percentage of total seats which where the two candidates were within five percentage points of each other. Elections are an opportunity for the public to express displeasure with current policy and policymakers, of which policymakers are acutely aware (Kingdon 2010; Fenno 2002). Upcoming elections also act as a disciplining effect on politicians. When a politician does not have a viable challenger during an upcoming election it changes the types of policies that a policymaker might pursue and their voting behavior (Besley and Coate 1997, Dal Bó and Rossi 2011, Ferraz and Finan 2011).

The political party that holds the legislative majority control of the state policymaking apparatus also has important effects on what policies are implemented (Key 1949, Epstein and o'Halloran 1999, Barrilleaux, Holbrook et al. 2002). Data on the majority control across all states in both the House of Representatives and the Senate (Nebraska is both unicameral and non-partisan and was excluded from this component of data collection) was collected. While the party in charge is important, the margins of their control can also influence the decision-making of a state (Depauw and Martin 2009). If a state is nearly evenly split along party lines, the political calculus and coalition formations are different than in a state which has many more Republican policymakers (Gamson 1961, Baron and Ferejohn 1989, Budge and Keman 1993, Sened 1996, Jackson and Moselle 2002). Majority control was calculated by taking the combined number of seats in the House of Representatives and Senate which are held by Democrats, divided by the total number of seats that are available in both chambers.

Variation in polarization can explain a state's decision to expand Medicaid. The effects of party polarization on policy outcomes are potentially far reaching (Jones 2001, Fiorina and Abrams 2008, Lindqvist and Östling 2010, Antonio and Brulle 2011, Azzimonti 2014, Barber and McCarty 2015, Rose and Bowling 2015). Binder found that gridlock and the inability for legislature to come to agreement increased as the interval between legislature medians increased (Binder 1999). McCarty similarly found that as Congress grew more polarized they were less likely to produce "significant enactments" (McCarty 2007). Data from Shor and McCarty (Shor and McCarty 2011) was used to calculate the polarization of individual legislative chambers.

Lastly, the federal politics of health reform shaped state responses to the ACA. Presidential vote-share can indicate to state leaders the level of popularity that a president has in their state. While the 2008 and 2012 elections certainly had several policy issues with high valence, in both instances health reform was an important topic. In 2008, the economy was the most important topic ranked by voters, but 78% of the public said that healthcare was either extremely or very important (Saad 2008). During the 2012 election, Barack Obama, who passed the ACA, and Mitt Romney, who passed state health reform while governor of Massachusetts, ensured that healthcare and health reform was a debated topic (Rutenberg and Zeleny 2012). The salience of the health reform and healthcare was also high on the list of the most important topics heading into the 2012 election (Saad 2012). Vote share was calculated by the percentage of popular vote for Barack Obama in 2008 and 2012 in each state, as recorded by the Federal Election Commission (Federal Election Commission 2018).

Civic Factors

State policymakers do not make decisions in a vacuum, but rather they can be influenced and constrained by the constituents they serve. Prior research has found that the level of civic engagement of the population can influence the outcomes of policy debates (Galston 2001, Mettler 2002, Campbell 2003). This category is comprised of five different variables which underscore the organizational capacity, general knowledge, and citizen participation in the legislative process.

Prior research has engaged in a debate about the influence of public opinion on public policy. Adherents of democratic theory have argued that governments can ignore their constituent wishes (Page and Shapiro 1983, Sobel 2001, Burstein 2003, Holsti 2004). Conversely, theories which feature little input from the voting public acknowledge that policymakers are also influenced by constituents (Korpi 1989, Domhoff 1998, Monroe 1998). The question is on how much influence the voting public has on policy decision. The ACA in general and the Medicaid expansion in particular, engendered strong opinions from the voting public, and if the knowledge of the law and policy was lacking, the salience of reform was not. Public opinion of Medicaid expansion was derived from the Cooperative Congressional Election Study in 2014, the first time this data has been used before, to estimate state-level public opinion.

Media elites and mass media coverage can shape public discourse around the Medicaid expansion through the number of editorials related to the expansion of Medicaid in state newspapers (MacKuen and Coombs 1981, Huckfeldt and Sprague 1995, Dalton, Beck et al. 1998, Perse 2001, Uscinski 2009, Perloff 2013). Even as rates of circulation and revenue have declined over time (Barthel 2017), newspapers remain an important provider of much of the public's knowledge about health and health policy (Brodie, Hamel et al. 2003, Barabas and Jerit 2009). Letters to the editor are an important venue in which common citizens are able to express

their opinion (Hynds 1992, Perrin and Vaisey 2008) and letters to the editor were the most read portion of the editorial page, about half of newspaper readers read the letters to the editor (Hynds1994). even with caveats on who is more apt to write a letter (Reader, Stempel III et al. 2004), as well as with the proliferation of new technology and social media platforms to express opinions, “local news organizations”, including the newspapers in this analysis, are consistently ranked as the most trustworthy source of information (Pew Research Center 2017). Two newspapers representing the two most populous Metropolitan Statistical Areas in each state were selected for inclusion. Letters to the editor and editorials were identified through an iterative search process.

The public can influence public policy through voting and awareness of the topic. While an imperfect indicator of civic capacity, the percentage of voter turnout in the 2008 Presidential election can act as a proxy for the level of involvement and civic capacity of a state in the democratic decision-making process (Hamilton 1993, Putnam 2001, Patterson 2009). The percentage of adults with a bachelor’s degree was used as proxy for general awareness of the policy, an approach which has been used by prior researchers (McClintock and Turner 1962, Hillygus 2005, Kam and Palmer 2008, Musick and Wilson 2008, Arceneaux and Nickerson 2009, Hustinx, Handy et al. 2010, Berinsky and Lenz 2011). Education and a general sense of efficacy can influence how involved an individual is in the policymaking process, how closely they follow the policymaking process, and how well individuals are able to organize in support or opposition to expanding Medicaid. Voter turnout data was supplied by the Federal Elections Commission and was the percentage of eligible voters who cast a ballot during the 2008 and 2012 election. Data on college education came from the United States Census Bureau, as the

average number of adults in a state in a given year, between 2010-2015 which have graduated with a bachelor's degree or higher.

Prior research has included the number of non-profits per capita as a proxy measure to understand the organizational capacity and civic-mindedness of a state (Putnam, Leonardi et al. 1994, Rice and Sumberg 1997, Knack 2002). The Nonprofit Almanac was used to find the number of health related nonprofit organizations (excluding hospitals) in a state, which was then standardized to create a per-capita metric across different population sizes. The formation of nonprofit organizations which are related to health can indicate a high level of civic participation amongst the general public, high awareness of policy issues related to health and health care, and the organizational capacity of individuals to influence policy decisions.

Prior Experiences with Health Reform

Prior experience with expanding Medicaid and implementing other elements of the ACA can normalize the implementation process of an expansion. A state that had, previous to the ACA, had a more generous Medicaid program, would be more likely to expand Medicaid. A more generous plan could indicate more administrative capacity and prior government experience to handle a larger population of newly eligible beneficiaries (Gold, Sparer et al. 1996, Leichter 1996, Sommers, Arntson et al. 2013, Lanford and Quadagno 2015). Additionally, a more generous pre-ACA Medicaid program could signal a willingness to further cover additional individuals. One measure of this generosity is in the types of benefits which are covered by the Medicaid program (Kaiser Family Foundation 2005), as well as provider reimbursement. The generosity of Medicaid benefit reimbursement varied substantially within the states, New Jersey has the lowest reimbursement rate in comparison with Medicare, paying only 37% and Wyoming had the highest, paying 143% of Medicare rates (Zuckerman, Williams et al. 2009).

Generosity of Medicaid program was derived as the average amount of money spent per beneficiary in each state, from 2009-2013, using data from the Centers for Medicare and Medicaid Services.

Medicaid is a jointly managed program between state and federal government, with the federal government establishing broad guidelines for benefits and eligibility and states responsible for the administration of the program. This ensures that there is regular discussion between federal and state governments. Federal law allows for states to seek modifications to existing regulations through waivers. Waiver applications require extensive negotiations with the federal government (Weissert and Weissert 2008). The administrative experience related to entering into discussions with federal agencies encourages states to learn skills to treat Medicaid expansion as a negotiation rather than as a “take-it-or-leave-it” program from Washington D.C. (Riley 1995, Agranoff and McGuire 2004, Thompson and Burke 2007, Thompson and Burke 2009, Ryan 2011). Information on the number of Medicaid waivers applied for by each state was collected from data supplied by the Centers for Medicare and Medicaid Services.

Lastly, a state which had implemented other components of health reform might be more likely to implement an expanded Medicaid program. Prior experience with the ACA normalizes behavior associated with health reform. Implementing the Medicaid expansion is not done in a policy silo, but is rather part of a broader array of steps which a state has taken towards health reform. The core components of the ACA implemented by the states are creating and managing a state-based exchange. Each state was scored based on the number of four components of the individual and SHOP exchanges were implemented by the state.

Economic Factors

Expanding Medicaid represents a large cash transfer between the federal and state government. The economic benefits of expanding the program can be felt widely throughout the

state. Hospitals in a state which has expanded Medicaid would reduce their amount of uncompensated care and increase their revenue, businesses would increase the number of their employees who receive health coverage, and the newly eligible could increase their economic earnings and productivity.

There is an expectation that a larger population that stands to gain from expansion would be more likely to benefit from implementing the Medicaid expansion (Price and Eibner 2013). From 2014-2017 the federal government covered 100 percent of the costs of expansion, slowly tapering off its level of support until it plateaus at 90 percent by 2020 and thereafter. However, even in those first years where the federal government covers the costs of coverage, states still incur a small portion of the costs, primarily administrative costs. With Medicaid spending accounting for more than a third of total state budgets (The Henry J. Kaiser Family Foundation 2018), even a small increase in the total spending on the program from states can have deleterious effects on state budgets, particularly amongst states that need to annually balance their budgets. Data on the newly eligible were collected from United States Census Bureau data contained in the American Community Survey. The costs of expansion was collected from modeling data supplied by the Health Insurance Policy Simulation Model (HIPSM), created by the Urban Institute, supplying state specific cost projections.

While states that expand Medicaid under the ACA are given a much more generous reimbursement from the federal government, the potential costs for state can be immense. Governors used the unknown cost of expansion to argue against expanding their program (Grogan, Singer et al. 2016, Rozier and Singer 2016). CMS found that cost projections for Medicaid expansion had increased by 49% (Cassidy 2016). Managed care plans for Medicaid populations can reduce programmatic costs for states (Rowland and Hanson 1996, Holahan,

Zuckerman et al. 1998). In states which more Medicaid enrollees who are in managed care plans, states would be able to project the economic costs with a higher degree of assurance and make it easier for a state to expand Medicaid. Data on Medicaid Managed Care plans were collected from the Centers for Medicare and Medicaid Services.

Hospitals stand as potentially the industry with the most to gain from a state deciding to implement the Medicaid expansion. Federal law requires hospitals to stabilize any individual who walks through their doors, regardless of their ability to pay; hospitals either have to engage in costly efforts to collect on money that would be owed or they have to write off the provision of care to those individuals as uncompensated. In states that have expanded Medicaid, their uncompensated care costs have decreased, leading to stronger financial standing (Dranove, Garthwaite et al. 2016). Hospitals as a group are one of the most well-respected organized interests (Berry and Wilcox 2018) and can leverage their esteem within a state to support their preferred policy options. The number of hospitals in a state was collected from American Hospital Association Masterfile data, normalized on a per-capita basis for the state's population.

Interest Group Factors

Where interest groups pressure is high and support for a policy, there is association with implementation, independent of the partisan characteristics of the state (Gerber 1999, Hean 2006, Dür and De Bièvre 2007, Hertel-Fernandez, Skocpol et al. 2016). Within a state there are several different interest group dynamics which can contribute to the implementation decision in a state. First, there is the tension between conservative and liberal interest groups. Tea-party type organizations and other libertarian groups organized and responded in opposition to Obama policy initiatives, particularly around health reform. These interest groups have formed into highly federated organizations, with national organizations acting as an umbrella to state

and local organizations which have minimal contact with each other. Scholars have highlighted the rise of these ideological pure interest groups and their effect on decision-making and traditional conservatism (Skocpol and Williamson 2012, Tarrow 2013).

A second interest group dynamic at play in these states is between traditionally conservative supporting organizations. The Medicaid expansion represents a potential boon to economic interests within the state, positively affecting small businesses, hospitals, and the health workforce, which on the whole has donated more money to Republican candidates and Political Action Committees. Hospital associations, medical associations, and state and local Chambers of Commerce have come out in strong support for expanding Medicaid, focusing on the financial and economic benefit for their organizations and for the business climate for the state overall (Rozier and Singer 2016). Conversely, groups and individuals who are more interested in ideological purity have consistently opposed expansion, setting these two groups at loggerheads (Hertel-Fernandez, Skocpol et al. 2016). The Medicaid expansion as a policy can open rifts between these two types of organizations. Whereas these traditional economic groups at the state level can gain a financial windfall if there states decided to expand Medicaid, it goes against the doctrinaire approach of the ideological groups.

Prior research has focused on measuring the influence of state-level Chambers of Commerce by modeling the presence of a dedicated health policy staffer and/or a board member who represents a health care company(Hertel-Fernandez, Skocpol et al. 2016). While illustrative of the influence that stakeholders can have on an interest group, the authors approach does have drawbacks. The variable the authors created to measure the level of individuals with health policy experience or employment background was capped on an interval scale from 0-4; this limits the amount of variation in explaining their presence in the organization. Additionally, this

approach makes several assumptions. The authors assume that having one board member is the deciding factor in these organizations decision-making. This assumption is not supported without knowing the total size of the board, the position of authority within the board or on a committee, and what role the board has in the day-to-day operations of these organizations.

Instead of measuring the presence of a board member to model the influence of an organization, I measure the influence of competing organizations through their political contributions to state policymakers. Scholars have shown that policymakers are more apt to respond positively to groups which they have received financial contributions (Langbein 1986, Austen-Smith 1997, Bell 2002, Stratmann 2005). I created a unique database of all campaign donations from 2010 through 2016 given to Democratic and Republican campaigns, candidates, and Political Action Committees. Using Federal Election Commission data, I have identified whether an individual or an organizational contribution is associated with pharmaceuticals, health insurance, hospitals, health services, health professional, or a health policy organization.

Institutional Factors

Variation in the institutional design and rules in each of the state can also influence the decision-making of related to expanding Medicaid. In an effort to curtail the ability of a governor to unilaterally act in implementing components of the ACA; nine state legislatures have enacted laws which limit the scope of gubernatorial power to implement any non-required component of the ACA without explicit legislative approval (National Conference on State Legislatures 2016). Governors in three additional states - Alaska, Kentucky, and West Virginia, have expanded Medicaid either through executive action, without any legislative approval. Ohio Governor John Kasich (R) circumvented the legislature when he expanded Medicaid through the

State Controlling Board, which is given legislative approval to make budgetary adjustments when the legislature is out of session (Ohio Office of Budget and Management 2016). The data on restrictions on executive action was collected through an analysis of state laws, regulations, and financial documents. There were four criteria included on the power of the executive: implementation of term limits, number of political appointments in comparison to the overall state bureaucracy, limitations on veto authority, and the budgetary power of the executive branch in comparison with the rest of state spending.

Beyond variations in the power of a governor in implementing the Medicaid expansion, there are institutional rules that affect the role of the legislature in the implementation process. Some of the variations included in the case selection process are related to term limits (Meinke and Hasecke 2003, Huefner 2004, Kousser 2005, Kurtz, Cain et al. 2009), legislative rules (Shepsle and Weingast 1984, Shepsle and Weingast 1987, Cox 2006), committee appointments (Krehbiel, Shepsle et al. 1987, Shepsle and Weingast 1987, Cox and McCubbins 2007, Jackman 2014) and other factors (such as legislative staff support) can inhibit or encourage legislative action. As noted above, legislative scheduling also varies from state to state, as well as what types of legislation can be heard during a legislative session (For example, the Wyoming Legislature is limited to meeting for sixty days total over a two year period and during even-numbered years the legislature has a “Budget Session” where the only bills the legislature can vote on are related to the budget, unless a super-majority votes to debate a non-budget related bill). The rules and procedures around who can call, what can be addressed, and when a special session can occur also differ from state to state. Data for legislative factors that influence debate and implementation were acquired from Squires measure of state professionalism (Squire 2007), as well other state measures of legislative limits (Carey, Niemi et al. 2006), legislative

supports (e.g. number of staff, (National Conference on State Legislatures 2016), and bureaucratic capacity (Huber and McCarty 2006, Burns, Evans et al. 2008).

Demographic Factors

The demographics of a state can influence the type of decision-making and program implementation which can occur (Poggione 2004, Page and Shapiro 2010, Margalit 2013). In particular I examine the association of three key demographic variables on the implementation of the Medicaid expansion. The first demographic included in the analysis was racial and ethnic identification in a state. Prior research has found the Medicaid expansion connected to racial attitudes in two ways: with large differences in opinion along racial lines and state implementation decisions related to white opinion (Grogan and Park 2017). Using Census Bureau data, I mapped out the breakdown of the state population by racial identification. A second demographic variable included in the analysis was the age distribution of the population (Campbell 2003). While generally not well understood, a substantial portion of Medicaid funding goes toward the elderly and the provision of long-term care (Kaiser Family Foundation 2018).

The AARP and other senior oriented organized interest groups were supporters of expansion because of the benefits derived by individuals between 50 and 64 who are ineligible for Medicare but are represented by the organization. Data from the United States Census Bureau was used to measure the percentage of state population 50 years or older. The division of gender within a state can also influence the policy implementation decisions. There are clear preferences between genders across a variety of different policy domains (Thomas 1991, Lewis 1997, Sainsbury 1999, Swers 2002, Chattopadhyay and Duflo 2004); related to the Medicaid expansion, women have more of a connection to the program and are more supportive of implementing expansion, in comparison with males (Grogan and Park 2017). Using United

States Census Bureau data, I collected the percentage of state population that identifies as female.

Case Study Selection

The results from the fsQCA case study analysis lists several potential marginal cases which fit the particular pathways identified through the program. But, it is essential to supplement the fsQCA identified cases with the deep knowledge on the outcome of interest. My prior work, knowledge of the topic, broad understanding of state politics allowed me to make sense of the different pathways and to differentiate across the selection of cases identified by fsQCA. Because I am interested in studying “patterns of diversity” (Ragin 1987) I wanted to maximize the heterogeneity in outcomes amongst the case studies selected. From the combination of deep knowledge of the states and the fsQCA identified cases, I selected three states for inclusion in the study: Arizona, Michigan, and Utah.

The results of the fsQCA analysis found in Chapter 4 provides more in-depth detail into the case selection methods employed, as well as the selection of the three states for further in-depth analysis.

Case Studies – Key Informant Interview Sampling

My approach to conducting the semi-structured key informant interviews was informed by my prior research experience, both amongst some of the states included in the case studies (Jones, Bagley et al. 2015, Jones, Bagley et al. 2015, Jones, Bagley et al. 2015) as well as developing interview protocols, conducting interviews, and being immersed in state politics in other projects (Grogan, Singer et al. 2016, Oberlander, Jones et al. 2016).

The key informant sampling followed a two-stage process. First, I leveraged purposive sampling, focusing on contacting individuals in various occupations and organizations to learn

from their specific viewpoint (Teddlie and Yu 2007, Maxwell 2008), followed by chain-sampling methods. The implementation of the Medicaid expansion is a complex social phenomenon, touching on financial, political, and ethical areas, while also including a variety of different organizations and individuals. This initial sampling framework employed a stratified sampling method (Teddlie and Yu 2007, Tashakkori and Teddlie 2010), selecting individuals from a variety of different positions and organizations within the state. I interviewed individuals from these broad categories:

- Majority and Minority leadership in both chambers.
- Leadership from both parties from all states' relevant legislative committees.
- Staff members from relevant legislative committees.
- Health policy advisor for each governor.
- Members of each state Department of Health or the Medicaid relevant government agency.
- Leadership of key interest groups who have lobbied for and against Medicaid expansion. This will include:
 - State hospital associations
 - Chamber of Commerce
 - State physician organizations
 - Tea-party organizations
 - Other state specific conservative and liberal organizations (for example, the conservative Mackinac Center for Public Policy in Michigan or the liberal Alliance for a Better Utah in Utah).

- Government Affairs directors at prominent provider organizations in each state
 - Leaders of state specific health policy organizations
 - Newspaper reporters from each state who had covered the debate

The selection of who I initially interviewed in each state was informed by research done prior to the beginning of the interviews in each state. I immersed myself in the politics of the state, the decision-making process, and compiled extensive documentation for each state. The documentation I collected is described below, but archival, government, and other records were collected for each of the case study states. During the process of reviewing the documentation, I noted which individuals were vocal during the debate over the Medicaid expansion, which organizations took part in the process, and the general timeline of events within the state. This prior-interview work helped inform the types of individuals and organizations I targeted in my interview efforts. Additionally this work shaped the types of questions asked of key informants. From this document collection, I identified an initial selection of key stakeholders across a variety of different settings and organizations within the state to interview.

At the conclusion of each interview, I employed chain sampling methods and asked the informant who else I should contact to learn about the decision-making process within the state (Biernacki and Waldorf 1981, Noy 2008). In most instances the individuals who were mentioned by informants had been previously been identified for potential interviews. The chain sampling approach was ended when a saturation point was reached within each state.

Each of the interviews were semi-structured, allowing me the flexibility to respond to informant answers and to focus the interview on the topics most pertinent or applicable to each of the key informants background and information (Leech 2002). The need for flexibility was

especially important because the interview guide (See Appendix for the interview guide) contained several distinct question themes, where key informants did not have the specific expertise across all themes. Each interview began by exploring the informant's background, their work and organization, and their role in the decision-making process related to the Medicaid expansion. Where appropriate, I then asked questions about the perspective of the organization, their stance and actions related to the implementation of the Medicaid expansion. Followed by questions about the political climate within the state and how other components of the ACA had been received by the state and how those other health reform efforts were similar or differed from the Medicaid expansion. I asked the informant their view on the major political figures within the state – the governor, legislative leaders, and bureaucratic actors – and whether and how they shaped the implementation decisions within the state. Lastly, I asked a series of questions related to the role of the national environment on the state behavior. In this section I investigate the role that federal-state relations, federated interest groups, and discussions with other state policymakers and organizations have had on the implementation decision.

I received approval from the Institutional Review Board at the University of Michigan. In exchange for informant openness, to develop trust and rapport with informants, and to protect informants from harm (Baez 2002), I do not include any identifying information from my interviews. Confidentiality of informants was undertaken at three points. First, I ensured confidentiality in the data collection process. I provided an informed consent form for all informants and included consent to participate language in my initial email reaching out to informants. Email communication with informants will also include background on the research project (I have included a draft of the informed consent document in the Appendix). I also verbally relayed the confidentiality at the beginning of each interview. Second, I ensured

confidentiality through data cleaning. I asked for informed consent to take notes prior to each interview (both in the email and interview), which were used to inform the memos after interviews. Lastly, I ensured confidentiality through data storage (McCosker, Barnard et al. 2001). All interview notes and identifying material was secured on a password protected hard drive kept behind locked doors. The interview notes and memos was only kept on my hard drive and was not placed within any cloud computing.

Interview Coding Methods

From a theoretical and methodological perspective, I approached the interview coding from a modified grounded theory. Grounded theory applies inductive methodology to the data collection and analysis process, leading to theoretical insights (Glaser 2017). Instead of applying an *a priori* theoretical framework to understand Medicaid expansion implementation decisions, I constructed the theoretical substance through the collection and analysis of inductive data (Strauss and Corbin 1998).

Grounded theory relies on a cyclical, iterative process of coding. As I collected the data through informant interviews, I simultaneously analyzed the data after each interview was conducted, using previous findings to shape future questions and areas to research (see the end of the Interview Protocol contained in the Appendix). From this iterative process I developed and refined codes and categories from my informant interviews (Charmaz and Smith 2003, Charmaz 2014) (Described below and the interview coding guide, which can be found in the Appendix). These codes and categories serve the purpose of identifying phenomenon which are identified from my informant interviews and allow me to capture patterns and themes from the data and to cluster the codes together to draw from the extensive informant interviews conducted (Walker and Myrick 2006). From these codes and categories I further developed theoretical concepts

(Creswell 2013) by engaging in memo writing, “the methodological link, the distillation process, through which the researcher transforms data into theory”(Lempert 2007). These memos were written continuously throughout the research process and they served to integrate the various ideas, emergent patterns, and “conceptualize the data in narrative form”(Lempert 2007).

In addition to following this grounded approach to the development of data themes from the interviews, I leveraged techniques from open and provisional coding to help organize and structure the data collected in the coding process. After the interviews were conducted and the interview notes and memos were written, I read through the documentation from each interview, using NVivo software (QSR International Pty Ltd 2015) to generate a series of initial codes (Hsieh and Shannon 2005). In general, these codes developed from the main data themes asked of the informants.

After initially reading through the totality of the interviews conducted, the coding scheme was further refined. During the second coding of the interview notes the initial codes that had been developed continued to be used. A research assistant was used for the second round of coding, to ensure the proper use of codes. The two researchers were each assigned the same five interviews to code, using the codebook developed through the first round coding. After coding the same interviews, the two researchers met and compared their use of the codebook and made additional refinement to the selection and use of codes. Once the independent test of coding was complete, each interview was read and coded a second time. After the interviews had been coded twice, the interviews underwent provisional coding, where once distinct categories were subsumed into larger categories (Miles, Huberman et al. 2013). The provisional coding was designed to streamline existing codes and to generate a cohesive coding structure.

Document Collection Methods

The key informant interviews were essential to context and understanding the development of decision-making around the implementation of the Medicaid expansion, but additional evidence was collected to supplement the interviews. In particular I employed methods related to data triangulation (Denzin 1973, Denzin 2017), using multiple and varied data sources, perspectives, and methods to converge “or explain more fully, the richness and complexity of human behavior by studying it from more than one standpoint” (Cohen, Manion et al. 2013). There were several additional secondary data sources from which this triangulation effort was undertaken (Tashakkori and Teddlie 2010).

Broadly, there were two types of material which were collected and analyzed across each of the states. First, I collected all instances of public testimony and floor debate across both chambers of the state legislature. The floor debate and public testimony offered exceptional insight into the legislative process related to each state’s efforts to expand Medicaid. These secondary data sources allowed me to identify which groups were aligned together in support or opposition to expansion, how individuals and organizations framed their position-taking on the legislation, and how the legislation itself evolved over time. These data sources were collected, either in written or audio form, from the state legislative journals and legislature websites.

In addition to the records I was able to collect through websites, I also contacted and received supplemental materials from each state's archives. From each of the state archives I was able to collect the presentations, meeting minutes, and written (but not presented) testimony from the general public who were unable to attend the meetings in person. In addition, the archives also contained legislative analyses and reports related to the Medicaid expansion that had been entered into evidence and produced by the state. In addition to the records which were collected by the state archives, I also collected reports from government agencies, think-tanks and interest

groups. Because each state is idiosyncratic in its organization and stakeholder environment, there was no set list of organizations which I could search for pertinent reports. Instead, while interviewing stakeholders in each of the states I would ask about the agencies and organizations which helped shape the state's implementation decision, which helped inform the groups I focused on in collecting this data.

Taken together, I employed process tracing methods for the documents that were collected and included in this analysis. For Collier, process tracing allows the researcher to draw “descriptive and causal inferences from diagnostic pieces of evidence—often understood as part of a temporal sequence of events or phenomena” (Collier 2011). According to George and McKeown, process tracing occurs when researchers examine “the decision process by which various initial conditions are translated into outcomes” (George and McKeown 1985). This method is particularly suitable for this analysis because it helps to describe social or political phenomena, evaluate causal claims, and assess prior hypotheses of decision making (George and Bennett 2005). Additionally, I am interested in examining state decision-making over time, which is a focus of process tracing (King, Keohane et al. 1994). To understand the unfolding events over time, it is important to be able to describe a situation at one point in time, by “taking snapshots at a series of specific moments...to characterize key steps in the process, which in turn permits good analysis of change and sequence” (Collier 2011). By collecting data through secondary data sources, I catalog the unfolding events unique to the three states included in my analysis.

Document Coding Methods

The coding protocols for the documents included in the analysis followed a similar overall structure as the interviews (Wodak and Meyer 2009); including the development of

document analysis codebooks, additional coders, and repeated reading of documentary material. For the floor speeches and public testimony I employed Critical Discourse Analysis, to understand how stakeholders, policymakers, and the general public use language to describe social policy (Blommaert and Bulcaen 2000, Wodak 2001). In particular, I was interested in understanding the overall stance of an individual towards the Medicaid expansion, how an individual framed their stance on the policy, and how an individual leveraged additional supportive material as part of their framing. This last category of information was looking specifically at how individuals use evidence and personal experience as part of their rhetorical framing of the policy (Cox and Cox 2001, Grogan, Singer et al. 2016).

However, it should be noted that there is one major difference between the analytic approach to the interviews and the document coding. The coding of the documents followed a within-case analysis. Rather than code documents over the entire breadth of the states, as was done with the interviews, I was more interested in capturing the idiosyncrasies associated within each state. While a similar codebook was used for the beginning of each of the three states, each code book differed somewhat by the end of coding the reports and testimony. These differences were caused by different frames, different experiences, and different policymakers across each of the states using different rhetoric in each of their particular circumstances. There were similarities in the types of framing that policymakers would use to discuss their stance on Medicaid expansion (e.g. the most common framing device was based in financial or economic arguments, both in support and opposition to implementing the expansion), but the individual circumstances which arose within the state influenced the specific framing, evidence, and rhetorical choices.

To develop these individual codebooks, each state started from the same general set of codes. Additionally, similar but unique codebooks were created for each of the major types of documents collected—testimony, speech, and reports. I used open and provisional coding techniques for each of the state and document type codebooks, which led to each of the codebooks evolving in different ways. Similar to the interviews, a second researcher coded 25 shared documents across each of the three state case studies. Once these shared documents were both independently coded, the responses were compared and differences between the codes were reconciled (See the Appendix for the general document codebook).

Chapter 4: National Results from fsQCA Analysis

“It has been frequently remarked that it seems to have been reserved to the people of this country, by their conduct and example, to decide the important question, whether societies of men are really capable or not of establishing good government from reflection and choice”

- Alexander Hamilton, Federalist No. 1

At its creation, Medicaid, with its roots as a social welfare program for the poor and vulnerable, was viewed as a temporary program that was often underfunded and overlooked (Moore and Smith 2005, Hoffman 2012, Smith 2017). Medicaid as a public insurance program has often been overlooked, yet it is now one of the bulwarks of the health insurance system in the United States. Adding to the essentialness of Medicaid has been the actions of 33 states that have implemented the Medicaid expansion as part of the ACA. The Medicaid expansion has been the main driver of increasing health insurance coverage in the United States (Freaan, Gruber, and Sommers 2017).

Yet, the implementation decisions made by states are complex, involving a variety of different political, institutional, economic, civic, policy history, and interest group factors. The results of the fsQCA analysis outlined below serves two purposes. First, it is an attempt to understand the various factors that contribute to whether and how a state implemented the Medicaid expansion. Second, through identification of the causal pathways, the selection of case studies for further analysis are identified.

There were two primary factors that were present in the causal pathways, civic and institutional factors. Below I walk through the data collection and analysis process associated with the fsQCA and end the chapter with some thoughts on new insights garnered by the fsQCA results.

Data Collection

Table 4.1 is the data matrix showing the variables that were included in the final model and the fuzzy-set membership scores for each of the states. After collecting the data for the fsQCA case selection analysis (see Appendix for the codebook related to the data collection process), each of the conditions were independently included in the fsQCA program (Ragin and Davey 2016). Using the developed data matrix, there are two key outputs to help guide the case selection and interpretation of the results: consistency and coverage. Consistency is the extent to which a causal combination leads to the outcome of interest and coverage represents the number of cases with the outcome which are represented by a particular causal condition (Elliott 2013).

The final model specification reported here followed an iterative process. The first analysis undertaken was to understand the consistency and coverage of each individual condition in the dataset. After initially running each individual condition, there were several factors which demonstrated low consistency and coverage across a variety of different combinations of conditions. These factors were excluded from further analysis. Relevant and theoretically related conditions were combined into similar categories, resulting in political, economic, institutional, civic, and interest group conditions. Each of these categories of conditions were comprised of anywhere between 3-5 individual conditions. Each of the individual conditions were standardized according their individual percentile for the condition across all the states. For example, if a state was in the 99th percentile for interest group contributions made to the Republican Party, then that state would be scored as a .99 (on a 0-1.0 scale). Once each of the

individual causal conditions were combined into the larger categories, the scores within each of the larger causal conditions categories were summed. Once again, states were given a standardized score of this “total” score for a causal condition. For example, if a state had a standardized score of 0.55, 0.45, and 0.60 (e.g. they were in the 55th, 45th, and 60th percentile) for the three causal conditions included in the category for “Prior Health Reform Experience” they would have a summed score of 1.60. If that score of 1.60 was in the 63rd percentile across all states, that state would be assigned a standardized score of 0.63 for “Prior Health Reform Experience”.

Table 4:1 Data Matrix for States						
State	Outcome	Conditions				
		Political	Economic	Institutional	Civic	Interest Group
Alabama	0	0.26	0.13	0.39	0.32	0.31
Alaska	0.86	0.66	0.76	0.55	0.45	0.33
Arizona	0.71	0.29	0.43	0.57	0.61	0.42
Arkansas	0.29	0.29	0.29	0.48	0.36	0.65
California	0.86	0.7	0.78	0.63	0.74	0.6
Colorado	0.86	0.62	0.74	0.62	0.54	0.47
Connecticut	1	0.55	0.775	0.54	0.65	0.37
Delaware	0.86	0.54	0.7	0.61	0.55	0.27
Florida	0	0.35	0.175	0.47	0.43	0.77
Georgia	0	0.3	0.15	0.37	0.42	0.58
Hawaii	1	0.61	0.805	0.63	0.65	0.32
Idaho	0	0.26	0.13	0.44	0.4	0.38
Illinois	0.86	0.48	0.67	0.59	0.53	0.49
Indiana	0.29	0.3	0.295	0.57	0.49	0.59
Iowa	0.29	0.52	0.405	0.52	0.53	0.41
Kansas	0	0.28	0.14	0.43	0.36	0.31
Kentucky	0.86	0.29	0.575	0.56	0.62	0.4
Louisiana	0.86	0.24	0.55	0.51	0.47	0.46
Maine	0	0.63	0.315	0.43	0.46	0.17
Maryland	0.86	0.71	0.785	0.59	0.59	0.48
Massachuset	0.86	0.54	0.7	0.6	0.55	0.47

ts						
Michigan	0.43	0.31	0.37	0.6	0.57	0.39
Minnesota	0.86	0.61	0.735	0.57	0.61	0.49
Mississippi	0	0.26	0.13	0.39	0.36	0.29
Missouri	0	0.44	0.22	0.47	0.44	0.44
Montana	0.71	0.52	0.615	0.61	0.54	0.32
Nebraska	0	0.32	0.16	0.39	0.47	0.43
Nevada	1	0.51	0.755	0.43	0.45	0.43
New Hampshire	0.71	0.59	0.65	0.57	0.55	0.38
New Jersey	1	0.46	0.73	0.61	0.54	0.52
New Mexico	1	0.64	0.82	0.51	0.58	0.38
New York	0.86	0.59	0.725	0.61	0.57	0.56
North Carolina	0	0.43	0.215	0.37	0.43	0.41
North Dakota	0.86	0.23	0.545	0.56	0.53	0.49
Ohio	0.71	0.41	0.56	0.54	0.58	0.49
Oklahoma	0	0.14	0.07	0.36	0.29	0.33
Oregon	1	0.58	0.79	0.6	0.52	0.55
Pennsylvania	0.86	0.36	0.61	0.53	0.54	0.51
Rhode Island	1	0.47	0.735	0.66	0.54	0.41
South Carolina	0	0.23	0.115	0.42	0.41	0.46
South Dakota	0	0.22	0.11	0.37	0.47	0.39
Tennessee	0	0.24	0.12	0.31	0.46	0.41
Texas	0	0.32	0.16	0.48	0.39	0.52
Utah	0	0.24	0.12	0.61	0.55	0.33
Vermont	0.86	0.64	0.75	0.71	0.6	0.16
Virginia	0	0.47	0.235	0.47	0.55	0.51
Washington	1	0.68	0.84	0.53	0.6	0.55
West Virginia	0.86	0.39	0.625	0.51	0.44	0.35
Wisconsin	0	0.57	0.285	0.33	0.48	0.58
Wyoming	0	0.14	0.07	0.38	0.37	0.35

The outcome of interest amongst the states was whether the Medicaid expansion was implemented. There is gradations between a state that chose not to expand the program and those that did implement it. 19 states were given a '0' for the implementation of expansion,

whereas only 8 states were given a score of ‘1’ for the outcome. Amongst the remaining 23 states, states were assigned their score based on the number of elements that was included in a traditional Medicaid program that a state implemented.

Table 4.2 is the Truth Table developed from the data matrix using the fsQCA program. The combination which had the highest consistency was having Political, Civic, and Institutional conditions present within a state. Civic factors were present in states with the highest eight consistency scores for different causal combinations. Similarly, the Political and Institutional factors were amongst the most consistently related factors with implementation.

Table 4:2 Truth Table						
Political	Civic	Economic	Institutional	Interest Group	Number	Raw Consistency
1	1	0	1	0	10	0.80576
0	1	0	1	0	4	0.797055
1	1	0	1	1	4	0.795539
0	1	1	1	0	1	0.795021
0	1	0	1	1	2	0.792453
0	1	1	0	0	2	0.792404
1	1	1	1	0	1	0.791035
1	1	0	0	0	2	0.790205
1	0	0	0	1	1	0.596838
1	0	0	0	0	1	0.594001
1	0	1	1	0	1	0.591936
0	0	1	1	1	3	0.541936
0	0	0	0	0	2	0.527199
0	0	1	0	1	5	0.521216
0	0	1	0	0	10	0.482507

Table 4.3 provides further support for the results of the Truth Table. Each of the causal conditions were included individually in the fsQCA program, both their presence and absence. The results of this analysis point towards the high consistency of Civic factors (both presence and absence) and its relations to a state implementing the Medicaid expansion. Yet, no condition

is considered necessary for the analysis (with a consistency score above 0.9). As is often the case with a causally complex social phenomena and fsQCA, there is no single condition that explains all of the state decisions around implementation of the Medicaid expansion. Rather, the combinations of causal conditions is necessary to understand the outcome of interest. Results from the fsQCA analysis highlights two paths that lead to implementation of the Medicaid expansion in states (see Table 4.4).

Table 4:3 Necessary Conditions for Medicaid Implementation		
Conditions Tested	Consistency	Coverage
Political	0.70	0.60
~Political	0.65	0.75
Civic	0.86	0.80
~Civic	0.81	0.87
Economic	0.64	0.63
~Economic	0.63	0.65
Institutional	0.65	0.66
~Institutional	0.70	0.70
Interest Group	0.59	0.66
~Interest Group	0.61	0.54

Civic factors, the quasi-necessary conditions identified above is present in each of the paths leading to Medicaid implementation. Additionally, in both of the paths, the institutional structure of the state influenced whether the state implemented the Medicaid expansion. The coding of the interest group conditions was based on contributions given to Republican candidates and the Republican Party, which led to the negation of interest groups in one of the causal pathways. The two causal conditions contained in Table 4.4 were selected due to their high consistency scores and were both above 0.80. However, it should be noted that these results are not as robust as other findings using fsQCA (Ragin 2008). Additionally, unlike with the Truth Table and the singular analysis of causal conditions, the Political factors were not included in the causal pathway.

Solution	Potential Cases	Raw Coverage	Unique Coverage	Consistency
Civic*Institutional*~InterestGroup	AZ, CO, CT, DE, HI, IL, IA, MD, MA, MI, MN, MT, NH, NM, ND, OH, RI, UT, VT	0.60	0.016	0.83
Civic*~Economic*Institutional	AZ, IA, MI, UT	0.60	0.035	0.83
Solution Coverage: 0.654752				
Solution Consistency: 0.837976				

Case Selection

From the causal pathways identified by fsQCA, cases can be selected for further in-depth analysis. Using the data matrix in Table 4.1, which includes the scores for each state across each of the different causal conditions, potential cases that meet the criteria identified by the fsQCA analysis can be highlighted.

Across both of the pathways, there were a total of nineteen states that were held the characteristics identified in at least one of the pathways. However, when comparing the sets of states that were included in both pathways, there was an overlap of four states: Arizona, Iowa, Michigan, and Utah. From the initial group of nineteen states that had been identified as potential sites for a case study, I then focused on the four that were shared amongst the two pathways. One of the goals of my analysis was to select states that were marginal cases in their decisions to implement the expansion, as well as demonstrated heterogeneity in the outcome (e.g. how a state implemented the expansion, if at all) to understand the “patterns of diversity” (Ragin 1987) in expansion implementation. Additionally, it is important to supplement the results of the fsQCA causal pathways with a deep knowledge of the outcome of interest. My prior work, knowledge of the topic, broad understanding of state politics allowed me to make

sense of the different pathways and to differentiate across the selection of cases identified by fsQCA.

On the first point, each of the four cases succeeded. Arizona, Iowa, and Michigan all narrowly implemented the expansion within their state; all had Republican governors and legislative majorities in the legislative chambers and were only able to pass enacting legislation with a short-lived coalition of support from Republicans and Democrats. Utah was the only state included in the four that did not implement the expansion, yet it also was a state with a Republican governor that had long supported expansion and expansion bills had passed the Senate twice in the state, only to be blocked for further passage by the House. Eventually, Utah had implemented a “partial” expansion to a subset of their population that was spurred by their debate over the ACA Medicaid expansion, but was not funded through federal monies set aside for health reform.

However, on the second point, there was overlap between two of the initially identified states in how state policymakers implemented the expansion. Arizona was the only state included in the initial analysis of state case studies that implemented a traditional Medicaid expansion, similar to what was called for in the original ACA legislation. As mentioned above, Utah did not implement the expansion as called for under the law, but rather implemented a partial expansion. Both Michigan and Iowa implemented the Medicaid expansion, but unlike with Arizona, both states used a waiver to usher in the expansion. Additionally, while there is some heterogeneity in how waiver states changed their Medicaid programs through the expansion populations, the general contours of the expansion programs in both Iowa and Michigan are quite similar to each other. There were two primary factors that contributed to the decision to focus on Michigan as the state for a case study. First, Iowa had the lowest set membership score of the four states identified. Second, do to proximity, I had developed

relationships and connections with policymakers across Michigan that would allow me access to understand the events that transpired in the state in the wake of the June 2012 Supreme Court case.

Sensitivity Analyses

Following previous work and best practices (Schneider and Wagemann 2010, 2012), a sensitivity analysis was performed for the absence of implementation of Medicaid expansion (See Table 4.5). Overall, the results of the negated outcome for this sensitivity analysis demonstrated lower consistency across each of the sets of factors in comparison with the original analysis.

From these sensitivity analysis, four different pathways were identified which led to the outcome of interest, a state not implementing the Medicaid expansion. Not surprisingly, Political factors were present in each of the four pathways. In connection with the factors highlighted in the causal pathways above, the absence of Civic factors was also present in each of the pathways. Similar to the analysis completed above, the states which met the criteria outlined by the results of the fsQCA were identified, with fourteen states total included in this portion of the analysis. None of the states identified in the case study selection were identified in this sensitivity analysis.

Solution	Cases	Raw Coverage	Unique Coverage	Consistency
Political*~Civic*~Institutional*~InterestGroup	AL, ID, KS, MO, NE, NC, OK, SC, SD, TN, WY	0.59	0.104	0.76
Political*~Civic*~Economic*~Institutional	ME, WI	0.42	0.007	0.72
Political*~Civic*Economic*InterestGroup		0.53	0.044	0.74
Political*~Civic*Economic*Institutional*~Int		0.41	0.002	0.72

erestGroup				
Solution Coverage: 0.65625				
Solution Consistency: 0.769737				

Conclusions

The analysis of state implementation of the Medicaid expansion using fsQCA was two-fold, both of which provide interesting results. First, the results of the analysis highlight the causal conditions that are related to state decisions to implement the law. This is the first instance of using fsQCA to analyze Medicaid implementation decisions. The results from this analysis provide new insight into the factors that contribute to implementation by the states. It is particularly interesting to note that Civic factors were related to implementation. Specifically, the Civic factors that were included in the analysis were the voter turnout, education, and participation in organizing in support of Medicaid expansion. Civic factors were present in the most consistent causal pathways identified through fsQCA. These results point to the importance that individuals in the general public have in affecting the policy implementation of Medicaid. This is a point that has not been identified in previous literature related to the Medicaid expansion. Institutional factors, which included restrictions placed on executive action, bureaucratic capacity, and legislative professionalism, was also associated with implementing the Medicaid expansion.

Additionally, an interesting result from the fsQCA analysis is the unclear role that Political factors play in implementation. Prior literature had uniformly pointed towards the essential role that politics plays in expansion decisions. While true, the results of the fsQCA analysis highlight the complicated nature of policy implementation. It is not politics alone that explains what occurred within states. Rather, a deeper examination of the internal mechanisms

and processes which shaped the ultimate outcomes within the states can provide additional insights into implementation.

The second important result from the fsQCA analysis is a systematic approach to the selection of case studies for the needed further analysis of the events within a state that led to the implementation decision. With the results from the analysis, three states were selected for selection to a case-study: Arizona, Michigan, and Utah. These states were present across each of the causal pathways identified by fsQCA. While variation in the outcome was key in the selection of states, it is important to note that the case study states share some important similarities as well as additional differences. Most notable amongst these similarities is that each state has a Republican governor and Republican majority control in the upper and lower chamber of the legislature. The states vary in interesting and important theoretically different ways, including:

1. Variation in how the state implemented the Medicaid expansion across the three states.

Michigan received a waiver to expand their program, modifying their existing Medicaid (pre-ACA) program and adding several unique components to the program. Arizona implemented a “traditional” Medicaid expansion, by merely expanding the eligibility of their existing program, without making any additional changes. Lastly, Utah initially sought a waiver to expand Medicaid, but was ultimately unable to implement the expansion. Eventually the state implemented a “partial” expansion of Medicaid, with only a marginal increase in the number of eligible individuals enrolled in the program.

2. Although each state has Republican majority control of the legislature, there is variation in the margins that each state’s Republican Party has in both bodies. On one extreme, Utah’s Republican Party held nearly 79% of all legislative seats in the House of Representatives and

the Senate. The two remaining states were much more evenly divided, with Republicans holding 57% of all legislative seats.

3. Even with Republican control over the executive and legislative branches, there is variation in how the national politics played out in each of the states. One of the states (Michigan) voted for Barack Obama in the 2012 Presidential election, with the other two (Arizona and Utah) going for Mitt Romney. Utah has been a consistently conservative state when it comes to national elections, while Arizona has been closer to becoming a contested state during national elections.
4. While all Medicaid program vary in important ways, these differences are particularly acute across these three states. Over the last several decades, Medicaid Managed Care has grown in popularity with state policymakers, with over 80 percent of Medicaid beneficiaries enrolled in a managed care plan. All of Arizona's beneficiaries are enrolled in their Managed Care plans, Michigan with the 19th highest penetration rate of Managed Care Plans, and Utah with the 33rd highest penetration rate of Managed Care Plans. The number of Medicaid Managed Care Organizations also varies, with Arizona ranking 7th with 13, Michigan ranking 9th with 11, and Utah ranking 22nd with 4 organizations.
5. All three of the states have previously received a Section 1115 Waiver, but two of the states (Arizona and Utah) have only received one waiver, while Michigan (11 waivers) has been one of the most active states at pursuing waivers. The intensity of the waivers though also varied. In Arizona's one waiver, they changed their entire Medicaid program, becoming the first state to implement a managed care plan for the population.
6. There is also variation in familiarity with a state in implementing other components of the ACA. None of the states have implemented a state-based marketplace. However, Michigan

implemented a Partnership exchange and Utah has a hybrid exchange, where the small group and individual exchange is on the federally facilitated marketplace and the Small Business Health Options Program (SHOP) program is state-based. With Arizona leaving both their individual and SHOP exchanges on the federally facilitated marketplace.

7. With the rate of uninsurance in the total United States at 13% in 2013 (prior to Medicaid expansion and the implementation of other key components of the ACA) the three states demonstrate variation in the insurance status of its citizenry. Arizona had the second highest rate of uninsurance in the nation, at 19% of the total population. Whereas the remaining two states came in under the national average, with Utah's uninsurance rate at 12% and Michigan at 11%.
8. There is institutional variance amongst the three states. Michigan's Legislature meets all year round, allowing those states to potentially have more opportunity to address legislation related to Medicaid expansion. Conversely, Arizona's legislature meets for 100 days and Utah's meets for only 45 days each year. Michigan and Arizona limit their elected representatives to three terms maximum, while Utah do not place any term limits on legislators. Additionally, the states vary in their administrative capacity, as measured by Burke and Wright (2002) analysis. Michigan's administrative capacity is ranked 1st in the nation, Utah is ranked 10th, and Arizona is ranked 33rd.
9. There is variation in the ethnic composition of the states included in the analysis. Looking at the African-American population, Michigan has the 17th highest percentage of state population, with Arizona as the 36th and Utah as 44th. Arizona has the 4th highest percentage of its population that identifies as Hispanic or Latino, Utah has the 13th highest percentage of its population, and Michigan is 38th. As for age, of the three states Arizona has the highest

proportion of their state population over the age of 65, ranking as the 10th oldest state, Michigan is ranked 18th, and Utah is 49th overall in age.

Taken together, the similarities and differences across each of the case studies allow me to identify and study the factors that were identified by fsQCA as important in understanding the implementation of Medicaid expansion, as well as to explore other interesting theoretical and practical considerations related to Medicaid expansion.

Chapter 5: Utah: Intra-Party Divisions, Policy Entrepreneurs, and Failed Expansion

“But this is a thing more ardently to be wished than seriously to be expected.”
- Alexander Hamilton, Federalist No. 1

Perhaps no state which actively pursued expanding Medicaid was as surprising as Utah. The state had not elected a Democrat to state-wide office since 1996 (Jan Graham was elected for two terms as Attorney General from 1993-2001) (Maddox and Fahys 1996). The state had not elected a Democratic governor since 1980 (Peterson 1984), no United States Senator since 1970 (Guthrie 1977), and the Democratic Party had not held a majority in either chamber of the legislature since 1961 (The Council of State Governments 1962).

The trend of Republican monopoly over state political apparatuses in Utah has only been strengthened in recent years. During the 2008 presidential election, Barack Obama carried 3 Utah counties (an improvement over John Kerry’s showing in 2004), but was outpaced by John McCain by nearly a two-to-one rate in the total vote counts. Obama’s 2012 reelection campaign fared worse against Utah’s favorite son, Republican candidate Mitt Romney, representing Obama’s worst electoral defeat during his two presidential elections, losing to Romney by 47 percentage points in the state (The New York Times 2012). The state legislature saw similar coalescing of Republican hegemony in both its chamber. From 2012-2016, Republicans on average held seventeen more seats in the Senate (out of a total of 29) and 43 more seats in the House of Representatives (out of a total of 75) than their Democratic counterparts. In both cases, the margin of control had increased over the previous decade.

Gary Herbert, the popular Utah governor, indicated his antagonistic stance towards the Medicaid expansion, when he called the ACA “a one-size fits-all plan” with a “massive, budget-busting Medicaid expansion” on the same day as the *NFIB v. Sebelius* Supreme Court decision (Herbert 2012). There was little support for expansion by other policymakers in the state. Speaker of the House Rebecca Lockhart called Medicaid expansion “coercion” and that the long-term funding obligations for the state were unsustainable (Stewart and Gehrke 2012), while Senate President Wayne Niederhauser called expansion a budget breaker for the state (Stewart 2012).

Yet, even with this background, Utah was closer to expanding Medicaid than nearly any other state, other than Maine and Kansas (where Republican governor’s vetoed expansion legislation). Utah’s experiences demonstrate the fracturing of the Republican Party in response to the Medicaid expansion. The fracturing was evident at three levels. First, a series of entrepreneurial policymakers provided the Republican Party a litany of different policy options for the expansion. The abundance of policy options caused splintering and indecision amongst legislators. Second, there was inter-chamber conflict over differing expansion plans. The 2013-2015 legislative sessions are marked by the persistent inability for the Senate and House of Representatives to come to any agreement over the programmatic details of the Medicaid expansion plans. Lastly, there was inter-branch conflict. Governor Herbert was a supporter of expanding Medicaid and his stance on expansion wracked the executive-legislative relationship.

Ultimately, Utah fell short in implementing the Medicaid expansion, eventually opting for a partial expansion of coverage of its population. Utah’s experiences highlight the limits of executive power in making implementation decisions, the role of strategic actors, institutional

design, and the role of the most powerful entity in the state, the Mormon Church, influenced whether and how the state implemented the Medicaid expansion.

Institutional Design and Limits on Power: Initial Response and 2013 Utah Legislative Session

Governor Herbert initially expressed deep skepticism towards the Medicaid expansion, primarily driven by his efforts to deflect Tea-Party backed primary challengers for his first reelection campaign (Herbert saw the danger of a conservative primary challenger first-hand when the darling of the Utah Tea-Party, Mike Lee, defeated moderate three-term Senator Bob Bennett in the Republican Primary in 2010). The governor's early stance on Medicaid expansion reflects those political concerns. In the initial aftermath of the Supreme Court decision, Herbert argued that Medicaid expansion was a non-starter because of the financial stress it would place on the state and federal government. If the state expanded the program, it would mean that Utah would receive "Chinese dollars"(Gehrke and Stewart 2012) and that "the road of good intentions is paved, not with gold, but with taxpayer money. Whether it takes you to hell or not, it's going to cost you a lot of money"(Gehrke and Stewart 2012). Yet, once Herbert successfully ran for reelection in November 2012, he struck a much more thoughtful and nuanced tone towards expansion. In the days following his re-election, the governor contracted for a cost-benefit analysis by Public Consulting Group (McEntee 2013) and called for being "careful and cautious going forward"(Gehrke and Dobner 2013) because there "are a lot of questions out there that haven't been answered"(Clark 2013).

As the state waited on the cost-benefit analysis, two bills introduced during the 2013 Legislative session and debated during the same House Business and Labor Committee meeting on March 6th, highlighted the role that of inter-party and inter-chamber disagreement going

forward (Utah State Legislature 2013). First, House Bill 153 would simply require the Utah “Department of Health to amend the state Medicaid plan to expand Medicaid eligibility to the optional populations” as called for under the ACA (2013). HB 153 was a long-shot to gain any traction in the House, though it did have bi-partisan support through its Senate sponsor, Brian Shiozawa (R). Shiozawa, an emergency room physician and previous president of the Utah Medical Association, had served on Governor Herbert’s Healthcare Task Force, prior to his election to the Senate in 2012 (Interview). Newly elected to the Senate and with no prior political experience, Shiozawa was often the lone Republican supporter for various public health related legislation, including expanded medical marijuana research (2016), mandated motorcycle helmets (2017), and restrictions on concealed weapons (2017). Over the course of the next three years, Shiozawa, with no official leadership position, became the main policy entrepreneur associated with the Medicaid expansion in the Senate. With Republicans holding a majority of membership on the House Committee, HB 153 was unsurprisingly sent back to the Rules Committee where it died at the end of the legislative session. However, this first attempt of a traditional expansion, demonstrated that Republicans would not uniformly reject the option under the ACA.

After discussing the traditional expansion bill, the Business and Labor Committee debated a bill that was the complete opposite. Initially, HB 391 was a short statement that declared the ACA null and void in Utah, a sentiment that legislative analysts for the state argued would likely be found unconstitutional by the courts. After debating the legality of nullification, committee members added new legislative language which would restrict the actions of the Governor in making implementation decisions related to the expansion. Herbert or any subsequent governor would be prohibited from expanding Medicaid unless the Legislative

Health Reform Task Force conducted an analysis of the charity care system, the Utah Department of Health and Human Services has completed an analysis of the impact of expansion on state budgets, and the Legislature had given their approval.

Supporters of the new language argued that expanding Medicaid is “not an executive decision, it’s a spending decision” and the Legislature has the right to weigh in on it (Clark 2013). Another Representative offered a religious dog-whistle for the measure by modifying Mormon theology and scripture when he declared that “it’s the nature and disposition of man and government to amass unbridled power” and that it was the responsibility of the state to check Federal power (Bammes 2013). Tying the hands of the executive did not come without intra-party divisions though. While HB 391 was passed favorably out of the Business and Labor Committee, with a vote of 9-6, three Republicans joined the three Democrats on the committee in voting against the bill. Senate Republicans were concerned that the bill would limit the Executive’s options going forward and could hinder negotiations with the federal government (Evans 2013). While Herbert assured his Republican colleagues that he would “counsel with lawmakers as part of a thoughtful, methodical process”(Clark 2013), the bill was passed out of the Legislature and signed by the governor with bi-partisan dissent in both chambers (Utah State Legislature 2013).

**Inter-Branch Conflict and Interim Committees: Role of Workgroups and Task Forces,
April 2013-November 2013**

After the 2013 Legislative session ended in Utah, three events occurred which would play a part in the implementation decision within the state. First, the Utah Department of Health released a cost-benefit analysis from the Public Consulting Group with five different scenarios related to implementing the Medicaid expansion. The initial options requested by the state for

analysis set a template for the legislative events over the next three years. At this early stage, the state wanted to know the effect of not expanding, a full expansion, and several different variations of partial expansion. While the exact details varied somewhat, going forward Utah would continue to consider each of these three policy options. This early cost-benefit analysis identified the full expansion as the most cost-effective for the state and beneficial for its citizens.

At the same time that the first cost-benefit analysis was received, two separate groups formed by the state began to examine the Medicaid expansion. The first group that was formed was established by Governor Herbert as the “Medicaid Expansion Options Community Workgroup” (Utah Department of Health 2013). The group first met in April 2013, with meetings scheduled monthly throughout the summer, with a presentation to Herbert at the end of September 2013. Comprised of 19 individuals: including four members of the State Senate (3 Republican and the Senate Minority Leader), policy advocates supportive of expansion from the Utah Health Policy Project and Voices for Utah Children, policy advocates oppositional to expansion from the Utah based conservative think tank the Sutherland Institute and the Utah Taxpayers’ Association, representatives from the Chamber of Commerce, as well as the CEO of Utah Hospitals & Health Systems Association and the two largest health systems in the state, Intermountain Healthcare and University of Utah Health Care (Leonard 2013).

During the introductory meeting, the work group examined several different options and features of an expansion plan. From this early stage of the decision-making process, Utah policymakers had begun to focus in on options that would provide the state maximum flexibility, including pursuing Section 1115 and 1332 waivers. The workgroup was also keenly aware of what was occurring in other states. Members of the group reported having conversations with architects of the Arkansas premium assistance model, as well as the feasibility of a provider tax

to offset state costs for expansion (Utah Department of Health 2013). Throughout the summer of 2013, the workgroup divided into separate sub-groups, formed along ideological and organizational similarities to develop and propose different options. Ultimately, the group devised seven different policies the state could use to move forward with expansion, mirroring the options examined by the Public Consulting Group, though with greater emphasis on flexibility for a partial expansion that would be difficult if not impossible to receive federal approval (Utah Department of Health 2013).

The second group that was organized to analyze and suggest options related to the Medicaid expansion was the Legislative Health Reform Task Force. Formed in 2008 by then Governor Jon Huntsman Jr., the task force was commissioned to make expanding health insurance coverage a priority, while also examining mechanisms for reducing costs in the state (Thalman 2008). While predating passage of the ACA, the task force was responsible for analyzing, debating, and developing legislation that would then be taken up by the whole legislature. With membership from both the House and Senate and a co-chair from each chamber, the committee, similar to standing committees tilted heavily towards Republican representation.

Similar to the Governor's Task Force, the overriding emphasis amongst the Legislative Task Force was flexibility. Even as other Republican states rejected the Medicaid expansion, for the task force, Utah would "not be the state of 'no,' we are the state of 'we have solutions, give us some flexibility'" (Leonard 2013). Meeting monthly and with public input, the Legislative Task Force devised nine potential options for expansion. In November 2013, on the eve of the start of the 2014 legislative session, the Legislative Task Force made a formal presentation and recommendation for three policies for Governor Herbert and the Legislature to consider (Utah

Health Reform Task Force 2013). The first option would be for the state to do nothing. The second option would require a Section 1115 waiver to complete a partial expansion of Medicaid up to 100% of the federal poverty level, with individuals with higher incomes purchasing insurance covered by tax credits in the marketplace, but which the federal government would only pay for 70% of the cost (reflecting Utah's FMAP prior to the ACA). The last option, with Arkansas receiving formal approval from the federal government, would mimic the private option and provide premium subsidies for the newly eligible (Health Reform Task Force 2013).

Intra and Inter-Chamber Conflict, 2014 Legislative Session

With recommendations from two state task forces, the stage was set for Governor Herbert to announce which policy option he would pursue related to Medicaid. On January 23, 2014, during a wide-ranging press conference Herbert was asked “when you're going to announce whether we'll expand Medicaid”. In response to the question, Herbert remarked that after studying all of the options presented to him, that “Doing nothing...I've taken off the table. Doing nothing is not an option” (Stewart and Gehrke 2014). Herbert went on to say that “We have about 60,000 people in the state of Utah that live below the poverty line which, because of just flaws in the Affordable Care Act, will not have the coverage that is necessary for them to access good health care” and that the coverage gap was “not right, it's not fair, and I'm going to work with the Legislature to find a solution to that problem. We have 45 days and we will have a solution by the end of the session” (Herbert 2014).

Legislative response to Herbert's statement, which portended future challenges for Medicaid expansion, came swiftly. The 2014 Utah Legislative session began on January 27th, only a few days after Herbert's remarks about Medicaid. Traditionally, the Speaker of the House and Senate President use their opening addresses to set the tone for the upcoming session and to

offer trite promises of bipartisanship and reminders of serving the public good (Interview). However, by 2014, after Herbert announced his intentions on Medicaid, Speaker of the House Becky Lockhart used her opening address to excoriate Herbert, stating that Utah needed an energetic leader in the state to stand up against federal intrusion and that the House should “encourage the Governor to lead and not just follow, to be innovative and not just reactive. We need energy in the executive and not an inaction figure in the Governor’s Office” (Smardon 2014). Lockhart went on to say “I cannot support and I do not understand why anyone would propose to saddle Utah any further with Obamacare. It’s an out in the open bait-and-switch, guaranteed to leave us worse off and sooner than we think” (Utah House of Representatives 2014). Lockhart’s comments raised the eyebrows of policymakers in the Capitol (Interview). Former Speaker of the House Dave Clark remarked that while there has “always been tension and frank discussions (between legislative leaders and the governor), typically those discussions aren’t done on the front page of the paper or in opening remarks”(Gehrke 2014). Herbert, for his part, replied to the opening speech to say that he welcomed “the Legislature back into general session and look forward to working with them. I hope we can all set aside politics and political ambition and focus on the work of the people of Utah”(Roche and Rombo 2014).

Lockhart’s comments and her intransigence against the Medicaid expansion were partially attributable to her conservative bona-fides, as well as the open secret that she would challenge Herbert for Governor in the 2016 election (Interview). Lockhart, married to an influential lobbyist in the state and former Chairman of the Utah Republican Party, was elected to the House in 1999 and rose quickly through the ranks of the House leadership (Roche 2010). Utah has a very hierarchal leadership (Interview); the previous four Speakers of the House had ascended from the position of House Majority Leader and only after the current Speaker had

retired or had been defeated in a re-election campaign (Rolly 2014). Lockhart, serving as the Assistant Majority Whip, was spurred to run for the highest office in the House when in 2010, then House Majority Leader Kevin Garn announced on the floor that he and an underage teenage girl had hot tubbed nude and that he had bribed the girl to remain silent. In response to this admission, the Speaker of the House led a standing ovation for Garn. Lockhart was troubled by the actions and led to her efforts to become Speaker of the House (Hesterman 2014).

With Speaker Lockhart challenging Herbert, whatever plans the governor's office had for the Medicaid expansion would require a deft political hand. Instead, the 2014 Legislative session highlighted how multiple policy options and inter-chamber disagreement would stifle efforts to expand Medicaid.

Healthy Utah Plan

As members in both the Senate and House were working on writing legislation to address the Medicaid expansion, Governor Herbert and his office had been in negotiation with the Obama administration on a plan to expand Medicaid through a waiver (Interview). In February 2014, Herbert unveiled his own "Utah solution" for Medicaid, the Healthy Utah Plan. Envisioned as a three-year pilot program, the Healthy Utah Plan would request \$258 million in block grants that the federal government would have sent to Utah to expand Medicaid, providing the state the flexibility and financial risk, of administering their own program (Utah Governor Gary Herbert 2014). Herbert was quick to point out that he was not "recommending an expansion of the federal Medicaid program. However, I am prepared to pursue a block grant from the federal government to bring Utah taxpayer dollars back to our state to fulfill our responsibility to care for the poorest among us" (Utah Governor Gary Herbert 2014).

The block grant approach to expanding Medicaid was a twist on what other waiver states (Arkansas, Michigan, Iowa, Indiana, and Pennsylvania) had applied for. These earlier waiver states had received approval for expansion, in some cases with original approaches to purchasing private insurance, but none of them had successfully received permission for a block grant. The Healthy Utah Plan also included what Herbert called a “work effort benefit”, which other waiver states had failed to receive federal approval for. Herbert’s plan would have automatically enrolled any individual who was eligible for Medicaid, but who was not employed, into a state developed program which would teach work training and job search skills (Office of the Governor of Utah 2014). The governor’s office projected that the Healthy Utah Plan would enroll 140,000 individuals during the duration of the three year pilot program (Office of the Governor of Utah 2014).

While unveiling his plan, Herbert mentioned that he was “optimistic” that he would receive federal approval for his plan and that he had discussed the plan with officials at HHS during a National Governors Association meeting (Roche 2014). While others argued otherwise, Herbert didn’t see his Healthy Utah Plan as a “Hail Mary’ touchdown throw” but as a “legitimate opportunity to do something that I think is going to be a game changer” (Roche 2014).

However, the need for a Hail Mary for Herbert was to convince Republicans in the House and Senate to approve his plan. With Speaker Lockhart arguing that “It would be irresponsible for the State of Utah to perpetuate reliance on federal money and continuance and reinforcement of a socialized medical system”, the leadership of the House was set against any plan that would require negotiations with the Obama administration or tap into funds made available through the ACA (Office of the Governor of Utah 2014).

Utah's Legislature only stays in session for 45 days a year. With Senate and House legislators waiting for guidance from Herbert, the timeline of writing, vetting, and getting support for a proposal that would affect state finances and health outcomes faced difficult challenges for enactment. Considering the level of political party uniformity evident in the state, there was no cohesive or over-riding vision for what kind of program should be implemented by the state, if at all (Interview). In the aftermath of Herbert's announcement of the Healthy Utah Plan and in the waning moments of the 2014 session, Both the Senate and the House unveiled their own plans to expand Medicaid.

Senate Expansion Plans, 2014 Legislative Session

On the same day as the unveiling of the Healthy Utah Plan, the Senate Health and Human Services Committee heard debate over Senate Bill 251, sponsored by Senator Shiozawa. SB 251 mirrored the type of Medicaid expansion that Hebert envisioned. For Shiozawa, his bill "merely gives the governor the ability to go back without his hands tied to negotiate in good faith for the state of Utah for a block grant for these patients. We retain legislative oversight" (Gehrke 2014). With Republicans controlling so many levers of the political apparatus in Utah, Democrats had little chance to effect policy. Under most policy domains, members of the Republican Party in Utah have a high level of cohesion and similar policy preferences (Interview). However, debate over Medicaid expansion uncovered rifts amongst Republicans. Passage of SB 251 was only accomplished because there was unified Democratic support for the bill.

It wasn't until the last week of the 2014 Legislative session before SB 251 would be debated on the floor of the Senate. With a split Republican caucus, supporters of SB 251 were very careful in how they framed their support for Medicaid expansion, quickly divorcing their support for expanding Medicaid with the broader goals or actions of health reform. These

Republican supporters cast aspersions on the ACA for creating the coverage gap which the state now had to deal with (2014) and couched their support in economic and financial terms.

Supporters even called voting for SB 251 as their least favorite action during the session and that “we have no options that I consider good. This is the best of the bad options before us” (2014).

After two days of debate, supporters of the bill were able to cobble together a coalition of Democrats and Republican members and the bill ultimately passed 19-6, with all six of the oppositional votes coming from Republicans.

House of Representatives Expansion Plans, 2014 Legislative Session

While the Senate was considering SB 251, the House was hearing debate on its own legislation related to the Medicaid expansion. House Bill 401 would have created what supporters called the Access Utah plan. Unlike their Senator compatriots, HB 401 was a rejection of Herbert’s Healthy Utah Plan and would create a two-year pilot program for individuals below 100% of the federal poverty level, using state money to cover the uninsured in the state, costing the state up to \$150,000,000 over the two year period of time and provide insurance coverage to just 54,400 people (Utah House of Representatives 2014). By both metrics, the Access Utah plan compared unfavorably to the Healthy Utah Plan. Yet, for Majority Leader and House sponsor Jim Dunnigan, that was a feature not a bug. The two year time period was viewed as a stopgap measure before the state could apply for a 1332 waiver and allow the state to gather information about the true costs of the expansion (Interview).

With the session waning, Speaker Lockhart kept to her promise that she would not entertain debate over any bill which would expand Medicaid and would draw down federal funds which had been made available by the ACA (Gehrke 2014). After the House of Representatives received SB 251, the House Rules Committee struck the enacting clause, killing the bill before it

could be heard in Committee or debated on the House floor. The Access Utah plan represented the only viable option for the state to expand Medicaid in 2014, yet even after receiving a favorable recommendation from the House Business and Labor Committee, there was no push from House leadership to send HB 401 to the full House floor for debate (Interview). House Republican leadership decided that Medicaid expansion represented a “generational decision” and that it was too important to try and hurry through the remaining days of the legislative session, as then Majority Whip Greg Hughes said “irreversible decisions ought to be made with as much deliberation and as much information as you possibly can” (Gehrke and McDonald 2014).

With only a few days remaining in the legislative session, Herbert was optimistic that he would be able to come to agreement with House and Senate leaders, even if it meant that “maybe it's a plan to have a plan” for how to best proceed on expansion (Gehrke 2014). With Herbert and Lieutenant Governor Spencer Cox meeting privately with the House and Senate Republicans (Interview) and staging photo-ops at federally qualified health centers (Stewart 2014) to bridge the divide between the Healthy Utah Plan and Access Utah plan, but significant differences still remained between the different branches of government (Interview).

With the House and Senate at loggerheads and no feasible path forward in either chamber, Dunnigan, the floor sponsor of the House’s partial expansion bill, amended his plan to instead require the Health Reform Task Force to “study programs to provide access to health care to individuals eligible for Medicaid” (Utah House of Representatives 2014), the same Legislative committee which had provided their recommendations just three months previously. All Herbert asked was that whatever the chambers decide to do on Medicaid, “don't tie my hands. Let me go back and try to negotiate the best deal I can for Utah” (Gehrke and McDonald

2014). The substitute House bill allowed Herbert and supporters of the Healthy Utah Bill to regroup and build a coalition for expansion, while also striking a deal with the federal government which could further encourage reticent Republicans to support the Healthy Utah Plan. Kicking the can down the road was the only policy option, which Speaker Lockhart allowed on to the House floor, passing the lower chamber 60-12, with only Democratic House members objecting. The Senate, with their hands tied by the House, similarly passed HB 401 on the last day of the legislative session.

Inter-governmental Negotiations and the Insurance Exchanges

Implementation decisions related to the Medicaid expansion were not the only health reform related policy that states had in the wake of the ACA. As the Herbert administration sought to finalize negotiations with the Obama administration over the Healthy Utah Plan, prior inter-governmental negotiations highlighted the familiarity that Salt Lake City had with the workings of Washington, D.C. Utah's experience with implementing insurance marketplaces demonstrates the dexterity and familiarity at negotiating with the Obama administration.

In May 2007 Governor Jon Huntsman and others in the Capitol decided that they wanted to mimic Massachusetts' health reform in Utah, though they did not have the political capital to include an individual mandate, they did find the idea of online marketplaces attractive (Interview). Because of the large number of individuals in the state who work in small businesses and independent contractors affiliated with multi-level marketing (Caruso 2015), experts from The Heritage Foundation and Harvard Business School crafted an exchange that would focus only on businesses with fewer than 50 employees (Interview). This online insurance exchange, called Avenue H, was operational prior to passage of the ACA and representatives from the

governor's office met with and helped guide the federal framework, principles, and regulations on the ACA exchanges (Interview).

With their prior experience operating an exchange, Herbert and his cabinet were debating what type of exchange to have for the state after the passage of the ACA. They were told from the same federal officials that they had helped develop the regulatory framework for the ACA insurance exchanges that Utah could only operate both an individual marketplace and SHOP exchange and that Avenue H would need to be shut down. Herbert's administration and the legislature were livid about having to close down something they had worked so hard to establish (Interview). In late 2012, the Herbert administration came up with the idea to bifurcate the exchanges, using Avenue H as the SHOP exchanges and a federally facilitated marketplace for the individual market exchanges (Interview). After meeting with Secretary Sebelius and Cindy Mann (Deseret News Editorial 2013) and three months of negotiations with HHS, the federal government signed off on the plan (Dobner 2013). Herbert was confident that with his successful history of entering into negotiations with the federal government and getting concessions on the implementation of exchanges, that his office would be able to negotiate with the Obama administration and come to an agreement that would gain approval from the federal government and be conservative enough to gain support amongst Republicans in the House of Representatives (Interview).

Inter-governmental Negotiations: April 2014-December 2014

With the Legislature pushing the Medicaid expansion off for a year, Herbert and his aides used the additional time to continue negotiations with the Obama administration and to work on finalizing federal approval for the Healthy Utah Plan (Interview). Starting the week after the Legislature ended officials from the Governor's office met with CMS officials, which the state

policymakers felt was well received in Washington, D.C. (Interview). The initial plan in the Governor's office was that with the combination of changes in what had been approved in other states (Arkansas, Pennsylvania, Iowa, and Michigan had all received federal approval for a waiver to expand Medicaid while Utah had debated the Healthy Utah Plan) and the allure of adding another Republican state to the stable of expansion states would fast-track negotiations with HHS (Interview). In April 2014, Herbert went to the White House to meet with Obama and Secretary Sebelius, and Herbert, quoting Sebelius reported that there was "nothing here (Healthy Utah Plan) that would be a deal breaker"(Burr 2014).

As Herbert called it during his meetings, he was hoping to capitalize on the "growing understanding in the Obama administration or the need for states to have more flexibility, to be able to address their own unique demographics, their own unique political situations" (Roche 2014). Herbert's aides echoed this statement, when they found that "the federal government can be much more agile than we've experienced before in terms of being able to talk back and forth about issues"(Stewart 2014). The Governor expressed optimism after his meetings in Washington, D.C. that within months, if not weeks, the state and the federal government would have their waiver finalized and that Herbert would be able to bring a proposal to the Legislature that will have the support of Republicans (Interview). As with much of his predictions on expansion, Herbert was overly optimistic and wildly mistaken.

Throughout the summer of 2014, as Herbert's aides continued to negotiate with the Federal government, one sticking point was the work requirement (Interview). Unfortunately for Herbert, the governor had repeatedly and loudly extolled the virtue and necessity of including the work requirement in any waiver or expansion of coverage in the state (Interview). The work requirement was the "last issue" before the framework for expansion was signed-off (Health

Reform Task Force 2014). Even as the Herbert insisted that the state was close to an agreement on the work requirement, the State hired legal experts in Washington D.C. and Utah to determine if there was a loophole to legally allow the work requirement to be included in the Healthy Utah Plan, even as other states had moved on from a similar requirement in their waiver applications (Moulton 2014, Worden 2014).

While Herbert privately expressed hope that he would be able to call the Utah Legislature back for a special session, Speaker Lockhart publically quashed those hopes when she announced that “this involves a lot of money potentially to the state of Utah, to our taxpayers, so I think what you're seeing is a desire to do this in a general session environment, as opposed to a special session environment. This is almost what you'd call a permanent decision and it needs to be made very carefully and very slowly.” Senate Republicans echoed that sentiment that Medicaid expansions decisions shouldn't occur in a “one-day session”(Gehrke 2014). Majority Whip Brad Dee encouraged his fellow Republicans in a caucus meeting to not consider the expansion plan “in a vacuum”, but rather to “view the entire budget and compare those together”(Moulton 2014).

Inter-branch Divisions, Summer 2014

Highlighting the divisions between the legislature and the executive branches on the Medicaid expansion was the actions of the Legislative Health Reform Task Force. While Herbert acknowledged the difficulty in asking the Legislature to “vote up or down on the Healthy Utah Plan, because we don't have all the details or specifics in place”(KUED The University of Utah 2014). Leadership on the Task Force openly rejected the need for expanding coverage, Senator Allen Christensen, one of the co-chairs of the committee, remarked that some of the individuals in the coverage gap “who don't need it, don't want it...some of them are rich people who just

want an easy way to walk into Maliheh Clinic (a free clinic located in South Salt Lake City) out there and get taken care of. Many of them are the illegals who are here and don't qualify for anything supposedly” (Stewart 2014).

Christensen was not the only Republican policymaker to use extreme language to describe their opposition to expanding Medicaid. Representative Mike Kennedy, a family physician and lawyer (Robinson 2015), as well as member of the Health Reform Task Force, questioned the efficacy of expanding access to health care providers. During a presentation given by a University of Utah physician, Kennedy remarked that “Sometimes access to health care can be damaging and dangerous. And it's a perspective for the body to consider is that, I've heard from National Institutes of Health and otherwise that we're killing up to a million, a million and a half people every year in our hospitals. And it's access to hospitals that's killing those people” (Roth 2014).

As the Health Reform Task Force met throughout the summer, they continued to hear presentations and updates from the Governor’s office, business leaders, academics, and the general public on the effects of the Healthy Utah Plan and other models for expanding Medicaid (Health Reform Task Force 2014). Uniformly, these presentations pointed to the need for the state to expand Medicaid. At the conclusion of one cost-benefit evaluation, the economist called the analysis straightforward and boring, “There are no significant tradeoffs, no significant upfront costs. Utah is already paying for expansion. The answer is painfully obvious”(Bennett 2014, Utah State Legislature 2014).

Inter-governmental Negotiations: Healthy Utah Plan’s Conceptual Framework, September 2014-December 2014

In Fall 2014, Governor Herbert announced that the state and the Obama administration had come to a conceptual agreement on the Medicaid expansion. The last remaining sticking point, the work requirement, was now referred by Herbert and his aides as a “work effort requirement”, with the arrangement that employment can be a goal of the Healthy Utah Plan and that the state can offer work training as a benefit for able-bodied individuals who receive subsidies to purchase insurance. Herbert, nor any of his cabinet heads or aides never publically used the phrase “work requirement” again (Interview). Calling the conceptual framework a “win, win, win all the way around”, Herbert proclaimed this his plan was “breaking new ground” and would provide a “better way to provide health care to the people of Utah”(Moulton 2014).

Republicans in the Legislature seemed unimpressed with the rhetorical sleight of hand performed on the work requirement. Representative Robert Spendlove, who prior to his election to the legislature was a key policy advisor to Governor Herbert, told the Task Force that “We are talking about able-bodied people that can work. Not having a work requirement I find very troubling”(Utah State Legislature 2014).

With the announcement of a conceptual framework complete, conservative groups within Utah and nationally began to actively oppose the Healthy Utah Plan. Considering the deep-red nature of the state, there was a surprisingly strong public support for Medicaid expansion in Utah. Polling in the wake of the failed efforts to expand Medicaid during the 2014 legislative session found that more than three-quarters of respondents supported the use of federal funds made available under the ACA to finance a Medicaid expansion and that there was four times as much support for Herbert’s Healthy Utah Plan in comparison with the House-supported Access Utah plan (Monson 2014). Regardless of age, income, or political leanings, polling found

majority support for the Healthy Utah Plan or the traditional Medicaid expansion over doing nothing at all (Stewart 2014).

However, within weeks of Herbert's announcement over the conceptual framework, a poll from a conservative think tank in Salt Lake City was conducted which gave reticent legislatures coverage to oppose the Healthy Utah Plan. The Sutherland Institute found that the policy option with the highest percentage of support was "to do nothing" with the Medicaid program and leave it as it stands (Sutherland Staff 2014). National groups were also spurred to action by Herbert's announcement of a finalized conceptual framework for expansion.

Federalism in Action released a report in September 2014 which railed against the Healthy Utah Plan and argued that if the state expands Medicaid, "it will become increasingly dependent on Uncle Sam" (Moody 2014). The Foundation for Government Accountability also jumped into the fray, publishing an op-ed in *Forbes* which railed against the Healthy Utah Plan and called it a new "entitlement for able-bodied adults" that will harm Utah's economy and purchased a URL, www.unhealthyutah.com, to host an online petition for Utahns who disagree with Herbert's plan (Ingram, Horton et al. 2014).

Interest Group Response to Healthy Utah Plan: The Role of the Church of Jesus Christ of Latter-day Saints, December 2014

In the first week of December 2014, Herbert official unveiled his Obama administration supported Healthy Utah Plan. During a press conference in the Capitol building, for the first time the governor was surrounded by industry, business, and faith leaders. Herbert couched his pursuit of the plan as "not a result of policies enacted here in Utah. The problem we are trying to solve comes as a result of a federal policy failure known as the Affordable Care Act. While I continue to support efforts at the federal level to fix the ACA or to repeal and replace it, the simple fact is,

Utah must deal with the realities of the law and make the best deal we can for ourselves” (Herbert 2014). Herbert went on to extol those individuals who fall into the coverage gap, as “single mothers, they are low-income adults, they are families with children. Two out of every three of them are employed, many working more than one job to make ends meet. Of the other third, many are the medically frail, who have conditions that make it impossible for them to work. They are our neighbors, our friends and our family members” (Herbert 2014).

One of the most striking features of the press conference was the silence of Utah’s most powerful organized interest, the Church of Jesus Christ of Latter-day Saints (Mormons) (Interview). Nearly two-thirds of the state population identifies as Mormon (The Church of Jesus Christ of Latter-day Saints 2017) as well as nearly ninety percent of the state legislature (Davidson 2016). Yet, when Herbert made his announcement, only one representative from the Mormon Church was present on the dais, Elder Gary E. Stevenson, and he did not move, nor did he utter a single word. The Mormon Church is very hierarchal, with a single individual acting as the President of the organization, followed by twelve other administrators. At the time of the press conference, Stevenson was not included in the top echelon of the Mormon organization. The only religious leader who spoke during the press conference was Reverend John C. Wester, of the Salt Lake City Archdiocese.

The day after Herbert’s press conference, the Church issued the following statement through their Public Relations department:

"We recognize that providing adequate health care to individuals and families throughout Utah is a complex and weighty matter. It deserves the best thinking and efforts from both the public and the private sectors.

"While the economic and political realities are being debated, we hope the discussion and decisions taken in this matter will be consistent with the God-given principles regarding care for the poor and the needy that in the end benefit all of His children. We reaffirm the importance for individuals and families to be as self-sufficient as their particular

circumstances allow and recognize that the lack of access to health care can impair a person's ability to provide for self and family.

"We commend public officials for their efforts to grapple with these difficult issues and pray for their success in finding solutions that reflect the highest aspirations of society"(The Church of Jesus Christ of Latter-day Saints 2014).

The Church's statement was a Rorschach test, lawmakers and the public could read the statement and pull out different and conflicting statements. Members of the legislature who were oppositional to expansion highlighted the importance of encouraging individuals to be "self-sufficient" and used those phrases to support their stance against the Healthy Utah Plan (Interview). Others who were supportive of expansion would cite the need for supporting "the God-given principles regarding care for the poor and the needy" whilst advocating for the Healthy Utah Plan (Interview). In both cases, policymakers believed that they were acting in accordance with the wishes of the Mormon Church. This was intentional on the part of the Mormon Church (Interview). Leaders of the church did not coalesce around a particular stance on the Medicaid expansion and did not use its resources to pressure the legislature to act (Interview).

The response of the Mormon Church to a different policy at the same time as the Medicaid expansion debate during the 2015 legislative session demonstrates the power of the organization in Utah politics. The Mormon Church has a long-history of providing money and resources against legislation which supports gay-marriage or the LGBT community, most famously with their involvement with the debate over Proposition 8 in California (McKinley and Johnson 2008), when a Church authored press release was read over the pulpit of all 1300 congregations within the state, encouraging its members to donate "of your means and time to assure that marriage in California is legally defined as being between a man and a woman" (The

Church of Jesus Christ of Latter-day Saints 2008). Yet, in 2015 there was a remarkable détente between the Mormon Church and the Utah LGBT community.

Prior to the 2015 legislative session, the same piece of legislation which would prohibit prohibiting discrimination over sexual orientation or gender identity had been killed by legislative leaders (2013, 2014, 2015). However, a series of behind-the-scenes meetings between top leaders within the Mormon Church, members of the Republican legislature, and leaders of the Utah LGBT community resulted in Senate Bill 296 (Interview). SB 296 was very similar to the earlier failed LGBT discrimination efforts, while adding exemptions for religious institutions (2015). At the introductory press conference for the bill, three high-ranking members of the Mormon Church attended the conference and each spoke in strong support of the legislation (Gehrke and Dobner 2015). Unlike prior iterations of the bill, SB 296 sailed quickly through the legislature, passing the Senate and House of Representatives within a week of the introductory press conference (2015). At the signing of the bill, held in the rotunda of the state capitol with several hundred onlookers, leaders of the Mormon Church were once present and cheered when the bill became law (Roche and Romboy 2015).

Ultimately, the Mormon Church did not place their resources (both financially and social capital) behind the Medicaid expansion. With seven full time lobbyists focusing solely on the Utah legislature, the church had the available resources to pressure the legislature on a variety of policies and legislation (Interview). The Church had previously been known to use its power to pressure Republican legislators to vote in accordance with the organizations preferred policy, most notably on a vote over immigration (Interview). There was no direction from the leadership of the Mormon Church to become engaged in the politics over the Medicaid expansion. Rather,

the lobbyists for the Mormon Church left the Medicaid expansion decision up to the individual legislators and did not apply pressure to the passage of the bill (Interview).

Inter-Branch Conflict: The Health Reform Task Force Recommendation, December 2014

On the same day of Herbert's press conference, the Health Reform Task Force held their penultimate meeting of 2014. It was during this meeting that the newly elected House Majority Leader, Jim Dunnigan, unveiled five options for the Task Force to consider. Two of the options would have called for expansion of coverage up to 138% of the Federal Poverty Level, including the Healthy Utah Plan. The other full expansion plan would discontinue coverage for individuals above 100% of poverty after 2020. The remaining options would offer subsidies to a sliding scale proportion of individuals below poverty (Dunnigan 2014).

Dunnigan represented the type of supportive policymaker in the House that the Herbert administration lacked during the 2014 Legislative session (Interview). He was knowledgeable on the subject, someone who was engaged in the policymaking process, and was in a position to exert influence over the unwieldy House Republican caucus. Dunnigan was also the only member of the House of Representatives who had participated in negotiations over the Healthy Utah Plan, making multiple trips to Washington, D.C., including a meeting with Secretary Burwell where the conceptual framework for the Healthy Utah Plan was finalized (Interview). Herbert had been actively courting Dunnigan's support for the Healthy Utah Plan since the 2014 legislative session had ended (Interview). As the co-Chair of the Health Reform Task Force, Dunnigan could give the plan a boost if he recommended it for the legislature to consider. Before making their final recommendation, Dunnigan called the Healthy Utah Plan a "good program", but tellingly he did not offer a full endorsement of the plan, saying "The question is, are we going to do it? I'm going to leave that right there"(Moulton 2014).

After Dunnigan’s presentation, Lieutenant Governor Cox and Dr. Patton, the executive director of the Utah Department of Health, made separate presentations on the Healthy Utah Plan. As part of their presentations, Cox reported on a recent update on the actuarial analysis by Milliman Consulting indicated a higher number of individuals eligible for subsidies and cost estimates for the state. The updated report found a forty-percent increase in the number of people in coverage gap, adding to the costs of both the Healthy Utah Plan and any other plans under consideration. While minor in its announcement, the change in projections, especially coming so late in the decision-making process was used as a boogeyman for Republicans who opposed the Healthy Utah Plan, using the word “Millman” to describe the unknown costs and fiscal danger of Medicaid expansion (Interview).

The Health Reform Task Force’s recommendation was technically non-binding on the legislature. Yet, the membership of the committee, comprising House and Senate leadership and content experts that could speak fluently on the specific of the policy options with the remainder of the caucus, ensured that their recommendations would frame future debates over expansion. After nine months of additional study time, reports, and presentations on the various options which the state had on Medicaid expansion, the legislatures selected two options, neither of which were a full expansion nor Herbert’s Healthy Utah Plan. Instead, the Task Force recommended plans which would only cover the medically vulnerable and would not cash in on federal funds made available through the ACA.

Strategic Actors, Institutional Design, and Inter-Chamber Conflict: New Speaker, Same Results, January 2015-April 2015

As the legislature and governor’s office prepared for the debate over the Medicaid expansion, a new political opportunity for the Healthy Utah Plan emerged. While the Senate had

grudgingly gone along with the Healthy Utah Plan, the House, led by Speaker Lockhart had roundly rejected the plan. Lockhart announced that she would not seek re-election in 2014, opening up a vacuum in the most powerful position in the lower chamber. With her eyes on challenging Herbert in 2016, Lockhart sought to gain state-wide recognition by running for the position of State Superintendent of Education. Lockhart was ultimately unsuccessful in her bid for the position and tragically died from Creutzfeldt-Jakob Disease, a neurodegenerative brain disease at 46, before the 2015 Legislative session began. In Lockhart's place, Representative Greg Hughes was elected as Speaker of the House. If Herbert could gain the support of Hughes, the new Speaker could signal a break in the Republican hostility over expansion.

In the normally staid fashion of Utah politics, Hughes was a flashy outlier. Equally beloved by his supporters as a political fighter (a metaphor he encouraged with his office décor of boxing gloves) and castigated by his opponents as underhanded, ethically dubious, and untrustworthy. Hughes was also somewhat of an outsider within Utah political circles, growing up in a rough section of Pittsburgh, Pennsylvania in a single-parent home (Interview). The new Speaker was cognizant of his fortunate rise in politics and life, with each of his fitted dress shirts monogrammed with the initials "LB", standing for "Lucky Bastard".

Hughes political life was rocky; his initial introduction to politics came through volunteering on the Bush-Quayle campaign in 1988, where he met Joe Waldholtz a campaign worker. Waldholtz's then girlfriend, Enid Greene, was the head of the National Young Republicans who was elected to Congress in one of Utah's 2nd Congressional District in 1994, with Hughes as one of the campaign managers. Greene gained notoriety when she was assigned to the House Rules Committee, the first time in seventy years that a freshman had been given that assignment, with Hughes gaining recognition nationally as well. Greene's ascension was

short-circuited when it was discovered that Waldholtz (by this point Greene's husband) had embezzled \$2 million to fund Greene's campaign. The scandal knocked Hughes out of national politics and he moved back to Utah where he began his construction and real estate business, while slowly working back into the political world (Interview). No longer interested in managing someone else's campaign, Hughes was first elected to the House of Representatives in 2002, where he put his touch on Utah politics as one of the founders of the Conservative Caucus, as well as being accused several times of unethical behavior and receiving reprimands from his fellow Republicans.

Frail Utah vs Healthy Utah

The 2015 legislative session pitted two competing types of expansion plans against each other, a Healthy Utah Plan versus what opponents and supporters called the "frail Utah" plan. The "frail Utah" approach actually included several iterations of bills, but all shared several similarities. Senator Allen Christensen, co-chair of the Legislative Health Reform Task Force, sponsored Senate Bill 153, which would extend coverage to just 16,000 Utahns, those who are below 100% of the Federal Poverty Level and were either medically frail or disabled (2015). Christensen was concerned that the Healthy Utah Plan would monopolize available social services funding for a lot of other worthy causes, while his approach would not extend coverage to those "who can possibly get by without it, like they have done forever" (Davidson 2015).

In an effort to contain intra-party and chamber squabbles, just prior to the start of the 2015 legislative session, Speaker Hughes and Senate President Niederhauser called for a special joint-caucus meeting behind closed doors for a "roll-your-sleeves-up, speak bluntly" (Gehrke 2015) summit over differences in the Medicaid expansion options (Semerad and Gehrke 2015). Emerging from the caucus meeting, Republicans reported that a divide still existed within the

party on the path forward (Interview). Leadership decided to let both bills play out and allow the Healthy Utah Plan and Frail Utah bills all go to committee and allow debate to determine which option was most feasible for expansion.

At the start of the 2015 Legislative session, speaking of the Healthy Utah Plan, Majority Leader Dunnigan offered some vague hope for Herbert's plan when he said that "I'm not necessarily persuaded it's not the way to go"(Moulton 2015). Organizations which would financially benefit from the expansion also began to provide greater support to the Healthy Utah Plan. Both the Utah Hospital Association and the Salt Lake Chamber of Commerce began airing supportive Healthy Utah Plan advertisements across the state to provide support (Interview). Greg Bell, the president of the Utah Hospital Association and former Lieutenant Governor of the state serving with Governor Herbert, had been an advocate for the Medicaid expansion since the Governor developed his plan (Interview).

The Utah Hospital Association was a valuable interest group in Utah politics, particularly as the good reputation of health care in Utah spread nationally (Interview). President Obama invoked the largest provider in the state, Intermountain Healthcare, during a speech to a joint session of Congress as an example of a health system that offers "high-quality care at costs below average" (The White House 2009). Further strengthening the role of the Utah Hospital Association in the Capital was the number of connections between the health care industry and the legislature. An analysis of conflict of interest statements found that nearly one-third of all legislatures were employed as physicians, hospital administrators, or insurance brokers, or declared some financial interests or controlling stake in a healthcare enterprise (Utah State Legislature 2017).

What's past was prologue for the 2015 legislative session and Medicaid expansion though. Once again, the Senate Health and Human Services Committee voted to recommend the Healthy Utah Plan, Senate Bill 164, through to the full chamber(2015), with the lone dissenting vote from the chair of the committee, Senator Christensen. The only change to the Healthy Utah Plan in the Senate was that it would only be in effect for two years, delaying the need to find agreement on financing the state's share of the program. Lacking any policy cohesion behind the Medicaid expansion, the same Senate committee passed the Frail Utah version of Medicaid expansion at the following meeting, setting up a head-to-head competition of the two bills within the Upper Chamber (2015). Ultimately, the Healthy Utah supporters were once again able to convince enough reticent Republicans to say that "As much as I hate this, I haven't seen a better option (than Healthy Utah). I'm going to plug my nose and I'm going to vote aye"(Utah State Legislature 2015) and the governor's plan again passed the Senate with uniform Democratic support and a slim majority of Republican senators (Utah State Legislature 2015).

Immediately after the Senate passed the Healthy Utah Plan, Speaker Hughes announced that the House does "not have the support to move forward on that legislation in any way" (Moulton 2015) and that the House was "done with the proposal of Healthy Utah" and would not waste the legislature time on the matter (Moulton 2015). What was not mentioned by the Speaker was the remarkable amount of shifting views amongst House Republicans since the beginning of the 2015 legislative session (Interview). Informal voting behind closed-door caucus meetings found that Republicans in the House had grown more comfortable with the Healthy Utah Plan (Interview).

Herbert responded to the bill being spiked by House leadership by releasing an angry press release, stating:

“The decision by House leadership to prevent the representatives of the people from hearing public comment—pro or con—and then voting on such an important issue is alarming and should be of significant concern to citizens across our state. All Utahns deserve transparency and accountability from their elected officials, particularly when their inaction is, by default, a vote to give the federal government \$800 million per year of Utah taxpayer money while getting almost nothing in return”(Herbert 2015)

Republicans in the Senate were equally as disgruntled, especially in response to the frail Utah plan. The day after Hughes announced the Senate passed Healthy Utah bill wouldn't be sent to committee, Senator Shiozawa, argued in the Capitol Rotunda that “Healthy Utah is not dead. We need to send one firm voice, one unequivocal voice over to the House. We've done our work, they need to do theirs”(Moulton 2015). The Senate Majority Leader implored the Senate to act unified in only sending one bill to the House, not wanting to empower the House by letting “what the House says or thinks influence what we do on the floor”(Utah State Legislature 2015). Ultimately the Senate decided against sending the frail Utah on to the House.

While the House let the Senate backed Healthy Utah Plan stew in the Rules committee, they unveiled their own version of a partial expansion, similar, yet lightly less draconian than the plan that the frail Utah plan that was voted down in the Senate. Majority Leader Dunnigan proposed the legislation as middle ground approach to expansion, covering an estimated 60,000 Utahns, providing “coverage to all the people in the ‘coverage gap’ at a cost we can sustain”(2015, Davidson 2015). Coverage expansion was accomplished by increasing funds to the already existing Utah Primary Care Network. Approved as a waiver in 2002 (Centers for Medicare and Medicaid Services 2017), the Primary Care Network extended only primary care coverage to a small subset of the state. However, the program, and Dunnigan's proposed expansion would not cover any in-patient hospitalizations, appointments with a specialist, or

several kinds of diagnostic exams, including MRIs and CT scans (Utah Department of Health 2017).

After a week of mounting pressure on Hughes, including Herbert threatening to renege on a decision to move the Utah State Prison out of his home district, the House Rules Committee decided to allow the Senate backed Healthy Utah Plan to be heard by the House Business and Labor Committee (Interview). For the second time, the Healthy Utah Plan and the Dunnigan's alternative expansion plan would once again go head-to-head in the same committee, on the same day.

As the Healthy Utah Plan was debated in the House committee, one weakness of Herbert's approach to Medicaid expansion became obvious. Unlike the Senate, Herbert was completely lacking a supportive and influential member of the House of Representatives. Speaker Hughes, like Becky Lockhart before him, was clearly against the bill (Interview). In addition to temporarily sidelining the measure (Hughes relished his role in the fight against the Healthy Utah Plan, framing a political cartoon from The Salt Lake Tribune of a caricatured Hughes in 1920's gangster clothing gunning down the bill), but Hughes also used his own Political Action Committee funds to distribute mailers against Herbert's plan. Herbert's attempts to co-opt Majority Leader Dunnigan, by including him in meetings with high-ranking federal officials and other perks, did not dissuade Dunnigan from repeatedly rejecting the Healthy Utah Plan. Yet, when the Healthy Utah Plan was looking for a co-sponsor for the Healthy Utah Plan, once again it was Dunnigan, placing him in the position of being the sponsor for both of the bills being heard before the House committee. Even Dunnigan was circumspect about his sponsorship of the Healthy Utah Bill, saying that "I wouldn't read too much into that"(Moulton 2015).

The first bill debated was the Healthy Utah Plan. Senator Shiozawa introduced the legislation while emphasizing the support of business leaders, religious leaders, and crime prevention organizations, as well as the conservative nature of the program, with an emphasis on keeping within state budget, use of private insurance, and personal responsibility. Providing support for his first point was the breadth of individuals and organizations which spoke in favor of the bill during the committee hearing. Representatives from business groups – Salt Lake Chamber of Commerce, Utah Food Industry Association, Utah Retail Merchants Association, Utah Mining Association, Associated General Contractors – health care organizations – Intermountain Healthcare, the Utah Medical Association, Utah Hospital Association, University of Utah College of Medicine, Utah Department of Health, American Heart Association, Utah Association of Addiction Treatment, Utah Substance Abuse Advisory Council – and social welfare advocacy groups – Coalition for Healthy Utah, AARP, and Voices for Utah Children – all made presentations and testified in favor of the bill. As well as eight citizens, including an erstwhile Republican political candidate (Chapman 2017), a mother in the Medicaid coverage gap with a child with chronic health conditions (Utah State Legislature 2015), the former director of the Division of Behavioral Health for Salt Lake County (Gorrell 2014), a former member of the State legislature and brigadier general (Carnegie Council for Ethics in International Affairs 2017), a mother of a addicted teenager who battled substance abuse addictions (Drake 2016), and an individual currently in the coverage gap with an untreated medical condition (Good4Utah.com 2017).

As remarkable as the long bench of supporters of the Healthy Utah Plan, was how the opposition had such little visible, public support. Only representatives from two libertarian think-tanks and a dermatologist with a private practice testified against the bill. After nearly two hours

of public input and testimony, the actual committee members debated the Healthy Utah Plan for only nine minutes, with only five representatives offering their own views on the bill. As expected, the Healthy Utah Plan died in committee on a 9-4 vote, including no votes from Majority Leader Dunnigan and the cousin of Lieutenant Governor Cox (Utah State Legislature 2015).

After voting down the Healthy Utah Plan, the House committee considered Dunnigan's bill. Compared to public testimony in behalf of the Healthy Utah Plan, Dunnigan's bill only had a smattering of support from the general public, with only three individuals speaking for the bill during public testimony. Alan Dayton, the director of Government Relations for Intermountain Healthcare spoke for both bills, offering his milquetoast calculation that his organization "prefers the plan that passes" the committee (Utah State Legislature 2015). Dunnigan, the architect of the Frail Utah plan was honest about the limitations of his plan, comparing the Primary Care Network to a Yugo car, but offering that "it still drives" (Utah State Legislature 2015). Representatives from the Utah Academy of Family Physicians, Utah Health Policy Project, Disability Law Center, and three individuals covered by the Primary Care Network all spoke out against the bill (Utah State Legislature 2015). At this stage in the political process, verbal and visible support for the Medicaid expansion did very little to sway reluctant Republicans and Dunnigan's bill passed with the same vote that rejected the Healthy Utah Plan.

With only a week left in the legislative session, House supporters of the Healthy Utah Plan attempted a last-ditch effort to save the governor's expansion plan. While meeting late into the night, freshman Democratic Representative Justin Miller rose to offer an amendment that had frequently been used by Republican leadership, to lift the Healthy Utah Plan from the Business and Labor Committee and place it on the Reading Calendar, effectively opening the governor's

plan up for debate. Speaker Hughes, realizing what was happening, encouraged the Representatives to “listen closely to this motion” and then referred to the House Parliamentarian (Utah State Legislature 2015).

For the normally sober chamber, arguments broke out amongst the ranks of the Representatives, with name-calling, threats, and yelling across the aisle (Utah State Legislature 2015). Miller’s motion was defeated 56-16, with four Republicans joining with Democrats to continue to debate the expansion. Immediately after the motion was rejected, a visibly angry Majority Leader Dunnigan rose to open a bill that would modify House rules to discourage any future attempts to rescue a bill killed in committee (The House ultimately changed the parliamentary rules in response to Miller’s attempts to lift the Healthy Utah Plan. Requiring a 2/3 majority vote to make such changes in the future, in lieu of the previous ½ majority which was in effect during House debate over lifting the bill (The Salt Lake Tribune 2015)).

Miller’s amendment was not the end of Democratic attempts to bypass and slow-down the political process. Democrats proposed several amendments for substitute bills, which caused Republican Representative Jacob Anderegg to angrily yell at the Democrats to “stop wasting our time”. An intense debate over Dunnigan’s bill occurred in the House, with more than a quarter of the House membership rising to speak in support or opposition to the measure. Eventually, after four hours of debate, the House passed the Frail Utah program, by a vote of 56-18 in the Chamber (Utah State Legislature 2015).

With passage of the Frail Utah bill in the House, the Utah legislature was still at a standstill. Mirroring his House counterpart, Senate President Wayne Niederhauser vowed that the House backed bill would not receive a committee hearing in the upper chamber. Once again, members of the House, Senate, and Governor’s office got together to try and find a compromise

measure for expansion (Interview). While publically saying that they were optimistic that some agreement could be reached (Moulton 2015), privately there was a major schism between the House of Representatives and Governor Herbert. By this point in the legislative session, Speaker Hughes was no longer taking phone calls from Herbert and the Speaker had contacted lawyers to provide a legal response in case the governor moved to unilaterally act to expand Medicaid (Interview).

Intergovernmental Negotiation and Informal Governance: “Gang of Six” and Utah Access Plus, April 2015-October 2015

With time running out of the session, the major Medicaid policymakers in the state once again convened a press conference and announced that once again, the state would require additional study to look into the Medicaid expansion. However, unlike last year, where the matter was deferred to the Health Reform Task Force, Governor Herbert, Speaker Hughes, President Niederhauser, Lieutenant Governor Cox, Senator Shiozawa, and Majority Leader Dunnigan formed a self-titled “gang of six” which would take the lead in further negotiations with federal officials and to iron out differences amongst themselves and their respective legislative bodies (Interview). The Senate and House both passed a resolution which gave a July 31st deadline for the policymakers to come to an agreement on an expansion plan and then to call a special session for consideration by the full legislature (2015).

Herbert again struck an optimistic tone while discussing the prospects of Medicaid expansion in Utah, remarking that the state was “closer than ever to finding a solution” but that they were not going to be “be able to find a conclusion in this session that's going to be satisfactory to us all”(Roche 2015). Hughes in particular took a hands-on approach to the negotiations over the summer (Interview). Stung by views that he was obstructionist in his

approach to Healthy Utah, Hughes remarked that he was optimistic that the House, Senate, and Governor's office would find agreement (Davidson 2015). Laying out his stakes of what success would look like for the conservative House, Hughes noted that the key concession he was looking for from the Obama administration was the option to cap spending on the expansion plan, then Utah could "finish the deal"(Davidson 2015).

One of the striking characteristics of the politics of Medicaid expansion in Utah after the formation of the gang of six is how cloistered the process became. In a state where such a high percentage of legislatures and policymakers were members of the Republican Party, many decisions were already being made behind closed doors and in caucus meetings (Interview). However, at the same time, previous debate over health care topics had a semblance of public and bi-partisan input; the Legislative Task Force meetings were open to the public and included presentations by insurers, providers, and patients, while Democratic legislatures were included on the task force. Many of these previous stakeholders, including Democratic and Republican members, health care organizations, and patients were excluded from the development of a framework and expansion plan under the "gang of six" and had no input into shaping what was to come next in the state's efforts to expand Medicaid (Interview).

Herbert broached the subject of further flexibility and spending caps when Obama visited Utah in early April 2015 (Burr, Davidson et al. 2015) and again when the gang of six met for the first time with Secretary Burwell at the end of April (Interview). While the formerly recalcitrant Hughes remarked after the meeting that they had a productive conversation, the meeting ended with no firm commitment by the federal government to allow Utah to cap their spending on expansion (Moulton 2015). During a presentation to the Health Reform Task Force, Dunnigan tamped down any expectation that there was a quick solution or coming to an agreement,

expressing doubt that the gang would meet their deadline and even floating the potential that no action will be taken until the 2016 legislative session (Knox 2015, Utah State Legislature 2015). In particular, the “gang of six” was attentive to the experiences of other states which had expanded Medicaid, meeting with officials and policymakers from Arizona, Arkansas, Kentucky and other states to understand their assumptions for costs and enrollment (Gehrke and Moulton 2015, Utah State Legislature 2015).

The “gang of six”, while focused on what other states had done, went into their joint negotiations unbound from either the Healthy Utah or frail Utah approaches (Interview). By mid-July the gang of six felt confident enough in their work that they announced that while there was more that need to be fleshed out, they had agreed to a broad conceptual framework for expanding Medicaid, branded Utah Access Plus. The proposed framework shared similarities with the Healthy Utah Plan, covering all eligible individuals below 138% of the federal poverty level. The major difference between the announced framework and prior versions of the expansion was the emphasis on a “budget neutral” future on state finances. The “gang of six” called on hospitals, providers, and pharmaceutical companies to pay a new tax that would fully fund the state’s portion of the costs associated with expanding Medicaid (Gehrke 2015). What was not part of the conceptual framework was the one thing that Hughes said was necessary, an enrollment or financial cap for the program.

While the Utah Hospital Association had previously expressed some willingness to help cover the state’s costs, they had not envisioned a financing system where the providers would be responsible for the entirety of the state contribution (Interview). During his monthly press conference, Herbert remarked that the gang of six was “trying to find the mathematics to make sure everyone pays proportional to what they receive in their benefit” (KUED 2015). Greg Bell,

who had served as Herbert's first Lieutenant Governor, was the chair of the Utah Hospital Association, and floated additional financing ideas to help cover the state's costs, including increasing the sales tax on food and cigarettes(Roche 2015).

There were two major changes to the political dynamics of the state after the "gang of six" budget neutral funding proposal went public. First, the proposed budget mechanism completely gutted the previously unanimous support for the Healthy Utah Plan from provider organizations. With hospitals paying 32 percent, physicians paying 22 percent, insurance companies paying 15 percent, and pharmaceutical companies paying 12 percent of the total cost of the plan (Gehrke 2015). The Utah Medical Association and pharmaceutical organizations in particular were vocally opposed to the funding proposal in the "gang of six" plan and soon provider organizations in the state were unanimously opposed to Utah Access Plus (Interview). Second, the framework developed by the "gang of six" had the consequence of making it more difficult for Republicans to support it (Interview). The group estimated that there would be \$52 million in new assessments and taxes, with physicians, for example having to pay an additional \$800 per year when renewing their medical license (Gurgel 2015, Utah State Legislature 2015). The tax increase was one of the largest considered by Utah in several decades and in a deeply conservative state was a political non-starter for many Republicans, without even considering that the money would be used to resemble policy established by the ACA (Interview).

At the end of September 2015, with the "gang of six" unable to meet their legislatively imposed timeline, Republican's from the House and Senate met in closed-door Caucus to have an informal presentation of a framework for Utah Access Plus. This meeting was the first opportunity for the newly aligned leaders of both chambers and the governor's office to gauge the response from recalcitrant legislatures, particularly in the House. After the closed-door

Caucus meeting, many of the House Republicans continued to express serious doubts about their support for expanding Medicaid, even if the state was not directly paying for it (Interview).

The first public exposure to Utah Access Plus was during a meeting of the Legislative Health Reform Task Force in October 2015. Because House Republicans continued to express hesitancy over the Utah Access Plus plan, the first public meeting and comments were an important occurrence to bring public support to bear on oppositional legislatures (Interview). The meeting after the unveiling of the Utah Access Plus was the longest Task Force meeting since the committee had been formed and it did not go well for the “gang of six” plan.

Provider organizations came out strongly in opposition to the budget neutral approach included in Utah Access Plus and the vast majority of all the public comments were oppositional to the new expansion plan. Representatives from the Utah Medical Association, Pharmaceutical Research & Manufacturers of America, Utah Hospital Association, Utah Retail Merchants Association, Utah Pharmacy Association, Utah Health Insurance Association, Utah Optometric Association, Utah Chiropractic Physicians Association, Utah Podiatric Medical Association, Pharmaceutical Care Management Association, Association for American Physicians and Surgeons of Utah, Utah Academy of Physician Assistants, National Association of Social Workers, Utah Plastic Surgery Society, American Academy of Pediatrics, and Utah Society of Anesthesiologists all spoke against the bill. Additionally, businesses, think-tanks, physicians, Democratic and Republican legislators, the CEO of one of the largest corporations in the state and Republican candidate for governor, and four citizens from the state spoke out against the plan (Utah State Legislature 2015). With the loss of so many key allies from the provider organizations, there were few supporters testifying in support of the proposal. Only three local health policy organizations, one physician, and a Bishop of the Mormon Church from downtown

Salt Lake City spoke in favor of the bill (Smardon 2014). While no binding vote or recommendation came from the Task Force meeting, Republican policymakers saw clear signals that powerful provider organizations were not supportive of the plan.

Institutional Design: Speaker Hughes and Utah Access Plus, October 2015

The budget neutral financing mechanism in Utah Access Plus was not the only change that added further barriers to the “gang of six” plan. Speaker Hughes, after months of negotiations over the Utah Access Plus at the last moment made two changes that would prove to be detrimental to the fledgling proposal. First, Hughes invoked the “Hastert rule” for the House, declaring that all of the necessary 38 votes for passage of Utah Access Plus in the House of Representatives would have to come from Republicans and no public vote would occur unless half of the Republican caucus agreed. The rationale behind this move was that it saved Republican Representatives from having to take a difficult vote out in the open, yet the decision surprised the rest of the “gang of six” members (Interview). Hughes decision was influenced by the state of Montana voting to implement expansion when a handful of the Majority Control Republicans formed a coalition with Democrats to narrowly pass the legislation (Interview).

The second decision that affected the outcome of Utah Access Plus was that Hughes and Majority Leader Dunnigan, the two most visible House members on health care and the two most influential members of the Caucus, explicitly did not pressure or advocate for the Utah Access Plus plan within their caucus (Interview). Rather, Hughes saw his position as an arbiter of information and not as someone who should push members to a desired outcome (Interview). Hughes remarked that “there is no pressure from leadership and everyone has to own their own decision. The good information will drive the ultimate decision, and I’m not going to try to artificially influence it one way or the other”(Gehrke 2015).

During debates over the Healthy Utah Plan in 2014 and 2015, the influence and pressure of provider organizations was able to convince several Republicans to support the measure (Interview). With the loss of the most ardent interest group and the changes to normal procedure announced by Hughes, the likelihood of Utah Access Plus making it out of the Republican Caucus room in the House was severely damaged (Interview). Representative Ray Ward, a physician and vocal supporter of the Healthy Utah Plan judged that there was less support for Utah Access Plus than there was for Healthy Utah Plan (Gehrke 2015). After the closed door meeting, Speaker Hughes emerged from the caucus room and announced that there was insufficient support for the Utah Access Plus plan. After a three hour meeting, only seven Representatives voted in support of Utah Access Plus (Interview).

With the failure of Utah Access Plus in October 2015, there was once again little time for Medicaid expansion supporters to coalesce around any plan before the start of the next legislative session. Herbert, the most visible supporter of expansion in the state, became disenchanted with making any progress with the House, saying “I hope there's another pathway forward, but it's really up to the Legislature to find something they're willing to pass" (Gehrke 2015). During a press conference after the failure of Utah Access Plus, Herbert remarked that he had “tried and tried and we’ve just not been able to get the votes. I understand politics. I suspect we’ll be working on an alternative to that this legislative session because the issue is still top of the mind for most of us in the state of Utah, for the people and the Legislature” (KUED 2016).

Political Alignment: Partial Expansion, Partial Support, January 2016-April 2016

With the third failure of a full expansion, Utah voters in 2016 listed health care as their most pressing concern for the state and the upcoming election (Utah Foundation 2016). Policymakers in the House again focused on some form of a partial expansion in the state, which

would only focus on the medically frail and those below 100% of the federal poverty level (Interview). Though there was little guidance from legislative leaders and from the governor's office and legislative leaders. In this void, legislative language was prepared for the upcoming session that was similar to the Healthy Utah Plan, a partial expansion to all individuals below the poverty level, and a plan covering only the most impoverished (Interview). Yet, by 2016, even with entrepreneurial politics pushing several different proposals, there was a marked lack of enthusiasm behind Medicaid expansion in the Legislature (Interview). Unlike previous years, neither Speaker Hughes nor President Niederhauser mentioned Medicaid in their introductory comments at the beginning of the 2016 legislative session. A week into the 2016 Legislative session, Niederhauser speaking about Medicaid expansion said that "There are problems out there that we are trying to solve. But sometimes the status quo isn't all that bad" (Davidson 2016).

For the third year in a row, Majority Leader Dunnigan wrote and sponsored legislation for a partial expansion of Medicaid and for the third year in a row he wrote different legislative language. In 2016, Dunnigan offered his most limited version of expansion yet, providing insurance for only 16,000 adults. House Bill 437 would primarily be focused on three high-risk and high-cost populations, all of whom must be childless and in extreme poverty (below 5% of the federal poverty level): the homeless, individuals involved with the justice system, or have mental health or behavioral health issues; as well as increasing eligibility for adults with children, up to 55% of the federal poverty level. Dunnigan did take one thing from the failed Utah Access Plus plan; his proposal would add a provider tax to subsidize the state's portion of the expansion. With a capped enrollment, HB 437 was supported by the Utah Hospital

Association, who agreed to pay for 45% of the \$31 million total state cost for the expansion (2016).

The marked shift in population for the partial expansion was a byproduct of demographic changes within Utah. The challenges of homelessness, drug problems, and mental illness within the state had become acute over the previous years and the 2016 Legislative session was particularly attuned to addressing the needs of these populations (Interview). Dunnigan pivoted away from expanding coverage to the broader population of the state and used the growing concern over certain subsets of the state's population to help create additional support by framing his proposal as not related to the ACA, but serving these pressing social issues (Interview). Utah had had gained national recognition for their efforts for housing first initiatives (Carrier 2015, Glionna 2015, McCoy 2015, McEvers 2015), including supportive coverage by the Daily Show with Jon Stewart (The Daily Show with Jon Stewart 2015). Yet, with all of that acclaim, the number of homeless in Salt Lake City was increasing, overwhelming available rescue centers and homeless shelters in the region (Cortez 2016). Even with a predominantly Mormon population (which has strict commandments related to addictive substances of all kinds), Utah had the ninth highest age-adjusted overdose death rate in 2015 (Centers for Disease Control and Prevention 2017).

After three years and scores of bills killed by the Utah House of Representatives, House Bill 437 was the latest chance for the state to expand Medicaid coverage, even if only marginally. By 2016, supporters of prior, more robust expansion proposals had been worn down from their previous failed efforts and realized that Dunnigan's bill represented the best chance to do anything related to expanding Medicaid coverage, with the idea that it could be the first step in a larger process of increasing insurance coverage (Interview). The desire to pass any coverage

expansion was especially noticeable during debate in the House Business and Labor Committee. Dunnigan's bill marked the first time that individuals had testified against incremental expansions now testified in favor of Dunnigan's bill. High profile community advocates, the Salt Lake Chamber of Commerce, representatives from the Salt Lake City Mayor's office, the Utah Department of Health, and even conservative think tanks all joined together in support of HB 437 (Utah State Legislature 2016). While not speaking for the Mormon Church, a formerly high-ranking official within the church and the current administrator of all for-profit entities owned by the Mormon Church, also spoke in favor of the proposal (Utah State Legislature 2016). With backing of the business, medical, conservative and liberal organizations, and the imprimatur of the Mormon Church, House Bill 437 passed out of the House Business and Labor Committee with 9-4 vote.

Debate within the House over Dunnigan's bill was also much less volatile than prior floor debates over partial expansion. A handful of Democrats rose in opposition to the bill, using colorful metaphors, such as Sophie's Choice and King Solomon, to describe feeling troubled about choosing which low-income populations would be served by the bill and which would not receive coverage, as well as being described as "less than crumbs, a cruel trick. It is seeing someone in the desert and giving them salt water to drink" (Utah State Legislature 2016). Yet, there was also a clear difference between Democratic debate over House Bill 437 and prior debates. Whereas in previous debates over partial expansions, all of the Democrats would rise and voice their opposition to the measure, only three Democrats in the House spoke during the floor debate on Dunnigan's bill. While the Democrats uniformly rejected the bill and were joined by six Republicans, HB 437 was able to pass with overwhelming support.

With passage out of the formerly unmanageable House, Senate approval of the bill became *fait accompli* (Interview). Unlike in 2014 and 2015, the Senate purposefully deferred to the House to act first on Medicaid expansion. Senators Niederhauser and Shiozawa wanted to know what type of proposal would actually pass the House and not waste the time of the upper chamber on debating for the third year in a row only to have the House block their bill (Interview). Now knowing that HB 437 was the best that the House could pass during the 2016 session, the Senate quickly followed suit and passed the bill, with four Republicans and four Democrats voting against the bill.

After three years of debate and numerous failed attempts, Utah finally passed the least expansive partial expansion option. Herbert signed the Medicaid expansion bill on Good Friday, along with 61 other bills (Utah Governor Gary Herbert 2017). However, Herbert called a special press conference at a downtown Salt Lake City free clinic to celebrate the signing. Two years ago, when he had initially given his support for expanding Medicaid, Herbert couched his argument in helping all Utahns improve access to health care services. However, after years of legislative battles and constant rejection of expansion, the main talking point for Herbert and Legislative Republicans was no longer one of improving access to care or bringing back federal money into their state. Rather, the focus of the argument and the celebration of passing a partial expansion was a means to combat homelessness, drug abuse, and mental health (McKellar 2016). Without those demographic and health changes in the state, it is unclear if any other argument would have been able to carry the message and pass an expansion bill (Interview).

**Intergovernmental Negotiations and Electoral Politics: Waivers and Donald Trump, April
2016-June 2017**

Unfortunately for Utah policymakers, passing HB 437 was not the last political hurdle that the state had to undertake. Because HB 437 made changes to existing federal law regulating the Medicaid program, the state was required to submit a Section 1115 waiver to CMS before the program could be implemented by the state. Utah, which had taken so long to work out a framework with the Obama administration over the defeated Healthy Utah Plan, would now have to undergo the same effort for a much smaller payoff in terms of financial and coverage benefit. Changing national dynamics due to the 2016 presidential election also posed a challenge for Utah policymakers.

With legislation passed and the waiver application submitted to the federal government, the experiences of Utah's Medicaid expansion highlight the role that the federal government plays on state policy and politics. While the state was awaiting final approval from the Obama administration on their waiver application, policymakers were forced to adjust their projections for the efficacy of HB 437. Utah focused the bulk of their coverage expansion on the recently decarcerated, homeless, or addicted (Interview). The expense of covering special populations with a fixed budget resulted in a substantial reduction in the numbers of individuals who could be covered by the new program. After initially projecting that 16,000 individuals would be eligible under the plan, new estimates reduced the total number to 9,000 (KUED 2016).

The surprise election of Donald Trump in November 2016 put Utah and its partial Medicaid expansion back in policy limbo with the ripples of the national election being felt in the state. As a candidate, Trump did not offer many stable policy views. However, on health care he consistently promised to repeal the ACA, while not make any cuts to Medicare or Medicaid (Brody 2015). With a new administration that promised to break drastically from the Obama presidency, policymakers in Utah had new options and potentially new flexibility for their

approach to Medicaid. However, for the most part, Utah was on the outside looking in from the Trump administration. After the release of the infamous Access Hollywood tapes, Governor Herbert and all of Utah's Congressional delegation distanced themselves from Trump (Lockhart 2016). Speaker Hughes was the only high-profile Utah politician who had remained supportive of Trump and he was well-connected to the incoming administration after sponsoring fundraisers with Donald Trump Jr. in Utah through the campaign, even being floated as a potential nominee in Trump's cabinet (Gehrke 2016).

Further complicating matters in regards to their partial expansion waiver was that by November 2016, the state still hadn't received an official acceptance from the Obama administration. All Utah policymakers had received was an informal message from federal officials that changes to the waiver application were going to be necessary before the Obama administration was going to sign off on the plan (Utah State Legislature 2016). The officials had been told that an expansion of coverage for low-income parents with children did not raise any issues and that portion would be approved, however there were concerns over the programmatic details for the expansion to special populations (Interview).

Ultimately, the Obama administration never responded to Utah's waiver application. After new HHS Secretary Tom Price and CMS Administrator Seema Verma were confirmed by the Senate in February and March 2017, they became responsible for approving Utah's waiver. Price and Verma quickly set a new tone for Medicaid and waivers, sending a letter to all 50 governors stating in part to provide states "more freedom to design programs that meet the spectrum of diverse needs of their Medicaid populations" (Price and Verma 2017). However, at the same time, with Congress in the midst of attempting to repeal and replace the

ACA, Trump indicated that his administration would not consider any waivers to the current law, including Utah's (Interview).

The slow response from the Obama and Trump administrations threatened to destabilize Utah's partial Medicaid expansion in two ways. First, the state had earmarked \$30 million to cover their portion of the costs of expansion. With no movement from the federal government, legislators began to clamor for using the earmarked funds for other policy initiatives (Interview). Second, with the election of Trump, conservatives in the state wanted to withdraw the waiver application for a partial expansion and add Herbert's long sought after work requirements and other conservative policy elements to their program. While initially resistant to these changes, Dunnigan eventually acquiesced to these demands and the state split their waiver, with one application for the low-income parents and a second for the special populations. Because the state expected a fast-track response to the low-income parent waiver, what Herbert had initially hoped would cover 140,000 people under the Healthy Utah Plan, would in actuality cover 3,000.

For the second waiver, focusing on the special populations of low-income childless adults who are chronically homeless, recently incarcerated, or had mental health or substance use disorders, Utah tacked on additional requirements for the federal government to approve. Utah proposed to add lifetime limits and Herbert's long desired work requirements as prerequisite to gain coverage. Eligible adults would only have coverage for up to 60 months over their lifetime, retroactive coverage would be done away with, and job-training or job-searching requirements would be made for the newly eligible (Utah Department of Health 2017). As of May 2018, Utah was still awaiting federal approval for their waiver applications.

Conclusion

The Utah case study highlights the limits of supportive Governors in implementing policy. While Governor Herbert advocated for Medicaid expansion for several years, as of March 2018 the state had not received any federal approval for an expansion of their Medicaid program. Herbert was handcuffed by the institutional design of the state, the breadth of policy entrepreneurs and policy options, and role of organized interests.

Collectively, even though the state had a supportive governor, a Senate which passed expansion bills several times, and support in the House, Utah had little to show for its efforts. Utah has the shortest legislative session in the nation, leaving the governor and supporters limited time to produce legislative language, corral support, and successfully go through the legislative process. Additionally, Herbert had little leverage in forcing action by the legislature. Because Republicans are so dominant within both chambers, there were fewer opportunities for supporters of expansion to cobble together a coalition to pass Medicaid expansion through. While calling legislative special sessions are normal in Utah politics, Herbert did not have the authority to force a vote and the governor knew that if he were to call a special session it would incite more ill feelings towards the Medicaid expansion.

Every legislative session from 2013 through 2016 saw several alternative plans related to Medicaid expansion. The breadth of policy options caused splintering within the Republican caucus. This splintering occurred between policymakers who opposed and supported expansion plans, as well as within the group of policymakers who supported the state enacting something. Additionally, the Medicaid expansion caused intra-branch divisions on the components that the program should contain. Adding to the breadth of options was the changing policy preferences included in each of the iterations of expansion legislation. Supporters of both the full and partial

expansions were constantly changing the components of the expansion programs, trying to unlock widespread support within the Republican caucus.

The 2018 legislative session saw Utah return once again to the Medicaid expansion. By the end of the session, Herbert signed into law a bill that would partially expand Medicaid up to 100 percent of the federal poverty level, as well as including a work requirement on the population. While Utah policymakers are optimistic that the Trump administration will be receptive to their plan (Interview), the likelihood of federal officials approving a plan that would provide different match rates for the same eligibility populations is small, placing any further developments in Utah's efforts to expand Medicaid in jeopardy.

Chapter 6: Arizona: Policy History, Institutional Design, and Strategic Actors

“Energy in the Executive is a leading character in the definition of good government... A feeble Executive implies a feeble execution of the government. A feeble execution is but another phrase for a bad execution; and a government ill executed, whatever it may be in theory, must be, in practice, a bad government.”

- Alexander Hamilton, Federalist No. 70

Arizona was surprisingly one of the first Republican led states to implement the Medicaid expansion. The implementation decision was surprising because even as the state underwent demographic shifts which lend itself towards becoming more politically competitive in the future (Casellas 2009), Arizona has been largely under the control of the Republican Party. Former Governor Janet Napolitano was the only Democrat to win state wide election in Arizona over the past twenty-five years (Hsu 2008) and outside of a two year legislative session (2000-2002), Democrats hadn't held majority control over either chamber of the legislature since 1978 (National Conference on State Legislatures 2016). There is perhaps no more surprising advocate to embrace and support expansion than Arizona Republican Governor Jan Brewer. The governor had built a political career off of spurning the federal government (famously wagging her finger at President Obama on the tarmac in Phoenix). Yet, even her personal antagonism towards the federal government sells short the improbable path towards expansion in the state. In 2012, there were 33 Republican governors in total (The New York Times 2014), of which 11 decided to expand Medicaid. Brewer was one of only four of those governors who expanded in a state with uniform Republican control over the legislature (along with North Dakota, Indiana, and Ohio) and is one of two governors who implemented a traditional expansion *with* legislative support.

Yet, in the case of Arizona, having a supportive governor was necessary, but not sufficient for the state to implement the Medicaid expansion. The state's surprising implementation decision was informed by three factors: the Medicaid policy history in the state, the economic downturn in the decade prior to the ACA, and the institutional design of the state that a supportive governor was able to leverage.

Arizona Medicaid Policy Background

Original Medicaid Implementation

The history of the Medicaid program in Arizona demonstrates both the states obstinacy with the federal-state program as well as its efforts to innovate, which was evidenced again during the ACA Medicaid expansion (Interview). Federal funding became available for states six months after President Lyndon B. Johnson signed Medicare and Medicaid into law in 1965. Even as states were required to develop and implement a new program with substantial state investment, twenty-six states had active Medicaid programs by the end of 1966, with eleven more joining the ranks of states with programs by the end of the following year (Moffitt and Moffitt 2003). By the start of the 1970s, all but two states had decided to implement a Medicaid program; Alaska implemented the program in 1972, but it was another decade before the last holdout, Arizona, enacted Medicaid.

A series of federal and state policy shifts between 1965 and 1982 influenced how Arizona eventually implemented Medicaid. Unlike federal projections when it was signed into law by Johnson, there was significant cost increases associated with Medicaid. In response, state and federal policymakers pursued cost-containment reforms (Arnett III, McKusick et al. 1986, Medicare Payment Advisory Commission 2007) which differed from traditional fee-for-service payment models (Ellwood and Lundberg 1996). Managed care organizations had been in

existence for several decades (Kongstvedt 2012), but passage of the Health Maintenance Organization Act in 1973 kick-started the rise of managed care by appropriating grants and loans to insurers for start-up costs and allowed employer sponsored insurance to the market (United States Congress 1973), as well as passage of the Tax Equity and Fiscal Responsibility (TEFRA) Act, which simplified the contracting requirements for government health programs (Tax Equity and Fiscal Responsibility Act 1982, Jones and Lewin 1996). Additionally, Medicaid waivers became much more readily available from the federal government, allowing states to modify their health programs (Singer 2016).

Arizona was the first state to marry the federal developments of managed care and available waivers when the state created the Arizona Health Care Cost Containment System (AHCCCS, pronounced 'Access') (Piatak 2015). One unique feature that prompted Arizona to finally implement the original Medicaid program was the State Constitution requiring counties, not the state, to be responsible for the delivery and financing of health care. The same trends in escalating health care costs which were emerging nationally were more acutely felt at the county level, placing greater financial burden on already financially strapped counties (Bachman, Beatrice et al. 1987). In the five year prior to the state implementing Medicaid the total costs of health care for counties more than doubled (Bogert 2016). Passage of a ballot initiative (which has proven to be an important tool for Arizona policymaking) limited the amount of tax revenues that the counties were able to collect, making it nearly impossible for their system of financing and management for indigent care to continue (Freeman and Kirkman-Liff 1985).

However, the implementation of the AHCCCS program in Arizona, while innovative in its design of managed care, was also limited by how the original architects devised the plan. These shortcomings of the program directly influenced the Medicaid expansion debate in the

state thirty years later (Interview). Access to AHCCCS was severely limited by its eligibility requirements, which were set for individuals below 34% of the Federal Poverty Level (Burwell and Rymer 1987, Tanenbaum 1995), leading to Arizona continually having one of the highest uninsured rates in the country (Interview) (Levit, Olin et al. 1992).

Ballot Initiatives and Eligibility Expansion

For a state that is politically conservative, delayed implementing Medicaid for sixteen years, and had some of the lowest eligibility levels in the nation, there was a remarkable transformation of the AHCCCS program in the decade leading up to the passage of the ACA. These transformations did not occur through legislative means, but through direct democracy. Arizona is one of 12 states which has a “direct initiative” program, allowing any proposal that achieves a threshold of citizen signatures automatic placement on the ballot at the next state-wide election (Arizona State Legislature 1998).

My analysis of all direct democracy initiatives highlights how these policymaking tools have been used to enact a series of progressive policies, including increasing minimum wage in 2016 (Rau 2016) (though in response to the minimum wage hike, Republicans in the legislature and governor’s office, in coordination with the Chamber of Commerce and other conservative organizations in the state have passed a series of bills that increase regulations related to citizen initiatives (2015, 2016, 2017, 2017)). There have been 177 different ballot measures voted on by the public since Medicaid was implemented in 1982 and health care has been one of the most popular policy domains included in the ballot initiatives, behind only taxation and elections.

These health care related initiatives have varied widely (including regulating smoking in public places and creating a single-payer system), but there have been several ballot initiatives related to expanding eligibility for AHCCCS. After trying and failing to pass eligibility

expansions through legislative means in the 1980s and 1990s at the same time that the state reduced funding for a series of health and social services program (Interview), AHCCCS advocates began the process of expansion via ballot initiative. In 1996, the state passed, by a 3 to 1 margin, the Healthy Arizona Initiative, which would redirect cigarette tax revenues to expand coverage by 180,000 people; though disputes with the Clinton administration on an enrollment cap stopped the implementation of the program (Nichols 1997). It was not until 2000 when Proposition 204 was passed by the state (Arizona Secretary of State 2000), leveraging tobacco lawsuit settlements to finance the program (West 2000), increasing eligibility for AHCCCS from 34% to 100% of the federal poverty level. Conservative Arizona was now a strange Medicaid bedfellow with their more liberal counterparts, California, New York, and Minnesota, with the most generous Medicaid programs in the country.

Arizona Financial Constraints

During the decade prior to the passage of the ACA, Arizona's economy was booming, with job growth and the economy in the state outpacing the national average. Though, paradoxically, the state was also reporting higher than anticipated enrollment in their newly expanded AHCCCS program, placing additional financial pressure on the state budget (Interview). This increase in program enrollment was exacerbated by the foundations of Arizona's booming economy, with a large segment of the jobs being created by small businesses, temporary employment, with low union membership. Just prior to the passage of the ACA, only seven states had a higher percentage of residents on their Medicaid programs than Arizona (The Henry J. Kaiser Family Foundation 2017). Even with tobacco settlement funds earmarked to cover the costs of the expansion, the state's general fund was forced to subsidize the cost of AHCCCS after three years of expansion. Yet, throughout these enrollment and fiscal challenges,

the general public was still overwhelmingly supportive of AHCCCS, with 81% of the public supporting universal coverage (Crawford 2006). The twin forces of increased enrollment and costs, whilst one million of its citizens still remained without insurance coverage, set the stage for Arizona's response to the ACA Medicaid expansion.

Arizona is one of five states that do not have a Lieutenant Governor (National Lieutenant Governors Association 2013), so when Barack Obama selected Janet Napolitano as his Secretary of Homeland Security, the governor's office fell to longtime elected official and Secretary of State of Arizona, Jan Brewer. The new governor inherited a financial mess which shaped one of her prevailing responses to the Medicaid expansion. Arizona was hit particularly hard by the Great Recession of 2008. Amongst all 50 states, only California had a larger debt obligation than Arizona. Brewer's first budget showed her mix of embracing Republican economic orthodoxy, as well economic populism and acceptance of federal funds. Brewer formed an economic coalition with Democratic legislators to implement a sales tax hike in the state and unlike some of her Republican counterparts, enthusiastically agreed to accept federal funds from the American Recovery and Reinvestment Act of 2009.

But, with the state in economic peril, Brewer often attempted to close budget gaps on the back of AHCCCS funding. During her first State of the State, Brewer argued that with the state under financial duress the "voters must be asked to re-consider the Prop 204 expansion. Contrary to what voters were told, there is no such thing as free health care" (Brewer 2010). Along with rescinding the ballot initiative expansion of AHCCCS eligibility, Brewer's first budget included defunding the Arizona Primary Care Program (which provides basic primary care services to non-Medicaid eligible recipients in the state), as well as becoming the first state to dissolve the CHIP program, KidsCare. Public polling was strongly in support of retaining the AHCCCS

expansion and rather than face political backlash and embarrassment of failing to overturn the ballot initiative, the Republican legislature simply just defunded the expansion (Interview). Brewer and Republican policymakers argued that the funding mechanism of using tobacco funds was no longer available and therefore the program was no longer legally binding (Newton 2010), the state froze enrollment and reduced eligibility for AHCCCS by 310,500 people . Even with these measures, the state was still projected to face an increased budget deficit of more than \$2 billion (Arizona Republic 2009).

FY 2011 was not an aberration in budget priorities for Brewer. With the enrollment freeze for AHCCCS in place, the blood was in the water for Medicaid (Interview). Brewer's FY 2012 budget put a hold on using General Funds to support AHCCCS spending until ACA expansion funds were available to the state in 2014, saving the state half a billion dollars (Interview). The Senate Appropriations Committee favorably passed out a bill that would completely eliminate AHCCCS (the bill was killed in the Senate after uproar by interest groups, a tepid response from Brewer, and a bevy of editorials against the bill by the normally conservative Arizona Republic (2011, Arizona Republic 2011)). Additionally, legislation was nearly enacted that would have 1) required identification determining citizenship prior to being admitted to a hospital (2011), 2) increased cost-sharing up to \$1,000 for prenatal care and childbirth for AHCCCS members(2011), 3) required a copayment of \$25 for any missed appointment for an individual covered under AHCCCS (2011).

From an administrative point of view, AHCCCS Director Tom Betlach eliminated coverage for some high-cost procedures, such as certain organ transplants, reduced mental health spending (which was particularly striking in the aftermath of the mass shooting in Tucson by Jared Loughner), and reduced state staffing of AHCCCS by one-fifth (Interview). While the

federal government rejected some administrative changes, Brewer's spokesperson remarked that with so much of their modifications viewed as "longshots" by the administration, "The governor is quite pleased that most of what she's requested has been approved" (Reinhart 2011). The legislature passed and Brewer signed into law a FY 2012 budget that reduced state expenditures by \$1.1 billion, with half of the savings coming from cuts to Medicaid (State of Arizona 2011).

On the eve of passage of the ACA, Arizona had one of the highest uninsurance rates in the country, had the second lowest proportion of its citizens with Employer Sponsored Insurance in the country (Kaiser Family Foundation 2017), its citizens held \$2.5 billion, or more than 8% of total health care spending in the state, of medical debt (St. Luke's Health Initiatives 2008), and AHCCCS enrollment increased by sixteen percent in 2008 and 2009, a nine-fold increase in enrollment from the previous year (Arizona Health Care Cost Containment System 2008).

Economic Benefit Driving Brewer Decision

As Congress was debating the ACA, the politics of health reform roiled Arizona. Thousands of angry Arizonans attended town hall meetings during the August 2009 recess and there was uniform opposition to the bill from Arizona Congressional Republicans (Sanders 2009). Brewer herself entered the fray when she wrote a letter to Senator Max Baucus (D-MT) Chair of the Senate Committee on Finance, imploring him to "bear in mind the fiscal realities states are facing as we attempt to maintain responsible balanced budgets while preserving services for our most vulnerable residents" (Brewer 2010). AHCCCS Director Betlach mirrored Brewers statement of financial concerns when he stated that the "estimate made by the Congressional Budget Office was that over 10 years, the cost to Arizona would be around \$500 million. We're estimating the cost to be over \$2 billion. Given our experience, given the number

of people we know are uninsured, we would expect to see some significant growth in our program” (Newton 2009).

After the June 2012 Supreme Court decision, Brewer released a statement, which while not mentioning Medicaid itself, set the “stakes for the November election. It is now up to the American people to save our country from the fiscal and regulatory nightmare known as Obamacare” (Brewer 2012). Yet, Brewer’s reaction to the Supreme Court decision differs substantially from her Republican governor colleagues. In the months after the Supreme Court decision, 10 Republican governors outright rejected the option to expand. Brewer took a much more calculating approach to the Medicaid expansion option, never publically mentioning her outright opposition to the optional expansion. Brewer met several times with physicians, hospital systems, and insurers in the state to hear their feedback on the expansion options (Interview). At the same time, the chief health policy advisor to the governor and members of the Brewer administration analyzed the fiscal impact of Medicaid expansion (Interview).

As Brewer was conducting her analysis on the expansion, she was aware of the shifting political environment within the Arizona State Legislature (Interview). While Republicans continued to hold majority control over the Democrats in both the Senate and the House of Representatives, for the first time in four years, Republicans did not hold supermajority status in either chamber. Instead, Republicans held a four (of 30 total seats) and ten (of 60 total seats) seat advantage in the Senate and House, respectively. Countering these potential gains for a bipartisan coalition was the election of a conservative firebrand as their new Senate President. Senator Andy Biggs, who had authored legislation to eradicate AHCCCS (2011) (and is currently serving in the United States House of Representatives and a member of the House

Freedom Caucus) was elected over incumbent and more centrist Senate President Steve Pierce (Arizona Republic 2012).

Brewer promised that she would present her support or opposition for the Medicaid expansion when she unveiled her FY 2014 budget, during the first week of the legislative session in 2013. Leading up to the State of the State speech, Brewer requested that Director of the Governor's Office of Strategic Planning and Budgeting John Arnold work-up two versions of the state budget, one including the expansion and one excluding it. Normally, Arnold would have the budget ready for distribution a week prior to its release, but in the case of 2013, Brewer told him to wait until after the speech was given (Interview). As well as creating two versions of a budget, Brewer made two versions of her speech for the legislature. Brewer described her decision on Medicaid as a wrestle that required spiritual faith to act. The evening before her State of the State Speech, Brewer was up late into the night praying to know what she should do, knowing “mathematically it was the right thing to do. But I had to get it from the heart that it was the right thing” (Arizona Republic 2013, Sanchez 2013).

Ultimately, Brewer’s decision to expand Medicaid followed a gradual process. She was influenced by key staff members, including Arnold, and Chief of Staff Scott Smith, as well as several advisors outside her administration (Interview). The most convincing rationale for Brewer was the injection of federal funding to the state. While Brewer would change rhetorical framing throughout the long political campaign to have the Republican legislature approve her plan (Brewer 2013), the crux of Brewer’s arguments were consistently centered on the financial benefits for the state.

Helping Brewer come to this realization of the financial ramifications of expansion was a group of organized interests in Arizona (Interview). Six months prior to Brewer’s announcement,

two former associates of the governor, Chuck Coughlin and Peter Burns, were hired by the Arizona Council of Human Service Providers and many of the largest health care providers in the state to form the Arizona Health Care Coalition, which was created to support Medicaid expansion (Interview). Coughlin was the former chair of Brewer's re-election campaign and had more than thirty years of experience lobbying and consulting on Arizona politics, including the main lobbyist for the Brewer backed sales tax increase. Burns had been the state budget director for a previous governor, but now operated a consulting firm which had been contracted by the Brewer administration to analyze the financial impact of expansion on the state (Reinhart and Sanchez 2012). Both Coughlin and Burns had the experience, connections, and reputations to help the hospitals get access to the Brewer administration and the legislature (Interview).

2013 State of the State

On the afternoon of January 14, 2013, Governor Brewer stood behind the lectern in the House of Representatives in the State Capitol to deliver the State of the State speech. In the lead-up to the speech, the Brewer administration had leaked her remarks to the news media, while redacting her stance on Medicaid (Arizona Republic 2013). Just prior to her announcement, with an eye towards cutting off conservative dissent towards her decision, Brewer remarked:

“Nor can we simply wag our finger at the federal government. Trust me: I tried that once... Like many of you, I oppose the President's health care plan. That's why, after weighing the pros and cons of the ObamaCare health exchange, I opted against Arizona's participation. I also led Arizona in joining a coalition of states that sought to block the program in court, and I've taken every opportunity to argue for health reform with less bureaucracy, more patient choice and fewer costs”(Brewer 2013).

Brewer stressed the fact that the expansion of Medicaid would only shift eligibility marginally higher than what the Arizona voters have twice mandated through ballot initiative (and which Brewer had cut a year previously), while protecting rural hospitals, injecting needed federal capital into the budget, creating jobs, and providing health care to hundreds of thousands (Brewer 2013). From a rhetorical perspective, the state was not implementing the Medicaid

expansion; rather Brewer framed the opportunity for the state as a Medicaid Restoration Plan, to bring the state back into line with previous levels of generosity. With audible gasps and applause from the audience, Brewer announced her support for the Medicaid expansion.

Arizona Finances and the “Bed Tax”

Arizona’s financial situation had improved under the Brewer administration. Yet, the state was still facing a structural deficit in regards to its budget. While the FY 2014 budget proposal submitted by Brewer and eventually passed by the legislature did not add to the state deficit, without the infusion of Medicaid expansion monies, the state would have to tap into rainy-day funds and Brewer would likely have to pursue another temporary tax hike (Interview). Or as Brewer ended her discussion on the Medicaid expansion in her speech, the legislature needed to “weigh the evidence and do the math”(Brewer 2013).

Part of the equation in keeping state finances in the black with the Medicaid Restoration Plan was the implementation of the “bed tax”. The Arizona Health Care Coalition, representing all the hospitals in the state had coordinated their response to Brewer’s questions about financing the state portion of the Medicaid expansion (Interview). Brewer knew that one of the biggest barriers to convincing Republicans in the legislature to support expansion would be the potential financial costs to the state (Interview). Brewer included two components in her Medicaid Restoration Plan to address those concerns. First, she included a “circuit breaker” that would “AUTOMATICALLY roll back enrollment if the federal reimbursement rates decrease” (emphasis in the original)(Brewer 2013). Second, she allowed “hospitals and health providers to assess a fee upon themselves” to ensure that the “State General Fund bears NO COST in expanding Medicaid” (Brewer 2013).

The “bed tax” supported by Brewer was the product of lobbying by the Arizona Health Care Coalition, which would place a tax of six percent on all hospital revenues to cover the state’s portion of the costs of expansion, generating an estimated \$154 million from providers. This was not Arizona’s first foray into implementing a “bed tax”. Rather, provider organizations had floated the idea of a “bed tax” in 2011 when Brewer was pursuing drastic cuts to the AHCCCS program, but the providers were unable to present a unified front and their proposal did not go anywhere with the administration (Interview). Similarly, eleven hospitals in the Phoenix area were able to use the “bed tax” as leverage to convince the state to bring back the KidsCare (CHIP) program to the state, so state policymakers were familiar with that component of the program.

In conjunction with Brewer’s speech, her administration released several documents related to the Medicaid Restoration Plan. Yet, Brewer’s comments during the State of the State and the documents released by her administration did little to satisfy influential members of the House and Senate (Interview). Senate President Biggs was “surprised by her level of commitment” to expansion (Reinhart 2013), while House Appropriations Chair John Kavanaugh authored an op-ed prior to the announcement rejecting the expansion. Brewer’s argument for the importance of the financial impact of Medicaid expansion became more acute the day after Brewer’s speech (Interview), when the Supreme Court of Arizona held that the state had been underfunding its education budget and required the state to increase their FY 2014 budget by more than \$300 million (2013).

Brewer immediately hit the road in the aftermath of her State of the State Speech to drum up support for the Medicaid Restoration Plan across the state. Over a ten day period, Brewer gave the same verbatim remarks to the Tucson Metropolitan Chamber (Brewer 2013), East

Valley Chambers of Commerce (Brewer 2013), Western Maricopa Coalition (Brewer 2013), Prescott Chamber of Commerce (Brewer 2013), and the Yuma Chamber of Commerce (Brewer 2013). Additionally, Brewer also staged two press conferences at the largest safety net provider in Maricopa County and a small hospital a few hours north of the state capital, where she was buttressed by a phalanx of local and state health care and business leaders, including CEOs of twelve health systems, three health plans, and four Chambers of Commerce (Dockendorff 2013). In each of these stops, Brewer continually hammered the point that the Medicaid Restoration Plan would be an economic stimulus for the state, business, and individuals (Brewer 2013, Brewer 2013, Dockendorff 2013).

Institutional Design Challenges to Expansion

At the opening of the 2013 legislative session, Brewer had elevated the Medicaid expansion to the most visible and important policy issue within the state (Interview). The hope amongst supporters and opponents of the Medicaid Restoration Plan was to resolve the policy question quickly, so as to not bog down the rest of the legislative tasks that needed to be accomplished (Interview). Yet, independent of raising awareness, having the support of the business and medical communities, and projections of state savings, supporters of expansion faced a daunting challenge with the Arizona State Legislature. National attention was turned to Arizona in the aftermath of Brewer's announcement of support (Interview). The national conservative media were vitriolic against Brewer, with the National Review publishing two editorials deriding the governor, chiding her for "exemplifying that unfortunately common strain of Republican leadership that is uncompromising in rhetoric but opportunistic in reality" (The Editors 2013) and exhibiting "conduct unbecoming of a chief executive" and "economic illiteracy" while being the "Veruca Salt of governors" (The Editors 2013).

Additionally, a series of factors related to the institutional design of the legislature added several challenges to Brewer and her coalition of supporters to implement the Medicaid Restoration Plan. Democrats in the House and Senate were uniformly in favor of Arizona's efforts to expand Medicaid (Interview), which gave Brewer some leeway in the number of Republicans that would need to support her plan; for a simple majority, only three Republican votes in the Senate and seven Republican votes in the House would be necessary for passage, which Brewer and her advisors thought was possible to cobble together (Interview). However, a 1992 ballot initiative mandated that any legislation that makes a "net increase in state revenues" or "the imposition of any new state fee or assessment or the authorization of any new administratively set fee" (Arizona State Constitution 1992) would require a supermajority of two-thirds support. Brewer and her supporters argued that the Medicaid Restoration Plan's "bed tax" fell under one of the exceptions included in the ballot initiative and Arizona Constitution, but the legal question of votes necessary for passage was unclear and would fracture the Republican Party.

Further, the timing of the rise of ideological interest groups, most prominently the Tea Party in Arizona, coincided with a larger than normal turnover in the legislature (Interview). While Republicans did not have supermajority control in either chamber, there was a fundamental shift within the Republican Party during the election. This ideological shift in the legislature led to Brewer and supportive members being placed at a decided disadvantage. In the 2012 legislative session, there was a higher than normal amount of turnover within the House and the Senate, creating 31 legislators who were new to elected office (Arizona Secretary of State 2017). These newly elected individuals were both more ideologically conservative than their peers, but they were also more loyal to the grass roots Republican and conservative

organizations which had helped elect them, rather than with Brewer (Interview). There was also an informal rule in both chambers of the legislature that leadership would not bring any bill to a vote on the floor unless a majority of the majority party is in support of the measure (Interview); this meant that nine Senators or nineteen Representatives could kill expansion before it even got to the floor for debate.

For political expediency, Brewer and expansion supporters were keen to keep the FY 2014 budget and the Medicaid expansion connected (Interview). The only legislation that needed to be passed by the legislature was the budget. Without the expansion language in the budget bills, staff in the governor's office and in the House and Senate would have to re-adjust the budget and cut additional state spending. While it was officially the responsibility of the House and Senate Appropriations committee to develop the legislative language, the budget making process was primarily driven by the Governor and their staff, in consultation with the legislative leadership (Interview). Opponents of expansion wanted to keep the budget and Medicaid expansion separate, hoping that the governor would lose leverage over the Medicaid Restoration Plan once the budget was passed.

Fracturing Republican Response

In early March 2013, Brewer held a rally in support for Medicaid expansion outside the Capitol building, joined by 200 "doctors, family physicians, nurses and other health care professionals" (Benson 2013). Unlike her previous comments, Brewer expanded her rhetorical repertoire to focus more on the morality of the Medicaid expansion, focusing on the "human toll" and "human cost of tragedy" of being uninsured (Benson 2013). Yet, a counter rally highlighted the challenge associated with bringing the conservative legislature on board with expansion.

Several dozen Republican legislators were dressed in all black, mourning the betrayal of the executive against her party during the rally (Interview).

Not only were the Republican legislature members against expansion, but a more localized, grass roots revolt within the Republican Party emerged in the wake of Brewer's support. In total, 21 Republican Legislative Districts and five Republican County Committees passed resolutions in opposition to Brewer's expansion of Medicaid (Maricopa County Republican Committee 2013). Each of these legislative districts and county organizations promised that if their elected officials signed-on to Brewer's plans that the organization would undermine re-election campaigns and support primary challengers (Interview). While these resolutions were non-binding, they served as a signaling function to politicians that the grass-roots Republican Party organizations would not support Medicaid Restoration (Interview).

Ultimately, the push by Brewer to expand Medicaid created a rift within the Republican Party. The party was divided by supporters and traditional economic interests, including the Chamber of Commerce, hospital organizations, and small business groups, which had aligned behind the Medicaid Restoration Plan and ideological interest groups who were more interested in the purity of their movement and the rejection of Obamacare and an increased role of government. The latter group viewed the push for expansion as a betrayal of values (Interview). The county and precinct Republican Party leaders remarked that they had worked too hard to put Republicans in the legislature to only see them turn against the people and principles that put them in that position (Interview).

In an effort to bridge the divide between the local and grass roots Republicans and Brewer and other Medicaid expansion supporters, the governor sent a letter to all local precinct committee members the week that she unveiled her Medicaid bill. In the letter, Brewer

emphasized the political aspects of failing to expand Medicaid, outlining the detrimental effect of having the Arizona GOP being “blamed for tens of thousands of Arizonans losing medical care” during an election year, while also casting Barack Obama as the shared enemy between the two groups (Reinhart 2013).

For the second time in two weeks, Brewer led a rally in support of Medicaid on the steps of the Capitol building, though during this rally Brewer was joined by Republican legislators for the first time. From the House of Representatives, Brewer was joined by three members of the House Health Committee, including the Chair and Vice-Chair, and two Senators. Buttressed by nearly enough Republicans to push her Medicaid Restoration Plan through the chambers, Brewer again touted her Republican values, stating that "I've always been proud to be a member of a pro-life party. With this legislation, we're talking about people's lives, I refuse to stand by and let this many people needlessly suffer, especially when we have a solution" (Dockendorff 2013). After the rally and without consulting House leadership (Interview), Brewer’s office said that the House Health Committee would hold an opening informational hearing on Medicaid expansion in the coming days.

Speaker Tobin was unhappy with the unilateral announcement of a House committee meeting on Medicaid Restoration. The Speaker of the House in Arizona designates committee assignments, bill assignments to committees, and which bills move from the committee to the full floor for a hearing (Interview). Tobin was aware of representation from the leadership and membership of the House Health Committee during the previous day’s press conference and rally (Interview) and rather than assign Brewer’s expansion bill to that committee, Tobin assigned it to the House Appropriations Committee, chaired by Representative John Kavanagh. Kavanagh was one of the most outspoken critics of the Obama administration and the ACA in

the state legislature, calling the Medicaid expansion “toxic” (The Daily Courier 2013) and argued that expansion was “going to cost us, although I think maybe our children and grandchildren, because the level of debt this is going to increase in the federal government is nothing that's going to be paid for in our lifetimes” (Chihak 2013).

The Republican Party was further divided when AHCCCS sent an email to anyone who had signed up at town hall meetings held by the agency, in which they said in part: “Thanks to so many of you who attended the Governor's rally to stand with her in support of restoring AHCCCS coverage to so many Arizonans in need. Governor Brewer stood with you on the lawn of the Capitol to make sure your voices were heard. **Remember that the Governor's plan must be approved by the Legislature** (Bolding in the original email)” and that individuals can “tell the Legislature directly why the Governor's plan is the right thing for Arizona.” Kavanagh was incensed by the move, charging AHCCCS as “acting more like a community organizer than a government agency”(Pitzl 2013). In response to the AHCCCS email, Kavanagh capped the number of formal presentations to the committee, because he anticipated a large public turnout (Interview).

The public did not disappoint Kavanagh when the House Appropriations Committee was gaveled into session on March 20, 2013. Even with no binding vote scheduled to take place, the Committee members heard testimony for over four hours on the Medicaid Restoration Plan (Arizona State Legislature 2013). There were 171 individuals who either spoke or indicated their position on the Medicaid expansion, with 156 of the individuals in support of Brewer’s plan. Due to time constraints, only 36 individuals were allowed to testify, of which 27 were in support of expansion. The health care sector was well represented during this meeting, with representatives from 76 health care organizations and 17 physicians who were prepared to testify in support of

the legislation. Opponents of the Restoration Plan were generally represented by the Koch supported Americans for Prosperity of Arizona, representatives from county level Republican Committee's, and erstwhile and failed Republican candidates for state and Congressional elections. While a fairly consistent rhetorical pattern emerged through the meeting, there was also a bit of colorful language, like when A.J. LaFaro, the Chairman of the Maricopa County Republican Committee ended his testimony by stating that "Jesus had Judas. Republicans have Governor Brewer" (Arizona State Legislature 2013).

With the first formal meeting in the House in the books, Republican legislators and organizations set out to create conflict and disrupt the Democratic-Republican coalition which was emerging in support of expanding Medicaid (Interview). The Center for Arizona Policy, a non-profit conservative interest group in the state and one of the most powerful lobbying groups in the state (Interview), argued that Brewer's plan would use state funds to subsidize abortions and the group began circulating an amendment that would disqualify Planned Parenthood from receiving public money. This line of argument resulted in one formerly supportive Republican to oppose Brewer's plan (Herrod 2013). Additionally, Republican leaders who were opposed to expansion focused on devising a plan that would reinstate coverage for all adults up to 100% of the federal poverty level, mimicking policy design in Wisconsin and returning AHCCCS coverage to what the voters had intended with the ballot initiative in 2000 (Interview). While Democrats had announced their uniform support for the Medicaid Restoration Plan, Brewer could, and did, effectively ignore their caucus in any policy discussion (Interview). Rather, Brewer's hold on Democrats in the legislature was predicated on limiting poison pill amendments which would split Democratic support.

Institutional Design and Brewer's Leverage

Even with Medicaid expansion the focus of Brewer's legislative agenda, through the first three months of the 2013 legislative session there was little to show for it. Both Senate President Biggs and Speaker Tobin held sway over the flow of bills from committee to the floor and neither was supportive of Brewer's plan (Interview). President Biggs remarked that "'I'm not going to put (Medicaid) expansion on the floor. The Republican Party in this state has said, 'Don't do this'" (Arizona Republic 2013). Legislative leaders wanted to drag out the process of legislation as long as possible, with the hope that if made to wait, that Brewer would focus on getting the budget passed (Interview) or that her interest in expansion would wane as oppositional legislators lobbied their colleagues (Interview).

While the institutional design up to this point of the Arizona legislature had shifted power towards Biggs and Tobin, as the legislative session continued without action on either the FY 2014 budget or the Medicaid expansion, several changes in the operations of the legislature shifted to give the governor more leverage. The Arizona Legislature is semi-professional, meaning the legislators do not meet all year, though the session length is dictated more by policymaking than a calendar. In an effort to contain the length of the session though, the laws regulating the legislature are to nudge the policymakers to quickly finish the business of the state. One of these rules dictates that after a session has reached its 100th day, the legislators only have one more week to finish up any remaining business. Actually finishing by that day is more aspirational than achievable, so the rules allow the legislators to stay open on a week-by-week basis. However, the legislative salary is reduced by two-thirds as an incentive to action. The legislators had to remain in the capitol, but now Brewer could use the power of the purse-strings

to influence legislative action. The only constitutionally required action that the legislature needs to conduct is to pass a budget, which by this point they had not done.

A second point of leverage that Brewer could utilize in her attempts to get Medicaid expansion passed was the veto. The Arizona Constitution allows for the Governor to have a line item veto power for appropriations bills only, which was the preferred method for Brewer to have the legislature pass the expansion. As Medicaid expansion stalled, Brewer vetoed three Republican bills; all of the sponsors of the bills were outspoken critics of expanding Medicaid. None of the bills were tangentially related to Medicaid: creating certification for music therapists (Brewer 2013), reporting government spending for state and local government entities (Brewer 2013), and reducing the penalty for violations of firework uses (Brewer 2013). Each of the bills passed with bipartisan support and the veto was a clear message to legislators who opposed expanding Medicaid (Interview).

In each of the veto letters to the legislature explaining her actions, Brewer ensured that the rationale was specific to the policy and why she felt that the legislation either did not measure up or was unnecessary for the state to pursue. After continued inactivity from the House and Senate on the Medicaid expansion, Brewer changed her tune and made explicit the power of the veto in achieving her policy ends. Brewer announced that she would stop signing any bills until the legislature began to make progress on the budget and Medicaid expansion.

Institutional Design in the Senate Budget Process

Leadership in the House and the Senate diverged in their strategies for how to contain the Medicaid expansion. Both Tobin and Biggs were hopeful that with enough time, that Brewer's support of expansion would waver or that they would be able to chip away the handful of Republicans in their chambers who supported the program (Interview). Senate President Biggs

became increasingly entrenched in his opposition to the Medicaid expansion (Interview), a stance that earned Biggs the public recriminations of normally supportive groups and individuals (Arizona Republic 2013). Speaker Tobin, on the other hand, was much more interested in engaging with the Brewer expansion plans as an active step to change it to fit his preferred policy position. Tobin and his staff began working on an alternative plan for expansion that would place additional restrictions on the program, including time limits on eligibility, while also increasing the power of legislative oversight over AHCCCS (Interview).

Senate President Biggs, in an effort to conclude the legislative session, decided to call Brewer's bluff on the necessity of including the Medicaid expansion as part of the FY 2014 budget. The Senate Appropriations committee met on May 15, 2013 to discuss a ten-billion budget that would not include a Medicaid expansion and to vote on the budget the following day (Arizona State Legislature 2013). Biggs gambled that an alternative plan that would take \$135 million from the state's rainy day funds and increase coverage in an enrollment capped program for childless adults below 100% of the federal poverty level would be sufficient for the Republicans in the Senate who supported the Medicaid Restoration Plan (Interview).

The Senate Appropriations committee meeting was staid, especially compared to other public forums related to expansion. For supporters of expansion in the Senate, they knew they didn't have the votes on this particular committee to stop Biggs' proposed budget that excluded the program (Interview) and the Biggs backed budget passed the Committee meeting along partisan lines (Arizona State Legislature 2013). Yet, both supporters and opponents of Medicaid expansion knew that the following day when the full Senate would debate the budget was the more consequential meeting.

Each year, the budget is divided into ten separate bills, based on the appropriations of a particular policy area (e.g. health and human services). When the full Senate convened in preparation for the FY 2014 budget, debate extended to five hours, with the majority of the time spent on the Medicaid expansion. Repeatedly, Republicans who opposed the Medicaid expansion brought forth “poison pill” amendments to act as a wedge to divide the tenuous Republican and Democrat coalition that had emerged around the Medicaid expansion. More than 20 amendments were offered by President Biggs and Senator Kelli Ward, yet throughout each of the amendments, six Republican Senators voted together in support of the Medicaid expansion (Arizona State Legislature 2013, Arizona State Legislature 2013). After five hours of voting, a coalition of Republicans and Democrats in the Senate voted on a Health and Human Services budget that included funding for the Medicaid expansion.

Intra and Inter Branch Divisions: House Response to Senate Budget

While Speaker Tobin was more open-minded towards expansion than President Biggs, he was not a supporter of Brewer’s plan and was annoyed by the Senate’s rash actions. The Senate budget did not include any consultation from House leadership, with Biggs remarking that “The deal was put together on the other side, and I wasn’t included. It’s not a process that I’ve seen happen before” (Reinhart 2013). The general consensus amongst House Republicans was that the budget passed by the Senate was an “unworkable” piece of legislation (Interview). Adding to Tobin’s annoyance was that the Senate’s actions undermined his own work on Medicaid. The same day that the Senate announced that they would move forward with their budget proposal, Tobin released a series of bills as a starting point for negotiations over Medicaid, including proposals that would require public input on Medicaid, increase reimbursement for hospitals which provide services to Medicaid enrollees, and increase the reporting requirements for

hospital expenditures (Interview). Tobin's bills, which he unsuccessfully attempted to use as negotiations with the Brewer administration, got subsumed by the actions of the Senate and the Speaker was angered by his Senate counterpart's actions (Interview).

The relationship between the House and the Governor's office was no better. Brewer and Tobin met several times for meetings after the Senate passed their budget, but no real progress was made, either on passing the Senate bill, or on Tobin's expansion plan (Interview). With no progress, Brewer went back to leveraging the veto to add pressure to legislators. In each of five veto letters that the Governor sent to the legislature, Brewer insisted that she regretted

“...being forced to write this letter. The transmission of these bills has left me little choice but to exercise the clear terms of a bill moratorium I enacted more than two weeks ago. At that time, 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” (Brewer 2013).

Within the state legislature, there was also a ratcheting up of pressure and animosity in regards to the Medicaid expansion. One Republican Representative, in an effort to increase the pressure on undecided House members to vote against expansion, encouraged his constituents to contact members of the House. Nine Republican Representatives in the House were sent the same email:

“A well-regulated militia, being necessary to the security of a free state, the right of the people to keep and bear arms shall not be infringed.

“If you are ever asked why you shot the person, the only answer from your lips should be, I felt my life, or/and my family's life was in immediate danger of death. So I did what I had to do in order to eliminate this threat. Keep repeating (this same sentence) every time the defense attorney or anyone representing the armed aggressor ask you. They will try to rephrase or use other words or terms to confuse you but if you stay with the answer I just gave you, you will be found justified” (Arizona Republic 2013).

The email was reported to the police and the offending Representative apologized for encouraging the public to give input on the Medicaid Restoration Plan.

Two weeks after the Senate passed their version of the FY 2014 budget bill, Speaker Tobin released his own budget bills. While Tobin did include funding for the Medicaid expansion in his budget, the overall budgets differed substantially from the Senate version of the budget. The far-right contingent of the House of Representatives took exception to Tobin's budget proposal and revolted against the Speaker, remarking that additional cuts of 5% across each budget would be necessary for them to sign off on the budget, as well as holding a separate vote on Medicaid expansion (Pitzl 2013).

With divisions amongst the Republican members of the House and between the House and the other branches of government in Arizona, the House Appropriations Committee held their second meeting devoted to debating the Medicaid expansion. Unlike the first committee meeting held five months beforehand, this meeting would hold a binding vote (2013). Yet, similar to the Senate, the Committee meeting was seen primarily as a formality. Regardless of what happened with the Appropriations Committee, the real action would take place during the full floor when an amendment would be offered that would insert the Medicaid expansion into one of the budget bills (Interview). Even with the meeting being a formality, there was a significant public turnout, with 132 individuals either testifying or wishing to testify during the three hour meeting (Arizona State Legislature 2013), with 70 percent of the individuals supportive of expanding Medicaid.

Before the House could even take up debate in their full chamber on the budget bills and the Medicaid expansion, Speaker Tobin surprisingly adjourned the House for two days "to give the members a break" (Arizona State Legislature 2013). This was a miscalculation on Tobin's part. Governor Brewer was so incensed by the House's delay tactics that even as the lawmakers were preparing to leave the Capitol Building, the governor released a proclamation invoking her

Constitutional authority to call a special session of the Legislature starting later that evening (Brewer 2013). This was one final point of leverage which Brewer had at her disposal to force legislative action within the state. The Arizona Constitution allows the executive quite a bit of leeway declaring special sessions, defining what legislation can be considered, supplying the legislative language that has to be considered in the session, and even making changes to the rules for a legislative session (Arizona State Constitution 2017).

Institutional Design: Medicaid Restoration Special Session

Special sessions in the Arizona Legislature are frequent occurrences, though Brewer's Medicaid Restoration session did differ substantially in circumventing House and Senate leadership (Interview). While Brewer had proactively been working around both Senate and House leadership up to this point, calling a special session brought the divisions between the branches into sharp relief. By calling a special session and presenting a budget that was only worked on by coalition Republicans, Brewer effectively shut out the remaining Republican legislators and the public from giving any input into the budget and Medicaid, and fracturing the Republican Party more than just strong-arming the Medicaid expansion through during regular legislative order would have done (Interview).

When the special session was gavelled in by Speaker Tobin a few hours after giving his "members a break", there were only 33 members of the House present, all Democrats and Republicans who supported the expansion and one Republican who was particularly incensed by the Governor's actions. Representative Adam Kwasman rose to make an announcement after the special session began and addressed the remaining Republican House members who were watching from the gallery above. Kwasman then proceeded to pace around his desk, yelling at

his colleagues and the governor, while earning warnings from Speaker Tobin for his actions, by stating that:

“Governor Brewer couldn’t wait two more days for ‘Obamacare’. She wanted ‘Obamacare’ so badly that she could not wait to impose high taxes and huge government programs on the people of Arizona. Members and those specifically in my party, I know that your constituents did not send you here to allow members of the minority party to run roughshod over this house and this body...Shame on the members of this House and shame on the governor for calling in this session. With that, I would like to introduce the conservatives in the gallery...these members agree with us, that we will not stand for unnecessary special sessions”(Arizona State Legislature 2013).

The next day, on Wednesday June 12, the House and Senate met concurrently to debate ten budget bills, including the expansion of Medicaid. Governor Brewer welcomed the legislature, with a message on the purpose of the session, ending with the reminder that:

“Majority. That word has meaning in our republic. I trust that over the next 24 hours or so, a majority of the House and Senate will put an end to the games" (Brewer 2013).

During eleven hours of floor debate between the two chambers (Arizona State Legislature 2017), the fracturing of the Republican Party in Arizona reached new depths. Republicans in the Senate and House offered 26 and 35 amendments respectively, to embarrass and give difficult votes for their supportive expansion colleagues. Even the language used during the debate was marked by vitriol, with conservative members asking their fellow Republicans ““How are you not embarrassed for yourselves?”, "I have never once ever been ashamed of what we've done in this body. I've disagreed, but I've never been ashamed. But I can tell you this process, from the governor on down, is an embarrassment", and "This governor who became famous for wagging her finger in the face of the president is now wagging her finger in the face of this state" (Arizona State Legislature 2013). Yet the amendments and vitriol ultimately amounted shouting into the wind for oppositional Republicans. At 3:40 AM, with a vote of 33-27 in the House and

18-11 in the Senate, the Arizona Legislature passed the FY 2014 budget including Brewer's Medicaid Restoration Plan with the assistance of 14 Republican legislators (2013).

While Republicans and conservatives in Arizona were excoriating the governor and supporters of expansion, Brewer responded via Twitter that "It's sad day when a respected pro-life advocate uses this sacred issue to bludgeon supporters of life-SAVING legislation. #shame #medicaid" (Brewer 2013). As well as releasing a longer statement that read in part that she was:

"grateful to the Arizona lawmakers who have acted with courage and conviction by completing the people's business... As an elected official of more than 30 years, I know that this process was not easy or without political risk. By joining me in extending health coverage to hundreds of thousands of Arizonans, legislators of my own party have come under sharp criticism in some quarters. Some have had threats made not just against their political future, but also their personal livelihood. But I also know this in my heart: The great majority of Arizonans stand with us" (Brewer 2013).

Conservative Republican Response to Medicaid Restoration Plan

Yet, signing the bill did nothing to tamp down conservative revolt over the Medicaid expansion. Maricopa County Republican Party Chairman, AJ LaFaro, who had previously compared Governor Brewer to Judas during a House Appropriations Committee, upped his rhetorical attack against Republicans who worked across the aisle when he wrote a letter to the Republican legislative members comparing the Medicaid Restoration Plan with Pearl Harbor and that "Their egregious actions will have serious consequences. Their political careers are all but over and their days numbered" (Arizona Capitol Times 2013) while also saying that Republicans should be grateful that gallows hadn't been built to welcome home members who voted to expand Medicaid.

Jilted Republican legislators and conservative grassroots organizations engaged in three distinct but interrelated strategies to slow or stop the expansion from going into effect. First, grassroots organizations engaged in the very mode of policymaking that had expanded eligibility

in AHCCCS a decade earlier, by organizing a petition drive that would require public support for the expansion. Led by the grassroots organization United Republican Alliance of Principled Conservatives, the group had three months to collect the necessary five percent (86,405 total) of signatures to have a ballot initiative placed on the November 2014 election (Arizona State Constitution 2017) (overlapping the summer months, made it particularly challenging for volunteer circulators to meet the signature goal (Interview)). Supporters engaged in innovative efforts to increase their signature collection, including setting up booths outside of every Arizona Diamondback major league baseball game, as well as having musician Ted Nugent announce support for the petition drive during a concert in Phoenix (Interview). Ultimately, the United Republican Alliance of Principled Conservatives fell a few thousand votes short of the necessary amount for inclusion as a ballot initiative (Reinhart 2013).

Second, once the ballot initiative failed, conservative organizations, led by the Goldwater Institute, pursued legal remedies to the implementation of the expansion program, which ultimately took nearly four years before the legal questions were answered by the state's highest court, twice. Lastly, the sub-state Republican Party organizations reengaged in more symbolic revolts against Brewer. Six legislative districts passed non-binding motions to "censure" Brewer and the 15 Republicans who supported expansion and offered votes of "no-confidence" in their continued presence on the Capitol (Arizona Freedom Alliance 2013, Bentley 2013, Gila County Watch 2013, Seeing Red AZ 2013, Seeing Red AZ 2013, The Associated Press 2013). Ultimately, the legal challenge was the most fruitful, though ill-fated, attempt to roll back the Medicaid Restoration Plan.

Legal Response to Implementation

The day after the United Republican Alliance of Principled Conservatives announced that they had failed to produce enough signatures to place the ballot initiative, the Goldwater Institute, representing all but two non-coalition Republican state legislators filed a lawsuit to overturn the law (Sunnucks 2013). In announcing their lawsuit, a representative from the Institute argued that the Medicaid expansion amounted to “taxation without representation. What they've basically tried to do is make an end run around one constitutional provision, and, by doing so, we think they've violated a second constitutional provision”(Reinhart 2013).

The Goldwater Institute has long been an influential legal and policy organization in the state (Interview). Formed in 1988 and named after Arizona Senator and failed Presidential candidate Barry Goldwater, the think-tank supports research and litigation with a primary focus on limited government, economic freedom, and individual liberty (The Goldwater Institute 2017). Prior to the lawsuit, the Institute had been active in producing research that demonstrated the deleterious economic effects of Medicaid expansion (The Goldwater Institute 2018).

The crux of the lawsuit, *Biggs v. Betlach* was that the financing mechanism contained with Brewer’s plan to expand Medicaid, was a violation of state law and separation of powers. While the State argued that the legislators “are a disgruntled faction within the Legislature that was outvoted by a bipartisan coalition” and that the other plaintiffs lack standing to sue the state over expansion, writing that “Courts cannot, and should not, become involved in internal, legislative disputes” (Scharf-Norton Center for Constitutional Litigation at The Goldwater Institute 2014).

Three weeks before the Medicaid Restoration Plan was implemented by the state, the first oral arguments on the legality of the expansion was heard by Judge Katherine Cooper of the Maricopa County Superior Court (Superior Court of Arizona 2013). During the first week of

February 2014, Judge Cooper released her ruling (Cooper 2014), holding that precedent established from the Arizona Supreme Court required that an injury must be “personal, particularized, concrete, and otherwise judicially cognizable” when legislators bring a lawsuit against a governor (Jones 2003). Cooper found that the Plaintiffs are a “minority group within the Legislature who lost a battle over H.B. 2010. They do not claim a concrete, individual injury” and she held that the “Plaintiffs lack standing and that Plaintiffs’ Complaint must be dismissed.”

With a ruling against the plaintiffs, the Goldwater Institute vowed to continue the fight, filing a motion with the Arizona Court of Appeals in March 2014. The lead counsel for the plaintiffs, Christina Sandefur, argued that the supermajority rule implemented by ballot initiative was at stake over the case and that the legislative actions was contrary to voter intent (Sandefur 2014). The Arizona Court of Appeals, in their ruling in April 2014, agreed with Sandefur and the plaintiff’s argument, with the court holding that the Arizona Constitution “does not grant sole authority to the legislature to decide when a supermajority is required to increase existing taxes or impose new taxes” but that the judiciary also has a place in making those determinations (Gemmill 2014). As for standing, the Court of Appeals agreed with the plaintiffs that the state “virtually held [the Legislators votes] for naught” (Gemmill 2014). The civil suit was once again sent back to the Superior Court to rule on the merits of the provider tax and the legality of the majority approval.

Before the Superior Court could hear the returned case, Brewer and Director Betlach filed a petition for review with the Arizona Supreme Court. In January 2015, on the eve of her replacement being sworn in as the 23rd governor of Arizona, the State Supreme Court unanimously held that Republicans who had sued the Brewer administration *did* have standing to bring a civil suit, not as individual legislators, but “[t]heir standing flows from their power, as a

group, to have defeated the bill, if a supermajority was required for passage” and remanded the suit to the Maricopa County Superior Court (Berch 2014).

With the case remanded and the issue of standing resolved, an hour-long hearing before Superior Court Judge Douglas Gerlach in July 2015 focused on the merit of the civil suit, specifically on whether the financing mechanism to establish a hospital assessment was a fee or a tax. For the plaintiff, they argued that because the assessment was broad-based and redistributive, it met the criteria as a tax and therefore the legislature needed a two-thirds majority to pass expansion legislation (Bolick, Altman et al. 2015). The State responded that because the assessment was only applied to hospitals and was kept separate from the general fund it was rather an assessment, and therefore only a simple majority of legislative votes were necessary for passage.

In August 2015, Judge Gerlach issued his ruling. Relying on *May v. McNally*, an Arizona Supreme Court case, the judge held that the provider assessment included in the Medicaid expansion legislation did “not qualify as a tax” (Gerlach 2015). Gerlach then held that the assessment in the Medicaid Restoration Plan met the criteria outlined by the Arizona Constitution, which allows for an exception for two-thirds voting requirement that is “authorized by an Arizona statute, that is not prescribed by a formula, amount, or limit imposed by the legislature or any other Arizona authority, and that is set by a state officer or agency” (Gerlach 2015).

The ruling against the plaintiffs by the Maricopa County Superior Court did not deter the Goldwater Institute from continuing their legal arguments against the AHCCCS expansion. The Institute appealed the Superior Court decision with the Arizona Court of Appeals (Sandefur and Dynar 2017) and during the oral arguments in early 2017, the Goldwater Institute lawyers were

sharply questioned by the three judge panel, calling their statements against the legality of expansion one “of the most circular arguments I’ve ever heard”(Arizona Court of Appeals 2017) and found for the State of Arizona, that it would “require a contorted reading” of the applicable precedent and law to mandate a supermajority for passage of the Medicaid Restoration Plan (McCurdie 2017). The Arizona Supreme Court sided with the Maricopa Superior Court and Appeals Court that “The assessment is imposed by the director on hospitals, a narrow class, and directly benefits hospitals by expanding coverage for uninsured patients, thereby increasing payments to the hospitals” (2017).

1,614 days after Governor Jan Brewer signed the Medicaid expansion into law, with a new governor and only twelve of the supportive legislators still holding office, the legal arguments over the constitutionality of the program in the state of Arizona finally came to a conclusion.

Intra-Party Divisions during the Legal Process and a New Administration

While the litigants were battling over the legality of expansion in the court system, Republicans in the legislature who opposed expansion took legislative steps to rein in the Medicaid Restoration Plan. A series of bills were introduced by Republicans that would repeal the expansion (2014), or would add work requirements and other conservative reforms to AHCCCS (2014), only to be vetoed by Governor Brewer (Brewer 2014).

Brewer attempted to bridge the division within the Republican Party when she wrote an open letter to thousands of precinct members, making an explicitly political argument about the future of the Republican Party and the need for stopping the in-fighting. “To continue efforts to potentially hurt and intimidate those who stood with me only puts Republicans’ chances for electoral success next year back in harm’s way. We are allies. It is time to move on, work

together for a united front in 2014 and focus on the key issues that face our state”(Fischer 2013). Yet, the 2014 primary election was an opportunity for malcontent Republicans to oust the coalition members of the Republican Party and to send a message statewide that implementation of the Medicaid expansion was an aberration.

County and grassroots Republican organizations had promised to primary every Republican “legis-traitor” who supported expansion. At face value, these conservative groups had moderate success at uprooting the coalition Republican who supported expansion. Of the 14 Republicans in both chambers that supported Brewer’s expansion plan, four did not win re-election in the 2014 Primary or General elections. However, when looking closer, the threat of conservative primary candidates did not play as large a part in the 2014 election for those Republicans (Interview). Two of the policymakers had illnesses and job transfers, which precluded them from running for public office again (Associated Press 2013, Associated Press 2013, Pitzl, Rau et al. 2014). One Republican supporter, Senate Majority Leader McComish, announced that he would not run for re-election, citing “far-right activists” and precinct committee workers who had taken control of the Republican Party in the state (Fischer 2014). But his handpicked successor (a member of the House who also voted to support expansion) won the primary election over a Tea Party backed candidate by twenty percentage points and was elected to the Senate (Associated Press 2014). The final supportive legislator who did not retain his seat did not have any primary challengers and lost to a Democrat in the general election(Arizona Public Media 2014). While the coalition Republicans did face more Primary challenges in 2014 than they did in 2012 (in 2012, 9 of the 14 Republicans did not face any opponents in the Primary, which was reduced to 3 candidates by 2014) none of the supporters of the Medicaid expansion lost their seat to a more conservative challenger (Interview) and

supportive Republicans increased the average margins of their electoral victories in comparison with 2012.

With Brewer Constitutionally disqualified from running for re-election for Governor in 2014 (the Arizona Constitution added an amendment in 1992 that only allows governors to succeed themselves once (Arizona State Constitution 1992)), the fate of Medicaid expansion was in the hands of the next governor. With six Republicans included on the Primary ballot, there was a nearly uniform opposition to the Medicaid Restoration Plan. The leading Republican candidate, State Treasurer and former Cold Stone Creamery CEO Doug Ducey (who billed himself, rather unoriginally, as “the conservative Ice-Cream Guy”(M.S.L.J 2014)) had no involvement in Brewer’s efforts to expand Medicaid and came out strongly against the program during the primary, remarking that “[t]here are states that do things better than we do... There's also many states that went to the federal government and asked for waivers. I would've liked to see us do all of that to push back before we would entertain any new spending” (Sanchez 2014).

The only Republican gubernatorial candidate that was supportive of the Medicaid Restoration Plan was Scott Smith, the mayor of Mesa, Arizona. Brewer rewarded Smith’s stance on Medicaid with her endorsement two weeks prior to the primary election (Sanchez 2014), which was preceded by a series of endorsements for other statewide offices for the candidates that expressed support for AHCCCS. With the endorsement, the little known Smith jumped in polls and fundraising, but it was ultimately too late to overcome the frontrunner Ducey, with Scott running a distant second (Arizona Secretary of State 2014).

With the Primary election behind him, Ducey’s stance on Brewer’s Medicaid expansion softened, saying that Brewer has “done what they have done” but that with a “three-year guarantee from our federal government, this is something that our next governor will have to

look for ways to improve and reform” (PBS 2014). In November 2014, Ducey was elected governor, handily defeating Democrat Fred DuVal (Arizona Secretary of State 2014). Yet, even with Ducey’s softened tone, advocates and patients of the Medicaid expansion in Arizona were leery of the damage that Ducey could make on the expansion program (Interview). These feelings of apprehension were not softened when Ducey hired Christina Corieri, formerly of the Goldwater Institute, as his senior Health and Human Services policy advisor (Office of the Governor Doug Ducey 2017).

Waivers, Federalism, and National Politics

As the state and plaintiffs were awaiting the ruling from the Maricopa County Superior Court, the recently elected Governor Ducey and his administration were busy putting their mark on AHCCCS through federal waivers. Similar to a lot of other states that pursued Medicaid expansion waivers during the Obama administration, Arizona initially sought to include work requirements and a five year lifetime limit for enrollee eligibility, along with increased cost-sharing, health savings accounts, and healthy behavior incentive programs (Arizona Health Care Cost Containment System 2015). It had become commonplace for states that were pursuing waivers to also ask for work requirements and lifetime limits, as well as the rejection of the requests by the Obama administration. Arizona and the Ducey administration continued to negotiate with the federal government over the next year, finally coming to agreement on a waiver that excluded its most conservative elements (Centers for Medicare and Medicaid Services 2016), including the work requirement, lifetime caps, and cost-sharing for individuals below the poverty level. Even with these elements stripped from the Obama administration approved waiver, Arizona officials touted their reforms as “truly and fundamentally

transforming the way we deliver health care in Arizona”(Office of the Governor Doug Ducey 2015).

Settled policy in Arizona, both through the passage of the Medicaid Restoration Plan by Governor Brewer and the subsequent waiver by Governor Ducey, did not remain settled for long. The election of Donald Trump fundamentally altered the politics of Medicaid and waivers for the state of Arizona. Even though Ducey had little personal affiliation with the Medicaid Restoration Plan implemented by his predecessor, he understood the financial implications of “repeal and replace”, which was underscored by reports by state think tanks (Seidman Research Institute W.P. Carey School of Business Arizona State University 2017) and the Arizona Chamber of Commerce (Alltucker 2017). Ducey himself was reticent to support the Senate Better Care Reconciliation Act of 2017 because it would penalize the state for expanding Medicaid earlier.

In the wake of the failed federal attempts to “repeal and replace” the ACA, the Trump administration announced that they were open to allowing states to implement work requirements in Medicaid and other welfare policies, quickly approving these components in Kentucky, Indiana, and Arkansas Medicaid programs (Goldstein 2018). Members of the Ducey administration had been in negotiation with the Trump administration prior to these announcements (Interview) and the state had prepared an updated waiver that would bring in a lifetime limit on eligibility, work requirements, and an increased number of eligibility redeterminations (Centers for Medicare and Medicaid Services 2018). Arizona was one of the first states to receive federal approval for the work requirements, though they did not receive approval for the lifetime caps from the Trump administration.

Conclusion

Governor Jan Brewer and the supportive Republicans overcame long odds and many challenges to become one of the first Republican states to implement a traditional Medicaid expansion. Brewer's support for expansion was buttressed by several critical factors in the state. First, Brewer was able to couch her Medicaid Restoration Plan as part of a larger policy history within the state. She was not merely implementing the ACA Medicaid expansion, but rather she was bringing the AHCCCS back into alignment with the stated desires of the Arizona general public (though the reason why Medicaid needed to be restored was because Brewer herself had defunded the original program). Brewer and supportive legislators rhetorically divorced their Medicaid Restoration Plan with the ACA Medicaid expansion, knowing that connecting their plan with the ACA would prove unpopular with the largely conservative state. Additionally, Arizona has a lot of pride in their AHCCCS program (Interview), with policymakers viewing themselves as pioneers of the Medicaid managed care model. For as stringent as the AHCCCS program was initially, over the decades, the public had consistently supported increasing eligibility. With this history of striving for expanding coverage, Brewer and supportive legislators was able to leverage this policy history to their advantage in the debate over the ACA Medicaid expansion.

Second, there were three institutional design components within Arizona that helped Brewer in her Medicaid expansion efforts. First, the state legislature was required to pass a budget, which Brewer was able to leverage by including the funding and language of the Medicaid expansion in conjunction with this "must-pass" legislation. Second, when the legislature was dithering in response to Brewer's efforts, Brewer was able to apply financial and political pressure on reticent legislators. As the 2013 legislative session continued on, the legislator salaries were reduced, while also having to remain at the state capital. Brewer's use of

veto's as a moratorium on other legislation signaled her intent and seriousness in implementing Medicaid. Lastly, and most importantly, Brewer was able to call a special session and provide the legislative language for the session. The ability to call the special session provided Brewer and Medicaid supporters to force legislative action, all completely done on their terms. Brewer and supportive Republicans authored the budget bills that were passed in 2013 and set the rules for the special session, enabling her to achieve her preferred policy outcome.

Third, role of organized interests was essential in the final outcome in the state. The timing of interest group organization mattered for the outcome in Arizona. The Arizona Health Care Coalition proactively organized and hired key individuals to lobby in behalf of the Medicaid expansion before Brewer had announced her decision to support expansion. This group also had the internal discipline and unity to conceive and propose of a policy intervention, the "bed tax" that helped bring necessary Republican support for expansion, by agreeing to pay a portion of the costs of expansion. For the Arizona Health Care Coalition, the Medicaid Restoration Plan was the most important piece of legislation to lobby. During the 2013 legislative session there were other health care related pieces of legislation, but the policy preferences and resource allocation of the Arizona Health Care Coalition and provider organizations never varied during the session.

Lastly, the economic climate with the state contributed to the need for expansion in Arizona. During the early 2000's, Arizona had a booming economy, driven by tourism, construction, and small business growth. These types of industries were particularly hard hit during the Great Recession of 2007-08 and structural deficits in the state budget contributed to growing unease amongst Republican policymakers. Brewer had implemented a sales tax hike, angering her Republican base to try and close the financial gap in the state, but there were still

budget shortcomings. Brewer was able to leverage the financial benefits of expansion to sell her Medicaid Restoration Plan to policymakers and the public. Ironically, prior to the ACA Medicaid expansion, Brewer had largely balanced the state budget on the back of AHCCCS funding; but the Medicaid Restoration Plan provided the perfect policy vehicle to quickly infuse cash within the state budget.

The strategies employed by Brewer in implementing the Medicaid expansion did not come without costs though. One effect of the politics of Medicaid expansion was the intra-party divisions which emerged within the Republican Party. Even with Brewer, who had engendered a lot of grass roots conservative support from her emphasis on border security and state's rights, was unable to keep the Party unified after she supported Medicaid expansion. The fault lines within the Republican Party emerged across a variety of dimensions, one of which was unique to Arizona. This was the divisions between different levels of the Republican Party. The State Republican Party, which was more economically interests focused, was generally supportive of the Medicaid Restoration Plan. In contrast with the County and Precinct Party administration, that was more ideologically focused. The disagreements flared constantly between the two Republican Party entities, with the County and Precinct portions of the party using a variety of mechanisms to try and keep the State apparatus and the Medicaid Restoration Plan in check, to little effect.

Chapter 7: Michigan: State Finances, Inter-Party Divisions, and Waivers

“To judge from the conduct of the opposite parties, we shall be led to conclude that they will mutually hope to evince the justness of their opinions, and to increase the number of their converts by the loudness of their declamations and the bitterness of their invectives.”

- Alexander Hamilton, Federalist No. 1

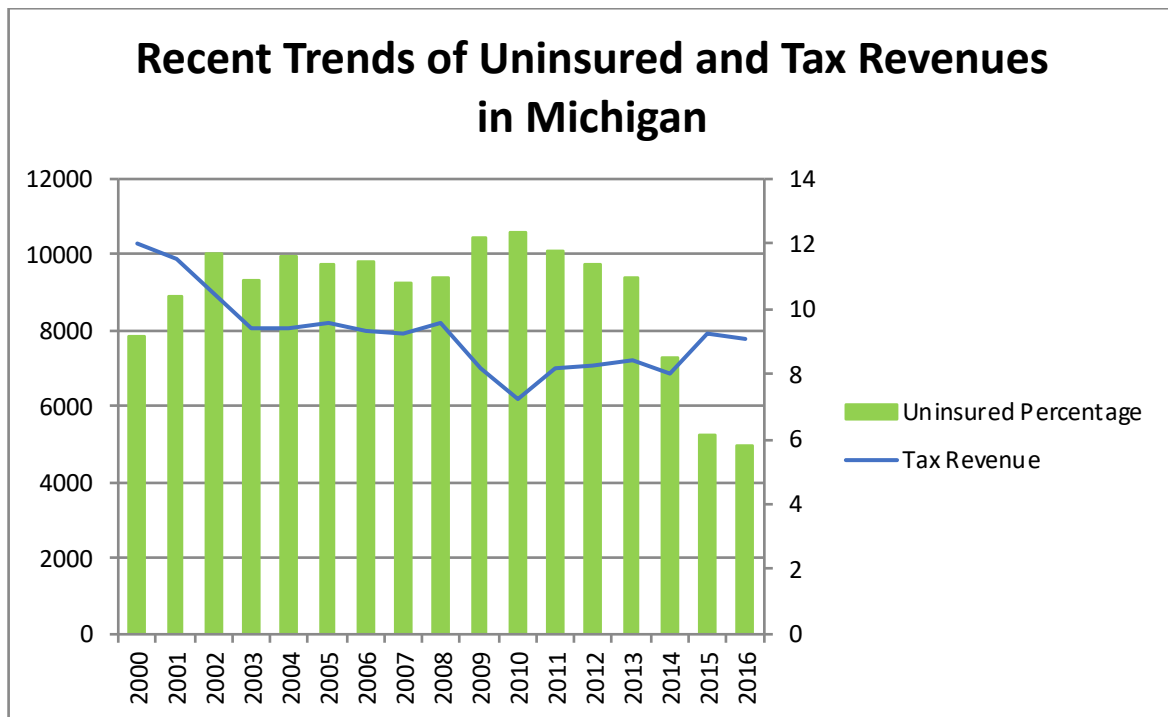
There were four overarching factors which helped contribute to Michigan’s decision to expand Medicaid: long-term financial and budgetary challenges in the state, shifting political environment with the election of a new governor and Tea Party legislators, the timing of when Michigan and Governor Rick Snyder (R) decided to pursue the Medicaid expansion, and the role of organized interests.

Michigan Economics

Few states were hit harder by the Great Recession of 2008 than Michigan. 60 of 83 counties in Michigan saw decreases in the Real Median Household income from 2005-2014, total housing ownership, and the percent of the population above poverty (Semega, Fontenot et al. 2017). Yet, in the case of Michigan, the economic trends associated with the Great Recession of 2008 masks the extent to which the state was financially unstable prior to the recession. From 2003 to 2007, the United States in total added 7.6 million jobs, yet Michigan was the only state to lose jobs during that time period, shedding 148,100 during that time period (Gantert 2014). In total, the employment base in the state was reduced by over 17 percent in the decade prior to the passage of the Affordable Care Act (ACA), the largest drop for any state during that time period (Oosting 2015). In the wake of the economic downturn, state finances were particularly hard hit,

with total tax revenue decreasing by over 15 percent in the decade prior to the ACA (even with an improving economy, the 2017 tax revenues for Michigan were five percent lower than the 2006 mark) (Pew Charitable Trusts 2017). Although Michigan had the ninth highest percentage of employees with Employer Sponsored Insurance (ESI) at the time of passage of health reform, businesses were dropping ESI coverage at a faster rate than national trends (Stock, Udow-Phillips et al. 2010), contributing to increases in the uninsurance rate in the state overall (State of Michigan 2011).

Figure 7.1. Uninsured and Tax Revenues in MI



Michigan Politics

Politically, Michigan has a long history of contested party politics. Similar to the other states included in this study, Michigan was led by a Republican governor and legislature during the debate and implementation of the Medicaid expansion; yet, unlike Arizona and Utah, this recent control by the Republican Party has been atypical of traditional party politics in Michigan.

Going back to 1969, Michigan has not elected concurrent governors from the same political party (State of Michigan 2017). The contested nature of politics in Michigan is also demonstrated by the partisan composition of the state legislature. In the thirty years prior to the passage of the ACA, there was split majority control between the two legislative chambers more than half of the time (National Conference on State Legislatures 2016). Prior to the 2010 election there was on average only a eight and four seat margin between Republicans and Democrats in the House of Representatives (out of 110 total seats) and Senate (out of 38 total seats), respectively.

Republicans have had majority control over both chambers and the executive since 2011, but an analysis of statewide and presidential elections demonstrates the success of the Democratic Party in the state. Even as the home-state of Republican nominee Mitt Romney, Barack Obama decisively won Michigan by 9 percent (Eggert 2012), continuing a stretch of Democratic electoral victories going back to 1988 (a streak which was broken by Donald Trump in 2016). From a Congressional viewpoint, a Republican has not been elected to the United States Senate since 1994 (Bradsher 2000), though Republicans have had more representation in the House of Representatives.

Year	Governor Political Party	State House of Representatives		State Senate		Presidential Elections	U.S. Senators
		Democratic Party	Republican Party	Democratic Party	Republican Party		
1980	R	64	46	24	14	R	D/D
1982	R	63	47	20	18		D/D
1984	D	57	53	18	19	R	D/D
1986	D	64	46	18	20		D/D
1988	D	61	49	18	20	R	D/D
1990	D	61	49	18	20		D/D

1992	R	55	55	16	22	D	D/D
1994	R	53	56	16	22		D/D
1996	R	58	52	16	22	D	R/D
1998	R	56	54	16	22		R/D
2000	R	52	57	15	23	D	R/D
2002	R	62	47	16	22		D/D
2004	D	52	58	16	22	D	D/D
2006	D	50	58	16	22		D/D
2008	D	58	52	17	21	D	D/D
2010	D	66	43	16	22		D/D
2012	R	46	62	12	26	D	D/D
2014	R	51	59	12	26		D/D
2016	R	46	61	11	27	R	D/D

Timing of Expansion and Waivers

The timing of Michigan’s decision-making and intergovernmental structure shaped whether and how the state implemented the Medicaid expansion. Michigan has been one of the most prolific states at negotiating with the federal government and pursuing waivers. Across all types of different waiver programs (Sections 1115, 1915, and 1332), Michigan has received federal approval for 17 waivers, the third highest amount for any state (behind Florida with 21 and Texas with 18; both states have much higher populations than Michigan), compared to the average state which had received 10 waivers. These waivers have included programs that expanded insurance access for behavioral health (Centers for Medicare and Medicaid Services 2018), for children (Centers for Medicare and Medicaid Services 2018, Centers for Medicare and Medicaid Services 2018), and the expansion of managed care programs in the delivery of care (Centers for Medicare and Medicaid Services 2018).

When Governor Rick Snyder signed the Medicaid expansion into law on September 16, 2013, Michigan was the 22nd state to expand Medicaid and Snyder was the 5th Republican Governor (after Susana Martinez (NM), Jan Brewer (AZ), Terry Branstad (IA) and Brian

Sandoval (NV)) to implement the program. However, Michigan was the third state which expanded their programs through waivers. When Michigan applied for its waiver, the application process from both a state and federal perspective had been streamlined considerably (Interview).

State	Expansion Signed into Law	Waiver Submitted	Waiver Approved	Waiver Implemented
Arkansas	April 23, 2013	August 6, 2013	September 27, 2013	October 1, 2013
Iowa	June 20, 2013	August 23, 2013	December 10, 2013	January 1, 2014
Michigan	September 16, 2013	November 8, 2013	December 30, 2013	April 1, 2014

Michigan policymakers learned from the Arkansas and Iowa experiences by talking with policymakers in those states (Interview); this learning amongst states has led to a diffusion of the types of components included in waiver applications (Grogan, Singer et al. 2016). Michigan shared similar cost-sharing and premium components with Arkansas and Iowa (Singer, Nelson et al. 2017), as well as a healthy behavior incentive program. But Michigan policymakers included several components of their expansion plan that were unique to the state. Michigan was also the first ACA waiver expansion state to include a Health Savings Account in their application, the state did not include the premium assistance model that Arkansas and Iowa implemented, and was the first state to implement a circuit-breaker in their waiver.

State	Cost-Sharing	Premiums	Healthy Behavior Incentive Programs	Premium Assistance (“Private Option”)	Health Savings Account
Arkansas	Yes	No	No	Yes	No*
Iowa	Yes	Yes	Yes	Yes	No
Michigan	Yes	Yes	Yes	No	Yes

*Arkansas initially did not include a Health Savings Account as part of their 2013 waiver application, but it did receive approval for the component as part of their 2015 reauthorization

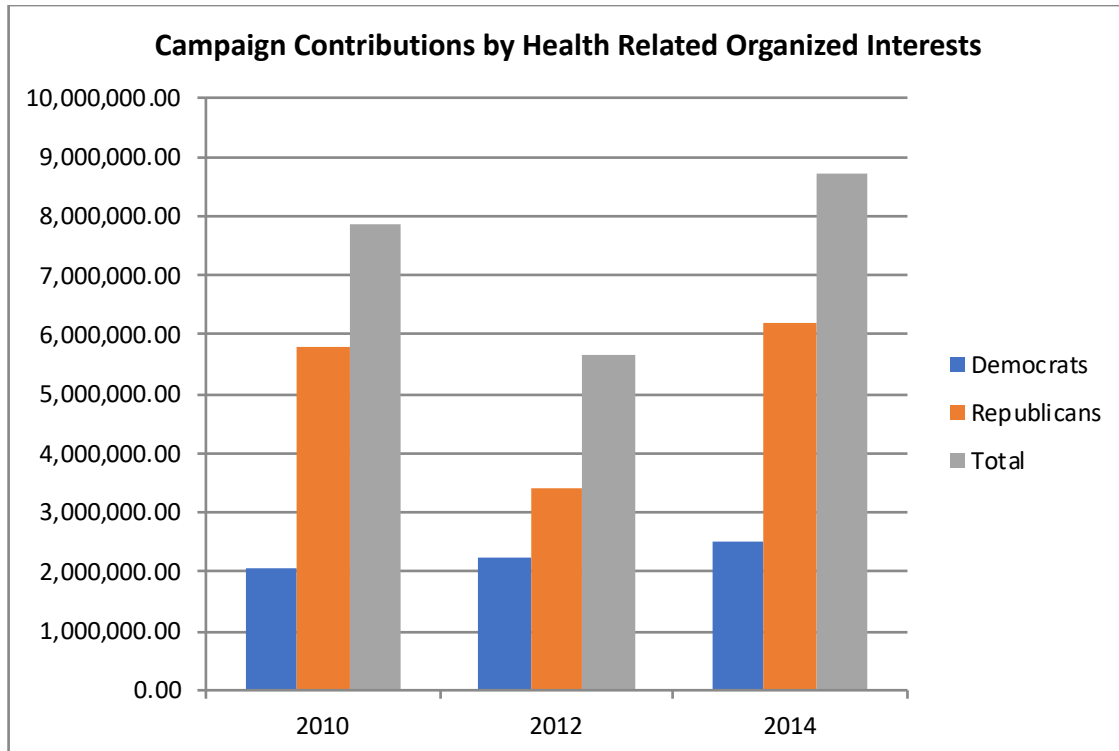
Organized Interests

The number of registered lobbyists in Michigan increased by nearly ten percent from the passage of the ACA and enactment of the Medicaid expansion (State of Michigan Secretary of State 2018). While these numbers represent lobbyists across a variety of different interests, it signals a substantial shift in the number of different formal organized interests operating in the state at the time of the debate over Medicaid (Interview). Additionally, organized interests can use campaign contributions to encourage a particular position on a policy. My 50-state analysis of campaign contributions from health related organized interests (defined as groups that represent health services organizations, insurance companies, health professionals, hospitals, and pharmaceutical companies) found that collectively (a) these organized interests are more apt to provide money to Republicans over Democrats and (b) increasing trend in total contributions over the lifespan of health reform. A similar dynamic is evident in Michigan, with more than seventy percent of all campaign contributions given by health related organized interests given to Republicans and an increase of campaign contributions by 11 percent between 2010 and 2014.

It is not only the number of organized interests or the money spent which influenced the policymaking process in Michigan, but also the expertise and the power of the organized interests which were engaged in the Medicaid expansion debate (Interview). A coalition of supportive organized interests across the political spectrum formed prior to Snyder announcing his support for expansion, representing the health workforce, the business community, hospitals, and insurance companies, which all had long-standing relationships and a high level of trust with policymakers (Interview). While oppositional organized interests, most notably Americans for Prosperity and the Tea Party, had money and manpower respectively, they did not have the

breadth of contact and long-standing relationships with policymakers in the state to have their position taken up by more than the most ideologically conservative within the state (Interview).

Figure 7.2: Campaign Contributions



2010 Gubernatorial Campaign

With the delay between when the ACA was passed, when the Medicaid expansion would be implemented, and Democratic Governor Jennifer Granholm term-limited (Michigan State Constitution 2018), a new governor would be in charge when health reform became operational in Michigan. There was a spate of candidates looking to fill Granholm’s seat, with sixteen individuals announcing their candidacy in the Democratic and Republican Parties (the most candidates seeking the executive office since Michigan’s statehood). Of these candidates, there were a number of well-known and longtime Michigan politicians seeking the office, including Attorney General Mike Cox, United States Representative Peter Hoekstra for the Republican

Party and Lieutenant Governor John Cherry, and Speaker of the House Andy Dillon for the Democratic Party.

Amongst these career politicians seeking the governor's office was Rick Snyder, a University of Michigan graduate in law and business who had worked in the private sector as an executive for Gateway Computers in California before returning to his home state of Michigan (Bomey 2015) forming a venture capital firm in Ann Arbor (Austin 2010) and had never run for elected office before. Snyder's timing for running for political office fit with the general trend in the state and nation, with 2010 marking the high point of the formation of the Tea Party and other grassroots organizations in Michigan and their growing resentment over politicians who had been in Lansing too long (Interview), though Snyder was never affiliated with the Tea Party.

In addition to his ability to portray himself as an outsider to Michigan politics, Snyder was able to parlay his private business experience to present himself as the candidate that would bring jobs back and re-energize the state economy. With the state economy reeling, Snyder remarked that "Our economy is in shambles and there is no doubt we are heading in the wrong direction. The economic problems in this state started long before the economic meltdown hitting the rest of this country due, in large part, to the lack of leadership and vision of the professional politicians in Lansing" (McGovern 2009). Snyder was also the only candidate that was able to tap into his personal wealth to be able to self-fund his campaign (Interview). His wealth allowed Snyder to increase his name recognition, for example by buying Super Bowl advertising time for the entire state where he labelled himself "One Tough Nerd", which became the handle of his prolific Twitter account (Phillips 2016). Taken together, as a candidate and a policymaker, Snyder was primarily focused on job creation and economic stimulus for Michigan, while also remaining largely independent from Republican or Tea Party policy orthodoxy (Interview).

As a candidate, Snyder rarely talked about health care, though “Healthcare Reform” was listed as one of his 10-point plan to revitalize Michigan, he did not go into any policy specifics on reform or the ACA (Rick Snyder for Michigan Governor 2010). Even after his election as Governor, Snyder remained quiet on the ACA; an analysis of all public statements related to the Medicaid expansion published in newspapers found that Snyder never publically said anything negative about the Medicaid expansion. Prior to the Supreme Court decision, Snyder’s only actions related to health care was the release of his “4x4” model that called for increased personal responsibility and the adherence of four healthy behaviors and four health measures (Snyder 2011); themes which would again be at the forefront when the state decided to pursue a waiver for expanding Medicaid.

After the Supreme Court decision in June 2012, Snyder was still not focused on the Medicaid expansion (Interview), never mentioning the program in his initial statement (Anstett and Spangler 2012) or blog post (Snyder 2012) after the ruling. Instead, much of his political capital was spent on implementing a state based insurance exchange (which the state legislature ultimately rejected implementing). Unlike other Republican Governors, and demonstrating his approach to policymaking, Snyder insisted that an analysis of the financial effects of expansion need to be conducted prior to any decision-making about the implementation of the Medicaid expansion (Anstett 2012).

Organized Interests and Snyder’s Support for Expansion

When Barack Obama signed the ACA into law, there was negative reaction from several organized interests in Michigan. The Michigan Health & Hospital Association released a statement expressing concerns over the lack of sustained reimbursement for the Medicaid expansion program and the financial challenges for their members (Michigan Health & Hospital

Association 2010) while the Michigan Association of Health Plans raised concerns about the lack of cost-containment strategies contained in the legislation (Michigan Association of Health Plans 2010). The Michigan Chamber of Commerce released a statement that read in part that “Obamacare is heavy on lip service and light on real reform...The solution to improving the quality and affordability of health care is through reforms that are sensitive to the dynamics of the marketplace” (Michigan Chamber of Commerce 2012).

Yet, the financial benefits associated with the Medicaid expansion pressed those formerly oppositional groups to form a coalition with the Michigan Primary Care Association and Community Health Centers, Michigan State Medical Society, Michigan Association of Community Mental Health Boards, Small Business Association of Michigan, Blue Cross and Blue Shield of Michigan, and Michigan Association of Health Plans, to lobby for implementation of the expansion (Interview). For some of these groups, the formation of a coalition was uncharted territory. Under different circumstances and with different policies, these individual groups had opposed each other, but the politics of the Medicaid expansion made strange bedfellows within the coalition (Interview).

Importantly, the coalition had formed prior to when Governor Snyder made his decision on the Medicaid expansion. In February 2013, Snyder unveiled his FY 2014 budget to the public, which included funding for expanded Medicaid. Snyder expressed his support at Sparrow Hospital (in Lansing, Michigan), with representatives from the coalition, as well as a number of white-coated physicians and nurses in scrubs. Snyder introduced his stance by announcing that he had only recently made his decision on whether to expand Medicaid and the he and the other government officials present (Lieutenant Governor Brian Calley and Budget Director John Nixon) had “crashed the event”. Initially, the press conference had been organized by the

coalition to encourage Snyder and the legislature to support Medicaid expansion, which led to the event being planned for the hospital in Snyder's backyard (Interview). Snyder remarked that he thinks these organizations "are right. The easy answer is that we are all here to support Medicaid expansion and that is the message I will be making tomorrow in the budget message" (Snyder 2013). For Snyder the two most important considerations in his support for expansion was the financial benefits for the state and sufficient physician capacity to handle the increased eligibility (Interview).

After Snyder's presentation, representatives from the coalition each spoke about their support for expansion. One particularly important theme that emerged from these comments came from Robert Sheehan, the CEO of the Michigan Association of Community Mental Health Boards, when he remarked that his organizations would now need to "urge the legislature to consider" the Medicaid expansion.

Institutional Design and Ideological Shift of Michigan Legislature

Term Limits

The legislature and was the crux of the Medicaid expansion decision going forward. The political climate which helped Snyder win election in 2010, posed a particularly daunting challenge for the Governor and expansion supporters. The Tea Party in Michigan reached its apex during the 2010 election, which resulted in a more conservative legislature that was antagonistic towards Obamacare (Interview).

The political dynamics in the state were also shaped by the institutional design of the legislature. In 1992 Michigan joined with fourteen other states that had implemented term limits on all members of the state legislature (National Conference on State Legislatures 2015). However, Michigan's term limits was the strictest in the nation, allowing the shortest amount of

time for elected officials to serve in the legislature, limiting legislators to three two-year terms in the House of Representatives and two four-year terms in the Senate (State of Michigan 2018). In the 2010 election for the state legislature, no state had more open seats than Michigan (Pallay and Graves 2011); fifty five seats, or forty percent of the total legislature, could not run for reelection, additionally 26 lawmakers announced that they were not running for reelection (Martin 2010).

This spate of open seats in Michigan, in conjunction with a wave of Tea Party associated members, refashioned Michigan politics and pushed the median legislator in a more conservative direction (Interview). A scorecard developed by the Michigan Tea Party highlights this ideological shift in the legislature. On a range from 0-100 (with higher numbers representing the ideal Tea Party candidate, the newly seated Republican legislators averaged a 73, compared to a score of 59 for the incumbent Republican legislators (Michigan Votes 2017). The election of conservative members in the legislature was not evenly distributed. The Senate not only retained its majority control after the November 2010 elections, but Republicans in the upper chamber now had supermajority control, which they have held since. Republicans gained 25 seats in the House, flipping majority control (Michigan Secretary of State 2010), but did not have a supermajority.

Budget Process

The budget process in Michigan is initiated by the Governor's office when they propose department specific requests for funding. Yet, the budget "is more than a statutory requirement. It represents a statement of priorities for the policy activities of state government" (State of Michigan State Budget Office 2018). Unlike other states, the executives control over the budget and leverage over the legislators is diminished once their proposal is sent to the Legislature.

The day after Snyder's introductory press conference, the governor had his first opportunity to present his priorities to the legislature during a Joint House and Senate Appropriations Committee meeting. Beyond reiterating the main talking points from the earlier press conference, Snyder also emphasized the effect that expansion would have on the state budget, allowing the state to save half of the projected \$103 million annual federal funding in a "health savings account" for the state to pay down their portion of the costs once the federal government decreases their share of the costs. Under these projections, no state general funds would be required to cover Medicaid expansion expenses until 2034, freeing up funds for other important projects (Michigan Government Television 2013).

After the presentation, the challenges Snyder faced on implementation were made clear. Budget Director John Nixon fielded questions from six members of the Joint Appropriations Committee on why the state would seek to actively partner with the federal government, the underlying assumptions of the cost and savings projections that the state made, and the need for personal responsibility amongst the newly eligible. Senator Patrick Colbeck (R) told Director Nixon that "If you're seeing reticence or pushback from us, I don't think it's a done deal that the Affordable Care Act is going to be coming into play. I, for one, am leery about tying my horse to that wagon" (Michigan Government Television 2013).

Once the governor has presented his budget to the Joint Appropriations Committee and given their presentation, the formal involvement of the Executive office on the budget is concluded. The budget process in Michigan alternates the chamber where the executive budget originates; in 2013 the House was the first to hold hearings on expansion. While the Snyder administration was ultimately unsuccessful in having the expansion included in the budget bill,

starting in the lower chamber provided momentum for legislative action several months later (Interview).

The first legislative action on Medicaid expansion in the House highlighted the challenges associated with Snyder's policy position. In March 2013, the House Appropriation Subcommittee on Community Health marked up the Snyder budget, cutting the proposed \$181.7 million coming from the federal government to support the Medicaid expansion, voting along party lines in the Committee and full House. Six weeks later, the upper chamber followed suit, once again stripping out the Medicaid expansion legislative language, with Senator Roger Kahn (R), the chair of the Senate Appropriations Committee, as the only Republican voting to keep the expansion language in the budget (State of Michigan 2013).

Members of the legislature who voted against the Medicaid expansion in the budget were quick to point out that they viewed their actions as merely the first step in a long process to determine if the state would implement the expansion. There was sufficient time for Snyder and his acolytes to further educate the House and Senate members on the appropriateness of the expansion and other legislative avenues open for the Medicaid expansion (Interview).

House Dissension and Negotiating Waivers

While both the Senate and House budget bills stripped out Snyder's proposal for expanding Medicaid, the proposal was not dead in either chamber. Rather, as it became obvious that neither the House nor the Senate had the appetite to include appropriations for the Medicaid expansion in the budget bills, the Snyder administration transitioned from lobbying for its inclusion in the budget to negotiating with legislators on what a "reform" of Medicaid would look like (Interview).

A group of four Republican legislators from both chambers had begun to meet to discuss the broad parameters of a Michigan expansion plan, with many of the “best ideas” from other states Medicaid programs being included (Interview). What emerged from these initial conversations with legislative stakeholders was that the state would need to pursue a waiver to bring more “skin in the game” for the newly eligible (Interview). Yet, unlike with the budget bill approach, pursuing legislation authorizing the state to apply for a waiver to expand Medicaid threatened to create divisions within the Republican Party.

Of the legislators that had been informally working on a Michigan plan for expansion the House members were more enthusiastic about the feasibility of passage. With the assistance of Speaker Jase Bolger, with pressure from the Snyder administration, Representative Mike Shirkey, along with Representatives Matt Lori and Al Pscholka, were selected to help flesh out and shepherd legislative language that would create an expansion program through Shirkey’s Michigan Competitiveness Committee (Interview). When he was initially approached by Bolger, Shirkey described being tempted to sink the chances of expansion by allowing his “personal prejudices” to intrude on the legislative process (Interview). Shirkey later described his stance on Medicaid as “not just a no on this issue, I was a hard no” (State of Michigan House of Representatives 2013).

For six weeks, Shirkey and the rest of the Competitiveness Committee worked with Republican members of the House to devise HB 4714 (Interview). This first iteration of the legislative language included radical changes to the Medicaid system, including a lifetime limits on eligibility, cost-sharing that exceeded federal regulations, required participation in wellness programs, and a circuit breaker ending the program as soon as the federal government stopped paying 100 percent of the costs (2013). These components of the House Republican plan were

seen by the representatives of organized interests as “poison pill” amendments that would allow Republicans to report to the hospital associations that they had voted in support of expansion, knowing that the Obama administration would not approve the waiver (Interview).

The first of six House Committee meetings related to the Medicaid expansion was held on May 14, 2013, in the Michigan Competitiveness Committee. In total, across all six of the Committee meetings, 126 individuals testified in regards to the Medicaid expansion, with more than half of those individuals indicating they were generally in support of expansion, but it took several iterations of the legislative language before general agreement from the Snyder administration and the coalition occurred. Because of the more far-reaching components of the legislative language, groups that had been supportive of expansion, including the AARP, the Michigan Consumers for Healthcare, Association of United Ways, and the Michigan Primary Care Association, all had representatives that testified against the bill during the first day of committee hearings on the subject. The Snyder administration privately raised concerns over the unanticipated consequences of the more radical components included in the bill (Interview).

In response to the concerns raised by the public testimony and pressure from the coalition and Snyder administration, an “ad-hoc” work group was formed and met for several weeks to iron out differences between the current legislative language in HB 4714 and the types of reforms that could gain approval with the federal government and Republican and Democratic votes in the House (Interview). This ad-hoc group was comprised of House leadership, representatives from the Snyder administration, and organized interests. From these meetings and input from groups beyond the coalition of initial supporters, came substitute legislative language that quelled the dissent amongst groups that were likely to support the expansion legislation, without repelling the needed Republican and Democratic support (Interview).

This updated legislation softened the circuit breaker language to only be activated if the federal government reneged on their ACA promised reimbursement or the state or if state savings are not sufficient for future costs and removed the lifetime limits such that members would not be excluded from the program. Rather once the newly eligible between 100 and 133 percent of the federal poverty level had been enrolled for forty eight months they could either (a) purchase private insurance on the federal health exchange or (b) remain on Medicaid but face increased cost-sharing requirements (2013), which would require a second waiver. The spokesperson for Speaker Bolger remarked after the unveiling of the substitute bill that “Our goal was for people to take more responsibility for their health and to pay for some of the cost... And there was a lot of thought that after the 49th month, people would just fall off this cliff. And that's why we're compromising" (Gray 2013).

With these changes to the legislative language, the expected cadre of organized interest supporters came out to testify to the Michigan Competiveness Committee. This included representatives from the Snyder administration (Michigan Department of Community Health Director James Haveman and Michigan Medicaid Director Steve Fitton), as well as representatives from the coalition. Additionally, the coalition was joined by the Michigan Unitarian Universalist Social Justice Network, Michigan Primary Care Association, Michigan Association of Community Mental Health Boards, Michigan Council for Maternal and Child Health, American Cancer Society/Cancer Action Network, Michigan Academy of Pediatrics, and MichUHCAN; all of whom switched their stances on the legislation with the amended language and testified in support of the House bill.

In addition to the testimony offered at the Committee meetings, there was written testimony sent to the members of the Competiveness Committee from the general public. Unlike

the formal testimony, the written testimony ran much more oppositional towards expansion, with only one author supporting expansion and the remaining 36 individuals opposing expansion, as well as expressed more vitriol than in the Committee presentations. For example, two members of the public encouraged the Committee to reject expansion and “end these unauthorized socialist tendencies as soon as possible” and reminded the legislators that “Tyranny commenced with the passage (sic) of Obamacare.” The written testimony was also much more explicit about the potential political ramifications for any individual who voted to support expansion, reminding the legislators that “everyone will be watching this vote very carefully” and that “This bill will be the straw that breaks the camel's back and destroy Gov. Snyder's re-election in 2014!!!”

With the uniform support of organized interest groups now on board, the Michigan Competitiveness Committee held their final meeting on the Medicaid expansion legislation on June 12, 2013. HB 4714, now called the Healthy Michigan Plan, passed out of the Committee by a vote of 9-5, with all five of the Democrats voting to support passage, along with four of the nine Republicans (State of Michigan 2013).

The day after the Michigan House Competitiveness Committee voted to pass the Medicaid expansion with bipartisan support for the measure the bill was expedited and placed for immediate passage. A series of amendments were offered by Democrats and Republicans during the floor debate, including exempting veterans of the armed services, limiting the state to authorize a state-based exchange, eliminating time limits, cost-sharing and wellness program requirements from the program, all of which were defeated. The only amendment that was approved by the full House would enroll all fee-for-service enrollees into contracted health plans as the mandatory delivery system for the program (State of Michigan 2013).

On the day Snyder signed the Fiscal Year 2014 budget into law, which he had initially hoped would include funding for a Medicaid expansion, he remarked that it was a “very solid budget. I’m proud of the hard work that’s gone in to make them happen. However, there’s still work to be done on Medicaid and the roads” (Office of Governor Rick Snyder 2013). A few hours after the Governor’s remarks, one half of the work to be done advanced through the House of Representatives as the lower chamber passed Medicaid expansion legislation.

In comparison with other states and the upper chamber of Michigan, there was a remarkable lack of debate or explanation of votes in the lower chamber. By the time the bill had gotten to the floor of the House it was clear from whip counts the bill had the necessary votes for passage in the lower chamber (Interview). Helping supporters get the expansion bill through the House was Speaker Bolger breaking with tradition and allowing the majority of the votes for the bill to come from the minority party (Interview). There were only eight individuals who gave a floor speech on HB 4714 and all eight of the speakers were supportive of the bill. The only Republican’s that stood to testify for the bill were one of the bill’s sponsors, Representative Matt Lori, and the chair of the committee which helped shape the bill, Representative Mike Shirkey.

One of the striking characteristics of the floor debate was the emphasis of the benefits of expansion for the state of Michigan writ large, instead of particularized for a subset of the population or region of the state. Michigan has one of the highest percentages of its population that identifies as African American (Kaiser Family Foundation 2018) and has a checkered history with racism (Fine 2007, Darden and Thomas 2013). Yet, the population of African Americans is not uniformly distributed through the state. More than 40 percent of Wayne County’s (where Detroit is located) population identifies as African American, while nearly half of the counties in the state have less than one percent of its population identifying as African

American (IndexMundi 2017). Representative Jim Townsend (D), representing portions of the relatively more diverse Oakland County, quoted a report from the Michigan League for Public Policy, listing 18 counties in Michigan that will have a higher percentage of their uninsured gain coverage under the Medicaid expansion than in Wayne County (State of Michigan House of Representatives 2013). Townsend’s highlighting the benefits of expansion while comparing to Wayne County was intentional, by addressing the argument that expansion would only benefit Democratic areas or racial minorities, which was one of the leading arguments amongst House Republicans (Interview).

At the conclusion of the floor debate, there was an outbreak of applause and cheering from the public gallery as the voting opened. The audience, this time joined by supportive Representatives, once again cheered and clapped when the bill overwhelmingly passed the House. Ultimately, there was broad bipartisan support for HB 4714. Only one Democrat, Representative Scott Dianda, who represents the uppermost portion of the Upper Peninsula of Michigan, voted against the expansion bill (Michigan Secretary of State 2017). After the vote, Dianda expressed concern that even with the structure of the waiver and the legislative language would prove to be too expensive for his constituents to cover the cost-sharing, even though individuals below the poverty level would be exempt from those costs (Interview).

	Yeas	Nays	Total
Republican	29	30	59
Democrat	47	1	48
Total	76	31	105

There was not nearly the same level of uniformity within the Republican Party, with the caucus almost evenly split on the vote. There were two overlapping characteristics of the Republicans that supported the Healthy Michigan Plan. First, they were more likely to be an

incumbent, residing in competitive districts, and in economically poor regions of the state. Second, there was uniform support for expansion from leadership (Interview). Not only did the Speaker of the House, Speaker Pro Tempore, and Majority Leader all support the legislation, but so did committee chairs for Appropriations, Commerce, Education, Elections and Ethics, Financial Liability Reform, Financial Services, Health Policy, Local Government, Michigan Competitiveness, Military and Veterans Affairs, Natural Resources, Regulatory Reform, and Transportation and Infrastructure (Michigan State Legislature 2013).

Senate Summer “Vacation” or Intra-Party Divisions

With passage in the House, the bill was transmitted to the Senate for consideration. Even though Michigan has a full-time legislature, every June, the body traditionally convenes for an “in-district work period” where the legislators do not travel to the capital for the summer months (Michigan Legislature 2018). With only a few days until the summer break would begin, supporters in the Senate and the Snyder administration were frantically trying to corral enough Republican support for passage, only to come up repeatedly short (Interview). Snyder was afraid of losing legislative momentum (Interview), so the governor cut short a trade mission to Israel to be in the capital to try and wrangle the votes and spur action by the Senate (Gautz 2013).

At this point, Senate leadership was not supportive of expanding Medicaid. The Senate Majority Leader, Randy Richardville did not have the votes to pass the House bill and policymakers in the upper chamber were upset that the House had softened the legislative language of HB 4714 (Interview). The Senate was constrained because there were fewer members overall and a higher percentage of Republicans that could block the progress of the expansion bill (Interview). With no viable path forward, the Senate adjourned for their summer break without taking a vote on the Medicaid expansion.

As a politician, Snyder was marked by his analytic and policy oriented approach to governing. After the Senate adjourned, Snyder was uncharacteristically emotional and angry; surrounded by physicians, nurses, and hospital CEOs, Snyder railed against the Senate and his own political party:

"Ensuring access to affordable, quality health care is one of the most significant challenges facing Michigan. The Healthy Michigan plan will help achieve that. Members of the state House already have acted on this and I appreciate their diligence. Unfortunately, the Senate did not even bring this critical legislation up for a floor vote before leaving for the summer. That's unacceptable. Our senators need to take a vote, not a vacation. . .I appreciate the fact that lawmakers have addressed other significant issues this year. But the job isn't done. I encourage all Michiganders to ask their senators why they left Lansing for the summer without finishing their work. That's what I'm going to do."

Snyder was not the only politician who was angry about the Senate Republicans actions, Senate Democrats used the adjournment as an opportunity to charge that "Senate Republicans have missed an important opportunity to do their jobs and govern in good conscience by not passing an expansion of Medicaid to nearly half a million low-income residents and their families in Michigan" (Michigan State Senate 2013). The growing division within the Republican Party was highlighted by Senator Rebekah Warren (D), remarking that "I think my colleagues from the other side of the aisle will find that they are actually in the minority today. They are letting a very small, but very vocal, faction of people drive a policy debate based on anger and fear" (Michigan State Senate 2013).

Senate Republicans were equally as upset with the governor for calling them out for adjourning (Interview). Senate Majority Leader Randy Richardville vocalized this anger when he spoke from the Senate floor:

"The reports of my death have been exaggerated. It's the same thing with the debate and discussion regarding reforming Medicaid in Michigan. That debate is not over, despite what you may be reading or hearing someplace else. The members of my caucus have been working hard to improve upon something that was hoisted upon us, if you will, by

the federal government with very little consideration of the impact it would have on the taxpayers of Michigan. The Michigan Senate is simply not ready to take a vote on whether or not to accept more than \$1 billion in federal dollars for Medicaid and the strings that come along with that. . . The legislation that we are talking about today will be referred to committee, and a legislative workgroup will spend the summer reviewing the current legislation and proposals offered by my colleagues that seek to improve upon what is already somewhat tremendous work that has been done by the House and other members of this committee. I look forward to working with the Governor—and I hope that he is still willing to work on this—the House, and my colleagues on the other side of the aisle to present a plan for a truly healthier Michigan” (Michigan State Senate 2013). Yet, even with Richardville’s promise of continued effort on the bill in the Senate, one of

the biggest proponents of expansion, Senator Roger Kahn, offered a less sanguine outlook for the upper chamber:

“One of my personal rules of politics is when it’s over, it’s not over. You know, we accomplish in our lifetimes only a tiny fraction of our hopes, mankind’s hopes, our dreams, and our needs. Nothing we do is complete, which is another way of saying that understanding always lies beyond us. . . We plant here seeds that one day will grow. We water the seeds already planted by prior legislatures. We water them knowing that they hold future promise. We lay foundations that will need further development. . . We cannot do everything, and there is a sense of liberation in realizing that. It may be incomplete, but it is a beginning, a step along the way, an opportunity for others to come and do the rest. We may never see the end result, but that is the difference between generations. We are workers, not God; politicians, not prophets. We are architects of a future not our own” (Michigan State Senate 2013).

Gubernatorial Bully Pulpit and Senate Workgroup Formation

Snyder kept on the offensive in the days after the Senate’s adjournment. Two days after the Senate left Lansing, Snyder penned an op-ed published in the Detroit Free-Press (the largest newspaper by circulation in the state), which once again castigated Senators from his own party for leaving the capital without voting on the Healthy Michigan Plan (Snyder 2013). The Snyder administration examined potential options that would force the Senate to reconvene and vote on the bill, though they determined that they did not have the legal authority to call the Senate back into session and force a vote (Interview).

The workgroup was led by Senator Kahn from the Appropriations Committee and was initially announced with six other Senate members, all of which were Republicans. Eventually, additional members of the minority party in the Senate were included in the discussions and development of the Senate substitute of the Healthy Michigan Plan. Snyder responded to the workgroup formation by remarking that it was “good progress” but also urging “Senate leadership to establish a specific date for a vote on this important legislation” (Snyder 2013).

With Snyder traveling across Michigan holding town halls and rallies in support of Medicaid expansion, the Senate workgroup began meeting to flesh out their approach to expansion (Interview). While the Legislature was on break, there were several days through the summer where procedural votes were occurring; during these days, the members of the Senate workgroup, Snyder administration officials, representatives from organized interests, and House members met (Interview). Underscoring the fracture between the executive and legislative branches in Michigan was that one of the points agreed to during these meetings was that the Governor would no longer refer to their legislative break as a “vacation” (Interview).

After a month of meetings, the workgroup introduced the Senate version of a Medicaid expansion bill. While supporters of the Senate bill pointed to large changes and increased reforms between the House and Senate versions, in actuality the differences were not significant (Interview). The Senate plan included adding more incentives to the healthy behavior incentive program and increasing the frequency of reports for the state on enrollment, access, and costs of expansion (2013).

Competing Plans – The Senate Government Operations Committee

At the same time that Kahn had unveiled the Healthy Michigan Workgroup plan, two other Senate authored Medicaid expansion plans were introduced as alternatives to the Snyder

backed Healthy Michigan Plan, SB 422 (2013) and the combination of SB 459 (2013) and SB 460 (2013)). These alternative bills were crafted so to siphon Republican support away from the Healthy Michigan Plan and to give an outlet for Republicans who felt overlooked during the negotiations around the Medicaid expansion (Interview). All three bills were assigned to the Senate Government Operations Committee, chaired by Senate Majority Leader Richardville.

With two days set aside for the Government Operations Committee to hear testimony on the three bills, the entire first day of debate was focused on the Senate substitute for the Healthy Michigan Plan. The four hours of public testimony began with three government officials – Steve Angelotti, Jim Haveman, and Steve Fitton. Angelotti was the Associate Director for the Senate Fiscal Agency and presented a brief overview of how the bill would work and the financial projections of implementing the substitute bill, which showed net cost savings for the state for 15 years (Michigan State Senate 2013). Haveman and Fitton jointly testified in behalf of Governor Snyder, arguing that the Healthy Michigan Plan should be “stamped as Made in Michigan” as a unique approach to expanding Medicaid (Michigan State Senate 2013). The Snyder administration officials also emphasized the readiness and preparation of the Medicaid system and organization in Michigan to be able to handle the reforms which the legislation would place on the government and that the Medicaid program in Michigan (Michigan State Senate 2013).

Representative Mike Shirkey described working “hand in hand” with Senator Roger Kahn, the chair of the Senate workgroup to improve the bill. These improvements included “more robust reforms, more robust controls, more robust accountability” in the Senate substitute (Michigan State Senate 2013). Shirkey closed his testimony by stating that the “version of the

legislation in front of you today is a substantial improvement over the House bill” (Michigan State Senate 2013).

Following the testimony from the Snyder administration and the House of Representatives, the coalition of organized interests which had been working together with the Snyder administration and legislators on the shape of the Medicaid expansion legislation, was called on to testify. Representatives from the Michigan Association of Health Plans, Michigan Health and Hospital Association, Michigan Chamber of Commerce, Small Business Association, and Blue Cross and Blue Shield of Michigan jointly testified before the committee. The effect of the politics of Medicaid was in full display during their testimony. All of these organizations had previously worked together and against each other on other policies (Interview). Yet, the ACA Medicaid expansion represented a win-win for each of the groups to bring in more customers and to bring more money into the hospitals and businesses (Interview).

The coalition touched on three similar topics during their testimony. The representatives argued that the state and their organizations were uniquely situated to implement the modified Medicaid expansion. Rick Murdock, the CEO of the Michigan Association of Health Plans reminded the Committee, his organization would be the one placed at financial risk for cost overruns in the Healthy Michigan Plan, but that the organization was “shovel ready” as soon as the legislation was passed and the waivers from the federal government were approved. Dave Finkbeiner, the CEO of the Michigan Health and Hospital Association, and others emphasized the economic stimulus of the Healthy Michigan Plan and the benefit that expansion would have on the more than half a million individuals employed by the hospitals, representing the largest employer in many of the legislators districts. Lastly, for a policy as politically charged as the Medicaid expansion, the representatives tried to make their support for the Healthy Michigan

Plan apolitical. These representatives never uttered the word Obamacare or ACA while discussing the benefits of expansion. In the case of the representatives from the Small Business Association and Chamber of Commerce, they had to walk back previous statements about tax policy and health reform.

After this orchestrated opening to the testimony, the Committee opened the floor for the general public to testify. Even without testifying, organized interests tried to make their mark on the debate, like the row of members of the Service Employees International Union (SEIU) who stayed in the committee room for the duration of the meetings, wearing their trademark purple and yellow clothing. While all the individuals and organizations up to this point were supportive of expansion, the rest of the public testimony on Senate substitute 4714 was mixed in its stance. Twenty-three organizations and individuals voiced support for expansion, while ten individuals expressed opposition to the Senate bill. Supporters of the expansion bill followed a similar script that was laid out by earlier testimony. Opponents of expansion offered more varied and oftentimes more emotional pleas against the Medicaid expansion. For example, Jane Wilson, representing the Conservative Constitution Americans (sic), argued that by expanding Medicaid it would act as “a death sentence to the poor. How many more children will die because they will have Medicaid?” before starting to cry and pounding her fist against the podium with each word, while repeating the phrase “Never give in. Never give in. Never give in.”

Alternative Expansion Legislation

The second day of public debate and testimony was reserved for hearing testimony on the two alternative expansion bills. When the Senate workgroup met during the summer of 2013, both of the alternative bills were presented to the group, but none of the components in the

respective bills were included in the Senate substitute (Interview), and this was the first appearance for either alternative bill before a Legislative committee.

The first of these alternative bills, SB 422 was sponsored by Senator Bruce Caswell (R-Jackson). Caswell had been working on his bill for over a year, presenting the seventh draft of the legislation to the Committee (Interview). Caswell wanted to differentiate his more “thoughtful” approach to expanding coverage with the “hurried” approach that the House and Senate had engaged in with the Healthy Michigan Plan. Caswell’s bill would divide the population along the federal poverty level. Individuals above that threshold would receive subsidies and cost-sharing reductions to purchase private insurance, while individuals below the poverty level would be offered a “basic health insurance plan” that would cover primary care appointments and other non-specialist services, while also requiring cost-sharing and premiums. For Caswell, one of the main features of his bill was that it would provide the state an additional three years to negotiate with the federal government, allowing state policymakers the time to determine the future of health reform (Michigan State Senate 2013). No organizations or individuals came to testify in support of Caswell’s bill after his presentation to the committee.

The second alternative bill presented to the Government Operations Committee was sponsored by Senator Patrick Colbeck (R-Canton Township), one of the most conservative officials in the Michigan Legislature (Interview). The central crux of Colbeck’s bills was to reduce the costs of health coverage in Michigan such that expanding Medicaid was no longer necessary as a policy outcome. Colbeck argued for a “free-market approach to improving high quality health care coverage”. For an ardent opponent of health reform, his plan relied on Section 10104 of the ACA to set up “Direct Primary Care” medical home plans in Michigan; this model of care would create a contracted relationship between a patient and physician where an

unlimited amount of primary care services would be provided to a patient for a monthly fee (2013).

Unlike Caswell's bill, Colbeck brought a retinue of supporters to testify with him at the Committee meeting: noted conservative writer, Republican policy advisor, and physician, Avik Roy; Tom Valenti, President of BlueSky Health, a patient centered medical home located in central Michigan; and Dr. Kenneth Fisher, a member of the organization Docs 4 Patient Care. Each of his coterie of supporters offered different arguments for why they supported Colbeck's bill. Roy argued that Medicaid is a flawed system that does not offer real access to health care, but merely provides an insurance card. Fisher was focused on the disruptive effect of the ACA on patient-doctor relationships, arguing that the ACA and the Health Information Technology for Economic and Clinical Health (HITECH) Act had increased the administrative costs and time associated with practicing medicine. Lastly, Valenti argued for improvements to quality and reduced costs which the direct primary care program would provide for the newly eligible.

After 10 hours of testimony on the Senate substitute Healthy Michigan Plan and two alternative bills, the Senate Government Operations Committee voted to pass all three bills on to the full Senate. Only the Senate substitute for HB 4714 was passed unanimously, while the alternative bills passed on party lines, 3-2. The Republicans on the Committee explained their rationale for passing all three bills as keeping the policy options open for the state and for allowing the bills to "see the light of day" and get more feedback and ideas (Interview). The committee members did not believe that the two alternative bills were ready for implementation but that "careful consideration" should be taken to address the problem of insurance coverage in the state (Interview).

Throughout the two days of testimony there was clear lingering animosity between the Senate and the Snyder administration. Senators laced comments throughout the proceedings which poked at the Governor's statement about "taking a vote and not a vacation". With a four week gap between the vote by the Senate Government Operations Committee and when the full Senate was going to reconvene from their break, Snyder kept up the pressure on the legislature, reminding the Senate that "This is an opportunity that we can't pass up. Too many Michigan lives depend on it" (Gray and Erb 2013). The coalition of organized interests hired the Martin Waymire public relations firm and organized an outreach campaign that had put billboards up throughout the state and structured email communications to legislators (Interview). The coalition was not alone in increasing outreach on the eve of the Senate vote, Americans for Prosperity – Michigan spent several hundred thousand dollars on radio advertisements, held events around Michigan, and had organized member communication to oppose the Senate substitute bill (Interview).

Institutional Design: the Near Failure of Healthy Michigan and Delayed Implementation

As the full Senate convened to debate the Medicaid bills, policymakers and political insiders in Michigan recognized that it was going to be a contentious and close vote (Interview). The twelve Democratic Senators were all prepared to vote in support of the Senate substitute bill (Interview), but there was less clarity if there was going to be eight Republicans to vote in support of the bill on the floor. Highlighting the expected contested nature of the vote, Lieutenant Governor Brian Calley signaled that he was on hand to cast the tie-breaking vote in support of expansion if the 38 member body tied on the bill (Neher 2013).

Senate leadership determined that Colbeck's bills, despite passing out of the Government Operations Committee, needed further refinement and input before it should be debated by the

full Senate (Interview) and his alternative bill was put back with the Rules Committee. Caswell's bill was the first to be debated by the Senate and there was very little support or enthusiasm for his approach. Besides Caswell, there was only one other member of the Republican caucus that spoke in favor of the bill before it ultimately failed to pass by a vote of 9-29. Only one Republican member of the Government Operations Committee voted in support of Caswell's bill on the Senate floor. Yet, the lack of Republican support for Caswell's bill should not be read as support for the Senate substitute. Rather, it is indicative of the desire to not engage with any legislation that would deal with the Medicaid expansion or the ACA (Interview).

With Caswell's bill voted down, the Senate would now consider their substitute for the Healthy Michigan Plan. Senator Colbeck, unable to present his own bill, had two primary mechanisms by which he could impede passage of Medicaid expansion. First, Colbeck offered two amendments that would have changed the financing of the program and reporting of costs for the state. In both instances the amendments were voted down with a majority of Republican opposed to the changes. Second, Colbeck was able to temporarily leverage a quirk of the institutional design of the Michigan Senate to nearly derail the Healthy Michigan Plan.

Before Colbeck could employ the second strategy, six Senators rose to testify about the Healthy Michigan Plan. Republican supporters were careful to craft their stance in a way that was divorced from the broader Obamacare. During his introductory remarks to the bill, Senator Kahn strenuously argued (at one point pounding his fist against the lectern to emphasize his point) that the bill being voted on was not Obamacare and the ACA. A second supporter began his remarks with the comment that the "ACA is one of the worst pieces of legislation passed by Congress in many years" and that hopefully there would be a day when it was no longer the law of the land, but that the state and hospitals needed the financial support of expansion. These

points were contested by opponents of the Healthy Michigan Plan; Senator Colbeck joked that “For a piece of federal legislation, we are sure talking about Obamacare a lot in the state legislature”.

The first attempt to pass the Medicaid expansion requires a short explanation of one of the rules of the Michigan Senate. The Michigan Senate Rules stipulate that any bill that passes the body must either have at least a 20 vote majority (of the 38 Senate members) or must end in a tie (with voting split 19-19) with the deciding vote cast by the Lieutenant Governor (Michigan State Senate 2018). As Lieutenant Governor Calley opened voting on HB 4714, Senators had one minute to cast their vote (Michigan State Senate 2018). As the minute was elapsing, the predictions about a tight vote for the Healthy Michigan Plan came to fruition. The vote stood as 19-18 for passage, with Senator Colbeck abstaining from voting against the bill as the seconds trickled down. Even though a slight majority of Senators had voted to approve the Healthy Michigan Plan, it had failed to pass the upper chamber because it did not have twenty votes, nor was it tied and Calley could not issue a tie-breaking vote (Michigan State Senate 2013).

While Colbeck made the strategic choice to invoke the little known loophole in the Senate rules, there was laughter from the public gallery, without realizing what Colbeck’s action meant for the passage of the bill. Lieutenant Governor Calley was less sanguine about Colbeck’s efforts to hinder the passage of the bill (Interview). As the seconds were clicking away on the vote and there was no movement from Colbeck to vote, Calley sat glaring at the Senator. Senator Arlen Meekhoff, requested a motion to reconsider, which passed with 21 votes, allowing supportive Senators one more opportunity to pass the bill (Michigan State Senate 2018).

After receiving the motion to reconsider, the Republican Caucus met for two and a half hours as the supporters of the Senate workgroup worked to flip one of the no votes (Interview).

Of all the Republicans that had voted against the Healthy Michigan Plan, the most likely to flip was Senator Tom Casperson, who represented twelve counties in the Upper Peninsula of Michigan, one of the poorest areas in the state that would benefit greatly from the Medicaid expansion. Casperson was the first person that Kahn and other supportive Senators met with in the Caucus to gain his support (Interview). Casperson only required one amendment to the Senate version of the Healthy Michigan Plan to swing his support and importantly not cost the fragile coalition in the House and the Senate any of its prior supporters (Interview). He requested limits placed on the amount that hospitals could charge uninsured patients for his support of the bill, as well as promises from Director Haveman, who joined in the negotiations with Casperson, on additional agreements that would benefit the economically struggling Upper Peninsula (Interview).

With Casperson now in support, the coalition of supporters for Medicaid expansion now had sufficient votes for passage of the Healthy Michigan Plan. When the number of “ayes” reached twenty, there was an audible gasp from the public gallery and a loud cheer. Once again, Senator Colbeck waited to vote and was jeered from the public gallery until he finally voted against the bill; with Colbeck’s “nay”, the Senate passed the Healthy Michigan Plan 20-18. In total, more than 200 people worked to shape the bill that was passed, from across the political aisle, with input from agencies, legislators, and organized interest groups (State of Michigan House of Representatives 2013).

Vote on Immediate Effect

One more element of the institutional design of Michigan was center-stage after passage of the Healthy Michigan Plan. The Senate now had to consider whether to give the legislation immediate effect. Immediate effect requires two-thirds of the members in support and would

allow Michigan to expand Medicaid starting on January 1, 2014, the first day of eligibility under the ACA. Failure to vote immediate effect would result in a delay of ninety days after the session ends in 2013, pushing the implementation date back to April 1, 2014. Even with the outcome of the expansion no longer in doubt, the Senate fell two votes short of getting immediate effect, costing the state more than \$600 million of funding from the federal government, as well as place the working poor who lack insurance at risk of paying the individual mandate fine (Oosting 2013).

Ideologically conservative individuals and groups saw the vote on immediate effect as one in a long line of tactics to stall or derail Michigan's push for Medicaid expansion (Interview). In the days following the passage of the Healthy Michigan Plan, Americans For Prosperity and Tea Party affiliated individuals ramped up pressure against acquiescing on the immediate effect, with former State Representative Jack Hoogendyk asking if the state was "ready to go RINO hunting" (Selweski 2013). Neither House Speaker Bolger nor Senate Majority Leader Richardville was willing to push hard on their members to reconsider immediate effect (Interview). Both Bolger and Richardville had voted in support of the Healthy Michigan Plan and had taken a stance in favor of expansion, but in response to the immediate effect question Bolger remarked that "'We have provided additional coverage for hundreds of thousands of additional Michiganders today. We're looking out for their health care. Today is a good day" and Richardville said "It's like we had this really big dinner. We got the dinner done and people are going to ask for dessert. We're going to skip dessert on this one" (Detroit Free Press 2013).

Intra-Republican Divisions, Intergovernmental Negotiations and National Events

Re-elections and the Healthy Michigan Plan

The week after signing the Medicaid expansion into law, the Mackinac Republican Leadership Conference was held on tony Mackinac Island on Lake Huron. On the heels of passing the Medicaid expansion, there were internal disputes within the Republican Party in Michigan and the 2014 reelection campaign for the governor, with a Tea Party backed candidate prepared to challenge the governor (Interview). In addition to potential challengers at the top of the ticket, six incumbent Republican members who voted in support of the Healthy Michigan Plan in the House and Senate faced a Tea Party backed primary challenger. Yet, for all of the far-right vitriol over Republicans had for the Healthy Michigan Plan and its Republican supports, Tea Party groups had minimal success at defeating or even threatening the Republicans who voted for Medicaid expansion in 2013. While each of the elected officials did have a Primary challenger, only one of the Republicans that voted with the Healthy Michigan Plan, Frank Foster, lost in the Primary election. The remaining officials won their Primaries by an average of 34% and each of the five Republicans went on to win reelection in the General election.

Intergovernmental Negotiations over Waivers

Due to the timing of the Michigan waiver application and negotiation, Michigan had a fairly straightforward interaction with the federal government in securing the first of their waivers required by the Healthy Michigan legislation (Interview). The types of reforms that were included in the first waiver, including healthy behavior incentives, health savings accounts, and cost-sharing, had precedence from other state's actions (Interview). Less than two months after the state submitted their waiver application, it was approved by the Obama administration (Tavener 2013).

The more pressing and potentially problematic negotiation from the state's perspective was the second waiver that was required by the enacting legislation of the Healthy Michigan

Plan (Interview). This waiver would require any individual that had been enrolled for four years to choose to either remain on the Healthy Michigan Plan with increased cost-sharing or to transition to the insurance marketplace and receive tax credits and cost-sharing subsidies. If the state of Michigan did not receive approval for this second waiver Healthy Michigan would be terminated two years after it was implemented. There were twin challenges to the second waiver for Michigan. First, federal rules do not allow premiums and cost-sharing for Medicaid population to exceed five percent of incomes between 100 and 150 percent of the federal poverty level (Centers for Medicare and Medicaid Services 2018). Second, Medicaid had never attached eligibility or benefits to time limits in the program.

To skirt these challenges, state and federal negotiators created an alternative solution. Even though the second waiver was breaking new ground in the Medicaid program, state policymakers reported that their interactions with the federal government had been positive and that the Obama administration had been open-minded through the process (Interview). In reality, it was in the best interest of both the Snyder and Obama administration's to come to an agreement on the waiver. In the case of the former, the governor was proud of the success of the Healthy Michigan Plan and the evidence of its effect on businesses, state finances, and individuals was growing (Interview). For the latter, the Obama administration wanted to encourage more states to implement the Medicaid expansion and did not want to appear unwilling to compromise (Interview).

However, what the federal government actually approved differed substantially from the waiver application that was submitted to CMS (Interview). The Obama administration approved requiring all individuals between 100 and 138 of the federal poverty engaging in the previously approved healthy behavior incentive programs, or being moved on to the insurance exchanges.

Those who successfully engage in the healthy behavior programs would see a reduction in their cost-sharing and premiums, bringing them within line of the five percent cap set by federal rules (Centers for Medicare and Medicaid Services 2015). With approval from the federal government, the Healthy Michigan Plan overcame their biggest obstacle, until 2016.

External Events Strengthening Support for Healthy Michigan Plan

For a contested policy, which had barely passed legislature, the first three years of the program was remarkably stable (Interview). With Snyder in the Governor's office until 2018, there were no legislative efforts to undermine or repeal the Healthy Michigan Plan, while also enjoying broad and bipartisan support within the state (Spangler 2017). Adding to the stability of the program was the growing body of evidence supporting the positive benefit of the program. Enrollment in the program has been strong (Office of Governor Rick Snyder 2014, Office of Governor Rick Snyder 2014), without decreasing appointment availability for primary care appointment availability (Tipirneni, Rhodes et al. 2015, Tipirneni, Rhodes et al. 2016) in regions of the state that were in most need for increased Medicaid accessibility (Tipirneni, Rhodes et al. 2017). An economic analysis of the Healthy Michigan Plan projected that it would add nearly 250,000 new jobs to the state's economy (with most of those jobs occurring outside the health care sector), save the state budget more than \$2.5 billion, and increase personal income by \$1.5 trillion through 2021 (Ayanian, Ehrlich et al. 2017), as well as reducing uncompensated care by hospitals (Davis, Gebremariam et al. 2016, University of Michigan Institute for Healthcare Policy & Innovation 2016) while improving outcomes for patients (Charles, Johnston et al. 2017).

The success of the Healthy Michigan Plan was tested by the election of Donald Trump in November 2016. Trump, who became the first Republican since George H.W. Bush in 1988 to

win Michigan, did not have a close relationship with Snyder and did not receive an endorsement from the governor. As Congressional Republicans and the Trump administration were working to “repeal and replace” the ACA, including making fundamental changes to the financing and eligibility standards of the Medicaid program, Snyder, along with other Republican governors who had expanded Medicaid, became advocates for the continuation of the Medicaid expansion program. In January 2017, during his final State of the State Speech, Snyder stated that:

“There’s going to be changes in health care. The important thing is that we need to let them know that Healthy Michigan is a model that can work for the rest of the country. That we should be speaking up and I look forward to working with my federal partners to talk about the value of this program, how it may even be enhanced as we go through these difficult and challenging questions and we look forward to reimagining health care for all Michiganders and our entire country with Michigan being a leader in that dialogue and I appreciate your support in that effort” (Snyder 2017).

Snyder took his message directly to Trump, where he met with the President, Vice-President Pence and other administration figures. Snyder was complimentary to the new administration, for “listening to the states. I frequently hear from residents that they want solutions made closer to home, so I’m very encouraged by the open dialogue we had this weekend and look forward to what I hope will be a great deal of collaboration with the President and Congress” (Office of Governor Rick Snyder 2017). Snyder disparaged the ACA, saying “it is also clear that the insurance portion of the Affordable Care Act has not worked and that we are seeing access reduced as insurance rates go up.” But that it was “imperative with reform of the Affordable Care Act that we are able to keep Healthy Michigan going with more flexibility in administering our state program, while at the same time bringing stability to the insurance marketplace” (Office of Governor Rick Snyder 2017).

When the American Health Care Act was being considered by the United States House of Representatives, Snyder, along with three other Republican Governors, sent a letter to Speaker of

the House Paul Ryan (R-WI), encouraging the House to not pass the legislation and suggested “fundamental reform of the Medicaid entitlement” that was not included in the legislation (Kasich, Snyder et al. 2017). Snyder then went on and sent personalized letters to each of the members of the House representing Michigan, containing information on the specific district-level effects of the American Health Care Act would have on their constituents (Office of Governor Rick Snyder 2017).

Work Requirements and Intra-Party and Branch Divisions

While federal efforts to “repeal and replace” the ACA failed in 2017, the shifting national political dynamics is still effecting the Healthy Michigan Plan. In January 2018, the Trump administration announced that they would allow states to impose work requirements for Medicaid enrollees, a shift in long-standing policy (Centers for Medicare and Medicaid Services 2018). Several Republican led states moved quickly to take advantage of this new federal flexibility for the program, with eleven states applying to the federal government to make the change to their Medicaid program, including Michigan. This legislatively supported pursuit of work requirements has created new divisions within the Republican Party in Michigan and between the branches of government.

In 2013, then Representative Mike Shirkey was tasked with helping to create and shepherding through the Healthy Michigan Plan. In 2018, now Senator Shirkey was the architect of Senate Bill 897, which would require able-bodied individuals enrolled in the Healthy Michigan Plan to work 29 hours a week in order to remain eligible for coverage (2018). The bill passed the Senate, 26-11 along party lines and moved on to the House (Michigan State Senate 2018). Shirkey claimed that he had been working with Governor Snyder on the work requirements bill, though the governor’s office released a statement after the bill was transmitted

to the House that read in part that “Despite our efforts to work with Sen. Shirkey, this version of the bill is neither a reasonable nor responsible change to the state's social safety net. We should not jeopardize the success of Healthy Michigan, which has helped hundreds of thousands of Michiganders” (Yin 2018).

However, the future of the Healthy Michigan Plan is unclear. Republican legislators will continue to have opportunities to make changes to the program as the Trump administration continues to make additional reforms allowable within Medicaid. With Snyder exiting the governor’s office in 2018, his successor in the executive office will have the opportunity to shape the state’s response to continued changes to the Medicaid program. Prior to Trump’s election, Healthy Michigan had a stable coalition of Republican and Democrat supporters within the House and Senate. The 2016 election shook up and weakened that coalition of support, with Republicans splintering around reforms that is newly permissible.

Conclusion

The success of Michigan in implementing the Healthy Michigan Plan was predicated on several factors. First, the state was still reeling from decades of economic stagnation and the Medicaid expansion was seen by policymakers as an opportunity to bring much needed federal capital into the state coffers. From the very first press conference, one of the core themes of the supporters of expansion was “Save Money. Save Lives”. The order of the slogan was not a mistake. Throughout formal and informal meetings and presentations, the financial benefit for states, businesses, and individuals, was at the forefront.

Second, the political dynamics within the state aligned in a way that allowed for the state to consider implementing the Medicaid expansion. These shifts occurred through different levels of state government, starting at the very top. Governor Snyder was a pragmatic policymaker,

more interested in the impact of a policy than being constrained by ideology. This flexibility allowed Snyder to help usher the Healthy Michigan Plan through a state legislature where Republicans had cemented their control.

Third, even prior to Snyder signaling his support for expansion, a coalition of organized interests had formed to push for their preferred policy position of implementing the ACA Medicaid expansion. This coalition was the key non-governmental actors that helped implement the Healthy Michigan Plan. From Snyder's first press conference, through the negotiations with the House and the Senate, representatives from the coalition were present. Their money, their experience, and their connections lent the Healthy Michigan Plan needed support.

Lastly, the timing of the Healthy Michigan Plan informed how the expansion plan looked, as well as provided the political room for supportive policymakers to implement the program. Michigan's pursuit of a waiver expansion program followed the successful waiver applications of two prior states, which allowed policymakers in Lansing to converse with and learn from their peers in Arkansas and Iowa. While Michigan was able to implement reforms that had not been in place in those earlier states, they had a template that they were able to follow. Without a waiver, similar to the legislative result when Snyder wanted the expansion included in a budget bill, it is unlikely that the state would have been able to implement the ACA Medicaid expansion.

Chapter 8: Themes from across the Case Studies

“Every man is bound to answer these questions to himself, according to the best of his conscience and understanding, and to act agreeably to the genuine and sober dictates of his judgment... No partial motive, no particular interest, no pride of opinion, no temporary passion or prejudice, will justify to himself, to his country, or to his posterity, an improper election of the part he is to act. Let him beware of an obstinate adherence to party; let him reflect that the object upon which he is to decide is not a particular interest of the community, but the very existence of the nation.”

- Alexander Hamilton, Federalist No. 85

Using comparative case studies, I examined the Medicaid expansion implementation decisions made by states, how the politics of health reform have been shaped by the Medicaid expansion, and the factors which have contributed to whether and how a state decided to implement the ACA Medicaid expansion. I find that partisanship matters in explaining implementation decisions, but scholars need to rethink what partisanship means with the ACA. In particular, the Medicaid expansion has been disruptive to the Republican Party, causing divisions to emerge within the party. The institutional design, organized interests, waivers, and national events have influenced whether and how a state decides to implement the Medicaid expansion.

With more than 45 million Americans uninsured, one of the central goals of the ACA was to expand health insurance coverage. The law contained several different mechanisms to achieve this goal, including cost-sharing reductions and insurance subsidies to make purchasing insurance more affordable, developing insurance exchanges to help compare insurance prices, and regulating the insurance industry. Another component of the ACA, the Medicaid expansion,

has had the largest effect in reducing the uninsured in the United States (Frean, Gruber et al. 2017). Yet, the overall effectiveness of the expansion has been blunted by the Supreme Court and state policymakers.

While the ACA is national in scope, the law devolves a significant amount of authority to states. This division of authority means that how reform looks has been largely determined by how and who implements the law in the states. The importance of state policymakers in shaping health reform took on more significance when the Supreme Court held in 2012 that the Medicaid expansion was the equivalent of an “economic dragooning that leaves the states with no real option but to acquiesce”. To remedy this unconstitutional coercion, the Court allowed states to voluntarily expand their Medicaid program. The decision changed the political calculus for implementation decisions and set up a natural experiment to understand contemporary state decision-making and implementation decisions in a hyper-partisan and polarized political environment.

Implementation decisions in the United States are complex social phenomena, influenced by a function of several intersecting factors, including the federated system of the United States (Greer 2010), the congruence of federal and state preferences (Erk 2007), socioeconomic context (Grogan 1999, Kim and Jennings 2012), and policy diffusion (Boushey 2010, Volden 2017). One common account of implementation decisions has focused on the role of partisanship. The general trend of implementation decisions for Medicaid supports this focus on partisanship. Nearly every Democratic policymaker has supported and implemented expansion. The only Democratic governors who have unsuccessfully implemented the program were Jay Nixon (MO), Terry McAuliffe (VA), and Ralph Northam (VA). Republican policymakers have had a much more complicated experience with the policy. All but one state that has opted out of

implementing the Medicaid expansion is currently led by a Republican (the aforementioned Virginia). Yet, more than forty percent of Republican governors and a third of Republican majority control state legislative chambers have voted to expand Medicaid.

The experiences of Republican state policymakers with the Medicaid expansion require a rethinking of what partisanship means in health reform. The Congressional debate certainly has the marks of a highly partisan policy. Only two Republicans (Senator Olympia Snowe (ME) and Representative Anh Cao (LA)) voted for health reform, though neither of those supportive votes was made on the final version of the bill. For the actual implementation of the Medicaid expansion, Republican state policymakers have been much more open towards the program.

Resetting of Health Politics and Republican Divisions over Health Care

The 2012 Supreme Court decision reset the politics of health reform. What had been settled during the bruising, yearlong congressional debate over health reform in March 2010 was now reopened for debate within 50 state capitols. The ACA was still the law of the land, but critics of health reform could now engage in proxy wars to undermine the effectiveness of health reform by limiting the scope of the Medicaid expansion. One unexpected result of resetting the politics of Medicaid expansion resulted in divisions for Republican policymakers and organizations.

Whereas Republican policymakers and organized interests remained unified when the ACA was being debated and the Supreme Court was deciding on the constitutionality of reform, the politics of Medicaid has been much more divisive. The division for both Republican policymakers and organizations occurred between traditional economic interests and ideological driven factions within the Republican Party. While the Medicaid expansion had important policy ramifications for increasing health care coverage, it also represented a massive infusion of capital

from the federal government for states. In the wake of the 2007-08 Great Recession and at a time when federal funding from the American Recovery and Reinvestment Act of 2009 was dwindling, many state policymakers and organizations recognized the importance of external funds to help balance the budget. This resetting of the politics of health reform after the Supreme Court decision was particularly noticeable amongst organized interests like the Chamber of Commerce. The national Chamber of Commerce had been one of the primary supporters of the *NFIB v. Sebelius* Supreme Court case. Ironically, with the Supreme Court decision on Medicaid, state chapters of the organization were organizing, testifying, lobbying, and spending money to convince states to implement the expansion.

At the same time, following passage of the ACA, there was a rise in conservative, ideologically driven organizations and policymakers. These groups and individuals viewed the ACA as the signature policy achievement of the Obama administration and continually sought to undermine the advancement of the law. These organizations, which most prominently included the Tea Party and Americans for Prosperity, sought ideological purity from policymakers within the Republican Party and were quick to turn on legislator or governor who seemed open to implementing the Medicaid expansion. While each of the states saw the same dynamic of divisions emerging in the wake of the Medicaid expansion, no state was more seriously undermined by the division than Arizona. Jilted Republican legislators engaged in lengthy court proceedings to reverse the policy outcome in the state.

Whether and how a state implemented the Medicaid expansion was a function of several different factors: the institutional design of the state, unified organized interests, waivers, and national events.

Role of Governors

Governors, unsurprisingly, are the key policymaker in the process of implementing the Medicaid expansion. The governor's power to draw attention to a policy, rhetorically frame an issue, and negotiate with the federal government is unmatched within the state. In the case of Arizona, Michigan, and Utah, the announcement of support by their respective governors was the catalyst for a legitimate debate on the policy.

Yet, the support of the governor for Medicaid expansion was necessary, but not sufficient, for a state to successfully implement the program. Gary Herbert was a popular, twice elected governor of Utah, and an enthusiastic supporter of expansion who used his political capital to attempt to implement the program. Even with the support of the Senate and a majority of the House of Representatives, Herbert fell short in his efforts of implementation. In Arizona and Michigan, even with gubernatorial support, the states were right on the brink of implementing, or not, the Medicaid expansion. Snyder's Healthy Michigan Plan initially fell one vote shy of passage and Brewer had to draw on a series of powers that were only available to the executive to pressure the legislature to act, before either state implemented the Medicaid expansion.

Not all states give equal power to their governor. There are only a handful of states that allow for a governor to unilaterally act in implementing policies; Governors in Kentucky and West Virginia were able to implement the Medicaid expansion through these executive orders. And for states with oppositional governors, there are limited viable paths forward to expansion. One recent development is the use of ballot initiatives to force enactment of expansion, similar to what occurred more than a decade ago in Arizona. So far, Maine has been the only state that has successfully passed a ballot initiative as part of the ACA Medicaid expansion, though advocates in Utah and Idaho are collecting signatures to place their own ballot initiative. Yet, Maine's

experiences highlight the limits of this approach. After Governor Paul LePage vetoed expansion legislation five times, he also refused to fund the ballot initiative expansion.

Institutional Design

The institutional design, or the rules that govern the politics within a state, varied substantially across the case studies. Both supporters and opponents of Medicaid expansion were able to leverage the institutional design to achieve their preferred policy outcome. In the case of Utah, Governor Herbert signed a bill into law during the 2013 legislative session that required that any governor would need to have the approval of the legislature, along with several other requirements, prior to the implementation of the Medicaid expansion. While Herbert knew that signing the bill would tie his hands and reduce his leverage, he also felt that vetoing the bill would anger his own base and caucus. Two years later, after being repeatedly rebuffed by the House of Representatives, lawyers for Herbert began to research legal options that would allow the governor to act unilaterally to implement the expansion program and pressure the legislature to supply the appropriations. During their legal analysis, one of the main challenges for Herbert to move forward was the legislation that he had signed in 2013.

However, not all of the institutional design challenges were self-inflicted. Herbert and supporters of expansion were also frustrated by the length of the legislative session and the professionalism of the legislature. Utah has the shortest legislative session of any state, meeting for 45 days. The time crunch that resulted from Herbert and other supportive policymakers in the legislature occurred every year that the state pursued the Medicaid expansion, which resulted in supporters working frantically during the last week of the legislative session to debate and attempt to pass bills. It also gave oppositional policymakers in the House a limited amount of time in which they would need to delay the expansion bill, making it easier to defuse any

legislative momentum that had been gained for expansion during the session. Herbert was also limited by the professionalism of the state's part-time legislature. During the months when the legislature was not in session, there were only a handful of days scattered through the calendar year when the body would meet together in the Capitol. Herbert gave updates on expansion to his caucus during those meetings, but it was too short and too infrequently spaced apart to generate legislative momentum. Herbert was not dithering during the rest of the year when the legislature was not in session, but unlike Arizona, Herbert had limited authority to call a special session. Opponents of expansion in the Utah legislature remarked that if Herbert called a special session, that they would gavel open the session and then close it without taking a vote and there was little that Herbert could do to force any other action.

While the institutional design of Utah limited Herbert's ability to pass and implement the Medicaid expansion, Governor Jan Brewer provides the clearest example of how supportive policymakers were able to leverage institutional design during Arizona's push for expansion. There were three powers that Brewer wielded as the executive that gave her leverage over oppositional legislators as the debate over expansion continued in the state. First, Arizona's legislature is in session longer than Utah, but it is not full-time. To encourage the legislature to finish its work in a timely manner, state law requires after the 100th day in session that legislator salaries decrease by two-thirds. Prior to this point, one of the key tactics used by oppositional legislators was to delay the budget bill, to increase the pressure on Brewer to cave on her expansion efforts because the budget needed to be completed by July 1st. The reduction of legislator salaries, while also requiring them to stay in Phoenix, placed financial pressure on the legislators to act on the budget and on Medicaid.

Second, Brewer leveraged the use of her veto pen when the legislature continued to fail to act on her legislative demands. Even with financial pressure placed on the individual legislators, opponents were still delaying the budget bills. Brewer decided to veto every piece of legislation that was passed by the legislature, regardless of topic or sponsor, until the legislature acted on her expansion plan. Over the last month of the 2013 legislation session, the governor made her rationale explicit to the legislature, by remarking that she would continue to veto every bill until they acted on her Medicaid expansion plan. Legislators were required to stay at the capital, but nothing they worked on would be implemented unless they acquiesced to Brewer's demands.

Lastly, Brewer was able to leverage the power that was invested in the executive to call special sessions to push the state over the edge towards expansion. Prior to the special session, the Arizona Senate had passed a budget which included funding for the Medicaid expansion. But when the set of bills was sent over to the House of Representatives, the Speaker of the House announced that the chamber would be in recess for two days. Brewer was so incensed by the unnecessary delay that she called a special session that started that very evening. In Arizona, the governor is imbued with the power to not only call a special session, but to also supply legislative language to be considered and the rules for debate. In this instance, Brewer was able to bypass committees and legislative leaders by supplying the legislative language that they were required to vote on, allowing her to control the process from the Governor's office.

In Michigan, Governor Rick Snyder and supportive legislators was able to overcome two challenges in institutional design that nearly derailed their efforts to successfully implement the Healthy Michigan Plan. First, originating from a 1992 ballot initiative, Michigan has the strictest term limits of any state. In 2010, right when the Tea Party was at its apex in Michigan, the state had the most open seats in any state, partially a product of the strict term limits. The term limits

led to Republicans taking over the Governor's office, as well as majority control and a rightward shift of both chambers of the legislature. Supporters of the Healthy Michigan Plan were able to overcome the effects of term limits because the leadership in the House and Senate were not drawn from the Tea Party back-benchers. Rather, the Republican leadership was more aligned with the traditional economic interests of the state and was more amenable to the arguments of positive financial effects of the Medicaid expansion.

Second, Senator Patrick Colbeck, who was affiliated with the Tea Party in the state, was able to briefly exploit Senate rules to temporarily defeat the Healthy Michigan Plan by choosing not to vote during the first attempt to pass expansion. With the Lieutenant Governor poised to cast the tie-breaking vote, Colbeck's non-vote initially caused the bill to fail. Because Snyder and supportive policymakers had settled on a waiver to expand Medicaid, they were able to leverage the flexibility of the waiver, which gave them the leeway to persuade one "no" vote with a simple change to the legislation and waiver application.

Snyder, however, was not uniformly successfully at navigating the institutional design in his state. While the Michigan Legislature meets year round, the laws governing when a bill goes into effect more closely resembles that of a part-time legislature. Other full-time legislatures have a set date for when a bill would go into effect, always in the same year as when the bill was passed. In the case of Michigan, the effective date for legislation was ninety days after the session ended for the year, meaning that the Healthy Michigan Plan was not operational until April 2014, causing the state to lose out of millions of dollars and extending the period of time when its citizens were uninsured.

Organized Interests

Organized interests played a central role in whether and how states implemented the Medicaid expansion. There are three emergent themes related to the role of organized interests during the debate over the Medicaid expansion. First, in the wake of the Supreme Court, coalitions of organized interests formed to either oppose or support a state's effort to implement the Medicaid expansion. The ability for the supportive coalitions to remain unified was essential to their ability to affect the policy outcome. Divisions emerged along two lines: ideological and financial. Similar to the dynamic in play with policymakers, conservative organized interests divided themselves between traditional economic interests and ideologically driven groups. While national conservative organized interests demonstrated homogeneity in their stance on the Medicaid expansion, at the state level traditional economic interests formed coalitions with hospital and provider organizations to support expansion.

Unique to organize interests were the divisions over the financing of expansion. Utah and Arizona both pursued a budget neutral approach that would cover the state portion of the costs of expansion. In the case of Arizona, the Arizona Health Care Coalition, comprised of every hospital provider in the state, devised and presented a "bed tax" to the Brewer administration. Utah was unsuccessful at keeping its supportive coalition together. When the "gang of six" emerged from their cloistered deliberations, they proposed spreading the state costs to hospitals, physicians, pharmaceutical companies, and insurers. With no input from these organizations during the development of the financing mechanism, this action gutted the previously uniform support for expansion from these health related groups.

Second, the timing of when organized interests mobilized in response to the Medicaid expansion had an important effect on the outcome. In the case of the two states that successfully implemented the expansion, a coalition of supportive interests mobilized and organized prior to

public announcement made by the governor. In the case of Arizona, organized interests failed efforts to minimize sizable budget cuts to health care programs in 2010 taught the coalition the importance of proactively responding to changes in health policies. In an effort to get in front of the debate over Medicaid expansion, the Arizona Health Care Coalition made two important hires, Chuck Coughlin and Peter Burns. Coughlin was the former campaign manager for Brewer and Burns had been the state budget director. With the health providers giving a uniform front and with well-connected individuals, the Arizona Health Care Coalition was able to not only set the agenda in the state, but to lobby Brewer before oppositional organizations and individuals. Arizona stands in stark contrast with Utah's experience. After Herbert announced his support for "doing something" with the Medicaid expansion, he engaged in a yearlong negotiation with the Obama administration over parameters of the state's waiver program. During that year period of time, there was no coalition forming amongst business, providers, and other organized interest groups. Herbert did not conduct a press conference with any organized interest groups until he had come to an agreement with the Obama administration. Up to that point, there was very little visible support from organized interests.

Lastly, the policy preferences and resource allocation which key organized interests placed on the Medicaid expansion influenced the policy outcome and varied across the states. The most acute example of this variation was in the case of Utah, where the dominant organized interest, the Mormon Church, was disengaged from the Healthy Utah Plan. Both the Mormon leadership and lobbyists remained largely silent throughout the state's efforts to implement the Medicaid expansion. The majority Mormon legislature interpreted the silence as tacit disapproval for the policy. Events during the same 2015 legislative session demonstrated the power of the

Mormon Church when its support quickly pushed LGBT discrimination legislation that had previously died in committee hearings, into law.

In Michigan and Arizona, there was no other organized interest entity with the clout and power of the Mormon Church in Utah. Instead, the breadth, stability, focus of the coalitions in these two states was essential for implementing the expansion. In Arizona and Michigan it was not just one organized interest or sector that was pushing for expansion, but it was business, labor, providers, insurers, and religious groups together. The ability to stay focused and unified was particularly impressive in light of the breadth of groups that comprised the coalition. The coalition members in both Michigan and Arizona were not naturally aligned with each other. Rather, the politics of the Medicaid expansion shifted insurers, providers, and business groups within the states to help push for the implementation of Medicaid.

Waivers and National Events

Waivers were an essential policy tool which gave supportive Republican policymakers the flexibility to bridge divisions within their party. The ability of policymakers to use waivers to “reform” their existing Medicaid programs changed the calculus of implementation in two important ways. First, it allowed supportive policymakers to create a new narrative around the Medicaid program. Traditionally, Republicans have not been supportive of the Medicaid program, labeling it as “broken” and outdated. Supportive Republicans were able to frame their support for the ACA Medicaid expansion as fixing the already broken program. Additionally, waivers allowed the policymakers to rhetorically divorce the Medicaid expansion with the Medicaid program. Even the names that were used to describe the expansion plans: Healthy Michigan, AHCCCS, and the Healthy Utah Plan, spoke to the effort to submerge the meaning of

the program they were attempting to implement. “Medicaid” is not included in any of the program titles and supportive policymakers rarely referred to expansion by that name.

Second, the use of waivers in these states changed the calculus of policymaker coalition formation. Governor Rick Snyder (MI) first attempted to implement the Medicaid expansion through the inclusion of legislative language in the FY 2014 budget. After several public meetings on the importance of expansion and weeks of private lobbying with the Michigan Legislature, Snyder’s wish was rejected by legislators in both chambers. It was only after Snyder and Republican policymakers began to focus on using a waiver that any traction was made in the legislature. Waivers were a powerful tool to simultaneously keep Democrats supportive of expansion, while also siphoning off enough Republican support for passage. Utah went through seven different iterations of expansion programs, with policymakers unsuccessfully trying to hit on the type of program that would unlock bipartisan support. The coalitions which formed in the wake of expanding Medicaid were temporary in nature; once the waiver bill was passed or rejected during a session, members of the two parties sorted back to their normal policy positions.

Though the focus of this project is on state politics and policy, the federated nature of the United States meant that national events had important implications for whether and how states implemented the Medicaid program. By 2016, each of the three states had entered into a period of stasis with Medicaid. Utah was working on submitting a waiver for their partial expansion, the Medicaid Restoration Plan was functioning as Brewer had intended, and the Healthy Michigan Plan had received federal approval for its more challenging second waiver. The unexpected election of Donald Trump in 2016 shifted the politics and policy of Medicaid and caused state policymakers to reevaluate and adapt their expansion programs. While the Trump administration

and Congressional Republicans promised to repeal and replace the ACA soon after the election, it proved to be more difficult than anticipated. Even as it seemed that the ACA was on its deathbed, policymakers in each of the case studies pursued additional reforms, by using waivers as the instrument to attempt these changes.

The Trump administration sent mixed signals to state policymakers during the early part of its administration. Utah, which had submitted their waiver application during the Obama administration and was still pending when Trump took office, was told by the new administration that the state would not consider any waiver applications while Congress debated health reform. Even with that message, Utah policymakers decided to split their existing waiver application and resubmitted with additional reforms that state officials hoped the Trump administration would approve. Even as the administration was quietly telling state policymakers that their waiver applications would have to wait, the newly confirmed HHS Secretary and CMS Administrator sent a letter to all governor's announcing a new approach to how waivers could be used for the expansion population. After the failure of "repeal and replace", the Trump administration stepped up their emphasis on waivers and providing more flexibility to states, announcing that states could begin to ask for work requirements in their welfare programs. States quickly took the Trump administration up on this offer, with all three of the case studies pursuing work requirements for their Medicaid programs. Arizona is the only state that has received federal approval for their work requirements and both Utah and Michigan have serious legal challenges to implementing their current work requirements plans.

The Medicaid program has proven to be far more durable than originally anticipated when it was devised more than fifty years ago. The structure of the ACA, with the Medicaid expansion, has further entrenched the program in American policy. Yet, the long-term outcome

of the Medicaid expansion is unknown. Congressional policymakers continue their attempts to “repeal and replace” the ACA, even as the pathway forward for Congress to act seems limited. While the ACA remains the law of the land, the Medicaid expansion represents the best option for reducing the ranks of the uninsured, buoying hospital and private business finances, and stimulating state budgets.

State policymakers will continue to grapple with implementation decisions around the Medicaid expansion. This is particularly true for Republican policymakers, where the politics and policy of the Medicaid expansion has had a remarkably destabilizing effect on their party. Federal policymakers will continue to grapple with how they approach program implementation and management, particularly if our hyper-partisan and polarized policy environment continues. No longer can the federal government simply supply financial inducements and expect that states will comply with the requirements of a law.

Taken in totality, the results of the implementation of the Medicaid expansion has broad consequence for the politics of health care in the United States, but also has lessons that can be applied in how researchers think about other policy domains. I have argued here that the implementation decisions undertaken by the states is a function of the confluence of different factors that influence policymaker and state behavior. One of the most prominent factors that has been identified as influencing these implementation and policymaking decisions is partisanship. I have argued that while partisanship is important, it can obscure important factors that contribute to whether and how a state decides to implement the Medicaid expansion. To that end, much of the analysis has focused on the common themes identified above that have shaped, influenced, and riven the Republican Party’s response to the Medicaid expansion. The role of partisanship

has remained constant throughout each of the analyses, with majorities in each chamber of the legislature and the executive office held by the Republican Party.

The role of partisanship is complex in understanding state behavior and actions within a federal system. At a national level, there are distinct patterns of partisanship associated with the implementation of policy. Democrats were uniformly in support of Medicaid expansion, whereas Republicans had a much more complicated relationship. This embracing and shunning federal policies at the state level goes far beyond health and the ACA, but also include education policy, energy policy, and environmental policy. With the inauguration of a new administration, the roles have reversed in the states, with Democratically led states leading the efforts to undermine the policy goals of the Trump administration. This is most evident by the actions of California, which has sued the Trump administration 38 times in 18 months across a variety of policies.

From a theoretical perspective though, the current and previous models of federalism is wanting in understanding what is happening in the states. Supporters of health reform viewed state decisions to implement expansion through a transactional federalism approach. In the wake of the 2012 Supreme Court decision, President Obama believed that states would not pass up such a good financial deal that the ACA was offering. Yet, these hopes of the power of financial inducements and transactional federalism to spur state action was ultimately not completely successful. Rather, polarization and hyper-partisan political environment has tamped down the expected support for implementing the federal program.

While the rise of polarization and hyper-partisan political environment is not a new development, the manifestation of how these factors contribute to state decision-making has not been a central component in the previous federalism literature. This prior literature and modeling have rather focused on levels of government and the competition which can emerge from those

levels, not political parties across levels of government aligned against each other. The models of federalism, such as layer cake, picket fences, and marble cakes, used to describe these relationships highlight the focus on state versus federal governments and the importance of level of government as the unit of analysis. The design and analysis of federated systems have been focused on reducing the number of “transgressions” of federalism (Bednar 2012) and minimizing competition between levels of government. Much of this prior literature (highlighted in Chapter 2) views political parties as noncentralized and nonprogrammatic entities (see Kramer 1994; Choper 1980).

Yet, understanding the federal system today requires an understanding of partisan competition and how this partisanship interacts with and exploits a federalist framework. Unlike these earlier models, policymakers at the federal and state levels have been able to leverage the system of federalism to amplify inter-party competition and disagreement *across* the levels of government. As members of the political parties have grown increasingly polarized and as party affiliation has taken on a central role in how we identify, policymakers have been able to leverage those divisions to generate policy competition between the parties. Rather than trench warfare between state and government policymakers who are both trying to protect their policy domain from encroachment from the other, individuals aligned within the same political party at the local, state, and national government can now work together to reject the policy goals of the opposing party.

This conception of the role of party amplifying partisanship across a federal system can be thought of as a reimagining of the traditional “picket fence” model of federalism. In the traditional model the different levels of government lie horizontally to each other, with the national government at the top and local government at the bottom. Laid across these levels of

government are the various policy domains where expertise and management are shared across types of government, for example education, health, and infrastructure are distinct from each other and agencies and individuals across the levels of government have responsibilities.

However, with the inception of a hyper-partisan political environment, the unifying factor that connects across the different levels of government are no longer the various policy domains, but rather the party itself. Affiliation to a particular party connects policymakers across the levels of government and affiliation to party has taken on a heightened sense of an individual's identification. When a member of the opposite party is the executive, the party affiliated policymakers act in concert to reject their policy goals, up and down the different levels of government.

Yet, the federalism framework also allows members of the opposing parties to engage in policy competition and develop their own policies. In the case of the Medicaid expansion, it was not merely enough for state policymakers to reject the ACA. Rather, state policymakers leveraged the institutional framework of federalism to attempt to change the ACA. The most prominent arrow in the quiver for state's acting to change federal policy has been waivers. Across each of the states, the option of a waiver allowed supportive Republican and Democratic policymakers to divorce what their state was attempting to do with the broader ACA. State policymakers were explicit about their desire to infringe on federal policy, calling their efforts a "Michigan (or Utah or Arizona) reform that isn't one size fits all, but is unique to our state". State policymakers were able to use the federalism institutional structure to advance the policy agenda for the political party not in power at the federal level. By dint of how the ACA was designed and the decision of the Supreme Court, state policymakers were imbued with power to shape how health reform would actually look in their state. Waivers still represent powerful tools

for intergovernmental policymaking, but in the case of recent events, they also are important rhetorical devices as well. Across each of the case studies, waivers were either explicitly or implicitly used as a fundamental part of state decision-making. Rhetorically, across each of the states, the option of a waiver allowed supportive Republican and Democratic policymakers to divorce what their state was attempting to do with the broader ACA.

When designing policies at the federal level and when thinking about the role of federalism in leveraging and amplifying partisanship, systems and models of federalism need to account for the changing political environment to offer theoretically rich understandings of what is happening in policymaking and policy implementation. Just prior to signing the ACA into law, President Obama optimistically remarked that there was “a new season in America”. While passage of the ACA was “remarkable and improbable”, the new season in America for Medicaid expansion continues to be marked by partisanship and polarization. The post-Trump era has demonstrated that the politics and policy of the Medicaid expansion remains dynamic and fluid. Even in our current political environment, unexpected political outcomes occur, if strategic actors are in place, the institutional design of a state allows those actors to leverage their position, and organized interests mobilize in response to the policy. Though political battles between policymakers, governments, and organized interests over whether a state will implement or alter their Medicaid expansion will continue. While much of the focus of health reform has been on the federal government, a deep understanding of the politics shaping policy in the states is essential for informing future health policy.

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APPENDICES

APPENDIX A: Codebook FSQCA Variables

Political Variables

Percent of Total Seats with Electoral Vulnerability

- Total seats from both the House of Representatives and Senate where the final campaign outcome was within 5%. A higher number indicates a higher number of seats which are toss-up within the state.

Rolling Average of Democratic Control Over Governors and Legislature

- A Democratic Governor in a given year between 2009 and 2016 is scored as a 2, majority control of Senate and House of Representatives is worth 1 point each. A state can then score up to 4 points in a given year. A higher score indicates that a state has a higher number of Democratic control over the major levers of power within a state.

Vote Share for Obama 2008

- Percentage of popular vote in 2008 for Barack Obama; higher score indicates a greater share of the vote for Obama.

Vote Share for Obama 2012

- Percentage of popular vote in 2012 for Barack Obama; higher score indicates a greater share of the vote for Obama.

Polarization of House of Representatives

- As measured by Shor and McCarty, the ideological distance between party medians in a state's House of Representatives, averaged between 2010-2014; higher score indicates a higher level of polarization.

Polarization of Senate

- As measured by Shor and McCarty, the ideological distance between party medians in a state's Senate, averaged between 2010-2014; higher score indicates a higher level of polarization.

Percent of Total Seats of Democratic Majority Control in Legislature

- Combined number of seats in the House of Representatives and Senate which are held by Democrats, divided by the total number of seats that are available in both chambers; lower negative number indicates that there are much more Republicans in a state legislature than a higher negative number (e.g. -16% is more Republican than -6%, although both indicate that there are more Republicans in both chambers). A higher positive number indicates a higher number of Democratic seats in both chambers than a lower positive number (e.g. 16% is more Democratic than 6%, although both indicate that there are more Democrats in both chambers).

Civic Factors

Non-profits per capita

- Total number of 501(c) (3) nonprofits and nonprofit organizations in 2012 by state per-capita.

Letters to the Editor

- The number of letters to the editor published in two major newspapers related to expanding Medicaid between March 2010 and December 2016. Newspapers were selected through the following criteria. First, using the U.S. Census Bureau designation, the two most populous Metropolitan Statistical Areas (MSA) was identified for each state include in the analysis. Second, the newspaper with the highest circulation within each of the separate MSA was selected, resulting in two newspapers representing each state. Higher number indicates a higher number of letters to the editor published.

2008 Presidential Voter Turnout

- The percentage of eligible voters who cast a ballot in the 2008 presidential election. Higher number indicates a higher voter turnout.

2012 Presidential Voter Turnout

- The percentage of eligible voters who cast a ballot in the 2012 presidential election. Higher number indicates a higher voter turnout.

Percent of State Population with College Education

- Data from US Census bureau on the average number of adults in a state in a given year, between 2010-2015 which have graduated with a bachelor's degree or higher.

Public Opinion of Medicaid expansion

- Using results from the Cooperative Congressional Election Study from 2014, which asked respondents "Should your state refuse to implement the expansion of health care for poor people, even if it costs the state federal Medicaid funds?" From each state there were respondents to that question, I ran a logistic regression, including demographic data to get at the odds ratio of an individual residing in each of the 50 states (with

Washington, D.C. as the reference group) would be supportive of expanding Medicaid.

Higher score indicates a higher public opinion result for Medicaid.

Prior Medicaid Experience

Generosity of Medicaid program, prior to implementation of the Medicaid expansion

- The average amount of money spent per beneficiary in each state, from 2009-2013.

Higher number indicates a more generous pre-ACA state.

Number of Core Components for SHOP and Insurance Exchanges implemented by a state (out of a total of 8)

- There are four main components related to the establishment and management of a state exchange: eligibility and enrollment, plan management, consumer assistance, financial management. States can take responsibility for 0-4 of these components for both the insurance and SHOP exchange, with a total range of 0-8.

Number of Medicaid Waivers

- Total number of Medicaid waivers, Section 1115 and all categories of 1915, which a state has applied for. Higher number indicates a higher number of waiver applications.

Economic Factors

Percent of Total State Population of Newly Eligible Who Would be Eligible for Expanded Benefits

- Taken from Census Bureau ACS data and KFF data, the number of individuals who are eligible or would be eligible for Medicaid coverage as a percent of the total state population, using 2014 population numbers.

Economic Costs of Expansion

- Using modeling data from HIPSIM and the Urban Institute, the number is the net state costs of expansion, expressed as a percent of costs relative to total general fund expenditures from 2014-2022. A negative number indicates cost-savings. In the normalized number, a higher number indicates a higher cost for expansion.

Number of Hospitals

- The number of hospitals (all types) within a state, as a ratio of per 100,000 citizens. Higher number indicates a higher level of hospitals in a state. Data was collected from American Hospital Association Masterfile.

Penetration Rate of Medicaid Managed Care Plans

- More managed care plans for Medicaid would allow a state to have a greater grasp on the costs of expansion. A higher number indicates a higher percentage rate. Data was collected from Centers for Medicare and Medicaid Services.

Interest Group Factors

Pharmaceutical-Democratic

- Total number of campaign contributions given from pharmaceutical organizations and individuals who are affiliated with pharmaceutical organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Pharmaceutical-Republican

- Total number of campaign contributions given from pharmaceutical organizations and individuals who are affiliated with pharmaceutical organizations, given to Republicans

running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Pharmaceutical-Third Party

- Total number of campaign contributions given from pharmaceutical organizations and individuals who are affiliated with pharmaceutical organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Insurance-Democratic

- Total number of campaign contributions given from Insurance organizations and individuals who are affiliated with Insurance organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Insurance -Republican

- Total number of campaign contributions given from Insurance organizations and individuals who are affiliated with Insurance organizations, given to Republicans running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Insurance -Third Party

- Total number of campaign contributions given from Insurance organizations and individuals who are affiliated with Insurance organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Hospitals-Democratic

- Total number of campaign contributions given from Hospitals organizations and individuals who are affiliated with Hospitals organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Hospitals -Republican

- Total number of campaign contributions given from Hospitals organizations and individuals who are affiliated with Hospitals organizations, given to Republicans running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Hospitals -Third Party

- Total number of campaign contributions given from Hospitals organizations and individuals who are affiliated with Hospitals organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Services-Democratic

- Total number of campaign contributions given from Health Services organizations and individuals who are affiliated with Health Services organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Services -Republican

- Total number of campaign contributions given from Health Services organizations and individuals who are affiliated with Health Services organizations, given to Republicans running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Services -Third Party

- Total number of campaign contributions given from Health Services organizations and individuals who are affiliated with Health Services organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Professionals-Democratic

- Total number of campaign contributions given from Health Professionals organizations and individuals who are affiliated with Health Professionals organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Professionals -Republican

- Total number of campaign contributions given from Health Professionals organizations and individuals who are affiliated with Health Professionals organizations, given to Republicans running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Professionals -Third Party

- Total number of campaign contributions given from Health Professionals organizations and individuals who are affiliated with Health Professionals organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Policy-Democratic

- Total number of campaign contributions given from Health Policy organizations and individuals who are affiliated with Health Policy organizations, given to Democrats running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Policy -Republican

- Total number of campaign contributions given from Health Policy organizations and individuals who are affiliated with Health Policy organizations, given to Republicans running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Health Policy -Third Party

- Total number of campaign contributions given from Health Policy organizations and individuals who are affiliated with Health Policy organizations, given to Third-party candidates running for Governor or either chamber of the legislature, totaled over the years 2010-2014.

Institutional Factors

Restrictions on Executive Action

- Analysis of state laws and regulations to understand the limits placed on unilateral executive action. Specifically, I went through each state constitution and regulations to catalog whether the governor had term limits, size of the appointment power to the state bureaucracy, veto authority and limits, and budgetary size of the executive in relation to the rest of the state spending. A higher number indicates that there are fewer restrictions placed on the executive.

Limitations of Debate

- Floor debate provides the opportunity for supporters and opponents to adjust introduced legislation through the inclusion of amendments and to debate the merits of the legislation. Each legislative chamber varies in the types of rules surrounding these floor amendments, including the number of amendments that can be introduced during debate, the length of time allowed for debate, and the means by which debate can be closed for a vote. A lower number indicates that there are more limitations placed on legislative debate. Data comes from an analysis of state laws and regulations to understand the limits placed on debate.

Term Limits/Legislative Professionalism

- States vary in the rules and institutional design for their legislature. The institutional design of the legislature, measured by the level of professionalism (Squire 2007), can vary substantially. Additionally, one component not cataloged by Squire is the variation in term limits placed on the legislators, which can limit policy proficiency and policy output (Carey, Niemi et al. 2006).

Legislative Staff Supports

- States vary in the level of support that they provide to their legislators during the legislative session and year round. A high number of legislative staff can support increased policy output and provide robust analysis of policies and legislation. A higher number indicates that there is increased legislative staff support (National Conference on State Legislatures 2016).

Bureaucratic Capacity

- Higher bureaucratic capacity can provide additional time and effort offsets for additional policy making. A more involved and professional bureaucratic organization can improve the level of policymaking within a state (Huber and McCarty 2004). Data on bureaucratic capacity has been developed by prior scholars and have been leveraged for the rankings of states (Leichter 1996, Huber and McCarty 2006, Burns, Evans et al. 2008).

Demographic Factors

Age of Population

- Data on the age distribution of the population was collected from the Census Bureau, with 2014 as the year collected. The measure is the percentage of the overall state population that is 65 years or older. A higher number indicates a higher overall percentage of the population that is older.

Racial/Ethnic Distribution of Population

- Data on the racial and ethnic distribution of a state was collected from the Census Bureau, with 2014 as the year collected. The measure is the percentage of the overall state population that identifies as African American, Caucasian, or Hispanic. A higher number indicates a higher overall percentage of the population that identifies with that racial or ethnic group.

Gender Distribution of Population

- Data on the gender distribution of a state was collected from the Census Bureau, with 2014 as the year collected. The measure is the percentage of the overall state population

that identifies as female. A higher number indicates a higher overall percentage of the population that identifies with that gender.

APPENDIX B: Consent for Participation in Interview Research

I volunteer to participate in a research project conducted by Phillip M. Singer from the University of Michigan. I understand that the project is designed to gather information related to the decision-making process for expanding Medicaid. I will be one of approximately 120 people being interviewed for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I decline to participate or withdraw from the study, no one on will be told.
2. I understand that if I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.
3. Participation involves being interviewed by Phillip M. Singer from the University of Michigan. The interview will last approximately 45-60 minutes. Notes will be written during the interview. An audio tape of the interview and subsequent dialogue will be made. If I don't want to be recorded or feel uncomfortable you may ask that it is turned off at any time.
4. I understand that the researcher will not identify me by name in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure.
5. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) for Health Sciences and Behavioral Sciences at the University of Michigan.

For research problems or questions regarding subjects, the Institutional Review Board may be contacted at irbhsbs@umich.edu or (734) 936-0933.

6. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

7. I have been given a copy of this consent form.

My Signature

Date

My Printed Name

Signature of the Investigator

For further information or questions, please contact:

Phillip M. Singer
pmsinger@umich.edu

APPENDIX C: Interview Protocol Form

Interviewee Name: _____

Interviewee Title: _____

Interviewee Institution: _____

Interviewer: _____

Thank you for taking the time to participate in this interview. My name is Phillip Singer and I am a doctoral candidate at the University of Michigan School of Public Health. This interview is part of research being conducted for my dissertation. As my earlier email mentioned, I am interested in learning more about your state's decision around the Medicaid expansion. You have been selected because you have been identified as someone who has a great deal to share about the experiences of your organization and state in the decision-making process. Your expertise will help me better understand the events that shaped the decision making. All of your responses will be kept anonymous, unless you give me permission to use your name. Before we start, do you have any questions for me?

Interviewee Background

- How long have you been in your present position?
- How long have you been at your organization?
- Briefly describe your role within your organization.
- What roles have you had in relation to implementing the Medicaid expansion?

Organizational Perspective

- What has been the position of your organization in relation to implementing the Medicaid expansion?
 - Probe: What has been the rationale for the position of the organization?
- What has your organization/institution done to either support or oppose expansion?
 - Probe: How effective has your organization felt these actions were?
 - Probe: Has support or opposition remained constant?
 - Probe: Who within your organization/institution has been the key decision-maker on a position for expanding Medicaid and the actions that your organization/institution has done to support their decision?
 - Probe: How did your organization/institution target who to apply pressure or work with in their efforts to support or oppose expansion?
- Did your organization partner with or coordinate with other institutions/organizations as part of your campaign to support or oppose the expansion?
- What do you consider the key moments or junctures in the decision-making process with the Medicaid expansion?

State Political Perspective

- How has the governor either pushed for or against expansion?
 - Probe: How much power does the governor have in leading the state to either expand or reject expansion?
 - Follow-up: Can the governor use an executive order to expand Medicaid? Have there been any discussions about using an executive order to expand Medicaid? What would the reaction be by the legislature and other interested stakeholders if the governor were to do that?

- In general, how would you describe the relationship between the governor and the legislators?
- How has the legislature either pushed for or against expansion?
 - Probe: How much power does the legislature have in leading the state to either expand or reject expansion?
 - Probe: Within the legislature, who were the key individuals on both sides of the debate related to Medicaid expansion?
- Within the legislature, what institutional rules which shaped the debate over expansion? Limits on amendments? Limits on testimony? Decisions on which committee would hear legislation? Power that a committee chair has on stopping or passing legislation? What about term limits?
- What affect has the legislative calendar, the frequency and duration of your states legislative sessions, had on debate around Medicaid expansion?
- Prior to health reform, how generous was the Medicaid program in your state?
 - Probe: How partisan was the support for the Medicaid program?
- What did your state do prior to the Supreme Court ruling in June 2012 to implement Medicaid expansion?
 - Probe: Who was involved in those discussions?
 - Probe: Was there any discussion that the Supreme Court case would repeal the law?
- Another component of the ACA was around the formation of insurance exchanges. How did the debate around expansion of Medicaid and the exchanges differ from each other?
- What interest groups have been involved in the Medicaid expansion decision?

- Probe: What arguments have these groups supplied to policymakers?
 - Probe: What has been your response to these groups' arguments?
- What was the nature of the debate over expansion in the legislature? Did it fall primarily along partisan lines?
 - Probe: Was there conflict within your party on decision-making about the expansion?
 - Probe: Was there any difference between rural and urban division over decisions to expand?
- What has been the most important factor affecting whether your state has expanded Medicaid?
- Were there ever discussions about using a waiver to expand Medicaid? Who initiated those discussions?
 - Probe: Why did the state choose to not go down a route of expansion by waiver? Was there bipartisan support for a waiver?
- If a state had expanded or attempted to expand Medicaid via a waiver: what were negotiations like with the federal government?
 - Probe: Who was involved in those negotiations? What aspects of the waiver were rejected by the federal government? Were there any 'pre-application' discussions between state policymakers and the federal government?
- How does the broader voting public feel about expanding Medicaid? Are there any polls which suggest support or opposition to expansion?

- Probe: What affect have these polls had on the debate around expanding Medicaid?
 - Probe: If there was little affect, why was that the case?
- How strongly have partisan interest groups come out in support or opposition to expanding Medicaid? What role have these groups, for example the Tea Party, had on the debate around expansion?
 - Probe: Are these groups strong or weak in your state? Why are these groups strong or weak in your state?
 - Probe: What have these groups done to express their opinions? Protests? Emails? Visit your office?
- Has your state hired any outside consultants to assist with planning or evaluation around Medicaid expansion? Which firms and what has been their role?
 - Probe: Who decided to hire those specific vendors? Was it an open process or no-bid? How long was the contract for?
 - Probe: Has your state had experience working with these vendors in the past? What has been the overall effect of working with outside vendors?

National Political Perspective

- What affect has the actions of other states had on the debate over Medicaid in your state? Especially states which share similar characteristics with you or are proximally near your state?
- Has there been any communication that you know of, between policymakers in your state and policymakers in other states around Medicaid expansion decisions?
- What has the interaction been like with federal officials over expanding Medicaid?

- Probe: How responsive has the federal government been in relation to answering questions or clarifying regulations?
- What effect did the November 2012 presidential election have on the decision-making in the state? What effect did the potential for President Obama's second term have on the debate over expanding Medicaid? Compare the 2014 and 2016 election cycle, what is different from these elections then from the 2012 in how the state will address the Medicaid expansion?
- What contact has your Congressional representatives and senators had on the discussion around expanding Medicaid?
 - Probe: what effect if any has these conversations had on the state decision on Medicaid?

Conclusion

- Which other organizations or individuals were important in shaping the decision-making within your state on the Medicaid expansion? Who else in the state do you think I should talk to, to learn about the debate and decision-making on the Medicaid expansion?

Thank you for participating in this interview. I found our conversation to be informative and insightful to understanding the decision-making process around the Medicaid expansion in your state.

Before we end, was there anything else that you think would add to my understanding of the topic or something that we didn't touch on in our interview?

If I need to clarify any information, can I reach out to you again?

You may reach me at my email address, pmsinger@umich.edu at any point if you have any clarifications, questions, or concerns. Thank you.

For Interviewer Use Only:

What was the best quote that came out of this interview?

What was the best story that came out of the interview?

What new information did you gain through this interview?

What questions should you add to the protocol after this interview?

What questions need more information after this interview?

APPENDIX D: Interview Coding Protocol

Table D:1 Interviewing Coding Protocol		
Code	Background	Notes
1.1 State Context	Important internal/external background to decision-making/policy discussions	
1.2 Public Response	How did the public respond to policy, the debate, or the Supreme Court decision	
1.3 Policy Setting	How Medicaid expansion as a policy interacted with other policy domains	
2.1 Institutional Setting	Associated to the actors and agencies responsible for the policy making process	
2.2 Authority	Related to whomever has the legal obligations, perceptions of obligations/responsibilities of different departments/actors	
2.3 Actor	Actions made by a particular individual, across a variety of different areas	
2.3.1 Bureaucratic	Member of Bureaucracy	
2.3.2 Executive	Member of Executive Branch	
2.3.3 Legislative	Member of Legislative Branch	
2.3.4 Judiciary	Member of Judicial Branch	
2.3.5 Local Government	Member of Local/County Government	
2.3.6 Non-Government	Member of non-governmental group	
2.4 Organizational or Individual Capacity	The resources available to an organization or an individual to ensure that it can implement expansion	
2.4.1 Limited Capacity	Perceived or evidenced capacity limitations to carry out policy goals	
3.1 Framing	The reasons given to account for an action, perception, or outcome	
3.1.1 Increased insurance coverage		
3.1.2 Reduced costs		

3.1.3 Improved State Finances		
3.1.4 Improved Business		
3.1.5 Improve Mortality		
3.1.6 Improve Quality		
3.1.7 Health Workforce		
3.1.8 Increased Costs		
3.1.9 Financially Detrimental		
3.1.10 Reform Medicaid		
3.1.11 Political Gain		
3.1.12 Morally Underserving		
3.1.13 Morally Right		
4.1 Position		
4.1.1 Supportive of Expansion		
4.1.2 Oppositional of expansion		
4.1.3 Neutral towards expansion		
5.1 Cause of Conflict		
5.1.1 Federal Overreach		
5.1.2 Inadequate state response		
5.1.3 Inadequate federal response		
5.1.4 Political		
6. Policy Outcome		
6.1 Legal Action		
6.2 Legislative Action		
6.3 Bureaucratic Action		

APPENDIX E: Document Coding Protocol

Table E:1 Document Coding Protocol		
Code	Background	Notes
1 Document Type		
1.1 Committee Meeting Testimony		
1.2 Floor Speech		
1.3 Government Reports and Documents		
2.1 Testimony		
2.1.1 Elected Official		
2.1.2 Bureaucrat		
2.1.3 General Public		
2.1.4 Interest Group		
2.1.5 Executive		
2.1.6 Positive Stance Towards Expansion		
2.2 Framing		
2.2.1 Increased insurance coverage		
2.2.2 Reduced costs		
2.2.3 Improved State Finances		
2.2.4 Improved Business		
2.2.5 Morally Right		
2.2.6 Improve Mortality		
2.2.7 Improve Quality		
2.2.8 Health Workforce		
2.2.9 Increased Costs		
2.2.10 Financially Detrimental		
2.2.11 Morally Undeserving		
2.2.12 Reform Medicaid		
2.2.13 Political Gain		
2.3 Evidence		
2.3.1 Use of Cited Evidence		
2.4 Personal Experience		
3.1 FLOOR SPEECH INDIVIDUAL		
3.1.1 Democrat Party		

Member		
3.1.2 Republican Party Member		
3.1.3 Leadership Member		
3.1.4 Positive Stance		
3.2 Framing		
3.2.1 Increased insurance coverage		
3.2.2 Reduced costs		
3.2.3 Improved State Finances		
3.2.4 Improved Business		
3.2.5 Morally Right		
3.2.6 Improve Mortality		
3.2.7 Improve Quality		
3.2.8 Health Workforce		
3.2.9 Increased Costs		
3.2.10 Financially Detrimental		
3.2.11 Morally Undeserving		
3.2.12 Reform Medicaid		
3.2.13 Political Gain		
3.3 Evidence		
3.3.1 Use of Cited Evidence		
3.4 Personal Experience		
3.4.1 Use of Personal Experience		
3.5 Amendments		
3.5.1 Amendments Offered		
3.5.2 Amendment Passed		
3.5.3 Amendment Failed		
3.5.4 Amendment includes reforms that restrict access/increase cost-sharing		
4 GOVERNMENT REPORT OR DOCUMENT		
4.1 Agency Name		
4.1.1 Health and Human Services		
4.1.2 Executive Office		
4.1.3 Budget Office		
4.1.4 Legislative Office		
4.2 Stance		
4.2.1 Positive Stance		

4.3 Evidence		
4.3.1 Use of Cited Evidence		
4.4 Framing		
4.4.1 Increased insurance coverage		
4.4.2 Reduced costs		
4.4.3 Improved State Finances		
4.4.4 Improved Business		
4.4.5 Morally Right		
4.4.6 Improve Mortality		
4.4.7 Improve Quality		
4.4.8 Health Workforce		
4.4.9 Increased Costs		
4.4.10 Financially Detrimental		
4.4.11 Morally Undeserving		
4.4.12 Reform Medicaid		
4.4.13 Political Gain		
4.5 Recommendations		
4.5.1 Expand Medicaid		
4.5.2 Explore Other Options		
4.5.3 Reject Expansion		
5 THINK-TANK OR INTEREST GROUP REPORT OR DOCUMENT		
5.1 Organization Name		
5.2 Stance		
5.2.1 Positive Stance		
5.3 Evidence		
5.3.1 Use of Cited Evidence		
5.4 Framing		
5.4.1 Increased insurance coverage		
5.4.2 Reduced costs		
5.4.3 Improved State Finances		
5.4.4 Improved Business		
5.4.5 Morally Right		
5.4.6 Improve Mortality		
5.4.7 Improve Quality		
5.4.8 Health Workforce		
5.4.9 Increased Costs		
5.4.10 Financially Detrimental		

5.4.11 Morally Undeserving		
5.4.12 Reform Medicaid		
5.4.13 Political Gain		
5.5 Recommendations		
5.5.1 Expand Medicaid		
5.5.2 Explore Waivers		
5.5.3 Reject Expansion		
5.6 Date		
5.7 Organizational Information		
5.7.1 State-based Organization		