To Expand or Not To Expand?

The Role of Elite Framing in the Politics of Post-ACA Medicaid Expansion

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Glossary of Acronyms and Terms

ACA	Patient Protection and Affordable Care Act
AFP	Americans for Prosperity, a conservative advocacy group known best for advancing the causes of the Tea Party, also works to disrupt the implementation of the ACA, especially Medicaid expansion. AFP is primarily backed by the Koch brothers, and is an increasingly influential power in state politics. Played a role in obstructing expansion in Tennessee.
CMS	Centers for Medicare and Medicaid Services, federal agency for oversight of Medicare and Medicaid.
FMAP	Federal Medical Assistance Percentage: the portion of funding paid by the federal government to cover the costs of the newly eligible population. If a state chooses to expand, the federal government pays for the following share of the newly eligible population: 2014-2016: 100% of costs covered by federal gov't 2017: 95% 2018: 94% 2019: 93% 2020-beyond: 90%
FPL	Federal Poverty Level
Managed Care Organizations (MCOs)	Managed care plans broadly refer to different types of health insurance. These plans serve as mediators between care providers and the patient. There are three types of managed care plans: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Point of Service (POS).
Medicaid	Social welfare program established during President Lyndon B. Johnson's Great Society. Provides government-funded healthcare to low-income individuals. The program is funded at the federal and state levels but is state administered.
Medicaid coverage gap	The population excluded from Medicaid because their income is too high to qualify Medicaid but not high enough to qualify for federal subsidies for private insurance.[1]
NCSL	National Conference on State Legislatures
NFIB or NFIB vs. Sebelius	*National Federation of Independent Business vs. Sebelius**:*** Supreme Court case decided on June 28, 2012. The court upheld the constitutionality of the ACA, but felt that a federal mandate for states to expand Medicaid up to 138% was a federal overreach. Thus, states are able to opt out of Medicaid expansion.
OHT	Ohio's Office of Health Transformation

[1] Samantha Artiga, Anthony Damico, and Rachel Garfield, "The Impact of the Coverage Gap for Adults in States not Expanding Medicaid by Race and Ethnicity," *Kaiser Family Foundation,* October 26, 2015.

SCI	State Coverage Initiative. Former Ohio Governor Ted Strickland created this body to advise on healthcare administration.
State of the State	Governors deliver these speeches every year. They usually run through each state agency's annual highlights/accomplishments. Also gives the governor a chance to comment on current local events.
TennCare	Tennessee's state Medicaid program.
Uncompensated Care	Refers to health care provided that is never paid for by the patient or the insurer. Usually, individuals without insurance incur this care. Hospitals are legally required to admit Medicaid patients but have no guarantee that those services will be covered. Uncompensated care cuts into hospitals' revenue and growth prospects.[2]
Woodwork Phenomenon	Federal fund matching program does not account for individuals who had always been eligible for Medicaid but had not signed up for the program, and because of increased attention on health insurance, decide to sign up. States are responsible for covering those individual's health coverage, which is an additional fiscal burden for the state. The federal government will only pay for the care of the *newly* eligible group.[3]

[2] Healthcare.gov, "Glossary."
[3] Benjamin Sommers and Arnold Epstein, "Why States Are So Miffed About Medicaid—Economics, Politics, and the 'Woodwork Effect,'" *New England Journal of Medicine,* July 14, 2011, Page 100-102.

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Abstract

The June 2012 Supreme Court ruling in *NFIB vs. Sebelius*, which made the Affordable Care Act's (ACA) Medicaid expansion optional, granted fifty individual state governments unprecedented discretion in the ACA's implementation. As states adopt or reject expansion, the overall pattern of Medicaid expansion can be explained by one of three explanations: state political ideology, partisan control of the state legislature, or economic need. However, there are a handful of anomalous states that pursued expansion in spite of being ideologically conservative and controlled by Republican lawmakers. This paper describes Republican governors' frames of Medicaid expansion in three such cases: Arizona and Ohio, where governors saw expansion through, and Tennessee, where expansion has not succeeded. After presenting the Medicaid narrative in each state, this paper will consider the impact of framing as a contributor to the political cascade that produces expansion. Ultimately, framing proves to be a moderate contributor to expansion, but in some instances, may have accelerated parts of the expansion process and shaped the public discourse around the policy. Medicaid expansion frames are important for the future of the policy, in terms of how easily it can be altered or undone.

Introduction

America's Healthcare Landscape

Our presence here today is remarkable and improbable. With all the punditry, all of the lobbying, all of the game-playing that passes for governing in Washington, it's been easy at times to doubt our ability to do such a big thing, such a complicated thing; to wonder if there are limits to what we, as a people, can still achieve. It's easy to succumb to the sense of cynicism about what's possible in this country.

But today, we are affirming that essential truth -– a truth every generation is called to rediscover for itself –- that we are not a nation that scales back its aspirations. We are not a nation that falls prey to doubt or mistrust. We don't fall prey to fear. We are not a nation that does what's easy. That's not who we are. That's not how we got here.

We are a nation that faces its challenges and accepts its responsibilities. We are a nation that does what is hard. What is necessary. What is right. Here, in this country, we shape our own destiny. That is what we do. That is who we are. That is what makes us the United States of America.

And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care. And it is an extraordinary achievement that has happened because of all of you and all the advocates all across the country.

—President Barack Obama, March 23, 2010

Under exceptional political circumstances—a huge federal deficit, Congressional tension, and a demoralizing economic recession—the Obama administration introduced one of the largest social benefit bills since Social Security and Medicare. The Patient Protection and Affordable Care Act (ACA) is considered Obama's landmark policy. The bill attempts to improve the quality of health care services, mitigate barriers to care, and alter the nature of healthcare

substantively. The ACA's goals include universal coverage, state-led health infrastructure innovation, and a shift from fee-for-service to managed care systems.[4]

The ACA did not roll out without challenges from multiple stakeholder levels, most notably from the Supreme Court. A major 2012 Supreme Court case, *National Federation of Independent Business (NFIB) vs. Sebelius*, upheld the constitutionality of most provisions in the ACA. But the justices agreed that the Medicaid expansion mandate, a major tenet of the ACA, was unconstitutionally coercive, and gave state governments the choice to opt out of expansion. The ACA intended to ensure that everyone—regardless of health status or income—had some kind of health care, but the court's ruling on expansion threatened that promise.

The federal government and states jointly fund Medicaid, but states design and administer the program on their own. Medicaid provides health care coverage to a sector of children, elderly adults, people with disabilities, and low-income adults. Prior to the ACA, states were required to provide insurance for certain low-income or dependent populations or they would lose federal funding for Medicaid.[5] The ACA does not change this statute; but it expanded eligibility requirements to include adults earning up to 138% of the Federal Poverty Level (FPL), which was about $16,000 per year for an individual in 2015.[6] Much of the controversy regarding

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[4] These goals are achieved by the following mechanisms. The individual mandate is a new requirement for all individuals to obtain health insurance, or pay an incrementally increasing fine for going without. Guaranteed issue refers to a practice in which insurance companies offer individuals health insurance regardless of their health status (i.e. pre-existing conditions). Managed care plans broadly refer to different types of health insurance. These plans serve as mediators between care providers and the patient. There are three types of managed care plans: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Point of Service (POS).

[5] Larry Jacobs and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs To Know* (New York: Oxford University Press, 2010).

[6] Vikki Wachino, Samantha Artiga, and Robin Rudowitz, "How is the ACA Impacting Medicaid Enrollment?" *Kaiser Family Foundation,* May 5, 2014.

> "How the Census Bureau Measures Poverty," *US Census Bureau* website.
> The Census Bureau determines the poverty line based on income. The cutoff varies by family structure and size. The Federal Poverty Line is computed with an algorithm that takes into account earnings (Social Security, pensions, unemployment compensation included); it excludes noncash benefits like food stamps and capital gains. This threshold is indexed to inflation annually, based on the Consumer Price Index.

Medicaid stemmed from its fiscal burden—Medicaid is often the largest line item in a state's budget—and the debate about whether welfare should be expanded. The ACA Medicaid expansion is separate from existing Medicaid. Under the new ACA provisions, the federal government assumes 100% of Medicaid expansion costs through 2017; federal funding gradually drops to 90% in 2020 and beyond.[7] Now that Medicaid expansion is up to the discretion of governors, the "Medicaid coverage gap," in which individuals earn too much to qualify for Medicaid and earn too little to qualify for federal subsidies for private insurance, persists. ACA reforms were designed to provide subsidies for private insurance above a certain income bracket, assuming that states would enroll the remaining low-income individuals for Medicaid. The Medicaid gap undermines the original intention of the ACA to provide insurance coverage to all Americans. As of March 2016, 32 states including Washington D.C. have expanded the program.[8]

The complexity of Medicaid extends beyond its funding structure. States can individually decide the income threshold to qualify for benefits, and those cutoffs vary dramatically. In Maryland, for example, parents and childless adults earning up to 133% FPL are eligible for Medicaid; across the Potomac River in Virginia, parents are only eligible up to 49% FPL, and childless adults cannot qualify for Medicaid.[9] States can also apply for a number of Section 1115 Waivers, which allow for greater program flexibility in terms of premium subsidies, beneficiary rewards for practicing "healthy behaviors," work requirements, time limits on eligibility and more.[10] There is high variability among states' Medicaid programs. Given the level of detail and

[7] See Glossary, "FMAP."
[8] "Current Status of State Medicaid Expansion Decisions," *Kaiser Family Foundation*, March 14, 2016.
[9] "State Medicaid and CHIP Income Eligibility Standards," *Centers for Medicare and Medicaid Services.*
[10] Robin Rudowitz and MaryBeth Musumeci, "The ACA and Medicaid Expansion Waivers," *Kaiser Family Foundation*, November 20, 2015.

range of options for Medicaid, voters are unlikely to be able to come to their own conclusions about their preferences for the program.

Given this brief description of recent healthcare reforms, the remaining chapters will delve into the politics of Medicaid expansion. Chapter 1 will describe existing but inadequate structural explanations for Medicaid expansion in the literature and raise the possibility that elite framing may help explain anomalous cases. Chapter 2 will outline my research methodology, including how I propose to assess the importance of framing in Medicaid expansion debates. Chapters 3, 4, and 5 describe Medicaid expansion politics in Ohio, Tennessee, and Arizona, respectively. In chapter 6, I compare framing strategies across the cases and contextualize framing in the state policymaking process. Finally, chapter 7 offers a conclusion of the research and a discussion of the broader implications of my research.

Chapter 1

Why Do Some, But Not All, States Expand Medicaid?

This chapter reviews the relevant literature for my question. The first section summarizes the literature on Medicaid expansion outcomes. The second portion of this chapter discusses the literature on framing. This culminates in my research question. There are three overarching bodies of research that explain Medicaid expansion since the passage of the ACA. This academic research employs both conventional and innovative political mechanisms to determine a pattern of Medicaid expansion in American states. These explanations can be divided into three themes: party control of the legislature, political ideology, and economic need.

First, research hypothesizes that party control over any given legislative body—Senate, House, or governorship—can indicate the likelihood of Medicaid expansion. States with Democrats controlling the House, Senate, and governorship tend to be more likely to expand Medicaid than states that have Republican control over a legislative body.[11] Democratic states are more likely to expand Medicaid because they are generally more generous with social welfare programs.[12] This explanation assumes that party members are partisan, meaning that they will adhere to party preferences and will be unwilling to negotiate with members of the opposite party.[13]

The second body of literature explores how the political ideology of states might determine the outcome of expansion. Political ideology refers to the set of guiding beliefs and

[11] Timothy Callaghan and Lawrence R. Jacobs, "Process learning and the implementation of Medicaid reform," *Publius: The Journal of Federalism,* Vol.44 (4), 2014, Page 541-563.
[12] Callaghan and Jacobs, "Process learning and the implementation of Medicaid reform," Page 542.
[13] Elizabeth Rigby and Jake Haselswerdt, "Hybrid federalism, partisan politics, and early implementations of the state health insurance exchanges," *Publius: The Journal of Federalism,* Vol. 43 (3), 2013, Page 370.

values of the two dominant political parties in the U.S.—the Democrats and the Republicans.[14] Thus, we would expect states that embody the Democrats' platform to vote in favor of expansion and states that favor Republican values to oppose it. There is a nuanced distinction between partisanship—the previous explanation—and ideology. While partisanship refers to individuals who must choose to adhere to political principles, ideology tends to direct the macro way a society should progress, in terms of whether it is organized in a liberal or socialist manner. State political ideology can be influenced by geographic region, economic activity, or ethnic diversity. Political ideology might govern the way policies are introduced in a state, but political partisanship might govern how politicians vote or lobby their constituents.

The third group of scholarship seeks to explain Medicaid adoption by state economic need. The National Association of State Budget Officers (NASBO) estimated that 23.6% of state expenditures was devoted to Medicaid in fiscal year 2011. With Medicaid occupying such a significant portion of any given state's budget, governors must carefully balance cost control of healthcare and budgetary prudence. Examining the economic pressures for states in the post-ACA landscape reveals a major motivation for political action: money.

Party Control

One predominant explanation in the literature is that the composition of a given state's legislature determines the likelihood of Medicaid expansion. This argument is grounded in the idea that majorities in the House and Senate behave predictably. Thus, we would expect states with Republican-controlled legislative bodies to reject expansion bills and Democratic-controlled bodies to support expansion bills. The more partisan, the more likely a politician will cling to

[14] David O. Sears, Richard R. Lau, Tom R. Tyler, and Harris M. Allen Jr., "Self-Interest vs. Symbolic Politics in Policy Attitudes and Presidential Voting," *The American Political Science Review*, Vol. 74 (3), 1980, Page 670-684.

party lines. If political partisanship explained Medicaid expansion decisions, Republican-controlled states should reject the expansion, which the evidence does not uniformly support. States like Arizona, Ohio, Arkansas, and Michigan were controlled by Republicans, but still opted to expand Medicaid.

Jacobs and Callaghan find a strong correlation between party control and Medicaid expansion. They confirm the expected pattern of Democratic Party-controlled states "moving fastest and farthest" towards expansion and Republican Party-controlled states slowly progressing or remaining generally inactive.[15] The study used an additive measure of each state's legislative progression on expansion to determine how influential party control was. Points were awarded based on whether states embraced expanded benefits or a streamlined payment system, among other new program initiatives. This measure was cumulative and summarized lawmaker "activity at a point of flux." For the most part, the distribution of Medicaid implementation reflected partisan control. Republican control corresponded with inaction or little action, while states controlled by Democrats were actively pursuing expansion.[16] But for states with split control within the legislature, or with divided government between the legislature and governor, legislative initiative on Medicaid is not attributable to party control. Jacobs and Callaghan address this deficiency in their article; they also consider economic strain on states and a state's history of Medicaid policy as possible explanations for progress on expansion.

Similar to Jacobs and Callaghan, Rigby and Haselswerdt hypothesized that after controlling for ideological agreement with the ACA, Democrat-controlled states were more likely to establish state exchanges for insurance. Insurance exchanges were similar to Medicaid expansion in that the empirical basis of the program should have appealed to all states, but

[15] Larry Jacobs and Timothy Callaghan, "Why States Expand Medicaid: Party, Resources, and History," *Journal of Health Politics, Policy and Law*, Vol. 38 (5), October 2013, Page 1032.
[16] Ibid., Pages 1028, 1029, 1032.

partisan posturing often obstructed implementation. Republicans, who unanimously opposed the ACA, did not want to reverse course and implement an ACA tenet. Rigby and Haselswerdt's research found that partisanship is a "prominent" explanation for the establishment of healthcare exchanges. Democratic governors pushed forward in conservative states, while Republican leaders blocked bills in liberal states. The authors also found that the party affiliation of elected insurance commissioners influenced whether or not the state adopted the health exchange.[17] Thus, legislative composition and connotations of party preference seemed to supersede the substance of the health reforms. This school of thought has a key limitation. Most research sorts party identity into two or three categories—Democrat, Republican, or other. That grouping ignores some of the nuance within "purple" or swing states, which is where the most anomalous Medicaid policy occurs.

Political Ideology

Political ideology is one of the most pervasive influences in policymaking and health policy is no exception.[18] Since Medicaid's creation in 1965 under Lyndon B. Johnson's Great Society, political party and preferences regarding healthcare grew increasingly intertwined. **T**he two major political parties in the U.S. polarized on their positions about the provision of social services, including healthcare. The Democratic Party states in its platform that healthcare is a core component of its value system as it offers "economic security" and contributes to the

[17] Rigby and Haselswerdt, "Hybrid federalism, partisan politics, and early implementations of the state health insurance exchanges," Pages 377 and 387.
[18] Nolan McCarty, Keith Poole, and Howard Rosenthal, *Polarized America: The Dance of Ideology and Unequal Riches,* (Cambridge, MA: MIT Press, 2008.)

John Aldrich and James Coleman Battista, "Conditional Party Government in the States," *The American Journal of Political Science*, Vol. 46 (1), 2002, Page 164–172.

prosperity of the middle class.[19] The Republican Party groups healthcare with other welfare "handouts" that dis-incentivize un-or-underemployed Americans from optimizing their labor potential. In order to satisfy their values of limited government intervention and greater individual choice, the Republican Party prefers stricter eligibility requirements for public health insurance programs.[20]

In 2010, the Democratic Party controlled the national Senate, House, and White House, advantaging legislation that would otherwise be subjected to the rigorous policymaking process. This enabled President Obama to squeeze through some of the biggest social policy reforms since the 1960's. The ACA did not get a single vote of support from Republicans in Congress; most Democrats supported it. Since the ACA was never bipartisan, we would expect party control at the state level to mirror that divide in terms of implementation of the ACA's optional provisions.

The seminal works in this school of thought generally follow a pattern of identifying policy proposals where one party acts against its fundamental goals or values. Grogan and Rigby explore ideological conflict in the implementation of another controversial healthcare program, the State Children's Health Insurance Program (SCHIP). When Democrat Ted Kennedy and Republican Orrin Hatch initially endorsed SCHIP, the program was hailed as successful collaboration between Democrats and Republicans. Yet ten years later, when the federal government went through the legislative reauthorization process to renew the policy, Republicans pushed for narrowing eligibility requirements while Democrats supported broader requirements.[21] What accounted for this transition from cooperation to collapse? The researchers

[19] Democratic Party Platform, 2012.
[20] Republican Party Platform, 2012.
[21] Colleen Grogan and Elizabeth Rigby, "Federalism, partisan politics, and shifting support for state flexibility: The case of the U.S. State Children's Health Insurance Program," *Publius: The Journal of Federalism,* 2009, Page 1.

concluded that ideological polarization heightened the national debate surrounding SCHIP renewal and contributed to the widening gap in politicians' preferences. In order to support their assertion, Grogan and Rigby examined the fifty states' program design of SCHIP, looking at variables like eligibility limits, cost of living index, and percentage of minority residents to understand the historical and current support for SCHIP in each state. The authors concluded that the SCHIP controversy and slow re-approval process was a result of intensifying ideological distance, which clouded previous federal-level consensus.[22]

Jones, Bradley, and Oberlander concurred with Grogan's assertion about the importance of ideology in understanding policies that initially had bipartisan support. Jones et. al. studied opposition to state-run health insurance exchanges, another important tenet of the ACA. Republicans were expected to embrace this component of the ACA because states would be given significant autonomy to design the marketplaces. Conservative ideology tends to favor federalism and states rights, and insurance exchanges were a huge administrative handoff from the federal government to the states. Why, then, did only a quarter of states implement this initially bipartisan policy? Jones and his collaborators concluded that other ideological constraints contributed to many Republican governors deciding to return control of exchanges to Washington.[23] These constraints include not wanting to be seen as supporting President Obama, hoping that the ACA would be reversed, or preferring to rely on the federal government to oversee this program because it would require too many state resources. These decisions ultimately gave the federal government more control over the exchanges, a practice that Republicans typically oppose. If ideology determined all expansion outcomes, then states with

[22] Grogan and Rigby, "Federalism, partisan politics, and shifting support for state flexibility: The case of the U.S. State Children's Health Insurance Program," Pages 8 and 17.
[23] David K. Jones, Katharine Bradley, and Jonathan Oberlander, "Pascal's wager: Health insurance exchanges, Obamacare, and the Republican dilemma," *Journal of Health Politics, Policy and Law,* Vol. 39 (1), 2014, Pages 129 and 130.

GOP roots would not even consider the policy. Some, but not all, evidence supports this conjecture.

Economic Need

The third predominant explanation of Medicaid expansion is economic. The Obama administration conceived a federal fund-matching scheme to pay for individuals who would join Medicaid when the eligibility requirements were expanded. The federal government covers 100% of the cost of expansion for the first three years—from 2014 through 2016—and continues to cover no less than 90% of costs for newly insured individuals from 2020 onwards.[24] Conventional economic thinking hypothesizes that less well-off states, facing tight budgets in the wake of the 2008 financial crisis and rising expenditures on education and healthcare, would be more inclined to engage with the federal fund matching formula and opt to expand.[25] Existing research confirms that the less affluent a state is, the more impactful fiscal incentives are in affecting policy change.[26]

The equation laid out by the Obama administration is a strong fiscal incentive for poorer states; that logic would predict that the poorer a state, the higher the likelihood of increasing Medicaid eligibility requirements.[27] Jacobs and Callaghan tested this prediction by using per

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[24] "State Health Care Spending on Medicaid: A 50-state study of trends and drivers of cost," *The Pew Charitable Trust,* July 2014.
[25] Jacobs and Callaghan, "Why States Expand Medicaid: Party, Resources, and History," Page 1033.
[26] Ae-sook Kim and Edward Jennings, "The Evolution of an Innovation: Variations in Medicaid Managed Care Program Extensiveness,'' *Journal of Health Politics, Policy and Law,* Vol. 37 (5), 2012, Page 815-849.

Sean Nicholson-Crotty, "Leaving money on the table: Learning from recent refusals of Federal grants in the American states," *Publius: The Journal of Federalism,* Vol. 42 (3), 2012, Page 449-466.

[27] Kim and Jennings, "The Evolution of an Innovation," Page 815-849.

Stan Dorn, John Holahan, Caitlin Carroll, and Megan McGrath, "Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs," *The Urban Institute,* June 2013.

capita state income to measure a state's economic environment and level of need for additional funds. They found evidence that economic need might not drive state decisions on Medicaid reform in a need-based pattern as explained above. Rather, states with high per capita income, like Connecticut and Massachusetts, have moved farther along on the continuum of Medicaid expansion than states with low per capita incomes like Mississippi. Despite a state's fiscal limitations, the low hanging fruit of federal funds may not be a decisive factor in the likelihood of expansion.[28]

Kim and Jennings echoed Jacobs and Callaghan's assertion about the importance of economics but diverge in results. Kim and Jennings concluded that a state's economic climate is the most determinative factor for the development of a Medicaid program. Kim and Jennings found statistical significance in variables like state's wealth as measured by gross state product per capita; this conclusion led them to suggest that wealthier states have more disposable resources and thus less pressure to control Medicaid costs.[29] This research supported the hypothesis that economic need predicts expansion outcomes.

In a study that pre-dates the ACA, Buchanan, Cappelleri, and Ohsfeldt concluded that economic factors such as voter per capita income had the greatest influence on Medicaid expenditure. The researchers identified independent variables such as personal per capita income, number of Medicaid recipients, previous years' Medicaid expenditures, and physician density in order to establish correlations with Medicaid spending. First, the article described states' social environments. Based on statistical regressions, data suggests that economic factors, rather than political factors, influenced spending. A key finding—that wealthier states tended to

[28] Jacobs and Callaghan, "Why States Expand Medicaid: Party, Resources, and History," Page 1035.
[29] Ae-sook Kim and Edward Jennings, "The Evolution of an Innovation," Page 839.

spend more on Medicaid than their poorer counterparts—is consistent with data in the post-ACA landscape.[30]

Although each of these bodies of research offers valuable insights for explaining Medicaid expansion, there are still state narratives that cannot be explained by control of state legislature, political ideology, or economic need. Another possible contributing explanation is that the way governors of Republican states frame Medicaid expansion to their constituents via speeches or media influences Medicaid expansion politics.

Beyond the fact that these three explanations are not empirically satisfactory, these explanations only point to the structural determinants of the politics of expansion. They do not provide room for arguments surrounding individual agency. Politicians can increase or decrease the likelihood of policy passage by talking about issues. There is the possibility that skillful policy entrepreneurs, like governors, might determine what policies succeed, more so than ideology or political party control. Studying framing highlights the role of individual capacity in expansion outcomes.

The second portion of the literature discusses framing as political tool. Framing is a multi-disciplinary concept that is intended to help illuminate how issues are narrated affects individuals' attitudes and preferences. Through framing, a communicator highlights one understanding of "the essence of the problem, suggest[s] how it should be thought about, and may go so far as to recommend what (if anything) should be done."[31]

For political purposes, the power of framing lies in its ability to synthesize complex policies that the average voter is unable to parse through and highlight two or three key themes,

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[30] Robert Buchanan, Joseph Cappelleri and Robert Ohsfeldt, "The social environment and Medicaid expenditures: Factors influencing the level of state Medicaid spending," *Public Administration Review,* Vol. 51 (1), 1991, Pages 67-73.

[31] Thomas Nelson, Rosalee A. Clawson, and Zoe M. Oxley, "Media Framing of a Civil Liberties Conflict and its Effect on Tolerance," *The American Political Science Review,* Vol. 91 (3), 1997, Page 567.

which then guide the individual's full understanding of an issue.[32] Many scholars apply framing as a political mechanism to help explain a myriad of political outcomes. In 2012, Tesler found that when the ACA healthcare reforms were associated with President Obama, support for the policy was significantly racialized as compared to when the policy was attributed to Bill Clinton's efforts in 1993. Latent preferences about race and religion among the public were activated when the first black President proposed the sweeping ACA. The support gap between black and white Americans nearly doubled—in 1993, 69% of blacks and 43% of whites supported healthcare reform, while in 2010, 83% of blacks and 38% of whites were in support. The racialization of healthcare policy, when the policy itself was for all intents and purposes consistent, demonstrated how framing altered public perception and support.[33]

For my research purposes, framing will be defined as: how the way governors discuss Medicaid expansion more broadly influences public perception about expansion policy. Expansion frames can alter public support for the policy. In order to satisfy their constituents, state legislators will align with voter preference, which could alter the outcome of Medicaid expansion.

Framing effects are also well illustrated in Nelson et. al.'s experiment about tolerance for the Ku Klux Klan. The aggregate results showed that participants were more likely to tolerate a KKK rally if the issue were framed as a free speech issue as opposed to a public safety issue. These frames were brought into being through language, emphasis, and imagery. Nelson et. al.'s findings were not broken down by respondents' race.[34]

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[32] Nelson et. al., "Media Framing of a Civil Liberties Conflict and its Effect on Tolerance," Page 568.

[33] Michael Tesler, "The spillover of racialization into health care: How President Obama polarized public opinion by racial attitudes and race," *The American Journal of Political Science,* Vol. 56 (3), 2012, Pages 690-704, 692, and 701.

[34] Nelson et. al., "Media Framing of a Civil Liberties Conflict and its Effect on Tolerance," Page 567.
James Druckman, "The Implications of Framing Effects for Citizen Competence," *Political Behavior*, Vol. 23 (3), 2001, Page 225-256.

There are, of course, numerous limits to framing. Hopkins investigated how American public opinion was not discernably different before and after strategic frames about the ACA, like "government takeover" or "death panels," were publicized. By identifying individual words—which ranged from "affordable" to "healthcare" to "pre-existing condition"—Hopkins tracked changes in the way the public searched for or used language about the ACA. He found that the public did not seem to directly respond to certain appeals the way politicians might have hoped.[35]

These two broad fields of scholarship—explanations for Medicaid expansion and framing—informed my research question. The existing explanations for expansion are inadequate, as they have not considered the role of an individual in determining outcomes. The effects of framing in the literature are incomplete because most literature relies on experiments. My research will address a deficiency in each body of work: I will study governors as agents in Medicaid expansion politics by describing their framing strategies and the practical challenges that informed those frames. Studying the framing of Medicaid expansion is worthwhile because of the policy's complexity and multi-faceted nature.

[35] Daniel J. Hopkins, "The Exaggerated Life of Death Panels: The Limits of Framing Effects in the 2009-2012 Health Care Debate," Georgetown University (unpublished manuscript), April 5, 2013, Pages 4, 8, 10, and 11.

Chapter 2

Examining the Role of Framing in Unusual Medicaid Expansions

Methodology

In order to research the role of framing in surprising instances of Medicaid expansion, I used a qualitative, case-study methodology. The case study method was best suited for me to provide a comprehensive and micro-level account of Medicaid expansion politics.[36] I used one case study strategy to examine anomalous or deviant cases that have outcomes not supported by the literature. This approach, according to Gerring, is exploratory and hypothesis generating.[37] In order to identify idiosyncratic or deviant cases, I organized the fifty states by expansion outcome and party control. Below is a chart of mispredicted states, unexplained by politics or ideology, from which I selected my cases:

State	Medicaid Expansion Outcome	Party Control (2013)
Arizona*	Expanded	Republican
Arkansas	Expanded	Divided
Indiana	Expanded	Republican
Iowa	Expanded	Divided
Kentucky	Expanded	Divided
Louisiana	Expanded	Republican
Maine	Did not expand	Divided
Michigan	Expanded	Republican
Missouri	Did not expand	Divided
Nevada	Expanded	Divided
New Hampshire	Expanded	Divided
New Jersey	Expanded	Divided
New Mexico	Expanded	Divided
North Dakota	Expanded	Republican
Ohio*	Expanded	Republican

[36] Gary King, Robert O. Keohane, and Sidney Verba, *Designing Social Inquiry: Scientific Inference in Qualitative Research* (Princeton: Princeton University Press, 1994.)
[37] John Gerring, *Case Study Research: Principles and Practices* (New York: Cambridge University Press, 2007), Pages 89 and 107.

Pennsylvania	Expanded	Republican
Tennessee*	Did not expand	Republican

[38]

I selected three states—Ohio, Tennessee, and Arizona—as my cases from a pool of unexpected expansion states with particularly treacherous or complex expansion politics. These cases fell into the set of states least likely to expand, according to the arguments put forth in the literature. With these three cases, I "control" for Republican power but still capture three distinct expansion outcomes. In Ohio, expansion succeeded, although Ohio Governor John Kasich used an unconventional strategy by expanding Medicaid via the state's Controlling Board, a little-known political body. In Tennessee, Governor Bill Haslam failed to expand Medicaid through legislative authorization, despite multiple attempts. This case offers insight for how elite framing interacts with non-elite framing. In Arizona, Governor Jan Brewer used the most "traditional" method—getting approval from her House and Senate. However, a new gubernatorial administration threatens the future of Medicaid expansion, leaving the outcome unclear.

In order to holistically present the expansion politics in each case, I used primary sources from each state's governor, secondary newspaper data, and third-party non-governmental and governmental publications. First, I identified "pivot points," such as when the *NFIB vs. Sebelius* ruling was decided, when the governor announced the expansion plan, when a committee considered the proposal, when the legislature voted on the plan, and when there was a legal challenge to expansion. These were important inflections in the trajectory of Medicaid expansion, and represented windows for governors to frame expansion. Then, I collected news coverage from major state newspapers the days before and days after those "pivot points." My second significant source of data was the governor's State of the State speeches, which told me

[38] Kaiser Family Foundation and National Conference of State Legislatures.

which policies were a priority, and how the governor wanted his or her voters to think about them. I used this information to identify each governor's general framing strategies, which fell into the following categories: Economic, moral/religious/humanitarian, pragmatic, and political.

Existing literature tells us that framing can change public opinion, but whether or not framing informs policy outcomes is still undetermined. Thus, my ultimate intent was to estimate how much framing mattered for the outcome of expansion in each case. I can suggest that framing succeeded if I tracked an increase in public or lawmaker support from right before expansion was proposed compared to shortly after.

My research examines framing in a real-world context, as opposed to most of the existing literature, which analyzes framing effects measured by laboratory experiments. Although "framing's real-world influence might be more limited and contingent than the bulk of experimental studies imply," there is very little non-experimental research on framing.[39] A major benefit to studying framing in real-world settings is that one can capture the constraints on politicians who deploy frames. These constraints include: 1) intra-party coordination, meaning that politicians in the same party must use consistent and relevant frames; 2) partisan polarization, because citizens are unlikely to be receptive to frames made by the opposing party; and 3) media's discretion in transmitting a frame to the public, which they are not guaranteed to do.[40] These checks are not fully reflected in an experiment, which typically relies on focus groups or public opinion polls.

Based on the aforementioned literature and case study approach, the following chapters will describe in detail the expansion politics in Ohio, Tennessee, and Arizona. Each case will also include the motivations for different framing strategies, in order to set up Chapter 6, which

[39] Hopkins, "The Exaggerated Life of Death Panels: The Limits of Framing Effects in the 2009-2012 Health Care Debate," Page 2.
[40] Ibid., Page 6.

will provide a cross-case analysis and an assessment of the role of framing in expansion outcomes.

Chapter 3

Ohio: Saved By the Controlling Board

Introduction

In this chapter I will describe how Ohio's governor expanded Medicaid despite Republican Party control of the government and anti-ACA sentiment. First, I will briefly characterize the state's historical relationship with Medicaid. Then, I will chronologically describe Governor John Kasich's expansion proposal, initial failure, and subsequent success. Within each event, I will explore the magnitude of framing as a political force behind Medicaid expansion. I argue that the role of framing in this episode was insignificant despite expansion's implementation. Although framing Medicaid as a moral and fiscal imperative fit with Kasich's moderate reputation, he could not successfully convince a skeptical legislature to vote in favor of the measure.

Despite its location on the edge of the Midwest, Ohio is a crucial player in national political outcomes. The state is an amalgam of industrial centers like Cleveland, Toledo, and Akron that lean Democrat, and conservative enclaves in Columbus and Cincinnati. State policies thus reflect a wide interval of political preferences. Because of its geopolitical diversity, the eye of the national political storm lands on Ohio. No Republican candidate has been elected to the presidency without winning Ohio.[41] And since 1960, Ohioans have never voted for the loser of the presidency.[42] The importance of elections in Ohio is not limited to policies at the federal level. When Ohio adopts a policy, it becomes more palatable to other conservative states.

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[41] Chris Cillizza, "Why Ohio is the most important state in the country," *The Washington Post,* October 11, 2012.
[42] Wayne Drash, "Presidential politics: Why Ohio is the 'big one,'" *CNN,* October 24, 2012.

Considering Ohio as a political trendsetter, its position on healthcare is important for both liberals and conservatives, since both voices have constituents in the state. First, it is important to establish the health status of Ohioans. United Health Care Foundation ranked Ohio 40th out of the 50 states for total population health in 2013. Over 19% of residents live below the poverty line.[43] Economic trends mirror poor performance on health indicators. Ohio's manufacturing municipalities were hit particularly hard by demographic shifts and de-industrialization in the 20th century.[44] Deindustrialization's most notable impact was employment; the unemployment rate reached nearly 10% in the 1980s.[45] Unemployment in turn contributed to a growing population without health insurance.[46] The downstream effects of those sectoral shifts and economic disruption linger today.

In 2014, Ohio spent more on health care per capita than 35 other states. Today, Ohio spends almost 20% more on Medicaid services than the nationwide average.[47] Per capita, Ohio spends 16% more on hospital care and 36% more on nursing home care than the nationwide average.[48] Despite these suboptimal trends, 60% of Ohio's residents indicated they had an "unfavorable opinion" of the ACA.[49] That, combined with a red governor's mansion and a red Congress, made Medicaid expansion all the more challenging in Ohio. Ohio's conservative ideology, GOP legislative stronghold, and shaky fiscal position made Medicaid reform a necessary but unlikely policy priority.

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[43] "The Ohio Health Care Landscape," *Kaiser Family Foundation*, August 1, 2014.
[44] Myron Magnet, "The Resurrection of the Rust Belt," *Fortune Magazine*, August 15, 1988.
[45] Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey.
[46] John Russo and Sherry Lee Linkon, "The Social Costs of Deindustrialization," *Manufacturing a Better Future for America*, July 2009.
[47] "Healthcare costs in Ohio," *Health Policy Institute of Ohio*, December 2014.
[48] Greg Moody and John McCarthy, "Ohio Medicaid Reform," Presented to the Ohio House Finance and Appropriations Committee, Healthier Ohio Working Group, May 7, 2013.
[49] 2014 Poll conducted by the Institute for Policy Research at the University of Cincinnati. Published in: Barrett Brunsman, "Ohioans reveal how they really feel about Obamacare," *Cincinnati Business Courier,* October 21, 2014.

Pre-Existing Condition: Ohio's Historical Healthcare Landscape

Within a year of the Great Society reforms, Ohio joined a majority of states and adopted Medicaid in 1966.[50] As the program evolved, the state grappled with challenges such as cost and uniform distribution of services. Medicaid was administered county-to-county, and care was uneven across the 88 municipalities. Reflecting a national trend at the time, Medicaid costs increased exponentially. This squeezed county budgets and raised questions about the program's sustainability.[51]

Prior to the nationwide ACA reforms, healthcare availability in Ohio was limited to a small population. In 2008, the following groups were eligible for Medicaid: pregnant women or uninsured children in families earning less than 200% FPL and adults with dependents earning up to 90% FPL.[52] Over 70% of Ohio's uninsured low-income residents are childless adults, but they are omitted from Medicaid.[53] These two groups stood to gain insurance with Medicaid expansion: parents between 90 and 138% FPL and able-bodied, childless adults between 0 and 138% FPL. [54] The 2010 Ohio Family Health Survey conducted pre-ACA reported that around one-third of nonelderly adults were in families earning less than 138% FPL.[55] However, a voluntary Medicaid expansion would require sizeable political preference shifts given historically stringent eligibility requirements.

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[50] Kaiser Family Foundation.
[51] "The Evolution of Medicaid Managed Care in Ohio," *The Center for Health Affairs*, September 2007.
[52] "Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland," July 2008, Page 29.
[53] Kelly Stamper Balistreri and Hsueh-Sheng Wu, "Demographic Analysis of Low-Income Adults without Dependent Children: Implications for the Expansion of Medicaid," Ohio Family Health Survey, 2011, Page 5.
[54] Daniel Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," *Journal of Health Politics, Policy and Law,* Vol. 40(6), 2015, Page 1217.
[55] Balistreri and Wu, "Demographic Analysis of Low-Income Adults without Dependent Children: Implications for the Expansion of Medicaid," Page 5.

Medicaid before *NFIB vs. Sebelius*

This portion of the case study will situate Governor Kasich in the post-ACA environment. The 2010 governor's race was a pivot point for healthcare in Ohio. The Republican nominee and eventual governor, John Kasich, was a political veteran who had served nearly twenty years in the Ohio house. As a ranking member of the House Budget Committee, Kasich supported limitations on social benefits. For example, the Penny-Kasich Plan proposed $30 billion cuts to Medicare by instituting an income requirement.[56] He also proposed a market-based health reform plan as an alternative to Clinton's 1993 Health Security Act.[57] After his congressional stint, Kasich switched his attention to national politics, and opened an exploratory committee to run for President in 1999. That campaign ended within six months. Kasich then worked in the private sector, at Lehman Brothers, until the company went bankrupt in the 2008 financial crisis. Healthcare and fiscal conservatism were inextricably linked in Kasich's early politics.[58]

In 2010, Kasich re-emerged in Ohio government. He ran for governor against an unopposed Democratic incumbent, Ted Strickland, as well as libertarian and Green party candidates. A central part of Kasich's first gubernatorial campaign was cost-conscious health care reform and his vow to "repeal and replace" the ACA. From August to October leading up to the November election, Kasich and Strickland polled closely, and election night was one of the tightest contests in state history. Kasich won by 80,000 votes—earning 49% to Strickland's 47%.[59]

[56] Richard Lacayo, "Remember the Deficit," *Time,* November 8, 1993.
[57] Zeke Miller, "Hillary Clinton Dined With John Kasich Over Healthcare Reform—In 1993," *Time,* July 23, 2015.
[58] Dan Zak, "Spurning the party line," *The Washington Post,* January 5, 2016.
[59] *The New York Times* Election Results, 2010.

After barely securing the governorship, Kasich made strategic choices to cement a Republican presence in his cabinet. He appointed his running mate, Republican Mary Taylor, Lieutenant Governor and director of the Ohio Department of Insurance.[60] Taylor had prior experience in the Ohio House and as an auditor of the state of Ohio.[61] Her position in the Department of Insurance is limited to overseeing private insurance and ACA compliance, not Medicaid administration.

Lieutenant Governor Taylor was vocal about the pitfalls of the ACA. Since 2010, Taylor has delivered over 20 speeches condemning the ACA.[62] In 2011, six months into her new position, Taylor penned an article which was published on the Ohio Department of Insurance website and on many local news platforms. Her op-ed is a step-by-step criticism of reforms in Obama's "convoluted…job-killing" healthcare plan.[63] In 2014, she stated that she "could not name a single thing" that the "catastrophic" bill did well.[64] Kasich's Lieutenant Governor appointment would serve as an additional hurdle for framing expansion because he would have to maintain consistent political preferences in his administration. On one hand, he and Taylor share opposition to the ACA, but Taylor's extensive and highly public anti-ACA record would make it difficult to justify supporting Medicaid expansion, a central part of the ACA.

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[60] Jaime Fuller, "Everything you need to know about Ohio Governor (and maybe 2016'er) John Kasich," *The Washington Post,* May 16, 2014.
[61] Ohio Department of Insurance website.
[62] Catherine Candisky, "Ohio official criticized for inaction; Ohio Lt. Gov. Mary Taylor active opposes the federal health care," *Dayton Daily News,* December 12, 2011.
[63] Mary Taylor, "Obamacare Suggests Government Knows Best—Not the Consumer," *State of Ohio, Department of Insurance,* September 8, 2011.
[64] Stephen Koff, "As Obama praises health care enrollment, Ohio's lieutenant governor gives a vastly different view (from just a block away)," *The Plain Dealer*, April 17, 2014.

Mary Taylor, "Guest Column: President's Healthcare Plan is Bad for Ohio and Our State Insurance Market," *Ohio Department of Insurance*, June 24, 2011.

Despite being at odds with national health reform efforts, Kasich was tasked with making good on his campaign promises to reform healthcare.[65] One tab on Kasich's campaign website is devoted to his umbrella goal of modernizing Medicaid.[66] Within this broad objective, Kasich's team drafted smaller goals including extending coverage to more Ohioans, creating a political body for Medicaid administration, and improving the application process for beneficiaries. Although he campaigned to "repeal and replace" the ACA, Kasich had started the process of expanding Medicaid in accordance with federal law.[67]

The governor initiated a series of administrative changes to expedite ACA implementation. In 2011, he established the Office of Health Transformation (OHT) to modernize Medicaid. OHT also streamlined health information technology information systems, improved payment systems, and consolidated certain health services. Kasich tapped Greg Moody, who had both private and public service experience in healthcare, to serve as OHT director. Moody's previous work on Medicaid focused on system performance and consulting on complex health care programs.[68] Kasich also invested in home health care and skilled nursing facilities.[69] These actions reflect the administrative tasks required to be in compliance with the ACA.

Kasich's first State of the State speech was pro-Medicaid. A focal point was the pragmatism of the new Medicaid plan, which was mentioned by name seven times. The governor emphasized how his Medicaid proposal was out of the box, "reform-oriented," and "forward-

[65] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," Page 1215.
[66] kasichforohio.com
[67] Eric Bradner, "Kasich in interview: Obamacare here to stay," *CNN,* October 21, 2014.
[68] Ohio Office of Health Transformation.
[69] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," Page 1215.

looking." He stated, "[it's] the kind of thing that makes sense." With political bodies like OHT already in place, Kasich framed expansion as a straightforward, practical next step.[70]

In his 2012 State of the State address, before the Supreme Court ruling that made expansion optional, Kasich emphasized the moral obligation that Ohioans had to lobby on behalf of the mentally ill, the disabled, and the poor. Kasich announced: "Somebody has got to stand up for them. Oh, they have a lobbyist, but we don't see Him here. Best lobbyist in the world. We'll all meet Him some day. So, you can't step on these folks…that would be sinful. That would be wrong."[71] In this instance, Kasich made a pathos appeal. An emotional and theological frame called on voters to think of Medicaid expansion as something more than a political issue. Emphasizing the Christian elements of expansion shifted the lens for voters to understand Medicaid expansion. As discussed in the literature review, framing might alter public preference or public discourse around expansion. Directly telling Ohioans that not expanding Medicaid is a sin evokes a different set of beliefs and emotions than telling voters that opposing expansion will insulate Ohio from an uncertain agreement with the federal government.

The *NFIB vs. Sebelius* decision was the next turning point in Ohio's journey to Medicaid expansion. Kasich continued to roll out healthcare infrastructure after the Court's decision. In 2013, Kasich created the Ohio Department of Medicaid, the state's first-ever state-level agency focused on efficiency and effectiveness.[72] Kasich further streamlined the accounting and dissemination systems associated with Medicaid. John McCarthy, who had previously served as Washington, D.C.'s Medicaid Director, was named director. The agency's main goal was to

[70] John Kasich, State of the State Address, 2011.
[71] John Kasich, State of the State Address, 2012.
[72] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," Page 1215.

Prior to 2013, Medicaid was administered at the county level.

track spending and strategize to minimize expenditures.[73] The department was also an additional accomplishment Kasich could reference in his eventual appeal for expansion. Through OHT and the Ohio Department of Medicaid, the organizational foundation for lawmakers to consider expansion was set.

An Unwavering Legislature

Kasich initiated Medicaid expansion in February 2013 when he proposed a biennial budget including expansion to the General Assembly. At the time, Republicans held a decisive majority in both chambers: they outnumbered Democrats 23-10 in the Senate and 60-39 in the House.[74] In the House, Democrats needed at least 11 Republican votes to approve expansion. Kasich's expansion plan would cover individuals earning up to 138% of FPL, a 38% increase.[75] This population of low-income childless adults was estimated to be around 300,000 Ohioans.[76]

In anticipation of partisan backlash, the governor presented five defenses of his plan alongside the proposal.[77] First, Kasich claimed that expanding Medicaid was not in any capacity supporting the ACA. The Republican Party and Kasich's mantra of "repeal and replace" contradicts this defense; if Kasich wanted to repeal the ACA, this expansion opportunity would also be eliminated. Kasich disputes this notion. This informational reconciliation did not go unnoticed. Ohio Tea Party leader Tom Zawistowski observed: Kasich "jams through Medicaid

[73] Ohio Department of Medicaid, Director's Biography.
[74] National Conference of State Legislatures, State Partisan Composition.
[75] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," Page 1215.
[76] Amy Goldstein, "Ohio will expand Medicaid after months-long battle between governor and legislature," *The Washington Post,* October 21, 2013.
[77] Philip Klein, "John Kasich's top 5 failed defenses of his Obamacare expansion," *The Washington Examiner*, July 21, 2015.

expansion at the same time he's saying, 'Join me in repealing the Affordable Care Act'" and called the move "schizophrenic."[78]

Second, Kasich suggested that Medicaid expansion would bring valuable federal funds into Ohio, a common justification for expansion.[79] Kasich tried to appeal to fiscally minded House representatives with convincing figures of statewide savings that would result from Medicaid expansion. Kasich's argument was that refusing expansion diverted federal money to other states, indirectly hurting Ohio.[80] This argument was particularly relevant for hospitals. According to Seth Vilensky, a former hospital administrator at the Cleveland Clinic, the burden on hospitals for "charity care" forced cuts in other service areas. Like most hospitals, the Cleveland Clinic would treat individuals without insurance, but would have to write off huge costs for uncompensated care. Vilensky noted that with expansion, "The benefit for hospitals is that there is a new portion of the population that have some payer source."[81] In states with dire budget concerns, the share of federal money often convinced skeptical politicians to support expansion.

Third, in light of the Supreme Court's ruling, Kasich claimed expansion was a declaration of states' rights. Since states administer Medicaid, expansion would increase the state's administrative capacity, which is favorable for states' rights advocates. Republicans who criticized the unwieldy size of federal government embraced this federalist argument. Fourth, Kasich made a humanitarian appeal to constituents—that expansion would improve the health

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[78] Zak, "Spurning the party line."

David Weigel, "John Kasich's Mysterious Plan to Repeal Obamacare but Save the Medicaid Expansion," *Bloomberg Politics*, April 24, 2015.

[79] Klein, "John Kasich's top 5 failed defenses of his Obamacare expansion."

[80] Robert Higgs, "Ohio's Medicaid costs expected to be about $470M lower than anticipated," *The Plain Dealer,* November 8, 2014.

[81] Seth Vilensky, Phone interview by author, March 29, 2016.

outcomes of Ohioans.[82] In his 2011, 2012, and 2013 State of the State speeches, Kasich cited Medicaid as a major necessity for individuals with mental illnesses or substance abuse problems. He used anecdotes about Ohioans being refused emergency room care because they were uninsured as a plea to voters.[83] Finally, Kasich defended his position on the grounds that heralded conservatives of the past—namely, former President Ronald Reagan—also expanded Medicaid.[84]

Despite Kasich's anticipatory strategy, on April 18, 2013, the House approved the state budget without Medicaid expansion by a partisan vote of 61-35.[85] The budget then moved to the Senate for consideration. By late June, the Senate also confirmed the budget without expansion. Both the House and the Senate also voted in favor of an amendment prohibiting Kasich from using federal funds for expansion without formal legislative approval.[86] This decision limited the governor's options for expansion. The budget was sent to Kasich, who exercised the line item veto to remove that constraint before approving the budget.[87] Because a budget needed to be passed by the start of the fiscal year, July 1, expansion was tabled.[88]

Kasich's main expansion foe, the Ohio House Republican caucus, mounted opposition from two perspectives: electability and ideology. The Republican Speaker of the House had to uphold his reputation of principled, by-the-books conservative policymaking. If expansion succeeded under his supervision, that legacy would be tainted. Secondly, House Republicans wanted to prevent a highly transparent and permanent roll call vote on expansion. A

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[82] Klein, "John Kasich's top 5 failed defenses of his Obamacare expansion."
[83] John Kasich, State of the State Address, 2011, 2012, 2013.
[84] Domenico Montanaro, "Ohio Republican Gov. Kasich on Expanding Medicaid: 'It's My Money,'" *National Public Radio*, May 1, 2015.
[85] Jason Hart, "House Passes Budget Without Medicaid Expansion," *MediaTrackers*, April 19, 2013.
[86] Jim Provance, "Kasich hopeful board Ok's Medicaid growth," *The Blade,* October 19, 2013.
[87] Jackie Borchardt, "House GOP guts governor's budget; Kasich's plan to expand Medicaid, reform taxes altered," *Dayton Daily News,* April 10, 2013.
[88] "The Ohio Budget Process," *Ohio Legislative Service Commission.*

straightforward yes/no vote would give upcoming GOP challengers more traction to contest seats. The Ohio Tea party had been clear that they would fund Republican challengers for seats occupied by Medicaid expansion supporters.[89]

This group of GOP opponents was separate from the 20 GOP representatives who "might shoot themselves" before voting for expansion for ideological reasons—they opposed social welfare policies. Tea Party activists denounced Kasich as a true Republican. Ohio Rising, a Tea Party 501(c)(4) focused on "liberating" Ohio from ACA mandates, led the movement opposing Kasich's administration. The group's director, Chris Littleton, stated of their rejection efforts: "'we don't take any great joy in [blocking Medicaid expansion]. We aren't doing this to get something from somebody…we sincerely believe [expansion] is really bad for Ohio and really bad for the long-term financial stability of Ohio.'"[90] Republicans in the General Assembly were not available for persuasion because they were concerned about ideological integrity or electability. This sentiment was at odds with the 63% of Ohio voters who favored expansion in June 2014.[91]

Kasich's Last Resort

With the legislature firm in their intent to block Medicaid expansion, made especially clear by their attempt to include written policy requiring legislative approval before accepting federal Medicaid dollars, Kasich switched gears. In October 2013, the governor turned to the Controlling Board, a seven-member panel led by the director of Ohio's Office of Budget and Management. The nearly-100-year-old institution was unique—only a handful of states had a

[89] Thomas Suddes, "Republicans protest Kasich maneuver; or do they?" *Dayton Daily News,* October 19, 2013.
[90] Borchardt. "House GOP guts governor's budget; Kasich's plan to expand Medicaid."
[91] Robert Higgs, "Controlling Board gives OK to use of federal money to pay for Medicaid expansion in Ohio," *The Plain Dealer*, October 21, 2013.

similar body.[92] The Controlling Board allowed the governor to circumvent the traditional legislative process in the House and Senate. While Kasich had never used the Controlling Board before, it has historically approved requests relating to education, environmental, transportation, and technology.[93]

After some political finagling, the seven seats of the 2014 Controlling Board were set in Kasich's favor. On October 21, 2013, Ohio Medicaid director John McCarthy requested the Controlling Board to approve the Ohio Department of Medicaid's use of federal funds to cover newly eligible Medicaid recipients.[94] As expected, the Controlling Board voted 5-2 in favor of expansion.[95]

In Ohio, the puzzle surrounding Medicaid expansion is not simply why it was successful given conservative state politics. Rather, the question is why Kasich leveraged so much—electability, ties to the GOP, relationship with his legislature—to pursue expansion. Why did Kasich go beyond the traditional scope of gubernatorial policymaking to use the Controlling Board to pursue a policy his constituents rejected? There is one umbrella explanation: Kasich's history of moderate and moral policymaking.

Even before Kasich entered the governor's office in Ohio, he had long-term political prospects. In 1999, he launched his first run for the Republican presidential nomination, but withdrew from the race within five months.[96] However, those aspirations laid the foundation for strategic political moves in the decade that followed. Kasich needed to have a distinguishable brand, a solid character profile, and legislative accomplishments. Kasich's experience as

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[92] Suddes, "Republicans protest Kasich maneuver; or do they?"
[93] Office of Budget and Management, Controlling Board, Search Approved Requests, Accessed January 20, 2016.
Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform," Page 1217.
[94] "The Ohio Health Care Landscape," *Kaiser Family Foundation*.

Jim Provance, "Ohio nears Medicaid expansion," *The Blade,* October 12, 2013.
[95] Goldstein, "Ohio will expand."
[96] "Kasich forms exploratory committee to run for president," *CNN*, February 15, 1999.

chairman of the national House Budget Committee and bipartisan work on the 1997 Balanced Budget Act provided historical precedence for pursuing policy that would help the bottom line. He established himself as a proactive, budget-oriented, moderate Republican. As governor, he called himself the CEO of Ohio.[97]

Medicaid expansion tied into this persona. As Kasich saw it, Medicaid expansion was a "fast-track" of funds into Ohio, money that would go directly to furthering his in-progress health reforms. This fiscal frame served Kasich, who today has a 60% approval rating, and the state of Ohio, which now has a $2 billion surplus and a 5% unemployment rate. Kasich's framing of Medicaid expansion as a fiscal issue bolstered his individual political platform, and separated him from a field of ideologically bound conservatives.[98]

Framing Medicaid as a moral decision also fit in with Kasich's character. When he spoke to the legislature, the media, or concerned citizens, Kasich used religious and "right vs. wrong" appeals to make voters connect Medicaid with charity, morality, and generosity. In late 2013, he stated that Medicaid expansion would help those "that live in the shadows of life." [99] The governor targeted the mentally ill, drug-addicted, and working poor as deserving populations that needed treatment, care, and assistance.[100] He encouraged Republican opponents to look at how the Bible suggests treating the poor.[101] In a well-cited instance, Kasich commented to an opposed Ohio legislator: "Now, when you die and get to the meeting with Saint Peter, he's probably not going to ask you much about what you did about keeping government small. But he is going to ask you what you did for the poor. You better have a good answer."[102] In addition to being a

[97] Zak, "Spurning the party line."
[98] Ibid.
[99] Goldstein, "Ohio will expand."
[100] Tom LoBianco, "Kasich says he's not an Obamacare hypocrite," *CNN,* May 27, 2015.
[101] Igor Bobic, "John Kasich Tells Critics of Medicaid Expansion To Read the Bible," *The Huffington Post*, October 7, 2015.
[102] Zak, "Spurning the party line."

pragmatic decision, Kasich described Medicaid expansion as "a matter of life or death."[103] Kasich positioned Medicaid as a right versus wrong and biblical imperative.[104]

Kasich's legislative circumvention did not go unnoticed by conservatives. Thirty House Republicans signed a letter opposing the Governor's Controlling Board maneuver.[105] Within a few months, there was an expected legal challenge to Kasich's use of the Controlling Board. The Ohio Supreme Court heard a lawsuit brought forth by dozens of Republican legislators against the Controlling Board. The plaintiffs cited the Ohio Code, which states that the Controlling Board cannot act in a way that deviated from the legislative intent of the General Assembly. According to the plaintiffs, legislative intent was established in the House and Senate-approved budget with the language stating that they opposed the governor pursuing expansion without legislative approval. But when Kasich employed the line-item veto to eliminate the clause that would have prevented Controlling Board use, the legislature never attempted to override the veto. The Court rejected the challenge, upholding expansion.[106]

Kasich's Re-Election

Kasich risked significant political capital by using the Controlling Board for expansion, which is traditionally a legislative responsibility. Republicans criticized Kasich for "effectively crimping the legislative process."[107] Another Republican representative described the events as

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[103] Geoffrey Cowley, "Obamacare wins in Ohio as John Kasich expands state's Medicaid coverage," *MSNBC,* October 22, 2013.
[104] Andrew Prokop, "Meet John Kasich, the man who defended expanding Medicaid on the GOP debate stage," *Vox*, August 11, 2015.
[105] Jim Provance, "Member changes to controlling board could mean yes vote on Medicaid expansion," *The Blade,* October 21, 2013.

Jim Provance, "Kasich hopeful board Ok's Medicaid growth," *The Blade,* October 19, 2013.
[106] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform." Page 1218.
[107] Jim Provance, "Ohio nears Medicaid expansion," *The Blade,* October 12, 2013.

"thinly veiled legislation."[108] But this political risk was not punitive in the short-term—Kasich was re-elected governor by a wide margin. On the heels of Medicaid expansion, Kasich easily secured a second term as governor, winning 86 of 88 counties and 64% of the vote, compared to Democrat Ed FitzGerald's 33%.[109] FitzGerald's disorganization and internal controversy distracted the campaign from policy debate; consequently, Medicaid was not a notable issue. The Tea Party, who supported Kasich in 2010, declined to endorse his 2014 re-election campaign because of Medicaid expansion.[110]

A NBC News exit poll found that 91% of Kasich voters felt the ACA as a policy "went too far," but 80% of Kasich voters approved of the way he "carried out" the ACA.[111] Barring the methodological problems with exit polls, these data show incongruence between voter preference and elected officials' actions. Although voters were satisfied with ACA implementation in Ohio, presumably including Medicaid expansion, Ohio lawmakers were not. Republican lawmaker views on expansion may have contributed to the successful Democratic challenge of five House seats previously held by Republicans. Although this shift did not change the overall GOP majority, it does indicate that some Republicans may have been punished for not supporting Medicaid expansion. The partisan breakdown in the Senate remained unchanged in the 2014 election.[112]

In 2014 and 2015, during Kasich's second term, after Medicaid expansion passed, Kasich spent little time discussing expansion's outcome. Perhaps this is because Ohio has not yet assumed the small percentage of the expansion cost, so other more immediate budgetary issues

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[108] Thomas Suddes, "Republicans protest Kasich maneuver; or do they?" *Dayton Daily News,* October 19, 2013.
[109] CNN Election Center, Governor: Ohio, *November 5, 2014.*
[110] Skinner, "Medicaid in Ohio: The Politics of Expansion, Reauthorization, and Reform." Page 1218.

Amanda Terkel, "John Kasich Faces Tea Party Protest Over Medicaid Decision," *The Huffington Post,* March 11, 2013.
[111] 2014 Election Exit Polls, *NBC News.*
[112] National Conference of State Legislatures.

received more attention. Another explanation is Kasich's popularity and the demonstrated voter support for expansion. Post-expansion frames are targeted to protecting electability, whereas pre-expansion frames are targeted to Republican voters in Republican districts. Kasich won a second term by a wide margin despite the expansion controversy, so he has not had to justify his decision to Ohioans. Now that Kasich is a presidential candidate, however, he frequently cites Medicaid expansion as an example of his cooperative governing style and willingness to look beyond partisan battles.[113]

This case study illustrates one state's Medicaid expansion success in spite of a GOP legislative majority, Republican governor, and resistance to the ACA. Because the governor was unable to enact expansion via the legislature, framing appeared to be a marginal factor in the outcome of expansion. Kasich's frames did not successfully persuade the Republican legislative caucus, but it is possible that competing frames did succeed in keeping Republican opponents decidedly anti-expansion. Perhaps because Kasich knew the Controlling Board was an available option, moral and fiscal frames appealed to his moderate constituents more so than lawmakers.

[113] "A Conservative Approach To Better Health Care," www.johnkasich.com.

Chapter 4

Tennessee: Governor Haslam Sings the Medicaid Blues

Introduction

This chapter provides a chronology of Medicaid expansion in Tennessee. After providing a broad snapshot of the healthcare landscape in Tennessee, I will explain the political developments that preceded the turning point for my research question—the 2012 Supreme Court decision that made Medicaid optional. Then, I will describe the process by which Governor Bill Haslam introduced Medicaid expansion to the legislature. What caused his plan to fail, revive, and fail again? This is the only case study where I examine a state in which Medicaid expansion did not succeed. Framing appeared fruitless against the ideologically ingrained General Assembly. However, it is plausible that frames put forth by "roving billionaires" and interest groups resonated more with Republican voters and Republican lawmakers.[114]

Aside from geographic diversity—the state spans a latitudinal swath of Appalachia and the South—Tennessee is culturally multi-faceted with a combination of rural agriculture, heavy industry, and country music.[115] Memphis is both the birthplace of the blues and the site of Martin Luther King, Jr.'s assassination. Nashville, the cosmopolitan capital, contrasts with the Blue Ridge Mountains and a decisively southern food culture. This variety means that political representatives are accountable to a wide array of constituents, and thus political preferences. The dominant political ideology, reflected in partisan composition of the General Assembly, is conservative.

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[114] Theda Skocpol and Vanessa Williamson, *The Tea Party and the Remaking of Republican Conservatism* (New York: Oxford University Press, 2012.)

[115] Christina Juris Bennett, *TennCare, One State's Experiment With Medicaid Expansion*. (Nashville: Vanderbilt University Press, 2014), Page 3.

Year	Senate (D)	Senate (R)	House (D)	House (R)	Party Control
2011	13	19	33	64	Republican
2012	13	20	34	64	Republican
2013	7	26	28	70	Republican
2014	7	26	27	71	Republican
2015	5	28	26	73	Republican
2016	5	28	26	73	Republican

[116]

Health indicators are as far from uniform as Tennessee's culture. Tennessee consistently ranks in the bottom quintile of national health indicators like obesity rates, per capita income, and education attainment. In 2010, Tennessee had the 8th shortest life expectancy in the nation.[117] In 2014, median annual household income was just above $40,000, the 7th lowest in the country.[118] The proportion of Tennessee's population that goes without health insurance was 10% in 2014, placing the state in the bottom quintile for coverage.[119] United Health Foundation ranked Tennessee 45th among all states for overall health.[120] Thus, Tennessee can be grouped with states like Mississippi, Alabama, or South Carolina, which have a potentially lethal combination of weak healthcare infrastructure and low health status. These states also share opposition to health care reforms, despite demonstrated need.

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[116] National Conference of State Legislatures (NCSL), Partisan Composition.
[117] Tennessee Department of Health.

Average life expectancy in Tennessee 76.4 years; the nationwide average is 78.9 years.
[118] Ashley Allen, Thomas C. Frohlich, and Alexander E.M. Hess, "Report: the most miserable states in the USA," *USA Today,* February 27, 2014.
[119] "Health Insurance Coverage of the Total Population," *Kaiser Family Foundation, State Health Facts.*
[120] "Press release: Coalition for a Healthy Tennessee forms to support Governor Haslam health plan," *Tennessee Business Roundtable,* December 16, 2014.

The State's Medicaid History

Tennessee's historically marbled relationship with Medicaid is important to contextualize the expansion attempt. Tennessee did not adopt Medicaid until 1969, four years after it was introduced nationally. Over the subsequent decades, efforts to enlarge the program exacerbated a precarious financial situation. In fiscal year 1987-1988, Medicaid expenditures hovered around $1 billion, but grew to nearly $3 billion by the 1992-1993 fiscal year. This exponential spending growth reflected rising healthcare costs, not an increase in participants. With 15% of the 1993 population using Medicaid services, then-governor Ned McWherther seized a "'window of opportunity'" to gain legislative approval to design a new state Medicaid system focused on expanded coverage and managed care. This unlikely program would eventually be known as TennCare. Broadly, the goals of TennCare were to reduce costs and expand coverage. TennCare's birth in 1994 was one of the earliest waiver-led state Medicaid plans, and its core structure mirrored many of the goals outlined in the ACA. For example, the program relied on private sector managed care insurance programs rather than a fee-for-service model.[121]

But by the late 1990's, the program began to unravel. Enrollment declines were met with spending increases, a contradiction that concerned both political and medical stakeholders. Because of low reimbursement rates and unreliable TennCare administrators who inconsistently confirmed which patients were on TennCare, hospitals around Tennessee began refusing TennCare patients. Although the hospitals concerns' were allayed through a piece-meal solution, TennCare was slowly being dismantled. On December 15, 1999, Blue Cross Blue Shield Tennessee (TennCare's largest managed care organization—a group that would provide coverage plans for Medicaid recipients) announced they wanted to withdraw from TennCare.[122]

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[121] Bennett, *TennCare, One State's Experiment*, Pages 10, 12, 13, 14-15, 16, 18, 76, and 99.
[122] Darin Gordon, TennCare Timeline, 2015. https://www.tn.gov/tenncare/article/tenncare-timeline.

Eventually, they reversed their termination notice, but the action prompted other managed care organizations to reconsider their involvement with TennCare.[123]

2005 was a decisive year for TennCare. Former governor Phil Bredesen was faced with the possibility that the state would go bankrupt if TennCare was not cut. Beyond the state expenditure crisis was concern that individuals on TennCare were making deliberate "'lifestyle choices'" to work for employers who did not provide health insurance. Bredesen noted that TennCare cuts were justified because "'the world is full of people'" who select jobs based on insurance provision, and Tennesseans should not be any different. The Bredesen era cemented the association between Medicaid and less-deserving individuals, which would make Medicaid expansion a difficult task down the road.[124]

In response to concern about the strength of TennCare's financial foundation, the business-minded Bredesen hired McKinsey & Company to review TennCare's business model. The results were sobering: the report found that TennCare was unsustainable and would soon obstruct other state spending needs. By 2006, the program had fractured: around 200,000 individuals were no longer eligible for benefits, and the risk sharing system was effectively removed. Academic and health reform advocate Gordon Bonnyman described the failure of TennCare as a political maneuver to "strip…budget decisions of their human consequences." The TennCare saga left unpleasant memories of fiscal mismanagement and inefficient care delivery. The program's blemished legacy also made further healthcare innovation challenging because opponents could connect new initiatives to TennCare.[125]

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[123] Bennett, *TennCare, One State's Experiment*, Pages 75, 76, 77, 92, and 99.
[124] Ibid., Page 92.
[125] Robert E. Hurley, "TennCare—A failure of politics, not policy: A conversation with Gordon Bonnyman," *Health Affairs,* Vol. 25 (3), 2006, Pages w217-w225.

Tennessee Medicaid Pre-*Sebelius*

In 2009, Bill Haslam, a moderate Republican, private sector veteran and experienced family businessman, announced his campaign for governor. Haslam was not a bread and butter politician; his family truck stop business was so successful that Haslam's net worth is estimated at $2 billion, making him the wealthiest elected official in 2015.[126] He had served two terms as Mayor of Knoxville, where he stabilized their economy and tripled the rainy day fund.[127] Haslam easily succeeded in the Republican primary, and was elected governor with 65% of the vote.[128] His campaign generally shied away from social issues, which he called "'frustrating and a distraction.'"[129] Haslam's campaign platform focused on economic development—particularly job growth.

During his first term, Haslam established himself as a principled Republican in the healthcare space. Haslam criticized the ACA for hurting small businesses and for expanding an already inefficient system. He opted not to establish a Tennessee-run healthcare exchange, instead deferring to the federal program. Although this move was praised by conservatives and hailed as a rebuke of the President, it goes against a core conservative principle of federalism and state's rights. Tennessee gave up the opportunity to operate their own health insurance marketplace, and instead increased federal oversight and intervention. Nonetheless, Republican Party elites supported Haslam's decision.[130]

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[126] Dan Alexander, "Tennessee Governor Bill Haslam Is New Billionaire, Richest Politician in America," *Forbes Magazine,* January 21, 2015.
[127] Tennessee Governor Bill Haslam, *National Governors Association.*
[128] "Tennessee Election Results," *The New York Times,* 2010.
[129] Bennett, *TennCare, One State's Experiment,* Page 129.
[130] Sarah McManamy-Johnson, "Haslam rejects Medicaid expansion," *The Lebanon Democrat,* March 28, 2013.

Tennessee's Turn

The following section explains the trajectory, and eventual failure, of expansion in Tennessee. From 2012 to 2014, the two years between the option for Medicaid expansion and Governor Haslam's re-election campaign, the onus fell to the states to make a major policy move on Medicaid. Medicaid expansion was certainly on the governor's agenda—AHealthyTN presented a pro-expansion petition to the governor with 4,500 signatures.[131] Haslam pledged to make a decision regarding expansion by fall 2013, a promise that would eventually be delayed.[132] During 2012 and most of 2013, Haslam resisted moving forward with what he, along with other Republicans, called "traditional" Medicaid—a rhetorical attempt to link expansion and the ACA. The governor rejected "pure" Medicaid expansion "under wholly federal auspices."[133] Haslam framed Obama's Medicaid expansion as conventional, but he was only interested in supporting an innovative, Tennessee-specific program. He wanted a plan that was something more than "'Medicaid with lipstick on it.'"[134] This frame sought to separate future expansion bills from pre-conceived perceptions of Obama's reform. Maintaining a rhetorical silo between the ACA and Medicaid expansion was crucial for Haslam to convince an anti-ACA legislature and voting base that expansion was necessary.

Haslam's Re-Election

In November 2014, the incumbent Haslam was re-elected in a historic landslide victory. There were no credible challengers: a weak Democratic candidate was announced with less than

[131] A pro-expansion interest group.

R. Neal, "Coalition presents TennCare/Medicaid expansion petition to governor," *Knox Views,* June 6, 2013.

[132] Bennett, *TennCare, One State's Experiment,* Page 132.

[133] Jackson Baker, "Another chance for Insure Tennessee," *Memphis Magazine,* August 1, 2015.

[134] Rick Lyman, "Tennessee Governor Hesitates on Medicaid Expansion, Frustrating Many," *The New York Times,* November 16, 2013.

a year until the election, and no strong conservative alternative ever emerged.[135] Haslam won all 95 of Tennessee's counties and 70% of the vote.[136]

Haslam's resounding success was due in part to his policy progress and reputation for getting things done during his first term as governor. Haslam reformed primary and higher education, the civil service, and taxes—all accomplishments that highlighted his fiscal conservatism and growth-minded leadership.[137] In his second-term victory speech, Haslam noted that during his first term, Tennessee achieved the lowest per-capita debt in the country. He also praised the education system, which boosted learning proficiencies in math and science at the primary level and now guaranteed high school graduates two years of free community college or vocational education.[138] On the employment side, Tennessee added hundreds of thousands of private sector jobs and was named "State of the Year" for economic development twice in a row.[139]

Shortly into his second term, on December 15, 2014, the governor announced a two-year pilot program called "Insure Tennessee."[140] The plan would provide healthcare to individuals earning up to 138% FPL.[141] At stake were the nearly 300,000 Tennesseans in the Medicaid coverage gap.[142] Unlike Medicaid expansion in other states, Insure Tennessee is cost-neutral because hospitals shoulder the cost not borne by the federal government. Tennessee followed the

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[135] Cameron McWhirter, "Tennessee Gov. Bill Haslam runs against some colorful rivals," *The Wall Street Journal,* April 3, 2014.
[136] Chris Kardish, "Why Medicaid expansion has reached a standstill," *Tribune Regional News,* April 1, 2015.
[137] "RGA Congratulates Tennessee Governor Bill Haslam On His Re-Election," *Republican Governors Association.*
[138] Bill Haslam victory speech, November 5, 2014. Accessed via WTVC NewsChannel 9.
[139] "Tennessee: Haslam Reflects on First Term, Lays Out Work Ahead," *Plus Media Solutions*, January 23, 2015.
[140] Gordon, TennCare Timeline, 2015.
[141] "Insure Tennessee: The Basics," *Tennessee Justice Center.*
[142] Holly Meyer, "Insure Tennessee debate weighs opposing views," *The Tennessean,* October 19, 2015.

> The "coverage gap" refers to the population whose income is too high to be Medicaid eligible but too low to afford private insurance. The ACA targets this gap by increasing the income cut-off for Medicaid recipients.

lead of other states pursuing expansion and included a "firewall" that automatically eliminates coverage if federal funding becomes insufficient.[143]

When Haslam first introduced his plan, he noted that Insure Tennessee was a departure from traditional Medicaid expansion, a better approach than what would have been possible in 2012 after the *Sebelius* decision. Insure Tennessee was, according to the governor, a "conservative approach that introduce[d] market principles to Medicaid."[144]

Haslam's early frames were three-pronged: fiscal, pragmatic, and rhetorical. First, the finances were budget-neutral: as long as the federal government made good on their promise to cover 90% of the expansion costs after 2020, hospitals would cover the remaining fees.[145] Haslam could empirically back up his claim that Insure Tennessee was a market-oriented plan that would not increase Tennessee's leverage. This was an advantage for a state with precarious finances.

The pragmatic framing of Insure Tennessee focused on improving health outcomes and saving hospitals. Beginning in 2010, layoffs in the state's hospitals garnered nationwide attention because health systems—ranging from Community Health Systems Inc. to Hospital Corporation of America Holdings Inc. to the academic medical centers at Vanderbilt University and the University of Tennessee—are among Tennessee's largest employers. Without federal subsidies and funds from expansion, hospitals in Tennessee stood to see a 2-5% drop in earnings. This would translate to further layoffs and hospital closures.[146]

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[143] "Insure Tennessee: The Basics," *Tennessee Justice Center.*
[144] Dave Boucher, "Tennessee's GOP Gov. to expand Medicaid program," *The Tennessean,* December 15, 2014.

"Haslam calls for 'extraordinary session.'" *The Lebanon Democrat,* Jan. 9 2015.
[145] Alex Tolbert, "Why Medicaid expansion failed in Tennessee," *The Tennessean,* February 10, 2015.
[146] Lyman, "Tennessee Governor Hesitates on Medicaid Expansion, Frustrating Many."

Zachary Tracer, "In Tennessee, Hospitals Want Obamacare, Republicans Don't," *Bloomberg Politics,* June 23, 2015.

The third frame was a strategy Haslam knew succeeded in states like Arkansas, Michigan, and Kentucky, among others. Creating rhetorical distance between the ACA and Tennessee's Medicaid expansion was arguably a political necessity. It allowed the space for Republican governors who previously rejected the national health reforms to embrace one of the bill's core components. This frame sought to shift the debate from "'pure politics to pragmatism.'"[147]

These pre-expansion frames are directed at legislators who may be open to persuasion on expansion. However, the plan also landed on welcome ears outside of the formal political system. Three major stakeholders, the Tennessee Hospital Association, the Tennessee Business Roundtable, and the Tennessee Medical Association, were on board with Insure Tennessee.[148]

Tennessee's fiscally frazzled hospitals[149] pledged to pay for the costs incurred by the state, which amounted to nearly $75 million.[150] Essentially, Haslam's plan and subsequent negotiations ensured the state would not be accountable for any of the costs associated with increasing Medicaid eligibility. Although other governors reduced their state budget load by passing hospital assessments, no other state had the entire outstanding cost covered by a non-state agent. Research such as a PricewaterhouseCoopers Health Research Institute's report found that in states that expanded Medicaid, hospital revenue increased and more individuals were covered. America's third largest publicly traded hospital conglomerate, Tenet Healthcare Corporation, found that in its hospitals in states that accepted federal Medicaid dollars, uninsured

[147] Margaret Newkirk and Toluse Olorunnipa, "Republican-led state governments begin to embrace Medicaid expansion funding," *Charleston Gazette,* February 4, 2015.
[148] "Tennessee: Health Care Extension for Poor Is Rejected in Senate," *The Associated Press,* February 4, 2015.
[149] Abby Goodnough, "With Hospitals Under Stress, Tennessee's Governor Pursues Medicaid Expansion," *The New York Times,* December 15, 2014.
[150] "Tennessee: Health Care Extension for Poor Is Rejected in Senate."

admitted patients dropped nearly 63%. Uncompensated care is a major drain on hospitals, which sometimes must resort to refusing care for individuals without coverage.[151]

Finally, Haslam found support from the Tennessee Business Roundtable, an advocacy group representing business, health, and civic voices. In a press release, Executive Director Charlie Howorth explained his agency's support for Insure Tennessee. He described the plan as a "departure from the traditional Washington way of expanding Medicaid" because Insure Tennessee is a "Tennessee solution to a Tennessee problem." The organization formed an 80-member coalition focused on supporting Insure Tennessee. In line with their business interests, the Tennessee Business Roundtable underscored the market implications of refusing expansion: tax dollars would be re-routed to other less-deserving states like New York or Connecticut. The organization also praised Haslam for bringing this money into Tennessee without issuing new taxes or re-routing other funding. Many of these messages—no new taxes, improved budgeting, and increased revenue—paralleled Haslam's own frames.[152]

Unsurprisingly, medical groups also came out in support of Haslam's plan. The President of the Tennessee Medicaid Association warned that without expansion, a "'health care crisis'" would ensue.[153] Their support was instrumental in directing the expansion debate away from politics and towards health and the idea that people would tangibly benefit from Medicaid expansion.

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[151] Newkirk and Olorunnipa, "Republican-led state governments begin to embrace Medicaid."

Uncompensated care refers to health, typically hospital, care that is never paid for by the patient or the insurer.

[152] "About Us," Tennessee Business Roundtable, tbroundtable.org

"Press release: Coalition for a Healthy Tennessee forms to support Governor Haslam health plan," *Tennessee Business Roundtable,* December 16, 2014.

[153] Tom Wilemon, "Tennessee medical groups urge expansion of Medicaid," *The Tennessean,* October 27, 2013.

Even Haslam's wavering foe came out in support of Insure Tennessee. Haslam's Lieutenant Governor, Ron Ramsey, had previously spoken out against Medicaid expansion, but changed his tune in 2014.[154] Ramsey supported his governor, stating:

"When a state has an opportunity to take power away from the federal government and institute real conservative reform, that is an opportunity that must be taken seriously. Governor Haslam has negotiated a deal which returns tax dollars back to Tennessee while using conservative principles to bring health insurance to more Tennesseans."[155] With a combination of some political and interest group support, Haslam appeared to have cemented a path for expansion to succeed.

First Round Failure

After proposing expansion, Haslam travelled all over Tennessee, reminding his constituents that Insure Tennessee was not "Obamacare." His distancing tactics appeared to pay-off: a poll showed that while 85% of Tennessee Republicans opposed "Obamacare," only 16% opposed "Insure Tennessee."[156] A 2014 Vanderbilt University poll found that 58% of registered voters supported expansion.[157] These numbers and the negligible cost of Insure Tennessee seemed to be a respectable counter argument to opponents' ammunition.

Tennessee is unique in that interest groups and think tank organizations served as major obstacles in the expansion process. Haslam's biggest obstacle came from beyond the traditional political playing field. Americans for Prosperity (AFP) is a conservative advocacy group best known for advancing the causes of the Tea Party. They also worked to disrupt the

[154] Goodnough, "With Hospitals Under Stress, Tennessee's Governor Pursues Medicaid Expansion."
[155] Boucher, "Tennessee's GOP gov. to expand Medicaid program."
[156] Perry Bacon Jr, "In rebuke of Tennessee governor, Koch group shows its power," *NBC News,* February 6, 2015.
[157] Dave Boucher, "Haslam's Tennessee Plan would expand health coverage," *The Tennessean,* December 15, 2014.

implementation of the ACA, especially Medicaid expansion. AFP is primarily backed by the Koch brothers, and is an increasingly influential power in state politics.[158]

In Tennessee, AFP spent human and financial capital to sway Republicans against expansion: they sent out mailings to Republican voters, bought radio ads warning residents that Republican lawmakers who intended to vote expansion were actually supporting "Obamacare," and sent nearly 100 protestors to the statehouse. AFP President Tim Phillips said of blocking expansion in Tennessee: "'Republicans have a once-in-a-generation opportunity to practice what they preach, which is limited government.'"[159]

It is important to note that the AFP's presence is nothing new to Tennessee's governor or his General Assembly. Rather, AFP's activity served to change the message and audience of the governor's appeals. The governor had to strategically provide lawmakers a justification for supporting expansion that would hold up when they had to explain their voting record during a re-election. Haslam also had to devise an electoral cost for legislators who might not vote for expansion.

Haslam's "Going Public" strategy—travelling around the state and meeting with voters and interest groups—produced one desired result, voter enthusiasm. If the voters demonstrated that they favored Medicaid expansion, vacillating lawmakers would have an incentive to vote for expansion—to represent their constituents' preferences. Voter support would also mitigate AFP's threat to unseat pro-expansion Republicans in the next general election.

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[158] Americansforprosperity.org.

> The Koch brothers are part of a philanthropic family that is highly involved in American politics. The family business is very successful, and their financial clout is used to advance a wide range of political causes.

[159] Fredreka Schouten, "Americans for Prosperity muscling in on state issues; Group helped kill Tenn. Medicaid expansion," *USA Today*, February 26, 2015.

Despite these preventative measures, on February 4, 2015, the Senate Health and Welfare Committee voted 7-4 against "Insure Tennessee."[160] Democratic lawmakers, who were out-numbered 28-5 in the Senate and 73-26 in the House, favored expansion.[161] Democrat House Minority Leader Craig Fitzhugh endorsed the plan, as did Republican Senators Lamar Alexander and Bob Corker.[162] Both Senators voted against the ACA in 2010, but Alexander said Insure Tennessee "'is a step in the right direction,'" and Corker agreed.[163] When the legislative session adjourned, the lone Democrat on the Senate Health and Welfare Committee called the failure of Insure Tennessee the "biggest failure" of the legislature.[164]

While the Health and Welfare Committee vote was not narrow or contested, it was notable that three of the four favorable votes were Republican Senators. Republican Senator and physician Richard Briggs was a leader in this attempt at expansion—he represented health advocates and Tennesseans who recognized the importance of health coverage.[165] Another Republican advocate, Becky Massey, was a consistent supporter of Insure Tennessee, given that there was "'no question [expansion] would make a positive different on people's health.'"[166] The third Republican Senator, Ed Jackson, defended his decision for procedural reasons. Jackson stated: "'I felt like [expansion] needed to go along to the other committees instead of just seven people deciding on it'" but also mentioned that Tennessee needed to address that it was "'on the bottom'" of national health.[167] Framing appeared to be insignificant, as none of the "yes" votes

[160] "Tennessee: Health Care Extension for Poor Is Rejected in Senate," *The Associated Press.*
[161] National Conference of State Legislatures, State Partisan Composition.
[162] Boucher, "Haslam's Tennessee Plan would expand health coverage."
[163] Emily Kubis, "Reactions to Medicaid expansion plan," *Nashville Post,* December 15, 2014.
[164] Jeff Yarbro, "Unfinished business," 2015, jeffyarbro.com.
[165] Andy Sher, "Insure Tennessee supporters renew push for Medicaid expansion," *Times Free Press*, June 30, 2015.
[166] Andy Spears, "Massey Stands Up for InsureTN," *Tennessee Citizen Action,* March 4, 2016.
[167] Dan Lampariello, "Sen. Ed Jackson reacts to Insure Tennessee decision," *WBBJ*, February 5, 2015.

referenced voter support in their justification. Despite an overwhelming 86% statewide approval rating at the time, Haslam's gubernatorial stronghold could not overcome the legislature.[168]

Within committee, justifications for voting against the proposal ranged from the sheer amount of information and detail to parse through to the fact that the plan created a "new entitlement program" that "expanded government" and Medicaid.[169] One opposed Republican described expansion as "'a tube of toothpaste with both ends cut off. Anywhere you touch it, it squeezes out and you can't shove it back in the tube once it's done.'"[170]

Despite endorsements from the Governor and the Lieutenant Governor, opposition also came from high-ranking congressional Republicans. Opponents of expansion were concerned with the integrity of the federal fund match and with being seen as collaborating with the Obama administration. Republican House Caucus Chair Glen Casada had given expansion "even odds" of passing, although he voted against the plan.[171] Republican House Majority Leader Gerald McCormick justified his opposition on "mistrust of the federal government" to keep their commitment to pay for Medicaid expansion.[172] The message from the Republican leadership was clear: expansion was at ideological odds with their vision for Tennessee.

After the vote, an AFP national spokesperson proclaimed Tennessee a success story that would discourage other Republican governors from pursuing expansion.[173] While the actions of the AFP alone cannot explain the plan's rejection, what is clear is that Haslam had to balance frames to both constituents and powerful outside groups, who have incongruent information streams and motivations. AFP targeted conservative lawmakers, implicitly suggesting to voters

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[168] Dave Boucher, "Insure Tennessee's swift failure surprises Haslam," *The Tennessean,* Febraury 7, 2015.
[169] Andrea Zelinski and Emily Kubis, "Why Insure Tennessee died," *Nashville Post,* 2014.
[170] Cameron Taylor, "Haslam makes case in front of General Assembly for Insure Tennessee," *ABC WATE 6,* February 2, 2015.
[171] Newkirk and Olorunnipa. "Republican-led state governments begin to embrace Medicaid expansion funding."
[172] Zelinski and Kubis, "Why Insure Tennessee died."
[173] Bacon, "In rebuke of Tennessee governor."

that their party leaders may not be serving their fundamental interests. AFP reminded Republican lawmakers and voters of GOP's opposition to Obama and the ACA, and served as a watchdog when politicians strayed from those beliefs by supporting expansion.

Perhaps the governor mistakenly invested public space, like appearances, and political capital in Tennessee voters when instead, he truly needed to convince influential interest groups who have more power over the General Assembly's voting preferences. Alternatively, perhaps lawmakers were more receptive to interest group frames.

Familiar Fate: "Politics over democracy"[174]

Within two months of Haslam's failed expansion endeavor, a group of Democratic senators, with Haslam's support, submitted Senate Joint Resolution 0093, a new plan for Medicaid expansion. In a similar fashion to the first attempt at Medicaid expansion, interest groups played a crucial role in the bill's outcome. The Tennessee Justice Center, which had been a strong advocate for the governor's February proposal, boosted their grassroots efforts when a second chance for expansion emerged. They cold-called and sent activists out door-to-door to petition Tennesseans to call on Lieutenant Governor Ron Ramsey to push Insure Tennessee to a full Senate vote.[175]

The new proposal narrowly escaped a subcommittee vote by a 3-2 margin to advance for review by the Senate Health and Welfare Committee (the same committee that deliberated on the governor's original proposal). The legislation was not expansion per se; rather, it would authorize Haslam to move forward with using federal funds to cover newly eligible Medicaid recipients. On March 25, 2015, the Health and Welfare Committee passed the measure by a vote

[174] Sher, "Tennessee Governor's Medicaid Expansion Plan Fails Again," *Tribune News Service,* April 1, 2015.
[175] Tennessee Justice Center, "Insure Tennessee Passed the Senate Health Committee," March 25, 2015.

of 6-2.[176] The two nays were Republican Senators, as were five of the six "yes" votes. Four of the six favorable votes originally supported expansion in 2014. The one convert, Republican Rusty Crowe, initially voted against expansion because he anticipated the bill would fail, but after rebuke from his district and supporters in the medical community, voted in support.[177] The remaining "yes" vote came from Doug Overbey, who did not participate in the initial vote that killed expansion. The second time around, however, Overbey was an outspoken proponent, noting that expansion was "'the right thing to do.'"[178] After succeeding in the Health and Welfare Committee, the bill moved to the rigorous Senate Commerce and Labor Committee.

On March 31, 2015, hundreds of expansion advocates singing hymns and donning purple "Insure Tennessee Now!" shirts gathered in the committee room to hear Republican Senator Doug Overbey present the bill to the Senate Commerce and Labor Committee.[179] Overbey emphasized, "'it's not an expansion to Medicaid…it is a Tennessee approach."[180] The committee briefly considered the proposal, and after minimal discussion, rejected the plan by a partisan vote of 6-2-1, ending consideration for the legislative year.[181]

This outcome was not unexpected. The Commerce and Labor Committee was predicted to be difficult: eight of the Committee's nine members were Republican. The committee also considered Medicaid expansion through an economic lens, and the possibility of Tennessee being held responsible for a contentious federal funding plan was daunting. The Lieutenant

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[176] Tom Wilemon, "Insure Tennessee survives committee vote," *The Tennessean,* March 25, 2015.
[177] Judy Garland, "On Insure Tennessee: It's Rusty Crowe's deeds, not his words, that matter," *Johnson City Press*, June 2, 2015.
[178] Blake Farmer and Chas Sisk, "First Vote Kills Insure Tennessee Medicaid Expansion," *Nashville Public Radio,* February 4, 2015.

Doug Overbey, "Obamacare imperfect, but Insure Tennessee is right for state," *The Tennessean,* April 19, 2015.
[179] Emily Kubis, "Insure Tennessee dies for a second time," *The Nashville Post,* March 31, 2015.
[180] Xavier Smith, "Insure Tennessee dies in committee," *The Lebanon Democrat,* April 1, 2015.
[181] Dave Boucher, "For Insure Tennessee backers, hope is lost again," *The Tennessean,* March 31, 2015.

Governor had previously expressed doubt about the bill's likelihood of success in committee. In his public statement post-vote, Lieutenant Governor Ramsey said: "while I appreciate Gov. Haslam's hard work, it is clear that serious questions and concerns regarding Insure Tennessee remain. Insure Tennessee was carefully considered and thoroughly examined by no less than four Senate committees. Now, it is time to move on."[182]

Some of the same arguments used to defend rejecting expansion in the first proposal reappeared during round two. Justin Owen, President of the Beacon Center of Tennessee, a free-market think tank, proclaimed that there was no distinction between Insure Tennessee and "traditional" Medicaid expansion. AFP, the vocal group that used manpower and scare tactics to oppose Haslam's plan, echoed this distinction. Director Andrew Ogles declared: "'if you are supporting Insure Tennessee…you are supporting Obamacare.'"[183] This is the major counter-frame that Haslam had to account for in his attempts to convince his legislature to pass the expansion resolution. Opponents' mission to merge the schemas surrounding Medicaid and the ACA posed an insurmountable challenge for Haslam.

In Tennessee, Haslam's rhetorical frame of Medicaid expansion as a local, homegrown solution was less effective than counter-frames connecting expansion to the unpopular ACA. Despite voter support for Insure Tennessee, frames put forth by the AFP seemed to resonate with lawmakers.[184] Lawmakers may have been overwhelmingly preoccupied with their electability, and recognized that interest groups, especially well-funded ones like AFP, could easily unseat politicians who go against their platform.

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[182] Sher, "Tennessee Governor's Medicaid Expansion Plan Fails Again."

Reid Wilson, "After months of debate, Tennessee Medicaid expansion dies a quick death," *The Washington Post*, February 5, 2015.

[183] Holly Meyer, "Insure Tennessee debate weighs opposing views," *The Tennessean,* October 19, 2015.

[184] Overbey, "Obamacare imperfect, but Insure Tennessee is right for state."

Chapter 5

Arizona: Incremental Obstinacy

Introduction

In this chapter, I narrate the surprising success of Medicaid expansion in Arizona. After providing a brief historical overview of Medicaid in Arizona, I describe the forces that motivated Republican Governor Jan Brewer to use substantial political capital to implement expansion. In Arizona, the absence of re-election pressure freed Brewer to dictate policy choices. Brewer was term-limited and her career prospects were not necessarily contingent on her decision-making as governor. Although framing did not produce expansion alone, framing may have contributed to a sub-set of Republican legislators supporting Medicaid expansion.

Among the fifty states in the Union, Arizona falls into the set of states least likely to consider expanding Medicaid for its poor residents. For the state-level features that scholars use to predict the outcome of Medicaid expansion—political ideology and partisan control—Arizona aligns more closely with unsurprising anti-expansion states like Texas, Mississippi, or South Carolina.

The state voted for the Republican presidential candidate in every election since 1952 with the exception of Bill Clinton in 1996.[185] Republicans generally also have a stronghold at the state level. Since the 1980s, only two Democrats were elected to the governor's seat.[186] The state legislature reflects this trend:

[185] 270twowin.com
[186] Arizona: Past Governors Bios, *National Governors Association,* accessed February 1, 2016.

Year	Senate (D)	Senate (R)	House (D)	House (R)	Party Control
2009	12	18	25	35	Republican
2010	12	18	25	35	Republican
2011	9	21	20	40	Republican
2012	9	21	20	40	Republican
2013	13	17	24	36	Republican
2014	12 *1 Independent	17	24	36	Republican
2015	13	17	24	36	Republican

[187]

Arizona is also ground zero for a crucial re-orientation of the Republican Party, started by Arizona native Barry Goldwater. In 1960, he published *The Conscience of a Conservative*, a manifesto outlining what would become highly influential conservative positions on education, civil rights, taxation, social programs, and the environment. In hopes of cementing these preferences into his party's platform, Goldwater entered the 1964 presidential race. After emerging from a highly contentious field to be the GOP nominee, Goldwater's presidential campaign ended in a resounding defeat by Lyndon B. Johnson.[188] Goldwater's loss reinvigorated a dormant GOP following a decades-long period of American history where liberalism was the favored ideology. Demographic changes that favored the Sunbelt catalyzed a conservative movement behind individualism, free enterprise, and fervent anti-communism.[189] Republicans

[187] National Conference of State Legislatures, State Partisan Composition.
[188] Lee Edwards, "Barry M. Goldwater: The Most Consequential Loser in American Politics," *The Heritage Foundation,* July 3, 2014.

Lyndon B. Johnson won the presidency in 1964 by the largest popular vote margin ever—61% spread among 44 states.

[189] Matthew Dallek, "The Conservative 1960s," *The Atlantic,* December 1995.

shifted to a consensus of "favoring government more robust abroad and less ambitious at home."[190]

Goldwater's writing laid the foundation for concretely putting conservative ideas into action.[191] His 1964 defeat eventually paid dividends for the Republican Party, particularly during the quintessential Ronald Reagan era, and even during George H.W. Bush's administration. Arizona's historical tradition of establishment conservatism makes the state even less likely to expand Medicaid, a social welfare program that Goldwater railed against.

Medicaid expansion in Arizona is also unexpected because it is home to the country's most draconian and controversial immigration statute. In April 2010, less than one month after the ACA became law, Brewer ratified *Support Our Law Enforcement and Safe Neighborhoods Act*, or SB 1070. The bill makes it a state misdemeanor to be in Arizona without proper documentation of one's immigration status. Additionally, it requires that law enforcement officials detain individuals they suspect are in the country illegally and verify their legal status.[192] This law solidified Arizona as one of the toughest states on immigration, and suggested that successful social policies tended to be right wing, strict, and traditional.

Historical Overview of Medicaid in Arizona

This section will describe Arizona's Medicaid history, from initial adoption to contemporary times. Historical factors like Arizona's late initial adoption of Medicaid and fluctuating funding for Medicaid contributed to an environment in which Medicaid expansion would be surprising. Studying expansion in Arizona is especially valuable because it was the last

[190] George F. Will, "What Would Goldwater Do?" *The Washington Post,* November 6, 2008.
[191] Ibid.
[192] Randal Archibold. "Arizona Enacts Stringent Law on Immigration." *The New York Times,* April 23, 2010.

state in the country to adopt Medicaid when it was nationally introduced.[193] Rather than embrace the national norm of state governments administering healthcare, Arizona's county governments managed that task. Instead of an Arizona-wide Medicaid department, each of the fourteen counties had their own distinct program to fund and provide care for the poor. The state government prided itself on the fact that such a financially "open-ended" program did not burden its budget and policy agenda.[194]

Nearly two decades after Medicaid's conception, Arizona initiated its Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS), in 1981. Despite holding out on Medicaid for so long, the new program was sold as distinct and trailblazing. In line with Arizona's conservative leaning, AHCCCS was introduced under the premise of fiscal conservatism and "market-oriented" ideology. County officials appreciated that the financial burden shifted to the state; low-income residents and their advocates felt statewide Medicaid would improve access and care quality; the federal government was satisfied that their national program was now fully diffused.[195]

Much of the rhetoric at the time of AHCCCS' creation emphasized how Arizona was able to draw on lessons learned from other states' Medicaid program implementation. Because the legislature had repeatedly resisted introducing state-level Medicaid, they had to substantively justify their position switch. Their approach was to present AHCCCS as a culmination of "best-practice" techniques gleaned from other states' experiments with Medicaid. Program objectives emphasized fiscal responsibility and administrative efficiency. Features like the focus on

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[193] Charles Brecher, "Medicaid comes to Arizona: A first-year report on AHCCCS," *Journal of Health Politics, Policy and Law,* Vol. 19 (3), 1984, Page 411.

[194] Brecher, "Medicaid comes to Arizona: A first-year report on AHCCCS," Pages 411, 412, 414.
Today, there are 15 counties in the state.
Open-ended meaning that there was no way to predict the actual cost of Medicaid per year because anyone who is eligible can receive benefits and the federal/state governments must foot the bill.

[195] Ibid., Pages 415 and 424.

capitation and cost-competition, outsourcing to private firms for administrative tasks, and the high proportion of local funding demonstrate this.[196]

Despite its delayed enactment, AHCCCS was still susceptible to many of the same challenges that obstructed Medicaid in other parts of the country. The program had barely entrenched itself when budgetary problems emerged: county revenue dwindled, pressuring hospitals around Arizona to impose cutbacks wherever possible. Revenue uncertainty combined with an 88% cost increase from 1983 to 1984 put the state in a tenuous situation.[197] Throughout the 1990s, Arizona's Medicaid program was consistently ranked in the "bottom-of-the-barrel" for per capita funding and quality of services.[198] Despite these concerns, over the next few years, eligibility requirements expanded to include low-income children, pregnant women, and developmentally disabled individuals.[199] This first cascade of expansion intensified in 2000, when 63% of voters passed Proposition 204, which expanded Medicaid coverage to individuals earning up to 100% FPL.[200] A previous settlement with tobacco companies covered the cost of expansion, which targeted around 50,000 childless adults who had been excluded from care.[201] This politically contentious population would become especially critical in the post-ACA climate.

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[196] Ibid., Page 415.

> "Frequently Asked Questions: Understanding AHCCCS and Proposition 204," *Arizona Chamber Foundation*, a non-partisan 501(c)(3) research body.
>
> AHCCCS is unique because initially, local governments continued to fund a portion of the non-federal costs, alleviating some pressure on the states. Also, state legislators favored a private contractor to handle the administrative side, which is unusual (most states have a Medicaid department that manages enrollment, insurance marketplaces, online sign-up, etc.)

[197] Brecher, "Medicaid comes to Arizona: A first-year report on AHCCCS," Pages 418-419.
[198] Eleanor Schorr, "Don't Look to Arizona As Health-Care Model," *The New York Times,* September 4, 1991.
[199] Ibid.
[200] "Frequently Asked Questions: Understanding AHCCCS and Proposition 204," Arizona Chamber Foundation.
[201] "Arizona Proposition 204 Boosts Medicaid Enrollment by 45,000, Arizona Daily Star Reports," *Kaiser Health News Morning Briefing*, June 11, 2009.

Budget vs. Bodies: Arizona Medicaid Pre-*Sebelius*

Jan Brewer arrived on Arizona's political scene in 1982, when she was elected to the state's House of Representatives. Her civil service continued in the state Senate and on the Maricopa County Board of Supervisors. Although she never graduated from college, Brewer's experience owning and operating small businesses made her a formidable Republican candidate.[202]

Just a year into President Obama's first presidential term, as healthcare was moving into the national limelight, Brewer accelerated her political stature through an unusual political practice. Arizona does not have a Lieutenant Governor position, so the Secretary of State takes over if the governorship becomes open. When Obama tapped Janet Napolitano for Secretary of Homeland Security in 2009, Brewer, as Secretary of State, was next in line. Upon assuming office, Brewer's agenda focused on downsizing government to remedy a $4 billion deficit. Brewer promised her constituents a more competitive, sustainable Arizona. Within a year of assuming office, Brewer and her administration were preoccupied with three complex and formidable policy conundrums: a statewide financial crisis, national health care reform, and immigration reform.[203]

The state felt the downstream effects of the 2008 financial crisis in a very real way. Arizona is twice as dependent on construction revenue than the nation as a whole, so the 2008 housing bubble stifled that source of revenue.[204] The response from Republican officials, who in

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[202] Kayla Webley, "15-Second Bio: Arizona Governor Jan Brewer," *Time,* May 15, 2010.

"Arizona's potential governor, Jan Brewer." *The Arizona Republic,* November 21, 2008.

[203] Jan Brewer, Inaugural Address, January 21, 2009.

[204] David Wells, "Medicaid Expansion and Sales Tax Reform Dominate Arizona's Budget Process."

2011 had a 21-9 Senate majority and a 40-20 House majority, was to cut the education and healthcare budgets, reduce new debt issuances, and halt the creation of new taxes.[205]

Arizona had to grapple with the more immediate challenge of alleviating a financial crisis before tackling the mandates laid out in the ACA. For fiscal year 2012, the upside of the two-year budget projection was a $67 million deficit (meaning, by 2014, Arizona would be in a $67 million hole); the downside was a $583 million shortfall.[206] 2010 revenues were at 2004 levels, but expenditures were 30% higher.[207] Arizona's annual budget must balance, so Brewer's administration was faced with the daunting challenge of conforming to conservatism while raising enough cash to reduce debt.[208]

The budget included cuts to the Department of Health Services, the Department of Economic Security, and the Department of Housing.[209] But most of the cuts in the 2011 proposal, for fiscal year 2012-2013, came from the fast growing program, AHCCCS, which occupied about a fifth of the entire budget.[210] The governor suggested the following means to reduce Medicaid expenditures: withdraw General Fund support for the program, and instead rely solely on litigation funds, thereby eliminating coverage for childless adults; reduce the provider rate by 5%; and tighten eligibility requirements for parents.[211]

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[205] National Conference of State Legislatures, State Partisan Composition, 2011.
[206] Luige del Puerto, "The real health care debate in Arizona: Medicaid expansion," *The Arizona Capitol Times,* December 10, 2012.
[207] John Arnold, "Arizona's budget crisis: How did we get here and where are we going?" *Arizona State University, Research and Ideas,* April 23, 2010.
[208] The Arizona state constitution prevents the state from operating in a deficit.
[209] "Highlights of Gov. Brewer's Proposed Budget Reductions for 2012," *Arizona Food Banks,* 2012.
[210] Mary Jo Pitzl, "Arizona lawmakers approve $1.1 billion in budget cuts," *The Arizona Republic,* April 2, 2011.
[211] Jan Brewer, Executive Budget Summary FY 2012-2013.

The Arizona legislature reduced funding for the Medicaid program, AHCCCS, by over $500 million—about half of the total cuts.[212] Consequently, childless adults could no longer apply for benefits; only those already enrolled on the books would receive coverage.[213] This reduction affected over 150,000 Medicaid recipients in the first year.[214] In 2011, 18% of the state population was on AHCCCS coverage, but the same percentage was uninsured.[215] Arizona faced an all-too-familiar cycle of budget cuts that led to rising healthcare costs, which in turn furthered budget pressure.

It is important to note that Brewer's 2011 budget proposal was formulated before the *Sebelius* decision—she was operating under the belief that Medicaid expansion was a federal mandate. Brewer restructured her state's expenditures to accommodate what she called the federal government's usurpation of fiscal decision-making, via required Medicaid expansion.[216] In other words, Brewer saw the ACA's Medicaid mandate as a loss of state authority, and pursued cost control methods to compensate for expanded eligibility.

Although the statewide focus was on balancing the budget, Brewer also devoted administrative attention to the ACA. In her 2010 State of the State speeches, Brewer addressed the "oppressive" nature of the ACA and told Arizonians "there is no such thing as free health care." She called on her state to take control of their health care fate as individuals: "the federal government may be failing in its role [to supply affordable healthcare], but we will continue to

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[212] "Restore and Expand AHCCCS: A Communications-Advocacy Toolkit for Arizona Hospital Leaders," From the Arizona Hospital and Healthcare Association.

Pitzl, "Arizona lawmakers approve $1.1 billion in budget cuts."

The overall 2012 budget was reduced by over $1 billion.

[213] Avik Roy, "How a GOP Governor Walked Arizona into Obamacare's Medicaid Expansion Trap," *Forbes,* January 19, 2013.

[214] John Gramlich, "Arizona Medicaid cuts to go into effect," *Stateline,* July 5, 2011.

[215] "Frequently Asked Questions: Understanding AHCCCS and Proposition 204," *Arizona Chamber Foundation.*

[216] Jan Brewer, The Executive Budget Summary, Fiscal Years 2012 and 2013.

do better in ours."[217] Under Brewer's leadership, Arizona joined *Florida vs. HHS*, a 26-state lawsuit that challenged the constitutionality of ACA (particularly the individual mandate) in the Supreme Court.[218] Arizona was a one of the earliest states to sign onto the national lawsuit, doing so two weeks after the ACA was ratified. Arizona's Attorney General declined to join the lawsuit, but Brewer called a special legislative session to get permission to take part in the litigation.[219] In a 2010 press release, Brewer described the ACA as "unreasonable, unsustainable and unconstitutional" and an "unprecedented intrusion" on state sovereignty.[220] Noting that the lawsuit would only cost Arizona around $5,000, Brewer emphasized Arizona's responsibility to uphold federalism and constrain this governmental overreach.[221] Her outspoken position on the ACA—this statement was published six months after the ACA's passage—cemented her as a staunch health reform opponent, making her eventual pursuit of expansion all the more puzzling.

Brewer's ideological switch from vehement opposition of the ACA to steadfast support of Medicaid is a constraint on framing. She needed an approach that was flexible enough to make it appear that she was not contradicting her previous commitment. The frame for Medicaid expansion had to be consistent with her rejection of the ACA. The ACA was highly partisan and many Republicans outright opposed all of its reforms. So when a Republican-governed state faced the choice of Medicaid expansion, the conservative leadership had to recognize and

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[217] Jan Brewer, State of the State address, January 11, 2010.
[218] Ezra Klein, "A lot of Republicans supported the individual mandate," *The Washington Post,* May 12, 2011.

> The individual mandate requires all Americans to acquire health insurance. The concept emerged during former President Clinton's attempt to reform healthcare via the Health Security Act. Republicans originally proposed and supported the mandate as an alternative to a single-payer system. Republicans who have changed their tune once the ACA was on the table rarely discuss this substantive inconsistency in the mass media.

[219] James King, "Governor Jan Brewer Enters Arizona In Obamacare Lawsuit," *Phoenix New Times,* April 7, 2010.
[220] Jan Brewer, "Obamacare is Wrong For Arizona and Wrong for America," *Arizona Governor Jan Brewer's press office*, September 13, 2010.
[221] Ibid.

> King, "Governor Jan Brewer Enters Arizona In Obamacare Lawsuit."

rationalize their earlier dismissal. Governor Brewer was no exception. In order to appropriately acknowledge her historical stance on the ACA, Brewer employed a humanistic frame. She asserted that "'although I didn't support Obamacare, I support taking care of the poor."[222]

Amidst the ACA and a fiscal crunch was Arizona's immigration reform, which garnered national attention—even condemnation from the President, who rarely opines about state laws.

Did the issue of illegal immigration intersect with Medicaid expansion? Preconceived notions about undocumented immigrants and provision of healthcare swirled: contrary to many assumptions, 78% of uninsured Americans are citizens, and immigrants are 35% less likely to visit an emergency room than non-immigrants.[223] Also, proponents of SB 1070 pointed to saved dollars from illegal immigrants leaving Arizona as a result of the bill—the state would then no longer have to pay for healthcare. However, the actual monetary effect of that population's departure is unclear.[224] These conjectures would suggest that expansion would be even more unlikely because expansion would permit more illegal immigrants to use scarce state funds.

A nuanced ACA provision added another layer of complexity to the provision of healthcare to the low-income. Under the ACA, a U.S. citizen must live above the poverty line to qualify for federal subsidies for private health insurance. However, regardless of income, all legal residents (who are not yet full citizens) are eligible for subsidies for private insurance. Once Medicaid expansion became optional, immigration status became much more relevant. If a state opts out of expansion, none of its American citizens below the poverty line can receive subsidies for Medicaid or private insurance. However, legal residents would be eligible for private

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[222] Josh Barro, "Before Donald Trump, There Was Jan Brewer," *The New York Times,* February 10, 2016.
[223] Erika Martin and Courtney Burke, "Health Reform: What Is The Future For Undocumented Aliens?" *Health Affairs Blog,* October 15, 2010.
[224] Daniel Gonzalez, "Arizona's illegal immigrants departure affecting businesses," *The Arizona Republic,* June 29, 2010.

subsidies.[225] This technicality presented an additional tactical choice for Brewer. Would she renege on SB 1070 by refusing Medicaid expansion, or take on Republicans and protect Arizona citizens by expanding Medicaid?

Opening the Expansion Door

Less than six months after the Supreme Court's ruling, Brewer announced the expansion plan to provide health coverage for individuals earning up to 138% FPL in her 2013 State of the State address.[226] In the version of her address disseminated early to lawmakers and the press, there was no mention of Medicaid expansion—Brewer went off script when she announced expansion.[227]

In her 2013 State of the State address, which began the pursuit of Medicaid expansion, Brewer reminded Arizonians that they had supported Medicaid expansion in the past.[228] First, in 2000, voters authorized Prop 204, an expansion of Medicaid eligibility to 100% FPL, similar to the initiative on the table.[229] Second, Arizonians also voted in favor of a provider assessment, or a charge on a healthcare provider to pay for newly eligible recipients, on nursing homes.[230] This is similar to how Brewer's expansion is paid for—via an assessment on hospitals. Brewer used a policy precedence frame in order to make voters, and indirectly, lawmakers more comfortable with expansion.

Brewer used these historical mandates to frame expansion as consistent and familiar. A positive decision on Medicaid would fit with how Arizona had voted before. The strength of this

[225] Sarah Kliff, "Arizona could make the Medicaid expansion an immigration fight," *The Washington Post,* January 24, 2013.
[226] Jan Brewer, State of the State address, January 14, 2013.
[227] David R. Wells, "Medicaid Expansion and Sales Tax Reform Dominate Arizona's Budget Process," *California Journal of Politics & Policy,* 2015.
[228] Jan Brewer, State of the State address, January 14, 2013.
[229] "Understanding AHCCCS and Proposition 204," *Arizona Chamber Foundation.*
[230] Roy, "How a GOP Governor Walked Arizona into Obamacare's Medicaid Expansion Trap."

particular framing strategy is that it addresses a universal voter concern that change is daunting and unfamiliar—and thus, bad.[231] Voters are consistently more likely to favor the status quo than a reform package because of the uncertainty associated with the distribution of gains and losses from a new policy. Thus, language like "restorative" or re-installment is more palatable than an untested reform.[232] Framing expansion as consistent with past policies would also make counter-frames less salient. A counter-frame that emphasized how Brewer's expansion was an innovative or unprecedented reform would be invalid because Arizonians had twice passed similar expansion measures.

The governor's proposal would make around 400,000 more people eligible for Medicaid. In anticipation of backlash regarding the federal fund-matching scheme, the plan also included an automatic rollback on enrollment in the event of a federal funding drop.[233] With this "circuit breaker," Brewer protected her proposal from a nationwide argument that the national government would renege on their promise to cover the newly eligible population. Other expansion-minded states like Iowa, Nevada and Arkansas also included a rollback in the event of a federal "cut and run" in their expansion plans.[234] The strategy was even backed by former

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[231] Raquel Fernandez and Dani Rodrik, "Resistance to Reform: Status Quo Bias in the Presence of Individual-Specific Uncertainty," *The American Economic Review,* Vol. 81 (5), 1991, Pages 1146-1155.

[232] Luige del Puerto, "The real health care debate in Arizona: Medicaid expansion," *The Arizona Capitol Times,* December 10, 2012.

[233] Critics fault the federal Medicaid expansion plan because there is no guarantee that the federal government will continue to fund 90% of the expansion after 2020. Those opponents argue that the federal government can go back on their word, leaving the financial burden to already unstable state governments. Brewer's response to this concern is essentially a program halt: all those who were newly eligible would immediately be kicked off Medicaid in the event that federal funding drops below 80%. Thus, Brewer can publicly say that the cost to Arizona is minimal.

[234] Sarah Baron, "10 Frequently Asked Questions About Medicaid Expansion," *Center for American Progress*, April 2, 2013.

> Melissa Attias, "Sebelius Tries to Reassure States on Medicaid Flexibility," *Congressional Quarterly Roll Call,* April 29, 2013.
>
> Maia Crawford et. al, "Alternative Medicaid Expansion Models: Exploring State Options," *Center for Health Care Strategies, Inc.,* February 2014.

Health and Humans Services Secretary Kathleen Sebelius, who emphasized to governors that there would be no penalty on traditional Medicaid if a state rolled back expansion.[235]

Brewer's choice to bundle expansion into the Arizona state budget for 2013 was designed to increase expansion's traction. Senate Majority Whip Adam Driggs explained that because the budget is broad in terms of policy changes, there is some "political cover" for voting in favor of a budget including expansion. In other words, a representative is not voting only on Medicaid when he votes for the budget, potentially softening the political blow. Another argument in favor of embedment is that a standalone bill for Medicaid is far easier for an array of stakeholders to target and dissect, and thus far more likely to fail.[236]

From January to May, Brewer held special public events around the state to get citizens on board with her policy. Two weeks after Brewer announced her policy plan, over 14 business and healthcare organizations announced their support for expansion at a small event.[237] A rally in early March attracted medical professionals donning white coats, with a handful of protestors in all black. At the event, which took place outside the Capitol building, the President of the Arizona Medical Association declared: Medicaid is "'not a 'red issue' or a 'blue issue' to doctors. It is a patient-care, humanitarian issue.'"[238] Overall, more formal organizations were in attendance at these events than the average citizen. Some groups were previously allied with Brewer, but others emerged in support of expansion because of new fiscal challenges and the possibility that without expansion, their business would be affected.

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[235] Attias, "Sebelius Tries to Reassure States on Medicaid Flexibility."
[236] Luige del Puerto, "Arizona Gov. Brewer faces tough decisions on how to expand Medicaid," *Arizona Capitol Times,* March 4, 2013.
[237] Rhette Baughman, "Governor Jan Brewer Joined by AZ Health Care, Business Leaders who Rally behind Medicaid Expansion," *Arizona Small Business Association*, January 18, 2013.
[238] Mary K. Reinhart, "Brewer rallies support for Medicaid-expansion plan," *The Arizona Republic,* March 6, 2013.

At these events, Brewer focused on the humanitarian aspects of Medicaid expansion. Noting that those who lost coverage would have no alternative means of healthcare, Brewer announced, "'the human cost of this tragedy can't be calculated.'" [239] At the last and largest rally, Brewer reminded a 200-person crowd of health care providers, patients, and other stakeholders: "' [expansion is] the right thing to do.'"[240] While these events did not pre-empt vigorous legislative debate, they achieved their purpose of offering forums for discussion.

Brewer's grassroots efforts seemed to increase the proposal's public salience. Polling numbers showed a gradual warming to Medicaid expansion. In April, Public Opinion Strategies, a national polling firm, conducted a survey in which 45% of respondents favored Medicaid expansion, and 25% opposed it.[241] The remainder of those polled indicated they had not heard of Brewer's plan.[242] By late May, three weeks before the legislature considered expansion, a poll by the same organization found that 53% of respondents supported Brewer's proposal.[243]

By holding attention-getting public events, Brewer behaved analogous to the presidential strategy of "Going Public," or directly appealing to American voters in order to pressure Congress into passing legislation rather than bargain with them. The "Going Public" theory notes that the strategy works better for outsider leaders—Brewer can be classified this way, as she is not an establishment conservative—and for politicians with little to lose in the short run—Brewer was term-limited, and was not pursuing another elected position after her tenure.[244]

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[239] Sy Mukherjee, "GOP Governor Shuts Down Lawmaking Until Her Party Agrees to Expand Medicaid," *Think Progress,* May 24, 2013.
[240] Jeremy Duda, "Arizona Gov. Brewer again rallies Medicaid supporters at Capitol," *The Arizona Capitol Times,* May 15, 2013.
[241] Jeremy Duda, "Poll Suggests Increasing Support for Medicaid Expansion, But Critic Questions Wording," *Arizona Capitol Times,* August 14, 2013.
[242] Mary Reinhart, "Poll says half favor Medicaid expansion," *The Arizona Republic,* April 5, 2013.
[243] Duda, "Poll Suggests Increasing Support for Medicaid Expansion."
[244] Samuel Kernell, *Going Public: New Strategies of Presidential Leadership,* Washington: Congressional Quarterly Press, 1986.

The governor's true audience at these events was the elected officials representing the individuals in attendance. In line with the stipulations of "Going Public," Brewer was hoping to increase public support such that elected officials would face political consequences if they opposed Brewer. Public support should have encouraged Republican officials to consider expansion—they would not only have the governor's endorsement, but they would be implementing a policy that the majority of voters were in favor of.[245]

Despite the public support scale sliding in the direction of expansion, critics noted that the wording of Brewer's Medicaid plan in polls was misinformed, potentially altering how people polled. One interest group said that the description of the expansion proposal was "generally positive," and did not adequately explain the circuit-breaker provision. According to the poll's critics, these factors presented a more favorable policy than expansion actually was.[246] This debate demonstrates the explanation posited in the literature: that framing via rhetorical choice can alter public support.

Regardless of voter sentiment, Brewer's opposition was vocal and well organized. In the early stages of Brewer's announcement, Republican representative Carl Seel delivered near daily speeches on the House floor stating why officials should oppose expansion. He was concerned about the lack of information about Medicaid expansion and the uncertainty surrounding the federal government's financing of expansion.[247] Republican Senate President and libertarian Andy Biggs said he thought there were "a million and one reasons" expansion was a bad idea.[248] Biggs, a millionaire by lottery victory, previously served eight years in the state House and

[245] Kernell, *Going Public: New Strategies of Presidential Leadership.*
[246] Duda, "Poll Suggests Increasing Support for Medicaid Expansion."
[247] Minutes of Special Meeting, Arizona House of Representatives Committee on Appropriations, June 10, 2013.
[248] Reinhart, "Poll says half favor Medicaid expansion."

chaired the House Appropriations Committee. He believed that Medicaid was socialized medicine and had sponsored a failed attempt in 2010 to eliminate the program entirely.[249]

On April 25th, 2013, an anti-expansion rally organized by a freshman Republican garnered the attendance and attention of dozens of Republican lawmakers as well as citizens opposed to Brewer's plan. The protest featured two skeletons labeled with a "victims of Obamacare" sign in front of the Arizona house.[250] The majority of the opposition's message centered on the possible political repercussions of opposition: would incumbency be threatened? The answer to their concerns was yes. A.J. LaFaro, the Chairman of the Maricopa County Republican Committee, wrote a letter warning Republicans that voting for expansion was an "egregious action" with "serious consequences…their political careers are all but over and their days numbered."[251]

By June 2013, the climate in both the desert and the legislature was boiling. According to Arizona's constitution, the deadline for a budget—and for expansion—was July 1. After threatening to block bills if the legislature did not make progress on the budget, Brewer upped the ante and announced a moratorium on all laws until Medicaid expansion was passed. She was good on her word, vetoing five bills before expansion moved forward.[252] Amidst stalling efforts by House Republicans, Brewer called a surprise special legislative session without formal permission from her fellow Republicans.[253] In Arizona, governors are able to convene these

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[249] Stephen Lemons, "Andy Biggs, The $10 Million Chairman, and His Tuesday Night Massacre," *Phoenix New Times*, February 24, 2011.
[250] Hank Stephenson, "Arizona's Medicaid opponents see their bills vetoed, but differ on reasons," *The Arizona Capitol Times,* May 6, 2013.
[251] A.J. LaFaro, Letter to Arizona Republican State Representatives and Senators, May 22, 2013.
[252] Sy Mukherjee, "Arizona GOP House Speaker Caves Under Pressure From Governor, Schedules Vote On Medicaid Expansion," *Think Progress,* June 5, 2013.
[253] Stalling efforts mostly consisted of different amendments to the budget. These included budgets with no Medicaid expansion at all, time limits on Medicaid eligibility, etc. Over 60 amendments were debated in the weeks leading up to Brewer's special session.

sessions—as many as they deem appropriate—to direct the focus of the legislature.[254] Governors must announce the intention of the session, and have to stick to that topic.[255] Brewer's abrupt move was anchored by a bipartisan coalition that formed months before the vote to consider other issues in the budget. In a vote that took place at 4am, the House approved the budget, including Medicaid expansion, by a 33-27 margin.[256] The coalition was a crucial voting bloc.

In the House, the Medicaid expansion proposal attracted a positive vote from nine out of the 36 Republicans in addition to the 24-member Democratic contingent that needed little convincing to support the plan.[257] Many of the Republican representatives who failed to do what their legislative leaders demanded had GOP opponents in the next election. Likely in anticipation of Republican backlash, the governor and health care industry allies raised nearly half a million dollars for the Republican endorsers' future campaigns leading up to the vote.[258] Republicans who supported Medicaid expansion might be in trouble when they ran for re-election. If their challenger were a more traditional Republican who saw Medicaid as a Democratic Party issue, or as an example of Brewer betraying party platform, the representative would then have to justify his ideologically inconsistent vote to his constituents.

The Senate followed the House's example, and approved the budget by a 19-11 vote. Five Republican senators joined the unanimous Democratic vote.[259] The funding guaranteed that Arizona's population earning up to 138% FPL would receive healthcare coverage.

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[254] David M. Thomas, "Arizona Legislative Manual," *Arizona Legislative Council*, 2003.
[255] Mary K. Reinhart et. al, "Dems, moderate Republicans debate $8.8 billion budget," *The Arizona Republic*, June 12, 2013.
[256] Michael Chihak, "Medicaid Drives Coalition to AZ Budget Adoption," *Arizona Public Media*, June 13, 2013.
Mary Reinhart et. al, "Arizona Legislature adjourns special session," *The Arizona Republic,* June 13, 2013.
[257] Chihak, "Medicaid Drives Coalition to AZ Budget Adoption."
[258] Howard Fischer, "Brewer: Money raised to support Medicaid expansion allies 'impressive,'" *Arizona Daily Sun,* February 7, 2014.
[259] Mary Jo Pitzl and Mary Reinhart, "Arizona Senate backs Medicaid expansion," *The Arizona Republic,* May 17, 2013.

Brewer's method to implement expansion can be described as incremental obstinacy. When it first appeared that the legislature was not receptive to expansion, Brewer played hardball. She stated she would veto any budget that did not include the expansion component. When that moratorium approach failed, she threatened to veto all bills the legislature proposed until Medicaid was expanded.[260] Instead of accepting defeat or circumventing the traditional legislative process, Brewer gradually asserted her legislative capital. This approach was unprecedented; no other Republican governors used such aggressive tactics to try to push expansion through. There are a number of reasons this strategy was effective in Arizona. Brewer did not have the weight of future political roles moderating her decision-making. She was term-limited, did not have long-term political aspirations, and was not a central GOP figure. Unlike aspiring president John Kasich, Brewer's did not need to make decisions that would eventually be defended by Republicans. Without party pressure she could act independently.

Brewer's Battle

Shortly after the legislature approved the budget, the question of expansion spilled into judicial territory. The plaintiff, the Goldwater Institute, contended that Brewer violated Arizona's constitution because the hospital assessment that helps to cover the costs of expansion can be viewed as a tax. Taxes must have the two-thirds of the legislature's support; Medicaid expansion passed with a simple majority.[261]

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[260] Barro, "Before Donald Trump, There Was Jan Brewer."

[261] The Goldwater Institute is a conservative think tank based in Phoenix. Barry Goldwater started the organization in 1988. The litigation sector of the non-profit is a proponent of libertarian fundamentals, and advocates for limiting government at all levels.

> Stephanie Condon, "Arizona Gov. Jan Brewer keeps up pro-Obamacare fight," *CBS News,* September 13, 2013.

The case originated in February 2014, with the backing of over 30 Republican lawmakers—out of the 53 Republicans in the 2014 General Assembly—but was dismissed by a state Supreme Court judge. That decision was later overturned, and the case moved forward, putting expansion in jeopardy. Ultimately, the court ruled in favor of Brewer and AHCCCS, confirming expansion's legality.[262] The ruling was a victory for expansion proponents including Brewer, but of greater concern was the upcoming 2014 gubernatorial election. If the policy could be reversed or challenged easily, then it would be unsafe depending on who controlled Arizona's government. Brewer did not mention Medicaid in her parting remarks as governor.

Medicaid was top-of-mind during the gubernatorial race. Former Arizona State Treasurer Doug Ducey emerged from a six candidate Republican primary and ran against the unopposed Democrat, Fred DuVal. The lone Democrat supported expansion and vowed to reject proposals to eliminate the reform. DuVal's position was unsurprising. He had been a critical player in AHCCCS's creation in the 1980's.[263] DuVal "applaud[ed]" Medicaid expansion and would keep the expansion in its full form as governor. [264] DuVal called expansion a "national best practice" that is "good for [the] budget [and] good for Arizonans."[265] The Republican primary candidates had a spectrum of opinions on expansion. "Go Daddy" executive Christine Jones, Ducey's only significant contender, was tepid on expansion, and stated that she would have included cost-

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[262] Josh Coddington, "Arizona Supreme Court to hear Medicaid arguments today," *The Arizona Capitol Times,* November 6, 2014.

Jeremy Duda and Ben Giles, "Superior Court judge upholds Brewer's Medicaid expansion," *Arizona Capitol Times,* August 26, 2015.

[263] Mary Jo Pitzl, "Will next governor keep Arizona's expanded safety net?" *The Arizona Republic,* October 15, 2014.

[264] "Meet Our Candidates: Fred DuVal for Governor of Arizona," *Planned Parenthood Advocates of Arizona,* October 30, 2014.

[265] "Ducey, DuVal on: Health care," *The Arizona Republic,* October 21, 2014.

containment mechanisms and eligibility limits in her expansion plan.[266] Ducey's position was clear: Medicaid was a "middle class entitlement."[267] When Ducey won the Republican nomination, the two general election candidates diverged on their Medicaid expansion policy preferences.

After winning the election with 53% of the vote, Tea Party-backed Ducey tempered his stance towards Medicaid. He said he would veto any bills repealing expansion so long as federal funding remained in place. At the same time, he began drafting reforms to cut Medicaid expansion. In the first year he took office, Ducey announced a Medicaid modernization plan under the name "AHCCCS Care." At the helm of Ducey's health care team was the Goldwater Institute's Christina Corieri, who had a part in the lawsuit that unsuccessfully tried to reverse expansion. Ducey's plan included three structural changes. First, Arizona Medicaid would have a five-year lifetime limit for able-bodied adults. Second, the plan introduced copays, which are patient payments made for services above a certain cost threshold, the rest of which is covered by insurance (or in this case, the Medicaid fund). Third, the nearly 400,000 able-bodied adults receiving coverage must be actively searching for employment or involved in job training or school in order to receive Medicaid.[268] Adult Medicaid recipients would also be expected to make a contribution in the amount of 2% of their annual household income to a health savings account. That account could only be accessed if the individual engaged in healthy behaviors like

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[266] Isiah Kurz, "The issue: The gubernatorial candidates' position on Medicaid expansion," *The Arizona Republic,* January 29, 2014.
[267] Doug Ducey, quoted in "Doug Ducey's Rocky Road to Defeat," *American Bridge PAC,* August 26, 2014.
[268] Jeremy Duda and Ben Giles, "Superior Court judge upholds Brewer's Medicaid expansion," *Arizona Capitol Times,* August 26, 2015.

Mary Jo Pitzl, "Gov. Doug Ducey's Medicaid plan calls for lifetime limits, copays," *The Arizona Republic*, August 3, 2015.

annual check ups or taking classes on how to smoking cessation.[269] The common theme throughout the proposal is individual responsibility—a conservative principle, according to Ducey—and reduced government involvement.[270]

None of these changes have been formalized; however, the General Assembly approved a waiver including these changes for Centers for Medicare and Medicaid Services (CMS) approval in February 2015. Ducey is somewhat at the mercy of CMS, who have yet to approve these reforms. When other states proposed similar reforms to Medicaid, CMS accepted some of the changes, like the health savings account component, which exists today in Arkansas, Indiana, and Michigan. However, work requirements and lifetime eligibility limits are unprecedented—CMS has never allowed them. [271] The future of Medicaid expansion in Arizona remains up in the air, but if Ducey proceeds with reforming the policy, he will have to re-frame Medicaid expansion.

Arizona is the only case where expansion passed by traditional legislative means, with both the House and Senate's approval. Several factors helped Brewer's case. Previous votes in favor of Medicaid were in recent memory, and this frame gave Republicans who could be convinced two solid reasons why they now supported this expansion proposal. Also, the fact that expansion was folded into the state budget made it more difficult for Republican opponents to obstruct the plan since they would be responsible for delaying funding across the state. Brewer's

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[269] Michael Ollove, "Should Medicaid Recipients Have to Work?" *Stateline*, October 8, 2015.

> The goal of a health savings account is to establish a safety net for Medicaid recipients to use in the event of an emergency. The balance can also be used towards copays for health services that Medicaid does not cover (dental or vision care are two common Medicaid service gaps). Medicaid recipients who earn above the poverty level and did not make an annual health savings account could be removed from the Medicaid rolls for 6 months. If a recipient earns less than FPL, they would owe the state that debt.

[270] Ducey's ideas tie back to the fundamental tension between healthcare as a public good, provided universally (or even partially) by government, or an entirely private commodity, distributed via employer or private companies. These two opposing ideas are the most basic distinction between how Democrats and Republicans view healthcare.

[271] Ollove, "Should Medicaid Recipients Have to Work?"

frames of policy precedence and economic advantage, in conjunction with other political forces, converted the subset of Republican lawmakers who ultimately supported expansion. Framing can matter even if it only altered the votes of that division of the opponent contingent. In Arizona, framing was not a central cause of expansion's success, but it remains especially relevant post-Brewer, because her successor has vowed to reverse Medicaid expansion.

Chapter 6

Cross Case Comparison

This chapter serves two purposes. First, it reviews my key findings and compares framing strategies from the three cases. Second, it contextualizes framing in the state-level policymaking process. How does framing interact with social welfare policies like Medicaid expansion? In what ways do framing strategies shift over the lifespan of a policy? Framing played a modest role in the Medicaid expansion outcomes in Ohio, Tennessee, and Arizona. Framing alone may not be helpful for predicting policy outcomes, but it is relevant for understanding how Medicaid expansion politics transpire after their initial implementation.

Each of the three narratives explored in the preceding chapters offers a differently tinted lens for understanding the environments in which Medicaid expansion was considered. The following analysis recaps my account of the politics of Medicaid expansion in Ohio, Tennessee, and Arizona.

In order to appeal to persuadable Republicans—who initially opposed but could potentially support expansion—Governor Kasich used moral and economic frames. Religion, "doing the right thing," and helping the less fortunate fit into a certain Republican schema of social policy—"Compassionate Conservatism." This political philosophy is useful for Republican politicians to both publicly support social services without promoting or authorizing government resources to do so.[272]

[272] Marvin Olasky, *Compassionate Conservatism: What It Is, What It Does, and How It Can Transform America* (New York: Simon & Schuster, 2000).

Associating morality with Medicaid expansion altered the program's associations with President Obama and federal government intervention. However, Kasich's opponents, Republicans in the legislature, were concerned with Medicaid expansion's association with the ACA and the uncertainty of federal funding. This paralyzed the Ohio legislature and forced Kasich to change strategies and to authorize Medicaid expansion via a special political body, the Controlling Board. Kasich's framing of expansion as a moral imperative failed to convince the necessary lawmakers to budge on expansion. Although framing did not accelerate the initial authorization of expansion, the emotional aspects of Kasich's moral frames will make undoing expansion challenging. Counter-frames will have to account for Kasich's connection of expansion with righteousness and religious obligation. Each of Kasich's frames had the additional benefit of bolstering his legacy as a moderate policymaker who could survive vetting at the national level. With presidential aspirations in the background of Kasich's governorship, each maneuver associated with Medicaid expansion had to fit into a narrative of prudent budgetary leadership, which includes healthcare.

Governor Haslam framed Medicaid expansion in Tennessee as a budget-neutral, homegrown policy that would improve TennCare, the existing but troubled Medicaid administrative body. The governor created a rhetorical distinction between the ACA and Medicaid as well as between the new expansion and past Medicaid policies. These strategies were necessary to contend with counter-frames, which linked expansion and the failed Medicaid program, TennCare. Other counter-frames connected Medicaid expansion and Obama's health reform, which was wildly unpopular among Tennesseans.

Although Haslam's framing selections were successful when deployed by Medicaid expansion proponents in other states, they proved inadequate in Tennessee. State-specific factors

weakened the effectiveness of the Insure Tennessee expansion proposal. A toxic combination of federal government mistrust, re-election pressures, and partisan posturing doomed expansion multiple times. Governor Haslam was unable to answer counter-frames from Tea Party groups, which portrayed Medicaid expansion as sympathetic to the ACA, and which discussed expansion in ways meant to stoke white racial resentment.[273] Despite consistent framing—Arizona and Ohio's governors used similar strategies—other political forces mitigated Haslam's appeals.

Governor Brewer's approach to Medicaid expansion in Arizona can be described as incremental obstinacy. Brewer was at an advantage because she was term-limited and free from Republican Party norms, and thus able to leverage more political capital in order to pursue expansion. By presenting Medicaid expansion using two specific frames: 1) policy precedence and 2) easing of fiscal burden, the governor cornered her legislature into responding to constituent support and gubernatorial pleas. In a historically conservative state controlled by a conservative legislature, Brewer had to make a strong economic case for Medicaid expansion and accommodate concerns about federal-level uncertainty into her bill. But to cement the bill with skeptic lawmakers, Brewer tied this Medicaid expansion to two previous policies. This strategy served to convince Arizonians, and indirectly, Republican lawmakers that Medicaid expansion today was native to Arizona soil. In other words, expansion was not a policy prescription sent from bureaucrats in Washington. Brewer also adequately acknowledged her opponent's rebuttals, categorically rejecting the notion that Medicaid expansion was an embrace of Obamacare. Although Brewer saw expansion through, framing likely was a small contributor to the small group of Republican lawmakers who supported expansion.

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[273] Martin Gilens, *Why Americans hate welfare: Race, media, and the politics of antipoverty policy* (Chicago: University of Chicago Press, 2009).

Cross Case Analysis

Here, I directly compare framing in the Ohio, Tennessee, and Arizona cases. I will point out the shared characteristics among the three cases, the common framing strategies employed across the cases, and the magnitude of framing in these states.

Four common characteristics influenced the content and distribution of frames across these cases. First, the governors of Ohio, Tennessee, and Arizona were anti-ACA. Gubernatorial opposition was of course expected—indeed, no Republican federal lawmakers voted in favor of the ACA. Was such opposition sincere or strategic? We might anticipate the rejection of the ACA as the expectation for loyal partisans. Governors do not want to be the party outlier, so instead follow the heed of Republican politicians in the public eye. Kasich's presidential campaign website promotes a "repeal and replace" approach to the ACA.[274] Kasich also declared: "From Day One, and up until today [2014] and into tomorrow, I do not support Obamacare…I believe it should be repealed."[275] Brewer eagerly signed Arizona onto a lawsuit challenging the ACA's constitutionality. The mantra of "repeal and replace" was ubiquitous in the GOP. Haslam issued the following statement after *NFIB vs. Sebelius:* "By electing Mitt Romney, we can be sure that the entire [ACA] will be repealed."[276] If we consider these governors' public statements at face value, it is unlikely that Brewer, Kasich, and Haslam were fundamentally and genuinely opposed to the ACA reforms. Rather, party pressures restricted their preference latitude. Strict partisan support for the ACA created a challenge for Republican governors who eventually sought to expand Medicaid.

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[274] www.johnkasich.com/healthcare
[275] Benjamin Domenech, "John Kasich Tries to Have It Both Ways on Obamacare," *The Heartland Institute*, October 21, 2014.
[276] "Tennessee Governor Bill Haslam's Statement on Supreme Court's ObamaCare Ruling," *Clarksville Online*, June 30, 2012.

Second, each governor made substantive rhetorical distinctions between the ACA and Medicaid. This is an important empirical specification. There is an informational inconsistency in seeking to repeal the ACA while supporting Medicaid expansion. This expansion opportunity would not have existed—at least, not in the same form—if the ACA were dismantled. Although Medicaid expansion is always a policy option, the ACA introduced supplemental benefits that made expansion fiscally attractive. An ACA repeal would likely change the main incentive for expansion, an unprecedented generous financing scheme. As a result, Republican or Republican-leaning states would be less enticed to expand Medicaid. However, it seemed that governors were more willing to reform Medicaid if they successfully framed it as a stand-alone program. Tennessee's Haslam, for example, artfully demonstrated this rhetorical strategy when he distinguished between "traditional" Medicaid expansion and his proposal, called Insure Tennessee.[277] Insure Tennessee was slightly modified from the expansion laid out in the ACA, but Haslam was able publicly cut ties with the unpopular ACA. This strategy was used in Michigan as well; Governor Rick Snyder's Healthy Michigan plan is identical to ACA Medicaid expansion, but does not carry the connotations of the term "Medicaid" or "Medicaid expansion."[278]

Third, the GOP had been in control of the Ohio, Tennessee, and Arizona legislature since the ACA passed. None of the states studied here had divided government when expansion became a state choice after *NFIB vs. Sebelius*. This fact made expansion all the more challenging for governors to achieve.

A fourth common trait shared by Ohio, Tennessee, and Arizona is that in none did a majority of Republican legislators support expansion. In other words, for Kasich in Ohio and

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[277] Dave Boucher, "Haslam's Tennessee Plan would expand health coverage," *The Tennessean,* December 15, 2014.
[278] "Medicaid Expansion in Michigan," *Kaiser Family Foundation*, January 8, 2016.

Brewer in Arizona to implement Medicaid expansion successfully, they needed some Republicans to join already supportive Democrats to pass expansion. This suggests that there is a specific audience for framing. Even before Ohio, Arizona, and Tennessee's governors came out with a stance on expansion, they would face an uphill battle against an already defiant GOP legislature.[279]

Governors have many choices regarding whom to direct political comments towards: voters, elected officials, or interest groups. For expansion-minded governors, framing could be used as a heuristic to enact public policy that was at odds with the interests of at least one of these groups. Framing emerges during "pivot points," or narrow windows of opportunity for expansion. Each proposal, committee meeting, and revision of expansion amounted to a pivot or inflection point that allowed the governor to deploy certain frames. These fleeting opportunities, however, had an intended audience. Since Democratic lawmakers already supported expansion, governors did not need to "spin" expansion to gain their votes. Since Republican lawmakers opposed expansion for partisan (among other) reasons, governors sought to incentivize them to betray their party. The most effective strategy for governors was to choose frames that would appeal to Republican voters in Republican districts. Research indicates that partisans tend to communicate only with other co-partisans, because their messages are more likely to be received.[280] The interests and motivations of this narrow population informed which kind of appeals governors used in their frames. The next portion of my analysis focuses on what framing strategies the governors of Ohio, Tennessee, and Arizona and used.

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[279] Stephen Koff, "Congress gives millions to Ohio, whether it needs it or not," *The Plain Dealer,* August 11, 2010.
[280] David Broockman and Timothy J. Ryan, "Preaching To The Choir: Americans Prefer Communicating To Copartisan Elected Officials," *American Journal of Political Science* (early version published online, 2015).

Ohio and Arizona: Morals

In both Ohio and Arizona, Governors Kasich and Brewer invoked religious appeals. Justifying policy positions with reference to religion is nothing new. Kasich and Brewer exploited a puzzling and still-unexplained trend of higher-than-expected white American working class support for Republican office-seekers who usually promote policies out of step with these voters' material interests.[281] White working class Americans, the people who would most benefit from Medicaid expansion, resisted the policy. Governors tried to combat this by making religion-inflected appeals.

White working class Republican voters' inconsistency presents a conundrum for politics and policy outcomes. Scholars have suggested that perhaps working-class Republicans are misinformed about the policies they are supporting, and with more information, would vote differently.[282] Other research concludes that economic policies get "bundled" with divisive issues like abortion or gay marriage, which distorts voter preference.[283] Another predominant explanation is that voters vote in this surprising way because they prefer the moral values of the GOP despite disliking the economic policies themselves.[284] All these possible voter biases mean that framing Medicaid expansion as a moral or Christian obligation could influence the intended audience of framing—Republican voters in Republican districts—enough to give their Republican lawmakers a reason to support expansion.

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[281] Larry M. Bartels, "What's the Matter with *What's the Matter with Kansas?" Quarterly Journal of Political Science*, Vol. 1 (2), 2006, Page 201-226.
[282] Bartels, "What's the Matter with *What's the Matter with Kansas?"*

> The phenomenon of poor working class individuals voting against their class interests is ubiquitous. In the UK, the Conservative Party consistently earns a third of the urban working class' votes despite its upper class reputation. This puzzle was studied in Robert McKenzie and Allan Silver's *Angels In Marble.* Similarly, in Germany, working class voters favor the Christian Democratic Union (CDU) and Christian Social Union (CSU) alliance over parties that we would expect to better serve their economic interests.

[283] Monica Prasad et. al, "The Undeserving Rich: 'Moral Values' and the White Working Class," *Sociological Forum*, Vol. 24 (2), June 2009.
[284] Ibid.

Kasich's linkage of Medicaid expansion with Christian values comported with his reputation as a compassionate conservative.[285] Research on moral values and politics supports the notion that moral values "act as motivational guides" for leaders to justify particular actions.[286] In Arizona, Brewer had to contend with religious rebuttals against her decision to pursue Medicaid expansion. Brewer's opponents challenged her religious integrity to undermine support for Medicaid expansion. According to Arizona Republican House Appropriations Committee Vice Chair Justin Olson, "'there's a distinction between what Jesus did and lobbying Caesar.'"[287] Maricopa County (Arizona) Republican Party Chairman A.J. LaFaro proclaimed: "'Jesus had Judas. Republicans have Gov. Brewer.'"[288] These comments served to make Republican voters question Brewer's loyalty to her faith and made her actions seem morally—even theologically—questionable.

The hypothesis that moral appeals cloud policy preference is compelling, but does not support the evidence discussed here. Moral appeals may be effective, but for Medicaid expansion policy, morality was not reason enough for voters in Republican districts to sway their elected officials. Working class voters should support politicians whose policies hurt them because those leaders are seen as supporting bills with Christian morals. However, in Arizona and Ohio, where the governors engaged with moral frames, very few Republican lawmakers were won over by their constituents' preferences. Doing "the Christian thing" may boost the governor's reputations, but was not a significant force in persuading Republican voters' minds.

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[285] Olasky, *Compassionate Conservatism: What It Is, What It Does, and How It Can Transform America*.
[286] Linda J. Skitka and Christopher W. Bauman, "Moral Conviction and Political Engagement," *Political Psychology,* Vol. 29 (1), 2008, Page 32.
[287] Jeremy Duda, "Supporters, opponents of Arizona Medicaid expansion clash at hearing," *Arizona Capitol Times*, March 20, 2013.
[288] Ibid.

Tennessee and Arizona: Medicaid Policy Heritage

In Arizona and Tennessee, governors framed Medicaid expansion as a continuation of their state's existing legacy of Medicaid. This "heritage" frame urged voters to consider Medicaid expansion in a historical and indigenous context. Governor Brewer spun the strengths and politics of her states' Medicaid program to assure voters that additional Medicaid expansion comported with their past voting record, which had favored other expansion-like initiatives. Two prior voter referendums set the precedent for favoring Medicaid expansion. Brewer also urged voters to be proud of Arizona's Medicaid program.[289] She portrayed AHCCCS as having successfully addressed cost-control concerns by exploiting private insurance and adhering to free-market principles. This programmatic legacy evolved from a sense of entrepreneurship early in the lifespan of Arizona Medicaid. In Tennessee, Haslam suggested that Medicaid expansion could begin to correct some of TennCare's administrative and financial deficiencies, and restore the program to its original capacity. TennCare had been innovative and trailblazing when it was first created, but administrative mismanagement and insufficient budgeting led to TennCare's downward spiral despite the promise of improvement.

It is highly unlikely that framing Medicaid expansion as familiar, indigenous policy is a pivotal reason why expansion passed in Arizona or why it failed in Tennessee. However, the fact that both governors used overlapping frames suggests that there are common arguments that elected officials recognize to be valuable and salient appeals.

Did Framing Matter?

Considering the diverse political environments and the breadth of frames used in Ohio, Tennessee, and Arizona, how much did framing matter in the outcome of expansion? Broadly,

[289] Tennessee's Medicaid program is called TennCare. Arizona's Medicaid program is called AHCCCS.

framing made a modest impact on Medicaid expansion in these states. Framing would be a significant factor for expansion if the governors changed the way that Republican voters in Republican districts perceived Medicaid. However, Arizona was the only state studied where the legislature was on board with expansion. Framing may have changed public perception of expansion—making it appear highly partisan, contentious, and dramatic—but framing did not alter outcomes positively. Although governors may not have achieved their desired outcome, framing still matters. Perhaps interest group framing overpowered the individual governors' frames, or elite framing confirmed Republican lawmakers' hesitation on expansion. Framing is still important even if it does not produce positive outcomes.

In Ohio, despite Kasich's moral frames, the legislature held fast, forcing the governor to bypass traditional policymaking and use the Controlling Board. Kasich failed to make the religious aspects of expansion resonate with Republican voters in Republican districts to such a degree that Republican voters pressured their representatives to change their position. Instead, framing served to rationalize his use of the highly controversial Controlling Board because Kasich's expansion frames fit with his political reputation.

In Tennessee, Haslam's frame of Tennessee-bred Medicaid expansion proved unsuccessful. The unraveling of the state's Medicaid program at the turn of the century could not be re-framed as a positive opportunity for growth and innovation. This was despite many empirical advantages: higher rates of insurance would improve poor health outcomes, expansion would not incur new state spending, and Tennessee legislators would be able to use other states' best practices for expansion.

Finally, in Arizona, the only case where both the House and Senate approved expansion, Medicaid expansion was strategically bundled with the state budget to optimize expansion.

Framing may have allowed the subset of Republicans who voted in favor of the budget to escape from voter scrutiny. But it is more plausible that the political consequences of stalling on the budget were greater than the cost of expanding Medicaid.

Although framing appears to have unsuccessfully convinced its intended audience—Republican voters in Republican districts—framing still informed the public narrative and political strategy. Framing still matters without outcomes changing, as is the case in Ohio, Tennessee, and Arizona. These cases show that politicians on all sides of the issue devote a lot of thought to framing expansion. Also, it is possible that framing succeeded even when expansion failed. In other words, Americans for Prosperity (AFP) in Tennessee successfully linked expansion with President Obama, contributing to expansion's failure in the legislature. That frame—associating Medicaid expansion with the unpopular president—helped produce the group's desired policy outcome. As these case studies revealed, governors were not alone in seeking to persuade Republican voters in Republican districts through frames. Framing did not necessarily fail in Tennessee just because expansion failed; rather, it appears that interest groups' frames were more effective than the governor's frames.

The Future of Medicaid Expansion Framing

Existing literature suggests that the durability of laws depends on the environment in which they were first ratified. Policymaking is altered by many factors: administration, national or international events, proximity to election year. [290] Those conditions influence the likelihood of downstream policy amendments. Thus, we would expect politicians to point to the circumstances that led to positive policy outcomes when subsequent reforms or amendments are

[290] Forrest Maltzman and Charles R. Shipan, "Change, Continuity, and the Evolution of the Law," *The American Journal of Political Science*, Vol. 52 (2), April 2008, Page 254.

proposed. Particular political conditions can make framing more or less important for determining political outcomes.

Here I explore how framing interacts with the dynamic policymaking process at the state level. Although Medicaid expansion will be credited to the governors who oversaw its legislative approval, policies evolve over time, and particularly, across gubernatorial administrations. Similarly, the role of framing evolves as leadership changes. Framing depends on whether a politician is introducing a policy or undoing a policy.

Framing thus remains relevant, as many seek to undo Medicaid expansion. Governors must bear in mind which frames were used to successfully pass Medicaid expansion and then design new appeals for a changed audience in order to reverse course. Once an expansion bill is passed, what frames must be used to undo the bill or chip away at portions of the bill? Part of the answer lies in Paul Pierson's work on welfare state retrenchment. By retrenchment, he means, "cut[ting] social expenditure, restructur[ing] welfare state programs to conform more closely to the residual welfare state model, or alter[ing] the political environment in ways that enhance the probability of such outcomes in the future." Pierson argues that the political forces explaining policy establishment differ from those explaining its retrenchment. [291] Can welfare policies survive today's period of fiscal austerity, which is a common prescription for America's current economic and political climate?

In order to successfully eliminate redistributive policies, like Medicaid expansion, governors must minimize the costs associated with cutting social spending. To do so, Pierson asserts that elected officials obfuscate, limiting the traceability of policy change. This protects their electability and reputation within the party for supporting the overall party mission. Also,

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[291] Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (New York: Cambridge University Press, 1994), Pages 6 and 17.

diffusing costs over time rather than introducing them all at once to a concentrated population minimizes political mobilization against those outcomes. Finally, politicians are often incentivized to make policy changes complex—hindering the media's ability to convey changes to the public, and thereby paralyzing public protests.[292]

These strategies are obviously relevant to framing's role in Medicaid expansion. The heavy lifting is not over once the legislature votes on expansion. Even if expansion is successful, elections, economic crises, or shifting political agendas can alter the environment in which expansion was endorsed and provide the conditions for a policy reversal.

Policy retrenchments have come to fruition in a handful of states that expanded Medicaid. As discussed earlier, elections have the power to change the political conditions under which expansion is considered and embraced. In Arizona, the November 2014 gubernatorial election altered the future prospects of a successful Medicaid expansion. Brewer's successor, Republican Doug Ducey, proposed a number of limits to Medicaid expansion upon assuming office. However, he has not yet entirely dismantled the program. Why would Arizonians, who had just supported a pro-expansion governor, soon elect a staunchly anti-expansion governor? There is no clear answer.

If he successfully cuts Medicaid expansion, Ducey would be undoing a high-profile program that was recently implemented. Ducey framed his Medicaid cutbacks as promoting individual responsibility by discouraging reliance on government services while simultaneously protecting the most vulnerable populations who needed health insurance.[293] Whittling down eligibility will be more difficult now since expansion has already passed than it would have been to prevent expansion from happening in the first place. Compared to other long-standing

[292] Ibid., Pages 19 and 21.
[293] Ken Alltucker, "Ducey's Medicaid reform plan raises questions, concerns," *The Arizona Republic,* August 17, 2015.

democracies, the U.S. has a particularly arduous environment for reversing policies because there are an unusually high number of veto players. Thus, changing the policy status quo is a challenge.[294] Critics of Ducey's reform suggest he is implementing a program to "blame the poor and make sure there's no way…to get out of poverty."[295] Ducey and his health policy team insist that their expansion alterations promote more fiscally sound behaviors surrounding health insurance. The Ducey administration will have to create their own set of frames to garner support for expansion cuts. Another challenge specific to retrenchment as it relates to Medicaid expansion is that it appears that expansion policy produced tangible benefits—more people with health insurance, lower uncompensated care costs for hospitals, fewer emergency room visits—undoing expansion must overcome the seemingly persuasive humanitarian frame.

The events that have transpired in Arizona since Ducey's election demonstrate that the frames employed to retrench expansion are defensive and reflect the potential for harm or loss. In contrast, frames needed to implement a policy tend to emphasize the benefits of expansion for the state and the individual. While Governors Brewer, Kasich, and Haslam tried to rally support from Republican voters in Republican districts, post-expansion governors must frame expansion retrenchment to appeal to the General Assembly. These framing appeals are different from the counter-arguments that Brewer, Haslam, and Kasich contended with as they pursued expansion. Arguing that the federal government funding might not pan out after 2020 is not a counter-frame. Rather, it weakens the primary frame that expansion takes advantage of free federal money. This distinction is important because frames subtly change how voters think about budgets or social welfare.

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[294] Alfred Stepan and Juan J. Linz, "Comparative perspectives on inequality and the quality of democracy in the United States," *Perspectives on Politics,* Vol. 9 (4), 2011, Page 844.
[295] Miriam Wasser, "Ducey-Care Only Makes It Harder for the Poor, Critics Say," *Phoenix New Times,* August 4, 2015.

Elections changed the conditions for Medicaid expansion in Kentucky as well. Republican governor Matt Bevin pledged to reverse the "unsustainable" and "unaffordable" Medicaid expansion in his 2015 campaign.[296] Bevin's predecessor, Democrat Steve Beshear, enacted expansion via executive order.[297] Despite Kentucky's new identity as the prototypical ACA success story—expansion contributed to a 10% drop in uninsured individuals within just one year—Bevin was still elected by a nine point margin.[298]

Angel Strong, an unemployed nurse from Jackson County, Kentucky, where 34% of the population lives below the poverty line, is on Medicaid. She voted for anti-Medicaid Bevin because of his positions against abortion and same-sex marriage. As told to a reporter, "My religious beliefs outweigh whether or not I have insurance."[299] Perhaps the surprising victory of anti-expansion candidates in Arizona and Kentucky can be attributed to the fact that American voters do not vote based on candidates' positions on health issues.[300] Instead, Achen and Bartels assert, voters adjust their own policy views based on candidates' social identities rather than candidates' policy preferences.

Given the challenge of retrenchment and the evolving nature of state politics, successfully framing Medicaid requires the perfect storm. Although framing may not predict policy outcomes, it still matters for public understanding of policy and the vitality of policy after its initial implementation. In Ohio, Tennessee, and Arizona, voter support for expansion as indicated in polls was not significant enough to sway legislators who seemed more accountable

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[296] Ashley Lopez, "Kentucky's New Governor Could Roll Back Medicaid, Even As State Benefits," *National Public Radio,* December 8, 2015.
[297] Ibid.
[298] Dan Witters, "Arkansas, Kentucky See Most Improvement in Uninsured Rates," *Gallup,* February 24, 2015.
Bevin garnered 53% of the vote, compared to his Democratic challenger who earned 44%.
[299] Lopez, "Kentucky's New Governor Could Roll Back Medicaid."
[300] Christopher H. Achen and Larry M. Bartels, *Democracy for Realists: Why Elections Do Not Produce Responsive Government* (Princeton: Princeton University Press, 2016.)

to partisan and ideological expectations. Even when the expansion debate was shifted to issues of morality or fiscal necessity, governors were all but required to employ unusual and extraordinary means to implement Medicaid expansion.

Chapter 7

Conclusion

"…and we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care."

—President Barack Obama, March 23, 2010

Six years have passed since President Obama suggested that America should consider healthcare as a right for its citizens. Not only is the ACA's success unclear, but crucial parts of the policy have yet to be implemented to their full potential. Obama's intentions in 2010 have been dashed in part by state irresolution. The politics of Medicaid expansion are not over. States that have not yet expanded can still opt to do so, while states that have expanded Medicaid can undo or curtail the program. Medicaid expansion in conservative environments is not only about who controls the General Assembly or the governorship. Expansion politics are national, regional, local, and individual.

Medicaid expansion produced complex state politics, as evidenced by the above case studies and discussion of framing. Aside from the question of whether framing contributes to positive expansion outcomes, an important lesson from this research is that people in power—political elites—think that framing matters. Governors, and politicians generally, spend substantial resources devising strategic messages based on public opinion polls and focus group feedback. These efforts are based on the premise that framing can produce different outcomes, but the accuracy of this belief is unclear. Political psychology scholarship posits that individuals are vulnerable to frames because they are uninformed and subject to politicians' suspect

motivations. But my research shows that elite manipulation does not change public preferences in a way that modifies policy outcomes. Framing may alter polling data, but the translation of that effect to actual public policy outcomes is shaky at best. My research demonstrates that the supposed risks of elite framing are not so alarming because elite frames interact with a multitude of messaging sources and do not alone produce unexpected policy results. Governors were not alone in seeking to persuade Republican voters in Republican districts through frames. Just as the federalists had their anti-federalists, pro-expansion governors had anti-expansion foes—and there were many of them. Thomas Nelson and Donald Kinder describe framing as a contest; the governor is just one participant in the frame game.[301] Future research might focus less on framers only as proponents of Medicaid expansion, and instead consider Nelson and Kinder's observation and look at the more difficult idea of framing as a competition. If in fact framing is a multi-player contest, concerns that the future of democracy is in peril because of elite framing are overreaching.

Nonetheless, framing does have a certain power in politics. An additional hurdle for future Medicaid frames will be the shifting demographics of the program. As a means-tested welfare program, Medicaid is often seen as a redistributive government handout for minorities and poor women and children, although whites are more likely than blacks to receive welfare overall. A redistributive welfare policy for non-whites is not a strong selling point for American public policy. But as the entire premise of healthcare is shifting post-ACA, Medicaid will encompass more than just the poorest of the poor, changing the demographics of beneficiaries and the images associated with the program. Increasing the income threshold to 138% FPL means that in addition to the poorest individuals who already qualify for Medicaid, more "just-

[301] Thomas E. Nelson and Donald R. Kinder, "Issue Frames and Group-Centrism in American Public Opinion," *Journal of Politics*, Vol. 58 (4), 1996, Page 1057.

poor" and poor Americans will enroll in the program. In the vast majority of states, this population will include minority populations as well as whites. This shift has the potential to complicate conventional, racially charged characterizations of Medicaid. Beyond the scope of the American healthcare landscape, framing strategies for welfare and other social issues reveal demographic and ideological trends of Americans. As the effects of the ACA and its subparts fully flesh out, frames that contributed the implementation of these policies will become increasingly relevant as policies are revised under new administrations and especially as Americans become more accustomed to having health insurance.