The Politics of Need: Examining Governors' Decisions to Oppose the "Obamacare" Medicaid Expansion

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Abstract

This article explains governors' decisions to support or oppose Medicaid expansions offered under the 2010 Patient Protection and Affordable Care Act. We theorize that governors' decisions to oppose the funding should depend on both political demands and the level of need in the state, though politics and need are often in tension. We find that governors' partisanship and the composition of the legislature have substantively meaningful effects on governors' decisions, but the level of need in the state exerts little effect on governors' decisions. This suggests that for high profile, highly politicized issues such as the Affordable Care Act, political considerations outweigh the needs of citizens and state economic conditions in gubernatorial decision making.

Keywords

health policy, public policy, governors, executive politics, legislative/executive interaction, legislative politics, federal/state, federalism, Bayesian statistics, quantitative methods, methodology

Introduction

"I cannot in good conscience deny Floridians access to healthcare," Gov. Rick Scott (R, FL) on deciding to accept Medicaid expansion following long-time opposition to Obamacare, February 20, 2013.

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"I'm trying to determine how the Medicaid expansion is going to pay for the surgery to remove the knife planted in my back," Henry Kelley, Florida Tea Party blogger, March 5, 2013.

—Alvarez (2013).

The statements from Florida Governor Rick Scott and Florida Tea Party activist Henry Kelley illustrate the difficulty that Republican governors faced in deciding whether to accept generous federal aid to expand Medicaid under "Obamacare." Scott entered Florida politics in 2009 by establishing an antihealth reform political action committee. He opposed reform throughout his closely fought successful gubernatorial campaign in 2010, in which he received substantial Tea Party support. To the dismay of key Tea Party supporters, though, Governor Scott dropped this key policy position by 2013, noting that the Supreme Court upheld the law and that to turn away federal money is negligent. Other governors face similar decisions. They are faced with conflicting demands from their party's legislative delegations, their core constituents, and citizens as they make policy decisions. This article seeks to explain why some governors opposed the Medicaid expansions and other governors did not.

Health care reform is the central accomplishment of the Obama administration. It has been a source of conflict between the parties since its passage in February 2010. The Patient Protection and Affordable Care Act (referred to interchangeably as the Affordable Care Act, ACA, or "Obamacare") is a complex bill that was designed to improve U.S. citizens' health care coverage and to extend coverage to a large portion of the millions of U.S. citizens who had no health insurance in 2010. One important piece of the policy's design was a Medicaid expansion in which the national government would assume initially all and eventually 90% of the cost of Medicaid for a previously non- Medicaid-eligible portion of the population, which is the group that is most at risk for being uninsured. In June 2012, though, the Supreme Court ruled that portion of Obamacare to be in violation of U.S. law and provided states a way to retain their existing Medicaid programs while rejecting the expansion (Rosenbaum and Westmoreland 2012).

The Court's Medicaid ruling was a surprise. The U.S. District and Appellate court decisions that preceded the June ruling did not address the Medicaid expansion issue, focusing instead on whether the national government could legitimately require persons to purchase health insurance. The Court upheld that portion of the ACA. The Court's Medicaid ruling gave U.S. governors the unexpected power to oppose expanding their Medicaid programs as required under the original law.[1]

Politics after Obamacare and the Medicaid Expansion

The ACA was passed under a unified Democratic administration with no Republican support, a circumstance that has fueled conflict between the parties. Republican criticism of the law contributed to their winning the U.S. House in 2010 (Balz and Branigin 2010; Brady, Fiorina, and Wilkins 2011; Campbell 2010). Complaints and warnings about Obamacare also figured prominently in the GOP platform in 2012 (Thompson

2012), and the number of U.S. House votes for its repeal, defunding, or prohibition topped 40 in September 2013. The attorneys general of 26 states mounted legal challenges to the law, which culminated in *National Federation of Independent Business v. Sebelius* (132 S. Ct. 603, 2011) being argued before the U.S. Supreme Court. Some states refused to establish health exchanges, which are the marketplaces through which citizens are to shop for and purchase their mandated health insurance (Rigby 2012). The federally established "health navigators" who were intended to help provide information about state insurance exchanges were a point of contention in some states. Insurance lobbyists in several states convinced legislators to pass laws to limit navigators' abilities to perform outreach (Kusnetz 2013). In short, national and state-level groups spent enormous time and efforts to defeat or block Obamacare.

The Court's 7-2 vote determined that states could not be forced to expand their Medicaid programs, despite a generous federal subsidy. (The Court upheld the legality of ACA with a 5-4 vote.) While the Court's 2012 decision was an overall victory for supporters of ACA, its Medicaid decision introduced an unexpected barrier to the policy's implementation and shifted the opposition's strategy.

As of October 22, 2013, 29 governors supported the expansion (though fewer saw it passed into law by their legislatures), 16 opposed it, and 5 were weighing their options. All Democratic governors supported the expansion, but not all Republican governors opposed the proposal. Ten Republicans supported the expansion, 5 were undecided, and 16 Republicans opposed it.

States' Preferences for Federal Money Differ

The refusal of Medicaid expansion under the ACA does not indicate a general disavowal of federal funds going to the states that rejected it or a stand against the federal deficit. In the past, governors typically accepted Medicaid expansions as a form of "free" federal money, and U.S. House and Senate members claimed credit for those expansions as a benefit to the states that was a bargain due to the steep subsidy (Brown and Sparer 2003). Of course, the money is never free, but Medicaid is highly subsidized, although it constitutes a large portion of states' spending even with the subsidies. The rejection of the Medicaid expansion seems understandable in light of the strong stand some Republicans have taken against the ACA, but is also surprising given that some states have high number of uninsured citizens who would gain health insurance coverage from the Medicaid expansion.

Both liberal-leaning and conservative-leaning states have refused federal funds at times in the past 50 years, for both practical and ideological reasons (Nicholson-Crotty 2012). Some states take cues from the federal government on health care spending, others are not as welcoming (Weissert and Scheller 2008). The division over Medicaid expansion is consistent with other recent partisan divisions, but differs in part because of Medicaid's prominence in state health coverage and its crucial role in the ACA plan.

The 1994 Contract with America was a precursor to the recent refusal by some Republican governors to expand Medicaid. Although Medicaid was not considered in the Contract, some Republican governors pushed for an end to the Medicaid
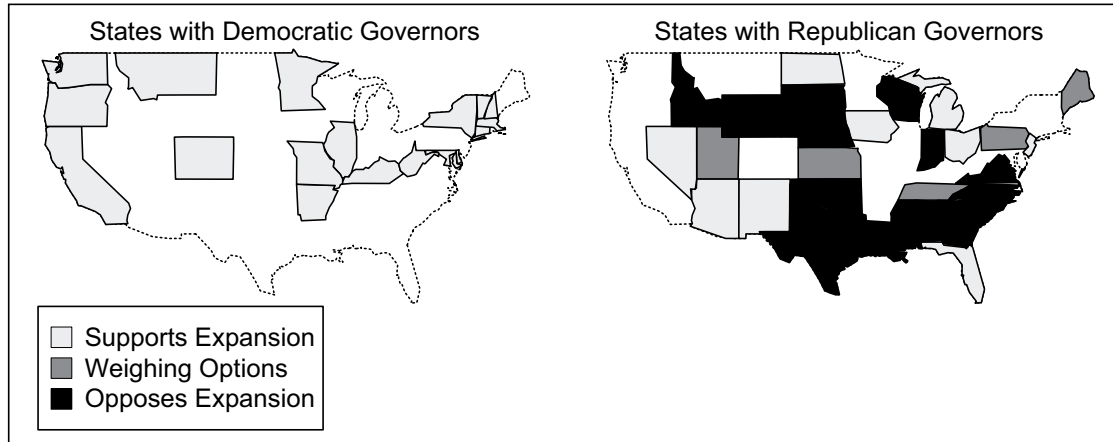
Figure 1. Governors supporting and opposing the expansion.
Note. Dark gray indicates states whose governor opposes the expansion. Light gray indicates states whose governor supports the expansion. Notice that all Democratic governors support the expansion while some Republican governors support the expansion and others oppose it. The Democratic governor of Hawaii and the Republican governor of Alaska are not shown, who support and oppose expansion, respectively.
Source: Authors' map using information from Kaiser 2014.

entitlement in favor of a more limited block grant program. Their success was stymied by the Clinton administration's reaction to the 1994–95 budget shutdown, in which the administration successfully created fears among the elderly about the effects of the block grant on nursing home care and care for special needs children. By 1996, despite early signs that the block grant initiative might succeed, the Republican push for Medicaid block grants was defeated (Thompson 2012; Figure 1).

The GOP governors' failure to secure a block grant for Medicaid in the mid-1990s led Republicans not to seek large Medicaid changes until fairly recently. Block grants and other proposals to cut Medicaid did not re-emerge until 2011, with the rise of the Tea Party bloc in Congress (Thompson 2012). If the block grant scheme supported by the Republican-led U.S. House had become law in the 2012 fiscal year, the effect would have been a huge cut in Medicaid spending, about $1.4 trillion, in addition to repeal of the ACA (Kaiser 2012). It is reasonable to expect that this antipathy toward Medicaid expansion among some Republican legislators may inform gubernatorial actions on program expansion as governors weigh the political costs and benefits of accepting the funds.

Despite their early disavowal of ACA and their states' participation in the legal challenge to the law, some governors have softened on their prior rejection of the Medicaid expansion. Republican governors who once opposed the expansion have shifted to supporting it, sometimes prefacing their acceptance of Medicaid funds with a disavowal of Obamacare. Ohio Governor John Kasich said of the uninsured "What are we going to do, leave them out in the street, walk away from them when we have a chance to help them?" (Klein 2013). His support of the Medicaid expansion was met with strong criticism from conservative groups and failed to receive support from the Ohio legislature, leading Kasich to circumvent the legislature and use a state board to

bring about the expansion. Governor Jan Brewer (R, AZ), who initially opposed the ACA, signed the expansion into law in June, 2013 after a protracted fight with conservatives in the Arizona House and Senate, with whom she was once joined in opposition to Obamacare. Florida's Scott shifted to support the Medicaid expansions after being assured that Florida would be allowed to continue with its managed-care style Medicaid program. It was not supported in the legislature, and he did not call a special session to address Medicaid. Kasich and Brewer, both strong governors, passed the expansion over the objections of their legislatures. Scott acceded to his lower House's demands and did not expand the program even though he had the support of the Senate, which was controlled by his party.

Governors May be Wary of Medicaid Expansion. Governors are often held responsible for state economic performance and spending regardless of whether they are able to affect either (Brace 1993). Medicaid is an enormous and constantly growing portion of state budgets, which crowds out other state spending needs (Altman and Beatrice 1990; Weissert 1992). Medicaid payments consumed nearly 24% of state budgets in 2011–12. They ranged from a low of 9.3% in Wyoming to a high of 30.1% in Florida in fiscal 2012 (National Association of State Budget Officers [NASBO] 2012). Medicaid is a state-federal program designed to provide the indigent or medically indigent access to mainstream medical care. The national government pays at least 50% of states' program costs, but can pay as high in 83% in states with lower median family incomes. It is not organized on a health delivery model, but is simply a payment system that relies on private providers as a source of care. The strain between the desire to provide access through generous eligibility and service coverage and the need to control Medicaid are long-standing problems faced by states and Medicaid program administrators (Holahan and Cohen 1986).

Under the ACA Medicaid expansion, the national government agrees to pay states 100% of state Medicaid costs for people with incomes as high as 138% of the federal poverty level through 2017, after which yearly reimbursement levels decline and are fixed at 90% beginning in 2020. The expansion would do much to increase health insurance coverage for the portion of states' citizens who do not have insurance. State governments recognize that the money is not free in the long run since they must pay 10% of the bill for persons who are at or below 138% of the federal poverty level in 2020. Some critics warn that the federal government may simply remove support for Medicaid with a change of party control of Congress, leaving the states responsible for the program's entire price (Coburn and Jindal 2013; Singer 2013).

The national government has not reneged on Medicaid spending commitments in the past, despite threats to block grant the program. The amounts states receive through the Federal Medical Assistance Percentages (FMAPs) have changed as states' wealth has changed.[2] Income increases in the South and Southwest have resulted in those states receiving lower FMAPs and higher state Medicaid shares. Income declines relative to national income per capita in parts of the East and the Midwest have produced increases in FMAPs (and lower state Medicaid shares) in those areas (Miller 2011). The lowered FMAPs may have greater effects on budgets in low-tax southern states,

and state governments in those states may be especially wary of increased Medicaid burden. Thus, there is some evidence of change in FMAP among the states, but no evidence of the U.S. government refusing to pay for Medicaid benefits.

There is also concern among some observers that states may experience a "woodwork" or "Medicaid surge" effect upon implementation of ACA. The concern is that new Medicaid enrollees and latent enrollees—those who were previously eligible but did not enroll—may come to the program in response to new knowledge about their eligibility and produce payment increases that are more costly to the states than expected (Lewin Group 2013). Existing research shows increased knowledge of Medicaid eligibility to increase program enrollment and service use (Stuber and Bradley 2005). Thus, there may be some reason to believe that Obamacare, with its health navigators and other outreach efforts to increase public knowledge, may produce higher Medicaid enrollments and spending for states.

Why Might Governors Refuse the Obamacare Medicaid Expansion?

Governors face a constant tension over their ties to their party, public opinion, the state legislature, and the public good. We theorize that each of these factors weighs on governors' decisions, and we use this framework to model their decisions empirically. The first three factors relate specifically to the political context of reform, and the fourth relates directly to need for health insurance.

Politics

Political beliefs and ideology affect Medicaid decisions, and partisan conflict has defined much of the debate over health reform (see, for example, Grogan and Rigby 2009). Governors often oppose an opposite-party president's position, but opposition is tempered by concern for the state budget. For example, several Republican governors willingly accepted Obama administration Recovery Act funds in 2009 (Pear and Goodman 2009), and governors typically accepted Medicaid expansions mandated by the national government regardless of party (Brown and Sparer 2003). However, in the case of the Medicaid expansion under the ACA, when the issue relates to key component of the Democratic president's signature legislative achievement, we expect the probability that a Republican governor opposes the president to be large. Similarly, Democratic governors should be substantially less likely to oppose the president on this highly salient, partisan issue. Rigby (2012) notes that partisan politics are the main influence on state government behavior on the choice to create state health exchanges, and the same may be true of the Medicaid expansion, even with such a large amount of aid available. This leads to the first hypothesis.

> **Gubernatorial Partisanship Hypothesis:** Republican governors are more likely to oppose the Medicaid expansion funds than Democratic governors.

Second, governors are accountable to a constituency, so they pay attention to voter preferences and opinion. Indeed, if governors cannot appeal to the majority of the voters in their state, then their future political prospects seem bare. Republican governors are more likely than GOP legislators to support redistributive policy spending because it benefits that statewide constituency from which they must seek support (Barrilleaux and Berkman 2003; Lewis, Schneider, and Jacoby 2013). Therefore, if the people of a state have a generally favorable view of the ACA, then we expect that governors will be less likely to oppose the expansion.

> **Public Opinion Hypothesis:** Governors are less likely to oppose the Medicaid expansion funds as the percent of the state with a favorable view of the ACA increases.

Third, any decision to accept Medicaid funds must pass through the legislature. Governors should be more likely to oppose the funds when they can expect their decision to oppose expansion to be supported by the state legislature. In particular, governors can expect fellow-opposition if their legislature is controlled by Republicans. This leads to the final hypothesis concerning politics.

> **Legislative Partisanship Hypothesis:** Governors are more likely to oppose the federal Medicaid expansion if the state legislature is under Republican control.

Citizen Needs

Regardless of party or public opinion, we expect governors to be responsive to the needs of the public. The proposed expansion is the most generous Medicaid reimbursement in the program's history, and most observers expected states committed to reducing uninsurance would adopt that portion of the ACA willingly. Given the effectiveness of past Medicaid expansions on insurance coverage (see, for example, Kail, Quadagno, and Dixon 2009), the decision to refuse a federal subsidy that would provide insurance to large uninsured populations is an extreme political choice. However, states vary in their need for a Medicaid expansion. While some states would benefit a great deal from the expansion, other states would benefit less.

In 2011, about 48.6 million noninstitutionalized adults between the ages of 18 and 64 were uninsured, about 15.7% of the noninstitutionalized adult population (Todd and Sommers 2012). The bloc of persons who are most likely to take advantage of the Medicaid expansions are those who will gain services as a result of the expansion, people whose incomes equal 138% of federal poverty level or less. Demand for expanded insurance should increase where there is more unrealized demand, for people who live in states that provide coverage at levels below the 138% mark. Two specific groups stand to benefit from expansion: the uninsured and health care providers.

The size of the uninsured population among the states may affect states' choices to expand Medicaid. Medicaid expansions were the sole effective tool used by states to increase health insurance coverage in the aftermath of the Clinton health reforms

(Barrilleaux and Brace 2007; Bernick and Myers 2008; Kail, Quadagno, and Dixon 2009), but only a handful of states with the most generous prior Medicaid policies used that approach to reducing uninsurance. Thus, Medicaid expansion is a policy tool that has proved to work well in reducing the numbers of uninsured in the states.

Health care providers also stand to gain from the expansion, especially in states with large numbers of uninsured. Expanding health coverage reduces the uncompensated care burden for providers, so that health care suppliers, hospitals, clinics, participating physicians, managed-care organizations, pharmacies, and other providers also stand to benefit from broader Medicaid coverage, which makes it more likely that they will get paid for the services they provide. Thus providers, especially not-for-profit and public hospitals, support Medicaid expansions. The not-for-profit hospitals are especially keen to see Medicaid expansions, because those expansions lead to expansions in state disproportionate share payments (DSH), which are payments made in addition to regular hospitalization for hospitals that treat large uncompensated care populations. With Medicaid expansion, the national government will cease to make DSH payments, which will harm the finances of hospitals with large uncompensated care burdens. The goal of the ACA is to reduce uninsurance, which would reduce uncompensated care. States that do not expand Medicaid are placing an increased burden on their not-for-profit hospitals, which provide more uncompensated care than for-profit hospitals.

Thus, the benefit that each state received from the expansion seems to increase with the size of the uninsured population. This leads to the hypothesis relating to needs.

> **Needs Hypothesis:** Governors are less likely to oppose the federal Medicaid expansion funds as the percent of uninsured in their state increases.

In summary, we expect governors' decisions to be affected by some mixture of their state's political circumstances and the health coverage needs within their state, and we present four hypotheses that fall within this heading. Now, we turn to measurement and estimation.

Empirical Analysis

Our outcome of interest is executive opposition to the Medicare expansion, so our outcome variable equals one if the governor opposes Medicaid expansion and zero otherwise.[3] We model the outcome using logistic regression as a simple linear function of the explanatory variables along with several control variables.[4] Our explanatory variables of interest are an indicator for whether the governor is a Republican, an estimate of the percentage of a state's citizens with favorable view of the ACA, an indicator for whether the legislature is controlled by Republicans, and the percentage of the state's population that is uninsured.[5] We use four other explanatory variables as controls. First, we include a measure of fiscal health, using the states' year-end reserves as a percentage of total spending and intended to capture states' ability to pay.[6] Second, we include the states' current Medicaid multiplier (its FMAP) to capture the relative

Table 1. Governors' Opposition to Expansion by Partisanship.

	Supports expansion	Opposes expansion
Democratic governor	19	0
Republican governor	15	16

Note. Notice that the data are quasiseparated in that no Democratic governor opposes expansion.

attractiveness of the new Medicaid money relative to the current rate. For example, it could be that the national government's offer to pay 90% of the new Medicaid expenses is not attractive to Mississippi, for whom the national government already pays 74% of Medicaid expenses. Third, African Americans and, fourth, those living in cities are more likely to enroll in Medicaid, so we include controls for the percent of the state that is non-white and the percent of the state living in metropolitan areas. We scale each explanatory variable to have mean zero and standard deviation 0.5, with the exception of binary explanatory variables, which we simply center by subtracting the mean. This allows us to place a common prior distribution on all coefficients (Gelman et al. 2008) and more directly compare the magnitude of the coefficients (Gelman 2008).

The usual likelihood estimation fails in two important ways with our data. First, and most importantly, the data are quasiseparated (Zorn 2005). The data reported in Table 1 show that being a Democrat governor predicts nonopposition perfectly. In this situation, maximum likelihood does not provide reasonable estimates.[7] As a solution, we follow Gelman et al.'s (2008) suggestion to build in a small amount of prior information into the estimation through a (scaled) Cauchy prior distribution. The prior for the model coefficients takes the form of a Cauchy distribution centered at zero with scale 2.5 (with a scale of 10 for the intercept).[8] The Cauchy distribution has very heavy tails, which allows very large coefficients, but places higher prior weight on coefficients that are between −5 and 5. Because continuous variables are rescaled to have mean zero and standard deviation one-half, a logistic regression coefficient of five means that a two standard deviation increase in continuous measures or change from zero to one in a dichotomous measure increases the probability of an event from 0.01 to 0.50 or from 0.50 to 0.99. Our prior simply suggests that effects larger than this are less likely, but not impossible.[9]

Second, the *N* of 50 states is too small to rely on asymptotic variance estimators. While maximum likelihood estimators are normally distributed about the true mean with the smallest possible variance for large sample sizes, these properties might not hold for small samples (Casella and Berger 2002; Train 2009).[10] Thus, instead of relying on the analytical (asymptotic) standard errors and assuming normality to conduct hypothesis tests and calculate confidence intervals, we use MCMC to directly sample from the posterior distributions of the model coefficients and transform these simulations to obtain substantively meaningful quantities of interest (King, Tomz, and Wittenberg 2000). We use the median of the posterior simulations as our point estimates and the 5th and 95th percentiles to construct a 90% (equal-tailed) credible interval. To
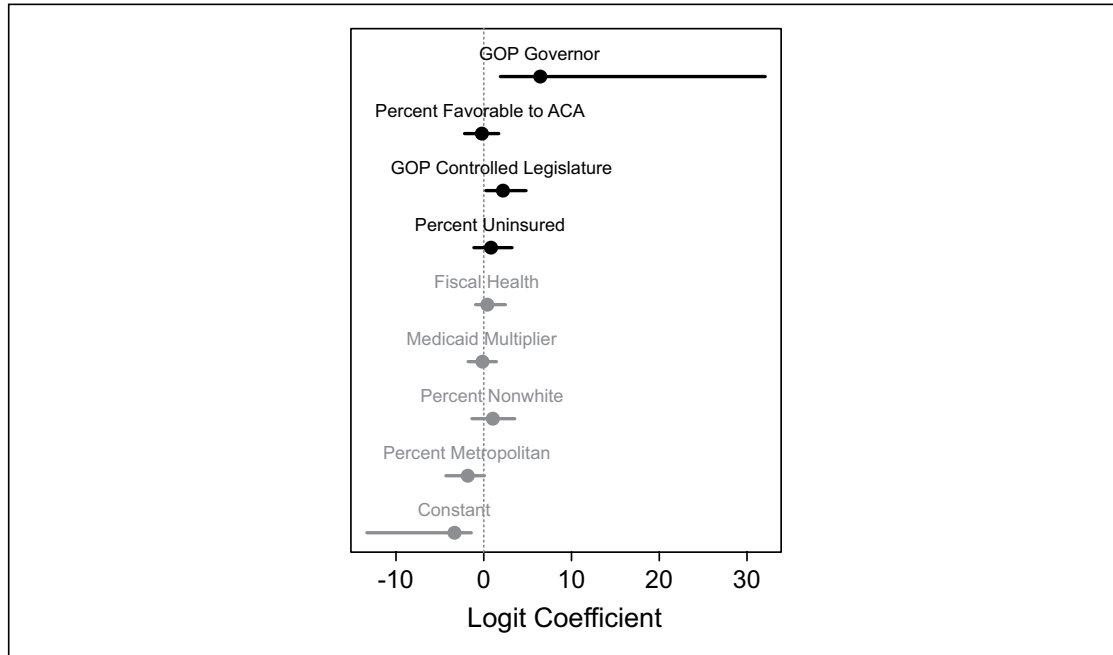
Figure 2. Coefficient estimates for a logit model of opposition to the expansion.
Note. Notice that the results are generally consistent with the hypotheses, except the percent uninsured does not have the expected large effect. ACA = Affordable Care Act.

assess the evidence for our hypotheses, we simply calculate the proportion of the simulations that are consistent with the research hypothesis, which we denote as $Pr(H_r|data)$. The quantity $1 - Pr(H_r|data)$ can be interpreted as the probability of the null hypothesis given the data and is approximately comparable to a classical p value for the directional hypotheses we examine.[11] Thus, $Pr(H_r|data) = 0.95$ is evidence comparable with $p = 0.05$. Because we have a small sample of 50 states, we interpret $Pr(H_r|data) > 0.95$ as strong evidence, $0.90 < Pr(H_r|data) < 0.95$ as moderate evidence, $0.85 < Pr(H_r|data)$ 0.090 as weak evidence, and $Pr(H_r|data) < 0.85$ as ambiguous evidence.

Estimates

Figure 2 shows the coefficient estimates and Table 2 summarizes the evidence for each hypothesis. Notice first that the data strongly support the Gubernatorial Partisanship Hypothesis ($Pr(H_r|data) > 0.99$), which suggests that Republican governors are more likely to oppose the expansion than their Democratic counterparts. In particular, in otherwise "Republican" states (GOP-controlled legislatures, 38% view ACA favorably, and all other variables set at their sample medians), having a Republican governor (as opposed to a Democratic governor) increases the chance of gubernatorial opposition by about 49 [23, 74] percentage points.[12] In otherwise "Democratic" states (legislatures not controlled by GOP, about 51% view ACA favorably, and all other variables set at their sample medians), having a Republican governor increases the chance of gubernatorial opposition by about 9 [1, 38] percentage points.[13]

Table 2. Evidence for the Main Hypotheses.

Hypothesis	$Pr(H_r \mid \text{data})$	Evidence
Gubernatorial partisanship	>0.99	Strong evidence in favor
Public opinion	0.57	Ambiguous evidence in favor
Legislative partisanship	0.97	Strong evidence in favor
Need	0.25	Ambiguous evidence

Note. Notice that we have at least weak evidence for each of the political hypotheses, but the evidence for the needs hypothesis remains ambiguous. The probabilities of the research hypothesis given the data are calculated by simply computing the proportion of the Markov chain Monte Carlo (MCMC) draws that have the correct sign (i.e., consistent with the research hypothesis). Because our sample is quite small, we interpret probabilities near 0.9 (comparable to the frequentist $\alpha = 0.1$) as offering some evidence for our hypothesis.

We have little support for our Public Opinion Hypothesis (). However, it is important to avoid drawing the conclusion that governors are unresponsive to public opinion because we consider this evidence ambiguous at best. First, in otherwise Republican states, increasing the favorability of the ACA from 38% to 51% leads to a 4 [−28, 35] percentage point decrease in the chance of gubernatorial opposition. Thus, the effect is in the hypothesized direction and effects as large as 35 percentage points are plausible based on the data (Rainey 2014a). Second, the substantively small estimate and ambiguous evidence is not robust to alternative measures and methods. We discuss this in more detail below but provide a brief preview now. First, an Obama victory in their state in 2012, for example, seems to make governors much less likely to oppose the expansion. Second, random forests suggest that alternative measures of public opinion, such as Obama's vote share in 2012 and the general ideology of the state, are important predictors of whether a governor opposes the expansion. Thus, we are hesitant to draw strong conclusions about the effect of public opinion on governors' decisions, since the inference depends on the measure and the method.

We have strong evidence for our Legislative Partisanship Hypothesis ($Pr(H_r|\text{data})) = 0.97$), which suggests that governors of states with a Republican-controlled state legislature are more likely to oppose the expansion. According to our statistical model, having a Republican legislature in an otherwise Republican state increases the chance of opposition by about 36 [0.05, 0.64] percentage points.[14] The model suggests that the composition of the legislatures has essentially no effect in otherwise Democratic states because Democratic governors are highly unlikely to oppose the expansion.

We have no evidence for our Needs Hypothesis ($Pr(H_r|\text{data}) = 0.25$), and the effect actually goes in the *wrong direction* so that the probability of opposing expansion *increases* with need. Again though, it is important to avoid drawing the conclusion that a variable has "no effect" based only on a lack of statistical significance (Rainey 2014a). Instead, we consider all effects contained in the 90% credible interval plausible. In Democratic states (states in with a Democratic governor and legislature that Obama won in 2012), the credible interval suggests that the effect of increasing the percent uninsured from 10% (25th percentile; North Dakota, Pennsylvania, and

Table 3. Evidence that Politics Matters More than Need.

Hypothesis	$Pr(H_r \mid \text{data})$	Evidence
The effect of gubernatorial partisanship is larger than the effect of need.	>0.99	Strong evidence in favor
The effect of public opinion is larger than the effect of need.	0.75	Weak evidence in favor
The effect of legislative partisanship is larger than the effect of need.	0.96	Weak evidence in favor

Note. Notice that while the evidence only weakly supports the claim that public opinion and legislative partisanship matter more than need, the data offer strong support for the claim that gubernatorial partisanship and legislative composition have a larger impact on the decision to oppose expansion than the level of need.

Maryland) to 17% (75th percentile; Arkansas, Arizona, Louisiana, Mississippi) is probably smaller than 1% and has almost no effect. This is simply because the probability that these governors oppose the expansion is nearly zero, regardless of the magnitude of the need.

However, the story is much different in Republican states, those with ACA favorability of 38% and with Republican governors and legislatures. Regardless of the level of need, governors in Republican states are quite likely to oppose expansion. When the percent uninsured is only 10%, the model suggests that these governors have about a 47% [19, 76] chance of opposing the expansion. Increasing the percent uninsured to 17% *increases* the chance of opposition to about 60 [31, 84] percentage points. Thus, although we cannot be confident about the sign of the difference, the model estimates that an increase in the level of uninsurance from 10% to 17% leads to an 11% [−15, 42] *increase* in the likelihood of opposition. Notice that the model suggests that a 15% decrease is plausible, so that we cannot rule out a small to moderate effect of need, but these effects pale in comparison with the estimates for the partisan control of the governorship and legislature.

These hypotheses—that the political variables have a larger effect than the need variables—are directly testable. Since the change in probability of opposition depends on the values of other explanatory variables, the fairest test is to compare the logit coefficients directly.[15] Table 3 shows the evidence from each of these tests. While the evidence for opinion is somewhat weak, we have strong evidence that gubernatorial partisanship and legislative control have a larger effect on the decision to oppose the expansion of Medicaid than the level of need in the state. It is worth noting, though, that the evidence that public opinion has a larger effect than need depends on the measure. We discuss this in more detail below.

Just to get a sense of how much more politics matters than need, consider the relative effects of the governor's partisanship and the level of need. Shifting from a Democratic to a Republican governor in an otherwise Republican state (38% favorable to the ACA and a GOP-controlled legislature) increases the chance of gubernatorial opposition by about 49% [23, 74]. Shifting from a low-need to a high-need Republican

state (38% favorable to ACA and a Republican governor and legislature) *increases* the chance of opposition by about 11 [−15, 42] percentage points. This suggests that moving to a Republican governor has a 61% [25, 96] larger effect than increasing the percent without insurance from 10% to 17%.

Robustness Check 1: Alternative Measures of the Key Concepts

To evaluate the robustness of our conclusions, we re-estimate the model using several plausible alternative measures of the key concepts. In place of the state-level estimates of ACA favorability, we consider Obama's share of the two-party vote in 2012, whether Obama won the state in 2012, a generic measure of state ideology (Tausanovitch and Warshaw 2013), the percent of the state that supports the Medicaid expansion, and the percent that supports the Tea Party. We also consider alternative strategies for modeling the composition of the legislature by including an indicator for GOP-controlled House, an indicator for GOP-controlled Senate, or both indicators. As an alternative measure of need, we consider states' shares of DSH payments per capita, the percent below 138% poverty, the rate of low birth weight infants, the heart disease death rate, and life expectancy. Table 4 summarizes the evidence for the main hypotheses using these alternative measures.

Notice that although the amount of evidence for the hypotheses might increase or decrease at the margin, the results are quite similar to those from the main model, and in some cases, are much stronger. The alternative measures of public opinion all have the correct sign, except for the percent supporting the Medicaid expansion. While the evidence for the hypothesis ranges from moderate to ambiguous, notice that the results are generally consistent with the smaller effect of public opinion that we find in the main text. Further, notice that the most obvious cue that governors face, whether Obama won their state in 2012, has a large effect, while much more subtle cues (such as the percent supporting the Medicaid expansion) have much smaller effects.

Regardless of how we measure the composition of the legislature, the model suggests that the legislature matters. However, it seems that the composition of the lower house has the largest effect. Lower houses' members are in districts with a smaller population size and may be better able to demand particular policy outcomes than members in the upper chamber who must represent a larger population in the electorate.

Perhaps the most interesting result from these additional analyses come from the alternative measures of need. All but one of the alternative measures suggests evidence against the hypothesis that governors of states with greater levels are *more* likely to oppose the expansion. Indeed, the coefficient for low birth weight rate infants is among the largest for the variables we consider and is in the wrong direction, providing strong evidence that governors in more needy states are more likely to *oppose* the expansion. As a whole, these alternative measures suggest more strongly than the level of uninsurance that the level of need in a state has little to no effect on governors' decisions to support or oppose expansion.

Table 4. Evidence for the Main Hypotheses Using Alternative Measures.

Hypothesis	Variable	Expectation	Estimate	$Pr(H_r \mid data)$	Evidence
Public opinion	*Percent favorable to ACA*	−	−0.21	0.57	Ambiguous evidence
	Obama's 2012 vote share	−	−0.82	0.76	Ambiguous evidence
	Obama victory in 2012	−	−1.85	0.94	Moderate evidence in favor
	State ideology	+	2.33	0.92	Moderate evidence in favor
	Percent supporting Medicaid expansion	−	1.01	0.17	Ambiguous evidence
	Percent supporting Tea Party	+	1.09	0.82	Ambiguous evidence
Legislative composition	*GOP controls both house and senate*	+	2.31	0.97	Strong Evidence
	GOP house	+	6.48	1.00	Strong evidence in favor
	GOP senate	+	2.17	0.97	Strong evidence in favor
	GOP house	+	6.44	0.98	Strong evidence in favor
	GOP senate (as separate variables in the model)	+	0.21	0.55	Ambiguous evidence
Need	*Percent without health insurance*	−	0.91	0.25	Ambiguous evidence
	DSH payments per capita	−	1.21	0.10	Moderate evidence against
	Percent below 138% poverty	−	0.53	0.35	Ambiguous evidence
	Low birth weight	−	2.76	0.02	Strong evidence against
	Heart disease death rate	−	1.23	0.09	Moderate evidence against
	Life expectancy	+	−1.50	0.09	Moderate evidence against

Note. The original measures appear in italics. Notice that the evidence for the Public Opinion Hypothesis is generally weak, though correctly signed except for the percent supporting the Medicaid expansion. The evidence for the Legislative Composition Hypothesis remains consistent with the estimates, though it seems that the state house matters more than the state senate. Finally, and more importantly, notice that all the measures of need are incorrectly signed and, in most some cases, we have moderate to strong evidence against the hypothesis. Thus, it seems that governors of states in greater need are more likely to oppose the expansion. GOP = Grand Old Party (Republican Party); ACA = Affordable Care Act; DSH = disproportionate share payments.

In addition to the absolute impact of need, we care about the effect of need compared to the effect of politics. Table 5 provides a summary of the evidence for the hypothesis that politics matters more than need for the three political variables and five alternative measures of need. Notice that, with the possible exception of life

Table 5. Evidence that Politics Matters More than Need for Alternative Measures of Need.

Hypothesis	DSH payments per capita	Percent below 138% poverty	Low birth weight rate	Heart disease death rate	Life expectancy
The effect of gubernatorial partisanship is larger than the effect of need.	1.00	0.99	1.00	1.00	0.96
The effect of public opinion is larger than the effect of need.	0.88	0.71	0.95	0.88	0.27
The effect of legislative partisanship is larger than the effect of need.	0.99	0.95	1.00	0.99	0.55

Note. Notice that the evidence for the hypothesis that politics matter more than need is supported more strongly by the alternative measures than the percent uninsured, with the possible exception of the life expectancy. DSH = disproportionate share payments.

expectancy, the evidence is generally stronger for the alternative measures. This provides especially strong evidence for our conclusion that politics matters more than need.

Robustness Check 2: Random Forests and Variable Importance

As an alternative to the parametric (and linear) approach above, we use random forests (Breiman 2001; Hill and Jones 2014) to evaluate the robustness of our claim that politics is more important than need. Random forests are simply a large collection of decision trees used to predict gubernatorial opposition to the Medicaid expansion. This approach allows a variety of interactions and nonlinearities to enter the model (Biau, Devroye, and Lugosi 2008) and, especially useful to us, provides a robust tool for assessing variable importance (Strobl et al. 2007).

Intuitively, random forests are a collection of decision trees that classify (with error) governors' decisions to support or oppose the expansion. Each tree in the forest is built as follows:

1. Select 32 cases (63%) without replacement to train the model. Set the remaining 18 test cases aside. Use training cases to build a decision tree to classify governors as opposing the expansion or not.
2. Select three predictors at random from a larger set of predictors. We consider eight variables measuring the political context and six variables measuring the level of need. The political predictors are the governor's partisanship, the percent favorable to the ACA, Obama's vote share in 2012, the general ideology of the state, the percent supporting the Medicaid expansion, the percent supporting the Tea Party, whether the state house is controlled by Republicans, and whether the state senate is controlled by Republicans. The need predictors are the percent without insurance, the percent below 138% of poverty, DSH

payments per capita, the low birth weight rate, the heart disease death rate, and life expectancy. From these three, choose the variable and, if continuous, the split that best classifies the observations in the training data. Continue drawing three predictors at random and optimally partitioning the data using these predictors until the splits are no longer statistically significant.

3. Use this tree to predict the 18 test cases. Compute the proportion of cases correctly predicted as a measure of model accuracy.
4. Now randomly permute each variable (one-by-one) and recompute the proportion of cases correctly predicted. If the variable is an "important" predictor of opposition, then the accuracy of the tree should decrease substantially. However, if the variable is "unimportant," then the accuracy should decrease only slightly or not at all.

To grow a forest, as opposed to a single tree, we simply repeat this procedure 1,000 times (i.e., grow 1,000 trees). This collection of trees serves as a forest and we assess each variable's importance by averaging the difference in accuracy before and after permuting each variable across the entire forest. This difference serves as our point estimate of variable importance. Larger values (positive and away from zero) indicate that a variable is more important and smaller values (closer to zero or negative) indicate that a variable is less important. To assess the uncertainty around these point estimates of variable importance, we follow Hill and Jones (2014) and grow 100 forests on bootstrap resamples of the data (i.e., we grow 100 forests by resampling 50 states with replacement 100 times and growing a forest of 1,000 trees on each resampled data set). We use the collection of average variable importance measures from these forests to obtain a 90% confidence interval around the estimates of variable importance. The estimates and 90% confidence intervals for each variable are shown in Figure 3.

The results offer stark support for our claim that politics matters more than need. Even without a close examination of the results, almost all of the political variables are important predictors and almost all of the need variables are *un*important. These results suggest that if one wanted to predict which governors oppose the expansion, one probably wanted to know whether the lower house is controlled by Republicans, Obama's margin of victory in 2012, the governor's partisanship, and perhaps the ideology of the state. All of these variables focus on the immediate political context.

However, a close examination only strengthens the evidence for the claim that politics is more important than need. The least important political variable is the percent of a state supporting the Medicaid expansion. This measure is based on a July 2012 Kaiser Family Foundation survey immediately following the Supreme Court decision. Since the political implications of the expansion were not yet well known, this measure might not be the best indicator of the electoral cost that Republican governors might pay for "supporting Obamacare."

The most important need variable, the low birth weight rate, seems somewhat important, but works in the wrong direction—governors in states with more low birth
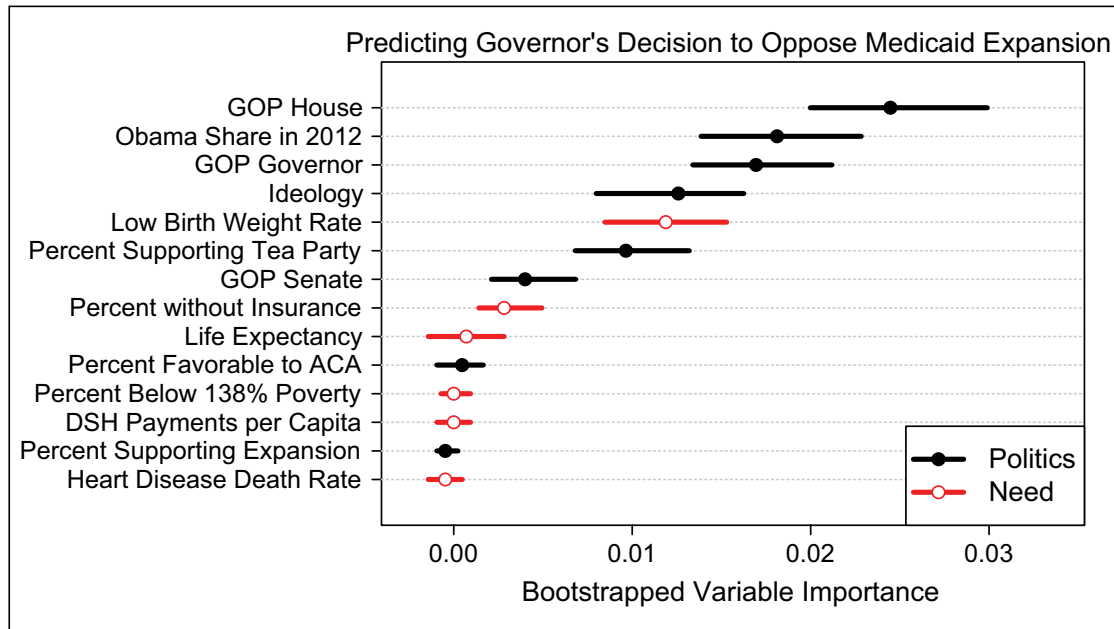
Figure 3. Bootstrapped variable importance from random forests.
Note. Notice first that most of the political variables are more important than the need variables. This offers clear evidence that politics matters more than need. Second, the only need predictor that seems to perform well is the low birth weight rate. However, this variable works in the wrong direction, so that states with more need are more likely to oppose the expansion. Finally, notice that the results for the measures of public opinion are inconsistent. Obama's vote share in 2012 is one of the most important predictors of opposition and the percent favorable to the ACA and the percent supporting the expansion are two of the least important predictors. ACA = Affordable Care Act.

weight infants are more likely to *oppose* the expansion. The random forests also suggest that the percent without insurance might have some predictive power, but again, it has an effect in the wrong direction.

The only real surprise from this analysis is the relative unimportance of the favorability of the ACA. However, it has the smallest effect of the political variables in the main model, and the random forests suggest it plays a relatively unimportant role as well. In short, the random forests offer solid evidence in favor of our claim that politics matters more than need.

Conclusion

In the case of Medicaid expansion under the ACA, economics and need have little effect on policy, which is driven almost entirely by partisan politics and possibly public opinion in states in which governors reject the expansion. The measures of need and "economics"—urbanization, DSH payments to hospitals, the percent of people uninsured—have no statistically meaningful effect and a much smaller substantive effect than the political variables. The results hold under a number of tests for robustness. Thus, the model suggests that governors' decisions are driven almost entirely by politics, which is unique in comparative state policy research.

It remains to be seen whether the politics of Obamacare and Medicaid expansion in the states play out similarly in other policy areas. Rigby (2012) notes that politics for the most part determined whether states created health market exchanges, an important piece of the ACA design. In comparative state politics research, the consensus for nearly 30 years has been that politics and economics jointly determine policy outcomes (Plotnick and Winters 1985; Wright, Erikson, and McIver 1987). Studies of state health policy design and spending have been part of that consensus (see, for example, Barrilleaux and Miller 1988; Kousser 2002). It may be the case that the heightened partisanship that has characterized the Obama era may be unique in our experience and that political and economic factors may prove useful in explaining policy outputs in other areas and in other times. It is also possible that state executives and legislatures may be more guided by partisanship than they were in the past, which may lead to increasingly partisan policy outcomes.

The Supreme Court shifted the terms of the ACA debate in June 2012 when they affirmed the constitutionality of the individual mandate but gave state governments the choice to accept or not accept Medicaid expansions to cover 138% of the federal poverty population. Evaluations of the 1990s-era state health reforms revealed Medicaid expansion to be the single most effective way to expand insurance coverage, so state decisions to refuse those benefits may prove to have substantial effects on access to care for the poor or working poor. In addition, citizens of states that do not expand Medicaid under the federal plan are ineligible for the subsidies for low-income persons that are available under ACA.

A possible silver lining in the Medicaid expansion dispute is that it provides an opportunity for evaluation of the decision's effects on health access and spending. State welfare reforms in the 1990s allowed states considerable discretion in program design, which has made possible evaluations of specific program features (see, for example, Soss et al. 2001). The Medicaid expansions may result in similar variation in programs under the ACA and afford similar program analysis possibilities. Baicker et al. (2013, 1722) report that the persons who received Medicaid coverage under the 2008 Oregon randomized Medicaid enrollment had ". . . increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain" but the investigators report no marked improvement in health status among enrollees. The 2013 Medicaid expansion decisions may enable analysts to develop similar models using a nationwide panel in a natural experiment.

State governments rely on federal money for large portions of their budgets (Cho and Wright 2007) and the Medicaid expansion is certainly a large infusion of federal money. Refusal to expand the program means states are giving up billions of dollars that would flow into their health systems, boost their economies, and reduce uninsurance. On the other hand, states that refuse the money may be staking out a strong states-rights position, one that has received substantial support in the courts over the past 30-odd years (Hanson 2008, 24–36). The debate within states about whether to expand Medicaid is ongoing and often reflects tension between politics and need. It is unclear how citizens will respond to their states' refusing benefits that leave large

numbers of citizens without health insurance. But for now, in the tug-of-war between politics and need, politics seems to be winning.

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Notes

1. Kaiser Family Foundation (2012) provides a succinct discussion of the 2012 Court decision.
2. The FMAP is calculated: $FMAP = 1 - .45 \times [(State\ PCI)2 / (U.S.\ PCI)^2]$. A state with average income receives an FMAP of 55%, and no state may receive less than 50% FMAP, where the national government matches state spending dollar for dollar, and no state may receive more than 83% FMAP (Miller 2011).
3. We maximize our statistical leverage by combining governors who publicly support expansion and those who have remained quiet into a single "does not oppose" category. We combine the "Supports Expansion" and the "Weighing Options" categories for two reasons. First, the two are conceptually similar. We are interested in why governors would publicly oppose such a generous offer from the federal government and particularly how politics and need affect this decision. Given our question, the decision to support the expansion or remain quiet on the issue are similar. Second, our data do not offer sufficient information to parse out the different effects that our explanatory variables have across these different outcomes.
4. See Section 1 of the Technical Appendix for the details.
5. The state-level estimates of the percent with favorable views toward the ACA are computed using multilevel regression with poststratification, combining the January 2012 through November 2012 Kaiser Health tracking polls with 2000 Census data (Lax and Phillips 2009). See Section 2 of the Technical Appendix for the details.
6. Note that Alaska is an outlier on this measure, with 2012 year-end reserves of 260% of their total 2012 spending. The next largest is North Dakota at 75% and the smallest is California at −2%. In Section 3.4 of the Technical Appendix, we show that excluding Alaska from the analysis does lead to a substantively meaningful change in the effect of fiscal health, but it does not change the effects of our key variables. See Section 3.4 of the Technical Appendix for the details.
7. Quasiseparation leads to estimated coefficients and standard errors of infinity. In practice, though, the estimates and standard error will be unexpectedly large. How large the estimates will be depends on the numerical precision of the optimization routine. For example,

using R's default convergence criteria for the glm() function, the estimated coefficient for the GOP governor indicator is 19.5 with a standard error of 2,146.4. When we increase the convergence tolerance standards as much as possible, we obtain an estimate of 33.4 with a standard error of 15,395,829.3. Of course, neither estimate is statistically significant, despite the pattern being extremely unlikely under the null hypothesis of no effect. See Zorn (2005) for a detailed explanation of this pattern.

8. We intentionally include less prior information than we actually have as suggested by Gelman et al. (2008). However, in Sections 3 and 4 of the Technical Appendix, we show that our results are robust to a range of prior specifications including increasing and decreasing the scale within the Cauchy family and considering alternative families such as the normal and scaled *t* families. We also considered non-Bayesian approaches, including various combinations of Firth's penalty (Zorn 2005), asymptotic approximations (Gelman et al. 2008), and bootstrapping (Efron 1979).

9. Zorn (2005) suggests using Firth's penalty when facing separation (see Bell and Miller 2013; Firth 1993). This approach is similar conceptually to our own, but relies on Jeffrey's invariant prior distribution, which is not directly interpretable as prior information in the context of regression models. Instead, we prefer the Cauchy prior, since it allows us to directly interpret the prior as actual prior information (Gelman et al. 2008). However, in Section 3.3 of the Technical Appendix, we show that the results are substantively similar if we rely on Zorn's (2005) suggested approach of combining Firth's penalty with likelihood profiling.

10. For the details, see Casella and Berger (2002), especially Theorem 10.1.6 (asymptotically distributed about the mean) and Theorem 10.1.12 (with the smallest possible variance). Train (2009, 200–202) discusses the asymptotic properties of MLE estimators and discusses using bootstrapped samples to obtain variance estimators. In Section 3.3 of the Technical Appendix, we show that the results are robust to using bootstrapping rather than MCMC. Another potential concern with small samples is that a single case drives the conclusions. In Section 3.4 of the Technical Appendix, we show that dropping any single state from the analysis does not change the substantive conclusions.

11. This comparability does not extend to situations in which the null or research hypothesis suggests that the effect lies in a noncontiguous region (e.g., Rainey 2014b).

12. The intervals given in parentheses are 90% credible intervals. We define "Republican" states (in part) to be those in which 38% view the ACA favorably because 38% favorability is the 25th percentile of the favorability measure. States such as Texas, Louisiana, South Dakota, and Tennessee have favorability measures near 38%. Similarly, we define "Democratic" states (in part) to be those in which 51% view the ACA favorably because 51% favorability is the 75th percentile of the favorability measure. States such as New Mexico, Oregon, Washington, and Maine have favorability measures near 51%. Utah has the lowest favorability at 27% and Hawaii has the highest at 63%.

13. While we discuss the difference in the effects across "Democratic" and "Republican" states, it is important to avoid drawing strong conclusions about the difference in these effects, since they are assumed by the structure of the model (Berry, DeMeritt, and Esarey 2014; Rainey 2014b; though see Berry, DeMeritt, and Esarey 2010). We present the effects in different contexts to give a sense of the magnitude of the estimates implied by the model, not to draw strong conclusions about the differences in the effects across contexts.

14. Unfortunately, we do not have sufficient data to parse out the separate effects of Republican-controlled, Democratic-controlled, and divided state legislatures. However, there are only four divided legislatures in the data (Iowa, Kentucky, New Hampshire, and New York). In

this situation, we draw heavily on prior literature to specify the model correctly. However, this conclusion is reasonably robust to alternative specifications, including a model that includes separate indicators for GOP control of the House and Senate.

15. Recall that the coefficients are comparable because we standardize all numeric explanatory variables to have mean zero and standard deviation 0.5 and simply center binary explanatory variables. This makes the magnitude of the coefficients comparable (Gelman 2008).

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